La Fe Policy Research and Education Center

Promoviendo Bienestar para Familias y Comunidad con Conocimiento, Confianza y Poder

Promoting Family and Community Well-Being through Knowledge, Trust and Empowerment

Reframing Health Care Reform: Latinos for a National Comprehensive Public Health Care Insurance Plan

Policy Brief

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I. INTRODUCTION

The current crisis in U.S. health care has a disproportionate negative impact on the health and financial security of millions of working Latinos.[1] Latino "bienestar" (well-being) is negatively impacted by a lack of equitable access to culturally and linguistically responsive quality health care.

For Texans, living on the forefront of this crisis, the lack of equitable health care is transforming the quality of life of their communities. Latinos are the most uninsured population across the country. They represent 37%, 39%, and 36% of all the uninsured population in the U.S. and Texas, and Texas/Mexico Border communities respectively. The health disparities[2] in Latino families and communities are intensified by the inequity in access to health care. The impact is devastating in terms of unnecessary suffering, costs, and lost productivity and self-sufficiency.

For nearly forty years, the history of health care reform at the national and state level can be amply described in one word – failure. For individuals and families access to affordable quality health care has worsened such that over 60 millions Americans have no health insurance coverage.[3] Yet, "there is a great deal of resistance to reform health care because industry players make so much money from the current system."[4] U.S. health care demonstrates significant amounts of rationing (particularly among the most vulnerable), is costly, retains minimal provider choice, is predominantly non-competitive, and of poor quality by most objective measures and comparability.[5]

Unlike most modern Western nations we do not treat health policy as a national responsibility reflecting a social contract affording everyone access to a comprehensive health care regardless of ones ability to pay.[6] Extensive research documents that the inefficiencies and inequities in U.S. health care cause death, disability, and health and financial risks for many Americans; and severely diminish our country's economic productivity.[7] Further, safety-net services are not enough to prevent avoidable illness, worse health outcomes, and premature death.[8] For people of color, as Latinos the inequities and health disparities are particularly salient.

Both a lack of and inadequate health insurance coverage is a major disparity for Latinos thereby limiting their opportunity to regular health/medical care home. The social determinants of Latinos, calls for policymakers to be sensitive to the most optimal means to improve access, reduce cost and address health disparities for Latinos. **That is why it is imperative that a public health insurance option be part of any major health care reform.**

A public health insurance system is premised on health and medical care as a personal social contract between ones/family health needs and providers of care, as opposed to a consumer commodity to be bargained for in a purported private market-driven health industry.[9] Most Americans want to expand health insurance coverage to all, contain cost, improve health care quality, and support an infrastructure that will eliminate racial and ethnic health disparities. None of which, has been achieved though espoused over the past three decades that such improvement would be accomplished by a litany of health industry representatives.

The realities of seemingly unlimited financial resources, lobbying expertise and political sway of corporate business and major health industry interest as the health insurance, pharmaceutical, hospitals are well understood. There efforts to derail any serious consideration for meaningful national "public health insurance" plan are already underway. **Nonetheless, failure to have a single-payer or other public health insurance option will continue to harm our nation's health and economic productivity, and disproportionately continue to worsen the bienestar of Latinos.**

So as the Obama Administration, Congress and key stakeholders embark on the most significant policy legislation since the New Deal, Latinos are poised to reclaim their bienestar by articulating their health care needs and engage in this process. Thus, we believe that the most optimal means for transforming Latino health care must include a public health option given the unique challenges facing Texas and Latinos.

II. HEALTH INSURANCE DISPARITY AND ACCESS

The appalling number of uninsured in Texas and on the U.S.-Mexico Border is having a devastating impact on the bienestar and health status of our communities and overwhelming our limited social safety-nets. *The challenge of health care accessibility for Latinos must include a multifaceted approach that: reduces the number of uninsured, improves access to culturally competent health care professionals of color, provides an alternative to Employer Sponsored Insurance (ESI) and eliminate immigration status requirements as determinate for coverage in any new health care reform plan*.

Reduce Uninsured

Latinos represent about 6 in 10 of the uninsured Texans. Recently released data indicate that 60.4% of Latinos, and 43.0% of Blacks were uninsured, compared to 29.2 percent of non-Latino Whites.

Texas perennially ranks 1st in the country as having the highest percentage of uninsured (25%). The state is attempting to address this unwanted ranking through reforming programs like Medicaid and CHIP, and other mechanisms such as state-supported reinsurance subsidize coverage program and health insurance regulatory changes, or programs that target creating opportunities for small-business to offer health insurance coverage. Texas has had limited success in reducing the growing number of its uninsured and under-insured citizens.[10]

Increase Health Professionals of Color

In 2007, Texas ranked second nationally in the number of health professional shortage areas of primary care, mental health, dental and nursing.

Vital to healthy outcomes and addressing health care challenges facing Latinos is the access to culturally competent health professional of color. Latinos have the highest percentage of uninsured and most likely to reside in the 119 of 246 Texas counties identified as health

professional shortage area. This is intensified by the lack of bilingual, bicultural health professionals, particularly physicians, dentist and pharmacist. To achieve parity with Latino population today, the number of Latino health professional parity particularly for Physicians must triple. *Thus, any national public health plan must give attention to increasing the health care workforce with a target focus on increasing primary health care providers, and health professionals of color.*

Provide ESI Alternative

Latinos disproportionately face health insurance disparities in comparison to non-Latino Whites with the same level of education and whether they are employed or unemployed.

Latinos lack the access to Employer Sponsored Insurance (ESI). For non-elderly Latinos, only 37% are covered through ESI compared to 64% of Non Latinos.

As the primary system for health coverage, ESI continues to decline in Texas. An alternative to ESI is needed to meet the health insurance disparities facing Latinos. With health care trends shifting more toward personal responsibility and cost to individuals, Latinos are experiencing the brunt of these trends. *Given their propensity to be employed in small business with limited access to affordable health care coverage and be uninsured, access to health care coverage must include a public health option.*

According to the Texas Department of Insurance, Texas has a large proportion of workers employed by small businesses. Almost 400,000 small businesses employ nearly 3 million Texans, but only about one in four of these companies offer health insurance to their employees. Many workers are in industries that have traditionally not offered health benefits, such as construction, agriculture, retail sales and service positions. The number of small businesses offering ESI has slowly been declining, from 1.4 million individuals covered in 2000 to 1.1 million in 2005 among an approximate 22% (86,106) of all small businesses. [11]

A recent analysis of health benefits among employers and employees found a wide range of cost exposure over time and by occupation and establishment size. A particularly important findings by the Kaiser Family Foundation in its publication, *Employer Health Insurance Cost and Worker Compensation* notes "Employer costs per hour for health insurance were higher for workers in higher wage occupations than for workers in lower wage occupations, but overall employer cost represented a lower percentage of payrolls for workers in high wage occupations that for workers in low wage occupations."[12] This finding is complementary to other policy research findings regarding ESI offered, their benefit and affordability, and take-up rates among different size establishments.[13]

Address Immigration

Latinos represent 58%, 48%, and 73% of the Non-Citizen population in the U.S., Non-Border States and Border States, respectively. About 41 % of U.S. Non-Citizen Population resides in states along the border. (Source: Current Population Survey, 2008)

Any new public health option must include all individuals regardless of immigration status. The exclusion of immigrants places undo strains on the health care system especially in Latino and border communities as they fall into the uninsured population silo. Currently, U.S. - Mexico States and their contiguous border communities exemplify the highest concentration of uninsured.

With a dismal outlook for expanding ESI in Texas and largest percentage of uninsured, we have increasing concerns regarding the exclusion of sectors of the uninsured (immigrants). The unintended consequence of not addressing immigration in national health care reform will result in an exacerbated two class system that placed undo burden on emergency rooms and Federally Qualified Health Clinics (FQHC) [14] and jeopardizes the health security of communities. *Thus, access to health care cannot be contingent on immigration status. All individuals should be responsible for contributing to and transforming their own health care.*

III. HEALTH INSURANCE DISPARITY AND AFFORDABILITY

The issue of affordability is salient given Latinos' propensity to be most likely to live in poverty, have lower education attainment, and be uninsured and employed. *Hence, health care reform efforts must put emphasis on affordability and reforms that reduce the cost of health care given Texas's diverse population, socio-economic condition and their elasticity to afford health insurance.*

Address Affordability

Latinos have lower levels of income compared to non-Latinos: 25% live below 100% of the Federal Poverty Level (FPL), 48% live between 100% and below 300% FPL, and only 9% live over 500% of the FPL. For non-Latinos, 11%, 28%, and 34% live at the respective percentages of the FPL.

The affordability of health care for individuals and families is a central concern in current federal and state health care reform efforts. As a policy decision, what is affordable is a critically important question in deciding what type of program design will best reduce the number of uninsured and under-insured. Approximately one-third to one-half of Texas Latinos has limited opportunity to purchase health insurance coverage because of their low Median Household Income (MHI), family size, and high numbers employed in small businesses. The limited to no elasticity for affording health insurance or health care cost-sharing is consistent in all the States' Metropolitan Statistical Areas (MSA), and in Border and rural communities. As a result, their access to health care is limited and their health and financial insecurity risks increase.

According to the Center for Public Policy Priorities' Basic Family budget estimator (2005), in no MSA in Texas can an individual live off the income set by the federal poverty guidelines (FPL).[15] To create a "culture of insurance coverage" is an espoused cliché that is not very helpful for families in economic circumstances where financial sustainability decisions are very difficult at best. In Texas, where adult eligibility for Medicaid is very income-restricted (22.3% FPL), it is particularly demonstrated.

It's evident that the FPL, which is the measure of need for Medicaid and other social services, is a terribly inaccurate estimation of what it takes to live anywhere in the state and country. The cost of living estimates produced by the Center for Public Policy Priorities are, for all areas and family sizes, mostly between 150% and 250% of FPL and even so, they are bare bones--they are the cost of sustainability and include no extras.

Intensifying the situation is a 2009 study which found that growth in premiums in Texas grew 5.8 times faster than wages from 2000 to 2007 and doubled in last nine years. This outpaced the national average which experienced growth in premiums three times that of wages nationally. According to American Medical Association, 2008 study, Texas's largest health insurers held 44% of share of Texas market The U.S. Dept of Justice considers Texas a "highly concentrated" health market where the two largest health insurance companies (both subsidiaries) holding 68% of the Texas market.[16]

Health care determinants such as income, education, employment patterns, language, and neighborhood environments impact what is affordable for individuals and families. Health care costs and affordability are particularly relevant to income, i.e., they contribute significantly to income disparities – stagnant wages and raising costs make it difficult if not impossible to afford health care.

IV. CHANGING DEMOGRAPHICS AND HEALTH DISPARITIES

Over the next decade, the changing demography will not only see a shift in the prevalence of disease from Whites to Latinos but also exacerbate existing health disparities. Noted in a recent White House summary report, racial and ethnic minorities experienced disproportionate higher rates of disease, fewer treatment options and reduced access to care.[17] *Therefore, the socio-economic, health disparities and environmental circumstances of uninsured Latinos must be considered in the development and implementation of an effective public health option.*

Address Health Disparities

Approximately a quarter of Latinos identify their health status as fair or poor health and one and three are uninsured. Real transformative health care not be realized without addressing existing health disparities.

Latinos are a hard-working and resilient group in the United States who represent 41.3 million or 14.1% of the total U.S. population of 293.7 million (U.S. Census/July 2004). The growth of the Latino population since 2000 is 17% as compared to an estimated 3% for non-Latinos. They accounted for 49% of all population growth since 2000. Their large growth is partly a function

of their youth; their median age is 26.9 (peak women fertility years) compared to the non-Latino White median age of 40, plus one in five children in the U.S. under age 18 is Latino. Recently, U.S. Latino births have also overtaken immigration as one of the largest contributors for the populations' growth.

In 2005, Texas was propelled into the "Minority Majority" status by significant growth among Latino population and other racial groups. Of the 22.8 million Texans, Latino accounted for 36.5% of the state's population; Whites were 47.8%; and Blacks comprised 11.5%. The Mexican-origin sub-group accounts for 76% of the total Latino population. Citizenship among Latino is 70% native, and 6% and 24% identified as naturalized and not-a-citizen respectively. Latinos are projected to represent over 53% in 2040 of the Texas population compared to 32% and 10% for Anglos and Blacks respectively.

Children 6-12 yrs old make up 11% of the Texas population with 43% of children in that aged group being Latino. Children 1-5 yrs old make up 8% of the state's population with 48% of children in that aged group being Latino. The median age of Hispanics is 26.6 whereas Texas' median age is 32. In addition, Latino seniors represent the second fastest growing group among the senior-age (65+) populations.

Data reported by Texas State Data Center found that Latino were more likely to identify in fair/poor health (26.3%) compared to Whites (15%), Blacks (22.4%) and other (17.8%). While, other fair/poor health indicators such as no high school diploma (40.6%), income less than $25,000 and no health insurance (26.5%) parallel demographic characteristics of Latinos. Region is also an indicator of fair/poor health in Texas specifically in non-urban areas.

As the health status of Latinos is worsening, it is transforming the health status landscape and setting the stage for insurmountable levels of chronic disease. With obesity as a precursor, it is estimated that Texas will surpass 33% (BMI over 30) by 2040. By that same period, Blacks and Hispanics will also reach record percentage of individuals who are obese at 50%. Hispanic children have the largest risk of obesity in the country and throughout Texas.

There is clear evidence that diabetes has become an epidemic given the rising numbers of diagnosed and projected undiagnosed diabetics. Hispanics are disproportionately impacted with diabetes. The prevalence of diabetes among Hispanic is 12.3% compared to 8.5% for Anglos. The highest prevalence's of diabetes across populations occurs more in women than men, those age 44 and above, and those with less than a high school education.

The incidence of diabetes for Hispanics in most often much higher along the Texas/Mexico border, urban communities like Houston and San Antonio, and among elder Hispanics in particular (e.g., over 50%). Based on national data sources, the prevalence of pre-diabetics (impaired fasting glucose) is 26.1% for Hispanics of Mexican decent (Mexican Americans). The mortality rate for Hispanics from diabetes is 52 per 100,000 compared to 21 for Anglos. Texas has the 12th highest rate of adult obesity at 26.3 percent and the 6th highest rate of overweight youths (ages 10-17) at 19.1 percent in the nation.

The total national estimated cost of diabetes in 2007 was $174 billion, including $116 billion in excess medical expenditures and $58 billion in reduced national productivity. The largest components of medical expenditures attributed to diabetes are hospital (over 50%) inpatient care. While the cost of diabetes for 2007 in Texas was more than $12 billion. This estimate includes $8 billion in excess medical expenditures attributed to diabetes, as well as $4 billion in reduced productivity.

In Texas, health care reform strategies, thus far, have been limited in scope and minimalist in vision with little impact on reducing the uninsured rate or strengthening and expanding health care safety-nets. Furthermore, the social determinants of Texans, particularly among Latinos, require policy-makers to be innovative in incorporating health disparities in their Health Care reforms strategies. *The effectiveness of national health care reform can is interdependent on addressing Health Disparities.*

V. SUMMARY

In concluding, health is everybody's business, but not everyone understands the complexity of our health care system or its relationship to inequalities and disparities. Pivotal to the health care dialogue is the voices of Latinos given their stake in this health care crisis and its impacts to their *bienestar (well-being).*

As the debate moves forward, the costs for a national comprehensive public health insurance plan will be a core issues. Again, ample evidence exists that such a system can be paid for if the abundant inefficiency and profits in our present system are eliminated along with tens of billions in tax subsidies benefiting a narrow few. Key examples of the inefficiencies include unnecessary care, failure to fully implement cost-effective chronic disease management programs, excessive administrative paperwork and bureaucracy, weak information system capability and transparency targeting care quality and costs, and use of costly medical technologies with limited evaluation and quality care returns.

The opportunity to have public health insurance coverage will increase the likelihood for regular access to a medical home for preventive primary care, cost-effective chronic disease management, or provide more critical and costly care in the event an unanticipated severe health problem arises. In short, it should provide the "opportunity" to maintain good health and not add to the risk of financial health care debt. Further, the coverage cost should not be a barrier to parents to pursue and retain individual and family financial security and self-sufficiency. The objective is to reduce disparities, not increase them.

Thus, we believe that health care reform encompassing a public health insurance plan will reflect Latino health care values and needs by giving attention to the income elasticity for cost-sharing among Latinos who have disproportionate: a) low-incomes; education and literacy levels (English and Spanish) that challenge the appropriate navigation and use of an already bureaucratic and often uncoordinated health care delivery system (particularly if the individual has a chronic disease); b) lack of access and informed capacity to make adequate choices about health benefits; c) residency in neighborhood environments that do not support healthy behaviors; d) or on/off insurance coverage resulting in poor health status.

We call for leadership that will stand up and fight for real comprehensive health care reform that includes a public health insurance option that will transform health insurance landscape for all.

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