SB 480 HEALTH CARE OPTIONS PAPER: Insuring California's Uninsured

Submitted by

INSURE THE UNINSURED PROJECT

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EXECUTIVE SUMMARY of SB 480 OPTIONS PAPER

BY INSURE THE UNINSURED PROJECT (ITUP)

Insure the Uninsured Project proposes that California begin to cover its 6.8 million uninsured through a balanced approach combining both public and private sector initiatives to improve affordability of coverage:

- Refundable targeted refundable tax credit to increase the offer rate for employers with low wage workforces
- Purchasing credit to increase take up rates by low wage workers for family coverage
- Refundable tax credit/voucher and structural reforms to increase coverage of the flex workforce (temporary, part time, seasonal, contract workers and the self employed) who are not typically offered coverage through an employer
- Medicaid §1115 waiver to cover low-income adults and
- Seamless coverage for those enrolled in public programs.

Under our proposal California's lowest income uninsured will be covered by expanding MediCal and Healthy Families; those with higher incomes will have improved access to and better affordability of private coverage.

In combination with California's existing coverage, this would give all California residents who cannot afford health coverage opportunities to secure affordable coverage through their employer, the individual market and/or public programs. It would lay the foundation for universal coverage if California can develop the political consensus for a single payor system or for a combination of individual and employer mandates to achieve universal coverage.

This is not the most cost effective approach for California's government; a combination of individual and employer mandates would be more cost effective for state government. However it is politically and economically feasible and would dramatically increase affordability of coverage.

Our challenge in designing these options is the inefficiency of incremental change in our multilayered, complex, and overlapping public/private system:

- How to cover the uninsured while avoiding paying twice for coverage to those already insured and for care to the uninsured already paid for by government
- How to account for unintended side effects such as crowd out and crowd in of public and private payors based on their changing economic incentives and
- How to reconfigure California's jig saw puzzle of coverage in a sensible fashion; which populations are best covered by expansion of public programs and which are best covered by financial assistance for private coverage.

This proposal addresses key weaknesses in California's system: lack of affordability of private coverage for low wage and flex workforces and the deterrence by complexity of

public coverage. It does not change the basic structure of either public or private coverage; that is addressed in other options papers. It seeks to avoid shifts for individuals with existing coverage and suggests a starting point for state health reform efforts to cover the uninsured.

INSURE THE UNINSURED PROJECT
SB 480 OPTIONS PAPER

Major Objectives

***Increase in low wage working adult coverage*:**
This program will offer coverage for adults without linkage to MediCal and Healthy Families through expanded public programs and subsidized private coverage. This proposal will also simplify and consolidate MediCal, county health and Healthy Families programs so that more of the eligible-but-unenrolled are enrolled.

***Increase in small employer offering*:**
This program seeks to increase California's low rate of offering of employment based health coverage by offering targeted premium subsidies through refundable tax credits to low wage small employers.

Increase in opportunities for affordable private coverage:
This proposal includes targeted premium subsidies for small employers, low wage workers and flex workers. Employment based coverage is already tax subsidized, but the tax subsidies are very low for low wage workers. Tax subsidies do not reach flex workers who are infrequently offered coverage through their own employer.

Increase in federal financing of care for California's uninsured:
This proposal seeks federal matching for California's state and county spending on the uninsured to finance the proposed expansion.

Improvements in delivery system for uninsured:
This proposal will move the delivery system for the uninsured from hospital emergency room based care to a primary care and managed care coverage system.

Increased flexibility and support for pioneering safety net clinics and hospitals:
This proposal includes increased programmatic flexibility and enhanced support for local programs seeking to increase coverage beyond the state expansions.

Increased opportunities for coverage for immigrants not eligible for public programs:
Private coverage does not exclude individuals based on their immigration status. Immigrants and their employers pay taxes; tax credits for private coverage is one approach to increasing coverage from immigrants.

Programmatic simplification:
California covers care for its low-income residents through an array of federal, state and county programs and financing. This proposal simplifies this array of programs to essentially two programs: one for persons with incomes below poverty and one for persons with incomes above poverty. Furthermore it will allow workers to get basic health coverage through the workplace as an alternative to applying for public programs.

Target Populations:

The proposal seeks to finance coverage of the uninsured with annual incomes up to $35,000 for an individual and $70,000 for a family. Below 100% of the federal poverty level (FPL) [up to $8,950 for an individual], there is comparatively little private employment based coverage offered and an array of public programs. We rely on expanding MediCal coverage through a Medicaid waiver.

Between 100 and 200% of FPL (between $11,610 and $23,220 for a family of two), there are significant amounts of uninsurance, private insurance and public coverage. Individual private insurance is not usually affordable for persons in this income range. We propose to expand opportunities for Healthy Families coverage and affordable private coverage for the uninsured between 100 and 200% of FPL.

Above 200% of FPL ($29,260 for a family of three), there is extensive private coverage and comparatively little public coverage. In the interests of avoiding crowd out or crowd in, we propose increasing private coverage above 200% of FPL.

We recommend balancing an increase in public coverage with improved opportunities for more affordable private coverage. We are seeking to increase affordability for small business, lower wage and flex workers while at the same time simplifying the complexities of California's jig saw puzzle of public programs and funding.

- **Coverage for low income adults through MediCal and Healthy Families.**

  This proposal would make adults without minor children and incomes below 200% of FPL eligible for MediCal and Healthy Families if §1115 waivers are approved by the federal government.

- **Tax subsidized coverage for uninsured low wage and flex workers and their families through employment and/or the individual market.**

  This proposal includes refundable tax credits for small employers of low wage workers and a subsidy for the uninsured low wage worker's share of employer coverage. This proposal offers a premium subsidy through a refundable tax credit/voucher for flex and other uninsured workers with incomes up to $35,000 for an individual and $70,000 for a family. The flex worker can use the premium subsidy through their employer (if the employer will contribute towards employment based coverage) or to offset the cost of individual private insurance.

- **Reaching immigrants.**
  Immigrants work, pay federal, state and local taxes and have high rates of uninsurance.
  - There are restrictions on federal funding for new immigrants and those immigrants without the requisite INS status (undocumented).
  - California covers new immigrants for MediCal and Healthy Families and covers undocumented families and children for emergency care and deliveries with federal matching Medicaid funds.
  - Some counties provide health care to the undocumented, while others do not.
  - There have been low rates of enrollment of eligible immigrants in Healthy Families and MediCal due to fear of *government*.

This proposal will increase private coverage opportunities for immigrants through targeted tax subsidies with no restrictions on their INS status. Adult legal immigrants will be eligible for MediCal and Healthy Families consistent with existing state policy for legal permanent residents. This proposal will increase federal funding for emergency services to undocumented immigrants.

Mechanisms for Expansions:

We would expand public and private coverage through a federal waiver, refundable tax credit premium subsidies and increased use of group purchasing.

- **MediCal and Healthy Families managed care coverage for low income adults.**

This proposal would expand the MediCal and Healthy Families programs for low income adults through a federal Medicaid waiver.

- In *Two Plan* counties, adults with incomes below the poverty level would choose between the county Local Initiative and its commercial competitor.
- In *Geographic Managed Care* (GMC) counties, adults with incomes below the poverty level would choose among the already contracting commercial managed care plans.
- In *County Organized Health System* (COHS) counties, adults with incomes below the poverty level would be eligible for the COHS.

➢ In *small counties* without mandatory MediCal managed care, adults with incomes below the poverty level would be eligible for fee for service MediCal coverage.

⇒ Low income adults with incomes above the poverty level would be eligible for Healthy Families for the same choice of plans currently contracted to cover the Healthy Families children and parents.

2. Employment based coverage and access to purchasing pools for uninsured low wage workers and their families.

This proposal uses refundable tax and purchasing credits to increase the numbers of small employers offering and the rates of low wage workers accepting offered

employment based coverage. We prefer that small employers use purchasing pools and that pools become a more efficient vehicle to increase coverage, but would not limit the subsidies to those employers using purchasing pools.

3. Purchasing pools, market reforms and improved access to employment based coverage for flex workers.

Flex workers (nearly half of uninsured workers) fall into job categories not typically offered health coverage by an employer. This proposal would enhance structures to purchase coverage: purchasing pools, underwriting reforms and a tax subsidy. It would give them an option to purchase coverage through the individual market or to use their refundable tax credit/voucher through group purchasing entities.

Health Benefits:

We propose to use existing benefit structures:

1. **MediCal benefits for low income adults below 100% (133%) of FPL**.
   Low income adults with incomes below the federal poverty level would qualify for MediCal managed care coverage for the full range of MediCal benefits.

2. **Healthy Families benefits for low income adults over 100% (133%) of FPL**
   Low income adults with incomes below the federal poverty level would receive the full range of Healthy Families benefits through Healthy Families managed care. This includes higher copays and a somewhat smaller benefit package than MediCal coverage.

3. **Knox Keene basic benefits plus prescription drugs for persons with tax subsidies.**
   We recommend that plans must include Knox Keene basic benefits (medical and hospital care, lab and radiological services, emergency and preventive care, home health and hospice services) and prescription drugs to qualify for the tax subsidies.

4. **Exemption from state benefit mandates**.
   California has an extensive list of benefit mandates enacted over time by the state legislature. We recommend that the basic benefits package designed to reach the uninsured be exempt from the benefit mandates.

Financing:

We propose to use existing state and local spending on the uninsured as the base to seek a federal waiver expanding coverage of the uninsured.

1. **Federal matching for adults**.
   This proposal adds new federal funding for care to low income adults and allows California to access its unspent federal S-CHIP allocation. The proposal seeks a

federal §1115 Medicaid waiver to cover adults without Medicaid or S-CHIP linkage. Oregon, Arizona, New York, Massachusetts and Tennessee already have such waivers. The waiver must be cost effective -- i.e. not cost the federal government more than it otherwise would have spent in the absence of a waiver. The federal government has approved such waivers from the states in conjunction with the implementation of managed care, prioritizing health benefits, consolidating and simplifying programs and transforming institutional subsidies into coverage. We recommend that California meet the cost neutrality test by implementing managed care for the exempt categories (disabled adults), consolidating and simplifying coverage and to some extent transforming MediCal institutional subsidies into coverage.

Medicaid has a federal matching rate of 1/1 for California and S-CHIP has a matching rate of 2/1 for California, which is subject to an expenditure cap. California should seek a 1/1 match for adults below 100% (133%) of FPL and a 2/1 match for adults over the federal poverty level for expenditures up to the federal S-CHIP spending cap for California. Thereafter, for any spending above the cap it should seek a 1/1 match.

2. **State and county financing for care to low income adults shifted.**
   This proposal shifts state and county financing which pays for care for low income adults to purchasing coverage as eligible individuals enroll in coverage.

3. **County match for adults.**
   All counties currently provide care and coverage for uninsured adults with a mixture of state, federal and county funds, which varies from county to county. As adults are enrolled by the state MediCal and Healthy Families programs, the necessary matching funds should be transferred up to a cap. We suggest that the cap be the three year average of funds the county spent on the population covered by the state programs. The county cap should grow based on the growth in the county health funding streams through realignment and Proposition 99.

- **State match for adults.**
  The state pays for care and coverage for uninsured adults with state general funds through an array of programs. State spending should be transferred into the new program as eligible individuals are enrolled. The state should be responsible for the growth in program costs above the county spending cap.

- **Tax credits with incentives for employer and employee premium contributions.**
  This proposal uses refundable tax credits to create financial incentives for uninsuring small employers and uninsured individuals to initiate coverage. The proposed tax credits subsidize some low income insured persons and employers who already offer coverage; some might discontinue coverage as a result of economic conditions but for the subsidy.

6. **Decrease in state tax revenues due to refundable tax credits, matched by increase in employer and employee contributions.**

A refundable tax credit is a cost to the general fund, and the state needs to ensure that the tax credit approach not be more costly than expanding coverage using federal matching funds for public programs. In general, we suggest that the state refundable tax credits not exceed 50% of premium cost. Under the new HIFA guidelines, it appears possible to secure federal matching to subsidize employment based coverage for those uninsured with incomes under 200% of FPL. Under S-CHIP it is possible to secure 2/1 match for the purchasing credit for uninsured working families who are offered but have not taken up coverage due to the cost.

7. **Tax increases**

We do not see a need for a tax increase to finance our proposal, as we are proposing to use current state and county and new federal funding to finance the expansion. To the extent that new revenues are required, we believe that a small tax on providers and health plans would generate more than adequate revenues. This approach succeeded in financing expansions in Minnesota, Florida, and Tennessee. Alternatively the state could extend the application of its sales tax on goods to services, thereby reducing the rate of the sales tax on goods and eliminating the tax inequity between goods and services.

Premium Subsidies:

We propose to subsidize premiums consistent with the best existing models.

- **100% subsidy for low income adults below 100% of FPL enrolling in MediCal**
  100% subsidy is the same formula used by the state MediCal program for parents with incomes below 100% of FPL.

- **90% for low income adults above100% of FPL enrolling in Healthy Families**
  90% premium subsidy for adults enrolling in the Healthy Families program is the same subsidy available to children and parents already enrolled or proposed to be enrolled.

- **50% for small employers covering low wage workers.**
  A refundable tax credit is proposed for 50% of the premiums of low wage workers of small employers. This is the same pre tax purchasing tax subsidy now available to high income wage earners. The target is low wage workers of employers of 200 or fewer employees with one third or more making less than twice the state's minimum wage ($12.50 an hour).

4. **Phased tax credit/voucher for flex and other uninsured workers.**
   A refundable tax credit/voucher is proposed for flex and other uninsured workers. The tax credit would be roughly 80% of the premium for low income uninsured workers and then phasing down and out as family income increases. Our

recommended dollar amounts are $1200 for flex employees up to age 40, $2400 for employees between 40 and 55 and $3600 for employees between 55 and 64. Our recommended subsidies for family coverage are $2200 for flex employees up to age 40, $3200 for families between 40 and 55 and $4500 for families between 55 and 64. This creates incentives to enroll in employer coverage or Healthy Families where they are available.

The standard we recommend to qualify for the tax credit is whether your job does not offer coverage. The flex worker should be able to use the tax credit/voucher to purchase coverage in the group or individual market place.

5. **Variable for low wage working families who are offered but did not take up employment based coverage.**
   The proposal uses the Healthy Families purchasing credit to provide premium assistance to uninsured low wage working families who are offered coverage in the workplace. We would not use refundable tax credits because of the difficulty in properly targeting and administering the credit for low wage working families.

6. **Effectiveness and efficiency of tax subsidies in increasing coverage.**
   This proposal seeks to make tax credits cost efficient by targeting aspects of the workforce with a high level of uninsurance. Our targets are small low wage employers, flex workers and workers laid off or changing jobs. The proposal treats all employers and employees within these targets equally; in other words those already purchasing coverage will get the credit as will those who start to buy coverage with the tax subsidy.

7. **Responsiveness of low wage small employers and low wage workers to subsidies.**
   The unanswered question about premium subsidies is whether they are effective in increasing coverage. If employers and employees are non-responsive, the subsidy could cost little, but also achieve little increase in coverage. The premium subsidy must be large enough to get the desired response and targeted to a responsive group of employers and employees.

8. **Timing, targeting and refundability of tax subsidies.**
   The target groups are small employers and low wage workers who often pay only small or no amounts of state income tax, but large shares of their income for state sales taxes and other state and local taxes. The tax credit must be refundable and timed quarterly to meet health coverage premiums. The credit comes in the form of health insurance vouchers and/or is tied to proof of insurance (e.g. the policy number and plan type) to prevent fraud and assure that coverage provides basic benefits.

Impacts on Existing Subsidized Coverage Mechanisms:

1. **Replaces counties' §17000 obligations and systems for low income adults with MediCal managed care coverage.**

Counties' §17000 obligations to provide health care to the indigent would be repealed as the state takes over this function through the expansion of MediCal and Healthy Families. Patients not enrolled in MediCal at the time of treatment have an opportunity to apply for three months MediCal retroactive coverage.

2. **Consolidates existing programs and financing.**
   This would consolidate a series of state and county programs and funding streams, which pay for care to the uninsured into the state/local match for a federal 1115 waiver.

3. **Adds a tax subsidy (refundable tax credit/voucher) for flex workers.**
   This adds a tax subsidy for flex workers purchasing private coverage. Few flex workers are offered coverage through their own employer, but many have employment based coverage as dependents. The premium subsidy is designed to avoid an incentive for flex workers with existing coverage as dependents to switch coverage.

4. **Adds a tax subsidy (refundable tax credit) for low wage small business.**
   We propose a refundable tax credit of 50% of premium for low wage workers. We target the credit to small employers (under 200 employees) whose workforce consists of 1/3 or more employees making less than twice the state minimum wage ($12.50 an hour). There is an existing tax subsidy in that employment based coverage is bought with a pre-tax dollar. This subsidy averages 30% of premium, ranging from 10% or less for minimum wage workers to 50% or more for highly compensated employees.

5. **Adds a premium subsidy (purchasing credit) for low wage workers and their dependents at their place of employment.**
   We propose a premium subsidy for low income uninsured working families. Rather than delivering this subsidy through the tax code, we suggest using the Healthy Families purchasing credit because the target population of uninsured working families not accepting coverage is small and has little or no state tax liability, while the universe covered by a tax credit would be large, and the paperwork and the complexities of delivering small, timed refundable tax credits through the tax code could be considerable.

Insurance and Risk:

We would use the managed care plans now contracting for public and private coverage. The financial risk is shared among plans, providers, government, employers and employees.

1. **Managed care (shared risk for plans and providers) for care to low income adults.**
   The proposal extends managed care coverage for low income adults through MediCal and Healthy Families. This places the risk of cost overruns for price and utilization on the contracting health plans and their contracting providers. It places the risk of cost

overruns due to enrollment increases on the state and federal governments. It shifts the risk for all three components of program cost increases away from county government, which has little or no revenue generating capacity.

2. **Managed care (shared risk for plans and providers) or fee for service coverage purchased through employers and purchasing pools for low wage workers and their families.**
   The proposal subsidizes managed care coverage for low wage workers and their families with refundable tax credits for small employers and purchasing credits for low wage working families. Contracting plans and providers bear the risk of cost overruns for price and utilization. The state, employers offering coverage and employees accepting coverage share the premium risk. Employees should bear the incremental risk for selecting more costly coverage i.e. the subsidy should be limited to less costly plans.

3. **Managed care or fee for service coverage purchased through reformed individual market, employers, and purchasing pools for flex and other uninsured workers.**
   The proposal subsidizes coverage for flex workers and their families with refundable tax credits. Contracting plans and providers bear the risk of cost overruns for price and utilization. The state and flex employees purchasing coverage share the risk of enrollment increases. We believe that the employee should bear the incremental risk for selecting more costly health plans i.e. the tax subsidy should be tied to the less costly health plans. We propose that plans (rather than uninsurable employees) bear the adverse selection risk -- i.e. subsidized individual coverage should be guaranteed issue with rate adjustments for age, geography and health plan selection and a 12 month pre-existing condition exclusion for flex workers; rate adjustments for higher risk individuals should not exceed 125% of adjusted premiums.

State Administration and Regulation:

The proposal uses and expands the existing authority of state agencies.

1. **DHS negotiates managed coverage for low income adults below 100% of FPL.**
   The state of California Department of Health Services (DHS) already purchases coverage for parents through MediCal and purchases coverage and pays for care for disabled adults through MediCal and pays for care for adults without minor children through County Medical Services Program (CMSP). The state negotiators responsible for MediCal managed care negotiations would be responsible for negotiating coverage for the low income adults below 100% of FPL. The existing MediCal fee for service program for small counties would be responsible for paying for care for low income adults in those counties without managed care.

2. **MRMIB negotiates managed care coverage for low income adults over 100% of FPL.**

Managed Risk Medical Insurance Board (MRMIB) would be responsible for negotiating coverage for low income adults above100% of FPL. MRMIB is preparing to purchase managed care coverage for parents through the Healthy Families parental waiver and already purchases coverage for uninsurable adults.

3. **Department of Managed Health Care regulates activities of health plans in small employer and individual markets.**
   The Departments of Managed Health Care and Insurance regulate health plans and insurers respectively. This proposal adds responsibilities to regulate the conduct of the health plans and insurers in the individual market in a manner similar to the small employer market -- i.e. subsidized individual coverage would be guaranteed issue and guaranteed renewable, with rate adjustments permitted for family size, specific age groups and geography and health plan selection and a 12 month pre-existing condition exclusion.

4. **State FTB and EDD distribute premium subsidies to low income workers, small employers and flex workers.**
   Franchise Tax Board (FTB) is responsible for collecting and administering taxes for individuals, families and corporations, while the Employment Development Department (EDD) is responsible for collecting employer/employee payroll taxes such as Unemployment Insurance, State Disability Insurance and the state Personal Income tax. Under our proposal:
   - EDD would distribute the premium subsidies for small low wage employers via refundable tax credits; this would be done quarterly.
   - FTB would distribute the premium subsidies (via refundable tax credits/vouchers) for flex workers who are self employed or unemployed and not receiving Unemployment Insurance benefits.
   - EDD would distribute the premium subsidies (via refundable tax credits/vouchers) for flex workers who are employed or unemployed and in receipt of Unemployment Insurance benefits.
   - Healthy Families would distribute premium subsidies via purchasing credits to eligible low income families.

County Roles:

This proposal would shift some county Health Department responsibilities to the state and others to the local managed care initiatives.

1. **Delivers services as contracting provider and contracting local health plan.**
   Under this proposal, county health departments would be released from their role as organizer and payor of a health care system for county indigent. The state would contract with local managed care initiatives to assume the role of organizer and payor of health care services to the county indigent. County hospitals would contract with one or more managed care entities.

2. **Determines eligibility for low income adults below 100% of FPL.**

County Social Services and Health Departments would determine eligibility of the county indigent with incomes below 100% of FPL. Healthy Families would determine eligibility for those with incomes above 100% of FPL.

3. **Transitioning county eligibles and funding.**
   Transition of county eligibles and funding to MediCal should be easy in the CMSP (small counties) and the large counties (such as Orange and San Diego counties) who pay for care. Transition into managed care is more difficult, but it has been done effectively for the MediCal categories mandated to participate in managed care.

   Counties with public hospitals face a more difficult transition since they act as *open door* providers. It is important that the county funding for care to be used as the match for federal funds follow (rather than precede) the enrollment of county patients into MediCal managed care. There will be a need for one time bridge financing.

4. **Flexibility to strengthen and empower pioneering local safety net delivery systems.**
   Some counties, community clinics and local managed care entities are interested, able and committed to deliver more care and services to the uninsured than the state is or will be. We recommend that these counties be given the option to develop County Organized Health Systems (i.e. managed care for the entire low income population) and the ability to consolidate all related public funding streams for that purpose.

Major Federal and State Legal and Regulatory Changes:

1. **Federal waiver to cover adults in MediCal and Healthy Families.**
   California needs to secure an 1115 waiver in order to cover unlinked adults through MediCal and Healthy Families. There is precedent for such waivers, including Tennessee, Oregon, Arizona, New York and Massachusetts. The waiver must assure cost effectiveness (otherwise known as federal cost neutrality). The waivers approved to date have achieved cost neutrality through managed care, prioritization of services, transmutation of other state, local and federal funding and other changes. For California to meet cost effectiveness, it should propose to include the disabled in managed care, collapse a series of different federal, state and county programs into expanded managed care coverage and as needed transform institutional safety net subsidies into coverage.

   The Bush Administration has indicated that it intends to encourage more state flexibility through its §1115 waivers under HIFA (Health Insurance Flexibility and Accountability), but with a tight control on federal cost increases. The HIFA waivers may be able to cover the costs of the refundable tax credit/voucher for persons with incomes below 200% of FPL. The waiver we are proposing shifts portions of MediCal into the Healthy Families program.

2. **State legislation to cover adults and set state and county financial participation requirements.**

California needs to pass legislation authorizing coverage of adults through MediCal and Healthy Families if federal financial participation is forthcoming. One contentious aspect will be the respective proportion of state and county match.

3. **State legislation to enact tax credits for small employers, low wage workers and flex workers, co-ordinate with federal tax subsidies.**
   California would need to pass legislation authorizing refundable tax credits for small employers, low wage workers and flex workers, and co-ordinate with federal subsidies. The purchasing credit authorized for low wage working families needs to be amended to make it workable for plans, purchasing pools, employers, employees and program administrators. Tax credits for employers need to be targeted to low wage small employers (our proposed definition of small is up to 200 employees and our definition of low wage is 1/3 of the workforce making less than twice the minimum wage -- $12.50 an hour). Our definition of flex worker includes the classes of workers not offered coverage on the job. We phase out the subsidy so that it ends at $70,000 for families and $35,000 for individuals.

How much is the tax subsidy? We recommend 50% of premium for low wage small employers and phased out premium subsidies for flex workers, starting at 80-90% of premiums. We suggest that tax subsidies be capped at a percentage of market prices, for example the average of the lowest HIPC/PacAdvantage rates.

Should state tax credits coordinate with the federal tax subsidies?

- For example if the federal government begins to offer a $1,000 or $2,000 tax credit, should the state tax credit be incremental or should the state subsidy be cumulative which could mean a 100% or even 150% subsidy for some? Our answer is incremental; this could be complex to administer.

4. **State legislation to enact underwriting reforms and purchasing pool for individual market.**
   California would need to pass legislation enacting underwriting reforms and purchasing pool(s) for the individual market. Tax subsidies will add significant new enrollment to the individual market. Those who purchase in the individual market need certain protections: assurance of the ability to purchase and retain coverage, clear and consistent prices that can be compared between plans and benefit packages.

5. **State and federal legislation expanding group purchasing opportunities for small employers, individuals and flex workers.**
   California and Congress need to pass legislation expanding group purchasing opportunities for small employers, individuals and flex workers. Group purchasing offers the potential (not yet completely realized) for administrative and benefit cost savings plus broader and more informed choices of plans. California needs to allow associations greater flexibility to form, to purchase and to negotiate price with health plans, and it needs to form, foster and incubate new group purchasing for individuals and flex workers. Congress needs to pass the legislation authorizing health marts, and

exempt these entities from state benefit mandates, but not from state underwriting and marketing rules governing the small employer market.

Administrative Simplification

1. **Ends overlapping responsibility between state and counties for health coverage of low income population.**
   This proposal ends California's bifurcated system between the state and counties as to financial responsibility for the low income population. This will simplify programs for patients, providers, and federal, state and county administrators

2. **Simplifies state and county MediCal and Healthy Families enrollment processes.**
   This proposal draws a clear bright line (at 100 or 133% of FPL) between MediCal and Healthy Families. Individuals with revolving door MediCal eligibility such as MediCal share of cost or pregnancy lonely care above the bright line would move into Healthy Families and have continuity of care and full scope benefits. This is for the most part a cost neutral shift.

   - We propose to consolidate the multiple MediCal sub-categories for coverage of children, parents and families.
   - We propose to eliminate the special rules for counting and disregarding income and assets in favor of basic and consistent rules. What are they?
     a. All net income counts
     b. No assets count
     c. Work income is subject to standard deductions for child care

- We propose to eliminate the distinctions between state and county coverage programs based on levels of disability, disease, condition or chronic illness.

3. **Allows entire family to enroll in subsidized coverage either through the workplace or through public programs.**
   Under the current system a low wage working family's coverage can be split between public and private coverage and within public programs between three or four different programs. This proposal would allow the family to stay together in one plan, whether at the workplace or in a public program.

4. H**ow do all the pieces fit together and simplify care to the uninsured?**
   We recommend incentives for uninsuring employers to offer coverage and uninsured employees to take up coverage; we develop public and private coverage opportunities for all who cannot afford coverage.

- Persons with incomes below poverty eligible for MediCal.
- Persons with incomes up to 200% of FPL eligible for Healthy Families. Persons with Healthy Families eligibility may use the program to pay their employee premium contributions for coverage through their work place.

- Small employers with more than one third of workforce earning less than twice the state minimum wage may access 50% premium subsidy through quarterly refundable tax credits.
- Flex and other uninsured workers eligible for public programs up to 200% of FPL and for private coverage with phased down premium subsidy up to individual income of $35,000 and household income of $70,000.
- Eligible families with ineligible family members may buy public coverage by paying the cost of public coverage for uncovered members.

Current Reform Experiences and How This Reform Proposal Will Improve Upon Them

1. **Tries to increase enrollment of unenrolled children and parents by offering workplace enrollment (not tried before in CA; mixture of experiences from other states).**

   California had greater difficulties with Healthy Families and MediCal enrollment than other states; part was due to the initial long application form and the public charge issue; part is still due to our large immigrant populations' fears of enrolling in public programs. We suggest using the workplace as a site to increase enrollment; we recognize that there are legitimate fears of crowd out and it may be best to pilot this effort in several communities to see if it works and has any crowd out effects.

2. **Tries to increase employment based coverage by offering large targeted subsidies to employers with low rates of offering (small short term subsidies resulted in poor participation).**

   Robert Wood Johnson Foundation funded several pilots around the country to test whether employment based subsidies increased enrollment; they had modest successes with increasing enrollment as subsidies increased. Several states have tried subsidies for employment based coverage without much success. Our proposal suggests a time limited test of large and targeted subsidies delivered through the tax system. We believe that uninsuring employers will be more responsive to large premium subsidies and to tax based incentives provided they are refundable and timed to the employer's premium payments. We propose targeting difficult markets (flex and transitional employees and small low wage employers) where there is not much coverage. If it succeeds, it will reach some of the most difficult persons to cover. If it fails to enroll new eligibles, it will not be costly, as the target markets do not now offer much coverage.

3. **Tries to provide coverage options for flex workers (not tried anywhere).**

   The effort to target flex workers with a premium subsidy has not to our knowledge been tried anywhere. However individual premium subsidies have been tried in Washington and Tennessee with substantial success, largely dependent on the size of the premium subsidy. Our proposal is unusual in suggesting refundable tax credits/vouchers as a way to deliver the premium subsidy. This approach could prove cumbersome or could be a way to reach uninsured workers that public programs do not reach.

4. **Covers low income adults through MediCal managed care (successful in Arizona, Oregon and Tennessee).**

MediCal managed care worked successfully to cover low income adults where it has been tried in Arizona, Oregon and Tennessee. There are challenges due to slow initial enrollment and accustoming new enrollees to using primary care physicians rather than hospital emergency rooms as the provider of first resort. The county uninsured population includes young healthy individuals with episodic emergency room use and older persons often with chronic illnesses who would greatly benefit from an organized accessible delivery system. There could be important health benefits from improving the delivery system for the chronically ill portion of the county population.

5. Tries to reach uninsured immigrants (including those with no federal financial participation) through private coverage (untested).

California is a state of immigrants (18% of the state's population) of whom nearly half are uninsured. Federal funding is restricted in the MediCal and Healthy Families programs for new immigrants and the undocumented. California covers emergency care for undocumented immigrants (those without INS registration in the proper categories).

This proposal would make it easier for immigrants who want coverage to buy in the private market. The tax reforms apply to employers and low wage workers regardless of the workers' immigration status. We do not know how immigrants or their employers will respond to these incentives. A sophisticated informational campaign will be needed. We must overcome language/cultural barriers to reach uninsured immigrants.

6. Unlike single payor and employer and individual mandate approaches, this will not cover all the uninsured, but it will give all the uninsured opportunities for affordable coverage. There will be a reduced need for explicit residual safety net funding.

The incremental expansion of public and private coverage we are proposing will not achieve universal coverage unless accompanied by a mix of individual, employee and employer mandates. Unless California's politicians can agree upon mandates or single payor and secure required federal assent, the system of increasing public and private opportunities for affordable coverage may be the most feasible political solution. It will diminish the need for safety net funding, but not eliminate the safety net institutions. There will be a need to explicitly rationalize residual safety net funding. Rather than allocating to institutions that treat few of the uninsured, appropriate funding must go to those providers where disproportionate numbers of the residual uncompensated uninsured are actually treated. Safety net financing should encourage integrated community systems of caring for the uninsured, rather than funding care through disconnected providers, programs and micro funding streams.

7. Tries to balance increases in public and private coverage opportunities.

This approach seeks to balance the growth in public and private coverage opportunities rather than rely on either one to the exclusion of the other. We believe that over time people and institutions do *follow the money* and thus various forms of crowd out (between public and private, and between employment based and individual private insurance) can occur and are more likely to occur if the expansion is unbalanced.

8. Who benefits?

Uninsured patients, the providers who treat them, small lower wage employers, low wage and flex workforces, health plans and state and county governments all benefit from changing the care of the uninsured from unfunded, uncoordinated care into managed care coverage with a balanced mix of state, local, federal and private financing. Chronically ill uninsured persons would particularly benefit from the move to well run managed care.

9. Who may not benefit?

Patients who enroll with poor quality providers or poorly performing managed care plans and provider groups will be at risk. Good, clear and reliable information, which is understandable to vulnerable populations and individuals with limited english speaking skills, is essential to making this proposal work. State and local regulators and negotiators will need to be skilled and vigilant in monitoring managed care plans and providers. Participating plans and providers will need to improve language and cultural access, enabling services and their care for chronically ill individuals. Some providers face special challenges in transitioning their practices into cost effective managed care modes

TAX CREDITS/VOUCHERS TO INCREASE EMPLOYMENT-BASED COVERAGE

Appendix 1

Overview

California has a low rate of employment-based coverage, especially in comparison to the rest of the country.[i] In 1999, Californians were 6.6 percentage points less likely to receive employment-based health insurance than the average American.[ii]

Employment-based coverage is the dominant form of coverage for working Californians. Employment-based coverage is purchased with a pre-tax dollar and encompasses a series of significant cross subsidies from younger to older, healthier to sicker and higher wage to lower wage workers.[iii] The tax subsidies for employment-based coverage do not assure affordability for those employers with a high percentage of low-wage employees. Pre-tax purchasing of employment-based coverage subsidizes about a third of the cost of employment-based coverage and up to half the costs of coverage for high-wage earners.[iv] It is poorly designed to provide affordable coverage for low-wage workforces, as it subsidizes less than 10% of premiums for low-wage workers. As a result, the average cost of coverage for an individual employee is over 20% of the wages of a minimum wage employee and the average cost of family coverage is over 50% of the annual wage of a minimum wage workers.[v] (See Chart 8 attached).

For the most part, California's uninsured are young, low-income workers; 65% are under age thirty; over two-thirds have incomes under 200% of the federal poverty level; and over 80% are employed or dependents of an employee.[vi] Latinos, young adults and immigrants have very high ratios of uninsured (over 40%), high workforce participation rates and face federal and state obstacles to participation in public programs.[vii]

In general, enrollment through the workplace is easy; employee participation rates are high even for low-wage workers, and coverage is highly valued.[viii] California's non-citizens work long hours for low wages, and frequently without health insurance; nearly half are uninsured.[ix] Restrictions on public coverage for many of the state's immigrants place a premium on developing alternative basic affordable private coverage through the work place for immigrant workforces -- the working backbone of many segments of California's economy.[x]

California has a broad range of industry types, which differ widely by average firm size, average pay and the rates at which they offer health coverage. Retail trade had approximately the same wage levels as reported for agriculture, but a far higher rate of employer offering.

EMPLOYMENT, PAY and OFFER RATES[xi]

Type of industry	Number of establishments	Average monthly employment	Average annual pay	Rate of offering by industry type[xii]
Agriculture	37,000	509,000	$18,000	46%
Construction	70,000	680,000	$37,000	61%
Manufacturing	57,000	1,915,000	$50,000	85%
Transportation and utilities	31,000	706,000	$46,000	90%
Wholesale trade	72,000	811,000	$46,000	78%
Retail trade	165,000	2,387,000	$20,000	71%
Finance, insurance and real estate	76,000	817,000	$55,000	86%
Services	500,000	4,352,000	$37,000	74%
Federal government		271,000	$45,000	99%
State government		391,000	$42,000	99%
Local government		1,505,000	$37,000	99%

We reviewed wage compositions for two industries with below average rates of offering coverage: the construction industry and the services industry. Within the construction category, there was a relatively narrow variation in average pay by type of construction firm.[xiii] The construction industry has a large proportion of very small employers and a high rate of employees shifting from job to job.[xiv] The services category encompassed a wide range of industry types with wide variations in average pay and firm size as displayed below.

SERVICE INDUSTRY, PAY and EMPLOYMENT[xv]

Type of industry	Number of establishments	Average number of employees	Average monthly employment	Average annual pay
Hotels and motels	5,800	32	187,000	$20,000
Beauty shops	8,000	4.5	36,000	$14,000
Building maintenance	5,800	15.5	90,000	$15,000
Automotive services, except repair	4,000	10	41,000	$17,000
Motion pictures	12,000	16.6	200,000	$55,000
Hospitals	984	334	329,000	$38,000
Legal services	22,000	5.5	121,000	$65,000
Educational services	7,000	26	183,000	$29,000
Child day care	7,000	7.5	53,000	$16,000
Engineering and management services	47,000	9.4	442,000	$58,000
Private households	173,000	0.9	151,000	$10,000

There is a reported difference between the offer rates of construction, durable manufacturing and non-durable manufacturing.[xvi] As displayed above, manufacturing has larger average firm size, higher average annual pay and a higher offer rate than the construction industry. We reviewed average hourly wages and hours worked between construction and manufacturing and within the manufacturing sector. Construction had higher hourly pay rates and lower hours worked; we assume construction also has fewer weeks worked annually than manufacturing due to shifting job sites. Durable and non

durable manufacturing each included industry types with higher and lower rates of pay. The apparel industry had particularly low rates of pay.

WAGES in the CONSTRUCTION and MANUFACTURING INDUSTRIES[xvii]

Type of industry	Hourly rate	Average hours worked
Construction	$23.02	36.7
Manufacturing	$15.32	40.6
Durable		
Lumber and wood products	$12.02	40.9
Furniture and fixtures	$11.04	38.7
Computer and office equipment	$18.98	39.4
Motor vehicles	$18.55	41.9
Aircraft	$21.33	42.9
Non durable		
Meat products	$10.68	42.7
Apparel	$8.98	39.4
Petroleum refining	$28.04	45.3
Movie production	$33.71	34.9

We reviewed the composition of California's workforce by employer size and wages:

9. 11% work for employers of less than 10 (where reported offer rates for health coverage are less than 50%),
10. 27% work for employers from 10 to 50 employees (where reported offer rates for health coverage are 75%),
11. 30% for employers from 51 to 250, and
12. 32% for employers with 250 or more employees (where reported offer rates for coverage are about 100%). [xviii] (See Chart 6 on offer rates by firm size).

Mean wages in California are $18 an hour; the 25th percentile is $9; the 75th percentile was $23 in the year 2001.[xix] California's minimum wage is $6.25; about one million workers (about 8% of employees) made the minimum wage or less in 1999. Half of minimum wage workers are under age 25, and two thirds are younger than 35. Nearly half of minimum wage workers are Hispanic; Hispanics had the highest reported rate of minimum wage workers -- 15%.[xx]

The reported offer rates for health coverage were: 58% for employees making less than $9.50 an hour, 87% for employees making between $9.50 and $14.25, 89% for employees making between $14.26 and $19.00 and 95% for employees earning more than $19.00 an hour.[xxi] In 1999, the highest 10% of salaried workers made $30 an hour or more. One third of the state's workers make wages of less than $12.50 an hour (or $25,000 annually).[xxii]

Poverty Levels and their Relationship to the State Minimum Wage[xxiii]

Poverty level: family of one	Poverty level: family of two	State minimum wage	Poverty level: family of three	Poverty level: family of four	200% of poverty: family of one	200% of poverty: family of two	Twice state minimum wage	200% of poverty: family of three
$8,950	$11,610	$12,500	$14,630	$17,650	$17,900	$23,220	$25,000	$29,260

California has experienced increases in health coverage "offer" rates by small employers, and more low-wage workers are now receiving private coverage through their employers. This is due to rising wages, not to increasing offer rates for low-wage workers. The offer rate did not improve (in fact it declined) for low-wage workers.[xxiv] Many predict that employment-based coverage will decline in response to rising health plan premiums and the slowing economy.[xxv]

California's uninsured are concentrated among smaller and predominantly low-wage workforces.[xxvi] California's low-wage workforces and small employers need both effective group purchasing[xxvii] and premium subsidies efficiently targeted to the uninsured.

REFUNDABLE TAX CREDITS/VOUCHERS TO INCREASE THE OFFER RATE FOR SMALL EMPLOYERS WITH LOW-WAGE WORKFORCES

a. Research

California's offer rates for very small businesses (10 employees or less) are particularly low -- about 50% as compared to nearly 100% offer rates by large businesses. Average pay steadily increases with firm size; the smallest average pay was for employers of 5-9 employees, and the largest was for employers of over 1000 employees the pay differential was about 50%.[xxviii]

Offer rates (about 20%) for small employers (2-200) with a high percentage of low-wage workers (full-time workers making less than $20,000 annually) were one-third the reported offer rates for all employers.[xxix] A tax credit targeted to this group of employers could be cost-effective if substantial numbers of the firms not now offering coverage can be induced by the subsidy to initiate coverage. (See Charts 6 and 9).

Uninsuring employers report that the primary reasons that they do not offer coverage are **affordability**.[xxx] While no definitive research has been done to quantify the response of employers to different levels of subsidy, the employer and employee responses to Sharp Health Plan's Focus product (which has a 50% premium subsidy) have been very strong.[xxxi]

If we fail to increase employer offer rates for low-wage workers in California, government's 100% cost of care and coverage will be substantial. There are a number of options a state can use to increase employment-based coverage. These include public program buy ins, premium subsidies through purchasing pools, health plan subsidies either in the form of reinsurance or relief from state mandates on covered benefits and refundable tax credits. None of these approaches has been more notably successful than the others. Iowa has had the most successful public program buy in (8500 participants), and Arizona had success with reinsurance (3610 small firms). Kansas reported 62 newly insuring firms responding to a small employer tax credit and Massachusetts reported 800 firms small firm enrolled in a premium subsidy program.[xxxii]

States such as Washington (130,000 enrollees), Minnesota (117,000) and Wisconsin (65,000) have had strong success with individual enrollment in premium subsidy programs, but report very little employer take up of employer premium subsidies.[xxxiii] Local plans in Wayne County, Michigan (1,977 small businesses), San Diego county, California (216 small businesses) and Muskegon County, Michigan (155 small and midsize employers) have reported substantial success in attracting employer enrollment. The philanthropic premium subsidy for FOCUS in San Diego was 50% while the two Michigan sites had 33-40% public premium subsidies.[xxxiv]

CSBA (California Small Business Association) has conducted surveys and focus groups among California's small employers, which indicates that small employers are significantly more receptive to refundable tax credits than to Medi-Cal program buy-ins and were typically unaware of the Healthy Families program.[xxxv] There are ranges of approaches introduced in the California legislature to provide public subsidies to increase employment-based coverage; they divide between tax credits and employer premium subsidies through a purchasing pool.[xxxvi]

California has two purchasing pools for small employers each with about 150,000 enrolled lives. Most small businesses are unaware of the pools, and their penetration in the small employer market has been less than expected.[xxxvii] Distributing premium subsidies to employers through existing purchasing pools is appealing due to the administrative efficiencies, but it may fail to reach most of the employers we would wish to target because participation rates in the existing pools are a small percent of the market.

b. Premium subsidy

Employer tax credits have to be set at high enough levels to cover a substantial portion of the cost of coverage in order to induce participation by uninsuring employers,[xxxviii] and allow low-wage employees to take up employer coverage. Challenges include: 1) calculating the size of the credit sufficient to induce offering; 2) designing a sufficiently targeted tax credit to be an efficient financial vehicle to increase employment-based coverage;[xxxix] 3) making it simple enough for small employers to use without access to sophisticated tax accountants; and 4) timing the credit to meet employers' premium payments. An unappreciated advantage of a well targeted employer tax credit is that it reaches uninsured workers not otherwise eligible for federal and state public programs and has radiating impacts -- i.e. the employer offers coverage for those with the credit and those without.

ITUP's proposal is that the premium subsidy (via refundable tax credits or vouchers) should be 50% of the premium. We selected that level because it has been successful in San Diego and is the current tax subsidy for the best paid employees. The Michigan pilot sites appear to have had enrollment success with 33-40% premium subsidies, however, the Robert Wood Johnson pilot projects had less success with 10-25% premium subsidies.[xl]

The targeted subsidy would be 50% of the premium for those employees making less than twice the state's minimum wage. For employees at twice the state's minimum wage or more, the average cost of family coverage is slightly under 25% of wages and the average cost of individual coverage is slightly less than 10% of wages. This targets the premium subsidy to those employees with the highest degree of unaffordability and least subsidies through pre-tax purchasing.

The premium subsidy should be carefully targeted and equitable (i.e. it must focus on increasing employment-based coverage where offer rates are low and treat new offerors and current offerors the same). A tax credit would be most cost-effective if targeted to uninsuring small employers; however, it creates a serious equity issue to subsidize a non-offering employer while excluding its competitor down the street who already offers coverage. Focus groups and workshops on this issue conducted by California Small Business Association indicate that "equity" will be essential in explaining tax credits to small employers.

We recommend initially targeting subsidies to those employers with from 10 full-time equivalent employees where at least a third of the workforce earns wages of less than twice the state's minimum wage ($12.50 an hour). The research suggests that only 20% of employers of less than 200 employees, with at least a third of their workforce making less than $20,000 annually, offer coverage. [xli] However, as will be discussed, a large universe of employers meets this definition.

Our research found that one third of the state workforce makes less than $12.50 an hour and two thirds of all workers work for employers of less than 250 employees. We were not able to determine the numbers of employers meeting our proposed target definition. The Employment Development Department indicates that it maintains and reports data by employer size and average wages, but they do not maintain and report data that indicates the wage composition of a given employer's workforce. [xlii]

Ninety nine percent of all California employers have fewer than 250 employees and two thirds have fewer than 10 employees. Since offer rates and average wages increases with firm size, we considered setting the employer cut off size at 10, 50 or at 250 employees. We recommended the smaller definition of employers of 10 employees or less in order to reach employers with the greatest propensity to cover low-wage uninsured employees in response to subsidies. Setting the target size too low may reach too few of the uninsured and create undue incentives to stay small.[xliii] However, it would be more cost-effective for California to initially target employers of a smaller size and then increase to larger sizes if the initial small employers and employees respond positively.

We investigated setting the subsidy target for those employers with low average wages. For example, the agriculture industry's average wages were only $18,000 annually ($9.00 an hour). However, half of agricultural employers already offer coverage. Targeting the subsidy by average wages would be equitable but would be less cost-effective than our suggested target.

We considered and then rejected targeting employer subsidies by the employee's family income. Thirty percent of all Californians have incomes below 200% of FPL and this group of employees has the highest rate of lack of coverage. Employers, however, do not know family income, and this is not information that employees would want shared with their employer.

We propose tying the subsidy to the Knox/Keene basic benefits package with the addition of prescription drugs; this is equivalent to the coverage of virtually all employer plans.[xliv] Some will argue for fewer benefits so that more plans would qualify and others would favor more benefits to be comparable to Medi-Cal coverage. We recommend adding prescription drugs to the Knox/Keene basic benefits plan[xlv] as it is impossible to practice modern medicine without them and impossible for low-wage workers to afford prescription drugs out of pocket. The Knox/Keene statute setting forth basic benefits does not limit the size of health plan co-payments, which could make low-wage subscriber's access to services difficult in plans with high patient co-pays.

Over the years, the Knox/Keene Act and the Insurance Code have been encrusted with a series of benefit mandates; these include mandates to offer and to cover specified benefits and mandates to include certain types of providers.[xlvi] We requested estimates of the added cost of these mandates, and one plan with experience in both the self-insured and insured markets suggests the added cost is 6% of premium. We recommend no new mandates, a careful review of the health and cost benefits of existing mandates and pilot testing the cost and employer responsiveness to basic coverage without the supplemental mandates.

EDD (Employment Development Department) and FTB (Franchise Tax Board) will need to collaborate to administer the subsidy for most small employers. EDD collects employer and employee payroll taxes, and FTB collects and administers the Bank and Corporations tax and individual income tax. Employers would self certify their eligibility for the credit and be audited and computer cross checked by FTB and EDD for compliance.

EDD and FTB already receive information from employers and the self-employed quarterly; it is possible, therefore, to time the tax subsidies from the tax agencies to meet quarterly health plan premiums. However, there is a lag time of up to four months in compiling the tax information for those (mostly small employers) who submit their taxes manually as opposed to those who submit their tax information electronically.

FTB points out that many small employers pay no tax other than the $800 Bank and Corporations tax and that some of the state's self-employed pay only the minimum tax. Employers typically also pay sales, property and utility taxes. To reach many of our target uninsuring employers, the tax credit needs to be refundable; this will require a state General Fund Appropriation.

Several small non-profit agencies point out that they are typically not benefited by tax credits but have the same health insurance affordability problems as any other low-wage

small employer. We recommend that they receive a premium subsidy as well in the form of a voucher for 50% of the cost of coverage of their low-wage employees.

Both state tax agencies point out that refundable tax credits can and have posed fraud problems. One potential solution is to make the refundable tax credit in the form of a voucher, which can only be used by the employer to purchase basic health plan coverage. This obviates the need to cross check the employer's purchase of basic health coverage.

EDD points out that it collects the Unemployment Insurance (UI) and State Disability Insurance (SDI) taxes which are dedicated to those programs. This proposal does not suggest a rebate of either the UI or SDI taxes.

FTB points out that many small and mid-sized employers are subsidiaries of larger corporations. FTB is able to distinguish between small business subsidiaries and stand alone small employers; we do not recommend subsidies for coverage offered by subsidiaries.

Ideally the health insurance premium subsidy should phase down and out as businesses grow in size and wage levels improve. We concluded this is too complex to design and model for the purposes of this paper.

We recommend that the approach should be thoroughly reviewed after three to five years to determine its cost-efficiency[xlvii] at covering uninsured workers and include a sunset if a targeted increase in employment-based coverage is not achieved. If the very small employer and employee response to the premium subsidy is strong, it should be expanded to employers of 50 or fewer employees and if that is successful to employers of 250 or fewer employees.

REFUNDABLE TAX CREDIT/VOUCHERS TO INCREASE THE TAKE UP RATE BY LOW-WAGE WORKFORCES FOR FAMILY COVERAGE

Appendix 2

Research

California has lower levels of employee contributions ($20 per employee per month for employee only coverage and $113 per month for family coverage) and a higher take up rate (nearly 90%) than the national averages.[xlviii] Family coverage is typically three times as costly as employee only coverage, and employee premium shares are usually a higher percentage of family than individual coverage.

The projections are that employees' share of health premiums will increase as health costs rise faster than wages, profitability declines, unemployment increases, and the economy moves into a recession.[xlix] The California Budget Project reports that average wages for low and middle income Californians fell after adjustment for inflation from 1989 to 2000, and that low and middle income employees worked significantly longer hours to make up for the decline in their hourly wages.[l] Medoff et al. point to a two decade long squeeze on wages, benefits and increasing shares of premiums for low-wage workers.[li]

According to at least one recent study, there may be as many as one million uninsured Californians who are offered coverage but decline it.

- In 1996, 17% of uninsured persons with incomes below poverty were offered but declined employer sponsored health insurance, and
- 28% of the uninsured with incomes between 100 and 200% FPL were offered but declined employer sponsored health insurance. [lii]

Several commentators have pointed out that declines in employee take up rates of offered coverage were offsetting gains in employer offer rates.[liii] These trends may be exacerbated during the recent economic slowdown.

Does California have an affordability problem for low-wage employees? We calculated employee premium contribution averages as a percent of employee incomes. We used two standards of employee wages to calculate affordability: 2% of wages (the contribution schedule for the state's Access for Infants and Mothers program) and 3% of wages. At two percent of wages, all individuals making at least the state minimum wage on a full-time, full year basis can *afford* the average employee share of individual premiums. In other words, working individuals with incomes above 133% of the federal poverty level do not spend more than two percent of wages on the average employee contributions for individual coverage.

However, our calculations of affordability of premiums for low-income working families produced very different results. Using 2% of family income as our benchmark, working families with incomes below $60,000 experience affordability problems. Using the 3% of family income as our benchmark, families with incomes below $45,000 (equal to the median family income) experience affordability problems. Roughly half of all families in California pay more than 3% of family income for health insurance premiums. Using these benchmarks, California has a very extensive affordability problem for below

median income working families with and without health coverage, but not for low-wage working individuals (unless they have incomes below 133% of the federal poverty level). See Chart 12. High income employees have the ability to secure substantial tax subsidies for their share of premiums through an Internal Revenue Code §125 account; due to their low-incomes and low-income tax rates, low-wage earners get little help from this source.

But does this level of an *affordability* problem affect the take up rate for employer offered coverage? Apparently it does, but it does not affect it as much as one at first might expect. The take-up rate falls from 97% for workers making over $19 an hour to 73% for workers making less than $9.50 an hour.[liv] A study from the Urban Institute found that California's low-wage Hispanics experience an offer problem (i.e. they are not offered coverage), but even the lowest wage Hispanic workers have a high take up rate. These low-wage working individuals value coverage even in the face of family coverage contribution requirements that may run up to 10% of income.

Urban Institute Findings on Offer and Take Up Rates For Low-wage Hispanic Workers[lv]

Offer rate, wages $7.50 or less/hour ($15,000 or less annually)	Offer rate, wages $7.50-$15.00/hour	Take up rate wages $7.50 or less/hour	Take up rate wages $7.50. $15.00/hour
38%	68%	80%	84%

Referring to *average* employee contribution levels masks the affordability problems actually experienced by some low-wage working families as many employers do not pay the average. A recent study by the California Small Business Association illuminates the extent of this problem. Small employers responding to the survey report their typical contribution requirements for employee only coverage are 75-100% of premium; their contributions for family coverage averaged 50%. Small employers reported a bi-polar distribution of contribution levels for family coverage -- 40% of offering small businesses report paying 80-100% of family coverage and 40% report paying 0-20% of family coverage.[lvi]

Research is needed to determine the make up of the employees who decline coverage, for what reasons and their potential responsiveness to a premium subsidy. Two recent studies shed some light on the take up problem. Howard Greenwald et al. report that the dominant reasons for lack of coverage for working Latinos are the cost of coverage and the lack of an employer offer; however, the study found 14% of respondents who do not "value" coverage were workers who had never had coverage.[lvii] Jill Yegian investigated the willingness of uninsured individuals with incomes over 200% of FPL to purchase individual coverage; she identified a somewhat larger subset of 30% of the non-poor uninsured who did not value coverage.[lviii] Many in the provider community refer to this group as the young immortals (most typically young males) who do not use health services or value coverage until an emergency event occurs.

In summary, affordability for low-wage employees is a problem for both the insured and uninsured, but take-up has not yet emerged as the most serious problem causing lack of insurance in California. The *value* that individual employees place on health coverage may be connected to affordability, the individual's demographic profile and the design of employee contributions. Employee premium contributions are typically based on a percentage share of the employer's composite rate. This design of employee contributions cross subsidizes from young and healthy employees who have a low likelihood of using health services to older, often better paid employees with more significant assets -- who for these reasons may place a higher value on health coverage. We recommend that employers structure the employee share of premiums based on a percentage of employee wages, rather than a percentage of employer premiums; this can be done in a cost neutral fashion. The following chart is an example of structuring employee premiums based on wages versus based on a percent of premium; for purposes of illustration we increased wages with age in a four employee firm.

STRUCTURING PREMIUM CONTRIBUTIONS BASED ON PERCENT OF WAGES OR PERCENT OF PREMIUMS

Average Monthly Salary	**Employee contribution (33% of average premium)**	**Employee contribution (2% of wages)**	**Employer contribution (67% of average premium)**	**Age-rated Premium**	**Average premium**
$800	$40	($16)	$80	$90 (under age 30)	$120
$1600	$40	($32)	$80	$105 (over 30)	$120
$2400	$40	($48)	$80	$125 (over 40)	$120
$3200	$40	($64)	$80	$160 (over 50)	$120

B. Proposal

ITUP's proposal is to target low-wage uninsured working families who must pay more than a designated percentage (e.g. 2-3%) of family income for employer sponsored family coverage. The challenges are: 1) design an effective tax credit to help the lower wage working family with an inordinate share of family income devoted to family coverage without inducing employers to reduce their contributions; 2) make the credit refundable and timed to the employee's monthly contributions; and 3) sufficiently target the credit so that it does not unduly subsidize those who need no subsidies. We investigated two alternatives: a refundable state tax credit and the Healthy Families purchasing credit.

The federal government has a refundable Earned Income Tax Credit (EITC) and a child care tax credit. California has a refundable child care tax credit. The federal EITC included a component to pay for health coverage, which was dropped, as it proved unworkable.[lix] EITC is used by 2.4 million Californians; the average pay out is $1601 and the income limits are $10,380 for a single adult, $27,813 for one child and $31,152 for two or more children.[lx] It was not workable to pay health premiums through the EITC in part because EITC is payable once a year, while employee's share of premiums are deducted monthly. It may be possible for California to "piggy back" a refundable health

insurance tax credit on top of the federal EITC, but it would not reach the employees when they need it -- in their monthly paychecks. There are several suggestions on how to correct this timing problem. Some involve advancing part of the refundable credit monthly through the employee's tax withholding and the remainder at the end of the year when the household's family income and tax liability is reported.[lxi] EITC is based on family income, while payroll tax deductions are based on an individual employee's wages, which often are only a portion of household income.

Federal and state child care tax credits reach both low and higher income families, decreasing in value as family income increases and phasing out at $100,000 adjusted gross income. Could we model an employee health insurance credit similar to the child care tax credit? The differences between employees' child care costs and their share of health insurance premiums are substantial: child care costs at least four times as much, employees can not go to work without it, and few employers contribute.

To provide a monthly or quarterly refundable tax credit for low-income employees' share of employer health premiums in California would require the cooperation of EDD, the Franchise Tax Board, the employee and the employer. FTB receives the information on family incomes as individuals file their annual tax returns. EDD receives information on employee wages quarterly; there may be as much as a four months lag in compiling the tax information submitted manually (as opposed to electronically) by small employers.

To simplify the administration of the credit, the employee could self-certify that they are eligible for the credit (as one does for number of dependents) and pay at a lower state tax withholding rate. Reconciliation to tax liability could be done at the end of the tax year. However, payment of the refundable portion of the credit would then be postponed until the end of the taxable year. Would this reach very low earners? FTB reports that individual filers with incomes below $9811 and joint filers with incomes below $19,071 are exempt from state income tax, but many file end of the year tax returns to recover their tax refunds.

The credit is likely to exceed state income tax liability of low-wage working families; thus, a refundable tax credit is needed, which requires a General Fund appropriation. Refundable tax credits pose unique tax fraud challenges for the administering tax agencies as some unscrupulous individuals have created phony tax refund mills. The Urban Institute reports that refundable tax credits are disproportionately not received by low-wage Hispanic immigrant workers due to limited English speaking skills, low educational attainment and lack of familiarity with the rules and eligibility for tax refunds; this is the same population that is disproportionately uninsured.[lxii]

A Healthy Families purchasing credit administered by MRMIB better targets uninsured low-wage families who cannot afford family coverage premiums, has a larger impact in increasing coverage for the uninsured and uses federal matching funds at a lower state cost than a refundable state tax credit. The Healthy Families legislation authorizes a purchasing credit to pay an employee's share of employer premiums.[lxiii] Medi-Cal's HIPP (Health Insurance Premium Payment) Program authorizes the Department of Health

Services to pay an employee's share of employer premiums. The Healthy Families program is limited to uninsured children and (if the waiver is approved) to their uninsured parents. Using the Healthy Families credit targets the funding to those who are offered coverage, but have not taken up the offer.

The purchasing credit and Medi-Cal HIPP program must be cost-effective -- i.e. not pay more for coverage than Healthy Families and Medi-Cal would otherwise pay for coverage. It is almost always less costly to the state to use the credit as the employer pays a share of coverage, but many employer plans have fewer benefits and higher co-pays than the Healthy Families program does. It is critical to provide supplemental or wrap around benefits to equalize coverage of those using the credit with those otherwise using the program without the credit. Wrap around benefits are easy to administer for uncovered benefits using Medi-Cal's fee-for-service program, but more difficult to administer for plans with higher co-pays and deductibles than Healthy Families.

The purchasing credit is less costly to the state than a refundable tax credit as Healthy Families has a 2/1 federal match while the refundable employee tax credit might be 100% state General Fund cost. The refundable tax credit helps both insured and uninsured families and is thus more equitable for all wage earners but less cost-effective than the purchasing credit in increasing coverage of the uninsured.

There are concerns about crowd out and crowd in at the intersections of public coverage, public subsidies and employer contributions. Healthy Families reaches a small niche -- less than 2% of Californians -- and is not very likely to induce significant crowd out of employer sponsored coverage. Healthy Families' purchasing credit assists uninsured families to purchase employer offered coverage; this credit is more likely to prevent than to increase crowd out. There is a concern that employers in response to a refundable tax credit which reaches more than half of working families could increase employee shares of premium and thus substitute the state tax credit to employees for the employer's own contributions.

California has many mixed immigration status, low-income uninsured families.[lxiv] Healthy Families does not reach family members ineligible for federal and state public programs. A refundable tax credit would be the better of the two approaches at reaching immigrant families who are deterred by their immigration status from enrolling in public programs.

On balance, we recommend implementation of the Healthy Families purchasing credit as the better of the two approaches to increase take up rates of employer offered coverage by uninsured employees.

REFUNDABLE TAX CREDIT/VOUCHERS FOR THE FLEX WORKFORCE

Appendix 3

➢ Research

The flex workforce may account for as much as 30% of workers and include nearly half of uninsured California workers.[lxv] The flex workforce includes part-time, seasonal, contract, temporary workers and the self-employed. Flex workers are as disparate as the day laborer, migrant worker, gardener, artist, entertainer and computer consultant; they have in common a low-rate of employment-based coverage and high rate of uninsurance. Flex workers are more disadvantaged than the rest of the workforce because there is typically no employer contribution. Only self-employed flex workers receive any federal and state tax subsidy (100% tax deductibility for the self-employed in 2003) if they purchase individual coverage. Recent research indicates that lack of coverage for a growing flex workforce is the key component in the past and projected future declines of employment-based coverage.[lxvi]

Those flex workers who do have employment-based coverage are often covered as a dependent of a full-time, full year worker.[lxvii] Since most flex workers are not covered through their own employer, the likelihood of crowd out or displacement of existing employer sponsored coverage for the employee is low.[lxviii] The studies we reviewed found that only 12% of flex workers had employment-based coverage through their own job; by contrast, most full-time, full year employees are offered coverage at work.[lxix] Coverage varies by the type of flex worker.[lxx]

- Self-employed: 39% uninsured, 29% covered through a spouse's job, 25% with individual coverage and 4% with public coverage;
- Part-timers: 36% uninsured, 37% covered through their spouses or their own job, 7% with individual coverage and 17% with public coverage;
- Seasonal: 28% uninsured, 48% covered through their own or a spouse's job, 3% with individual coverage and 20% with public coverage;
- Temps: 53% uninsured;
- On call workers: 33% uninsured, and
- Full-time workers 15-16% uninsured, 75% with employment-based coverage, 3% with individual coverage and 3% with public coverage.[lxxi]

Flex workers are typically much younger than the overall work force, and, thus less costly to insure. In 1995, among all the different types of flex workers, a very large percentage (estimates ranged from 31-42%) was between the ages of 16 and 24. Their tenures as flex workers are typically short.[lxxii] As workers age, they are increasingly likely to spend longer periods working in the flex workforce.[lxxiii] 20% of workers aged 50 to 64 are employed in flexible work arrangements; demographic trends among the baby-boom generation indicate that an increasing number of 50-64 year olds may seek similar arrangements in the future.[lxxiv]

We include in the flex workforce, the 1.5 million self-insured Californians, who are typically older, with higher incomes and greater assets, more males and more non-Hispanic whites than the part-time, seasonal and temporary workforces.[lxxv] 51% of the self-employed work in the services industry, and this ranges from doctors and accountants to home care workers; 10% are in agriculture, comprising over 25% of the agricultural workforce. The self-employed comprise 10% of California's workers. Temp workers, by contrast, are mostly young workers and comprise 1-2% of the workforce.[lxxvi] Part-timers are the largest and fastest growing component of uninsured flex workers.[lxxvii]

There are a number of efforts to cover flex workers throughout California and across the country. These include the efforts to cover home care workers, child care workers, public and academic flex workers, Silicon Valley temp workers, employees in the construction, high tech, artistic and entertainment industries.[lxxviii] Typically these efforts include both a new or revised purchasing structure such as a union, ERISA or association trust or a public purchasing entity and some form of public and/or employer subsidy. None that we have reviewed are self-financed by the premiums of flex workers themselves other than Working Today, an association plan for free lancers based in New York. (See Models for Flex Workers Coverage attached as Chart 13).

- **Proposal**

Individual refundable tax credits could be an efficient way to fund coverage opportunities to workers who are unlikely to be covered through their own employment. Challenges in designing such subsidies include: 1) timing, 2) size, 3) simplicity, 4) refundability, 5) targeting and 6) linkage to efficient group purchasing and/or a reformed individual market.

ITUP recommends refundable tax credits tied to the purchase of health coverage for low and moderate-income persons who are not offered coverage through the workplace. This means that workers who are not offered employment-based coverage (whether flex or not) can get the credit to purchase coverage.

ITUP's proposal is that the premium subsidy for the self-employed be linked to quarterly estimated tax payments to the Franchise Tax Board and delivered as a refundable tax credit/voucher matched to an individual's quarterly premium payments to carriers. Franchise Tax Board points out that some of the self-employed do not pay estimated taxes quarterly as their income flows are highly seasonal in nature, especially centered on the holiday season.

We recommend that the premium subsidy for flex and other uninsured employees be in the form of a voucher/refundable tax credit and tied to quarterly premium payments to health plans. FTB and EDD inform us that refundable tax credits have been subject to fraud by unscrupulous tax mills. The health voucher approach we suggest would vastly reduce the opportunities for fraud.

Our recommendation is that the premium subsidy is made available for all low and middle wage workers *who are not offered coverage* at the workplace. We initially proposed limiting this subsidy to flex workers, but the definitional line drawing involved (as to who qualifies for the subsidy and who does not) is complex and the results inequitable (e.g. an uninsured employee working 24 hours or less each might get the subsidy while those uninsured and working 25 hours might not qualify).

- Workers who are offered coverage by an employer, but do not take up offered coverage would be ineligible for this credit; they could be eligible for premium assistance through the Healthy Families purchasing credit discussed earlier.

⇒ Some employers offer coverage to some classes of workers but not to others- e.g. coverage is offered to store or restaurant managers, but not to other classes such as salespersons, waitresses, busboys or dishwashers who work less than 25 hours a week. Under our proposal, part-time workers not offered coverage would qualify, but the full-time managers who are offered coverage would not.

⇒ Some employers such as realtors may offer coverage to clerical office staff, but not to salespersons earning commissions. The sales staff could qualify for the credit, but the clerical office staff would not.

⇒ Thirty to ninety day waiting periods to begin coverage for new employees are not uncommon among employers. These distinctions exist now for many employers, and we do not propose to change them.

⇒ We are concerned that there may be incentives for personnel managers to game the subsidy by limiting their offers of coverage; for example, to higher paid employee and longer tenured classifications. If this occurs, state and federal law need to be amended to deny favorable tax subsidies for employment-based coverage to employers whose employee classification systems effectively exclude lower income workers.

⇒ Individual tax credits/vouchers will also be used to finance transitional coverage during job layoffs or for workers changing jobs.[lxxix]

We propose that the voucher/refundable tax credit for flex employees be administered through a cooperative effort of FTB and EDD. FTB receives taxpayer information about family household income annually. EDD has up to date, employee specific wage information on a quarterly basis, but does not know the employee's household income. The uninsured worker would self-certify their eligibility for the credit during any quarter of the tax year; the credit/voucher would begin in the ensuing quarter.[lxxx] EDD and FTB would cross check and audit as necessary.

We want to avoid incentives for *offering* employers to drop coverage and shift their employees into the individual market and for insured employees to drop coverage to avail themselves of the premium subsidy. We recommend that the subsidy for low-wage workers (under 200% of FPL) not offered coverage should approximate an employer's share of premium cost of basic coverage for small employers. We recommend $1200 for employees up to age 40, $2400 for employees up to age 55 and $3600 for employees between 55 and 65; these amounts would need to be adjusted for rising health premiums, possibly tied to the rate adjustments negotiated by the most efficient group purchasers.[lxxxi] The uninsured flex worker must pay at least 10% of the cost of individual coverage and

20% of the cost of family coverage. The employee who drops or declines employer offered coverage is not eligible for the credit.

We also wish to avoid incentives for families eligible for Healthy Families to seek the credit because the cost of the credit/voucher could be 100% state costs while Healthy Families is 67% federally reimbursed. Our proposed subsidies for larger family sizes are thus much lower as a percentage of premium. For family coverage, we are proposing $2,200 for employees up to age 40, $3200 for employees from age 40 to 55 and $4500 for employees from ages 55 to 64. Under the recent federal guidance letter on federal §1115 waivers, it may be possible to secure federal matching for vouchers for persons with incomes of less than 200% of FPL.[lxxxii]

HIPC/PacAdvantage Lowest Priced Plan Monthly Premiums in Los Angeles[lxxxiii]

Age *Individual subsidy* *Family subsidy*	Employee only	Employee and spouse	Employee and children	Employee, spouse and children
Under 30 *$1200* *$2200*	$91	$210	$200	$294
30-39 *$1200* *$2200*	$106	$232	$207	$346
40-49 *$2400* *$3200*	$122	$266	$231	$367
50-54 *$2400* *$3200*	$167	$335	$249	$408
55-59 *$3600* *$4500*	$205	$400	$288	$449
60-64 *$3600* *$4500*	$255	$500	$342	$607

The value of the individual tax credit/voucher should phase down beginning at 200% of FPL and phase out entirely at $35,000 (adjusted annual gross income) for an individual and $70,000 for families. For individuals, this is about 400% of the federal poverty level and somewhat higher than the state's median adjusted gross income of $29,000 for individuals. For families, this is about 400% of the federal poverty level for a family of four and significantly higher than the state median adjusted gross income of $45,000 for households. [lxxxiv]

As discussed previously, our proposed credit/voucher reaches both low and middle-income tax payers who have no employer contribution and little if any tax subsidy equivalent to the tax advantages of those covered through their employer. This proposal achieves tax equity. Some may say that low-income earners pay little state income taxes; however, they do pay sales taxes, tobacco taxes, utility taxes and property taxes. The reported percentages of the income devoted to state taxes are: 12% of income for the

lowest 20% of households, 9.2% for the second 20% of wage earners and 8.5% of income for the middle 20% of households.[lxxxv]

As there are several federal proposals and federal budget authority for a tax credit for individuals, California would need to coordinate its approach with the approach if any eventually gets approved in Congress.[lxxxvi] The recent proposal from the Bush Administration is $1000 for an individual earning up to $15,000 annually and $3000 for a family earning up to $25,000 annually. The projected costs are $90 billion over 10 years or about $1 billion annually for California. These amounts come close to California small employer premiums for young workers, but do not make coverage affordable for older workers.[lxxxvii] Our proposal makes coverage affordable for flex workers of all ages.

The individual market has none of the intra-workplace premium subsidies of the employer market. The individual market's premium structure may be more attractive to some young, healthy and high paid workers than the employment-based system. For lower income young workers or for higher income, older or sicker workers, individual coverage is a market of last resort, and its premium structure is a disincentive to enrollment. An estimated 5% of Californians (1.5 million individuals) now receive coverage through the individual market. The credit/voucher we propose will attract a new mix of young and older low and middle-income uninsured workers and could add as many as 1.5 million new enrollees. We expect that most low-wage working families will enroll in Healthy Families, which offers broader benefits and lower premiums. Low and middle income flex workers and middle-income flex worker families will be attracted into the individual market by the subsidy taht we propose.

The individual market is now dominated by Blue Cross, Blue Shield, Health Net and Kaiser Permanente -- large carriers with long experience in this market. The premium subsidies we propose are likely to attract new market competitors, and the structure of the premium subsidies should increase price competition and broker marketing efforts in the individual market.

Individual purchasing can result in adverse selection as individuals may buy coverage only when they need it. Carrier underwriting policies do exclude coverage for individuals identified as high risk. California's individual market has not been reformed (as its small employer market has been) and requires market reforms that assure access to coverage, deter adverse selection and restrain underwriting abuses in order to make our proposed approach viable. It would be unacceptable to subsidize entry into this market and permit carriers to continue to exclude high risk individuals. We propose the following individual market reforms:

- Guaranteed issue and renewal with a 12 month pre-existing condition exclusion for those without continuity of coverage (as already defined under California law)
- Age and geography rating
- A 25% cap on initial health status rating.[lxxxviii]

The market reforms must include transparent pricing so that individuals purchasing coverage will have access to clear and consistent price information, comparable to other

major purchases such as a car. Other states regulating the individual market made mistakes, which California needs to avoid; such mistakes include a pure community rate, which led young healthy individuals to drop coverage, and an escape hatch for association coverage, which allowed some carriers to cream the individual market's good risks with association coverage and leave the bad risks for a few remaining carriers.

Individual purchasing is not as efficient as group purchasing; we propose combining the tax subsidies with better access to group purchasing opportunities for flex workers through associations, Taft Hartley and ERISA trusts, purchasing pools and large employers and a reformed individual market. There is no public purchasing pool comparable to the HIPC/PacAdvantage for individual purchasers; one needs to be funded and established. Employer associations, union trusts and self-insured large employers who already purchase coverage should be permitted, indeed, encouraged to serve as the purchasing/bargaining agent for those flex workers with vouchers. Flex workers who would wish to use their vouchers to purchase coverage through Healthy Families or Medi-Cal should be allowed to use their vouchers to purchase public or private coverage at a transparent and actuarially sustainable amount.

§1115 WAIVER TO COVER INDIGENT ADULTS WITHOUT MINOR CHILDREN

Appendix 4

A. Research

California covered medically indigent adults (MIAs) through Medi-Cal with no federal matching funds until 1983. Medi-Cal coverage was terminated because the state was in recession and no federal matching funds were available for their care. State funding was transferred to the counties, which took on the responsibility for operating health systems for indigent adults. County programs provide care for a mix of chronically ill adults and individual Medi-Cal emergency episodes for healthy adults.

In California, there are about 1.2 million indigent adults with incomes below the federal poverty line and another 2 million with incomes between 100% and 250% of FPL.[lxxxix] Thirty eight percent are parents with children who can be covered under Medi-Cal or under the state's §1115 waiver to cover the parents of Healthy Families children. Over 60% are adults, who are not parents of minor children and, thus, not eligible for either the Medi-Cal or Healthy Families absent a federal Medicaid §1115 waiver to cover *unlinked adults*.[xc] 75% of uninsured adults are citizens or legal permanent residents and, thus, are not disqualified for Medi-Cal by immigration status.[xci] Persons who have not yet received full, legal permanent resident status from the Immigration and Naturalization Service can be eligible for limited scope Medi-Cal benefits (emergency care only).

We estimate that there are 730,000 uninsured, unlinked adults below 100% of FPL and 1.2 million uninsured unlinked adults between 100% and 250% of FPL. Under an approved §1115 Medicaid waiver, citizens and legal permanent residents (75%) would be eligible for full scope benefits, and undocumented and others without legal permanent residency status (25%) would be eligible for limited scope benefits.

Arizona, Oregon, Massachusetts, Tennessee and New York already have federal §1115 waivers to cover indigent adults through Medicaid managed care. Oregon and Tennessee were particularly successful at reducing their numbers of uninsured through waivers.[xcii]

B. Proposal

We propose that California seek an §1115 waiver to cover indigent adults using federal matching funds. The waiver would cover those adults with incomes below poverty level (730,000) through Medi-Cal and cover adults with incomes between 100 and 200% of FPL (900,000) through Healthy Families. An §1115 waiver would allow California to access federal matching funds for emergency services to adult immigrants not otherwise eligible for Medi-Cal (roughly 25% of the above figures), thus, helping California's financially troubled trauma and emergency services.

To simplify this discussion, we use the figures of 100% of Federal Poverty Level (FPL) for Medi-Cal and 200% of FPL for Healthy Families. We recognize that many would prefer the threshold eligibility of 133% of FPL for Medi-Cal eligibility and 133-250% of FPL for Healthy Families, but the data is more readily available to explain these ideas by using the figures of 100 and 200% of FPL, respectively. The recent federal guidelines put a severe burden of proof on a state seeking to expand public coverage above 200% of FPL and make it easier for a state to set the bright line between Medi-Cal and Healthy Families eligibility at 133% of FPL rather than 100% of FPL.[xciii]

California counties are funded through realignment, Prop 99 and a county match to care for indigent adults (MIAs). They report spending at least $1.5 billion on care for 1.5 million indigent uninsured.[xciv] These funds could be doubled with a federal Medicaid match or tripled with a Healthy Families style match, but only if the state and counties are willing to use the money to expand coverage. The National Governor's Association is on record in support of expanding Medicaid to cover indigent adults and a bipartisan group of senators agreed on a $28 billion budget augmentation for states to expand their public programs for the uninsured.

Counties have developed very different local delivery systems and funding, some of which are excellent models and building blocks to cover the uninsured.[xcv] We propose that California combine its funding streams for indigent health care, seek a federal waiver to deliver managed care to the MIAs and allow sufficient local flexibility to induce pioneering counties' support, cooperation and participation.

Our proposal divides California counties into three groups: CMSP (County Medical Services Program for small counties), payor and provider MISP (Medically Indigent Services Program) counties.

County Medical Services Program for 34 Small Counties

County Medical Services Program pays for care to indigent adults in 34 mostly rural counties with small populations. CMSP counties operate a fee-for-service system of care for the uninsured indigent through the state Department of Health Services. It is similar to Medi-Cal, but with no federal matching funds and fewer benefits. CMSP program eligibility could be readily expanded and needed services added with the infusion of federal matching funds.

CMSP counties spent $176.4 million in FY 2000 on care for 63,000 users of services (a cost per user of $2800).[xcvi] Of that total, 54% was spent on hospital inpatient services, 14% on hospital outpatient care, 19% on pharmacy and 13% on medical care (this includes both community clinic services and physician visits).[xcvii] The program appears to provide comparatively little funding for out of hospital care to uninsured indigent adults. In a recent ITUP study of 10 Northern California counties, we found that CMSP paid for about tow thirds of hospital care to the uninsured; while it paid for only about 15-20% of community clinics uninsured visits.[xcviii] Clinics' uninsured visits were not totally uncompensated, but were paid in part through CMSP, EAPC, other state programs, other

county programs and the patients themselves; the biggest contributors were other state programs and patient payments.[xcix]

We estimate that reported users of CMSP services are 80% of uninsured, unlinked indigent adults below the federal poverty line in the 34 CMSP counties and 37% of uninsured, unlinked indigent adults below 200% of FPL.[c] In using the term uninsured, unlinked indigent adults, we refer to individuals who could not qualify for either Medi-Cal or Healthy Families due to linkage -- a term which includes families with children, the disabled and aged, and excludes single individuals and couples without minor children.

For 1998-9, CMSP was funded as follows: realignment $124 million, state general fund $20 million, Proposition 99 $10 million, and county funds $5.5 million.[ci] The addition of an equal amount of federal matching funds would allow the program to expand eligibility, enrollment and access to medical services quite dramatically. At recent workgroups that we conducted in Redding and Eureka, California, the participants pointed to the deterrent effect of Medi-Cal/CMSP assets test and the difficulties they experience in enrolling eligible patients into the Medi-Cal and CMSP programs in rural areas due to the inaccessibility of county social services offices as the two largest reasons for low enrollment in public programs.

In the small Northern and Central California counties we studied, few to none of the hospitals reported receiving any DSH funding to defray their costs of care for the uninsured even though many of these counties had high percentages of their populations uninsured, low income and/or in receipt of MediCal.[cii] In general, this lack of access to federal DSH funding is due to hospitals which are the sole source of care in their communities not meeting the state's threshold of low income patients in order to qualify for DSH funding.

Solano County is incorporating its program for the medically indigent adults into its Medi-Cal managed care plan beginning in January 2002. In a recent study that we completed of 10 Northern California small counties, the impact of Medi-Cal managed care in reducing inappropriate emergency room usage in Solano was apparent and notable.[ciii] We would urge adoption of a County Organized Health System for the rural Northern California counties.

Medically Indigent Services Program (MISP) Payor Counties

Payor counties, such as Orange, San Diego, Sacramento, Santa Barbara and Fresno pay private providers for their care to medically indigent adults. Some such as Santa Barbara operate a hybrid system – a public outpatient system and payments to private hospitals for their care for county indigents. Payor counties care to the uninsured is financed through realignment, Prop 99 and county matching funds. We found wide variation in the proportion of state realignment and Prop 99 funds devoted to care for each county's indigent uninsured: ranging from less than 50% to over 100%. Many of the payor counties, especially in the Central Valley have very large percentages of their population

who are uninsured and low income. Payor counties have no access to federal matching funds for their MISP programs which cover indigent adults.

In some payor counties, individual private hospitals receive significant DSH (Disproportionate Share Hospital) and SB 1255 funding to defray their costs of caring for the uninsured.[civ] University of California hospitals in Orange, San Diego and Sacramento contribute the required state/local match. In other payor counties with high percentages of uninsured such as Tulare and Santa Barbara, local hospitals do not meet the state's thresholds in order to qualify for DSH funding.

Eligibility rules and the eligibility process for the payor county programs we examined are roughly the same as for Medi-Cal. Covered services are somewhat less. Provider payments are typically a modified fee-for-service within a capped allocation.[cv]

We found that the relative shares of county funding between hospital emergency and inpatient care vs. outpatient care were widely divergent. For example one county devoted 61% of county funding to inpatient care and 29% to outpatient care while a neighboring county devoted 58% to outpatient care.[cvi]

In our studies, we found that community clinics in many payor counties received little or no funding for their care to uninsured adults from the county.[cvii] This was particularly true in Central Valley counties.

We propose that the payor county programs be incorporated into managed care through the state's Medi-Cal program.[cviii] Setting capitated rates will be challenging because of the actuarial differences between the population using county systems and the larger and healthier population of poor persons who are eligible but not using county health services, the uncertainties of enrollment in an expanded, state administered program and the lack of good statewide data on this population's use of health care.[cix]

- In San Diego County for example, there are an estimated 541,000 uninsured -- about 19% of the county's population under age 65. San Diego County covered 22,000 indigent adults at a cost of $40 million in the year 1997-8 through its CMS program. We estimate that there are 54,000 uninsured, unlinked adults in the county with incomes below 100% of FPL; about 40% of this eligible population uses the county program.
- The county reports spending 49% of its CMS budget on inpatient services, 37% for specialty care and 12% on primary care clinics.
- The county's CMS program pays for 19,700 (274 bed days per 1000 uninsured unlinked adult with incomes below 100% of FPL) inpatient days and 31,000 (574 visits per 1000) emergency room visits and 133,000 medical visits (2.4 visits per uninsured, unlinked adult with incomes below 100% of FPL).[cx]
- San Diego County hospitals receive about 60% of the DSH funding levels of Orange County Hospitals.

- In Orange County for example, there are 667,000 uninsured -- about 23% of the county's population under age 65. Orange County covered 26,000 indigent adults at a cost of $52 million in the year 1998-9 through its MSI program. We estimate there are 67,000 uninsured, unlinked adults in the county with incomes below 100% of FPL; about 40% of this eligible population uses the county's MSI program.
- The county spends 74% of its MSI budget on hospital services, 20% for specialty care and 3% on primary care clinics.
- The county MSI program pays for 28,800 inpatient days (430 bed days per 1000 uninsured unlinked adults with incomes below 100% of FPL) and 9,400 emergency room visits (140 visits per 1000) and 100,000 medical visits (1.5 visits per unlinked, uninsured county indigent adult).[cxi]

- In Tulare County for example, there are about 86,000 uninsured -- about 26% of the county's population under age 65. Tulare County covered 8,000 indigent adults at a cost of $6 million in the year 1998-9 through its MISP program. We estimate there are 15,000 uninsured, unlinked adults in the county with incomes below 100% of FPL; about 50% of this eligible population uses the county's MSI program.
- The county spends 50% of its MSI budget on hospital inpatient and emergency services, 50% for outpatient care and 0% on community clinics.
- The county MISP program pays for 4,100 inpatient days (273 bed days per 1000 uninsured unlinked adults with incomes below 100% of FPL) and 2,000 emergency room visits (133 visits per 1000) and 25,000 medical visits (1.6 visits per unlinked, uninsured county indigent adult).[cxii]

Provider networks in counties, such as San Diego and Fresno, is quite restricted and would need to be expanded.[cxiii] In San Diego, primary care is reimbursed only in community clinics, and clinics are reimbursed for only 1 in 8 uninsured visits through the CMS program;[cxiv] private physicians would need to be added to the mix. In Fresno, the county's indigent program is concentrated in a private hospital, the Fresno Community/University Medical Center, and the network would need to be expanded. In many Central Valley payor counties, community clinics receive little or no funding from the county and would need to be added to the provider network.

Selected payment rates would need to be increased to Medi-Cal levels. In San Diego and Orange counties, private hospitals report to OSHPD that their inpatient reimbursements through the county program for the medically indigent are approximately the same as under the Medi-Cal program; Orange hospitals, however, report their outpatient reimbursement under the county program is half of their reimbursement under the Medi-Cal program. Fresno private hospitals report their county program payments per inpatient day and per outpatient visit are about half of the Medi-Cal program. Sacramento private hospitals report their county program payments per inpatient day and per outpatient visit are about 10% less than Medi-Cal program payments. [cxv]

Financing of county health care in payor counties is a mix of realignment, Prop 99 and county General funds:

- For example, in San Diego County in 1998-9, county health was financed by $74 million in realignment, $8 million from Prop 99 and $26 million in county General Funds.[cxvi]
- In Orange in 1998-9, county health was financed by $69 million in realignment, $8 million from Prop 99 and $28 million in county General Funds.[cxvii]
- In Tulare in 2000-2001, county health was financed by $12.5 million in realignment, $1 million in Prop 99 and county matching funds. Tulare reported spending $6 million on care to the uninsured.[cxviii]
- County health departments provide more health services than care to uninsured adults; for example, they provide public health services. Less than half of available county health revenues in San Diego, Tulare and Orange Counties are devoted to their county programs for the uninsured indigent adults.

The chronically ill, in particular, would benefit from the introduction of a managed care delivery system, by improving their access to an organized delivery system of primary and specialty care services.[cxix] The biggest service deficit in payor counties' health programs for uninsured adults is the lack of access to primary and outpatient care.[cxx] Access to primary care would need to be greatly expanded to make a managed care delivery system work in these counties.

Each of these counties already has a managed care system in place for Medi-Cal families, and Orange and Santa Barbara County have a managed care system in place for the entire Medi-Cal population. The addition of low-income adults would be easiest for the health plans in Orange, Santa Barbara and San Diego counties, but would not be difficult for the commercial managed care plans in Fresno or Sacramento.[cxxi]

Over the past decade, Orange County has seriously considered merging its MSI (Medical Services to Indigents) program for uninsured adults into CalOptima, its Medi-Cal managed care system; health officials in Orange conducted extensive studies, but concluded the MSI program's funding was insufficient. At ITUP workgroups on approaches to improve county care to indigent adults, Santa Barbara and San Mateo County health officials have made similar observations, but without the detailed financial study undertaken in Orange. The addition of federal matching would double available funding and meet the funding needs projected by CalOptima in Orange County.[cxxii]

In our opinion based on the regional workgroups we have conducted to date, transition to managed care would be manageable in payor counties with the addition of federal matching funds, which doubles total program funding. Program income eligibility could be expanded; services and selected provider rates could be increased with the availability of federal matching funds.

Medically Indigent Services Program (MISP) Provider Counties

"Provider" counties, such as Los Angeles, San Bernardino, Santa Clara, Kern and San Francisco, provide care to the medically indigent adults through county hospitals and

clinics.[cxxiii] Provider counties' care to the uninsured is financed through realignment, Prop 99, county matching funds, and federal funding though the DSH and SB 1255 programs.

Provider counties' eligibility levels are typically broader than the Medi-Cal program, the CMSP counties and the payor counties. In Alameda and Santa Clara Counties, indigent, uninsured adults are eligible for care with incomes up to 200% of FPL; those with incomes between 100 and 200% of FPL are expected to pay on a sliding fee scale basis. In Los Angeles County, sliding fee scale contributions are expected for those with incomes over 133% of FPL. Provider counties do not typically exclude uninsured patients based on age, immigration status or categorical linkage to Medi-Cal and Healthy Families as the payor counties and the small CMSP counties do.[cxxiv]

Provider counties do not use a Medi-Cal or Healthy Families style enrollment process, but typically assess patient eligibility on an encounter basis. In Los Angeles, a patient's eligibility is assessed on admission or at the first visit, then re-assessed monthly for inpatient and semi-annually for outpatient care. In San Francisco, eligibility is reassessed monthly or on each visit. In Alameda County eligibility is redetermined annually.[cxxv]

Provider counties rely on a shifting mix of federal Medi-Cal matching through DSH (SB 855) and SB 1255 programs, state realignment and Prop 99 funding and county General Funds to support their care to the uninsured. The respective contributions are constantly shifting with recent declines in SB 855 and Prop 99 and recent increases in realignment and SB 1255 funding. Counties use only a portion of their health revenues for care to the uninsured; they also provide public health services and care to many Medi-Cal patients. Unlike MISP payor counties, provider counties have access to federal matching funds for hospital based care to the uninsured through the DSH and SB 1255 programs. Federal funding for provider counties is imperiled by a series of proposed federal technical adjustments to the DSH program which many of these counties feel will unravel their tenuous mix of county, state and federal safety net funding.

- Alameda County health was financed in 1998-9, in part, by $48 million from realignment, $7 million from Prop 99, $40 million from DSH (SB 855), $12 million from SB 1255 and $48 million from county General Funds. In Alameda in 1998-9, $67 million was budgeted for care to the uninsured.
- Santa Clara County health was financed in 1998-9, in part, by $42 million from realignment, $8 million from Prop 99, $43 million from DSH, $12 million from SB 1255 and $37 million in county General Funds. Santa Clara County spent $93 million on care to the uninsured in 1998-9.
- Los Angeles County health was financed in 1998-9, in part, by $395 million from realignment, $66 million from Prop 99, $237 million from DSH, $172 million from SB 1255, $114 million from the county's §1115 waiver and $160 million in county General Funds. Los Angeles County spent $765 million on care to the uninsured in 1998-9.[cxxvi]

Counties' federal funds through DSH and SB 1255 cannot be used to match other federal funds in meeting the matching requirements for Medicaid and Healthy Families.

However, county realignment, Prop 99 and county General Fund can be used as local match in the federal Medi-Cal or Healthy Families programs. Some counties already use a portion of these funds as the match for DSH and SB 1255, and more information needs to be gathered on the extent of matching opportunities in provider counties.

The financial status of county hospitals in provider counties is heavily dependent on their success in attracting and retaining Medi-Cal eligible patients within the county system. For example, in Los Angeles County with the state's largest and highest percentages of uninsured, the county hospitals' inpatient ratios are roughly 1/3 uninsured, and over 55% Medi-Cal.[cxxvii] Many uninsured patients admitted to the county hospital eventually qualify for Medi-Cal due to the efforts of county eligibility staff. Some county hospitals are experiencing declining Medi-Cal participation due to a number of factors including increasing competition from private hospitals and declines in local Medi-Cal enrollment.

Some Local Initiatives operating Medi-Cal managed care plans have been extraordinarily successful. They have strengthened local safety net providers, improved the delivery system for Medi-Cal eligibles, created innovative expansions of coverage and succeeded in the head to head competition for Healthy Families enrollment.[cxxviii] Others have been markedly less successful in these roles.

Delivery systems in provider counties are, for the most part, based in the county hospital for both historic and financial reasons associated with medical education and state and federal financing rules. Academic medicine, hospital workers' unions and others believe strongly in this delivery system. The relative emphasis each county places on hospital based care and primary care outside hospital settings is very different.

- In Los Angeles, 85% of spending occurs in the county hospitals; the mix is 53% inpatient, 37% outpatient, and 8% emergency. 3% is spent for primary care through community clinics and other private partners.
- In Alameda, the mix is 35% inpatient, 55% outpatient, and 8% emergency. 10% is spent for primary care through community clinics.
- In Santa Clara, 82% of spending occurs in the county hospital; the mix is 35% inpatient, 49% outpatient, and 14% emergency. 3% is spent for primary care through community clinics.
- In San Francisco, the mix is 50% inpatient, 33% outpatient, and 14% emergency. 0.2% is spent for primary care through community clinics.[cxxix]

Private hospitals and doctors are not reimbursed by provider counties for their care to the indigent uninsured, except to a limited degree through Prop 99, SB 12 and DSH.[cxxx] A study in Los Angeles County noted that in private hospitals less than a third of net DSH funds were used for care to the uninsured, and over two thirds were used in public hospitals.[cxxxi]

Contra Costa County is the only provider county which uses its public, managed care delivery system for its indigent adults.[cxxxii] Several provider counties, including Alameda, Los Angeles, San Bernardino and San Francisco have considered merging the Medi-Cal

and uninsured into a single managed care delivery system, county wide. Obstacles to such plans include competing interests of local providers, and the challenges of consolidating funding streams and programs.

Provider counties report their unduplicated users and expenditures to the state of California. While the accuracy of the county count of unduplicated users is less than 100%, the reported annual cost per unduplicated users and the reported participation of the county indigent uninsured in county health programs is as follows:

Provider Counties Eligibles, Users and Spending[cxxxiii]

County	Uninsured	Unlinked uninsured adults below 200% of FPL	County reported unduplicated users	Participation rate	County reported uninsured spending	Spending per unduplicated user
Alameda	200,000	48,000	55,000	114%	$67 million	$1218
Los Angeles	2.6 million	624,000	646,000	103%	$765 million	$1182
Santa Clara	258,000	62,000	68,000	110%	$93 million	$1367

This may indicate that provider counties are doing an excellent job of reaching the uninsured -- i.e. unlinked, uninsured adults are participating in the provider counties' programs at a much higher rate than in the payor or CMSP counties -- or it could be distorted by inaccuracies in the count of unduplicated users. Another comparison is to look at bed days, emergency room visits and outpatient visits for the target adult population, which avoids the uncertain accuracy of the county report of unduplicated users. The use of hospital and emergency room care in the provider counties equals or exceeds that of commercially insured populations while use of primary and outpatient services is somewhat less than the commercially insured.

Provider Counties: Eligibles, Days and Emergency and Outpatient Visits[cxxxiv]

County	Uninsured	Unlinked uninsured adults below 200% of FPL (eligibles)	Hospital days and days per 1000 unlinked uninsured adults below 200% of FPL	Emergency room visits and visits per 1000	Outpatient visits and visits per uninsured adult below 200% of FPL	Spending per unlinked uninsured adult below 200% of FPL
Alameda	200,000	48,000	12,600 (262 per 1000)	19,000 (396 per 1000)	155,000 (3.2 per eligible)	$1395
Los Angeles	2.6 million	624,000	191,000 (306 per 1000)	251,000 (402 per 1000)	1,923,000 (3.1 per eligible)	$1224
Santa Clara	258,000	62,000	12,200 (197 per 1000)	31,000 (500 per 1000)	154,500 (2.5 per eligible)	$1500

For provider counties, instituting Medi-Cal managed care coverage for the MIAs poses several challenges: competition with private providers, shifting from episodic to managed care and enrollment of their current patient populations in Medi-Cal coverage.

- In some California counties, there is already strong competition between private and public hospitals over care to Medi-Cal patients, allocation of federal DSH funding, funding of indigent care and even the renovation and rebuilding of public hospitals. Moving the uninsured into managed care will open heretofore closed county programs to contracting private providers. This competition will create conflict among competing local provider interests requiring resolution by managed care plans.
- Care and funding for indigent adults has been heavily concentrated within hospital settings in some provider counties. Moving to a more balanced delivery setting may be perceived as a threat to hospital-based union jobs, funding, medical education and vested decision making authority.
- Safety net providers report difficulties actually enrolling their eligible patient populations in programs such as Medi-Cal and Healthy Families. To the extent that counties' funding is reduced and their patient populations do not in fact enroll they are left with less funding to serve the same patient loads -- an untenable result.
- Provider counties treat working, uninsured immigrant populations, some of whom would not be eligible for full scope Medi-Cal managed care services, under a waiver.

To resolve these important challenges, we suggest the following options:

- Repeal counties' §17000 obligations for health care; they are outdated and this responsibility appropriately resides at the state and federal levels who already provide the bulk of funding for county health;
- Limit counties' financial obligations to a base of their three-year average expenditures on the uninsured being moved into coverage plus a factor for actual revenue growth;
- Place health plans at risk to control price and utilization and put state, rather than county government, at risk for the growth in the uninsured population;
- Have the funds follow the patients, i.e. county funds are not transferred until patients actually enroll;
- Give provider counties a "breathing room" option during a two-year transition period to use their Local Initiatives as the dominant managed care option for indigent adults;
- As a part of the waiver, seek federal authority for more County Organized Health Systems -- which allow for a comprehensive, local negotiated managed care system;
- Leave an adequate residuum of better allocated safety net funding; and,
- Give pioneering counties the option to fold in local DSH, SB 1255, SB 12 and EAPC funding, and implement COHS plans to enroll more of their local uninsured patients.

Important benefits include: increased federal funding for emergency, trauma and primary care, better access to care and a significantly improved delivery system. This approach could help Los Angeles County's public and private providers avoid the threatened financial meltdown as its waiver phases out.

- This approach increases emergency and trauma funding by accessing a federal match for unlinked adults and for immigrants not now eligible for Medi-Cal or Healthy Families.
- It replaces hospital emergency room centered system with a managed care system, beginning with primary care and linking access to specialty and hospital care.
- It gives the patient choices of provider and links the community and county providers together in a system of care responsible to the patient.
- It replaces Los Angeles County's bail out waiver with its declining levels of federal support with a sustainable waiver, financing an organized system of care for the county indigent.

California has substantial federal, state, and county financial commitments to "safety net" providers and barriers that impede efforts to develop health coverage and systems of care for the indigent:

- Multiple, disconnected programs and funding streams dedicated to the care of the indigent uninsured.[cxxxv]
- Funding streams, financial incentives and delivery systems for care to the indigent uninsured that are at odds with the managed care approaches for the insured commercial, Medi-Cal and Healthy Families populations.[cxxxvi]

Under ITUP's proposal, the state would connect state and county programs and funding streams for the uninsured with a federal Medicaid/Healthy Families match. For example, we propose to merge stand alone programs into coverage for the uninsured; this would include programs for adults and families such as GHPP, Family PACT, AIM, Medi-Cal share of cost, Medi-Cal pregnancy only coverage, Breast Cancer, Prostate Cancer, AIDS, and Tuberculosis Treatment Funds as well as CHDP screening and treatment and CCS. Safety net programs dedicated to particular providers, such as emergency room doctors, rural and community clinics, county hospitals, and trauma centers, would be merged to buy coverage for the indigent uninsured. Interested counties would have the option to organize coherent, local, managed care delivery systems for the uninsured, and the state would contract with managed care entities and/or operate a fee-for-service system in the remaining counties. Federal matching would allow for expansion of eligibility, services and payments for primary, emergency and trauma care. Medi-Cal managed care would be able to improve local delivery systems especially for chronically ill low-income adults.

We propose to draw a bright line between Medi-Cal and Healthy Families programs so that all individuals and family members with incomes above that line are eligible for Healthy Families and all individuals and family members with incomes below that line are eligible for Medi-Cal. We suggest that the line should be drawn at either 133% of FPL.[cxxxvii] We recommend that the Medi-Cal asset test be eliminated and all the Medi-Cal subcategories of eligibility be consolidated, thus vastly simplifying the Medi-Cal application and eligibility determination process and creating substantial federal, state and county administrative savings. We recommend that all net available income is counted with a single deduction for child care and for work expenses. Some persons with Medi-Cal eligibility will be shifted into Healthy Families as the subcategories such as

Medi-Cal share of cost or pregnancy only coverage are eliminated. We propose that eligibility, once established, is good for one year. If the annual redetermination process shows an increase or decrease in income, moving the individual's eligibility between Medi-Cal and Healthy Families, that shift would be done administratively, rather than requiring the person to reapply for a new program. These changes will assure continuity of care and require a §1115 waiver.

Medi-Cal 12-Month Retention for Major Aid Categories, 1994-1997[cxxxviii]

Starting Year	All	SSI/SSP	AFDC-Cash	M/C only Families	M/C Only A/B/D	Share of Cost	OBRA
1994	75%	90%	78%	35%	64%	8%	40%
1995	73%	90%	75%	36%	70%	9%	40%
1996	60%	86%	66%	24%	54%	3%	26%
1997	72%	91%	71%	37%	65%	11%	

Source: DHS Annual Reports.

The safety net would be funded albeit at a reduced level, reflecting the enrollment of many of the uninsured into coverage and the shift of their financing. For example, hospitals receiving DSH funding are capped at their actual cost of uncompensated care to Medicaid and uninsured patients; as uninsured patients are enrolled in Medicaid, the DSH cap cuts the payment which a hospital can receive; rather than inure these *savings* to the federal government, we recommend reinvesting these funds in increased coverage. We suggest restructuring the residual safety net funding so that is linked to the disproportionate financial burdens of caring for genuinely uninsured patients with no other payment source. Current safety net funding is not linked to care of uninsured patients with no other source of payment; it has become a series of intricate and impenetrable institutional subsidies, reflecting trade-offs negotiated at county and state levels between and among provider associations and state and county governments. Funding is narrowly channeled (silo funding): this amount is for emergency room doctors, this portion is for public and that portion for private DSH hospitals, this pot for community clinics and that pot for specialists. We suggest that safety net funding be linked to systems of care for the uninsured and be proportionate to their care of the residual uninsured.

Chart 13: MODELS OF COVERAGE FOR FLEX WORKERS

Model	Target & Eligibility Criteria	Premium Subsidy Source	Administrative & Organizational Issues	Benefits	Underwriting
Western Growers Association	Growers, shippers, packers. $250 membership fee. 3,300 members and 150,000 lives covered.	Employer and employee contributions	State licensed MEWA	Health insurance, including transitional coverage, Workers comp, Legal services, and legislative representation.	None
San Francisco Family Child Care Workers	150 self-employed family child care workers, with income above 100% of FPL, below 250-300% FPL.	$250,000 Mayoral Allocation for 2/3rds of premium, Employee pays 1/3rd Healthy Families coverage for dependent children	SF Health Plan to administer, Individual plan, Knox-Keene modification pending	$5 co-pay, comprehensive benefits, dental, vision	None
Union Privilege	Temporary, full-time employees who are kept in temp status; Part-timers kept below the hour threshold to qualify for benefits	Employer contributions on a reverse sliding fee scale, Employee premiums on a sliding scale between 100 and 300%. Vouchers/tax credits - 50% of premium	Purchasing entities such as union trusts and employers associations	Limited benefits, targeted to be less costly than those on market	Large pool, shared risk, guaranteed issue and renewal and portability
SEIU Local #99	School employees w/o benefits	$1.25 an hour from school district, matching payments from employee	SEIU Local 99 and local school district would administer	Costs $150 pmpm; Prescription and dental benefits	None Only 300 of the eligible 1200 participate.
Santa Clara Valley Health Plan	Home care workers working at least 35 hours per month	County tobacco tax settlement, State match, Federal match, $7 pmpm from workers	SCVHP and county Administration on Aging	Full scope benefits, but limited network	None On and off problem is difficult to administer
Los Angeles County	Home care workers, working at least 30 hours per week	Federal, state and county match	County Local Initiative Plan	Full scope benefits, but limited network	None
SEIU	Home care workers and private janitors	Federal, state and county match for home care workers; $1.50 an hour from building	County purchasing for home care workers; ERISA or Taft Hartley trusts for janitors and/or	Full scope, but limited provider networks	None

		owners for janitors	home care workers		
Model	**Target & Eligibility Criteria**	**Premium Subsidy Source**	**Administrative & Organizational Issues**	**Benefits**	**Underwriting**
Working Partnerships	Flex workers	Kaiser's STEPS Health Plan subsidizes 80% of premium, Healthy Families for dependent children	Temp workers Association through Working Partnerships	Full scope, but limited provider networks	None Healthy workforce with unstable enrollment
Entertainment Industry	Flex entertainment industry workers and small businesses, Low eligibility thresholds	Employers pay a percent of earnings. Higher wage earners cross subsidize lower wage earners	Taft Hartley and ERISA trusts	Full scope with more limited benefits for transitional coverage	Cyclical, boom-bust nature of employment, Carriers' perception of occupational risk
Alameda Alliance	Coverage for IHSS workers, uninsured family members, etc.	Tobacco settlement and annual operating surplus	Based on clinic, provider and community connections	Full scope within Alliance network	Yes
Temp Agencies	Temp workers	Mix of employer contributions and employee (50-100%)	Temp agency	Full or limited benefits	Employee interest is low and turnover is high, Temp wages are low, High end, long-term temps are the best potential market
Taft Hartley trusts	Unionized unbenefitted flex workers	Union management collective bargaining	Taft Hartley trust provides hours banking, consolidates multiple employers	Full benefits	Unusually strong cohesion and little adverse selection of existing members, Offers transitional coverage opportunities when employee hours and/or days decline and/or during job changes between employers
Community Health Group	Uninsured workers working for small employers	None	Trusts	Full scope, limited network	None
SHARP Health Plan	Uninsured workers working for small employers	Philanthropy	Individual or group product	Full scope	None

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[x] Public programs can be a poor fit for immigrants due the "fear" factor, the exclusion of the not-yet-documented in mixed status families and the difficulty in adjusting Medi-Cal and county health program eligibility policies to coverage for workers. Professor David Hayes Bautista of UCLA points to the low rate of use of health services by immigrants, even when they are covered and the need to develop coverage, care models and prices appropriate for the immigrant community. Western Growers' Association has developed low cost plans and cross border coverage for some migrant farmworkers. See ITUP Conference Binders 1999-2001 Tabs on Employment-based Coverage and Immigrant Coverage available at www.work-and-health.org/itup.
[xi] California Employment Development Department, Labor Market Information, Covered Employment and Wages- Major Industries 1999 at www.calmis.ca.gov.
[xii] These estimates based on our review of the Health Insurance Policy Program series 1996-2000 by Brown and Schauffler, Levitt and Gabel, California Employer Health Insurance Benefits 2000, Wm. Mercer Inc. Employer Sponsored Health Insurance: A Survey of Small Employers in California (CA Health care Foundation, Aug. 1999) and Fronstin, Health Insurance Coverage and the Job Market in California. The estimates of coverage by industry vary significantly from study to study by the different authors and in the Brown Schauffler report from annual report to annual report.
[xiii] For example there was little difference in average annual pay between residential and general building contractors, or between carpentry, painting, plastering and masonry; heavy construction and electrical work had significantly higher pay. See Labor Market Information, Covered Employment and Wages- Construction Industry 1999 at www.calmis.ca.gov.
[xiv] Ibid. See discussion in ITUP Flex Working Group on the Flex Workforce.
[xv] See Covered Employment and Wages- Services Industry 1999 at www.calmis.ca.gov.
[xvi] See n. 12.
[xvii] See California Employment Development Department, Labor Market Division, 2001 Average Weekly Hours, Average Hourly Earnings and Average Weekly Earnings at www.calmis.ca.gov
[xviii] See California Employment Development Department, Labor Market Information Division, 1999 Number of UI Insured Employees by Size of Reporting Unit at www.calmis.ca.gov
[xix] Phone interview with Employment Development Department on 9/14/01.
[xx] See California Employment Development Department, Labor Market Information Division, Hourly Pay and the Minimum Wage (March 2001) at www.calmis.ca.gov
[xxi] Brown et al, The State of Health Insurance 2000
[xxii] Phone interview with Employment Development Department
[xxiii] US Dept. of Health and Human Services, 2001 Poverty Guidelines at www.aspe.hhh.gov/poverty.
[xxiv] See Brown et al, The State of Health Insurance 2000 and Levitt et al, 2000 California Employer Health Benefits Survey
[xxv] See Wm. Custer, The Changing Sources of Health Insurance (Center for Risk Management and Health Insurance Research, Dec. 2000), and Acs and Blumberg, How A Changing Workforce Affects Employer Sponsored Insurance, Health Affairs (Jan/Feb. 2001) projecting a long term decline in employment-based coverage.
[xxvi] Brown et al, The State of Health Insurance 2000, Recent Trends, Future Prospects; Levitt and Gabel, Employer Health Benefits 2000 and California Health Benefits Survey 2000.
[xxvii] The HIPC had initial success in negotiating premium reductions, but has not grown to a size where it is able to consistently exercise strong bargaining power. There is some belief that its benefits package is too broad to be attractive to small businesses on the verge of purchasing coverage. See Long and Marquis, Have Small Health Insurance Purchasing Alliances Increased Coverage, Health Affairs (Jan/Feb. 2001).

[xxviii] California Employment Development Department, Labor Market Information Division, Reporting Units, UI Insured Employment and Payroll by Size of Reporting Units (1999) at www.calmis.ca.gov
[xxix] Levitt and Gabel, Employer Health Benefits 2000 (Kaiser Family Foundation, 2000).
[xxx] See Brown and Schauffler, The State of Health Insurance, 1999 (Health Insurance Policy Program, 2000) and Levitt and Gabel, California Health Benefits Survey 2000
[xxxi] See Sharon Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured (Commonwealth Fund, Nov. 2000) and R. Kronick and D. Strom, Survey of FOCUS Program< Report of Findings (2001) (unpublished manuscript)
[xxxii] Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured
[xxxiii] Ibid.
[xxxiv] Ibid.
[xxxv] Resource Group, Report of Small Business Employer and Employee Health Insurance Coverage, (Ca Small Bus. Assn., 1999)
[xxxvi] See e.g. AB 32 (Richman and Figueroa), AB 39 (Thomson and Campbell), AB 482 (Cedillo) and AB 694 (Corbett) offering premium subsidies from 20 to 50%.
[xxxvii] See Long and Marquis, Have Small Health Insurance Purchasing Alliances Increased Coverage, Health Affairs (Jan/Feb. 2001); Levitt and Gabel, California Health Benefits Survey 2000 and Wm. Mercer Inc. Employer Sponsored Health Insurance: A Survey of Small Employers in California (CA Health care Foundation, Aug. 1999)
[xxxviii] See Meyer and Wicks, A Federal Tax Credit to Encourage Employers to Offer Health Coverage and Pauly and Herring, Expanding Coverage via Tax Credits: Trade Offs and Outcomes
[xxxix] California previously enacted and then repealed a small and untargeted tax credit, which was not well designed to reach the uninsured. See discussion of SB 1207 (Keene) in Wulsin, California at the Crossroads (Center for Governmental Studies (1994) at p. 85. See Franchise Tax Board Analysis of AB 39 (Thomson and Campbell) at www.ftb.ca.gov.
[xl] See Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured and D. Helms et al., Mending the Flaws in the Small Group Market, Health Affairs (Summer, 1992).
[xli] Levitt and Gabel, California Health Benefits Survey 2000.
[xlii] Phone interview with Employment Development Department. Professor Kronick's research on FOCUS in San Diego suggests that about 80,000 uninsured full-timeemployees work for uninsuring small employers of less than 50 employees and make less than $12 an hour. This was about 12% of San Diego's total uninsured. R. Kronick and D. Strom, Survey of FOCUS Program, Report of Findings
[xliii] For example, if the subsidy cut off is set at 10 employees, 12% of the workforce is affected and the subsidy may set a disincentive for an employer with 10 employees to hire a new employee and lose the 50% premium subsidy on the other low-wage employees.
[xliv] See Schauffler and Brown, The State of Health Insurance in California, 1999.
[xlv] Health and Safety Code §1345
[xlvi] A recent list of California's mandates to offer, to cover and to include particular providers can be found in Wulsin et al, California's Uninsured: Programs, Funding and Policy Options (ITUP, January, 1998) at www.work-and-health.org/itup/reports.
[xlvii] While we believe the approach is promising, no state has yet reported a breakthrough in increasing employment-based coverage. See Sharon Silow-Carroll et al, Expanding Employment-based Health Coverage: Lessons from Six State and Local Programs (Commonwealth Fund, Feb. 2001) at www.cmwf.org.
[xlviii] Brown, The State of Health Insurance 2000, and Levitt, California Health Benefits Survey 2000 (Kaiser Family Foundation, 2001).
[xlix] See Acs and Blumberg, How a Changing Workforce Affects Employer Sponsored Coverage, Health Affairs (Jan-Feb. 2001) and Bilheimer and Colby, Expanding Coverage: Reflections on Recent Efforts, Health Affairs (Jan-Feb. 2001)
[l] California Budget Project, The State of Working California: Income Gains Remain Elusive for Many California Workers and Families (9/3/2001)
[li] J. Medoff et al, How the New Labor Market is Squeezing Workforce Health Benefits (Center for National Policy, June 2001) at www.cmwf.org.

[lii] Mark Merlis, Public Subsidies for Required Employee Contributions Toward Employer Sponsored Health Insurance (Institute for Health Policy Studies, Dec. 2000) Average employee contributions for single coverage grew from $8 a month in 1988 to $35 a month in 1999; for families the contribution increased from $52 a month to $145.
[liii] See Jon Gabel et al., Embraceable You: How Employers Influence Health Plan Enrollment, Health Affairs (July-Aug. 2001)
[liv] Brown, The State of Health Insurance 2000
[lv] L. Blumberg and L. Nichols, The Working Uninsured In California (Urban Institute and Kaiser Family Foundation, 2001).
[lvi] Resource Group, Small Business Health Insurance Coverage, 1999
[lvii] See H. Greenwald et al, California's Working Latinos and Health Insurance: New Facts and Policy Challenges (Univ. of So. Cal. School of Public Administration, Oct. 2001). The small number of workers in this study who declined to take up an employer's offer of coverage reported less ability to speak with providers, greater satisfaction with public or free clinics and shorter times of stay in the US.
[lviii] California Health Care Foundation, To Buy or Not to Buy: A profile of California's Non-Poor Uninsured (1999) at www.chcf.org.
[lix] See L Zelenak, A Health insurance Tax Credit for Uninsured Workers Commonwealth Fund, Dec. 2000) at www.cmwf.org and Merlis, Public Subsidies for Required Employee Contributions Toward Employer Sponsored Health Insurance.
[lx] California Budget Project, How Can A State Earned Income Tax Credit Help California's Working Poor Make Ends Meet (3/01) at www.cbp.org.
[lxi] See n. 12
[lxii] Katherin Phillips, Who Knows about the Earned Income Tax Credit (Urban Institute, Jan. 2001)
[lxiii] Insurance Code §12693.15 and 12693.27
[lxiv] Brown, The State of Health Insurance 2000. The public coverage rates of mixed status families fell significantly between 1994 and 1999.
[lxv] Wulsin et al, Developing Models of Coverage for the Flex Workforce (ITUP, 2000) p. 2 available at www.work-and-health.org/ITUP
[lxvi] Acs and Blumberg, How a Changing Workforce Affects Employer Sponsored Health Insurance, Health Affairs ((Jan. Feb, 2001) and Jon Gabel et al, Embraceable You: How Employers Influence Health Plan Enrollment, Health Affairs (July Aug. 2001)
[lxvii] Wulsin, Coverage for the Flex Workforce p. 1 and 12
[lxviii] Ibid. For example, 6% of temporary workers had coverage through their own employers and nearly 45% through spouses and 16% of part-time workers had coverage through their own employers and 36% through spouses.
[lxix] Ibid.
[lxx] Ibid.
[lxxi] Ibid.
[lxxii] Ibid.
[lxxiii] Employment Policy Foundation - Employment Trends - Temporary Work, A Catalyst for a Stronger Economy - Krishna Kundu: June 15, 2000. www.epf.org
[lxxiv] National Coalition on Health Care - Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States - Findlay & Miller: May 1999.
www.americashealth.org/releases/erosion.html
[lxxv] California Employment Development Department, Labor Market Information, Self Employment in California 1999 (Oct. 2000) at www.calmis.ca.gov
[lxxvi] Wulsin, Coverage for the Flex Workforce
[lxxvii] See n. 2.
[lxxviii] Wulsin, Coverage for the Flex Workforce
[lxxix] Congress and the Administration are now considering proposals for between $3 and $8 billion annually to pay for health insurance for the newly unemployed. R. Pear, Bills Would Help New Jobless Keep Insurance, New York Times, (10/14/01) p. A-16. A variant on this approach is to finance transitional coverage through a short term government loan, which would be repayable in installments once the individual is again covered through employment-based coverage and forgiven for employees with income

below a certain income threshold such as 300% of FPL. See J. Gruber, Transitional Studies for Expanding Health Coverage (Nat'l Bureau of Economic Research, Dec. 2000) available at www.cmwf.org.

[lxxx] See Curtis et al, Expanding Healthy families to Cover Parents: Issues and Analyses Related to Employer Coverage (Institute for Health Policy Solutions, Jan. 2001). Rick Curtis makes the salient point that coverage is more directly linked to wage levels than to family income; thus a family with two wage earners making $12,500 each is less likely to be insured than a family with a single wage earner making $25,000. We may be able to achieve more cost effective targeting of tax credits by linking them to wages than to family income. This is a difficult concept for those accustomed to public programs that link eligibility to family income.

[lxxxi] See HIPC/PacAdvantage rates effective 1/1/01. In Los Angeles, the low rate for small business employees 30-40 is $106, for employees 50-54 it is $167, for employees 60-64 it is $255. The proposed federal legislation sets the tax credit at $1000-1200 per adult and $2400-3600 per family. See e.g. HR 1136 (Norwood) and HR 2261 (Johnson)

[lxxxii] See Health Insurance Flexibility and Accountability Demonstration Projects at www.hcfa.gov/medicaid/hifademo.

[lxxxiii] PacAdvantage Rates Effective 1/1/2001

[lxxxiv] See e.g. HR 2261 (Johnson) and S2320 (Jeffords)

[lxxxv] California Budget Project, Who Pays Taxes In California (April 2001) at www.cbp.org.

[lxxxvi] See discussion of the pros and cons of federal tax credit proposals by J. Frogue, A Guide to Tax Credits for the Uninsured (Heritage Fdn., May 5, 2001) at www.heritage.org and I. Lav, Tax Credits for Individuals to Buy health Insurance Won't Help Many Uninsured Families (Center on Budget and Policy Priorities, Feb. 2001) at www.cbpp.org.

[lxxxvii] See n. 17.

[lxxxviii] We are recommending a longer (12 months) pre-existing condition exclusion and a broader rate band for health status than the small group market reforms to account for adverse selection. The 25% adjustment for health status is comparable to the MRMIB premiums for the Medi-Cally uninsurable.

[lxxxix] Brown et al, The State of Health Insurance 2000

[xc] Ibid. Those with minor children are eligible for but unenrolled in Medi-Cal and will be eligible once the federal waiver is approved. Brown estimates that half are single adults without minor children and 13% are couples without minor children.

[xci] Ibid.

[xcii] See R. Kronick et al. Expansion of Health Care to the Working Poor: Lessons from Other States (CA Policy Research Center, 1999)

[xciii] See Health Insurance Flexibility and Accountability Demonstration Projects at www.hcfa.gov/medicaid/hifademo. These guidelines give strong guidance that the waiver requests should not exceed 200% of FPL and should not tamper with the basic minimum Medi-Cal eligibility such as coverage for SSI eligibles and children up to age 6 and up to 133% of FPL.

[xciv] See Wulsin at al: California's Uninsured: Programs, Funding and Policy Options (Insure the Uninsured Project, July 1997) available at www.work-and-health.org/itup.

[xcv] Counties such as San Francisco, Alameda and Santa Clara are using their Local Initiatives as a building block to cover segments of the uninsured. In San Diego, local managed care organizations such as Sharp and Community Health Group are acting as the focal points of local efforts to cover the uninsured. In Orange and San Mateo Counties, the County Organized Health Systems may serve as the building blocks. See Wulsin et al, Insure the Uninsured Project Conference Binders 1999 and 2001, Tabs on County, Clinic and Local Initiative Efforts to Cover the Uninsured available at www.work-and-health.org/itup.

[xcvi] 2000 Summary of County Medi-Cal Services Program Expenditures (CMSP Governing Board, 8/30/01

[xcvii] Ibid.

[xcviii] M. Hickey, An Overview of the Uninsured in Northern Rural California (ITUP, Sept. 28, 2001) available at www.work-and-health.org/itup.

[xcix] Ibid. Self pay accounted for 27% of clinics' uninsured revenues, EAPC and other state programs for 37%, CMSP and other county programs for 28% and CHDP for 9% of clinics' uninsured revenues.

[c] As a rule of thumb, CMSP counties account for 10% of the state's uninsured.

[ci] Peter Long, An Overview of California Financing and Coverage (ITUP, Sept. 28, 2001).

[cii] Hickey, An Overview of the Uninsured in Northern Rural California

[ciii] Hickey, An Overview of the Uninsured in Northern Rural California. In the other nine study counties, Medi-Cal accounted for disproportionate emergency room visits. In Solano, possibly due to its COHS, Medi-Cal emergency room visits were proportionate.
[civ] See Wulsin et al, Clinics, Counties and the Uninsured (Insure the Uninsured Project, 1999).
[cv] Wulsin et al, Clinics, Counties and the Uninsured
[cvi] See Silverman, An Overview of the Uninsured in the Central Valley (Insure the Uninsured Project, Jan. 18, 2002) and Ahmed, Overview of the Uninsured in Southern California Counties (Insure the Uninsured Project, Feb. 2, 2002).
[cvii] Ibid.
[cviii] For example there have been extensive discussions of Cal Optima managing care and coverage for the medically indigent adults in Orange County; the principal obstacle is financing, which could be solved with a waiver. See Roohe Ahmed, An Overview of the Uninsured in Orange and San Diego Counties (ITUP, Oct. 2001).
[cix] For example, in analyzing county efforts to care for the uninsured, we discovered large discrepancies between Orange and San Diego County's own data for the county programs for the medically indigent and the data reported by the county to the state's MICRS (medically Indigent Care Reporting System). This would change the number of uninsured seen in a county system by a factor of three hundred percent. The discrepancy results from the reporting of episodic emergency room care to the uninsured paid for by the county under Prop 99 together with the county data for the costly chronically ill and seriously injured using the county system for indigent adults. See Wulsin et al. Clinics, Counties and the Uninsured: Phase One (Insure the Uninsured Project, 1999). See also Roohe Ahmed, An Overview of the Uninsured in Orange and San Diego Counties.
[cx] Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000)
[cxi] Ibid.
[cxii] Silverman, An Overview of the Uninsured in Tulare County (Insure the Uninsured Project, Jan. 18, 2002).
[cxiii] For example in Fresno, most of the funding is directed to a single community hospital, which has taken over the responsibilities of the old county hospital. In San Diego, community clinics are the sole contracted source of primary care.
[cxiv] Wulsin, Clinics, Counties and the Uninsured: Phase One
[cxv] Office of Statewide Health Planning and Development, Individual Hospital Financial Data for California: Report Periods July, 1997-June, 1998.
[cxvi] Clinics, Counties and the Uninsured: Phase Two
[cxvii] Ibid.
[cxviii] Silverman, An Overview of the Uninsured in Tulare County (Insure the Uninsured Project, Jan. 18, 2002).
[cxix] See D. Greiff and Wulsin, Improving Care for Uninsured High Utilizers in Public and Private Health Delivery Systems (Dec. 2000) (unpublished manuscript)
[cxx] The use of outpatient care is far lower than for an insured population, while the use of hospital services is far higher.
[cxxi] The COHS programs in Orange and Santa Barbara and the managed care plans in San Diego have wide experience in managing care for the uninsured and/or the chronically ill portions of Medi-Cal.
[cxxii] Clinics, Counties and the Uninsured: Phase One and Phase Two
[cxxiii] Clinics, Counties and the Uninsured: Phase One.
[cxxiv] Children comprise roughly 10% of county uninsured spending, and in Los Angeles the undocumented account for an estimated 11-12% of county uninsured spending. Ibid.
[cxxv] Ibid.
[cxxvi] Clinics, Counties and the Uninsured: Phase Two
[cxxvii] Clinics, Counties and the Uninsured: Phase One
[cxxviii] Clinics, Counties and the Uninsured: Phase Two
[cxxix] Ibid.
[cxxx] Clinics, Counties and the Uninsured: Phase One
[cxxxi] Indigent/Bad Debt Net Surplus or Deficit 1995-6 and SB 855 Revenues (Los Angeles County Dept. of Health Serv. 10/97)

[cxxxii] Insure the Uninsured Project, Conference Binder 1999, Counties, Local Initiatives Tab and ITUP 2002 Conference Summary available at www.work-and-health.org/itup/conference.
[cxxxiii] Data on county users and county spending derived from county reports to California Department of Health Services. This use and budget data is from 1998-9. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000.
[cxxxiv] Data on county hospital days and visits derived from county reports to California Department of Health Services for 1998-9. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000.
[cxxxv] See Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000). Public safety net providers depend on realignment, Prop 99 and DSH (disproportionate share hospital) funding; non profit community clinics depend on EAPC, CHDP and federal grants and contracts; private hospitals depend on DSH, and private doctors depend on SB 12, Prop 99 and patient copayments. State programs such as Family PACT and Breast Cancer Treatment and stand alone Medi-Cal coverage for perinatal care may need to be merged into the system we are proposing. None of the funding streams are now connected to a coherent delivery and financing system. There are also transitional challenges in coordinating with the Medi-Cal programs for the disabled as county eligibility is often the "waiting room" while Medi-Cal eligibility for disability is being assessed.
[cxxxvi] Medi-Cal managed care is based on a primary care doctor while care to the uninsured is often funneled and managed through a public hospital emergency room or outpatient department.
[cxxxvii] See n. 5.
[cxxxviii] P. Long, An Overview of California Financing and Coverage (ITUP, Sept. 2001).