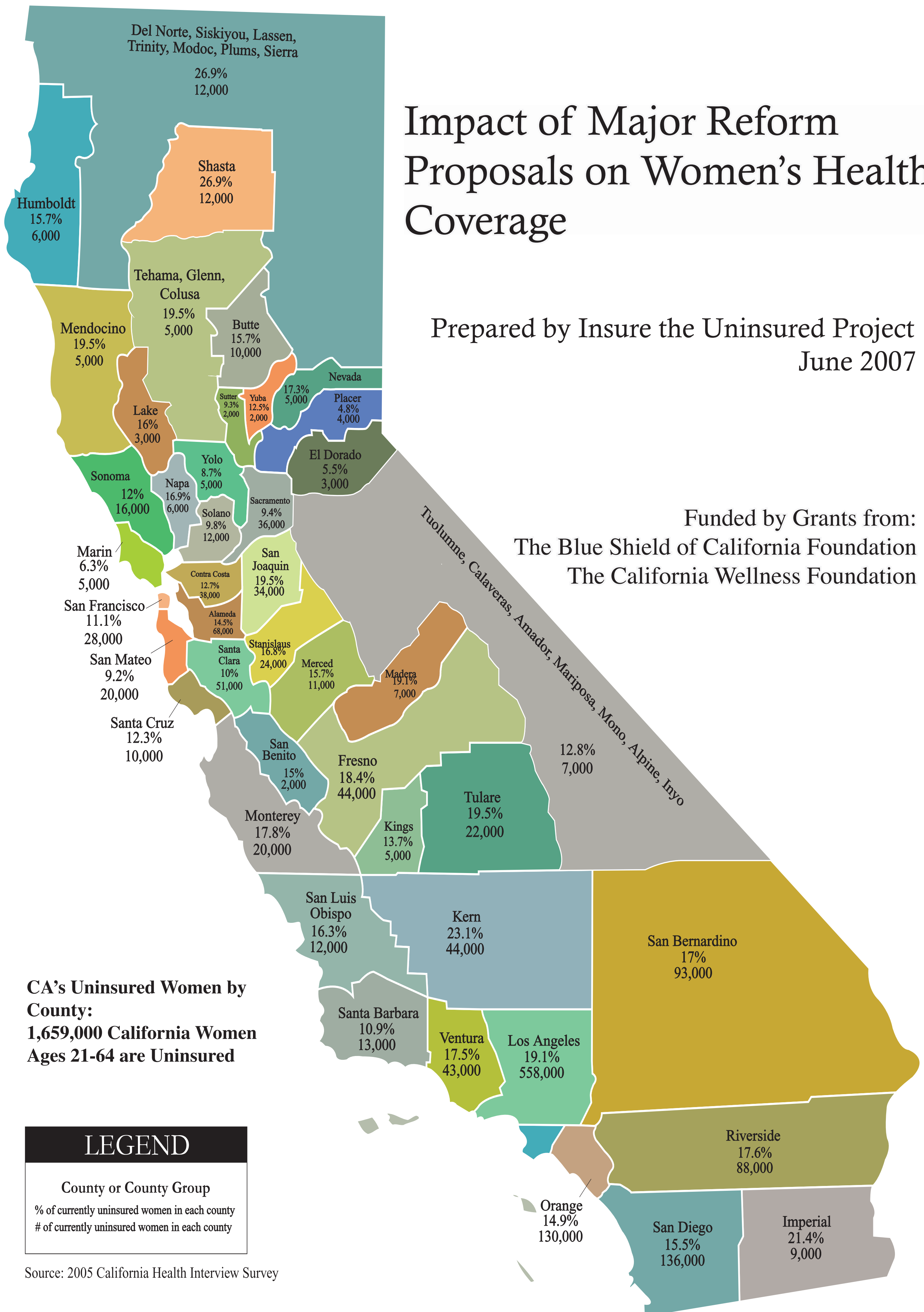

Impact of Major Reform Proposals on Women's Health Coverage
Prepared by Insure the Uninsured Project
June 2007
Funded by Grants from:
The Blue Shield of California Foundation
The California Wellness Foundation
Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plums, Sierra
26.9%
12,000
Shasta
26.9%
12,000
Humboldt
15.7%
6,000
Tehama, Glenn, Colusa
19.5%
5,000
Butte
15.7%
10,000
Mendocino
19.5%
5,000
Lake
16%
3,000
Sutter
9.3%
2,000
Yuba
12.5%
2,000
Nevada
17.3%
5,000
Placer
4.8%
4,000
El Dorado
5.5%
3,000
Yolo
8.7%
5,000
Sonoma
12%
16,000
Napa
16.9%
6,000
Solano
9.8%
12,000
Sacramento
9.4%
36,000
Marin
6.3%
5,000
Contra Costa
12.7%
38,000
San Joaquin
19.5%
34,000
San Francisco
11.1%
28,000
Alameda
14.5%
68,000
San Mateo
9.2%
20,000
Santa Clara
10%
51,000
Stanislaus
16.8%
24,000
Merced
15.7%
11,000
Madera
19.1%
7,000
Tuolumne, Calaveras, Amador, Mariposa, Mono, Alpine, Inyo
12.8%
7,000
Santa Cruz
12.3%
10,000
San Benito
15%
2,000
Fresno
18.4%
44,000
Tulare
19.5%
22,000
Kings
13.7%
5,000
Monterey
17.8%
20,000
San Luis Obispo
16.3%
12,000
Kern
23.1%
44,000
San Bernardino
17%
93,000
CA's Uninsured Women by County:
1,659,000 California Women Ages 21-64 are Uninsured
Santa Barbara
10.9%
13,000
Ventura
17.5%
43,000
Los Angeles
19.1%
558,000
Riverside
17.6%
88,000
LEGEND
County or County Group
% of currently uninsured women in each county
# of currently uninsured women in each county
Orange
14.9%
130,000
San Diego
15.5%
136,000
Imperial
21.4%
9,000
Source: 2005 California Health Interview Survey

Insure the Uninsured Project

Insure the Uninsured Project's (ITUP) fundamental goal is to increase health coverage of California's 6.6 million uninsured. ITUP regional workgroups seek to develop consensus on local efforts to cover the uninsured. Our goal is to support local decision makers in their efforts to simplify and expand coverage for the uninsured. Each year, ITUP releases reports on 48 counties, six California regions, and a statewide overview reflecting comparative data and trend analysis. These reports aim to inform local decision makers on critical matters. The reports form the foundation for ITUP's regional workgroups and annual conference. ITUP was founded in 1996 and is a project of the Center for Governmental Studies. ITUP has been supported through a series of grants from the California Wellness Foundation, Blue Shield of California Foundation, The California Endowment, LA Care Health Plan, and project-specific grants from the California HealthCare Foundation.

Insure the Uninsured Project
2444 Wilshire Blvd., Suite 415
Santa Monica, CA 90403
Phone: 310-828-0338
Fax: 310-828-0911
Email: info@itup.org
www.itup.org

ITUP

INSURE THE UNINSURED PROJECT

IMPACTS OF PROPOSED HEALTH REFORMS ON WOMEN'S HEALTH COVERAGE

In this paper Insure the Uninsured Project (ITUP) reviewed six separate health reform proposals to increase health coverage of California's uninsured. We assessed how they will increase coverage for uninsured women and how they interface with existing programs that pay for care to uninsured women.

The starting points for our policy recommendations are whether care and coverage for uninsured women are improved. We reviewed the impacts of the reform proposals on eligibility, benefits, affordability, choice of providers, maternity coverage, family planning, breast and cervical cancer screening and treatment, chronic diseases, county health programs and multi-cultural and linguistically accessible care. Each section closes with ITUP's policy recommendations.

In this report, we refer to women with incomes below the poverty level as low income, women with incomes from 100% of poverty to 300% of the federal poverty level (FPL) as moderate income and women with incomes over 300% of FPL as higher income.

We include separate appendices with an analysis of impacts on uninsured women of the proposed reforms, a matrix of the six state reform efforts, a review of existing state and county programs for uninsured women, and a sampling of health plans' cost of health coverage.

The opinions expressed here are those of Insure The Uninsured Project alone and not those of any other entity. We thank the Blue Shield of California Foundation and The California Wellness Foundation for their support in funding this paper.

1. Eligibility

Background

Over 1.6 million California women aged 21-64 lack insurance at a point in time:

- 72% have incomes below 250% of the federal poverty level (slightly over $25,000 for a single woman, $50,000 for a family of four),
- 80% are US citizens and legal permanent residents,
- 52% are employees, 48% are not, primarily taking care of children at home.[1]

1 UCLA Center for Health Policy Research, California Health Interview Survey (2005).

Proposals[2]

Governor Schwarzenegger's proposal will cover all California women through shared responsibility financing from individuals, employers, employees, counties, the federal government and providers. It will be a mixed system of several forms of public coverage and many forms of private employment based and individual health coverage. It is the only proposal with an individual mandate.

All women will be required to secure coverage.

- Low income women below poverty will be covered through Medi-Cal.
- Moderate-income women from 101% to 250% of FPL will be covered through a subsidized commercial insurance product, purchased through MRMIB (Managed Risk Medical Insurance Board).
- Women with incomes over 250% of FPL ($25,000 for a single woman, $50,000 for a family of four) will be required to purchase coverage through their employers or the individual market.[3]
- Undocumented women will be covered through private coverage or in some county health systems

Senator Kuehl's bill will cover all California women through a tax financed single payor system. Private and public providers will deliver the services, the state will pay their bills on a fee for service basis as Medicare now does for persons over age 65; private health insurance for the most part will disappear. All women will be covered regardless of income or immigration status.

Senator Perata's measure will cover working California women and families through shared responsibility financing from employers, employees, and the federal government.

- Low income parents below poverty will be covered through Medi-Cal managed care.

---

2 We reviewed each proposal and where we had questions called the author's staff for clarifications. These proposals are works in progress and subject to change and modification. Many of the provisions are interesting concepts without much specificity in their descriptions and legislative language. This is particularly true of the Senate Republican proposals. We relied on language, plus written summaries and descriptions, plus communications with legislative staff in seeking to decipher the concepts in all six measures. We used the version of each measure as of June 1, 2007.

3 Minimum benefits are Knox-Keene coverage, plus prescription drugs with a deductible of not more than $5,000, with maximum out of pocket protection of $7500 for an individual and $10,000 for a family.

- Moderate-income working[4] women from 100% to 300% of FPL will be covered through a subsidized Healthy Families or Medi-Cal like insurance product, purchased through MRMIB.
- Women with incomes over 400% of FPL ($40,000 for a single woman, $80,000 for a family of four) will be required to purchase coverage through their employers or the individual market; their obligation to purchase coverage is capped at 5% of income; women with only retirement incomes are exempt.
- Counties will continue to be responsible for care to low-income women who do not have other coverage.

Speaker Nunez's bill will cover California's working women through shared responsibility financing from individuals, employers, employees, counties, the federal government and providers. It will be a mixed system of several forms of public coverage and many forms of private employment based and individual health coverage.

- There is no individual mandate requiring women to purchase coverage, but there is a requirement for working women to accept coverage offered by an employer.
- Coverage expansion will begin with all children and working families.
    - Low income parents below poverty will be covered through Medi-Cal managed care.
    - Moderate-income uninsured working women from 100% to 300% of FPL will be covered through a subsidized insurance product, purchased through MRMIB and financed by Medi-Cal, employers and employees.
    - Working women with incomes over 300% of FPL ($30,000 for a single woman, $60,000 for a family of four) will be required to accept coverage offered through their employers or through the purchasing pool operated by MRMIB.

The Senate Republican proposal will increase coverage for uninsured women by expanding tax deductibility and favorable tax treatments, particularly for Health Savings Accounts (HSAs) and high deductible plans and giving health plans increased regulatory flexibility to offer more affordable plans with greater patient out of pocket responsibilities.

---

4 For these purposes, working women include those employed full or part-time and those with employed spouses. Past proposed reforms such as SB 2 would have covered the employees of mid sized employers, but not their dependent family members and did not apply to small employers or to many part-time workers. It appears that self-employed women are not eligible for the premium subsidy up to 300% of FPL but are subject to the mandate if they have incomes above 400% of FPL.

The Assembly Republicans proposals would also increase coverage for women by expanding tax deductibility for HSAs and high deductible plans. These proposals also would give health insurers greater regulatory flexibility in plan design so that they can offer lower cost products.

Table 1: Average Federal Health Benefit Tax Expenditure Per Family, 2004[5]

Family Income	Average Annual Benefit from Tax Expenditures for Health Coverage
$10,000 to $20,000	$292
$20,000 to $30,000	$725
$30,000 to $40,000	$1,231
$40,000 to $50,000	$1,448
$50,000 to $75,000	$2,134
$75,000 to $100,000	$2,640
Over $100,000	$2,780

Policy Recommendation: *There should be coverage for all women with significant simplification of the current maze of public and private programs and eligibility rules.[6] The state should support expanded coverage for uninsured low income women through both public and public-private (shared responsibility) programs and increased support for coverage of higher income uninsured women through stronger, better targeted tax policies[7] and better affordability and accountability in the private sector. Mandates (individual and/or employer) will cover many more women than voluntary efforts will.*

Expanded tax deductibility somewhat increases affordability of coverage for higher income uninsured women, but will be singularly ineffective in increasing coverage for lower income unin-

5 Sheils and Haught, The Cost of Tax-Exempt Health Benefits in 2004, Health Affairs, Web Exclusive (February 25, 2004)

6 In California, each program has its own eligibility rules, application and eligibility process. This is difficult and confusing for most women and families to navigate. We would urge a simplified application and process, swift and computerized processing, bright lines and easy hand-offs between programs and one application that suffices for all programs for which individuals may be eligible.

7 Tax deductibility has little impact in increasing coverage for the uninsured because the benefits inure primarily to higher income individuals who already are insured. Large, targeted, refundable tax credits or vouchers are more effective in covering the uninsured than tax deductibility. The Heritage Foundation had an interesting proposal in the early 90s to turn the federal tax benefits for health coverage upside down so lower income individuals would receive the largest assistance and higher income individuals the least. See S. Butler, "A Policy Maker's Guide to the Health Care Crisis: the Heritage Consumer Choice Health Plan (Heritage Foundation 1992)

sured women. The state of California should support federal efforts to equalize the tax treatment (i.e. tax deductibility) of individual coverage; however this will have little impact on expanding coverage for most uninsured women. (See above chart on distribution of federal tax expenditures)

Expanding public and public-private programs will be most effective at increasing coverage for low and moderate uninsured working women.

- *The state of California should expand the Healthy Families program to cover moderate-income (100-250% of FPL) working women in families with available federal Medicaid matching funds under Section 1931b.*
- *The state of California should seek federal matching funds through an 1115 waiver and take over responsibility from the counties for coverage of low and moderate women without minor children living at home.*[8]
- *The coverage expansion proposals should apply to self-employed working women in the same degree as employed women.*[9]

2. **Affordability (premiums, co-pays and deductibles)**

Background

California women pay for health coverage for themselves and others through state, federal and county taxes[10], and they pay out of pocket for health premiums[11], copays and deductibles[12]. These out of pocket burdens have been increasing at rates faster than the rise in worker's wages, but

---

8 Section 1115 waivers have been granted to cover low-income adults not otherwise eligible for Medicaid in an array of states, including Oregon, Arizona, Hawaii, New York, Vermont, Massachusetts, Tennessee and Delaware. Los Angeles County received a §1115 waiver to pay for outpatient care to uninsured low-income adults in 1995. Other states, such as Minnesota, Washington and Pennsylvania cover low income adults with state funds and no federal match. Minnesota and Washington rely on provider assessments, comparable to the Governor's proposal to finance their programs.

9 Speaker Nunez and Senator Perata's measures would subsidize coverage for moderate income working women, but not the self-employed.

10 Taxes pay for roughly half of US health spending.

11 The cost of premiums for employment based coverage and individual coverage for the self employed are partially offset by tax deductibility, tax sheltering and the advantages of pre-tax purchasing, Table 1 graphs the income distribution of favorable federal tax policies for private health insurance and spending.

12 Deductibles and copays are not typically tax sheltered or tax deductible unless expenses exceed 7.5% of income; however HSAs allow tax sheltering for the amount deposited in the health savings account.

slower than the over-all rise in health spending.[13] Consumer directed health care is an over-all strategy to slow the overall growth in health spending by increasing consumer out of pocket responsibilities.

There is an explicit cost trade-off between higher patient out of pocket burdens and lower monthly premiums for employers and individuals. Increasing co-pays and deductibles shifts the cost of health care to those individual women who need care and services the most. See table below.

Table 2: Individual Plan Monthly Premiums - 2007

Los Angeles

Health Plan	***25 year-old female, single***	***35 year-old female, single***	***55 year-old female, single***	***25 year-old female, married, children***	***35 year-old female, married, children***	***55 year-old female, married, children***
HMO Products						
Kaiser-$30 Copay/$2700 Deductible Plan with HSA option	$68	$99	$205	$201	$267	$480
Kaiser-$25 Copayment Plan	$202	$242	$394	$704	$797	$895

Small employer and individual premiums no longer vary by the gender of the worker; however individual insurance can be purchased with or without maternity benefits at a significant premium reduction for younger individuals. Actuarially the most significant gender variation is for young women as the costs of maternity coverage are assigned to women rather than shared between men and women. See Woolhandler and Himmelstein, Consumer Directed Health Plans, Except for the Healthy and Wealthy, It's Unwise.

Families and older women face unique affordability challenges. Premiums for women, ages 50-65, are roughly three times the premiums for women 20-30 years of age. Premiums for family coverage are roughly three times the premiums for individual coverage. See table below.

Table 3: Individual Plan Monthly Premiums - Los Angeles[1]
2007

Health Plan	***25 year-old female, single***	***35 year-old female, single***	***55 year-old female, single***	***25 year-old female, married, children***	***35 year-old female, married, children***	***55 year-old female, married, children***

13 Kaiser Family Foundation/Health Research and Educational Trust, Survey of Employer Sponsored Health Benefits at www.kff.org.

PPO Products						
Blue Shield-Shield Spectrum PPO Savings Plan 4000/8000 (HSA eligible plan)	$52	$96	$301	$164	$303	$661
Blue Shield-Shield Spectrum PPO Plan 5000	$61	$108	$285	$197	$322	$627
HMO Products						
Blue Shield-Access+ Value HMO	$198	$263	$422	$599	$786	$979

Proposals

Governor Schwarzenegger's proposal seeks to reduce premiums for insured women and improve affordability of their coverage by reducing the cost shift or hidden tax on private health insurance to pay for providers' uncompensated care to uninsured and Medi-Cal patients.

Under the Governor's proposal uninsured women would pay for an increasing share of their health care costs as their incomes rise.

- Women who are uninsured with incomes below 100% of FPL would pay no premiums or deductibles and would pay nominal co-payments under Medi-Cal for all but preventive services.
- Moderate-income uninsured women (101%-250% of FPL) would pay sliding fee scale premiums ranging from 3-6% of income and modest but unspecified copays and deductibles.
- Uninsured women with incomes in excess of 250% of FPL ($25,000 for a single woman) would be mandated to buy coverage with subsidies only through tax deductibility and tax sheltering and have the option to choose among high deductible plans with low premiums or low and moderate deductible plans with significantly higher premiums.

Senator Kuehl's bill would replace premiums, deductibles and copays with income and payroll taxes and modest copays. Higher income women would pay significantly more and lower income women would pay substantially less under this reform than they do now; uninsured women would pay more for comprehensive health coverage than they now do out of pocket for their

health care.[14]

Under Senator Perata's bill, uninsured low income parents would pay no premiums, copays and deductibles; uninsured moderate income working women (100-300% of FPL) would pay modest premiums and copays. The scope of premiums, copays and deductibles for women over 300% of FPL is unspecified as the coverage is to be developed by MRMIB. MRMIB is directed to develop three different tiers of copays, deductibles and premiums for the uniform benefits package. The basic premiums for basic coverage through the pool are as set forth in Table 2 and 5 in Appendix A. Women would pay for the incremental cost of more expensive plans they choose to purchase through the pool. No limits on consumers' out of pocket costs are placed on commercial coverage purchased either individually or by employers outside the state purchasing pool.[15] A woman's obligations to purchase coverage under the individual mandate are capped at 5% of a woman's income; retirees and women with incomes less than 400% of FPL are exempt.

Under Speaker Nunez' bill, uninsured low-income parents would pay no premiums, copays and deductibles; uninsured moderate income working women (100-300% of FPL) would pay modest premiums and copays consistent with the Healthy Families program. Uninsured working women over 300% of FPL would be covered through their employers or through the state purchasing pool, but with no subsidies. The scope of premiums, copays and deductibles for women over 300% of FPL is unspecified as the coverage is to be developed by MRMIB; MRMIB is directed to develop three different tiers of copays, deductibles and premiums for the uniform benefits package. The basic premiums for basic coverage through the pool are as set forth in Table 2 and 5 in Appendix A. Women would pay for the incremental cost of more expensive plans they choose to purchase through the pool. No limits on out of pocket costs are placed on commercial coverage either purchased individually or by employers outside the pool. Women are required to accept employer sponsored coverage, where offered (rather than opting for public coverage); some form of Medi-Cal wrap-around coverage would be available for women with incomes up to 300% of FPL to offset any increase in out of pocket costs or reduction in covered benefits.

The Senate Republican proposal seeks to increase affordable coverage by increasing tax deductibility for high deductible plans and HSAs. This approach trades lower premiums for higher exposure to out of pocket costs. The HSA features, if funded, offset the increased out of pocket exposure. The proposal directs both the Department of Managed Health Care and CalPERS to

---

14 Sheils and Haught, The Health Care for All Californians Act: Cost and Economic Impacts Analysis (The Lewin Group. January 2005) and Sheils, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California (The Lewin Group, March 2002)

15 Employee Retirement Income Security Act (ERISA) precludes California from regulating employers' self-insured plans, but permits the states to regulate commercial insurance bought by individuals or employers. However too inflexible state regulation of private insurance could lead more employers to self-insure.

enhance regulatory flexibility for High Deductible Plans. The proposal would change Medi-Cal to more closely resemble commercial coverage: greater patient cost sharing, fewer benefits and higher provider reimbursement rates. The Assembly Republican proposal is comparable, and it includes a voluntary health savings account (HSA) for Medi-Cal families.

Policy Recommendation*: Increasing patient cost sharing for low income individuals has demonstrated bad health and financial outcomes: less use of preventive and primary care services and delays in seeking treatments until the condition worsens and becomes more costly to treat.[16] Properly targeted copays and deductibles for those with sufficient incomes can create appropriate financial incentives to use more cost effective and clinically effective services and treatments and deter unnecessary use of care.[17] Increased cost sharing for higher income patients has reduced health costs without shown adverse health outcomes.[18] Adjusting cost sharing burdens by income, by clinical and cost effectiveness of services and treatments and capping cost sharing for the chronically ill could create a more cost effective system with better health outcomes.*

The proposals by the Governor, Speaker and Senate President would use a percentage of wages or income to set cost sharing in public coverage, which is an important advance to assuring affordability; they do not regulate cost sharing in unsubsidized employer plans outside the state purchasing pool, where premiums in commercial coverage for families, persons aged 50-65 and low-income workers are particularly unaffordable.[19] There is little that the state can do through legislative actions to correct employer and health plan practices with respect to employees' out of pocket costs that would be effective.[20] Private employers could correct these imbalances by adjusting employee premium shares from a percentage of premiums to a percentage of employee wages as Pitney Bowes and some other large employers have done.[21] The state could subsidize premiums for those low and moderate-income individuals, employees and families whose premium contributions exceed a specified share of income as the Governor, Speaker and Senate President's proposals have proposed for low and moderate-income women. The Speaker's bill improves affordability for most low and moderate-income women outside the purchasing

---

16 JP Newhouse and the Insurance Experiment Group, Free for All? Lessons from the RAND Health Insurance Experiment, Harvard University Press 1993.

17 Ibid. See Buntin et al. Consumer directed Health Plans: Early evidence about the Effects on Price and Quality, Health Affairs October 24, 2006.

18 Ibid.

19 See chart on page 5.

20 ERISA (Employee Retirement Income Security Act) preempts the state from regulating employer decisions as to how to apportion the costs of health coverage. States can regulate insurance, and some propose pure community rating – a single composite rate – to equalize the costs of coverage for younger and older workers. Pure community rating would shift premium burdens from older to younger workers who in general make less, cost less, and have less coverage than older workers; it is not recommended in this paper.

21 Benefit Based Copays in the Real World: the Employer Perspective, American Journal of Managed Care vol. 12 no. 13 (November 2006).

pool through its offer of wrap around coverage.

Giving greater incentives for high deductible plans and HSAs shifts affordability burdens from the point of purchasing coverage to the point of seeking care; it could both increase coverage and reduce access to preventive medical services and physician visits, particularly for those women who become ill and most need medical care.[22]

3. **Scope of benefits**

Background

Medi-Cal has the lowest per capita cost, pays the least to private providers and covers the broadest set of benefits (including vision, dental and mental health services) while commercial coverage costs significantly more and Healthy Families is in the middle in terms of both cost and the extent of covered benefits (dental, vision and limited mental health benefits are covered in Healthy Families). The essential price differences between Medi-Cal, Healthy Families and commercial coverage are due to: provider reimbursement rates, provider delivery networks and tightly managed care.

Fee for service coverage is more costly than HMO coverage for comparable benefits due to the tighter utilization controls and incentives in HMOs. However fee for service plans with substantial cost sharing typically cost less than HMOs, which use much less cost sharing. (See chart)

Table 4: Individual Plan Monthly Premiums - Los Angeles 2007

	25 year-old female, single	***35 year-old female, single***	***55 year-old female, single***	***25 year-old female, married, children***	***35 year-old female, married, children***	***55 year-old female, married, children***
PPO High Deductible Product						
Blue Shield-Shield Spectrum PPO Plan 5000	$61	$108	$285	$197	$322	$627
HMO Products						
Blue Shield-Access+ Value HMO	$198	$263	$422	$599	$786	$979

Individual coverage costs more than employment-based coverage for a comparable benefits

22 A $5000 deductible plan would leave a woman with $30,000 in annual income at risk for 16% of her gross annual income (or 20% for women with annual incomes of $25,000).

package due to the higher costs of individual selling and plan administration, medical underwriting, as well as adverse selection – the decision to purchase coverage only when needed.[23] Individual coverage, for women other than the self-employed, lacks the favorable tax advantages that employment based coverage enjoys. Small employer coverage is more expensive than coverage for large employers for a comparable benefits package due to the higher costs of selling and plan administration for small employers.[24]

Proposals

Under Governor Schwarzenegger's proposal, women who are uninsured with incomes below 100% of FPL would receive Medi-Cal. Moderate-income uninsured women (100%-250% of FPL) would receive subsidized basic coverage of Knox-Keene benefits plus prescription drugs through plans contracting with MRMIB. Uninsured women with incomes in excess of 250% of FPL would be required at a minimum to purchase catastrophic coverage (i.e. $5000 deductible coverage for a Knox-Keene benefits package plus prescription drugs) through their employer or in the individual market. Women who are undocumented and not otherwise insured would receive county health services in those counties that provide care to the undocumented.

Senator Kuehl's bill would cover comprehensive benefits comparable to Medi-Cal (with the exception of long term nursing home care) through a fee for service system.

Under Senator Perata's bill, uninsured low income parents would qualify for Medi-Cal managed care benefits; uninsured moderate income working women (100-300% of FPL) would qualify for Healthy Families like benefits from plans contracting with MRMIB. The scope of benefits for women over 300% of FPL is unspecified as the coverage is to be developed by MRMIB. There will be three tiers of benefits and women will be expected to pay for the incremental costs if they select the more expensive coverage options. Prescription drug benefits must be covered as part of commercial coverage purchased within but not outside the pool.

Under Speaker Nunez' bill, uninsured low-income parents would qualify for Medi-Cal managed care benefits; uninsured moderate income women (100-300% of FPL) would qualify for Healthy Families like managed care benefits. The scope of benefits for women over 300% of FPL is unspecified as the coverage is to be developed by MRMIB. Prescription drug benefits are part of commercial coverage purchased in the pool by employers and employees. Women would be required to accept employer sponsored coverage, where offered, rather than opting for public

---

23 See Gabel et al, Trends in the Golden State: Small Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet, Health Affairs (June 14, 2007). The study points out that 83-85% of premiums went for benefits in small group coverage; while only 55% of premiums went to the cost of claims in individual coverage in 2002, a sharp drop from 75% in 2002.

24 Congressional Research Service, Insuring the Uninsured (1989)

coverage. Medi-Cal wrap around will fill in the benefit gaps and offset higher copays and deductibles for working women up to 300% of FPL both in and out of the pool.

The Senate Republican measure proposes to reduce the scope of benefits for Medi-Cal to benefits equivalent to commercial coverage[25] in order to fund an increase in Medi-Cal provider reimbursements to Medicare levels. It also proposes increased regulatory flexibility for health plans with respect to "co-payments, deductibles, mandates and benefits". The measure proposes to increase both regulatory flexibility and tax deductibility for HSAs and high deductible (or catastrophic) coverage, which may lead some uninsured higher income women to purchase coverage and some insured higher income women to reduce their scope of covered benefits. The Assembly Republican package is comparable.

***Policy recommendation**: All California women should have coverage for the basic (Knox-Keene) package of covered services plus prescription drugs. Low-income women need broader benefits[26] with lower levels of cost sharing than do higher income women who have more disposable income to pay for benefits out of pocket. Women with serious and/or chronic illnesses need a broader, more comprehensive benefits package than do healthy women. The Medi-Cal and Healthy Families benefit packages are far more appropriate for the health and economic needs of low and moderate-income women than are catastrophic coverage or limited benefit packages or even standard commercial coverage.*

The underlying argument for reducing the scope of currently covered benefits is the assumption that coverage results in increased costs due to higher utilization and higher provider prices. Reducing the scope of covered benefits (e.g. high deductible plans) is one of many possible approaches to controlling rising health costs. The biggest potential danger in this approach is the diminution in the use of preventive and primary care services that are essential to the maintenance of good health. Another potential danger in this approach is that disaggregating covered benefits between healthy and less healthy women may lead to a "premium death spiral" for more comprehensive coverage, as only those individuals who most immediately need the broader coverage retain it.

Catastrophic coverage is important to protect the financial well-being of subscribers and their medical providers, while coverage for preventive and primary care is far more important to maintaining and improving health status of subscribers. To maximize health outcomes and financial security for women, a benefits package should include primary care, preventive services and catastrophic coverage. Some options for consideration are: 1) front-loaded coverage with low copays and deductibles but a low annual maximum expenditure cap, 2) doughnut coverage with a package of low or no co-pay preventive and primary care services combined with catastrophic coverage, 3) state assumption of risk/responsibility

---

25 Commercial plans are less likely to cover dental and vision services and more likely to have higher co-pays and deductibles. There is as yet no specificity as to what services would be reduced.

26 For example, higher income women can typically afford the costs of new eyeglasses or a dental cleaning out of pocket, whereas low-income women often cannot; low-income women with poor eyesight without glasses face serious challenges at the work site and in the home.

for catastrophic expenses above a certain dollar amount and 4) Healthy Families coverage.

4. Choice of delivery networks and providers

Background

Over half of young, uninsured low and moderate-income women lack a usual source of care; thirty percent use community clinics or county clinics and a fifth see a private doctor(s) in their own offices.[27] Insured women choose their own doctors, but typically within a delivery network under Medi-Cal managed care or commercial coverage.[28]

There are geographic, trust, cultural and linguistic preferences important in selecting a primary care provider and delivery network. Many health plans exclude or restrict participation by physicians based on their willingness to negotiate favorable prices and meet plan standards for quality care. As a general proposition, Medi-Cal managed care plans include most safety net delivery systems and have more limited participation by private practitioners, while commercial plans are the opposite, strongly dominated by private providers with limited safety net provider participation. Many private doctors choose not to participate in Medi-Cal due to its lower payment rates, creating severe access challenges in rural areas and for certain specialties. Healthy Families plans offer a mix of commercial and safety net delivery systems.

Proposals

Governor Schwarzenegger's proposal would increase choice of doctors for uninsured women by offering Medi-Cal or subsidized commercial coverage for uninsured low and moderate-income women and by requiring health plans to guarantee issue coverage to women excluded due to a pre-existing medical condition. It would increase choice of doctors for current Medi-Cal enrollees by increasing reimbursement rates to Medicare levels.

Senator Kuehl's measure would increase choice of doctors by returning to a fee for service medicine that reimburses doctors at the same state established rates for all their patients. There would be few organized delivery networks as private insurance and most HMOs would be eliminated.

Speaker Nunez' and Senator Perata's bills would increase choice of doctors for uninsured women by offering Medi-Cal or a subsidized Healthy Families plan for low and moderate income working women and unsubsidized coverage from a state purchasing pool for uninsured women with incomes in excess of 300% of FPL.

The Senate Republican and Assembly Republican proposals would increase choice of doctors by increas-

27 Center for Health Policy Research, California Health Interview Survey (2005).

28 Doctors can choose to participate or not in Medi-Cal, in HMOs, as a preferred provider in a PPO; some choose not to accept any insurance; their patients must pay cash for their doctor's charges and seek reimbursement (if available) from their insurer.

ing tax deductibility for HSAs and high deductible plans (typically fee for service coverage); these will primarily benefit higher income uninsured women for whom state tax deductibility provides a meaningful financial incentive. The proposals will also increase Medi-Cal payments (and enrollee access) to doctors to levels comparable to Medicare payments while reducing Medi-Cal covered benefits to levels comparable to commercial coverage.

Policy recommendations:
Increasing Medi-Cal rates is a high priority to improve low-income women's choice of doctors, as physician rates (other than for OB services) under Medi-Cal have been nearly flat for twenty-five years.[29] *Low and moderate income women would accept tightly managed care if out of pocket payments are minimized, while higher income women would generally prefer broader choice of providers and accept a trade-off for higher premiums and out of pocket responsibilities.*[30]

5. **State programs for maternity services**

Background

Between Medi-Cal and AIM (Access for Infants and Mothers),[31] California covers maternity services for all pregnant women up to 300% of FPL and pays for over 40% of deliveries. Fewer than 4% of California's births are to uninsured women, indicating that outreach, coverage and enrollment efforts for perinatal care and coverage have been successful. Both programs have federal matching. The two programs are somewhat different.

- AIM is a commercial style of coverage and covers all health services to the pregnant woman.
- Medi-Cal pregnancy only coverage covers only pregnancy related services; it pays providers on a fee for service basis.
- Medi-Cal also encompasses the Comprehensive Perinatal Services program (CPSP) that pays for health education, nutritional and psycho-social counseling that reduces the risks of poor birth outcomes for high risk women.

Proposals

Governor Schwarzenegger's proposal would fold a portion of AIM and Medi-Cal pregnancy only services into state subsidized programs purchasing coverage for individuals and families with incomes up to 250% of FPL. Undocumented women would be the responsibility of the counties; however the state would continue its Medi-Cal pregnancy only coverage. Women with incomes over 250% of FPL would be required

---

29 Most of the benefits from the increase inure to private doctors and hospitals as most community clinics and public hospitals are already reimbursed at cost.

30 Ginsburg, M. et al, Deconstructing Basic Benefits: Citizens Define the Limits of Coverage Health Affairs, November-December 2006, and Ruth Helman, Public Attitudes on the US Health Care System, EBRI Issue Brief #275 (November 2004).

31 Medi-Cal covers perinatal and pregnancy related services for women, regardless of immigration status up to 200% of FPL. AIM covers perinatal and other health services for women, between 200% and 300% of FPL –i.e. $40,000 to $60,000 for a family of four.

to purchase commercial coverage with not more than a $5000 deductible, and the coverage would be guaranteed issue.

- Among the questions needing attention are:
  1) how does AIM for women 250-300% of FPL interface with the commercial high deductible coverage for women who become pregnant;
  2) how does Medi-Cal pregnancy only coverage for undocumented women interface with county programs for undocumented women,
  3) how does Medi-Cal, AIM and CPSP fee for service pregnancy only coverage interface with state subsidized commercial coverage for women with incomes 100-250% of FPL and
  4) are maternity benefits part of the minimum benefits package for women with incomes over 250% of FPL; are they subject to the $5000 deductible and are they guaranteed issue as well?

Speaker Nunez' and Senator Perata's proposals would cover maternity and other health benefits for women in working families with incomes up to 300% of FPL through state subsidized purchasing pool coverage, but would not cover non-working women. It would seem logical to fold in a portion of AIM and Medi-Cal pregnancy only coverage for women who would otherwise end up with coverage through two programs; this is not specified in the bill. Senator Perata's would also mandate that women over 400% of FPL purchase coverage.[32] It is likely that maternity benefits with low or no copays are meant to be covered for higher income women covered through the pool, but this will be determined in part by MRMIB. The Speaker's bill will require women to take employer-sponsored coverage with a wrap around administered by MRMIB to assure affordability and coverage of basic benefits.[33] The definitions and details of how the covered benefits wrap around will work is left to the Managed Risk Insurance Board; it is likely, but unspecified, that maternity benefits in this model will include low or no copay prenatal care.

The tax incentives in the Senate Republican package could provide additional financial help and incentives for higher income women seeking to purchase coverage, including maternity benefits. The de-regulatory components of the package for health plans are not yet specified but mention greater flexibility for less costly benefit designs; it is uncertain whether this would give commercial health plans greater flexibility to design and market coverage that exclude maternity benefits (this would allow plans to substantially reduce premiums and increase affordability but could lead to a decline in maternity coverage).

***Policy recommendations**: AIM and Medi-Cal pregnancy only benefits should be merged into full scope benefits for uninsured women who become insured through either the state purchasing pools or expanded Medi-Cal and Healthy Families coverage. There is no good reason to require multiple program applications and uncoordi-*

---

32 Maternity coverage is a mandated benefit for employer sponsored coverage and for individual HMO coverage; it is not a mandated benefit for individual insurance coverage. Furthermore in the individual market, a health plan can deny coverage to a pregnant women as a pre-existing medical condition, unless the woman is protected by HIPAA.

33 Wrap around coverage would presumably reduce the copays and deductibles to Medi-Cal levels and include CPSP services, such as health education, nutritional and psycho-social counseling. This may prove complex to administer since it requires the program administrator to fill in the gaps of commercial coverage on an individual by individual basis.

nated delivery systems for low and moderate-income women, as one of the biggest challenges for women, families and providers with the existing system is confusion about the multiplicity of programs and unforeseen gaps and traps in coverage.

Stand-alone maternity coverage through AIM and Medi-Cal should be retained for those women not otherwise covered or not yet enrolled in the Governor, Speaker and Senate President's proposals. Maternity coverage should be part of the minimum benefits package for state regulated individual coverage, employment-based coverage and subsidized coverage through purchasing pools and should be guaranteed issue coverage for all women required to purchase coverage.

Access to prenatal care should not be compromised by large deductibles and high co-pays as the increased risks and costs of bad birth outcomes are far too high a price for society to pay for the savings in premiums. Health plans should not be given increased flexibility to exclude maternity benefits or deny or delay or exclude coverage for pregnant women. Pioneering plans for the uninsured should be given the flexibility to mix and match[34] public and private coverage to increase coverage of uninsured women.

6. Impact on state programs for family planning services

Background

Family PACT covers family planning services for all uninsured women and men up to 200% of the Federal Poverty Level. There are unique family planning delivery networks in communities across the state. California receives a very favorable (90/10) federal match on family planning services; however recent changes in federal law through the Deficit Reduction Act have eliminated federal matching for some program participants.

Proposals

Governor Schwarzenegger. Speaker Nunez and Senator Perata's proposals would leave Family PACT as a stand-alone program, rather than incorporating it into the coverage expansions for uninsured women. In their proposals, family planning will be a minimum covered benefit for subsidized coverage purchased for women through the purchasing pools and there will be no or low copays. It is unclear whether Family PACT providers would be incorporated in the delivery network. It appears that family planning will be a minimum covered benefit for women with state regulated employment based or individual insurance coverage and for women required to purchase coverage; it is unclear to what extent copays and deductibles

---

34 "Mix and match" refers to the ability to create a product that consolidates existing public programs and new private coverage in expanding care to the uninsured. For example local health plans in Santa Clara and Los Angeles are trying to develop coverage for uninsured child care providers, mostly very small businesses and self employed women with a high rate of uninsurance. These pilots would be more affordable for younger child care workers if they can wrap around or supplement existing maternity benefits offered by AIM and Medi-Cal. San Francisco and San Mateo counties are developing coverage through their local health plans for all the uninsured up to 400% of FPL (San Mateo) and 500% of FPL (San Francisco), each of these plans would benefit from the ability to wrap around existing public coverage such as AIM and Medi-Cal. Current law prohibits designing private coverage in a manner designed to crowd maternity benefits into public programs.

may negate access to covered family planning services.

Senator Kuehl's measure would include family planning[35] as a covered benefit and incorporate the program and its funding. The service would be paid on a fee for service basis to all providers.

The tax incentives in the Senate Republican package could provide additional financial help and incentives for higher income women seeking to purchase coverage, including family planning services; however the incentives to purchase high deductible plans could leave more women with no coverage for family planning services. The de-regulatory components of the package are as yet unspecified, it is unclear whether this would give commercial health plans greater flexibility to design and market coverage that exclude family planning. The proposal to de-fund state programs that extend coverage to the undocumented is also unspecified; it is unclear if this impacts family planning services to undocumented women.

Policy recommendations: *Family PACT should be integrated into coverage for women enrolled in the coverage expansions and maintained as a stand-alone program for women not otherwise insured. Family planning services should be a part of the minimum basic package of services for all with employment based or individual coverage. There should be delineated a vital package of preventive services including prenatal care and family planning that must be exempt from high co-pay and deductibles.*

Pioneering plans for the uninsured should be given the flexibility to mix and match public and private coverage to increase coverage of uninsured women.[36]

7. **Impact on state programs for breast and cervical cancer screening and treatment (Breast Cancer Screening and Treatment Program, BCSTP, and Every Woman Counts)**

Background

California has existing coverage for breast cancer screening and treatment services for uninsured women with incomes up to 200% of FPL. California pays for cervical cancer screening in a similar fashion through the Every Woman Counts program. A portion of these programs is federally matched. There is an existing state mandate for health plans to cover preventive breast cancer screening services. Health and Safety Code §1367.6

Proposals

Governor Schwarzenegger, Senator Perata and Speaker Nunez' proposals would each leave breast cancer screening and treatment as a stand-alone program. Public subsidized coverage proposed in each plan for newly insured women would cover breast cancer screening and treatment. The Governor's proposed minimum benefit has a $5,000 deductible that would cover most cancer treatments but could leave screening

---

35 SB 840 should be clarified to specifically delineate coverage for family planning, screening and other preventive services.

36 See n. 35 above.

services at risk. The Speaker and Senate President have deferred the decisions on copays and deductibles for women with incomes over 300% of FPL through the state purchasing pool to the pool administrator; it is unclear how the tension between affordability and the extent of out of pocket responsibilities will be resolved by MRMIB.

Senator Kuehl's measure would include breast cancer screening and treatment as a covered benefit and incorporate the program and its funding. The service would be paid on a fee for service basis to all providers.

The tax incentives in the Senate Republican package could provide additional financial help and incentives for higher income women seeking to purchase coverage, including breast cancer screening and treatment services; however the incentives to purchase high deductible plans could leave more women with no coverage for breast cancer screening services. The de-regulatory components of the package are not specific as to what flexibility is desired and how it might impact preventive services such as breast cancer screening. The proposal to de-fund state programs that extend coverage to the undocumented does not specify which programs are at issue; it is unclear if this impacts breast cancer treatment services to undocumented women.

Policy recommendations: *BCSTP should be integrated into complete coverage for women covered through the coverage expansions and maintained as stand alone coverage for low income women not otherwise insured. A vital package of preventive services including breast and cervical cancer screening, prenatal care and family planning should be delineated and exempted from high co-pays and deductibles.*

Pioneering plans for the uninsured should be given the flexibility to mix and match public and private coverage to increase coverage of uninsured women.[37]

8. Chronic diseases

Background

Care for individuals with chronic diseases accounts for a very large share of health spending. Chronic diseases increase with age and with lack of access to appropriate primary and specialty care and preventive services.

Uninsured low income women with chronic illnesses typically receive episodic care in county systems (a substantial share of county health programs), but too often the episodic nature of the county care system does little to alleviate, improve or manage the underlying symptoms, resulting in avoidable hospitalizations, repeat visits to the ER, premature disability, loss of earning power and in some cases, preventable loss of life.[38] For uninsured women with chronic illnesses who are ineligible for county programs, the

37 See n. 35.

38 See N. Lurie et al. Termination from Medi-Cal -- Does it Affect Health, New England Journal of Medicine vol. 311

challenges are far worse; many forego care due to cost and access barriers, causing their conditions to worsen rapidly and too often irretrievably.[39] Several counties recently received federal coverage expansion grants ($180 million annually) from the state to improve coverage and care for uninsured patients with chronic illness.[40]

Health plans typically exclude women with chronic conditions where this is permissible under state law, such as in the individual market.

Proposals

Improved care for low-income women with chronic diseases is a feature of the Governor, Speaker and Senate President's proposals. This is achieved by expanding Medi-Cal and subsidized pool coverage for low-income women with a strong chronic disease care management component. County programs for the lowest income women will be transitioned into Medi-Cal managed care in the Governor's proposal, and county programs for moderate-income women will be transitioned into subsidized pool coverage. Senator Perata and Speaker Nunez' proposals leave county responsibility for non-working and self-employed, low income, uninsured women and leave all current county funding in place. The Governor's proposal leaves half of existing funding to fund county care (to the extent it exists) for undocumented women.[41]

The Governor's proposal could create the greatest change in existing county programs for women with chronic illnesses and has the greatest potential to improve chronic care to uninsured women because it extends public coverage to more uninsured women and assures greater continuity of care and coverage, by eliminating coverage gaps. Underwriting reforms in the Governor, Speaker and Senate President's plans would, with some differences, reform health plans' exclusions of women with chronic conditions.[42]

(Aug. 16, 1984), and Termination from Medi-Cal – One Year Later, New England Journal of Medicine vol. 314 (May 8, 1986).

39 Strunk & Cunningham, Treading Water: Americans' Access to Needed Medical Care, 1997-2001. Center for Studying Health System Change, 2002; Cunningham, Declining Employer-Sponsored Coverage: The Role of Public Programs and Implications for Access to Care. Medical Care Research and Review, Vol. 59, Issue 1, March 2002; Hoffman & Gaskin, The Cost of Preventable Hospitalizations among Uninsured and Medicaid Adults. Kaiser Family Foundation, 2001; Ayanian et al., The Relation between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer. The New England Journal of Medicine, Vol. 329, 1993; Roetzheim et al., Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes. American Journal of Public Health, Volume 90 Issue 11, 2000; Families USA, Getting Less Care: The Uninsured with Chronic Health Conditions. 2001; Moy, Bartman, Weir, Access to Hypertensive Care: Effects of Income, Insurance, and Source of Care. Archives of Internal Medicine, Vol. 155 No. 14, 1995; Ayanian et al., Unmet Health Needs of Uninsured Adults in the United States. JAMA, Vol. 284 No. 16, 2000; and Obrador et al., Level of Renal Function at the Initiation of Dialysis in the US End-stage Renal Disease Population. Kidney International, Vol. 56 No. 6, 1999.

40 J. Mannanal, Health Coverage Expansion Programs, Summaries of Selected Applicants (Insure the Uninsured Project (April 2007) at www.itup.org

41 Some counties exclude care for the undocumented, some counties cover emergency care for the undocumented and other counties, primarily those with county hospitals, care for undocumented women as they would for any other county resident. Between 16 and 20% of uninsured adults are undocumented persons.

42 Each proposal is somewhat different, in the extent of mandates and the accompanying individual market reforms.

Senator Kuehl's measure would include care for chronic conditions as a covered benefit and incorporate the county programs and their funding; it would reduce financial barriers to care by eliminating deductibles and reducing co-payments. The services would be paid on a fee for service basis to all providers. To improve the health outcomes efficacy of this fee for service open panel provider model, the bill should include disease management, pay for performance incentives and development and promotion of centers of excellence for treatment of chronic conditions, and it should give information about and incent patient participation in the most successful model programs.[43]

The Assembly and Senate Republicans plans include increased funding for MRMIP's program for the medically uninsurable. The tax incentives in the Senate Republican package could provide additional financial help and incentives for higher income uninsured women seeking to purchase coverage; however the incentives to purchase high deductible and catastrophic coverage plans could leave women with chronic conditions no coverage for the types of early and low cost intervention services most important to treating their chronic conditions. The de-regulatory components of the package for health plans are not specified; the bill does mention increasing "rate flexibility in the small employer markets"; it is unclear whether this refers to efforts to give commercial health plans greater flexibility to increase premiums for women with chronic conditions or to reduce premiums for women who enroll and participate in successful models. The de-regulatory components of the package could improve access to lower cost community-based providers.

***Policy recommendations**: Effective models of treating women's chronic conditions include pay for performance, centers of excellence in the treatment of the conditions, targeted disease management, continuity of providers and coverage, and appropriate financial incentives for patients and providers, and these elements should be present in all the proposals. Model programs and pilots in clinics and counties for uninsured women need to be retained, built upon and spread as part of the reform efforts.*

High deductible, high co pay plans, while affordable, are not efficacious for the treatment and management of chronic conditions.

The Governor's proposal has an individual mandate with guaranteed issue with variations limited to age, family size and geography. Senator Perata's proposal effectively has an individual mandate for employees and the self-employed and guaranteed issue with similar features to the Governor's proposal; his proposal adds an interesting concept to stop consumer gaming; subscribers can upgrade or downgrade coverage only in the month of their birthday and can only change up or down one class of coverage each year so that a person cannot contract a costly illness and then promptly switch from a high deductible plan to one with low co-pays and deductibles. Speaker Nunez' proposal has an employee mandate; his proposal beefs up funding for coverage of the medically uninsurable in MRMIB, and curtails plan rejections for minor conditions. Neither the Speaker not Senate President's proposals cover individuals not in the workforce. The Speaker's proposal does not assist the self-employed, who comprise a large share of the individual market. Minnesota has one of the best pools for the medically uninsurable; it is financed by an assessment on all private health insurance.

43 SB 840 has general language with respect to improving the quality and performance of the health system.

Women with chronic illnesses are not well served by being excluded from private coverage due to their medical conditions; either a large increase in funding for MRMIP (Major Risk Medical Insurance Program)[44] or guaranteed issue of coverage in the individual and mid sized employer markets is necessary to assure their coverage.

9. Multi-cultural and linguistically accessible health care

Background

California is home to many diverse immigrant communities from around the globe; some immigrant women are fluent in English and some are not. As a result community clinics and some county health programs have developed programs with unique cultural and linguistic capacities to communicate with and care for diverse immigrant communities. Some public Medi-Cal managed care plans and some commercial plans have developed special expertise and capacities in communicating with and caring for immigrant patients, and some have not yet. Each county has a different demographic make-up and enrollment in coverage and very different needs for multi-cultural and linguistic services.

The uninsured immigrant women who are now treated in these unique systems could lose access to their trusted sources of care if they are covered by a plan whose provider networks lack the requisite linguistic and cultural skills.

Policy recommendation*: In Medi-Cal, Healthy Families and the subsidized pool for moderate income uninsured women at least one contracting plan should have a local network of providers with the requisite cultural and linguistic capacities and information should be developed and available so subscribers are familiar with the capacities of the plans, providers and networks they select. Commercial networks have strong financial incentives to develop networks with the necessary communication skills as insured immigrants use covered services less than insured citizens.*[45]

10. County health services

Background

Each of California's 58 counties has a health care program for uninsured women who are medically indigent adults – i.e. low income women without minor children living at home.[46] Each county sets its own

---

44 Legislative Analyst's Office, Health Coverage for the Hard to Insure (December, 2005) at www.lao.ca.gov Two thirds of MRMIP subscribers have incomes in excess of 300% of FPL. Nearly 60% of subscribers are women. Subscribers must pay premiums at least 25% higher than individual market premiums, and nearly half of disenrollees report they discontinued coverage due to the high cost of premiums.

45 Waidmann and Ahmad, The Potential Role for Bi-National Health Insurance and Other Options in Meeting the Needs of the Uninsured Immigrant Population (Urban Institute, June 2006), and Goldman et al, Immigrants and the Cost of Medical Care, Health Affairs (November/December 2006)

46 There are five distinct types of programs:

eligibility criteria, which range from at or near the federal poverty level to as high as 500% of FPL. Counties also set their own residency requirements; some provide care to undocumented women, some do not, while others pay only for emergency care to undocumented women.[47]

Counties determine their own delivery networks; some include only public hospitals and clinics; some only have private hospitals and doctors. Some block grant their funds to a single local hospital. Free and community clinics are a part of some counties' delivery networks and excluded elsewhere.[48]

Funding for county health includes state and county funding and in some counties (primarily those with public hospitals) federal funds as well.[49]

Proposals

The Governor's proposal seeks to cover all but undocumented women and would divert half of realignment and federal funds to help pay for the state's new program for uninsured women. The Speaker and Senate President's measures would cover working women, leave care for the non-working women to county governments and leave all state and federal funds with the counties.

The Senate Republican plan would switch federal and state funding for the uninsured from hospital to clinic based services and would eliminate state funding in some as yet unspecified programs that pay for care to the undocumented.

- payor counties, such as Orange, pay private providers who deliver the care;
- provider counties, such as Los Angeles and San Francisco, pay their own county owned and operated facilities who deliver the care;
- hybrid counties, such as Tulare, pay private hospitals for hospital-based services and operate their own public clinic systems;
- block grant counties, such as Fresno, contract with a local hospital for a lump sum payment for their care to the uninsured, and
- CMSP counties, such as Imperial, operate a Medi-Cal like program that pays private providers and clinics on a fee for service basis for care to the county indigent.

47 In general, the public hospital county facilities are open to all county residents, regardless of immigration status, while payor counties exclude the undocumented. CMSP counties pay for emergency services to undocumented women, in a fashion comparable to Medi-Cal.

48 Alameda and Los Angeles (through its public-private partnerships) are examples of counties with a heavy reliance on the community clinic infrastructure for care to the uninsured.

49 Counties use all or parts of state realignment ($1.5 billion) and Prop 99 ($26 million), SB 12 ($57 million), county match ($341 million) , tobacco litigation settlement ($419 million) and federal DSH (Disproportionate Share Hospital, $1 billion), Safety Net Care Pool ($586 million) and new Coverage Expansion funds ($180 million) to pay for care to the uninsured. Counties spend at least $1.8 billion on care to 1.4 million users of county indigent health services. Slightly more than half the expenditures are for care to women, who in county systems use inpatient and emergency services somewhat less than men and use outpatient services somewhat more.
Counties also provide public health services to their residents regardless of income and immigration status at a net county cost of $577 million.

Policy recommendation: *Funding should follow patients; as the state takes over responsibility for coverage for uninsured women, the funding should follow.*[50] *County and clinic safety net delivery systems should be afforded ample opportunity to participate in the state managed care programs for the uninsured and a period of transition.*[51] *Managed care will require county systems to evolve and develop a greater emphasis on and access to clinics, primary care, continuity and efficacy of care, and identification and management of patient costs.*

California should seek an 1115 waiver, as other states already have, to secure federal Medicaid matching for care and coverage to uninsured low- income women.[52] *Existing state and county funding should serve as the state match to the maximum extent permissible under federal law.*[53]

11. Mental health treatments

Background

Counties have programs, funding and responsibility for mental health care to low income uninsured women. These programs are separate and distinct from county health programs. Medi-Cal has followed a similar model; contracting with county mental health on a capitated basis for mental health services to Medi-Cal eligible women. At the operational level, there is little coordination between county physical and mental health programs to the detriment of providers and patients with a mixture of mental and physical health conditions.

Healthy Families and commercial coverage have a different model that integrates mental health and medical coverage, but place numerical limits on some mental health inpatient and outpatient services.

Proposals

The proposals from the Governor, Speaker and Senate President follow the Healthy Families and commercial plan model offering integrated but limited mental health services. They make no changes in county mental health programs, nor do they build upon them.

Senator Kuehl's measure would cover all mental health services on a fee for service basis.

---

50 Counties are very concerned that the state will take the funding and that state administrative obstacles will impede enrollment, leaving the county providers in extremis.

51 Counties with public hospitals want to retain their vital roles in the delivery system. Even in payor counties, such as San Diego or Orange, there are intricate funding and delivery of care arrangements that will take time to transition into a managed care model.

52 Nearly a dozen states, including Massachusetts, New York, Arizona, Vermont and Oregon, have 1115 waivers to cover indigent adults with federal matching funds.

53 There are many different forms of county match: a straight percentage of expenditures (New York), certified public expenditures (California's hospital and coverage expansion waiver) and intergovernmental transfers or IGTs (California prior to the 2005 waiver). The federal government is disallowing IGTs (Intergovernmental Transfers) wherever possible, maintaining the matches are illusory. Federal rules do not permit states and counties to use federal funds to match federal funds, to double match, to double dip or to use foundation or other private funds as the match. States can use bona fide provider taxes/assessments as a match under certain circumstances; California agreed not to use provider taxes as a match during its five year hospital waiver, approved in 2005.

The proposals of the Assembly and Senate Republicans make no changes in county mental health programs and may give health plans greater, but unspecified flexibility for mental health coverage.

Policy recommendations*: Consideration should be given to re-connecting local mental and physical health services for low-income women. The state should consider seeking a §1115 waiver to secure a match for mental health services for low income uninsured women using current county mental health spending as the state match.*