Presentation to California Association of Health Insuring Organizations

Insuring Uninsured Working Adults?

What Can and Should We Do?

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Health Costs:

- Projected increases of 7-8% a year for next decade
  - ✓ Hospitals: 6.5%
  - ✓ MDs: 6.5%
  - ✓ Rx: 12%
- Medicaid: 7-8%
  - ✓ Slow enrollment growth
  - ✓ Large growth in waiver spending
- Private Insurance: 7-8%
  - ✓ Flat enrollment
  - ✓ Slower growth in plan profits
- Health Spending grows from 14.9% to 18.4% of GDP
  - ✓ Half due to price increases: 40% due to utilization growth; population growth and aging account for the rest

Source: Heffler et al, Health Affairs

Employer Insurance:

- Premiums increased 11.2% last year, 5 times the rate of worker's wages and of overall inflation

- Offer rates for all small firms (3-199) declined from 68% to 63%
  - ✓ Offer rates for very small firms (3-9) declined (58% to 52%)
  - ✓ Offer rates for medium sized firms (50-199) declined from 97% to 92%

- Employee contributions increased proportionate to the overall increase in employer premiums; respective shares remained unchanged
  - ✓ Take up rates remained very high (90%) in CA, but the very small numbers of employees declining due to cost doubled

Source: Kaiser/HRET, Employer Health Benefits Surveys

Employer Health Insurance

- Costs nationwide: $575 billion
- Tax subsidies: $210 billion or $1,482 per family
  - ✓ Families with incomes < $100,000 = $2,780 per family (26% of total tax subsidies)
  - ✓ Families with incomes > $10,000 = $102 per family (0.7% of total tax subsidies)
  - ✓ Families with incomes $10-20,000 = $292 per family (2.7% of total tax subsidies)
  - ✓ Families with incomes $20-30,000 = $725 per family (6.5% of total tax subsidies)
- Average family income in CA: $49,000

Source: Sheils et al, Health Affairs

New CPS Data on the Uninsured

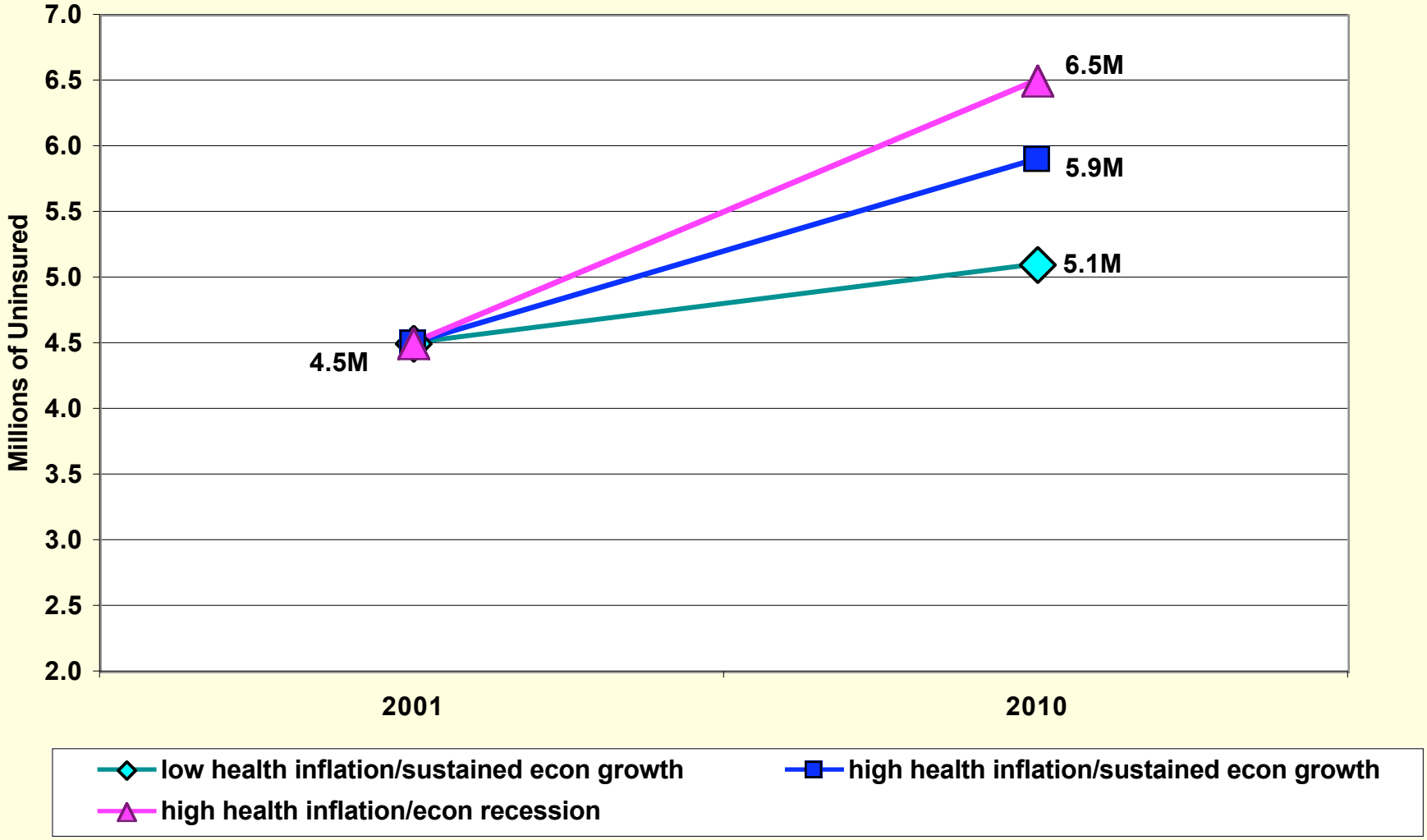
- California's numbers of uninsured grew by 200,000; its percentages of uninsured fell from 18.9% to 18.3% -- one of only two states

- Nationally the uninsured rate rose from 15.2% to 15.6%
  - ✓ Uninsured rates for full time workers rose by 0.7% to 17.5%
  - ✓ Uninsured rates for young adults rose by 1.5% to 30.2%
  - ✓ Uninsured rates for adults living alone rose by 0.7% to 19.6%
  - ✓ Uninsured rates for children continued to decline (Medicaid and S-CHIP enrollment growth) to 11.4%

- Public coverage increased (rising poverty and slow economy)
  - ✓ While private coverage fell (rising premiums and slow economy)

Source: US Census Bureau, Poverty and Health Insurance in the United States, 2003

Projected 2010 Uninsured in California Based on Premium Increases and Economic Changes (CHIS 2001, Custer 2000)



Tough Policy Choices:

- Employer mandate builds on employment based system that has a stacked tax deck disfavoring coverage for low-wage workers.

- Individual mandate requires restructured federal tax policies to subsidize coverage for low income working families; it might destabilize the system of employment based coverage.

- Single payor covers all residents for all services and consolidates cost controls with a single state agency; it faces the challenges of raising taxes equal to two thirds of the current state budget.

- Expanding MediCal and Healthy Families to cover low income workers and parents requires roughly $1.5 billion in new revenues from hard pressed, deficit ridden governments.

1115 Waivers

- Arizona, Oregon, Tennessee, New York, Massachusetts and Delaware have federal 1115 Medicaid waivers to cover adults without minor children living at home.

- Utah and Los Angeles County have narrower 1115 waivers to pay for outpatient services to uninsured adults.

  ✓ Issues: Financing, Waiver Design, Budget Neutrality, and Impacts on Counties and Safety Net Providers

Financing:

- Counties spend at least $1.8 billion on care to the uninsured, mostly on uninsured adults
  - ✓ Small counties (CMSP) spend about $230 million
  - ✓ Large counties (MISP) spend about $1.6 billion
- County health funding for care to the uninsured comes primarily from state and (in public hospital counties) federal governments
  - ✓ Payor counties (e.g Orange and Solano) spend a mix of realignment, Prop 99 and county funds
  - ✓ Provider counties (e.g. San Mateo and Monterrey) spend a mix of federal (DSH and 1255), realignment and county funds
- Funding streams are static, frozen or declining; yet health costs and numbers of uninsured adults are growing and projected to grow quite fast for the next decade.

COUNTY TYPES

- Provider: Counties operate public hospital (Monterrey and San Mateo)

- Payor: Counties pay privates (Orange)

- CMSP: Small contract back counties -- MediCal lite -- (Solano)

- Hybrid: County operates public clinics, pays private hospitals (Santa Barbara and Santa Cruz)

- Private Hospital Only: County block grants its funds to a single private, ex-county hospital (Merced and Fresno)

Financing Challenges:

- Existing inter-county distribution of funding per uninsured is highly inequitable, varying by a factor of 9-1 (Orange, Tulare and Santa Barbara at low end).

- In general, Bay Area and CMSP counties are best funded and Central Coast, San Diego and Orange counties are worst funded.

- Payor and hybrid counties are worst funded. Provider and CMSP counties are best funded

- Spending and care to the uninsured follows funding not need.

- Federal funds can't match federal funds

- County consensus will be quite difficult to achieve!

Waiver Design Issues: Eligibility

- 1.1 million uninsured adults below 100% of poverty

- 1.2 million uninsured adults between 100% and 200% of poverty
  - ✓ 0.2 million uninsured parents between 100% and 200% FPL

- Coverage for emergency services for the undocumented

- County variations:
  - ✓ Poverty levels
  - ✓ Immigration status
  - ✓ State uniformity or a state minimum with county flexibility

Waiver Design Issues: Services

- Scope of Services, Choices:
  - ✓ Outpatient only (LA)
  - ✓ Basic (hospitals, medical and Rx)
  - ✓ Healthy Families
  - ✓ MediCal
  - ✓ County Option, state floor
- Dental
- Mental health
- Emergency and trauma care out of network

Waiver Design Issues: Reimbursement Levels

- Reimbursement Options:
  - ✓ MediCal
  - ✓ Healthy Families
  - ✓ County option
  - ✓ Cost based reimbursement
  - ✓ In and out of network providers
  - ✓ Statewide uniformity, state minimums, no state role, or let the plans do it.

Waiver Implementation Issues: Utilization

	Inpatient days	**Outpatient visits**	**Emergency services**
Insured adult	236 days per 1000 insured	4 visits per insured	154 visits per 1000 insured
County services per indigent adult with income below 200% of poverty	180 days per 1000 uninsured	2 visits per uninsured	220 visits per 1000 uninsured

Delivery Networks (Existing)

	Provider counties	**Payor counties**	**CMSP counties**	**Private hospital counties**	**Hybrid counties**
Public hospitals	Yes	No	No	No	No
Private hospitals	No	Yes	Yes	Yes, but limited to one hospital	Yes
County clinics	Yes	No	No	No	Yes
Non-profit community clinics	Yes, in a few counties	Yes	Yes	No	No
Private doctors	No	Yes	Yes	No	No

Design Issues: Delivery Networks

- Central role for public or other safety net hospitals, in those counties where applicable
  - ✓ Managed care receptiveness

- Inclusion and roles for free and community clinics
  - ✓ Place at the table (HF)
  - ✓ Place in the sun (M-C)

- Roles of private hospitals and doctors in provider counties
  - ✓ Emergencies only
  - ✓ Patient overflow from safety net providers
  - ✓ Place at the table (M-C) or place in the sun (commercial)

- Transformation from ER centered and episodic care to primary care and managed care

Design issues: Managed Care Expansion

- COHS experiences with MIAs (Solano)

- Medically indigent adults
  - ✓ Solano, Contra Costa and San Diego experiences;
  - ✓ Orange viewpoint

- COHS experiences with Aged and Disabled (LIs?)

- Aged and disabled (two plan model vs. specialty plans)

- Rural counties (role of COHS)

- Transition and start-up

State 1115 Givebacks:

- Managed Care (Arizona)
- Rationing (Oregon)
- DSH (Tennessee)
- Managed Care for Aged and Disabled (NY and Mass.)
- California:
  - ✓ Managed care for aged and disabled
  - ✓ DSH financing redesign
  - ✓ Eligibility simplification (process and/or rules)
  - ✓ State-wideness and uniformity (highly contentious)
  - ✓ Entitlement for adults and benefits comparability
  - ✓ LA transformation

Budget Neutrality

- What is the base?
  - ✓ Existing spending
  - ✓ Hypothetical spending
    - -- E.g average per capita spending

- What is the growth rate?
  - ✓ California average
  - ✓ National average
  - ✓ Other

- Political or policy considerations are paramount
  - ✓ CPR
  - ✓ MediCal redesign
  - ✓ The elections

Safety Net Issues:

- *Local decision making vs. State*
- *Central place in the sun*
- *Inviting others to the table*
- *Reimbursements (cost, cost plus, and/or FQHC)*
- *Protecting favorable local environments (Bay Area)*
- *DSH and 1255 impacts*