

ITUP DISCUSSION OF REFORM OPPORTUNITIES

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ITUP

**INSURE THE UNINSURED
PROJECT**

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HEALTH REFORM OPTIONS

INTRODUCTION

Health care reform has quickly become a topic of much debate and prominence. The possibility of universal health coverage may be viable if stakeholders are willing to commit themselves to compromise. In California, there are three significant new proposals currently on the floor: Governor's Schwarzenegger's Healthcare Proposal, Assembly Speaker Fabian Núñez's, 'Fair Share Health Care,' and Senator Pro Tempore Don Perata's SB 48, joining Senator Sheila Kuehl's single payor bill. Each proposal addresses the issue of California's 6.6 million uninsured—a figure that has gained great notoriety over the past months. The proposals promise the foundation for universal health coverage of all Californians through a combination of public and private coverage, individual and employer mandates, and the redirecting of current safety net funding.

While these plans have many similarities, they also offer unique approaches to bringing about health care reform. It is important to consider the components of reform as we move forward in California and seek the most realistic approach to coverage expansion and coverage reform. In order for any proposal to effectively address the issue of the uninsured, it must first address the issues of cost containment and sustainability over time. As such, financing is also a critical piece of any reform. There is no one perfect way to consider this problem; it requires thought, analysis, and ultimately, compromise on the part of stakeholders, policy makers and citizens. It is important that we are educated on the various components of health care reform in order to assess which mix and match of these elements would produce the strongest and most practical proposal long term.

This paper offers an opportunity to explore the pieces of reform and to consider the dynamic interplay between each part. We hope it will provide crucial insight into the many facets of the three California proposals currently under consideration.

MODELS

BACKGROUND

UNINSURED

Over the course of a year 6.6 million Californians are uninsured, 4.8 million are uninsured at a given point in time and 10 million are uninsured at some point over the

course of a two-year period.¹ Due to increasing enrollment in public programs the number of uninsured has been stable and the percentage of uninsured Californians has been dropping for the past 10 years.² The uninsured receive on average half as much care as the insured do, and we all pay for that care. The uninsured pay out of pocket, all Californians pay through federal, state and local taxes and the privately insured pay through the cost shift (reflected in higher premiums) to pay for hospital uncompensated care.³

PUBLICLY INSURED

Over 12 million Californians use public programs: 6.7 million through Medi-Cal, 900,000 through Healthy Families, 1.5 million through county health programs and over 3 million through Medicare.⁴ The number and percentage of Californians using Medi-Cal and Healthy Families has been growing quite quickly for the past decade. Half of Medi-Cal patients are enrolled in HMOs.

County health systems for the uninsured vary widely in eligibility, benefits, provider networks and reimbursement rates from county to county. Medi-Cal and Healthy Families have the same eligibility and covered services in each county.⁵

Public programs are now the most important source of financing for hospital services,

¹ Brown, et al., The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. UCLA Center of Health Policy Research, August 2005. www.healthpolicy.ucla.edu/pubs/files/SHIC03_RT_081505.pdf.

California Current Population Survey. California Department of Finance, March 2005. www.dof.ca.gov/HTML/DEMOGRAP/ReportsPapers/documents/CPS_Extended_3-05.pdf.

² Where are The Uninsured Now, 10 Year Overview. Insure The Uninsured Project, June 2006. www.itup.org/reports.html/Uninsured/10YrTrendrev7_5.pdf.

³ Hadley and Feder. Hospital Cost Shifting and Care For The Uninsured. Health Affairs, Fall 1985. content.healthaffairs.org/cgi/reprint/4/3/67.pdf.

Hadley and Holahan, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Kaiser Family Foundation, May 10, 2004. www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

Kominski et al., Cost of Insuring California's Uninsured. UCLA Center for Health Policy Research, May 2005. www.healthpolicy.ucla.edu.

⁴ Overview of Health Insurance Coverage and Health Care Financing for Low-Income Populations in California, 1998-2006. Insure The Uninsured Project, September 2006. www.itup.org/reports.html/Statewide/HCFReport2006Final.pdf.

⁵ Programs for the Uninsured: A 48 County Comparison. Insure The Uninsured Project, January 2006. www.itup.org/reports.html.html.

County Programs for the Medically Indigent in California. California HealthCare Foundation, August 2006. www.chcf.org

accounting for 53% of hospital revenues.

PRIVATELY INSURED

Nearly 14 million Californians have full year private insurance; over 12 million get it through their employers and a smaller number (1.7 million) buy individual private insurance. The numbers are larger for those with part-year private coverage.⁶ Roughly half of the privately insured enroll in HMOs such as Kaiser; virtually all the rest are in PPOs (preferred provider organizations).

Private health insurance varies widely in cost and coverage, percentage of employer and employee contributions, benefit design and networks of covered providers.

WHAT'S SO BAD ABOUT UNIVERSAL? WHAT'S SO GOOD ABOUT UNIVERSAL?

Every other developed nation has universal health coverage. The reasons for universal coverage are twofold: to keep all Californians healthy and productive and to prevent financial catastrophes, when, as is inevitable for each of us, an individual needs costly medical treatment.

The opponents of universal coverage usually call it socialized medicine. What do they mean by this? They mean to suggest that government workers will be delivering/denying your health care.

The British system comes the closest to a true socialized medicine model where the government owns the hospitals and employs the doctors.⁷ In America, the Veterans Administration hospitals (open to all veterans) and our local public hospitals for the poor are the closest to a socialized medical system. None of the many state proposals for universal coverage under serious consideration in the state legislature is proposing anything akin to the British model.

The Canadian single payor system is like Medicare in the US; the government pays the bills of private doctors and hospitals for all citizens. Medicare is limited to seniors and the disabled while the Canadian system covers all its residents. The delivery system is entirely private, and the payment system is completely public; private insurance plays an increasingly larger role as sub-contractor to Medicare for Part A and B (hospitals and doctors) coverage for those seniors who choose private coverage and as the exclusive purveyor of Part D coverage for prescription drugs.

⁶ Brown et al., The State of Health Insurance in California; Findings from the 2003 California Health Interview Survey. UCLA Center for Health Policy Research. www.healthpolicy.ucla.edu.

⁷ Shaffer, SB 480 Health Care Options. California Health and Human Services Agency, March, 2002.

Many developed countries' systems are a mix of public and private functions like the US; the key difference is that in the US a large share of the population is uninsured and our per capita health costs are over twice as high and growing much faster than the other developed nations.⁸ In the German and Dutch systems, coverage is mandatory – employers and employees and individuals must buy insurance through private insurers for care from private doctors and clinics. In the US, except in Hawaii and now Massachusetts, coverage is voluntary for individuals and employers.

The phrase “socialized medicine” is meant to imply that the government is inappropriately involved in the delivery of your medical care. Does government already pay for your medical care? Yes, it helps pay for some of the care for the uninsured, the publicly insured Medicare and Medi-Cal populations, those with employment based insurance and those who are self employed. The only insured people with no government subsidy for the costs of their care are those buying individual coverage who are not self employed – about 4% of all Californians.⁹

Government helps to pay for care to the uninsured in all public and most private hospitals and in most private, non-profit, free and community clinics. Furthermore, government helps pay for the medical education of doctors, nurses and other providers, for hospital construction and for clinical research. Government issues licenses to operate or practice for most health care professionals and most health care facilities.

We are already a mixed public private system. Private doctors, hospitals and health plans deliver care to both the publicly insured and the privately insured. The difference is providers and plans are typically paid less for their care to their publicly insured patients than they are paid for their care to their privately insured patients and therefore understandably prefer “the private sector”.

The real issues behind the “socialized medicine” tag are twofold: first providers do not want government to set and control their rates or fees, their style of practice and reimbursement (nor do they particularly like it when private plans do so); second private health plans do not want to be displaced/replaced by a government payor (like Medicare).

The only universal coverage proposal under consideration that eliminates private insurers is the single payor measure authored by Senator Kuehl. There is a significant cost savings of nearly 8% of health costs through eliminating private insurers, but little political traction for doing so.

⁸ White, Health Care Spending Growth, How Different is the US from the Rest of the OECD? Health Affairs, January/February 2007. <http://content.healthaffairs.org/cgi/content/abstract/26/1/154?rss=1>

⁹ President Bush's recent proposal offers a \$7,500 tax deduction for individuals and \$15,000 for families, putting those purchasing individual coverage on an equal tax footing with the self employed and those with employment based coverage.

Single payor regulates hospital rates and physician fees as well, and it is the only proposal that caps the rate of growth in health spending. The other measures rely on a mix of improvements to the competitive market that has lost control over spiraling health costs and regulatory controls -- these can include rate setting and certificate of need controls on hospital capital spending.

Typically, but not always, private insurance pays hospitals and doctors more for their services than do public programs such as Medi-Cal and Medicare.

Private health insurance premiums have been growing at a very fast pace, three to six times the rate of worker's wages, recently slowing to twice the rate of growth in worker's wages.¹⁰

RISING HEALTH COSTS AND PREMIUMS

Over-all health costs are growing faster than wages and incomes, accounting for a steadily increasing share of the Gross Domestic Product. Health costs are projected to continue to grow at over 8% per year. This creates financial distress for employers who offer coverage, for taxpayers and for insured employees who may experience both reduced benefits and increased out of pocket responsibilities to pay for their benefits. It is projected, all things being equal, that for each percent increase "in health spending relative to personal income, the number of uninsured people increases by 246,000."¹¹

REFORM MODELS

How much difference is there anyway?

There are many different models being considered to reform California's healthcare system and cover the state's uninsured. They have much in common: they all rely heavily on private doctors and hospitals, they all envisage some employer and employee contributions and they all seek to control rising health costs.

There are wide distinctions between the plans as well. Among the differences are the role of private insurers, the scope of covered benefits, the redistribution of resources to pay for reform, the impacts on job creation and economic productivity and the manner in which costs are controlled.

¹⁰ Trends and Indicators in the Changing Health Care Marketplace, Kaiser Family Foundation, <http://www.kff.org/insurance/7031/print-sec3.cfm>.

¹¹ Gilmer and Kronick, It's The Premiums, Stupid: Projections Of The Uninsured Through 2013. Health Affairs, April 2005. content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143

REFORM MODELS

	Eligibility	Benefits	Cost controls	Financing
Single payor SB 921 (Kuehl)	Universal, including seniors with Medicare and all immigrants	Comprehensive, except for long term care in nursing homes	Regulation of provider reimbursements, elimination of health insurers and bulk purchasing of prescription drugs and medical supplies	Employer and employee payroll taxes and income tax surcharge for high income individuals, redirection of safety net funds
Garamendi	Universal for all residents under age 65	Basic	Managed competition, individuals pay for incremental cost of more costly plans and services	Employer and employee payroll taxes
Individual mandate	Universal for all residents	Individual choice	Purchasing pool for individuals Increased patient exposure to costs of care	Individual mandate, employer, employee and individual premiums Redirection of safety net funds
Employer mandate	All full time employees	Basic benefits	Purchasing pools	Employer and employee premiums
Universal responsibility	All residents under 65	Basic benefits	Purchasing pools	Employer, employee and individual premiums/fees Sales tax on health services
Incremental (children, parents and low income adults; premium subsidies)	Low and moderate income uninsured	Medi-Cal or Healthy Families benefits	State programs	Federal, state and local match Redirection of safety net funds

SINGLE PAYOR¹²

Single payor is modeled after the Canadian system that covers a comprehensive array of benefits with low co-pays and no deductibles. It would be financed by payroll taxes (as Medicare is) rather than by employer and employee premiums. It would replace all existing employer, employee and individual premiums and all patient out of pocket expenditures and shift these costs to taxes -- at a cost of \$90 billion in new taxes.

Cost controls

A single payor system would control rising health costs by setting caps on the growth in health spending, controlling hospital budgets and capital expenditures, setting physician rates and acting as a bulk purchaser of drugs and medical supplies. It would eliminate private insurers and HMOs, and government would pay providers for all services on a fee for service basis as Medicare does now. Patients would have free choice of providers.

Key differences

Some key differences from the other reform measures are: trading in all existing health premiums and out of pocket costs for taxes, covering seniors, eliminating private insurance and replacing HMOs and PPOs with fee for service reimbursement and complete freedom of choice of providers and caps on the growth in health spending.

What do opponents say

Insurers oppose the elimination of their role, hospitals and doctors oppose state rate setting and employers oppose payroll taxes. The measure's proponents claim this approach controls costs better than any other measure and assures all Californians equal access to care and treatment.

ITUP's view

ITUP's concerns are that the proposed taxes have limited prospects of securing a two thirds vote in the legislature, the cost containment focuses exclusively on price and supply controls with few or no restrictions on consumer demand, and seniors experience a windfall of coverage expansion without commensurately contributing to the financing.

¹² Senator Sheila Kuehl has introduced a series of bills to establish single payor in California. SB 921 Kuehl is analyzed by the Lewin Group in Sheils & Haight, The Health Care for All Californians Act: Cost and Economic Impacts Analysis. Health Care for All Education Fund, January 2005. www.healthcareforall.org/lewin.pdf.

GARAMENDI – UNIVERSAL MANAGED COMPETITION¹³

The Garamendi proposal would cover basic benefits for all Californians under age 65. It would be financed by payroll and other taxes. Every Californian would select their health plan and doctor in that health plan. Individuals choosing more expensive plans or more comprehensive services would pay out of pocket for the incremental costs above the least expensive plan(s) for the basic covered services. A similar proposal by Senator Ron Wyden of Oregon has recently been introduced in the Senate.

Cost controls

Costs would be controlled through “managed competition” among plans and provider networks. Managed competition is an approach championed by Professor Alain Enthoven of Stanford University under which plans and providers compete based on their costs and quality for subscribers and enrolled patients. It requires that subscribers pay, without any subsidy, for their plan and provider network choices above the least expensive basic plan(s).

Key differences

The key differences from other reform measures are the reliance on managed competition, trading premiums for taxes and eliminating tax subsidies for the incremental costs of added benefits and plans.

What do opponents say

Some advocates oppose the “unequal access” that will result from allowing individuals to buy more expensive plans and benefits; others oppose the reliance on managed competition as opposed to rate regulation as the means to control rising health costs. Some employers oppose paying employer payroll taxes in lieu of employer premiums to finance the reform. Some safety net providers and academic medical centers are concerned that their unique roles will not be adequately supported in a managed competition model.

ITUP’s View

ITUP concerns are that managed competition had its heyday in controlling costs in the mid '90s and then has failed to sustain and build on its initial success. The proposed taxes to finance the reform have limited prospects of securing a two thirds vote in the legislature. Furthermore managed competition has limited ability to control costs in

¹³ See Wulsin, California at the Crossroads, Choices for Health Care Reform. Center for Governmental Studies, 1994 for an analysis of the original measure. Senator Ron Wyden’s Healthy Americans Act is a recently introduced and updated and innovative version of this approach. See analysis by Sheils et al., Cost and Coverage Estimates for the “Healthy Americans Act, The Lewin Group, December 2006. <http://wyden.senate.gov>.

communities with only one hospital or a single dominant hospital chain or medical group.

UNIVERSAL -- INDIVIDUAL MANDATE¹⁴

An individual mandate would require every Californian to enroll in either public or private basic coverage. It would subsidize the premiums of individuals for whom coverage is unaffordable, using safety net funding for care to the uninsured as part of the financing for premium subsidies.

Cost Controls

Costs would be controlled by increasing consumers' exposure to the costs of care. Health plans would be required to guarantee issue all coverage, regardless of an individual's medical condition(s). A purchasing pool would design the benefits, negotiate premiums with health plans and administer the system of premium subsidies.

What do Opponents Say

Unions and many advocates oppose the potential shift in financing from employers to the individual. Many are concerned that there is inadequate information on providers' prices, quality and treatment effectiveness for consumers to be effective shoppers in the health market. Many are concerned that the financing burdens on individuals would be unaffordable, resulting in many residents ignoring the law and remaining uninsured. Some insurers oppose purchasing pools and guaranteed issue of individual coverage.

ITUP's View

ITUP's concerns are that most individuals are inexperienced with comparison-shopping for health services and the information is under-developed to facilitate informed consumer decision-making. The affordability criteria, premium subsidies, financing and relationships with employer sponsored coverage are as yet undeveloped in California. Increasing out of pocket responsibilities for patients does reduce their use of unnecessary care; however particularly for lower income individuals, it also decreases their use of needed services and results in untreated conditions that worsen and ultimately cost more to treat.

¹⁴ The Heritage Foundation originally proposed this. See Wulsin, California at the Crossroads: Choices for Health Care Reform. Center for Governmental Studies, 1994.

Massachusetts is an updated hybrid of the original proposal. See Holahan & Blumberg, Massachusetts Health Care Reform: A Look at the Issues. Health Affairs-Web Exclusive, September 2006. www.healthaffairs.org.

EMPLOYER MANDATE¹⁵

Employer mandates require employers to offer a basic set of services to their employees and to pay a share of the premium costs. Subsidies to increase affordability for low wage employers and employees may be offered through the tax code (refundable tax credits or tax deductibility) or through premium subsidies. Premium subsidies may be offered through a purchasing pool. Safety net, Healthy Families and Medi-Cal funding may be used to help assure affordability through the purchasing pool, through employer buy-ins to public programs or by subsidizing the employee share of premiums. Mandates can be designed to apply only to large and mid-sized employers, only to full-time, permanent employees or to all sizes of employers and all types of employees.

Cost Controls

The purchasing pool may be designed to encourage managed competition or simply to distribute premium subsidies. The mandate may include underwriting reforms requiring health plans to guarantee issue coverage to those who are mandated to purchase.

What do Opponents Say

Employers oppose employer mandates for a combination of reasons: lack of adequate cost containment, failure to assure affordability and impacts on job creation/retention in California. Some carriers view employer mandates as setting the stage for a slippery slope to state regulation of health insurance premiums, which they strongly oppose.

ITUP's Views

ITUP's concerns are ERISA challenges, coverage for the flex workforce and the regressive structure of employment based coverage. ERISA's (Employee Retirement Income Security Act) preemption of state regulation of self-insured employers has been interpreted by the Supreme Court to bar state employer mandates. It may be possible, however, for a state to design "pay or play" financing under a state's innate taxing power, provided its requirements are not linked to a particular benefit package or a dollar figure equaling the cost of the desired coverage. Flex workers are part-timers, seasonal, contract, contingent and temporary workers and new hires. These types of workers are often not reached through employer mandates that are most conducive to covering the long term, full year, full time workforce. Employment based coverage is subsidized by favorable federal and state tax rules providing the purchase of coverage through an employer is bought with pre-tax dollars; this subsidizes the cost of coverage by on average 30%. However the tax benefits of this arrangements primarily inure to upper income employees and do very little to help low wage employers and employees with

¹⁵Analysis of SB 2. Insure The Uninsured Project. <http://www.itup.org/pdfs/SB2LetterSept042.pdf>

Yelowitz, Pay-or-Play Health Insurance Mandates: Lessons from California. Public Policy Institute of California, October 2006. <http://www.ppic.org/main/pubs.asp>.

affordability. Furthermore employee contributions are typically structured such that lower wage young workers subsidize the premiums of better paid, older workers.

UNIVERSAL -- SHARED RESPONSIBILITY¹⁶

Shared responsibility combines an employer, employee and individual mandate to purchase a basic benefits package. It is unclear what the respective financial responsibilities of employers, employees and individuals would be. Premium subsidies would be available for low wage individuals and low wage employees through a purchasing pool.

Cost Controls

The purchasing pool could act simply as a conduit for the premium subsidies or it could serve as a prudent purchaser of coverage and facilitator of managed competition.

Medi-Cal, Healthy Families and safety net funding could be directed through the purchasing pool to subsidize premiums for those with appropriate eligibility.

What Opponents Say

Some employers and advocates oppose mandates on principle, while others want to see the details to assure that affordability is enhanced. Some insurers oppose mandates, maintaining that health coverage should be voluntary for employers, employees and individuals.

ITUP's views

ITUP's concerns are the absence of adequate cost containment and financing to assure the long-term sustainability of a mandate. While a mandate can pass the state legislature on a simple majority, the funding necessary to subsidize premiums and assure premium affordability requires a two thirds majority vote, and the employers' obligations must be designed in a manner that passes muster under ERISA preemption

¹⁶ Universal Coverage, Universal Responsibility, Q & A. Blue Shield of California Foundation, www.blueshieldca.com/producer/documentlibrary/RRC_2002-28.pdf?sec=news&pg=prodalerts.

Thorpe, An Analysis of the Costs and Coverage Associated with Blue Shield of California's Universal Health Insurance Plan for All Americans. Blue Shield of California Foundation, June 11, 2004. www.blueshieldca.com/bsc/images/thorpeanalysis.pdf;jsessionid=KEVBCITAD53UZJP3YYSSGLNF5XDCEITT

Halvorson, et al., A Proposal to Cover the Uninsured in California. Health Affairs, published online December 12, 2006, content.healthaffairs.org/cgi/content/full/hlthaff.26.1.w80/DC1.

Governor Schwarzenegger, Senate President Perata and Assembly Speaker Nunez have all introduced variants of this proposal for consideration in 2007.

rules.

INCREMENTAL¹⁷

The state legislature could enact different incremental reforms that would help some of the uninsured: coverage for uninsured low-income children, parents, low wage adults and premium subsidies for low wage workforces.

1. AB 773 (Chan) and Proposition 86 would have covered all uninsured children up to 300% of the federal poverty level (FPL).¹⁸ Ninety percent of the state's 800,000 uninsured children have incomes below 300% of FPL. Well over half of uninsured children are eligible but not enrolled in Medi-Cal and Healthy Families. The projected General Fund cost is \$250 million annually for the children not now otherwise eligible for Medi-Cal and Healthy Families.
2. Parents of Healthy Families children (i.e. parents with incomes from 100% to 200% of FPL) can be covered with federal matching funds paying for half or more of the projected cost.¹⁹ We estimate that at least 300,000 parents could be covered.
3. Low wage adults can be covered using federal matching funds to pay for half the costs of their coverage if the state requests and secures a federal §1115 waiver and uses existing county health expenditures as the match. Approximately 4.2 million uninsured Californians have family incomes below 200% of FPL and could be covered through public program expansions with public funds.²⁰
4. Premium subsidies for low wage workforces refer to pilot programs in California and elsewhere across the nation in which employers, employees and government each pays a share of the premiums for private coverage. The Lewin Group projected this would

¹⁷Sheils, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California. The Lewin Group Inc., March 2002, www.lewin.com.

Sheils, Estimated Cost and Coverage Impacts of Three Policy Proposals to Expand Health Insurance Coverage for Children in California. The Lewin Group, November 2005, www.lewin.com.

¹⁸ AB 773 (Chan) was vetoed and voters rejected the Prop 86 proposed \$2.60 tax increase per packet of cigarettes. Voter surveys show strong (80%) support for covering children of all incomes and immigration status. See Greenberg et al., Recent Statewide Poll Shows Voters Say Yes to Health Insurance for all Kids, Little Awareness that Prop 86 Addressed this Issue, November 2006. The 2007 proposals by Governor Schwarzenegger, Senator Perata and Speaker Nunez would cover all children.

¹⁹ The 2007 proposals by Governor Schwarzenegger, Senator Perata and Speaker Nunez would cover all Healthy Families parents up to either 250% or 300% of the federal poverty level.

²⁰ Brown, et al, The State of Health Insurance in California; Findings from the 2003 California Health Interview Survey. www.healthpolicy.ucla.edu.

Lucien Wulsin et al., SB 480 Health Care Options. Insure the Uninsured Project, March 15, 2002. www.itup.org/report.html#solution.

The proposals by Governor Schwarzenegger, and Speaker Nunez would use a federal waiver to cover adults up to 250 and 300% of poverty respectively. Senator Perata would rely on mandates/assessments on employer, employee and individual self employed persons to cover working adults. Non-working low income adults would remain the responsibility of California's 58 county health programs

cover about 200,000 of the state's uninsured.

5. Refundable tax credits are another form of premium subsidy. They could be designed as vouchers for individuals to purchase individual coverage or to pay for the employee share of coverage offered by their employer. Large vouchers were projected to cover 1.5 million of California's uninsured.²¹ Small refundable tax credits (as previously proposed by President Bush) were projected to cover very few of the uninsured.
6. Tax deductibility is a form of premium subsidy that is most helpful to those in high tax brackets. President Bush's recent proposal offers a \$7,500 tax deduction for individuals and \$15,000 for families. This is projected to increase coverage for about three million of the uninsured nationwide, including about 360,000 uninsured Californians. Tax deductibility is a particularly inefficient mechanism to cover the uninsured because so many of the uninsured in California earn low wages and have little or no federal or state income tax liability.²²

The legislature would need to resolve the question of long term and sustainable financing for major public program expansions. Furthermore, at the intersection between public programs and private coverage there is an unpredictable amount of spill-over (crowd-out) of individuals with existing coverage. This effect increases as public programs expand to offer coverage to individuals at higher incomes with greater access to private coverage.

ELIGIBILITY

There are about six and a half million uninsured Californians. Most (over three quarters) are connected to the workplace as employees and their family members. Most (nearly 85%) have low and moderate incomes (below 300% of the federal poverty level). Most are young (nearly two thirds under age 30) and therefore less costly to insure.

ELIGIBILITY OPTIONS

All uninsured residents	All uninsured residents under 65	All uninsured full time workers	All uninsured full time workers and their families	All low and moderate income uninsured	All uninsured children	All uninsured children and parents up to 300% of FPL for whom FFP (federal financial participation) is
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²¹ Sheils, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California. The Lewin Group. <http://www.statecoverage.net/statereports/ca71.pdf>.

Wulsin et al, SB 480 Health Care Options Paper. Insure the Uninsured Project, March 15, 2002, www.itup.org/report.html#solution.

²² Burman, et al., The President's Health Insurance Proposal – A First Look. Urban Institute and Brookings Institute, January 23, 2007. http://www.urban.org/UploadedPDF/411412_firstlook.pdf

						available without a federal waiver
6.6 million (course of the year)	6.6 million (course of the year)	2.2 million	4.2 million	4.4 million	800,000 (point in time)	900,000 (point in time)
4.8 million (point in time)	4.8 million (point in time)					

Universal vs. Incremental

This is often cast as an argument for doing what we can this year and moving to cover the remaining uninsured in future years. In the interim, priorities change, budgets change and the other moving parts of the system evolve as we discuss in a later section. We cannot and will never cover the uninsured unless all the moving parts of coverage are integrated into at least “a coordinated system” for the reasons discussed later in this paper under “Intersection Costs.”

The costs of covering all the uninsured are obviously higher than the costs of covering some of the uninsured. Potential savings are much higher as well.

The principal potential savings are the redirection of funding that pays for care of the uninsured to help pay for coverage of the uninsured.

Safety net providers will seek to preserve safety net funding in any eventuality, but with greater justification if only some of the uninsured are covered.

It is difficult to separate which existing costs of the uninsured are paid to what provider by what funding stream.

There are greater administrative cost savings possible if all are covered. Our American administrative system for coverage is the most complex and costly to providers, plans, employers and the insured public of any in the world. The multiplicity of federal, state and county programs and funding streams for the uninsured could be radically simplified in any reform measure.

Adding coverage for all the uninsured spreads the fixed costs of our health system across 6.6 million new subscribers. In either a perfectly competitive or a perfectly regulated market this would allow price and premium reductions for all the existing insured. Universal coverage invites and facilitates wholesale system reform while incremental reform is more likely associated with modest tinkering in controlling costs.

Costs of coverage vary by age. The least costly components of the uninsured are young children (low costs and low rate of uninsured) and young adults (low costs but high rate of uninsured). The most costly to cover are individuals over age 50 or medically uninsurable individuals.

Kaiser Premiums for Larger Small Groups: \$30 copays and \$1000 deductible

Kaiser Premiums for Individuals: \$30 copays and \$1500 deductible

Effective 7/1/06 – 12/31/06

	Kaiser Small Group Premiums (employee only)	Kaiser Individual Premiums (individual only)
< 30	\$89	\$80
30-39	\$105	\$116
40-49	\$142	\$184
50-54	\$190	\$286
55-59	\$235	\$286
60-64	\$302	\$343

Per capita costs of health coverage for Latinos (who have a high rate of uninsurance) are quite low because their utilization of services is low even when insured.²³ Costs per capita of new immigrants (who have a high rate of uninsurance) are also low because their utilization is low even when insured.²⁴ The cost of immigrant coverage (when insured) is reported to be 30-50% less than the cost of coverage for US citizens.²⁵

Similarly most of the uninsured (75%) are in working families, and their costs per member per month are much lower than for the smaller percent (25%) of the uninsured, that are not working.²⁶ Costs of covering the part year uninsured are low as well since either a public program or private coverage is already paying for their coverage for part

²³ Waidman, The Potential Role for Bi-National Health Insurance and Other Options in Meeting the Needs of Uninsured Immigrant Populations. Urban Institute, June 2006.

²⁴ Ibid

Goldman et al., Immigrants And the Cost of Medical Care, Health Affairs, November/December 2006. www.healthaffairs.org

²⁵ Ibid.

²⁶ Brown et al., The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. UCLA Center of Health Policy Research, August 2005. www.healthpolicy.ucla.edu/pubs/files/SHIC03_RT_081505.pdf

of the year.²⁷

The cost of coverage to state government (as opposed to over-all cost of coverage) is least for those individuals where there is a federal subsidy (federal matching or a tax subsidy), a contribution from the employer or a significant contribution from the individual or family.

Public vs. Private coverage²⁸

Public coverage costs less than equivalent private coverage in part because providers are paid less and in part because utilization is more tightly controlled. In general, Medi-Cal and Healthy Families cost less, and private coverage is more expensive than the average cost. A tightly managed Medi-Cal HMO can cost as much as 50% less.

Public coverage is more standardized and less flexible than private coverage. Private coverage has fewer state and federal rules governing coverage than does public coverage. Private self-insured coverage (an option used by some large employers) is regulated by the federal government and is exempt from state regulation; it has the least rules governing health plans, and therefore is estimated to cost 5-10% less than equivalent state regulated private coverage.

California has the capacity to exempt new coverage for the uninsured from federal Medicaid and S-CHIP rules if it takes no federal financial participation (FFP) or if it seeks and secures an 1115 waiver for the costs of the population to be covered. California also could exempt new coverage for the uninsured from some of the state mandates to offer particular services, cover benefits and include particular providers in the health plan network to make new coverage less expensive.

LOW WAGE / INCOME – PUBLIC VS. PRIVATE²⁹

Employment based coverage is purchased with a pre-tax dollar; this subsidizes the coverage for workers based on their combined federal and state tax brackets. Low

²⁷ Hadley and Holahan, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Kaiser Family Foundation, May 2004.

<http://www.kff.org/uninsured>

²⁸ The premium costs of a tightly managed HMO paying providers at Medi-Cal rates are roughly half the cost of a loosely managed HMO paying providers at commercial rates.

Robertson and Milliman, Essential Health Benefits. Blue Shield of California Foundation, 2003.

²⁹ Governor Schwarzenegger, Senator President Perata and Speaker Nunez would expand public coverage up to 250-300% of FPL. Senator Perata would only cover families through public programs and would cover working and self-employed adults without family members living at home through their employment.

wage workers have the least federal and state tax subsidy (6-7%) attached to private employment-based coverage, and high wage workers have tax subsidies of up to 50% of premium cost associated with employment based coverage.³⁰

EMPLOYER SPONSORED HEALTH INSURANCE

Costs nationwide: \$575 billion; tax subsidies: \$210 billion or \$1482 per family

- Families with incomes over \$100,000 = \$2780 per family (26% of total tax subsidies)
- Families with incomes less than \$10,000 = \$102 per family (0.7% of total tax subsidies)
- Families with incomes between \$10-20,000 = \$292 per family (2.7% of total tax subsidies)
- Families with incomes between \$20-30,000 = \$725 per family (6.5% of total tax subsidies)

Source: Sheils et al. Health Affairs (2004)

Median Family Income for a California Family of Four in 2006 = \$67,814³¹

The costs of coverage for low wage workers and their dependents makes up the highest percent of their wages – up to 2/3rds of wages for family coverage for a minimum wage worker.

³⁰ Sheils and Haught, The Cost of Tax Exempt Health Benefits in 2004. Health Affairs, February 25, 2004.

<http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf>

Marginal tax rates are calculated by combining the state and federal income tax rates, the federal Medicare and Social Security tax rates and the Unemployment Insurance and State Disability Insurance tax rates.

³¹ U.S. Census Bureau, www.census.gov/hhes/income/4person.html

PERCENTAGE OF EMPLOYEE GROSS WAGES REQUIRED FOR FAMILY COVERAGE (\$10,000), FOR INDIVIDUAL COVERAGE (\$4,000) COMPARED TO 4% OF INCOME³²

Wages	Annual income	% of income for family coverage	% of income for average individual coverage	4% of income
\$7.50 an hour	\$15,600	64%	26%	\$624
\$10.00 an hour	\$20,800	48%	19%	\$832
\$25.00 an hour	\$52,000	19%	7.6%	\$2080

State and federally subsidized public coverage makes the most sense for these workers and their families for two reasons: first, subsidies may be available making coverage more affordable and second the public coverage model is better suited to individuals and families with lower ability to pay for the costs of coverage and services.

CURRENT AND POTENTIAL ELIGIBILITY FOR FEDERAL MATCHING

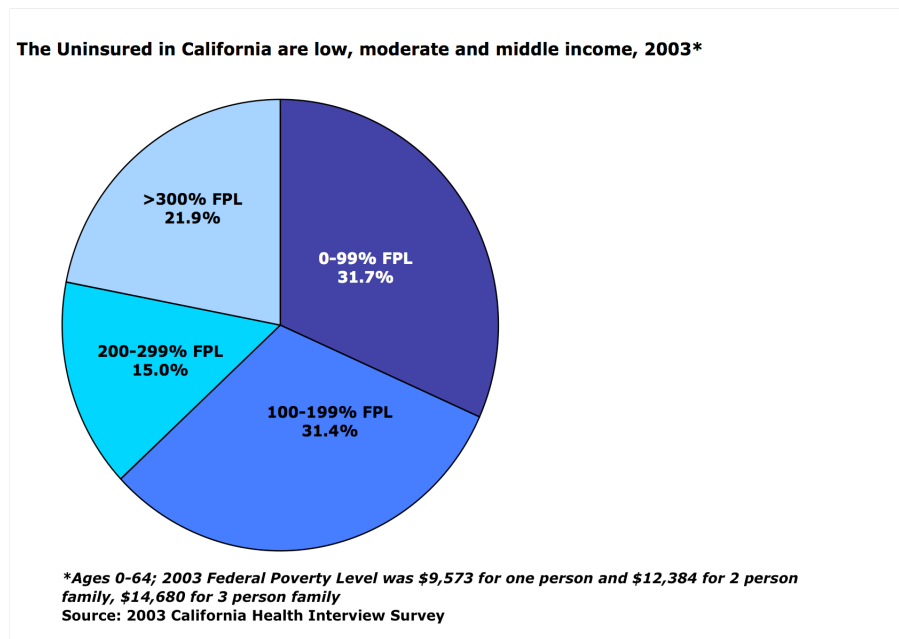
	0-100% of FPL	100-200% of FPL	200-250% of FPL	250-300% of FPL
Families	Medi-Cal	Children and pregnant women eligible for Medi-Cal or Healthy Families Currently eligible for coverage of catastrophic medical expenses through Medi-Cal Parents potentially eligible at state option	Children eligible for Healthy Families, pregnant women eligible for AIM Currently eligible for coverage of catastrophic medical expenses Parents potentially eligible at state option	Infants and pregnant women eligible for AIM Currently eligible for coverage of catastrophic medical expenses Parents and older children potentially eligible at state option
Adult	Currently eligible	Currently eligible for	Currently eligible	Currently eligible

³² Governor Schwarzenegger has proposed that uninsuring employers pay 4% of payroll and uninsured employees and individuals pay from 2-6% of wages or income for their coverage.

Individuals	for county health Potentially eligible if state requests and federal government approves Medicaid 1115 waiver.	county health, depending on county Potentially eligible if state requests and federal government approves Medicaid 1115 waiver	for county health, in a few counties	for county health, in a few counties
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HIGHER WAGE/INCOME³³

Only about one fifth of California’s uninsured have incomes above 300% of the Federal Poverty Level (\$30,000 for an individual, \$60,000 for a family of four).³⁴ Higher wage workers and their families have little potential eligibility for federal financial participation in their costs of coverage, a far higher state and federal tax subsidy for employment based coverage and much greater capacity to contribute towards the costs of coverage. Private employment-based coverage makes the most sense for higher-wage workers. This can be accomplished through an employer mandate or without an employer mandate as Massachusetts did by requiring employers to set up tax-free purchasing for their employees. Higher wage individuals or their employers could be permitted to buy into Medi-Cal or Healthy Families at full cost (cost is less than private coverage); however commercial plans, private doctors and hospitals strongly prefer the private



coverage model.

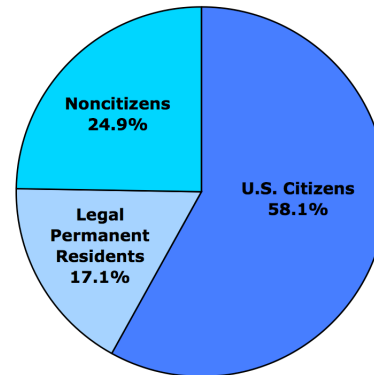
³³ Governor Schwarzenegger, Senate President Perata and Speaker Nunez would all cover higher income persons through employment-based coverage or the individual market.

³⁴ Brown et al., The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey. UCLA Center for Health Policy Research, August 2005. www.healthpolicy.ucla.edu/pubs/files/SHIC03_RT_081505.pdf

RESIDENTS/CITIZENS

US citizens and most legal permanent residents are eligible for full scope Medi-Cal and Healthy Families to the extent otherwise eligible based on incomes and family composition. Federal matching funds (FFP) are available for limited scope (emergency and perinatal care only) benefits for residents without legal permanent residency status to the extent otherwise eligible for Medi-Cal. About 1.3 million of the 6.6 million uninsured are undocumented adults.³⁵

Citizenship and Immigration Status of California Uninsured Adults, 2003



**Ages 18-64*
Source: 2003 California Health Interview Survey

The advantages of pre-tax purchasing are available through employment-based coverage regardless of citizenship or immigration status to all persons employed in California. Immigrant workers are the backbone of many important sectors of California's economy including agriculture and residential construction. Federal efforts to effectively regulate and regularize the status of immigrant workforces are under consideration in a series of bi-partisan bills in Congress.

PARENTS/KIDS

Federal law would allow California to increase its income thresholds from 100% to 200% of FPL (or higher) for working parents and from 250% to 300% for uninsured children. California could increase its income thresholds for parents under either Medi-Cal (1/1 match) or under its federal S-CHIP waiver (2/1 match) for parents. California has a federal waiver allowing it to increase coverage for uninsured children under Healthy Families up to 300% of FPL and for parents up to 200% of FPL.

Since the Healthy Families program is nearing its maximum allocation from the federal government, it makes more sense for the state to expand Medi-Cal (1/1 match) for parents; California could choose to conform the expansion for parents to the existing Healthy Families coverage for their children so that the whole family is in the same plan with the same rules. This could require federal waiver approval or may be able to be done as a state plan amendment.

³⁵ *ibid.*

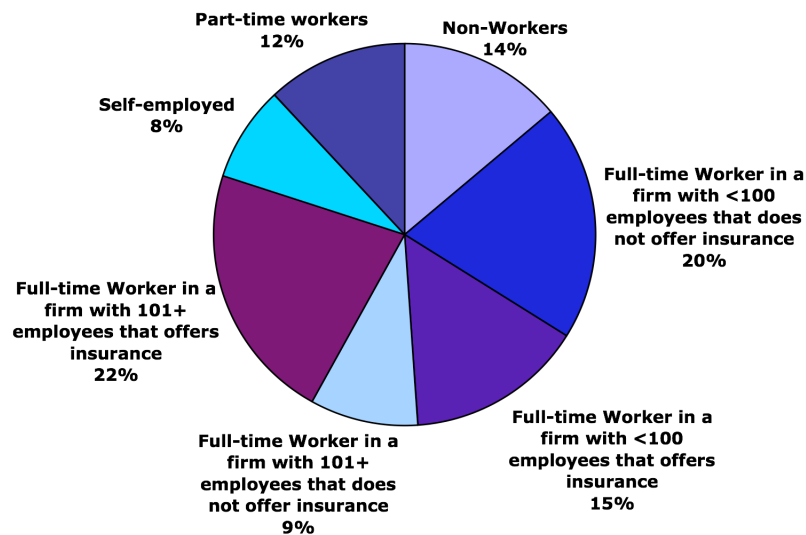
The Governor's proposal would require immigrant workers to purchase coverage, but with no subsidy for undocumented adults except to the extent subsidies are available through local government. Senator Perata's proposal requires coverage through the workplace but without public subsidy.

California should seek to expand the federal allocation for S-CHIP, which is scheduled to expire this year. Failure to expand the allocation means California will face a large deficit in its Healthy Families program as enrollment growth is far exceeding the available federal funds.

WORKERS/NON-WORKERS³⁶

Full time workers are covered in the employer mandate approaches, but unemployed

Distribution of the Uninsured in California, by Employment Status of Head of Household, 2001



Source: Employment status of uninsured from 2001 California Health Interview Survey. Uninsured part-time workers, non-workers, and children are assigned to the insurance and employment status of the family head, using analysis from the merged February and March 2001 Current Population Survey. Uninsured full-time workers are characterized by their own employment status.

workers, part-time workers, self-employed and other types of flex workers are not covered. All types of workers and non-workers are covered in the individual mandate approaches. There could be some shift from employment-based to individual coverage in an individual mandate if the subsidies for workers' coverage are more favorable under the individual mandate. Only lower income workers and non-workers would be covered in an expansion of public programs; there could be some shift from employment-based to public coverage.

³⁶ Senator Perata's proposal does not require coverage for non-workers, such as those laid-off, or part time workers, or seasonal workers. The Governor's and Speaker Nunez would cover the unemployed, seasonal and part time workers.

One key consideration will be how to keep employer and employee contributions in the financing mix in an expansion based on an individual mandate or in expansions of public coverage. Massachusetts envisages a more limited benefit package and greater cost sharing for the newly insured as one of the impediments to crowd out.

Similarly, an expansion building on employment-based coverage must address continuity of coverage for workers whose employment and thus coverage, fluctuates -- whether with changes in the economy or the changing seasonal nature of their work. Employer mandates are less flexible than individual mandates in adjusting to economic changes and the transformation of work.

THE RIGHT TO CHOOSE

California law allows employees offered coverage at their jobs to initially decline private coverage and opt instead for public coverage, which typically has fewer out of pocket responsibilities, or for no coverage (a somewhat rare occurrence). It saves the employer and costs state government if the employee opts for public coverage. Rhode Island now restricts an employee's right to choose and requires the employee to take proffered employment based coverage so that costs are not shifted to the state.³⁷

California law does not permit a parent whose child is eligible for Medi-Cal to opt for Healthy Families where the out of pocket responsibilities are higher even when parents prefer to keep all their children in the same program. Permitting parent choice among public programs would slightly reduce state costs and slightly increase costs to families.

Individuals can choose to be uninsured either because they do not want public coverage or cannot afford the costs of private coverage for which they are otherwise eligible. For those few who do choose to be uninsured, their health care costs are partially shifted to tax payers and partially cost shifted to private coverage.

³⁷ Rhode Island's RIte Share Premium Assistance Program: Estimated Savings, Fiscal Year 2005. Rhode Island Department of Human Services, November 2005.

Speaker Nunez proposes to require parents to select employment based coverage where offered with the potential to wrap around public coverage for uncovered services.

SERVICES³⁸

Virtually all insured Californians have at least coverage for hospital, doctors and prescription drugs with some out of pocket responsibilities in the form of copays and/or deductibles. Smaller percentages have coverage for dental and vision services. Most have little or no coverage for long term care services such as nursing homes and home health services. About half of the employed insured are enrolled in HMOs, and about half of those with Medi-Cal coverage are also enrolled in HMOs.

BENEFIT OPTIONS

<i>Scope of benefits</i>	Comprehensive with long term care	Comprehensive without long term care	Basic	Catastrophic	Outpatient only
<i>Design options</i>	Size of deductibles and co-payments	Provider networks	Essential services	Cost consequences of plan, provider and treatment choices	Interface with programs paying for partial coverage

Decisions about a benefit package for the uninsured have large cost consequences. The choices for state policy makers are how many services are covered, how much do individuals pay out of pocket and what provider networks and plans are selected.

Comprehensive vs. basic vs. catastrophic

Comprehensive public coverage typically refers to Medi-Cal, which covers long term care for seniors and the disabled and a range of services for the mentally ill and developmentally disabled that are not often covered through private insurance. Comprehensive private coverage typically refers to coverage with low co-pays and no deductible and dental and vision services.

Basic coverage in the private market excludes dental and vision services and has larger

³⁸ The benefit packages covered in the proposals by Speaker Nunez, Senate President Perata, and Governor Schwarzenegger are somewhat unclear, but lean towards public coverage for low and moderate wageworkers and minimum private coverage with basic or catastrophic benefits for the uninsured above 250 or 300% of FPL, respectively.

copays and sometimes deductibles of \$500 or \$1000. Basic coverage typically restricts access to specialty care and more complex and costly services except on referral from a primary care physician. Basic public coverage usually has low co-pays and deductibles and covers hospital, medical services and prescription drugs with limited provider networks.

Catastrophic coverage often has a \$5,000 or even a \$10,000 deductible or may be limited to hospital services only. Catastrophic coverage is becoming more common for upper income self-employed professionals who can afford the financial risk and prefer the lower premiums.

Out of pocket

Out of pocket responsibilities refer to patient co-pays, deductibles and co-premiums – the share of premium that a subscriber must pay. Under state and federal law, public programs (with the exception of Medicare) have low to no out of pocket responsibilities. This policy is in accord with the applied research showing that low-income patients reduce their use of necessary services in response to co-pays and deductibles, and this costs the public program more in untreated medical conditions.³⁹

Out-of-Pocket Costs for an Individual HMO Plan (Blue Shield Access+ Value HMO)			
Age	19-29	40-44	50-54
Monthly premium	\$198	\$286	\$343
Deductible	\$2,000	\$2,000	\$2,000
Office visit copay	\$35/visit	\$35/visit	\$35/visit
Specialist visit copay	\$50/visit	\$50/visit	\$50/visit
Preventive care copay	\$35/visit	\$35/visit	\$35/visit
ER services	\$150/visit	\$150/visit	\$150/visit
Generic drugs	\$10/prescription	\$10/prescription	\$10/prescription
Formulary brand-name drugs	\$35/prescription	\$35/prescription	\$35/prescription

Source: Blue Shield of California HMO Plan Details, rates effective February 1, 2007.

In the private market, increasing co-pays, deductibles and co-premiums are the norm as a means to reduce plan costs. The impact of increasing co-pays and deductibles is to reduce use of covered services and to shift some of the cost to the patient/subscriber. The research findings are that the non-poor can reduce their use of services appropriately, saving coverage costs with no adverse impacts on the patient's health.⁴⁰

³⁹ Manning et al., Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment. Rand, February 1988. www.rand.org/pubs/reports/2005/R3476.pdf

⁴⁰ Ibid.

Some employers have switched to policies that tailor the patient's out of pocket responsibilities to employee wages, mitigating the adverse impacts of copays and deductibles on patient health for their low-income employees.

Substantially increasing co-insurance in private insurance creates incentives to shift coverage for low-wage workers from the private to the public sector. There are few state or federal restrictions on the out of pocket responsibilities for patients enrolled in private insurance.

Out of pocket responsibilities have been growing faster than worker's wages, but slower than the over-all rate of growth in health costs and premiums.

Knox-Keene and the Insurance Code

Knox Keene is a state law governing HMOs but not those health insurers who offer a fee for service coverage. Knox Keene's minimum benefit plan requires coverage of hospital and physician services but does not require coverage of prescription drug benefits. Knox-Keene has an array of mandates to offer particular services, to include particular providers or benefits – these are typically referred to a state mandate.

State insurance law has no comparable minimum benefits requirement, thus allowing a health insurer to offer coverage for only hospital based or outpatient only services at a far lower cost. State insurance law also allows private individual insurance coverage to exclude maternity benefits – an additional cost reduction. The state's Insurance Code has a complementary array of "state mandates".

Medi-Cal/Healthy Families Coverage

This issue can be looked at as either benefits design or as financing. Under either guise, coverage expansion should avoid replacing existing publicly or privately covered benefits. Medi-Cal, Healthy Families and AIM pay for a disproportionate (42%) share of California's births⁴¹. Due to its unique eligibility features, Medi-Cal pays for a disproportionate share (about 30%) of hospitalization and emergency services. Medi-Cal accounts for 69% of public hospital revenues. Medi-Cal also pays for a disproportionate share of services related to mental illness and developmental disabilities and long term care services for the elderly and disabled. Medi-Cal represents 52% of nursing home revenues.⁴²

⁴¹ Medi-Cal Facts and Figures, California HealthCare Foundation, January 2006. www.chcf.org/documents/policy/MediCalFactsAndFigures2006.pdf

⁴² Ibid.

Public programs like Medi-Cal and Healthy Families are “payors of last resort” to private insurance. Extending coverage through private employment based coverage or an individual mandate shifts existing public costs to the private sector. This saves money for the state and federal government but increases private sector costs.

There are several ways for California to design benefits in a coverage expansion to avoid shifting coverage from the public to the private sector. The first way is a federal waiver authorizing a mixed public-private coverage model for the uninsured. Second, supplemental services coverage for the uninsured can wrap around existing public coverage just as Medicare Supplement policies do, although this entails coordination of benefit challenges. Third, the Health Access Program (HAP) model developed in San Francisco that provides a “care not coverage” model in order to avoid the loss of state and federal funds.

Just Coverage – Essential Benefits⁴³

The concept of essential benefits involves cost effectiveness, medical practice standards and clinical efficacy. For years, studies have suggested that about one third of health care services do little or no good for the patients. Recent studies from John Wennenberg and others at Dartmouth point to wide variations in physician practice patterns, leading to huge cost differentials in the costs of treating patients in different California communities. But little agreement is reached on what those non-essential services are and what can be done to stop paying for them. Some propose increasing patients’ out of pocket responsibilities on services of limited clinical efficacy or cost effectiveness, while others suggest the spread of information on cost and medical efficacy to providers and patients.

Recent efforts led by Marge Ginsburg of Sacramento Health Decisions have used consumer discussion groups playing sophisticated health games to prioritize health treatments and trade-offs in benefits design.⁴⁴ Consumers prioritized narrow networks, practice guidelines, clinical effectiveness and cost/benefit exclusions of high cost/low value services-they rejected high cost sharing plans.

Some combination of benefits design, information, consumer and provider education and appropriate financial incentives for both patients and providers should be targeted to eliminate, or at least reduce, reimbursement for services of little or no benefit.

⁴³ Ginsburg et al., (De) constructing “Basic” Benefits: Citizens Define The Limits of Coverage, Health Affairs, November/December 2006. content.healthaffairs.org/cgi/content/abstract/25/6/1648

Wennberg et al., Evaluating the Efficiency of California Providers In Caring For Patients With Chronic Illnesses, Health Affairs Web Exclusive November 16, 2005.
<http://www.content.healthaffairs.org/cgi/reprint/hlthaff.w5.526v1>

⁴⁴ Ginsburg et al., (De) constructing “Basic” Benefits: Citizens Define The Limits of Coverage, Health Affairs, November/December 2006. content.healthaffairs.org/cgi/content/abstract/25/6/1648

Outpatient only⁴⁵

CalKids has been a successful model of coverage for outpatient services for uninsured children, not otherwise eligible for Medi-Cal or Healthy Families. The advantage is access to medical care for most routine needs. The cost ranges from half to a third of the cost of full scope coverage. CalKids is back-stopped by potential eligibility for emergency Medi-Cal and CCS, which do pay for emergency and hospital services.

Most low income uninsured adults are eligible for county health programs that often have somewhat better coverage of hospital based services, but poor access to routine medical services on an outpatient basis. An outpatient only benefits package would meet important low-income patient needs; it must be designed to coordinate with and supplement not supplant existing county health services.

In most counties, there is no coverage for hospital care to the uninsured with incomes over 200% of FPL. Limiting coverage to outpatient care leaves higher income uninsured without adequate coverage and susceptible to financial ruin from an uncovered hospital stay.

One benefit design option that may make cost savings sense is an outpatient benefits package for lower income uninsured and catastrophic coverage for higher income uninsured. This adds care and coverage coordination challenges to an already too complex system. Limited benefits packages may reduce the incentives for crowd-out of existing employment based coverage in the context of an individual mandate since employers would be reluctant to drop existing coverage so that their employees had an outpatient only or catastrophic benefits package.

Choice of plans/choice of providers

There is a wide difference in the costs of health plans for essentially the same benefits plan. There is also a wide difference in the costs of providers for delivering the same package of services. It is important that consumers have a choice of plans and a choice of providers. ITUP does not believe that public taxpayers should subsidize incremental cost difference of higher cost plans, nor should employers be obligated to do so, nor should they be precluded from doing so. Individuals should be able to pay for the incremental cost difference of more costly plans they desire.

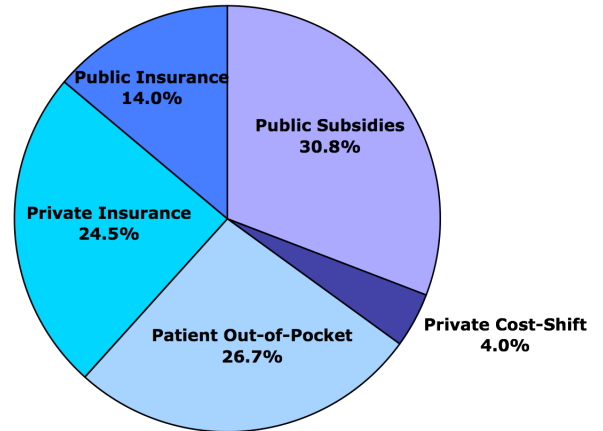
COSTS AND FINANCING

⁴⁵ Glenn Melnick et al, Evaluation of the Los Angeles CalKids Program, Center for Health Financing and Policy, University of Southern California February 2002 at www.chcf.org

Approximately \$200 billion is spent on health care in California: 45% by government, 35% by private insurance, 13% by individuals and 7% by others. Hospitals receive 30% of the pie, doctors and other clinicians (20%), pharmacy (10%), dentists and other practitioners (10%) and administration (7%).⁴⁶

Half the care of the uninsured and two thirds of the projected costs are estimated to be already in the system.⁴⁷ Care to the uninsured (well over \$10 billion in California) is now paid by the uninsured themselves, by federal, state and local taxpayers and by the cost shift (an add-on) to the premiums of private employers, employee and individuals for the costs of uncompensated care. Uninsured individuals pay for about 25% of their care out of pocket; federal, state and county governments pay 45%, and private insurance pays 25% (mostly in the form of premiums for the part year uninsured).

Sources of Funding for Care to the Uninsured



Source: Hadley and Holahan, *Who Pays and How Much? The Cost of Caring for the Uninsured*, February 2003

Most of the proposals to cover the uninsured rely on a mix of public funds, individual payments and employer contributions to finance expanded coverage.

State Fiscal Impact Summary of Governor's Proposal (Dollars in Millions)						
COSTS	STATE	LOCAL	FEDERAL	TOTAL COSTS	INDIVIDUAL TAX REDUCTION	SAFETY NET CARE POOL*
Increased Medi-Cal/Healthy Families Program Coverage	\$1,283		\$1,357	\$2,638		
Subsidy for Persons 100%-250% FPL	\$1,135		\$1,135	\$2,270		\$542
Persons w/o Green Cards Provided Coverage by Counties		\$1,000	\$1,000	\$2,000		
Prevention and Wellness Measures	\$150		\$150	\$300		
Section 125 Tax Treatment (State Income Tax Reduction)	\$900			\$900	\$900	
Section 125 Tax Treatment (Federal Income Tax and FICA Reduction)					\$7,500	

⁴⁶ Health Care Affordability and Coverage Briefing Materials, Governor's Health Summit. California HealthCare Foundation, July 2006.

⁴⁷ Hadley and Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Kaiser Family Foundation, May, 2004.

Kominski et al., *Cost of Insuring California's Uninsured*. UCLA Center for Health Policy Research. http://www.healthpolicy.ucla.edu/pubs/files/CostofInsuring_PB_052405.pdf

Medi-Cal Rate Increase	\$2,206		\$1,832	\$4,039			\$224
TOTAL COSTS	\$5,675	\$1,000	\$5,474	\$12,147		\$8,400	\$766

*Safety Net Care Pool funding is included in the federal cost column and is split in this column to show how these funds are being used.

Source: Governor’s Health Care Proposal, January 2007.

FINANCING OPTIONS

<i>EXISTING FINANCING FOR CARE TO THE UNINSURED</i>	Medi-Cal and private insurance part year coverage	County programs	Institutional subsidies	Mini-programs	Consumer out of pocket	Cost shift to private insurance for uninsured uncompensated care
<i>NEW PROPOSED FINANCING FOR COVERAGE OF THE UNINSURED</i>	Federal match and state match	Employer, employee and/or individual premiums/fees	Provider taxes/assessments	County match	Tax incentives	Payroll taxes vs. consumption taxes Taxes vs. fees or premiums

“THE COST SHIFT”

In our current system, most employers and most employees contribute towards the cost of coverage while some do not. A recent California HealthCare Foundation study reports that two thirds of California employers, employing 90% of all California employees, offer coverage.⁴⁸ As discussed earlier, the rationale for continuing employment-based coverage is the large tax break (30% of premium cost) associated with pre-tax purchasing.

The costs of care to the uninsured for those employers and employees who do not contribute are then picked up by the “cost shift” (to employers and employees who do pay) and by state, federal and local taxes.

There is a second cost shift among employers in the costs for dependent coverage in two adult working families from those employers who offer less generous dependent health benefits to those employers who offer more generous dependent benefits. This is a growing cost shift as businesses differentially reduce their contributions for dependent

⁴⁸Snapshot of Employer Based Insurance, Coverage and Cost. California HealthCare Foundation, 2006. <http://www.chcf.org/documents/insurance/SnapshotEmployerCostsCoverage2006.pdf>.

coverage.

The third cost shift for uncompensated care occurs with Medi-Cal patients. Medi-Cal pays less than cost and private insurance pays more than cost. This is a very large cost shift and an increase in Medi-Cal rates could reduce it, if and only if providers and plans in turn reduced rates for the privately insured.

The concept of a “free rider” is one who receives benefits for oneself or one’s employees without contributing towards their cost. Mandates are one way to assure that free riders contribute. If all employers and employees and individuals contributed towards the cost, the cost shift burden on those with coverage would be reduced. How much?

In a 2002 study of nine separate California reform proposals, John Sheils of the Lewin Group estimated an average savings of \$400 per insured worker per year by extending coverage for the uninsured.⁴⁹ The New America Foundation recently projected the cost shift for the uninsured is about 10% of premiums.⁵⁰ According to a recent study by Families USA, the cost shift for health care provided to individuals without health coverage was approximately \$5.8 billion in 2005 and will exceed \$8.2 billion in 2010.⁵¹ Another recent proposal to cover the uninsured by George Halvorson, et al. of Kaiser Health Plan estimated that covering the state’s uninsured could result in a 3-9% savings in employer-sponsored premiums.⁵² ITUP reviewed OSHPD data for the cost of bad debt and charity care to private hospitals and based on that data we estimate the maximum cost shift for hospital uncompensated care to the uninsured is \$1.3 billion -- roughly a 2% add-on to private insurance premiums.⁵³

EMPLOYERS: THE (UN)AFFORDABILITY OF COVERAGE

The cost to employers and employees who offer and take up coverage is \$60 billion.⁵⁴

⁴⁹ Sheils, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California. The California Health and Human Services Agency, March 2002.
<http://www.statecoverage.net/statereports/ca71.pdf>

⁵⁰ Harbage and Nichols, A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System. New American Foundation, December 2006.
<http://www.newamerica.net/files/HealthIBNo3.pdf>

⁵¹ Paying A Premium: The Increased Cost of Care for the Uninsured. Families USA, June 8, 2005.
<http://www.familiesusa.org/resources/publications/reports/paying-a-premium-findings.html>

⁵² Halvorson et al., A Proposal to Cover the Uninsured in California. Health Affairs, December 12, 2006.
<http://content.healthaffairs.org/cgi/content/full/hlthaff.26.1.w80/DC1#8>

⁵³ We assumed that all private hospital bad debt and charity care to the uninsured are completely cost shifted to private insurance but at no more than cost (as opposed to charges), and we assumed that no public hospital bad debt and charity care is cost shifted because public hospitals have so few privately insured patients. If health plan negotiators exact a further discount for Medi-Cal DSH payments to private hospitals, the cost shift for hospital care to the uninsured is considerably less.

⁵⁴ Harbage and Nichols, A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented

California's mean annual wage in the first quarter of 2006 was \$43,429.⁵⁵ Employers and employees now pay on average \$4,000 per employee for individual coverage (8.8% of average wages for health benefits) and over \$10,000 for family coverage.⁵⁶ Employees pay on average \$500 for their share (average 12%) of individual coverage and \$2,800 for their share (average 25%) of family coverage.⁵⁷ Costs are projected to increase by 8% annually.

Employment based health coverage is heavily subsidized by the federal and state tax code provisions that permit purchase with pre-tax dollars. This tax preference inures primarily to high wage earners and those employers with well-compensated workforces. Employment based coverage has low tax subsidies and high affordability barriers for employers with low wage workforces.

If mandated, premium contributions for uninsuring employers and uninsured employees, should be set at an affordable amount. Care should be taken not to disrupt California's economic growth or job creation. As discussed earlier, employment based coverage is a large percent of the wages of minimum wage workers.

Under a mandatory approach, premium contributions for uninsuring employers and employees could be set at a flat amount per employee (e.g. \$4000 per employee), at an average regional cost of coverage per employee (e.g. \$3,750 in Los Angeles and San Diego, \$4,000 in the Bay Area and \$4,250 in rural California) or at an average percent of wages (e.g. 6% of wages).⁵⁸

Either a flat amount or the average cost per employee would overpay for the real costs of coverage for the uninsured because the uninsured are markedly younger, use less care and their coverage costs much less than does coverage for the insured.

We favor a "percent of wages" approach because it links employer and employee contributions to affordability. A "percent of wages" approach might collect less than the actual costs of coverage for the uninsured because the uninsuring employers and uninsured employees have much lower wages; however they are also much younger

Health Care System, New America Foundation, December 2006. <http://www.newamerica.net/publications/>

⁵⁵ The mean annual wage in the first quarter of 2006 was \$43,429. See OES Employment and Wages by Occupation, State of California, 1st Quarter of 2006, Employment Development Department. www.labormarketinfo.edd.ca.gov/cgi/career/?PAGEID=3&SUBID=152

⁵⁶ California Employer Health Benefits Survey. CHCF, November 2006. www.chcf.org/documents/insurance/EmployerBenefitsSurvey06.pdf

⁵⁷ *ibid*

⁵⁸ The Governor, Assembly Speaker and Senate President all propose that uninsuring employers and uninsured employees pay based on a percentage of wages or payroll. The Governor's proposal is that uninsuring employers pay 4% of payroll and uninsured employees pay from 2-6% of wages/income into a state pool for coverage of the uninsured.

and lower risk. Employers and insured employees who already offer coverage at a higher percentage of wages could decide to drop coverage contributions to the lower percent – crowd in.

Affordability is also challenging for family coverage, which typically costs three times as much as individual coverage, and for employees over 50 whose coverage often costs three times as much as coverage for employees younger than 30.⁵⁹

INDIVIDUALS

Individuals pay out of pocket for care with co-pays, deductibles and for coverage with co-premiums – about \$800 annually per capita.⁶⁰ These amounts vary widely depending on the type of coverage offered (by their employer or purchased individually) and the health of the individual. On average, individual contributions have been rising faster than employee wages or individual incomes and slower than the rise in costs of health coverage.⁶¹

For many individuals out of pocket expenditures are very small, while for others (particularly the chronically ill, older individuals, the self-employed and the uninsured) out of pocket expenses are very high.⁶² In 2003, about one third of families with high out-of-pocket costs, those exceeding \$2,000 or more in the past year, reported their out of pocket medical costs impaired their ability to pay their other bills; two thirds are not adversely impacted.⁶³

The function of insurance is to protect individuals from the catastrophic costs of health care and to encourage appropriate access and use of medical care.

- Individuals' co-pays and deductibles should be linked to the goals of coverage, i.e. encouraging appropriate access and deterring unnecessary access, and adjusted by ability to pay.
- Individual premium contributions, if mandated, should be linked to wages or incomes

⁵⁹ The Governor, Speaker and Senate President solve the affordability challenge for low and moderate income workers through the option for public coverage; however for families and older workers the most affordable option proffered is coverage with a \$5,000 deductible and a tax preferred health savings account.

⁶⁰ California HealthCare Foundation, Snapshot, Health Insurance: Can Californians Afford It?, 2005. www.chcf.org/documents/insurance/HealthInsuranceAffordability.pdf; Banthin and Bernard, Changes in Financial Burdens for Health Care, The Journal of the American Medical Association Vol. 296, No. 22, December 13, 2006. <http://www.jama.ama-assn.org/cgi/content/full/296/22/2712>; and Tu, Rising Health Costs, Medical Debt and Chronic Conditions, Center for Studying Health System Change Issue Brief No. 88, September 2004. www.hschange.com/CONTENT/706/706.pdf

⁶¹ Out of pocket has fallen from about 40% of health spending to less than 15% today. California HealthCare Foundation, Health Care Affordability and Coverage Briefing Materials, July 2006.

⁶² Ibid.

⁶³ Ibid.

and calculated in an amount adequate to fund the individual's share of the costs of basic coverage. We suggest a sliding fee scale premium such that median income individuals pay the full cost of coverage.

- Individuals should pay out of pocket (with no tax subsidies) for the incremental costs of more costly coverage options. In other words, if basic coverage costs \$3000 per employee and an individual wants more extensive and expensive coverage options, costing \$4000, the \$1000 incremental cost should be borne by the individual without any preferential tax treatment (such as tax deductibility, HSAs, HRAs or refundable tax credits). Such a policy could be quite complex to administer as premiums vary by age and geography, so the premium cost of a benchmark plan is highly variable.

EXISTING PUBLIC SPENDING

California spends state, federal and county funding on care to the uninsured in many ways.

- Counties report spending about \$1.8 billion on care, primarily to uninsured adults.⁶⁴ This is financed by the state realignment and tobacco tax, county match and some counties' litigation settlement funds.⁶⁵
- California hospitals report receiving \$1.5 billion from counties for their care to the uninsured. California hospitals report an additional \$1.6 billion in care to the uninsured as uncompensated hospital bad debt and charity care; this is partly offset by federal DSH and safety net pool funds for hospital uncompensated care to the uninsured, in the amount of \$2 billion.⁶⁶
- California community clinics report providing nearly \$500 million in services to the uninsured that are partially reimbursed by federal, state and county programs (at least \$350 million).⁶⁷

Medi-Cal pays for hospital care, emergency services and prenatal care and deliveries for individuals who are otherwise uninsured. Medi-Cal also pays for many of the part year uninsured who cycle on and off public and private coverage when they are not uninsured.⁶⁸

⁶⁴ Chen, A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2006, ITUP, October 2006. www.itup.org/reports.html

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Kominski et al, Cost of Insuring California's Uninsured, UCLA Center for Health Policy Research, February 2005. <http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=141>

California has unique programs for coverage of the uninsured for specific diseases such as breast, cervical and prostate cancer, specific providers such as emergency room physicians (SB 12) and community clinics (EAPC), specific services such as Family Planning or preventive care to uninsured children, specific conditions such as pregnancy, and a range of severe chronic diseases and conditions such as CCS (California Children's Services) and GHPP (Genetically Handicapped Persons Program).⁶⁹ If mental health is to be a covered service, the state and county governments have a large financial investment in these services as well.

California could incorporate these funds and programs into coverage for the uninsured. By "phasing-in" funding as individuals are insured, programs for the uninsured are not decimated by shifting the funds prior to enrollment. Some funds are of a "use it or lose it" nature, whereas others are tied up in intricate county/state/federal formulas and funding relationships.

There should be no windfalls or double dipping under a reform.⁷⁰ Hospitals cannot retain federal funds for their uncompensated care to the uninsured once the care to the uninsured is compensated through a coverage expansion. Similarly clinics with federal §330 grants are subject to equivalent rules. California will need to seek a §1115 waiver (as other states have done) to allow some of the federal funds to be used for coverage, rather than care, otherwise they will revert to the federal government.

EXISTING PRIVATE SPENDING

Private hospitals and doctors provide substantial amounts of free care in office, hospitals and emergency room settings. Others volunteer in clinics and/or provide in kind care to clinic patients. Some of the cost of this care is cost shifted to privately insured patients. Some is paid out of pocket by patients. Some reduces the take home pay and bottom lines of private practitioners and facilities.

- Our best estimate of the cost shift to private insurance for hospital uncompensated care for the uninsured is \$1.2 billion or 2% of premiums.⁷¹ Others use higher estimates of 10% of private insurance premiums.⁷²

⁶⁹ Chen, A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2006, ITUP, October 2006. www.itup.org/reports.html

⁷⁰ Senator Perata's proposal would leave all county funding with the counties and leave counties with a reduced residual obligation for the unemployed and part time employed uninsured – about one third of the uninsured. Governor Schwarzenegger proposes that the state take half the county and DSH hospital funding while leaving counties with a residual obligation for undocumented adults about one sixth of the uninsured.

⁷¹ We assumed that all private hospital bad debt and charity care to the uninsured are completely cost shifted to private insurance but at no more than cost (as opposed to charges), and we assumed that no public hospital bad debt and charity care is cost shifted because public hospitals have so few privately insured patients. If health plan negotiators exact a further discount for Medi-Cal DSH payments to private hospitals, the cost shift for hospital care to the uninsured is considerably less.

⁷² Harbage and Nichols, A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System. New American Foundation, December 2006.

- As a part of reform, the state could require that the savings from eliminating the cost shift be passed through to private subscribers as premium reductions; the state currently has no mechanism in place to assure this occurs at the hospital or insurer level.

TAX SUBSIDIES AND INCENTIVES

Two types of tax subsidies and incentives need to be considered: tax deductibility and refundable tax credits or vouchers. Tax deductibility concentrates the subsidy on upper income tax brackets and provides the most help to those who need it least. Refundable tax credits or vouchers typically concentrate their assistance on individuals in lower income tax brackets who face the largest affordability barriers for coverage.

In designing financing of coverage, we should assure maximum tax relief for insured and uninsured Californians. Federal tax policy is far more important than California's since states have much lower income tax brackets.

Small tax subsidies have little impact in increasing coverage for the uninsured while large tax subsidies have much larger impacts, but they are much more expensive.

Tax policy must also address tax equity to ensure that similarly situated individuals and businesses are treated equally. Take the example of two shoe stores, one that offers coverage (and already gets a subsidy through pre-tax purchasing) and one that doesn't. If the second shoe store gets a tax subsidy to start offering coverage, the subsidy would need to be higher than existing tax policy to create any incentive to start offering. However, the question becomes how much higher should the subsidy be, and should the first shoe storeowner who already offers coverage get the same tax break? Similarly, if refundable tax credits or vouchers are offered to low income uninsured individuals to buy individual coverage, should the low-income individuals who already buy individual coverage get the same refundable tax credit as uninsured individuals? Tax equity is very expensive since most employers already offer and most individuals already have coverage.

President Bush's proposed tax deductibility eliminates the tax inequity for individually purchased coverage and provides meaningful subsidies for the uninsured in high tax brackets but little or no assistance for most uninsured individuals because they have little or no federal or state income tax liability.⁷³

<http://www.newamerica.net/files/HealthIBNo3.pdf>.

⁷³ Burman, et al, The President's Health Insurance Proposal – A First Look, Urban Institute, January 2007. <http://www.urban.org/publications/411412.html>

NEW REVENUE OPPORTUNITIES

New revenue opportunities typically set off a feeding frenzy of stakeholders with pent-up, unmet demands and expectations. There could be new revenues from the federal level for state efforts to cover the uninsured, but the federal budget deficit makes that unlikely.

The state still has a structural budget deficit despite growing tax receipts, as well as a two-thirds majority vote requirement for new taxes. Proposition 98 guarantees that schools receive about 40% of any new tax revenues unless the revenues are directed to a special health care trust fund.

Local governments have some new revenues from the recent run up in home values but many local jurisdictions have little inclination to spend them on health care for the uninsured.

FEDERAL GOVERNMENT

Promising immediate opportunities at the federal level are the federal match available for low income working parents under Medicaid or S-CHIP and §1115 waivers to cover low-income adults, using county spending on uninsured adults as the match. President Bush's 2007 budget proposal contains tax deductibility for individual coverage that will provide strong tax relief for the upper income uninsured and the ability for states to use the hospital DSH funds to pay for coverage of the uninsured.

Democratic Congressional leaders are likely to seek to increase funding for S-CHIP to support state efforts to cover uninsured children and might give states flexibility and funding for pilot programs for the uninsured.

The National Governor's Association may continue to push for a federal Medicaid match for state programs for uninsured adults and will apparently be joined by major health plans (AHIP). The health plans also seek funding for tax credits and tax deductibility for individual coverage and to offset the spiraling costs of family coverage.

The federal government has the ability to tighten or loosen ERISA preemption of state's ability to regulate self-insured employers but is unlikely to do so.

STATE GOVERNMENT

If we expand public coverage where do we get the state match? Proposition 86, which contained \$2 billion in new revenues for care to the uninsured, was narrowly defeated in a campaign where the tobacco industry outspent the health industry by 7-1.

The Governor, Speaker and Senate President have outlined proposals for universal coverage that expand public coverage for the uninsured up to 250 or 300% of FPL. The state match could be provider assessments, employer, employee and individual assessments or premiums.

The federal government does allow provider taxes or assessments to qualify as the state match for Medicaid. There are restrictions to prevent illusory, discriminatory and quid pro quo matches.⁷⁴ The federal government does not permit employer, employee or individual co-premiums to qualify as a Medicaid state match; however, to the extent they are general-purpose taxes or assessments they would be eligible as a match. To further complicate the task of state policy makers, the state already agreed, as a part of its recent five-year hospital §1115 waiver, not to adopt a provider tax to fund its Medicaid program during the waiver.⁷⁵

California has severe obstacles to raising taxes through the legislature due to the two-third's vote requirement and Proposition 98's guarantee of at least 40% of any new revenues to schools. This puts a premium on casting any new revenues as a fee or assessment. User fees must be linked to the cost of the service being provided; in other words, a user fee for significantly more than the cost of the service is likely a tax, not a fee. Subscriber premiums for health insurance coverage appear likely to meet the test for a user fee. The other alternative is to take an acceptable new source of revenue and proposed state spending to the state's voters who rejected three such proposals in 2006.

In our view the most attractive source of new revenues would be to reduce the sales tax on goods and apply the sales tax to services. As a nation, we have shifted from a goods consuming economy to a service economy and the tax burden on good and services should be equalized.

There is already a cost shift hidden tax on health care to pay for care to the uninsured; the hidden tax on health care could be replaced by an explicit and more equitable tax of health services. For example, a one percent tax on health services raises nearly \$2 billion. As discussed above California's hospital waiver (unless amended) precludes a provider tax as a state Medicaid (Medi-Cal) match for five years.

The state could finance health coverage for all with a payroll tax or fee in lieu of employer and employees' health premiums. While this could be designed to be cost neutral in its totality, there would of necessity be winners and losers among employers with this approach. Depending on design and amount, it could make coverage significantly more affordable to low wage employers and employees and small businesses than it is now, and it could be used as a state match for federal Medicaid or S-CHIP funds.

⁷⁴ 42 CFR 433.50 et seq.

⁷⁵ Harbage and Ryan, Questions and Answers about the 2005 Medi-Cal Hospital Waiver, California HealthCare Foundation, August 2005. www.chcf.org

California should weigh the advantages of continuing to build health coverage on an employment base. On the plus side, it takes advantage of large though highly regressive federal tax policies. On the negative side, it impairs California's business competitiveness in the global economy as compared to countries that finance health care through either an income tax or consumption taxes. Industries such as restaurants are not severely impacted, because Californians are unlikely to fly/drive to another state for a meal due to the costs of mandated health coverage for their workers. Other industries such as manufacturing and agriculture are part of the highly cost competitive global markets and would be impacted by mandated health coverage. Policy makers should consider a gradual shift away from employment based financing towards income and consumption based financing as being far healthier for California's economic future. One approach could cap employer and employee contributions at the over-all growth in wages-this may have some appeal to business and labor.

LOCAL GOVERNMENT

County government in California has the legal responsibility for care to the uninsured (W&I Code §17000) without either the finances or financial base to do so adequately. Our calculations are that counties receive on average \$345 per uninsured per year from federal, state and local sources to pay for care to the uninsured compared to a \$4000 health costs per year per insured through employers.⁷⁶ County contributions to this financing mix (county match) are far smaller than the state (realignment and Prop 99) and federal (DSH and Safety Net Care Pool) shares of financing.

Our recent research found that counties in the aggregate are spending ever-smaller shares of this existing revenue base for care to the uninsured.⁷⁷ While Prop 13 curtails the ability of county governments to raise new revenues, the recent boom in home prices has benefited many counties with rising property tax revenues.

Some counties are extraordinary pioneers in expanding coverage for the uninsured,⁷⁸ while for others the uninsured are a low political priority. Pioneering counties are often those with the most funds to tackle the problem, combined with the political will and fundraising and organizational infrastructure skills to do so. These counties should have a leading role in reform efforts.

Counties with public facilities have more resources, stronger incentives and local infrastructure. They would prefer to maintain and expand their central role and act as a

⁷⁶ Chen, A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2006, ITUP, October 2006. www.itup.org/reports.html.html

⁷⁷ Fox, Where are the Uninsured Now? A Ten-Year Overview, Insure the Uninsured Project, June 2006. www.itup.org/reports.html.html

⁷⁸ Mannanal, Directory of Local Efforts to Expand Access for California's Uninsured, Insure the Uninsured Project, January 2007. www.itup.org/reports.html.html

key building block in expanding coverage. Counties without public facilities are far more interested in handing off their statutory role and their funding for care to the uninsured to state government. We should allow those counties to do so and repeal their W&I Code §17000 responsibilities for health care to the indigent uninsured if they choose do so.

County and local ballot measures have been more successful in raising funds for health care for county residents than state ballot initiatives have been. Counties are severely restricted by the state constitution in their ability to bring revenue-raising ballot initiatives before local voters.

Financing: San Francisco model vs. Massachusetts model⁷⁹

In the last year, Massachusetts and San Francisco, California each passed legislation to cover all of the uninsured. They are similar in combining a redirection of safety net funding from care to coverage with employer contributions and individual premiums, but they differ in their mandates on employers and individuals.

The centerpiece of San Francisco's funding for expansion is its existing safety net funding. Massachusetts secured a federal waiver to allow the re-direction of its safety net funding from care to coverage. San Francisco maintained a central role for the public safety net and called its expansion "access not coverage" to skirt the potential of a Catch 22 where the county would replace federal funds with local revenues.

San Francisco's ordinance has a pay or play tax or assessment on employers, but anticipates receiving little employer revenue. San Francisco includes premiums from individuals but does not mandate them and projects significant revenues from individuals. Massachusetts has an individual mandate and projects substantial individual premium contributions. They also include a small pay or play tax or fee on uninsuring employers but projects significant voluntary contributions from employers.

Nearly half the cost of the San Francisco expansion comes from the county, and the county has a central role in the administration and delivery of services under the program. In Massachusetts, the administrative challenges are far more imposing and the state has created a brand new entity – the Insurance Connector – that performs a variety of roles critical to the program's success. Neither took a hands-off, "leave it to the market" approach to the challenge of helping individuals with public subsidies to navigate their coverage and provider choices.

⁷⁹ Chen and Wulsin, Coverage Initiatives: Design and Effectiveness, Insure the Uninsured Project, January 2007. www.itup.org/reports.html

Waivers⁸⁰

The Governor and the Speaker's proposals both would seek a federal §1115 waiver to cover adults. Medicaid waivers under §1115 require cost neutrality; in other words, the cost to the federal government after the waiver must be the same as the projected cost without the waiver. Thus California could seek a waiver for coverage of low wage adults not otherwise eligible for Medi-Cal, but must offer a cost savings in return such as moving the disabled into managed care – a common exchange in a number of other states. Another possible point for state-federal negotiations would be to trade some of the federal hospital subsidies, such as DSH and the Safety Net Care Pool, that would otherwise be lost in a coverage expansion for a federal match to county funding for care to indigent adults.

Employment based vs. Consumption based Financing – a possible transition

California and the United States pay for health coverage (private and Medicare) based on employer payrolls. Taken to extremes, loading societal costs on to jobs can impair job creation, a problem in some European political economies. Financing health care based on a consumption tax could increase the costs of goods and services to consumers in the US, but increase the competitiveness of US employers in the international market. Senator Ron Wyden has an interesting new approach being considered in Congress to cash out employer contributions.⁸¹

We urge consideration of financing health coverage with a balanced mix of individual fees, premiums or taxes, employer premiums, fees or taxes and a sales tax on services.

Costs: newly insured vs. already insured

The costs of covering the newly insured are far less than covering the already insured for several reasons. First, the newly insured are much younger and somewhat more male, thus much less costly to cover. Second, their most expensive care is already in the system and being compensated. Third, Latinos represent a higher percentage of the uninsured – a population that uses much less services even when insured. Fourth, the uninsured are lower-wage workers – a population that uses fewer services even when insured. Fifth many of the uninsured are covered part year by public programs or private coverage and uninsured part year. In a well-designed reform, administrative costs

⁸⁰ Wulsin et al, SB 480 Health Care Options Paper, prepared for the California Health and Human Services Agency by Insure the Uninsured Project, March 15, 2002. www.itup.org/report.html; and Insure the Uninsured Project, Testimony to the California Performance Review Commission, August 2, 2004. www.itup.org/reports.html

⁸¹ Healthy Americans Act at <http://wyden.senate.gov> and Sheils et al, Cost and Coverage Estimates for the Healthy Americans Act, The Lewin Group, December 2006. <http://wyden.senate.gov>

should decline and unit costs of service should decline as well since fixed costs are spread across six and half million new subscribers.

Intersection costs⁸²

There are four different intersecting programs each with different moving parts and actors that must be accounted for in financing coverage of the uninsured: private employment based coverage, private individual coverage, public state coverage (MediCal and Healthy Families) and public county coverage (W&I §17000 programs) different in each of 58 California counties. Over time, subscribers will migrate among these programs depending on which offers the most valuable coverage at the lowest cost to the subscriber.

In addition, each employer makes decisions on the scope of coverage and the amount that their employees pay for coverage that in turn influence decisions by their employees to opt for their employer's coverage, their spouse's coverage or public coverage where available. Furthermore state, federal and county governments change their policies to shift costs among themselves and between the public and private sectors. None of these actors are static or unaware over time of the decision-making by others. In this dynamic, intersecting system, the decisions of each actor influences the payment obligations of others, and they adjust their policies accordingly.

For example, an expansion of public programs for low-income adults would reduce the numbers of uninsured, reduce use of county health programs and somewhat reduce private coverage of low-income adults. An employer mandate would reduce the numbers of uninsured in county health programs and the numbers of persons using Medi-Cal and Healthy Families and shift some of the insured from private individual coverage to private employment-based coverage. An individual mandate to purchase or enroll in available public or private coverage would reduce the numbers of uninsured and persons using county health programs with relatively little impact on enrollment in state programs or employment based coverage. However once the individual mandate is combined with premium subsidies, a migration from employment-based coverage would occur depending on the degree of subsidy for individuals and their covered benefits through the new state program, compared to what is offered by an individual's employer.

Providers make conscious choices among the multiplicity of private payors and public programs as to which offer the highest and most timely reimbursement in relation to the time, risk, cost and effort required to treat the program's patients. As the four programs and many different health plans participating in each program offer different reimbursement levels for different providers and for different types of providers, it is very difficult to predict outcomes of reimbursement policy changes on an ever-changing

⁸² Sheils, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California, prepared for the California Health and Human Services Agency, April 2002. www.statecoverage.net/statereports/ca71.pdf

playing field.

While the Medi-Cal program may offer the best package of services and the lowest out of pocket costs for subscribers, it may also offer the lowest reimbursement for private providers. A private fee for service indemnity plan may have the highest premiums, highest reimbursement rates, highest unit cost for covered services and a broad array of high cost participating providers. What is the value of each option for subscribers of different economic circumstances and/or for competing providers?

In considering the intersections, the following questions are worth some thought:

- Will an increase in Medi-Cal reimbursement rates lead to a decline in private insurance rates as uncompensated care is reduced?
- Will more private physicians participate in Medi-Cal, or will private plans increase reimbursement rates so that the cost differential between public and private payors is maintained?
- Does high cost translate to high quality or is high cost a function of favorable demographics and a positive payor mix?
- Do patients follow their perceived medical best interests by enrolling in the plan that covers their personal physician or do they follow their financial best interests by enrolling in the plan with the most benefits and the least cost to the subscriber?
- What are uninsured patients' allegiances to their safety net provider(s) and to what degree would they choose to enroll with their existing provider or choose a new one?

COST CONTAINMENT

Background

American health care costs about twice as much as coverage in the other developed countries and that cost differential is accelerating due to systemic dysfunction.⁸³ According to a recent speaker from McKinsey and Company at the New America Foundation conference in December 2006, 20% of the cost difference is accounted for by higher administrative costs, 50% by higher prices, and 30% by the fragmented and dysfunctional delivery system.⁸⁴

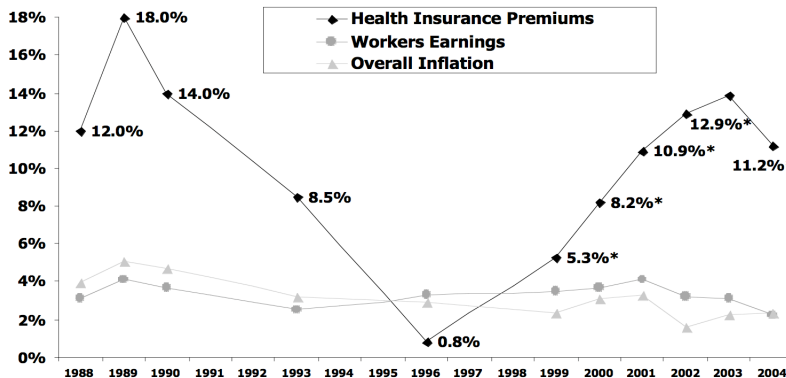
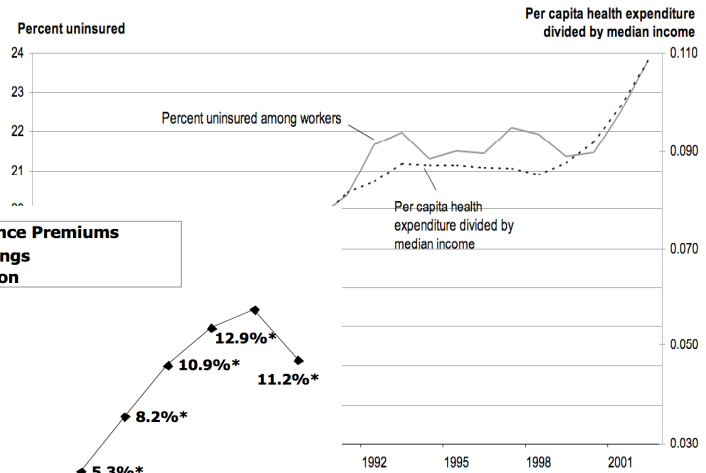
California has been a pioneer in cost control: initiating HMOs, PPOs, selective

⁸³ White, Health Care Spending Growth: How Different is the United States from the Rest of the OECD, Health Affairs, January/February 2007. www.healthaffairs.org

⁸⁴ McKinsey and Company, Accounting for the High Cost of US Health Care, January 2007. http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp

contracting and managed competition. As a result, until recently California's HMO premiums and health costs have been lower than in many eastern and mid-western states and more Californians are enrolled in HMOs.⁸⁵

Percentage Uninsured Among Workers And Per Capita Health Expenditure Divided by Median Income, 1979-2002



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits:1993, 1996 ; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S.).

For the past six years, health costs and premiums have been soaring at unsustainable rates, four to six times the rates of increase in worker's wages in California and nationally. California's health coverage price advantage over the rest of the country has now dissipated, except in the Medi-Cal program where costs per covered life are among the lowest in the country. California PPOs are comparatively more expensive than the rest of the country and California HMOs are now as expensive as plans in the rest of the country. A declining percent of insured California employees enroll in HMOs (from 54% to 49% in the past 6 years).⁸⁶

The rise in private premiums topped out at 16% in 2003 and has since declined to 8% -- still more than twice the rate of increase in the CPI (Consumer Price Index).⁸⁷ Hospital, physician and prescription drug costs are all now rising at nearly the same unsustainable rates, partly due to price increases and partly due to increased use of services.⁸⁸

⁸⁵ California Healthcare Foundation, California Employer Health Benefits Survey 2006.

www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480

Source: Kronick, *It's the Premiums Stupid: Projections of the Uninsured through 2013*, April 2005.

⁸⁶ *ibid.*

⁸⁷ California Healthcare Foundation, California Employer Health Benefits Survey 2006.

www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480

⁸⁸ Zuvekas and Cohen, Prescription Drugs and the Changing Concentration of Health Care Expenditures, *Health Affairs*, Vol. 26, No. 1, January/February 2007.

<http://www.content.healthaffairs.org/cgi/reprint/26/1/249?maxtoshow=&HITS=10&hits=10&RESULTFO RMAT=&fulltext=hospital,+prescription+drug+costs&andorexactfulltext=and&searchid=1&FIRSTINDE>

At the 2002 ITUP conference, Professor James Robinson of UC Berkeley pointed out that rising health costs are attributable to every one of us. It includes rising provider prices, increasing utilization of services, higher plan profits and the fall out from the consumer revolt against HMO abuses and shift to higher cost, less cost efficient plans.

CHART OF PREMIUMS, HEALTH COSTS AND WAGES (1996-2006)							
Year	Wages	Premium Increases	All Health Services	Hospital Inpatient	Hospital Outpatient	Physician	Prescriptions
1995	3.0%	2.5%	2.2%	-3.5%	7.9%	1.9%	10.6%
1996	3.5%	1.5%	2.0%	-4.4%	7.7%	1.6%	11.0%
1997	4.0%	2.5%	3.3%	-5.3%	9.5%	3.4%	11.5%
1998	4.5%	3.5%	5.3%	-0.2%	7.5%	4.7%	14.1%
1999	3.5%	5.5%	7.1%	1.6%	10.2%	5.0%	18.4%
2000	3.5%	8.0%	7.8%	4.1%	9.8%	6.3%	14.5%
2001	3.5%	11.0%	10.4%	8.5%	14.6%	7.7%	13.5%
2002	2.9%	12.5%	10.1%	8.2%	13.0%	7.9%	13.1%
2003	3.0%	14.0%	7.8%	6.1%	11.1%	6.3%	8.9%
2004	2.7%	11.5%	7.5%	5.3%	11.2%	6.0%	8.3%
2005	3.0%	9.0%	7.4%	7.1%	10.4%	7.1%	4.8%
2006	3.5%	7.5%	7.7%	5.1%	10.3%	7.7%	7.2%

Source: Ginsburg et al. *Tracking Health Care Costs: Spending Growth Remains Stable at High Rate in 2005*, October 2006.

Premiums for employment based coverage and the rates of premium increases have been particularly high in those areas where managed competition does not work well, as there are few or no competing systems. Thus residents of Los Angeles, San Diego and other urban Southern California counties have access to more affordable coverage than do residents of much poorer rural Northern California and Central Valley counties.

To some observers, we have entered an era of market failure that cries out for government intervention with strong regulatory reforms. Others call for more effective

[X=0&resourcetype=HWCIT](#); and Ginsburg et al., *Tracking Health Care Costs: Continued Stability But At High Rates In 2005*, Health Affairs Web Exclusive, October 3, 2006.
www.content.healthaffairs.org/cgi/reprint/25/6/w486?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=hospital%2C+prescription+drug+costs&andorexactfulltext=and&searchid=1&FIRSTINDEX=20&resourcetype=HWCIT

market competition, better, more transparent, more usable information on price and quality and greater exposure of consumers to the cost consequences of their health care decision-making.

Impacts of rising health prices on the mix of public and private payors

Conventional wisdom is that employment based coverage is declining due to rising prices. This may not be true in California over the past decade as the employer offer rate increased relative to the rest of country. Over the past decade, California's rates of private coverage increased for the first five years and then fell for the past five. California HealthCare Foundation (CHCF) studies show that the percentage of Californians with private health insurance was constant during the period from 1995-2005. From 1995-2000, the rates of employment based coverage increased in a very healthy economy, then during the time frame 2001-2005 (when income and wage inequities worsened), private coverage declined, ending up about where they started.⁸⁹ However, the make-up of employment based coverage shifted with young workers, low wage workers and family coverage experiencing declines in employment based coverage. Most of the decline in employment-based coverage for children over the past five years shifted to growing shares of California children with public coverage and small increases in private individual coverage leading to an over-all decline in the numbers of uninsured California children.

CHCF studies found that California employers' rate of offering coverage (67%) has not declined during this time frame and now significantly exceeds the national average where previously California employers were well under the national average.⁹⁰ The two thirds of employers who do offer coverage employ nearly 90% of all California employees.⁹¹

The CHCF study found that employees' take up rates for coverage are higher in California than the national average. Employers are passing through some of their increased premium costs to employees in the form of increased employee co-insurance premiums, co-pays and deductibles. Employees' share of premiums has grown from 10 to 13% of the premium for individual coverage and from 23 to 29% of the premium for family coverage. However California employers still pay a higher share of coverage than

⁸⁹ California Healthcare Foundation, California Employer Health Benefits Survey 2005. <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=117114>, California HealthCare Foundation, Snapshot: Individual Health Insurance Market 2005. <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=117115>; and Buntin et al., The Role of Individual Health Insurance Market and Prospects for Change, Health Affairs, Vol. 23, No. 6, November/December 2004. <http://content.healthaffairs.org/cgi/content/abstract/23/6/79>

⁹⁰ California Healthcare Foundation, California Employer Health Benefits Survey 2005. <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=117114>

⁹¹ *ibid.*

their national counterparts.⁹²

Slowing soaring Worker's Comp premiums (driven in large measure by health care costs) have historically been the highest priority for small businesses particularly in the construction and manufacturing sectors. As a result of recent reforms, these premiums have been dropping for the past several years.⁹³ Small employers' current number one concern is the rising cost of their health insurance premiums.⁹⁴

There are also concerns that manufacturing jobs are moving out of the country due to the high and growing burden of health care costs on employers who must compete in the global marketplace.

The stop-gap solution to the cost crisis in private coverage has been to increase employee cost sharing and offer less coverage with higher co-pays and deductibles. Employees and individuals are now paying more and more out of pocket, and their out of pocket costs are growing faster than their wages and incomes. It should be emphasized, however, that consumer out of pocket spending pays for a declining share of over-all health spending; in other words, the burden of growing health costs falls even more heavily on the state and federal governments and insuring employers than it does on individuals. Employers believe that none of the current array of cost control techniques are very effective and in default of any other solution, they plan to continue increasing their employee's share of premiums while searching for a better solution.⁹⁵

There is concern that the strategy of shifting costs to employees is inspiring low wage employees to drop employment-based coverage and switch to public coverage where available. The loss of employment-based coverage appears to be most pronounced for dependent coverage. Anecdotally, ITUP's regional workgroup participants report low wage working families are responding to increased co-insurance requirements for employer sponsored private insurance by dropping their employer coverage for dependents to enroll their children in Healthy Families.

Some propose insulating consumers from the impacts of increased out of pocket costs by increasing their access to tax deductibility for their out of pocket health spending and for their purchases of individual coverage. As discussed earlier, the benefits of tax deductibility primarily inure to higher income families; this dampens the impacts of higher

⁹² *ibid.*

⁹³ State of California, Department of Industrial Relations Division of Workers' Compensation, A Study of the Effects of Legislative Reforms on California Workers' Compensation Insurance Rates, January 2006. http://www.dir.ca.gov/dwc/Study_legislativeReformsCaWCInsuranceRates/Study_legislativeReformsCaWCInsuranceRates.html

⁹⁴ Hopkins, Putting a Band-Aid on Small Firms' Health Costs, USA Today, April 19, 2006.

⁹⁵ California Healthcare Foundation, California Employer Health Benefits Survey 2006. www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480

copays and deductibles in decreasing utilization among higher income families, gives little relief to lower income working families and would further increase federal budget deficits.

The following options are meant to encourage our informed dialogue and to develop a consensus on cost controls without which no reform is likely to pass and be signed. California's policy-makers choices are to improve the market, to increase regulatory controls or to enact some combination of market reforms and regulatory controls.

COST CONTAINMENT OPTIONS

Market based reforms	<i>Information on provider and plan prices and quality</i>	<i>Purchasing pools for small, mid sized and individual purchasers</i>	<i>Standardized basic benefits (Just Coverage) and pricing</i>	<i>Bulk, competitive purchasing of drugs and medical supplies</i>
Regulatory reforms	<i>Hospital rate regulation in regions without competitive markets</i>	<i>Medical underwriting reforms (guaranteed issue and renewal) of minimum basic benefits for mid sized and individual purchasers</i>	<i>Information on treatment effectiveness and cost benefits of medical treatments</i>	<i>Reform in cost sharing burdens for low wage employees</i>
Reforms common to both	<i>Electronic medical records</i>	<i>Emphasis on wellness and prevention</i>	<i>Reshaping health plan and provider reimbursements and incentives</i>	<i>Chronic disease management</i>

MARKET-BASED REFORMS

California's History of Market-Based Reforms

In 1982, California embraced price competition and provider contracting as the antidote to rising health care costs, and competition did restrain cost increases in the public and private sectors for about five years. In 1992, California embraced managed competition as the cure-all to double-digit health inflation. This too had a five-year window of driving down costs. However a combination of hospital and plan consolidations, medical group failures and the public rejection of HMOs led to a weakening of plans' negotiating leverage and incentives and a renewal of health inflation. What can be done to reinvigorate market based cost controls?

Quality and effectiveness evaluations⁹⁶

This would allow consumers and plans to get a better look at and more accurate assessment of the quality and effectiveness of medical care, new technologies and prescription drugs. These evaluations would be independent of the marketing claims of the promoters.

Who makes these assessments? Should it be payors and providers who have financial interests in the outcomes, or should it be academic medical experts and independent researchers, who may have less at stake in the outcome and conceivably less accountability to the public's competing interests in the results of these assessments?

Transparency of price, cost and quality information⁹⁷

This would improve the information on price and quality available to consumers and employers, plans and providers. The first step is to more widely disseminate and better organize the information that is available. Surprisingly little information about health plan prices is distributed by state agencies to the public except under the auspices of brokers or plans. The Department of Managed Health Care and Department of Insurance have and could readily post health plan prices.

Little information on comparative hospital and clinic costs is distributed to consumers although some of this information is collected and reported by OSHPD. Provider billings and health plan responses are nearly indecipherable and frequently inexplicable to ordinary consumers. Hospital charges are an accounting fiction; typically four times hospital costs and provide no useful information.

⁹⁶ Wilensky, Developing a Center for Comparative Effectiveness Information, Health Affairs Web Exclusive, November 2006. <http://content.healthaffairs.org/cgi/content/long/hlthaff.25.w572v1/DC1>; and Rowe et al., The Emerging Context For Advances In Comparative Effectiveness Assessment, Health Affairs, November 7, 2006, Web Exclusive. <http://content.healthaffairs.org/cgi/content/abstract/25/6/w593>

⁹⁷ Office of the Health Insurance Commissioner, Transparency in Health Care: Lessons from Other States, 2006. www.dbr.state.ri.us/divisions/healthinsurance/; and California HealthCare Foundation, Price Check: The Mystery of Hospital Pricing, December 2005. www.chcf.org/documents/hospitals/PriceCheckMysteryHospitalPricing.pdf

Little published information is available to consumers on provider fees; state government, federal government and health plans could and should make this information available to consumers. The federal government and one health plan (Aetna) have started this process.

Quality information is being developed and collected by government, plans and employers. It needs to be widely available and disseminated in consumer useable formats.

The second step is to improve the information on quality and price. Physician information needs to be collected and distributed. The quality information, to be meaningful, must be adjusted by the severity of a patient's conditions and be tracked over a period of time and needs to identify those providers with superior and poor outcomes.

Hospital and physician charges have become primarily an irrelevant accounting artifact - an outmoded measure, paid by only a very small percent of the population. Patients/consumers need a realistic, easily available list of providers' real fees and prices.

Disclosure of and/or restrictions on premium/benefit ratios⁹⁸

How much of your premium(s) goes toward health benefits and how much towards non-benefit costs? The figure is highly variable between plans and highly relevant in deciding what plan to purchase, and it ought to be routinely disclosed to potential purchasers. Comparative information could be readily compiled and disclosed by the state's regulatory agencies. Administrative costs can be substantially reduced in the context of an individual or employer mandate. The Governor proposes caps on administrative expenses to give plans and providers incentives to maximize health benefits for their subscribers and patients.

Chronic disease management

The bulk of health plan expenses in a given year are from a small percentage of individuals (70% of health costs are attributable to 10% of individuals).⁹⁹ Some are individuals with singular events such as severe accidents, and some are individuals who are chronically ill (whose expenses are likely to be recurring). One response to rising costs is to better manage the cost of care for and improve the health status of individuals

⁹⁸ The major reform proposals call for limiting plan and hospitals' non-benefit costs to not more than 15% of premium or payment. Non-benefit costs for large self-insured plans can be as low as 5% of premium. Administrative costs in the small employer and individual markets are much higher due in part to selling and underwriting costs that can be reduced in the context of an individual or employer mandate.

⁹⁹ Berk and Monheit, The Concentration of Health Care Expenditures, Revisited, Health Affairs, Vol. 20, No. 2, March/April 2001. <http://content.healthaffairs.org/cgi/content/abstract/20/2/9>

with chronic illnesses. Better information, incentives and techniques could improve health outcomes and reduce costs.

Plans and capitated providers experience significant savings from improved care management. Unless provider and plan financial incentives are aligned, the savings for one party may be at the expense of reduced income for the other party. In addition, the financial savings from improved health and functioning may inure to another plan or provider group. There is a need to combine chronic disease management with a careful rethinking and retargeting of provider compensation.

Preventive care

Preventive care such as early and timely prenatal care or dental sealants for children can produce long-term health savings. The savings are long term and therefore typically do not inure to the plan or provider paying for or delivering the coverage and services in the first instance. Some preventive services are efficacious only for specific sub-populations.

While health plans are ranked in quality assessments based on their efficacy in delivering some preventive services, the actual delivery network is far removed from and not necessarily responsive to plan administration. Plan and provider compensation need to be reworked to financially reward and penalize those networks that have demonstrably excellent and inadequate delivery of preventive care.

There also needs to be a respected statewide repository for studies on the extent and impacts of prevention, with particular attention to variations by plan, provider network, region, and ethnic and income distribution.

Lifestyle and personal responsibility

There is wide recognition that lifestyle choices such as smoking, over-eating and substance abuse affect health costs and little agreement on how to combine societal messages, with corporate and individual responsibility for the increased health costs and risks. We need a system redesign that delineates the best roles and proper incentives for employers and individuals, for plans and providers to improve health status. Should smokers pay higher premiums and how much should smokers benefit (in reduced premiums) if they cease smoking?

24-hour coverage¹⁰⁰

For over 15 years, there has been an interest in merging health coverage with the health component of workers compensation to create 24-hour coverage; pilots have been authorized but none have experienced signal success.

The operational difficulties are that worker's compensation is 100% employer paid, first dollar, fee-for-service coverage with a heavy reliance on a network of industrial medicine practitioners while health insurance involves a very different managed care network of providers and a share of costs borne by the employee(s). Furthermore worker's compensation insurers and the health plans operate very differently.

Possible options to make 24-hour coverage work more effectively are: complete merger (the Garamendi proposal), partial merger (with the health plan operating all aspects of health coverage but under different rules) or the use of managed care for worker's compensation health networks.

Standardized scope of benefits and managed competition¹⁰¹

Professor Alain Enthoven and others have proposed managed competition in which providers and plans would compete on the basis of price and quality. This requires a standardized scope of benefits, transparent information on prices and quality, competition among accountable provider networks and pricing differentials for employee choice of plans and/or networks.

The current market has few of these features. Many plans now have broad and loosely managed networks of care in response to the consumer revolt against HMO excesses of the 90s; the Enthoven approach requires a return to narrow, tightly managed networks.¹⁰² Health coverage should be restructured to make this theory more of an operational reality with tiered co pays indicating the respective price and quality differentials.

¹⁰⁰ Kominski et al., Evaluation of California's 24-Hour Coverage Pilot Demonstrations, UCLA Center for Health Policy Research, November 2001.

http://www.healthpolicy.ucla.edu/pubs/files/DWC_FinalReport_112001.pdf; and Farley et al., Assessment of 24-Hour Care Options for California, RAND, 2004.

http://www.rand.org/pubs/monographs/2004/RAND_MG280.pdf

¹⁰¹ Enthoven and Tollen, Competition In Health Care: It Takes Systems To Pursue Quality And Efficiency, Health Affairs Web Exclusive, September 7, 2005.

<http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.420v1>; and Enthoven, Sustaining a Market Based Healthcare System, Healthcare Financial Management Association, Vol. 58, No. 7, July 2004.

http://chppcor.stanford.edu/publications/sustaining_a_marketbased_healthcare_system/

¹⁰² Mays et al., Market Watch: Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies, Health Affairs Web Exclusive, August 11, 2004.

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.427>

Income adjusted models of cost sharing¹⁰³

Pitney Bowes developed this cost sharing model. It adjusts employee cost sharing (including premiums, co-pays and deductibles) to an employee's wages and creates incentives for the chronically ill to use appropriate services. The net effect is to re-configure cost sharing burdens; low wage workers pay less out of pocket than they would in traditional commercial coverage. We strongly encourage expansion of this model.

In low wage firms, workers typically pay a larger share of the health premiums.¹⁰⁴ On average, low-wage workers now pay over 300% more for their share of health premiums than do higher wage workers (4.2% vs. 1.2% of wages). Low wage workers earning less than \$15 per hour pay over a third of the health insurance premiums for their family coverage while higher-wage workers pay slightly less than a quarter of their family premiums.

Consolidate care in centers of excellence¹⁰⁵

Centers that provide the largest volumes of particular services often experience a learning curve that allows them to provide more efficacious, higher quality, lower priced care for particular conditions. Some trauma center and transplant teams describe this as "learning to dance." California has experienced particular problems with hospitals that perform too few procedures to maintain high quality – an issue highlighted in recent transplant scandals at distinguished California facilities. Consolidating care in centers of excellence can also freeze out new competitors and reduce the incentives that produced excellence in the first instance.

California has lost existing trauma centers and emergency rooms due to the financial losses for the centers and physicians on call. California may need to consider enhanced licensure responsibilities combined with restructured payments to assure an adequate and well-distributed supply of high quality centers of excellence.

Bulk purchasing of drugs and medical supplies ¹⁰⁶

Bulk purchasing allows aggregated buyers to secure a big purchaser discount, which can be quite substantial, but as the recent Congressional debate clarified the large

¹⁰³ Benefit Based Copays in the Real World: the Employer Perspective, American Journal of Managed Care, Vol. 12, No. 13, November 2006.

http://www.ajmc.com/files/articlefiles/A166_Nov06BenefitS353to58.pdf

¹⁰⁴ U.S. Bureau of Labor Statistics (BLS), 2006 Survey of Benefits, <http://www.bls.gov/ebs/>

¹⁰⁵ Birkmeyer et al., DataWatch: Will Volume-Based Referral Strategies Reduce Costs Or Just Save Lives, Health Affairs, September/October 2002. <http://content.healthaffairs.org/cgi/content/abstract/21/5/234>

¹⁰⁶ Legislative Analyst's Office, Lowering the State's Costs For Prescription Drugs, February 2005. www.lao.ca.gov/2005/prscrptn_drugs/prscrptn_drugs_021005.htm

potential savings are directly related to the ability to exclude drugs from the formulary whose manufacturers will not negotiate fair prices. VA, Kaiser, large public hospital systems, and community clinics secure these discounts-individual consumers do not. Bulk purchasing will require infrastructure and purchasing expertise; it may also require restricted formularies and/or sharply tiered copays for the successful bidders.

Another option is reference pricing which could set reimbursement prices for a range of interchangeable drugs at the price of the lowest.

Consumer directed health plans, HRAs and HSAs¹⁰⁷

The insurance market and federal government policy makers have supported the growth of consumer driven health plans, HRAs and HSAs to slow rising costs. Employers' response has been to slowly increase the rate of purchasing high deductible plans, but typically without an accompanying HSA or HRA.¹⁰⁸ High deductible plans are growing in popularity for self-employed professionals. Consumer directed plans have not yet been accompanied by strong transparent information on price and quality differentials among providers to allow for informed patient decision-making.

The evidence to date shows a small degree of risk selection by healthier populations and cost savings of up to 15% through reduced utilization. The research to date shows that reduced utilization is highest for the plans without an accompanying HAS where subscribers are exposed to the greatest risk out of pocket spending.

High wage workforces which have the disposable income to take greater financial risk for their own coverage and the ability to negotiate with providers may be an appropriate market for these products. These plans may not offer the right coverage model for low income workers who 1) need the access to providers offered by low deductible and co-pay plans and 2) may not use health care services to same degree as higher income persons.¹⁰⁹

REGULATORY REFORMS – APPROACHES TO MARKET FAILURE

Expansion of underwriting reforms and purchasing pools and

¹⁰⁷ Buntin et al., Consumer-Directed Health Care: Early Evidence About Effects on Cost And Quality, Health Affairs Web Exclusive, Vol 25, No. 6, 2006. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w516>; and Fronstin and Collins, Early Experience With High-Deductible and Consumer-Driven Health Plans. The Commonwealth Fund, December 2006. <http://www.cmwf.org/>

¹⁰⁸ California Healthcare Foundation, California Employer Health Benefits Survey, 2006. <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480>

¹⁰⁹ The Tomás Rivera Policy Institute, Research Synthesis: Health, Consumer-Driven Health Care: Early Research Findings Provides Some Answers, But Biggest Questions Remain, April 18, 2006, Number 3.

establishment of a minimum benefits package¹¹⁰

Some suggest expanding the existing underwriting reforms for small employers (guaranteed issue, time limits of pre-existing condition exclusions, guaranteed renewal and rate bands) to mid sized employers and the individual market. This would improve market transparency and reduce carriers' efforts to compete on the basis of risk selection and increase their incentives to better manage the costs of high cost subscribers.¹¹¹ It would change the market, but would it reduce costs?

A number of health plans have exhibited such marked enthusiasm for their medical underwriting, termination and exclusion policies in the individual market that the state is cracking down on plans' underwriting excesses and consumer lawsuits are spreading.¹¹² The health plans defend their practices as necessary to keep prices affordable for healthy individuals. The state purchasing pool for the medically uninsurable (MRMIP) has had no increase in its \$40 million state subsidy since its initial funding over 15 years ago. Health plans assisted the pool by supporting legislation and agreeing to take on responsibility for the medically uninsurable that had been in the MRMIP plan for three years. This measure sunsets in 2007. California needs to either 1) make it the responsibility of health plans to fund the medically uninsurable (as many other states already do), or 2) it needs to adequately fund the pool with state tax revenues.

Some carriers contend that underwriting reforms would increase premiums by adding persons now priced or underwritten out of the market due to their risk profiles. Carriers particularly warn against adverse selection and the potential for cost increases in the individual market by adding in high-risk individuals now without coverage due to their risk profiles. There are many low risk, low cost uninsured that would enter the market if prices fell, mandates were imposed or premiums subsidized. Without such reforms, low risk insured exit the market as premiums increase more than their incomes. Policy makers should consider which plans and which elements of the private market are enrolling the very healthy young low risk uninsured and which are enrolling the older, chronically ill, medically uninsurable uninsured and assure that payments are adjusted to compensate for adverse risk enrollment.

¹¹⁰ Each of the three major proposals has a variant of this reform. All have purchasing pools and reforms in medical underwriting exclusions of the medically uninsurable. Individual or employer mandates make no sense without a reform that assures that all impacted by the mandate are guaranteed access to coverage at a non-discriminatory price. Senator Perata's proposal would standardize but not prohibit medical underwriting, cover the medically uninsurable through MRMIB, the state purchasing pool and assess all plans a surcharge to pay for the subsidy needed to cover all the medically uninsurable through the pool.

Massachusetts and Vermont are consolidating their individual and small employer markets as part of their reforms. None of the three California proposals is clear on whether the individual and small employer markets would be merged.

¹¹¹ Aspects of this reform are in the Governor's, Speaker and Senate President's plan. Senator Perata's plan includes an assessment on all health plans to fund the high-risk pool for the medically uninsurable operated by MRMIB.

¹¹² Girion, Healthy, Insurers Don't Buy It, Los Angeles Times, December 31, 2006, and Some Carriers Deny Coverage Based on Occupation, Los Angeles Times, January 8, 2007.

Recently PacAdvantage, the small business purchasing pool, discontinued operations as its contracting plans had increasingly become the dumping ground for the worst small employer risks.¹¹³ Among the issues contributing to its demise were the ability of plans to operate underwriting and pricing differently in and out of the pool and the inability of the pool to attract a growing number of subscribers. This highlights the risk of adverse selection for purchasing pools even in reformed markets.

Premium regulation¹¹⁴

Health plan premium regulation has been suggested, particularly for individual and small employers who have weak bargaining positions and no realistic options to self-insure. Rate regulation in California applies already to certain types of insurers (such as auto) with salutary effects in decreasing premium increases. States such as Pennsylvania and Massachusetts regulated health insurance premiums for individuals.

The critiques of general rate regulation are that it inhibits innovation and is typically captured over-time by the regulated industry. The critiques for health insurance rate regulation in particular are that it does not control the underlying cost drivers – provider prices and consumer utilization. At this time, hospital, physician and drug costs and health plan premiums are all equally out of control.

The appeal of rate regulation results from the high compensation of certain health plan executives, high plan profits and low payout of health benefits combined with spiraling premiums. In other words, plans and their top executives are not succeeding at their underlying task of controlling costs and premiums for the payor, yet are substantially profiting from their inability to control rising costs. Profits are and should be a marker of the plan's success in controlling rising health costs, but ought to be shared with employers and employees by markedly reducing plan premiums. Insurance Commissioner Garamendi used the bully pulpit and the inherent powers of the Commissioner to assure that the Workers Compensation reforms were implemented and the savings passed through to the payors.

Western European countries have been very successful in applying budget or expenditure caps to lower uncontrolled health care spending with or without the mediation of insurers. Health plans may need additional authority and techniques to control health spending for this approach to be successful in California. Budget or expenditure caps are a blunt instrument that applies equally to the most and least efficient plans and providers. To be successful, there needs to be flexibility to adjust for

¹¹³ Grgurina and Lee, Pacific Health Advantage (PacAdvantage) Closure of Insurance Operations, August 2006. www.pacadvantage.org/documents

¹¹⁴ Families USA, Understanding How Health Insurance Premiums Are Regulated, September 2006. www.familiesusa.org/assets/pdfs/rate-regulation.pdf; and Sood et al., Should California Regulate Health Insurance Premiums, California HealthCare Foundation March 2004. <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=81373>

the migration of risks between plans since those plans most successful at the fine arts of medical underwriting may shift risks to those plans least successful in avoiding the most costly individuals.

Hospital rate regulation

After a period of cost quiescence, hospitals have re-emerged as a major driver in the nation's escalating costs. Some of the rise in hospital costs is the result of external factors: seismic upgrades, nursing shortages and tighter nurse to patient ratios. Elsewhere, hospitals are merging to gain local market control and become stronger bargainers with managed care plans. In some communities, there is a single hospital and no competitors. In others, the newly merged systems are dominant, while in still others healthy competition prevails.

Hospital rate regulation was in place in a handful of major states, such as New York, Maryland and Massachusetts throughout the 70s and 80s. California tried but was unable to enact rate regulation in the late 70s and early 80s and then did a 180-degree turn to enact hospital competition in 1982.

Rate regulation was abandoned everywhere but Maryland in favor of market competition. Rate regulation provides hospitals the security of a set rate of return and little incentive to change; however competition when successful is far more dynamic in changing the market norms. Rate regulation has had a history of success in Maryland.¹¹⁵

It may be time to re-think rate regulation for local California markets where competition has failed to constrain costs. Based on the research for our regional workgroups, competition appears to be still working well to curtail hospital and health costs in Los Angeles, Sacramento and San Diego, but is not working at all well in the rural areas of the North, Central Valley and Central Coast. In these markets, California should consider all payor rate setting, which could also eliminate or constrain the cost shift from public to private payors for uncompensated care of publicly insured patients.

Certificate of need (CON) for capital expenditures

Certificate of need was a 1970's construct to slow the medical arms race for new expensive and underused technology that was escalating hospital costs.¹¹⁶ Hospitals must secure the approval of local health planners before investing in capital expenditures above a certain dollar figure. It was abandoned in California as part of the 1982 market reforms, but continues with some effectiveness in other states.¹¹⁷

¹¹⁵ McDonough, Tracking the Demise of Hospital Rate Setting, Health Affairs, Vol. 16, No. 1, January/February 1997. <http://content.healthaffairs.org/cgi/reprint/16/1/142.pdf>

¹¹⁶ Simmons, Hospital Planning: What Happened to California's Certificate of Need Program, California Research Bureau, August 2006.

¹¹⁷ California Research Bureau, Hospital Planning: What Happened to California's Certificate of Need

The case for CON is that it acts when markets do not work effectively to slow capital spending on questionable projects. The counter is that the process is costly and political and ultimately slows dissemination only at the margins.

As a contrast of the outcomes of the two systems, New York's Hospital Commission just recommended the closure and consolidation of a number of facilities with low bed occupancy in areas of excess capacity.¹¹⁸ California has the opposite problem: several large hospital systems are closing emergency rooms and facilities in urban areas of high and unmet medical needs, but low profitability, while others are building extremely expensive new facilities in communities with the right payor mix.¹¹⁹

As the state is a large funder of hospitals and hospital construction, the state should not be a passive bystander in terms of where facilities are located but rather should place high priorities on funding and locating new services in medically underserved areas.

More neighborhood health and wellness centers

Wellness and preventive care can be the keys to a healthy population. Together they have the potential to help slow the growth in the nation's health costs. Private markets will not locate wellness and public health centers in neighborhoods with many uninsured and low-income residents as the residents lack the disposable income to purchase the services out of pocket. County governments for the most part triage their finances to support emergency services where the prevention of death and cure of sickness is far more immediate and concrete; many counties do not make a high priority of wellness and preventive care for the uninsured and low-income communities.

Investments in prevention and wellness have long-term savings, but not immediate payoffs. Wellness will require sustained, long term, targeted public and private investment with constant reassessments of the effectiveness of those investments.

Program, Simmons, Charlene, August 2006. <http://www.library.ca.gov/html/statseg2a.cfm>

¹¹⁸ The Commission's report is available at www.nyhealthcarecommission.org. A summary compiled by the Business Council is available at www.bcnys.org/whatsnew/2006/1129bergersummary.pdf.

¹¹⁹ Engel, Los Angeles County Officials Concerned about Closure of Emergency Services at Centinela Medical Center, Los Angeles Times, October 15, 2006; Engel and Trounson, UCLA Seeks Extra Funds for Hospitals, Los Angeles Times, November 14, 2006. <http://www.latimes.com/news/local/la-me-ucla14nov14.1.436833.story?coll=la-headlines-california>; and Kogan, The Battle Over Hillcrest, Voice of San Diego, January 17, 2007 at <http://www.voiceofsandiego.org/articles/2007/01/02/news/03hillcrest.txt>

Electronic medical records¹²⁰

There appears to be bi-partisan agreement on the need for and value of electronic medical records (EMRs), including a consensus that over the long term, it will reduce costs and improve the quality of medical care provided. However EMRs will be costly to develop. The areas of dispute are who owns the information, who can access it for what purposes and who should pay for the not insignificant costs of implementation. We believe that the patients ultimately own the information; it is accessible to the patients, their treating providers and the health plans paying for their treatment. The implementation costs should be spread broadly among all public and private payors in proportion to their shares of enrollment.

RESHAPING INCENTIVES: THE DELIVERY SYSTEM

The health care we receive is a function of the system we design and fund. For example, if we compensate adequately for back surgery and hardly at all for physicians' advice to exercise in particular ways to strengthen the back, we will get more back surgeries. Plan and provider incentives need to emphasize the best health outcomes and delivery systems for the population covered.

Autonomy vs. a public service model

A public service model includes water and sewage, police, fire, and education. Some health care, such as public health, follows the public service model.

Most health care is a complex, bewildering mix of public and private, profit and not for profit roles, incentives, payors and institutions. Plans and health providers understandably want better reimbursement and less government regulation/oversight. But what happens when the public safety is imperiled by hospital, plan and provider conduct as has been in the public eye through local media coverage.¹²¹ It usually appears that the public regulators are the last to know, often after media exposure. Government intervention comes after the crisis and with a heavy hand.

¹²⁰ Policy Issues Surrounding Health Information Technology, Health Affairs, Vol 24, No. 5 (2005): 1221. <http://content.healthaffairs.org/cgi/content/full/24/5/1221>; Hillestad et al., Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs, Health Affairs, Vol. 24, No. 5, 2005. <http://content.healthaffairs.org/cgi/content/abstract/24/5/110>; and Girosi et al., Extrapolating Evidence of Health Information Technology Savings and Costs, RAND, 2003. http://www.rand.org/pubs/monographs/2005/RAND_MG410.pdf

¹²¹ Examples include the crisis in quality and accountability for care at King Drew Medical Center, the scandals surrounding organ transplants at several leading California facilities, the unwarranted terminations of individual coverage by many large health plans.

The tension between provider and plan autonomy and the public service model is keen in the location and composition of hospital care and services. Should hospitals divest themselves of unprofitable services such as emergency rooms or trauma care or leave unprofitable locations in poor neighborhoods or rural communities? Can boutique or specialty hospitals corner the most profitable services? How does/should a hospital's medical and nursing staff collaborate with the hospital's administrators in fulfilling the obligations of the institution? Should government use its roles and authority in licensure and capital construction to assure geographic access to vital health services? What is the government's responsibility to fund unprofitable but essential services or locations?

We would suggest that complete provider autonomy is not an option for vital health services, nor are we likely to conform health care to a public service model. More effective, efficient, consistent and proactive public supervision and oversight is required to replace the heavy-handed, after the fact reaction to scandal and crisis.

ERs and trauma services

Emergency rooms and trauma centers have been closing due to the concentration of uncompensated care to the uninsured in that particular hospital service. When trauma centers and ERs close, both the BMW driver in a freeway accident and the homeless gun shot victim are imperiled.

California's state and local governments and voters have responded with large increases in funding for hospitals' emergency and trauma services, and yet vital facilities continue to close. The large increases in federal, state and local funding made available to hospitals for emergencies are completely disproportionate to the very limited funding available for primary care and preventive services to the uninsured, resulting in a distorted and badly imbalanced delivery system.

We recommend that policy makers consider making a condition of licensure that all general hospitals above a certain bed size and in key locations must operate an emergency room unless exempted for good cause and that hospitals offering the requisite specialty services must have a trauma center unless exempted for good cause. The state's corollary obligation is to use its federal and state funding to adequately support essential emergency and trauma services for all Californians. These are vital public services, not market commodities to be swapped out for more profitable lines of hospital care.

Urgent Care Services

Privately insured, publicly insured and uninsured patients are all using and overcrowding hospital emergency rooms for services that could be delivered through lower cost, after hours urgent care centers. We need to promote and financially support local, accessible urgent care clinics available on weekends and after-hours and to assure they

are open to patients regardless of their ability to pay.

Specialty vs. PCPs (primary care physicians)

The model of access to specialty services upon referral from a primary care physician is the right one and should be promoted, rather than eroded. Primary care physicians need to be more appropriately compensated and reinforced for their significant role in referring to specialists only where medically appropriate.

Location, composition, compensation

Certain locations and demographic patient compositions are more costly and others more profitable than others. Compensation of health plans and providers needs to be better adjusted for the severity, complexity and challenges of care for the populations being served.

COMPENSATION REFORMS

Compensation for health care providers was designed on a piecework basis for some good reasons; health care is a service that is heavily dependent on highly skilled and dedicated professionals. Like airplanes or space shuttles we want quadruple redundancy in health care so we, the patients, do not “crash.” Thus hospitals were paid their reasonable and necessary costs and doctors for their usual and customary charges. Reimbursement was on a piecework basis for each separate procedure, and each was assigned a different value. This created large inflationary incentives that persist to the present day in both the public and private sector programs.

Compensation needs to be adequate and should encourage innovation, quality and excellence without creating an inflationary cycle and expectations. Compensation needs to become far more flexible than the rigid outdated formulas that inordinately reward certain specialties and procedures.

Capitation vs. fee for service; isn't there a 3rd way?

Fee for service creates inappropriate incentives to over-treat and no dis-incentives or penalties for poor quality, high volume services. Capitation arrangements create the opposite incentives to under-treat patients. There needs to be a third way that adjusts compensation to create the right incentives for high quality and cost efficiency. Pay for performance incentives for plans and providers might be the right approach to improve

the quality of care and patient outcomes.¹²²

Quality incentives vs. sticks

The current system relies on heavy, infrequently and erratically applied sticks such as malpractice suits and license revocations to improve quality and patient outcomes rather than developing compensation reforms that reward high quality, dis-incent poor quality and have self-correcting incentives for providers to improve patient's health outcomes, reduce unnecessary costs and steadily increase provider quality.¹²³

Charge inflation

Hospital charges have ceased to bear any reasonable relationship to hospital costs. They have now grown to nearly four times hospitals' real costs. They have become an accounting artifact – a gimmick to maximize hospital reimbursement from a few insurers, not a market price to sell hospital services to patients. A few patients are actually dunned mercilessly to pay hospital charges to preserve this outdated concept. The concept and the noxious billing practices that it engenders occur in both public and private hospitals and should be eliminated in California.

Uncompensated care and the cost shift

In the past, the cost shift to privately insured employers and employees paid for a hospital's uncompensated care to the uninsured. Hospital contracting for public and private patients put financial pressures on hospitals to lower costs, reduce/end the cost shift, and each facility now jury-rigs its own unique solution. Some hospitals (due to their patient mix) are able to switch these uncompensated care costs to public payors -- the Medicare and Medicaid DSH (Disproportionate Share Hospitals) and Safety Net Pool programs. Others have had unique market powers and fortunate geographic placement to resist health plan demands to lower their rates. Still other hospitals had no public or private recourse for their uncompensated care burdens and sought ever more energetically to discourage uninsured patients from seeking care in their institution. We have a patchwork of uneven ad hoc solutions. Several states including Massachusetts, Maryland and New York institutionalized and fairly compensated their financing of the cost shift to pay for uncompensated care to the uninsured.

The old system is broken in California and needs to be replaced. California could

¹²² Sorian, Measuring, Reporting, and Rewarding Performance in Health Care, The Commonwealth Fund National Committee for Quality Assurance, March 2006.
http://www.cmwf.org/usr_doc/Sorian_measuringreporting_912.pdf

¹²³ Fuhrmans, A Novel Plan Helps Hospital Wean Itself Off Pricey Tests, Wall Street Journal, January 12, 2007. http://online.wsj.com/article_print/SB116857143155174786.html

eliminate the hidden tax of the cost shift by covering the uninsured. It could require reductions and rebates in hospital rates and health plan premiums to return the cost shift to the employers and uninsured individuals who pay for it through their premiums. California could quantify and pay rationally for the cost shift as other states already do. A provider tax or fee to fund providers' uncompensated care would be one such solution.¹²⁴

Medical education costs¹²⁵

The health care system pays for the costs of graduate medical education through the Medicare and Medicaid programs but in an incoherent and erratic fashion that over-compensates some and underpays others. Counties with county hospitals often contract with the local medical schools for the services of their faculty, interns and residents to care for low-income patients. Medical education costs are above and beyond the costs for comparable non-academic institutions and benefit the entire society and should be compensated accordingly, rather than creating added financial burdens on the facilities that care for the uninsured. This will require state and federal cooperation due to the over-lapping funding roles of Medicare, Medi-Cal and counties.

Negotiated rates

Rate negotiations shocked hospitals and doctors into a period of controlled health costs; that period has ended. While the contracting model has dynamic potential and rate negotiations still have the flexibility to be successful, its actual performance is now falling far short of its conceptual promise.

While American medicine is over-priced compared to other countries and American health outcomes are trending worse than in other industrialized countries, there remains a strong commitment to quality and technological innovation in American medicine that must be preserved. It is unclear what external events will precipitate change. Some patients are already going overseas or across borders to Canada and Mexico for better-priced care. Some employers are setting up their own on-site medical clinics for their employees.¹²⁶ Some US retailers have begun offering low cost medicines and

¹²⁴ The Governor has proposed a 4% assessment for all hospitals and 2% for all physicians to pay for increased Medi-Cal rates and coverage for the uninsured. Minnesota and Washington State also have such assessments. Their value includes the match between funding growth and demand on program funds.

¹²⁵ Rich et al., Medicare Financing of Graduate Medical Education, Intractable Problems, Elusive Solutions, Journal of General Internal Medicine, Vol. 17, No. 4, April 17, 2002. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1495035>; and Wynnet al., Working Paper: Alternative Ways of Financing Graduate Medical Education, U.S. Department of Health and Human Services, May 2006. <http://www.aspe.hhs.gov/health/reports/06/AltGradMedicalEdu/report.pdf>

¹²⁶ Freudenheim, Company Clinics Cut Health Costs, New York Times, January 14, 2007. http://www.nytimes.com/2007/01/14/business/14clinic.html?incamp=article_popular_4-

insurance.¹²⁷

High tech pricing?

New technology is costly to develop, but unit costs decline as it becomes widely adopted and disseminated. Reimbursement does not rapidly adjust to the decline in unit costs. Some technology is truly revolutionary while others provide modest incremental improvements in treatment. Current pricing rewards the innovator but does not assess or weigh the marginal improvement in patient care. For example, a recent New York Times article on treatments for prostate cancer described three treatments: surgery, radiation seeds and multiple beam radiation therapy.¹²⁸ One procedure is highly profitable for providers and the manufacturer, but costs four times the other two, but provides some increase in patient outcomes. The challenge is to price new technology for its true cost benefits in improved patient care.

ROLE OF SAFETY NETS

Safety nets forever? Safety net as a building block?

Safety nets consist of county operated hospitals, free and community clinics, county operated health plans and for some purposes, private hospitals and doctors with unique missions and locations to care for the uninsured. Many of these hospitals were formed for unique purposes of caring for the uninsured; some are in over-bedded communities and may become redundant in the context of a reform that covers all the uninsured. They will need to evolve and compete on an equal footing, and some will inevitably disappear.

Others are the primary source of care in their communities and may need to expand to accommodate the needs of the newly insured. Many safety net providers have limited working relationships with private sector health plans and private sector providers and if coverage to the uninsured is to be provided through a private model, they will need to develop these relationships. Many have the cultural and linguistic capacities that will make them valued partners.

¹²⁷ CostCo to sell health insurance in California, CBS News, June 12, 2005. <http://www.cbsnews.com/stories/2005/06/12/ap/business/mainD8AM95BO0.shtml>; and Wal-Mart's Low Cost Generic Drug Program to Begin Earlier than Expected, October 10, 2006. <http://www.medicalnewstoday.com/medicalnews.php?newsid=53633>

¹²⁸ Saul, Profits and Questions on Prostate Cancer Therapy, New York Times, December 1, 2006 <http://www.nytimes.com/2006/12/01/business/01beam.html?ex=1322629200&en=e06d47594a765cce&ei=5088&partner=rssnyt&emc=rss>

PRESERVE INTACT OR EVOLVE?

As discussed above, if all the uninsured are covered, safety net providers face an evolution. If the model is public managed care, the evolution is less severe than if the model is commercial or private insurance since almost all safety net providers have either a Healthy Families or Medi-Cal contract. In rural communities, there is neither little public nor much private enrollment in HMOs; the adjustment of rural providers to at-risk managed care contracting will be challenging. We need to recognize that not every public or private provider in every existing site is necessary now, nor will be necessary in their current form a reformed system. There need to be opportunities for safety net transformation, but no assurances that change will preserve ineffective and inefficient care models in the status quo.

Public managed care entities already compete successfully in the markets for publicly insured patients, but are not now participating nor are they well-situated to be competitive in private markets because they lack sophisticated marketing operations to reach employers. They could successfully transition in a transformed market with state purchasing pools, but not in a market heavily reliant on a broad and loyal network of agents and brokers.

SPECIAL PROTECTIONS

Safety net providers have special market advantages in the Medi-Cal and Healthy Families markets. In addition, public hospitals and community clinics have special rates to compensate for their reasonable and necessary costs of treating uninsured and public funded patients. In a reformed system, some of these special protections become obsolete and others make expansion using safety net providers unnecessarily costly. Some will constitute double dipping.¹²⁹

While safety providers would prefer to maintain all existing protections, the reform efforts need to distinguish those protections that remain significant in a reformed system as opposed to those that are obstacles to an efficient reform. For example, safety net providers funding for their care to the uninsured should follow the patients as they enroll in coverage, rather than stay in place as a county or provider windfall. Over time safety net providers need to compete on a level playing field; they have adequate strengths in the form of linguistic and cultural capabilities, key locations, capital investments and dedicated staff to do so.

¹²⁹ The Governor has proposed to transition about \$2 billion in county and DSH funding to pay for care to the uninsured. The state would take responsibility for nearly 85% of the uninsured and take only half the funding.

Funding

Clinics and public hospitals have special funding arrangements with the federal and state government that are at risk as the uninsured become insured. For example, clinics have federal §330 grants that help pay for their uncompensated care to the uninsured, when the uninsured are insured, clinics cannot retain these funds. Similarly, public hospitals have significant revenues through DSH, SB 1255 and the safety net care pool that pay for their uncompensated care to the uninsured. When the uninsured are insured, hospitals can no longer retain these funds. The state should seek federal waivers as necessary to allow these funds to be used to pay for coverage of the uninsured, rather than returned to the federal government and/or distributed to other states. The Bush Administration's recent budget proposal includes flexibility for states to make these adjustments in the absence of a waiver.

County relationships/governance

County Boards of Supervisors govern public hospitals and public clinics. In some counties, these Boards are not well-positioned to operate medical facilities. Furthermore the public facilities and their staff become enmeshed in county rules and bureaucracies that inhibit their ability to react promptly and effectively to change and impair their ability to compete with private sector providers.

Some counties may wish to turn responsibility to a quasi-public governing authority with the capacity for faster and more effective decision-making. County lines are political boundaries, but medical care is often regional in scope. There ought to be increased authority for public providers and plans to operate and be governed regionally.

Public vs. private

Expansion of public coverage benefits those providers and plans with a major presence in the Medi-Cal and Healthy Families programs. Expansion of private coverage, whether through employers or individual coverage, benefits those plans and providers with major roles in the private market. These are not the same providers.

It is possible to mix and match such that coverage for the low income uninsured is through the public sector while expansion for the higher income uninsured is through private plans. It is also conceivable to defer these decisions to a buying entity such as MRMIB or Cal-PERS that could negotiate for the best combination of price, benefits and access for the uninsured.

POLITICS OF CHANGE

Major change is difficult because the Legislature is little inclined to make one or more major interest group(s) extremely unhappy, because taxes and appropriations require a two thirds vote, each interest group wants an exception and it often takes a huge crisis to propel action. For these reasons, most change is incremental or driven by large breakthroughs outside Washington DC or Sacramento. However, no meaningful and sustained change is possible without momentous decisions from the state and federal government authorizing and directing the nature of change. The necessary changes cannot come from existing private markets or from existing public programs.

We are currently at this crisis moment, not because the numbers of uninsured are growing, but because the price of coverage is exceeding the growth in wages and employers' ability to pay. In short, we may be in a crisis of the insured, rather than a crisis of the uninsured.

Massachusetts, Vermont and San Francisco reforms have captured policy maker's imaginations and could be the spark and building blocks for major health reform. California's Governor, Assembly Speaker and Senate President have introduced proposals that make change possible if we collectively can summon the will and statesmanship to seize this uniquely propitious moment.

Does it take a Third World War or another Great Depression?

War and major economic crisis are two precipitating factors that mobilize the entire society to support major change. The public reaction to the Iraq war could mobilize the forces of domestic reform, or not. Medicare and Medicaid were passed in the unique moments of social transformation.

Bi-partisan consensus

Bi-partisan consensus is conceivable if both parties could agree on a common agenda to expand coverage while controlling costs. While Congress is sharply divided by party lines and unable to develop consensus on major policy issues confronting our nation, local government is more frequently able to muster such consensus. California state government achieved such consensus on a range of important issues in 2006 and could again for health coverage in 2007.

Threading the needle

This approach requires a finely calibrated package that avoids all stakeholders' red lines and enhances everyone's bottom lines slightly. This could produce a very expensive reform.

Stakeholder statesmanship – sharing the pain

Each stakeholder agrees that reform is necessary and sacrifices sufficiently to allow a well-crafted reform to pass.

The fear of change itself

Change is hard enough, but the fear of change can be absolutely paralyzing. Typically opponents of reform exaggerate the adverse impacts to forestall the proposed change.

What's in it for me?

Business and parts of labor want more effective cost controls. Providers want to increase their revenues and profits and would prefer a reform that expands coverage but does not control rising costs. These positions are inherently in conflict. The public wants a thorough reform that makes no negative impacts on their benefits or access to provider's services.

Plans are in the middle of trying to navigate these competing expectations; they have failed to control rising costs of providers and are reducing benefits and coverage to satisfy employers' demands for price restraint. This alienates part of the public, but not yet to the level of the revolt against HMOs of the mid to late 90s.

California, the Golden State

Californians have understandable pride in our state's history at the leading edge of change. As a state, we are now the world's fifth largest economy. As a major port for trade with Asia and Latin America, we impact and are impacted by the explosive economic growth of China, India and other Asian nations. We are a port of entry for immigration from Latin America and Asia. We must maintain our competitive edge by creating health and educational policies that keep California in the forefront.