OVERVIEW OF PUBLIC AND PRIVATE EFFORTS AND OPPORTUNITIES

TO INCREASE COVERAGE FOR

CALIFORNIA's WORKING POOR

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by

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INTRODUCTION

This is a review of public and private efforts to cover California's uninsured working poor.

Uninsured employees work for both large and small businesses at both high and low wage levels. They are concentrated among:

1. very small businesses, including the self employed,
2. retail and construction,
3. low wage work forces,
4. part time, provisional, temporary or seasonal employment (the flex workforce)
5. persons changing jobs or going from welfare to work (the frictionally uninsured) and
6. in Southern California and rural counties.

To cover California's uninsured, two problems must be solved: affordability and structure.

Affordability is a problem because:

- Two thirds of the uninsured have incomes below 200% of the federal poverty level.
- Health premiums represent a high percentage of total compensation for low wage workers.
- The tax advantages of employer based coverage are highly regressive, providing little subsidy for low wage workers.
- The employee contribution is usually structured in a regressive fashion, which is particularly unaffordable to young, low wage working families.
- There is often no public or private contribution towards the cost of transitional coverage for those changing jobs or moving from MediCal to work -- the frictionally uninsured

Structure is a problem because:

- There are high "non-benefit" costs associated with marketing and administering individual and small business coverage, and half the employed uninsured work for small business or are self employed.
- We lack effective structures to purchase coverage for the flex workforce -- part time, seasonal, temporary, construction, migrant and other workforces who frequently change jobs, and half the employed uninsured are in the flex workforce or are self employed.

We will discuss four separate functions entailed in covering the uninsured in this paper:

1. PAYOR: who pays for care or coverage
2. REGULATOR: regulating the market conduct of health plans and providers
3. HEALTH PLANS: organizing the delivery of care
4. PROVIDER: delivering care.

STATE OF CALIFORNIA

The state of California is both a payor and a regulator. It funds providers, counties and health plans through a multiplicity of disconnected programs and different revenue streams for care to its 6.5 million uninsured and 5 million MediCal patients. It also regulates the counties, health plans and providers that deliver care. It neither delivers nor organizes care.

California's distinguishing feature is the lack of connection between its programs and lack of accountability attached to its revenues for the uninsured. Their multiplicity, variability and differences make it unusually difficult for counties, plans, or providers to construct a sensible delivery system for the uninsured. The positive is the extent of California funding and different programs for the uninsured.

State Programs for the Uninsured

Program	Eligibility	Impact/Results	Amount (Year) and Source
MediCal	Pregnant women and infants up to 200% FPL Children age 1-6 up to 133% FPL, ages 6-18 up to 100% FPL Adults with categorical linkage to AFDC/TANF, SSI	Insures 5 million California residents Covers almost 50% of all births. Covers over 50% of poor and 20% of near poor	$18 billion (1997-8); 50/50 federal/state funds
Healthy Families	Uninsured children 2-18 not eligible for MediCal; family income 100-200% FPL; nominal premium payments	50,000 children covered at an average overall cost of $75 pmpm	$200 million from federal and state funds (1998-9)
Child Health and Disability Prevention (CHDP)	Children <21 up to 200% FPL	Provides 500,000 screening exams annually and follow up treatment for uninsured children	$70 million (1997-98 estimate) from state funds
California Children's Services (CCS)	Children with qualifying conditions in families up to $40,000/yr.	Covers full services and case management for MediCal, uninsured and privately insured children with qualifying conditions	$85 million from state funds
AIM (Access for Infants and Mothers)	Pregnant women and infants <2 up to 300% FPL	Served cumulative total of 27,000 pregnant women	$45 million from Proposition 99 funds and $2.5

		and 23,500 infants since 1992	million from beneficiary share of premiums (1996-7)
Major Risk Medical Insurance Program (MRMIP)	Medically uninsurable individuals rejected by commercial carriers	Served 18,000 cumulative total of otherwise uninsurable persons since 1991	$40 million from Proposition 99 funds (1996-7) to subsidize subscriber premiums ($44 million)
Genetically Handicapped Persons Program (GHPP)	Adults, otherwise uninsured/uninsurable, with certain qualifying congenital conditions	Serves approximately 800 persons with unusual and high cost medical care needs	$11 million (1996-97) from state funds
County Health	Indigent adults	Serves over 1.5 million medically indigent individuals	$1.15 billion in state realignment funding (1997-8)

Healthy Families

Eligibility

Healthy Families covers uninsured children in working families with incomes over the MediCal program limits, but less than 200% of the federal poverty level. Eligibility is redetermined annually, and coverage is continuous for a year. It excludes those eligible for MediCal, for private insurance, new immigrants and the undocumented.

An estimated 400,000 children are potentially eligible for Healthy Families. Anticipated enrollment by the end of 1998-9 is 200,000. As of December 17, 1998 about 51,000 children had enrolled. San Francisco, San Joaquin and Shasta are all having comparatively greater success with enrollment. Southern California counties with high percentages of uninsured such as Los Angeles and San Diego are having much lower than expected enrollment.

23% of enrollees were Asian/Pacific Islanders and 40% Latino. While Latino immigrant communities have been particularly reluctant to enroll, Asian communities have had better than anticipated enrollment. African American enrollment also appears to be low -- 3.5% of enrollees.

INS policy is becoming somewhat clearer that receipt of Healthy Families by children will not constitute a public charge.

Employer participation

The legislation provides a purchasing credit for families with uninsured children who opt to have their children covered through their employer. MRMIB has not implemented this option believing that the

legislative provisions are unworkable.

Family Coverage

The federal legislation provides an option to extend coverage to the entire family provided it is cost effective. California has not taken this option. To make this option cost effective, the state, the county or the employer and employee must contribute the added premium cost for coverage of parents.

Financing

The program is financed with federal SCHIP funds, a state match and subscriber premiums. California's matching ratio is 2/1; the state has nearly $850 million in available federal matching funds for the first few years of the program, which will decrease to $550 million thereafter. The program's budget for FY 1998-9 is $197 million. The state expects to spend about 60% of its federal allotment when the program is fully implemented.

Outlook:

The program is neither fish nor fowl, neither government coverage, nor employment based coverage -- the two dominant forms of coverage in California for the working poor. Rather it is subsidized individual insurance, an untested model. Its relationships and linkages to MediCal and employment based coverage are critical. "Crowd in" of both MediCal and employment based coverage is a real possibility, on which there is as yet no reliable information.

MediCal

MediCal, California's version of the federal Medicaid program, covers over 5 million Californians -- half of the state's poor and 20% of the state's near poor. It is a welfare based program, whose eligibility rules have become so complex as to defy common description and understanding. While low wage workers participate in MediCal, particularly for hospital based care, it was initiated as a welfare program, and would need to be revamped to make it accessible to low wage workers and their employers. The poverty level working population is significantly underenrolled in MediCal for a variety of reasons, including the welfare stigma. There are no provisions for employers or employees to buy into MediCal.

Eligibility

MediCal covers the low income uninsured with categorical linkage, i.e. children and some parents, the aged, disabled. Single adults, childless couples and traditional two parent working families are excluded from MediCal eligibility. Undocumented immigrants have coverage for emergency and perinatal care only.

Income eligibility levels and asset rules vary depending on age:

- Income levels are set at the federal poverty level for older children, at 133% of FPL for the younger children, and lower than 100% of FPL for parents. For pregnant women and infants up to age one, the income levels are 200% of FPL.
- There are no asset tests for children and pregnant women.
- The state's medically needy and spend down programs allow those with higher incomes to qualify for MediCal, they are of major importance in paying for hospital care to the working poor, but are underutilized and poorly designed to pay for outpatient care.
- MediCal's work income disregards assure that only an employee's net income is counted in determining eligibility; however the financial work incentives of the SSI and AFDC programs do not apply to the rest of MediCal eligibles.

In 1997, California passed legislation to increase MediCal eligibility for uninsured, low income children by: eliminating the asset test, increasing eligibility income levels to 100% of poverty, and simplifying the application process. The state did not take the federal options for presumptive and continuing eligibility for MediCal children.

An estimated 670,000 uninsured children (most of them children of the working poor) are now potentially eligible for, but not enrolled in, MediCal. Anticipated enrollment by the end of 1998-9 is 200,000. As of December 15, 1998, it is believed that about 30,000 children had enrolled.

California also passed legislation implementing the federal government's restrictions on public assistance coverage for immigrants and AFDC/TANF mothers and children. It was not anticipated that either change would have an impact on MediCal eligibility (as California's MediCal rules remained largely unchanged); however, it has.

After more than twenty years of steady growth, the numbers of MediCal eligibles have fallen throughout the state. The decline has been about 6% (300,000) between 1995 to 1998. This is likely due to a number of intertwining factors: the impacts of state and federal actions on immigrants' perceptions and fears about enrolling in government programs, the decline in TANF enrollment as a result of welfare to work, and the improving state economy.

California provides transitional coverage for some TANF families transitioning to work, but has not opted to implement most of the federal options for continuing eligibility of those enrolled in managed care. Few families transitioning from welfare to work use the existing option. It is unknown why this is so.

California has not implemented the new opportunities under federal for higher income thresholds and income disregards under §1931 or for coverage of two parent working families.

Applications and the eligibility process

The MediCal application process is complex, costly and a major deterrent to achieving eligibility, especially for outpatient care and services to the working poor. MediCal's application process and eligibility rules are linked to the application processes and rules for AFDC, TANF and SSI. SSI and TANF eligibles are automatically enrolled in MediCal; all others must separately apply.

County welfare offices take and process MediCal applications and all eligibility requirements must be documented and verified. Once enrolled, eligibility is redetermined quarterly, and children's coverage is maintained for only one month during transitions to Healthy Families. The mail in application process and shorter, simpler application for uninsured children do not apply to the rest of the program.

Delivery networks

MediCal has several different managed care programs; some are mandatory and others voluntary. Most families whether working or on welfare in the state's thirteen largest counties are required to participate in managed care. MediCal's managed care programs are different from those under either Healthy Families, AIM or the state HIPC.

- Some counties such as Alameda, Los Angeles and Santa Clara are *dual choice* between a county plan and a commercial plan.
- Some are *multiple choice* (such as Sacramento and San Diego) from a range of competing commercial plans.
- Some are *single choice* (such as San Mateo, Orange and the other County Organized Health System

(COHS) counties). In the single choice counties, all MediCal eligibles must participate in managed care; they choose their providers from the COHS network.

Institutional Subsidies

MediCal provides a range of significant institutional subsidies for community clinics, public hospitals and other safety net providers to extend care to the working poor. DSH is scheduled to decline and FQHC to decline and ultimately expire under federal law changes mandated in the Balanced Budget Act.

SB 855 (DSH)	$1.1 billion
SB 1255	$909 million
FQHC	$200 million
Emergency only (undocumented)	$630 million
Pregnancy only (up to 200% of poverty)	$335 million
Medically Indigent Children	$390 million
Medically Needy Families	$756 million
SB 1732	$60 million

Financing

MediCal is financed with federal Medicaid funds, and a one for one state match. Local governments may match as well. For specific programs and services, such as case management, SB 1255 and DSH, California's counties pay the match. California has over $9 billion in federal matching funds and a smaller amount of state and county match. The program's budget for FY 1998-9 is over $18 billion**.**

Recommendations for change:

1) Develop the connections among state, federal and county health programs for low income persons so that program eligibles access and maintain coverage seamlessly.

2) Healthy Families

Make the connection between the program and employers and use it to increase employment based coverage
Count only net available income in determining program eligibility
Cover new immigrant children
Develop a plan to cover uninsured children above 200% of federal poverty level (focus on the work force connection; begin with coverage where employer participation in coverage is low -- such as uninsured children from the flex workforce and transitional coverage).
Permit employer and county buy-ins for family coverage.

3) MediCal

Break the program's welfare connections and image
Simplify the eligibility process for attaining and maintaining coverage to make it accessible to the working poor

Take the federal options to extend continuous coverage
Provide time limited transitional coverage to all families going to work
Take the federal options to cover two parent working families and increase the income thresholds for working families
Seek §1115 waiver to simplify the eligibility rules and process, cover low income uninsured working families, consolidate programs and transform the institutional subsidies into coverage for the uninsured
Integrate MediCal spend down coverage with wrap around policies developed by health plans for outpatient coverage
Permit employer buy-in of family coverage

4) Other

Coordinate the state's smaller programs for the uninsured with the big programs of MediCal, Healthy Families and County Health
Audit the effectiveness of state subsidies and tax preferences in achieving their goals
Refocus the state's discretionary spending, subsidies and tax preferences to improve provider, plan and employer incentives and capacities to cover the uninsured working poor

COUNTY HEALTH

California counties are responsible for the indigent uninsured with no other source of coverage. These include the working poor who are single adults, working parents, childless couples and new immigrants.

California counties act as payors and providers for the county indigent and as health plans for MediCal beneficiaries. They do not regulate health plans or providers. Counties pay for care with a mix of federal, state and county revenues. County delivery systems have been slowly evolving from the hospital, emergency room centered models of the past.

In California, there are three very different county health systems for the uninsured:

- The "provider" counties provide care in a public hospital and public clinics. These include Los Angeles, Alameda, San Francisco, Kern, Santa Clara and a number of other counties.
- The "payor" counties pay private providers. These include Orange, Sacramento, Fresno and San Diego among others.
- The small, mostly rural counties contract back with the state of California to administer a fee for service system comparable to MediCal.

Several counties, including, Contra Costa, San Diego, San Mateo and Los Angeles, have experimented with health plan models of delivering care to the uninsured with decidedly mixed success.

The large counties are well positioned to serve as a base to expand delivery of care and coverage to the uninsured. They have the mission and a funding base, they are developing the delivery structures and some have the political will and consensus of local stakeholders.

- County patients are for the most part very low income individuals with incomes below the poverty level; however county health programs also see significant numbers of persons between 100% and 200% of FPL.
- County patients are bi-modal, comprising significant shares of young working men and older working women.
- The barriers to participation by the working poor include long waits in public facilities, and counties'

welfare style application and eligibility processes. Some counties have radically simplified their application and eligibility processes and have enrolled private providers to increase access and decrease their geographic and waiting time access barriers.

- County revenues under realignment are growing, but not necessarily being used for care to the uninsured. Many provider counties are losing MediCal patients and DSH revenues to their private competitors.
- Counties now operate public HMOs for MediCal and Healthy Families enrollees and have consolidated mental health programs for the MediCal and county indigent.

Many large counties are planning major restructuring of their delivery programs for the indigent uninsured. Some would like to merge their MediCal and county indigent programs.

Revenue Streams for County Health

Description	**Funding Source**	**Recipient**	**Amount (year)**
SB 855 and SB 1255	Federal dollars, matched by public hospital dollars	Hospitals serving a high percentage of MediCal and uninsured	Federal DSH $ to 123 DSH Hospitals: $1.1 B divided roughly equally between private and public hospitals; $450 M from SB 1255 to 67 hospitals
Prop 99 Tobacco Tax	State taxes on sale of tobacco products	Counties, Private Hospitals and Physicians, MRMIB, CHDP	$494 million (1997-98)
Realignment	State vehicle license fees and sales tax; replaced state funds	Counties, for health and social services	$1.15 billion (1997-98)
County General Funds	Counties	County health departments or private providers	$480 million (1996-7)
Emergency Medical Services fund	Fines for motor vehicle violations	Private emergency room physicians and on call specialists	$40 million (1995)
FQHCs (federally qualified health centers)	Federal and state funds administered by state DHS	Community health centers and county clinics	$ 206 million (1994-95)

Efforts to Cover the Uninsured

Some counties are switching from a model of care to a model of coverage for the county indigent. The COHS model is best for those counties who wish to cover the uninsured because all MediCal funds within the county (except DSH and FQHC) can serve as the basis for the program. State and federal law changes would be necessary before a COHS could incorporate DSH and FQHC funding, and for a COHS to truly merge its county indigent and MediCal funds and populations. Orange, San Francisco, Los Angeles and San Diego have to varying degrees at differing times expressed interest in a COHS approach.

Potential Evolution of County Delivery Systems for Uninsured

County	**Alameda**	**LA**	**San Francisco.**	**San Diego**	**Orange**
Direction	Public managed care system	Public private partners	Public managed care system	Private managed care	Managed care network
Who	Alameda Alliance (LI)	DHS	COHS	COHS	Cal OPTIMA (COHS)
Consolidation of program revenues	Possibly	No	Possibly	Yes	Yes

Local Initiatives have a far smaller share of MediCal spending, and the need to maintain a strong competitive position vis a vis its commercial competitor. Several of the LIs such as Alameda and San Francisco are interested in using the LI structure to cover discrete working populations such as uninsured day care and home health workers.

Efforts to improve county care for the uninsured working poor:

- Los Angeles has a §1115 waiver to pay for outpatient care to the uninsured and uses it to contract with community clinics, private doctors and hospitals to extend access to care for the uninsured, tripling the geographic sites and expanding hours and days.
- San Diego and Alameda counties have developed model relationships with community clinics for care to the county's uninsured.
- Santa Clara county has shifted care from its county hospital emergency room to public and private outpatient clinics.
- Santa Clara, Alameda, San Mateo and San Diego have all tried interesting improvements in the county eligibility and application process that have some potential to improve participation by the working poor.

County reform efforts are hampered by their balkanized and rule laden funding streams, hospital centric history and culture, and the lack of connections between county health and the workplace. No county has in the past focused its efforts on extending coverage to the working poor. San Francisco has the clearest blue print and consensus to offer coverage to the working poor in the future.

Recommendations for Change:

1) Facilitate individual county reform efforts to cover the uninsured

Authorize and support individual county reform efforts and §1115 waivers
Change state statutes to permit consolidation of programs and revenues to cover the uninsured on a county by county negotiated basis

2) Provide flexibility and retargeting of DSH

Revise distribution formula to emphasize care to the uninsured
Revise formula to allow counties and private hospitals to switch their delivery systems from inpatient to outpatient care

3) Support more COHS pilots for counties

Expand the number of COHS pilots
Negotiate the award of COHS pilots to those counties who are undertaking efforts to cover the uninsured

4) Support Local Initiative efforts to cover the uninsured

HEALTH PLANS

The state of California also regulates the content of benefit plans and market place conduct of health plans. California's large and small employers have increasingly turned to tightly managed health plans to organize delivery systems for their employees. The state of California has done so for most MediCal families and for Healthy Families children.

California health plans act on behalf of payors as organizers of a delivery system of care. Their delivery systems place primary emphasis on a primary care physician to act as a gatekeeper to the range of covered services. California's working poor have limited access to primary care, primarily through community and county clinics and out of pocket payments to private physicians

Most health plans have done little to cover the uninsured. Some health plan practices (such as underwriting exclusions and pricing of policies for continuing coverage) contribute to the problem. A few health plans, such as Kaiser, Blue Cross, Sharp and Community Health Group, have voluntarily initiated limited scope programs to cover the working poor; most plans have not.

- The Kaiser efforts are:

    1. to cover uninsured children of the working poor not eligible for existing forms of public assistance, and
    1. to create affordable transitional coverage for individuals already enrolled with Kaiser who lose their employer based coverage.

Kaiser typically offers standard benefits using its own delivery system.

- Blue Cross, by contrast, has focused on individual coverage for low income uninsured children and families through a network of private doctors and community clinics. Blue Cross' coverage has been

for limited, outpatient benefits, which wrap around government programs' coverage of hospital costs. Blue Cross has had limited enrollment in its MediFam policy ($80 per family per month). The free or low cost California Kids program for uninsured children has had a strong enrollment, but is dependent on philanthropic support.

- Sharp Health Plan is running a pilot program offering coverage subsidized by the Alliance Health Foundation to uninsuring employers.
- Community Health Group has designed, marketed and targeted a more affordable plan to uninsuring employers with no premium subsidies. CHG's provider network agreed to reduced rates and the plan is subsidizing administration for the start-up period.

To date, Kaiser remains unique among California's commercial plans in seeing the opportunity to market affordable transitional coverage. At a minimum, public and private health plans ought to seek to keep insured those individuals and families who already have insurance but are in transition between jobs or from welfare to work:

1. San Joaquin and San Francisco Local Initiatives have subsidized transitional coverage for families transitioning from welfare to work.
2. COBRA and Cal COBRA create structures to continue coverage for employees in transition, but health plan premiums are unaffordably high for the working poor.
3. Continuation and conversion policies offer an opportunity to continue coverage, but again health plan premiums are set at unaffordably high levels for all but the least healthy and most affluent of individuals.
4. State HIPAA implementation offers yet another opportunity to assure affordable transitional coverage; however, health plans have sought the narrowest application of HIPAA protections for persons needing transitional coverage

Recommendations for change:

1) Simplify and promote enrollment in affordable transitional coverage:

Simplify and ease the availability rules
Make prices affordable
Provide a choice of benefits
Subsidize low and moderate wage working families and give incentives to higher income families to purchase transitional coverage

2) Approve appropriate, limited benefit plans:

Must wrap around actual coverage to provide a complete basic benefits package

3) Healthy Families wrap around designs

Design affordable group and individual coverage for uninsured low wage working parents and uninsuring employers that "wraps around" Healthy Families coverage for their children.

EMPLOYMENT BASED COVERAGE

Employers, employees and unions are payors of coverage for the working poor. 80% of uninsured Californians are connected to the workforce as employees or dependents. Employment based coverage is

thus the logical starting point for covering the working poor and may be the best way to increase coverage in immigrant communities. Tax subsidies are available through employment based coverage, but not for most individual coverage.

- Employers provide coverage for more than half of all Californians under age 65. While this is much lower than the national average, it is the predominant form of coverage for California employees.
- Over three fourths of full time employees as well as 22% of part time and 39% of seasonal workers are covered through their employers.
- 54% of Asians and 41% of Latinos are insured through the workplace, and 7% of Asians and 2% of Latinos buy individual private insurance.

Most uninsuring employers cite affordability as the principal reason for not offering coverage. However, for the past five years, premiums have been stable or declining, jobs and profits have been growing and the competition for employees in a tight labor market has increased.

For the first time in over two decades, a growing number of employers are reported to be offering coverage to their employees. Yet a growing number of employees are declining coverage because of cost -- the premium shares they must pay, particularly for family coverage.

Uninsured employees are concentrated among:

1. very small businesses, including the self employed
2. retail and construction
3. low wage work forces
4. part time, provisional, temporary or seasonal employment (the flex workforce)

To cover the working poor through the workplace, two problems must be solved: affordability and structure.

1. Affordability is a problem for employers and low wage employees because:

   Health premiums represent a *high percentage of total compensation for low wage workers*.
   The *tax advantages of employer based coverage* are highly regressive, *providing little subsidy for low wage workers*.
   The *employee contribution is usually structured in a regressive fashion*, which is particularly unaffordable to young, low wage working families.
   Employers may have increased the share of premium directly paid by employees.
   Businesses prefer tax credit solutions to government subsidies, but annual tax credits are poorly designed to pay monthly or quarterly premiums for employers with low or no profit margins.

1. Structure is a problem because:

   There are *high "non-benefit" costs* associated with marketing and administering *individual and small group coverage*.
   We *lack effective structures to purchase coverage for the flex workforce* -- part time, seasonal, temporary, construction, migrant and other workforces who frequently change jobs.

There are a number of employer and union efforts to increase coverage of the working poor:

Employment Based Coverage

Program	Eligibility	Benefits	Costs	Opportunity	Obstacles

UDWA	Domestic workers			Coverage for domestic workers	Carrier pricing and participation
Child care providers	Child care workers			Association coverage through HIPC; LI or Healthy Families premium subsidy	Carrier willingness, Healthy Families decision on purchasing credit
LAANE: Living Wage Coalition	Employees of govt. contractors		$1.25 an hour	Coverage for employees of govt. contractors; political organizing	Carrier willingness, Healthy Families connection
Justice for Janitors and HERE	Employees of janitorial services, hotels and restaurants, flex workforce			Union organizing	Employer opposition
SEIU Local # 99	Unbenefited school employees	Limited benefits (outpatient only)	$80 per family per month	Union administration and purchasing	Creation of an affordable and desirable benefit structure; and family participation
UFW	Agricultural workers, flex workforce			Union organizing	Employer opposition
Teamsters	Teamsters members, flex workforce			Union administration and purchasing; mandatory participation	
Western Growers' Assn.	Agricultural workers, flex workforce	Limited benefits (low annual maximum, tight limits on mental health and exclusions of substance	$100 per family per month	Coverage for agricultural workers	State and federal benefit mandates and limits on ability to self insure

		abuse services)			

Recommendations for change:

1) Improve affordability for employees

encourage employers to design affordable employee premium contributions for low wage workers and their families
use Healthy Families to subsidize employee premium contributions for family coverage

2) Improve affordability for employers

use Healthy Families to subsidize uninsuring employer premium contributions during a three year limited period
increase availability of purchasing pools for self employed
develop and pilot refundable quarterly tax credits for low wage, very small businesses
improve access to and increase employer participation in purchasing pools for small, mid sized and large employers
provide 24 hour coverage that truly integrates workers comp and employer health

3) Improve health coverage for uninsured workforces with a high degree of government involvement

day care
home care
government contractors and government subsidized employers

4) Emerging union efforts to organize around lack of health coverage

janitorial industry
hotel and restaurant industry
garment industry

5) Efforts to create new employment based structures to offer coverage to the flex workforce

Motion Picture and TV Fund
Schools
Temporary employment agencies
Association coverage
Working Partnerships

PROVIDER NETWORKS

California providers both deliver care and organize delivery systems. Providers receive the patient, state, federal and county funds to provide care for the uninsured. While the program funding which providers receive is balkanized, poorly organized and less than adequate, providers are the logical starting point to organize a better delivery system. Some providers have the strongest day to day incentives to organize such a system.

Prop 99, and some county health program funds are received by providers on a fee for service basis as reimbursement for services that the providers deliver to uninsured patients. Significant amounts of funding for the uninsured (e.g., realignment, SB 855 and 1255) are received as *block grants*. They are not explicitly tied to actual delivery of services to the uninsured. Providers and counties have wide flexibility in the use of these funds. Much of state and federal funding for private hospitals, doctors and clinics bypasses the structure of county government.

Most provider financing for the uninsured is tied to a model of delivery emphasizing emergency room and hospital based services and comparatively little for primary care or preventive services. Provider funding is balkanized:

> private doctors are paid from SB 12 and Prop 99,
> free and community clinics from EAPC, and
> private hospitals from SB 855 and Prop 99.

Balkanization impairs the ability of government policy makers to design sensible systems of care for the uninsured, but allows providers the flexibility to do so voluntarily.

Some providers are using the flexibility of the financing in the current system to design creative approaches to care for the uninsured. For example, Citrus Valley Hospital has developed a unique community based approach to provide health care to the working poor in its geographic region. The approach was initiated by a private hospital and is based on agreements between private providers to work together to provide care to the uninsured in the community.

The agreements between providers are:

- to provide care to specific numbers of uninsured children (below 200% of FPL) and
- to make appropriate referrals among the providers such that primary care is delivered in primary care settings, specialty care is available on referral from the appropriate specialists, and follow up care after emergencies is available as well.

Providers agree to provide a certain number of appointment slots or to take responsibility for a certain number of patients.

The local hospital, community clinics, private doctors, county clinics, Kaiser Permanente, 14 local school districts participate. Los Angeles County provides back up hospital care for services more complex than the area's private hospitals are able to deliver at County/USC.

The program, Every Child Healthy Option (ECHO), is an integrated health care delivery system covering acute care, emergency care and specialty care for uninsured children. The program has been successful; in 1997 it had 600 extra "slots," which providers donated to family members of ECHO children.

Others are not using the funds to care for the uninsured, but are using the funds for other purposes.

Recommendations for change:

1) Develop voluntary, local, integrated delivery systems of care to the uninsured.

2) Increase providers' accountability to provide care to the uninsured with funds received.

3) Increase both formal and informal working partnerships between public and private sector providers to

provide care to the uninsured.

4) Improve public and private funding of primary care for the uninsured and the coordination between primary care clinics and doctors and hospital emergency rooms.

PURCHASING POOLS

Purchasing pools are potential platforms to cover the working poor because they are able to lower "price" through bargaining and administrative efficiencies. Pools are also a potential framework to cover the flex workforce of part time, seasonal, temporary, contract, provisional and other employees.

Pools do not yet act in any relevant fashion to cover the uninsured working poor, and none have any imminent plans to do so. The gain in bargaining and administrative efficiency from a purchasing pool is not by itself a sufficient marginal price reduction to attract new enrollment. Pools need a subsidy source, such as Healthy Families, to make coverage more affordable for uninsuring employers and uninsured employees.

Pools are more than the "big three" purchasing entities of PERS, PBGH and the HIPC (which serve public employers, large employers and small business respectively). They also include private pools such as Word and Brown and Benefits Alliance, employer associations such as Western Growers Association, labor union plans such as the Teamsters or UFW and Joint Powers Agreements such as the VEBA for San Diego schools.

Program	Eligibility	Benefits	Costs	Opportunity	Obstacles
HIPC (Health Insurance Plan of California: a purchasing pool)	Employers of 2-50 employees	Comprehensive		Cover uninsured; Expand to individual, mid sized markets and flex workforce	Need for subsidies; Need for legislative approval
Pacific Business Group on Health (a purchasing pool)	Employers of 2,000 + employees	Comprehensive		Take over the HIPC	Need to connect to small business and immigrant employers
VEBA (a joint powers agreement)	School district employees	Comprehensive		Cover the unbenefited school district employees	Need for subsidies -- Healthy Families or other
Western Growers' Assn. (an association)	Agricultural workers, flex workforce	Limited benefits (low annual maximum, tight limits on mental health and exclusions	$100 per family per month	Coverage for agricultural workers	State and federal benefit mandates and limits on ability to self

		of substance abuse services)			insure

Recommendations:

1) Purchasing pools are most needed

in the individual market and
for the flex workforce.

2) Industry based association coverage is the approach most likely to succeed in covering the flex workforce.

3) Small business pool needs to be aggressively expanded.

4) PBGH and CalPERS should begin to develop coverage options to be offered to the non benefited flex workforce of private and public employers.

5) PBGH, HIPC and CalPERS need to loosen the entry barriers to employer participation.

Market Reforms

The state of California has adopted market reforms to control some activities by health insurers designed to insulate themselves from the risks of insuring small businesses and their employees with serious medical conditions. The reforms govern:

1. issuance and renewal of policies
2. setting of premiums and
3. the imposition of pre-existing condition exclusions on individuals with an adverse medical or claims history.

These reforms apply in different measure to the small group, individual, mid sized and large group markets.

	Individual	Small business (2-50)	Mid sized and large
Guaranteed issue	no, except for a small number of HIPAA protected individuals	yes	no
Guaranteed renewal	yes	yes	yes
Restrictions on pre-existing condition exclusions	yes, 12 months for individuals and 6 months for families of 3 or more	yes, 6 months	yes, 6 months

Restrictions on premium setting based on claims experience or medical status	no	yes	no
Portability	yes	yes	yes

Market reforms ensure that employers can purchase and retain coverage for all their employees. But they have little direct impact on covering the working poor because very few of the uninsured are medically uninsurable -- i.e., an insurer would not reject them if they or their employer applied for coverage. However they have substantial indirect impacts since they govern:

1. the market conduct of carriers,
2. the price of coverage,
3. the stability of employer and individual coverage once acquired, and
4. the ability of purchasing pools to function.

California's reforms improved the functioning of the small employer health market. Some carriers predicted a rise in premiums in response to the reforms. The unanticipated impact was to reduce premiums as the reforms substantially improved overall market competitiveness. The underwriting debate in California is *whether and how to* extend the small employer reforms to the individual and mid sized employer market.

Individual Market

California's individual market encompasses about 2 million individuals. They primarily purchase fee for service coverage from insurers, and secondarily managed care coverage from HMOs.

California has in place several individual market reforms including:

- guaranteed renewal,
- limits on differential issuance and renewal rates, and
- limits on pre-existing condition exclusions.

It does not require guaranteed issuance or community rating of individual coverage. In 1998, legislation was passed to extend California's small group reforms to the self-employed and the federal HIPAA reforms to the individual market. The Governor vetoed this legislation.

Many of the self employed working poor are uninsured and federal tax policies are providing increased tax subsidies to encourage the self employed to purchase coverage. Furthermore, Healthy Families program is a subsidized individual insurance policy. The combination of market reforms, improving tax deductibility and Healthy Families subsidies have the potential to reduce the extremely high percentages of uninsured, self employed working poor.

Mid-Sized Employers

Some carriers use underwriting exclusions and experience rating in the mid sized market to exclude "high risk" employers: such as auto dealers, doctors, restaurants and bars, lawyers, miners and employer associations. The Governor vetoed the legislation to apply the small group reforms to employers between 50 and 100 employees.

Mid sized employer market reforms are unlikely to have any impact on the working poor, as a high percentage of employers (over 90%) in this size range already offers coverage to their employees.

Uninsured employees for mid sized employers are likely to be flex and/or low wage work forces. To impact the working poor employed by mid sized businesses, subsidies need to be very carefully targeted to uninsured flex and/or low wage employees and their families.

Transitional coverage

GOAL: to provide available, affordable and continuous coverage for the working poor in transition from job to job, from welfare to work, as marriages form and dissolve, or during periods of unemployment or short term disability.

Existing transitional coverage options:

1. COBRA gives those employees who are changing jobs the option to purchase continuing coverage (at 103% of the employer's average premium)
2. Cal COBRA extends COBRA coverage and protections to the employees of small businesses of less than 20 employees.
3. HIPAA portability protections guarantee access to individual coverage for those workers with 18 months of continuous coverage and no other coverage options.
4. California's continuation and conversion protections allow options for ongoing coverage for specific individuals.

None of these patchwork options provides affordable, available or continuous coverage. Premiums are typically high; there is no subsidy for low wage and low income individuals. These options are tightly hemmed in with rules, restrictions and administrative hurdles to curtail their use and availability.

Public programs also do not assure affordable transitional coverage. Healthy Families, which could subsidize COBRA premiums for children, does not do so. Similarly, MediCal has a little known and infrequently used program of transitional coverage for families going from welfare to work.

The Flex Workforce

Mechanisms for covering the part time, contract, seasonal, provisional employees working for multiple employers need to be developed. The Institute for the Future reports that in 1996 a quarter of all employment was in the "flex" workforce and projects this will rise to over one third by the year 2000.

Legislation governing underwriting reforms, purchasing pools and associations needs to be changed so that those employers and entities seeking to cover the flex workforce will find it easier to do so.

Recommendations:

1. Individual market

    all carriers must either participate in the individual market or contribute to funding a Basic Health Plan (equivalent to the minimum mandated Knox-Keene coverage)
    use Healthy Families and the tobacco tax and the tobacco settlement to subsidize Basic Health Plan premiums for working poor families
    all individual products must be guaranteed issue.

2. Transitional coverage

    during all transitions, carriers must offer and issue to existing policy holders a choice of continuation coverage or Basic Health Plan coverage

transitional coverage premiums shall not exceed the lower of individual, small or mid sized employer premiums
fund transitional Basic Health Plan coverage for the working poor and give tax incentives for higher income persons purchasing transitional coverage

3. Mid sized market

guarantee issuance of all products to all employers
permit premium variations limited to age, family size, geography and a limited occupational rating factor

4. Associations and MEWAs

all associations may negotiate administrative (but not claims experience) premium discounts for small employer market