

California and Health Reform: Some Background Facts

Prepared by Insure the Uninsured Project

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PROJECT**

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Insure the Uninsured Project's (ITUP) mission is to work with state policy makers, counties, health plans, employers, unions, community groups, providers and other public and private entities to increase coverage of California's uninsured.

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Section I: California's Uninsured

In California, the most recent estimates of the numbers of uninsured are 7 million – a significant increase due to the high rate of unemployment during the recession.¹ Most uninsured are younger adults and therefore less costly to cover; 55% of the uninsured are between the ages of 18 and 40.² California's young adults (18-25) have the highest uninsured rate (25%).

Most uninsured cannot afford to pay the full costs of coverage themselves; 61% have incomes of less than 200% of federal poverty level (FPL),³ but some can afford to pay most or all the costs since a quarter have incomes in excess of 300% of the FPL.⁴

There are common misconceptions that most of the uninsured are unemployed, laid off, disabled or seniors, yet nearly 85% are working or the spouses and children of workers.⁵ The majority (54%) are employed full time,⁶ but many of the uninsured fall under the category "flex workforce" and are not readily covered under the employment-based or private individual markets, as will be discussed later. In summary, California's uninsured are predominantly young, low wage workers and family members.

We have a mixed system where some Californians are privately insured, some publicly insured, and others fall through the gaps and are uninsured. Nineteen million (nearly 60% of Californians under the age of 65) have private employer based or individual coverage.⁷ 6.8 million have Medi-Cal coverage and 925,000 children are enrolled in Healthy Families with over 70,000 now on a waiting list.⁸ Four million aged and disabled Californians have Medicare, typically in combination with other public coverage such as Medi-Cal or private Medigap supplemental insurance.⁹

Another common myth links California's uninsured with their immigration status. In fact, 63% of uninsured Californians are US citizens, 15% are legal permanent residents and 22% are immigrants without a green card.¹⁰ On the other hand, undocumented immigrants do have high rates of uninsurance, due primarily to their status as low wage workers in low wage industries with low rates of offering coverage.¹¹ Even when insured, undocumented workers and new immigrants use health care services far less than citizens or long time legal permanent residents – about one third to one half less.¹²

Within California there are wide regional variations in the rates of uninsured, driven primarily by wage and income levels and poverty rates.¹³ The lowest rates of uninsured are in the Bay Area and Sacramento regions; the highest are in the Southern California and \ Central Valley regions -- uninsured by region: Bay Area (9.3%), Sacramento (9.6%), San Joaquin Valley (17.2%), Los Angeles (17.8%).¹⁴

Access to care: Uninsured Californians have very poor access to care as compared to the publicly and privately insured.¹⁵

1. 49% of uninsured Californians report they have no usual source of care.
2. 6% of privately insured Californians report they have no usual source of care.



3. 12% of Medi-Cal insured Californians report they have no usual source of care
4. 12% of Healthy Families insured Californians report they have no usual source of care.

Counting the Uninsured, CHIS vs. CPS: CHIS (California Health Interview Survey) is a California specific survey of health insurance and health status. According to CHIS (2007), about 5 million Californians are uninsured at a point in time and 6.5 million over the course of the year.¹⁶ CPS (Current Population Survey) is a national survey; the 2008 report found nearly 6.7 million Californians are uninsured; this is a point in time response.¹⁷ The high unemployment due to the recession has increased this figure to over 7 million.¹⁸ We believe that CHIS is more accurate for California as it has a larger sample size and its numbers of publicly insured are far closer to the actual administrative numbers than CPS, which appears to undercount enrollment in public programs; however these figures need to be adjusted for the large increase in unemployment since the CHIS survey was last administered.¹⁹ CHIS' on line data interface (Ask CHIS, www.chis.ucla.edu) allows the user to compare health statistics by county and region with in California.



Section II: California's Public Programs

Medi-Cal: There are 6.8 million Californians enrolled in Medi-Cal. The state, county and federal governments spend \$40 billion on the program. California's per beneficiary spending is one of the lowest in the country -- \$2,740 in FY 2006.²⁰ California recently discontinued many services to adults including dental, vision, podiatric and hearing services.²¹ California covers:

1. Parents with incomes up to 100% of FPL.
2. Children with incomes up to 133% of FPL for young children and 100% of FPL for children over age 6.
3. Disabled and elderly with incomes up to 133% of FPL.
4. Pregnant women with incomes up to 200% of FPL for pregnancy-related care.
5. Undocumented immigrants for emergency care and pre-natal care only and
6. Legal permanent residents for standard benefits.

California does not cover Medically Indigent Adults (MIAs) for whom there is no federal financial participation (FFP).

Healthy Families/ Access for Infants and Mothers (AIM): Healthy Families covers children up to 250% of FPL and AIM covers pregnant women and infants up to two years of age and incomes up to 300% of FPL. Healthy Families covers about 925,000 children at a cost of over \$1.2 billion and has a wait list of over 70,000 and growing and may have to start terminating children's coverage in October due to the state's budget deficit.²² Healthy Families covers children who are legal permanent residents and excludes undocumented children. Subscribers choose among multiple competing public and private plans. California does not cover the parents of Healthy Families children although it could receive federal matching funds if it chose to do so.

Medi-Cal managed care models:²³ California uses three different Medi-Cal managed care systems and is scheduled to expand them over the next two years in eight additional counties. County Organized Health Systems (COHS, a single, local, public HMO) cover families, the disabled and elderly in nine large, small and medium sized counties, such as Orange, Santa Cruz, and San Mateo. Two plan models (two competing health plans, typically one local public, one private) cover families in twelve large counties, such as Los Angeles, San Francisco and Kern. Geographic managed care (multiple competing private plans) cover families in two counties, San Diego and Sacramento. Except in the COHS counties, the most costly eligibility categories (such as the disabled, elderly and children with severe medical conditions) are exempt from mandatory enrollment in managed care, but may do so voluntarily. These plans are important community based managed care plans that are potential building blocks to care for the uninsured.

County systems for the MIAs: California's counties are responsible for care to the Medically Indigent Adults (not otherwise eligible for Medi-Cal), including about 1.5 million persons with incomes of less than 200% of FPL. Counties spend about \$1.8 billion on care for this population.²⁴ There are four types of county systems:

1. Provider counties like Los Angeles and San Francisco operate public hospitals and public clinics.



2. Payor counties like Orange and San Diego pay private hospitals, doctors and clinics.
3. Hybrid counties like Tulare and Sacramento operate public clinics and pay private hospitals for their care to the indigent.
4. Thirty-four small counties like Humboldt, Imperial and Marin pool their resources and pay (on a fee for service basis) private hospitals, doctors and clinics for a narrower range of services than Medi-Cal.



Section III: California's Private Coverage

Most of the privately insured have employment-based coverage, and most of the uninsured are workers. Contrary to popular misconception, California businesses have a higher rate (70%) of offering coverage than the national average (63%).²⁵ The majority (60%) of very small employers with 3-9 employees offer coverage; over 83% of small employers with 10 to 50 employees offer coverage.²⁶ Our problem is affordability of coverage for low wage workforces; only 27% of lower wage firms offer coverage in California and virtually all non-offering firms report that price is the key determinant of their decisions.²⁷ What is different about low wage firms? First, the benefits of "pre-tax dollar" purchasing are minimal for these employees,²⁸ and second, health insurance can make up a very large percent of low wage worker's compensation.²⁹

Rising premiums are slowly eroding the state's employment-based system. The price of coverage doubled between 2002 and 2008, and rates of coverage through California's large and small employers shrunk by 4% in the same time frame.³⁰

About 2 million Californians buy individual insurance.³¹ Faced with a steep rise in their own premiums, they are buying ever-simpler coverage.³²

The flex workforce: By flex workforce, we refer to temporary, seasonal, part-time, self-employed micro-businesses and contract workers.³³ They are found in every industry from child care³⁴ to agriculture³⁵ and from real estate and construction to light manufacturing and service industries.³⁶ All have very low rates of coverage through the private employment based system and high rates of uninsured.³⁷ Some flex workers work two and three part-time jobs at a time and others work for multiple employers in serial fashion.

Barriers: Employment based coverage does not work well for them as it is constructed around the model of the full-time, full year, more or less permanent workforce.³⁸ Individual coverage is medically underwritten, more costly for fewer benefits, with high non-benefit costs and low to nil tax advantages (except for the higher income self-employed).³⁹

Solutions: In California, some Taft Hartley trusts (such as SAG, the Screen Actors Guild) and some MEWAS (Multiple Employer Welfare Arrangements such as Western Growers and United Agricultural Plan) have developed industry wide coverage plans that are potential building blocks to cover the flex workforce. The missing link, as with low wage small employer workforce, is access to financing for care to low wage workers.⁴⁰

Underwriting and purchasing pools: In order to improve availability and stability of coverage for small employers, California adopted underwriting reforms and a purchasing pool for small employers with 2-50 employees in 1992.⁴¹ For California small employers, coverage is guaranteed issue and renewal; rates may vary based on age, 4 family sizes and 9 geographic regions, and \pm 10% based on claims experience or medical condition.⁴² This has eliminated the denials, discontinuance notices and rate spikes that plagued this market.



The Health Insurance Plan of California (HIPC)/PacAdvantage was a statewide purchasing pool for small employers; it began as a public pool operated by MRMIB and then transitioned to a private non-profit operated by Pacific Business Group on Health. At its high point it covered 150,000 individuals and initially delivered a strong competitive shock to the market. Over time, adverse selection turned the pool into a non-competitive high-priced, bad risk pool that eventually closed its doors.⁴³

California has far fewer underwriting controls on health plans in its individual market than for small employers; there are no guaranteed issuance of coverage protections and no controls on medical rate underwriting. As a result, denials of coverage, rescissions and other carrier underwriting practices are widely used to deny and sometimes terminate coverage for those individuals with serious illnesses.⁴⁴ For some of those denied coverage, there is a state program, Major Risk Medical Insurance Program (MRMIP), which is California's bad risk pool for the medically uninsurable. Enrollment is quite limited with a waiting list; fewer than 8,000 subscribers participate out of an estimated 170,000 medically uninsurable uninsured.⁴⁵ The pool's problems include severely limited state funding, limited benefits and high cost premiums.⁴⁶



Section IV: Cost containment

California was an early exponent and practitioner of the HMO and price competition models of reducing rising health prices. Its HMO models date back to the '30s with Ross-Loos and Kaiser Health Plan as the earliest pioneers.

Competition: In 1982, California changed state laws to encourage price competition in its commercial markets and its Medicaid program; certificate of need laws governing hospital capital expenditures were repealed.⁴⁷ Several large commercial plans have changed from non-profit to for profit status as have a number of large hospitals.

HMO penetration: Over 50% of insured employees are enrolled in an HMO⁴⁸ and about 50% of Medi-Cal subscribers as well. Many of the state's HMOs have been absorbed/bought by the five dominant health plans. The most costly eligibility categories of the Medi-Cal program are still enrolled in traditional fee for service medicine.⁴⁹

Changes: California has changed from a low priced to a medium priced market in terms of HMO plan prices/premiums.⁵⁰ In 2008, California employer premiums increased at twice the national rate (9.2% vs. 4.8%).⁵¹ Premiums increased four times faster than inflation during the period 2002-2008.⁵² Small employer premiums increased by over 30% more than large employers.⁵³

Regional variations: Competition appears to work and result in lower cost coverage in urban areas, such as San Diego, Sacramento and Los Angeles. However, in rural areas and other regions with a single dominant hospital, competition has not proven a viable strategy to curb high and rising health costs and premiums, and HMOs have been unable to gain a foothold.⁵⁴



Section V: California's Safety Net

California has five different safety net institutions:

1. Best known are the public hospitals in twelve major urban areas, accounting for 12% of the state's hospital beds;⁵⁵
2. Less well known are public outpatient clinic networks in six smaller counties without public hospitals;⁵⁶
3. 875 non-profit community and free clinics deliver primary care and, in some cases, specialty care as well throughout the state;⁵⁷
4. Those private hospitals and their medical staffs located in poor neighborhoods and communities and treating a high share of Medi-Cal and uninsured patients;⁵⁸
5. Thirteen public managed care plans organizing and paying for care in 23 California counties with mandatory managed care.⁵⁹

How much care do they provide? Community and free clinics provide on average 1 visit per uninsured.⁶⁰ Counties pay for roughly 85 inpatient days, 90 emergency room visits and 900 outpatient visits per 1000 uninsured.⁶¹ Public managed care plans have between 60% and 100% of the market share of Medi-Cal managed care subscribers and between 7% and 54% market share of the Healthy Families children in their counties, so some are very successful competitors while others are less so.⁶²

Inter-county variability in funding, access to care and income eligibility is enormous. The community clinic patient visits per uninsured ranges from a low of 0.2 in some counties to a high of over three in others.⁶³ County income eligibility limits for MIAs range from 63% of FPL to 500% of FPL.⁶⁴ County provider networks range from only one community hospital to all the community hospitals in the county.⁶⁵ The volume of county reimbursed inpatient hospital care ranges from a low of 12 days per 1000 uninsured in some counties to over 120 days per 1000 uninsured.⁶⁶ Funding per uninsured varies by a factor of 6:1, depending on two ancient funding formulas and whether the county operates a public hospital.

Uncompensated care: Clinics and Hospitals

Hospitals: In 2006 California hospital facilities provided \$1.7 billion in the costs of bad debt and charity care to the uninsured – about 3.3% of hospitals' net patient revenues.⁶⁷ In addition, hospitals reported \$2 billion in uncompensated care costs to Medi-Cal patients.⁶⁸ As between counties, bad debt and charity care varies from a low of 1% of hospital revenues to a high of over 5%.⁶⁹ In 2006, California hospitals reported net operating losses of \$2 billion – nearly 4% of patient revenues.⁷⁰

Clinics: In 2006, California's free and community clinics provided \$231 million in uncompensated care to the uninsured – about 12 % of their revenues.⁷¹

DSH/SNCP/Private DSH and Supplemental Payments: Disproportionate Share Hospital (DSH) funds are supplemental payments that assist hospitals with unusually high percentages of uninsured and Medi-Cal patients. In 2006, some private hospitals received \$477 million in DSH like payments and \$292 million in supplemental payments to offset



their uncompensated care.⁷² Public hospitals received \$1 billion in DSH and \$578 million in Safety Net Care Pool funds to offset their uncompensated care.⁷³

Initiatives and local infrastructure: Potential building blocks for federal reform

Initiatives refer to county initiatives to cover some of their uninsured. Infrastructure refers to the local safety network, including community clinics, county hospital and public managed care plans.

County initiatives: At one end of the spectrum these include Healthy San Francisco, the WELL program in San Mateo and Basic Health Care in Contra Costa that seek to deliver managed care to the county's uninsured using a network of county hospitals, county clinics and community clinics managed through the local health plan.⁷⁴ These programs have sought to coordinate, integrate and transform the local delivery system. At the other end of the spectrum are initiatives, such as FOCUS in San Diego and SacAdvantage in Sacramento, which sought, through the use of premium subsidies, to increase small employer purchasing using a network of private providers, including non-profit community clinics; these initiatives were also managed through local non-profit health plans.⁷⁵ The latter two initiatives were time-limited pilots to test new designs for covering the uninsured on a small scale. They were unable to find long term financing, or achieve market penetration and were ultimately discontinued and did not create a new model for their communities. Thirty California counties and Kaiser Health Plan have local initiatives for uninsured children known as Children's Health Initiatives (CHIs); most have now frozen their enrollment and have long waiting lists due to their inability to secure long term financing.⁷⁶

Initiative financing: The large initiatives used a mix of county funds and subscriber contributions.⁷⁷ The smaller initiatives relied on philanthropy in the case of San Diego and a small allocation from Sacramento County with a combination of employer and employee contributions.⁷⁸ CHIs rely on a mix of local, public and private philanthropic funding.⁷⁹

Ingredients for success: The prerequisites for these initiatives are a strong committed and collaborative local provider network, dedication to improving care to the uninsured, strong innovative locally based managed care and pioneering county leaders. They need long term stable financing and federal and state flexibility to mix and match the funding streams for the uninsured and eliminate the program silos.

Coverage expansion: The federal government allocated \$180 million annually to finance local coverage expansion initiatives for adults as part of a § 1115 waiver that California received in 2005. The state allocated funds to 10 counties based on competitive grants; each county used different designs, building on local infrastructure and targeted to local needs.⁸⁰ The counties are in the second year of a three-year funding cycle. The pilots ranged from redesigning the delivery system to shift "frequent users" of emergency services into medical homes in Alameda, from improved care management for diabetics in San Diego, to integrating community clinics with the county delivery system in Kern and Ventura, to the wholly redesigned and integrated delivery system discussed above in San Francisco, Contra Costa, Santa Clara and San Mateo.⁸¹



Section VI: Comparison: California to National

California's percentage of uninsured is one of the highest in the nation.⁸² California's enrollment in public programs is well above the national average and its costs per eligible are far below the national average.⁸³ The state has achieved singular success in covering pregnant women (3% uninsured births) and children (6% uninsured).⁸⁴ California's employment based coverage is about average and its costs per subscriber are close to the national norm.⁸⁵ California's enrollment in HMOs is more than twice the national average and its HMO premiums are slightly lower than the national average.⁸⁶

ABX1 1 (Nunez), introduced November 8, 2007 in Special Legislative Session, passed the Assembly on December 17, 2007, defeated on 1-7 vote in Senate Health and Human Services Committee on January 28, 2008⁸⁷

California tried to achieve coverage for all Californians in 2007-08 in a bi-partisan effort led by Governor Schwarzenegger and Assembly Speaker Nunez. The bill was accompanied by a ballot measure scheduled for the November 2008 ballot. The measure was defeated in the Senate Health and Human Services Committee after facing strong opposition from the single payor advocates on the left and the "no new taxes" advocates on the right.

Some of the features were similar to those now being discussed at the national level. It was premised on shared responsibility; all contribute, all benefit and all make the necessary changes to put in place affordable accessible coverage for every Californian.

1. All individuals would be required to enroll in private or public coverage with hardship exclusions for those for whom coverage was unaffordable
2. All employers would be responsible to offer coverage to their employees or pay into a trust fund for their coverage; this responsibility was to be phased in as a percentage of payroll, beginning at:
 - a. 1% for Social Security wages up to \$250,000
 - b. 4% for Social Security wages up to 1,000,000
 - c. 6% for Social Security wages up to \$15,000,000
 - d. 6.5% for Social Security wages over \$15 million
3. Shared responsibility applied to all levels of government: California would have required counties to pay part of the match for covering MIAs residing in their communities. The state would request the federal government to pay a Medicaid matching share for the Medically Indigent Adults (MIAs).
4. Shared responsibility with hospitals: Hospitals had agreed to a 4% provider tax to help pay for half the costs of increasing their Medi-Cal reimbursement to Medicare levels and to help pay for some of the costs of hospital care to the uninsured becoming insured and to a transition of some DSH funds to help pay for coverage of the newly insured.
5. Benefits: California proposed that the Managed Risk Medical Insurance Board, known as MRMIB (the entity that purchases private coverage for the medically uninsurable, pregnant women and uninsured children), would set the minimum



level of benefits, with a strong emphasis on prevention and wellness. California proposed to grandfather all existing forms and levels of coverage for those with insurance.

6. Insurance reforms: California would have required all plans to sell on a guaranteed issuance, guaranteed renewal basis, with variations for age, geography and family size and no pre-existing condition exclusions in the small employer and individual markets. California did not propose to rate band premium variations for those individuals in their 20's. California would have required an 85% minimum loss ratio for all plans.
7. Affordability: California proposed to cover the uninsured up to 150% of FPL through Medicaid (Medi-Cal) and would have covered uninsured children through Healthy Families (CHIP) up to 300% of FPL. California proposed refundable tax credits to the uninsured purchasing through the state purchasing pool (Exchange/Gateways) for individuals whose premiums exceeded a graduated share of their incomes up to 400% of FPL. California proposed to limit balance billing of patients for out of network care.⁸⁸ California would have required employers to offer §125 plans to all employees to maximize the tax advantages of their premium contributions. California excluded undocumented adults from public subsidies as part of its reform proposal.
8. Value purchasing: California would have required cost and quality transparency for providers and plans so that patients, subscribers and payors would have the opportunity to assess which plans and providers afforded the highest value. California would have required pay for performance in its Medi-Cal program and provided standard data and comparable information to all providers, patients and payors. California proposed to limit pool subsidies to lower cost plans; those choosing more expensive plans and benefits would pay the incremental difference – creating managed competition incentives. California would have triggered repeal of reforms if program costs exceeded program revenues, and the state government failed to balance the program's deficit.



Section VII: Recommendations

Observations from ITUP Board and Regional Workgroup participants. ITUP's Advisory Board⁸⁹ meets semi-annually; it discusses and makes policy recommendations on options to cover California's uninsured.

Board Observations:

State level (as opposed to national) exchanges would be more responsive to the needs of the diverse populations in the many different local markets that comprise California.

Payment reforms are essential to make coverage affordable and sustainable for the long term; fee for service needs to be replaced with a payment structure that incentivizes quality, the best patient outcomes and more cost efficient delivery of care.

All the uninsured should be covered with particular attention to developing a new model of coverage for flex workforces, for whom neither the employment-based nor the individual market is working effectively. They should be covered through pools such as the proposed Exchange/Gateways. Reform should assure affordable coverage for legal immigrants by removing the five-year restriction on coverage for new legal immigrants.

Mental and physical health services must be re-integrated; patient care is not being enhanced by carved out services where providers do not communicate and know their patients' physical and mental health conditions and thus cannot operate as the patient's care team.

California has important local building blocks, such as Local Initiatives, County Organized Health Systems, pioneering local safety nets and Children's Health Initiatives, which should be used, expanded and given increased flexibility to increase coverage for the uninsured.

California's state budget has been in dire straits due to the severe national recession and high unemployment, causing severe cuts to the state's health, education and social service programs. Health reform financing should be designed in ways that improve state's fiscal conditions, such as calculating a state's Federal Matching Percentage (FMAP), based on its rate of poverty and adjusting the FMAP to conform to the business cycle and assist states during economic downturns.

Regional Workgroup Recommendations:

ITUP reviewed the proposed federal legislation with workgroup participants in five of the state's regions;⁹⁰ their recommendations were as follows:

1. Phase in coverage for MIAs as quickly as possible.
2. Start with prevention and improve wellness programs and incentives for healthier lifestyles.
3. Adjust the covered benefits to available financing.
4. Assure opportunities for COHS and Local Initiatives to participate in the Exchange.



5. Coordinate coverage for those with Medicare and Medi-Cal (the Medi-Medis). Providers, patients and plans should experience this coverage as seamless and coordinated.
6. Improve consistency and coordination of reimbursement between Medi-Care, Medi-Cal and private insurance so their incentives are compatible.
7. Preserve and enhance consumer choice
8. Improve transparency of information to consumers/patients about plans and providers.
9. Expand HIT to all providers and stop paying for duplicative tests and other redundant services.
10. No federal subsidies for state mandated benefits in excess of the federal minimum benefits package.
11. Assure adequate risk adjustments in and outside of the “Exchange.”
12. Improve/simplify/standardize/computerize billing and claims payment to reduce administrative costs.

Prepared by Lucien Wulsin, Insure the Uninsured Project, August 31, 2009

¹ Jacobs, K, No Recovery in Sight, Health Coverage for Working Age Adults in the United States and California (UC Berkeley Labor Center, April, 2009) at <http://laborcenter.berkeley.edu> Those estimates likely understate California’s numbers as our unemployment has now grown to 11.9 – thirty year high.

² Ask CHIS, California Health Interview Survey, 2007, www.chis.ucla.edu For an excellent recent study, see Brown ER, Kronick, R, Ponce, N, Kinchloe, J, Lavarreda, S, Pecham, E, The State of Health Insurance in California: Findings from The California Health Interview Survey (UCLA Center for Health Policy Research, August 2009) at www.healthpolicy.edu

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ California Department of Health Care Services, Overview of Medi-Cal Beneficiaries by Month January, 2006 to July, 2009 www.dhcs.ca.gov and California Managed Risk Medical Insurance Board, Healthy Families Program: July 2009 Summary at www.mrmib.ca.gov

⁹ CHIS, 2007

¹⁰ 2005 California Health Interview Survey, Health Insurance, the Lack of Coverage and Demographic Characteristics (UCLA Center for Health Policy Research, 2007) at www.healthpolicy.ucla.edu

¹¹ CHIS, 2007

¹² Ku, L., Health Insurance and Medi-Cal Expenditures of Immigrants and Native Born Citizens in the United States, American Journal of Public Health 1322-1328 (July, 2009);



Goldman, D., Smith, J. and Sood, N., Immigrants and the Cost of Medi-Cal Care, Health Affairs (November-December 2006) at <http://content.healthaffairs.org>

¹³ Fox, 2006 Overview of the Uninsured: December 2007 (Insure the Uninsured Project, December 2007) at www.itup.org/reports

¹⁴ CHIS, 2007

¹⁵ CHIS, 2007

¹⁶ Ibid.

¹⁷ US Census Bureau, Current Population Survey, Income, Poverty and Health Insurance Coverage in the United States: 2007 (Department of Labor, August 2008) at www.census.gov. California ranked 7th of the highest uninsured rates.

¹⁸ Jacobs, No Recovery in Sight.

¹⁹ There is a very substantial under-reporting of Medi-Cal (Medicaid) coverage in the CPS data.

²⁰ Overview of Medi-Cal Beneficiaries by Month, January, 2006 to July, 2009; Kaiser Family Foundation, State Health Facts, Medicaid Payments per Enrollee. FY 2006. Costs per disabled and elderly enrollee are closer to the national average than California costs per enrolled child and per adult (other than the elderly and disabled).

²¹ California Department of Health Care Services, Optional Benefits Excluded from Medi-Cal Coverage (May 29, 2009) at <http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom>

²² California Managed Risk Medical Insurance Board, Healthy Families Program: July 2009 Summary and MRMIB, Healthy Families Program Wait List Effective July 17, 2009 at http://healthyfamilies.gov/myhealthyfamilies/hfp_wait_list.aspx

²³ California Department of Health Care Services, Medi-Cal Managed Care at www.dhcs.ca.gov/services/pages/Medi-CalManagedCare.aspx and California HealthCare Foundation, Medi-Cal 101 (2007) at www.chcf.org/topics/medi-cal

²⁴ California counties spend about \$367 per California uninsured as compared to the average premium for employment-based coverage of \$4900; we divided county reported spending by 4.9 million uninsured. Medi-Cal coverage for MIAs was discontinued in 1982-3. See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008) and Dam and Wulsin, A Summary of Health Care Financing for Low Income Californians 1998-2008 (Insure the Uninsured Project, August 2008) at www.itup.org/reports

²⁵ National Opinion Research Center, California Employer Health Benefits Survey (December 2008) at www.chcf.org

²⁶ Ibid.

²⁷ Ibid.

²⁸ The tax benefits of pre-tax purchasing are proportionate to one's tax bracket as a result low wage workers and their employers have comparatively lower benefits from this tax policy. Sheils and Haught, The Cost of Tax-Exempt Health Benefits in 2004 Health Affairs (February 25, 2004) W 4-106 at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1>

²⁹ Average employment based premiums for an individual account for 29% of a California minimum wage (\$8.00 an hour) worker's salary, and average premiums for family coverage would account for 81% of the salary. By contrast, they account for 4.9% and 13.4% of the salary of a worker making \$100,000 annually.



³⁰ Ibid.

³¹ CHIS, 2007

³² Gabel et al, Trends in the Golden State: Small Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet, Health Affairs, (June 2007) at www.chcf.org

³³ Wulsin et al, Developing Models of Coverage for the Flex Workforce (Insure the Uninsured Project, December, 2000) at www.itup.org/reports

³⁴ Pizzitola, Covering Childcare Workers: an Update (Insure the Uninsured Project, June 2009) at www.itup.org/workgroups/childcare

³⁵ Diringer, Health Care for California's Farmworkers (August, 2009)

³⁶ The size of the flex workforce is in some dispute – a mid range of the estimates is 16% of one in six workers. Wulsin et al, Developing Models of Coverage for the Flex Workforce.

³⁷ Ibid. Only 12% of flex workers receive their coverage (if any) through their jobs.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid. See Diringer, Health Care for California's Farmworkers for an update on MEWAs for agricultural workers.

⁴¹ AB 1672 (Margolin) of 1992.

⁴² Oliver and Dowell, Interest Groups and Health Reform: Lessons from California Health Affairs, Spring 1994

⁴³ Grgurina, J., Employer Purchasing Pools: California's Experience, in Friese et al, Rising Health Cost: Employer Purchasing Pools and other Policy Options University of Wisconsin Center for Excellence in family Studies, 2003) at <http://familyimpactsseminars.org> and Wicks, Building a national Insurance exchange: Lessons from California (California HealthCare Foundation July 2009) at www.chcf.org

⁴⁴ Girion, Proposal Would Combat Rescissions of Health Insurance Policies in California Los Angeles Times (June 3, 2009) See also the recent policy brief, Coffman, J. Reforming the Private Insurance Market: Lessons for California (Berkeley Center on Health, Economic and Family Security, August, 2009)

⁴⁵ See Cummings, L., California's High Risk Medical Insurance Program (Managed Risk Medical Insurance Board, June 26, 2008) at www.mrmib.ca.gov The 170,000 medically uninsurable are those uninsured in poor health. See Ask CHIS

⁴⁶ Legislative Analyst's Office, Assessing Recent State Efforts: Health Care for the Hard to Insure (December 2005) at www.lao.ca.gov

⁴⁷ For an assessment of selective contracting, see Zwanziger, Melnick and Bamezai, The Effect of Selective Contracting on Hospital Costs and Revenues, Health Services Research, October 2000 at www.pubmedcentral.nih.gov. Their conclusions were that in highly competitive markets, hospital costs and revenues fell, but in non-competitive or moderately competitive markets, costs and revenues were very little impacted by selective contracting.

⁴⁸ CHCF, California Employer Health Benefits Survey and Medi-Cal 101.

⁴⁹ Only 19% of Medi-Cal spending occurs in Medi-Cal managed care plans. CHCF, Medi-Cal 101

⁵⁰ CHCF, California Employer Health Benefits Survey

⁵¹ Ibid.



⁵² Ibid.

⁵³ Ibid.

⁵⁴ Zwanziger, The Effect of Selective Contracting on Hospital Costs and Revenues. HMO coverage for individuals is the most expensive and least available in rural northern region of California where there is little competition and great resistance to HMOs and most affordable for individuals and small employers in the Southern California region where competition is the strongest. Fox, 2006 Overview of the Uninsured: December 2007 (Insure the Uninsured Project, December 2007) at www.itup.org/reports

⁵⁵ California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008) and A Summary of Health Care Financing for Low Income Californians 1998-2008 (Insure the Uninsured Project, August 2008) at www.itup.org/reports. See also www.caph.org

⁵⁶ To our knowledge, there is no good data source describing the costs and services delivered in these free standing county clinics; they exist at least in Santa Barbara, San Luis Obispo, Santa Cruz, Stanislaus, Sacramento and Tulare; they are vestiges of closed county hospitals. There is no good data on the county clinics in counties with public hospitals either.

⁵⁷ ITUP, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured and A Summary of Health Care Financing for Low Income Californians 1998-2008. See also www.cpga.org

⁵⁸ We identify the two largest providers of care to the county indigent uninsured, Medi-Cal insured, the privately insured and the Medicare insured. Typically, hospitals see a very different patient mix; one set of hospitals treat the highest percentage of Medi-Cal and county indigent while a different set of hospitals care for the highest share of Medicare and privately insured. See ITUP reports on 48 counties under ITUP Regional Workgroups at www.itup.org/workgroups/regionalworkgroups

⁵⁹ ITUP, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured

⁶⁰ Ibid. We calculate clinic visits per uninsured by dividing the clinic OSHPD reported visits by 4.9 million uninsured.

⁶¹ Ibid. There are two separate data sources for this calculation – hospitals' OSHPD reports and counties' MICRS and CMSP reports. By way of comparison, California average utilization figures for adults in an HMO delivery system are 250 days per 1000 and four outpatient visits per year.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ ITUP, A Summary of Health Care Financing for Low Income Californians 1998-2008

⁶⁸ Ibid.

⁶⁹ California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured

⁷⁰ Summary of Health Care Financing for Low Income Californians

⁷¹ Ibid.



⁷² Ibid.

⁷³ Ibid.

⁷⁴ Mannanal, Directory of Local Efforts to Expand Healthcare Access for California's uninsured (Insure the Uninsured Project, January 2007) at www.itup.org/reports and Pizzitola, California's Coverage Initiatives: Year One Challenges and Successes and a Forecast for Year Two (Insure the Uninsured Project, December 2008 at www.itup.org/reports

⁷⁵ Ibid.

⁷⁶ www.cchi4kids.org

⁷⁷ Mannanal, Directory of Local Efforts to Expand Healthcare Access for California's uninsured

⁷⁸ Ibid.

⁷⁹ Diringer and Wunsch, The Future of Children's Coverage in California (The California Endowment, September, 2008) at www.cchi4kids.org

⁸⁰ Pizzitola, California's Coverage Initiatives: Year One Challenges and Successes and a Forecast for Year Two and Espejo, Overview and Update of California's Section 1115 Waiver Coverage Expansion Initiatives (November 12, 2007) at www.itup.org/reports

⁸¹ Ibid.

⁸² See n. 17.

⁸³ Kaiser Family Foundation, State Health Facts. Medicaid Enrollment as a Percent of Population and Medicaid Payments Per Enrollee. In 2006 California ranked first in enrollment as a percent of population and 50th in Spending Per Enrollee. These figures are somewhat deceptive as California's nursing home care spending is particularly low and there is wide variation in spending per eligible based on beneficiary category as discussed in n. 20.

⁸⁴ Managed Risk Medical Insurance Board, AIM Fact Book 2002 at www.mrmib.ca.gov About 4% of children 0-4 are uninsured, 4.8% of children 5-11, 7.2% of children 12-14 and 6.3% of children 15-17. Ask CHIS at www.chis.ucla.edu

⁸⁵ CHCF, California Employer Health Benefits Survey

⁸⁶ California's HMO premiums are just below the national average while PPO and POS premiums are well above the national average. Ibid.

⁸⁷ AB X1 1 (Nunez) of 2007-8 at www.leginfo.ca.gov

⁸⁸ In California, charges are about 300% of costs.

⁸⁹ Board composition is listed at www.itup.org/itupteam.html. It includes distinguished state and local leaders from business and labor, consumers and plans, providers and government who are committed to increasing coverage of the uninsured.

⁹⁰ Executive summaries of the regional workgroups are available at www.itup.org/regional-workgroups.html. The participants are a mix of local leaders from plans, providers, advocates, local government, business and labor.