

November 3, 2005

Sandra Shewry, Director
California Department of Health Services
1501 Capitol Mall
Sacramento, California 95814

Re: \$180 Million Annual Funding for Coverage Expansion

Dear Sandra,

Thank you for the opportunity to comment on coverage expansion opportunities under the state's 1115 waiver. Insure the Uninsured project (ITUP) would urge that the funds be allocated in response to competitive grant proposals submitted by interested local and regional coalitions. The goal should be to increase coverage and funding of the uninsured with **no** supplanting of existing state, federal, local and private funding. The funds should be targeted to local needs of the uninsured, opportunities to increase coverage of the uninsured identified by local and regional partnerships and promising pilots that have the potential to become statewide models. California should use local pilots to identify, develop and promote the most promising approaches to use in a statewide federal coverage expansion waiver when this waiver expires.

We think there are three possible models that have great promise but need local testing: 1) improving affordability of employment based coverage for low wage workers (e.g. FOCUS in San Diego), 2) constructing public private partnerships with premium contributions from government, employers and employees (e.g. local Healthy Kids programs and coverage for home care workers) and 3) re-building and expanding county coverage (e.g. Solano or Contra Costa managed care models).¹ Each of these approaches has weaknesses as well, such as program ramp up and uncertain initial participation levels, difficult and time-consuming coalition building and reliance on flat or faltering local revenues.

¹FOCUS was administered by Sharp Health Plan, and provided sliding premium subsidies averaging 50% for low wage uninsured small business employees. When after three years the premium subsidies were discontinued about 80% of employers continued to offer coverage. Similar successes occurred in Michigan with a one third public subsidy and two thirds from employers and employees. However, SacAdvantage offering subsidized coverage through PacAdvantage, the small employer purchasing pool, has not had comparable success.

A number of California counties have developed strong local public private partnerships to fund and deliver care to uninsured children, to uninsured older home care workers and to young uninsured working adults; the essential difference from the first model is that coverage is built through local safety net plans and the premium subsidies are far deeper.

Contra Costa and Solano each use well run local health plans 1) to organize, manage and deliver services to uninsured county indigents and 2) to expand program eligibility and participation. These may prove excellent models for other counties.

Eligibility: target uninsured low wage workers without minor children living at home

In our view the funds are best targeted at increasing coverage for low wage uninsured workers. Where possible, local safety net health plans should be the delivery network. Where feasible, uninsuring employers and uninsured low wage employees should have the opportunity to buy into the coverage offered. We expect that each local or regional coalition would have different targets, priorities and approaches. In some rural areas, the target could be uninsured farm-workers. In other areas, it might be uninsured child care workers, foster parents, garment workers, low wage service industries, low wage small business or low wage light manufacturing or construction.

We do not think the new coverage expansion funds should be used for uninsured Healthy Families parents as the state already has approved federal waiver funding that should be used for these purposes. We do not think that the funds should be used for covering uninsured children as the state also has federal waiver funding available for these purposes. We recommend the funds should be used for uninsured workers with no minor children living at home for whom there is otherwise no possibility of federal financial participation. We urge that the waiver coverage expansion funds be coupled with implementation of the already approved federal waiver to cover parents of Healthy Families children.

Services: target preventive and outpatient services

ITUP's research found county health systems are very poorly funded to care for the uninsured, and county funding streams such as realignment and Prop 99 are not keeping pace with the growth in the uninsured.² Among poorly funded county health services, hospital based and emergency services are significantly better funded; outpatient, primary care and preventive services are substantially worse funded, and adult dental services are the worst funded. There are very wide variations in funding and priorities from county to county. If a county or a region were building on its county health system, expanding coverage of a limited outpatient benefit package would be our highest recommended priority in most counties.

However if a county or region is building on a voluntary system such as either employment-based coverage or individual purchasers, the highest priority for individual purchasers appears to be catastrophic coverage. There is little evidence that employers or individuals will purchase an outpatient only benefit package. Covering only catastrophic costs provides important financial protection, but does not produce meaningful health benefits. We recommend covering those preventive and outpatient services that will improve individual and public health and reduce the demand on hospital emergency rooms combined with coverage for catastrophic hospital costs. In the interests of balancing improvements to access to care with affordability to individuals, outpatient

² Wulsin et al., Counties, Clinics, Hospitals, Health Plans and California's Uninsured (ITUP, 2004) at www.itup.org

services might have a small or no deductible and inpatient services a substantial deductible or expenditure cap.

Delivery Networks -- use local safety net health plans to construct the delivery network

The cost, efficacy and quality of care vary widely among providers. Local safety net providers are the bulwarks of care to the uninsured. We recommend using local safety net health plans with broad flexibility to develop the most cost and quality effective networks of care possible.

The local plan(s) must creatively resolve the natural tension between local safety nets that may prefer to narrow choice to only their own networks and the uninsured, who want access to a broader selection of culturally appropriate, quality providers. To the extent that uninsured participants and uninsuring employers are expected to pay sliding fee scale premiums, choice of providers becomes a paramount consideration. Without relying on premium contributions in the plan design, the most important design feature is improved access through convenient, culturally appropriate outpatient services.

Matching Funds – maximize funding for the expansion

Coverage expansion should maximize coverage by maximizing all potential funding. State, county and local funds spent on the uninsured should all be available to be used as match. Private funding cannot be used as the match, but should be encouraged in the coverage expansion design. Opportunities for funding from employers and employees should be available and encouraged. Counties and regions should be given flexibility and support to build coverage that wraps around or incorporates existing state and federal program funding such as Medi-Cal and Healthy Families. Counties and regions participating in the coverage expansion should be required as a condition of participation not to supplant existing local funds during the three-year pilot.

While we recognize the substantial state budget deficit makes it unlikely that state government will provide the match, we would encourage the state to make coverage expansion a high priority and budget state funding for the \$180 million annual match in years three to five of the waiver. If counties are to pay the match with local CPEs (certified public expenditures for the uninsured), there needs to be clarity as to what qualifies as a CPE and what does not. Some have suggested that the counties must certify at a rate of 2/1 or two dollars in local expenditures on the uninsured for each dollar in new federal match; it should be clarified with the federal government that the local matching rate for coverage expansions is 1/1.

State Matching Opportunities

As discussed earlier, we think the state should encourage experimentation with local pilot programs. If the counties are not interested or if the state wishes to provide the match and run a state program, we think there are several state programs that could be expanded using state General Funds as the match for the new federal funds: EAPC (Early Access to Primary Care), MRMIP for the medically uninsurable, GHPP for persons with severe medical conditions, CMSP for the low income uninsured and cancer screening and

treatment programs for the low income uninsured. EAPC pays for free and community clinic services to the uninsured; it is currently configured as a last resort bad debt pool for clinics; it could be transformed into coverage for primary care services for low-income adults, similar to the Utah model. MRMIP provides coverage for medically uninsurable individuals; the program could offer sliding fee premium subsidies for low-income medically uninsurable individuals. GHPP pays for specialty services through a limited provider network for uninsured individuals with designated medical conditions; the covered conditions and individuals could be expanded. CMSP pays for medical care to low income uninsured adults; it could be expanded with matching funds to cover uninsured adults with incomes up to 200% of FPL and transformed into a well-run managed care plan following the model of Solano Partnership discussed above.

If the state wishes to create a new state-run program as a foundation for future expansion, we think Maine's Dirigo Plan, Washington Basic Health Plan, MinnesotaCare and MassHealth are excellent models for state expansion. Some common themes are: coverage of basic health services, purchasing pool, successful interface with existing funding, and opportunities for employer and individual financial participation.

Funding Frequent User Initiatives

Several large urban counties are interested in doing a better job of managing care for chronically ill individuals who need and use a range of services from county health, mental health, social services and other county programs. Los Angeles, San Francisco, Alameda and other counties have been pioneers in these efforts, and the California HealthCare Foundation has funded several important pilots. These efforts are important models that should be more widely tested; many need one-time infrastructure investments in data systems and case management systems with immediate costs to the county and longer-term returns on the investment. They do not appear to be coverage expansions; however they could and should be funded through a similar competitive grants process under the \$180 million annually designated as managed care expansion funds. The target population for frequent user initiatives has many characteristics in common with a subset of the SSI disabled population that is proposed to be enrolled in managed care under separate provisions of the state waiver.

While the 1115 waiver funds are limited, we think this is an extraordinary opportunity for California to use local pilots to test and build consensus among the many promising coverage approaches for low income uninsured workers. We deeply appreciate the opportunity to comment on the concept paper, and thank you for your kind consideration of our comments.

Sincerely,

Lucien Wulsin Jr.
Project Director, Insure the Uninsured Project