

Draft Summary
REGIONAL WORKGROUP ON COVERING THE UNINSURED IN
ORANGE AND SAN DIEGO COUNTIES
COSTA MESA, CA
Thursday, November 1, 2001
10a.m. – 3p.m.

After introductions, Lucien reviewed a list of issues that San Diego County and Orange County have in common:

- private (not public) providers,
- UC hospitals,
- numerous uninsured,
- few public dollars for county health,
- no funding for care to undocumented immigrants,
- pioneering local health plans,
- strong and constructive local health coalitions,
- payor (not provider) counties,
- low employer premiums,
- competitive health plan markets, and
- low DSH and SB 1255 funding.

Lucien reviewed Roohe Ahmed's *Overview of the Uninsured in Orange and San Diego Counties*. See charts of the uninsured in Orange and San Diego Counties.

Orange County has a higher percent of uninsured than San Diego, even with fewer people with incomes below 200% of the FPL. Lucien suggests Rick Brown's data could be incorrect for the two counties.

MediCal enrollment are state figures, and they are different from (higher than) the CPS report. State uses actual case counts, and Rick uses Current Population Survey (CPS) data, and people surveyed don't always answer accurately. They might respond that they have 'private coverage' instead of 'Medi-Cal' if they are enrolled in a MediCal managed care plan such as Sharp or Blue Cross.

Monica Buhlig stated that it is hard to use Rick Brown's data for a given county. Rick Brown's data is very good state wide, but not as good for a particular county because of the small sample size. CA Health Information Survey (CHIS) survey data that includes a 55,000 sample (by Rick Brown) will be available next May.

Healthy Families is a tiny percentage of the overall population and a small fraction of MediCal enrollment.

Jan Frates commented that the bulk of uninsured in these charts are probably adults. This data includes the undocumented as well. Jan discussed the "de facto poor," who must pay large shares of their income for rent. They may not be considered "poor," but still can't afford health insurance.

Lucien: Is the large number of uninsured in Orange County the result of uninsured persons with incomes over the MediCal and Healthy Families income limits? Patsy Calvert comments that looking at data without separating out the components is misleading. Lucien refers to SB480 Options Chart 3, which breaks out the components of the uninsured; he notes that this is statewide, not county specific data.

Healthy Families enrollment issues:

There was a discussion of efforts in both counties to increase Healthy Families enrollment. All agreed that using CalOptima as an umbrella organization to coordinate outreach is very helpful. Kathlyn Mead contrasted Orange County's coordinated Healthy Families outreach effort with San Diego County, which is more diffuse, the community is quite competitive and has failed to come together behind a coordinated effort.

- Too much money is spent by the state on advertising, which is ineffective, and not enough on community efforts that are far more effective.
- Community health centers would rather not move families into Healthy Families, because they don't want to risk losing their patients to a more traditional provider.
- San Diego has had a lot of success in outreach through employers. In San Diego, outreach efforts are more fragmented than in Orange and depend on the efforts of individual groups, plans and providers. San Diego's outreach funding comes from CalWorks funding, which is limited county funding. Kids Health Assurance Network has been very effective despite their limited funding.
- Russ English reports that outreach in Orange through employment has not been as successful as community based outreach efforts. Monica states that new employees are learning about Healthy Families in San Diego. The biggest problem is that Healthy Families will cover the dependents of employees, but what about covering the employees themselves.

MediCal enrollment issues:

Lucien noted that San Diego County appeared to be more successful than Orange County at getting eligible people into Medi-Cal.

- Kathlyn Mead says that San Diego has adopted a new approach to Medi-Cal enrollment. Dr. Ross turned the county around to create an environment among county staff, which promotes rather than deters enrollment in public programs. Dr. Ross left 2 years ago, but the county is still doing a good job of getting eligible people on Medi-Cal. There is a culture change that has occurred. Healthy Families is also helping Medi-Cal enrollment because of dual enrollment. Kathlyn says that Medi-Cal did major outreach efforts to the community to show that they are a helpful service.
- Monica Buhlig says that Medi-Cal had a bad stigma, people were associating Medi-Cal with welfare, so there has been a big effort to change the appearance of Medi-Cal. This was a local San Diego campaign. Medi-Cal staff has been very pleased with the efforts that have been made.
- Marty Earlabough-Gordon asked if eligibility workers were placed in community-based organizations in San Diego? Monica says yes, clinics have outstationed eligibility workers. Outreach workers are being placed in health centers in

Orange County. And outreach is done in OC schools; school nurses are also being used for school based outreach.

Community Clinics and Hospitals in Orange and San Diego

Clinics:

Lucien reviewed the data on clinics and the uninsured. ITUP looked at 5 years of clinic data from OSHPD. In Orange County, clinics are far smaller than in San Diego, but their patient visits are far more likely to be uninsured and their MediCal visits are declining while the uninsured are growing very substantially. The largest payor source for the uninsured was "other state programs". The second biggest payor source was patients themselves. County funding streams for uninsured clinic patients showed markedly different results – the county program is a far better payor in San Diego than in Orange County.

- Patsy Calvert reports that Orange County was very successful in moving people from TANF to work through CalWorks, but many are shifted onto 1931b MediCal. The MediCal population has skyrocketed in the last 2 years, so this data might not be accurate today.
- Jan Frates says that Orange County had the lowest unemployment rate (2%) in the state. People are moving off welfare and into employment, but not always with benefits (either public or private).

Lucien asks if it is possible that in San Diego, the clinics have stronger relationship with health plans?

- Marty notes that San Diego was subject to the same kinds of outside influences, yet their Medi-Cal patient loads skyrocketed. Clinics in San Diego must have done something right to attract those patients. Clinics in Orange have a good relationship with CalOptima. Clinics in San Diego are very different from clinics in Orange County and MediCal is more important to them because most are reimburse through MediCal/FQHC. UCI-Santa Ana is the only federally qualified center (FQHC) in Orange.
- Marty says that the chart that shows different payor sources is very accurate. Orange County clinics are mostly mission-based -- to serve the uninsured. They want people covered in any way possible. As people get insured, OC clinics need to look at what kind of a payor mix they need to have. If they only want to see the uninsured, they need to know what that means for their funding and their patients.
- Kathlyn says that clinics in San Diego embraced managed care. They worked with health plans to develop marketing strategies. Clinic success in San Diego is a result of private practices that were willing to take limited numbers of Medi-Cal patients. Community health centers benefited from default enrollment. Kathlyn says that San Diego clinics embraced capitation. The best way of serving the uninsured is to have an insured population. Many San Diego clinics have commercial contracts, and see themselves as serving the broader community. Patients have a comfort level in terms of what can be offered in community health center as opposed to private.

Lucien asks whether the Medi-Cal population and uninsured populations go to different providers in Orange County. Do Medi-Cal patients see mainly private providers (not clinics) in Orange, in contrast to San Diego clinics, which play huge role in serving Medi-Cal patients? Does this pattern translate to the uninsured population?

- Marty says that in Orange County, Cal Optima expanded the number of private providers willing to see Medi-Cal patients and the same policies apply to the county's MSI program. It's different in San Diego, where the county contracts with community health centers as the exclusive primary care provider for the MSI population. For MSI in Orange, it's any willing provider.
- Jan says that in San Diego, some of the larger hospitals that see many uninsured patients contract with community clinics to divert non-urgent patients. If someone comes into the ER who does not need to be there, they will be sent to a clinic.
- Marty says that the number of county dollars that go into the clinic system in San Diego is higher than in Orange County; there is probably higher reimbursement. Lucien confirms the total volume of dollars going into clinics is much higher in San Diego than in Orange County. The county payment rate per visit is better in San Diego, but Orange County clinics had a lower cost per visit, so it balances out.

Hospitals

ITUP looked at OSHPD (Office of Statewide Health Policy and Development) and MICRS (Medically Indigent Care Reporting System) reports for Orange and San Diego County. These are hospital reports to the state (OSHPD) and county reports to the state (MICRS) on payments for care to the county indigent uninsured. So that from one report you have what hospitals say they are paid by the county and in the other the county says what it is paying the hospitals. The figures in these reports could have reporting errors as you can see in these counties major differences between what the hospitals report and what the county reports, particularly for outpatient and emergency services. Orange hospitals, for example, report they are reimbursed for quite a lot of hospital based outpatient care while San Diego facilities report being paid for very few hospital outpatient visits.

Comments

- In Orange County, a large number of clinics are hospital-based (St. Joseph's, UCI); these are hospital clinics not community clinics. This could explain why Orange County community clinics are smaller and have lower utilization compared to San Diego clinics and Orange hospitals are much higher than San Diego. There are not that many hospital-based clinics in San Diego, but there are more community clinics in San Diego.

In ITUP's report, Orange County hospitals report getting \$100 million through DSH, and San Diego County hospitals report getting only 60 million through DSH. Why the differences?

- Kathlyn reports that it is the diffusion of Medi-Cal patients. In Los Angeles County for example, a few hospitals admit most of the Medi-Cal population. In

San Diego, care to MediCal patients is diffused in terms of any one hospital having significant volume. Many hospitals are close to the DSH thresholds, but not quite there.

Hospitals in Orange County had one third of their total volume of services provided to the uninsured (we added hospitals' reported cost of bad debt and charity care and the net payments from the county) paid for by MSI. Orange clinics were not as effective billers of MSI; only about 6% of their uninsured visits were paid by MSI. Why are hospitals better able to identify those that are uninsured and eligible for MSI and bill and get paid for it than a clinic is? NB. Clinics in Orange County and San Diego report they are reimbursed for about 6% and 10%, respectively of their uninsured patients by the county.

- Russ points out that Orange's MSI program has always been run on a hospital emergency room as the focal point.
- It's difficult to get people to apply for county health programs because of welfare stigma.
- Not all clinics have out-stationed people to take applications.
- At the hospital level, it's a big bill. For clinic patients it is a small bill.
- How does the county determine eligibility? It's partially declarative and partially verified. Verification doesn't apply to every aspect of the application. Clinic patients would rather pay for their care than go through the hassles of verification.

Mary Pinkerson asked that we look at populations over 65 next time we do our research.

Peter Long's Overview of California Financing and Coverage

Peter Long looked at overall programs and funding in California.

- Medi-Cal is the big payor; its expenditures have been slowly and steadily growing and caseload is expected to grow significantly in the current budget year.
- Medi-Cal enrollment dipped then increased. The shift to managed care has been very significant. The retention rate is a problem primarily for people not enrolled in cash assistance programs.
- County money through realignment is growing, especially in San Diego and Orange County. CHIP allocations are going south.
- Healthy Families enrollment has steadily grown, and will grow more if we get a federal parent waiver.
- CCS and CHDP have been growing.
- At the federal level, DSH payments are supposed to decline beginning in 2003.
- Community clinics experienced growth in encounters for children and middle age adults. There has been significant growth in their Medi-Cal and county revenues.

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Recommendations

- Single application for all programs,

- Cover Parents through HF (talk to delegation)
- Stronger primary care component of MSI,
- Better access to specialty care,
- Contract with systems of care for the uninsured - UCI, CHOC, Hoag/SOS
- How do you develop systems of care for the uninsured? UCI, CHOC are unique in terms of organized systems of care to the uninsured,
- Outreach money should leave the state and come to the county

Hilary Frazer discussed the HRSA Community Access Program grant to the Orange County collaborative that includes CalOptima. The county wanted to deal with uninsured issues, so it includes an employer-based piece and a component for uninsured kids. She wrote a grant, and created 2 pilot ideas. Community Access Program is a national program. OC received a one-year grant for \$823,000 to design these 2 products.

- 1st pilot - Hoping by end of this year, they'll have an implementation ready pilot product for uninsured kids in Orange County that are low income, but ineligible for Medi-Cal and Healthy Families. Possibly for 2000 kids in Orange County, which is an adjunct to California Kids and KP Cares for Kids. This would cover up children up to 250-300% of FPL.
- 2nd Pilot program for the uninsured working for small businesses (50 employees and less) based on the success of the FOCUS program in San Diego.

Public coverage recommendations:

What needs to be done in San Diego and Orange County?

- Outreach dollars should leave the state and go to the counties. State is doing a poor job on outreach and advertising; communities are doing an excellent job.
- We need training for Spanish speaking CAAs and more funds for locally based efforts.
- Need to change the incentives of CAA to include retention as well as enrollment.
- EDS doesn't do a good job in administering reimbursements for approved applications.
- Most people prefer Healthy Families to the Medi-Cal model. The implementation may be flawed, but it's a learning process and there is greater openness to change.
- There is a problem with the marketing theory of HF; the problem is not brand identification; it is closing the deal and that is labor intensive and local.
- Jan suggests we use Broker Commission Model.
- We need to change incentives to keep coverage.
- Program seamlessness and retention.

Lucien whether we should move the MIAs into a Medi-Cal managed care model with an 1115 waiver. Lucien reviewed the county MIA population. One group is young and healthy. Lucien says their use episodes are very infrequent, but for very expensive emergency care. This isn't very different from a Healthy Families parent or Medi-Cal parent. Another portion of the county MIA population is seriously or chronically ill often with use of multiple state and county programs. Lucien says they are just a successful SSI application away from MediCal eligibility

- Hilary thinks it's very different. Just because some MIAs will end up on SSI does not mean they are predominantly the SSI population. In terms of bringing the MIAs into a managed preventive care model it's not clear how much more (in terms of magnitude) it would cost relative to what the county now spends for its population enrolled in the MSI program.

Lucien says that to get a federal 1115 waiver to cover the MIAs you have to make changes that assure the federal government that there is federal cost neutrality. One option is to put the disabled into managed care. What do you think, would that be good or bad for the disabled based on your experience?

- Hilary says that most of CalOptima's disabled members report they are satisfied. Consumer satisfaction doesn't necessarily equate with good care.
- Kathlyn says it takes a long time to gather all the data. You have to look at 2 or 3 years of enrollment before you can make any assumptions about whether the population is better or worse off.

Lucien asked about the Medi-Cal asset test. ITUP's Northern California workgroup participants reported that they have numbers of people who are disqualified/deterred by Medi-Cal's asset test. This may be because it's more rural. Lucien wants to know if it's a problem in Orange County and San Diego County.

- No one knows that it is. We'd like to get rid of it, but it's not a big problem in actually disqualifying anyone.

Private Coverage; see SB 480 Options Paper Charts.

ITUP looked at four options to cover the uninsured.

- Small low wage employer tax credit,
- MediCal/Healthy Families waiver to cover adults,
- Healthy Families Purchasing Credit, and
- Refundable tax credits for flex workers.

Public coverage for unlinked adults allows CA to offer emergency only benefits to the undocumented and full benefits to US citizens and legal permanent residents, but it requires a federal waiver.

To assess the feasibility of a waiver, ITUP looked at different payor and provider counties. How many adults are uninsured and unlinked below 100% of FPL and how many are participating in county programs and how much care are they getting? See hand out for the surprising answers.

Half the uninsured are flex or unemployed, half are full time/full year employees. For full time workers, we looked at a 50% premium subsidy for low wage workers working for small employers. We picked 50% because that's what a high wage worker gets through pre-tax purchasing.

- How many people could we affect? One third of workers make less than twice the state minimum wage.

- If you put enough money on the table, the uninsured employers and employees will come. How much money and how many we do not yet know.
- How many of those employers are very small versus how many are very large. 2/3rds of workers work for businesses of 250 or fewer employees.

We looked at offer versus take up. California has a low offer rate and high take up rate. About a million of the uninsured are offered but do not take up coverage offered by their employer due to affordability. Could we solve their take up/affordability problem with new money? The answer was surprising; on average, there is not an affordability problem for employee only coverage; however there is a very big affordability problem for family coverage (we used 2% and 3% of income as the affordability threshold) which affects workers up to the state's median household income. It would take quite a lot of money to fix the affordability problem for family coverage, and most families are taking up the offer of family coverage even though it is not *affordable*. We recommended using the HF purchasing credit because there is a 2/1 federal match, and the funds are targeted to the uninsured who have not taken up employer offered coverage.

The flex worker coverage problem is significant. About 1/3rd of workers are flex workers. Most employers don't offer coverage to flex workers even though they offer coverage to full time full year workers. What can we do? We investigated refundable tax credits. It is workable if they could self-certify, receive a quarterly voucher and use it with a carrier in a reformed individual market which guarantees issuance of coverage and has transparent and comparable pricing information.

There are local solutions on the employer side. San Francisco and other counties are developing coverage for home care and possibly child care workers.

- Kathlyn says that for home care workers, funding is public, and we need county administration. There is a question of whether or not the individual county will take advantage of the opportunity. Kathlyn favors more models like coverage for In-Home Support Services workers in San Francisco. Caring for the Caretakers is a big issue in SD.

What about an educational component?

- Proposition H was a beginning for discussing the issue of the uninsured in Orange county.

Coverage for childcare workers?

- Kathlyn says that it depends on the funding. Many people are competing for the Proposition 10 money.

Lucien asked about Group Purchasing.

- Kathlyn says there is a misunderstanding about what it gets you. The difference is choice of plan options for employees. The issue for uninsured employers is affordability, not "choice," so Group Purchasing doesn't necessarily help. There is no role for Group Purchasing unless it can cut premiums.

Kathlyn discussed the private buy-in into Healthy Families. We want employers to pay a portion of the cost if they are willing.

Private Coverage Recommendations:

- HRSA Pilot Program Options for Uninsured Children and Small employers
- Home Care workers coverage
- Employer/employee options to Buy In to public programs
- Crowd Out. There are concerns about crowd out; there is not a thorough understanding of what it takes to be eligible for these programs and this issue needs to be discussed and resolved out front, not hidden in the closet.

Follow Up: Lucien discussed the dinner meeting and annual ITUP conference in Sacramento on February 21, 2002. ITUP will be available to this workgroup for consultation by phone, fax or e-mail throughout the year. We will hold a second regional workgroup next year. Please complete your evaluations and return them to us so we can have your input on how to improve these workgroups.