

Topics covered in the workgroup included the California health care reform proposals, potential impacts of these proposals, SCHIP reauthorization, and proposed changes to Medicaid funding methodology for public and UC hospitals. To preface the day's discussion, ITUP staff provided an overview of five health care reform proposals, highlighting the eligibility, benefits, financing and cost containment of each. Workgroup participants shared their perspectives, concerns and goals for health care reform in the coming year. The workgroup materials can be viewed on our website: <http://www.itup.org/Workgroups/RegionalWorkgroups/Orange/Orange.html>.

Statewide Reform Options

In California, a number of health care reform proposals have emerged, all taking unique approaches to fixing what many have termed the state's "broken system." Discussion of the components of each of five plans revealed varying levels of support and concern from representative stakeholder groups, including physicians, hospitals, health plans, consumers, county health and legislators. Participants identified cost, shortage of Medi-Cal providers, complexity, health status, and lifestyle choices as problems with the current system. Locally, the safety net in Orange County is precarious due to funding and access issues. CalOptima in particular is precariously funded while reimbursing providers more than the state is paying. There was consensus around the concept of shared responsibility; however everybody must have a financial stake, including the state, medical device manufacturers and the pharmaceutical industry. In any reform effort, the money must follow the patients. Lastly, coverage for kids is still a priority; some believe it should be pushed to the front while others view it as a piece of comprehensive reform.

Overall, *Governor Schwarzenegger's* proposal was praised for its comprehensive approach; however participants called for greater clarification and revision of some plan details. The proposal has many interconnected parts, all of which must remain intact in order for the plan to work. For instance, the 15% administrative spending and profit cap and 85% patient care spending requirement requires clarification of both administrative costs/profits and patient care. This type of market reform does not necessarily prevent costs from being raised in order to compensate for the cap. Physicians and others recommended that expanding the scope of practice for physician extenders must be based on clinical guidelines and accompanied by physician oversight and quality monitoring. Furthermore, concern that the 2% physician fee to partially finance Medi-Cal rate increases is both inequitable and ineffective, as not all providers care for Medi-Cal patients and rate increases do not guarantee increased provider access. However, acknowledgement by the Governor and legislators that Medi-Cal is underfunded is a big step in the right direction. Enforcement and collection of the fee and the 4% hospital fee would create new administrative work and costs for the state. The county healthcare agency expressed concern over redirection of realignment funds currently used to pay for care to indigent adults. Orange County would need twice as much funding to care for indigent adults in the county as the number of eligible patients in Orange County would double under the governor's proposals to place responsibility for care to the undocumented uninsured with the counties.

Senator Kuehl's single payer bill received mixed reviews. On the one hand, participants were skeptical about the absence of a financing plan and the ability to secure enough votes to ultimately pass one, the transition to a single payer system, the role of private insurers and the exclusion of long term care from the otherwise comprehensive benefits package. However, the emphasis on cost savings and primary and preventive care and shift away from employer-based coverage were well received by some. Feasibility of the Senate Republican Caucus' Cal CARE came into question. Specifically, the expansion of "Section 125" offers less tax benefit for lower income individuals. These plans are not portable between jobs and require enrollees to anticipate future medical costs throughout the year, without the ability to rollover

used funds from year to year. With increased flexibility in coverage comes certain tradeoffs. Allowing out of state insurers to enter the market could take profits outside of California. Additionally, realigning Medi-Cal benefits to more closely mirror private benefits could create savings but might fail to meet the needs of the distinctive Medi-Cal patient population. Even within the privately insured population, out of pocket costs can be barriers to accessing care. While Cal CARE aims to cover all kids, the funding would come from a redirection of First Five dollars pending approval by the voters.

CMS Proposed Rule

A recently proposed change to Medicaid would alter the current funding methodology for public and UC hospitals. The proposed rule would impose a payment limit on Medicaid reimbursements to “governmentally operated providers”, subject to a narrower definition of reimbursable costs. Public providers would no longer be permitted to receive up to Medicare-like rates. Public providers would be further limited to recovery of costs related on to caring for Medicaid beneficiaries. This change could destabilize the safety net and impact private hospitals as well. Similarly, the rule proposes to change the definition of “unit of government” to include only those entities with “general taxing authority.” Currently, public and UC hospitals are included in the definition, allowing them to draw down federal dollars based on the dollar amount the hospital expends to care for Medicaid and other low-income patients. Under the proposed rule, only those funds derived from tax revenues will be eligible to be matched. UC hospitals and other academic medical centers nationwide do not have general taxing authority and would be severely limited in their ability to draw down federal matching funds.

Recommendations

Workgroup participants shared general recommendations for health care reform that were both general and of particular importance to their respective organizations.

- Provide preferential tax treatment to physicians who treat safety net patients in order to preserve the safety net
- Use CalOptima as a model of care coordination
- Increase the sales tax to finance universal coverage
- Implement a tax credit, rather than deduction, for purchase of health insurance
- Focus on universal coverage rather than single payer
- Clarify the role of behavioral health and fate of current mental health funding (i.e. Prop 63) in the various reform proposals
- Increase and maximize funding for CalOptima and maintain its provider network
- Continue to maintain support for local safety-net providers that continue to care for low-income patients not eligible for coverage.