

The regional workgroups for 2007 focused mainly on the state health care reform proposals. Additional topics included universal coverage for children, SCHIP reauthorization, and local solutions for adult coverage expansion. While earlier workgroups focused on the six main proposals, more recent workgroups concentrated on understanding the Governor's proposal and AB 8 (Núñez/Perata) and most recently the Governor's proposal as introduced in the special legislative session. There was overwhelming support for the reform effort by workgroup members who recognized that the Governor and legislators have brought attention to health care reform and created an important opportunity. Workgroup participants sought to better understand the options and issues as well as identify areas for clarification. Discussion of the options for reform revealed varying levels of support and concern from representative stakeholder groups, including physicians, nurses, hospitals, clinics, health plans, consumers, county agencies and legislators. Workgroups were convened in Orange, San Diego, Los Angeles, Humboldt and Mendocino Counties, the Central Valley (held in Fresno), the Central Coast (in Santa Barbara), and the Bay Area (in San Mateo). As part of larger meetings around the state on health care reform, ITUP partnered with various groups to convene meetings in Riverside and San Bernardino Counties, Solano and surrounding counties. The former was in partnership with Inland Congregations United for Change (ICUC)/PICO and the latter with the Children's Alliance of Solano County. Additionally, workgroup members participated in five calls held in September, October and November to discuss the legislative proceedings at the end of the regular session and the special session.

Statewide Health Care Reform

The Governor, legislative leaders and legislators on both sides of the aisle have been through numerous drafts of their respective health care reform proposals throughout the course of the year. The Governor has gone from a set of concepts and principles to draft legislative language (ABX1 2) introduced in the special legislative session. Bills introduced by Speaker Núñez and Senate President Pro tem Perata (AB 8 and SB 48, respectively) merged to become AB 8. The bill was later vetoed by the Governor and was reintroduced with revisions as ABX1 1 (Núñez/Perata) in the special session. The Assembly Republican Caucus initially introduced CalCare and then introduced CalCare Plus in the special session. With the exception of the Governor's draft bill, workgroup participants discussed the regular session proposals in person and discussed special session proposals on three of the five statewide calls. Overall, regional workgroup members were very interested and engaged in the process and expressed their support and views to the Governor and legislative leaders for their efforts in a number of ways throughout the year.

Coverage

Universal coverage and shared responsibility are the buzzwords in this year's reform debate. For most workgroup participants, universal coverage means a restructuring of the current system in order to achieve this end. While the single payer model is on the table again this year, it garnered little support from our workgroup participants. Despite near unanimous support for universal coverage, there was considerable debate around the other issues on the table such as individual and employer mandates. While an individual mandate will cover more people, consumer groups oppose it and labor groups are more inclined to support an employer mandate. Participants in Los Angeles acknowledged that an individual mandate goes hand in hand with guarantee issue coverage. An individual mandate must also be accompanied by a robust subsidy that does not over-strain the state general fund. This speaks to both financing and affordability issues which are discussed in greater detail below. Shoring up the kids coverage and funding issue is a high priority; however there was consensus that it should be done in the context of a larger reform. Simplification of eligibility, enrollment and recertification in public programs—akin to the provisions of SB1/AB 32—should also be included.

Under an individual mandate which includes a purchasing pool, both the self-employed as well as individuals included in the mandate regardless of whether they receive a subsidy should be able to purchase through the pool; this is not spelled out in either ABX1 1 or ABX 1 2. Further clarification on the inclusion of seasonal and part-time workers in the pool is also needed.

The issue of coverage for undocumented adults poses a challenge in the reform debate. While the more comprehensive proposals cover all children, not all adults will have access to subsidized coverage through the pool, specifically undocumented adults. While this population is working and subject to an individual mandate to the extent it can be enforced, they are limited in their coverage options. The county health systems, the default source of care for undocumented adults in most reform proposals, offer varying levels of coverage and services, and in many counties, little or no coverage.

Benefits

Workgroup participants called for greater clarification and definition of covered benefits in the proposals. They also discussed specific services that must be covered, including dental, vision, and mental health. Absent from the proposals as currently written, these benefits compose meaningful coverage as does coverage that focuses on primary and preventive care with minimal cost sharing for those services. Policymakers should work towards defining an affordable standard benefits package offering a basic level of care. In addition workgroup members prioritized the inclusion of prevention and wellness services with minimal cost-sharing in order to promote prevention, primary care and early intervention

Financing

Shared responsibility involves both shared contribution and benefit. Individuals, employers, physicians, hospitals, and counties would be actively involved in the financing of reform with respective benefits depending on the model. However, participants identified a number of groups who do not have a stake in the reform, namely pharmaceutical companies and medical device manufacturers as well as the state who all need to participate to a greater degree. Participants from rural areas emphasized equitable distribution of resources if the counties, providers, employers, etc. are expected contribute their share.

Workgroup participants consistently expressed that the fees on providers are non-starters. Specifically, physician groups felt that the fee is both inequitable and ineffective. Not all physicians treat Medi-Cal patients and therefore do not stand to gain from enhanced Medi-Cal reimbursement rates. Similarly, increased rates do not necessarily improve access to care. With revenues for physicians declining in recent years, the burden of the fee will have a greater impact. However acknowledgement that current rates are low is a step in the right direction as is the intention to improve them.

With limited representation by business leaders, there was minimal feedback on the level of employer contribution in the various plans. One business representative shared that his large employer and others like it would willingly participate and continue to spend the same amount on employee coverage as at present. Another representative shared that employers are more willing to contribute to employee premiums when all employers are doing the same. Physicians who are also employers expressed concern over the double burden they would face in a model where in both their physicians and employer roles, they are required to contribute.

Hospitals recognize both the benefit and value of expanded and universal coverage and support it. However, they face a similar dilemma in addressing a proposed hospital fee. While some hospitals stand to gain from many of the provisions in the proposal such as more insured patients and Medi-Cal rates increasing to Medicare levels, the 4% fee might prove burdensome for others.

Participants in Los Angeles, a county with a great deal to gain from health care reform, expressed support across the board for reform and universal coverage. They also emphasized the need to create a system with real financing behind it in which federal matching opportunities are maximized and the county has adequate resources to meet the increased patient demand on the system. Orange County will face a substantially larger patient load if caring for undocumented adults becomes the counties' responsibility; however they will have less funding to fulfill this requirement if a county contribution is part of the financing for the reform. The Central Valley is home to a disproportionate number of undocumented residents, which must be acknowledged in a redistribution of county funds. Issues around coverage expansion and the safety net are discussed below.

There is still a considerable portion of the financing needed besides the aforementioned sources. Under discussion are revenue from leasing the state lottery to a private company, increase the sales tax or another consumption tax and increase the tax on cigarettes. With a cigarette tax looking most likely near the close of the special session, it is unclear whether the other options are indeed off the table. Like other states, California's previous attempts to pass an increase in the cigarette tax through the ballot process failed, there is concern over another try. Not only have recent similar efforts been unsuccessful, but the cigarette taxes are not viewed as a long term sustainable funding source. Workgroup members offered alternative ideas such as taxes on other products that diminish health such as unhealthy fast foods. With the financing slated to go before the voters in November 2008, it is important to consider and anticipate possible opposition campaigns and parties who would oppose both the financing and the policies.

Affordability

While some modeling has been done regarding population movement and costs, participants had further questions about the cost of premiums and affordability. Specifically, participants inquired about the premiums for those in the high-risk pool. Under an individual mandate, the offerings to low and moderate income individuals and families should be affordable with minimal out of pocket costs; high-deductible plans would not be well suited to their needs. The most recent proposal from the Governor takes further steps to assure affordability by offering refundable tax credits to higher income individuals. As was mentioned in discussions of covered services and benefits, affordable coverage options must also be desirable to consumers and offer them meaningful coverage for their money.

The 15% cap on insurer administrative costs and profits will help control costs; however definition of administrative costs, profits and patient care is needed. Some participants voiced concerns over the impact that such a regulation would have on insurers. Firstly could insurers respond by raising prices in order to compensate for the cap? Secondly, this requirement on insurers could drive them from California. Some workgroup members identified pharmaceutical purchasing as an area for cost containment. Overall, participants supported the inclusion of meaningful cost containment as a vital component of reform.

Access

Access to care was a consistent topic at our workgroups. Overall, there was concern as to whether the existing delivery system could handle the increased patient load of up to 25% more insured patients. This would be particularly problematic for rural areas, where access to both specialty and primary care is limited. Furthermore, geographic accessibility is a concern in rural areas, with some patients forced to travel unreasonably far to access care and with emergency care being the only alternative. Despite existing regulations to ensure geographic accessibility, this is still an issue for plans operating in underserved communities like Mendocino County. Greater enforcement is needed as well as steps to expand provider networks to include more local providers. In San Diego County, workgroup participants identified problems with access to specialty and diagnostic care. All patients must have access to culturally and linguistically appropriate care.

Providers

Physicians

Physicians are interested in improving reimbursement rates and enhancing their liability protection. Physicians are also interested in preserving their relationship with their patients. Specifically, adequate workforce capacity is a concern as is access to specialty providers. Guarantee issue is critical as physicians face daily challenges in care and compensation for their uninsured, medically uninsurable patients. In terms of the proposed expansion of scope of work for physician extenders, physicians and others agreed that any expansion must be accompanied by requirements for physician oversight, quality monitoring and clinical guidelines.

Hospitals

Physician and workforce capacity issues also impact hospitals in the reform debate.

Safety Net

As with other provider entities, the financing of the reform paired with capacity issues is of utmost concern to the counties. Redirection of realignment and safety net care pool funding threatens the ability of counties to care for the indigent population. This shift of funds could potentially impact the funding for other county health programs.

Counties deliver care to the medically indigent in as many ways as there are counties. Recognition of this distinctiveness as well as sharing and promotion of best practices is crucial to the success of the county health systems in coverage expansion. This means allowing for creative options such as the County Medical Services Program (CMSP) in rural areas so that each county can respond to the reform in the way that fits local conditions. Provider counties, such as Los Angeles and Alameda, must be given the opportunity to compete for the county's indigent patients as well as allotted adequate resources to care for the residual population of uninsured patients.

Clinics, an integral part of the safety net also face capacity issues in terms of their infrastructure. Many clinics in Los Angeles must be expanded, remodeled and secure new equipment in order to meet the increased demand for care and specifically specialty and diagnostic care. The influx of new patients to clinics will not necessarily be accompanied by increased clinic revenue due to the Catch 22 of federal financing rules. With many uninsured patients enrolling in Medi-Cal and joining a managed care plan, some will no longer seek their care at community clinics. Revenue brought in by programs like the Public-Private Partnership in LA helps clinics to fund care for other uninsured patients. Among community clinics there is consensus that they would like to see all clinics included in the Local Coverage Option in both of the recent proposals.

Overall, the safety net must be preserved and strengthened as part of any reform, which means adequately funding it and supporting its infrastructure and workforce and participation in the reformed system.

Local Coverage Solutions

While waiting for reform at the statewide level, many counties have launched initiatives to expand coverage to their counties' uninsured. In ten California counties, federal funding as part of the Medicaid §1115 waiver will help to expand coverage for uninsured adults. These counties were selected through a competitive grants process. Among them are programs that aim to coordinate care for individuals with chronic conditions and frequent users of health services, including the establishment of a medical home. Eligibility, benefits and financing are fairly similar across the grantee counties; some counties, such as San Francisco and San Mateo, are currently or plan to go beyond the scope of the coverage initiative to create broader programs.

The counties that began planning in advance of the state's RFP have had to adjust their programs to meet the requirements for funding. The counties have been challenged to follow a frequently changing timeline set by the state and must begin their programs in the absence of a contract with the state and the assurance of subsequent federal funding. Further issues to be fleshed out include administrative cost claiming, proof of citizenship enforcement, and evaluation.

Coverage for Kids

With health care reform at the forefront of California's legislative agenda, coverage for all children is perceived as a realistic goal in the move towards universal coverage. The local and statewide Children's Health Initiatives (CHIs) are hard at work creating sustainable coverage programs for children, through legislative means and local efforts. However, the CHIs are concerned about maintaining enrollment and staffing in light of the elimination of OERU funding in the final budget and the uncertain fate of S-CHIP. The cut eliminated reimbursement for OERU activities or costs after June 30, 2007. Many counties are operating a waiting list of their children ages 6 to 18. In the meantime, the local CHIs continue to implement innovative and effective strategies to enroll, retain and educate children and their parents

In the Central Coast, Santa Barbara and San Luis Obispo counties have garnered strong support for their CHIs. The Santa Barbara County Board of Supervisors provided one-time financial support for the Healthy Kids program which also partners with community providers to help with enrollment and promotion of preventative care and appropriate utilization of health care services. San Luis Obispo County works with DSS for eligibility determination and continues to conduct successful fundraising events.

The Central Valley CHIs have also been successful in building strong coalitions while facing many of the same challenges around funding as other CHIs around the state. This is particularly problematic for funding premiums for 6-18 year olds who are not supported by First 5 dollars. These counties have turned to local businesses, hospitals and private foundations to fund premiums; San Joaquin County is addressing the issue head on, creating a fund development plan. The sustainability of these programs rests in large part on an interim and long-term commitment from the state to fund children's coverage as well as a bi-partisan commitment from the federal government to adequately fund S-CHIP.

Priorities and Recommendations

At each workgroup meeting participants shared their recommendations and priorities for covering the uninsured locally and statewide. There was consensus on several priorities.

- Universal coverage
- Ensure sustainability for children's coverage and reauthorize S-CHIP funding
- Ensure adequate capacity, access and quality for newly insured
- Maintain and support the safety net
- Control rising health costs and premiums

Distinctive regional priorities emerged from the workgroups. For example:

- Allow flexibility in delivery of services to the indigent population (North Rural)
- Ensure adequate access in rural areas (North Rural)
- Comprehensive benefits must include coverage of dental, vision and mental health services (North Rural, Orange County)
- Resolve inequities in Medi-Cal and Medicare payments in San Diego (San Diego County)
- Enhance funding for providers including reimbursement rates, infrastructure and facilities (Bay Area)