BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Texas

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Labor Neighbor Research & Training Center

ALLIANCE FOR A JUST SOCIETY

In Texas, the state political leadership is opposed to the ACA. We found ourselves in a situation where the general public is hearing a constant drum beat that the ACA is a negative thing, and where the prevailing notion is that it is immoral for citizens of Texas to enroll in it. It is incredibly negative– we consistently had to work against it.
—Ron Cookston, Executive Director, Gateway to Care

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The process to certify Navigators in Texas had nothing to do with improving our ability to help people find health insurance. It was simply an impediment to success. After two enrollment periods, we still have more uninsured people in Texas than in any other state. If we really want to enroll people, especially in the Latino community, we need door-to-door outreach—a program that puts Navigators on the front porches of every home.
— Orell Fitzsimmons, Former Navigator, and Labor Neighbor Organizer, Houston Texas

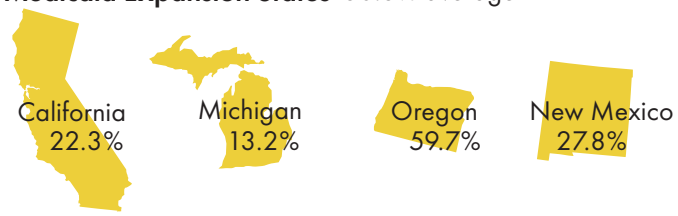
FORMER TEXAS GOVERNOR RICK PERRY, LIKE OTHER REPUBLICAN GOVERNORS, strongly and publicly resisted Medicaid expansion, declaring that Texas would not allow the Obama administration to "force us into the fool's errand of adding more than a million Texans to a broken system."[1] Not only has Texas opposed Medicaid expansion; the state's Republican administration has moved administratively and programmatically to resist ACA implementation and make enrollment difficult. In a state where almost one in five residents is poor (17.6 percent) and that has a 23 percent uninsured rate (23 percent of Latinos, 14 percent of whites, 22 percent of African Americans, and 23 percent of Asian-Pacific Islanders), former Governor Perry chose to reject the insurance that Medicaid would bring to 1.5 million low-income Texans, claiming "skyrocketing taxes and a budget crumbled under the weight of oppressive Medicaid costs." Perry followed up his initial opposition to expansion with implementing cumbersome training and administrative procedures and licensing requirements geared to slow and impede the ability of navigators to inform and enroll Texas residents in the new ACA marketplace. As one advocate commented, "State Department of Insurance demanded that navigators be finger printed, registered with state, and background checked - creating a barrier to building the outreach process. They required organizations to register with the state and wouldn't accept the training that the existing departments had done. They required additional training during the period when they should have enrolled people in March. When the highest level of enrollment was happening they pulled people out for 5 days – to train them."[2]

These barriers hindered, but did not stem, the tide of Texas' enrollment. With approximately 730,000 people signed up through the health exchange by May 2014, Texas ranked third nationally in the number of people enrolled, after Florida (983,000) and California (1.4 million).[3] This report, part of a 10-state study, reviews Texas' enrollment efforts and consumers' attempts to access health care in the state's low-income African-American, white, Latino, and, where applicable, Asian-Pacific Islander communities. The methodology includes key actor interviews with Texas-based navigators, policy and health care professionals, and advocates, as well as 126 surveys in Spanish and English with low-income community residents at food pantries, health clinics, and homeless service centers. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Texas outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

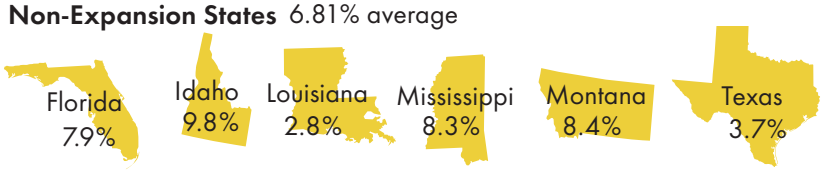
ENROLLMENT

Percent Medicaid and CHIP Enrollment Increase from 2013 Pre-Enrollment to April 2014[4]

Medicaid Expansion States 30.8% average



Non-Expansion States 6.81% average



According to one survey, the percentage of uninsured people in Texas decreased by three percentage points between 2013 and 2014; Medicaid and CHIP enrollment increased by 3.7 percent, 3.1 percentage points less than the average among other states in this study that rejected Medicaid expansion and a full 27.1 percentage points lower than the 30.8 percent average increase in the Medicaid expansion states studied.

Because 33 percent of uninsured Latino adults and 22 percent of uninsured African American adults live in two southern states, Texas and Florida, examining how enrollment and access to care affected these populations is a key component of our analysis. Latinos are disproportionately likely to fall in the "Medicaid coverage gap" in Texas (people in the "Medicaid coverage gap" are those who would have been eligible for Medicaid had their state opted for Medicaid expansion but whose incomes are too low to qualify them for premium subsidies in the state's health insurance marketplace). More than 55 percent of the people in the coverage gap in Texas are Latino; 26 percent are white and 15 percent are African American. Furthermore, looking at the share of all U.S. residents in the coverage gap who live in Texas, we find that 59 percent of U.S. resident Latinos in the coverage gap are in Texas, along with 12 percent of all African American residents and 12 percent of white residents (these figures do not include undocumented immigrants).

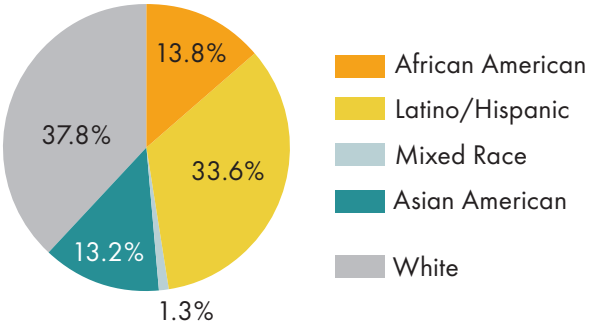
Race/Ethnicity	Racial breakdown of people in Medicaid coverage gap in Texas	Texas' share of all U.S. residents in Medicaid coverage gap, for each racial group
African American	15.3%	12%
Latino/Hispanic	55.7%	59%*
White	26.1%	12%

http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/

* people in the coverage gap can purchase insurance, but because of their income they are less likely to be able to afford it

Given the higher percentages of people of color who are uninsured, efficient outreach planning would target those populations for enrollment—but Texas' outcomes suggest that this was not the case.

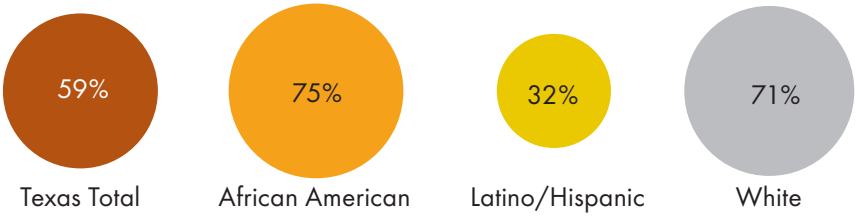
Percentage of Texas marketplace enrollees through April 2014, by race



Percent of survey respondents with coverage

Do you have medical coverage?

Percent Yes



Percent of survey respondents with medical coverage who got it in the last 12 months

Given the higher percentages of people of color who are uninsured, efficient outreach planning would target those populations for enrollment—but Texas' outcomes suggest that this was not the case. Latinos, the group with the highest percentage of uninsured residents, totaled only a third of the total new enrollees. African Americans, almost a quarter of whom are uninsured, were only 14 percent of new enrollees. Asian Americans, with an uninsured rate of 23 percent, were 13 percent of new marketplace enrollees. Whites, uninsured at a substantial rate (14 percent) but still least likely of all racial groups to lack insurance, had the highest percentage of marketplace enrollees at 38 percent. It is significant to note that in our survey of low-income residents, only 32 percent of Latinos had medical coverage, and although three out of four African Americans were insured, only 19 percent of those with coverage were new enrollees. At 71 percent, whites had the second highest percentage of survey respondents with medical coverage and matched Latinos for the highest percentage of new enrollees surveyed, at 50 percent.

Labor Neighbor organizer and former Navigator Brenda Cisneros asserts that "even though more than half of the people in my community have never had insurance, it was clear from the start that a comprehensive outreach program to Hispanics was not in the cards. The Website did not have a Spanish portal and there were never enough Hispanic Navigators at any of the major mass events."

Latino Enrollment

Percent of state population	38.4%
Percent of marketplace enrollees	33.6%
Percent of Latino survey respondents with coverage who are new enrollees	50.0%

White Enrollment

Percent of state population	44.0%
Percent of marketplace enrollees	37.8%
Percent of white survey respondents with coverage who are new enrollees	50.0%

African American Enrollment

Percent of state population	12.4%
Percent of marketplace enrollees	13.8%
Percent of African American survey respondents with coverage who are new enrollees	19.0%

BARRIERS TO ENROLLMENT

DIFFICULTY

Did you find the enrollment process easy, somewhat difficult or very difficult?

Race/Ethnicity	Percent somewhat or very difficult
Texas Respondents Overall	**32%**
African American	29%
Latino/Hispanic	40%
White	20%

Did anybody help you enroll?

Race/Ethnicity	Percent Yes
Texas Respondents Overall	**48%**
African American	57%
Latino/Hispanic	60%
White	33%

While home Internet access is not an absolute prerequisite to enrollment, significantly less than 40 percent of survey respondents had access – with a strong racial disparity: 73 percent of whites had Internet access compared 34 percent for African Americans and 26 percent for Latinos.

Do you have Internet access at home?

Race/Ethnicity	Percent Yes
Texas Respondents Overall	**38.8%**
African American	33.9%
Latino/Hispanic	25.6%
White	73.3%

Do you have an email address?

Race/Ethnicity	Percent Yes
Texas Respondents Overall	**45.5%**
African American	48.1%
Latino/Hispanic	23.5%
White	71.4%

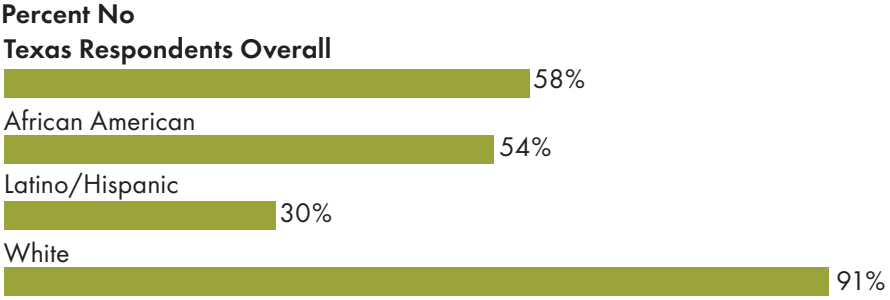
Although nearly half of the new enrollees surveyed (a third of whites and close to six of ten African Americans and Latinos) had assistance with enrollment, a third (40 percent of Latinos, 29 percent of African Americans, and 20 percent of whites) found the enrollment process "somewhat or very difficult." Staff members from six of the outreach organizations interviewed mentioned enrollment barriers erected by the state, including arbitrary training requirements, certification "hoops" ("I was fingerprinted three times," said one navigator), website glitches that included periodic shutdowns, and "just plain old uncooperativeness" from state officials.[5]

From the standpoint of enrollees, there were significant barriers to electronic enrollment. While home Internet access is not an absolute prerequisite to enrollment, significantly less than 40 percent of survey respondents had access – with a strong racial disparity: 73 percent of whites had Internet access compared 34 percent for African Americans and 26 percent for Latinos. Similarly, less than half of our survey respondents had email addresses, a necessary component of the enrollment process: 71 percent of whites, 48 percent of African Americans, and 24 percent of Latinos. Said one survey respondent, "I use my phone for Internet, but it won't work on this application. And anyway, I didn't have an email address before I applied. Now that I have one I hope they don't send me more stuff to fill out because it is a real pain in the butt."[6] "We frequently found people who didn't have access to an email address or Internet and actually spent time getting people an email address," recounts Tiffany Hogue, Health Care Program Director at the Texas Organizing Project. "Technology was a barrier but even people who were technically savvy wanted to talk through what they were seeing online with a real person to ensure that they understood their options correctly."[7]

Immigration status issues also created difficulties. Approximately 1.7 million undocumented immigrants live in Texas and 2 million U.S.-born Texas children have at least one parent who lacks legal status.[8] Many Latinos are afraid to apply for medical insurance. A young Latino in Houston who refused to answer survey questions told an AJS surveyor, "there is no guarantee that the *migra* won't use enrollment information to come after families. I need health insurance, but I need not to be deported more."[9]

PLAN COSTS AND SERVICES AVAILABLE

When you enrolled in a health plan, were you informed that financial support was available for low income people?



Many of these health plans are complicated; do you know which services are included in your coverage and which aren't? (asked of respondents whose first language was not English)

Race/Ethnicity	Percent No
Latino/Hispanic	57%

More than half of our survey respondents (58 percent) did not know that financial support was available for low-income people. However the percentages were the reverse of the other racialized trends: twice as many whites (91 percent) as people of color (42 percent) were unaware of potential financial support. Part of the problem, says Martha Blaine, Executive Director of the Community Council of Greater Dallas, was lack of advertising dollars for outreach: "because we had a federal exchange we had no money for promotion. No PSA's, radio, TV – no money in the state to do any of that. We were at the mercy of the HHS advertising budget. We had to use all of our social service networks to get the word out… and there are people NOT connected to social services that could be covered but it was hard to reach those people without media." "Familiarity with the concept of insurance is another important issue," points out University Health System President/CEO George B. Hernández, Jr. "For many, this is their first opportunity to purchase health insurance. While they may know some of the key concepts like co-pays, deductibles, medical homes and some of the medical terms like lab tests and meds, they don't necessarily understand how to put these things together in terms of how their policy would work." [10]

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In a conversation in Spanish with one of our surveyors, one middle-aged Latina respondent said, "Even though the application was in Spanish, I still didn't know what I was getting. I am hoping for cheaper medicine for my arthritis."

Most advocates did not think that language access was a major issue. One advocate pointed to the availability of 101 languages through the language line; another assessed the language outreach as "a great effort," and a third asserted that bi-lingual work is "very normal" because of the high percentage of Latinos in the state. While we would not dispute these statements, our survey found that issues of outreach and knowledge about how insurance policies worked were often compounded by language. Fifty-seven percent of our Spanish-speaking survey respondents who did not speak English as their first language did not understand what services were included in their insurance coverage. In a conversation in Spanish with one of our surveyors, one middle-aged Latina respondent said, "Even though the application was in Spanish, I still didn't know what I was getting. I am hoping for cheaper medicine for my arthritis." "Health literacy is a problem," says Gateway to Care Director Ron Cookson. "Sometimes we spend hours with people. People don't understand insurance, copays, deductibles, etc. (T)hey don't have the basic background information about how to use their insurance."[11]

COVERAGE TO CARE

My concern is helping people understand what they have and how to use it.... we need to look at how to engage people in understanding how to access different treatment modalities.[12]
—Stephen Williams – HHS – Public Health Assistant

Although the enrollment process in Texas was racially uneven, with a significantly higher enrollment percentage among whites (38 percent) who already comprised a lower percentage of the uninsured (23 percent) than Latinos (59 percent of the uninsured, but only 34 percent of marketplace enrollees), overall Texas did have the third highest number of enrollees behind California and Florida. Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we examine some key issues related to access and treatment.

STATE OF HEALTH

Do you have one or more medical conditions that have affected you for more than 3 months?

Race/Ethnicity	Percent Yes
Texas Respondents Overall	**60.2%**
African American	67.9%
Latino/Hispanic	46.3%
White	52.9%

Chronic diseases cause seven of every ten deaths. In addition, health care costs for an individual with one or more chronic diseases are five times the costs for an individual without chronic disease.[13] Heart disease, cancer,

diabetes, and stroke are among the most widespread chronic diseases in Texas, according to Texas Health Resources. Forty-six percent of Latino, 53 percent of white, and two-thirds of African American survey respondents indicated that they had one or more chronic illnesses (medical conditions that have affected them more than three months).

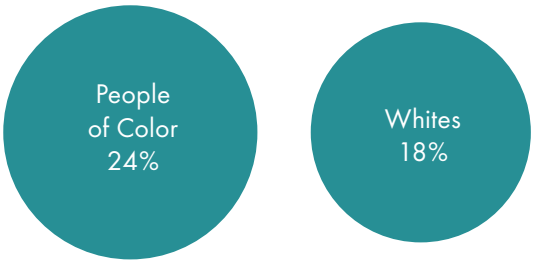
GENERAL ACCESS TO CARE

A personal doctor (also called primary care provider) is the one you would regularly see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

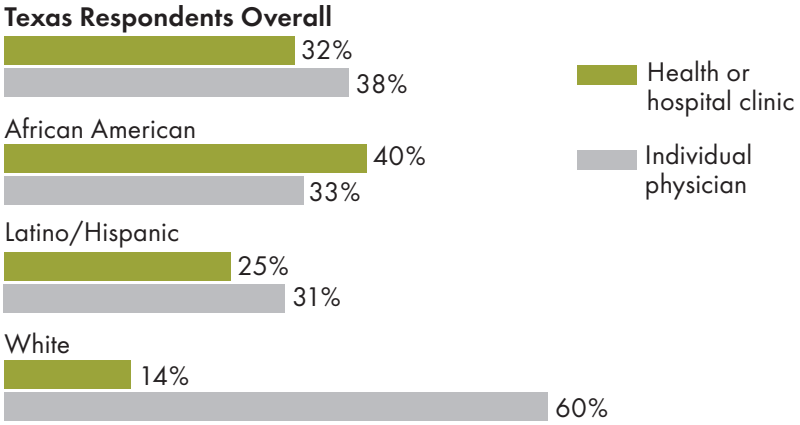
Race/Ethnicity	Percent Yes
Texas Respondents Overall	**71%**
African American	73%
Latino/Hispanic	58%
White	83%

Last time you saw your doctor?

More than a year ago



Where do you go for your primary health care needs?



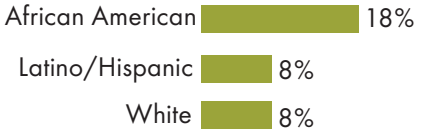
Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment.

Although seven in ten survey respondents say they have a personal doctor, only 38 percent visit that doctor regularly for their primary health needs (31 percent of Latinos, 33 percent of African Americans, and 60 percent of whites); 18 percent of whites and 24 percent of people of color have not seen their doctor in more than a year.

	Hospital ER or "no regular place to go"
Texas Respondents Overall	**30%**
African American	28%
Latino/Hispanic	35%
White	27%

How long does it take you to travel to your health care provider?

More than 1 hour



As with enrollment data, racial disparities are also evident in survey responses to issues of health access. Although seven in ten survey respondents say they have a personal doctor, only 38 percent visit that doctor regularly for their primary health needs (31 percent of Latinos, 33 percent of African Americans, and 60 percent of whites); 18 percent of whites and 24 percent of people of color have not seen their doctor in more than a year. African Americans have the largest disparity in travel time to doctor visits with 18 percent traveling more than an hour (8 percent more than an hour and a half) compared to 8 percent each for whites and Latinos. Significantly, 30 percent of survey respondents (27 percent of whites, 28 percent of African Americans, and 35 percent of Latinos) use the emergency room for their primary health care needs or "have no regular place to go."

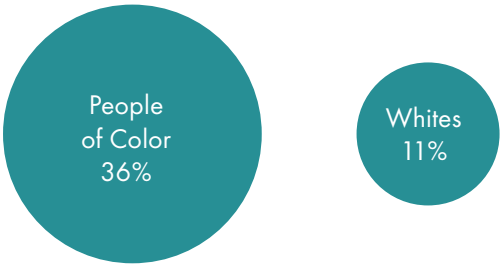
URGENT CARE ACCESS

In the last 6 months, did you have an illness, injury or condition that needed care right away?

	Percent Yes
Texas Respondents Overall	**40%**
African American	35%
Latino/Hispanic	36%
White	50%

In the last six months, when you tried to get an appointment for care you needed right away, how long did you usually have to wait to see someone?

Percent waiting more than 7 days



In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Race/Ethnicity	Percent sometimes/never
African American	27%
Latino/Hispanic	25%
White	13%

Survey responses to issues of urgent care, an important dimension of access, were also racially stratified. Whites reported the highest level of need, with fully half of survey respondents indicating an urgent condition in the last six months. Only 11 percent of whites had to wait more than 7 days for treatment and 13 percent thought they had not gotten care in a timely manner. Slightly over a third of both African American and Latino respondents reported an urgent condition in the last six months, but 36 percent of the respondents of color had to wait more than seven days for care and a quarter responded that they had not gotten care in a timely manner.

In the last 6 months, how often did your doctor or other health provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

Race/Ethnicity	Percent sometimes/Never
Texas Respondents Overall	**50%**
African American	51%
Latino/Hispanic	54%
White	34%

Although the ACA makes provision for insurance networks to include alternative modalities, only approximately half of survey respondents (54 percent of Latinos, 51 percent of African Americans, and 34 percent of whites) had a discussion with their health provider about non-medical modalities like acupuncture, chiropractic care, meditation, diet or exercise; this response is 8 percentage points higher than our national survey where only 42 percent of physicians discussed alternative medical modalities with patients.

Use the Internet to communicate with provider or insurer

Race/Ethnicity	Percent of those with insurance who use the Internet to communicate with providers or insurance company
African American	21%
Latino/Hispanic	23%
White	42%

Slightly over a third of both African American and Latino respondents reported an urgent condition in the last six months, but 36 percent of the respondents of color had to wait more than seven days for care and a quarter responded that they had not gotten care in a timely manner.

SUMMARY OF FINDINGS

Racial Disparities in Enrollment: The percentage of uninsured whites (14 percent) is a full 17 percentage points less than the uninsured rate for Latinos (31 percent) in Texas. Latinos are more than twice as likely as whites to fall into the state's Medicaid coverage gap (55.7 percent of people in the coverage gap in Texas are Latino; 26.1 percent are white), and in our survey, whites were twice as likely as Latinos to be insured: 71 percent versus 32 percent. Both African Americans (29 percent) and Latinos (40 percent) found the enrollment process difficult, compared to 20 percent of whites. These outcomes are built, at least in part, on two factors:

1) The digital divide, evidenced by survey responses indicating that whites have Internet access and email addresses at more than three times the rate of Latinos and more than twice the rate of African Americans—and are twice as likely to use the Internet to communicate with doctors or insurance companies. These issues of access were compounded by general website difficulties and particular failures on the Spanish language website;

2) Legal, language, and cultural barriers: While outreach, particularly in Spanish, may not be an overwhelming barrier, the combination of language, fear of legal reprisals for mixed status families, and lack of familiarity with culturally-specific insurance and medical terms adds up to significant obstacles to enrollment.

Racial Disparities in Access: Of our survey respondents, 35 percent of Latinos versus 27 percent of whites and 28 percent of African Americans have no medical home or place for regular care. Significantly, 40 percent of survey respondents had a condition or illness within the last six months for which they needed urgent care, and over a third of African Americans and Latinos had to wait more than seven days for service, versus 11 percent of whites.

Medicaid Coverage Gap: However, with Texas potentially losing $9.58 billion in federal Medicaid funds by 2022, the biggest barrier to increased enrollment is the state's rejection of Medicaid expansion and the resulting coverage gap. Paule Anne Lewis, Chief Executive Officer of the San Jose Clinic in Houston points out that the ACA rollout in Texas still hasn't touched two groups, "those that have citizenship issues and those too poor to qualify for subsidies through the marketplace."[14] Without Medicaid expansion, 1.3 million Texans who make too much to qualify for Medicaid but not enough to receive a subsidy through the ACA marketplace fall into the coverage gap. [15]"We've had a hostile environment with the Governor speaking publically against the program," says Tiffany Hogue. However, with Texas potentially losing $66 billion in federal Medicaid funds by 2022, advocates point out that that there is broad support for expansion with the Texas Association of Business, 40-50 local chambers of commerce, and the medical establishment all supporting expansion. With the possible crafting of alternative programs in Tennessee, Utah, Wyoming, and Florida, "perhaps," says one advocate, "there's a possibility for a compromise in Texas."

Pathways to alternative health modalities have not become a normal dimension of health access, with just half of doctors talking with patients about non-medical approaches to health.

In order to improve enrollment and care options, we recommend the following:

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Increase enrollment and federal funding by expanding Medicaid. The current enrollment process has reached too few people and the Texas system of "managed care" has not facilitated desired access or treatment outcomes for either doctors or patients. At this point, the rational policy alternative is to increase enrollment eligibility for 1.3 million low-income Texans by taking advantage of federal funds available for Medicaid expansion;

Target for enrollment low-income residents already enrolled in income-based programs. Immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets;

Improve language access. Latinos and, to a lesser extent, Asian-Pacific Islanders have uninsured rates that are significantly higher than whites in Texas, and culturally appropriate language access is still not an everyday reality. Complete multilingual application materials and website access are not readily available. To address these issues, Texas should establish a right to enroll in health coverage in the enrollee's primary language. The state should require plans to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3), and regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403). Texas should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Simplify the insurance-shopping experience. The state should simplify multilingual print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay.

Keep provider information current. The state should require plans to continually update information about which providers are in their networks; provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of navigators. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators are in an ideal position to perform this role. Texas should simplify the process for certifying and extend the role of navigators to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Texas should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes. The state should impose penalties, including exclusion from exchanges, against plans that do not succeed in reducing disparities within targeted timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment, as do California and Washington.

Increase payment rates to primary care physicians. Medicaid only pays 50 percent on the dollar of the real costs to Medicaid providers, says advocate George Hernandez. Federal support for increased Medicaid payment levels ended on Dec. 31, 2014. Since payment levels strongly affect providers' willingness to see Medicaid patients, Texas should use state funds to continue Medicare-level payments to primary care physicians who serve Medicaid beneficiaries as 15 states (AK, AL, CO, CT, DE, HA, IA, MD, ME, MI, MS, NE, NM, NV, SC) plan to do.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be provided free transportation.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Texas is a state with 17.6 percent of its residents living in poverty. Insurance is one step towards better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health—particularly in poor rural communities.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the ten states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in non-traditional services. Because health status is determined more by factors outside the clinical setting than by the nature of health care services, pursuant to Sections 2703 and 4108 of the ACA (42 U.S.C. § 1396w-4) states should direct Medicaid dollars toward non-traditional services like care coordination and community support for high-risk individuals with chronic disease.

Invest in school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 14.9 percent of state residents reside), to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

ENDNOTES

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