REFLECTIONS AND RECOMMENDATIONS ON BUILDING COVERAGE FOR CALIFORNIA'S UNINSURED

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Insure the Uninsured Project (ITUP) seeks to increase health coverage of California's 6.5 million uninsured. ITUP is funded by grants from the California Wellness Foundation Blue Shield of California Foundation and The California Endowment.

ITUP supports efforts throughout the state to develop practical solutions to cover the uninsured. ITUP works closely with state, county and local initiatives, purchasing pools, commercial health plans, employers, policy makers, hospitals, doctors and community clinics to address the issue of the uninsured in California. ITUP serves as a non-partisan source of information, networking, and technical assistance on efforts and opportunities to cover the uninsured. ITUP seeks to develop common ground among organizations and individuals that are most interested and able to expand coverage among the uninsured.

This report surveys the need and prospects for improvements in care, coverage and financing for the uninsured. We believe that economic and political conditions are right for a major expansion in coverage of the uninsured, if coupled to effective cost controls. We welcome your thoughts and comments.

EXECUTIVE SUMMARY

California has a high percentage of its population uninsured. The uninsured are predominantly young, low wage working families. Children's uninsured rates are falling while uninsured rates for young working adults are growing at the fastest rates. In California and nationally, the rates of increase in health costs and premiums are the prime cause of the growth in the uninsured.

California has made important progress in covering the uninsured including: expanded coverage for children and parents, underwriting reforms and purchasing pools for small employers and a growing momentum for change at state and local levels. There are many state and local leaders of good will seeking both immediate and long term, far-reaching solutions.

Major legislation is being proposed to reduce California's high rate of uninsured; these proposals include mandating employer and individual coverage, coverage for all children and enacting a Canadian style single payer system. Universal coverage could be incrementally achieved in California sequenced as follows: first, all children, second Healthy Families parents, third low wage working adults, finally universal coverage (via mandates, pay or play or taxes) if linked to cost controls. The missing ingredients for success are stakeholder statesmanship.

An increasing number of counties, regions and local initiatives are developing innovative pilots to increase coverage of the uninsured. Most cover children; some cover adults and parents. Some test new forms of coverage such as managed care for the county indigent or purchasing pools and premium subsidies for low wage workforces. Local efforts build

on the strengths and needs of local communities: 1) Local Initiatives, County Organized Health Systems and Community Health Plans who are willing and able to lead experiments, commit financing and take risk, 2) public hospitals and community clinics who treat Medi-Cal, county indigent and uninsured patients without discriminating based on the patient's payor source, and 3) strong and cohesive local leaderships. The biggest challenge to local innovation is the frozen, fragmented and often incomprehensible thicket of federal and state programs and funding streams on which they rely. California is unique in that local government with the least access to funding shows the greatest leadership and creativity in covering the uninsured.

ITUP recommends the following broad approaches to increase coverage:

Private Sector

Challenges	Employer Does Not Offer Health Coverage	Employee Does Not "Take Up" Health Coverage	Employee is Not Eligible for Employer's Coverage
Solutions	▪ Improve affordability of private health coverage for low wage workforces ▪ Reduce cost and premium inflation ▪ Employer and individual mandates	▪ Public subsidies of low wage worker's share of family premiums ▪ Restructure employees' share of premiums to a percent of wages ▪ Reduce health inflation ▪ Individual and employee mandates	▪ Purchasing pools and other structures to cover flex workers ▪ Develop financial assistance for low wage flex workers ▪ Individual mandates

Public Sector

Challenges	Low Wage Working Adults Ineligible for Medi-Cal or Healthy Families	Undocumented Workers	Families Eligible for Medi-Cal and Healthy Families, but Not Enrolled (673,000 parents and children)
Solutions	▪ Make low-wage working adults eligible for coverage with federal, state and county matches ▪ Create a basic health plan with premium subsidies	▪ Improve funding for local safety nets and re-structure delivery systems ▪ Foster employment-based solutions ▪ Increase federal matching opportunities	▪ Connect families through providers, the workplace, the school and the child care centers ▪ Simplify programs and reduce enrollment costs ▪ Reduce churning and

	premium subsidies for employees over 100% of FPL	(amnesty, children and new legal residents)	enhance retention and program continuity

THE UNINSURED

Recent Trends in Coverage

The percentages of uninsured Californians have been high, but steady as compared to the rest of the nation, where uninsured rates in most other states rose markedly since 2000.[1] National uninsured rates increased the most for young adults, low wage working adults and adults living alone.

Over the past two years, uninsured rates for children fell sharply in California and nationally.[2] Growth in public coverage, especially for children, offset declines in private coverage in California.

Double digit rises in health care costs and premiums combined with an economy with little job or wage growth have led to declines in employment-based coverage.[3] Three factors are at play: declines in employer offer rates, slow job and wage growth[4], and a lethal combination of rising employee health premiums with stagnant wages leading to declines in take-up rates.[5]

If the economy continues to improve, private insurance coverage may reverse its decline, if meaningful cost controls can reduce the rise in private premiums. The long-term projections however are for slow, steady erosion in private coverage and a slow steady rise in state and national rates of uninsurance for the next decade.[6]

California's public coverage (Medi-Cal and Healthy Families enrollment) has grown from 5.1 million in 1995 to nearly 7.5 million Californians in 2005.[7] This growth in program beneficiaries was due to eligibility expansions for working poor families, administrative streamlining, coordinated outreach and enrollment efforts and a weak or negative job growth from 2001 to 2004. Due to the increase in beneficiaries combined with escalating per capita health costs, spending growth in California's public health programs have substantially exceeded the growth in state revenues and spending for

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[1] United States Census Bureau, Income, Poverty and Health Insurance Coverage in the United States 2003 (August 2004) at www.census.gov Comparison of Uninsured Rates Between States Using Three Year Averages 2001-2003 at www.census.gov.

[2] Ibid; Brown and Lavarreda, Job Based Coverage Drops for Adults and Children, But Public Program Boost Children's Coverage (UCLA Center for Health Policy Research, Feb. 2005)

[3] Ibid

[4] See Greenhouse, Falling Fortunes of the Wage Earner, New York Times, April 12, 2005

[5] Blumberg and Holahan, Work, Offers and Take-Up: Decomposing the Source of Recent Declines in Employer-Sponsored Coverage Urban Institute 2004.

[6] Gilmer and Kronick, It's The Premiums Stupid: Projections Of The Uninsured Through 2013, Health Affairs, Web Exclusive (April 2005).

[7] Ta and Wulsin. A Summary of Health Care Financing for Low Income Individuals in California 1998-2005 at www.itup.org

virtually all other state programs.[8] This level of public health spending growth cannot be sustained absent new revenues.

Growth in Health Spending

Per capita costs of private coverage have increased at nearly twice the rates of public coverage and at five to six times the rates of worker's wages. The sectors of the workforce facing the greatest affordability challenges are near elderly employees between the ages of 50 and 64; for example, premiums for 60 year olds are over three times the cost of coverage for 20 year olds.[9] Family coverage for an employee, spouse and dependent children costs about three times, as much as coverage for employee only coverage. Those losing employment-based coverage are mostly young low wage workers and children, whose coverage is comparatively more affordable.

Per capita costs of public programs have been growing more slowly than per capita costs of private coverage.[10] This is in part due to state program restraints on prices. Within public programs, aged and disabled beneficiaries (who in California are not for the most part in managed care) have had the fastest growth in per capita health costs.

Health care costs are increasing due to both increases in utilization of services and increases in the prices of services.[11] While prescription drug coverage costs increased at the fastest rates, the costs of hospital and physician services have grown at fast rates as well, as have the non-benefit costs (administration and profits) of health plans.

The public sector proposes to respond to escalating costs by moving more MediCal beneficiaries from fee for service into managed care. The private sector is moving more subscribers out of HMO's and into fee for service PPOs with fewer covered benefits and higher patient cost sharing. [12]

To summarize, fewer persons have private coverage and their per capita costs continue to rise sharply, outpacing both worker's wages and employer's profits; more costs are being shifted to patients and employees. More individuals (mostly children) have public coverage; the costs of public coverage are outpacing the growth in state and local revenues and the public sector is proposing to shift more patients into managed care. Health spending growth in both the public and private sectors cannot be sustained, and therefore changes will occur; at this point we simply do not know what those changes will be.

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[8] Ibid.

[9] For example in Los Angeles, the two lowest cost standard benefit plans for individual employees 20-29 offered through PacAdvantage are Kaiser South and Salud con Health Net at $131.43 and $133.51 per month respectively. Whereas for employees 60-64, comparable coverage from Salud con Health Net and Kaiser costs $377.47 and $379.43 per month respectively. See www.PacAdvantage.org.

[10] See Smith et al, Health Spending Growth Slows in 2003, Health Affairs (Jan 2005)

[11] Ibid.

[12] See California HealthCare Foundation, California Health Benefits Survey 2004 at www.chcf.org and Kaiser Family Foundation and Health Research Education Trust, Employee Health Insurance 2004 Annual Survey at www.kff.org and Kaiser Family Foundation, Trends and Indicators in the Changing Health care Marketplace, 2004 Annual Update at www.kff.org

Recent Surveys on the Numbers and Composition of the Uninsured

1. Numbers of uninsured

The national 2004 Current Population Survey (CPS) and the 2003 California Health Interview Survey (CHIS) report the same number of uninsured – 6.5 million. According to the 2003 California Health Interview Survey (CHIS), 6.5 million Californians were uninsured at some point during the survey year.[13] This figure represents 21% of the state's population under the age of 65; there was a small decrease in the percent of uninsured Californians between 2001 and 2003. The national 2004 Current Population Survey (CPS) reports 6.5 million uninsured (at a point in time).[14] There was a slight decrease in the percentage of uninsured Californians between the 2003 and 2004 surveys.

Both studies appear to have a very significant undercount of actual Medi-Cal and Healthy Families enrollment.

- Actual program enrollment in Medi-Cal and Healthy Families is projected at 7.5 million at a point in time in 2005-6; that figure is much larger over the course of a year as many cycle on and off both programs.[15]
- CHIS reports 4.85 million persons under 65 enrolled in Medi-Cal and Healthy Families for the whole year.[16]
- CPS reports 4.8 million persons under 65 enrolled in Medi-Cal and Healthy Families at a point in time.[17]

2. Short Term and Long Term Uninsured

The short term and long term uninsured are somewhat demographically different.[18] The short term uninsured are more likely to have higher incomes, to be white and to be women, and the long term uninsured who are more likely to Latino, male and lower income. CHIS reported 6.5 million uninsured over the course of a year; 3.7 million are uninsured throughout the year and 2.9 million are uninsured during a part of the year.

3. Employment Based Coverage

CHIS reports that over half of Californians have employment based coverage all year and that 10% have "other" insurance, mostly individual coverage, for a full 12 months.[19] The percentages of insured with employment-based coverage are declining and the percentages of insured with other, primarily individual coverage are increasing.

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[13] See n. 1 and 2.

[14] See n.1

[15] Medi-Cal and Healthy Families enrollment of children is about 4.2 million at a point in time. Ta and Wulsin. A Summary of Health Care Financing for Low Income Individuals in California

[16] For children, it is 2.8 million. Brown and Lavarreda, Job Based Coverage Drops for Adults and Children, But Public Program Boost Children's Coverage

[17] For all persons, the figure is 5.3 million and for children, it is 2.8 million. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States 2003 (August 2004) at www.census.gov Comparison of Uninsured Rates Between States Using Three Year Averages 2001-2003 at www.census.gov.

[18] Brown and Lavarreda, Job Based Coverage Drops for Adults and Children, But Public Program Boost Children's Coverage

[19] Ibid.

According to a recent study by Linda Blumberg and John Holahan, decline in employee take-up rates is the largest contributor (64%) to the recent fall in employer coverage, followed by changes in work (28%) and declines in offer rates (7%). [20]

The California HealthCare Foundation and Health Research Educational Trust found that California's employers are responding to the double digit increases in health premiums by dropping coverage for their employees – the offer rate fell from 70% to 67% over the past four years. Most of the decline in employer offers was due to a fall in small employers' offer rate.

Many employers who maintain coverage for their employees are passing premium increases on to their employees in the form of increased shares of premiums and higher copays and deductibles.[21] Employees' share of premiums for employee only coverage increased from 10% to 13% of premium, and employees' share of family premiums increased from 23% to 27%. Employees of all income levels are dropping family coverage, presumably because they can no longer afford to pay the increasing premiums due to their stagnant wage levels.[22]

In California, employers' premiums were well below the national average; they have now increased to the national average.[23] California premiums for employment based coverage have been increasing at a faster rate than premiums nationally. California employers' premiums for PPO coverage are now well above the national average. HMO premiums are only slightly less than the national average. California has a far higher rate of HMO enrollment than nationally, but that rate has fallen somewhat to about 50% of all employees, while PPO enrollment has markedly increased to 36% of all employees.

California employers are increasingly pessimistic about their own and health plans' ability to control escalating health plan premiums. Nearly three quarters are very or somewhat likely to increase employees' share of premiums. One percent of survey respondents state that they are likely to drop coverage for their employees in 2005.

As Professor Kronick of UC San Diego Medical School notes the constant increase in health costs and premiums correlates to a steady rise in the percentage of uninsured. However it is a steady, persistent drip-drip increase in the uninsured that is occurring, rather than a tidal wave.[24]

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[20] The loss of employment based coverage was most severe among employees earning less than 200% of FPL; however losses due to declining take-up were very high for employees with incomes in excess of 200% of FPL. Blumberg and Holahan, Work, Offers and Take-Up, Decomposing the Source of Recent Declines in Employer Sponsored Coverage (Urban Institute, 2004) at www.urban.org

[21] California HealthCare Foundation and Health Research and Educational Trust. *California Employer Health Benefits Survey*, 2004,

[22] Blumberg and Holahan, Work, Offers and Take-Up, Decomposing the Source of Recent Declines in Employer Sponsored Coverage

[23] California HealthCare Foundation and Health Research and Educational Trust. *California Employer Health Benefits Survey*, 2004

[24] Gilmer and Kronick, It's The Premiums Stupid: Projections Of The Uninsured Through 2013

Why Are Californians Uninsured?

Professor Brown of the UCLA Center for Health Policy Research points to the lack of employer offer as accounting for most of California's uninsured workers: 60% were not offered coverage, nearly a quarter were not eligible for offered coverage and almost 15% did not take up coverage for which they were eligible, mostly because they could not afford their share of premiums.[25] Uninsured employees and uninsuring (not offering) employers report exactly the same complaint – they cannot afford the premiums for coverage.

Professor Kronick of UC San Diego Medical School offers an important perspective.[26] He points out that the percentage of uninsured working for small employers of less than 100 employees who do not offer coverage (20%) is roughly equal to the numbers of employees working for larger employers of more than 100 employees who do offer coverage (22%). Based on his research, our focus on small employer offer rates misses the point that uninsured employees are spread across the spectrum of large and small, offering and not offering employers.

Urban Institute researchers Blumberg and Holahan, as discussed earlier, point to the declining take-up rate (due to premium increases vastly exceeding wage increases) as the prime cause of recent declines in employer sponsored coverage.

Californians are uninsured for five principal reasons. Solving one or more of them would greatly reduce but not eliminate the high numbers of uninsured Californians. Each call for a different type of solution.

- Many working (primarily low wage) adults are either not offered or are not eligible for coverage by their employer (80% of uninsured workers).[27]
- Many adults and their family members lose and gain coverage over the course of the year due to "status" changes, such as changing or losing jobs, separations and divorces, attaining the age of 21, and losing and gaining public coverage (also referred to as churning) -- over 40% of the uninsured – we refer to this group as the frictionally uninsured.[28]
- 1.7 million low-income working adults are ineligible for Medi-Cal coverage but do use county health coverage in California.[29]
- 673,000 Californians are eligible for, but not enrolled in, Medi-Cal and Healthy Families.[30]

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[25] Brown, Access to Health Insurance in California Feb. 16, 2005, Presentation to the 9th Annual Insure the Uninsured Project Conference at www.itup.org/conference

[26] Brown and Kronick, Developing California's Health Coverage into a System for the Future Feb 11, 2005, Presentation to Insurance Commissioner Garamendi.

[27] See n. 25. This is a cost issue. Most employers who do not offer coverage cite affordability as the reason.

[28] This is a cost and structure issue. For example, employers and public programs can offer improved opportunities to retain coverage for those with status changes, but the cost to the individual or family must be affordable.

[29] County health coverage is not considered coverage, but would be considered coverage if incorporated into Medi-Cal or Healthy Families as other states from Massachusetts and New York to Oregon and Arizona have done with 1115 waivers.

- Undocumented persons are ineligible for federally funded public coverage programs with the exception of Medi-Cal coverage for emergencies and pregnancies only.

THE CURRENT POLICY ENVIRONMENT

The uninsured have been on the state's policy agenda for more than the past decade. Important progress has been made including: expanded coverage for children and parents, underwriting reforms and purchasing pools for small employers and a growing momentum for change at state and local levels. The key current health questions bedeviling California are: 1) how to solve the state's budget crisis (without cutting eligibility for health programs), 2) how to stop double digit health insurance premium increases and stem the increase in the numbers of uninsured without destabilizing the delivery of care to the uninsured and 3) how to build consensus for change among stakeholders who are entrenched and defensive of their positions.

The challenge is difficult due to California's convoluted public programs, the dependence of its safety net providers on declining and inequitably distributed revenue streams, the disconnect between its large and growing immigrant communities and its "frequent" voters, policy gridlock in the state and federal governments and "sky-is-falling" clarion calls from interest groups seeking their own best interests. There are many state and local leaders of good will seeking both immediate and long term, far-reaching solutions. Our collective challenge is to thread the needle of the possible.

Federal Context

Federal policy makers propose to increase coverage of the low wage uninsured through tax subsidies of individual coverage, association health plans and greater Medicaid flexibility. These are marginal approaches that do not achieve significant increases in coverage of the uninsured,[31] but they may be of some, albeit limited, use in increasing coverage of California's uninsured.

- Refundable Tax Credits – Tax credits are proposed to offset some of the cost of purchasing individual health coverage for individuals who do not qualify for Medicaid and are not offered coverage by their employers. The subsidies phase out at 200% of the federal poverty level. The proposed $1 billion in credits for uninsured Californians could afford significant financial help with premiums for young uninsured workers (who are typically the least likely to purchase coverage), but are generally insufficient to cover premium costs for older workers.[32] It is structurally quite difficult to use an annual refundable tax credit to pay monthly insurance premiums for young low-wage workers; some

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[30] Two thirds of the un-enrolled uninsured are children. It is possible that many of these children are actually enrolled, but not identified as such in the CHIS and CPS surveys. See notes 17-19

[31] Henry J. Kaiser family Foundation, Coverage and Cost Impacts of the President's Health Insurance and Tax Deduction Proposals (March 2004) at www.kff.org

[32] As discussed earlier in footnote --, the premiums for young individuals are such that refundable tax credits could significantly improve affordability for young workers. There is a need for an intermediary financing mechanism to translate annual tax credits into monthly premiums. Banking the tax credits through a state agency such as MRMIB could do this.

intermediate mechanism is needed to translate the proposed annual credits into monthly premiums for uninsured individuals.

- Association Health Plans – AHPs are proposed to lower the cost of providing health benefits for small employers by enhancing group purchasing powers, bypassing state regulation of insurance. Group purchasing can lower costs by negotiating rates and reducing administrative costs. AHP's allow purchasers to bypass some state mandates to cover particular services that can be costly to small employers – possibly 10% of premium. However, this proposal could unravel California's successful underwriting reforms and purchasing pools, as association health plans could skim the best underwriting risks as has occurred in other states.
- Medicaid Flexibility – Medicaid flexibility is proposed to give state policy makers broad flexibility in re-designing the program in exchange for curtailing program growth. This has yet to take form in a concrete Administration proposal.

The Bush Administration proposes to restrict the innovative (in the view of the states) local financing that under-girds California and other states' Disproportionate Share Hospital (DSH) program for safety net hospitals and local match for Medi-Cal and Healthy Families outreach on the grounds that the local matches are illusory or even in some cases fraudulent. The United States Senate narrowly balked at the Administration's proposals to cut Medicaid spending; however a House Senate budget compromise includes instructions targeting a $10 billion reduction in federal Medicaid spending over four years -- $250 million annually in California. National Governor's Association (NGA) and National Conference of State Legislators (NCSL) have recently called for increased federal flexibility to allow states to pare benefits and increase cost sharing.[33]

State Context

In contrast to the direction of the federal government, the state of California incrementally expanded public programs and is debating wholesale reforms of health coverage. The efforts of health policy makers in Sacramento have very little in common with the direction of the Bush Administration's reform efforts.

Governor's Proposed 2005-06 Budget

In Governor Schwarzenegger's Proposed 2005-06 Budget, there are no proposed eligibility cuts and several provisions to expand coverage for children. General Fund revenues are projected to increase by 7% and General Fund spending by 4%. Medi-Cal spending would grow by 8%.[34]

[33] National Governor's Association, Medicaid Reform: A Preliminary Report June 15, 2005
[34] ITUP, Summary of the Governor's 2005-06 Health Budget at www.itup.org/reports

Proposed Improvements in Children's Programs

Revise and simplify Medi-Cal/Healthy Families application and streamline eligibility processing for children
- Savings: $1.2 million in '05-06 and $16 million ongoing

Restoration of application assistance fees for Certified Application Assisters
- General Fund cost: $5.9 million
- Projected impact: 15,000 more children enrolled in Healthy Families in 05-06

Medi-Cal/Healthy Families Bridge Performance Standards
- Ensures counties refer children to Healthy Families when they lose Medi-Cal eligibility
- General Fund cost: $2.1 million to establish and monitor Bridge Performance Standards
- Projected impact: 10,000 new kids enrolled in '05-06 and 27,000 thereafter

Healthy Families Buy-in Option Available for local Healthy Kids Initiatives
- Allows county programs for uninsured children to contract with Healthy Families

Children's Medical Services (CCS, CHDP and GHPP) Augmentation
- General fund increase of $11.6 million, total fund increase of $22.7 million

Medi-Cal Redesign

The Governor's proposed Medi-Cal redesign includes expanded managed care coupled to renewal of the state's selective contracting waiver and reform of the DSH (Disproportionate Share Hospital) program. This requires a major federal 1115 waiver.

Table of Proposed Medi-Cal Redesign Changes

Managed Care Expansion for Seniors, Disabled and Families
- Families and children must enroll in managed care in 13 new counties
- Seniors and disabled must enroll in managed care in 28 counties
- Long term care pilot in three counties
- Savings in '08-09 of $177 million ($89 million General Fund)

Renewal of selective provider contracting waiver and reform of DSH (Disproportionate Share Hospitals) and SB 1255 programs
- California seeks renewal of its five-year waiver for selective provider contracting
- California requests MediCal managed care inpatient days count for purposes of computing hospitals' DSH allocations and payments
- California seeks an increase in federal matching funds for indigent care and increased flexibility in how the funds are used
- Federal government requests California to abandon Intergovernmental Transfers (IGTs); California proposes to switch to Certified Public Expenditures (CPEs) to fund DSH and SB 1255 for safety net hospitals

These linked changes will be strenuously disputed in the legislature and in the federal waiver process and may eventually be uncoupled. For those seeking to increase coverage of the uninsured, we think there are advantages in the Schwarzenegger Administration's proposals. First, extending managed care to disabled adults creates a managed care platform and allows interested counties to build a consolidated managed care network that can serve for coverage of working uninsured adults as well. Seniors and disabled advocates are quite concerned that managed care means less of the care they most urgently need. Second, increasing federal funds and loosening the strictures of DSH and 1255 allows state and local governments to increase funding for outpatient care to the

uninsured, to more carefully target funding to facilities actually caring for the uninsured and to reconfigure and right-size public hospital facilities. Hospitals are concerned to assure that no hospital receives less and that the over-all allocation grows substantially. Counties are concerned about paying more and receiving fewer federal funds in their own county systems

ITUP's regional workgroup research found that DSH funds are inequitably distributed – overcompensating those facilities with a high percent of MediCal and low share of uninsured and under-compensating those facilities with high percentages of uninsured patients.[35] Moreover, facilities in poor counties with high MediCal participation and high percentages of uninsured often receive little or no assistance so long as the burdens of caring for the poor and uninsured are more or less equally distributed. There is a strong case to be made for more equitable and accountable distribution of the funds in question.

Potential for Big Picture Reforms

Governor Schwarzenegger has rhetorically embraced coverage for all children and an individual mandate requiring all Californians to enroll in public or private coverage. The business community in the aftermath of the narrow repeal of SB 2 by Proposition 72 could be interested in a win-win reform proposal to expand coverage and control costs. Major legislation is being proposed to reduce California's high rate of uninsured; these proposals include mandating coverage, coverage for all children and enacting a single payor system. There is some possibility that universal coverage could be incrementally achieved in California sequenced as follows: first, all children, second Healthy Families parents, third low wage working adults, finally universal coverage (via mandates, pay or play or taxes) if linked to cost controls.

The missing ingredients for success are stakeholder statesmanship and agreement on effective cost controls. The following is a chart of major legislation to cover some or all of California's uninsured. For these purposes we used early versions of current bills to flesh out the approach, rather than later amended versions.

Matrix of Uninsured Legislation 2005

Legislation: Universal Coverage

Bills	Eligible	Benefits	Cost controls	Financing	Who administers	Employer impacts
SB 840 Kuehl	All California residents eligible	All benefits, except nursing home care	Regulation of prices, elimination of health plans, bulk purchasing and cap on program growth	$70 billion in unidentified taxes Existing funds	State health agency as single payor	Replaces employer premiums with payroll taxes
AB 1670 et seq. Richman and	All California residents under age 65 mandated to	Full scope for persons with incomes below 200% of FPL	Purchasing pool, electronic enrollment, program	Gross premium tax on all health plans Funding	State health agency and health plans	Subsidizes small low wage employers

[35] Wulsin and Hickey, Counties, Clinics, Hospitals, Employers Health Plans and California's Uninsured (ITUP, October 2003) at www.itup.org

Nation	buy coverage	and catastrophic ($5000 deductible) and preventive care for persons with incomes above 200% of FPL	simplification, delay in hospitals' seismic safety upgrades, Center for Quality Medicine	priorities: uninsured children, Healthy Families parents and subsidies for low wage small employers		
SB 2 Burton and Richman	Employer and employee mandate to cover all Californians working full time for large and medium sized employers	Full scope Knox Keene HMO benefits plus prescription drugs	Purchasing pool	Employers and employees are required to pay or play – i.e. buy coverage or pay a fee to MRMIB for coverage	Managed Risk Medical Insurance Board (MRMIB)	Large and medium sized employers require to offer coverage for their full time employees

Proposed Legislation: Children's Coverage

Bills	Eligible	Benefits	Cost controls	Financing	Who administers	Employer impacts
AB 772 Chan and SB 437 Escutia	All uninsured California children enroll in MediCal or Healthy Families	Full scope MediCal or Healthy Families as applicable	Streamlines application and renewal processes for uninsured children	Existing funds Estimated additional cost of $100 million	Department of Health Services and Managed Risk Medical Insurance Board	Voluntary employer buy-in options
SB 38 Alquist	Uninsured children with incomes 250-300% of FPL enroll in Healthy Families	Full scope Healthy Families		State General Fund and federal match	Managed Risk Medical Insurance Board	None

There is also legislation to reduce the prices of care for the uninsured, who currently pay top dollar for hospital, prescription and other medical services.[36] Two bills seek to regulate the prices charged by hospitals for the uninsured and two measures seek to control the prices of prescription drugs for the uninsured. While these bills do not cover the uninsured, they would provide limited relief from the price escalation practices that have emerged from providers intent on maximizing their revenues from government and insured patients and indifferent or unconscious to the price gouging impacts on the uninsured.

[36] SB 24 Ortiz and AB 774 Chan on hospital billing and AB 75 and SB 19 Ortiz on pharmacy costs to the uninsured.

There is greater stakeholder consensus on designing expanded coverage to the uninsured than there is on designing effective cost controls. There is a necessary period of education and debate on effective cost controls that may occur in the context of the AB 1528 Commission of Cost Controls. Unless there is agreement on effective cost controls; there is little to no likelihood of support from the employer community or the Administration.

The peril of combining coverage expansions with cost controls is that those who are most interested in expanding coverage of the uninsured (some hospitals, clinics and doctors) often have the least bottom line interest in effective cost controls. Those with the strongest bottom line interests in effective cost controls (some business and labor) have little concrete tangible self interest in expanding coverage of the uninsured. Furthermore many in each camp can be satisfied with relatively small improvements, such as safety net provider increases in DSH, FQHC (Federally Qualified Health Centers) or EAPC (Early Access to Primary Care) funding for those with the heaviest burdens of caring for the uninsured, and better data on cost and quality so that market competition works better for employers as purchasers.

The narrow ballot box defeat of SB 2 demonstrates the equal peril of proceeding with an imbalanced reform that alienates and energizes an important potential ally for change -- the business community. California's health stakeholders have repeatedly demonstrated their capacity to defeat in the legislature or at the ballot box[37] any meaningful health reforms, but unlike in other states, they have yet to demonstrate their capacity to coalesce in support of a balanced and negotiated reform.

County Context

An increasing number of counties, regions and local initiatives are developing innovative pilots to increase coverage of the uninsured. Most cover children; some cover adults and parents. Some test new forms of coverage such as managed care for the county indigent or purchasing pools and premium subsidies for low wage workforces. Some are deeply engrained in the public delivery system while others are oriented to public-private partnerships.

Why are local efforts proliferating in California? First and foremost are the strengths and needs of local communities: 1) Local Initiatives, County Organized Health Systems and Community Health Plans who are willing and able to lead experiments, commit financing and take risk, 2) public hospitals and community clinics who treat Medi-Cal county indigent and uninsured patients without discriminating based on the patient's payor source, and 3) strong and cohesive local leaderships.

What challenges do they face? The biggest challenge is the frozen, fragmented and often incomprehensible thicket of federal and state programs and funding streams on which they rely. It is somewhat odd that the level of government with the least access to funding shows the greatest leadership and creativity in covering the uninsured.

[37] Two over-whelming defeats for single payor and employer mandate initiatives in the 90's to which all stakeholders but the ballot proponents were opposed, and the narrow 2004 referendum defeat of an employer mandate, opposed only by the business community

To date, there has been little concrete state-level support for county pilots either in the form of enhanced flexibility or financing. The increased federal match for counties covering uninsured children 250-300% of FPL has yet to materialize and the increased federal match for counties covering Healthy Families parents has not even been submitted. While the Governor's budget has provisions to allow local pilot programs to use the state Healthy Families program to buy coverage for local Healthy Kids efforts, it fails to provide vital financial assistance in the form of consolidation/coordination with existing state and federal funding programs such as Emergency Medi-Cal, CHDP Gateway and others. Some policy makers at the state level are deeply skeptical of local efforts, and many of the local policy pioneers are frustrated by the state's inability to match their pace and increasingly dismissive of unresponsive state program bureaucracies.

County by County Reform Efforts[38]

Managed Care for the County Indigent	Premium Subsidies for Small Employers	Expansions for Uninsured Children, Home Care Workers, Child Care Workers, Parents and Young Adults	Purchasing Pools and Local Health Plans	Enhanced Federal Financial Participation
Contra Costa	San Diego	Alameda	Siskiyou	Los Angeles
		Kern		
Solano	Sacramento	Los Angeles		
		Riverside		
	San Francisco	San Bernardino		
		San Francisco		
		San Joaquin		
		San Mateo		
		Santa Clara		
		Santa Cruz		

Private Sector

The uninsured consist mainly of young, low-income workers and their families.[39] Sixty-five percent are under age thirty, seventy percent have incomes under 200% of the federal poverty level, and over eighty percent are either employed or the dependents of an employee. Latinos, young adults and immigrants have very high ratios of uninsurance. Most are uninsured because they are not offered coverage at the workplace and many but not all cannot afford coverage in the individual market. Both the uninsured worker and the uninsuring employer cite the same reasons: the lack of affordable coverage.

Employment-Based Coverage

[38] See Phan, Directory of Local Efforts to Cover the Uninsured in California (August 2003) at www.itup.org/reports

[39] Brown, Access to Health Insurance in California, Presentation to the 9th Annual Insure the Uninsured Project Conference at www.itup.org/conference

Employment based coverage covers nearly 60% of all Californians under the age of 65, but is declining due to cost increases and job losses from a weak economy. Small and mid sized employers' offer rates of coverage to their employees have declined somewhat. Many employers who still offer coverage are passing spiraling premium costs on to their employees, leading some workers to decline coverage due to unaffordable shares of premiums.

Employment-based coverage is one third subsidized by federal and state tax policies that allow for purchase of employment based coverage with pre-tax dollars.[40] This creates strong financial incentives for employers to cover high wage employees and weak incentives to cover low wage workers. For example, a recent study by John Sheils of the Lewin Group reports that families making over $100,000 a year receive, on average, tax subsidies of $2,780 per family for health coverage whereas families earning from $10,000 to $20,000 annually receive tax subsidies averaging $292 per family. The design of premiums and financing for employment-based coverage is such that young and typically lower paid workers cross-subsidize the premium costs of older, typically better paid employees who use more health services.

Employment-based coverage typically includes an employee share of premium (e.g. workers pay 20-30% of premium); this arrangement cross subsidizes coverage from young, lower wage workers to older higher wage employees as well. In addition, employees can increasingly tax shelter their shares of premiums and health expenditures; those tax shelters primarily benefit higher income employees and do little for low wage workforces.

As a result of federal and state tax policies and standard industry practices, employment-based coverage is not well designed to provide affordable coverage for industries with predominantly low-wage workforces. The regressive nature of financing for employment-based insurance results in wide disparities in access to private health insurance for low wage as contrasted with high salaried workforces. Over three fourths of families with incomes in excess of 300% of FPL have job based coverage as compared to less than one third of employees with incomes between 100 and 200% of the Federal Poverty Level.[41]

Can this be fixed? Some employers (for example Pitney Bowes) have shifted their employees' share of premium to a percentage of wages – an approach that is far more helpful to low wage working families. Several health economists recently proposed to the President's Commission on Tax Reform to turn the tax subsidies of employment based health coverage upside down such that low wage workers receive the largest premium subsidies.

Costs of private health coverage have been increasing at double-digit rates for the past three years, driven by the cost demands of hospitals and doctors and the soaring use and prices of prescription drugs; many health plans are reporting healthy profit margins as well. Faced with consumer backlash, many health plans have largely abandoned their

[40] Sheils and Haught, The Cost of Tax Exempt Benefits in 2004, Health Affairs Web Exclusive February 2004

[41] Brown et al, Job Based Coverage Drops for Adults and Children, But Public Program Boost Children's Coverage

often unpopular efforts to curtail rising health costs by restricting provider choice and coverage of services and replaced it with an approach that shifts the burden of rising costs to patients and employees. Recent research suggests that higher income workers prefer broad choice of providers and are willing to live with high out of pocket costs while lower income households would sacrifice wide choice of providers for greater financial protections.[42] To summarize the market-based solution of shifting rising costs to employees is somewhat acceptable to higher income employees who can tax shelter their rising out of pocket burdens. It is not a viable approach for lower wage workers.[43]

California cannot change federal tax policy, however we can increase affordability for low-wage workers by interfacing public and private coverage. This can be achieved by public program wrap around, buy-ins or premium subsidies. Some small employers, unions, community groups and local health plans are involved in efforts to design viable pilots to increase coverage of low wage workforces.[44] These pilots take several forms: first, to reduce uninsuring employer and uninsured employee costs by wrapping their contributions around existing public subsidies, second, to design affordable coverage that covers essential basic and preventive services and contracts with only the most cost effective plan(s) and/or provider networks, and third, to seek to develop stakeholder consensus on workable approaches to control rising costs and premiums and insulate low wage workforces from the market trends that shift unaffordable premium increases on them.[45]

Individual Coverage

A small but growing number (about 7%) of Californians under the age of 65 purchase individual coverage.[46] Recent studies suggest that about half are self-employed and more surprisingly about 40% have incomes of less than 200% of the federal poverty level.[47] Individual coverage is not tax subsidized, except for the self-employed for whom it is tax-deductible, a benefit primarily for higher income individuals. The design of the individual insurance premium structure does not cross subsidize from young to old and from healthy to ill because it is age rated, individually purchased and medically underwritten. As a result it offers much less affordable coverage for older and sicker individuals than employment-based coverage does. Young and healthy workers, however,

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[42] Helman et al, Public Attitudes on the US Health Care System (Employee Benefit Research Institute November 2004) at www.ebri.org and Kaiser Family Foundation, Health Insurance Survey (October 2004) at www.kff.org

[43] Employers too are skeptical of consumer driven health care as a panacea for their employees. See Trude and Conwell, Rhetoric vs. Reality: Employers Views on Consumer Driven health Care (Center for Studying Health Systems Change, July 2004)

[44] Pilots to increase employment based coverage have had some but limited success, depending on project design, amount of subsidy and the receptivity of local communities. See Chavira, Premium Subsidies for Low Wage Workforces: What is an Appropriate Price Point? (June 2004) at www.itup.org.

[45] See for example, Wulsin, California ChildCare Providers for Action, Health Policy Recommendations November 2004 at www.itup.org/reports

[46] Brown, Presentation to the 9th Annual Insure the Uninsured Project Conference at www.itup.org/conference

[47] Ziller et al, Patterns of Individual Health Insurance Coverage 1996-2000 Health Affairs 9May June, 2004)

may find the individual market offers less costly coverage than does the employment-based market.

In California, the individual insurance market is weakly regulated (compared to small employers) and typically inaccessible to those with serious health conditions.[48] The medically uninsurable must purchase through the Major Risk Medical Insurance Program if they can afford it. MRMIP acts as incubator, covering the individual for up to three years after which medically uninsurable individuals are eligible to purchase in the individual market without encountering underwriting exclusions. The individual market has the highest share of premium devoted to health plan's administrative costs, risk, commissions and profits and thus the lowest share of premium devoted to benefits.

There is some merit to using the individual market to increase coverage of the young, healthy working uninsured with refundable individual tax credits as the Bush Administration proposes. With a billion dollars from the federal government, California could design a system to cover one million young, uninsured low wage workers. The challenge for California would be how to make credits and pools work to cover portions of the uninsured. In ITUP's view, tax credits need a financing mechanism to convert them into monthly premiums. Credits should be accessible through a purchasing pool (this might be the financing mechanism as well), and credits should be available only for those contracting health plans agreeing to issue coverage to all persons with the credits. A good working model is Washington State's Basic Health Plan.

Large employer purchasing pools, are being developed by a number of Fortune 500 corporations, these could be combined with tax credits to increase coverage for flex workers. Flex workers are those part time, seasonal, contract and temporary workers who are not typically offered coverage even though their employer offers coverage to full time workers.[49] Some employers might be willing to part pay for coverage of valued flex workers.

Some propose to join an individual mandate with refundable individual tax credits. There is some merit to an individual mandate if combined with effective cost controls, purchasing pools, insurance reforms and premium subsidies for low-income persons. Many individual mandates are designed to replace employment-based coverage; this is a very costly transaction that can only be done at the federal level and entails shifting the subsidies for employment-based coverage into premium subsidies for individual coverage; there is over $200 billion at stake in such a transaction and thus likely to be substantial opposition from employers, unions and health plans. However a state could design an individual mandate that would not dismantle the employment-based system, but could be designed to act in concert with it. An individual mandate would need to assure affordable coverage for those who otherwise lack access to both public and private coverage. As initially designed, AB 1670 (Nation and Richman) combined an individual

[48] See Kelch, Rules Governing California's Individual insurance Market (April 2005) at www.chcf.org
[49] See Wulsin and Shofet, Developing Models of Coverage for the Flex Workforce, December 11, 2000 at www.itup.org/reports

mandate with expansion of public programs for uninsured children and parents and premium subsidies for coverage of low wage small businesses workforces.

Pilot Programs[50]

Several pilot programs currently test the effectiveness of premium subsidies, group purchasing, limited benefits and public program "wrap arounds" and buy-ins.

Table of Proposed Private Pilots in California

Premium Subsidies	Group Purchasing	Limited Benefits	Public Program "Wrap Arounds" and Buy-ins
Focus in San Diego	SacAdvantage	Western Growers	Healthy Families Purchasing Credit
SacAdvantage	Community Health Plan of the Siskiyous	Primary Value Plan	Medi-Cal's HIPP
Kaiser's Steps Program	California Child Care Providers for Action	Millennium Benefits	Los Angeles Healthy Kids
California Child Care Providers for Action		Blue Cross' MediFam	California Child Care Providers for Action

Map for the Future: Private Sector

California needs to develop policies to improve affordability of private coverage for and participation rates by low wage workforces, flex workers, transitional employees and small employers and slow the run up in costs and premiums. Such policies include:

- effective cost controls,
- matching employer contributions with appropriately targeted subsidies,
- shifting employee premium contributions to a percentage of wages,
- more effective group purchasing,
- pilot programs targeted to the uninsured,
- opportunities for public coverage buy-ins, wrap around coverage and purchasing credits or refundable tax credits to improve affordability and ultimately
- a well designed employer, employee and individual mandate that resolves the issues of affordability for low wage workforces.[51]

California has a wholly inadequate tax base to cover all the uninsured through expansion of public sector programs. The higher income uninsured are better covered through the private sector to avoid crowd-out incentives and cannibalization of existing markets. An added advantage of improving private coverage in California is that it does not ask, "where is your green card" but rather "may we have your credit card?"

[50] See Phan, Directory of Local Efforts to Cover the Uninsured in California (August 2003) at www.itup.org/reports

[51] See Wulsin, An Open Letter on SB 2 (September 2004) at www.itup.org

Cost control needs to become a top priority of employers, unions, purchasing entities and the state legislature. ITUP recommends strengthening the purchasing power of large and small employers, purchasing pools and union trusts. Health plans must regain their impetus and effectiveness in controlling health costs. Alternatives to managed competition must be developed for rural areas and other regions that lack the competitive market infrastructure; this may require state regulation of provider rates and health plan premiums in non-competitive markets. Development of local health plans and purchasing pools should also be pursued in these markets, as they may be able to develop less costly coverage. Antitrust actions are needed in selected markets where the market powers of local providers are used to prevent competition.[52] In order for managed care to succeed, purchasers and consumers need readily understandable and easily useable information on price and quality. Benefit plans must be standardized so coverage and prices are easily comparable. Consumers need to know the prices of the provider networks they select and have some well designed financial exposure to the price consequences of their choices.

ITUP believes that an achievable road to coverage for all Californians is to combine an employer, employee and individual mandate with subsidies for low wage workforces and individuals and affordability assurances to moderate premium growth for public and private payors.

Public Sector

Nine million Californians receive their coverage through Medi-Cal, Healthy Families and county health.[53] Expansion of coverage to the uninsured through public programs makes more fiscal sense than expansion through the private sector if the target uninsured population to be covered is eligible for federal matching funds (federal financial participation or FFP, one for one through Medicaid and two for one through Healthy Families).

However state and federal budget deficits and the vast complexity of California's public programs[54] impede efforts to cover the uninsured. California has developed inconsistent and conflicting incentives for state and local strategies to improve financing of care to the uninsured.[55] Moreover the funding streams, financial incentives and design of some

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[52] See Robinson, Consolidation and the Transformation of Competition in Health Insurance, Health Affairs (November/December 2004)

[53] 7.5 million participants in Medi-Cal and Healthy Families and at least 1.5 million using county health programs

[54] For example, public safety net providers depend on realignment, county match and DSH (disproportionate share hospital) funding. Non-profit community clinics depend on Family PACT, patient payments, EAPC, CHDP and federal grants and contracts. Private hospitals depend on DSH and cost shifting, and private doctors depend on SB 12, and patient payments. Neither the funding streams nor providers are connected into a coherent system, and most providers are averse to merging their efforts and funding streams.

[55] For example, Medi-Cal managed care as promoted by the state government to control state costs may deny county and private hospitals access to federal DSH funds on which they depend for financial survival. State government has no statutory responsibility for the uninsured; that responsibility resides at the county level; however California counties have little ability to raise their own revenues due to Prop 13, and counties therefore turn to the state and federal government for financing. County leadership developed federal financing for hospital care (DSH and SB 1255) and primary care (1115 waiver) to the uninsured;

county delivery systems for the uninsured conflict with the managed care approaches for the Medi-Cal and Healthy Families populations[56]

Medi-Cal is a complex system with fast growing enrollment – 6.7 million beneficiaries. It requires a major federal and state overhaul to make it relevant to cover the working poor; yet many advocates and providers resist any changes in program design since Medi-Cal is also the vital bulwark of funding for safety net institutions through Disproportionate Share Hospitals (DSH) and Federally Qualified Health Center (FQHC) reimbursement and for county Departments of Health, Mental Health and Social Services.

Medi-Cal has been expanded to cover two-parent, working families with incomes up to 100% of the federal poverty level and can be further expanded as other leading states have done to cover parents with incomes up to 200% of the Federal Poverty Level. Medi-Cal income thresholds for low wage working families can be increased under the "1931b option". California has begun to simplify its application and eligibility processes for the nearly 675,000 children and their parents in working families who are eligible but do not enroll in public coverage; it may be able to automate eligibility.[57] The stigma of Medi-Cal can be severe for the working uninsured, especially among Latino and Asian immigrant populations who typically prefer the Healthy Families model.

Healthy Families is a newer, very fast growing program covering nearly 800,000 children. California is authorized by the federal government to cover the uninsured parents of Healthy Families children as well, but lacks the $100 million in state match to get this expansion off the ground.[58] Healthy Families is more popular with enrollees and the general public than Medi-Cal, as it lacks the connotation and connections to "state and county welfare," but it still has many program glitches in need of repair, including the churning of children's coverage and failure to reach and enroll otherwise eligible children. Healthy Families lacks the strong support that safety net providers have for Medi-Cal because their Medi-Cal reimbursements are higher. Healthy Families is more strongly supported by private sector providers and commercial health plans, as its design is closer to commercial coverage.

County health is a very slow growing, predominantly state-funded, primarily county-run program for uninsured low-income persons not eligible for any other public or private coverage – 1.7 million participants. ITUP's studies found that funding per uninsured for all of county health (including public health) is about one quarter the cost of a well-run Medi-Cal managed care plan.[59] That figure may somewhat overstate the immediate

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there has been no financial support by the state. There is a counter-productive blame game between the state and the counties about the perilous state of local safety nets.

[56] For example, managed care is based on 24 hour access to a primary care doctor while care to the uninsured is typically funneled and managed through a hospital emergency room. Medi-Cal managed care creates incentives to reduce hospital days, yet the system's very success reduces hospitals' receipt of Medi-Cal DSH funds – one of the most important funding streams for hospital care to the uninsured.

[57] Public programs were historically developed for the non-working population and public program policies are very slow to adjust to the needs of low wage working individuals and families.

[58] See Ta and Wulsin. A Summary of Health Care Financing for Low Income Individuals in California

[59] Wulsin and Hickey, Counties, Clinics, Hospitals, Employers Health Plans and California's Uninsured (ITUP, October 2003

financial needs of county health as many counties do not see themselves as responsible for care to uninsured children or to uninsured adults with incomes above 200% of FPL or to immigrants without green cards. The figure does not understate the needs of the uninsured.

ITUP's studies found that use of county health services and the scope of county health eligibility, benefits and reimbursement vary enormously from county to county, depending in large part on the amount of state and federal funds flowing into a given county health department and secondarily on the priorities of local Boards of Supervisors. In general, small counties participating in CMSP and Bay Area counties with large public facilities are better funded; those counties without public hospitals, with high population growth and/or the lowest levels of historic (1976-1983) commitments to county health had the lowest funding. Central and Southern California regions had the lowest funding.

Most funding streams for county health are either slow growing or actually declining. County health creatively sustains itself by crafting new revenue sources: DSH and 1255, Targeted Case Management and Medi-Cal Administrative Claiming, Los Angeles Waiver, Prop 99 and Tobacco Litigation Settlement and most recently new voter approved local taxes in Los Angeles and Alameda. Counties with public hospitals may receive some increases in funding as a part of the hospital waiver renewal discussed earlier. The next logical step is for counties and the state to seek a federal match for coverage of adults under an 1115 waiver; some counties are enthusiastic while others are opposed to this approach. Counties with no access to DSH or SB 1255 because they lack a public hospital have stronger incentives to support a waiver while some counties with public hospitals are more skeptical because of their fears that they will lose patients in a competitive market, and their funding streams that finance care for their residual uninsured will be disrupted.

County health programs in some counties are policy pioneers for the entire state; whereas, programs in other counties are quite static. In general, the pioneers are those counties with the most funding, those with public providers and/or those with a locally owned and controlled Medi-Cal managed care plan. Developing innovative coverage programs also afford local plans and safety net providers competitive market advantages in the Healthy Families and Medi-Cal programs.

Local Safety Nets and the Uninsured

Access to health care for the uninsured is typically fragmented and incomplete. The deficit in access to funding for care is most severe for primary care and outpatient services. ITUP's studies found that in the aggregate use of county funded inpatient and emergency services for the uninsured below 200% of the federal poverty level is somewhat comparable to the use of those services by commercially insured adults in managed care.[60] However the use of county funded outpatient and primary care services were less than half that of commercially insured adults. Without coverage, uninsured Californians lack early access to medical services and too frequently end up being treated

[60] Ibid; Wulsin, Insuring Uninsured Adults: What Can and Should We Do? Presentation to California Association of Health Insuring Organizations (October, 2004) at www.itup.org

in hospital emergency rooms for preventable conditions, if treated at all. Sixty percent of California's uninsured adults report **no** physician visits during the course of a year compared to less than 30% of insured adults.[61]

Local safety nets, comprised of community clinics, emergency rooms and public hospitals, are the traditional loci of care for the low income uninsured. These resources are often not connected to each other and thus do not provide an organized delivery system for uninsured patients. In Solano and Contra Costa counties for example, care to indigent adults is now delivered through a managed care network -- the local MediCal managed care plan -- and this increases use of outpatient services and reduces hospital and emergency room utilization. Healthy Kids programs report that with coverage, previously uninsured children strongly shift their patterns of care from emergency rooms to preventive services and primary care.[62]

In most counties, care to uninsured adults is delivered episodically through the county clinics, county hospitals and emergency rooms. For some of the uninsured such as healthy young adults, episodic emergency room centered care can be sufficient to meet their most urgent health needs. However for uninsured adults with serious illnesses or chronic conditions, an organized delivery system is crucially important to effective, quality care.

Over the past decade, there has been some degree of integration of public delivery systems with non-profit community clinics in counties such as Santa Clara and Los Angeles; Alameda is probably the most integrated. However in many Central Valley Central Coast and some Bay Area counties, there is no meaningful integration in caring for the uninsured; the public and private safety net systems operate on separate, parallel and competing tracks.

Local safety nets are imperiled for two reasons: the lack of a managed care delivery system and the inadequate patchwork of federal, state and county funding for programs. Solving safety net funding problems alone will not integrate community clinics, counties and private hospitals into a coordinated delivery system. This can be done with "quasi coverage" as Contra Costa does in which the uninsured patient's care is managed through the Local Health Plan, but there is no flow of funding following the patient. Or it can be done with real coverage as the Partnership Health Plan does for working adults in Solano County where the funding follows the shift in patient's care seeking patterns.

Map for the Future: Public Sector

To expand access and care for the uninsured through the public sector, California's strategies should include:

- Maximizing financial matching from the federal government for children, parents and low wage adults

[61] Zuckerman et al, State Profiles: Health Insurance, Access and Use: California (Urban Institute, July 2000)

[62] Trenholm, Howell and Hughes, Santa Clara Healthy Kids Program Reduces Gaps in Kids Access to Medical and Dental Care (April 2005) at www.mathematic-mpr.com

- Coverage for uninsured children
- Implementing the federal waiver for Healthy Families parents
- Developing state/county/federal financed managed care coverage for low wage adults who, due to categorical linkage, do not qualify for federally-funded public programs[63]
- Coordinating funding through existing federal and state programs with local pilots
- Making effective connections between public coverage programs and low wage private sector employment[64]
- Consolidating public programs such as Medi-Cal, Healthy Families, County Health and California's multiple mini programs for the uninsured
- Developing funding for low wage workers ineligible for federally-funded coverage.[65]

California should, where possible, use the Healthy Families model for expansions rather than the more costly Medi-Cal model. California needs to restructure its DSH and 1255 funding programs for hospitals. DSH and SB 1255 should be re-targeted as much as feasible to providers' care for the uninsured. DSH distinctions between hospital inpatient and outpatient services should be eliminated and the financial penalties for closing excess county hospital beds should be dropped.

Need for Caution at Intersections

Employment based coverage and individual coverage are by their design unaffordable for low wage workforces since they are built on poorly designed tax incentives. Public coverage is by design not available for most low wage workers absent a federal waiver. In trying to expand coverage for low wage workforces, it is necessary to correct the design flaws of either the public or private sectors or both; there is a need for caution so that the financial incentives of the new system neither disassemble or destabilize private coverage nor over-burden the underfinanced system of public coverage.

[63] This includes young low wage working men and women without coverage at work and older men and women losing coverage due to job and family composition changes.

[64] States as disparate as Maine, Massachusetts, Arizona, Iowa, New Mexico, New York and Michigan are trying to connect their public programs to the workplace. See Silow-Carroll, Stretching State Health Care Dollars, Building on Employer-Based Coverage (October 2004) at www.cmwf.org

[65] This includes many workers who are in the process of securing, but have not yet attained from INS the requisite legal immigration status. It is difficult but not impossible to use tax credits for employment-based coverage. California covers new legal immigrants with 100% state funding; federal legislation has been proposed to secure a federal match.

ITUP RECOMMENDATIONS

ITUP recommends the following broad approaches to increase coverage:

Private Sector

Challenges	Employer Does Not Offer Health Coverage	Employee Does Not "Take Up" Health Coverage	Employee is Not Eligible for Employer's Coverage
Solutions	▪ Improve affordability of private health coverage for low wage workforces ▪ Refundable tax credits, public program buy-ins or other premium subsidies for low wage workforces ▪ Employer and individual mandates ▪ Reduce cost and premium inflation	▪ Public premium subsidies of low wage worker's share of family premiums ▪ Restructure employees' share of premiums to a percent of wages ▪ Individual and employee mandates ▪ Reduce health inflation	▪ Purchasing pools and other structures to cover flex workers ▪ Develop financial assistance for low wage flex workers, including refundable tax credits, public program wrap-around or other premium subsidies ▪ Individual mandates

Public Sector

Challenges	Working Low Wage Adults Ineligible for Medi-Cal	Undocumented Eligible for Limited Public Benefits (emergency, prenatal and delivery)	Families Eligible for Medi-Cal and Healthy Families, but Not Enrolled (673,000 parents and children)
Solutions	▪ Make low-wage working adults eligible for Medi-Cal and Healthy Families with federal, state and county matches ▪ Create a basic health plan with premium subsidies, buy-ins and/or wrap around for employees over 100% of FPL	▪ Improve funding for local safety nets and re-structure delivery systems ▪ Foster employment-based solutions ▪ Increase federal matching opportunities (amnesty, children and new legal residents)	▪ Connect families through providers, the workplace, the school and the child care centers ▪ Simplify programs ▪ Reduce the cost of enrollment procedures ▪ Reduce churning and enhance retention and program continuity