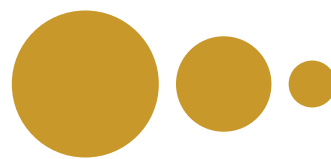


# POVERTY RESEARCH *Now*

CENTER FOR POVERTY RESEARCH



SPRING 2014 ISSUE

## FOCUS ON POVERTY AND HEALTH



Dr. Mitchell Katz, Director of the Los Angeles County Department of Health Services, speaks at the Center's 2013 conference on the Affordable Care Act.

### ENSURING ACCESS TO A HEALTHY LIFE

By Alex Russell

The Affordable Care Act (ACA) was a step toward addressing challenges to accessible care. Poverty, however, creates additional barriers that can be difficult to overcome even with safety net programs designed to serve the poor.

"The medical part is often the easiest thing, the most straightforward thing. The most challenging part of the medical interaction is the poverty," said Dr. Mitchell Katz at our 2013 conference on the ACA. Katz is the Director of the Los Angeles County Department of Health Services, one of the largest safety net hospital systems in the U.S.

Health care costs in the U.S. have increased significantly since 2000. In 2012, the average amount spent on personal health care was just over \$7,500, an increase of 55 percent over that figure in 2000.<sup>1</sup> During that period, health care costs as a percentage of GDP and the uninsured rate also grew.<sup>2</sup>

Care can be especially challenging for the poor, since not all of those who qualify for public coverage will be enrolled. We see one example of this among children, the most vulnerable population living in poverty. In the 2012 Centers for Disease Control and Prevention National Health Interview Survey, 7.5 percent of poor children and 10.1 percent of near-poor children still went without coverage<sup>3</sup> even with expansions to programs like Medicaid and the Children's Health Insurance Program.

### POVERTY AND HEALTH POLICY

In times of rising inequality and declining real wages, access to health care is central to building the human capital necessary to have a chance of escaping poverty. Poverty research and poverty programs have long recognized poor health to be associated with low income. Indeed, poor health may be a consequence of poverty, a cause of poverty, or both.

The Center for Poverty Research is one of three national centers for poverty research funded by the U.S. Department of Health & Human Services. Our mission is to facilitate non-partisan academic research on poverty in the U.S., to disseminate this research and to train the next generation of poverty scholars.

Health policies are a central part of today's non-cash safety net, which is one of our four main areas of research. In this issue of *Poverty Research Now*, we offer a sampling of research, supported by the Center and produced by our affiliated scholars, that shows the many connections between health and poverty.

— Ann Huff Stevens, Director



Ann Huff Stevens is the Director of the Center for Poverty Research and Chair of the Economics Department at UC Davis.

Her research interests include the incidence and effects of job loss, understanding connections between economic shocks and health, and poverty dynamics.

Where health care and poverty intersect, affordable or subsidized insurance solves only part of the problem. Studies by our Research Affiliates have found that living in poverty in itself is associated with long-term health risks. One study found a strong association between childhood poverty and chronic illness in adulthood. Another found that low-income immigrant patients often have difficulties receiving patient-centered care despite hospital policies designed to serve them better.

Health care is an issue that touches every population we study, from low-income immigrants to the rural poor. With problems of this complexity, poverty research provides a starting point for removing barriers to a healthy life.

<sup>1</sup> Centers for Medicare & Medicaid Services. "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Calendar Years 1960-2012."

<sup>2</sup> U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2012."

<sup>3</sup> Covered at the time of the interview; poor=family income <100% of FPL, near-poor=family income 100-200% of FPL; Centers for Disease Control and Prevention. "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2012."

Our research agenda spans four themed areas of focus: Labor Markets and Poverty; Children and the Intergenerational Transmission of Poverty; The Non-traditional Safety Net, focusing on health and education; and Poverty and Immigration

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## POVERTY DURING ADOLESCENCE MAY PREDICT LONG-TERM HEALTH

Growing up in poverty may impact more than the chance of a better financial future. The stress of early life poverty may in fact be associated with serious health problems well into adulthood. Ongoing research by Graduate Student Fellow Natalie Troxel and Research Affiliate Paul Hastings examines the association between poverty and compromised adult health, which may have implications for healthcare costs in the U.S.

The human body is constantly adapting to environmental stresses, like being exposed to flu viruses at work or being caught in rush-hour traffic. The body copes with these stresses by adjusting the activity of immune, neurological, metabolic, and other biological systems. Constant adjustments, however, can have a negative impact on long-term health.

In this study, indicators of poor health, including high blood pressure, elevated glucose levels and being overweight, were combined into a single index of risk for health problems. Neighborhood affluence, neighborhood safety and family resources during childhood and adolescence together accounted for 4.5 percent of the differences in health risk indexes 15 to 20 years later. The results included controls for gender.

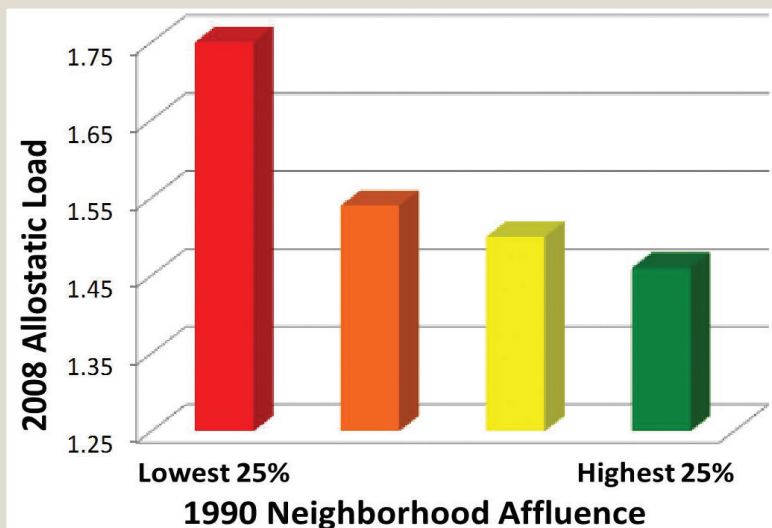
Extended out to the hundreds of millions of people in the U.S., that figure has larger implications. Lower levels of neighborhood affluence in adolescence was the single strongest predictor of risk for later health problems.

Given the long-term costs of treating chronic illnesses, it is likely that many of these adults will remain economically distressed throughout their lives. Chronic health problems may create a negative feedback cycle, which increases the likelihood that their children will also suffer health problems.

These analyses suggest that it may be more effective and economical to interrupt this cycle by focusing interventions on neighborhoods at risk, rather than focusing on specific at-risk youth or families.

**Natalie Troxel** is a Ph.D. candidate in Psychology at UC Davis.

**Paul Hastings** is Chair and Distinguished Professor of Psychology at UC Davis.



*“Allostatic load” is a measure of wear and tear on the body caused by constant adaptation to stress. Individuals from the least-affluent neighborhoods (in red) had the highest levels of allostatic load, indicating that they may also have the highest risk for chronic health problems.*

*Data source: 1990 U.S. Census Data, Quartiles for Neighborhood Affluence*

## PUBLIC INSURANCE MAY REDUCE THE INCENTIVE TO WORK AMONG CHILDLESS ADULTS

Public insurance can provide needed medical coverage to those who cannot afford it. Considering that private insurance is often bound to employment, a public option could have an impact on the labor market if it reduces incentives to work. This new study, supported in part by a 2012 Center for Poverty Research Small Grant, finds that public health insurance may lead to lower rates of employment and earnings among low-income childless adults. These findings may have implications for the Affordable Care Act.

In Wisconsin, the state’s public health insurance program, the BadgerCare Core Plan, led to a 2.4 to 10.5 percentage-point decline in quarterly employment rates among low-income childless adults for up to nine quarters following enrollment. The net effect of insurance enrollment on earnings, including those who lost or changed jobs, was a reduction of approximately \$125 to \$445 of income per quarter. Early results also show that childless adults not enrolled in public health insurance were more likely to change jobs.

The majority of those with private health insurance nationwide have coverage through their employers.

This would indicate that an accessible public health plan would lead to more job transitions. Early results in this study suggest the opposite: applicants waitlisted for the BadgerCare Core Plan were more likely than enrolled applicants to have changed jobs.

Policymakers should be aware of possible reductions in labor supply among childless adults with the ACA’s Medicaid expansion. However, extrapolating from Wisconsin’s experience may not be straightforward. Medicaid is an entitlement program while the BadgerCare Core Plan was not. Under Medicaid, individuals would be free to exit and reenter the program as their eligibility changes. Differences in requirements for coverage under the Core plan versus Medicaid may also be important.

**Thomas DeLeire** is a Professor of Public Policy at Georgetown University. His research focuses on labor and health economics.

*This study was supported by a Center for Poverty Research Small Grants Award, which every year funds new work by scholars across the country working in all social science disciplines.*

## ROLE MODELS MAY LEAD TO POORER HEALTH

Health problems such as diabetes are often considered the result of genetics or individual choices. Less frequently do we consider the impact that our network of family, friends and co-workers can have on how we manage our health. In a new study, Visiting Graduate Scholar Elyse Kovalsky found that individuals often measure their own health by comparing themselves with others in their social networks, which may contribute to health disparities in the U.S.

One way people assess their own health is to compare themselves with available role models within their social networks of family, friends and co-workers. Individuals create distance between their own health and that of role models by pointing out differences in specific behaviors and decisions.

The study found that people most frequently make comparisons with negative role models, identifying others who take worse care of their health. Some participants offered economic explanations for others' poor diabetes health, citing economic constraints such as lack of access to doctors or medication.

Comparing oneself to embedded role models at the individual level may

have implications at the community level, especially in areas with a high prevalence of health conditions like diabetes. Research suggests that people are most likely to be connected with others who are similar along many dimensions, including ethnicity and social class. Because of this, social networks may contribute to larger-scale health inequalities by encouraging these kinds of comparisons.

For policymakers, health providers and researchers interested in reducing health disparities and improving the health of the most disadvantaged members of society, it is critical to understand the impact social networks have on health, as well as opportunities for intervention. Public health campaigns and initiatives to address health disparities should acknowledge these role models in their health messaging. Health providers can also inquire about their patients' embedded role models, and can discuss the range of tools a patient has for assessing his or her health.

**Elyse Kovalsky** is a Ph.D. candidate in Sociology at Northwestern University and was a 2012 Visiting Graduate Scholar at the Center for Poverty Research.

## ETHNIC CONCORDANCE MAY NOT PROMOTE PATIENT-CENTERED CARE

In recent years, ethnic concordance—matching the ethnicity of healthcare workers to that of their patients—has been promoted as an important measure for achieving “patient-centered care” for minority patients in the U.S. A new study by Research Affiliate Ming-Cheng Miriam Lo and Graduate Student Fellow Roxana Bahar found that among low-income immigrants, ethnic concordance may actually introduce unexpected problems into clinical communications.

Patient-centered care encourages greater partnership between patients and healthcare workers. Proponents of ethnically concordant care—matching the ethnicity of healthcare workers to that of their patients—argue that shared cultural beliefs and social experiences encourage mutual trust and respect, which assures patient-centered care.

This study finds that ethnic concordance may facilitate direct communications between patients and co-ethnic health workers, but does not automatically promote patient-centered care. Low-income immigrants want patient-centered care but often have little voice in deciding treatment options. Ethnic concordance can also introduce additional problems, especially when medical staff is perceived to engage in “social distancing”, or when patients link their doctors' professional ethics and competence to their race.

Co-ethnic healthcare workers, like any healthcare workers, must actively engage in open-ended communication and treat patients with compassion and respect. It is noteworthy that not a single patient in this study considered better “matching” with providers or staff (e.g., same race, same national origin, same gender, etc.) to be more important than open and patient-centered communication. Instead, they emphatically expressed the desire to be respected and listened to, preferably through direct communication.

**Ming-Cheng Miriam Lo** is a Professor of Sociology at UC Davis.

**Roxana Bahar** is a Ph.D. candidate in Sociology at UC Davis.

## CONFERENCE ON AFFORDABLE CARE AND POVERTY



*Laura Schmidt, Professor of Health Policy at UCSF presents findings about the health system in post-Katrina New Orleans.*

In 2013 the Center hosted top health care experts from across the country to discuss the rollout of the Affordable Care Act (ACA) and what the health care expansion means for poor and low income families in the U.S.

Presenters at the conference, held in November at UC Davis and open to the

public, considered the ACA from diverse perspectives, including access to care, how hospitals will implement the reform, as well as broader impacts on personal finances and labor markets.

Conference keynote speaker Mitchell Katz said he thinks about the ACA's impact in terms of both health insurance reform and health system reform. Katz is the director of the Los Angeles County Department of Health Services, which serves more than ten million residents, about one million of whom have no medical insurance.

“I'm more interested in health system reform, and I think that's the part that's going to affect more low-income people,” he said.

“Health care access, health and socioeconomic status are very much related to the Center's work,” said Center Director Ann Huff Stevens.

## U.S. HEALTH CARE COSTS, INSURANCE & POVERTY 2000 – 2012

**2000:** The national uninsured rate is 13.7%. Per capita amount spent for personal health care in the U.S. is \$4,128.<sup>1</sup>

**2002:** Tennessee's TennCare Medicaid waiver is extended to 2010. The program began in 1994, replacing the state's fee-for-service model with a managed-care model to reduce health care costs. In 1995 enrollment reached 1.2 million residents.

**2006:** Massachusetts mandates minimum health coverage for nearly every resident, requires most employers to provide coverage and provides free insurance for residents earning less than 150% of the federal poverty level. That year, 9.6% of residents had no coverage.

**2006:** Of children under 18 in the U.S., 11% are uninsured. Of those, 29.5% live in poverty.<sup>2</sup>

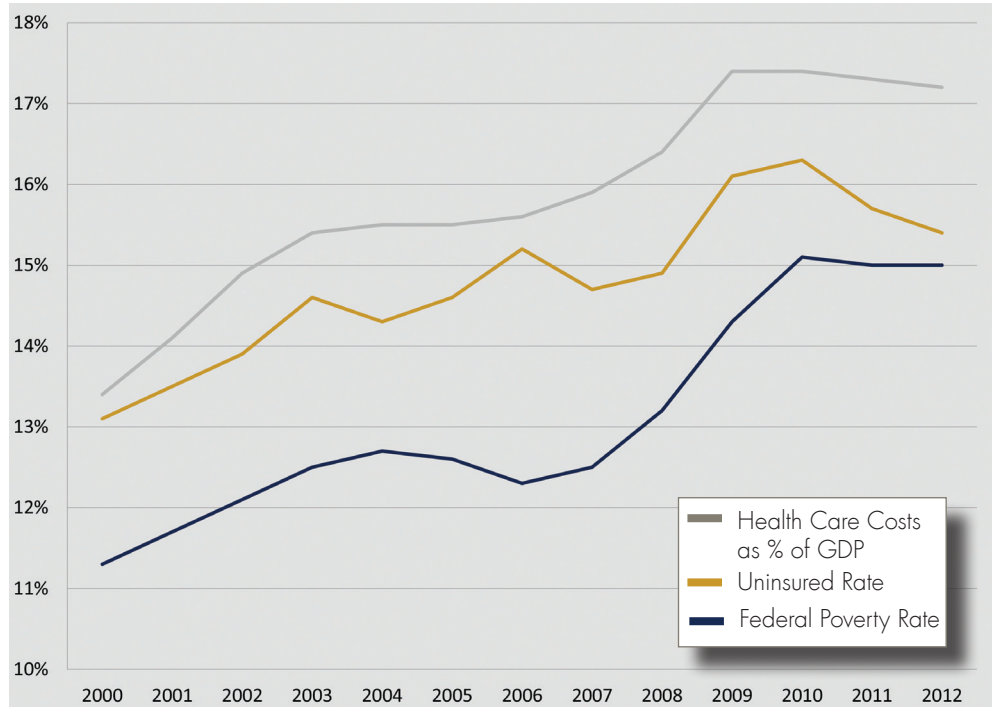
**2008:** Oregon expands Medicaid to 30,000 of its residents on the waiting list. A 2013 study found the coverage to generate no significant improvements in measured physical health in the first two years, but did increase use of health care services, raised rates of diabetes detection and management, lowered rates of depression and reduced financial strain.<sup>3</sup>

**2009:** Wisconsin launches the BadgerCare Core Plan to provide health insurance to adults without dependent children who have incomes below 200% of the Federal Poverty Line.<sup>4</sup>

**2009:** Congress reauthorizes the Children's Health Insurance Program (CHIP), which includes \$100 million through FY 2013 for outreach to children who are eligible but not enrolled.

**2010:** Wisconsin's BadgerCare enrollment is suspended in October after applications immediately exceeded the program's budget. By December the waitlist reaches 89,412.<sup>4</sup>

**2010:** National uninsured rate is above 16%. The average annual amount an individual in the U.S. pays for personal health care is \$7,097.<sup>5</sup>



Sources: U.S. Census Bureau; Centers for Medicare & Medicaid Services.

**2010:** The ACA ends pre-existing condition exclusions for children and lifetime limits on coverage, allows parents to cover children up to 26 years old and ensures a patient's right to appeal their insurance company's denial of payment for care.

**2011:** ACA requires insurance companies to spend at least 80% of premiums on medical care. Medicare participants can get key preventive services for free, and also receive a 50% discount on brand-name drugs in the Medicare "donut hole."

**2011:** Vermont establishes Green Mountain Care to provide public care coverage for all residents. It will expand state Medicaid in 2014 to cover households with incomes up to 133% FPL.

**2012:** The rate of uninsured in Tennessee: 13.9%; Massachusetts: 4.1%; Wisconsin: 9.7%; Oregon: 15.4%; Vermont: 7%.<sup>6</sup> The national uninsured rate: 15.4%. Of children under 18, 9% are uninsured; of those, 32% live in poverty.<sup>2</sup>

<sup>1</sup> 2012 dollars, Centers for Medicare & Medicaid Services, 2013

<sup>2</sup> U.S. Census Bureau. 2013. "HIB-8. Health Insurance Coverage Status for Children Under 18 in Poverty: 1999 to 2012."

<sup>3</sup> Katherine Baicker et. al. (2013) "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine*. 368:1713-1722.

<sup>4</sup> Thomas DeLeire. (2014) "State Public Insurance Reduced the Incentive to Work among Childless Adults." UC Davis Center for Poverty Research Policy Brief.

<sup>5</sup> 2012 dollars, Centers for Medicare & Medicaid Services, 2013.

<sup>6</sup> U.S. Census Bureau. "Health Insurance Coverage Status and Type of Coverage by State—All Persons: 1999 to 2012."

## ABOUT THE CENTER

The Center for Poverty Research at UC Davis was founded in the fall of 2011 with core funding from the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services.

We are one of three federally designated poverty research centers in the U.S. Our mission is to facilitate non-partisan research on U.S. poverty, disseminate this research, and train the next generation of poverty scholars.

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