

# The Uninsured

## Examining Access to Specialty Care for California's Uninsured

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### Introduction

More than 6.5 million Californians—over 20 percent of the state's population—were uninsured in 2002.<sup>1</sup> Uninsured individuals are more likely than the insured to go without needed care and less likely to have a regular source of care.<sup>2</sup> The consequences of both may be particularly serious among individuals with chronic illness. For example, asthma patients whose conditions are not appropriately managed are more likely to seek treatment in emergency rooms and undergo hospitalizations that could have been prevented with timely care.<sup>3</sup> People with diabetes whose condition is not closely monitored risk extremely serious complications such as heart disease, permanent kidney failure, blindness, and nerve damage.<sup>4</sup>

Uninsured individuals rely on the safety net—community clinics, hospitals, and private physicians who deliver care without respect for ability to pay. Several recent studies have advanced the understanding of how safety-net providers fill a crucial gap in the country's health care system for primary care, but less is known about their role in delivering specialty care. Indeed, there is reason for concern that fragile clinic funding arrangements, worries among private physicians about incurring significant financial risks, and shortages in the supply of

specialists may make access to specialty care particularly problematic for the uninsured. Because such access is vital to helping patients with chronic conditions or complex medical cases avoid preventable threats to their health, the California HealthCare Foundation (CHCF) commissioned Mathematica Policy Research, Inc. to conduct research exploring the following questions:

- How and how well are California's uninsured able to obtain specialty care?
- Is access to specialty care for the uninsured becoming easier or more difficult?
- How and how much does access to specialty care for the uninsured vary from one community to the next?

This issue brief summarizes the study's approach and main findings. The research team found widespread problems in access to specialty care for the uninsured in California, with many communities experiencing worse access compared to two years ago. Although local efforts now underway have the potential to chip away at the problem, substantial obstacles will remain unless local health leaders and state policymakers take additional steps. Suggestions for short-term and longer-term action are presented at the end of this brief.

## Background and Methods

In California, where the percentage of uninsured people is higher than the national average, the issue of access to specialty care is particularly relevant. Health care providers, policymakers, and consumer advocates—as well as consumers themselves—have a stake in understanding and potentially improving how well the safety net serves the uninsured population.

The research team developed a broad approach to address the study questions, including two statewide surveys of key safety-net providers and detailed case studies in four communities. The first survey, conducted by telephone between November 2002 and April 2003, targeted the medical directors of all 101 federally qualified health centers (FQHCs) in California. Each was asked about the specialty care access problems faced by their centers' uninsured patients.<sup>5</sup> The second survey, which was mailed to 64 hospitals named by the FQHC medical directors as places where they commonly refer uninsured patients for specialty care, asked a sample of hospital outpatient department directors about the factors that affect hospitals' willingness and capacity to provide care for the uninsured, as well as how they accommodate the needs of uninsured patients.<sup>6</sup>

Case studies of the safety net for specialty care were conducted in four communities—two where the FQHC medical directors reported relatively good access to specialty care, and two where they reported relatively poor access.<sup>7</sup> Because the respondents were assured that their identities would be kept confidential, the names of the four communities are not disclosed. However an overview of the characteristics of their respective safety nets for specialty care is shown in Table 1. The case studies complemented the surveys by providing insight into how services are sought, including differences in service delivery across communities. They included interviews with a diverse set of providers and other knowledgeable informants during summer 2003, as well as focus groups composed of uninsured individuals who reported needing specialty care in the past year.

## Findings

### Difficulty Obtaining Specialty Care

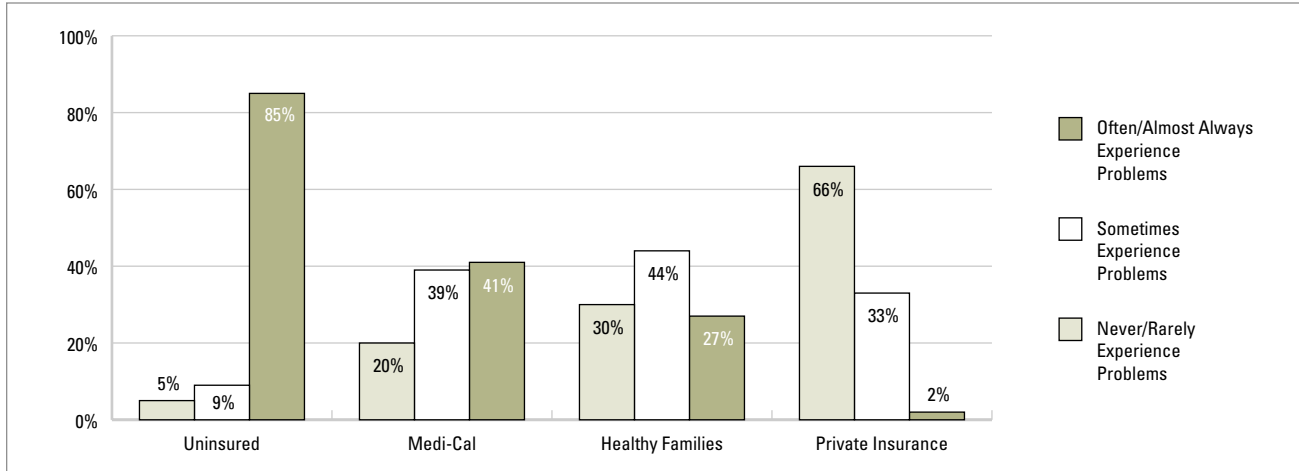
Access to specialty care for the uninsured population is a widespread problem in California. Eighty-five percent of the FQHC medical directors report that their patients have problems in obtaining care “often” or “almost always” (see Figure 1).

**Table 1. Case Study Communities: Profiles of the Safety Net for Specialty Care**

SAFETY NET STRUCTURE	Community 1	Community 2	Community 3	Community 4
Concentrated/dispersed system	Concentrated	Dispersed	Neither extreme	Neither extreme
Most common specialty care referral destinations for uninsured patients*	One public hospital (minor teaching)	None listed	One public, major teaching hospital and two non-profit hospitals (non-teaching)	One public major teaching hospital, one public minor teaching hospital, one major teaching nonprofit hospital
Availability of private physicians	Limited	Some	Considerable	Some
Free clinics providing specialty care	None	Yes	None	None
Medicaid managed care	Two-plan Model	Geographic Managed Care	Voluntary (prepaid health plans)	County Organized Health System

\*As listed by FQHC medical directors.

**Figure 1. Percent of Medical Directors Reporting Patients Experiencing Problems Obtaining Specialty Care**

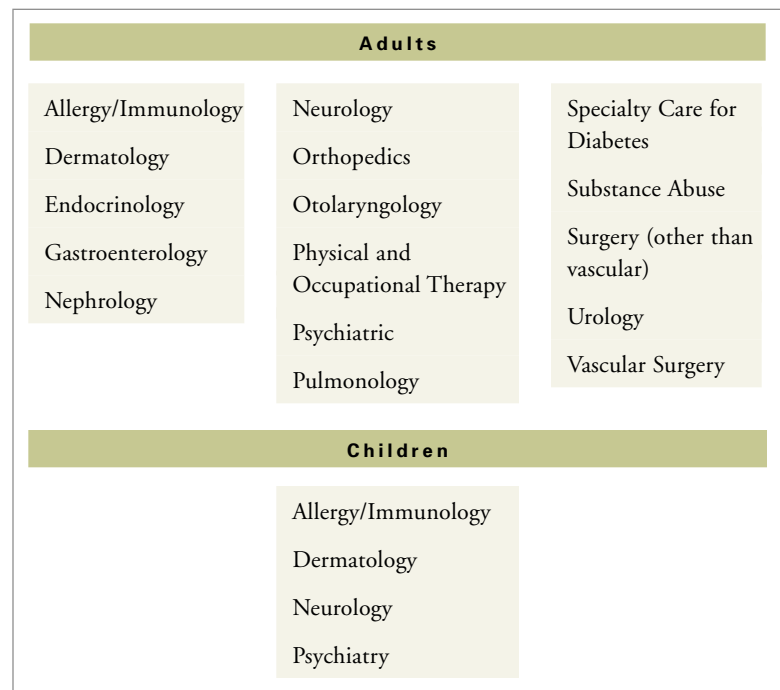


FQHC medical directors characterized adults’ access as “often” or “almost always” problematic for 16 of the 24 specialties listed on the survey (Figure 2). Neurology, allergy/immunology, and orthopedics were among the specialties most frequently cited as problematic. Children were reported to fare better, but access is still reported as “often” or “almost always” problematic for several specialties.

The case studies clarified that the major problems involve difficulties in finding a specialist willing to accept patients and the inability to obtain a timely appointment. Formal referral agreements between FQHC primary care providers and specialists that would cover patients across the board appear rare: Typically, FQHC physicians and staff work hard to secure specialty care for their uninsured patients on a case-by-case basis. This, of course, reduces the time available for patient care. Waiting times for the most problematic specialties are often months long, as shown by the case studies and the hospital outpatient department survey.

Half the FQHC medical directors said access to specialty care for their uninsured patients is worse today than it was two years ago, while only 15 percent reported that it had improved. In the case study communities, respondents reported access had worsened because of an increase in the demand for

**Figure 2. Most Problematic Specialties for Uninsured Adults and Children\***



\*At least half of the medical directors surveyed reported their uninsured patients “often” or “almost always” experienced problems obtaining these services.

such care due to population growth, more uninsured people, or increased health needs within this population.

The four case study communities illustrated many of the problems reported in the medical directors survey. Efforts now underway in three of the four have the potential to improve access to specialty care for the uninsured. Specifically, two of the four communities are working to cover more uninsured children through county health insurance programs, and several FQHCs are beginning to offer some specialist services in-house. These efforts appear poised to reduce the problems for some patients, but will fall far short of addressing the full set of access problems described above. In the fourth community, no actions have been taken to improve specialty care access for the uninsured.

### Provision of Specialty Care for the Uninsured

Hospitals are the major source of specialty care for the uninsured who use FQHCs, accounting for 73 percent of the organizations listed by FQHC medical directors as common specialty referral destinations for their patients. Government-owned hospitals represent only about 20 percent of California community hospitals, but account for about half the hospitals named as major specialty referral destinations for FQHC patients. Major teaching hospitals are also disproportionately represented, accounting for over one-fourth of the major specialty referral destinations. In addition, almost all the major specialty referral destination hospitals are urban hospitals. While only 16 percent of the FQHC medical directors listed a physician practice as one of the top three referral destinations for specialty care, the collective contribution of private physicians could still be large if each took a few uninsured patients into their practice.

The hospitals named as major specialty referral destinations are not limited to those traditionally thought of as safety-net providers. Medical directors reported that almost half of the hospitals they named are not primarily focused on providing services to low-income populations.

While hospitals responding to the survey cited many factors as important to their capacity or willingness to provide specialty care for the uninsured, at least half reported the following as *very* important: nonprofit status and mission, the hospital board's views on charity care, receipt of Medicaid disproportionate share funding, overall shortage of specialists in the community, and negative financial margin.

### Community Characteristics That Affect Access<sup>8</sup>

The study did not find significant differences in reported access problems for urban versus rural FQHC communities. However, the researchers did find substantial variation across communities in the breadth and depth of the problems with access to specialists. FQHC communities whose populations are at least 40 percent Hispanic were significantly more likely to report access problems for ophthalmology, orthopedics, and laboratory services for adults and allergy/immunology services for children. Impaired access to these services is likely to have a negative effect on care management and health outcomes in these communities. For example, laboratory and allergy/immunology services are essential for appropriate management of asthma.

The study did not uncover the reasons for differences in access among communities with larger Hispanic populations. Since over 50 percent of uninsured

Californians are Hispanic,<sup>9</sup> this finding should be taken seriously and may warrant further investigation.

The four case studies of California communities suggest that the following factors are also important in determining access to specialty care:

- *Strong relationship between FQHCs and hospitals.* Specialty care access for the uninsured depends heavily on informal and formal relationships between individuals' primary care physicians and other physicians and hospitals. At present, the relationships between primary care safety-net providers and hospitals are not particularly strong.
- *Community support.* Community support for delivering care to the uninsured varied across the four case study communities in terms of the availability of private funding to support the safety net and the presence of advocacy groups, coalitions of community health leaders concerned with access to care, and local programs designed to facilitate access.
- *Size of the uninsured population.* When only a small share of the population lacks coverage, providers in the community are less fearful that their offices will be inundated with uninsured individuals if they agree to accept a few patients.
- *Supply of specialist physicians.* Communities are faced with the challenges of specialist shortages and difficulty in attracting specialists. This echoes the mention of shortages as a reason for access problems in both the medical directors survey and the hospital outpatient departments survey.

## Implications

The study findings about the nature of specialty care access problems provide insight into the reasons for the worse clinical outcomes that have been well-documented for uninsured and low-income individuals.<sup>10</sup> They suggest a need for attention, both from local health leaders in the short term and state and national policymakers over the longer term.

## Short-Term Action Steps

Local health leaders (including those working at hospitals, FQHCs, and other primary care clinics focused on low-income populations; health department directors; physicians active in community-wide issues; and decision-makers at local foundations and charitable organizations) can take the following steps:

1. *Assess the severity and nature of specialty care access problems.* An assessment could consist of interviews with primary care physicians who serve the uninsured, as well as a representative of the relevant hospital outpatient departments, to identify which specialties either are not available or have long waiting times for appointments, and why. Such an assessment would provide a solid foundation for developing a plan to improve access.
2. *Develop and execute a plan for improvement, to the extent feasible.* While it may sometimes be beyond the ability of local health care leaders in underserved and low-income communities to solve specialty care access problems on their own, they should explore the following:
  - Implement or expand local initiatives to provide insurance to low-income residents;

- Strengthen primary care/hospital relationships;
- Provide advanced training to primary care providers to reduce the need for specialty care;
- Consider bringing specialists to primary care settings, such as FQHCs, on a part-time or full-time basis if the service demand is large enough; and
- Build on existing efforts and experience with volunteer initiatives.

State policymakers should identify specialties with widespread shortages, since community-wide physician shortages for certain specialties contributed to the access problems in many communities. Shortages in low-income areas could be exacerbated by any additional cuts in Medi-Cal that reduce provider reimbursement. State policymakers could, without cost, instruct hospitals receiving disproportionate share hospital funds to ensure that all specialty services are open to at least some low-income uninsured patients on a timely basis, provided the patients have a medical referral.

### Longer-Term Implications

State policymakers should consider the following:

1. *Assist and motivate communities to make local improvements.* Because community support for the uninsured varies across communities, some are unlikely to address access problems for the uninsured—particularly for uninsured adults—without outside influence. Matching funds are an often-used tool to motivate local spending. Only money raised from public or private sources that exceeds any local subsidy for the uninsured in the prior year should count toward a match.

2. *Consider policy change to encourage physician volunteerism.* To the extent that widespread shortages across California are confirmed, state policymakers should consider actions that might prevent the uninsured in some areas from being completely shut out from access to specialty care. A loan repayment program for selected specialists who serve shortage areas could be considered. Tax breaks for physicians who provide volunteer services in such areas could also be considered as compensation for a portion of the value of the services they provide to the uninsured.

In addition, national policymakers should examine the degree to which the specialty care access problems identified here exist among the states. If the problem is national in scope, policymakers should consider changes similar to those suggested for the state level.

Along with the strategic and policy action steps discussed above, further research should aim to:

- Identify reasons for the disparity in access to specialty care in communities with a large Hispanic population;
- Further shape potential policy interventions listed above, document the hidden costs of underuse of specialists; and
- Document the cost of inefficiencies in the current system for referring uninsured individuals to specialists.

### Conclusion

The results of this study suggest that, contrary to the prevailing perception, California's uninsured do not have ready access to specialty care—a problem that can be particularly severe when they become seriously ill.

Further research will be needed to identify and explore viable options for expanding health coverage and care access for this population.

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## ENDNOTES

1. California HealthCare Foundation. *California's Uninsured 2003*, Oakland, CA: January, 2004 ([www.chcf.org/documents/insurance/CaliforniaUninsuredSnapshot2003.pdf](http://www.chcf.org/documents/insurance/CaliforniaUninsuredSnapshot2003.pdf)).
2. Institute of Medicine. *Coverage Matters*. Washington, D.C.: The National Academy Press, 2001.
3. California Department of Health Services. "California County Asthma Hospitalization Chartbook." August 2000. ([www.dhs.cahwnet.gov/ps/deodc/ehib/ehib2/PDF/Hosp%20Chart%20Book%202000.pdf](http://www.dhs.cahwnet.gov/ps/deodc/ehib/ehib2/PDF/Hosp%20Chart%20Book%202000.pdf)).
4. American Diabetes Association. *Type 2 Diabetes Complications*. ([www.diabetes.org/type-2-diabetes/complications.jsp](http://www.diabetes.org/type-2-diabetes/complications.jsp)).
5. The response rate for this survey was 76 percent. Because the response rate was not 100 percent, the figures reported in this brief are estimates within about plus or minus 5.5 percent.
6. The response rate for this survey was 48 percent.
7. A "community" was defined for case study as the major catchment area of the surveyed FQHC, along with the medical facilities where the people who live in that area typically go for specialty care, which may be located outside that area.
8. The analysis reported in the first paragraph of this section used U.S. Census data for California and the medical directors survey. The FQHC community was defined as the ZIP code in which the FQHC is located, and "rural" was defined as a population density of fewer than 100 people per square mile.
9. California HealthCare Foundation. *California's Uninsured 2003*, Oakland, CA: January, 2004 ([www.chcf.org/documents/insurance/CaliforniaUninsuredSnapshot2003.pdf](http://www.chcf.org/documents/insurance/CaliforniaUninsuredSnapshot2003.pdf)).
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