Examining Access to Health Care for Uninsured and Undocumented Communities in California

Presentation By Montzerrat Garcia Bedolla

California State University, Long Beach

College of Health and Human Services

March 24, 2023

Thank You

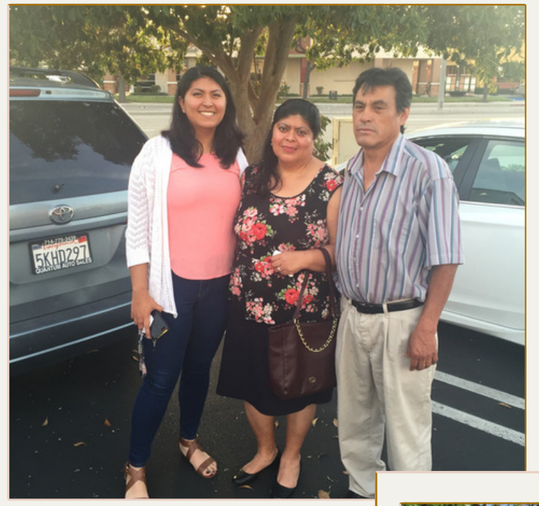
Thesis Chair
Dr. Laura D'Anna
Director, Center for Health Equity Research
Associate Professor, Department of Health Science
California State University, Long Beach

Thesis Committee Member
Dr. Javier Lopez-Zetina
Associate Professor, Department of Health Science
California State University, Long Beach

Thesis Committee Member
Dr. Judy Jou
Associate Professor, Department of Health Science
California State University, Long Beach

Interest

- Undocumented and uninsured lived experience
- Health care is human right
- Health care access as a social determinant of health
- Community organizing and research as tools to move forward policies that make health care more accessible
- Contribute to public health by decoupling immigration status and health insurance eligibility



Introduction

Affordable Care Act (ACA) 2010

- 7.1% decrease in health uninsurance rate for Hispanic/Latinos, 5.1% drop for Black people, and 3% decrease for Whites (Buchmueller et al., 2016)
- Reduction from $62.8 B/year to $42.2 B/year in federal uncompensated care (Karpman et al., 2021)
- **Undocumented immigrants ineligible for health insurance (Sun-Hee Park, 2011).**

California's Agency

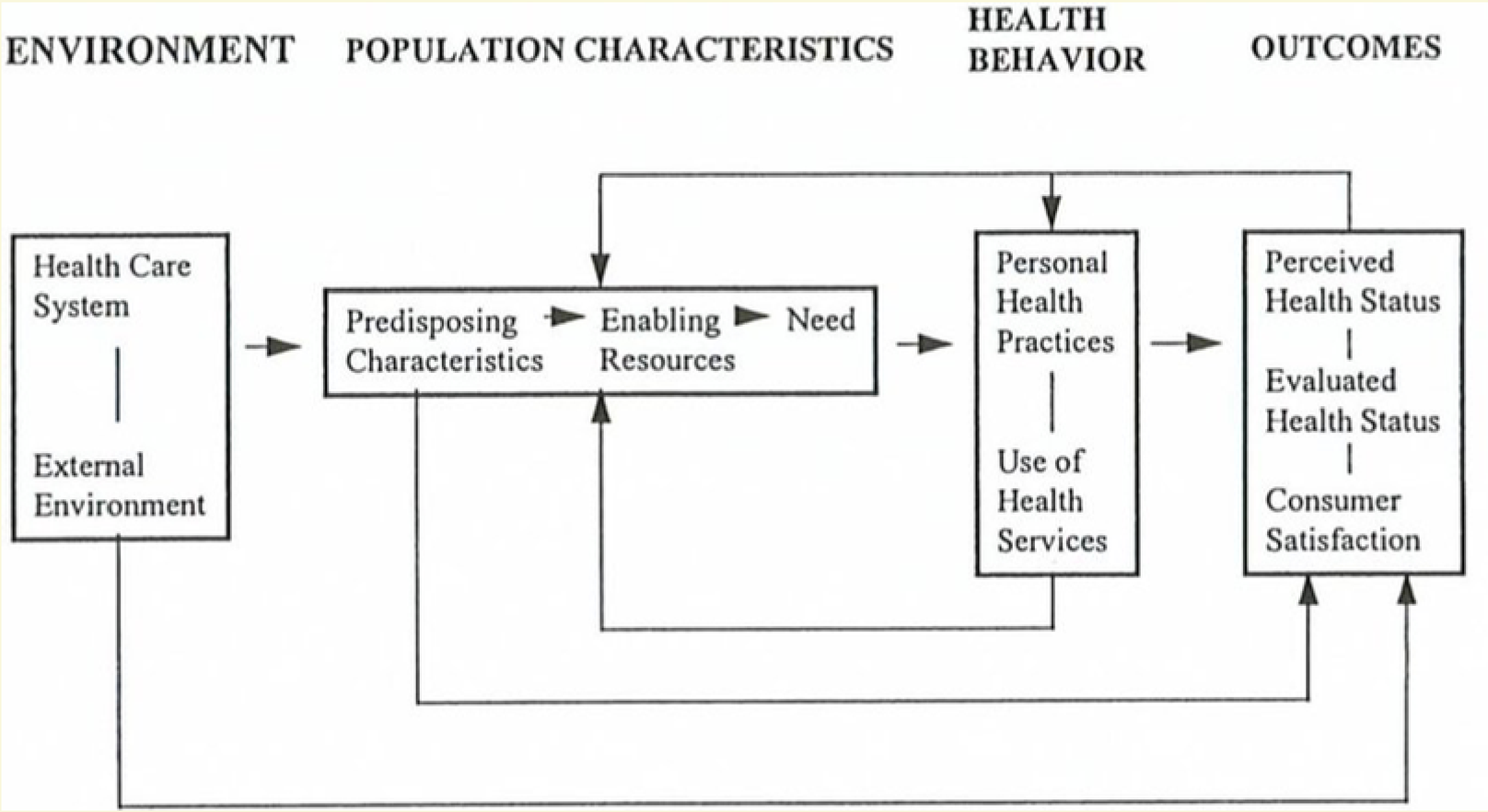
- California is estimated to have 3.2 M people uninsured, 1.9 M being undocumented (Dietz et al., 2021).
  - Undocumented immigrants without health insurance have the most dismal access and use of health case services (Ortega et al., 2018)

County Medically Indigent Adult Programs

- Since the early 20th century, California has provided safety-net services (including health care services) to 'medically indigent adults' who are not eligible for Medi-Cal through the "17000" obligation (Menacho et al., 2015).

Introduction

Andersen's and Newman's model of health care access and utilization



Health Care System/External Environment: restrictive policies/programs

Predisposing Factors: immigration status, income, education level, health beliefs about the health care system and public charge fears

Enabling Factors: usual source of care, health insurance status, and number of years lived in the U.S.

Illness Level/Need: Delayed care and ER use

Significance

Health Insurance Rates

- California's uninsurance rate was 14.5% in 2009
- California opted into Medicaid expansion in 2013-2014 leading to an uninsurance rate of 8.5% (ITUP, 2021).
- By 2020, California's uninsurance rate dropped to 6% - a decrease attributable to expanding Medi-Cal eligibility to low-income Californians and undocumented populations (ITUP, 2021).

Economic Impact

- California's uncompensated care decreased from $3.05 B in 2013 to $1.33 B in 2017 (California Health Care Foundation, 2019)

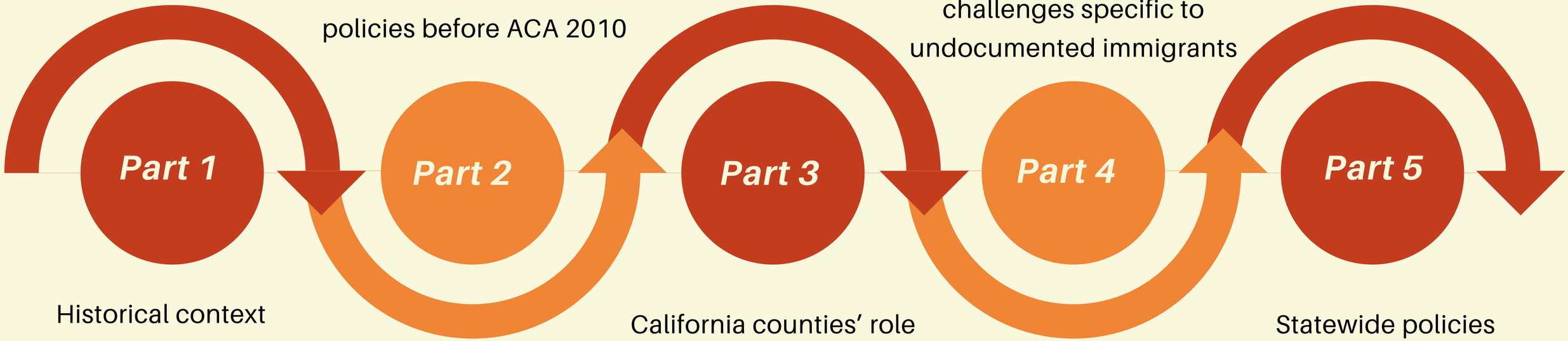
Future of Safety-Net Services in California

- Medically indigent adult programs within California pose an important consideration - what is more important to provide - access to health care services or health insurance?

Overall Benefit

- Having uninsured populations destabilizes local health care systems
- Having insured communities benefits everyone and incentivizes people to live healthier lives

Background



Historical context outlining how immigrant bodies were alienated from health care settings since 19th century

Co-constructions of health insurance eligibility and immigration status through a retelling of federal and statewide policies before ACA 2010

California counties' role in constructing medically indigent adult programs post-ACA 2010

Health care access as social determinant of health, health care disparities among health care indicators, and challenges specific to undocumented immigrants

Statewide policies (#Health4All) that increased access to health insurance to uninsured, undocumented immigrants.

Background

Affordable Care Act 2010

CA #Health4All Policies

Health Disparities

CA County Medically Indigent Adult Programs

California Pauper Act of 1901
17000 obligation - Section 17000 of the CA Welfare and Institutions Act 1933
Proposition 13 1978 cut health care funding
AB 8 in 1979
1982 budget deficit in CA

1882 Chinese Exclusion Act
Cubic Air Ordinance and Residence District Ordinance
1907-08 Gentleman's Agreement
Alien Land Acts of 1913 and 1920

Immigration Reform and Control Act of 1986
CA Proposition 99 in 1988
1991 CA State and Local Realignment
CA Proposition 187 1994

Personal Responsibility and Opportunity for Work Reform Act of 1996
2004 CA Proposition 1A
2005 Hospital Financing Medicaid Waiver

Immigration Act of 1924
1932 proposed universal health care fails
Rise of employer-based insurance after WWII
Bracero Program 1942-1964
Hart-Celler Immigration Act of 1965
Medicaid Act and Social Security Act of 1965

Background

California County Medically Indigent Adult Programs

- **Safety-net programs** and services for medically indigent adults - people that do not qualify for Medi-Cal.
- Counties have the **discretion in spending** their funding in order to meet the needs of each county and have jurisdiction over eligibility requirements and delivery system (ITUP, 2019).
- Operate based on four models of service delivery:
  - **Provider:** delivery services through public county-owned hospitals/clinics
  - **Payer:** contract services or reimburse private hospitals/clinics
  - **Hybrid:** operate public clinics but not public hospitals, can contract private hospitals
  - **County Medical Services Program (CMSP):** administers programs in 35 rural counties

Research Questions

Study Aim

To explore California's ability to provide health care access and services to uninsured and undocumented immigrants through medically indigent adult programs post-ACA implementation.

Question 1

Do correlations exist between **model** of service delivery (provider, payer, hybrid, and County Medically Indigent Program) and **eligibility guidelines** (whether programs are offered regardless of immigration status) among county medically indigent adult programs?

Question 2

Do correlations exist between **health care access indicators** (usual source of care, emergency room visits, delayed care) and **county demographics** (county population, county uninsured population, estimated undocumented county population, Latino population)?

Methods

Hypotheses

Question 1

Correlations **exist** among model of service delivery and eligibility guidelines

Question 2

Correlations **exist** between health care access indicators and county demographics

Sampling Method + Variables

2019 Secondary Data, N=58

Insure the Uninsured Project

Model, Eligibility

U.S. Census Bureau

County Population, % Latino Population, % Uninsured Population

Center for Migration Studies

Estimated Undocumented Population

California Health Interview Survey (2019)

% Usual Source of Care, % ER Visits, % Delayed Care

Statistical Analysis

Normality, Non-parametric assumptions met - SPSS 28

Question 1

Nominal, Categorical Level Data
Descriptive Statistics
Chi-Square Test of Independence
Fisher's Exact Test

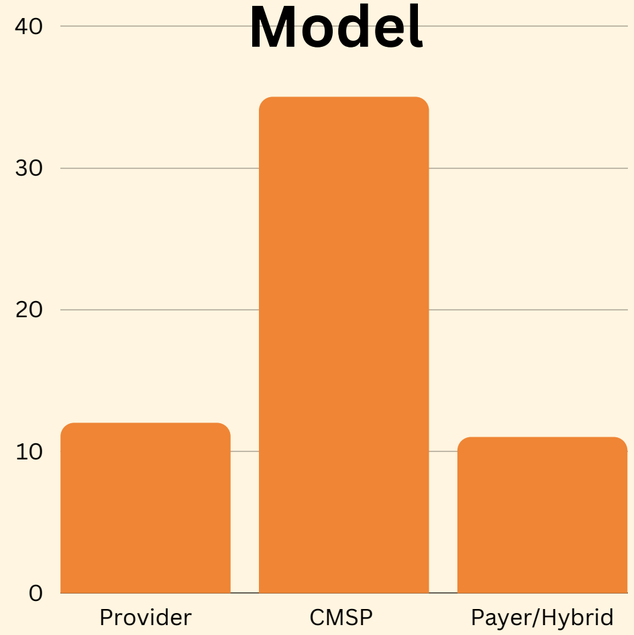
Question 2

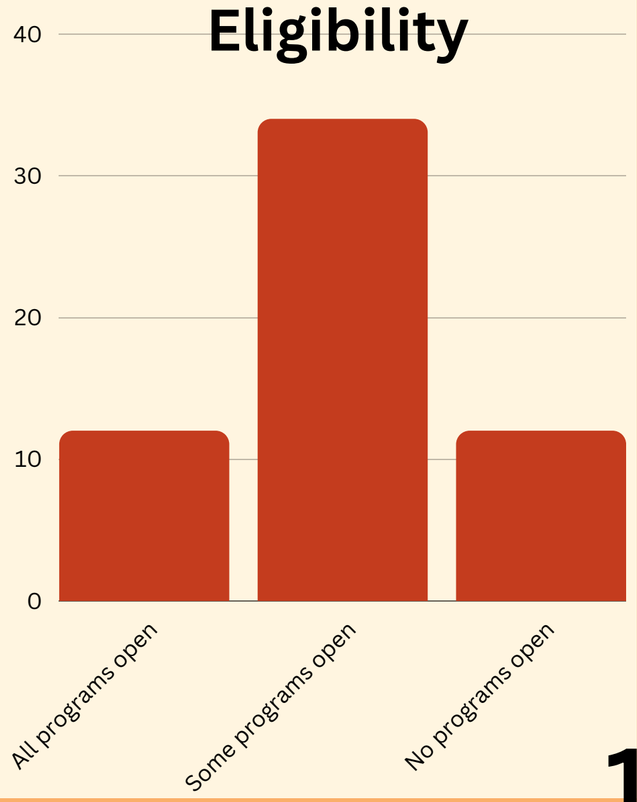
Ratio Level Data
Descriptive Statistics
Pearson's r

Results: Descriptive Statistics

Model & Eligibility

- Frequency Distributions
  - **Model**
    - Provider: 12
    - CMSP: 35
    - Payer/Hybrid: 11
  - **Eligibility**
    - All programs open: 12
    - Some programs open: 34
    - No programs open: 12





Results: Descriptive Statistics

Health Indicators & County Demographics

- Mean
- Standard Deviation
- Minimum
- Maximum

	County Population	% of Estimated Undocumented County Population	% of Latinos per County	% of Insured People per County	% of Usual Source of Care per County in 2019	%of ER Visits per County in 2019	% of Delayed Care per County in 2019
Mean	676505	7.8%	32.2%	7.9%	86.8%	20.8%	15.9%
Std. Dev	1441858	10.3	18.4	2.1	4.6	5.4	3.9
Min	1235	.46%	7.9%	4.2%	78.6%	9.8%	7.9%
Max	9829544	69.8%	85.8%	13%	96.1%	36.8%	25.3%
N	58	57	58	58	58	58	58

Results: Bivariate Analyses

- **Fisher's Exact Test and Chi-Square Test of Independence Results, two-tailed**
  - The association between model and eligibility was significant, **p<.001**
- **Pearson's r Correlation Results, two-tailed**
  - Five significant correlations between the ratio level variables were detected
    - **Strongly and Positively Correlated**
      - % of uninsured per county & % of Latinos per county, r(56)=.56, **p<.001**
      - % of delayed care per county & % of ER visits per county, r(56) = .54, **p<.001**
    - **Moderately and Negatively Correlated**
      - %of ER visits per county & % of Latinos per county, r(56) = -.39, **p=.003**
      - %of delayed care per county & % of Latinos per county, r(56) = -.45, **p<.001**
      - %of usual source of care per county & % of uninsured per county, r(56) = -.37, **p=.004**

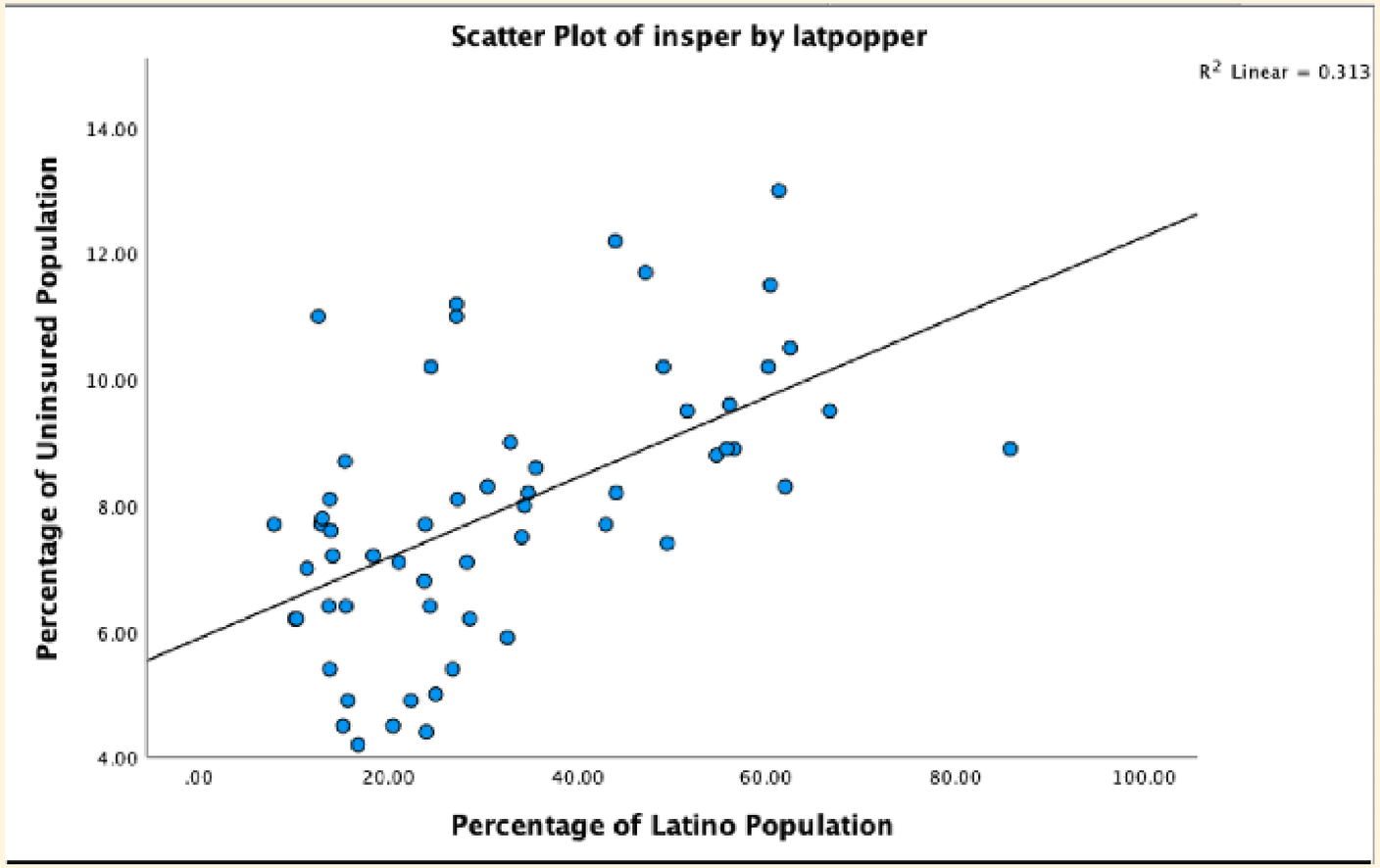
Discussion: Model and Eligibility

The statistically significant correlation between model of service delivery and eligibility was expected.

- Political and social perspectives influencing county design of medically indigent adult programs.
- These findings help contextualize that a relationship between the type of model will impact the eligibility guidelines and vice versa.
    - Although we are not able to know the direction of the association, it can be helpful for counties to rethink the ways that their model and eligibility guidelines currently create and/or exclude uninsured and undocumented immigrants.

Discussion: Health Indicators & County Demographics

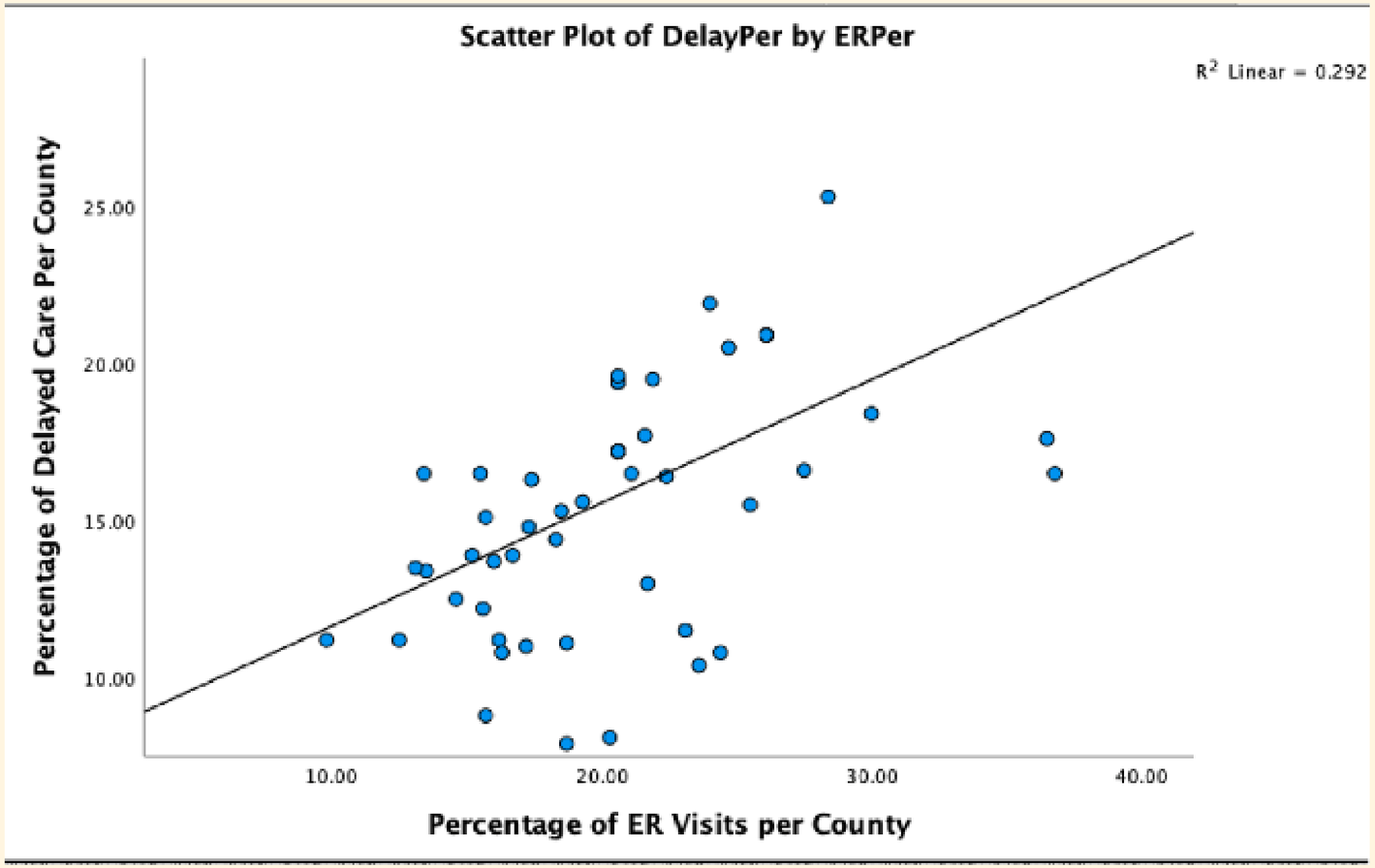
Finding 1: Percentage of uninsured per county and percentage of Latinos per county were strongly and positively correlated, r (56)=.56, p<.001.



- This result meets the expectation that counties with larger Latino populations may have larger uninsured populations.
- Policies that target Latino populations may benefit uninsured populations and vice versa.

Discussion: Health Indicators & County Demographics

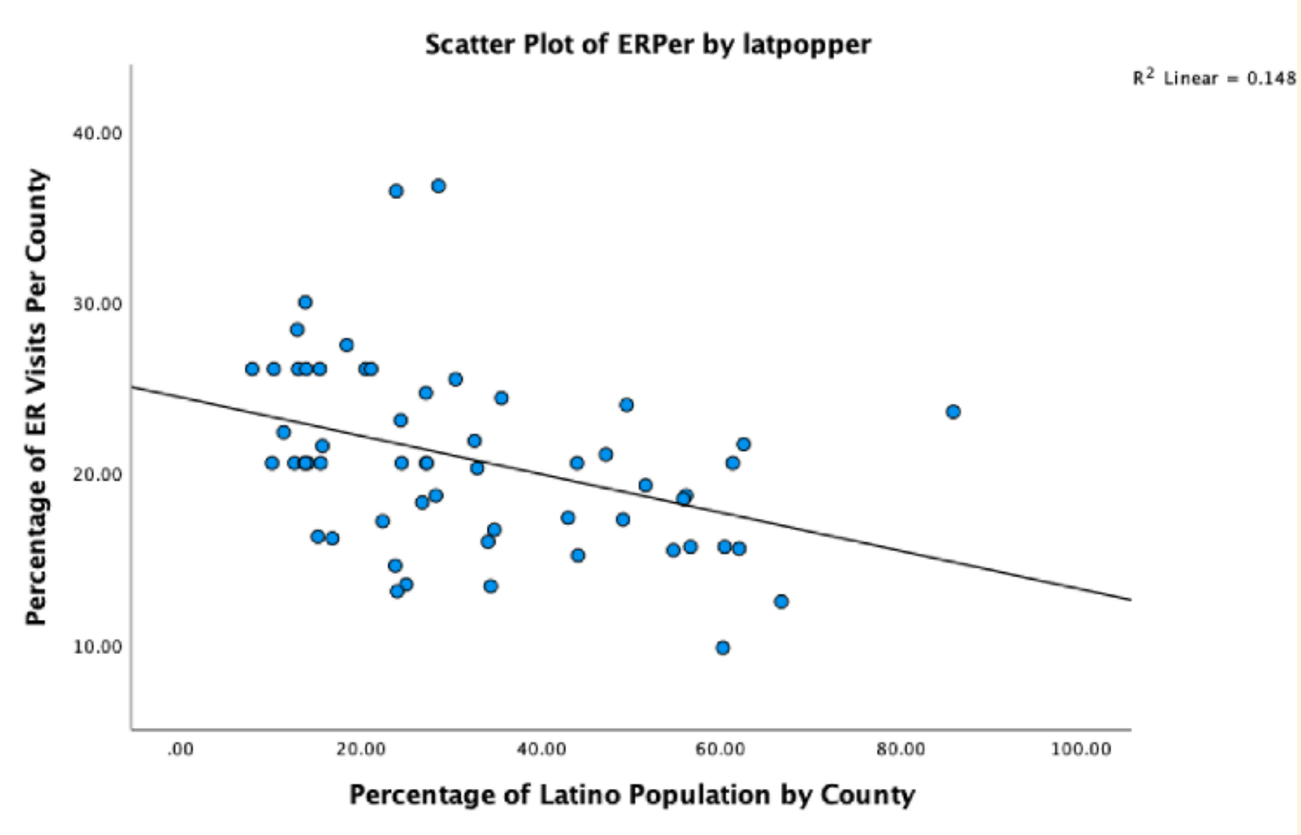
Finding 2: Percentage of delayed care per county and percentage of ER visits per county were strongly and positively correlated, $r(56) = .54$, $p<.001$.



- This is expected since individuals who delay care often result in needing last resort interventions such as the ER room.
- Delayed care and increased used of ER visits can have detrimental economic impacts in the long-term.

Discussion: Health Indicators & County Demographics

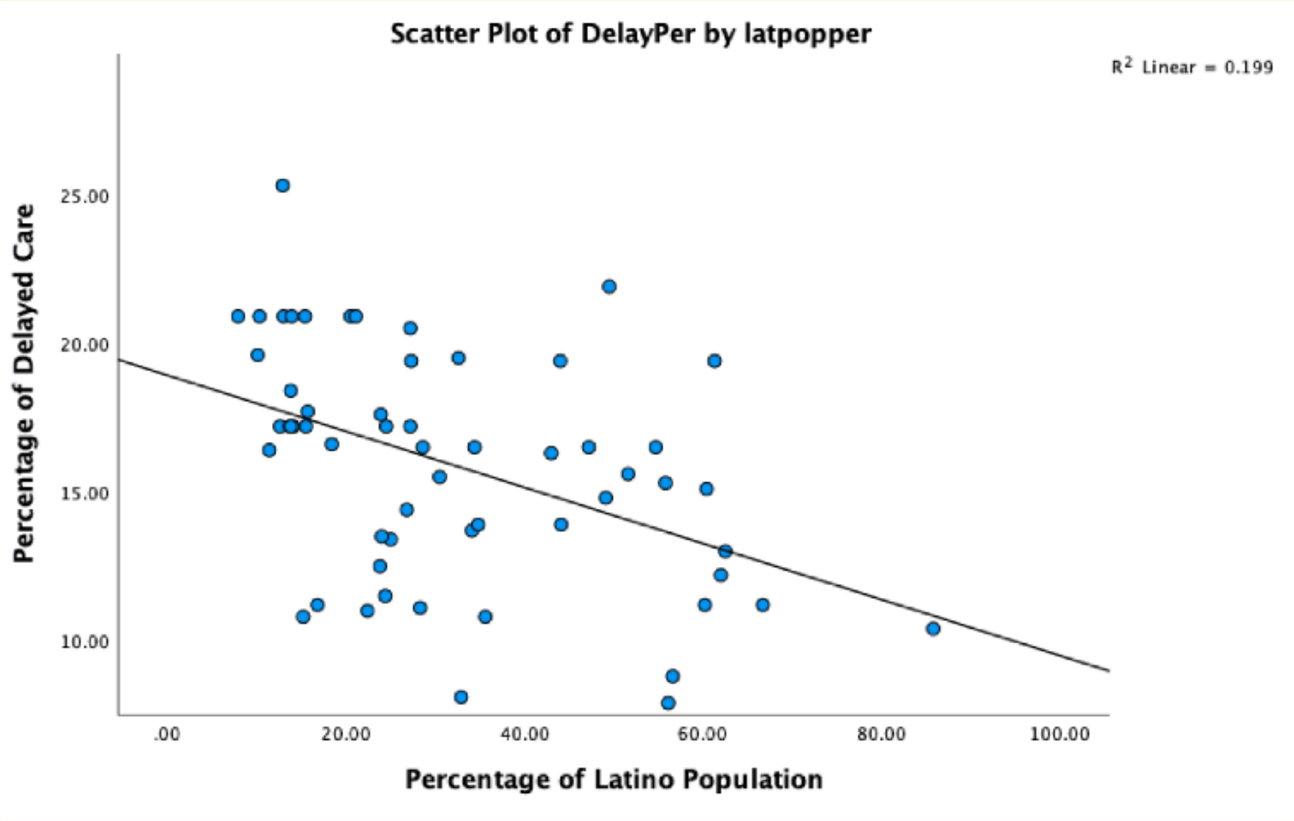
Finding 3: Percentage of ER visits per county and percentage of Latinos per county were moderately and negatively correlated, r(56) = -.39, p=.003.



- This was a surprising finding to see that the higher the ER visits percentages per county correlated to lower percentage of Latinos in the county.
- It was also surprising to see that ER visits are related to Latino population but not uninsured populations - since Latino and uninsured populations were correlated in Finding 1.
- This negative correlations may be explained by alternative variables outside of the scope of this study's variables.

Discussion: Health Indicators & County Demographics

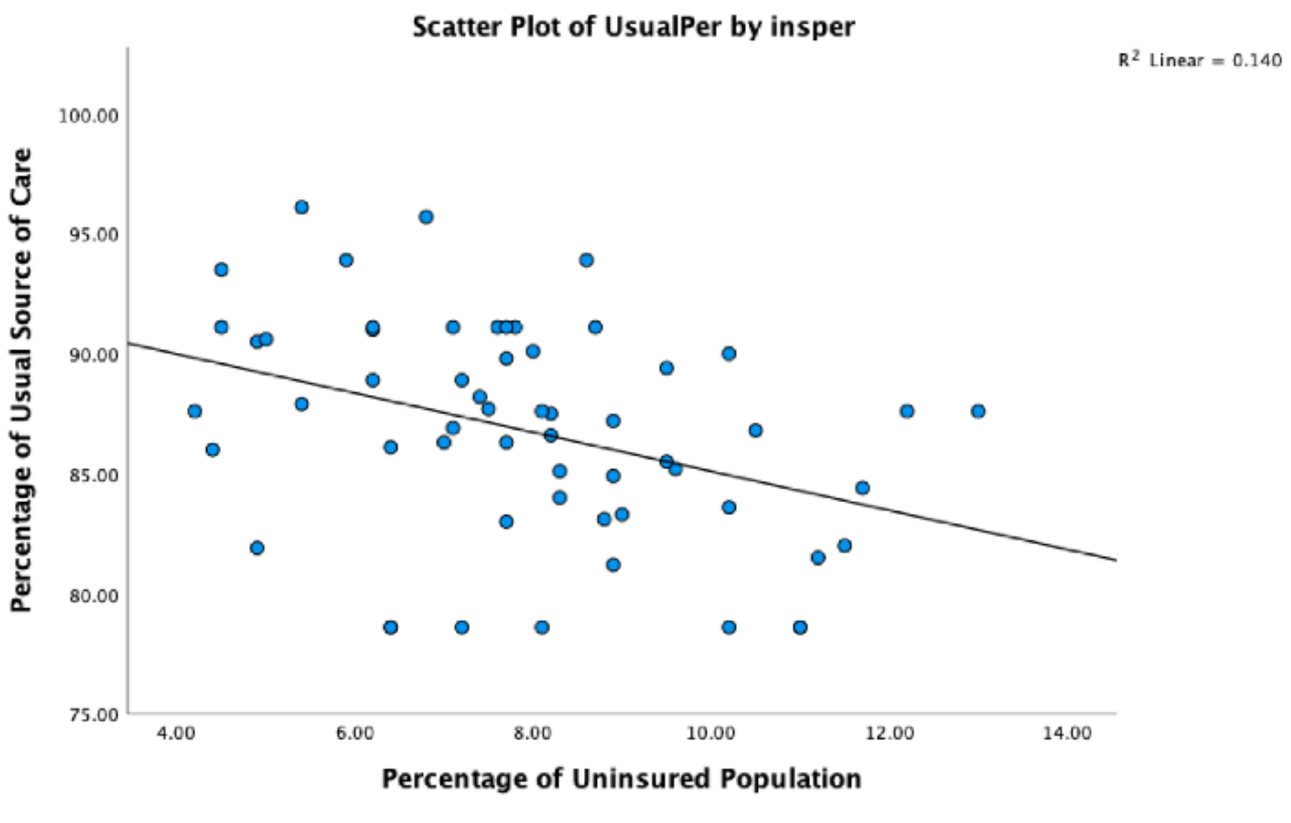
Finding 4: Percentage of delayed care per county and percentage of Latinos per county were moderately and negatively correlated, $r(56) = -.45$, $p<.001$.



- It was also surprising to see this finding on its own, or to see that the higher the delayed care percentage per county, the lower the Latino population.
- However, when we consider Finding 3 on ER visits and Latinos, it does make sense that delayed care per county is negatively correlated to Latino population since Finding 2 positively correlates ER visits and delayed care.
- This is telling us that counties with low Latino populations correlate with having higher percentages of both ER visits and delayed care - ideally they are utilizing health care because they are insured.

Discussion: Health Indicators & County Demographics

Finding 5: Percentage of usual source of care per county and percentage of uninsured people per county were moderately and negatively correlated, r(56) = -.37, p=.004.

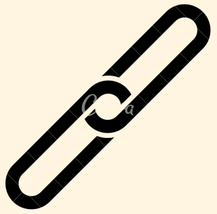


- This was an expected result that is confirmed throughout the literature on access to health care since those insured report higher rates of usual source of care compared to uninsured populations.
- This can also be interpreted as counties with lower uninsurance rates (higher insurance rates) correlate with higher usual source of care percentages per county.
- These findings can contribute to debunking narratives around uninsured and undocumented immigrants overutilizing health services such as ER visits that can be expensive for the local or state resources.

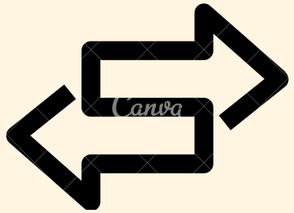
Discussion: Health Indicators & County Demographics

- **No correlations among the percentage of estimated undocumented population were detected.**
  - This is important to note since it was expected to at least have a correlation between percentage of estimated undocumented immigrants by county and percentage of uninsured population by county.
    - Nonetheless, the undocumented immigrant population as a whole is difficult to capture in both county populations because of many barriers such as fear of sharing citizenship status in health forms or government and health surveys such as the California Health Interview Survey.
- **There were also no correlations among overall county populations and other county demographics and health care access indicators.**
  - That was surprising, but it can also point that county size may not be a significant factor in health care access indicators.

Implications



- **Who's responsible?**
  - The push and pull between state and county responsibilities to take care of the health of all medically indigent adults is a key takeaway from this research study.

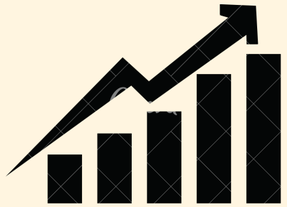


- **Structural barriers and changes**
  - A structural change that can happen is having counties embrace and operationalize a different model of delivery to allow more flexibility into their own definitions and eligibility guidelines.

- **Health Insurance does not equal health care use**
  - Important to think about the infrastructure and workforce needed to sustain a health care system that prioritizes health care access as a human right. Is California prepared? Is the U.S. prepared?

Limitations

- **Data Collection**
  - Self-reported surveys
  - California Health Interview Survey data was not representative of the undocumented population
  - True population of undocumented immigrants in California
  - County Medically Indigent Adult Programs in California are critically under tracked and undocumented



- **Statistical Analysis**
  - Not able to analyze whether type of model or eligibility guidelines had a correlation with health care access indicators such as usual source of care, ER visits, and delayed care or county demographics.
    - Cannot compare nominal with ratio data

Recommendations

Future studies can...

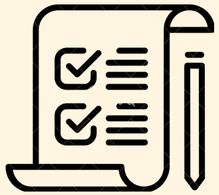
1) Collect health data that represents the undocumented population through innovative methodologies in order to analyze health outcomes among undocumented immigrants.

2) Further explore more characteristics of medically indigent adult programs, such as how much funding each program receives, income eligibility, and the annual reach that these programs have across California.

Recommendations

Through this research study, it is important for policy makers, immigrant health activists, and public health advocates to...

1) Reimagine health care local systems to better utilize the resources they have, such as indigent funds, that is centered in health equity principles. Those resources go to those who need them the most.



2) Advocate for nationwide policies that help make undocumented immigrants eligible for health insurance, whether that is a federal immigration reform and/or continuing to protect programs that defer deportation and offer work authorization.

3) Update or create health insurance programs that support newly insured undocumented immigrants to better and more effectively take advantage of available health care resources.

Conclusion

It is possible to decouple immigration status from health insurance eligibility.


Q
Canva
A