

ITUP 2003/2004 Regional Workgroups: Findings and Recommendations

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Executive Summary

ITUP held eight regional workgroup meetings between September 2003 and June 2004: Bay Area, Central Coast, Central Valley, Los Angeles County, North Rural (2), San Diego County and Orange County. Of all workgroups, four issues stood out as primary and pervasive concerns: children's coverage, coverage for adults, SB 2 and the Medi-Cal redesign. The workgroups' recommendations on these issues are listed below.

Children's Coverage

Medi-Cal/Healthy Families

- Increased Medi-Cal/Healthy Families support for outreach, enrollment and retention efforts.
- Program simplification and streamlining
- Statewide implementation of the One-E-App.
- "No Wrong Door" enrollment
- Increased implementation of local Children's Health Initiatives.

Developing Children's Health Initiatives (Healthy Kids)

- Community "champion(s)" for children's coverage
- Broad community collaboration
- Enlisting business support
- Inter-county or regional collaboration for smaller counties to maximize economies of scale and share resources.
- A statewide program to alleviate financial burden for counties

Coverage for Adults

- Federal match for county health spending on §17,000 patients
- Redirecting some Medi-Cal spending to help provide match for expansion to Healthy Families parents (AB 1524-Richman).
- Study of Healthy Families parents' current access patterns to determine safety net impacts.

- Best practices for developing coverage for low-income workers:
 - Health coverage survey of employees to determine health services needs
 - Community collaboration in program development, administration and outreach
 - Multi-lingual orientations for workers

SB 2

- Educate the public on the uninsured, dispel myths and rectify misinformation about the bill
- Continue health reform dialogue, “if not this, then what?”
- Support establishment of Health Cost Containment Commission

Medi-Cal Redesign

- Maximize opportunities for federal match for care and coverage of adults
- Create regional Medi-Cal managed care for smaller counties
- Explore use of “Social HMOs” (currently pilot programs) for Medi-Cal Long Term Care beneficiaries

ITUP is funded by the California Endowment, the California Wellness Foundation and the Blue Shield of California Foundation to conduct regional studies of health coverage and access and hold workgroups with local stakeholders throughout the state. In 2003-2004, ITUP completed its third year of regional studies and workgroups, producing fifty individual county summaries, six regional overviews and two aggregate statewide summaries. These and other workgroups materials are available on the “Workgroup” portion of ITUP’s website, www.itup.org.

ITUP held eight regional workgroups between September 2003 and June 2004: Bay Area, Central Coast, Central Valley, Los Angeles County, North Rural (2), San Diego County and Orange County. This report summarizes the health care challenges and recommendations identified and discussed within each meeting.

The agenda of each regional workgroup was designed by local participants to meet their needs and interests. Some meetings were focused on a single issue, while others covered a range of topics relating to the uninsured and access to health services.

From all eight workgroups, four issues stood out as primary and pervasive concerns: children’s coverage, coverage for adults, the employer mandate, SB 2, and Medi-Cal redesign.

CHILDREN

Children's coverage was discussed in the majority of the workgroups this year. Each workgroup identified similar challenges and concerns with Medi-Cal and Healthy Families programs as counties struggle with outreach, enrollment and retention for children eligible for either program.

➤ **Medi-Cal/Healthy Families support for outreach, enrollment and retention efforts.**

According to the 2001 California Health Interview Survey, approximately 64% (656,000)¹ of uninsured children in California are eligible for either Medi-Cal or Healthy Families but not enrolled. Many of these children remain unidentified to counties and their families unaware of coverage options. Following the state budget reductions in outreach and enrollment funding, all counties struggle to maximize remaining resources to expand efforts to reach and enroll uninsured children.

Funding reductions have particularly affected certified application assistors (CAAs). In many regions, CAAs have proven to be invaluable resources in helping families enroll in the appropriate programs. The Orange County Workgroup participants, for example, report their CAA network has had tremendous enrollment and retention success. In most regions, CAAs are also valuable in keeping children enrolled as families face redeterminations and other administrative hurdles to continue coverage. CAAs in Orange County make regular calls to see if parents and their children are keeping appointments and reminding parents to complete any necessary paper work to keep their children enrolled. These relationships help families maintain coverage for their children.

¹ 2001 California Health Interview Summary, www.chis.ucla.edu.

However, this support is labor intensive and costly. Retention cannot be maximized without adequate funding. Increased support for outreach, enrollment and retention efforts is needed to reduce the number of uninsured children in California.

➤ **Simplify Application Process and Streamline Programs – “No Wrong Door”**

Almost all workgroup participants agreed that the lack of a statewide universal application for all public programs such as the One-e-App poses enrollment barriers. Such an option would prevent families from having to fill out multiple forms and reduce confusion over program eligibility. Program simplification and streamlining are also necessary to reduce consumer confusion and promote enrollment. The verification process should be radically simplified, relying primarily on computer cross checks, rather than repetitive paper chases for all the required documentation.

The county-based enrollment system was also cited as a very fixable barrier to Medi-Cal/Healthy Families enrollment. Santa Clara and Alameda participants cite the turn-around in the local Social Services Departments as key to their enrollment success. Currently, only county employees can enroll children in Medi-Cal. San Diego workgroup participants propose expanding enrollment opportunities in their region to include non-county sites, such as CBOs and community clinics, and use non-county workers for assistance as San Mateo and Santa Clara Counties have done with their Children’s Health Initiatives (CHIs). Counties that created a “no wrong door” system and expanded training and availability of application assistors and eligibility workers were able to reach more uninsured children.

➤ **Children’s Health Initiatives (CHIs) facilitate Medi-Cal/Healthy Families enrollment**

Currently, nine counties have children’s health initiatives (CHIs) to cover low-income, uninsured children ineligible for Medi-Cal or Healthy Families. Counties with CHIs found success in reaching Medi-Cal/Healthy Families children through efforts to cover children not eligible for either of these programs.² The recent evaluation of Santa Clara County’s Healthy Kids program showed that for every child enrolled in Healthy Kids, another child was enrolled in either Medi-Cal or Healthy Families.³

➤ **Roadblocks to New Local Children’s Health Initiatives (CHIs)**

While the number of CHIs grows, many counties face significant barriers to moving forward. Such road blocks include local funding, political will, community collaboration and having the local administrative and services structures to provide managed care to the target population. Many moving pieces need to come together to produce a successful program, and it is extra-ordinarily labor intensive to do so county-by-county.

➤ **Funding Sources and Business Support**

Funding is a significant concern. Many Children’s Health Initiatives are funded by local First 5 Commissions, Local Initiatives, philanthropic foundations and other private supporters. Local First 5 Commissions have been able to provide significant support for coverage for children 0-5 years. However, First 5 funding cannot necessarily be relied upon long-term, due to the regressive nature of the tobacco tax and Commissions’ other funding priorities. Private sources, such as foundations, businesses and health plans have

²Alameda, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara and Santa Cruz (which is also available to Monterey County children).

³ Christopher Trenholm. *Expanding Coverage for Children: The Santa Clara County Children’s Health Initiative*. (Mathematica Policy Research Inc., June 2004).

provided additional support for several CHIs, most of which, however, is limited and short-term. Some counties are also using tobacco settlement funds. A statewide Healthy Kids program would alleviate the fiscal and administrative pressure on local commissions.

Bay Area, Los Angeles, Orange, Central Coast and Central Valley programs have collaborated with the business community to support their initiatives. For example, in San Joaquin County, The Health Plan of San Joaquin, the Local Initiative that administers the Healthy Kids program, is partnering with the local Chamber of Commerce and hospitals for support. Central Coast workgroup participants suggest appealing to companies' desire for local "success stories". Other businesses may respond to the argument that healthier children and families improve employee attendance and overall productivity.

Foundation support is a vital component of CHIs' fiscal base. Each of the current CHI programs receives some support from statewide or local and community grantmaking foundations. Several foundations are helping counties in the development process, yet foundations cannot commit to premium support for the long-term. Many workgroup participants articulated the need for funding beyond program development and administration, to support premium assistance to their lowest income enrollees.

➤ **Community "Champion(s)" for Children's Health and Build Broad Community Collaboration**

Some Bay Area and Central Coast counties' success in building political will resulted from collaboration with a health care "champion" in the local government, such as the Board of Supervisors. Others developed momentum through local health plans,

community-based organizations that provide services to low-income families, public agencies and children's and health advocacy groups. Some of these same coalitions provide community outreach.

➤ **Opportunities to Reduce Cost and Improve Access for all Children**

In some counties, the absence of leadership and political will for a CHI prevents progress. Political objections to including undocumented children keep some counties from pursuing an initiative for uninsured children. Some counties have addressed these concerns by highlighting the financial benefit of covering these children. MediCal is already paying for emergency services. Preventive care, made possible with coverage, would improve undocumented children's health and reduce the cost and incidence of emergency care for children's unmet health needs. Allowing children to go to a doctor or clinic rather than the emergency room for services reduces the demand for emergency services and benefits all Californians (regardless of coverage status) when true emergency care is needed.

➤ **Inter-County or Regional Collaboration for CHIs**

Counties that lack a public hospital and/or public managed care system do not have the public infrastructure and incentives in place to run a program for uninsured children who do not qualify for Medi-Cal/Healthy Families. Central Coast counties discussed the potential for collaborative inter-county or regional children health initiatives to address these administrative issues. Counties without a public managed care system could work with those counties who can provide the necessary structure. Such partnering would allow smaller counties to take advantage of greater economies of scale. MRMIB could

allow those counties seeking to expand coverage for uninsured children to contract for its existing Healthy Families network of plans and providers.

COVERAGE FOR ADULTS

Challenges discussed in the regional workgroups concerning adults were: funding care for county indigent patients, funding county-level Healthy Families parental expansions (AB 1524-Richman) and covering low-income workers.

➤ Federal Match for County Health Spending on \$17000 Patients

Providing health services to low-income uninsured adults without access to public coverage programs has been a county responsibility since the early 1980s when the state of California terminated MediCal coverage for adults. Counties spend close to \$2 billion for over 1.5 million uninsured individuals using county health services.⁴ For most counties and local safety nets, this is a significant and growing fiscal burden, and funding streams do not keep pace with demand and cost of indigent health services. Without regular access to preventive care, county indigent patients are far sicker at the time care is sought; county patients often require more extensive and costly care than those with health coverage and are more likely to seek care in hospital emergency rooms. County and local safety nets are heavily reliant upon state and federal fiscal support; county health has a limited funding base of frozen or declining revenues; all three levels of government are in dire budget crisis.

⁴ See ITUP, *Overview of the Uninsured: California Summary* (June 2004) at www.itup.org.

Securing a federal match for county health spending on §17000 patients would improve counties' abilities to meet the health care needs of the indigent population. Los Angeles County and the California Association of Public Hospitals has proposed that the Schwarzenegger Administration seek a federal §1115 waiver to allow counties to opt into a program that provides federal matching funds for care to county indigent patients. Counties would have to meet minimum standards of eligibility and benefits and could not back out existing spending. This proposal would eliminate variations in county programs for indigents statewide and unify the delivery systems for county indigent so that eligibility and access does not vary by county residency.

The California Performance Review Commission recently recommended a state/county swap of responsibilities; the state would take over full responsibility for health care to indigent adults and In Home Supportive Services while counties would be fully responsible for mental health and children's social services.⁵ State takeover and a federal Medicaid match for coverage of adults would simplify program administration, improve the ability to deliver care efficiently and promote statewide uniformity in delivering care to low-income persons. New York, Massachusetts, Tennessee, Oregon and Arizona have already implemented federal waivers to cover adults.

- **Redirect some Medi-Cal Spending to Help Provide Match for Healthy Families Expansion for Parents; Seek and Secure Federal Approval for Local Match under AB 1524**

⁵ See California Performance Review at www.Report.CPR.ca.gov.

California has an 1115 waiver to cover at least 200,000 uninsured Healthy Families parents with a 2/1 federal match, but the state has not implemented the waiver due to its budget crisis.⁶ AB 1524 (Richman) permits counties to provide a local match for federal funds to expand Healthy Families coverage to parents of enrollees under 200% FPL. No county has yet been able to provide such a match because the state and federal governments have not implemented AB 1524.

Failure to implement this waiver also limits children's coverage. Families are more likely to enroll in a coverage program if all members of the family are eligible. Segmented eligibility fractures access to coverage and health services for all family members.

Some of the funding for Healthy Families parental expansion may already be in the delivery system. Medi-Cal share of cost currently pays for hospital care for these parents and Medi-Cal coverage for maternity care overlaps as well. It may be possible to redirect some overlapping state General Fund spending to contribute to the match.

➤ **Expansion of Coverage to Adults and Impacts on the Safety Net**

Some workgroup participants expressed concern for the impacts on local safety nets if Healthy Families parents or other adults are covered. If uninsured adults currently access services through the county safety net system, health coverage will allow them to seek care elsewhere. A resulting change in county hospitals' payer mix could reduce DSH funds county hospitals receive. The demographics and utilization patterns of this population, however, have not yet been fully studied. ITUP's LA workgroup participants

⁶ Lewin Group. *Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California*. (CA HHS, April 2002).

suggested forming a workgroup to study the impact a parental expansion would have on safety net providers.

➤ **Low-Income Workers**

County-based programs seeking to cover low-income workers were the focus of the Bay Area regional workgroup. Alameda, Contra Costa, Santa Clara, San Mateo and San Francisco counties have established coverage programs for low-income home care workers. Most of these programs require a minimum number of hours worked per month and are funded through a combination of county, state and federal Medicaid funds; workers pay a share of premium, roughly equivalent to the Healthy Families program participants. The Bay Area programs only cover home care employees, not their dependents. Shared best practices include:

- Health coverage survey of employees to determine health services needs
- Community collaboration in program development, administration and outreach
- Multi-lingual orientations with workers
- Regular meetings with stakeholders

Remaining challenges for covering this population are resolving workers' ongoing eligibility when they become sick and fail to meet minimum hourly work requirements in order to qualify for coverage and the uncertainty of continuing state funding given the state's budget crisis.

Coverage for childcare workers is the focus of planning efforts in Los Angeles and Santa Clara. A survey in Los Angeles found that up to half of childcare workers surveyed are uninsured; other surveys found the rates of uninsurance ranged from 20% to 33% of childcare workers. Questions to-be-answered during the planning process include: the

demographics and health care needs of the uninsured child care worker, health plans' willingness to insure very small and self employed child care businesses, potential funding from local First 5 Commissions, and the design of and extent of premium subsidy needed and its impact on projected participation.⁷

SB 2 (BURTON AND SPEIER) – LARGE EMPLOYER MANDATE

SB 2 would phase in a mandate that large and then medium sized employers offer and pay 80% of the costs of health coverage to their full time employees; employers of more than 200 employees must pay 80% of the costs for family coverage as well. Small employers are exempted; however if the Legislature passes a 20% tax credit for small employers health insurance, employers of 20-50 employees will be required to offer coverage as well. It is estimated that SB 2 would cover 800,000 employees and dependents.⁸ Most workgroup participants expressed strong support for SB 2 and raised many questions about its implementation.

SB 2 allows the affected employer the following options: either provide employee health coverage or pay a fee into a purchasing pool that will provide private health insurance for the firm's workers. MRMIB has the responsibility of designing an effective implementation strategy for this quite complex employer and employee coverage mandate. Issues to be resolved by MRMIB include: setting an affordable "fee" for employers and employees, establishing covered benefits, creating and maintaining a sustainable state purchasing pool, preventing adverse selection of the pool, clarifying the

⁷ See Chavira, "Connecting the Dots", and "Dynamics of Price Point Participation" (Insure the Uninsured Project, 2004) at www.itup.org.

⁸

roles of and program interface with Medi-Cal and Healthy Families, ensuring protection/participation for safety net providers, containing costs, protecting workers from wage or job loss, and keeping California businesses open and prospering.

Workgroup participants were very concerned that the November 2004 ballot referendum efforts to repeal SB 2 (if successful) would cripple future efforts to cover the uninsured in California.

➤ **Cost Containment Commission**

Most workgroup participants believed that health care costs and insurance premiums were out of control and that effective cost containment is vital for employers and public agencies to continue to provide coverage and for SB 2 to succeed. The public-private workgroup met in December 2003 and discussed a series of options to reduce the rate of growth in health costs and premiums.⁹ The Administration has yet to appoint or staff the California Health Care Quality Improvement Cost Containment Commission, established through AB 1528 (Cohn), as a companion to SB 2. Workgroup participants support efforts to appoint the Commission and to begin discussion and deliberation leading to prompt recommendations and action on health care cost containment.

➤ **Educate Public about the Uninsured and Dispel Myths and Misinformation**

SB 2 advocates and some business groups are battling over the referendum to repeal SB 2 in the November 2004 election. Many workgroup participants felt SB 2's passage represents a tremendous step forward and that a repeal would be a devastating blow to

⁹ See Public Private Workgroup Cost Containment Options at www.itup.org.

reform efforts. Challenges include misleading information about the bill and public myths about the uninsured.

The referendum's wording on the ballot may confuse voters. A "No" vote would repeal SB 2; a "Yes" vote would preserve the bill. Most workgroup participants recommend efforts to dispel myths about the uninsured and misinformation about the bill and allow voters to decide based on the facts and not misinformation.

If SB 2 survives the ballot referendum; litigation will ensue to challenge its implementation on the grounds that federal ERISA law pre-empts state efforts to mandate that employers pay for health coverage for their employees and that the SB 2 "fee" was actually a tax, requiring a two thirds vote of the state legislature.

➤ **Health Care Reform Dialogue**

Many workgroup participants believe SB 2 presents a unique opportunity to educate the public on health care reform and engage all sides in a dialogue for solutions. Many recommended challenging those who oppose SB 2's mandate to offer other realistic solutions, in effect asking "if not this, then what?"

MEDI-CAL REDESIGN

In an effort to improve Medi-Cal's efficiency and reduce state spending, the Schwarzenegger administration proposes a program overhaul. Included within the administration's goals for a redesigned Medi-Cal are controlled costs, improved fraud

detection and auditing systems, and simplified program administration.¹⁰ Components may include: co-premiums for some enrollees, tiered benefits, and expansion of managed care for the aged, blind and disabled (ABD) and into smaller counties. Many workgroup participants fear the Governor’s proposal will reduce Medi-Cal enrollment and services and restrict beneficiaries’ access to care.

ITUP believes that increased use of managed care may provide savings and more appropriate use of services¹¹; most workgroup participants are much less sanguine about any advantages of expanding MediCal managed care.

ITUP believes that re-design is an opportunity to seek federal matching for care to adults through an 1115 waiver¹²; most workgroup participants are distrustful of the other programmatic sacrifices that may be entailed in seeking an 1115 waiver.

➤ **Medi-Cal Managed Care Expansion**

Proposals impacting Medi-Cal coverage and beneficiaries’ access to services include managed care for smaller counties, a federal waiver to support county services for indigent adults (see above discussion under “Coverage for Adults”) and Social HMOs, managed care for long term care patients that incorporates social services required by this population.

Currently, very few of the smaller counties have managed care for Medi-Cal patients.

Many workgroup participants told us that their counties, their clinics and their provider networks are too small to absorb the financial risks of managed care. Some rural counties

¹⁰ Governor’s Budget Summary, 2004-2005.

¹¹ See ITUP’s Health Budget and MediCal redesign recommendations at www.itup.org.

¹² See ITUP’s discussion papers on 1115 waivers at www.itup.org.

have experimented with managed care, but were forced to discontinue when catastrophic care cases depleted resources. Pooling small counties' Medi-Cal patients into a regional managed care system may provide a feasible alternative to MediCal fee for service.

➤ **Social HMOs for Long Term Care**

Many workgroup participants are concerned for ABD patients' continued access to care were they to be enrolled in managed care. Social HMOs are designed to meet the social and support service needs of the members, beyond their traditional medical care.

Currently, social HMOs (such as On Lok and SCAN) are pilots providing social and medical benefits to Medicare and MediCal members, This experiment in managed care may be a model for providing managed care with ample supplementary services to long term care patients.

CONCLUSION

This paper summarizes common health coverage challenges and sixteen recommendations discussed in ITUP's eight regional workgroups over the past year.

More detailed, executive summaries of each workgroup are available under

“Workgroups” on our website, www.itup.org. ITUP plans to continue these meetings through July 2005.