Where Does Health Care Go From Here?
A Review of the Options for California

A Mid-Term Analysis of the
State Health Care Options Project
Papers Solicited by the
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Executive Summary

In the past year, the state of California has undertaken an ambitious and important exercise with the Health Care Options Project (HCOP), established with the passage of SB480 and led by the California Health and Human Services Agency. With the participation of numerous government, community and industry stakeholders, HCOP has given the state a valuable set of options for determining the future of health care in our communities, state, and nation.

It is not news that our current system of health care is in crisis. A recent national commission warned of "a perfect storm" in health care, of many different problems in the health care system coming to a head at once. Of these, the most glaring is the number of working families who are uninsured, and who, as a consequence, have significant problems in getting the care they need.

The health system in California is in greater distress than that of the United States as a whole. In California, nearly 7 million are uninsured—over one in five non-elderly Californians lack health care. Over 80% of the uninsured are in working families that play by the rules and pay taxes, and yet don't have basic access to care.

The minimal care the uninsured get in California is provided by a patchwork of public hospitals, community clinics and other providers that are under-funded and overburdened—and one more budget cut away from closing. Recent studies show that the uninsured in California are half as likely to have seen a doctor as the insured—and half as likely to have been to an emergency room. In California, those who are insured have seen their out of pocket costs skyrocket in the mid-1990's even as employers were reaping the benefits of level or declining premiums. The recent hikes in premiums in an economic downturn now further threaten job-based coverage.

The health system in California is in crisis. HCOP has performed a valuable service by collecting some of the best researchers and experts to detail proposals to further address the needs of the uninsured. While nothing can take the place of political leadership to address the most glaring problem of our health care system, **HCOP has started a crucial discussion that can move us forward to "universal" health care coverage.**

Most of these proposals demonstrate that progress toward universal access to health care is possible. HCOP shows that there are several paths to work to the vision of universal health care. Most of these proposals demonstrate

that universal health care is economically and socially viable. It is up to us and to our political leaders to make these findings politically viable.

The analysis of Health Access California indicates that most of these proposals would meet the following conditions, using the current system as the baseline. Most proposals would:

- increase coverage to the uninsured
- improve care to vulnerable populations, including seniors, the disabled, immigrants, and persons with chronic conditions.
- make care affordable for more people
- be affordable to society as a whole
- not decrease access or quality for those who already have coverage
- make the health system more comprehensible for consumers

Health Access has done its own evaluation of the proposals based on these criteria, and while some plans were found wanting, most showed that these goals can be achieved.

These proposals fall roughly into three categories: those that would achieve universal access to quality, affordable health care for all Californians, the mission of Health Access; those that would make progress towards this goal from the current system; and those that may be steps backward or at best sideways. Health Access supports both those proposals that achieve universal coverage and those that make progress toward this objective. Health Access opposes proposals that decrease access or quality for the insured or the uninsured.

Many of these options are preferable to the letting the current system continue to deteriorate in access and financial stability. Health Access California will continue to fight for proposals that move us toward universal access to quality, affordable health care for all Californians.

Note: This analysis was drafted in January-February, 2002. The papers are being revised in response to cost and quality analyses prepared by the Lewin Group and AZA consulting. Health Access will publish a final report once the papers are final. We offer this now to assist those following this process. We appreciate the input of several authors and of other observers. Any errors remain our own.

***Health Access**, founded in 1987, is a statewide consumer coalition dedicated to achieving quality, affordable health care for all California residents. This umbrella coalition includes more than 200 membership organizations representing seniors, the disabled, immigrants, communities of color, labor, children and families. Health Access has sponsored universal health care proposals and advocated and won specific reforms that provide greater access to care for all residents and California's most vulnerable populations, for the insured and the uninsured.*

Report Card on the Health Care Options Project

A rating on how the proposed plans measure up in covering the uninsured, improving care to vulnerable populations, making health care more affordable, and not decreasing access or quality to the insured or the uninsured.

Title of Proposed Plan	**Author(s)**	**Midterm Grade**	**Final Grade**
A Draft Single Payer Health Care Reform Option	James Kahn, MD, MPH, et. al.,	A	
Cal-Care: A Single Payer Health Plan for California	Judy Spelman, RN, Health Care for All	A	
The California Health Service Plan	Ellen R. Shaffer, PhD, MPH	A	
Stepping Up to Universal Coverage: A Proposal for Health Care Reform in CA	Richard Brown, PhD, & Richard Kronick, PhD	B+	
The Managed Care Expansion Program	Bob Brownstein, et. al., Working Partnerships	B	
The CHOICE Option	Helen Schauffler, PhD	B	
The Cal-Health Option	Helen Schauffler, PhD	C	
Current System	**Status Quo**	C	
The California PacAdvantage Premium Program	Peter Harbage, Katie Horton, & Jennifer Ryan	D	
Insure the Uninsured Project	Lucien Wulsin, Jr., et. al.	D	

A: The plan truly would get California to universal or near-universal coverage

B: The plan improves California's health care system, expands coverage, and moves the state closer to the goal of universal coverage

C: The status quo, with its assets and flaws, or a plan with a similar balance

D: The plan would have a detrimental impact on California's health care system.

**The grades are intended to rate the plans proposed, not the authors or the workmanship of the drafting. Many of the plans are explicit that they would not provide universal coverage. Rather, often explicitly in an attempt to offer more politically feasible alternatives, they are crafted to expand access to coverage and improve the current system from the status quo.*

The Status Quo

Current System

Midterm Grade: C

In order to evaluate plans to change the health care system, we must first establish a baseline evaluation of the current system.

The current system provides coverage for 27 million of 34 million Californians, in many cases with significant out of pocket costs or limits on benefits. It leaves almost 7 million Californians with no health insurance of any sort and forced to rely on an inadequate safety net of public hospitals, community clinics, and other providers.

Expansions of coverage in the last several years have made most children eligible for health coverage through Medi-Cal, Healthy Families or job-based coverage of their parents. Significant streamlining of Medi-Cal and Healthy Families and energetic enrollment efforts have improved enrollment of those eligible though much remains to be done to get every child covered. Significant barriers include lack of community knowledge about the availability of health benefits and immigration status of family members. In most families with immigrant members, one or more family members lacks clear legal resident status. Because of this and the recent history in California in which both benefits and residency were jeopardized by taking advantage of legally available benefits, many families with immigrant members have been reluctant to enroll their children in government programs.

Seniors face significant out-of-pocket costs and limits on benefits because of the design flaws of the Medicare program. Millions of Californians with job-based health coverage lack dental or vision coverage and many pay significant out of pocket costs, in the form of share of premium, co-payments or deductibles. These out-of-pockets costs increased during the early to mid 1990’s while employer premiums were level or declining because of the bad labor market. The need for the passage of the Health Access HMO Patient Bill of Rights, signed by Governor Davis in 1999, was proof that even those with health insurance have trouble getting health care when they need it.

Those who have no health insurance face the greatest barriers to care. Only 13% of the uninsured have been seen in an emergency room in the last year while 23%-33% of the insured have been cared for in an emergency room. In many counties, particularly those without public hospitals and community clinics, care for the indigent is severely limited. Even in those counties with public hospitals and community or county clinics, the uninsured face substantial barriers to obtaining needed care at all, much less timely care.

This lack of access and coverage is coupled with a high overhead system in which insurers and some large providers spend a significant share of the premium dollar on marketing, screening out high risk populations (that is, those that need health care), attempting to deny or avoid payment, and paying returns to investors. The cost analyses done for the Health Care Options Project generally validate what virtually every other reputable study has found: the insurance model of financing health care is not cost-effective for society as a whole.

The current system makes up in incomprehensibility what it lacks in affordability. Consumers know that if they are over 65, they get Medicare but many are surprised to find how little it covers and how much it costs. Consumers know that they get health coverage from their employer or they must buy it themselves. But few recognize that once they are over 50, coverage is essentially unavailable unless it is a continuation of employment-based coverage. Few consumers can find their way through the thicket of multiple insurers and layers of providers if something goes wrong. One survey found that 42% of Californians had had some problem with their health insurer and that in a small but chilling number of cases that problem had resulted in disability or worsened condition. (Schauffler 1998)

A November 2001 report by the nonpartisan National Coalition on Health Care, chaired by former Presidents Carter, Bush and Ford, warned that “powerful economic forces…have unleashed a ‘perfect storm’ that could increase dramatically the number of uninsured people in the U.S.—with as many as 6 million people in total losing their coverage in 2001 and 2002.” With rising health insurance premiums, rising unemployment, a general recession, and government inaction, the report estimated that “a total of 86 million Americans could suffer a gap in their health coverage.” In the grading scheme of this report, it may take significant policy change just to maintain a “C”, given the threats on the horizon to job-based coverage, the individual health insurance market, and safety-net providers.

On the horizon are a plethora of proposals to make health coverage even more unaffordable and incomprehensible for the average consumer, including various versions of vouchers and so-called consumer driven plans designed by insurers and purchasers to shift the cost and the burden of assuring safe care to the individual consumer.

James G. Kahn, MD, Thomas Bodenheimer, Kevin Grumbach, Krista Farey, Vishu Lingappa, Don McCanne.

A Draft Single Payer Health Care Reform Option

Midterm Grade: A

This proposal is a single payer model in which all California residents of more than three months, including those with unclear immigration status, would be covered for all health services, including long term care, home health and prescription drugs as well as physician, hospital and other care. It would improve coverage for virtually every Californian, including some such as Medicare enrollees who are insured but lack key elements of coverage such as prescription drug coverage and nursing home care.

It appears that it would make care more affordable for most Californians by regulating out of pocket costs. However, the proposal includes co-payments for some care. Although these co-payments would be income-tested, the experience is that most policy analysts underestimate barriers to needed care for moderate-income consumers created by out of pockets. It may also include dental and vision coverage though that is not certain.

This single payer proposal would also make health care more affordable for society as a whole by reducing administrative overhead through eliminating health insurers and through reducing physician and hospital overhead by using state government as the sole or single payer of health care costs in contrast to the current system of multiple payers and overhead ranging from 5% to over 30% for private insurers.

This single payer proposal is also distinguished by its explicit inclusion of group HMOs, such as Kaiser Permanente, as a model for providing care as well as both fee-for-service and salaried physicians. Since Kaiser is a well-established system, serving more Californians than there are residents of most Canadian provinces, this is an interesting element of this proposal that preserves an important component of the existing system.

The proposal would generally decrease costs for employers that now offer insurance and increase costs for those that do not with a modest net increase to the employer community. It also tends to decrease costs for lower and middle income families while increasing costs for higher income groups, particularly those over $100,000, because of the progressivity of the taxation plan.

This system, very similar to Medicare in its structure, is the easiest for consumers to comprehend: it builds on the existing delivery system but replaces the many sources of health coverage and funding with a single payer for health services.

Judy Spelman, RN, and Health Care for All - California

Cal Care: A Single Payer Health Care System for California

Midterm Grade: A

This single payer proposal is more complex than that offered by Dr. Kahn, et al. Like the other single payer proposal, it contemplates the State of California as the single purchaser or payer of virtually all health services for all Californians with tax revenues as the funding source.

This proposal would also cover all California residents of more than three months, including legal immigrants and those with unclear legal status, with a longer residency requirement for long-term care. Its benefit package is based on Kaiser Permanente large group benefit packages, including drug benefits through a formulary, and those additional benefits covered by Medicaid and Medicare, including limited long-term care and home health. Similar to the other single payer proposal, this increases coverage for some insured populations, such as seniors who lack prescription drug coverage.

Affordability would be improved for the uninsured. The impact on the insured is less clear because the proposal does not specify what out-of-pocket costs would be. Also, the document publicly available at the time of this publication does not specify precisely what taxes would be imposed on individuals, so it is difficult to determine progressivity or regressivity. The paper states a preference for a payroll tax, but it is unclear how other income, such as capital gains, would be treated. Employers would also pay the payroll tax so employers that currently fail to provide coverage would find their costs increased. The impact on employers now offering coverage is unclear in the available draft.

Affordability for society as a whole would be achieved through global budgets and through “strong internal cost containment” and “administrative streamlining”. Cost controls on pharmaceuticals are discussed at length. This paper proposes creation of a new governing structure for health care, including an elected commissioner and appointed commission of ten members that would determine taxation to support the health system, as well as administer it. It also proposes a structure of county level health office and departments that would negotiate contracts and fees for providers as well as establish budgets. This may need to be rethought, given the variability in size of counties in California (from Alpine with a few thousand residents to Los Angeles with many millions).

Generally, this would improve access and quality for those who are already insured by covering additional benefits, and by prohibiting co-payments and deductibles. The publicly available version of the proposal does not specify how

it would treat group HMOs such as Kaiser Permanente or existing delegated medical group models but instead offers discussion of various approaches.

This system, because of its local administrative structure and the creation of new state government entities, is slightly more complex for both consumers and providers than the Kahn proposal but far simpler than the existing hodge-podge of coverage and funding from both the public and the private sectors.

Ellen R. Shaffer, PhD

The California Health Service Plan

Midterm Grade: A

This proposal differs from the single payer proposals in that all physicians would be salaried public employees and all health facilities would be public facilities. Similar to the single payer proposals, the State of California would provide for most health services for all Californians and would finance these services through tax revenues. This combines both a single public payer system and a single public delivery system.

This system would provide comparable access to comparable care for all Californians. It is the system that assures that the most vulnerable populations are treated in the same way as the most affluent. This proposal as currently drafted includes hospice, home health, and some nursing home care as well as dental and vision care.

This proposal also provides the greatest assurance of cost control for both individuals and the society as a whole by making the entire system a public system of both financing and delivery. Also, Dr. Shaffer recommends a population health approach that further enhances cost control by concentrating on the most cost effective elements of health care for the greatest number.

This proposal includes group practices as a delivery system element with an emphasis on primary care, use of evidence based guidelines and input from local communities served by the group practices. These are intended to improve care for the currently insured as well as the uninsured. Any person with health insurance who has faced a major illness in California knows that the term "integrated health system" is at best a misnomer and at worst a cruel joke on a consumer facing literally life and death decisions about how to obtain care.

In the existing delivery system in California, even those with ample insurance and the ability to pay substantial out of pocket costs often find timely care unavailable because of shortages of physicians, nurses and hospital beds as well as insurance company barriers to care. While at first glance, this proposal with its dramatic restructuring of the delivery system might be considered to pose a threat to quality and access for the most affluent and best insured, it is not clear that in actual practice such would be the case.

This system is perhaps the simplest of all to comprehend: both the health delivery system and health funding would be the responsibility of state government.

E. Richard Brown, PhD, UCLA and Richard Kronick, PhD, UCSD

Stepping up to Universal Coverage: A Proposal for Health Care Reform in California

Midterm Grade: B+

This proposal incorporates two major elements: an expansion of the existing Medi-Cal/Healthy Families to adults without children at home up to 150% of poverty (roughly $13,500 for a single person or $6.50 per hour) and requiring employers either to pay a state tax for health coverage through the Healthy California program or to play by providing coverage. Medi-Cal, Healthy Families and AIM would be combined into a single Healthy California program with benefits comparable to those in Healthy Families and CalPERS. Self-employed persons would receive coverage through the Healthy California program. The Healthy Families/Medi-Cal expansion would cover citizens and legal immigrants. Most persons with unclear immigration status are working people or their dependents so employer coverage provided under the pay-or-play mechanism would cover them.

The proposal would significantly expand coverage for the uninsured without diminishing access or quality for those currently either through job-based coverage, Medi-Cal or Healthy Families. Those covered by Medi-Cal would have those benefits now provided by Medi-Cal. The program would also include coverage for dental and vision care, coverage that many with job-based coverage now lack. The proposal also requires that job-based benefits be actuarially equivalent to those offered by CalPERS, a standard which some job-based coverage does not meet today.

This proposal would make care significantly more affordable for many low income consumers by providing coverage either directly through Healthy California or through employment based coverage in the second phase. The proposal requires that participants pay a share of premium for the more expensive two-thirds of the plans offered through Healthy California but assures that one plan is available without share of premium. The proposal provides for co-payments for physician services and prescription drugs but none for preventive care or for hospitalization. Modest out of pocket costs are customary in the current health system but may deter low and moderate-income individuals and families from seeking necessary or appropriate care thus creating later health costs. The lack of co-pays for preventive services acknowledges this deterrent effect: a perfectly routine physician visit that involved one or two prescriptions could cost $10-$15—not much for an affluent person but real money for someone making less than $6.50 an hour (the upper limit of eligibility for a single adult).

In order to meet the cost-neutrality standards required for a federal Medicaid waiver, the proposal assumes greater control of Medi-Cal and Healthy Families costs due to increased market share. This takes advantage of the increased purchasing power of the pool created by the Healthy California program. Also, this eliminates the cost shift that now occurs as employers dump the cost of coverage on government programs by failing to pay for employment-based coverage.

This proposal provides a simpler system than the current one: consumers would know that either they get health coverage from their employer, their employer pays for it through the State, or the State pays for it. The self-employed, who now have great difficulty in purchasing coverage in the individual market, would be able to obtain and afford coverage.

Bob Brownstein, et. al., Working Partnerships USA

The Managed Care Expansion Program

Midterm Grade: B

This proposal would expand eligibility for Medi-Cal and Healthy Families to all legally resident Californians up to 400% of poverty. This increases eligibility levels for children and parents as well as including adults without children at home. All newly eligible enrollees will be enrolled in the publicly-run managed care plan, in most cases either the Local Initiative of Medi-Cal managed care or the County Organized Health System. This is explicitly intended to strengthen safety net institutions that serve the remaining uninsured. The vast majority of California residents live in counties served by one or the other of these systems. The benefits would be those available through the existing Healthy Families program.

This proposal would significantly expand coverage for many vulnerable populations, including low and moderate income working people, the self-employed, and flex workers. It also now incorporates one of the best features of the Santa Clara experiment on which it is modeled: that is inclusion of all persons regardless of immigration status. In Santa Clara as in Alameda and other counties that have enrolled persons without regard to immigration, it has been discovered that most families that include immigrants have at least one family member that has unclear immigration status for some reason or another. This ambiguity and the attendant fear of loss of residence in the United States deter even those who are indisputably legally resident from seeking coverage. Given the high proportion of uninsured who are immigrants or in families with immigrant members, limiting coverage to those legally resident creates greater barriers than had been previously understood.

Individuals who are covered through this proposal would be required to pay a share of premium on a sliding scale determined by income. Other out-of-pocket costs are not described in the current version of the proposal.

The proposal estimates the cost to the State of California to be about $4 billion but proposes a phase-in over 15 years in order to allow transition and to absorb the cost increases.

The proposal appears to have no negative consequences for those who already have coverage. It is deliberately designed to protect access and quality for the remaining uninsured by strengthening safety net providers.

This program would likely face problems with consumer comprehensibility comparable to those in the existing system: because it is a system based on individual income in which individual consumers must apply (and presumably re-apply) for coverage, many consumers who are eligible may not be aware of its existence and others will be deterred by the burden of application. In Santa Clara County, significant progress has been made in the short term in overcoming these obstacles: whether this can be replicated elsewhere or over time remains to be seen. In contrast, Medicare eligibility is determined once and continues in effect permanently. The result is that virtually every Medicare-eligible senior is enrolled in the program.

Helen Schauffler, PhD

The CHOICE Option

Midterm Grade: B

This proposal, an ambitious re-thinking of earlier reform proposals, would attempt to expand coverage by requiring employers to pay a payroll tax or provide coverage as well as permitting, but not requiring, workers to pay a share of premium so that the worker receives coverage.

Workers can participate if they have worked full-time or part-time three of the last 12 months, are eligible for COBRA and are receiving unemployment benefits. Except in a severe economic downturn, these criteria should make eligible almost all persons with a labor force connection.

Benefits will be "comprehensive" and based on existing comprehensive packages but will be limited to those determined by an independent panel of physicians to be "medically necessary" in order to preserve affordability. This is an interesting approach that raises numerous difficult issues not raised in other proposals. For example, under some definitions of medical necessity, contraception is not medically "necessary" for most women: appropriate, but not necessary. Similarly, in the past, some definitions of medical necessity have excluded care for those with degenerative conditions (California Children's Service still does.) While that may not be the intent of the author, definition of benefits based on medical necessity can limit access and quality. It is our understanding that the author may be considering this approach further.

Affordability for the individual consumer is affected by both co-payments and share of premium that are contemplated in the proposal. The proposal includes a variety of co-payments for those with incomes above 150% of the federal poverty level. As with other proposals that contemplate out-of-pocket costs, this raises concerns about deterring needed care for low- and moderate-income families. The share of premium is based on a sliding scale incorporating both income and family size up to 2% of total wages up to the maximum for Medicare ($84,000 in 2001) for workers above 150% of poverty. Like Medicare, this tax on earned income up to a cap is not as progressive as a tax on all income with no cap. Issues of worker privacy could be resolved by basis the determination of poverty on wages earned with the employer in question rather than all income. For many workers who currently perceive themselves as paying no share of premium, it may be perceived as an increase in health costs. Further, unless employers are required to adjust wages to cover this share of premium, for some workers, it may well be an increase in costs. The proposal is designed to assure

affordability for the lowest income workers. Its impact on moderate income working families is worth exploring further.

Workers are not required to participate in the system and may simply choose not to insure. This creates the potential of adverse selection: that is, younger, healthier workers may choose not to be insured while older workers with more health conditions would pay the share of cost for coverage. It also raises interesting public policy questions in a state in which strict regulation on secondhand smoke, seat belts, motorcycle helmets and other measures have been justified on grounds of health impact: is wearing a seat belt more important to an individual's health than health insurance? Why require one and not the other?

Employer share of premium is based on the size of firm without regard for profitability. Small firms pay only 5.5% of payroll while firms over 50 pay 6.3% of payroll. The tax is refundable if workers are covered by the health plan offered by their employer. The proposal states that the employer tax is less than the current cost of premiums for employers of all sizes.

We look forward to the analysis of the cost implications for society and for state government. Without such a detailed analysis, it is difficult to estimate whether the proposal includes sufficient revenues, relies on cost controls on providers or is adequately funded. It is possible that the publicly available version may combine lack of cost controls with insufficient revenues and thus result in greater costs to society.

The proposal also contemplates restructuring the delivery system. The proposal specifically eliminates from State contracts all health plans and insurers that use the delegated medical model. Those providers contracting with the State operated system will not be paid on a capitated basis: instead physicians will be paid "discounted" fee for service and hospitals paid using DRGs. The proposal anticipates that payments to providers will be better than private sector compensation and that no prior approval of physician decision-making will be required. The proposal also states that group model HMOs such as Kaiser Permanente and the various public managed care plans set up under Medi-Cal managed care (Local Initiatives, County Organized Health Systems) will contract with the State system and presumably will continue to be paid on a capitated basis. Employers will continue to be able to purchase coverage from health plans and insurers that use capitation but the State program will not do so.

Because of the innovative nature of this proposal, it is difficult to determine its impact on those who are already insured: will their employers shift them to the State CHOICE Program with its required share of premium? Would this be an improvement in affordability? In quality? For those who are uninsured, many could be covered if their employers either provide coverage or pay the tax and the worker then chooses to pay their share of premium. Workers, currently

insured or uninsured, could opt not to have coverage: the social equivalent of eliminating seat belt requirements or occupational safety standards. For those who are now insured, this would be a step back. The proposal publicly available as of this date does not contemplate changes to funding for safety net providers or other elements that would undermine access or quality for the current and remaining uninsured.

Like the proposal by Brown and Kronick, this proposal would improve comprehensibility for consumers somewhat: consumers would know that either they get coverage through Medi-Cal or Healthy Families, through their employer, or by paying a share of premium to get coverage through the State CHOICE program. While not as simple for the consumer as Medicare or other single payer proposals, this proposal would be a step forward in comprehensibility and probably in access.

Helen Schauffler, PhD

The Cal-Health Option

Midterm Grade: C

This proposal, based on AB32 by Assemblymember Keith Richman, would expand coverage by extending Medi-Cal and Healthy Families to cover legally resident adults without children at home with incomes up to 250% of poverty, the same level now authorized for parents and children. The benefits would be those offered in those programs. The author is considering additional benefits for other populations, such as prescription coverage for seniors, which may be added in future drafts.

The proposal would improve access for vulnerable populations by extending coverage and improving enrollment of eligible low- and moderate- income consumers.

The proposal also contemplates a “standard uniform benefit package” for individuals over 250% of poverty that would be 10%-20% less expensive than existing coverage. This benefit package would exclude prescription drugs and includes out-of-pocket costs for consumers with substantial health needs. This package places a greater cost burden on those with greater health needs, most likely to be persons over 50, persons with chronic health conditions and other vulnerable populations.

Like other expansions of Medi-Cal and Healthy Families coverage, this proposal assumes federal matching funds would be available. This proposal does not specify how the requirement for cost-neutrality would be met.

The summary now available proposes transferring funds from the safety net to help finance coverage expansions by transferring 70% of the average per capita cost of safety net funding per uninsured person. This approach assumes that the safety net is adequately funded to provide care to the uninsured. It is not. This approach also assumes that most of the uninsured would be eligible for coverage and would be willing to enroll. But many of the uninsured are immigrants or have family members with immigration issues that make them reluctant to enroll in public coverage programs. The combination of these two facts means that de-funding the safety net to fund coverage expansions reduces access for the uninsured. While a supporter of the bill concept, Health Access California vigorously opposed in the legislative process those provisions that harmed safety-net providers. It is our understanding that this aspect of the proposal is under review by the author and may be further revised to address these concerns.

This proposal would reduce access for some uninsured, specifically those not eligible for coverage expansion—and who thus would be negatively impacted by cuts to safety-net providers—and would reduce access and quality for those already insured, specifically by creating a package of limited benefits of some sort.

This proposal, like others that continue to rely on means-tested coverage, is less comprehensible and less readily accessible for consumers than the single payer proposals, the health service model or even the "pay or play" model. This proposal relies on consumers to be the moving party in enrolling (and re-enrolling) determined on income eligibility standards that policy experts often have difficulty delineating. Unlike Medicare which covers everyone over 65, this proposal and other income-based coverage expansions require consumers to seek coverage multiple times and to provide financial information repeatedly.

Peter Harbage, Katie Horton, and Jennifer Ryan

The California PacAdvantage Premium Program

Midterm Grade: D

This proposal contemplates using premium subsidies for small employers participating in the existing small group purchasing pool with a sliding scale subsidy for employers up to 350% of the federal poverty level. The program would cover small employers and their employees without health benefits in the previous six months if those employers chose to participate in the plan. The benefits would be comparable to those in CalPERS, Kaiser Permanente, or the federal employees plan.

The increase in coverage would likely be modest in such an approach although it would roughly double the number of employees in the existing small group purchasing pool. While small employers are disproportionately unlikely to offer health insurance, it is not clear that cost is the only barrier. Small employers cite the inability to get information about health insurance options as a significant barrier to getting coverage. Although California has had a small business purchasing pool for almost a decade, it is unclear whether an expansion of that pool combined with a subsidy would address such barriers.

California already has the cheapest health insurance premiums in the United States—and very nearly the lowest rate of employer purchase of health insurance. Health insurance premiums in California are a half to two-thirds the price of those in other states where small employers are far more likely to provide health coverage. Employer participation in the existing small group pool in California has been less than anticipated and only a fraction of the small employer market. Experience in other states with premium subsidies suggests that these programs require high overhead with little expansion of coverage compared to expansions of programs such as Medicaid/Medi-Cal or SCHIP/Healthy Families.

Issues of employee privacy are also raised by this approach: should employers know about total family income, family members, and family immigration status? Without careful design, an employer premium subsidy program may put vulnerable populations at risk for problems other than lack of health insurance, including immigration problems or employer discrimination based on family size. The authors indicate that future drafts of the proposal will assure that employee privacy is protected.

This approach also leaves low-income workers responsible for out of pocket costs in addition to share of premium. The share of out-of-pocket costs would vary depending on the plan selected. Low- and moderate-income people are

likely to be inappropriately deterred from seeking necessary care by out-of-pocket expenses. Hence out-of-pocket costs would put vulnerable populations at greater risk.

The premium subsidy approach does not make health care affordable to society as a whole. Instead, it simply subsidizes employers and does little to reduce the overall number of uninsured. Although this proposal targets employees of small employers and might reduce the number of uninsured by as many as 100,000, it would leave almost 7 million uninsured.

As proposed, the premium subsidy approach would not disturb access or quality for those already insured---unless employers who now offer health benefits chose to drop them for six months in order to obtain the subsidy. This has not been the experience in other states but in California. A six-month period in which employees are unable to obtain coverage is a modest deterrent to an employer not committed to providing health benefits.

A premium subsidy approach may be difficult to implement because educating employers and workers about its availability is challenging, especially without educating employers how to drop coverage to take advantage of the program.

Lucien Wulsin, Jr., et. al., Insure the Uninsured Project

Insure the Uninsured Project (ITUP)

Midterm Grade: D

This proposal, one of the most complicated of the nine offered, provides expansions of coverage for some populations while proposing reduced access to care for some.

It would expand coverage to low-income adults without children at home by covering them through either Medi-Cal or Healthy Families. This expansion would be restricted to legal residents for which a federal match is available. The proposal also contemplates expanding job-based coverage by using tax and purchasing credits to small employers and low-wage workers of those employers. The tax credit would be limited to 50% of the premium cost. Finally, flex workers would benefit from tax subsidies and underwriting reforms to make individual insurance more available.

Experiences in other states, including New York and Massachusetts indicate that tax credit for health care have modest results at best for increasing coverage to the uninsured. A small employer given a choice of paying half the cost of health care for its low-wage workers, or paying nothing, have generally chosen to pay nothing and forego providing health coverage to their employees. Health care premiums are expensive for small businesses, even with a subsidy of 50%.

The other major argument against tax credits for health is that they are inefficient, directly scarce resources to employers who already provide health care to their workers for competitive reasons. This proposal addresses some of this concern by narrowly targeting the tax credit. However, this also means that many categories of workers are left out, such as low-wage workers of large employers, like a Wal-Mart.

The proposal calls for a study of and moratorium on mandated benefits. Some benefits may be reduced for some consumers. The proposal does not appear to specify which mandated benefits would be eliminated but mandates in California include contraceptive drugs and devices, supplies for diabetics, mental health parity, childhood immunization, pap smears and mammograms. Many of these benefits were enacted to protect vulnerable populations, including women, children, people over 50 and those with chronic conditions. Thus, this proposal might make access to care worse for vulnerable populations although it is not entirely clear which mandates would be eliminated for which populations.

The expansion of Medi-Cal and Healthy Families to cover adults without children at home would meet the federal test for cost-neutrality by transferring low-income

disabled persons to managed care, thus lessening and disrupting the existing care of this very vulnerable population.

The federal cost-neutrality test would also be met by reducing Medi-Cal subsidies to existing safety net providers. As adults are transferred to Medi-Cal and Healthy Families, what counties currently spend on providing health care would be transferred to pay part of the state share of the cost of Medi-Cal and Healthy Families. This first presumes that the tax credits and state program expansions would cover virtually all of the uninsured, while experience suggests that both approaches leave many uncovered. Other implicit assumptions are that care for the uninsured is adequately funded and that the uninsured have access to care that is comparable to that of the insured—studies refute both presumptions.

This transfer would defund the safety net of county hospitals, community clinics and other services that provide minimal access for a portion of the uninsured, including both those eligible for Medi-Cal and Healthy Families under the proposal and those who are not. For example, in Los Angeles County, 2.6 million persons are uninsured while 624,000 would be eligible under the coverage expansion. The proposal implies that because the number of unduplicated users is similar to that of which would be covered under the expansion, this transfer of funding works. What about the other two million uninsured? Where do they get care when the county hospitals and community clinics lose their funding? A recent study by the Urban Institute indicates that in California, only 40% of the uninsured saw a doctor in the last year—and only 12% went to an emergency room—while the insured went to the doctor or an emergency room nearly twice as often. A cost-neutral solution that robs from the county share of health funding perpetuates or worsens the manifestly inadequate access to care. While the author maintains that the proposal would get a better match for county dollars, it robs the counties ability to provide basic safety-net services—for the insured and the many uninsured left—that will be needed under this system, and into the future.

Thus, the proposal would in some counties endanger care for populations not eligible for the coverage expansions, including most particularly immigrants and the homeless. Similarly the proposal contemplates transferring state funding, perhaps from programs that serve persons with unclear immigration status as well as those eligible under the coverage expansions. The proposal mitigates this partially by stating that the shift in county funds should occur after enrollment of county patients in Medi-Cal and Healthy Families and by providing one-time bridge funding. Again, to the extent that enrollment does not occur, is not sustained, or is not available due to immigration or other barriers, transfer of funds is problematic. The proposal acknowledges these and other concerns with this element of the proposal but nonetheless suggests this approach.

This proposal also includes a premium subsidy program for small employers and low-wage workers. As with the other premium subsidy proposal, this proposal

raises issues of equity and cost-effectiveness as well as worker privacy and effectiveness in expanding coverage. This proposal, which contemplates subsidizing small employers and flex workers that purchase coverage directly, also raises concerns about fraud and administrative complexity. Again, it is difficult to understand how small employers and low-wage or flex workers will learn of this subsidy and if they do, how small employers will be deterred from dropping coverage to take advantage of the subsidy. While employers that fail to offer coverage cite cost as a major barrier, the willingness of their compatriots in other states with far higher premiums to provide coverage makes us skeptical that a partial subsidy will be effective in expanding coverage.

While this proposal incorporates some simplification of the existing hodge-podge of public and private funding and coverage, its complexity is daunting. Further, while the proposal would expand coverage for some, numerous elements of the proposal would reduce access or quality for some populations and put others at risk of loss of access or quality.