INCREASING ACCESS:
building working solutions

A Series of Community Voices Publications

BY

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ECONOMIC AND SOCIAL RESEARCH INSTITUTE

Community Voices

HEALTHCARE FOR THE UNDERSERVED

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INCREASING ACCESS: building working solutions

Featuring Examples from the Kellogg Foundation's Community Voices Initiative

prepared for

W.K. KELLOGG FOUNDATION

by

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ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

The Economic and Social Research Institute (**ESRI**) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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About Community Voices: HealthCare for the Underserved

Across the U.S., 13 communities form the building blocks of a national effort to heal the health care system. The national effort is called Community Voices: HealthCare for the Underserved and it is a five-year W.K. Kellogg Foundation initiative.

The W.K. Kellogg Foundation launched Community Voices in August 1998 to help ensure the survival of safety-net providers and to strengthen community support services given the unlikely prospect of achieving universal health coverage in the next five years. Building from the community level, the initiative gives the underserved a voice to help make health care access and quality part of the national debate. The underserved includes working poor, individuals or families who receive public assistance, and those who lack any or adequate health insurance. The size and scope of Community Voices reflects the compelling need to improve coverage and access and include the 70 million Americans who currently have little or inadequate health care into the system, or stated differently, the 108 million that do not have insurance that insures access to primary health care including coverage for oral health care services.

SUMMARY

The booming economy masks a disturbing trend in the U.S.: a growing number of people lack access to basic health care services. This report documents the extent of the problem, delineates the many forces driving barriers to access, and presents a comprehensive, multi-faceted framework for addressing the problem. It lays out a series of policy recommendations, along with a list of potential funding sources, and descriptions of promising community-based efforts geared to improving access to underserved populations.

The Access Problem

The "access problem" directly affects large numbers of uninsured working families with low/moderate incomes, children and adults who are eligible for government-funded insurance programs but are not enrolled, a group of people – mainly single adults – who are ineligible for both work-based and government-funded coverage, and disadvantaged populations who face a host of non-insurance barriers to care.

Over 44 million people lacked health insurance in 1998, and the number is expected to reach 52 to 54 million over the next decade even with continued economic growth. If the economy takes a downturn, the number would likely surpass 60 million.

Lack of affordable health coverage has consequences for both uninsured individuals and the health care system as a whole. People who lack coverage frequently delay or forego important preventive and primary care services, resulting in avoidable emergency room care and hospital admissions that drive up costs in the system. Employers incur costs associated with lost work time and diminished worker productivity when uninsured employees neglect health conditions. Physicians, hospitals, and other health care providers incur costs associated with bad debts and charity – costs that are increasingly difficult to pass along in today's competitive health care marketplace. To the extent that some of the cost of uncompensated care is passed on, we all pay higher health care premiums as a result.

We also pick up some of the tab for the uninsured as taxpayers. Outlays in federal and state programs are higher as a result of gaps in private insurance coverage (e.g., lower-wage workers without employer-sponsored coverage who qualify for Medicaid or whose children are covered under CHIP). And all Americans "pay" in terms of insecurity: we are all vulnerable to losing coverage if we lose a job; even temporary loss of coverage can lead to financial ruin if catastrophic illness occurs.

Lack of insurance is not the only barrier to receiving health care. A host of linguistic, cultural, racial, geographic, and organizational factors present impediments that jeopardize the health of large segments of our population. In addition, unsafe housing, poverty resulting from joblessness or low wages, poor nutrition, poor air quality, and other "social determinants" have an adverse impact on health for low-income individuals and families. The resulting, largely avoidable health problems reduce the productivity of our labor force and place a strain on hospitals as well as the entire health care system.

Thus, the access problem directly or indirectly affects all Americans and all sectors of society. The business community, federal and state governments (supported by taxpayers), health care providers, and patients themselves all share the burden. As a result, they should all be part of the solution. They all have something to gain through a better-designed system.

If we can cut through the rhetorical, and often ideological debate over how to address the access problem, we will realize that there are basically three sources of funds to improve coverage: employers, employees, and government. (Most economists believe that most or all of employers' payments are ultimately borne by workers). The challenge is to design a way to combine contributions from these three sources in a way that:

- Assures that working families' contributions are in line with their ability to pay;
- Recognizes the difficulty facing many smaller companies as they try to finance health coverage; and
- Strengthens government's commitment to public health and to ensuring basic health care within our mixed, public/private health care system.

Forces Driving the Access Problem

Factors contributing to the access problem include the following:

- A large portion of small firms is unable or unwilling to offer health coverage to their workers; cost is the major obstacle.
- The labor force includes a large number of part-time, temporary, and contract-based jobs that frequently do not include health coverage.
- Many workers – particularly those earning low wages – turn down an employer's offer of health coverage because they cannot afford their share of the premium.
- Many workers face problems retaining affordable coverage when they change jobs or lose their jobs; this is especially true for individuals with chronic medical conditions who may be offered only very expensive coverage.
- People buying coverage on their own face higher costs, fewer protections, and do not receive the tax benefits that people with work-based coverage receive.
- Health costs are accelerating again, making it more difficult to purchase health insurance, particularly for small businesses and individuals.
- Many children and adults who are eligible for Medicaid, CHIP, and other programs are not enrolled, often because they lack information about eligibility or refuse enrollment due to the stigma of welfare programs.
- Changes in welfare policies have contributed to a decline in Medicaid coverage; many people leaving welfare take jobs without health coverage, and they are unaware of Medicaid continuation options.
- Many adults without dependent children are ineligible for subsidized health coverage, and are "adrift" from both work-based and government-funded coverage.
- Changing demographics, including increases in minority and immigrant populations, will contribute to the rising numbers of uninsured in the future.
- The design of the health care delivery system imposes a variety of obstacles to timely access to health care services. They include: lack of transportation, childcare, and evening or weekend hours; inadequate staffing; language and cultural barriers; lack of respect; and others.
- Some employers do not provide paid sick leave or flexible hours to enable workers to take time to seek health care for themselves or family members. This can lead to delays in seeking needed care and ultimately higher costs and lost productivity.
- Many areas of the country are experiencing a shortage of primary care physicians and other medical professionals, and the pipeline of professionals in training contains too few minorities to meet the needs of vulnerable populations.
- Critical needs including oral health and mental health are often neglected and inadequately covered, even among people who have basic health insurance.
- Risk factors outside the health care system – such as poor housing conditions, violence, inadequate nutrition, and other factors associated with poverty – have an adverse effect on health.

Strategies for Broadening Insurance Coverage

The following policy recommendations, as part of a comprehensive reform strategy, are geared to broaden access to insurance coverage:

- Expand employment-based coverage by requiring employers to offer coverage or contribute to insurance pools; though controversial and subject to some adverse side effects, this reform is the most effective way to expand coverage within the private, employment-based insurance system. It requires:
  - Establishing purchasing co-operatives for small firms or "buy-ins" to existing group plans such as FEHBP or state employee health plans;
  - Providing subsidies or tax credits to vulnerable employers; and
  - Providing direct subsidies or refundable tax credits to low-income workers to help them afford their share of employer-sponsored coverage, and to low-income people purchasing COBRA coverage.

- Political realities may require a serious effort to provide strong incentives to employers to offer coverage, and individuals to obtain insurance, before enacting the above requirement. In addition to purchasing co-operatives and "buy-ins," this includes:
  - Providing substantial subsidies or tax credits to employers who newly offer coverage to employees;
  - Providing significant tax credits to purchase individual coverage for those remaining without access to employer-based coverage; and
  - Establishing state rate bands in the individual and small-group insurance markets to reduce the disparity in health insurance premiums related to risk factors.
- Increase enrollment of eligible populations into government-funded insurance programs. This can be accomplished through:
  - Conducting outreach through public awareness campaigns;
  - "Out-stationing" eligibility workers in a variety of community sites such as health clinics, child-care centers, schools, religious institutions, and social service agencies;
  - Holding eligibility workers accountable for erroneously denying benefits, and providing incentives to promote appropriate enrollments;
  - Simplifying the application process and providing information and application forms in multiple languages;
  - Computerizing the application submission and response process to reduce human bias and error, and speed turnaround; and
  - Instituting 12-month continuous Medicaid eligibility, "presumptive" eligibility, and single insurance cards that do not denote source of payment.
- Expand government-funded programs and develop new insurance products. This could include:
  - Expanding eligibility for existing government-funded insurance programs such as Medicaid, Medicare and CHIP (e.g., extending CHIP eligibility to parents, and allowing people with incomes above current cut-offs to "buy-in" to Medicaid or CHIP on a sliding scale basis; instituting a buy-in to Medicare for early retirees); and
  - Developing new insurance products tailored to the needs of vulnerable, low-income people who remain disenfranchised from other sources of coverage.

Overcoming Non-insurance Barriers: Redesigning the Delivery System

Enrollment in a public or private insurance plan does not by itself ensure utilization of appropriate health care services. A host of logistic, cultural, and organizational non-insurance barriers to care must be overcome to meet the needs of patients as they try to gain access to the system. Recommendations for reducing these barriers to access include:

- Strengthen the public health system and programs geared to training and placement of minority medical practitioners in underserved areas.
- Improve the primary care system and access to it by:
  - Ensuring accessible hours and locations for primary care clinics/providers, and ensuring adequate security for public safety;
  - Supporting school-based clinics by securing reimbursement and funding; and expanding services offered to meet needs such as preventive, dental and mental health care;
  - Conducting community assessments to ascertain gaps in services and to engage stakeholders in the process of access improvement;
  - Addressing unmet needs such as oral health and mental health through enhanced insurance coverage of these services, increased public awareness of the problems and treatment options, and facilitated entry into treatment;
  - Improving staffing through the use of allied medical professionals and the team approach to care delivery, and reducing language/cultural barriers through bilingual practitioners or liaisons and cultural sensitivity training; and
  - Strengthening health education and promotion, teaching prevention and wellness, and providing information about community resources.
- Make special efforts to assist vulnerable populations, including people with special health care needs

(e.g., AIDS, substance abuse, mental health problems), minorities, single low-income men ineligible for existing government-funded insurance, undocumented as well as legal immigrants, migrant workers, people returning to the community from the criminal justice system, rural populations, and homeless people.

- Build linkages between primary care sites and diagnostic centers, specialist physicians, and hospitals:
  - Helping patients navigate the health care system to ensure they get the services they need in the most appropriate setting;
  - Establishing a coordinated information system among the provider settings that assures confidentiality, to ensure that practitioners are abreast of prior treatments, medications, and other relevant aspects of a patient's medical history; and
  - Promoting a more comprehensive approach to disease management.
- Improve financial viability of safety net providers, enabling them to adjust and thrive in a changing environment. Possible strategies include:
  - Establishing state-wide indigent care reimbursement pools and supplemental state funding programs;
  - Paying safety net providers enough to enable them to meet the complex medical and social needs of a vulnerable population;
  - Merging safety net hospitals with other hospital systems to buttress bargaining clout;
  - Allowing safety net institutions greater flexibility in their labor-management relations, purchasing of supplies and equipment, and access to capital, while maintaining the commitment to indigent care;
  - Forming close relationships between safety net hospitals and community health centers to provide a ready source of patient flow;
  - Developing efficient, vertically-integrated systems;
  - Reducing excess hospital capacity, and re-deploying resources to meet vital community public health needs; and
  - Helping primary care clinics negotiate contracts with, and attract patients from managed care organizations; and helping safety net providers that are creating or joining HMOs to track data on cost and quality and work with state insurance regulators.
- Reduce risk factors associated with social determinants of poor health. This includes supporting or expanding successful programs geared to:
  - Improving housing and other environmental conditions to address and prevent problems associated with lead-based paint and asthma;
  - Educating children and parents about the relationship between the environment and health, for example through school-based asthma programs;
  - Improving nutrition of at-risk populations, for example through the WIC program;
  - Providing job opportunities and wages that allow families to achieve a standard of living with the nutrition, shelter, and other basic needs that are crucial to good health; and
  - Foster safe and healthy neighborhoods through an effective combination of creating opportunities (e.g., for education, training, and jobs) and reducing crime and unsafe living conditions that threaten people's health.

Financing Sources

In addition to contributions from employers and individuals, potential funding sources for the above efforts to improve access include:

- Tap unused federal CHIP funds to increase coverage to children and their parents;
- Use portion of federal TANF funds earmarked for outreach and enrollment initiatives to prevent changes in welfare status from causing people to lose health coverage;
- Cap open-ended tax subsidies;
- Reallocate a portion of disproportionate share hospital (DSH) funds;
- Use tobacco settlement funds;
- Develop community benefit legislation and conversion funds to require non-profit providers and

those converting to for-profit status to make a commitment to improving access for vulnerable populations;

- Reduce health system inefficiency and inappropriate medical care, and re-channel savings toward access expansion efforts;
- Coordinate or integrate funding from the array of categorical programs that address non-insurance barriers to care (e.g., food supplements, family planning, substance abuse treatment, transportation); and
- Utilize funds dedicated to housing, education, the environment, law enforcement and other "non-health" areas to improve conditions that affect health.

The report highlights a number of promising models to improve access to timely health care conducted as a part of the Community Voices initiative, composed of thirteen projects sponsored by the W.K. Kellogg Foundation. These projects feature local partnerships to broaden access to care and insurance coverage, as well as to strengthen the safety net. The report illustrates how Community Voices programs are working to enroll people eligible for, but not participating in government-funded programs, help small employers obtain affordable coverage, reduce language and cultural barriers, and work through community-based organizations to provide primary health and dental care to vulnerable populations.

This report concludes by emphasizing that the current barriers to health care access are leaving far too many Americans insecure about meeting their health care needs. Now is the time to address this problem. Improving access to health care not only brings security and peace of mind to millions of families, but also fosters a more productive workforce and cohesive society. Just as we all bear the cost of the access problem and must contribute toward the solution, we will all benefit from a better system.

1. INTRODUCTION

Despite a booming economy, more than 44 million Americans lack health insurance, and countless children and adults face cultural, linguistic, and organizational barriers to receiving health care. Social determinants such as unsafe housing and poor nutrition pose additional obstacles to good health for vulnerable populations. These access problems directly or indirectly affect *all* Americans, and the situation calls for action. While incremental efforts pursued over recent years generally have had modest but positive results, the growing number of people without access to health care demonstrates the need for a bolder, more comprehensive approach. At the same time, reforms must be realistic and politically feasible. Finding a balance between these two requirements is a daunting challenge. This report attempts to begin the process of meeting that challenge by presenting a framework for a public/private strategy to improve access for all Americans.

The following section briefly describes the extent of the access problem and its consequences, making evident the need for reform. Section Three presents the many diverse forces driving the access problem that preclude easy solutions. Section Four presents strategies geared toward broadening insurance coverage; including controversial approaches and an alternative, combination approach that tries to blend effectiveness with pragmatism. In Section Five we present ways to redesign the health care delivery system to assure that people facing a variety of non-insurance barriers to access actually receive a full range of health and social services on a timely basis. In Section Six, we present potential sources of funding for the recommended programs; financing options are clearly a critical element of a successful health care reform strategy. The report ends with a glossary of terms that briefly explains key government programs and issues related to the safety net.

The report highlights innovative efforts to improve access, such as those being implemented through the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved program. Successful initiatives tested on a small scale today could have tremendous impact if expanded for large-scale implementation.

2. WHAT IS THE PROBLEM?

Notwithstanding a tight labor market and strong economy, 44.3 million Americans did not have health insurance coverage in 1998, and the number of uninsured continues to rise each year.[1] Even if the economy remains strong over the next decade, a projected 52 to 54 million non-elderly people will be uninsured in the year 2009. If a downturn in the economy occurs, the picture will be even more dire, with as many as one in four non-elderly Americans – 61.4 million people – without health insurance in 2009.[2]

Who are the uninsured?

The majority of the uninsured are people tied to the workforce. About 80 percent of the uninsured in 1997 were full-time workers or their dependents.[3] Adults who work for low wages are the most likely to be uninsured: 17 percent of all full-time workers and 48 percent of full-time workers with incomes below the poverty line are without health coverage.[4] These workers are either not offered or are ineligible for coverage at their workplace, or they decline work-based coverage – generally because they feel they cannot afford their share of the premiums.

The uninsured who are not tied to the workforce often cannot afford private, individual insurance, and many are not eligible for government-funded health insurance programs such as Medicaid or the State Children's Health Insurance Program (CHIP). Others are not aware that they or their children are eligible for government-funded programs, or they fear participation because of their immigration status or the stigma of accepting "welfare."

[1] United States Census Bureau. *Health Insurance Coverage 1998.* Washington, DC, October 1999.

[2] Findlay, S. and J. Miller. *Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States.* National Coalition on Health Care, May 1999.

[3] Kaiser Family Foundation. *The Uninsured and Their Access to Health Care.* Fact Sheet, October 1998.

[4] United States Census Bureau, 1999.

It is essential to point out that the uninsured population is a "moving target." There are constant shifts, with new people losing insurance coverage as others attain it. This dynamic quality of the uninsured poses a difficult challenge to solving the access problem.

Why are we concerned about the uninsured?

Lack of health coverage has consequences for uninsured individuals, the health care system, and society as a whole. The uninsured are more likely to encounter difficulty obtaining care, and use fewer health care services. Many of the uninsured go without needed primary and preventive care that may avert a serious health crisis, and in fact, the uninsured often suffer adverse consequences from postponed or delayed care.[5] Among hospitalized patients, the uninsured are up to three times more likely to die in the hospital, and less likely to receive discretionary procedures than insured patients.[6]

Uninsured *children* who are in poor health receive significantly less care than do insured children in poor health, and this gap may be growing.[7] Uninsured children experience worse health outcomes and are more likely to be hospitalized with avoidable conditions than insured children.

When the uninsured do receive medical care, it is often in an inefficient way – using emergency rooms for routine care, and requiring hospitalization for avoidable flare-ups of chronic conditions, for example. Such inappropriate use of resources places a strain on hospitals and drives up costs in the entire health care system.

But the access problem indirectly affects *all* Americans. We are all vulnerable to losing coverage if we lose a job.[8] Even temporary loss of coverage can lead to financial ruin if catastrophic illness occurs.

And we all pay for this problem either directly or indirectly. Employers incur costs associated with lost work time and diminished worker productivity when uninsured employees neglect health conditions. Physicians, hospitals, and other health care providers incur costs associated with bad debts and charity – costs that are increasingly difficult to pass along in today's competitive health care marketplace. To the extent that some of the cost of uncompensated care is passed on, we all pay higher health care premiums as a result.

We also pick up some of the tab for the uninsured as taxpayers. Outlays in federal and state programs are higher as a result of gaps in private insurance coverage (e.g., lower-wage workers without employer-sponsored coverage who qualify for Medicaid or whose children are covered under CHIP).

Are there other obstacles to care?

Lack of insurance is not the only barrier to receiving health care. A host of linguistic, cultural, racial, geographic, and organizational factors present impediments that jeopardize the health of large segments of our population. In addition, unsafe housing, poor nutrition, poverty resulting from joblessness or low wages, and other "social determinants" have an adverse impact on health for low-income individuals and families. Multi-lingual nurses and physicians, transportation, outreach, nutrition counseling, and patient education are a few "non-insurance" services that could greatly enhance both health and access to health care, but are lacking in many isolated and disadvantaged neighborhoods.[9]

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[5] Rowland, D., J. Feder, and P. Keenan. "Uninsured in America: The Causes and Consequences." In S.H. Altman, et al., eds. *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* Chicago: Health Administration Press, 1998.

[6] Hadley, J., E.P. Steinberg, and J. Feder. "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcomes." *Journal of the American Medical Association,* 265(3): 374-9, 1991.

[7] Newacheck, P.W., J.J. Stoddard, D.C. Hughes, and M. Pearl. "Health Insurance and Access to Primary Care for Children." *New England Journal of Medicine*, 338(8): 513-9, 1998.

[8] In 1997, nearly one of three non-elderly adults was uninsured at some time during the previous two years. (*The Uninsured and Their Access to Health Care,* Kaiser Family Foundation Fact Sheet, October 1998.)

[9] Lewin, M. "Barriers to Health Care Access: Beyond Insurance." In J. Meyer and S. Silow-Carroll, eds. *Building Blocks for Change: How Health Care Reform Affects Our Future*. Washington, DC: Economic and Social Research Institute, 1993.

As with lack of insurance, these non-insurance barriers and social determinants affect all Americans. Largely avoidable, environment-related health conditions and delayed treatment raise health system costs and damage the health and productivity of workers and potential workers.

We must all share in the solution.

In sum, the "access problem" directly affects large numbers of uninsured working families with low/moderate incomes, children and adults who are eligible for government-funded insurance programs but are not enrolled, a group of people – mainly single adults – who are adrift from both our work-based and public assistance-based health coverage systems, and disadvantaged populations who face a host of non-insurance barriers to care.

The business community, federal and state governments (supported by taxpayers), health care providers, and patients themselves all contribute to the cost of the access problem. Since these parties all share this burden, they should all be part of the solution. They all have something to gain through a better-designed system.

If we can cut through the rhetorical, and often ideological debate over how to address this problem, we will realize that there are basically three sources of funds to improve coverage – employers, employees, and government. (Most economists believe that most or all of employers' payments are ultimately borne by workers). By drawing on these sources, we can move away from our current hodge-podge of limited and inadequate funds to selected providers to assist them with the burden of providing uncompensated care. As we extend health coverage to the uninsured, we will be able to reduce subsidies for safety net providers.

Few would contend that any one group should foot the whole bill for improving access; the challenge is to design a way to combine contributions from employers, workers, and government. Indeed, in some cities, pilot projects are underway to divide premium costs for uninsured workers into three equal parts paid by firms, workers, and government. Asking working families to contribute to the cost of coverage is important, but their share should be in line with their ability to pay. For lower-income families, this share must be supplemented by either the companies for whom the employees work, by government, or through some combination.

In this report, we present a comprehensive strategy that assists people who have difficulty affording coverage in a way that is consistent with our mixed, public/private health care system. The strategy affords considerable autonomy and independence for health care providers and recognizes the difficulty facing many smaller companies as they try to finance health coverage. It is a strategy in which we all share in the solution.

3 . Forces Driving the Problem

A number of forces contribute to the access problem, related to the structure of the voluntary employment-based health insurance system, the changing nature of the workforce, the rising cost of health care, the design of government-funded programs, forces outside the health care system that affect health, and other factors.

A large portion of small firms do not offer health coverage to their workers.

The voluntary nature of employment-based health coverage combined with the high cost of insurance results in many employers – particularly in small firms – simply not offering health insurance as a benefit to employees.[10,11] Forty-five percent of firms with 3 to 9 workers did not offer health benefits in 1999, compared to only eight percent of firms with 50 to 199 workers and one percent of firms with more

[10] There was a general decline in work-based coverage from the late 1980s through the mid-1990s: between 1987 and 1997, the portion of non-elderly population with employment-based coverage declined from 69.2 percent to 64.2 percent. (Employee Benefits Research Institute. *Sources of Health Insurance and Characteristics of the Uninsured.* Data from the U.S. Census Bureau's March 1998 Current Population Survey, December 1998.) In the late 1990s, work-based coverage rates leveled out.

[11] More than one-third of non-elderly people are not insured under employer-sponsored coverage. (Lyke, B. *Tax Benefits for Health Insurance: Current Legislation.* CRS Issue Brief, Congressional Research Service, Library of Congress. Updated April 5, 1999.)

than 200 workers.[12] In 1997, 35 million people worked in firms that did not offer insurance to their employees.[13]

The portion of Americans insured through their employer declined from 67 to 60 percent from 1977 to 1996, with minorities and workers without high-school diplomas experiencing the sharpest declines.[14] While one would expect the low unemployment rates and strong economy experienced since 1996 to lead more employers to offer health coverage as a way to attract and retain workers, we do not see evidence of this. The portion of firms with 3 to 199 employees offering health insurance remained unchanged at 60 percent between 1996 and 1999.[15]

Cost is the primary reason that employers do not provide health coverage to workers.[16] The cost of small-group insurance policies is substantially higher than for large groups, in part because insurers' marketing and administrative costs cannot be spread over a large enrollee base, and in part because of higher mark-ups to protect against adverse selection. The administrative burden on small employers is another obstacle, and employers are wary of establishing a new benefit with profits uncertain from year to year. Also, small-group premiums can be more volatile, changing as the health-risk profile of covered lives changes.

Further, the structure of the small-group insurance market has posed some barriers to small firms trying to obtain coverage. Historically, small-group insurers were able to exclude firms with high-risk employees, exclude individuals with high-risk profiles, and exclude or delay coverage for pre-existing conditions. Small-group insurance market reforms enacted by states and included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) placed limits on many of these obstacles, but the impact of these reforms has been modest. An estimated nine percent of workers in small firms obtained coverage as a result of small-group market reforms. The overwhelming majority of small firms did not respond to the changes, and cite high cost as the major obstacle to offering coverage.[17]

The problem of employers not providing health benefits is also evident in the area of retiree health coverage. The proportion of companies offering such coverage declined from 40 percent to 28 percent over the 1993-1999 period.[18] Even among large firms, the proportion offering retiree health benefits fell from 80 percent to 67 percent over this period.[19]

The labor force is shifting in the direction of jobs that frequently do not include health coverage.

An important factor contributing to the access problem is the changing nature of the workforce. Three related trends are resulting in more jobs that do not include health coverage.

- First, jobs have declined in the manufacturing sector and other industries with high union representation, which were associated with high insurance coverage rates. The movement is toward service sector jobs, which are less likely to offer coverage.

[12] Kaiser Family Foundation/Health Research and Educational Trust. *1999 Annual Employer Health Benefits Survey.* Washington, DC: October 1999.

[13] An additional 10.1 million people were ineligible for health benefits at their workplace. While many of the 45 million workers without access to health insurance from their workplace obtained coverage through other means (family member, another employment source, or individually purchased insurance), 17.8 million of these workers were uninsured in 1997. (Thorpe, K. and C. Florence. "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997." *Health Affairs,* 18:2, Mar/Apr 1999)

[14] Gabel, J.R. "Job-Based Health Insurance, 1977-1988: The Accidental System Under Scrutiny." *Health Affairs*, 18:6, Nov/Dec 1999.

[15] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[16] In one survey, 83 percent of small employers said the reason for not offering health insurance was that the premiums were too high. (Kaiser Family Foundation. *Small Employers and Health Insurance.* Fact Sheet, Web site 1999 <www.kff.org>.)

[17] Kaiser Family Foundation. *State Reforms of Small Group Health Insurance.* Fact Sheet, Web site 1999 <www.kff.org>.

[18] Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans 1999: Report of Survey Findings*. New York: Mercer, Inc., 1999.

[19] Kaiser Family Foundation. *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*. Washington, DC: October 1999.

- Second, the trend toward a global and information-based economy has contributed to a decline in demand for low-skilled workers in the U.S., resulting in reduced real wages and reduced portion of low-skilled workers with health benefits.[20]
- Third, there is a movement away from traditional wage and salary jobs, and toward "alternative" arrangements – part-time, temporary, independent contract, and consulting work – which are less likely to be eligible for work-based insurance. For example, about ten million workers were *not eligible* for the health plan at their workplace in 1997, generally because they did not work enough hours each week or weeks per year, they did not work for their employer long enough to qualify, or their status as a contract or temporary worker disqualified them for coverage.[21]

It is clear that the employment-based health insurance system has not adjusted to the "new" workforce. The growing number of people in the service sector and in alternative work arrangements indicates that unless the gaps are filled, there will be even less access to work-based health coverage in the future.

Many workers turn down an employer's offer of health coverage because they cannot afford their share of the premium.

For workers who do have access to employer-sponsored health insurance, a growing number are declining the coverage, most often because they feel they cannot afford their share of the premium. Employee contributions for work-based coverage have been rising as a percentage of the premium and in inflation-adjusted dollars. Employee contributions were on average 3.5 times higher in 1998 than in 1977 (using 1998 dollars), increasing from 20 percent to 27 percent of the premium over this period.[22] The 1999 average annual worker contribution for family coverage was almost $1,750, an amount that can be unaffordable, particularly among low-income workers.[23]

Between 1987 and 1996, the proportion of workers offered employer-sponsored health coverage who declined it rose from 11.7 percent to 19.9 percent.[24] In fact, the decline in employer-sponsored coverage during this period was due mainly to a reduced "take-up" rate, rather than a decline in the proportion of employers offering coverage.[25] Some workers decline coverage because they can obtain insurance through a spouse's health plan or other means. But in 1997, 2.5 million workers who were eligible for work-based insurance declined it and *remained uninsured*.[26] The vast majority of these workers (generally lower-income) desired coverage but considered it too expensive. Given other needs, such as housing and food, their required premium contribution was deemed too high a price to pay.

One encouraging note is a recent finding that among small employers (3 to 199 employees), more firms paid the entire premium for single coverage in 1999 than in 1996 – reversing the trend from 1988 to 1996.[27] It is not clear, however, whether the reversal will continue, given current acceleration of premium costs, described further below.

Many workers still face problems retaining affordable coverage when they change jobs or lose their jobs.

One consequence of a system where insurance is tied to one's job is that people are vulnerable when they are *between* jobs or face *waiting periods* before new

[20] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[21] Thorpe, K. and C. Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997." *Health Affairs,* 18:2, Mar/Apr 1999.

[22] Gabel, J.R., Nov/Dec 1999.

[23] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[24] Cooper, P.F., and B. Steinberg Schone. "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs*, Nov/Dec 1997, pp. 142-9.

[25] In fact, the reduction in take-up more than offsets a small increase in the portion of workers eligible for work-based coverage. (Gabel, Jon R. November/December 1999).

[26] Thorpe and Florence, 1999.

[27] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

coverage becomes effective. People who have their coverage interrupted may go long periods of time without any protection. In 1997, for example, 2.7 million of the 10.1 million people ineligible for coverage at their workplace were in a "waiting period."[28]

Changing health plans when changing jobs also has implications for access, since enrollees may need to switch physicians or are unfamiliar with the new health plan's rules. People who recently changed health plans are less likely to receive follow-up care after emergency room visits, and are more likely to delay seeking needed care, getting prescriptions filled, and having a primary care doctor.[29]

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) helped some workers between jobs by giving them access to their former employers' health plans for a limited period, but workers must pay the full premium plus a small fee (the equivalent of 102 percent of the premium). Nearly 4.7 million former employees were using COBRA coverage in the spring of 1999.[30] Yet it is reported that less than five percent of those eligible for COBRA opt for it because of the high cost.[31]

HIPAA was intended to help by requiring insurers to offer coverage to workers entering the individual market and placing limits on pre-existing condition exclusions. But experience shows that HIPAA is not sufficient. It does not eliminate waiting periods to qualify for coverage, it requires people to exhaust 18 months of COBRA benefits before qualifying for guaranteed individual coverage, and it imposes no limits on what insurers may charge for the individual policies.[32]

Many of the uninsured are lower-wage workers who change jobs frequently and experience intermittent spells of unemployment. Some may go on and off Medicaid at least once during a year's time. In designing new policies for the uninsured, it is important to address the needs of workers facing many transitions.

People buying coverage on their own face higher costs, fewer protections, and less subsidization than do people with work-based coverage.

People without access to employer-sponsored health coverage may attempt to purchase coverage on their own in the individual insurance market. About 16 million people purchase individual policies in the U.S. This type of coverage, however, is considerably more expensive, on average, than group coverage, and it has fewer protections regarding the ability to get coverage initially, to renew coverage, and to avoid large increases in premiums related to a change in health status.

Another disadvantage for people purchasing individual coverage is that they do not benefit from the tax subsidies provided to those with employer-sponsored coverage. Health insurance contributions by employers and health spending under flexible spending plans are excluded from employee gross income when determining federal income and Social Security/Medicare taxes. This subsidy was "worth" $107 billion in 1998 in terms of foregone federal revenues.[33,34] In contrast, individuals purchasing individual coverage must do so using after-tax dollars.[35]

[28] Thorpe and Florence, 1999.

[29] Burstin, K.S., et al. "The Effect of Changes of Health Insurance on Access to Care." *Inquiry,* 35: 389-97, 1988.

[30] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[31] Findlay and Miller, May 1999.

[32] Findlay and Miller, May 1999.

[3] Exception: benefits received by "highly-compensated employees under discriminatory self-insured plans" are partly taxable (Lyke, 1999, p. 2).

[34] Sheils, J. and P. Hogan. "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs*, 18(2), Mar/Apr 1999.

[35] A medical expense deduction is available to taxpayers who itemize their deductions to deduct unreimbursed medical expenses that exceed 7.5 percent of adjusted gross income. These medical expenses may include the employee's share of premiums for either employer-sponsored coverage or individual market policies, out-of-pocket payments for medical care, and certain transportation, lodging, and long-term care costs. Most taxpayers do not reach the 7.5 percent floor, and many choose to take the standard tax deduction rather than itemizing deductible expenses. Only about 4 percent of all taxpayers claimed a medical expense deduction in 1996. (Lyke, 1999)

Congress is considering bills to provide a tax deduction for people buying coverage on their own. But a recent study by Professor Jonathan Gruber shows that *nine of ten people who might do so either have no federal income tax liability or are in the 15 percent tax bracket, which means that a deduction would only slightly lower their net costs of buying health insurance.*[36]

Health costs are accelerating again, exacerbating all of the above problems.

All of the above factors that reduce access to health coverage are likely to be exacerbated in coming years, as health costs are accelerating. Three recent surveys indicate that employers are now facing the largest premium increases since the early 1990s, and small employers are facing the greatest price hikes. Health benefit cost escalation was very modest over the 1993-1998 period, reflecting shifts to managed care, increased use of utilization review, cutbacks in retiree health benefits, and premium cuts or freezes by health plans to gain market share. Part of the current surge in prices is attributed to insurers trying to make up for losses in recent years.[37]

A survey by Hewitt Associates LLC concludes that companies can expect an 8 to 10 percent increase in premiums for the year 2000. It found a 7.8 percent hike in premiums in 1999, and projects an average health plan cost of $4,853 per employee in 2000.[38]

A survey by William Mercer found that insurance premiums increased 7.3 percent in 1999, nearly three times the rate of inflation. According to this survey, premiums are expected to rise 7.5 percent in 2000, marking the third straight year of significant premium hikes.[39]

Another survey, by the Kaiser Family Foundation and the Health Research and Educational Trust, found a more modest premium hike – 4.8 percent from Spring 1998 to Spring 1999 – but still more than twice the rate of general inflation. Importantly, the smallest firms with 3 to 9 employees reported the highest premium increase of 9.2 percent, indicating that it will be even harder for small firms to offer coverage in the future. Seventy-two percent of employers surveyed said that they worried that health care costs will increase faster than they can afford, and 70 percent worried they will have to cut benefits or their contributions.[40]

Children and adults who are eligible for Medicaid, CHIP, and other programs frequently are not enrolled.

An estimated 4.7 million children – 42 percent of the 11.3 million uninsured children – were eligible for Medicaid but not enrolled in 1997.[41] While enrollment in state Children's Health Insurance Plan (CHIP) is growing rapidly, about one-fourth of children enrolled in CHIP are in one state (New York), while many other states have enrolled only a small portion of eligible children. Among 21 state-funded insurance programs for children, between one percent and 52 percent of eligible families actually enrolled, according to one study's estimates.[42] A large number of adults are eligible for Medicaid or other government-funded health insurance programs but are similarly not enrolled.

There are many reasons for the lack of enrollment, generally related to lack of information about eligibility and barriers to application: [43]

- Families are not aware that government-funded programs are available or they do not know how to apply for them;

[36] Gruber, J. *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*. Washington, DC: Kaiser Family Foundation, January 2000.

[37] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[38] Hewitt Associates LLC. "U.S. Health Care Costs to Increase Into the Double Digits for Second Consecutive Year." Press Release. Lincolnshire, IL: November 9, 1999.

[39] Mercer/Foster Higgins, 1999.

[40] Kaiser Family Foundation/Health Research and Educational Trust, October 1999.

[41] Kaiser Family Foundation, October 1998.

[42] Gauthier, A. and S. Schrodel. *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform*. Washington, DC: Alpha Center, May 1997.

[43] Families USA, Children's Health Campaign. *Outreach Strategies in the State Children's Health Insurance Program*. Washington, DC: June 1998.

- People are not aware of the changes in Medicaid and assume that eligibility is limited to single-parent families receiving cash assistance;
- Families have difficulty obtaining an application form, understanding the questions, and correctly completing the form, especially if there is a language barrier;
- Eligibility rules are often complex and restrictive, for example excluding undocumented children or requiring third-party verification of parents' statements (some workers, particularly migrant workers, have difficulty getting employers to provide them with written statements verifying income);
- Premiums or other enrollment fees deter some low-income people from enrolling;
- Undocumented parents fear that enrolling their children in programs will lead to deportation; and
- Some people avoid enrollment due to the stigma of receiving public "welfare."

Medicaid coverage is now declining due in part to changes in welfare policies.

The 1996 welfare reform law, along with state reforms and a strong economy, has led to a major reduction in welfare cash assistance rolls. But new welfare rules are also apparently contributing to the ranks of the uninsured. Medicaid coverage has edged downward from 12.7 percent of non-elderly Americans in 1992 to 10.4 percent in 1998. While the legislation guarantees continuing Medicaid coverage for those leaving cash assistance if they qualify, or transitional coverage for those earning too much money to qualify, it appears that large numbers of former welfare recipients are losing Medicaid coverage and not gaining coverage at new jobs. This affects both adults and children; in the 1997-1999 period, for example, the proportion of children without health coverage has increased as Medicaid coverage declined.[44]

Preliminary reports indicate that the majority of former welfare recipients are getting jobs that do not provide coverage, or are declining coverage because their share of the premiums is too high. It also appears that many of these individuals do not know that they can retain Medicaid when they leave cash assistance roles or when they get jobs. Frequent job changes and the associated "waiting periods" exacerbate the problem.[45] A recent study found that among women who had been off welfare for more than one year, 49 percent were uninsured, while only 28 percent had private/employer coverage, and 22 percent had Medicaid coverage. For children who previously received welfare benefits, 29 percent were uninsured after one year, 47 percent had Medicaid, and only 29 percent had private insurance.[46]

Many adults without dependent children are ineligible for subsidized health coverage.

Many low-income adults without dependent children are ineligible for Medicaid. While some states include single people in Medicaid or other insurance programs, many states exclude this group from coverage, or provide coverage only to those with extremely low incomes (e.g., less than 50 percent of poverty). This group includes many adults with chronic illnesses or special health care needs. It includes people who are working at low wages in jobs that do not provide health coverage, and it includes many who are unemployed and "unemployable." They cannot afford to purchase private health coverage on their own. The uninsured status of these individuals contributes to the cost of health services and the erosion of safety net viability.

Changing demographics will contribute to the rising numbers of uninsured in the future.

Minorities and immigrants disproportionately lack health insurance. Minorities comprised 24 percent of the population in 1997, but represented 46 percent

[44] Feder, J., C. Uccello, and E. O'Brian. *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance.* Washington, DC: Kaiser Family Foundation Project on Incremental Health Reform, 1999.

[45] Findlay and Miller, May 1999.

[46] Garret, B., and J. Holohan. "Health Insurance Coverage After Welfare." *Health Affairs,* 19(1), Jan/Feb 2000.

of the uninsured.[47] In 1997, 21.5 percent (7.4 million) African Americans, 34 percent (10.5 million) of Hispanic Americans, and 20.7 percent (2.2 million) Asian and Pacific Islanders had no health insurance – compared with a 15 percent rate among white Americans. Urban areas with the highest minority and immigrant populations have the largest uninsurance rates.[48]

The reason for higher incidence of people without coverage is that minorities and immigrants are more likely to have the following "risk" factors: [49]

- Low-wage jobs that do not offer health coverage;
- Lower incomes and reserve funds (therefore less ability to purchase individual coverage or pay their share of work-based insurance); and
- Non-traditional, part-time, or temporary jobs that generally do not offer health coverage (including jobs in the "informal" sector).

Even factoring out income-related factors, minority workers are still more likely to be uninsured.[50] Expected growth in both minority and immigrant populations in coming years is likely to contribute to an increase in the ranks of the uninsured.[51]

The design of the health care delivery system imposes non-insurance related obstacles to timely access to health care services.

Even among individuals with private or government-funded health insurance, a variety of organizational and cultural barriers prevent timely access to primary, preventive, and other necessary health care services. Such barriers include:

- Lack of interpreters or bilingual clinic staff in hospitals, clinics, and physicians' offices, and lack of written health promotion material in multiple languages;
- Lack of neighborhood clinics and/or transportation to primary care centers and hospitals;
- Loss of safety net providers who cannot remain financially viable in the changing health care market;
- Physician office and clinic hours that conflict with work schedules;
- Long delays for appointments and long waiting times at overcrowded facilities;
- Lack of child care; and
- Impersonal treatment and lack of cultural sensitivity or respect from health care providers.

These non-insurance barriers are particularly acute among vulnerable populations such as minorities, immigrants, and people with special health care needs. For example, low-wage workers are more likely to work for employers who do not provide paid sick leave or flexible hours that allow taking time to seek health care for themselves or family members. If these workers do not have access to health services during evening or weekend hours, they may delay seeking care, ultimately resulting in higher costs and lost productivity.

The access barriers noted above are augmented by a shortage of health care practitioners in certain areas of the country, while there is a surplus in other areas. There is a lack of primary care physicians and other medical professionals in certain inner-city neighborhoods, rural regions, and other "underserved" areas. Further, the pipeline of professionals in training contains too few minorities to meet the needs of vulnerable populations.

Critical needs such as oral health and mental health are often neglected or inadequately covered, even among people with health insurance.

Too many Americans are not obtaining needed dental care, mental health care, and other services outside the traditional medical model. Such services are often not covered or inadequately covered under private

[47] U.S. Census Bureau. Current Population Survey, March 1998.

[48] Levan, R., E.R. Brown, L. Lara, and R. Wyn. *Nearly One-Fifth of Urban Americans Lack Health Insurance.* Los Angeles: UCLA Center for Health Policy Research, December 1998.

[49] Findlay and Miller, May 1999.

[50] Hall, A., K.S. Collins, and S. Glied. *Employer-Sponsored Health Insurance: Implications for Minority Workers.* New York: Commonwealth Fund, February 1999.

[51] The proportion of the population comprised of minorities is expected to rise sharply in coming years, from 24 percent in 1999 to 35.8 percent in 2020. (U.S. Census Bureau, 1999)

health insurance, and are out of reach for many of the 44 million uninsured. Neglecting these services can affect emotional and physical health, nutrition, productivity, and general well-being. Oral health care, for example, not only affects an individual's comfort, but also influences appearance, speech, and ability to eat. Oral health affects nutrition, health status, and employment potential.

Mental health is another area that is too often neglected and has a tremendous impact on individuals, families, and the economy. In the United States and other developed nations, major depression is the leading cause of disability. Manic-depressive illness, schizophrenia, and obsessive-compulsive disorders are among the other major causes of disability. Mental, addictive, and dementia disorders accounted for nearly $100 billion in direct health care spending in 1996 (about one-tenth of total health care spending), plus nearly $79 billion in lost productivity in 1990. Mental disorders affect nearly one in five Americans in any year.[52]

Yet the majority of those with a diagnosed mental disorder are not receiving treatment. A variety of barriers prevent many from obtaining mental health treatment:

- Lack of insurance for 16 percent of the population;
- "Under-insurance" for mental disorders;
- Lack of trust, negative past encounters, and racism and discrimination experienced by racial and ethnic minorities; and
- Stigma associated with mental disorders, making people reluctant to seek care and the public reluctant to expand funding.

Further, the mental health system is fragmented and difficult to maneuver, particularly for those with complex needs and those with limited financial resources.[53]

Risk factors outside the health care system have an adverse effect on health.

There are multiple factors outside the health care delivery system that affect the health of individuals, causing some to experience more severe health problems than others do. These *social determinants* of health include the physical environment (including housing, air quality, etc.), the social environment, income levels, nutrition, violence, individual behaviors, individual biology, and overall well-being.[54]

Poor housing conditions, for example, can lead to or exacerbate existing health problems. Millions of accidents occur at home every year, with residential fires, scald burns, and fall-related injuries accounting for more than 2.5 million emergency room visits by children under the age of 14 in 1998. Rodent infestation, lead-based paint, mildew, poor indoor air quality, and other household hazards associated with poverty also contribute to childhood illnesses such as lead poisoning, asthma and respiratory diseases:[55]

- Lead poisoning, associated with dilapidated housing conditions, adversely affects the health of over one million children under six years of age each year, sometimes causing developmental delays. Environmental lead exposure also has been found to affect oral health, increasing the incidence of decay and other dental problems.[56]
- Severe asthma is frequently associated with unhealthy indoor air quality, inadequate, inner-city housing (e.g., smoking, dust mites, molds and dampness, and cockroaches), outdoor pollution, and lack of appropriate preventive health care.[57,58] The correlation between *poverty* and asthma has been shown to be especially strong, with Latino and African American children disproportionately

[52] United States Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[53] United States Department of Health and Human Services, 1999.

[54] Institute of Medicine. *Leading Health Indicators for Healthy People 2010.* National Academy Press, 1999.

[55] U.S. Department of Housing and Urban Development. *Building Communities and New Markets for the New Century*, Washington, DC: 1998.

[56] Moss, M.E., B.P. Lanphear, and P. Auinger. "Association of Dental Caries and Blood Lead Levels." *Journal of the American Medical Association,* 281(24): 2294-8, 1999.

[57] Other factors include genetics, behavior, and climate.

[58] Treatment for asthma is often medical intervention only; health care providers typically do not address environmental factors or advocate for environmental reforms.

affected. One study found that African Americans and Hispanics had asthma-related hospitalization rates from three to five-and-a-half times those of whites.[59]

People living in poverty are also particularly at risk of stress-related behaviors and conditions such as mental illness, substance abuse, domestic violence, and inadequate nutrition. Poor nutrition can lead to a host of health problems including acute complications of diabetes (hypoglycemia, short-term illnesses, and exercise-related problems), as well as long-term complications (renal disease, autonomic neuropathy, hypertension, and cardiovascular disease). Poor nutrition also can be associated with limited access to dental/oral health care.

Poverty has a strong effect on perinatal outcomes as well. Lower-income women in the U.S. are at higher risk of pre-term delivery, and among these women there is a higher incidence of low birth-weight babies. Poverty contributes to these outcomes by "restricting access to health care; affecting nutrition before, during and after pregnancy; and producing stress, which can result in other risk factors such as smoking, teen pregnancy, drug abuse, poor mental health, and inadequate shelter and living conditions."[60]

4. Strategies for Broadening Insurance Coverage

This section offers a blueprint for broadening health insurance to all Americans, consisting of a series of public and private strategies. Some of the strategies are controversial, many have been proposed before, and some are being tested on a small scale. They are presented not as a menu from which to select one or two of the "safer" or "cheaper" approaches. Rather, they are presented as components of a *comprehensive, multi-faceted plan* that is necessary to fill the many gaps in coverage for different population subgroups. Specifically, the reforms outlined below are geared toward expanding coverage to:

- Employees and their dependents;
- Children and adults eligible for existing government-funded insurance programs but not enrolled; and
- Individuals who are not tied to the workforce and are not eligible for existing government-funded programs.

It must be stressed that all of the recommendations involve complex design issues and tradeoffs in terms of price, effectiveness, and equity. But just because there are no "easy" solutions does not mean we should abandon the effort to improve health and health care for millions of Americans.

Expand employment-based coverage by requiring employers to offer coverage or contribute to insurance pools.

With the vast majority of uninsured people tied to the workforce, clearly the central piece of a comprehensive reform strategy is to expand work-based coverage.[61] Though controversial and not without "costs," one way to do this is to require employers to offer coverage or contribute toward insurance pools from which all workers could obtain coverage.[62] This requires establishing pooling mechanisms as well as providing financial support to vulnerable employers and employees.

So far, Hawaii is the only state to have successfully implemented a requirement on employers to provide health insurance to workers. Since the program took effect in the mid-1970s, the proportion of people without insurance in Hawaii has been very low, and

[59] New York City Department of Health. *Childhood Asthma.* City Health Information, Vol. 15/3, December 1996.

[60] Institute of Medicine. *WIC Nutrition Risk Criteria: A Scientific Assessment.* Washington, DC: National Academy Press, 1996.

[61] An alternative is to eliminate employment-based coverage and replace it with either (a) individual coverage and a mandate on individuals to purchase coverage, or (b) a publicly financed national health plan. Both of these options, however, are deemed politically unfeasible at this time and are therefore not pursued in this report.

[62] A few design issues include: setting a minimum contribution level (e.g., 50% or 70% of premiums), and defining "employee" in terms of number of hours worked per week, temporary or contract status, etc. Other recommendations described in this report would provide coverage options for those workers and non-workers who would remain without insurance under the employer requirement.

there is broad support for the program with no significant opposition by the business community. In November 1999, the governor of Tennessee proposed legislation that would require all employers with 25 or more employees to provide health insurance by the year 2002, but the business community is strongly opposed and the fate of the proposal is uncertain. Massachusetts, Oregon, Minnesota and Washington have passed some form of requirement on employers (generally a choice of either funding coverage or contributing to a pool) in the past, but political or logistical obstacles prevented these plans from getting off the ground.

Clearly, requirements on employers can have some adverse side effects. There would be some downward pressure on wages (constrained by the minimum wage) as firms try to keep their total compensation costs constant. There could also be some job loss, particularly when wages are not lowered to offset the cost of funding health coverage. And some businesses could suffer losses if they cannot offset required health care outlays through some combination of price increases, wage cuts, or layoffs.

Nevertheless, a requirement on employers to contribute to health coverage in one way or another is the most effective way to expand coverage if we retain an employment-based health insurance system. In effect, we would be making a decision to treat health coverage for working-age adults and children the same way as we treat coverage for the elderly and social security. Employers would be required to treat some form of contribution to workers' health coverage as a cost of doing business.

Establish purchasing co-operatives for small firms or "buy-ins" to existing group plans.

As an alternative to purchasing a small-group health insurance policy, employers of small firms (and perhaps medium and large firms) should have the option to contribute toward a purchasing pool that offers a number of "approved" health plans to large numbers of people. This would allow for spreading of risk and administrative costs. Also, it removes the burden on individual employers of selecting, monitoring, and administering their own health plans. Further, it would provide employees in small firms a greater choice of health plans, and a better chance of continuing the same health plan if they switch jobs. State-run risk pools, business coalition plans, and public/private purchasing cooperatives are potential models for such pools.

Another advantage of allowing employers to contribute to a pool rather than manage their own health plan is that this approach addresses the substantial mobility of workers in lower-wage jobs. Five or six different workers may flow through one of these jobs in the course of a year and employers facing both this high turnover and employing a lot of part-time workers may prefer making contributions to a pool over running a health benefits program.

Another approach is to permit small firms and individuals ineligible for work-based coverage (part-time, self-employed) to buy into existing large group health plans, such as the Federal Employee Health Benefit Plan (FEHBP) or state employee health plans. Similarly, workers approaching age 65 could be allowed to buy into Medicare. This option has the advantage of working through existing administrative structures.

There is a risk that giving employers a choice of purchasing a health plan or contributing toward a large pool would result in adverse selection – i.e., only high-risk groups would join the pool, driving up the cost of the large-group entity. Opening up a large-group plan to *individuals* poses an even greater risk of adverse selection. But government subsidization could alleviate this problem, and having the pooling option could make the new coverage requirement on employers more palatable and affordable.

Provide subsidies or tax credits to vulnerable employers.

Given that the high cost of insurance is a real and worsening problem for employers (particularly small firms and businesses with low-wage workers), a requirement that employers contribute to health coverage should be coupled with targeted public subsidies to reduce the burden on vulnerable employers.

The financial assistance could take the form of direct subsidies or tax credits, and provisions must be made to transfer payments before the end of the year (that is, employers must receive the funds during the year when their premium contributions are due). A challenge is to target the subsidy to firms most vulnerable to closing or laying off workers under the new coverage requirement, in order to

avoid merely transferring the financial burden from the private sector to the public sector. Possible criteria could be based on a combination of the firm's annual revenue and average salary of employees.

Provide subsidies to employees to help them afford their share of employer-sponsored coverage.

In addition to assistance for vulnerable *employers*, subsidies should assist low-income *individuals* with employer-sponsored coverage who are paying a substantial part of the cost themselves. As discussed above, low-wage workers are often required to pay a significant portion of their limited wages toward insurance premiums. Direct subsidies or a refundable tax credit (available during the year when it is needed) would enable many low-income workers to meet their premium requirements without sacrificing funds for housing, food, childcare, or other competing needs.

Similarly, the subsidy should be available to help low-income families with COBRA coverage, whereby they are paying more than 100 percent of the premium for insurance under their former work-sponsored plan.

Short of requiring employers to contribute, provide strong incentives to employers to offer coverage, and individuals to obtain insurance.

Acknowledging that requiring employers to contribute to the cost of health coverage is a "hard sell" politically and may be a long-term goal, much can and should be done in the short term to encourage expansion of employment-based insurance. For example, the pooling mechanisms and subsidies to employees discussed above should be included in any comprehensive reform strategy. In addition, the following incentives should be implemented:

- Provide subsidies/tax credits to employers who newly offer coverage to employees.
- Provide significant tax credits to purchase individual coverage for those remaining without access to employer-based coverage.
- Establish rate bands for the individual and small group insurance markets to reduce wide disparities in premiums related to risk.
- Increase enrollment of eligible populations into government-funded insurance programs.
- Conduct outreach through public awareness campaigns and "out-stationing."
- Simplify the application process and reduce language barriers.
- Expand government-funded programs and develop new insurance products.
- Expand eligibility for existing government-funded insurance programs (e.g., Medicaid, CHIP).
- Develop new insurance products tailored to the needs of vulnerable, low-income people.

Provide subsidies/tax credits to employers who newly offer coverage to employees.

Subsidies could be used as a way to encourage employers to begin offering coverage. The subsidies, in the form of tax credits or direct subsidies, would be available to employers who have not offered health insurance to their workers over a designated prior period, and it should be phased out over a few years. That is, it should be used to help "jump start" firms that need an extra push to get started, rather than an ongoing government "buy-out" that would in effect penalize employers who have responsibly provided coverage all along. As with the proposed subsidy mentioned above (under *required* employer participation), the subsidy under a voluntary program should similarly be paid in regular installments during the year, rather than after filing tax returns, to help with cash flow when premiums are due.

To overcome disappointing enrollment in past employer subsidy programs, two features are critical: 1) a sizeable subsidy amount, and 2) strong marketing/outreach. Pilot projects and employer surveys show that a significant subsidy amount (for example, at least 50 percent of the premium cost) is required to encourage a large portion of employers to offer coverage. The subsidy also should have a long enough phase-out period so that employers would feel they have time to work their new insurance expense into their long-term budgets. A second critical component is a sophisticated, broad-based marketing campaign. Past attempts have floundered in large part because eligible firms were never made aware of the program.

A few states (Kansas, New York, Massachusetts) are experimenting with employer subsidies to encourage work-based health coverage. *Also, there are some pilot programs operating on local levels, including a small business premium subsidy under the Denver Health Community Voices Initiative, described in Feature Box 1, p. 20.*

Provide significant tax credits to purchase individual coverage for those remaining without access to employer-based coverage.

As discussed in Section 3, people who purchase individual health insurance have to pay their health care premiums with post-tax wages, while people with employer-sponsored coverage enjoy a substantial subsidy in the form of a *tax exclusion*. A new tax subsidy program could extend tax preferences to people purchasing coverage on their own, thereby assisting workers and others who remain without access to work-based insurance to obtain coverage.

A refundable tax credit, which would provide rebates to those with little or no income tax liability, is preferable to a tax deduction. Further, the subsidy should be made available during the year when premiums are due rather than only at year's end. These and other design issues would need to be addressed regarding eligibility, timing, and administration.[63] While adding to the cost of the program, the size of the subsidy must be significant in order to be effective.

Establish rate bands for the individual and small group insurance markets to reduce wide disparities in premiums related to risk.

Many states have established rate bands to reduce the variation in insurance premiums related to an individual's health risk. This has helped to make individual and small-group coverage more affordable to high-risk persons seeking insurance in these markets, and we recommend that more states move in this direction.

There are two caveats worth mentioning, however. First, by reducing the disparity in premiums, the price of coverage for people with *low* risk will *rise*, making coverage less affordable to them. Second, reducing variation does not address the overall higher prices in the individual and small-group markets that are due to higher marketing and administrative costs. For these reasons, we place greater emphasis on opening up larger group entities and risk pools to small employers and individuals, described above.

Increase enrollment of eligible populations into government-funded insurance programs.

A concerted effort must be made to find and enroll people who are uninsured but eligible for existing government-funded insurance programs. The federal government provides money under TANF and CHIP for outreach and enrollment. Currently, there are many federal and state initiatives geared to distributing information about CHIP and Medicaid, and coordinating the application process with other public programs. These efforts have been supplemented by a $13 million foundation initiative to identify and enroll uninsured children in Medicaid and other health insurance programs. The more successful efforts should be expanded and replicated.

A prerequisite for successful outreach is an understanding of the obstacles keeping so many people from enrolling in programs, such as lack of information, language barriers, and complex application procedures (delineated in section 3 above). *The following are some ingredients of a strong enrollment program.*

Conduct outreach through public awareness campaigns and "out-stationing."

Informing the public involves a broad-based media campaign coupled with targeted outreach. A combination of television, radio, billboards, newspapers and other media should be used to describe the health insurance program to the public and provide information about how to apply.

Information about the programs should be targeted to locations and agencies that serve the eligible populations. To enhance CHIP enrollment, for example,

[63] See, for example: Meyer, J.A., S. Silow-Carroll and E.K. Wicks. *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges.* Washington, DC: Kaiser Family Foundation, January 2000.

FEATURE BOX 1
SMALL BUSINESS PREMIUM SUBSIDY PROGRAM
DENVER HEALTH COMMUNITY VOICES (DHCV)

As part of an effort to test new approaches at improving the health of Denver's medically underserved populations, Denver Health Community Voices (DHCV) is assessing the impact of a small business premium subsidy. The program targets low-income, small businesses newly offering coverage to workers. By making health insurance more affordable to small business employers and employees under a research study design, DHCV hopes to provide lessons and recommendations for public policy. As of January 2000, 23 small businesses were receiving subsidies under the program, and a new marketing campaign is geared to expand participation.

Eligibility: Businesses are eligible for the subsidy if they:

- Choose to contract with Denver Health Medical Plan for the Small Business HMO;
- Have 2-50 employees enrolling in the plan;
- Had net income of less than $50,000 the previous year;
- Did not offer coverage over the prior 90 days.

Amount of Subsidy: The subsidy is worth 20%-50% of the premium for both the employer and employee, determined by a sliding scale based on the firm's net income the previous year. The subsidy is available during years 1 and 2, and again in years 4 and 5. It is not available in year 3 because DHCV is trying to determine the extent to which businesses retain coverage without financial assistance.

Outreach/Marketing: An advertising campaign focuses on radio and targeted print ads in business journals and ethnic newspapers. Additional marketing is conducted through direct mail, presentations, brokers, billboards, and bus exteriors.

Financing: The premium subsidy under the current five-year, $5 million study is funded by the W.K. Kellogg Foundation and The Colorado Trust. It is hoped that successful results will lead to ongoing public financing in the future.

Sources: Denver Health Community Voices, *Annual Progress Report July 1, 1998-December 31, 1999,* and Personal Communications December 1999 and February 2000.

information should be available at schools and child-care centers in low-income neighborhoods, child support enforcement programs, and agencies that serve children and pregnant women. The staff at these agencies must be trained to assist parents in completing application forms. Actually placing eligibility workers in such agencies – the practice of "outstationing" – as well as contracting with community-based groups to conduct enrollment activities, have had much success. A targeted direct mail campaign, coordinated with other programs, also could help reach individuals most likely to be eligible.[64]

Eligibility workers should be held accountable for erroneously denying enrollment. In addition to closely monitoring denials, states could use incentives to promote appropriate enrollments. Under this approach, workers would be paid more if they enroll more eligible people. Safeguards should be built in, however, to assure that ineligible people are not inappropriately enrolled as a result of these incentives.

A number of Community Voices programs are focusing on enrolling eligible children and families into CHIP and Medicaid. A collaborative effort in West Virginia, for example, has used community-based outreach and information dissemination to help enroll more than 13,000 children in CHIP. This initiative is described in Feature Box 2, p. 22.

[64] Families USA, June 1998.

Simplify the application process and reduce language barriers.

Information about health insurance programs and the applications themselves should be available in the languages represented in communities. With high rates of uninsurance among Hispanic people, for example, public awareness messages and applications should include Spanish versions, and bilingual eligibility workers should be available.

Applications should be simple, short, and widely distributed. Obtaining applications should not require making appointments, and the forms should be available in convenient locations with extended hours of operation. The application should be easy to understand, with a minimum of items that require third-party verification. Submitting a completed application should be made easy as well: options include mail-in, telephone, fax, and Internet submissions that do not require face-to-face interviews, as well as expanded sites for in-person application (e.g., out-stationing).

A computerized, Internet-based enrollment system, for example, would enable hospitals and clinics to electronically submit applications to the state for CHIP/Medicaid eligibility and receive quick responses. This can help reduce the uncompensated care burden on providers and improve access to care for the uninsured by getting them into health plans that cover a wide range of preventive and primary care services. *Denver's AppTRAK enrollment program is highly computerized to reduce human error and bias, while it tracks the performance of enrollment workers.*

In states that have separate Medicaid and CHIP programs, a coordinated system of a single application and joint eligibility workers could enhance enrollment in both programs. Also, states should adopt options that allow 12-month continuous Medicaid eligibility, and "presumptive eligibility." The former ensures Medicaid coverage of a full year regardless of income fluctuations during the year. The latter allows immediate Medicaid enrollment for children who appear to meet eligibility criteria. These options reduce both disruptions in care and the administrative burden on parents.[65]

Finally, states should consider instituting single insurance cards that do not denote source of payment to providers. This would reduce the stigma associated with "welfare" programs, and improve treatment by providers.

Expand government-funded programs and develop new insurance products.

Regardless of whether employers are required or encouraged to offer coverage, and regardless of the success of enrolling eligible people into existing government-funded programs, a significant number of people will remain without health insurance. They include:

- Those tenuously connected to the workforce (very part-time, self-employed);
- Workers who decline employer-sponsored coverage (generally because they cannot afford their share of the premium); and
- People unemployed or out of the labor force who do not meet eligibility requirements for government-funded programs (e.g., they do not have children, they have incomes above their state's Medicaid threshold, they are undocumented immigrants, they have been rejected for private insurance due to health risk, they are early retirees and are not yet eligible for Medicare).

For all of these subgroups, a combination of expanded public programs and new insurance programs (including state risk pools and government-subsidized private plans) could help fill the gaps. *FirstHealth of the Carolinas, a Community Voices grantee in North Carolina, is developing a health plan for its own employees, and plans to open it up to small businesses, children ineligible for CHIP or Medicaid, and charity care patients. This model serves to expand access while pooling risk among diverse populations.*

Expand eligibility for existing government-funded insurance programs (e.g., Medicaid, CHIP).

Eligibility for Medicaid, CHIP, and other government-funded insurance programs could be expanded

[65] Center on Budget and Policy Priorities. *Steps States Can Take to Facilitate Medicaid Enrollment of Children.* Washington, DC: November 1998.

FEATURE BOX 2
ENROLLING ELIGIBLE CHILDREN IN CHIP
WEST VIRGINIA COMMUNITY VOICES

The West Virginia Community Voices Project (WVCV), a partnership of state agencies, state and local coalitions, and community organizations, has been collaborating with the Healthy Kids Coalition and the state to enroll all eligible children in West Virginia's CHIP. More than 13,000 children have been enrolled through this effort, bringing the state's enrollment to more than 75% of eligible children as of November 1999. (Eligibility is based on family income up to 150% of the federal poverty level.) The effort has focused on a grassroots outreach effort, linked with provision of information and tools for enrollment.

Information Dissemination: Critical to the effort was the development and wide distribution of information, including:

- A monthly "Healthy Kids" newsletter providing information about CHIP to 1,200 subscribers;
- An updated CHIP Training Manual distributed to state and local agencies, community groups, churches, schools, and others;
- An 8-page newspaper insert containing a complete CHIP application, application instructions, and prevention/health education articles, reaching 34,000 households through newspapers and more than 340,000 children through schools;
- An 18-page policy brief with recommendations on expansion and improvement of CHIP, distributed to legislators, agency policymakers, and others;
- A web site that contains the above publications; as well as others pertaining to the uninsured, welfare reform, health survey results, and minority health, among others.

Community Outreach: Community-based outreach was conducted through schools, churches, health care providers, social service agencies, and family resource networks. WVCV outreach workers were trained regarding the application form, enrollment and eligibility procedures. The outreach workers, in turn, trained community volunteers. Both groups helped families fill out the application to ensure that all documentation and required information was provided. The application was then mailed to the welfare office where it was processed. In some cases, the outreach workers also worked with the welfare office when a case was rejected; they often had success in clarifying a policy or issue that allowed a child to be enrolled.

In addition, community forums on health care coverage, including the CHIP program, were conducted in ten locations. The forums were highly publicized in the local press.

Sources: West Virginia Community Voices: A Partnership for Healthcare, *Annual Report to the W.K. Kellogg Foundation,* December 31, 1999, and Personal Communication, February 2000.

to include more low-income people and those without work-based coverage. This approach is not without precedent. Medicaid was expanded during the late 1980s and early 1990s for children and pregnant women. Despite fears that these expansions would result in public coverage merely substituting for private coverage, evidence indicates that the vast majority of this expansion was for uninsured children and did not represent "crowd out" of private coverage.[66]

Also, the CHIP program spurred Medicaid expansion by offering federal matching funds to states that either expand Medicaid or implement a new insurance program for uninsured children. Further expansions of Medicaid or CHIP could extend coverage to

[66] Dubay, L. *Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says.* Washington, DC: Kaiser Family Foundation Project on Incremental Health Reform, October 1999.

parents of children already eligible for the program. Similarly, eligibility could be designed as a "buy-in" program, providing a full subsidy for families with incomes below 100 percent of the poverty level, and requiring sliding scale premium contributions for families above the poverty line.

Develop new insurance products tailored to the needs of vulnerable, low-income people.

For those who remain outside both public and private health insurance plans, new insurance products should be developed that are shaped by the particular needs of the targeted populations. The programs should include services, for example, that address some of the factors that have kept them disenfranchised from other sources of coverage – e.g., substance abuse, mental health, and emergency services. In addition, the language and cultural needs of these groups must be incorporated into both the benefit design and the outreach/educational component of the program.

These programs could include indigent care pools at the state level, or more focused community-level programs. A few Community Voices sites are developing health insurance products that target local groups who are not receiving health care services through other means. *The El Paso First Health Network, for example, has developed a primary care, managed care plan for uninsured residents, described in Feature Box 3, p. 24.*

5. Overcoming Non-insurance Barriers: Redesigning the Delivery System

Until we implement some combination of reforms that move us to universal coverage, many people will remain without insurance. Moreover, enrollment in a public or private insurance plan does not by itself ensure *utilization* of appropriate health care services. A host of logistic, cultural, and organizational non-insurance barriers to care, outlined in section 3, must be overcome to meet the needs of patients as they try to gain access to the system. Efforts should focus on: strengthening the public health system, enhancing access to and delivery of primary care, addressing the special needs of vulnerable populations, building integrated delivery systems that emphasize a continuum of care, ensuring viability of safety net providers, and addressing social determinants and poor community health.

Strengthen the public health system.

The most dramatic improvements in our health have emerged from public health advances over the last century. Investments in public health at the federal, state, and local levels can yield important payoffs in terms of life expectancy, quality of life, and other health measures. A clean water supply, for example, can avert raging epidemics and the virtual elimination of waterborne diseases. The reduction or elimination of toxic substances in the air can cut down on the incidence of certain types of cancer and other diseases. Prevention through public health investments has been the most humane, effective, and often the least costly approach to addressing many of the nation's health problems.[67]

While the U.S. has addressed some of the traditional public health challenges such as clean water and, to some extent, a safe food supply, other challenges loom large. In many communities, as many as a third of children are not fully immunized for preventable diseases by their second birthdays. Preventive measures to reduce the incidence of HIV and AIDS, as well as other sexually transmitted diseases, are not used to their full potential. Children and adults are still subjected to physical violence and emotional trauma. Teenage pregnancy rates have been reduced in recent years, but are still very high in many cities.

Another important public health need is for comprehensive prenatal care to reduce the incidence of infant mortality, low birth-weight babies, and maternal mortality and morbidity. This can be accompanied by efforts to monitor child health supervision and out-of-home child care facilities.

Many communities are struggling to support their public health departments, environmental agencies, and rural development agencies. They need ade-

[67] Meyer, J.A. and M. Regenstein. *How to Fund Public Health Activities.* Report prepared for Partnership for Prevention. Washington, DC: 1994, and personal communications with HRSA officials, 2000.

FEATURE BOX 3
PRIMARY CARE PLAN FOR THE UNINSURED
COMMUNITY VOICES – EL PASO, TEXAS

Facing one of the highest rates of uninsurance in the country, El Paso's Community Voices program developed and implemented a primary care health plan in collaboration with El Paso First Health Network. Offered through a managed care, prepaid health plan, the program targets El Paso County residents who are at or below 100% of poverty and who are not receiving similar health care benefits through Medicaid, Medicare, CHIP, or other programs. As of January 2000, the program was serving 6,560 individuals. Of these, about 38% are children, but this is expected to decline when Texas fully implements its CHIP program.

Benefits: The benefits include primary care services: physician office visits, in-network specialist care, office-based lab and x-ray. (Dental, substance abuse, mental health, inpatient and emergency services are not included in the plan.) Participating network providers include physicians and nurse practitioners, with payment rates based on Medicaid fee-for-service plus 5%.

Outreach: The program reached its enrollment goal ahead of schedule, through a targeted outreach effort that utilized Community-Based Organizations (CBOs). Ten CBOs, selected because of their established, trusted positions in their communities and their ability to identify eligible persons, were trained to conduct enrollment. The CBOs sent out fliers, met with school principals, organized enrollment sessions at places of employment and churches, and arranged for a Spanish radio station to announce the program.

Funding: A W.K. Kellogg Foundation grant is supporting infrastructure development, and the local hospital district is contributing $2 million per year to pay for the health services under the plan. These funding sources are assured for five years, during which time Community Voices hopes to develop strong relationships with various community entities with a goal of continuing the program in the future.

Source: Community Voices – El Paso, Texas. *1999 Annual Progress Report to the W.K. Kellogg Foundation,* and Personal Communication, January 2000.

quate financing to improve nutrition, sanitation, and occupational safety, as well as to provide treatment for substance abuse and to avoid and treat sexually transmitted diseases.

The federal government runs programs such as Maternal and Child Health Block Grants, Ryan White (related to HIV/AIDS) and the Migrant Health program to address many of these problems. *Nevertheless, only an estimated one percent of total health spending has been devoted to public health over the past decades, even though these outlays may be the most cost-effective expenditures in the health care system.*

Some areas are under-funded or under strong budgetary pressures. For example, operating through the Health Resources and Services Administration's Bureau of Primary Care, the National Health Service Corps awards scholarships, loan repayment plans and grants to help staff community health centers and other safety net providers in under-served communities. In this critical program to promote training and placement of primary care providers in areas of greatest need, applications far outnumber funded slots.[68] *This and other programs that focus on expanding the "pipeline" of minority health practitioners that are so important in low-income areas should be strengthened.*

Many of the specific *recommendations* that follow involve expanding efforts already undertaken by the U.S. Public Health Service and state and county

[68] Meyer, J.A. and S. Silow-Carroll. *Promoting Efficient, Effective and Equitable Health Care: The Role of HRSA.* Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, February 1996.

health departments. Some recommendations involve new efforts that can be channeled through or in collaboration with these organizations. Others can flow from public/private partnerships among state or county agencies and coalitions, business associations, health care organizations, and the philanthropic and foundation communities.

Improve the primary care system and access to it.

Once an individual is enrolled in some type of government-funded or private health insurance plan, he or she should have a regular source of quality primary and preventive health care. Opportunities for such care are greatly enhanced through: primary care clinics in accessible locations with convenient hours; school-based clinics that bring health care to children; assessment of community needs and engagement of stakeholders in improving access; addressing unmet needs such as oral and mental health; adequate staffing with cultural sensitivity and appropriate language skills; and strong community-based health promotion and education.

Ensure accessible hours and locations.

Clinics located in unsafe neighborhoods or in areas not easily accessible by public transportation pose a major logistical barrier to care. Also, office hours that conflict with normal work schedules preclude many working people from making appointments for needed services. Lack of childcare places another hurdle before mothers seeking heath care services.

Reducing these logistical barriers requires the following:

- Assure that clinics and health centers are in "safe places," either in low-crime areas or with adequate lighting and security; this may require coordination and cooperation with the local police department and municipal government;
- Improve public transportation to primary care sites (as well as to specialists and hospitals); until this is accomplished, van services or taxi reimbursement should be available;
- Ensure that primary care services are available during some evening and weekend hours in addition to daytime hours; and
- Provide a supervised play room or childcare alternative at primary care sites to permit mothers and siblings to meet with practitioners.

Support school-based clinics.

Important strides have been made in providing basic preventive and primary health care to low-income children and adolescents through school-based clinics.[69] By *bringing practitioners to where the children are*, school-based clinics overcome a number of barriers to help reach some children and adolescents who may otherwise go without health care. In a parent survey conducted by the Vision for Health/Baltimore Community Voices program, parents reported that school-based health centers enable them to "avoid having to wait long hours at the doctor's office, emergency room visits, and their child does not have to miss a day of school."[70] *School-based clinics are particularly important for lower-wage working parents who are not provided sick leave or flexible hours; these parents lose pay or risk their jobs to take a child to the doctor or dentist.*

School-based health clinics can play a key role in preventive care by ensuring appropriate immunizations, educating children and their parents about controlling asthma and other chronic conditions, and recognizing and addressing early signs of lead poisoning, malnutrition, and other social determinants of poor health. Their role can be expanded to provide comprehensive care including dental and mental health care.

In addition, the staff at school-based clinics can serve an important function in enrolling uninsured children in government-funded programs when parents are unaware of their eligibility, and referring children to needed social services.

[69] United States General Accounting Office. *Health Care Reform: School-Based Health Centers Can Promote Access to Care*. Letter Report, HEHS-94-166. Washington, DC: May 13, 1994.

[70] Vision for Health Community Voices Initiative – Baltimore, *Annual Progress Report to the W.K. Kellogg Foundation: July 1, 1998-December 31, 1999,* p. 3.

School-based health clinics need a stable source of funding. In addition to continued and enhanced federal support, these clinics should be recognized by managed care plans as "participating providers," to obtain reimbursement from public and private insurers.

Conduct community assessments to ascertain gaps and to engage stakeholders.

Community-based clinics and health centers should provide a wide range of basic health care services such as pre-natal and well-baby care, family planning services, and substance abuse treatment. But each community is unique in terms of health needs, services patterns, and availability of practitioners. Thus, community-based efforts are needed to track health problems and assess unmet needs. Such assessments can help public health departments, health planners and local agencies make necessary adjustments to fill gaps in service delivery. They also serve an important role in *engaging* community members to become more active participants in improving access to health care.

Community-based assessments, generally consisting of surveys and focus groups, have been key features in many Community Voices initiatives. *Ingham County Health Department in Michigan, for example, is a Community Voices grantee that is using interviews, meetings, focus groups, and learning sessions to assess current service provision, as well as to mobilize stakeholders for community action. These activities are described in Feature Box 4, p. 27.*

Address unmet needs such as oral health and mental health.

Community assessments often find that *oral health* is much neglected. Effectively 108 million Americans lack health insurance if oral health is considered to be an integral part of primary healthcare, because their insurance plans fail to cover or adequately cover oral health services. Because of its impact on nutrition and employability, good oral health is particularly critical for at-risk populations. Many Community Voices programs are working toward improving dental care for the underserved, by supporting the following kinds of activities:

- Mobile dental vans in low-income neighborhoods;
- Provision of dental care at school-based clinics;
- Dental services at youth correctional facilities;
- Community education about good oral health and prevention;
- Recruitment of dentists and dental hygienists in rural and underserved areas;
- Including oral health coverage in insurance plans; and
- Consortia and conferences that focus on improving oral health for at-risk populations.

In addition, it is important to incorporate oral health into primary care. *In Detroit, physicians are agreeing to do dental health screening as part of primary care visits, and other cities are similarly experimenting with "putting the teeth into primary health care." Specific efforts to improve oral health by Community Voices New Mexico are highlighted in Feature Box 5, p. 28.*

Mental health care is another critical need that is often unmet. Access to mental health care services must be improved by overcoming financial, organizational, and attitudinal barriers to treatment.

Recommendations include:[71]

- Enhancing insurance coverage of behavioral health and substance abuse care;
- Improving coordination of physical health, mental health, and social services;
- Ensuring the supply of mental health services, providers, and state-of-the-art treatment;
- Initiating public awareness campaigns stressing that mental disorders are valid, treatable conditions;
- Tailoring treatment to age, gender, race, and culture; and
- Facilitating entry into treatment, including access through primary care clinics, schools, and the child welfare system.

Improve staffing and use of allied medical professionals, and reduce language/cultural barriers.

Staffing at primary care sites must be improved. This means providing an adequate *number* of physicians,

[71] United States Department of Health and Human Services, 1999.

FEATURE BOX 4
COMMUNITY ASSESSMENT AND MOBILIZATION
INGHAM COMMUNITY VOICES, LANSING, MICHIGAN

Through the Ingham Community Voices program, the Ingham County Health Department in Michigan gathers key information about health care issues while at the same time engaging community "stakeholders" (consumers, businesses, unions, elected officials) in the process of improving access. The initiative has engaged several hundred community members in both *planning* and *capacity building* activities.

Planning for new Access Strategies includes:

- Engagement Interviews – interviews with providers, purchasers, insurers, and consumers served to document access issues for the uninsured from various perspectives;
- Community Forums – Two large-scale meetings were held in 1999 in which community members refined principles for an "organized system of care" and began developing a blueprint for change;
- Breakfast and Dinner Clubs – Nine community learning sessions focused on the uninsured population, services to the uninsured, and funding sources; and
- Targeted Focus Groups – Individuals participated in twelve focus groups, helping to enhance community involvement, especially among underserved persons and minorities.

Capacity Building includes:

- Leadership Institute – Interviews and surveys are identifying the determinants of health, barriers to access, and indicators of community health;
- Summit Teams – Strategies are being developed in response to the Leadership Institute findings by ongoing teams at neighborhood-level Health Summits;
- Health Realization Training – Hundreds of individuals have attended classes and retreats focusing on improving personal well-being, relationships, and listening skills;
- Democratized Data – A geographic information system is being developed for use by neighborhood and community teams seeking to advocate for programming and policy changes; and
- Consumer Involvement – Consumers, including uninsured individuals, have been placed on local governing and advisory bodies.

In addition, the Ingham County Health Department (the Community Voices grantee) is conducting a health assessment survey to determine changes in coverage and health provisions in the community over the past three years. It is analyzing health status data for African Americans and for Hispanic residents. Also, it is tracking utilization and demographic information on 9,000 newly covered uninsured persons through the Ingham Health Plan, and has developed case management procedures based on this information.

Sources: Ingham County Community Voices, *Annual Progress Report Year 1, July, 1998-December 31, 1999,* and Personal Communications, February 2000.

nurse practitioners, physician assistants, nurses, and support staff to avoid overcrowding and long delays, as well as optimizing the *utilization* of trained practitioners. A promising approach is the delivery of coordinated care by a team of professionals, with each member doing what he or she does best, and maintaining close contact with the others so that patient care is integrated. *This model utilizes the training and experience of nurse practitioners, midwives, physician assistants, dental hygienists, and social workers to provide frontline care in a cost-effective fashion. Physicians and dentists play important roles in this model, but their skills and knowledge are used when they are required.*

Some states have been pressured to enact "scope of practice" laws that erect barriers blocking nurses, physician assistants, and other professionals from performing at maximum levels. For example, laws may limit the ability of some professionals to func-

FEATURE BOX 5
ORAL HEALTH FOR AT-RISK POPULATIONS
COMMUNITY VOICES NEW MEXICO

Community Voices New Mexico (CVNM) is developing an oral health program to serve at-risk and underserved populations, through the Division of Dental Services at the University of New Mexico Health Science Center. CVNM is supporting 40% of the dental chief position in year 2000, and matching public and private funds support three dentists and a variety of initiatives.

Direct dental services are being provided (or planned for year 2000) in several settings in an attempt to increase access to underserved populations:

- Medicaid enrollees in the Southeast Heights area of Albuquerque;
- "Medically compromised" patients who previously had no access to care;
- Hospital patients requiring emergency dental care;
- Developmentally disabled patients;
- Residents of youth correctional facilities of the Juvenile Justice system; and
- Native American and low-income pediatric patients.

Due to the extreme shortage of oral health providers in rural areas of the state, alternative models of care for oral health services are currently under development. Recent legislation has enabled dental hygienists to function as the primary oral health provider with the consulting dentist as a specialist. Also, the University of New Mexico School of Medicine trains primary care and emergency physicians to manage oral infections and trauma through the Division of Dental Services. Emergency Medicine residents spend two weeks in the dental clinic learning techniques to provide emergency dental services. Statewide, a locum tenens program has begun to provide dental services in rural areas of the state.

CVNM, Division of Dental Services, and the Department of Health are sponsors of a new, statewide oral health council. The council's purpose is to create and support oral health legislation and policies that encourage coordinated access of care. Members include organized dentistry and dental hygiene, governmental leaders, community representatives, consumers, and public health officials.

CVNM is involved with oral health providers to develop standards of dental care for the developmentally disabled. The proposed standards set a minimum educational requirement for providers, recommend frequency of service, and implementation of a quality assurance program, scheduled to begin in the fall of 2000.

Sources: Community Voices New Mexico. *Annual Progress Report, W.K. Kellogg Foundation Community Voices, New Mexico's Shared Solutions,* December 31, 1999, and Personal Communications, February 2000.

tion without immediate supervision of doctors or dentists on site, or limit the ability of nurses to write prescriptions under any circumstances. *While these laws are defended as protecting patients' safety, they are frequently motivated by protecting one set of professionals' economic interests relative to another group's interests.* Certainly, there are many tasks and procedures that should only be performed by physicians and dentists. But many others can be safely and effectively performed by allied medical professionals, resulting in more timely care and lower costs.

The staff should be *culturally sensitive* as well, with at least some staff speaking the languages predominant among patients and all staff educated about health-related beliefs and practices of the surrounding community. This is particularly important in neighborhoods with large numbers of immigrants.

Responding to a growing Hispanic population and a survey identifying language as the primary obstacle to obtaining adequate healthcare for Hispanics, FirstHealth Community Voices in North Carolina undertook a number activities to reduce language

and cultural barriers to care. These are described in Feature Box 6, p. 30.

Strengthen health education and promotion.

A key to improving health and access to health care is *educating* people about how to lead healthy lives, and about available community resources. Health promotion campaigns teach people how to take better care of themselves and their families. It encourages people to reduce behaviors that increase their risk of health problems, such as smoking and illegal drug use. It promotes behaviors that help prevent disease and improve overall health, such as immunizations, exercise, good nutrition, and age-appropriate screening. It teaches people at risk of specific diseases how to reduce the likelihood of early onset, and educates those with chronic conditions how to minimize acute episodes. And it can be as simple as reminding people about scheduled clinic visits to reduce missed appointments.

Education about community resources and how to access them is equally important. This requires resource guides and inventories in languages appropriate to the community. The information must be disseminated widely, through media campaigns and a variety of existing community organizations such as schools, childcare centers, religious institutions, work sites, employment offices, and social service agencies. Community surveys (discussed above), in addition to identifying needs, also can play a role in educating target populations about the importance of prevention and about existing resources.

All of the Community Voices initiatives have been active in health promotion activities. *The efforts by Vision for Health/Baltimore Community Voices are described in Feature Box 7, p. 31.*

Make special efforts to assist vulnerable populations.

Expanding access to health care requires special efforts to reach *vulnerable* populations. Vulnerable groups include people with special health care needs (e.g., AIDS, substance abuse, mental health problems), minorities, undocumented as well as legal immigrants, migrant workers, people returning to the community from the criminal justice system, rural populations, and homeless people.

These groups, among others, may have particular difficulty gaining access to the health care system, requiring special services or efforts to bring them into the mainstream. Many of the recommendations already outlined in this report (e.g., applications in multiple languages, bilingual staff, out-stationing, and engaging the underserved in developing solutions) are particularly important in reaching vulnerable groups.

Although the issue of immigrant access to government-funded health care programs was addressed and resolved positively in 1999 by the Public Charge Clarification, funds were not made generally available to inform affected immigrants of this change. When such regulatory or policy changes occur, to make any difference nationally, sufficient funding must be authorized to inform the affected public of those changes and their implications.

In addition, the use of trusted community members and familiar neighborhood settings (e.g., beauty salons, churches) can help reach individuals who may be uncomfortable dealing with "official" representatives in formal settings. Finally, respectful attitudes and cultural sensitivity among outreach workers and health care practitioners are critically important (and too often neglected) in bringing vulnerable populations to and keeping them involved in the health care system.

An example of reaching out to a vulnerable group is Baltimore City Health Department's plan to open a Men's Health Center to serve uninsured males who have no funds for preventive or primary health care. The Center will have extended hours and serve men 19-64 years old. It will provide a wide range of services, including family planning referrals, immunizations, dental services, domestic violence prevention, substance abuse and mental health treatment services and referrals, AIDS/HIV and other STD screening, TB screening, high blood pressure, and diabetes diagnosis/treatment and lab services. Cultural sensitivity will be given prime importance to meet the needs of the city's various ethnic groups and to foster an inclusive program.

FEATURE BOX 6
REDUCING LANGUAGE AND CULTURAL BARRIERS
FIRSTHEALTH COMMUNITY VOICES – NORTH CAROLINA

To help meet the needs of a growing Hispanic population in their service area, FirstHealth of the Carolinas (a private, non-profit rural health care network and Community Voices grantee), has implemented the following activities:

- Training for health providers to better understand the health values and culture of Hispanic patients;
- One-day Spanish class for employees and providers;
- Home instructional training program for employees;
- Certified interpreter training program for bilingual employees and volunteers;
- Competency tests for bilingual employees to determine their skill level and for classification as Customer Service Interpreters or Medical Interpreters;
- Educational sessions for community members (primarily Hispanic) on navigating the health and social service system and referral process;
- Follow-up patient satisfaction telephone calls with Hispanic patients, and development of a Spanish survey;
- Employment of a bilingual patient representative in the Emergency Department of a network regional hospital;
- Hiring of Spanish-speaking nurse or family liaisons at school-based services; and
- Telephone Language Line providing interpreters for multiple languages, accessible in FirstHealth hospitals, primary care clinics, and dental clinics.

Additional efforts to reduce language and cultural barriers involve collaborations between FirstHealth Community Voices and other community groups includes:

- Providing leadership for BRIDGES (Bringing Resources and Information to Diverse Groups and Environments), which is working with the Hispanic population in Moore County and has conducted information fairs, CPR training, and health screenings;
- Sponsoring a multi-agency informational fair that includes assistance with immigration, health screenings, referral, and other services;
- Preparing health-related articles in Spanish for a local monthly Spanish newspaper; and
- Working with a community college to examine the effects of racial differences on community development, through a series of educational programs, surveys, and an alliance with the college's Race Relations Committee.

Sources: FirstHealth of the Carolinas, *1999 Community Voices Annual Report*, December 1999, and Personal Communications, February 2000.

Build linkages between primary care sites and diagnostic centers, specialist physicians, and hospitals.

Another way to enhance the accessibility, as well as quality of health care services is by increasing coordination and alliances among primary care clinics (or primary care group practices) and between those clinics and specialty clinics, outpatient diagnostic and in-patient treatment facilities, and social service agencies. Such linkages can help patients navigate the health care system to ensure they get the services they need in the most appropriate setting.

A coordinated *information* system among the provider settings, designed to assure confidentiality, would ensure that practitioners are abreast of prior treatments, medications, and other relevant aspects of a patient's medical history. It enables patients to

FEATURE BOX 7
HEALTH EDUCATION AND PROMOTION
VISION FOR HEALTH - BALTIMORE COMMUNITY VOICES

Building residents' capacity to manage their own health care is a key goal of the Vision for Health Community Voices' health promotion campaign. During its first 18 months, the program has helped provide culturally appropriate knowledge and tools to "create health and wellness." Their education and health promotion activities include the following:

- Monthly Vision Connection meetings to educate and inform residents on various health-related topics such as violence prevention, blood pressure screening and medication;
- Saturday workshops to teach older residents about managing their own health;
- Community-wide training programs to teach community advocates about health programs and other resources to reduce barriers to care;
- Collaboration with the Bon Secours Urban Medical Institute (UMI) to provide health promotion and outreach services to link neighborhood residents with UMI's fitness center and health education;
- An on-site Health Promotion Center in a public housing project in collaboration with the city housing department and Jobs Plus Initiative; the center is staffed by two full-time workers and two resident aids;
- Hypertension screening program in collaboration with the Black Alliance, CHAMP program, and Gilmore Homes public housing program;
- Placement of Health Promotion advocates in schools and a community center;
- A Dental Sealant program established in three elementary schools to help prevent tooth decay;
- Dental survey to identify dental needs and to educate about the importance of oral health.

Future health promotion activities involve:

- Collaboration with Sight-and-Sound to provide free eye screenings and low cost eyeglasses;
- Outreach and promotion of a continuum of care for HIV/AIDS population;
- Development of a Health Resource Directory to hand out to community residents.

Sources: Vision for Health Consortium, *Annual Progress Report to the W. K. Kellogg Foundation, Vision for Health Community Voices Initiative July 1, 1998-December 31, 1999*, and Personal Communications, February 2000.

return to primary care settings after receiving care elsewhere (hospital, emergency room, or specialist) knowing that records are automatically updated and forwarded.

Linkages between care settings also reflect and promote a more comprehensive approach to disease management. Some promising delivery models involve academic health centers and other hospitals reaching out to the community to develop a continuum of care that begins with early intervention and preventive screening.

Improve financial viability of safety net providers.

Uninsured and underinsured people can rely on safety net providers to the extent that these physicians, clinics, and hospitals remain financially viable. The shifts to managed care, public funding cutbacks, welfare reform, and increases in the number of uninsured are putting additional financial pressures on already-strained community health centers, academic medical centers, and other traditional safety net providers.

Efforts should be made to teach safety net providers how to adjust and thrive in a changing environment.

One study found the following "coping strategies" among four academic medical centers (AMCs) and the state and local governments in which they are located:[72]

- Establishment of indigent care reimbursement pools and supplemental state funding programs;
- Payments to safety net hospitals that enable them to provide the full range of services to patients with complex medical and social problems;
- AMC mergers with other hospital systems to buttress bargaining clout;
- Allowing safety net institutions the flexibility afforded non-profit businesses in their labor-management relations, purchasing of supplies and equipment, and access to capital, while maintaining the commitment to indigent care;
- Formation of close relationships between AMCs and community health centers to provide a ready source of patient flow; and
- Development of competitive, vertically integrated systems.

In addition, communities should strive to reduce excess hospital capacity, and re-deploy resources to meet vital community public health needs. Primary care clinics, too, must adjust to the competitive market by improving their skills in negotiating contracts with and attracting patients from managed care organizations. Safety net providers that are creating HMOs must learn how to work with state insurance regulators, including implementing new ways to track and submit data.

Reduce risk factors associated with social determinants of poor health.

There are a variety of ways to reduce "social determinant" risk factors that cause or exacerbate health problems. *The ability of children and parents to address environmental problems is limited, requiring broader reforms in public health as well as housing, education, law enforcement, and other areas. Specific recommendations include housing improvements, school-based asthma programs, nutrition programs, promotion of safe neighborhoods, and others.* Since many social determinants of health are poverty-related, anti-poverty programs ranging from job training to refundable tax credits can have a positive impact on health over the long run. In addition to addressing existing unhealthy conditions, the goal should be *prevention*.

There are many examples of successful programs geared toward reducing social determinants of poor health; such programs could be expanded or used as models for addressing other health risks. For example:

- The Center for Disease Control's Lead Poisoning Prevention Branch has significantly helped to reduce the incidence of lead poisoning in children. The branch was created to educate people, support research, develop programs and policies, and provide funding to state and local health departments to prevent childhood lead poisoning. Among its many accomplishments, the program developed and improved lead poisoning prevention programs in 39 states and in more than 150 counties and cities across the country, and expanded the efforts to provide follow-up care for more than 100,000 children identified with excessive blood lead levels.
- Patient management tools and programs developed for asthmatic children have been implemented throughout the country to assist children in managing their asthma. The New York City Health Department's Bureau of School Health has developed a school-based program for children identified with asthma. When a child with asthma is identified, he or she is matched up with the school nurse who will seek appropriate care for a child who does not already have a primary care physician. Additionally, the school nurse is responsible for arranging a school plan which includes providing health education materials for the child's teachers and making certain that the children and parents are aware of the importance of medication and the proper way to self-medicate. The children and parents may continue to learn about asthma management through "Open Airways for Schools," a project run by New York City school nurses through a grant provided by the American Lung Association.

[72] Meyer, J.A., M.W. Legnini, and E.K. Waldman. *Current Policy Issues Affecting Safety Net Providers*. Policy Brief. Washington, DC: Economic and Social Research Institute, August 1999.

- The Women, Infants and Children (WIC) program run by the Food and Nutrition Service of the U.S. Department of Agriculture targets low-income pregnant and lactating women who are nutritionally at risk. The WIC program provides supplemental nutritious foods, nutrition education and counseling at WIC clinics, and nutrition screening and referrals to other health, welfare and social services. Recent studies have confirmed that women who receive WIC benefits have lower rates of low birth weight babies than do women with similar incomes who do not participate in the program.

6. Financing Sources

The program initiatives and strategies designed to expand health insurance coverage and overcome barriers to care carry a price tag, and must be fully financed. The recommendations for expanding insurance to the uninsured, outlined in Section 4, require additional contributions by employers and employees, as well as government funds for: subsidies/tax credits to employers, workers, and low-income individuals and families; expansions of Medicaid and other government-funded insurance plans; outreach efforts to enroll people already eligible for public programs; and new insurance products or indigent care pools. *The programs geared toward reducing non-insurance barriers to care, described in Section 5, also require new funds or the rechanneling of existing funding streams.*

Financing has always been a thorn in the side of health care reform, with a variety of needs and interest groups competing for limited public funds. Yet to do nothing also has a price tag that all Americans bear, in terms of reduced productivity, inefficient use of health care services, higher costs to privately insured individuals, and insecurity related to the risk of losing coverage.

There are, actually, specific public funding sources that could appropriately be channeled toward programs aimed at improving access to health care. Some combination of the following sources should be adequate to cover the comprehensive reform envisioned here:

- Tap unused federal CHIP funds to increase coverage to children.
- Use federal TANF funds to increase coverage for people leaving welfare.
- Cap open-ended tax subsidies.
- Reallocate a portion of disproportionate share hospital funds.
- Use tobacco settlement funds.
- Develop community benefit legislation and conversion funds.
- Reduce health system inefficiency and inappropriate medical care.
- Coordinate fragmented funding streams, and utilize non-health funds to improve conditions that affect health.

Tap unused federal CHIP funds to increase coverage to children.

With the enactment of the State Children's Health Insurance Program (CHIP) in 1997, the federal government made available about $40 billion over ten years for states to provide health coverage for millions of uninsured children. Federal CHIP funds are available to states at an enhanced matching rate determined for each state, generally between 65 percent and 79 percent. The states' portion could be financed with general funds, tobacco settlement funds (see below), cigarette taxes, intergovernmental transfers, or other sources.

Despite the generous federal contribution, a large portion of federal funds available for CHIP/Medicaid expansion activities remains unused. In the first year CHIP funds were available to states (FY 1998), less than 20 percent of the federal allotment was utilized, with only two states – New York and South Carolina – using 100 percent of their allotted amounts. *While CHIP activity is accelerating, most states are still using their first year's federal allotment in the current third fiscal year of the program.*[73]

[73] Health Care Financing Administration data, Baltimore: U.S. Department of Health and Human Services, 1999; and Oliver, L. and M. King. *SCHIP: Money Matters.* Washington, DC: National Conference of State Legislatures, January 2000.

In addition to financing actual health care services, a portion of CHIP funds could be used for application assistance and other outreach activities. In fact, CHIP funds can be used to help children in enrolling in any government-funded or private health plan, potentially benefiting undocumented children and others not eligible for CHIP.

Use federal TANF funds to increase coverage for people leaving welfare.

Thanks to legislation easing prior restrictions, states can use a portion of "TANF" funds for outreach and enrollment initiatives to prevent changes in welfare status from causing people to lose health coverage.

The Personal Responsibility and Work Opportunity Act of 1996 allocated $500 million in federal matching funds at enhanced rates to help states de-link cash assistance (Temporary Assistance to Needy Families [TANF]) and Medicaid eligibility determinations. While the original legislation allowed states four years to use these funds with a sunset provision, a very low take-up rate led to elimination of this restriction.[74]

Thus, the states now have the latitude and the time to develop innovative strategies for assuring that people who lose cash assistance may retain Medicaid coverage – at least during a transition period until they are able to secure private coverage (many people leaving welfare take jobs without health benefits).

Activities already underway in the states include informational brochures; public service announcements; billboards, posters, and print advertising; training for health care providers, school personnel, staff of community organizations, and public health agencies; and efforts to re-contact and reinstate people whose cases were recently closed.[75] States can go further to take advantage of available federal dollars, using TANF funds for transportation, support groups, and other creative ways to ensure coverage.

Cap open-ended tax subsidies.

Dollars for broadening insurance coverage and improving access to care could be made available by placing a cap on federal health-related tax subsidies. Federal and state governments forgo an estimated $125 billion a year in revenues associated with special tax breaks related to health care, with the primary subsidy related to the ability of employees to exclude from their federal tax liability, without limit, the value of their employers' contributions to their health coverage. In fact,[76] the federal government provided more in health-related tax subsidies in 1998 than it spent for its share of Medicaid. *But while Medicaid is targeted to the low-income population, the bulk of this tax expenditure flows to middle- and upper-income households.*

The federal government could set a ceiling on the amount of employer contributions to health coverage that employees may exclude from their tax liability, for example at a level of $4,000 a year for family coverage and $2,000 a year for single coverage. This would still allow workers to exclude the bulk of their employers' contribution while raising substantial revenues that could be better targeted to families who are unable to afford health coverage. In addition, such a ceiling would provide incentives for employees to select health plans in a cost-conscious manner and introduce more cost discipline into the health care system.

[74] As of June 30,1999, only $50 million, or 10 percent of the available funds, had been drawn down by the states. The cost of this delay in using available federal assistance is reflected in the recent decline in Medicaid enrollment – a break in the long-term upward trend in Medicaid coverage. Between 1996 and 1998, the number of children on Medicaid living in households with incomes below the federal poverty line (FPL) declined by 1.3 million, from 9.2 million to 7.9 million. Sadly, this decline fully offset the enrollment in the CHIP program over that period, leaving the number of uninsured children roughly the same as it was when CHIP was enacted in 1997. (Cohen Ross, D., and J. Guyer. *Congress Lifts the Sunset on "$500 Million Fund" and Extends Opportunities for States to Ensure Parents and Children Do Not Lose Health Coverage.* Washington, DC: Center on Budget and Policy Priorities, December 1999).

[75] Cohen Ross and Guyer, December 1999.

[76] Sheils and Hogan, 1999.

Reallocate a portion of disproportionate share hospital funds.

States can take several steps to utilize the flexibility built into Medicaid's Disproportionate Share Hospital (DSH) program to create funding sources to improve access to care for vulnerable populations.

Enacted in 1981, the DSH program was intended to support hospitals serving large numbers of Medicaid enrollees and indigent patients. States are expected to receive an estimated $9.2 billion in DSH funds from the federal government in fiscal year 2000.[77] This represents about eight percent of federal spending on Medicaid, on average, although there is considerable variation across states. Despite some federal budget cuts in DSH payments enacted in 1997, over the next five years, federal DSH spending is expected to be about two and a half times as much as federal contributions to states under CHIP. States can optimize DSH funds to improve access in a number of ways.

First, many states have not used all available DSH funds. Pennsylvania, for example, used only 55 percent of available DSH funds in 1998 while Kansas used 53 percent.[78]

Second, states should be discouraged from using large portions of DSH funds for outlays they would make anyway with their own funds – in order to free up money for other purposes (e.g., roads, tax cuts) completely unrelated to health. For example, states might use a large proportion of their federal DSH funds to pay for mental health facilities for which they would normally use state-only dollars. This "fungibility" of DSH money can limit the program's positive impact on health.

Third, states can take steps to assure that net DSH payments (gross payments less intergovernmental transfers) flow to institutions serving the largest numbers of Medicaid and indigent patients. There are indications that DSH fund distribution sometimes reflects differences in clout among hospitals rather than the portion of vulnerable patients served.

Fourth, states can place some requirements on facilities related to their efforts to improve primary and preventive care. Although DSH is a program to assist *hospitals* (and all funds must flow through hospitals), states can require hospitals to use a certain portion of their DSH funds for *primary care.* In Georgia, for example, hospitals seeking DSH funds must file an annual primary care plan with the state showing how they will use at least 15 percent of their net DSH allocation for primary care. This 15 percent share of DSH can be used to construct primary care clinics for the homeless; to provide primary care to the medically indigent, women, and minorities; to conduct health screenings; and to fund initiatives to reduce infant mortality. Georgia and other states have also used some of its DSH funds to expand Medicaid coverage. Tennessee and Hawaii have folded their DSH funds into their Section 1115 waivers prior to 1995, which was the base year for the calculation of the DSH allotments.[79] This expands Medicaid to previously ineligible populations.

Use tobacco settlement funds.

Another source of funds emerges from settlements between the states and tobacco manufacturers. In 1998, the attorneys general of forty-six states, five commonwealths and territories, and the District of Columbia reached an agreement with the five major tobacco companies, representing 97.5 percent of the industry. The tobacco companies will pay the states $206 billion over the next 26 years. Four other states – Florida, Minnesota, Mississippi, and Texas – settled individually with the tobacco industry for more than $40 billion.

The tobacco settlement contains a number of provisions designed to curb youth smoking, including banning the use of cartoons and the targeting of youth in advertising, promotion, packaging, and labeling of products. It also bans outdoor advertising, transit advertising, the distribution and sale of apparel and merchandise with brand-name logos, brand names for stadiums, and brand name sponsorship of events where the paid participants or contestants are underage.

[77] Guyer, J., A. Schneider, and M.O. Spivey. *Untangling DSH: A Guide for Community Groups to Using the Medicaid DSH Program to Promote Access to Care.* Boston: The Access Project, forthcoming June 2000.

[78] Guyer, Schneider, and Spivey, 2000.

[79] Guyer, Schneider, and Spivey, 2000.

Under the agreement, a payment to states of $4.5 billion on April 15, 2000 will be followed by annual payments increasing to $8 billion in 2004. The settlement also provides for "up front" payments of $13 billion over the 1998-2003 period.[80]

Key public health provisions of the agreement are included in consent decrees to be filed in each state. Clearly, there will be a good deal of debate and controversy over which health-related needs deserve top priority (e.g., health education in schools versus efforts to expand health services). The bottom line, however, is that the settlements provide a large amount of funding. Texas, for example, received the largest amount of CHIP funding in any state, but still expects to receive more funds from its tobacco settlement than under CHIP. The challenge is to direct a significant portion of tobacco funds to meeting basic health care needs of vulnerable populations.

Develop community benefit legislation and conversion funds.

"Community benefit" legislation can assist vulnerable populations to gain access to health care by imposing certain requirements on nonprofit providers if they want to retain their tax-exempt status. Such requirements may relate to the provision of all types of health care – not just emergency treatment – to any patient seeking it, including those who cannot pay. Similar types of legislation may be used to require organizations converting from nonprofit to for-profit status to establish foundations committed to improving access to health care for disadvantaged groups.

Federal legislation provides a rather loose and flexible standard that places very general responsibilities on nonprofit hospitals to be responsive to the needs of their communities. In order to maintain their federal tax exemption, nonprofit hospitals must meet federal standards including: having a board of directors composed of individuals drawn from the community, having an open medical staff, providing nondiscriminatory treatment to Medicare and Medicaid patients, and maintaining an emergency room open to all without regard to ability to pay.[81]

States can and should go further to tie the tax exemption to efforts to meet access needs in their communities. Eight states have already done so, expanding on the federal statute and enacting their own community benefit legislation. First, New York, California, Indiana, and Idaho enacted planning and reporting laws requiring that nonprofit hospitals assess the health care needs of their communities, develop community benefit plans responsive to identified community needs, and periodically report to oversight agencies detailed information on the amount and types of community benefit they provide. Massachusetts has a similar initiative, but it is voluntary, and the state has issued guidelines for both hospitals and HMOs.

Second, Texas, Pennsylvania, and Utah have established minimum expenditure requirements. This more prescriptive approach requires hospitals to provide a minimum amount of community benefit (including charity care) in addition to requiring process-oriented planning and reporting. Pennsylvania and Utah have specific standards for local property tax exemption that mandate community benefit outlays.

Only Texas and Indiana have provisions in their laws calling for the imposition of specific penalties on hospitals for failing to report the required information in line with community benefit legislation. These provisions allow the respective oversight agencies to assess a penalty of up to $1,000 for each day that a hospital fails to file a community benefit report. In Pennsylvania and Utah, an institution that fails to comply with the statute is not eligible for a tax exemption. Other states do not have specific penalties. None of these states has tied compliance to receipt of DSH funds.

Some states, such as California, have required health plans converting from non-profit to for-profit status to set aside a certain amount of conversion funds to be used to promote better access to care for vulnerable populations. This frequently means using the money to set up a new foundation making grants related to access to care.

[80] National Governors' Association, Web site <www.nga.org>.

[81] Coalition for Nonprofit Health Care. *Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations.* Washington, DC: July 1999.

Reduce health system inefficiency and inappropriate medical care.

While estimates vary, there is mounting evidence that a substantial amount of money is wasted in the delivery of inappropriate, and in some cases, dangerous medical care, as well as the failure to deliver medically appropriate primary and preventive care in a timely fashion.[82] Through concerted efforts to reduce errors and inappropriate care, and to enhance prevention and health promotion, we could channel some of the savings into the kinds of unmet needs outlined in this report.

Medical errors alone are estimated to be responsible for injury in as many as one of every twenty-five patients, and one in seven injuries result in death (approximately 180,000 deaths per year). Such errors are estimated to cost up to $100 billion per year in the U.S.[83]

Also, various studies document the failure to deliver timely preventive care with proven effectiveness. For example:

- Only 50 percent of people actually received preventive care that was recommended by their health care provider;[84]
- 54 percent of patients with diabetes did not see an ophthalmologist during the prior year even though complications involving eyesight are a serious threat for patients with diabetes;[85] and
- Only 50 percent of Medicare enrollees who survived first heart attacks received beta-blockers, which substantially reduce the likelihood of second heart attacks among people who survive the first one.[86]

An effective program that both increases the use of timely preventive care and reduces inappropriate medical care can reduce mortality rates and improve quality of life while at the same time save substantial amounts of money. Physicians, hospitals, and medical researchers should continue to develop practice protocols to identify best medical practices. Managed care organizations should be held accountable by employers and government to work with providers in their networks to adhere to these protocols. Most importantly, purchasers, health plans, and providers need to work together to determine how savings from better patterns of care can be channeled into assistance for vulnerable populations facing barriers to health care access.

Coordinate fragmented funding streams, and utilize non-health funds to improve conditions that affect health.

Many of the non-insurance barriers to care are addressed through a scattered and often uncoordinated array of categorical programs that fall outside of the traditional health care model. *Programs offering food supplements, family planning assistance, substance abuse treatment, transportation, and housing assistance are typically not coordinated with health services. Also, these services are often inadequately funded, with long queues for participation.*

States should consider integrating or consolidating some of the fragmented funding streams so that the wide range of services that affect public health are managed in a coordinated fashion. In some cases, funding could be re-deployed from a social service program into Medicaid, so that payments to health plans serving lower-income people are adequate to cover some of these vital services. Health plans cannot be expected to provide nutritional services, substance abuse treat-

[82] One comprehensive study found that 30 percent of patients received contraindicated acute care (meaning that care that should not have been delivered was delivered); 40 percent of patients with chronic illnesses or disabilities did not receive recommended chronic care; and 20 percent of such patients received contraindicated chronic care. (Schuster, M.A., E.A. McGlynn, and R.H. Brook. "How Good is the Quality of Health Care in the United States?" *Milbank Quarterly*, 76:4, December 1998)

[83] Agency for Health Care Policy and Research. "Reducing Errors in Health Care." *Research in Action*, September 1998.

[84] Schuster, McGlynn, and Brook, December 1998.

[85] Weiner, J.P., et al. "Variation in Office-Based Quality. A Claims-Based Profile of Care Provided to Medicare Patients With Diabetes." *Journal of the American Medical Association,* 273(19): 1503-8, May 17, 1995.

[86] Krumholz, H.M., et al. "National Use and Effectiveness of Beta-Blockers for the Treatment of Elderly Patients After Acute Myocardial Infarction: National Cooperative Cardiovascular Project." *Journal of the American Medical Association,* 280(7): 623-9, August 19, 1998.

ment, or transportation if they are not being paid to do so. Integrating funding could help manage both health care and supportive social services under one roof.

Further, *states could utilize funds dedicated to housing, education, law enforcement, the environment, and anti-poverty programs to improve the conditions that impact health.* Better housing, safer streets, better-trained and educated workers, and purer air and water quality will reduce the need for health care services, and improve health and productivity.

7. Conclusion

The booming U.S. economy masks a disturbing reality. At a time of low unemployment and unprecedented prosperity, a basic need – regular access to quality health care – remains unfulfilled for millions of Americans. Further, the problem is getting worse, with the number of people without health insurance projected to continue rising *even under continued economic growth.*

But the access problem is not limited to lack of health insurance. There is a multitude of *non-insurance* barriers that keep people – particularly the most vulnerable populations – from receiving the medical care they need. Many of these barriers are related to the accessibility of health care services, but others go beyond the health care system entirely. *Social determinants* such as housing, crime, nutrition, and other poverty-related conditions have a profound influence on health and well-being.

In this report we have delineated the varied forces driving the current access problem. *Only by understanding the many factors that have led us to the current situation can we begin to outline a framework for addressing the problem.*

This report presented a series of policy recommendations that constitute a comprehensive, multi-faceted program of reform. The multi-pronged approach is necessary to address the multitude of underlying forces and aspects of the problem. It included policies geared to:

- Expand insurance to working individuals and families with low/moderate incomes;
- Enroll children and others eligible but not enrolled in government-funded programs;
- Develop new programs for those ineligible for existing private and government-funded coverage; and
- Address the non-insurance barriers to health care and social determinants faced by disadvantaged populations.

Acknowledging that these reforms require new funds and/or the re-channeling of existing funding streams, the report laid out a number of potential financing sources. The strategy combines contributions from employers, employees, and government.

We do not intend to imply that there is a simple solution to the access problem. All of the reforms suggested here involve tradeoffs and many face political and administrative obstacles. Further, despite the list of funding sources, there are always competing needs that are just as real. *This report argues, however, that the current trend is leaving far too many Americans insecure about meeting health care needs. And all Americans are bearing the cost of the access problem in a variety of ways.*

Now is the time to reverse the trend. Improving access to health care not only brings security and peace of mind to millions of families, but also fosters a more productive workforce and cohesive society. ◆

GLOSSARY

CHIP or S-CHIP – The State Children's Health Insurance Program

CHIP is a federal block grant program, created by the Balanced Budget Act of 1997, that was designed to help states provide health insurance coverage to children whose family income is too high to be eligible for Medicaid, but too low to afford private coverage. With its federal CHIP allotment and required state matching funds, a state can expand Medicaid eligibility or create a separate state-run program to provide health insurance for children under age 19 with family incomes up to 200 percent of poverty.

COBRA – Consolidated Omnibus Reconciliation Act of 1986

COBRA requires employers to offer employees and their dependents the opportunity to continue their employer-sponsored group health plan coverage upon the occurrence of certain "qualifying events." These events include termination of employment, layoff, death and other events that cause employees to lose their employer-sponsored health insurance. In general, employers are required to offer COBRA coverage for 18 or 36 months. Certain provisions of COBRA were modified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DSH – Disproportionate Share Hospital Payment Adjustment Program

The federal Medicaid DSH program requires states to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" by making supplemental payments for inpatient hospital care services to hospitals that serve large numbers of Medicaid and uninsured patients. A state must make DSH expenditures before it can receive Medicaid matching funds from the federal government for covering these services.

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIPAA is federal legislation that regulates the sale of health insurance in the small-group market to encourage broader risk pooling. HIPAA prohibits insurers from denying coverage to any employer, limits insurers' ability to exclude coverage for prior medical conditions, and provides greater assurance that people will not be denied coverage when they change jobs. HIPAA does not regulate premiums; this is left up to states. The legislation provides limited assurance of being able to convert group coverage to individual coverage.

Medicaid (Title XIX of the Social Security Act)

Medicaid is an entitlement program, funded and sponsored jointly by the federal and state governments, that provides health insurance coverage to certain low-income individuals and families. Medicaid was enacted in 1965 as an amendment to the Social Security Act. The federal government establishes broad national guidelines for the program, but states are given flexibility in establishing eligibility standards, determining the type, amount, duration and scope of benefit coverage, determining payment rates for covered services, and administering the program.

TANF – Temporary Assistance for Needy Families

TANF is a federal block grant program that was created under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also called Welfare Reform. TANF replaced the Aid to Families with Dependent Children (AFDC) program that was commonly referred to as welfare. TANF provides limited and temporary financial assistance and work opportunities for needy families by granting states federal funds and flexibility to develop and implement their own welfare programs. In return, the federal government requires measurable results related to moving families into work and self-sufficiency.

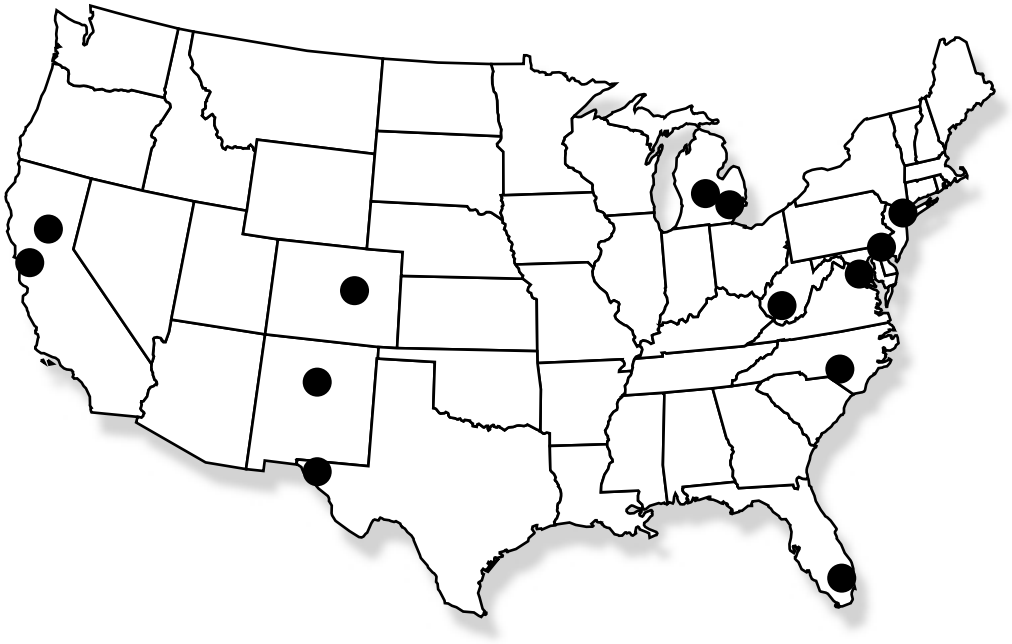
Tax Subsidies

Tax subsidies for health care consist of preferential income tax treatment of contributions to the cost of health care premiums made by employers and employees, as well as out-of-pocket expenditures for health care made by families that exceed a certain proportion of their incomes. The largest tax subsidy related to health care involves allowing employees to exclude their employers' contribution to health coverage from their income for purposes of calculating federal income tax liability.

WIC – Special Supplemental Nutrition Program for Women, Infants and Children

WIC is a federal nutrition program administered by the United States Department of Agriculture. The program provides food supplements through a voucher system, nutrition education and counseling, and access to health services through referrals to low-income women, infants and children. States and localities and almost 50,000 merchants across the country cooperate and participate in the program.

COMMUNITY VOICES LEARNING LABORATORIES



The W.K. Kellogg Foundation's five-year initiative Community Voices: HealthCare for the Underserved has thirteen diverse communities – or learning laboratories – across the country.

These thirteen learning laboratories serve as working centers that will sort out what works from what does not in meeting the needs of those who receive inadequate or no healthcare.

These learning laboratories were selected to serve some of the hardest-to-reach populations including those living in poor urban and rural areas, immigrants, Native Americans and the homeless. The communities are:

- Alameda County/Oakland, California
- Albuquerque, New Mexico
- Baltimore, Maryland
- California Native Americans
- Denver, Colorado
- Detroit, Michigan
- El Paso, Texas
- Lansing/Ingham County, Michigan
- Miami, Florida
- North Carolina (select rural counties)
- Northern Manhattan, New York
- Washington, DC
- West Virginia

The learning laboratories will conduct a range of activities aimed at reducing the number of people without healthcare coverage. They will utilize community-based programs to reach those most often slipping through the cracks of the healthcare safety net. The Foundation is providing each learning laboratory with a nationally recognized resource team of consultants to assist with communications, public policy and evaluation.

The four broad outcomes of models for Community Voices include:

- *Increasing access to community health services for the underserved and uninsured focusing on primary care and prevention.*

- *Preserving and strengthening community health services while communities work to build a healthier environment for all.*
- *Changing community health delivery systems to foster more cost-effective, high-quality care.*
- *Establishing community models of best practices providing different approaches and strategies other communities can select from and adapt to their own unique circumstances.*

The ultimate goal of Community Voices is that the learning laboratories will develop models that other locations can select and adapt to best meet their own local needs and circumstances. The models built will include providers, community members, community organizations, and community-based health and human service agencies that can contribute to improving health and healthcare.

The learning laboratories are establishing service networks. They are using the Foundation's five-year grants to support dedicated human resources, time and infrastructure development to design, plan, test, implement, refine and firmly root cost-effective delivery systems.

Informing policy is an integral part of the work of each learning laboratory. Policy issues related to the project goals of sustaining the safety net and expanding coverage for uninsured and underinsured individuals and families are being identified, examined and studied. In addition, communications is a key component to each of the learning laboratories' activities. At the beginning of the initiative the learning laboratories participated in a media training session. Site visits and other meetings have also taken place to help equip the learning laboratories with the necessary skills to effectively develop and integrate communications plans into their activities. Lastly, evaluation of the whole initiative will be conducted and each learning laboratory will also conduct its own evaluation.

The W.K. Kellogg Foundation was established in 1930 to *help people help themselves.* To achieve the greatest impact, the Foundation targets its grants toward specific areas. These include: health; food systems and rural development; youth and education, and higher education; and philanthropy and volunteerism. Within these areas, attention is given to the cross-cutting themes of leadership; information systems/technology; capitalizing on diversity; and social and economic community development programming. Grants are concentrated in the United States, Latin America and the Caribbean, and the southern African countries of Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe.

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OTHER PUBLICATIONS

The Community Voices Publication Series

The 13 communities selected to be part of the Kellogg Foundation's Community Voices: Healthcare for the Underserved initiative function as learning laboratories.

As a result of the focused work done, both individually and collectively by the learning laboratories, the Community Voices initiative has identified a series of health issues and concerns. These concerns are being addressed in two ways: experimenting with innovative solutions at the local level and raising public attention at the national level. The publication series developed by Community Voices will document the efforts as well as market and promote the findings.

The following published reports are available for downloading at: www.communityvoices.org

- *Oral Health for All: Policy for Available, Accessible, and Acceptable Care*
- *State of the States: Overview of 1999 State Legislation on Access to Oral Health*
- *Disparity Cavity*

Other topics in the publication series will include:

- Increasing Access: Building Working Solutions Part II
- Mental Health Parity
- Mental Health
- Substance Abuse
- School-Based Health Care
- Men's Health: Coverage and Payment Deficiencies
- Women's Health: Gaps in Coverage for those Aged 54-65
- Service-Worker Industry
- Insurance Practices
- Community Expectations from the Healthcare System
- Health Professions Education, Minority Taxpayers & Community Benefit
- Oral Health
  - – Big Cavity
  - – Adult Access to Oral Health
- Media Training
- Social Determinants of Health and its Policy Implications
- Asian American Health
- Small Business – Coverage for Workers
- Data Shortcomings – Community Characterization

To check on the release of these publications in the coming months, please visit the Community Voices web site at www.communityvoices.org

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