

**NCLR**  
NATIONAL COUNCIL OF LA RAZA

# HISPANICS AND HEALTH INSURANCE

## Volume 2: Analysis and Policy Implications



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*A Joint Project of:*

*Labor Council for Latin American Advancement*

*and*

*National Council of La Raza*

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## EXECUTIVE SUMMARY

### BACKGROUND

Over the past year, the Labor Council for Latin American Advancement (LCLAA) and the National Council of La Raza (NCLR) have worked together to analyze the health insurance status of Hispanic Americans and its implications for health care reform. The first report of the collaborative effort, *Hispanics and Health Insurance -- Volume 1: Status*, reviewed and analyzed data on health insurance coverage for Hispanics versus Blacks and Whites. The findings were consistent -- **Hispanic Americans are much more likely than either Blacks or Whites to be without health insurance, public or private, regardless of gender or age, irrespective of family, income, or employment status.** This second volume further analyzes the data, identifying the most critical gaps in health insurance coverage and examining the implications of *uninsurance* and *underinsurance* for Hispanics and the broader society. It provides a brief overview of various types of health care reform proposals, weighs major types of reform proposals against ten NCLR/LCLAA principles for health care reform, and identifies requirements for health care reform that will equitably address Hispanic needs.

### HEALTH CARE GAPS AND NEEDS

**There is wide agreement that the health care and health financing systems in this country need fundamental reform.** The United States relies on a voluntary employer-based private health insurance system and a "safety net" public health insurance system -- Medicare and Medicaid. There is no requirement that employers provide health insurance for their workers or workers' families, and the public insurance system generally excludes the working poor and near-poor and their families, and adult males without children. Free or low-cost medical care for those without health insurance -- through community clinics, hospitals, and other facilities -- is available only in some locations for some people. Both the public and private health insurance systems are eroding as a result of many factors, among them the shifting U.S. labor market structure, legislation affecting the content of health insurance policies, and -- most of all -- rapidly increasing health care costs. Many health care problems and gaps affect Hispanics disproportionately. For example:

**Lack of continuity in health insurance:** Health insurance coverage can disappear suddenly due to a change in employment, retirement, employer policies, or eligibility status for public programs. A recent longitudinal Census Bureau study covering a 28-month period between 1987 and 1990 found that only about two in five Hispanics (40.2%) and nearly two in five Blacks (37.8%), compared to more than two in three Whites (67.8%), had continuous private health insurance coverage.

**Uninsured workers, especially Hispanics:** The total number of uninsured U.S. workers 16 to 64 years of age increased by 7.4%, from 19.0 million in 1988 to 20.4 million in 1990; the number of uninsured Hispanic workers increased by 39.4%, from 3.3 million in 1988 to 4.6 million in 1990. In 1987, 78% of uninsured Hispanics lived in families headed by employed persons. Hispanic male and female workers remained more likely to be uninsured than comparable Black and White workers. In 1990, Hispanic workers were two and one-half times as likely as White workers to be uninsured -- 41.1% versus 16.5% for men, and 30.4% versus 12.6% for women.

**Lack of insurance coverage for the working poor:** Except where a company is unionized and health insurance is a required component of a collective bargaining agreement, lower-skill, lower-paid workers typically do not receive health insurance from their employers. This is especially true for Hispanics. Less than one in five working poor men and women (individuals who were employed but had family earnings below federal poverty line) received employer-based health insurance in 1990 -- and Hispanic men and women were the least likely to be insured.

**Increased cost sharing:** Employer-based insurance policies increasingly require worker contributions to premiums, large deductibles, copayments, as well as out-of-pocket expenses for services which are not covered. The median out-of-pocket "cap" set by employers in 1991 was \$2,100 per family. Such costs represent a special barrier for Hispanics, whose earnings fell from 69% of non-Hispanic earnings in 1974 to 63% in 1989.

**Medicare gaps:** Although most elderly receive Medicare, coverage levels vary; 96.2% of White elderly, 93.3% of Black elderly, and 90.1% of Hispanic elderly received Medicare in 1990. Some Hispanic elderly do not automatically qualify for Medicare because they are not Social Security recipients. In 1990, only 80% of Hispanic elderly received Social Security, compared to 88% of Black and 93% of White elderly.

**Limited Medicaid coverage:** There are large variations in Medicaid coverage, since states have great discretion in determining program scope, size, eligibility, and procedures. Many low-income Hispanics do not receive Medicaid because they are among the working poor. A little over one in ten low-income working Hispanic males (10.1%) received Medicaid in 1990, compared to more than one in three low-income non-working Hispanic males (36.4%). Similarly, about one in four low-income working Hispanic females (26.9%) received Medicaid, compared to about half of low-income non-working Hispanic females (49.8%).

**Certain population segments are extremely likely to lack private health insurance and also be unable to obtain public health insurance.** They include the following overlapping groups: the working poor and their families, low-income males, the near-poor, and children of families with limited incomes. Hispanics are overrepresented in these groups.

## IMPACT OF UNINSURANCE AND UNDERINSURANCE

**An Hispanic family living at the poverty level cannot afford to purchase the "typical" amount of health care on the open market or to purchase individual health insurance.** Assume conservative projected expenditures for housing (30% of disposable income) and food (cost of the Department of Agriculture's Thrifty Food Plan) for a family of four living at the 1991 federal poverty level of \$13,359, and just \$4,911 remains. If such a family purchased health insurance through a group or paid directly for a "typical" amount of health care, it would spend *all* its remaining disposable income on health care, and have nothing left for clothes, furniture, telephone, transportation, child care, or other expenses. The family could pay its share of an employer-based plan requiring moderate cost-sharing *if* the employer covered the entire premium for all dependents, and *if* actual health care costs were relatively modest. Only a family with Health Maintenance Organization (HMO) or Medicaid coverage would pay less than 10% of its disposable income for health care. A fortunate family might receive free or reduced-cost health care at a community health center or clinic. Since the typical Hispanic family with total income around the poverty line is a working family that does not receive health insurance from an employer and is ineligible for Medicaid, its total disposable income is effectively reduced by the amount of health care costs. This reduction can drive a family's disposable income well below the poverty level.

**Rising health care costs threaten the financial status of moderate-income Hispanic families as well.** In 1991, the median family income for Hispanics was \$22,330. Assuming federal and state taxes totaling about \$4,000, total disposable income is \$18,330. Assuming a conservative 30% of disposable income is spent for housing and an even more conservative 25% is spent for food, only \$8,249 is left for all other expenses. NCLR calculations indicate that even for a family at this moderate income level, being uninsured means that typical health care costs would take about 60% of the disposable income available after shelter and food costs have been met. While insurance -- whether purchased by the employer or the family -- provides protection against devastating expenses, the maximum out-of-pocket cost sharing required by employers for families with private insurance in 1991 was more than \$2,000 per family, not counting uncovered expenses. Moreover, an uninsured family has no protection against major medical expenses; even a moderate illness requiring some hospitalization could easily cost more than \$8,000, leaving the family with long-term debt.

**While lack of health insurance is often described in financial terms, its effects can also be measured in human suffering.** Americans without health insurance receive less preventive care and less overall health care than insured Americans. According to a 1992 General Accounting Office (GAO) report, uninsured persons were less likely to use preventive and early detection services such as pap smears, blood pressure checks, and breast examinations. One recent study concluded that "lack of health insurance was the strongest and most consistent predictor of inadequate screening." Research also shows that when the uninsured finally seek care, their condition may be at an advanced stage and treatment may be unsatisfactory or

unsuccessful. Uninsured patients reportedly have shorter hospital stays, receive fewer services, and undergo fewer procedures, once hospitalized, than insured patients, and when they receive care, it is often in inappropriate settings or involves inadequate patient care management. Because Hispanics are the least likely of all major population groups to have health insurance, they are especially likely to face these negative health impacts.

**Current gaps in health insurance, public and private, provide a severe disincentive to work for those with limited wage potential.** It can be more financially practical to remain unemployed and receive Medicaid benefits and welfare than to work in a no-benefits job and still live below the poverty level. Many single mothers face a choice between working with no health care benefits, or turning to welfare in order to provide their children with Medicaid. A focus group study by NCLR found that low-income Mexican American single mothers were extremely likely to report remaining unemployed to retain Medicaid coverage or quitting jobs with no health insurance when they or their children needed medical care.

## **ANALYSIS OF HEALTH CARE REFORM PROPOSALS**

**There is wide agreement that the health insurance system in this country is in need of major reform.** Over 60 health care reform bills have been introduced in the House of Representatives and Senate during the 102nd Congress; many more proposals are still being modified or have not yet been introduced as legislation. NCLR and LCLAA have adopted a set of principles to be used as a basis for analyzing the responsiveness of health care reform legislation in addressing fundamental problems for Hispanics in the current health insurance and health care delivery systems; they include Universal Coverage, Comprehensive Care, Quality of Care, Administration and Financing, Elimination of Non-Financial Barriers, Supply and Distribution of Health Care Workers, Alternative Health Care Delivery Systems, Responsiveness to Diversity, Consumer Outreach and Public Education, and Accountability and Enforcement.

While there is no consensus as to the type and extent of health care reform which is currently needed, strategies can be categorized into a few major types:

- **Government-Based Single-Payer Plans**, which would provide health insurance under a government-financed national program, detaching health insurance from employment and making the government the primary funder of health coverage. Most of the proposals would provide coverage for all Americans by financing services primarily through government tax revenues, but leave the delivery of care in private hands.
- **Multi-Payer "Pay or Play" Plans**, which would establish a combination of employment- and government-based insurance. Employers would be required to provide private health insurance coverage to their employees, or pay into a public system that would serve as a safety net for Americans not covered by employers.

- **Consumer-Based Plans**, designed to provide individuals or families with the financial resources -- through tax credits or certificates -- to obtain health insurance in the private market. The Consumer-based approach would reduce government involvement in providing health insurance, and instead place responsibility for obtaining health insurance and health care upon the individual, with employer participation.
- **Piecemeal Modifications of the Current System**, typically designed to improve or build on the existing system, reforming only specific components of the health insurance system or increasing coverage for certain segments of the U.S. population. LCLAA and NCLR believe that piecemeal reforms are inadequate to address the insurance and health care needs of Hispanics. An initial review of the first three types of proposals -- those attempting to accomplish comprehensive reform -- indicates that, from an Hispanic perspective:

Both single-payer and "pay or play" proposals could go a long way towards providing coverage for at least a minimum set of basic services for the one-third of Hispanic Americans who are uninsured. The working poor and their families, children, and low-income persons not covered under current programs would have a source of health insurance for at least a minimum set of relatively uniform basic health care services. The consumer-based plans would also expand coverage to those not now receiving Medicare, Medicaid, or employment-based coverage, but the health care plans which could be purchased by those relying entirely on the maximum value of the health certificate would be determined at the state level. Therefore, consumer-based plans would not necessarily assure that a specified set of minimum services would be available to all.

All these approaches could fall short of meeting NCLR/LCLAA's principles related to universal coverage. One concern is the extent to which they would cover people in Puerto Rico. Another concern is the extent to which they would cover and reach persons who have no fixed address such as the homeless, who travel as migrant and seasonal farmworkers, who do not file tax returns (for tax-credit-based proposals), or who have ambiguous, temporary, or transitional immigration status.

No plan automatically assures comprehensive care for all Americans, and budget considerations are likely to limit the level of services provided. While all types except the piecemeal proposals talk about assuring some (typically not fully defined) level of minimum coverage for everyone in the system, budget issues assure that there will be limitations in coverage. This is particularly clear for consumer-based plans, which often specify a dollar cap in the amount of financing to be provided per person and per family. While the single-payer and "pay or play" plans tend not to specify an annual dollar cost per person or for the entire health care system or to clearly define ways in which costs will be contained, it seems extremely unlikely that the current economic situation and federal budget deficit will permit a reformed health care system to assure comprehensive care for everyone in need of it. The nation will face difficult decisions about how to allocate limited resources -- and this is likely to mean that each



plan will specify a minimum benefits package which excludes certain types of health care expenses, or limits coverage for those unable to pay. While these plans do not tend to address the question of "rationing" directly, they all reflect concerns about cost containment.

**The extent of cost sharing required to obtain basic benefits will have major impact on actual access to care for families with low and moderate incomes.** In all three major types of proposals, the potential cost of participation may keep low-income people from obtaining care.

**State variations in financing -- and in coverage -- are a potential concern under all three major types of approaches, and especially in consumer-based proposals.** Many of the major proposals do not clearly define the level of state autonomy or flexibility with regard to benefit packages, fee schedules, total expenditures, and state contributions to costs. To the extent that considerable state flexibility is permitted, federally-imposed minimum benefit requirements will be the primary protection against tremendous variations in comprehensiveness of services.

**None of the proposed approaches fully addresses access issues related to non-financial factors.** Everyone, especially low-income individuals and families and those with limited English proficiency and limited education, needs to be able to find, obtain access to, and receive adequate services from health care providers. Overall, the various proposals are not specific in requiring that services be linguistically or culturally appropriate. Outreach and public education needs are minimally addressed. Many of the proposals contain limited provision for encouraging an increased supply and improved distribution of health care workers, primarily through increased funding for the National Health Service Corps, community health centers, and migrant health centers, and/or reimbursement incentives to providers practicing in rural or underserved areas. Most include very limited quality of care monitoring or accountability and enforcement procedures, and do not explicitly address issues of equal access and non-discrimination.

## CONCLUSIONS

Many of the major health reform proposals offer the potential for significant improvements in Hispanic health insurance coverage -- but none of them automatically addresses the majority of Hispanic concerns as summarized in the NCLR/LCLAA principles for evaluating health care reform alternatives. Those plans offering perhaps the greatest potential for something approaching universal coverage and a consistent set of minimum benefits regardless of geographic location are the single-payer and multi-payer "pay or play" plans. However, many ambiguities and unanswered questions make it clear that to create a plan which assures equitable and adequate health care coverage for Hispanics requires not only careful review, but also efforts to educate policy makers about the special concerns and needs of Hispanics. NCLR and LCLAA have reached the following conclusions regarding health care reform:

1. **The time has come for comprehensive health care reform.** In light of the multifaceted health insurance and health care access problems faced disproportionately by Hispanic Americans but also by every segment of U.S. society, a comprehensive approach to health care reform is essential. Only comprehensive reform will assure that the needs of Hispanics -- including the working poor and their families, children, and low-income populations, who are very often uninsured -- are fully addressed.
2. **Health care must be viewed as an entitlement -- as a right, not a privilege; as a national mandate, not a state option.** In theory, all three of the major types of comprehensive plans could provide something approaching universal coverage. However, breadth of coverage -- particularly for individuals and families from working poor and other lower-income families -- can be reduced by many financial factors, among them variability across states in benefits packages, cost sharing, reimbursement rates, and variations in state contributions to overall expenditures. LCLAA and NCLR will only support health care reform which assures health care coverage regardless of geographic residence.
3. **A minimum set of basic benefits must be assured for everyone.** Comprehensive care for all Americans, from prenatal to long-term care, should be the goal of any health care system. NCLR and LCLAA believe that an absolute commitment must be made to assuring that basic health care benefits -- including preventive, early diagnostic, primary treatment, inpatient, and outpatient care -- are provided and maintained for everyone, regardless of ability to pay. We are particularly concerned with assuring that lower-income Americans have full access to preventive care and health screening; the investment of more public resources on preventive care will both prolong and improve lives and lower treatment costs in the future. Moreover, political considerations must not be permitted to exacerbate disparities in coverage; we must provide health care for the poor as well as the rich, for the very young as well as the very old, for acute as well as chronic illness.
4. **Health care reform must eliminate the disincentive to work caused by the linkage of public health coverage and unemployment.** The failure in most states to provide Medicaid coverage for the working poor and near-poor has forced many working mothers to leave the labor force in order to assure basic health care for their families. Any health reform system should provide incentives to work, recognizing that workers have additional expenses and assuring that the decision to take a low-paid job does not make health insurance less available or affordable.
5. **Available public dollars must be used to provide health coverage for those with the greatest financial barriers to health care -- currently uninsured and underinsured lower-income Americans of all ages.** The United States should work towards a progressively financed health care system that provides universal and comprehensive health coverage. Among the individuals and families not receiving preventive or regular health care are not only the uninsured but also many families who have health insurance

but cannot afford to meet deductibles, copayments, and other cost-sharing requirements. While all individuals and families should contribute equitably to the costs of health coverage, highly progressive policies are essential to assure that regular health care does not become unavailable through cost increases which cannot be met by low- and moderate-income families.

6. **Universal health insurance coverage does not mean universal health care access; health care reform must eliminate non-financial as well as financial barriers to care.** Health care reform will provide real access to care for Hispanics only when non-financial barriers have been reduced, the supply and distribution of health care workers -- especially bilingual Hispanic health care workers -- has been significantly increased, community-based facilities have been expanded and strengthened, and resources for Hispanic-focused health promotion efforts by community-based entities have been greatly expanded. These barriers face not only the one-third of Hispanics without health insurance but also a significant proportion of those with health insurance. Health care reform will be truly comprehensive only if it fully addresses not just the financial obstacles to health care access but also these additional barriers, as identified in the NCLR/LCLAA principles for health care reform.

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# I. INTRODUCTION

## BACKGROUND

Over the past year, the Labor Council for Latin American Advancement (LCLAA) and the National Council of La Raza (NCLR) have worked together to analyze the health insurance status of Hispanic Americans and its implications for health care reform. Access to health care is a critically important issue both for LCLAA, the Hispanic support group of the AFL-CIO, and for NCLR, the largest constituency-based national Hispanic organization, because the two organizations share a commitment to improving the socioeconomic status and quality of life of Americans of Hispanic descent.

The first report of the collaborative effort, *Hispanics and Health Insurance -- Volume 1: Status*, was primarily statistical; it reviewed and analyzed data on health insurance coverage for Hispanics versus Blacks and Whites. It examined Hispanic health insurance coverage overall and by subgroups, by state, by age, by employment status, by poverty status, and by employment and poverty status combined. It looked at health insurance coverage for workers and dependents, for men and women, for adults and children. It reviewed public and private coverage.

The findings were consistent -- Hispanic Americans are much more likely than either Blacks or Whites to be without health insurance, public or private, regardless of gender or age, irrespective of family, income, or employment status. The major findings of that report are briefly summarized in Section II of this volume.

## PURPOSES OF VOLUME 2

This volume is designed to further analyze the data presented in Volume 1: identifying the most critical gaps in coverage, including private versus public coverage as well as variations in coverage among the top ten states in Hispanic population; reviewing factors which contribute to Hispanics being *uninsured* or *underinsured*, such as the nation's two-tiered employment structure and the rapidly rising costs of health care; and identifying the ways in which lack of health insurance coverage for Hispanics is similar to and different from the lack of coverage of other population segments. The volume examines the implications of uninsurance and underinsurance for Hispanics and the broader society, in terms of lack of access to health care, human suffering, the impact of health care costs on poverty status, disincentives to work caused by gaps in private and public insurance coverage, and the costs to society of allocating a high and growing share of the nation's financial resources to health care.

It is clear from the data on Hispanic health insurance status, as well as from many other perspectives and analyses, that health care reform is required to create adequate access to health care. This volume provides a brief overview of various types of health care

reform proposals, categorizing them into four basic types for purposes of review. It presents ten principles for health care reform against which LCLAA and NCLR believe the various proposals should be weighed, to determine their probability of providing improved and equitable access to health care for Hispanics. And it indicates the extent to which the major types of reform proposals appear promising from an Hispanic perspective.

**Specific demographic and socioeconomic characteristics of the Hispanic population affect public and private health insurance coverage and contribute to the understanding of the report's analyses.** Hispanics -- the second largest U.S. minority -- are younger than the general population, and have lower educational levels, higher male labor force participation rates, and lower incomes. They are especially likely to be among the working poor. The Hispanic population is growing rapidly, having increased 53% between 1980 and 1990, and is geographically concentrated. More than half of Hispanics live in California (34%) and Texas (19%), and 85% live in these two states plus New York (10%), Florida (7%), Illinois (4%), New Jersey (3%), Arizona (3%), New Mexico (3%), and Colorado (2%). Thus state-by-state differences in labor market structure, employment opportunities, and public insurance coverage can have major impact on Hispanic health insurance status.

## **NEED FOR HEALTH INSURANCE REFORM**

**There is wide agreement that the health care and health financing systems in this country need fundamental reform.** By the year 2000, it is estimated that the United States will be spending \$1.53 trillion or nearly 15% of its Gross National Product (GNP) on health care, compared to \$420.1 billion or 10.5% in 1985.<sup>1</sup> Moreover, costs to individuals and families are rising rapidly. Faced with an average 20% rise in health care costs annually over the past few years, employers are reducing coverage or shifting costs to employees. The median private health insurance plan's deductible for individual coverage increased from \$150 in 1990 to \$200 in 1991 -- a one-third increase in a single year.<sup>2</sup> Public insurance costs are skyrocketing along with private costs, and many states have reduced Medicaid coverage; low reimbursement levels for public insurance programs have led many health care providers to refuse Medicare and Medicaid patients. The number of uninsured and underinsured Americans is rising rapidly. These critical problems have given rise to numerous proposals for increasing health care access, from strengthening employer- and family-based insurance to restructuring the entire health care delivery system.

**Health insurance is a critical, but not a sufficient, factor in assuring Hispanic access to health care.** Access is also negatively affected by residence in communities with too few health professionals or health care facilities, the undersupply of Hispanic health care workers, lack of preventive and primary health care, inadequate outreach and public education, language differences, and other factors. This report does not directly address these issues; its purpose is to analyze correlates to the type and extent of health insurance coverage among Hispanics, not the effectiveness of health care delivery systems in serving Hispanics. However, these issues are briefly addressed as they relate to lack of insurance and to health care reform initiatives.

## LIMITATIONS

**The analyses included in the report are limited by data availability and format.** For example, the report focuses primarily on the extent to which Hispanics and other Americans are insured or uninsured. Except for information on dependent coverage, data on Hispanic underinsurance rates are generally not available, nor are data measuring the comprehensiveness or appropriateness of health insurance coverage for Hispanics. However, some non-Hispanic-specific information about these issues is provided, and the effects of increased cost sharing are analyzed for Hispanic families at the poverty level and at the median family income level. In addition, data on continuity of health insurance coverage for Hispanics versus other major population groups are provided, based on a recent Census Bureau report. State data, generated through special analyses, are provided for the top ten states in Hispanic population.

**The report is designed to provide policy-relevant information about Hispanic health insurance status and its implications, rather than a comprehensive analysis of insurance-related factors.** Many other kinds of analyses would be useful in extending public and policy maker understanding of Hispanics and health insurance, as well as related factors affecting health care access. NCLR and LCLAA hope to carry out some of these other analyses in the future. The two organizations also expect to provide careful reviews of specific health reform proposals on the basis of the ten NCLR/LCLAA principles for health care reform which are specified in the report.



## ENDNOTES

1. General Accounting Office, *U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform*, (GAO/HRD-91-102), Washington, D.C.: U.S. Government Printing Office, June 1991, p. 7; and Levit, Katharine R., Helen C. Lazenby, Suzanne W. Letsch, and Cathy A. Cowan, "National Health Care Spending, 1989," *Health Affairs*, Health Insurance Association of America, Spring 1991, p. 119.
2. Foster Higgins, *Indemnity Plans: Costs, Design and Funding*, Report 1, 1991 Health Care Benefits Survey. Princeton, NJ: Foster Higgins Survey and Research Services, 1992.

## II. HISPANIC HEALTH INSURANCE STATUS

### OVERVIEW

This section presents an overview of Hispanic health insurance coverage, including the socioeconomic factors related to the type and extent of coverage. Most of the data and analysis come from the first report produced through the joint project between NCLR and LCLAA, *Hispanics and Health Insurance, Volume 1: Status* (March 1992). The data presented come from the March 1991 Current Population Survey (CPS) conducted by the Bureau of the Census, unless otherwise indicated.<sup>1</sup> Additional information included in this report was collected from a special March 1991 CPS tabulation, which provides comparisons between Hispanics and non-Hispanic population groups by state and selected socioeconomic characteristics.<sup>2</sup>

Since most health insurance data come from the Census Bureau, which considers Hispanics to be an ethnic rather than a racial group, Hispanics are included both in one of the racial groups (most often White) and in the Hispanic category. Special tabulations must be generated to eliminate this overlap and compare the health insurance status of Hispanics, non-Hispanic Whites, and non-Hispanic Blacks. The report uses -- and appropriately labels -- data based on the non-overlapping categories of Hispanics, non-Hispanic Whites, and non-Hispanic Blacks where available.

### INSURED AND UNINSURED POPULATIONS

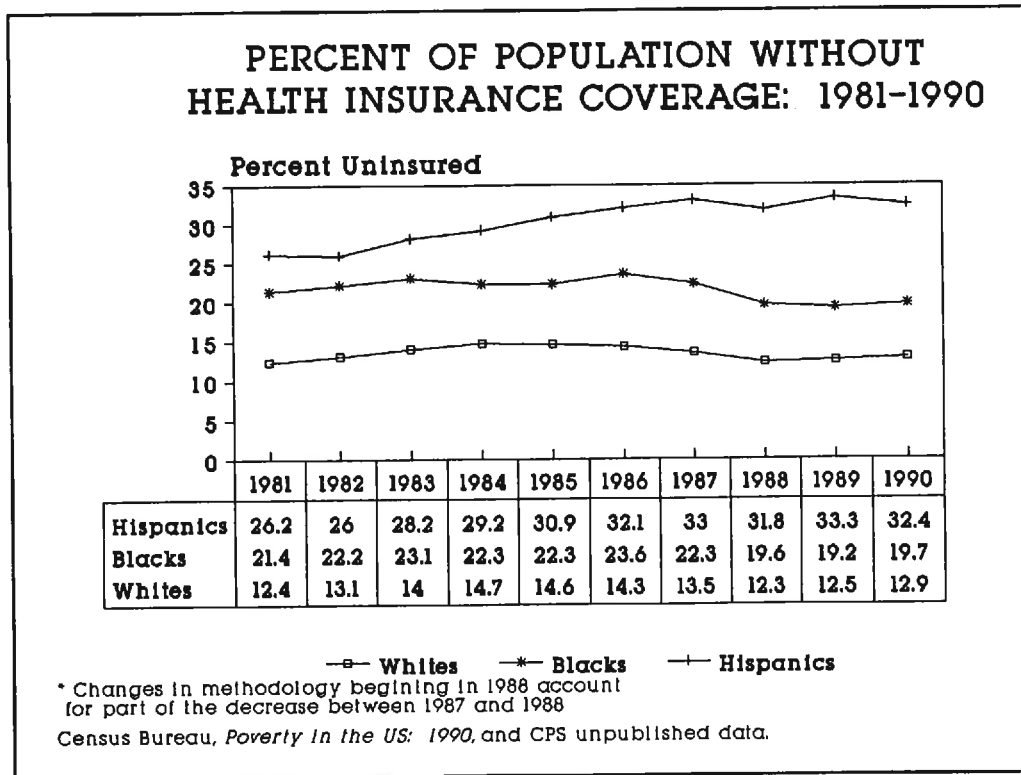
**Hispanics are more likely than either Whites or Blacks to have no health insurance coverage.** In 1990, over 6.9 million Hispanics (32.4% of the Hispanic population) were uninsured, compared with 26.9 million Whites (12.9%) and nearly 6.1 million Blacks (19.7%). Hispanics are overrepresented among the uninsured; in 1990, they comprised 9% of the U.S. population and over 20% of the uninsured population.<sup>3</sup>

**Over the last decade, the number of uninsured Hispanics increased at a faster rate than the number of uninsured Blacks and Whites.** During the 1980s, the number of Hispanics without health insurance increased 86.5%, from 3.7 million in 1981 to 6.9 million in 1990. By comparison, the number of uninsured Whites increased 12.1%, from 24.0 million in 1981 to 26.9 million in 1990; and the number of uninsured Blacks increased 8.9%, from 5.6 million in 1981 to 6.1 million in 1990. In 1990 there were more uninsured Hispanics than Blacks, despite the fact that there are fewer Hispanics than Blacks in the total population (22.4 million versus 30.0 million). If current rates of uninsurance and Hispanic growth continue, there will be an estimated 13.8 million uninsured Hispanics by 1999.

**Over the past decade, Hispanics have consistently had a higher percentage of uninsured than Whites or Blacks.** As Figure 1 indicates, the percent of Hispanics without health insurance has increased steadily, from 26.2% in 1981 to 32.4% in 1990, whereas the

percent of uninsured Blacks has decreased slightly, from 21.4% in 1981 to 19.7% in 1990, and the percent of uninsured Whites has remained relatively constant, with 12.4% uninsured in 1981 and 12.9% in 1990.

**FIGURE 1**

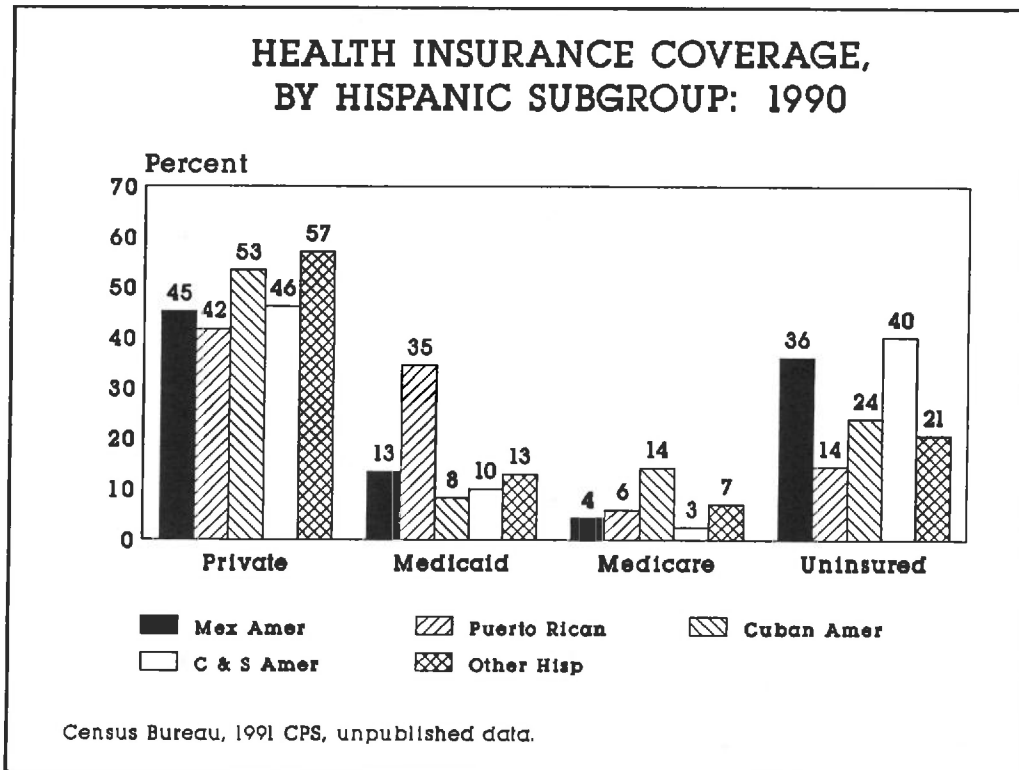


Hispanics 18 to 24 years of age are more likely to lack health insurance than any other age group, although the percentage of uninsured Hispanics is far greater in every age group than the percentage of Whites or Blacks. In 1990, 28.3% of Hispanic children under 18 were uninsured, compared with 12.5% of White and 14.4% of Black children. In the same year, nearly half of Hispanics between the ages of 18 and 24 (48.0%) were uninsured, compared to nearly one-fourth of Whites (24.7%) and one-third of Blacks (33.7%) of the same age. Moreover, while only 0.7% of White elderly and 2.0% of Black elderly lacked health insurance, 5.2% of Hispanic elderly had no health insurance coverage.

**Health insurance coverage varies widely among Hispanic subgroups:** Puerto Ricans are more likely than other Hispanic subgroups to receive Medicaid, Cuban Americans and Other Hispanics are more likely to be covered by private insurance, and Mexican Americans and Central and South Americans are more likely to be uninsured (See Figure 2).<sup>4</sup> These differences reflect a variety of factors, including the states in which Hispanic Americans reside

-- due partly to state-by-state differences in Medicaid eligibility requirements -- as well as the labor force participation rates, socioeconomic status, and median ages of the different subgroups.

**FIGURE 2**

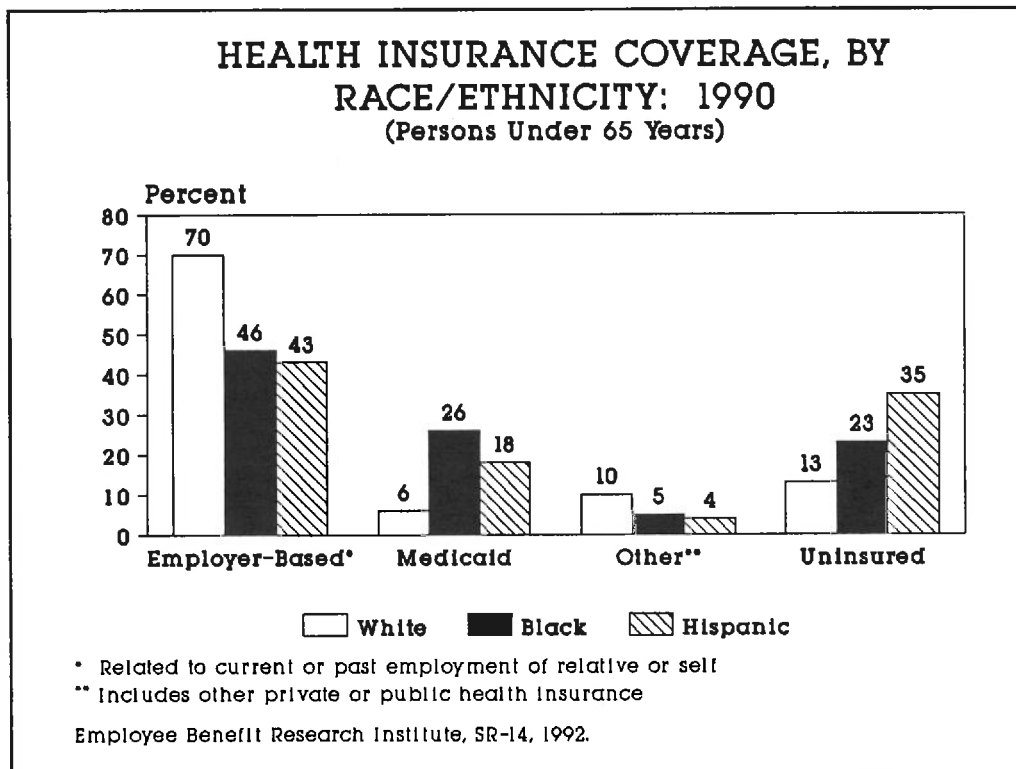


Hispanics are less likely than Whites or Blacks to be covered by private health insurance, and less likely than Blacks to be covered by public health insurance. Less than half of Hispanics (48.0%) were covered by a private source of health insurance in 1990, compared to more than three-fourths of Whites (76.7%) and a little over half of Blacks (51.8%). Although 28.1% of Hispanics were below the poverty level in 1990, only 18.2% received Medicaid; in comparison, 10.7% of Whites lived in poverty and 7.2% were Medicaid recipients; 31.9% of Blacks lived in poverty and 25.2% received Medicaid. In 1990, 5.9% of Hispanics had Medicare coverage, compared to 13.7% of Whites and 10.1% of Blacks.

Although employer-based health insurance is the principal form of health insurance for working-age Americans and their families, this is not the case for Hispanics and non-Hispanic Blacks; it applies only to non-Hispanic Whites. Hispanics under 65 are less likely to receive employer-based health insurance and more likely to be uninsured than non-Hispanic Whites or Blacks of the same age group. In general, persons under 65 are more likely than those 65 and over to lack health insurance, mainly because there is no public health insurance program for employed working-age persons or their families when an employer does not provide

coverage, while most persons 65 and over can qualify for Medicare. A little more than two out of five Hispanics under 65 (43.3% or 8.7 million) and less than half of non-Hispanic Blacks (46.3% or 12.7 million) were covered by employer-based health insurance in 1990, while 70.3% of non-Hispanic Whites (112.9 million) received such coverage. Furthermore, non-elderly Hispanics were nearly three times as likely as non-Hispanic Whites under 65 to be uninsured; in 1990, 34.8% of Hispanics under 65 (7.0 million) were uninsured, compared to 13.1% of non-Hispanic Whites (21.0 million) and 22.8% of non-Hispanic Blacks (6.2 million)<sup>5</sup> (See Figure 3).

**FIGURE 3**



**Hispanic males have the highest labor force participation rates in the nation, but are far less likely than non-Hispanic males to receive employer-based health insurance.** In 1990, less than half of employed Hispanic males (49.7%) received employer-based health insurance, compared to seven in ten White (71.0%) and three in five Black working males (59.8%). While Hispanic women were slightly better off than their male counterparts, in 1990 employed Hispanic women (56.9%) less often had employer-sponsored health insurance than employed White (73.7%) or Black women (62.8%).

**The concentration of Hispanics in low-wage occupations and industries which offer few fringe benefits helps to explain their low levels of private health insurance coverage.** According to a 1992 General Accounting Office (GAO) report on Hispanic access to health care,

the high rate of uninsurance among Hispanics is partly explained by their employment in jobs that do not provide health insurance benefits to employees. In 1987, approximately half of all Hispanic workers (50%) were employed in industries with high (30%-32%) and moderate (21%-22%) rates of uninsured employees, compared to about 44% of all White and 35% of all Black workers.<sup>6</sup> Moreover, because of their low yearly earnings, Hispanics often cannot afford to purchase health insurance for themselves and their families, where they are required to pay part or all the costs of employer-based health insurance, or where they have no employer-based insurance and must obtain insurance on an individual, private basis. Private health insurance purchased individually (not sponsored by one's or a relative's employer) is the least likely coverage option for most Americans, due to high cost. In 1990, 6.2% of Hispanics were covered by private health insurance purchased individually, compared to 7.8% of Blacks and 13.5% of Whites.

**Hispanics are far more likely than comparable non-Hispanic Whites to be uninsured regardless of labor force participation.** In 1990, working Hispanics (35.9%) were over three times as likely as working non-Hispanic Whites (11.4%) to be uninsured. In the same year, nearly three out of five unemployed Hispanics (59.6%) were uninsured, compared to less than three out of ten unemployed non-Hispanic Whites (27.0%)<sup>7</sup> Figure 4 provides comparisons of the uninsured Hispanic and non-Hispanic White populations.

**Over half of Hispanic part-time workers and over three out of ten Hispanic full-time workers are uninsured, and both groups of workers are more likely than comparable non-Hispanic Whites to be uninsured.** In 1990, three times as many full-time Hispanic workers (33.3%) were uninsured as full-time non-Hispanic Whites (10.3%); and twice as many part-time Hispanic workers (50.7%) were uninsured as part-time non-Hispanic Whites (24.5%).<sup>8</sup>

**Hispanics with lower incomes are much more likely than Hispanics with higher incomes to be uninsured, and Hispanics are less likely than non-Hispanic Whites to be covered by health insurance at every income level.** In 1990, Hispanics with incomes below \$25,000 were twice as likely to be uninsured as those with incomes between \$25,000-\$49,999 (40.9% versus 20.5%). Compared to non-Hispanic Whites with incomes below \$25,000 in 1990, Hispanics with similar incomes were more than twice as likely to lack health insurance coverage (40.9% versus 18.3%). In the same year, Hispanics with incomes between \$25,000-\$49,999 were nearly three times as likely to lack health insurance as comparable non-Hispanic Whites (20.5% versus 7.3%), and Hispanics with incomes over \$49,999 were more than three times as likely as comparable non-Hispanic Whites to be uninsured (22.0% versus 6.1%).<sup>9</sup>

**Poor Hispanics are more likely to lack health insurance coverage than low-income Blacks and Whites, and are less likely than Blacks to receive Medicaid, the publicly financed health insurance program for low-income families.** In 1990, 28.1% of all Hispanic individuals were below the poverty level (living on incomes of less than \$6,800 annually), compared to 31.9% of Blacks and 10.7% of Whites.<sup>10</sup> Over four in ten poor Hispanics (41.3%), compared to three in ten poor Whites (30.6%) and slightly less than one in four poor Blacks (24.3%) were uninsured in 1990. As shown in Figure 4, Hispanics at the poverty level

were more than one and one-half times as likely as non-Hispanic Whites to be uninsured in 1990. In addition, less than half of poor Hispanics (44.7%) and less than two-fifths of poor Whites (39.3%) were Medicaid recipients, compared to more than half of poor Blacks (57.8%).

**FIGURE 4**  
**PERCENT OF UNINSURED HISPANIC AND NON-HISPANIC WHITE**  
**POPULATIONS, BY SELECTED CHARACTERISTICS: 1990**

<b>CHARACTERISTICS</b>	<b>HISPANICS (%)</b>	<b>NON-HISPANIC WHITES* (%)</b>
<b>Uninsured</b>	32.4	10.7
<b>Income</b>		
< \$25,000	40.9	18.3
\$25,000-\$49,999	20.5	7.3
> \$49,999	22.0	6.1
<b>Percent of Poverty</b>		
< 100%	42.1	26.8
100%-124%	46.9	25.2
125%-149%	47.7	21.9
> 149%	24.1	7.8
<b>Labor Force Participation</b>		
<b>Employed</b>	35.9	11.4
<b>Unemployed, Looking for Work</b>	53.8	31.1
<b>Unemployed, on Layoff</b>	65.3	22.9
<b>Work Status</b>		
<b>Full-Time</b>	33.3	10.3
<b>Part-Time</b>	50.7	24.5
<b>Unemployed</b>	50.5	25.1

\* These data differ from previously cited White data. "Hispanic" is an ethnic rather than racial category; special tabulations were generated to compare Hispanics and non-Hispanic Whites.

Census Bureau, March 1991 CPS, unpublished data, prepared by D. Himmelstein, M.D. and S. Woolhandler, M.D., M.P.H.

**A majority of low-income Hispanic families lack health insurance. More than half of Hispanic families just above the poverty level have no health insurance, and Hispanic families**

living below or near the poverty level are much more likely than comparable White or Black families to be uninsured. More than two in five Hispanic families living below the federal poverty level (43.5%) lacked health insurance coverage in 1990, compared to one in three poor White families (33.0%) and a little more than one in four poor Black families (27.8%). Among Hispanic families with incomes of 100-124% and 125-150% of poverty, more than half (51%) were uninsured, compared to about one-third (30-35%) of Black and White families.<sup>11</sup>

**Working Hispanics whose incomes place them below the poverty level -- the "working poor" -- are especially likely to be uninsured.** While uninsured Blacks are heavily represented among the non-working poor and uninsured Whites are more likely to be working and not poor, uninsured Hispanics are heavily represented among the working poor.<sup>12</sup> In 1990, over three-fifths of Hispanic (62.3%) and White (63.2%) families below poverty had one or more working member(s), compared to nearly four in seven similar Black families (55.7%).<sup>13</sup> Medicaid eligibility varies by state, with eligible Hispanics underrepresented among Medicaid recipients. Since most working poor individuals and families typically do not qualify for Medicaid, low-income working Hispanics and their families are generally without health insurance. Moreover, the percentage of uninsurance is higher for near-poor Hispanics (100%-149% of poverty) than for those below the poverty line (See Figure 4).

**Working poor Hispanic males are more likely to be uninsured than working poor White or Black males.** Almost seven in ten adult Hispanic males (69.4%) who were employed, but whose earnings did not exceed the poverty level, lacked any form of health insurance in 1990. Almost two of three comparable Black males (63.9%) and slightly more than one in two White males (54.9%) were uninsured. Just one in five working poor Hispanic men received private health insurance (20.6%), compared to almost one in four working poor Black men (23.0%) and one in three working poor White men (32.7%). Just 16.4% of working poor Hispanic, 13.9% of Black, and 18.1% of White males received employer-based health insurance in 1990.

**More than half of working poor Hispanic women have no health insurance, and only one in five has private health insurance; Hispanic women are more likely to be uninsured than comparable Black or White women.** In 1990, more than one of every two Hispanic working poor women were uninsured (53.4%), compared to two in five comparable White women (40.0%) and one in three comparable Black women (35.6%). Only 21.9% of low-income, working Hispanic women were covered by private health insurance, compared to 24.3% of comparable Black women and 34.0% of comparable White women; 13.9% of Hispanic working poor women, 17.1% of Whites, and 18.7% of Blacks received employer-based health insurance.

**Data also suggest that Hispanics are more likely than Whites to receive employee but not dependent coverage.** Just 39.4% of Hispanic and 40.3% of Black children in families had employer-based health insurance in 1990, compared with 66.8% of White children. Nearly the same proportion of White householders and White children in families had health insurance from an employer (67.8% versus 66.8%). On the other hand, while 48.0% of Hispanic householders



received employer-based health insurance, only 39.4% of their children under 18 received it. This suggests that Hispanics were more likely than Whites to receive employee but not dependent coverage -- because dependent coverage either was not available or it required too high an employee contribution.

#### **TYPE AND EXTENT OF HEALTH INSURANCE COVERAGE BY STATE**

**The numbers of uninsured Hispanics are greatest in the states with the largest Hispanic populations, but the percent of uninsured Hispanics varies greatly by state.** In 1990, the four states with the largest number of uninsured Hispanics were California (2,834,000), Texas (1,589,000), Florida (548,000), and New York (458,000); these are the top four states in total Hispanic population. However, among the top ten states, the four states with the highest percent of Hispanics without health insurance as of 1990 were Texas (38.3%), California, (37.0%), New Mexico (35.4%), and Florida (34.0%) (See Figure 5).<sup>14</sup> State data are from special tabulations of the March 1991 CPS, and include only the top ten states where Hispanics are concentrated; Figures 5, 6, and 7 present these state data.\*

**Among the 50 states and the District of Columbia, four states with large Hispanic populations ranked among the worst with regard to percent of population with insurance coverage in 1990:** New Mexico ranked 51st in health insurance coverage, with 22.2% of its total population uninsured; Texas ranked 50th with 21.1%, California ranked 46th with 19.1%, and Florida ranked 44th with 18.0% (51st being worst).<sup>15</sup>

**In all the top ten states in Hispanic population, Hispanics are more likely than non-Hispanics or the general population to be without health insurance.** In 1990, 38.3% of Hispanics in Texas had no health insurance coverage, compared with 11.7% of non-Hispanics and 21.1% of the total Texas population; 37.0% of Hispanics in California were uninsured, compared to 9.6% of non-Hispanic Whites and 19.1% of the total population (See Figure 5).

**Hispanics are overrepresented among every state's uninsured population, compared to their proportion of the total state population.** In 1990, the uninsured Hispanic population comprised 54.3% of New Mexico's total uninsured population, although Hispanics represented 38.2% of New Mexico's total population; 49.9% of the uninsured and 25.8% of the total population in California; 44.5% of the uninsured and 25.5% of the total population in Texas; 23.1% of the uninsured and 12.2% of the total population in Florida; and 21.1% of the uninsured and 12.3% of the total population in New York.<sup>16</sup>

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\* CPS was not designed to capture representative samples of state populations. Percentages of uninsured Hispanics by state could be obtained only for those states with the largest Hispanic populations, since the standard error for other states may be too large to assure reliable data.

**FIGURE 5**  
**PERCENT UNINSURED HISPANIC, NON-HISPANIC,**  
**AND TOTAL POPULATIONS, BY STATE: 1990\***

STATE	PERCENT UNINSURED		
	HISPANIC POPULATION	NON-HISPANIC POPULATION	TOTAL STATE POPULATION
Texas	38.3	11.7	21.1
California	37.0	9.6	19.1
New Mexico	35.4	10.2	22.2
Florida	34.0	13.9	18.0
Arizona	31.1	9.5	15.5
Colorado	26.0	11.8	14.7
Illinois	23.2	9.2	10.9
New York	23.1	9.5	12.1
New Jersey	18.2	8.6	10.0
Massachusetts	15.3	8.5	9.1

\* Top ten states in total Hispanic population, 1990.

Census Bureau, March 1991 CPS, unpublished data, prepared by D. Himmelstein, M.D. and S. Woolhandler, M.D., M.P.H.

**In all the top ten states, Hispanics less often receive employer-based health insurance coverage than the total population.** State data for the top ten states in total Hispanic population indicate that in 1990 Hispanics were an average of 17.1 percentage points less likely to receive employer-based health insurance coverage than the states' total population. As shown in Figure 6, Hispanics in Massachusetts were about half as likely as the total state population to receive health insurance coverage sponsored by an employer (34.0% versus 64.9%). In two states, Illinois (55.5%) and New Jersey (51.6%), over half of Hispanics received employer-sponsored health insurance in 1990; nationally, 41.8% of Hispanics received employer-based health insurance during the same year. Hispanics in Massachusetts (34.0%) were the least likely to receive employer-based health insurance in 1990, followed by Hispanics in New York (37.4%), Florida (37.8%) and New Mexico (38.8%).<sup>17</sup>

**FIGURE 6  
EMPLOYER-BASED HEALTH INSURANCE COVERAGE OF  
HISPANICS AND TOTAL POPULATION, BY STATE: 1990\***

STATE	EMPLOYER-BASED HEALTH INSURANCE	
	% HISPANIC	% TOTAL
Texas	41.4	55.5
California	40.2	53.8
New Mexico	38.8	48.2
Florida	37.8	51.8
Arizona	43.7	58.1
Colorado	48.0	59.9
Illinois	55.5	63.8
New York	37.4	61.6
New Jersey	51.6	67.5
Massachusetts	34.0	64.9

\* Top ten states in total Hispanic population, 1990.

Census Bureau, March 1991 CPS, unpublished data, prepared by E. Moyer, Ph.D.

**Medicaid coverage for Hispanics varies tremendously by state.** Poor Hispanics in Massachusetts were over four and one-half times as likely to receive Medicaid benefits as poor Hispanics in Texas (41.3% versus 8.8%) in 1990, despite the fact that the Hispanic population below poverty in the two states was similar (36.7% versus 32.1%). In 1990, among the top ten states, Florida (7.6%), Texas (8.8%), and New Mexico (10.3%) had the lowest percentages of Hispanics covered by Medicaid (See Figure 7). Hispanics in most of the largest states in Hispanic population have Medicaid coverage rates lower than the rate for Hispanics nationwide. In 1990, eight of the top ten states -- all states except Massachusetts (41.3%) and New York (31.7%) -- had a Medicaid coverage rate below the national Hispanic Medicaid coverage rate of 18.2%.<sup>18</sup>

**FIGURE 7**  
**PERCENT HISPANICS AND TOTAL POPULATION WITH**  
**MEDICAID COVERAGE AND BELOW POVERTY, BY STATE: 1990\***

STATE	HISPANIC POPULATION		TOTAL STATE POPULATION	
	% Covered by Medicaid	% Below Poverty	% Covered by Medicaid	% Below Poverty
Texas	8.8	32.1	5.6	17.7
California	15.1	20.8	9.5	12.5
New Mexico	10.3	38.2	6.9	27.8
Florida	7.6	19.5	12.6	12.7
Arizona	10.9	28.3	4.7	15.7
Colorado	12.6	24.5	5.8	11.7
Illinois	12.7	20.0	8.4	11.9
New York	31.7	30.5	9.7	13.0
New Jersey	17.6	18.7	5.4	7.6
Massachusetts	41.3	36.7	7.1	8.9

\* Top ten states in Hispanic population, 1990.

Census Bureau, 1990 Census; and Census Bureau, March 1991 CPS, data prepared by E. Moyer, Ph.D.

## CONCLUSIONS

**By every measure, Hispanic Americans are more likely than either Blacks or Whites to be without health insurance, regardless of state residency, gender, or age, irrespective of family, income, or employment status.** Moreover, Hispanics are less likely to receive any type of health insurance, public or private. The longstanding problem of uninsurance among Hispanics is major obstacle to health care access. While health insurance is a necessary but not sufficient factor in assuring Hispanic access to health care, it is a critical entry point to the health care system.

**Near-poor Hispanic families are especially likely to be uninsured.** As income rises, a larger proportion of Hispanic families remain uninsured than comparable White or Black families. Black families are more often insured at lower incomes, whereas White families are more often insured at higher incomes. This is due in part to the fact that low-income Black

families are more likely to be covered by publicly financed health insurance, and higher-income White families are likely to have health insurance provided by an employer or can afford to purchase it. Hispanics are overrepresented among the working poor and near-poor, unable to afford private coverage, less likely to obtain coverage from an employer, and usually ineligible for public insurance coverage.

**Working poor Hispanic men are the group of workers most likely to be uninsured.** Compared to Blacks and Whites in similar circumstances, both working poor Hispanic males and females are less likely to receive private health insurance -- including employer-based insurance -- and more likely to be uninsured. Working poor men are more likely than working poor women to be uninsured.

**Large variations exist in the type and extent of Hispanic health insurance coverage by state.** As of 1990, Hispanics in Texas and California were *least likely* to be insured, those in Massachusetts and New York were least likely to receive employer-based health insurance, and those in Florida and Texas were least likely to receive Medicaid. Hispanics living in Massachusetts and New Jersey were *most likely* to have some kind of health insurance, those in Illinois and New Jersey were most likely to have employer-based health insurance, and those in Massachusetts and New York were most likely to receive Medicaid. These variations reflect such factors as state business and industrial and employment base, Hispanic socioeconomic status, and state Medicaid eligibility requirements.

## ENDNOTES

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18. *Ibid.*



### III. GAPS IN THE PRIVATE AND PUBLIC HEALTH INSURANCE SYSTEMS

#### OVERVIEW

**The current U.S. health insurance structure -- and the health care delivery system -- excludes many Americans.** The United States does not have a single system, public or private, of assured health insurance financing and health care access. It relies on a private health insurance system that depends upon employers to make coverage available for workers and their families. The "safety net" public health insurance system -- Medicare and Medicaid -- assures coverage for most persons 65 or over, the disabled, and some low-income people, primarily unemployed women and their children. There is no requirement that employers provide health insurance for their workers or workers' families, and the public insurance system generally excludes the working poor and adult males without children. Free or low-cost medical care for those without health insurance -- through community clinics and other facilities -- is available in some locations for some people.

**Gaps in public and private health insurance have resulted in a large proportion of uninsured Americans -- and Hispanics are more likely to be uninsured than any other major population group.** While the White population is especially likely to be covered by a private insurance source and the Black population receives significant public coverage, the Hispanic population is most likely to be uninsured. In 1990, one in 11 Americans, and one in five uninsured Americans, was Hispanic.

**While the health insurance system has long been failing Hispanics, it is now failing mainstream America as well, largely due to rapidly increasing health care costs.** Medical costs continue to skyrocket. In 1990, the U.S. spent \$671 billion or 12.0% of its Gross National Product (GNP) on health care, more than any industrial country, compared to \$420.1 billion or 10.5% of its GNP in 1985.<sup>1</sup> Yet an increasing number of persons are without health insurance coverage; the number of uninsured Americans increased from 31.0 million in 1981 to 34.6 million in 1990.

**In addition to the uninsured, well over 20 million Americans are underinsured; they have private health insurance policies that place them at significant financial risk.** While reliable estimates of the number of underinsured persons are limited, and depend on varying definitions of underinsured, millions of persons have inadequate coverage. For instance, in 1987, the Pepper Commission estimated that 20 million Americans had health insurance policies that left them vulnerable to spending more than 10% of their income on medical care.<sup>2</sup>

**Continuity of health insurance is a major concern, especially for Hispanics.** Health insurance coverage can disappear suddenly due to a change in employment, retirement, employer policies, or eligibility status for public programs. A recent longitudinal Census Bureau study covering a 28-month period found that more than 61 million U.S. residents (26.5% of the



population) were uninsured for at least one month between 1987 and 1990. This long-term study produced figures twice as high as previous estimates of how many Americans are sometimes without coverage. During the study period, 46.4% of Hispanics did not have continuous health insurance coverage of any type, compared to 39.8% of Blacks and 24.2% of Whites. About two in five Hispanics (40.2%) and nearly two in five Blacks (37.8%), compared to more than two in three Whites (67.8%), had continuous private health insurance coverage between 1987 and 1990.<sup>3</sup>

**Costs of health care are increasing, even for those covered by health insurance.** Both public and private insurance have limits on what types of costs are covered and the maximum reimbursement for a particular procedure. Private insurance policies increasingly include deductibles -- amounts which must be paid by the individual before the insurance begins to provide reimbursement -- and copayments through which the insured person typically must pay a specified percentage of costs up to a maximum amount, such as 20% of the first \$3,000, after which the policy may pay 100% of costs.

Both private and public health insurance leave significant and widening gaps in both who is covered and the extent of coverage -- and these gaps leave a disproportionate number of Hispanics without adequate health insurance. A variety of factors which have contributed to this growing problem are examined below.

## PRIVATE HEALTH INSURANCE

### Affordability and Availability

**Private health insurance can provide flexible and relatively comprehensive coverage for meeting most health care needs.** Comprehensive private health insurance can be purchased individually but is more often obtained through an employer as a fringe benefit. In addition, other kinds of groups -- such as professional associations -- may offer members the opportunity to purchase health insurance; this may be comprehensive coverage or more limited insurance such as a policy which covers only costs of hospitalization. The purpose of insurance is to transfer the risk of economic loss from an individual to an insurer who agrees to pay for the losses suffered by the insured in return for a set premium. This agreement is possible because the insurer is able to pool the risks of a large number of insured individuals, and can predict the probable claims to be filed by the entire group during a given period.<sup>4</sup> Since these risks have to be shared in order to control the cost of insurance, it is usually more expensive for an individual or small group to purchase health insurance than for a large group. Thus, private health insurance can be purchased individually at higher costs, although voluntary employer-based benefits are the primary form of private coverage for Americans under 65.

**Private health insurance coverage has been eroding as a result of many factors, including the shifting U.S. labor market structure, legislation affecting the content of health insurance policies, and -- most of all -- rapidly increasing health care costs.** Employers may

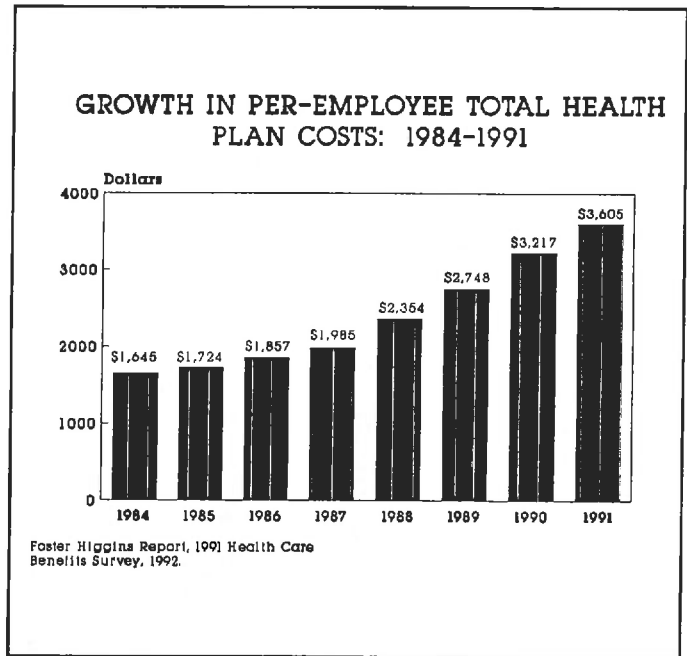
voluntarily choose whether to make health insurance available to their workers and/or their dependents, unless coverage is required by a union contract or local or state law. As described in earlier sections of this report, many U.S. workers receive no health insurance coverage. Others receive less coverage than in the past.

**The costs of private health insurance have soared, making it less affordable for employers to provide.** As seen in Figure 8, total per-employee health plan costs increased from \$1,645 in 1984 to \$3,605 in 1991, an average increase of 13.2% per year.<sup>5</sup> The General Accounting Office (GAO) reports that the current situation of rising costs "threatens the viability of the voluntary employer-based system." The National Federation of Independent Business recently reported that about 19% of firms not currently offering health benefits had ceased to offer insurance recently, mainly because it was no longer affordable. In an effort to cut costs, an increasing number of larger employers have left the insurance market and become self-insured -- that is, assumed the risk for their employees' health care costs themselves, rather than paying an insurance company to perform this role.<sup>6</sup>

**Insurance company practices have changed significantly in response to rising health care costs.** Premiums have gone up, and premium guarantees may last for only a few months, with the result that health insurance costs to employers or individuals are not only high but also unpredictable. The practice of community ratings, which considered all subscribers in a particular geographic area, industry, or other broad grouping in determining the risk pools and subsequent premium amounts, has been largely abandoned in favor of individual review of a group and its members, and efforts to determine who is "insurable" -- individuals who do not have serious pre-existing health conditions that make them a "high risk." It has become more difficult and more costly for small employers to provide health benefits to their workers, and for a family without employer-based insurance to purchase a private health insurance plan.

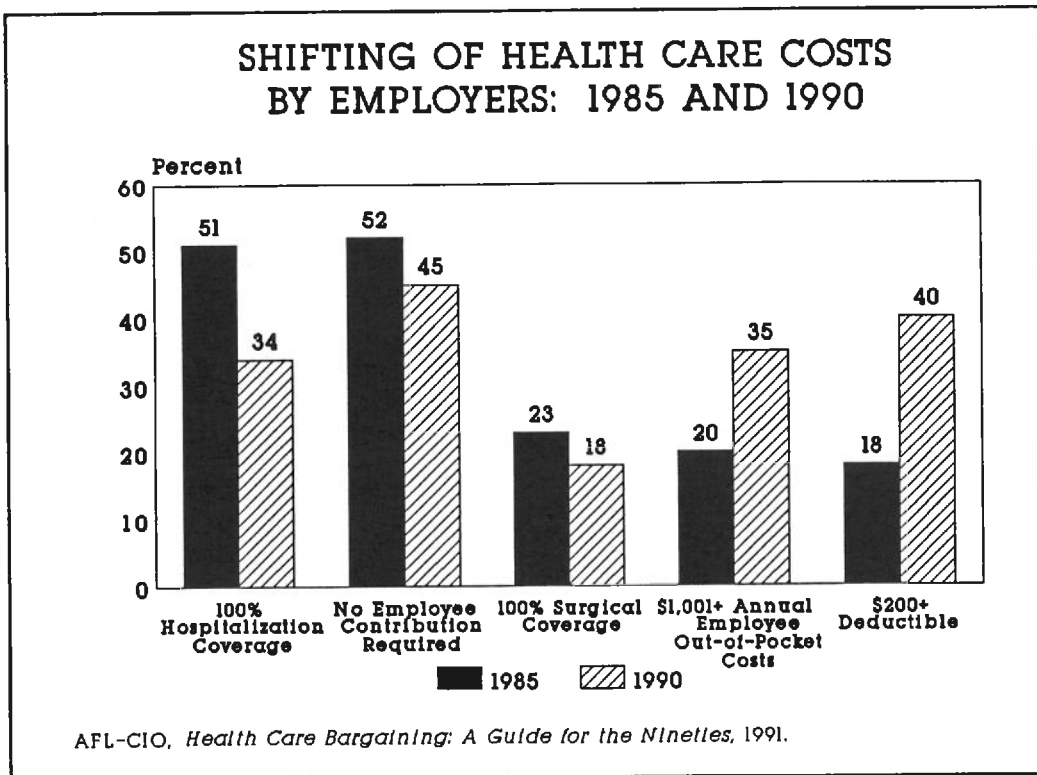
**Individuals and families are paying more for health care as a result of employer cost shifting.** Since health insurance premiums negotiated between the insurance company and the employer have been increasing rapidly, employers are having to pay more for coverage than ever before -- and they are shifting a part of the costs to employees. Regardless of the purchaser, the individual health insurance recipient typically pays a part of the premium and/or other out-of-

**FIGURE 8**



pocket expenses. Many employers have increased the deductible and/or are no longer offering -- or no longer paying for -- dependent coverage. The proportion of employers requiring individual deductibles of \$200 or more doubled from 18% in 1985 to 40% in 1990. Between 1985 and 1990, the percentage of employers offering plans covering 100% of hospitalization and surgical costs decreased, and the percent of employers requiring employee contributions to health insurance premiums increased (See Figure 9).<sup>7</sup> In addition, some employers are restricting employee choice, covering -- or fully covering -- health care costs only when certain physicians or hospitals are used. Health maintenance organizations (HMOs) and other managed care plans may be offered as an optional or required alternative to individual physicians selected by the insured.

**FIGURE 9**



### Labor Market Factors

Contributing to the growth in the number of workers without employer-based health insurance has been a shifting economy which has resulted in a two-tiered work system, characterized by increasing numbers of low-wage, no-benefit jobs, particularly in the service industry. Since the mid-1970s, the United States economy has experienced a profound reversal in the pattern of economic development and income distribution.<sup>8</sup> Since 1973, real

wages (wages adjusted for inflation) have stagnated or fallen, and the distribution of income and wealth has become more unequal -- so unequal that the richest 1% of all Americans now receive nearly as much income after taxes as the bottom 40% of Americans combined.<sup>9</sup> Recent economic trends have divided our nation economically, and contributed to racial and employment-sector disparities. In addition to global competition, especially in the manufacturing sector, factors fueling this two-tiered system include structural macro-economic shifts, low educational levels, demographic changes, cutbacks in federal programs, and discrimination.<sup>10</sup> Hispanics have been especially hurt by the trend towards a two-tiered work and economic system.

**A shift in job creation from manufacturing to the service sector has created a "mismatch" between worker skills and needs and available jobs.** The service sector, including cleaning, protective, food, health, and personal services, has grown faster than any other sector of the economy. The number of jobs in the manufacturing industry decreased by 1.8 million from 20.3 million in 1980 to 18.5 million in 1991; whereas 10.4 million jobs were created in the services industry, from 17.9 million in 1980 to 28.3 million in 1991.<sup>11</sup> Levitan and Shapiro found that between 1980 and 1986, 11 million new jobs were created; the number of jobs in the goods-producing industries dropped by 0.7 million, while service-sector jobs increased by 10.5 million. The U.S. Department of Labor estimated that from January 1981 to January 1986, almost 11 million workers lost their jobs as a result of plant closings or mass layoffs.<sup>12</sup> Many displaced workers from the goods-producing industries were forced to leave manufacturing jobs and find positions in the service sector, where pay was lower and their skills were not transferable.

**Hispanics are increasingly employed in low-paid service jobs.** The number of Hispanics employed in the manufacturing industry increased by only 144,000 between 1985 and 1991, while the number employed in the service industry increased by 828,000. Employees in the manufacturing industry earned an average of \$455.03 per week in 1991, compared to an average of \$331.13 per week in the service industry.<sup>13</sup> When movement between industries is examined, it is found that Hispanics and Blacks generally drifted downwards into low-income jobs during the 1980s. Although there was some growth in high-income employment, these jobs generally went to Whites, with more education and higher skill levels. For Black males, and to a lesser extent Black females, high-income employment increased slightly, middle-income employment remained stagnant, and low-level employment increased. For Hispanic males, there was no high-income employment growth, middle-income employment remained virtually the same, and low-income employment increased. Hispanic females experienced some growth in the two higher-income sectors. There was a higher mobility from middle-income jobs to high-income jobs for White males, while employment in low-income jobs remained constant. The same is true for White females.<sup>14</sup>

**The late 1970s and the decade of the 1980s were a period of stagnant income levels and consistently high poverty rates for Hispanics, even during years of economic expansion.** In 1989, Hispanic earnings were 63% of non-Hispanic earnings, a drop from 69% in 1974.

While some Americans regained the economic ground lost during the recession of the early 1980s, Hispanics benefitted least from the economic recovery.<sup>15</sup>

**Hispanics have become a larger part of the labor force, while earning less.** Hispanics constituted 3.7% of the labor force in 1970, and 9.3% in 1989.<sup>16</sup> Meanwhile, Hispanic median family income in constant (1989) dollars fell from \$24,339 in 1973 (the first year for which figures are available) to \$23,446 in 1989, while White median family income rose slightly, from \$35,175 to \$35,975. A majority (57.5%) of Hispanics had individual incomes below 200% of the poverty level (\$13,600) in 1990, compared to a similar proportion (55.3%) of Blacks and half that proportion (28.8%) of Whites.

**Except where a company is unionized and health insurance is a required component of a collective bargaining agreement, lower-skill, low-paid workers typically do not receive health insurance from their employers.** This is particularly true of Hispanics. Only a little over two in five working-age Hispanics (43.3%) -- and a slightly higher percentage of Blacks (46.3%) -- received employer-sponsored health insurance in 1990, compared to seven in ten Whites (70.3%). Overall, two in five Hispanics with incomes of less than \$25,000 (40.9%) were uninsured in 1990, compared to less than one in five non-Hispanic Whites with similar incomes (18.3%). Union affiliation is closely connected to insurance status; in 1987, only about 5.2% of union members were uninsured, compared to 16.5% of all workers combined. With the decline in union jobs, many low-wage, lower-skill workers have lost a powerful ally in advocating for health and other fringe benefits in the work place. The proportion of union members decreased from 23.3% of employed persons in 1983 to 16.1% in 1991. Union members made up a larger concentration of employees in the manufacturing industry (24.1%) than in the service industry (8.4%) in 1991. The percent of Hispanics in unionized jobs decreased from 24% in 1983 to about 16% in 1991, and Hispanics (16%) and Whites (15%) were less likely to hold union jobs than Blacks (21%).<sup>17</sup>

**Hispanics are overrepresented in industries which offer few fringe benefits.** Access to health care is directly related to employment in certain industries and occupations. Compared to non-Hispanics, a greater proportion of Hispanics work in agriculture, construction, manufacturing, and retail trade industry groups. According to a 1992 GAO report on Hispanic access to health care, the high rate of lack of insurance among Hispanics is partly explained by their employment in jobs that do not provide health insurance benefits to employees. Furthermore, according to the GAO report, if Hispanic workers had the same rate of health insurance coverage as White workers, only 18% Hispanic families would have been uninsured in 1989, instead of nearly twice that many (32.3%).<sup>18</sup>

**Part-time workers are often excluded from health insurance coverage, and Hispanics are less likely than non-Hispanic White part-time workers to have health insurance.** In 1990, just under half of Hispanic part-time workers (49.3%) and three-fourths of comparable White non-Hispanic workers (75.5%) had some type of health insurance coverage.

## **Variations by State**

**Often, where a worker lives determines whether s/he receives employer-based health insurance.** As previously shown, there are variations by state in the percentage of Hispanics receiving health insurance coverage from an employer or a relative's employer. For example, Hispanics in Illinois and New Jersey are more likely to receive employer-based health insurance than Hispanics in Massachusetts, New York, Florida, and New Mexico. Variations in the rates of employer insurance coverage by state are affected by the state's economic base and growth rate, industrial concentrations, unemployment rate, population characteristics, unionization, state laws regulating insurance coverage, and many other factors.

**Unlike White and Black males, Hispanic males are not significantly more likely to have health insurance if they are employed.** In 1990, 41% of working Hispanic males were uninsured, as were 42% of non-working Hispanic males; in comparison, 28% of working and 35% of non-working Black males were uninsured, as were 17% of working and 23% of non-working White males.<sup>19</sup>

## **PUBLIC HEALTH INSURANCE**

### **Structure, Costs, and Benefits**

The two very different major forms of public health insurance are Medicare and Medicaid, which target specific segments of the population.

**Medicare, enacted in 1965 as Title XVIII of the Social Security Act, was designed to provide access to health care and basic medical coverage primarily for individuals 65 and over and disabled persons.** It was enacted out of a concern that these populations were at risk of financial devastation as a result of health care costs. Medicare is "non-means-tested," available to individuals eligible for Social Security based on age or disability, with no income limits. Moreover, since Social Security is a federal program with federally specified eligibility requirements, Medicare criteria are the same regardless of state.

**Medicare is the most costly federal domestic program after Social Security, at an estimated cost of \$86.9 billion in Fiscal Year (FY) 1989.** Medicare Part A, which is financed through a portion of the Social Security payroll tax, reimburses providers for hospitalization, most in-hospital services, in-hospital drugs, skilled nursing care, home health care, and hospice care. Medicare Part B, which is largely financed through general revenues and individual premiums, covers doctors' fees, outpatient hospital services, and in-hospital services by radiologists, anesthesiologists, and psychiatrists. However, private physicians are not required to take Medicare patients. There is growing cost sharing required; the annual deductible increased from \$75 in FY 1990 to \$100 in FY 1991. The monthly premiums increased from \$28.50 in FY 1990 to \$31.80 in FY 1992, and are set to increase to \$36.60 in FY 1993, \$41.10 in FY 1994, and \$46.10 in FY 1995.<sup>20</sup>

**Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is the principal public source of health insurance for impoverished individuals and their families.** Medicaid was originally intended to help cover health care for people already receiving cash benefits under Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). Thus, it is "means-tested," serving mainly poor women and their children, the aged, and the blind and disabled. States also have the option of covering other categories of medically needy people who may not be eligible for AFDC or SSI. Administered and funded by states with matching grants from the federal government, Medicaid uses eligibility criteria based on state AFDC standards, which are extremely complex and varied, as is the application process. States typically limit eligibility to persons earning less than a specified proportion of the federal poverty level -- \$13,359 for a family of four in 1991 -- set at their discretion. Monthly income limits and overall resource limits are also used to determine eligibility, and also vary widely from state to state. Aside from setting eligibility criteria, each state administers its own program; determines the type, amount, duration, and scope of services; and sets the rate of reimbursement for services.<sup>21</sup> Aside from the federally mandated set of services that must be provided by every state's Medicaid program -- such as inpatient and outpatient hospital services, physician services, and skilled nurse services -- there are many optional services which a state can choose to cover or exclude.<sup>22</sup> As with Medicare, in many cases, private physicians can generally choose whether to take Medicaid patients. Like other health care costs, Medicaid costs have been escalating, drawing more than \$100 billion in federal and state funds in FY 1991.

### **Coverage of Eligible Populations**

**The Medicaid program covers a lower proportion of its target population than Medicare, due to its complex and state-determined eligibility criteria and application process.** It is easy to measure the coverage of the Medicare program since it targets all those 65 and over who are eligible for Social Security. The effectiveness of Medicaid in serving low-income populations is more difficult to measure because of state variations in eligibility. The elderly are less likely to be uninsured than younger populations; overall, 95.6% of the elderly received Medicare in 1990, and only 0.9% of all persons 65 years and older were uninsured, compared with 12.9% of those under 18, 18.7% of those ages 18 to 44 years, and 12.7% of those ages 45 to 64. On the other hand, less than half the poverty population (45.2%) received Medicaid, and about 28.6% were uninsured.<sup>23</sup>

**Although most elderly receive Medicare, coverage levels vary, depending on Social Security eligibility.** Thus 96.2% of White elderly, 93.3% of Black elderly, and 90.1% of Hispanic elderly received Medicare in 1990. Some Hispanic elderly do not automatically qualify for Medicare because they are not Social Security recipients. In 1990, only 80% of Hispanic elderly received Social Security, compared to 88% of Black and 93% of White elderly.<sup>24</sup> Many Hispanics are not eligible for Social Security because they did not pay into the system at all, or not long enough to derive benefits. A history of employment in farm work and domestic labor, which were not covered by Social Security until recently, helps to explain this scenario.

**Despite Hispanics' low incomes, the Medicaid program has been of less benefit to low-income Hispanics than to low-income Blacks.** Although 28.1% of Hispanics were below the poverty level in 1990, only 18.2% received Medicaid; in comparison, 31.9% of Blacks lived in poverty, while 25.2% received Medicaid, and 10.7% of Whites lived in poverty, while 7.2% received Medicaid. Less than half of poor Hispanics (44.7%) and less than two-fifths of poor Whites (39.2%), compared to nearly three-fifths of poor Blacks (57.8%), were Medicaid recipients. Consequently, a greater portion of poor Hispanics (41.3%) and Whites (30.6%) were uninsured than poor Blacks (24.3%).

**Many low-income Hispanics do not receive Medicaid because they are among the working poor.** Working Hispanics living below the poverty level are more likely than non-working Hispanics with similar incomes to be uninsured. A little over one in ten low-income working Hispanic males (10.1%) received Medicaid and nearly seven in ten (69.4%) were uninsured in 1990, while over one in three low-income non-working Hispanic males (36.4%) received Medicaid and over half (52.6%) were uninsured. Similarly, over one in four low-income working Hispanic females (26.9) received Medicaid and over half (53.4%) were uninsured, while nearly half of low-income non-working Hispanic females (49.8%) received Medicaid and less than two in five (38.8%) were uninsured.

**The complexities of Medicaid enrollment mean that persons may be eligible but not know it.** For instance, the "spend down" process allows a family or individual to qualify under the Medicaid Medically Needy Program by subtracting incurred medical expenses from gross income. Thus, persons with incomes above the Medicaid income eligibility threshold can become eligible if they incur sufficient medical expenses. However, many people are unaware of this Medicaid provision.

### **Variations by State and Subgroup**

**There are large variations in Medicaid coverage by state, because great discretion is left to states in determining program scope, size, eligibility, and procedures.** Thus where a low-income individual lives often determines whether s/he benefits from Medicaid. Since about 85% of the Hispanic population are concentrated in ten states, Medicaid eligibility criteria and coverage in those states to a large degree determine health care availability for low-income Hispanics. Of special importance are the income limits for Medicaid eligibility for a family of four who receives AFDC. Figure 10 lists the 1992 AFDC income threshold for a family of four in the ten top states in Hispanic population. The range of coverage is extremely wide -- from Texas, which currently provides Medicaid only to persons with a family income below \$2,652, 19.0% of the national poverty level for a family of four, to California, which covers individuals with a family income of less than \$9,456, 67.8% of the federal poverty level. The income limit in New York is \$8,244 a year for a family of four; in Massachusetts \$8,016; in New Jersey \$5,856; in Colorado \$5,184; in Illinois \$4,968; in Arizona \$4,812; in New Mexico \$4,668; and in Florida \$4,368. Thus in states which have very low Medicaid income limits -- such as Texas, Florida, New Mexico, and Arizona where nearly one-third (32.1%) of U.S. Hispanics lived in 1990 -- only a small proportion of low-income Hispanics receive Medicaid.



**FIGURE 10**  
**AFDC ELIGIBILITY CRITERIA AS A FORM OF MEDICAID**  
**ELIGIBILITY FOR TEN STATES WITH THE**  
**LARGEST HISPANIC POPULATIONS\***  
**(For a Family of Four)**

STATE	AFDC INCOME THRESHOLD*		DATE OF LATEST CHANGE	RANK**
	\$	As a % of Poverty		
California	9,456	67.8	1/91	3
New York	8,244	59.1	1/90	6
Massachusetts	8,016	57.5	1/88	8
New Jersey	5,856	42.0	1/87	21
Colorado	5,184	37.2	1/88	28
Illinois	4,968	35.6	1/92	30
Arizona	4,812	34.5	1/91	33
New Mexico	4,668	33.5	1/91	35
Florida	4,368	31.3	1/92	36
Texas	2,652	19.0	1/85	50

\* AFDC eligibility for each state is one factor in determining Medicaid eligibility; mainly available to female-headed households and their children. The 1992 federal poverty threshold, \$13,950, was used to calculate percent of poverty level.

\*\* Rank is based on AFDC eligibility of the 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Lower number rank indicates less stringent criteria.

U.S. Department of Health and Human Services, Office of Family Assistance, AFDC State Plan, July 1992.

**Other Medicaid policies also have major impact on access to health care.** As shown in Figure 10, some states, including Texas, New Jersey, Massachusetts, and Colorado, have not updated their AFDC income thresholds since 1988 or before. Also, policies such as covered procedures and levels of reimbursement to hospitals and physicians for Medicaid patients and the uninsured help determine the degree to which Hispanics and other poor populations receive adequate hospital care. If reimbursement rates are low, many health care providers may refuse

to serve Medicaid clients, or may provide them limited care. Procedures not covered may not be performed, regardless of need.

**Differences in Medicaid coverage by Hispanic subgroups reflect their geographic concentrations and state variations in Medicaid regulations, as well as variations in socioeconomic and employment status.** For example, about 40% of Puerto Ricans are concentrated in New York, which has a Medicaid program with relatively high income limits and relatively broad coverage of its poverty population, and many other Puerto Ricans live in Northeastern and Midwestern states with relatively high levels of coverage. In addition, low-income Puerto Ricans are more likely than other Hispanics to be unemployed -- and therefore eligible for Medicaid in states which do not cover the working poor. Thus low-income Puerto Ricans are more likely than other low-income Hispanics to receive Medicaid, and are less likely to be uninsured. Mexican Americans, on the other hand, are less likely to receive Medicaid and more likely to be uninsured. This reflects both the fact that a high proportion of low-income Mexican Americans are among the working poor, and the high proportion living in states such as Texas, Arizona, and New Mexico, which have very stringent Medicaid eligibility limits.

## CONCLUSIONS

**There are major gaps in private and public health insurance coverage.** Certain groups of Hispanics, the population most overrepresented among the uninsured, are systematically excluded from the public and private health insurance systems.

**Although employment is the primary determinant of private health insurance coverage, employment does not guarantee health insurance coverage -- especially for Hispanic workers and their families.** While the entire population is affected by strains placed on private health insurance coverage, Hispanics are the group of workers most likely to lack employer-based health insurance coverage -- and least likely to be able to purchase non-employer-based private insurance.

**The decline in employer-sponsored health insurance is evident in the increased number of uninsured workers, particularly Hispanic workers.** The total number of uninsured U.S. workers 16 to 64 years of age increased by 7.4% between 1988 and 1990, from 19.0 million to 20.4 million. By comparison, the number of uninsured Hispanic workers 16 to 64 increased by 39.4%, from 3.3 million to 4.6 million.<sup>25</sup> In 1987, 78% of uninsured Hispanics lived in families headed by workers.<sup>26</sup> Hispanic male and female workers remained more likely to be uninsured than comparable Black and White workers. In 1990, Hispanic workers were two and one-half times as likely as White workers to be uninsured -- 41.1% versus 16.5% for males, and 30.4% versus 12.6% for females.

**Medicare and Medicaid reach a high proportion of eligible elderly, blind, and disabled, although rates of coverage are lower for Hispanic than other elderly, largely because Hispanic elderly are less likely than Blacks or Whites to be receiving Social Security, which**

provides the typical basis for Medicare eligibility. Medicaid is not designed to reach all low-income individuals and families who lack and cannot obtain private health insurance; state discretion makes coverage uneven, based more on geography than on need.

**Even where public health insurance is an "entitlement," eligible persons and families do not receive it automatically.** This analysis focuses on insurance status and the impact of eligibility, while recognizing that many factors other than eligibility help determine the extent to which eligible individuals actually receive public insurance benefits to which they are entitled. For example, according to a previous NCLR analysis, many eligible Hispanic elderly are not receiving Medicaid buy-in benefits made possible by the recently-established Qualified Medicaid Beneficiaries (QMB) program -- which requires Medicaid to pay for Medicare premiums, deductibles, and other out-of-pocket expenses for eligible low-income seniors -- primarily because of linguistic and cultural barriers, unfamiliarity with government programs, and lack of appropriate outreach and information to Hispanic communities.<sup>27</sup> Similarly, the Medicaid expansion to pregnant women and young children can be of major benefit to Hispanics -- but only if they are made aware of the new coverage and how to obtain it.

**Population segments most likely to lack private health insurance and also be unable to obtain public health insurance include the following overlapping groups:** the near-poor and working poor and their families; individuals working in the service rather than the manufacturing sector, part-time workers, non-unionized workers, and low-skill workers; and low-income males, regardless of employment status.

**The working poor and near-poor and their families are particularly likely to be uninsured.** Almost universally omitted from Medicare and Medicaid are single people and childless couples under 65 who do not meet the disability test. Fewer than one in five low-wage workers receive employer-based health care benefits for themselves, let alone their dependents, yet they and their families are seldom eligible for Medicaid. Low-income males are rarely eligible for Medicaid, since Medicaid eligibility is based on AFDC, which in many states excludes fathers and was never intended to cover males without dependent children. Near-poor Hispanic families seldom receive employer-based health insurance, and almost never are eligible for public insurance. More than half of Hispanic families (51%) that are near the poverty level (between 100 and 150% of poverty) are uninsured, as are a little over three out of seven Hispanic families (44%) living below the poverty level.

**The percentage of uninsured Hispanic children remains very high.** In 1990, Hispanic children (28.3%) were twice as likely to be uninsured as Black (14.4%) or White children (12.5%). New national legislation may help somewhat; changes in legislation that take effect this year will provide automatic Medicaid eligibility to pregnant women and children up to age six whose family income does not exceed 133% of poverty. The expansion should assist poor and near-poor Hispanic children under six years of age to obtain access to health care.

**It is precisely because Hispanics are likely to participate in the labor force despite their working poor status -- employed in lower-skill, lower-wage jobs -- that they and their**

**families so often lack any type of health insurance.** By working, they typically become ineligible for public health insurance through Medicaid. Low-wage workers often cannot afford to cover required contributions to health insurance premiums, deductibles, copayments, and other out-of-pocket expenses for themselves or their dependents. Thus a large proportion of employed workers, especially Hispanics, are without health insurance -- or without full family coverage. A study by the Children's Defense Fund concludes that the proportion of children with employer health coverage declined by nearly 14% between 1977 and 1987. The children most affected were minority children in low- and middle-income families and those living in working poor families.<sup>28</sup> Such families cannot afford to purchase health insurance on an individual basis.

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## IV. CONSEQUENCES OF LIMITED HISPANIC HEALTH INSURANCE COVERAGE

### OVERVIEW

**Having no health insurance -- or health insurance requiring extensive cost sharing -- makes regular health care unaffordable for the "typical" Hispanic family, and almost all health care unaffordable for families living in poverty.** Health care costs are so high that only families with relatively high disposable incomes can afford regular and preventive care or major medical procedures not covered by health insurance.

**Because Hispanics so often lack health insurance, their access to adequate health care is severely limited.** Uninsured persons are more likely than insured persons to receive irregular or inadequate care, and they spend proportionately more of their disposable income on health care. Being uninsured contributes to poor health and to disadvantaged socioeconomic status for Hispanics. In addition, with the increasing costs of medical care, employers are shifting costs to employees, so many insured Hispanics are seeing their health coverage weakened and their own health care expenses increased. The burden of cost shifting is particularly heavy for families with low and moderate incomes.

### VALUE AND COST OF COVERAGE

**Health care costs are high and growing, and out-of-pocket costs represent a considerable share of these costs.** The 1987 National Medical Expenditure Survey found that the average amount paid for medical expenditures for persons under 65 receiving care was \$1,420 per person; on average, persons using health services paid about half their medical expenditures (50.7%) out-of-pocket. On average, Hispanics spent \$1,150 per user on health care in 1987 and covered 47.8% of costs out-of-pocket; Blacks spent \$1,761 with 38.0% covered out-of-pocket; and Whites spent \$1,399 with 52.7% covered out-of-pocket.<sup>1</sup>

**Cost sharing is now the norm for employer-based health insurance.** A decade ago, individuals and families with employer-based coverage typically were not required to contribute any part of the premium costs for their own insurance, and family coverage was often provided with little or no premium cost-sharing. Deductions were typically \$100 per person per year or less. The major out-of-pocket costs for families were uncovered expenses, often including mental health services, vision care, and dental care. The Foster Higgins 1991 survey of health care benefits indicates that the total cost to employers of providing employee health benefits has increased according to a "20% trend" since 1988.<sup>2</sup> The cost increase to employers between 1990 and 1991, however, was somewhat less -- 12.1% -- primarily because of increased cost sharing, which shifts costs to employees through premium contributions, deductions, and copayments. As of 1991, over half of employers providing health insurance to their workers (55%) required employees to contribute to the premium costs for employee-only coverage, and



over three-fourths (76%) required premium contributions for family coverage; the employee share averaged 20% of the costs of employee-only coverage and 28% of total premiums for family coverage. Half of all employers had individual deductibles of \$200 or more in 1991, compared to one-quarter of employers five years earlier; the median traditional medical plan deductible was \$200, and the median family deductible was \$400 or more. Copayments or coinsurance -- which usually require that an employee pay a set percentage, usually 20%, of the first few thousand dollars of most eligible medical services -- are now routine for outpatient costs as well as for inpatient services. Most employers (93%) place a dollar cap on the employee share of covered costs; the median maximum per family member was \$1,050 in 1991, up from \$1,000 in 1990. The median family out-of-pocket cap in 1991 was \$2,100, up from \$2,000 in 1990, and nearly four in five employers (79%) set the family maximum at \$1,500 or more.<sup>3</sup> These caps are generally the same for all employees covered by the plan, regardless of salary level.

**Average health care expenditures appear to be heavily affected by an individual's type and extent of insurance coverage.** For Whites, Blacks, and Hispanics, those with health insurance coverage had higher health care expenditures but paid a smaller proportion of the overall expenditures out-of-pocket per person, compared to those without health insurance coverage. In 1987, among Hispanics under 65 with private health insurance, total expenses were \$1,185 per person using medical services, and the proportion of out-of-pocket expenditures was 50.7%. Hispanics who were uninsured all year had an average of \$514 in total medical expenditures per user, and 81.0% was covered out-of-pocket. Hispanics with public insurance spent a mean of \$1,591 per user -- the highest mean total expenditure -- with 13.9% covered out-of-pocket -- by far the lowest proportion spent out-of-pocket. The proportion of health care costs covered out-of-pocket was lower for uninsured Whites (78.1%) and Blacks (68.0%) than for uninsured Hispanics (81.0%).<sup>4</sup>

**Public and private expenditures on insurance are very large and increasing rapidly as a proportion of total spending -- but many Hispanic families receive no benefit from these expenditures.** In 1990, employers providing health insurance spent an average of \$3,161 per employee on medical indemnity plans; the amount increased 13% to \$3,573 in 1991.<sup>5</sup> Total Medicaid expenditures to medical vendors in FY 1990 were \$68.7 billion -- including federal and state combined payments and excluding administrative costs -- and over 25 million eligible persons were served.<sup>6</sup> Thus, the amount spent per Medicaid recipient was approximately \$2,705. However, one-third of all Hispanics, and one-half of Hispanic families with incomes between \$13,359 and \$20,038 (100 to 150% of the poverty level), did not benefit from these expenditures because of their uninsured status. A total of 602,000 Hispanic males and 326,000 Hispanic females living below the poverty level worked but were uninsured. An additional \$2.5 billion would have been spent on Medicaid in 1990 if these individuals had not worked and had been eligible to receive Medicaid. Along the same lines, an aggregate amount of \$2.9 billion would have been spent by employers if these Hispanics had been employed in jobs offering the typical medical indemnity plan.

**Uninsured working poor or near-poor families have less available income than insured working-poor families, because of added out-of-pocket medical expenses.** Young Hispanic adults who are employed, yet receive incomes that place them below the poverty level, are particularly likely to be without health insurance; in 1990, only about three in ten working poor Hispanic males (30.6%) were insured, compared to nearly six in ten (58.9%) of all working Hispanic males. The number of Hispanic young adult householders with health insurance coverage declined by 19.8% from 1979 to 1990.<sup>7</sup> Hispanics are young and have a larger family size than non-Hispanics. These factors may impede many Hispanic individuals and families from accessing the health care system.<sup>8</sup>

**The chart on the following page illustrates the costs of a typical amount of health care for a family at the poverty line with various types and levels of health insurance coverage.** Figure 11 demonstrates use of disposable income for an Hispanic family of four living at the 1991 federal poverty line -- \$13,359 for a family of four. The column at the far right indicates the total disposable income remaining after basic costs for shelter, food, and health care have been paid for -- the money remaining for transportation, basic costs for clothing, child care, work-related expenses, and all other expenditures. The first family has employer-based health insurance through a Health Maintenance Organization (HMO) and pays the average employee share of 25% of the typical premium cost of \$316 a month for an HMO plan, plus limited copayments for office visits and prescription drugs, for a total of \$1,048 per year.<sup>9</sup> The second family has employer-based coverage through a medical indemnity plan, but pays typical out-of-pocket expenses of \$1,300, a mixture of up to \$400 in deductibles, plus copayments and non-covered expenses on total health care costs of about \$4,000. The third family does not have employer-paid insurance but purchases a plan either through the employer, another group, or privately, paying insurance premiums of \$3,573 per year (the typical cost for an employer-based group plan) plus the same out-of-pocket expenses as the second family. The fourth family has no insurance and must pay directly for its health care; its health care costs total \$5,175 -- which uses 1987 National Medical Expenditure Survey data for typical expenditures, adjusted upward 50% to conservatively reflect health care cost increases over the past five years; it assumes that three of the four family members will require health care at some point during the year (which is the national average), and that the family must cover all costs. The fifth family is fortunate enough to qualify for Medicaid in spite of having at least one working member, through participation in the JOBS welfare reform program; it pays only a small out-of-pocket share of its health care costs, calculated based on 1987 per-person out-of-pocket health care costs for Hispanics receiving public health insurance, adjusted upward 50% to conservatively reflect cost increases since 1987.

**The chart makes it clear that a family living at the poverty level cannot afford to purchase the "typical" amount of health care on the open market or to purchase individual health insurance.** With the projected "typical" expenditures, the third and fourth families would spend all their disposable income on health care, and have nothing left for clothes, furniture, telephone, transportation, child care, or other expenses; the fourth family would actually be in debt even without covering these other expenses. The second family could pay its share of an employer-based plan requiring moderate cost-sharing if the employer covered the entire premium

for all dependents, and if actual health care costs were relatively modest; however, if there were a serious illness and the family had to meet typical deductibles and maximum copayments plus other usual out-of-pocket expenses, estimated by Foster Higgins at \$2,100, the family would have only \$2,811 in disposable income remaining, rather than \$3,611. Only the families with HMO coverage and Medicaid coverage would pay less than 10% of their disposable income for health care. A fortunate family might receive free or reduced-cost health care at a community health center or clinic, but access to such services is not necessarily available to low-income Hispanic families.

**FIGURE 11**  
**AGGREGATE AMOUNT PAID BY AN EMPLOYED HISPANIC**  
**FAMILY AT THE 1991 POVERTY LINE FOR BASIC NEEDS,**  
**BY INSURANCE STATUS**

FAMILY OF FOUR	INCOME (Poverty Line)	HOUSING*	FOOD**	HEALTH CARE	REMAINING DISPOSABLE INCOME
FAMILY #1 Employer-Paid Health Maintenance Organization	\$13,359	\$4,008	\$4,440	\$1,048	\$3,863
FAMILY #2 Employer-Paid Indemnity Plan***	\$13,359	\$4,008	\$4,440	\$1,300	\$3,611
FAMILY #3 Uninsured;*** Purchases Health Insurance	\$13,359	\$4,008	\$4,440	\$4,873	\$38
FAMILY #4 Uninsured; Pays for Medical Care	\$13,359	\$4,008	\$4,440	\$5,175	-\$264
FAMILY #5 Medicaid	\$13,359	\$4,008	\$4,440	\$498	\$4,413

- \* U.S. Department of Housing and Urban Development housing affordability standard, 30% of income; yet in 1989, 43.6% of Hispanic renter households paid more than 30%.<sup>10</sup>
- \*\* Equal to the maximum Food Stamp allotment for 1991, which is tied to the cost of purchasing a nutritionally adequate low-cost diet, as measured by the Agriculture Department's Thrifty Food Plan.
- \*\*\* Estimate based on the cost to an employer of indemnity medical plans in 1991, plus typical out-of-pocket costs paid by the employee. Estimates are conservative since indemnity plans purchased individually may be more costly than those purchased through a group.

In order to make ends meet, a family with one earner may decide that another family member must enter the labor force -- in an intact family, the mother may seek work, or a child may leave school to work. This will increase the family's disposable income, but the family will also incur additional expenses such as transportation and additional clothing costs; if there are young children, as much as \$3,000 a year may be spent on day care.

**Many uninsured working poor and near-poor Hispanic families and individuals may "functionally" be below the poverty level as a result of the costs of medical care.** The federal poverty line may not accurately account for the added costs an uninsured family bears for medical costs. A family is officially classified as poor if cash income is less than the poverty threshold, which was \$13,359 for a family of four persons in 1991. When the poverty line was first established in mid-1960, it was determined that families generally spent about one-third of their income on food. A poverty line was then calculated by determining the lowest-cost "nutritionally adequate" diet and multiplying this by three.<sup>11</sup> The current poverty threshold is established each year simply by increasing the previous year's threshold by the change in the Consumer Price Index. There has been considerable debate over the adequacy of the official poverty line in determining poverty. Over the past three decades, the costs of various goods and services have changed. It is estimated that the average American family spends less on food, while the proportions of disposable income spent on housing, health care, and child care costs have increased.<sup>12</sup>

**Since the typical Hispanic family with total income around the poverty line is a working family that does not receive health insurance from an employer and is ineligible for Medicaid, its total disposable income is effectively reduced by the amount of health care costs.** This reduction can drive a family's disposable income well below the poverty level. Similarly, a low-income family can be lifted from poverty by receiving full health insurance to cover what were previously entirely out-of-pocket expenses. Unfortunately, since slightly over half of near-poor Hispanic families are uninsured, and most of the rest have limited insurance coverage with significant cost sharing, the former scenario is more likely than the latter.

**Rising health care costs threaten the financial status of moderate income Hispanic families as well.** In 1991, the median family income for Hispanics was \$22,330. Figure 12 provides calculations on basic costs for "typical" Hispanic families at this income level. The family's disposable income is likely to be about \$4,000 below the total income level due to federal, state, and local taxes, so the total disposable income shown in the figure is \$18,330. (This tax estimate includes federal withholding, Social Security and Medicare taxes, and state withholding; taxes would be higher in some locations such as the District of Columbia, which has a relatively high "state" income tax, and lower in California, which has a more progressive state income tax.) Since a family at this income level is not eligible for Medicaid, the fifth family from the poverty-level income table is eliminated from this chart. The figures indicate that even for a family at this moderate income level, being uninsured means that typical health care costs would take about 60% of the disposable income available after shelter and food costs

had been met. While insurance -- whether purchased by the employer or the family -- provides protection against devastating expenses, an illness requiring outpatient surgery or brief hospitalization could easily find both Families #2 and #3 paying an additional \$800 or more in copayments and out-of-pocket expenses; the typical out-of-pocket health care costs for families with private insurance in 1991 were \$2,100 rather than the \$1,300 shown in the figure. Moreover, the uninsured Family #4 has no protection against major medical expenses.

**FIGURE 12  
AGGREGATE AMOUNT PAID BY AN EMPLOYED HISPANIC  
FAMILY AT THE 1991 POVERTY LINE FOR BASIC NEEDS,  
BY INSURANCE STATUS**

FAMILY OF FOUR	NET INCOME*	HOUSING **	FOOD ***	HEALTH CARE	REMAINING DISPOSABLE INCOME
FAMILY #1 Employer-Paid Health Maintenance Organization	\$18,330	\$5,499	\$4,582	\$1,048	\$7,201
FAMILY #2 Employer-Paid Indemnity Plan****	\$18,330	\$5,499	\$4,582	\$1,300	\$6,949
FAMILY #3 Uninsured;**** Purchases Health Insurance	\$18,330	\$5,499	\$4,582	\$4,873	\$3,376
FAMILY #4 Uninsured; Pays for Medical Care	\$18,330	\$5,499	\$4,582	\$5,175	\$3,074

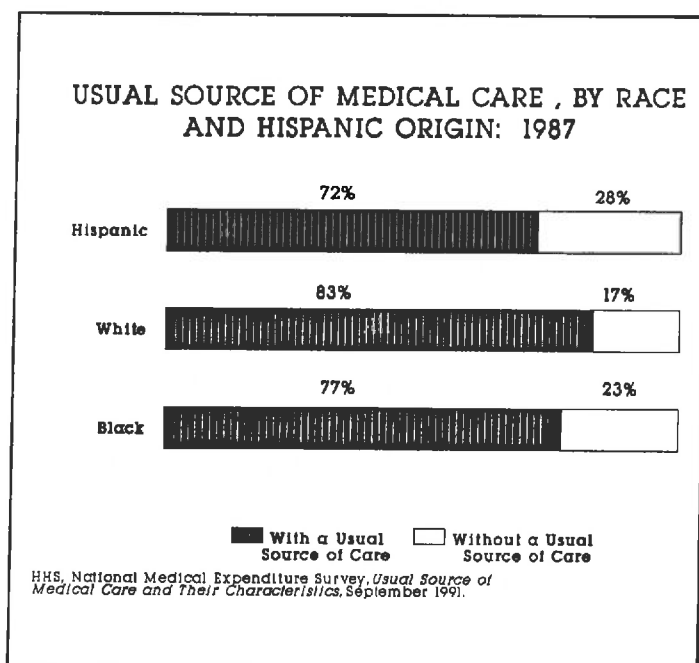
- \* Net income after \$4,000 in federal and state taxes.
- \*\* U.S. Department of Housing and Urban Development housing affordability standard, 30% of income. In 1989, 43.6% of Hispanic renter households paid more than 30%.<sup>13</sup>
- \*\*\* Estimated at 25% of disposable income.
- \*\*\*\* Estimate based on the cost to an employer of indemnity medical plans in 1991, plus typical out-of-pocket costs paid by the employee. Estimates are conservative since indemnity plans purchased individually may be more costly than those purchased through a group.

Because they are less likely to have health insurance, Hispanic families are less likely than non-Hispanics to enjoy not only the added buying power but also the added security that comes with health insurance. Beyond its monetary value, health insurance provides security from the financial devastation that can result when an uninsured family member suffers a major illness. Medicare was enacted out of just such a concern. However, no similar protection exists for younger, working families.

## ACCESS TO HEALTH CARE

Americans without health insurance receive less preventive care and less overall health care than insured Americans. Persons with private or public health insurance are more likely to use health services than the uninsured, and the uninsured are less likely to have a regular source of health care than persons with insurance coverage.<sup>14</sup> Low-income uninsured persons are unlikely to receive screening for preventive purposes, placing them at higher risk for contracting or dying from certain cancers and other diseases that could be prevented or treated successfully with regular screening and early detection. According to a 1992 GAO report, uninsured persons were less likely to use preventive and early detection services such as pap smears, blood pressure checks, and breast examinations.<sup>15</sup> One recent study concluded that "lack of health insurance was the strongest and most consistent predictor of inadequate screening."<sup>16</sup>

FIGURE 13



Hispanics are less likely than Whites to seek health care, and uninsured Hispanics are especially likely to go without regular health care. According to a 1991 study by the Agency for Health Care Policy and Research (AHCPR), Hispanics were less likely than Whites or Blacks to have a usual source of health care, and compared to Whites and Blacks, uninsured Hispanics less often used any health services at all. Uninsured Hispanics were less likely than insured Hispanics to have a regular source of medical care, see a physician, or use any health services.<sup>17</sup> As shown in Figure 13, in 1987, over one-fourth of all Hispanics (27.9%) lacked a regular source of health care, compared to about one in six Whites (17.0%) and nearly one in four Blacks (22.9%);<sup>18</sup> this probably reflects the low rates of

insurance coverage for Hispanics. While nearly three-fourths of all Hispanics (72.3%) used health services in 1987, only a little more than half of uninsured Hispanics (55.0%) used such services. Uninsured Hispanics have less access to preventive and primary health care, and tend to postpone care, compared to uninsured White Americans. Compared to uninsured Hispanics, slightly fewer uninsured Blacks (53.2%) and significantly more uninsured Whites (69.2%) used any health services.<sup>19</sup> Research by Braveman, et al. found that the uninsured, particularly Hispanics, were less likely than their insured counterparts to seek out medical assistance, use preventive services, or receive adequate prenatal care.<sup>20</sup>

**Among those with a usual source of care, Hispanics and Blacks are more likely than Whites to receive care from a source other than a physician's office.** The study by AHCPR found that among Hispanics with a regular source of care, less than three-fourths (73.7%) went to a physician's office, as did an even lower 69.6% of Blacks but 86.5% of Whites. About one in six Hispanics (16.4%) and one in seven Blacks (14.5%) went to a local clinic or other non-hospital facility, compared to one in 16 Whites (6.1%). About one in ten Hispanics (9.9%) used a hospital emergency room, compared to nearly one in six Blacks (15.8%) and less than one in 20 Whites (4.4%) (See Figure 14).<sup>21</sup>

**FIGURE 14**  
**SITE OF CARE FOR PERSONS WITH A USUAL SOURCE**  
**OF MEDICAL CARE, BY RACE/ETHNICITY: 1987**

<b>RACIAL/ ETHNIC GROUP</b>	<b>% PHYSICIAN'S OFFICE</b>	<b>% HOSPITAL EMERGENCY ROOM</b>	<b>% OTHER NON- HOSPITAL FACILITIES*</b>
<b>Hispanic</b>	73.7	9.9	16.4
<b>White</b>	86.5	4.4	6.1
<b>Black</b>	69.6	15.8	14.5

\* Other non-hospital facilities include health center, company, school, and other clinic.

U.S. Department of Health and Human Services, National Medical Expenditure Survey, *Usual Source of Medical Care and Their Characteristics*, September 1991.

## HUMAN SUFFERING

While lack of health insurance is often measured in financial terms, its effects can also be measured in human suffering. Lack of health insurance often leads to poor quality or

delayed care, sometimes with serious negative health consequences. Research on the uninsured shows that when they finally seek care, their condition may be at an advanced stage and treatment may be unsatisfactory or unsuccessful. For example, research by Weissman and Epstein found that patients who lack insurance may receive unequal treatment, even after hospitalization. Specifically, uninsured patients in their study were found to have shorter hospital stays, receive fewer services, and undergo fewer procedures once hospitalized than insured patients.<sup>22</sup> Another study reviewing the health care of low-income populations found that when the uninsured received care, it was often in inappropriate settings or involved inadequate patient care management.<sup>23</sup> Uninsured hospital patients were between 44% and 124% more likely to die while in the hospital than similar patients with health insurance; the in-hospital death rates were 1.2 to 3.2 times higher among uninsured patients in 11 of the 16 groups studied.<sup>24</sup> These high death rates are correlated with the lack of preventive care and the postponement of care; uninsured patients typically enter the hospital much sicker than insured patients. Because Hispanics are the least likely of all major population groups to have health insurance, they are especially likely to face these negative health impacts.

**The leading causes of death for Hispanics differ than those of White non-Hispanics, and Hispanics are more likely than other Americans to contract certain diseases.** While heart disease and cancer were the first and second leading causes of death for both Hispanics and non-Hispanics in 1989, the percentage of deaths attributed to these diseases was lower among Hispanics.<sup>25</sup> Homicide, HIV/AIDS, and perinatal conditions were among the top ten killers for Hispanics, whereas none of these conditions was among the major killers of non-Hispanic Whites.<sup>26</sup> Diabetes and chronic liver disease were responsible for a higher percentage of deaths among Hispanics than among non-Hispanic Whites. Incidence data for Hispanics are very limited, but subgroup and regional studies suggest health problems which affect Hispanics disproportionately. For example, Hispanics are especially likely to suffer -- and die -- from diabetes; Mexican Americans have high rates of stomach and cervical cancer; the percentage of Hispanic AIDS cases is twice the rate expected given their percentage of the population, with rates especially high for Puerto Ricans and Other Hispanics, and Hispanic children comprise one-fourth of pediatric AIDS cases; and Puerto Ricans and Other Hispanics have disproportionately high infant mortality rates. Many of these statistics reflect a lack of preventive care and/or early detection and treatment among Hispanics -- often a result of lack of health insurance.

**Low-income uninsured persons may be reluctant to seek care because of the added financial burden -- or because immediate payment is required, as in some hospital emergency rooms.** Many postpone care until they are sicker and their medical problems become too serious to ignore. Many conditions can be prevented or successfully treated if persons receive the timely medical care and screening that comes with health insurance coverage.<sup>27</sup> Individuals postponing needed medical care and not receiving preventive care are likely to use a hospital emergency room as a main source of health care, which is much more costly than at a physician's office. Regular health screening and prompt and early treatment are less costly and more appropriate practices, but may be viewed as nonessential expenditures, and therefore



unaffordable. Cost becomes a secondary concern only when the medical problem becomes an emergency.

**Spiraling costs for employers as well as for health care facilities serving the uninsured are a consequence of the growing number of "medically indigent."** A report by Families USA summed up the situation: "Cost-shifting due to uncompensated care and the lack of insurance offered by employers accounts for approximately 27% of employers' health care costs. In the face of rising premiums, more employers choose not to offer coverage at all, ultimately increasing the costs of coverage for those who remain insured."<sup>28</sup> Rising costs due to lack of preventive care and growing numbers of uninsured lead employers to reduce their own health coverage, which further reduces use of preventive care by the newly uninsured, which further increases the costs of providing health services to those without insurance, which increases costs to employers even further -- thus closing the "vicious circle" of ever-increasing health care costs.

#### **DISINCENTIVES TO WORK**

**Current gaps in health insurance, public and private, provide a severe disincentive to work for those with limited wage potential.** It can be more financially practical to remain unemployed and receive Medicaid benefits and welfare than to work in a no-benefits job and still live below poverty level. This disincentive to work has increased along with the growing number of employers providing no health benefits to low-wage, lower-skill workers and the rising costs of health care. These policies affect Hispanics disproportionately.

**Single mothers are especially negatively affected by the lack of public or private health insurance.** Families with a female householder represented 12.7% of non-poor U.S. families and 53.1% of poor families in 1990.<sup>29</sup> Once single mothers with limited job skills fall below the poverty line, it is very difficult for them to escape. Bane and Ellwood found that as females with children move off welfare and find employment, they are confronted with decreasing returns for their efforts. For example, once the female worker reaches \$6.00 an hour, she is earning \$1,000 more than what she earned at \$5.00 an hour. However, at \$6.00 an hour, even under the new JOBS program designed to get people off welfare, she is likely to lose her Medicaid benefits, effectively reducing her disposable income to about what she would receive if she were not working at all, and leaving her vulnerable to unexpected medical expenses.<sup>30</sup> Therefore, single mothers are especially likely to become welfare-dependent in order to provide health care for their families.

**Female-headed families are an important segment of the Hispanic poor -- and lack of health insurance helps keep them on welfare.** In states including Arizona, California, Colorado, New Mexico, and Texas, Hispanic woman-maintained households make up a quarter of the households receiving Aid to Families with Dependent Children (AFDC).<sup>31</sup> Many single mothers face a choice between working with no health care benefits for their children, or turning to welfare in order to provide their children with Medicaid. A recent study sponsored by the

Ford Foundation and conducted in part by NCLR found that low-income Mexican American single mothers were extremely likely to report remaining unemployed to retain Medicaid coverage or quitting jobs with no health insurance when they or their children needed medical care.<sup>32</sup> In this same study, Puerto Rican single mothers receiving AFDC cited the loss of Medicaid coverage for their children as a barrier to self-sufficiency, since working would make them ineligible for public health insurance, yet the jobs for which they were qualified tended to be low-wage jobs without health insurance.<sup>33</sup> The study used a series of structured discussions known as "focus groups" to gather information on low-income Mexican American, Puerto Rican, and Black women's attitudes about welfare. In every focus group, women cited the need for health care as the main reason they participated in AFDC. Some quotations from women in the focus groups are provided in the box which follows.

#### VOICES ON WELFARE

- ◆ *The only reason I like the welfare checks is for the Medicaid. [My daughter] has kidney problems. The doctor she sees is very expensive. When I work in the packing sheds, they take away my welfare check and my Medicaid card. (Pharr, TX)*
- ◆ *I was working but they cut my AFDC and my Medicaid, so I quit. I needed the Medicaid. If they hadn't cut me off Medicaid, I could have still worked. (Kansas City, MO)*
- ◆ *We don't really need the welfare, but we need [Medicaid]. I tried to get just the [Medicaid]. (Phoenix, AZ)*
- ◆ *I had insurance, but it wouldn't cover my pregnancy. I quit my job and got on AFDC. I needed the [Medicaid]. (Phoenix, AZ)*
- ◆ *[When I was working] they took me off Medicaid, and that's one of the reasons I got on AFDC. (Kansas City, MO)*
- ◆ *I heard you get [Medicaid] for a year after you get a job. I think it could help people to get off [AFDC]. Step-by-step will probably work. I think a lot of people are afraid of getting cut-off immediately. (Phoenix, AZ)*
- ◆ *They've [caseworkers at the welfare agency] been telling us recently that we have to take classes or else and that is like a threat. But they don't stop to think that if they take our medical cards the children are going to suffer. (Philadelphia, PA)*
- ◆ *I wouldn't mind being out of welfare, I can work, but the kids, I have three, it would be difficult to work and sustain three kids. All my money would go to pay the doctor. (Philadelphia, PA)*

**If there were universal health care coverage, more people would work.** This is particularly true for young mothers whose limited skills relegate them to low-paid, limited-skill jobs. Health benefits are used by employers as incentives to attract higher-income, higher-wage workers for whom they must compete, but often are not available to workers with more limited education and skills. Ironically, those workers with the least resources to obtain health care individually are also those most likely not to receive employer-based coverage.

## **COSTS TO THE INDIVIDUAL AND SOCIETY**

**Lack of health insurance not only negatively affects an individual's health status but also increases the total cost of medical care.** In the long run, lack of screening and early treatment contributes to the increasing costs of health care and health insurance for all. Thus, providing insurance for all Americans can be thought of as a cost containment mechanism.

The costs of U.S. health care are borne by all groups in society, and have negative effects on them all, and on society as a whole:

- **Federal monies that could be spent on other social programs are allocated to health care spending as a result of increasing costs.** Money is being drained that could be used to improve America's health care delivery system or provide other badly needed services such as education and employment training. According to a GAO study, in 1970 the U.S. health care system absorbed about 7.4% of national income; by 1989, that had increased to about 11.6%. In comparison, national income spent on Canada's health care system increased from 7.4% in 1970 to about 9.0% in 1989. If U.S. spending on health care had increased only as fast as Canada's spending, relative to the country's national income, the report estimates that the U.S. could have devoted over \$140 billion during the period to other uses. Moreover, assuming that current trends persist, more than \$125 billion could be saved over the next five years. In addition, total federal spending in 1990 would have been about \$50 billion less if health spending during the 1980s had grown only at the average rate of increase for all federal outlays.<sup>34</sup>
- **Corporations lose profits as a result of providing health care benefits.** Foster Higgins reported that in 1989, the total cost of corporate health benefits represented 26% of net earnings; by 1990, total health costs rose to 45% of net earnings.<sup>35</sup> Without such increases, corporations would have more funds to invest and to return to their stockholders. Employers spend larger and larger amounts of money on health care benefits as the rise in medical costs continues. In turn, employers are shifting the additional costs to their employees and reducing benefits. Of particular concern are decisions by employers to discontinue coverage for their employees' dependents, increasing the total number of uninsured and shifting the extra costs of care to employees and their families.
- **Individuals ultimately bear many of the costs of health care which are not covered by insurance.** In addition to the impact on human suffering through late or inadequate medical care, high health care costs are draining individuals' disposable income and

limiting spending which is needed for other purposes, especially by those with limited resources.

- **Many hospitals, particularly public hospitals, are disproportionately overburdened in serving medically indigent – uninsured -- patients.<sup>36</sup>** The hospitals most affected are those in areas with large concentrations of uninsured and low-income people. Such hospitals may be unable to meet demands for service because of limited resources and overcrowding, and may provide limited or poor quality services. Their financial viability is severely strained.
- **Additional money spent on health insurance by small businesses, government employers, and nonprofit organizations could be used for other purposes if health insurance costs were controlled.** For instance, nonprofit organizations and public agencies could provide more programs, raise salaries, or hire additional staff.<sup>37</sup>

## CONCLUSIONS

**The high costs of health care make regular preventive care and prompt treatment unaffordable for most Hispanics without health insurance.** A poor or near-poor Hispanic family purchasing a typical amount of health care on the open market would spend all its disposable income on shelter, food, and medical care -- leaving nothing for clothing, furniture, transportation, child care, or other expenses. Even an Hispanic family at the median income level would spend more than 60% of its remaining disposable income, after covering food and shelter, on health care. Insurance reduces the economic burden, but increased cost sharing means that even an insured family with an employer-based medical indemnity plan could easily spend more than 10% of its disposable income on out-of-pocket expenses.

**Lack of health insurance has many negative impacts not easily measured in financial terms.** It can be weighed in human suffering, including unnecessary and premature deaths, and in disincentives to work, when the choice is between a low-paid, no-benefits job and welfare with medical insurance for a mother and her children.

**The spiraling costs of health care represent a major burden not only for the uninsured and underinsured, but for every segment of society.** Medical expenditures consume resources needed for other public purposes, from education to job training and housing. Costs to individuals leave them limited funds for other expenses, which has a negative economic impact on the society as a whole. Private-sector employers spending more on health insurance for their workers have lower profits to distribute or invest in research or facilities. Nonprofit organizations and government employers have less money to provide services and run programs. Everyone in society suffers from the high costs of health care and the lack of universal medical coverage.

## ENDNOTES

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## V. IMPLICATIONS FOR NATIONAL HEALTH CARE REFORM

### OVERVIEW

**There is wide agreement that the health insurance system in this country is in need of major reform:** medical and health insurance costs are skyrocketing; employment-based health insurance is eroding; employers and workers are paying more for basic coverage; health insurance is unavailable to millions of Americans, while millions more are underinsured. In response to this crisis, legislators and policy makers are calling for changes in the organization of the current health financing system that will improve the affordability, availability, and accessibility of health care. While most Congressmembers agree that improvements are needed, there is little agreement on exactly what should be changed and how.

**Hispanics and Hispanic organizations have an obligation to communicate their unique interests and concerns to policy makers and opinion leaders involved in the health care debate.** Making health care available and affordable for Hispanics requires that the current health care reform debate address the special demographic and socioeconomic conditions of Hispanic Americans, and the structural elements and policies in the current private and public health insurance systems that serve as barriers for Hispanics. Past experience suggests that the policy debate on health care may well proceed with minimal attention to Hispanics unless these issues become part of the current debate over health care reform.

**The extent to which pending legislation will equitably benefit Hispanics depends particularly upon the degree to which it adequately addresses the needs of the working poor and their families, children, and low-income people.** Options that expand public programs to cover everyone with incomes below 200% of the poverty threshold would help half of uninsured Whites, and three-fourths of uninsured Blacks and Hispanics, while options that expand coverage to all employed workers and their families would help all but 25% of uninsured Hispanics, 20% of uninsured Whites, and 40% of uninsured Blacks. It is estimated that 77% of uninsured Hispanics could be covered through an employer-based approach and 71% by targeting low-income families and individuals.<sup>1</sup> A combined, comprehensive approach to health care reform would avoid systematically favoring some segments of the uninsured population over others.

### NCLR AND LCLAA PRINCIPLES FOR HEALTH CARE REFORM

**In order to monitor and play a part in the policy debate around issues of health care reform, NCLR and LCLAA have adopted a set of principles that should be met by a national health care reform proposal to assure that it addresses the specific health service needs and access barriers of Hispanic Americans.** The ten principles, which are listed on the following pages, will be used as a basis for analyzing the responsiveness of proposed health care reform legislation to the health insurance and health care delivery system needs of Hispanics.



**NCLR AND LCLAA TEN PRINCIPLES  
FOR EVALUATING HEALTH CARE REFORM PROPOSALS**

1. **Universal Coverage.** Whatever the structure of our health care system, it is essential that all individuals, regardless of income, employment status, age, geographic residence, or citizenship status have access to health care and health insurance coverage. We are particularly concerned with how any proposed plan would affect the working poor, children, migrant and seasonal farmworkers, and the undocumented, as well as the inclusion of Puerto Rico in any reform plan. It is essential that health care be adequate for all, and that all have equal consideration in obtaining their fair share of health care without discrimination. This implies that there must be safeguards against each state having its own system, to avoid gaps in coverage such as those present in the Medicaid program, for which every state has its own guidelines.
2. **Comprehensive Care.** Ideally, a health care reform proposal should be as comprehensive as possible in the types of services that are covered: preventive, diagnostic, therapeutic, health maintenance, rehabilitative services, and long-term care. At a minimum, it must include basic health care services for everyone.
3. **Quality of Care.** High quality comprehensive care should not be based on ability to pay, location, or nature of the service provider. The system should have incentives and safeguards to assure consistent high quality care.
4. **Administration and Financing.** Emphasis should be on administrative simplicity, cost containment, and eliminating financial barriers to care. Regardless of the financial system -- single or multiple payers, or the extent to which costs are shared by individuals, employers, public, or private sources -- administrative simplicity is key in reducing administrative costs and thus overall health care costs. Likewise, we look for a system which will minimize difficulties caused by changing employment status and/or residence; thus we encourage national minimum standards and federal minimum requirements to achieve some degree of uniformity among states, to avoid discriminatory situations -- such as Medicaid -- in which individuals are penalized depending on the state in which they reside.
5. **Elimination of Non-Financial Barriers.** Some barriers to equal access and high quality health care are non-financial, and cannot be eliminated through finance reform. A national health program should give attention to the needs of all populations. It should address cultural, language, geographic, and other non-financial barriers to health care access and delivery.

- 6. Supply and Distribution of Health Care Workers.** A major barrier limiting equal access to high quality health care is the maldistribution of health care workers, especially physicians; many rural areas and central cities have a great shortage of physicians. Similarly, there are far too few Hispanic or Spanish-speaking health care professionals to meet the need. A reform proposal should emphasize the expansion of education/training programs and recruitment, promotion, and support for Hispanic health care workers at every level. We encourage making appropriate use of foreign medical graduates, particularly from Latin America, to help alleviate the great shortage of Spanish-proficient physicians and other health care professionals in medically underserved areas where Hispanics are concentrated. Likewise, we encourage the expansion of public financing or loan forgiveness for health professionals with a required period of payback (community) service, as well as exploration of other incentives to get health care professionals to rural and other medically underserved areas.
- 7. Alternative Health Care Delivery Systems.** It is critical that a health care system provide and encourage alternative structures for service delivery, including community and migrant health centers and managed systems of care. An ideal system should emphasize community-based care. Ongoing evaluation and planning to improve health care delivery, with consumer and provider participation, are also important.
- 8. Responsiveness to Diversity.** It is essential that a health plan look at local as well as national realities, and at the differing needs and the varied cultures and belief systems of diverse populations. Our current system tends to focus on the health care needs and problems of urban areas and middle-income Americans. Attention to the needs of farmworkers, rural populations, residents of central cities, and other communities with distinct and varying needs and values is critical, and we look for programs which assure their inclusion in the planning process for health care delivery.
- 9. Consumer Outreach and Public Education.** A health care system should address the need for general health education, as well as the need for outreach regarding the rights and responsibilities of consumers in health care access, disease prevention, and delivery of services.
- 10. Accountability and Enforcement.** Because equal access and non-discrimination are basic principles for any national health system, it is critical that a system include built-in assessment and monitoring mechanisms to review non-discrimination in access and service delivery as well as quality of care.

The NCLR/LCLAA principles take a comprehensive approach in addressing the barriers to Hispanic health care access, including factors related to health insurance as well as other factors related to health services development and delivery which negatively affect access.

**The NCLR/LCLAA principles focus on the health care access dilemma specific to Hispanics.** Three of the NCLR/LCLAA principles are central to the national health care reform debate and resemble principles expounded by other national organizations: these include universal coverage, comprehensive care, and administration and financing. The remaining seven principles, while they are necessary and appropriate components of a health care system for all Americans, are essential determinants in the responsiveness and appropriateness of the health care system for Hispanic Americans. These include: quality of care, elimination of non-financial barriers, supply and distribution of health care workers, alternative health care delivery systems, responsiveness to diversity, consumer outreach and public education, and accountability and enforcement.

**Many of the major health care reform proposals overlook the NCLR/LCLAA principles that address issues not directly related to financing and coverage.** Aside from improvements needed in financing health services and assuring basic health care for all Americans, a host of cultural and non-financial factors affect the appropriateness and availability of health care for Hispanics, but may not necessarily be problems for non-Hispanic populations. Thus, such principles may not be strongly advocated by others concerned with health care reform, or addressed as important issues in the health care reform debate. The National Association of Community Health Centers identifies the following needs which must be addressed in order to overcome non-financial and cultural barriers to health care access: outreach, health education, and health promotion efforts; community health prevention; broad, early intervention services for families, children, and others with special health care needs; patient support activities carried out in multiple languages; services offered at times and in locations sensitive to community needs; the availability of physicians and facilities sufficient to meet local demand, particularly in rural areas and inner cities; and services designed to ameliorate the severe health effects caused by widespread poverty.<sup>2</sup> Culturally-appropriate services and bilingual/bicultural health care workers at every level are a special concern for Hispanics, as are outreach materials and approaches which not only reach limited-English-proficient persons but also recognize the limited literacy of a large proportion of Hispanic adults.

## **PROPOSED APPROACHES TO HEALTH CARE REFORM**

**Health care reform has become a major public issue.** Over 60 health care reform bills have been introduced in the House of Representatives and Senate during the 102nd Congress, and the Bush Administration has developed its own proposal.

**There is no consensus as to the type and extent of health care reform which is currently needed, but strategies can be categorized into a few major types.** In general, health care reform proposals offer alternatives for expanding access to health care through

changes in health care financing and payment mechanisms. Strategies which have been suggested include expanding public programs, providing tax incentives to increase access to private coverage, mandating employers to provide coverage, creating a government-financed single program, or improving existing public and private systems through a combination of approaches. Most of the proposals fall into one of four categories -- government-based single-payer plans, multi-payer or "pay or play" plans, consumer-based plans, and single-focus or piecemeal proposals. Many specific proposals are still being modified or finalized; other plans have been announced, but not yet introduced as legislation. Thus the analysis provided here describes each of the major categories of proposals, identifies some of the better-known bills or proposals in each category, and reviews the extent to which each type of proposal seems to address the NCLR/LCLAA principles, but does not attempt to assess any individual bill or proposal.

### **Government-Based Single-Payer Plans**

**Proposals under the government-based single-payer plan category would provide Americans with health insurance under a government-financed national program.** This approach would essentially replace the current health insurance financing system by detaching health insurance from employment and making the government the primary funder of health insurance or health services coverage. Individuals and families would be covered regardless of geographic residence or employment status.

**Most of the proposals would provide universal coverage by financing services primarily through government tax revenues but would leave the delivery of care in private hands.** Provision is made in many single-payer plans to enable consumers to choose their preferred type of care, whether going to a doctor or community health center which charges a fee for services to be reimbursed by the single payer system, or buying into a managed-care system such as a Health Maintenance Organization (HMO) which charges a monthly premium. However, at least one proposal would establish a British-type system in which the federal government would both pay for and operate the health services system. Depending on the proposal, the system would generally be administered by the federal government, a newly established quasi-public agency, or by the states operating under federal guidelines. There would be at least a minimum uniform benefits package which includes some preventive services, with some proposals covering all medically necessary services including long-term care. Some single-payer plans would eliminate the Medicare and Medicaid programs, since coverage would be provided under the new system.

Costs are typically estimated using a "global budgeting" approach rather than estimating or capping costs on a per-person or per-family basis; various provider reimbursement approaches are recommended, such as a combination of annual negotiated budgets for health care facilities such as hospitals, along with fee schedules for reimbursement of other providers such as physicians or community health centers. Some proposals would set national annual expenditure limits, such as requiring that total costs not increase more than a specified percentage over the previous year, and establish state budgets. In some plans, premiums, deductibles, and co-

payments are prohibited. Others include them, but provide assistance for low-income individuals. Most proposals call for caps on out-of-pocket expenditures by individuals and families.

Among the current single-payer proposals are the Russo-Wellstone, Dingell-Waxman, and Stark bills.

### **Multi-Payer "Pay or Play" Plans**

**Proposals under the multi-payer "pay or play" approach would establish a combination of employment- and government-based insurance to provide Americans with health coverage.** This model, generally known as "pay or play," would mandate employers to provide private health insurance coverage to their employees, or pay into a public system that would be responsible for Americans not covered by employers, including workers whose employers decline to participate and those who are not employed. This category of health care reform builds upon the current private and public health insurance systems, where employers have the primary responsibility for providing health insurance to employees and their families, and government provides a safety-net program. Health service delivery would remain in private hands, with provision for both managed care and fee for service systems. Private health insurance companies would continue to administer coverage offered by employers. The public plan could be federally- or state-administered, depending on the proposal. Proposals call for a set of required minimum benefits for both employer and public plans, and include private health insurance reforms. Some plans would continue Medicare and Medicaid benefits, providing for coordination of coverage.

**Proposed financing and cost containment mechanisms vary.** Financing typically assumes a combination of employer payments (to support its own plan or into the government system), federal funding, state funding, and individual contributions. Estimated costs for the plans are often not clearly defined in dollar terms. Some plans call for a national board to set goals for national, state, and regional expenditures. Premiums would be linked to income, with provisions to subsidize those of lower-income families and individuals in both employer-sponsored and public plans. Proposals also provide for individual and family deductibles and copayments for at least some services; while waivers would typically be provided for those below the poverty level, they would not necessarily be provided for the near-poor. Out-of-pocket expenditure caps would be established for individuals and families.

Among the current "pay or play" plans are the Kennedy-Mitchell and the Rockefeller (Pepper Commission) bills.

### **Consumer-Based Plans**

**Plans using a consumer-based approach typically offer a system designed to provide individuals or families with the financial resources to obtain health insurance in the private market.** Proposals generally offer individuals tax credits, offset by the amount of the

employer's contribution, to help them purchase health insurance individually or through an employer. Some proposals focus on providing low- and moderate-income individuals and families with transferable tax credits -- including refundable tax credits to benefit those whose total tax bills are less than the amount of the credit -- or certificates for obtaining health insurance. There is typically a specific "cap" on the amount of the credit or certificate -- for example, \$2,500 for an individual and \$3,750 for a family of three or more. In one proposal, the entire cost of health insurance premiums would be entirely deductible for the self-employed. Proposals also include market reforms to help small employers and individuals obtain insurance, and assist states to establish risk pools for individuals who are medically uninsurable. Some plans would provide a great deal of flexibility to the states, allowing them to develop a single unified health care plan rather than maintaining Medicaid as a separate system. Malpractice reform is also included in some proposals.

**A major premise behind this approach is that the current tax and regulatory treatment of health plans negatively affects the health insurance market's ability to function efficiently.** The consumer-based approach would reduce government involvement in providing health insurance, and instead place responsibility for obtaining health insurance and health care upon the individual, with services obtained through the private market. It is argued that individual consumers, like employers, should be offered tax incentives to obtain health insurance, and tax breaks in health insurance need not continue to favor higher-wage employees receiving fringe benefits.<sup>3</sup> The expectation is that once more consumers are injected into the health insurance market, competition will be created, there will be less duplication of coverage, increased flexibility in state programs, and increased efficiency in public programs, and all this will help to control costs.

Major proposals in this category are the Bush Administration plan and the Heritage Foundation proposal. Because the tax-credit portion of the Administration's plan has not yet been introduced in legislative form, its provisions cannot be analyzed with precision. Some other components have been introduced as piecemeal approaches or are assumed to be covered through the regular appropriations process, which makes it difficult to analyze the plan in its entirety.

### **Piecemeal Modifications of the Current System**

**Piecemeal modifications of the current health insurance system are sometimes viewed as health care reform proposals.** Yet these proposals generally are designed to improve or build on the existing system, reforming only specific components of the health insurance system, or increasing coverage for certain segments of the U.S. population. This category of proposals is so varied that it does not include any set of typical components. Examples are proposals which provide incentives or increased flexibility to enable states to develop their own health care programs, make changes in insurance underwriting and rating practices, make it easier for small businesses to offer health insurance, help contain costs through such approaches as medical malpractice reform, expand continuity of coverage, and expand public programs to cover more low-income women and children.

**There are fundamental dangers with the piecemeal approach.** In principle, the changes targeted by piecemeal plans are needed, yet it is not clear whether they alone could accomplish major changes in the health care system. According to a recent report by GAO, piecemeal reforms are unlikely to reduce the current growth in national health spending.<sup>4</sup> Many of the piecemeal proposals being considered as health care reform may not achieve measurable improvements in affordability and accessibility of health care, and thus should not be considered synonymous with health care reform. Since piecemeal plans may give the impression that something is being done about the expanding health insurance coverage, when in fact little has been done, they may actually discourage the kind of comprehensive health care reform which is essential to assure access to health care for all Americans. For example, small market reform plans which address the problems of small employers in offering health benefits to their employees, but do not require a single employer to provide coverage, may help some employees obtain employer-based coverage, but not to the degree necessary to effect real change in the insurance status of most workers.

## **APPLICATION OF PRINCIPLES**

**These different approaches vary in the extent to which they offer opportunities for creating a health financing and delivery system which adequately addresses the problems of uninsurance and underinsurance among Hispanic Americans.** The sections below provide an initial overview of some of the issues, concerns, and questions which the three more comprehensive strategies raise in relation to the NCLR/LCLAA principles. The analysis does not evaluate any particular bill. For purposes of discussion, the principles are grouped into two categories based on their relationship to health care reform issues. The first set encompasses three core principles -- universal coverage, comprehensive care, and administration and financing, including cost containment -- which have become central to the health care reform debate. The second focuses on the other seven principles, which are receiving less attention in the current debate, but are of particular importance in assuring that the reforms result in a health care system which is responsive to and appropriate for Hispanic Americans -- quality of care, elimination of non-financial barriers, supply and distribution of health care workers, alternative health care delivery systems, responsiveness to diversity, consumer outreach and public education, and accountability and enforcement. The analyses are based on a review of one or more major bills or proposals in each of the four categories, as well as summaries prepared by various sources, including the Congressional Research Service, the Children's Defense Fund, the American Public Health Association, the Heritage Foundation, and other sources. Because of the very large number and great diversity of the proposals and the frequency with which they are being modified, the analysis examples are derived from major bills and major summaries in each category.

### **Core Principles**

The principles of universal coverage, comprehensive care, and administration and financing are closely related, and all are affected by questions of cost containment. The extent

to which the three major types of proposals -- single-payer, multi-payer "pay or play," and consumer-based plans -- address Hispanic concerns related to these principles is summarized below, and unanswered questions and concerns are identified.

### *Universal Coverage*

**Both single-payer and "pay or play" proposals could go a long way towards providing coverage for at least a minimum set of basic services for the 32% of Hispanic Americans who are uninsured.** The working poor and their families, children, and low-income persons not covered under current programs would have a source of health insurance for at least a minimum set of relatively uniform basic health care services. The consumer-based plans would also expand coverage to those not now receiving Medicare, Medicaid, or employment-based coverage, but the health care plans which could be purchased by those relying entirely on the maximum value of the health certificate could be largely determined at the state level. Therefore, consumer-based plans would not necessarily assure that a specified set of minimum services would be available to all Americans, unless such provisions -- e.g., an entitlement or a minimum federal "floor" -- were built in.

**All these approaches, however, could fall short of meeting NCLR/LCLAA's principles related to universal coverage.** One concern is the extent to which they would cover people in Puerto Rico. Another concern is the extent to which they would cover and reach persons who have no fixed address such as the homeless, who travel as migrant and seasonal farmworkers, who do not file tax returns (for tax-credit-based proposals), or who have an ambiguous, temporary, or transitional immigration status.<sup>5</sup> There is also a question of "portability" and continuity of coverage. All the plans express concern for assuring continuity of coverage, but to the extent that plans are employer-based or state-specific, individuals who change employment or move may find themselves at least temporarily without coverage. "Pay or play" plans have the potential for addressing this through a variety of requirements for notification; the extent to which these would be workable in practice is unclear. This problem is likely to be minimized under a single-payer system, and could also be addressed by consumer-based plans.

### *Comprehensive Care*

**No plan automatically assures comprehensive care for all Americans, and budget considerations are likely to limit the level of services provided.** While all types of plans talk about assuring some (typically not fully defined) level of minimum coverage for everyone in the system, budget issues are likely to result in limitations related to benefits or services. This is particularly clear for consumer-based plans, which often specify a dollar cap in the amount of financing to be provided per person and per family. While both the single-payer and "pay or play" approaches focus on making sure individuals and families are provided with a minimum set of benefits, the consumer-based approach focuses on providing dollars which individuals can use to purchase benefits. Although relying on tax credits could provide access to health insurance markets and at least some type of minimum plan for many families



and individuals who are now uninsured, it is questionable whether a tax credit limited to a maximum of \$3,750 for a family of three or more (the amount specified in one of the major tax-credit proposals) would be sufficient to purchase a basic benefit package, especially in high-cost areas. The proposed maximum credit is just about equal to the amount estimated in Section IV of this report as the cost of purchasing an indemnity plan for a family of four (\$3,573), not counting deductibles and coinsurance. Assurance of adequate funding for a minimum level of coverage under consumer plans is thus to a large extent dependent on the efficacy of market mechanisms in holding down overall medical costs.

**Adequacy of minimum benefits is also a question for single-payer and "pay or play" proposals.** While the single-payer and "pay or play" plans tend not to specify an annual dollar cost per person or for the entire health care system or to clearly define ways in which costs will be contained, it seems extremely unlikely that the current economic situation and federal budget deficit will permit a reformed health care system to assure comprehensive care for everyone in need of it. The nation will face difficult decisions about how to allocate limited resources -- and this is likely to mean that each plan will ultimately specify a minimum benefits package which excludes certain types of health care expenses, or limits coverage for those unable to pay. While these plans do not tend to address the question of "rationing" directly, they all reflect concerns about cost containment. Assurances of adequate funding levels over the long-term to provide minimum coverage for everyone is thus dependent to a large extent on the ability to control costs; unfortunately, there is at present little evidence that current cost containment proposals could do so effectively.

**The extent of cost sharing required to obtain basic benefits will have major impact on actual access to care for families with low and moderate incomes.** It is clear that many Americans with health insurance do not seek regular medical care because they cannot afford the deductibles, coinsurance, and other out-of-pocket expenses. In all three major types of proposals, the potential cost of participation may keep low-income people from obtaining care. Some single-payer or "pay or play" approaches require a premium, deductibles, and/or copayments. While provisions are sometimes made for subsidizing part or all of this payment for individuals and families with incomes at or below 200% of poverty, the charts in Section IV suggest that this may be insufficient to guarantee access to care even for Hispanic families whose incomes are above 200% of poverty. Similarly, sliding scales established under consumer-based tax-credit plans may not provide low-income individuals and families with sufficient funds to purchase appropriate health insurance; any tax subsidy would also need to be adjusted to keep pace with rising health care costs.

**The probability is high that those who can afford to pay will continue to receive far more comprehensive health care than those dependent upon public resources.** Under the consumer-based and "pay or play" system, it is clear that employers may continue to offer benefits beyond those mandated by the government, with or without cost sharing. The extent to which private insurance will continue to exist under a single-payer system is unclear, but the availability of supplemental insurance, not unlike the current Medicare supplemental policies, seems likely.

**There is also concern that "pay or play" and consumer-based approaches may result in major gaps in level of coverage among the employed and between the employed and unemployed.** Under these plans, employers will continue to be a major source of health insurance for employed individuals and their families. Employers typically use health care benefits as one means of recruiting and retaining personnel for whom they must compete in the labor market; thus, those employers who depend upon personnel in skill-shortage occupations are likely to provide far more than the minimum benefits required of employers, or provided by the government for people not covered through employer plans. On the other hand, employers who have no difficulty in obtaining qualified personnel are more likely to provide more limited or minimum benefits, especially as costs increase. Undereducated populations, those with limited English proficiency and low literacy levels, and those experiencing substantial employment discrimination are likely to be concentrated in these "limited benefit" sectors of the economy.

**The *net* effects of these proposals on economic growth and job creation and the *specific* effects on marginal business and workers are poorly understood.** Research on the effects of employer mandates in providing health insurance suggests that "pay or play" approaches may lead to job loss; a major question is what happens to employers -- including small businesses and nonprofit entities -- that cannot afford either to pay *or* to play. A recent study by CONSAD Research Corporation suggests that the jobs most in jeopardy would be those held by part-time, low-wage earners, younger employees, Blacks and Hispanics, and less educated workers.<sup>6</sup> It can be argued, however, that any reform method which increases health insurance coverage of workers through either employer mandates or corporate tax increases -- which would include single-payer and consumer-based plans -- may have the same results in the aggregate. Moreover, the existence of some form of universal coverage would also increase rewards for -- and thus incentives to -- work.

#### ***Administration and Financing***

**Single-payer or "pay or play" plans involve a major role for the federal government in program administration and reimbursements.** Under single-payer plans, the federal government might either administer the program -- directly or through contractors -- or the states might administer parts or all of the program under federal guidelines. "Pay or play" plans divide administrative responsibilities between employers and their insurers and the federal or state governments, again with some plans calling for use of contractors.

**State variations in financing -- and in coverage -- are a potential concern under all three major types of approaches.** The extent of state flexibility in determining benefits packages and levels of expenditures for health care is a major question for Hispanics, given the Medicaid experience. Many of the major proposals do not clearly define the level of autonomy or flexibility to be provided to the states with regard to benefit packages, provider reimbursement, total expenditures, and state contributions to costs. To the extent that considerable state flexibility is permitted or funding depends on state matching funds, federally-imposed minimum benefit requirements will be the primary protection against tremendous

variations in comprehensiveness of services. Under some consumer-based proposals, eligibility for tax-credit certificates for purchasing health insurance would be limited to people not covered by other public programs, although states would be allowed flexibility in designing a unified health care plan, which might "fold in" the Medicaid program. This approach, while helping to provide coverage for additional people, would not necessarily reduce existing state variations in coverage. Moreover, it is unclear to what extent consumer-based plans would provide for adjusting the individual and family "caps" upward or downward by state to allow for differences in health care costs; the maximum per-family amount specified in one of the major plans would be sufficient to purchase comprehensive services in some locations but far more limited services in others.

**A dilemma central to the health care reform debate is cost containment -- how to expand health care coverage for the millions of uninsured and underinsured Americans without adding to already spiraling health care costs or overburdening federal and state budgets.** As already noted, the extent to which these plans will provide anything approaching comprehensive care for low- and moderate-income Americans depends to a great extent upon whether changes in administration and financing are accompanied by cost containment. Many of the bills in each of the three major categories, and some of the piecemeal proposals as well, include some provisions for -- or indicate an expectation of -- cost containment, but it is extremely difficult to predict the actual cost-containment effects of the various proposals. For example, with the costs of administration estimated at up to 20% of total health care costs, single-payer plans assume that eliminating multiple payers will lead to cost reductions; some plans also set national annual limits on expenditures. Some plans in every category call for medical malpractice reform as a cost-containment mechanism, and plans assume that creating larger risk pools will reduce costs. Expanded use of coordinated coverage is expected to reduce duplication of payments by having each person have only a single source of insurance. However, actual cost containment is difficult to predict at present, especially since one likely effect of increasing coverage will be to stimulate demand, which, according to standard market principles, would *increase* rather than decrease the price of medical services.

**A major unanswered question in analyzing most of the proposals is the level of expenditure versus the level of revenues to be generated.** Direct costs are more clearly determined in the consumer-based plans than in the single-payer and "pay or play" proposals, which provide for minimum benefits rather than defining maximum tax credits or costs per person or family. Single-payer proposals tend to rely on global budgets to help contain health care costs. Similarly, some "pay or play" plans create a federal board to establish national, state, and regional health expenditure goals among other responsibilities. It is unclear under either of these approaches how budgeted resources will be allocated, who will be involved in making allocation decisions, and how the process will protect the needs of low-income, culturally diverse populations.

**Varied financing mechanisms are recommended, and some proposals are very unclear on how revenues are to be generated.** Single-payer plans call for a variety of financing mechanisms, from a new value-added tax (VAT) on certain goods and services to

corporate taxes and individual income taxes -- usually highly progressive. Some single-payer plans call for state contributions as well, without necessarily defining how these funds are to be raised. The private portion of "pay or play" plans depend on a combination of employer payments to insurers and employee contributions. The public portion usually includes financing through payments from employers not choosing to offer employer-based insurance, federal revenues, individual payments, and state funds. Plans are sometimes not specific as to whether new taxes will be required. The consumer-based approach, by essentially capping the amount of tax credits provided to an individual or family, relies on market forces and malpractice and administrative reforms to contain costs, and relies on the market to allocate resources. It is difficult to predict the level of minimum benefits likely to be available to those Americans unable to contribute significantly to the costs of their own health care.

### **Additional Principles**

In addition to the core principles, NCLR and LCLAA are concerned with the following additional issues: quality of care, elimination of non-financial barriers, supply and distribution of health care workers, alternative health care delivery systems, responsiveness to diversity, consumer outreach and public education, and accountability and enforcement.

**None of the proposed approaches fully addresses access issues related to non-financial barriers and responsiveness to diversity: they seem to assume that universal health coverage guarantees universal access to health care.** Everyone, especially low-income individuals and families and those with limited English proficiency and limited education, needs to be able to find, obtain access to, and receive adequate services from health care providers. Overall, the various proposals, whether single-payer, "pay or play," or consumer-based, are not specific in requiring that services be linguistically or culturally appropriate. Moreover, none of the proposals appears to address directly the question of bilingual health care workers, in spite of the fact that the most technically skilled provider will be unable to effectively diagnose and treat a patient with whom its health workers cannot communicate. There are numerous examples of limited-English-proficient Hispanics -- from foreign diplomats to recent immigrants -- seeking emergency or other health care from a public or private hospital in a community with a large Hispanic population, only to find that not a single health care worker, from the physician to the receptionist, speaks any Spanish.

**Outreach and public education needs are minimally addressed.** For example, single-payer and consumer-based plans tend to leave the development of enrollment procedures -- including outreach and application procedures -- to the administering agency, rather than specifying requirements for outreach in multiple languages, for low-literacy populations, or for people unlikely to be reached through mainstream media or methods. Some plans are slightly more specific, with some proposals providing for enrollment by mail and outreach at accessible sites. Experience with such programs as Medicaid and Supplemental Security Income indicates that special attention must be given to this issue since the effectiveness of outreach efforts is likely to vary by state and region, and minorities with limited education, literacy levels, and/or proficiency in English often do not receive the benefits to which they are entitled.

**Consumer-based approaches pose special outreach and education problems, since individuals and families will have to decide how best to use the tax credit or certificate to which they are entitled.** Yet proposals appear to assume that all consumers are equally well informed and prepared to make a choice among health insurance plans where benefits may vary. In fact, many consumers, especially those who have limited experience with health insurance or multiple providers, are unlikely to be familiar with the range of options and the considerations important in finding a plan which is appropriate to their needs. Some consumer-based plans provide for the development of booklets designed to help people decide where to go for health care; however, it is not clear that the format or content would be easily used by individuals with limited literacy or English proficiency, or with a limited knowledge of health care options. In addition, limited-income consumers who lack the resources to supplement the tax-credit or certificate amount are likely to have fewer options than higher-income consumers, and may require very different materials, focusing on how to use their limited resources most appropriately.

**Many of the proposals contain limited provisions which may partially address the need to encourage an increased supply and improved distribution of health care workers, as well as to support certain alternative health care delivery systems.** They do this primarily through expansion of primary care services in underserved areas, including the National Health Service Corps, community health centers, and migrant health centers, and/or reimbursement incentives to providers practicing in rural or underserved areas. The major approaches also make provision for reimbursing services provided through managed care plans, such as HMOs. The existence and adequacy of these provisions need to be carefully addressed, especially as they relate to the need to increase the number of Hispanic Americans going into the health professions, and to improve the supply and distribution of health service workers in areas where Hispanic Americans seek care.

**Most of the proposals include limited quality of care monitoring or accountability and enforcement procedures, and do not explicitly address issues of equal access and non-discrimination.** General provisions are made in many single-payer and "pay or play" proposals for the establishment of national commissions or boards to develop quality goals or standards and to support outcomes research and the development of practice guidelines. Others rely on the peer review system used by Medicare. However, it is not clear if these will be sufficient to assure that Hispanic Americans receive equal quality care or if overall care is of high quality. Specific statements requiring non-discrimination in health service delivery are included in only a few proposals; the development of the standard qualified health plans established under the various proposals is considered part of the implementation process. While existing civil rights legislation and regulations require that federally-funded programs assure non-discrimination, failure to emphasize the importance of equal access or define specific procedures for assuring non-discrimination may mean that clear enforcement procedures are not immediately developed or implemented. Even when such systems are in place, experience demonstrates that civil rights enforcement mechanisms do not necessarily serve Hispanics equitably.<sup>7</sup>

**NCLR and LCLAA believe that all these principles should be explicitly addressed as a part of legislation which seeks to provide universal health coverage.** It may be argued that many of the issues on which the health proposals are silent may in fact be addressed in the planning and implementation process. However, experience suggests that failure to include such provisions and protections in the legislation leads to their being minimized, ignored, or forgotten in the development of policies, regulations, plans, and procedures. Given the high proportion of Hispanics without health insurance or regular health care, both financial and non-financial barriers must be addressed.

## **CONCLUSIONS**

As the preceding analysis clearly demonstrates, many of the major health reform proposals offer the potential for significant improvements in Hispanic health insurance coverage -- but none of them automatically addresses the majority of Hispanic concerns as summarized in the NCLR/LCLAA principles for evaluating health care reform alternatives. Those plans offering perhaps the greatest potential for something approaching universal coverage and a consistent set of minimum benefits regardless of geographic location are the single-payer and multi-payer "pay or play" plans. However, many ambiguities and unanswered questions make it clear that to create a plan which assures equitable and adequate health care coverage for Hispanics requires not only careful review, but also efforts to educate policy makers about the special concerns and needs of Hispanics.

Based on this extensive review and analysis of Hispanic health insurance status, gaps, and impact, NCLR and LCLAA have reached the following conclusions regarding health insurance and health care reform:

- 1. The time has come for comprehensive health care reform.** In light of the multifaceted health insurance and health care access problems faced disproportionately by Hispanic Americans but also by every segment of U.S. society, a comprehensive approach to health care reform is essential. Piecemeal proposals may improve access to health care for certain segments of the population, but will not assure anything approaching universal coverage. Moreover, by giving the impression of positive change at limited cost, piecemeal approaches may reduce the probability of comprehensive reform. Only comprehensive reform will assure that the needs of Hispanics -- including the working poor and their families, children, and low-income populations, who are very often uninsured -- are fully addressed.
- 2. Health care must be viewed as an entitlement -- as a right, not a privilege; as a national mandate, not a state option.** In theory, all three major types of comprehensive plans could provide something approaching universal coverage. However, breadth of coverage -- particularly for individuals and families from working poor and other lower-income families -- can be reduced by many financial factors, among them variability across states in benefits packages, cost sharing, reimbursement rates, and

variations in state contributions to overall expenditures. The Medicaid experience makes it clear that consistent federal standards will be essential to assure that a farmworker family in Texas, a Cuban family in Florida, a Puerto Rican family in New York, and a Central American family in Washington, D.C., are all assured of the same basic health benefits -- and that these benefits continue if they should move across state lines. LCLAA and NCLR will only support health care reform which assures adequate health care coverage regardless of geographic residence.

3. **A minimum set of basic benefits must be assured for everyone.** Comprehensive care for all Americans should be the goal of any health care system, from prenatal to long-term care. However, given budget constraints, difficult choices are going to be made. NCLR and LCLAA believe that an absolute commitment must be made to assuring that basic health care benefits -- including preventive, early diagnostic, primary treatment, inpatient, and outpatient care -- are provided and maintained for everyone, regardless of ability to pay. The pervasive negative effects of poverty on health status must be eliminated. We are particularly concerned with assuring that lower-income Americans have full access to preventive care and health screening; the investment of more public resources on preventive care will both prolong and improve lives and lower treatment costs in the future. Moreover, political considerations must not be permitted to exacerbate disparities in coverage; we must provide health care for the poor as well as the rich, for the very young as well as the very old, for acute as well as chronic illness.
4. **Health care reform must eliminate the disincentive to work caused by the linkage of health coverage and unemployment.** One of the greatest inequities in the present public health insurance system is the failure in most states to provide Medicaid coverage for the working poor and near-poor, a policy which has forced many working mothers to leave the labor force in order to assure basic health care for their families. Any health reform system should provide incentives to work, recognizing that workers have additional expenses and assuring that the decision to take a low-paid job does not make health insurance less available or affordable.
5. **Available public dollars must be used to assure health coverage for those with the greatest financial barriers to health care -- currently uninsured and underinsured lower-income Americans of all ages.** The United States should work towards a progressively financed health care system that provides universal and comprehensive health coverage. It is clear from the NCLR/LCLAA analyses that among the individuals and families not receiving preventive or regular health care are not only the uninsured but also many families who have health insurance but cannot afford to meet deductibles, copayments, and other cost-sharing requirements. Health care reform may institute a system which initially assures basic benefits for all at affordable costs. However, if cost containment measures are not immediately as effective as projected, budgetary restraints and rising health care costs will cause major pressures to reduce costs by increasing cost sharing or other means. While all individuals and families should contribute equitably to the costs of health coverage, highly progressive policies are essential to assure that

regular health care does not become unavailable through cost increases which cannot be met by low- and moderate-income families. Public resources should focus on populations who would otherwise be effectively excluded from the current health care system. Where federal or state boards make resource allocation decisions, it is critical that the needs of low-income, culturally diverse populations be addressed.

6. **Universal health insurance coverage does not mean universal health care access; health care reform must eliminate non-financial as well as financial barriers.** Hispanic health care access is affected not only by the ability to pay for services, but also by such barriers as lack of physically accessible community-based health care facilities; unequal distribution of health care workers and facilities, with the result that rural areas and inner cities may be underserved; provider facilities which fail to recognize the needs of the working poor for evening and weekend hours; lack of bilingual/bicultural health care workers at all levels; and a lack of outreach and health education, including use of media and materials appropriate for individuals with limited literacy and/or limited English proficiency. Health care reform will provide real access to care for Hispanics only when non-financial barriers have been reduced, the supply and distribution of health care workers -- especially bilingual Hispanic health care workers -- has been significantly increased, community-based facilities have been expanded and strengthened, and resources for Hispanic-focused health promotion efforts by community-based entities have been greatly expanded. Moreover, health reform must provide for ongoing accountability and proactive enforcement of non-discrimination policies. These barriers face not only the one-third of Hispanics without health insurance but also a significant proportion of those with health insurance. Health care reform will be truly comprehensive only if it fully addresses not just the financial obstacles to health care access but also these additional barriers, as identified in the NCLR/LCLAA principles for health care reform.



## ENDNOTES

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5. Coverage of all persons -- including undocumented persons -- should be universal on both equity and public health grounds. Wholly apart from the question of coverage of the undocumented is the extent to which the proposals cover other classes of persons legally in the United States, but who are neither citizens nor permanent residents. There are significant numbers of persons in this category; for example, at any point in time there are several hundred thousand tourists, visitors, and temporary foreign workers in the U.S. In addition, there are tens of thousands of parolees, refugees, and asylum applicants who have filed *bona fide*, nonfrivolous claims; most but not all of these individuals will eventually receive permanent resident status. There are currently several hundred thousand Salvadorans and Chinese students who are temporarily protected from deportation and are authorized to work; but whose long-term immigration status is unclear. There are perhaps another 100,000 persons whose status is in transition, i.e., who adjust to permanent resident status each year within the United States; prior to their adjustment, many of these individuals were either technically undocumented, or had some other temporary or ambiguous status. Finally, there are perhaps several hundred thousand native-born citizen children and permanent residents whose household head is undocumented or has some other ambiguous or transitional status. Many if not all of these groups have some claim, on equity grounds, to coverage under a universal health care system; from a public health perspective, denying these persons access to the health care system would appear to be counterproductive.
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