

August 4, 2009

Dear,

ITUP (Insure the Uninsured Project) is a small business with five employees; our mission is coverage for all of California's now seven million uninsured.<sup>1</sup> We fully support your efforts to cover the uninsured and develop more affordable, higher quality and comprehensive coverage for those with existing coverage. We would like to offer a few comments for your consideration.

### **Small Businesses**

Over the past fifteen years, we have worked extensively with small businesses throughout California on efforts to increase coverage for the uninsured and improve affordability of coverage for small employers who offer coverage. In general, the small employers we have worked with do want more affordable coverage, they do want the uninsured covered, they want some assistance from the government in a shared responsibility framework, they like the concept of refundable tax credits but need to know how it would work, they have been unreceptive to Medi-Cal (Medicaid) coverage for their own employees. Their strongest concern is for more affordable coverage, immediately and for the long term; the increases they have experienced over the last ten years are simply unsustainable. The "Exchange" model of purchasing for small employers is the type of reform that has been of great interest to them, but they have seen the California HIPC/PacAdvantage fail due primarily to adverse selection but also to a failure to constantly innovate and secure more affordable prices and coverage.<sup>2</sup>

There was great interest in Healthy Families (California's CHIP program) among small employers and disappointment that the program never developed "premium assistance" or any other way to interface with those small employers who cover their employees but not their dependents.<sup>3</sup> Developing the public/private interface through premium credits or other mechanisms is crucial to assuring affordable coverage for small employers and low wage working families.<sup>4</sup> The recent decisions by California's Governor and state legislature to decimate Healthy Families plays into small business' real and oft stated concerns that, when economic times are tough, the state government bails out on programs and leaves the employer and employees in very tough straits. In ITUP's view, a gradual phase in of funding from employers as was envisaged in AB X1 1 (Nunez) would be best for small businesses and their uninsured employees in a slowly recovering economy.<sup>5</sup>

## **Controlling Costs, Improving Value**

Over the past four years, we worked with a group of business, labor and consumer leaders on efforts to get better value, improve quality and reduce the inexorable rise in health premiums and underlying costs. The group's conclusions are that good, reliable and transparent data, strong and consistent quality and efficiency incentives for providers, plans and patients, better integrated delivery networks and strong and informed purchasing are the necessary ingredients to slow the rise in health spending, get rid of unnecessary care and improve the quality of care.<sup>6</sup> We want to highlight the issue of properly aligned incentives, if fee for service has payment incentives pointing in one direction while managed care HMO incentives point in the opposite direction, they cancel each other out and we end up with no effective incentives at the point of service where provider and patient decisions are made. Unless coverage expansions and better control over rising costs are linked quite inextricably, coverage expansions become unsustainable—as the experiences of the past 15 years of state reforms and expansions in Tennessee, Oregon, Massachusetts and California demonstrate.<sup>7</sup> The legislation under consideration needs to be greatly strengthened to slow the rise in health spending, get better value and reduce the thirty percent of medical care that is inappropriate and unnecessary. The provisions need to be interlinked so that the failure to contain costs and improve quality has clearly delineated consequences for the sectors of health care system where costs are uncontrolled and quality is not improving.<sup>8</sup>

## **Flex Workforces**

Over the past ten years, we have worked with a range of stakeholders, including elements of labor, business and health plans on efforts to design and develop coverage for the “flex workforce”; by this term, we mean the self employed, temp, seasonal and part-time workers, micro-businesses and contract workers who have high rates of uninsured and low rates of employment-based coverage even though many work for large employers who offer coverage for their full-time, full year employees.<sup>9</sup> A typical group of flex workers are child care workers, who are mostly low wage, female and minority employees and employees in micro-businesses.<sup>10</sup> The employment-based coverage system does not work for them, as it is too costly and is designed for and best serves large employers with full-time workers; the tax preferences that undergird this system are highly regressive and skewed to support high wage workforces.<sup>11</sup> Individual coverage does not work, as it is even more costly for the covered benefits, unavailable for those in less robust health and, for all but the self-employed, missing any tax advantages.<sup>12</sup> A few industries, such as entertainment, have developed good models of coverage for this workforce.<sup>13</sup> Our conclusion is that flex workers need a new model of coverage – a group purchasing model with significant sliding fee scale subsidies tied to their incomes and pro rata contributions from both employers and employees.<sup>14</sup> The Exchange models that are under discussion and debate would work well for the flex workforce; we would hope that the entire flex workforce would have the opportunity to participate—not simply those flex workers who require subsidies, are self-employed and work for very small businesses.<sup>15</sup>

## **Safety Net Delivery Systems**

In California, we now have over seven million uninsured depending on a diverse but fragmented safety net system that struggles to meet their needs due to inadequate, silo-based funding that guarantees a fractured and uncoordinated delivery system; these systems will need to evolve, coordinate and consolidate as part of reform.<sup>16</sup> Local health plans, known in California as Local Initiatives and County Organized Health Systems, have developed better models of care for the publicly funded Medi-Cal and Healthy Families populations and have piloted programs for some of the uninsured, such as home care workers, cab drivers and children. Healthy San Francisco, Contra Costa's Basic Health Program and San Mateo's WELL program are examples of these successes.<sup>17</sup> We think these are excellent models for care to the uninsured to be covered through the Exchange and through Medi-Cal expansions to California's population of medically indigent adults, now receiving highly variable care in 58 counties. We commend these systems to your consideration.

Most of California's uninsured do not have any usual source of care; when they do, it is most often through a community clinic or a county clinic (in those counties with county clinics).<sup>18</sup> We have an even greater dearth of primary care for California's uninsured than for hospital-based care to the uninsured.<sup>19</sup> Primary care is mainly delivered through free and community clinics; half are federally qualified health centers; half are not.<sup>20</sup> They are not evenly distributed throughout the state, and some poor communities have a very large deficit in their supply of primary care clinics;<sup>21</sup> clinics need to be expanded as proposed in both the House and Senate legislation. Model clinic structures exist in Alameda, San Diego and Los Angeles;<sup>22</sup> they are increasingly able to manage their patients within a managed care structure and can and should be important building blocks in better integrated delivery systems for the uninsured that will be developed as part of reform. In our experience, community clinics have few privately insured and few Medicare insured patients<sup>23</sup> and are not viewed and treated as a valued part of these delivery networks although they should be. California's local health plans have been a more welcoming fit for the community clinics, which ought to be assuming stronger roles in their governance and leadership as well.

## **Role of Managed Care**

Nearly half of California's privately insured and half of its publicly insured are enrolled in HMOs both by choice and by state mandate.<sup>24</sup> California's Medi-Cal program has been a national leader in developing selective contracting<sup>25</sup> for hospital services and its local publicly managed care programs for parents and children. It is one of the least costly programs per eligible in the country.<sup>26</sup> Most of the costly eligibility components of the program are still in fee for service systems with very poor reimbursement levels for physician services.<sup>27</sup> We support your efforts to increase the Medicaid program's reimbursement levels for primary care to closer to Medicare levels. We hope the final legislative package will afford states the latitude to expand managed care, re-integrate physical, mental and behavioral health delivery systems and provide medical homes to the more costly eligibility categories, such as to the disabled, individuals with Medicare and Medicaid coverage

(Medi-Medis) and CCS children with gain sharing provisions that allow for reinvestment of the savings they achieve.<sup>28</sup>

Thank you for your extraordinary efforts to increase coverage of the uninsured and your kind consideration of our comments.

Sincerely,



Lucien Wulsin Jr.  
Insure the Uninsured Project



Scott Hauge  
Small Business California

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<sup>1</sup> See Ask CHIS (the California Health Interview Survey) at [www.chis.ucla.edu](http://www.chis.ucla.edu) and Ken Jacobs, No Recovery in Sight, Health Coverage for Working Age Adults in the United States and California (UC Berkley Center for Labor Research, April 2009) at <http://laborcenter.berkeley.edu>

<sup>2</sup> California Healthcare Foundation, Building a National Exchange: Lessons from California (July 2009) at [www.chcf.org](http://www.chcf.org) Underwriting reforms need to apply identically inside and outside the Exchange, or it is likely to become a very costly bad risk pool. Exchanges need to foster innovations in plan design and delivery systems to secure more affordable coverage for their members

<sup>3</sup> In a survey of its members, CSBA found that among those small employers that offered coverage for their employees, over a third paid 75% or more for dependent coverage and over 40% did not pay for dependent coverage. The Resource Group, Insuring Dependent Children: a Report on Small Business Employer and Employee Data (California Small Business Association, November 1999) at [www.itup.org/reports](http://www.itup.org/reports) While Rhode Island is among the states that have pioneered “premium assistance” to connect employers and employees with public subsidies through the CHIP program, California has not done so in part due to the difficulties in administering “premium assistance” and in part due to the obstacles in the state legislation implementing CHIP. Two of the options considered in California by small business groups and child health advocates are “take out” and “buy in”. Under the “take out” option, the employee uses the CHIP allotment to pay the employee share of the dependent coverage offered by the employer; “take out” keeps the family together in a single plan. Under the “buy in” option, the employee applies the employer contribution towards the costs of CHIP coverage; “buy in” accesses the often times more comprehensive coverage offered by Healthy Families, but entails managing family coverage through two different insurers and different provider networks.

<sup>4</sup> In California, coverage for the entire family costs about three times as much as individual coverage, creating a severe affordability challenge for low wage working families and small employers. In the California reform effort that culminated in AB X1 1 (Nunez) of 2007-08, the bill’s architects were unable to agree on the proper design of the interface and included intent language for those who would implement the legislation to design this particular feature of the reform.

<sup>5</sup> The AB X1 1 (Nunez) negotiations between Governor Schwarzenegger and Democratic Assembly and Senate leaders on the issue of employer contributions compromised at 1% for payrolls of less than \$250,000, 4% between \$250,000 and \$1 million, 6% between \$1 million and \$6.5 million.

<sup>6</sup> Pizzitola, Consumer Driven Care: Transparency and Value (Insure the Uninsured Project, July 2008) and Cost Containment Findings from Our 2008-09 Workgroup (Insure the Uninsured Project, March 2009) at <http://www.itup.org/Workgroups/CostContainment/cost-containmentworkgroup.html>

<sup>7</sup> California expanded Medi-Cal coverage for parents up to 100% of FPL and Healthy Families (CHIP) children up to 250% of FPL over the past 10 years and has reduced its rate of uninsured children to about 6%. Yet during this year’s budget debate the Governor has proposed rolling back eligibility for

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parents and children; in the most recently enacted version of the 2009-10 budget the Healthy Families program is reduced by \$177 million General Funds (\$530 million in total funding), threatening loss of eligibility for a half million California children through waiting lists and terminations of coverage at annual recertification. California Department of Finance, California State Budget 2009-10 (July 29, 2009)

<sup>8</sup> In past California reform efforts, there have been crude efforts to develop such linkage; for example a trigger that would roll back the reform efforts was in AB X1 1 if costs exceeded revenues and the “gorilla in the closet” for an earlier effort would have allowed employers to buy into the Medi-Cal program for their coverage if premium increases exceeded a certain percent above CPI. We think that the trigger ideas are good, but need to be more refined, the consequences directed to the specific area of over-spending and the imposition as automatic as legislatively possible (like base closing commissions); for example if the overspending is in the area of brand name drugs, the response might be reductions in the length of patent protections; if it is realm of hospitals, it might be global budgeting, or if doctors, it might be re-imposition of far better designed and targeted sustainable growth rates.

<sup>9</sup> Wulsin, Ahmed and Shofet, Developing Models of Coverage for the Flex Workforce (Insure the Uninsured Project, December 11, 2000), at [www.itup.org/reports](http://www.itup.org/reports); Insure the Uninsured Project, Options to Increase Coverage for the Child care Workforce (August 2002) and California Child Care Providers for Action: Draft Health Policy Recommendations (November, 2004) at <http://www.itup.org/childcare-workgroup.html>

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Many Americans are working a patchwork of different jobs with no coverage through any of them and frequent gaps in their work schedules as demand for their services fluctuates. The efforts of Fortune 500 companies to develop a pool for flex workforces highlight the need for a pooling mechanism, but without the right mix of employer/employee and public subsidies, as can be offered through the Exchange, real progress in covering flex workforces has proven quite difficult.

<sup>16</sup> Community clinics depend on a mix of Family PACT, patient sliding fee payments, county reimbursements and federal and state grants to pay for their care to the uninsured. Community clinics in California have an uncompensated care burden for their care to the uninsured of \$231 million (over 16% of net patient revenues). We calculate that clinics provide on average one visit per California uninsured resident per year. Dam and Wulsin, A Summary of Financing for Low Income Individuals in California 1998-2008 (August 2008) at [www.itup.org/reports](http://www.itup.org/reports) Hospitals depend on a mix of DSH, Safety Net Care Pool, DSH like and DSH supplements, county funds and private cost shifting to pay for their care to the uninsured. Hospitals in California have an uncompensated care burden of \$1.8 billion or 3.3% of net patient revenues for their care to the uninsured and report receiving payments of \$.7 billion from counties for their care to the uninsured. A Summary of Financing for Low Income Individuals in California 1998-2008 at [www.itup.org/reports](http://www.itup.org/reports)

Counties report spending \$1.8 billion on care to the uninsured (about \$276 per uninsured as compared to California’s average private insurance premiums in excess of \$4,000 per individual), of which 48% is spent for hospital inpatient care, 40% for outpatient services and 8% for hospital emergency services. County funding includes realignment, county match, tobacco litigation settlement and (only in some counties) net county DSH and safety net care pool. Fox, 2006 Overview of the Uninsured (Insure the Uninsured Project, October 2007) at [www.itup.org/reports](http://www.itup.org/reports). Counties report paying for about 84 inpatient days per 1000 uninsured in public and private hospitals and 0.9 outpatient visits per uninsured from a combination of private doctors, community and county clinics and hospital outpatient departments. Wulsin and Tuttle, California’s Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008) at [www.itup.org/reports](http://www.itup.org/reports).

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<sup>17</sup> Mannanal, Directory of Local Efforts to Expand Health Coverage Access for California's Uninsured (Insure the Uninsured Project, January 2007) at [www.itup.org/reports](http://www.itup.org/reports) and Pizzitola, California's Coverage Initiatives, Year One Challenges and Successes and a Forecast for Year Two (Insure the Uninsured Project, December 2008) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>18</sup> Insure the Uninsured Project, Caring for California's Uninsured (April 25, 2007) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>19</sup> California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (October 2008) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>20</sup> A Summary of Financing for Low Income Individuals in California 1998-2008 (August 2008) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>21</sup> California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured.

<sup>22</sup> Wulsin, Clinics, Counties and the Uninsured: a Study of Six Urban California Counties (Insure the Uninsured Project, February 1999) and Clinics and Counties: Phase II (Insure the Uninsured Project, March 2000)

<sup>23</sup> Privately insured patients comprise 4-6% of clinic patients except in the rural northern region where clinics are often the sole source of medical care in their communities. Medicare patients are 4-8% of clinic patients except in the rural north (for the same reason) and the Bay Area, where two Asian health clinics stand out as delivering care to Medicare managed care and fee for service patients. California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured.

<sup>24</sup> Dam and Wulsin, A Summary of Financing for Low Income Individuals in California 1998-2008 (August 2008) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>25</sup> This twenty-five year old program, which had immediate cost savings, was meant as a temporary step along the path of reform; the follow-up steps were never engaged. We are left with a lingering program with misguided incentives (i.e. it is per diem reimbursement with incentives for longer than necessary lengths of stay), a public and private hospital patch (the DSH program which pays some hospitals for some of their uncompensated care) and a higher volume of hospital cost shifting than hospitals' bad debts and charity care to the uninsured (we calculated the 2006 cost of bad debt and charity care for California hospitals at \$1.7 billion, according to the state's OSHDP data and the cost of Medi-Cal uncompensated care at \$2 million for the same time period). See A Summary of Financing for Low Income Individuals in California 1998-2008 at [www.itup.org/reports](http://www.itup.org/reports)

<sup>26</sup> Ibid.

<sup>27</sup> Harbage Consulting and Health Management Associates, California Medi-Cal Waiver Options (July 13, 2009) at

<http://www.google.com/url?sa=t&source=web&ct=res&cd=5&url=http%3A%2F%2Fwww.sor.govoffice3.com%2Fvertical%2FSites%2F%257B3BDD1595-792B-4D20-8D44-626EF05648C7%257D%2Fuploads%2F%257BE9F4DEEF-0AC1-4793-BCB0-E1627DBFDD37%257D.PDF&ei=mDdzSpn4N8uwlAfDkanuCg&usq=AFQjCNEOzxRzy2Tmq0y3jyPWftnR8KE4hg&siq2=gpa07iEHq2vmwDpjVOMi1q>

<sup>28</sup> Ibid. California has had very successful SHMO (social health maintenance organization) models, such as OnLok and SCAN, that should be expanded and SHMOs for the homeless should be pilot tested as well.