

## MAJOR FINDINGS

- The large proportion of uninsured Californians gives California a unique landscape and strong interest in federal reforms to improve coverage, eligibility, access, and prevention efforts.
- California has infrastructure and local initiatives in place that can be important building blocks for federal reform.
- Designing a better system of coverage for the flex workforce (temps, part time, seasonal, self-employed, multiple jobs) is paramount in the reform efforts, and proper mechanisms must be implemented to improve affordability, portability and continuity of their coverage.
- California's experience with the PacAdvantage purchasing pool reveals that Exchanges (whether state or national) must operate under the same rules as the market and vice versa, or the Exchange will be subject to adverse selection.
- Any expansion of public programs like Medicaid must be careful not to increase state spending, as the current budget crisis has drained California's General Fund resources.

## WORKGROUP NOTES

### *Opening Remarks*

Lucien Wulsin, ITUP: Overview of California Health Coverage ([PowerPoint](#))

### *Panel 1: Covering Small Businesses and the Low Wage Workforce*

Al Hernandez-Santana, Executive Director, Latino Coalition for a Healthy California  
Scott Hauge, President, Small Business California & Small Business Owner  
Joel Diringer, Principal, Diringer and Associates

### **Immigrants**

- 10 million immigrants live in California, the largest proportion and total number in the nation; 1/4th of registered voters are immigrants
- California's economy is dependent on immigrant labor, as 42% of workforce is foreign born
- Seasonal workers (including forestry, fishery, agriculture) have trouble accessing coverage and very few are offered coverage through their own jobs.

-Major barriers for immigrants: affordability of coverage/care, cultural competency and language difficulty, continuity of care for migratory workforces.

### **Small Business**

-In an annual poll to determine priorities, health insurance coverage has topped the list five years in a row.

-Small business is not opposed to offering coverage in a shared responsibility construct, but has trouble with ever escalating costs and premiums.

-Small business is supportive of participation in pooled purchasing (such as the Exchange) and appropriate refundable tax credits/subsidies.

- Affordability is a challenge for both the small employer and low wage employee; government assistance is needed.

### **Farm Workers**

-Agriculture is \$36B industry in CA and a large portion are flex workers (seasonal, part-time workers who work for multiple employers); the industry has low operating margins and seasonal volatility in employment.

-One third of US agricultural workers live in CA, most are immigrant and low-income; 70% of agricultural workers have no health coverage

- We need shared responsibility of employer and employee contributions with public subsidies and low copayments/deductibles with proper access to prevention

-Federally funded migrant health centers need to be supported to improve access in these populations

- The terms “employer” and “employee” need to be better defined to address eligibility/portability issues for migratory and seasonal workers who often work for farm labor contractors

-Portability has and can be further developed through bi-national coverage

- MEWAs in CA cover agricultural workers and when appropriately capitalized and regulated the organizations work well.

-A greater effort in prevention, health education and public health needs to be undertaken. For example, obese farm workers don't have access to the healthy foods that they are growing.

Joel Diringer's *Consensus Report Of Local Agriculture and Labor Representatives* can be accessed [here](#).

### **Panel 2: Value Purchasing Strategies (Cost Containment)**

Peter Lee, Executive Director, National Health Policy of the Pacific Business Group on Health ([PowerPoint](#))

Betsy Imholz, Special Projects Director, West Coast Office, Consumers Union ([PowerPoint](#))

### **Access, Cost, Quality**

- We need to focus our nation's reform effort to assure that patients "always and only" get the right care
- Value purchasing should measure performance and use data to purchase "better value" care. The proposals need to have adequate, public data reporting.
- Patients want and need to be more actively engaged in decision-making about their care; comparative effectiveness information helps them do that.
- In the current health care system we get what we pay for -- volume; we need to transition to paying for improved patient health outcomes.
- Public and private payments need to be better aligned so they are giving the same incentives to the delivery system.
- In CA there is substantial cost shifting, as much as 40 cents on the dollar from employers goes for hospitals' uncompensated care; this should be reduced.
- There's no silver bullet for "bending the curve" on health care costs, but a constellation of measures.
- We need to assure transparency across the system and improve the incentives for patient safety; public reporting of outcomes by facility/provider is what drives safety and quality improvements.
- Non-payment for facility-caused conditions also creates a strong incentive to improve.
- Substantial savings –in money and lives--can be found in safety improvements; \$45 billion each year could be saved by eliminating hospital-acquired infections, for example, according to CDC.
- Incentives need to be in place to encourage getting the "right care" and discourage unnecessary interventions, which add cost and safety risks.

### ***Panel 3: Exchanges, Local Infrastructure and Safety Net Initiatives***

Tangerine Brigham, Deputy Director, San Francisco Department of Public Health  
John Grgurina, CEO, San Francisco Health Plan

### **Healthy San Francisco**

- In developing Healthy San Francisco, there was recognition that care to uninsured rests at the local level; the goal was to provide access to care for the uninsured, irrespective of barriers such as employment status and insurance coverage
- The program includes employer spending requirements, which have encountered ERISA litigation, but do not appear to have negatively affected local job growth
- The program uses the local public managed care system, as program administrator, without insurance underwriting exclusions.
- The program has steadily expanded provider networks, bringing in community clinics, local doctors and hospitals and providing a medical home for each patient.
- To date, ¼ of regular participants in the program are new to the health care system (those who have not received care from the local safety net in the last 2 years)

- User response to Healthy San Francisco has been extremely positive, though there is still some confusion about the program's covered benefits and cost sharing
- San Francisco General Hospital has experienced a decrease in ER utilization for the population enrolled in Healthy San Francisco

Kaiser Family Foundation's *Survey of Healthy San Francisco Participants* can be accessed [here](#).

### **PacAdvantage – California's small employer purchasing pool**

- With PacAdvantage, California tried to level the playing field and lower overall costs for small employers through managed competition, but the purchasing pool eventually became subject to severe adverse selection and closed.
- Insurance companies do not like 'sliced' business, where employees have a choice among multiple competing health plans; insurers are not willing to negotiate a lower price in an Exchange as compared to their rates in the existing employer market
- An Exchange has to have adequate safeguards from adverse selection through consistent rules for all plans operating in the marketplace

### **Panel 4: Lessons Learned from State Reform Efforts, ABx1 1**

Sumi Sousa, Health Consultant to the Speaker of the Assembly, California State Assembly

David Maxwell-Jolly, Director, California Department of Health Care Services

### **Lessons Learned**

- There needs to be a heightened focus on prevention.
- Market restructuring needs to preserve the consumers' choices in the existing marketplace while transitioning to a system where everyone will participate; existing coverage and care arrangements should not be disrupted.
- While there are promising federal reform provisions such as raising Medi-Cal eligibility from 100%FPL to 133%FPL, increasing primary care reimbursement rates, and coverage for medically indigent adults, state financing of an increased Medicaid match will be problematic in California. In California's budget context, there are no anticipated general fund resources available for the next 4 yrs.

### **Documents**

- For ITUP's report, *California Health Reform: Some Background Facts*, [click here](#); to read an executive summary of the report, [click here](#).
- To review important comparisons between California and the United States, [click here](#).