

To: ITUP Conference Attendees, Regional Workgroup Participants and Medi-Cal Redesign Workgroups

April 28, 2004

Dear Friends,

These are some thoughts on California's public health programs and the state budget crisis. We are facing a \$14 billion budget deficit, and it needs to be solved partly with new revenues and partly with program reductions and efficiencies. We need to see the budget crisis as an opportunity for system improvements.

Costs of public and private health insurance have increased dramatically.¹ On the private side, there has been a small decrease in covered lives and large increases in health costs and premiums per covered life. In public coverage, MediCal and Healthy Families enrollment of low wage working families and children have increased significantly while costs per eligible have not. Per person costs of aged and disabled enrollees have also increased significantly in line with the cost increases in the private sector. Prescription drugs and hospital costs have been prime contributors to the health cost explosion, as have been the non-benefit costs of private insurers and health plans. Cost containment is necessary for both public and private sector health coverage.

New revenues

There is a need for new state revenues – a combination of taxes and/or fees. Some assert that any new taxes slow the state's economic recovery and restoration of job growth. While increased payroll taxes may slow job growth, not all taxes slow job and economic growth; some taxes will increase economic growth by shifting resources to more productive uses. For example a tax on tobacco, gambling or alcohol used to pay for education, infrastructure or preventive health care, diverts revenues from less productive to more productive uses. When the new revenues are used to bring in federal matching funds, the economic benefits of these taxes are multiplied. Cigarette and alcohol taxes should be considered, as well as luxury excise taxes, gas guzzler taxes, closing tax loopholes to promote tax equity and excess profits taxes on those who have taken advantage of market conditions and oligopolies to run up the cost of basic services. A budget crisis is the time to enact long needed tax reforms: such as equalizing sales tax burdens between goods and services and equalizing property taxes among similarly situated property owners. Tax equity helps to set the table for a balanced economic growth. In several states, provider taxes supply the financing for public program expansions; provider taxes have the dual advantages of equalizing the cost of uncompensated care burdens among providers and re-capturing some of the reduction in uncompensated care.

¹ Levit et al, Health Spending Rebound Continues in 2002, Health Affairs (January 2004) and California Legislative Analyst's Office, Analysis of the 2004-05 Budget Bill (Feb. 2004) at www.lao.ca.gov

Eligibility

MediCal and Healthy Families enrollment is up, particularly for families, due to the slow job recovery and our state's successes in enrolling the eligible-but not enrolled children. But that enrollment growth has plateaued. The worst thing we can do is cut, block grant, roll back or freeze eligibility for MediCal and Healthy Families. Everyone loses: the beneficiaries, the plans, the providers, county governments and employers and individuals buying private insurance (by increasing the uncompensated care cost shift).

Services

California covers a wide array of optional services; some such as adult day health care and hospice are less costly alternatives to institutional care and must be preserved. It is critical that we maintain prescription drug coverage and adult dental care. Dental access for low-income populations is very poor; cutting adult dental coverage means parents, seniors and the disabled will get no dental care at all. Without coverage of prescription drugs, modern medicine is helpless to treat patients. There are opportunities to reduce spending by carefully reviewing and reducing the scope of the MediCal formulary. Payment for over the counter medications, except for very specific items such as diabetic supplies, could be discontinued. Coverage of some optional services should be suspended for the next few years. Chiropractic, podiatric and acupuncture services are examples of services that are not essential even though in some instances, they are less costly alternatives to more traditional medical treatments. Savings: \$9 million.

Reimbursement rates

MediCal payment rates are typically far lower than commercial coverage; there are areas of the program where payments are higher than some commercial coverage; these include the filling fees for pharmaceuticals. Reimbursement for some services, such as prescription drugs, nursing homes and hospitals have been on semi-automatic pilot while reimbursements for many other services, such as physicians have been frozen for many years with sporadic legislatively approved catch up increases when state budget conditions permit. We ought to carefully review reimbursement rates service by service to ascertain where budget savings can be achieved, rather than, for example, cutting physician rates across the board.

Utilization

Utilization of services is up, especially for the aged and disabled populations. This is consistent with the increase in utilization for the privately insured. There are two approaches to slowing the growth in utilization: an increase in out of pocket patient responsibilities and managed care. The private sector has substantially increased employee out of pocket responsibilities. However, increasing patient out of pocket responsibilities (co-pays) for low income public patients is counter-productive; first the patients have few financial resources and second, it results in reduced use of preventive services.

Managed care

The Legislative Analyst's Office has recommended, and I believe we should support the extension of MediCal managed care to the aged and disabled. Why? MediCal managed

care has improved access to physician services for families; MediCal managed care in many counties increased physician reimbursement and has improved families' access to outpatient and preventive care. County Organized Health Systems (COHS) have improved the coordination and delivery of services to the aged and disabled. Properly applied, managed care can both improve MediCal patients' access to quality care and save state dollars.

This is not to say that all forms of managed care are equally applicable to improving care for the aged and disabled. COHS have a successful track record and experience; existing systems could be expanded into regional COHS. This will however require an 1115 waiver and possibly a change in the federal law constraining COHS expansion. Some Local Initiatives (LIs) may be ready to take on the responsibility of managed care for the aged and disabled while others are not. The advantage of selecting those LIs who are ready and willing is that they incorporate local safety net providers, some of whom are very concerned that managed care for the disabled may threaten their financial viability. Consideration should also be given to contracting with specialized commercial managed care systems that have a demonstrated track record and experience in improving the delivery system for the aged and disabled under Medicare. The state needs to be very careful in selecting only those plans that have the expertise and capacity to improve care and services. California's county based competitive managed care models (two plan model and geographic managed care) are not well suited to expansion as the numbers of aged and disabled enrollees in any given county are small; their per person costs are high; the financial risks and the potential for adverse selection among plans would be high and could be very de-stabilizing under a competitive model.

We should expand mandatory managed care for families in the less populous regions now exempt, but use a different model; managed care should not be defined by county boundaries but rather organized by regions. In larger counties with adequate numbers of providers and covered lives, such as Ventura, managed care could use either the two plan competitive model (a county local initiative and a commercial competitor), or the county could join an existing County Organized Health System such as Santa Barbara and become part of a regional network. In small rural counties such as Kings or Shasta, there are insufficient covered lives and insufficient providers in each community to support competitive models of managed care; a well-designed regional County Organized Health System could better organize the existing delivery system and improve access to specialty services in rural regions. As discussed above, federal law caps enrollment in County Organized Health Systems, and an 1115 waiver or change in federal law may be necessary. The Central Valley should be treated as one or possibly two regions; a County Organized Health System may be appropriate for rural Central Valley areas, while competitive managed care models could apply in the large urban centers such as Sacramento and Fresno where competition can work.

In the Bay Area, it may make sense for existing managed care plans to begin to consolidate into regional networks, possibly creating one network for the West Bay region and another for the East Bay region. This will save on plans' administrative costs.

Co-payments

Co-payments are the other way to reduce utilization; however co-payments for low income patients typically deter use of both essential and non-essential services, thus defeating their purpose. If we maintain a fee for service system for the aged and disabled, rather than moving towards managed care, we need to re-consider and re-design co-payments. Co-payments should be applied selectively rather than across the board; for example, co-payments could be appropriate for non-emergency use of hospital emergency rooms in regions where there is adequate physician access. Selective co-payments may be a useful approach to encourage the use of less costly care, service and treatments.

Prioritizing services

We should begin to review covered services to distinguish between the most essential and less essential care and services. Oregon's rationing exercise makes sense in delineating and deleting coverage for those services with the least medical efficacy. One proposal recently published in Health Affairs would rank prescription drugs along a continuum of value; there would be no co-payments for life saving services, but substantial copays or no coverage for life-style enhancing drugs such as Viagra.²

Costs of administration

Public program administrative costs are already low but can be further reduced. One-E-App has the potential to computerize and simplify eligibility as does elimination of the asset test, eliminating duplication between MediCal and Healthy Families, mail-in applications and eliminating repetitive verifications of compliance with eligibility requirements that do not change. There is no reason for the MediCal and Healthy Families bureaucracies to duplicate and replicate certain functions, such as plan audits. Fifty-eight counties and two state agencies separate bureaucracies for determining eligibility and then interfacing with each other adds costs and complexity to the program. In general, the Healthy Families model of administration is significantly less costly.

Program simplification

MediCal eligibility is enormously complex due to 40 years of incremental improvements. To change, simplify and rationalize it will require a carefully thought out 1115 waiver. As a starting point, we suggest that 1) all available income should be counted and treated in the same fashion for all applicants and program eligibles; 2) the asset tests for families should be dropped; 3) MediCal coverage for children and parents should extend to 133% of the Federal Poverty Level and Healthy Families coverage applies above that level; the MediCal share of cost program for parents should be dropped and subsumed into Healthy Families.

Pharmaceuticals

The stakeholder discussions with state officials on MediCal program re-design are turning up multiple options to reduce the costs of prescription drugs. These include better

² Kleinke, Access versus Excess: Value Based Cost Sharing for Prescription Drugs, Health Affairs January 2004

management of MediCal's fee for service pharmacy benefit program for a savings of over \$500 million and collection of uncollected negotiated pharmacy discounts (\$800 million).

Competitive bidding

Federal law allows the state to competitively bid and sole source contract many ancillary services. There are substantial savings to be had via competitive bidding for MediCal's ancillary services; this will also give better control over fraud and abuse of medical supplies.

Maximize federal financial participation

There are substantial savings to be had by moving state General Fund programs into MediCal and Healthy Families. AIM costs over \$100 million annually and could be moved into MediCal or Healthy Families or both. Federal financing is available for prenatal care to immigrants for a state General Fund savings of over \$200 million (two years). MediCal's rehabilitation and habilitation options can pay for components of mental health, developmental services and juvenile justice services, now paid for with the state General Fund. MediCal can pay for special education and school health services in public schools as well. EAPC may be able to be folded into MediCal rates for community clinics. With a waiver, the remainder of the state's IHSS program could be incorporated into MediCal.

Coverage of parents and other adults³

The largest solutions to the state's budget crisis will require negotiations, trade-offs and consensus among the state and federal and county governments. The state, federal and county governments have a very large investment totaling nearly \$1.8 billion in county health coverage for adults not eligible for MediCal due to categorical linkage. Much of this funding⁴ comes from state and county funds (realignment, Prop 99 and the required county match) that are eligible for federal matching, but only if the state seeks and secures a federal 1115 waiver from the federal government to cover adults as New York, Massachusetts, Oregon, Arizona and Tennessee have already done. Los Angeles County has floated an interesting proposal that is a good starting point for this discussion. This approach will require ample room to fit within a federal budget cap. California could negotiate an ample cap if the federal government recognizes the historical success of the state's cost containment efforts. In California we rank last in expenditures per eligible and the state can logically assert that the federal budget cap should be set at the national average of expenditures per eligible. California can also seek to include its large allocated but unspent federal S-CHIP allocations as part of the cap computations.

³ There were four excellent papers discussing these options prepared by Bob Brownstein, Rick Brown, Helen Halpin Schaffler and Lucien Wulsin and an excellent financial and programmatic analysis by the Lewin Group in the SB 480 State Health Care Options Project. The ITUP paper is available at www.work-and-health.org.

⁴ Current funding for county health services is inequitable between counties among the regions; as a result access to care and eligibility for the uninsured county indigent is highly variable between counties. See ITUP Report on Findings from the 2001-3 Regional Workgroups at www.work-and-health.org; click on reports.

Reform of SB 855 (Disproportionate Share Hospitals) and SB 1255

California established its DSH (SB 855) and SB 1255 programs to assist hospitals with the disproportionate burdens of caring for the uninsured in hospital emergency rooms and trauma centers. These programs have evolved over time from their intended purposes; some hospitals receive large DSH allocations but provide little care to the uninsured; while the facilities in very poor counties with high proportions of uninsured and low income patients receive little or no funding. Federal regulators are pressing California and other states to demonstrate that there is indeed a qualifying local match and that the federal and local matching funds are serving their intended purposes. California's DSH and SB 1255 formulas and matching requirements need to be re-examined, redesigned and restored to their original purposes of assisting those hospitals with disproportionate shares of caring for the uninsured. This can be done with or without an 1115 waiver. However if coverage of adults and managed care for the disabled becomes a part of the waiver negotiations, it makes sense to re-design DSH as a part of the waiver as well.

Federal legislation

Congress has an important role to play in easing the burden on financially pressed state governments' health programs; legislative relief is possible by temporarily raising the federal matching rate, allowing states such as California to access their unspent S-CHIP funding, and providing a federal match for states covering new immigrants (ICHIA).

Thank you for considering our thoughts and suggestions.

Sincerely,

Lucien Wulsin Jr.