THE CALIFORNIA HEALTH CARE OPTIONS PROJECT: INTERIM REPORT

Prepared for:
The Health Resources and Services Administration

Prepared by:
The California Health and Human Services Agency

September 2001

HEALTH AND HUMAN SERVICES AGENCY
State of California

GRAY DAVIS
GOVERNOR

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Developmental Services

Emergency Medical Services Authority

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Health Services

Health and Human Services Data Center

Managed Risk Medical Insurance

Mental Health

Rehabilitation

Social Services

Statewide Health Planning and Development

Workforce Investment

Ms. Joyce G. Somsak
Senior Health Policy Advisor
Health Resources and Services Administration
Community Access and State Planning Grant Programs
5600 Fishers Lane, Room 11-25
Rockville, MD 20857

September 28, 2001

Dear Joyce:

On behalf of the California Health and Human Services Agency, I am pleased to submit to you the enclosed Interim Report on the status of the California's Health Care Options Project, supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

As reflected in Attachment 2 of the report, we have made considerable progress on the project, and have begun the process to more fully develop the nine options for expanding health coverage in California. The project will culminate in a series of five statewide symposia in January and February of 2002, in which we anticipate the options will provide the basis for meaningful public debate and discussion on the health coverage options. As part of a more comprehensive report, we plan to include the findings of these symposia, in addition to all the major components outlined in the guidance provided by HRSA, in a final report to you by late March of 2002.

I hope that you find this report helpful and informative. Please do not hesitate to contact me at (916) 654-3301 if you have questions concerning our project. Thank you.

Sincerely,

Genie Chough
Assistant Secretary for Programs and Fiscal Affairs

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EXECUTIVE SUMMARY

PROJECT DESCRIPTION

On February 28, 2001, the California Health and Human Services Agency (CHHS) received a one-year State Planning Grant of nearly $1.2 million from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services to support the Health Care Options Project (HCOP). The purpose of HCOP is to guide the State in a systematic exploration of different approaches to achieving universal coverage by engaging in an in-depth examination of a range of reform options. These options will be quantitatively analyzed and reviewed through a public process. The results will be forwarded in a report to HRSA and the State Legislature that will contain the quantitative analysis and a thorough discussion of various stakeholder perspectives. The report will provide policy makers and both public and private stakeholders with the necessary tools to use in future policy discussions and any future actions they may take aimed at reducing the current and growing uninsured population in the State. The project helps California to implement SB 480 (Solis), enacted in 1999, which calls upon the Secretary of CHHS to examine options for achieving health coverage.

HCOP has three main components:

? A synthesis of existing data and research, which identifies existing data sources and makes them available for analytic efforts.

? The development and modeling of coverage options, which involves (1) the commissioning of options papers by health policy experts to describe and assess a full range of alternative approaches; and (2) selection of a modeling contractor to analyze each proposed option in a way that will allow for comparison of the potential impacts across the options.

? The public discussion of coverage options through multi-site symposia, which provides an opportunity for experts, stakeholders, and other members of the public to critically examine and provide input to the options and analyses.

The project design provides for substantial input at each stage of the process from members of the public, policy experts and other stakeholders. A detailed discussion of this participation is provided below.

PROGRESS TO DATE

HCOP is proceeding on track to be completed by February 2002. Substantial progress has been made on the data and research synthesis and on the development of health reform options. Dates and venues have been selected for five public symposia to be held throughout California in January and February.

Synthesis of Existing Data and Research. CHHS is working closely with the relevant State departments to identify and assure that existing data sources are available for analytic efforts including development of options papers and modeling.

? The California State Library has commissioned six background papers on the health care in California. The papers provide information on:

- The California health care market
- Employer-sponsored health insurance
- Characteristics of the uninsured
- Access for immigrants
- Access for older Californians
- Equity and quality

The library also has compiled an extensive bibliography on health coverage, and is in the process of assisting reform proposal authors with their research needs. This reports and bibliography are available at http://www.healthcareoptions.ca.gov/doclib.asp.

? CHHS and other State agencies are working with reform proposal authors and potential modelers to identify and obtain access to State program data and other information that may assist in the development of reform options. State data that may inform the effort includes summary information from the Medi-Cal and Healthy Families programs and from State payroll tax filings. Information about how current programs and taxes are administered also is being provided.

Develop and Analyze Coverage Options. Through a competitive process, CHHS has selected nine grantees to develop health reform options that are the set of approaches to be analyzed and discussed during the project. The nine grantees are each working to produce draft reform proposals by mid-October, which will be refined and finalized by the end of the project. The selected grantees are pursuing a variety of approaches (and combinations of approaches) to expanding access to coverage, including single-payer approaches, pay-or play approaches, employer and individual tax credits, insurance subsidies, and expansions of existing public programs or structures. A summary of the nine approaches is attached.

CHHS also has selected two finalists who will compete to be the modeling contractor under the project. The modeling contractor will prepare a comparative quantitative analysis of the financial and distributional effects of each proposed health reform option. The two finalists have had discussions with the authors of each of the reform options and recently submitted their final proposals to the State on September 21, 2001. A finalist will be chosen before October 15, 2001. Once a final modeling contractor is selected, they will work closely with the reform option authors to identify the key parameters of the reform options and to model each approach.

Public Discussion of Coverage Options. The California State Library has selected dates and locations for policy option symposia that will be held throughout the State in January and February of 2002. The Library and CHHS are working with the HCOP Advisory Group (discussed below) and the grantees of the project on the design and format for the symposia.

PUBLIC AND EXPERT PARTICIPATION

HCOP is being conducted with substantial input at each stage of the process from members of the public, policy experts and other stakeholders.

In developing the solicitations for the reform options and the modeling contractor, CHHS developed an interagency process including State representatives named in SB 480, legislative staff, and experts in the field, to draft two Solicitations for Proposals (SFPs) consistent with the objectives of SB 480. In April 2001, CHHS sought public review and comment on the drafts.

To notify interested parties of the SFP release, CHHS mailed nearly 1,000 letters announcing the SFP release, launched healthcareoptions.ca.gov -- a new website dedicated to the project, and posted an SFP advertisement in the State Contract Register. On June 29, 2001, CHHS held a Bidders' Conference to provide an overview of the SFPs and respond to questions regarding SFP instructions and requirements for potential reform option authors.

To ensure public participation during the selection process and other key decisionmaking points, CHHS invited a cross-section of stakeholders to join an Advisory Group, including: providers, associations, insurers, health planners, consumers, businesses, local government, and labor interests, as well as legislative staff. The purpose of the Advisory Group is to provide public policy input to CHHS on the project. Advisory Group members have participated in two Advisory Group Forums. At the first forum, held on August 1, 2001, the Advisory Group provided meaningful feedback on selecting option papers and model submissions. A second Advisory Group Forum provided CHHS with an opportunity to receive input on the design and format for the symposia and to delineate the key issues that should be analyzed in comparing the coverage options at the symposia. Upon selection of the final model contractor, the Advisory Group will meet to discuss the design and assumptions used for the economic analysis of the coverage options.

As discussed above, once the reform option papers are modeled and more fully developed, HCOP will culminate in a series of five public symposia to be conducted throughout the State in early 2002. It is our hope that the symposia will provide a public forum for the Advisory Group, experts, Legislative staff, and other stakeholders to critically examine and provide input to the options and analyses. In August, an independent contractor was hired to evaluate the public input process. The results of this evaluation will be included in the final reports to HRSA and the Legislature.

CONCLUSION

The California HCOP is progressing as planned. The work products of the project are exciting and should provide the basis for a stimulating debate and important discussion in the State on the best ways to expand access to health coverage. We anticipate completing the project and submitting the final report to HRSA in March of 2002.

SECTION 1: BACKGROUND

The complexity and turbulence of California's health care environment is made more so by seven million uninsured and millions more underinsured. Mechanisms that both mitigate and exacerbate access to care include Medicare and Medicaid, job-based health insurance that covers about two in three working Californians, and the market dominance of managed care organizations on the one hand and huge constellations of providers on the other. Over the years new entitlements have been created and new procedures have been introduced to improve access to care, improve quality of care, protect privacy, and more equitably distribute health care resources. Each category of innovation adds rules and requirements to an already heavily regulated system with hundreds of thousands of payers, providers, and purchasers of care. With the Congress and the President about to agree to new protections for managed care subscribers litigation threatens to add yet further burden.

Earlier this year, the California Health and Human Services Agency began its effort to explore options for increasing the number of Californians who are covered by health insurance. As one component of this project, California State University, Northridge, developed a series of brief papers that would assist policy-makers and the public to understand the complex issues involved in any effort to expand health care coverage. These papers describe the health care marketplace in California and the role of employment-sponsored health insurance. They profile California's uninsured and underinsured populations and explore the unique issues of access to health services for immigrants and the aging population. Finally, there is a paper covering ethical and quality considerations in relating to access to care. Following are highlights of each of these papers. The full papers are available on the Health Care Options Project (HCOP) website, www.healthcareoptions.ca.gov. Each paper provides a list of references and recommended readings on the topic covered. The HCOP website also contains a more comprehensive bibliography on health care access issues that was prepared for this project by the California Research Bureau.

THE HEALTH CARE MARKET

Governments and private employers purchase health insurance for nearly 80 percent of Americans. Throughout the nation the majority of persons with job-based health insurance and about two in ten elderly with Medicare (50 percent in California) receive health care through thousands of organizations that deliver health care through various kinds of managed care arrangements. About two-thirds of Americans have job-based health insurance and millions of early retirees and Medicare beneficiaries continue to look to their former employers for health benefits. Additional millions are Medicare and Medicaid (Medi-Cal in California) beneficiaries. While most Americans have job-based health insurance or qualify for entitlements, 40-45 million are perennially uninsured and medically indigent. In California 7.3 million are uninsured with several additional million underinsured. Given the exigencies of health need everyone is a potential health care consumer, the availability of health insurance notwithstanding. Persons without health insurance usually delay care as long as possible, self-medicating and hoping for the best. They enter private and public health systems as non-paying but now sicker and more expensive patients. The cost of their uncompensated care adds overhead to the market impacting purchaser, provider, and payer alike.

Almost all California businesses with several hundred or more employees provide for employee health insurance but fewer than half of smaller companies (under fifty employees) do so. Working persons make up eight in ten of the uninsured. California ranks last among the states in the number of persons with job-based health insurance. The Californians least likely to have health insurance are low wage earners, Latino males, young adults, non-citizens, and working women.

EMPLOYER SPONSORED INSURANCE AND THE UNINSURED IN CALIFORNIA

National health expenditures in the United States as a proportion of the gross domestic product (GDP) are a long time concern. In the early 1990s, the expectation was that health expenditures would reach 18 percent of the GDP within the decade. This troubling forecast alarmed government and employers alike. The prospect of escalating insurance premiums seemed to foreshadow a cost-doomed end to employment-based health insurance. Premiums were rising much faster than the rate of inflation. These cost increases prompted a shift away from traditional fee-for-service insurance programs toward managed care arrangements that slowed cost growth. Further reductions in health expenditures were accomplished through the Balanced Budget Act. As a result, the level of national health expenditures stabilized at about 13 percent of GDP. However, estimates from the Health Care Financing Administration predict that national health expenditures will approach 16 percent of GDP by 2010.

Although California resembles the rest of the country in the number of large, medium, and small employers, and in the rate at which people qualify for and accept employer-sponsored insurance, growth in the number of uninsured Californians was higher than the growth on average in the rest of the country. In 1999, 22 percent of individuals under age 65 in California were uninsured, which compares to only 17 percent on average for the rest of the country. Several factors contribute to this difference. California's larger employers are more likely to offer employer-sponsored insurance than smaller employers are. White-collar businesses such as finance or professional service are also more likely to offer insurance benefits than companies in construction and agriculture. Low wage earners are less likely to be offered or to obtain insurance. Additionally, Latinos are less likely to be insured and non-citizen Latinos are much less likely to be insured than people from other races or ethnicities are.

PROFILE OF THE UNINSURED IN CALIFORNIA

More people are becoming aware of the number of medically uninsured and the implications the uninsured population has for health care affordability and quality. Recent surveys indicate that Californians are willing to pay additional taxes to assure that all families and children have access to affordable health insurance. Current estimates are that 22 percent of the state's population is uninsured. Without insurance they have limited access to medical care and either forgo or delay treatment because of the out-of-pocket cost. Many of the uninsured access care through safety net providers - community clinics, county clinics or hospitals -- or through hospital emergency departments. The uninsured are a continual financial drain to hospitals throughout California, most of which operate on very thin profit margins.

Many people believe the uninsured are also the unemployed. This misconception masks the fact that eight out of ten uninsured are employed. Latinos and young adults make up the largest proportion of the uninsured although the uninsured include persons of every socio-economic strata. Persons are uninsured for many different reasons. Some work for employers that choose not to provide job-based health insurance. Other employees do not meet eligibility criteria for job-based coverage. Some are unemployed, do not have access to affordable group coverage, and are ineligible for public insurance programs. Some persons are employed in low-income jobs and are unable to afford the out-of-pocket costs of group or individual coverage. Those with chronic or pre-existing health conditions can find that private insurance is unaffordable. Experience, cultural, and language barriers, lack of literacy in English or their language of origin, and fear of immigration or other government authority also create an array of barriers to health insurance for many immigrants. For those potentially eligible for public insurance, bureaucratic processes can be confusing and intimidating. These procedures too often serve to dissuade rather than encourage enrollment. Potential solutions for reducing the number of uninsured in California include: (1) employer and individual tax credits tied to purchase of health insurance, (2) subsidized insurance coverage for small businesses, (3) streamlined and uniform eligibility and enrollment processes across all public insurance programs, (4) expanded eligibility limits for public health insurance programs, (5) use of the single payer model, and (6) enhanced outreach efforts to identify and link the uninsured with available resources. The magnitude of the uninsured issue in California will require the application of multiple interventions. Local programs targeting the uninsured as well as programs developed in other states may serve as models for California in expanding health coverage for the uninsured populous.

ACCESS TO HEALTH CARE FOR CALIFORNIA'S IMMIGRANTS

The working poor and indigent members of California's diverse immigrant communities face formidable barriers to care. The increased federal role in welfare and child health insurance reform has led California to re-evaluate safety net policies and to experiment broadly in health and welfare reform. While California is seeking to increase the number of insured families through the expansion of Medi-Cal and Healthy Families programs, a consistently large number of immigrants statewide remain uninsured. With confusing information about welfare reform, thousands of legal immigrants have not sought public benefits, even though they remain eligible for a variety of programs, because they believe that accepting these benefits could affect their immigration status. Effective outreach to California's immigrant families requires culturally appropriate messages and styles of communication using familiar elements of an immigrant group's "ethnic culture."

COVERAGE AND ACCESS TO CARE FOR OLDER CALIFORNIANS

The population of California is aging rapidly in what has been described as the "graying of the Golden State." Currently an estimated 3.6 million Californians (11 percent of the total state population) are ages 65 or older, but the older population will more than double by 2030 to 8.9 million (17 percent). The fastest growing age group is the "very old", those age 85 and over, who will increase nearly fourfold in numbers from 450,000 in 2000 to 1.7 million by 2040. The aging of the population in California will have major impact on health care costs as well as the health care system.

Most Californians ages 65 and over have the advantage of Medicare coverage. Yet, the elderly remain disadvantaged because they lack comprehensive health benefits and lack access to affordable coverage for long-term care. These gaps in health care coverage leave seniors unprotected against high out-of-pocket costs and at-risk for catastrophic costs in the event that long-term care is needed. Gaps in insurance coverage affect seniors by imposing burdensome financial liabilities in several areas of health care services such as pharmaceutical costs and long-term care. Several options for controlling costs and expanding coverage to ensure the adequacy, affordability, and accessibility of health care for older Californians should be considered.

QUALITY AND EQUITY CONCERNS IN HEALTH INSURANCE COVERAGE/NON-COVERAGE

Equity is not the same as equal; however, systems of health care rarely acknowledge the impossibility of achieving equal health status for all. Much ill health is due to social circumstances including poverty, poor housing, inadequate nutrition, inappropriate health behavior, and lack of preventive and primary care. Systems of care, including third party payer-fostered systems, must distinguish between medical, social, and psychological need. Good health care contributes to health and good health is a precondition to quality of life. Health care also provides essential caring and validation functions.

Persons are more effective participants in society when they are in good health and can access quality care. If utilization of health care is not significantly associated with better outcomes, a major component for consideration may be the quality of care. Both equity and quality depend on providing arrangements that foster ethical gate-keeping and respectful, appropriate care, address social as well as individual needs, and reward correct incentives. Other essential considerations include an integrated system with decentralized service, benefits standards, and rational staffing and delivery. Unfortunately the data about causes of disparities in access, outcomes, and health care quality are inadequate. Ongoing data assessment is necessary to develop short and long-range strategies.

Quality and equity require financially neutral decision-making at the bedside. Difficult rationing decisions should not be made at the bedside. Extensive public discussion, education and conversation with patients, and policies regarding standards of appropriate care must be developed and supported well in advance of bedside decision-making. Given the problematic relationship between health care and health, justice requires consideration of alternative spending on other needs. The allocation of public health measures that reach larger groups and improve health in the longer term should also be re-evaluated. Such measures are critical to equity and quality in a system of universal care.

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SECTION 2: UNINSURED INDIVIDUALS AND FAMILIES

OVERVIEW

Of the more than seven million uninsured in California, the proportion of uninsured is markedly higher for some population groups than others. Groups disproportionately impacted include Latinos, low-income individuals and families, and males between the ages of 18 and 34 years. The perception that the majority of the uninsured are not employed is false considering that the majority of this population comes from families where at least one person is employed.

Recent public opinion polls show that the California residents are concerned about the uninsured and believe that some action needs to be taken to address the problem. Studies show that the uninsured have limited access to medical care and have had to delay medical treatment or seek care only after their illness becomes so serious that medical care must be sought. Any consideration of system change must consider removing barriers to health insurance access. Proposals for reducing the number of uninsured include: expanding health coverage under public programs (e.g. Medi-Cal and Healthy Families); offering Healthy Families coverage to the parents of eligible children; offering employer tax credits to encourage more businesses to offer health insurance (California has a lower rate of employer sponsored insurance compared to the national average); subsidizing plans for persons unable to obtain coverage due to preexisting or chronic conditions; and expanding insurance purchasing pools for small employers. Other ideas include streamlined and coordinated eligibility and enrollment procedures for public programs that would enroll more people quickly through enhanced grass roots education and outreach through cultural and language affinity media.

BACKGROUND

The uninsured rate in California remained relatively stable for the period from 1994 until 1998. Although the population of the State was increasing, more people were obtaining insurance coverage through their employers as the economy began to grow following the recession of the early 1990s. The drop in the number of uninsured slowed in late 1998 with implementation of welfare reform, which caused a significant number of people to move off of welfare and into employment. Many of these people lost the health care coverage that they had received through the Medi-Cal program. From 1996 to 1999 the number of low-income parents enrolled in Medi-Cal dropped by 155,846 persons. The proportion of California's non-elderly population on Medi-Cal dropped from 14.4 percent in 1994 to 11 percent in 1998. (Families USA Foundation, 2000 / UCLA Center for Health Policy Research, 2001)

However, California's robust economy at the end of the decade encouraged employers to provide health insurance to more persons. Some persons who lost Medi-Cal eligibility were able to obtain insurance coverage through their employer but other individuals were placed in jobs where health insurance was unavailable. Current estimates are that 22 percent of California's non-elderly (below 65 years) population is uninsured, which translates into approximately 7 million persons. The uninsured rate among non-elderly persons in California declined from 23.3 percent in 1994 to 22.4 percent in 1999. (UCLA Center for Health Policy Research, 2001 / Health Insurance Coverage in America 1999 Data Update, 2000)

Similar gains in coverage occurred nationally for several reasons:

- The growing economy resulted in more people becoming employed and getting health benefits through their employer.
- The enactment of the Children's Health Insurance Program (Healthy Families in California) provided health insurance coverage to eligible children under 18.
- Increased efforts were made to enroll more children in the Medicaid (Medi-Cal in California) program when their families met the income criteria.

Despite recent improvements, compared to the nation as a whole, California has proportionately many more uninsured: 22 percent vs. 16 percent (42.6 million uninsured in the U.S.). Only New Mexico, Texas, Louisiana, and Arizona have higher uninsured rates than California. (U.S. Census Bureau Current Population Reports, 2000)

THE SCOPE

The vast majority of the uninsured in California work or live in families with working adults. Over eight in ten of the uninsured in California are working or have a family member that is employed. (UCLA Center for Health Policy Research, 2001) A high proportion of the working uninsured (over 70 percent) are low-income families. (Kaiser Family Foundation California Health Policy Brief, 2001) The uninsured can be divided into several categories:

- Employed individuals who are not covered through their employer.
- Self-employed individuals who opt not to purchase health insurance coverage.
- Persons who are unable to afford health insurance coverage through the employer where there is a share of cost passed on to the employees.
- Part-time, contract, and seasonal workers who are not eligible for health benefits through their employer.
- Persons who become unemployed and lose coverage.
- Persons who do not qualify for public programs (e.g. Medi-Cal).
- Dependents of working family members in which the employer does not provide dependent coverage or the employee chooses not to opt for dependent coverage.
- Persons with chronic conditions who may be able to pay for coverage but are unable to obtain it due to eligibility and pre-existing condition restrictions from insurance companies.

California faces unique challenges in several of these categories:

Employer-sponsored coverage - Approximately 74 percent of workers in California have employer-sponsored insurance (ESI) compared to 81 percent of workers in the rest of the U.S. (Kaiser Family Foundation California Health Policy Brief, 2001)

Immigrants - Many in the State's large immigrant population are non-citizens who are ineligible for public insurance programs, but often work in low paying jobs in which ESI is not provided.

Dependent coverage - Some people undervalue the worth of purchasing health insurance for themselves or their dependents. Findings from the Healthy Families Program suggest that even though the monthly out-of-pocket premiums are low, the most commonly cited reason identified for why enrolled children leave the program is premium costs.

Literacy and cultural issues - Adults with inadequate reading comprehension or those without prior health insurance experience are easily discouraged from applying for coverage be it employment or public based.

The availability of adequate health insurance coverage has a direct impact on access to medical services. The uninsured are more likely to not have a regular source of medical care compared to the insured population. Nearly 40 percent of uninsured adults and 25 percent of uninsured children have no regular source of health care. Options available to the uninsured seeking medical care include the hospital emergency department, public providers, safety net providers (e.g. community clinics) and health providers willing to accept uninsured patients (some providers are willing to offer discounts to cash paying patients).

Persons without insurance are more likely to delay seeking medical care. A recent survey of Californians found that one in five Californians (20 percent) reported that either they or a family member had to postpone medical care because of a lack of insurance coverage. Another study focusing on the uninsured nationally found that when compared to the insured population:

- Uninsured children are 70 percent more likely to have forgone medical treatment for common conditions compared to the insured population.
- 40 percent of uninsured adults did not get a recommended medical procedure.
- The uninsured are less likely to receive preventative care.
- The uninsured are more likely to be hospitalized for illnesses that could have been avoided compared to the insured population.
- For cancer patients, the uninsured are more likely to be diagnosed with a late stage cancer due to delays in diagnosis and treatment. (Kaiser Family Foundation, Medicaid and the Uninsured, 2001)

Similar barriers to care occur with another group, the underinsured. The underinsured are persons with some job-based health insurance coverage but with out-of-pocket requirements that exceed their ability to pay. In many of these instances a large deductible or large co-insurance bar all but the very seriously ill from accessing needed medical care.

ISSUES

Data compiled on the uninsured in California highlights some of the issues impacting this problem.

One in five Californians are uninsured

- More than eighty percent of the uninsured are members of families in which one or more persons work.

- Almost two-thirds of the uninsured come from families that earn less than 200 percent of the federal poverty level. (Health Insurance Coverage in America 1999 Data Update, 2000)
- Minority populations are more likely to be uninsured.
- More persons between the ages of 18 and 34 years are uninsured and a majority of the uninsured in this cohort are males.
- Latinos are more likely to be uninsured compared to other ethnic groups. This group tends to work in lower-wage jobs, work in industries that do not offer health insurance or offer very limited health coverage, and/or work for smaller companies that do not provide health benefits. It is estimated that about 35 percent of all Latinos in this country lack insurance. (Schur and Feldman, The Commonwealth Fund, 2001)

Among California's uninsured

- 19 percent are under age 19;
- among low-income children (less than 200 percent of poverty and under 19 years), approximately 28 percent are uninsured;
- among adults (ages 19-64) in the State, approximately 25 percent are uninsured;
- 40 percent of the low-income nonelderly (less than 200 percent of poverty, including children) are uninsured;
- low-income uninsured adults (less than 200 percent of poverty and between the ages of 19-64) comprise 47 percent of the total low-income adult population in the State.

Barriers that impede access to insurance coverage

Research regarding employer-sponsored insurance provides insight into why individuals do not receive coverage through their employer. Although some persons opt not to participate, the data show that 88 percent of eligible qualified workers (where the employer offers health insurance) accept this benefit. (Kaiser Family Foundation and Health Research and Educational Trust, 2001) Factors that bar individuals from employment-based insurance include:

- Persons not eligible for insurance because they work part-time, are contract employees or are employed as seasonal workers.
- Some cannot afford the employee cost-sharing portion of the premium, which averages $20 per month for individuals and $113 per month for families within California. (Kaiser Family Foundation and Health Research and Educational Trust, 2001)
- Employers do not offer a health insurance benefit.
- Employee fears the consequences of disclosure of previous or current medical condition.

Healthy Families and Medi-Cal also have difficulty enrolling needy Californians. Data shows that 29 percent of uninsured children (approximately 535,000 individuals) are eligible for Healthy Families and 39 percent of uninsured children (approximately 726,000 individuals) are eligible for Medi-Cal. (UCLA Center for Health Policy Research, 2001) Factors that appear to limit enrollment in these public insurance programs include:

- The enactment of welfare reform has tightened eligibility requirements for Medi-Cal.
- The bureaucracy and paperwork associated with public programs leaves many people confused and frustrated with the process.

- Misunderstanding among the general public regarding public programs and eligibility requirements.
- Fear by non-citizens that enrollment in these public programs may trigger Immigration and Naturalization Service investigation and charges.
- Language barriers.

Persons also drop out of these public programs for a variety of reasons including:

- Program eligibility requirements not being met, incorrect documentation provided, and non-payment of the monthly premium. (Managed Risk Medical Insurance Board, 2001)
- Implementation of welfare reform resulted in many people losing Medi-Cal eligibility. California was one of twenty states in which total Medicaid (a.k.a. Medi-Cal) enrollment declined (2.8 percent in California) from June 1997 to December 1999. (Kaiser Family Foundation Medicaid and the Uninsured, 2000)

CHALLENGES

Addressing the issue of the uninsured in California will require innovative solutions to make progress in expanding health insurance coverage to the seven million uninsured. A recent survey of California residents reported 72 percent willing to pay additional taxes (up to $50 per year) to ensure that everyone had health insurance coverage in the State. (Robert Wood Johnson Foundation/Lake Snell Perry and Associates, 2000)

Structuring health insurance options may require more cost sharing by the employee. If monthly premiums for the employee are set too high, individuals will opt to forgo coverage especially if this additional expense is going to pose a financial burden to the individual or family. Some analysts have suggested that instead of health insurance employers should provide employees with a cash benefit to be used for purchasing health insurance (referred to as defined contribution). A recent survey of employers showed reluctance to this idea with the general consensus among employers that employees are better off under employer-sponsored health insurance. It would be impossible for an individual to have the same bargaining clout that a large employer would have in purchasing insurance. Employers also serve in many instances as the advocate for their employees with insurance companies negotiating benefits and handling complaints. (Kaiser Family Foundation and Health Research and Educational Trust, 2001)

One approach to immediately impact the number of uninsured children is to include parents in Healthy Families and Medi-Cal programs. Data show that low-income children with insured parents are twice as likely to have health insurance coverage compared to children with uninsured parents. As a result, targeting coverage for the parents also helps to improve the rate of insurance coverage for eligible children. (The Commonwealth Fund, Health Insurance a Family Affair, 2001)

Alternative solutions for dealing with the uninsured in California include:

- Purchasing pools for small employers to help them buy insurance at a reasonable rate.

- Tax credits for small businesses and individuals to encourage the purchase of health insurance coverage.
- Expanding public programs (e.g. Healthy Families and Medi-Cal) to include higher maximum income eligibility levels and to expand coverage to the parents of eligible children.
- Integrating the various public insurance programs under a common organizational umbrella with common enrollment procedures/forms and integrating eligibility standards with other public assistance programs (e.g. School Lunch Program).
- A single payer model where everyone is provided with coverage in the State and that is organized under a uniform payment system.

A number of local initiatives are underway in California that could be implemented on a statewide basis.

- The San Francisco Cares for Kids Program, a proposed initiative in San Francisco, would cover children under the age of 19 in families earning up to 300 percent of the federal poverty level who are not eligible for Healthy Families or Medi-Cal.
- The VIDA Pilot Project in the San Fernando Valley provides advocacy to low-income families in assisting them in accessing and improving the quality of health care services. The program helps participants apply for health services for which they are eligible, provides counseling, and offers information on immigration and public charge issues related to public programs.

Some model programs operating in other states that could be replicated in California include:

- The New Mexico Health Insurance Alliance offers a basic health insurance package to small employers, self-employed and persons who lose group insurance coverage.
- In Massachusetts, the MassHealth Family Assistance Program provides financial assistance to low-wage workers and family members to help cover the cost of health insurance premiums in addition to subsidizing the cost of insurance premiums for small businesses.
- The Healthcare Group of Arizona enables small businesses (2 to 50 employees) to purchase prepaid coverage. (The Commonwealth Fund, Expanding Employment Based Health Coverage: Lessons from Six State and Local Programs 2001)

Covered benefits must also be considered in addressing the needs of the uninsured. Programs such as Healthy Families and Medi-Cal may serve as models. The Cal-Health Program under consideration by the State Legislature (Assembly Members Thomson, Aanestad, Richman and Koretz, AB32, 2001) defines a basic benefits package as including:

- Inpatient and outpatient hospital care
- Emergency medical care
- Physician care (primary and specialty care)
- Diagnostic services (e.g. laboratory, radiology)
- Mental health services (inpatient and outpatient)
- Preventive services (e.g. screenings, routine physicals, etc.)

- Prescription drug coverage

Proposed solutions to the uninsured challenge in California must consider factors such as:

- Promoting the "affordable-value tradeoff" of insurance.
- Streamlining enrollment and eligibility procedures so that people are not confused and frustrated with the process.
- Using a defined set of comprehensive medical benefits adequate to meet medical and hospital care needs.
- "Welcoming" immigrants and non-English speaking populations to the concept of health insurance.
- Integrating new programs with existing insurance options and payment structures especially where the focus is on the expansion of employer based coverage.
- Assuring flexibility in meeting the insurance needs of the various subgroups of uninsured individuals in the State.

IMPLICATIONS FOR POLICY MAKERS

Consideration of California's diverse population is an essential first step to develop solutions to the needs and problems of the uninsured. No one solution or program is likely to meet all of the needs of the uninsured in the State. Instead a combination of solutions targeting specific segments of the uninsured population (e.g. the employed uninsured, children, immigrants, unemployed, self-employed, etc.) ought to be examined. A combination of solutions integrated together may provide the best mechanism to reduce the number of uninsured in California.

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SECTION 3: EMPLOYER-BASED COVERAGE

OVERVIEW

In 1999, national health expenditures reached $1.2 trillion, which was almost $4400 per capita according to the Healthcare Financing Administration (Heffler, Levit, Smith, Smith, Cowan, Lazenby, and Freeland, 2001). Although it is an astronomical figure, one must keep in mind that it actually represents a slowdown in the growth of health care expenditures since 1993. In fact, health care spending has remained at about 13 percent of the gross domestic product (GDP) from 1993 to 1999. This is remarkable, because the estimates in the early 1990s were for expenditures to reach as high as 18 percent of GDP (Rice, 1996). According to the Health Care Financing Administration (HCFA), this reduction in the rate of national health expenditure growth is a result of one-time savings brought about by two factors. These include shifts to managed care, and the impact of the Balanced Budget Act (BBA) on home health, nursing home, and hospital costs (Heffler, Levit, Smith, et al. 2001). Even though growth in healthcare spending has decelerated for the past six years, indications are that much of the savings brought about by managed care plans have been wrung out of the system. For instance, the projection for health spending as a share of GDP in 2010 is expected to reach 16 percent, this will double the size of health care expenditures to $2.6 trillion. The per capita spending will increase to about $8,700 (HCFA, 2001). Because most individuals under the age of 65 rely on health coverage available through employers, and because the price for that health coverage has risen, there has been a trend where fewer individuals are able to obtain coverage through work (Medoff, Shapiro, Calabrese, and Harless, 2001). Currently, there are approximately 42 million people without health coverage in the United States, which is an improvement over the 1998 total of 44 million (Holahan, 2001). These include individuals who are ineligible for Medicare or Medicaid (Medi-Cal in California). It also includes individuals who are working, and yet cannot afford to buy, or are not offered, health insurance through their work.

THE NEED

Of the 42 million people in the United States who are uninsured, an estimated 6.8 to 7.3 million are living in California (Cubanski and Schauffler, 2001). As with the country as a whole, the uninsured rate in California has also improved, opposing a trend in growth that has persisted since 1988 (Fronstin, 2000; Brown, Ponce, and Rice, 2001). However, it is still important to note that 85 percent of the uninsured in California are working, or are dependents of someone who is employed, therefore many policy makers recognize the need to improve access to employer-sponsored insurance (Cubanski and Schauffler, 2001).

Much of the improvement in the rate of the uninsured is explained by the low unemployment rates throughout the country, which result in more employer-sponsored insurance to attract employees, and a slow down in the number of individuals who are losing publicly funded coverage (Fronstin, 2000). This holds true for California, where the rate for people covered by Medi-Cal dropped from 11 percent in 1998 to 10.5 percent in 1999, but the rate of employer-sponsored insurance rose from 58.3 percent to 60.6 percent in the same period (Brown, Kincheloe, and Yu, 2001). In fact, it appears that California is narrowing the gap between itself and the rest of the nation according the Kaiser Family Foundation's "California Employer Health

Benefits Survey," which indicates that the percentage of all firms offering health benefits in California grew from 48 percent in 1999 to 60 percent in 2000. That growth outpaced the national rate, which grew from 61 percent in 1999 to 67 percent in 2000. However, there is considerable room for improvement since California is still among the states with the highest rates of uninsured totaling 24.4 percent of the non-elderly population in 1998, and although the rate decreased to 22 percent of the non-elderly in 1999, it is still considerably higher than the national average rate of 17 percent (Fronstin, 2000; Cubanski and Schauffler 2001).

THE SCOPE

A number of factors influence employment-based health insurance.

Employer size

The larger the organization an individual works for, the higher the probability that they will be offered employment-sponsored insurance. In the United States as a whole, 99 percent of firms with more than 200 workers offer health benefits. Nationally coverage drops with the size of the company. For instance only 60 percent of firms with fewer than 200 workers provide health insurance. In fact, the fewer the total number of employees, the lower the rate of employer-sponsored insurance. The most dramatic drop in the percent of businesses offering health benefits is from 72 percent for firms that employ 10 to 24 workers, to 55 percent for firms that employ between three to nine workers (Hoffman and Schlobohm, 2000).

Industry Sector

Government agencies have the highest rates of employee insurance coverage, with only seven percent levels of uninsured workers. This is followed by finance, professional service, mining or manufacturing, and transportation industries which all have uninsured rates ranging between 11 and 15 percent. The industries with the highest level of uninsured workers are the construction industry at 32 percent, and the agriculture industry at 37 percent (Hoffman and Schlobohm, 2000).

Employee income

In the period between 1987 and 1996, insurance coverage for low-wage workers making $7.00 per hour or less declined from 54 percent to 42 percent in the United States. However, the rate increased from 87 percent to 90 percent for workers earning more than $15.00 per hour in the same period (Hoffman and Schlobohm, 2000). Furthermore, companies where a large proportion of workers earn low wages are less likely to offer employer-sponsored insurance (California Employer Health Benefits Survey, 2001). Low wage earners are definitely at higher risk of being uninsured.

Geographic location

Although one third of all non-elderly with income levels below 200 percent of poverty level in the United States are uninsured, there are a number of states where they exceed 35 percent uninsured. These include New Jersey, Maryland, South Carolina, Georgia, Florida, Arkansas, Texas, New Mexico, Arizona, Nevada, Alaska, and California (Hoffman and Schlobohm, 2000).

ISSUES FOR CALIFORNIA

In 1998, California was only surpassed by Texas and Arizona in the size of its uninsured populations (Fronstin, 2000). In 1999, three states, Louisiana, Texas, and New Mexico, had higher uninsured rates than California (Brown, Ponce, Rice, 2001). Hawaii continues to maintain the lowest uninsured rate of 10 percent, due to its "employer mandate" that requires employers to provide insurance for their employees (Hoffman and Schlobohm, 2000).

When comparing California to the nation as a whole, many of the characteristics of industry and employment rates are similar. For example, approximately 77 percent of the firms in California and nationally employ between three to nine employees. These similarities persist during comparisons to the strata from 10 to 50, from 51 to 999, and for firms with over 1000 employees (Schauffler, McMenamin, and Zawacki, 2000). In addition, premiums for employer-sponsored insurance for small firms employing less than 50 people rose at a higher rate than did the premiums for larger firms both in California and nationally (Schauffler, McMenamin, and Zawacki, 2000).

However, California differs from the rest of the nation in some very important aspects such as levels of employment in small firms, race, citizenship status, choice of plans available, costs of health benefits to the employer and employee, and participation in purchasing cooperatives. Some of the differences are surprising considering traditional assumptions about what should be done to reduce the number of uninsured in California.

As stated earlier, California has a similar proportion of large and small employers, however, more persons work for firms with fewer than 1000 employees in California than in the rest of the country. For example, 12 percent of California's workforce is employed in firms with three to nine employees, while the average for the country is 10 percent (Schauffler, McMenamin, and Zawacki, 2000). Therefore, because smaller employers are less likely to offer health benefits, a higher proportion of California workers are at risk for being uninsured.

According to Fronstin, where large differences become apparent is in the race and ethnicity of the non-elderly workforce. California has a smaller proportion of white and black workers than the rest of the country. However, the proportion of Asian and Latino workers is much higher in California than the average of the other 49 states. For example, in 1998, Latinos made up 27 percent of the non-elderly workers in California, compared to eight percent in the United States. Furthermore, only 70 percent of the California non-elderly workers are United States born citizens, while 10 percent are foreign born naturalized citizens, and the remaining 20 percent are foreign-born non-citizens. This is in contrast to a four percent naturalized citizen and a six percent foreign-born non-citizen rate for the United States.

Fronstin also demonstrates an important distinction between the rates of uninsured workers in California and in the rest of the United States based on the characteristics of race and ethnicity. Where white, black, and Asian workers are just as likely to be uninsured in California as in the rest of the country, California Latinos are more likely to be uninsured than those from other states. With further analysis, Fronstin found that the bulk of the difference (47 percent) between the uninsured rates for California Latinos is explained by their higher rate of non-citizen status as

compared to the rest of the country. Another 43 percent may be explained by differences in education level, size of employer firm, wage level, and industry. A smaller proportion of about eight percent is explained by the differences in hours of work, age, and gender.

In another report outlining factors that contribute to the high rate of uninsured Latinos, Claudia Schur and Jacob Feldman noted that the high cost of insurance is the main barrier to obtaining coverage. This is true for groups other than Latinos, however, according to their study, Latinos are more likely to work in agriculture, construction, and other industries that are less likely to offer insurance. Furthermore, Latinos earn less on average than white non-Latino workers and are almost three times more likely to be in the lowest income category. Even so, when offered insurance, Latinos are generally as eligible as other groups and also accept insurance at about the same rate (Brown, Ponce, Rice, 2001).

California workers who are offered insurance have more choice than those offered insurance in other parts of the country. Although the number of choices vary by the size of the institution, California workers are more likely to have a choice between two or more plans than workers in the rest of the United States. However, most covered California workers will have an HMO plan, and are less likely to have a PPO, POS, or conventional plan than workers in other parts of the United States (Schauffler, McMenamin, and Zawacki, 2000). By comparison, HMO and POS plans are cheaper in California than in other states, while PPO plans are more expensive. Participation in purchasing coalitions in California is also steadily increasing. This may indicate why premiums for California workers are lower than premiums in the United States, and why employee contributions to their health benefits plan is also lower for Californians (California Employer Health Benefits Survey, 2001).

IMPLICATIONS FOR POLICY MAKERS

As many of the uninsured cite cost as the reason for not buying health insurance as do employers: 57 percent of California employers that do not offer health insurance state that they do not offer coverage because of high premiums. The second most common reason is because employees are covered elsewhere, at 20 percent. Six percent state that the firm is too new to offer insurance, five percent feel that turnover is too high to warrant providing insurance, and two percent believe that administrative difficulties in offering insurance are too great. An additional three percent say that the company is able to attract employees without having to offer insurance. One percent of employers responded that they do not offer coverage because they are not able to qualify for a group policy at group rates. Another one percent stated that most of their competitors do not offer insurance (California Employer Health Benefits Survey, 2001).

Larger firms have been influential in fueling the shift from traditional health coverage plans to managed care programs in conjunction with their efforts to contain health care costs. As stated earlier, the cost containment that shift produced appears to be a one-time effect that may be coming to an end. As a consequence, health benefit costs may begin to accelerate again. This is important, because it is widely believed that efforts to shift rising costs to employees in the late 1980s and early 1990s may have been a catalyst for the rapid rise in the number of uninsured individuals. Fortune 500 firms are definitely interested in regulating the cost of their health benefits. To that end, they utilize competitive bidding, shift employees to managed care plans,

and focus on price rather than quality (Maxwell, Temin and Watts, 2001). About a third of the employers in California state that within five years they are somewhat or very likely to switch to a "defined contribution" plan where the employer would provide employees with funds to purchase their own insurance coverage (California Employer Health Benefits Survey, 2001).

The strong economy, mostly due to the low rate of unemployment, is largely credited with much of the reduction in the rate of the uninsured in California between 1998 and 1999. Because insurance prices were relatively stable, employers were able to use insurance as a means of attracting workers. Nevertheless a large proportion of the uninsured currently are ineligible for Medi-Cal, or other public coverage (Brown, Kincheloe, and Yu, 2001). The challenge for policy-makers is to find new mechanisms to increase employment-based coverage in a state that already has lower premiums for employer-sponsored insurance coverage, and lower costs per employee contribution than the average in the rest of the United States. Insurance premiums are beginning to rise, and the effects of several years of economic recovery on the rate of the uninsured only started to appear in 1998 and 1999. If the economy should change, and unemployment begins to rise, it would seem likely that the rate of uninsured would also begin to rise. None of the barriers to obtaining insurance were changed with the growing economy. Most people without insurance say that they are unable to afford purchasing coverage on their own. This is especially important in California, since there are, on average, more Californians living below 200 percent of the poverty level than the average in the rest of the country.

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*Recommended reading.

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SECTION 4: THE HEALTH CARE MARKETPLACE

OVERVIEW

For the vast majority of Americans, health care is readily accessible because employers or governments purchase health insurance for them and managed care companies or insurance companies arrange for and pay for their care. Nationally 155 million persons have job-based health insurance and millions of early retirees and Medicare beneficiaries continue to look to their former employers for health benefits. Medicare and Medicaid (Medi-Cal in California) entitlements benefit additional tens of millions. While most Americans have job-based health insurance or qualify for entitlements, 40-45 million are uninsured and medically indigent. In California 7.3 million are uninsured with several additional million underinsured. Given the exigencies of health need, everyone is a potential health care consumer, the availability of health insurance notwithstanding. Persons without health insurance usually delay care as long as possible, self-medicating and hoping for the best. They enter private and public health systems as non-paying but now sicker and more expensive patients. The cost of their uncompensated care adds overhead to the market, impacting the range of opportunities open to purchasers, providers, and payers alike.

About two-thirds of working Californians under the age of 64 have job-based health insurance, nearly all through managed care plans. While virtually every business with several hundred or more employees does so, only half of California's smaller companies (under fifty employees) provide job-based health insurance. Working persons make up eight in ten of the uninsured. California ranks last among the states in the number of persons with job-based health insurance. The Californians least likely to have health insurance are low wage earners, Latino males, young adults, non-citizens, and women employed part-time.

Health care costs inflated moderately and the market remained stable in the early-mid 1990s principally because market dominance enabled managed care plans to negotiate and sustain lower provider prices and to control utilization. The market became more turbulent later in the decade and remains so today. Growing public and government antipathy towards the Health Maintenance Organization (HMO) form of managed care coupled with increasing provider consolidation into large multi-hospital and multi-medical group arrangements gave providers more bargaining power to negotiate favorable fee-for-service and fewer capitation reimbursement agreements with payers. In response to the loss of their bargaining clout, payers covered anticipated increases in medical claims expenses and protected underwriting profit by hiking premium charges. Rates leaped in 1999 and continue to rise today. Employers now face double-digit rate change as they renew insurance coverage. Health care costs are growing at 2.5 times that of general inflation. Despite disparities in access to care in urban and rural communities, and with millions uninsured, health care consumes 14-15 percent of the nation's Gross Domestic Product (GDP), up from about 10 percent a decade ago. One strategy for stabilizing the market, ending disparities in access to care, and slowing cost inflation is universal health insurance. The Canadian health care system offers an effective model for doing so.

THE NEED

In addition to the more than two-thirds of Californians under age 64 with job-based health insurance, an additional 4.5 percent purchase health insurance themselves. The latter include the self-employed, persons employed but unable to obtain job-based health insurance, the unemployed but not impoverished, and/or persons who are medically uninsurable and not impoverished. Although additional millions have Medicare or Medi-Cal entitlements, more than one in five Californians, 7.3 million, are uninsured. Only Arizona and the District of Columbia had higher proportions of uninsured than California. California's uninsured add to overhead or burden costs in the health care market. (U.S. Bureau of the Census, Household Economic Studies, Current Population Reports; and Schauffler and Brown 2000) Because of a slowing economy and changes in Medi-Cal entitlement, more are likely uninsured today.

Of six million working Californians without health insurance, a majority, especially those with incomes below 200 percent of the federal poverty level (FPL), are chronically uninsured (five or more years or never insured). They are also disproportionately Latino or immigrant. Among Latino adults in California, one in three reports never having health insurance. More than two-thirds of California's poorest paid workers are Latino and more than half of California workers employed by companies with 2-50 employees, are chronically uninsured. (Blumberg and Nichols 2001) In other words, because a majority work for smaller companies, and smaller companies are the least likely to provide job-based health insurance, proportionately fewer working Latinos have health insurance than other populations.

Increase in the absolute number of uninsured is tied to two variables: the willingness or lack of willingness of employers to purchase of employee health insurance and the impact of federal welfare reforms. Every year some of the tens of thousands of persons leaving welfare find employment offering job-based health insurance. Others are not as fortunate. They become medically indigent as their entitlement to Medi-Cal ends and the private sector entry level jobs they obtain either do not include job-based health insurance or require employee cost-sharing that effectively places health insurance beyond the reach of these new but low wage earners. Although outside of the market in the sense that they lack the means to pay for care the medically indigent profoundly impact the market nevertheless. Every person is a potential health care consumer whether insured or not. Persons without insurance and otherwise unable to pay for care usually wait, self-medicate, and hope for the best. When their need becomes serious hospital emergency departments, licensed community clinics, or public health clinics typically are the initial point-of-access to care. In a statewide survey in 1999 more than one in three uninsured persons said they deferred medical care when they needed it because they could not afford to pay.

Uncompensated care is an invisible overlay to market transactions. It makes the market less efficient and increases costs to purchasers, payers, and providers. This burden is unrelated to the price pressures associated with new technologies, increasing prescription drug cost and utilization, salary and work benefit increases, or the imperatives of funding hospital earthquake reconstruction. Uncompensated care has tax and public spending consequences also. In California, medically indigent persons in need ultimately look to the counties for services, as they are the level of government designated in law as the provider of last resort.

Another population unseen but nevertheless influential are the many who despite having health insurance, are in reality medically indigent. For these mostly low wage earners, the deductibles and/or co-insurance required by their job-based health insurance effectively serves to bar access to the early care so important to reducing risk of more serious medical need and later complication.

The economic slowdown accelerating today and what appears to be a slowing in the number of additional California employers purchasing group health insurance means that the number of uninsured is increasing. When adults do not have job-based health insurance their children live without health insurance as well. Although other factors contribute, many low wage earners find even the modest cost of premiums for coverage for their children through the Healthy Families Program beyond their financial reach.

Cost is the most important factor employers say they consider when deciding to purchase group health insurance. In 1999 monthly premium charges in California for group HMO policies ranged from $145 for single-person coverage and $405 for families, with Preferred Provider Organization (PPO) premiums 70 percent or more higher. Premiums have been rising steadily since 1996. Employers respond to every increase by considering whether to add or drop coverage, change benefits, or require additional employee cost-sharing. Statewide in 2000 the data indicate continued employer commitment with employers paying an average of 88 percent for single coverage and 77 percent for family coverage. (Schauffler and Brown 2000, ix-xiv) The impact on employer decision-making caused by rising energy costs, the business slowdown, and rising health insurance premiums remains to be seen.

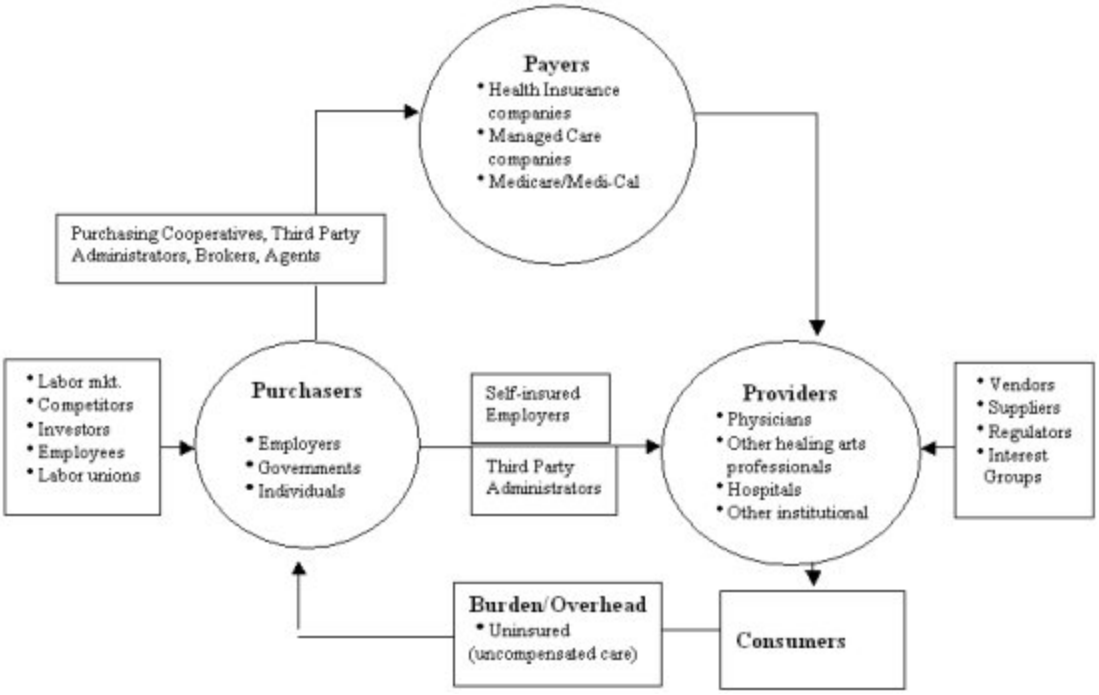
THE SCOPE

The health care market is dynamic with myriad interests, some very influential, others less so, vying for more of the huge amount of health care spending California's 1.3 trillion dollar economy generates annually. Figure 1, on the next page, depicts some but by no means all of the market influences that create reasonable access to affordable health care for about 28 million of 35 million Californians.

The Market

The health care market reflects but does not duplicate America's overall market economy where in theory goods and services are fairly apportioned through relatively unfettered rational transactions between willing buyers and sellers. Where demand does not far exceed supply, markets for essentials such as food, clothing, shelter, and transportation remain relatively stable. Shoppers for shirts for example, although personal taste, advertising, experience, emotion, or other factors may sway their preferences seem to make rational choices as they compare quality, value, and price. They choose a green or blue shirt because they like the style, color, the fit, and because the asking price is what they are willing to pay. Both buyers and sellers "know" what is in their own best interest, "know" quality, and "know" what constitutes a fair price. The logic of these transactions holds true in most markets for life essentials with two significant exceptions: the electricity market and the health care market.

Figure 1: Health Care Market



Unless they are expert about a particular subject, life experience guides most people as they make "market" decisions about product or service efficacy and value. Unfortunately experience is imperfect preparation for the complexities and nuances of the health care market. Knowing which provider or treatment is in their best interest, what constitutes quality care, price comparing especially when health need is urgent or emergent are not what most people can do or want to do.

In the health care market third party payers, particularly managed care payers, make market decisions for most of us. More than 90 percent of Californians under age 64 with job-based coverage are enrolled in some type of managed care plan. The payer mechanism differentiates the health care market from other markets. Few retail markets are quite like it. Payers -- insurance companies, managed care organizations, Medicare and other government health entitlement programs -- hold consumers at arms-length as they arrange for care and assure access to care. In many ways the involvement of payers is analogous to the role parents play in the lives of their children. They protect even as they decide what is in the child's interest. Parents gradually relinquish these roles as the child becomes more competent. The analogy is only partially applicable to the health care market because very few consumers or purchasers of care for that matter can ever become competent health care market decision makers. The complexity of an environment overlain with medical jargon, the fear compromised health engenders, technical and scientific issues, and life and death urgencies make it impossible to do so.

Acting in our stead, payers negotiate the price of health care, purchase care, evaluate provider and care quality, and arrange for access to care. In doing so they add significant administrative

and sales overhead to the cost of care. The vast majority of insured Americans access health care, services and often consumables through these intermediaries who presumably understand the market and its forces and how to most effectively and efficiently transact business there. Though they are the principal purchasers of care, employers are no more advantaged than individual consumers are. Because very few are expert in the business or art of medicine, employers defer to payer judgment using the price of the insurance premium as the criterion for selecting one health plan over another.

The cost of traditional indemnity insurance is prohibitive for all but a handful of employers. Most limit employee choice to one or more managed care arrangements: HMO, PPO, and/or Point of Service (POS) plans. Managed care payers have dominated the California market for nearly twenty years. In managed care the payer negotiates provider fees in advance, selects the providers plan subscribers can look to for care, controls consumer and provider utilization, determines the scope and terms of benefits, and establishes quality standards.

Although continuing to enroll the most persons, HMO membership has been declining for several years in California. Today about 55 percent of persons with job-based insurance (29 percent nationally) are enrolled in HMOs. Higher wage employees generally opt for PPO (25 percent) or POS (19 percent) plans when employers make those managed care alternatives available. Workers in higher paying jobs usually have more choice when it comes to employer-provided health insurance. Because PPO and POS plans typically require higher deductibles or other out-of-pocket charges than HMOs, most persons choosing PPO and POS plans tend to be persons who can afford the cost, i.e., higher wage earners. (California Employer Health Benefits Survey 2000) Also in California today about half of Medicare beneficiaries and most non-elderly Medi-Cal beneficiaries are enrolled in HMOs.

Some communities in California are medically underserved while others have a surfeit of health care providers. Providers are attracted to communities where the economy is relatively stable and where people have the ability to purchase health care. In markets with high HMO or other managed care penetration, physicians and hospitals have little choice but to settle for lower prospective reimbursement rates from payers. In such markets, providers are more apt to market elective services, advertise, develop joint ventures with one another, and consolidate in seeking to redress payer dominance.

Since managed care began to dominate the market in the late 1980s, market forces have encouraged the development of multi-medical practice groups and multi-hospital companies. These groupings, or consolidation, greatly reduce the competitiveness of physicians in solo or small medical group practice and diminish the negotiating ability of some independent hospitals. Unless they add value because of specialization or have branded reputation in a locale, standalone providers are unable to negotiate best terms and prices from payers. Conversely in markets dominated by multi-hospital companies, large medical groups, or Independent Practice Associations (IPAs), payers have little bargaining recourse. Consolidation has occurred throughout California. Today, three multi-hospital organizations control about 40 percent of the beds in metropolitan Los Angeles and 45 percent in San Francisco compared to 14 and 18 percent respectively in 1994. In addition, four multi-hospital companies now own half of the rural hospitals in California. (Spetz, Seago, and Mitchell 1999)

The jockeying of payers and providers in a market hugely impacted by the medically uninsured and the uncertainty of the economy is not without casualties. Since 1998, 130 medical groups in California, some with thousands of physicians such as the MedPartners Provider Network, have filed for bankruptcy because of inadequate cost controls, low payments, and market competition. (Dower, and others 2001) MedPartners Provider Network, with responsibility for care to 1.1 million persons, operated as a licensed HMO as well as service provider to several dozen managed care organizations throughout the state. HMOs are also succumbing. For example, no longer able to meet required cash reserves, Maxicare, with 254,000 subscribers and also one of the oldest HMOs in California, filed for bankruptcy protection in May 2001 reporting losses of $65 million on revenues of $725 million. (Sacramento Business Journal 2001, "Maxicare Health Plans Inc. Grappling for Survival.")

Unlike wheat or gasoline prices that fluctuate with changes in demand and supply, health care costs seldom fall. They occasionally plateau, as they did in the early 1990s, and then rise again as they are doing now. Slower price increases result less from the entrants of more providers and/or seemingly greater efficiencies in the market than from the relative success of providers or purchasers in their market negotiation. "When insurers are earning underwriting profits (profits before investment income) they strive to enlarge their market share …thus premiums rise more slowly than medical claims expenses do. Eventually, price competition eliminates underwriting profits, and insurers shift their strategy to restoring profitability by raising premiums" (Gabel, and others 2000, 145). Across-the-board premium increases are expected to continue well into this decade. For instance, CalPers, one of the largest health insurance purchasing cooperatives in the nation, recently approved HMO premium increases of 13.2 percent and premium increases of 17 percent for its self-funded PPOs in 2002.

Payers

Only two percent of non-elderly Californians had indemnity health insurance in 1998 while about 70 percent were enrolled in only four of the largest full service Knox-Keene Health Plans. HMOs also enroll most of California's non-elderly Medi-Cal eligibles and two of four million Medicare beneficiaries.

> Health plans assume an intermediate position on the chain of production and distribution, squeezed between physicians, hospitals, and other providers on the one side and corporate benefits managers, governmental agencies, and consumers on the other. The boundaries of these industry segments have fluctuated continuously with private purchasers establishing self-insured plans, public purchasers offering direct-service benefits, providers launching insurance products, insurers acquiring providers, and everyone dabbling with great enthusiasm and little success in the others' business. (Robinson 1999, 5)

Health plans have been relatively successful in lowering prices by selectively contracting with competing hospitals serving particular locales. Similarly, competition among the various managed care plans in particular locales also reduces premiums to employers. (Morrisey 2001)

> Employers succeeded in harnessing the run-away health costs of the late 80's and early 90's with a powerful dose of managed care. In applying extreme cost-cutting measures, however, the business community often failed to consider either the underlying cost drivers or the perspective of patients or providers. This myopic obsession with cost resulted in a dysfunctional market. The squeeze also brought a frenzy of consolidations with market domination and a new round of price increases. (McNeill 1998, 24)

Prices that held throughout the early and mid-1990s began to rise in the late 1990s as hospitals and physicians become increasingly resistant to capitation reimbursement and consumers through their employers and in the media began blaming HMO capitation for restricting access to quality care. Capitation gives financial incentives to providers to control utilization, prescribe less expensive procedures, prescribe generic and less expensive drugs, and encourage prevention and wellness.

Purchasers

During WW II employers responded to labor shortages, wage and price controls, and government incentives by beginning to offer health insurance as a benefit to attract and retain workers. By the early 1950s societal expectations had firmly tied health insurance to the workplace. Today the majority of working Californians have some form of job-based coverage. But employer participation is by no means uniform. Of the approximately 700,000 private businesses in California, only two in ten with 3-9 employees provide job-based health insurance. On the other hand fully 95 percent of the 28,000 businesses with 51-1000 or more employees provide job-based health insurance. Businesses with less than 51 employees employ the most Californians but these smaller organizations are also the least likely to purchase group health insurance. Most voice cost as the reason for not doing so. (LoSasso, and others 1999) Coverage available to small employers through purchasing group arrangements such as Pacific Health Advantage (formally the Health Insurance Plan of California) or California Choice attract a comparative handful of small employers: 13,000 out of the 540,000 employers statewide. Although they give individual employers a choice of health plans, the prices the purchasing groups are able to obtain for their member employers are similar to market prices for insurance products available through traditional source. (Rybowski 1996)

Without legislation mandating job-based health insurance, the State's small employers are not likely to shoulder what they perceive as an unfair burden to their bottom line. Their decision impacts community health, quality of life, worker and family health, and the competitiveness of California business.

But large employers are by no means sanguine about market realities. Many report that today's insurance premium increases are making them less certain about their historic role as health care purchasers. In a recently published survey of 408 of the Fortune 500 companies, more employers reported considering employee cost sharing as their only short-term solution to the continuously rising costs of health care, a commodity of variable quality. Their views of the long term are guarded with some respondents even questioning the viability of America's job-based health

insurance system. Some also report considering direct contracting with providers to eliminate third party payer administrative and sales fees. Others use or are considering a "defined contribution" approach as an alternative to dropping job-based coverage altogether (Maxwell and others 1999). In defined contribution, employers cap their dollar obligation for health care by specifying the maximum amount they contribute and then leaving it to employees to apply the cap to the range of plans the employer makes available to them. Doing so creates price elasticity as plans become responsive to the employee as "shopper." (McNeill 1998) Some large employers also self-insure. Doing so allows employers to replace "health insurance" with "health benefits" tailoring the scope of benefits to their own liking under the protection of federal Employee Retirement Income Security Act (ERISA) legislation. Self-insured employers generally arrange for medical services, claims management, and stop-loss coverage through third party administrators. (Krampf 1995)

In its annual national and California survey of private firms the Kaiser Family Foundation-Health Research and Educational Trust found one in three employers "very" or "somewhat likely" to change from their present insurance arrangements to defined contribution in which they give their employees cash to purchase health insurance on their own. California companies, they report, are more inclined towards defined contributions than companies elsewhere in the nation. The survey also found that most employers are not inclined to support the use of tax credits to support worker purchase of health insurance on their own. Respondents felt that employees would have a hard time handling the paperwork and shopping on their own for the best coverage. (California Employer Health Benefits Survey 2000)

The State of California is a major purchaser of care for high need/low resource persons. About 5 million Californians are Medi-Cal recipients. Medi-Cal pays nearly two-thirds of all California nursing home care charges, covers dental care for about 2 million persons, and maternity and delivery charges for more than 200,000 babies annually. (Medi-Cal County Data Book 1999) Other major State purchased health programs include: (1) Healthy Families (children in low wage working families but above Medi-Cal eligibility thresholds), (2) Access for Infants and Mothers (prenatal, delivery, postpartum, and well baby care for low income women), (3) Major Risk Medical Insurance Program (for persons unable to purchase affordable health insurance because of pre-existing medical condition), (4) California Children's Services (care to low income children with serious medical challenge), (5) Early and Periodic Screening, Diagnostic, and Treatment (preventive health services for Medi-Cal eligible children and in-home support services to homebound medically fragile children), (6) Child Health and Disability Prevention (screening, assessments for early detection and prevention of disease and disability, immunizations), and (7) programs that reimburse the counties for medical and mental health services to the medically indigent. Funding for most of these programs involves a mix of federal and state resources. Although it spends billions for health care, the State of California is infrequently the provider of care. With some exceptions, State-purchased health services are delivered to constituents by contracting providers, including Medi-Cal contracting hospitals and providers affiliated with contracting private or public health plans.

The number of Medi-Cal recipients declined in California from about 15 percent of the non-elderly population in 1995 to 11 percent in 1999 largely because of welfare reform. No longer qualifying for cash assistance and unaware of temporary Medi-Cal coverage thousands become

medically indigent each year because the low wage entry-level job most obtain do not include job-based health benefits.

Providers

In the waning 1990s the Medicare cost-cutting provisions of the federal Balanced Budget Act (1997) began to seriously impact California hospitals, skilled nursing facilities, and physicians. Although some of the cuts were rescinded in 2001, revenue increases were mitigated by hospital energy cost increases statewide that ranged from 30-50 percent and natural gas cost increases of 300 percent. Increases in receivables aging also challenged the financial health of hospitals. From an average 60 days a decade ago, receivables from third party payers now average about 100 days statewide. Slow reimbursement especially from managed care payers continues despite California's prompt payment law (Health and Safety Code 1371) that requires payment within 45 days.

Sixty percent of California hospitals have negative patient care margins. About one in four receive state subsidies as a disproportionate share hospital (DSH) for service to large medically indigent populations. Hospital revenues are below the costs of care for a majority of hospitals statewide. Overall in 2000 California's hospitals had patient margins (net patient revenue less expenses) one third that of 1997 levels. Total hospital margins (including revenues from non-operating sources) averaged only 2.5 percent in 2000. (California Hospitals Continue to Face Financial Pressures, California Healthcare Association Special Report 2001)

Slowing receivables and revenue decline coupled with a severe nursing personnel shortage puts additional pressures on budgets as hospitals, skilled nursing facilities, and other providers compete for nurses. Projections are for a statewide shortfall of 25,000 nurses by 2006. (Nurse Shortage Fact Sheet, California Healthcare Association 2000) Adding to the financial squeeze is the large numbers of medically indigent accessing hospital emergency and trauma care services. Statewide, California hospitals lost $400 million in uncompensated emergency care in 1999. Thirty percent of the losses are in Los Angeles County where nearly one-in-three are medically indigent. Since 1990 about 12 percent of California hospitals have closed their emergency departments. Emergency departments struggle to remain viable even as patient wait times increase and needed facility and equipment improvements are deferred.

California has 90,000 currently licensed allopathic and osteopathic physicians but only about two-thirds are active in non-federal patient care roles. The active physician-population statewide in 1994 was 177:100,000. Today it is 190:100,000. Increases in the absolute number of physicians in practice have not depressed physician fees or changed practice patterns. About 50 percent of generalists and 33 percent of specialists in urban areas of the state had contracts with HMOs, including Medicare and Medi-Cal contracting HMOs, in 1998. On the other hand only about one in four generalists and 15 percent of specialists received more than half of their income from capitation, the mechanism most likely to achieve cost savings. Among 85 percent of specialists, fee-for-service remains the major form of reimbursement. Nearly half of generalist physicians and two thirds of specialists in California reported no uninsured patients in their practice in 1998 and only 60 percent reported care to some Medi-Cal insureds. (Dower, and others, v)

IMPLICATIONS FOR POLICY MAKERS

Health care costs are influenced by a number of factors. The health care market is not as responsive to supply or demand as other retail markets. In the 1970s federal legislation sought to contain price inflation and even expand access by using mechanisms such as Certificate of Need tied to comprehensive health planning. Those efforts were unsuccessful. In the 1980s and 1990s public policy towards the health care market nationally and in California was essentially hands-off. The assumption was that the give and take of purchaser, provider, and payer transactions would fairly determine price and apportion more services to more people. This approach has also not constrained cost inflation or re-distributed health care goods and services.

As HMOs began to predominate during the early 1990s prospective contracting, particularly the use of capitation mechanism, slowed health care cost increases. Despite the overlay burden of the uninsured, high HMO penetration throughout most of California and the emergence of huge countervailing provider networks created a kind of stasis in the market with price volatility lessened during those several years. However, during the same period public and provider antipathy towards HMOs began to grow. In recent years these sentiments have begun to unsettle the market as physicians and hospitals opt-out of capitation and even other forms of prospective payment. Consumers too, feeling inadequately served by HMOs, pressure employers for alternatives to HMOs.

> There is no management of care going on…if it were not for the discounts that insurers can negotiate for groups with lots of employees…it would be like the old indemnity world when employer and patient paid for each service and there were few attempts to hold down cost. (NY Times, 25 May 2001, National Edition, A1)

A largely fee-for-service environment without any meaningful utilization control or prospective agreement about reimbursement with huge uncompensated costs of care to the uninsured returns the market to where it was twenty years ago. Increased costs will in turn compel more employers to drop job-based health insurance thereby worsening the uninsured crisis.

Affordable universal coverage for everyone including the 7.3 million uninsured Californians stops cost shifting and removes barriers to access. The Canadian single-payer system offers a model for consideration.

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SECTION 5: OPTIONS FOR EXPANDING COVERAGE

The following are brief summaries of the nine draft options for expanding health care coverage in California. Each draft options is currently being further developed by authors with whom the State has entered into contract under the Health Care Options Project. Below is a list of grantees and a brief description of the type of reform that is being contemplated by each health reform author and type of financing being considered (where it has been identified). Many important details are not included in the summaries, including those describing the target levels for subsidies, the benefits that would be offered and program administration, because the authors are still refining their proposals.

E. Richard Brown, et al, University of California, Los Angeles. This grantee is proposing to expand coverage by expanding current public programs and by creating a pay-or play requirement for employers. All individuals would be permitted to join the new insurance program, which also would cover people eligible for Medi-Cal and Healthy Families. Employers would pay a premium to the new program for any employee not covered by employer-sponsored insurance, and the employee also would contribute to the new program a percent of their wages. The program would be funded through maximizing federal matching, premium payments by employers and employees (those without employer-sponsored insurance) and premium contributions by people with self-employment or unearned income.

Helen Schauffler, University of California, Berkeley. Choice Proposal. This grantee is proposing to expand coverage by offering all workers and their families and all those eligible for Medi-Cal and Healthy Families the option of enrolling in a new program called Choice. Choice would be funded through an employer payroll tax, which would vary by firm size, and by family premiums, which would be capped as a percentage of family income.

Helen Schauffler, University of California, Berkeley. Cal Health Proposal. This grantee is proposing to expand coverage by expanding eligibility under the current Medi-Cal and Healthy Families programs and increased outreach to increase enrollment of children in the program.

Judith Spelman, Health Care for All. This grantee is proposing to expand coverage by creating a single, publicly financed program that would be available to all California residents. The program would be financed through folding in of existing public program spending and administrative savings, a payroll tax, a tobacco tax, and an increase in the income tax.

James G. Kahn, et al, University of California, San Francisco. This grantee is proposing to expand coverage by creating a single, publicly financed program that would be available to all California residents. The program would be financed through a payroll or other employer tax, folding in of existing public program spending (or charging programs for delivery of services if they cannot be folded in), administrative savings, a tobacco tax and tobacco settlement funds, and other potential sources of revenues if needed.

Working Partnerships, USA. This grantee is proposing a locally managed, incremental strategy to achieve universal coverage by providing health insurance to the uninsured through

public authorities. Premiums would be subsidized on a sliding scale basis, with the subsidy coming from the State General Fund.

Lucien Wulsin, Jr., Insure the Uninsured Project. This grantee is proposing to expand coverage through a combination of (1) refundable tax credits (or vouchers) targeted to small employers with a substantial percentage of lower income workers; (2) refundable tax credits (or vouchers) targeted to families that have to pay more than a designated percentage of their income for employer-sponsored insurance; (3) refundable tax credits (or vouchers) for workers not offered employer-sponsored insurance; and (4) a public program expansion for indigent adults without minor children. A maintenance of effort requirement for California counties would provide part of the revenue to support the program.

Ellen Shaffer. This grantee is proposing to expand coverage by creating a single, publicly funded program that transfers the responsibility of financing and delivering health care to the public sector. Health care services would be delivered by clinicians and other health care workers employed by the State. The program would be financed through a sliding-scale employer contribution, an increase in State income taxes (to replace individual premium contributions) and folding in of existing public program spending and administrative savings captured by the State.

Katie Horton, HealthPolicy R&D. This grantee is proposing to expand coverage by providing a subsidy to employers that have not provided health insurance within the previous 6 months for their uninsured employees and their families with incomes below 350 percent of poverty. For employers to begin offering coverage, premiums would be split 40 percent from the employer, 40 percent from the subsidy pool, and 20 percent from the employee (the subsidy would be higher if coverage is purchased through the State purchasing cooperative). A limited amount of public funds would be made available each year for the subsidies.

SECTION 6: CONSENSUS BUILDING STRATEGIES

[THIS SECTION WILL BE FURTHER DEVELOPED FOR FINAL REPORT]

HCOP is being conducted with substantial input at each stage of the process from members of the public, policy experts and other stakeholders.

In developing the solicitations for the reform options and the modeling contractor, CHHS developed an interagency process including State representatives named in SB 480, legislative staff, and experts in the field, to draft two Solicitations for Proposals (SFPs) consistent with the objectives of SB 480. In April 2001, CHHS sought public review and comment on the drafts.

To notify interested parties of the SFP release, CHHS mailed nearly 1,000 letters announcing the SFP release, launched healthcareoptions.ca.gov -- a new website dedicated to the project, and posted an SFP advertisement in the State Contract Register. On June 29, 2001, CHHS held a Bidders' Conference to provide an overview of the SFPs and respond to questions regarding SFP instructions and requirements for potential reform option authors.

To ensure public participation during the selection process and other key decisionmaking points, CHHS invited a cross-section of stakeholders to join an Advisory Group, including: providers, associations, insurers, health planners, consumers, businesses, local government, and labor interests, as well as legislative staff. The purpose of the Advisory Group is to provide public policy input to CHHS on the project. Advisory Group members have participated in two Advisory Group Forums. At the first forum, held on August 1, 2001, the Advisory Group provided meaningful feedback on selecting option papers and model submissions. A second Advisory Group Forum provided CHHS with an opportunity to receive input on the design and format for the symposia and to delineate the key issues that should be analyzed in comparing the coverage options at the symposia. Upon selection of the final model contractor, the Advisory Group will meet to discuss the design and assumptions used for the economic analysis of the coverage options.

As discussed above, once the reform option papers are modeled and more fully developed, HCOP will culminate in a series of five public symposia to be conducted throughout the State in early 2002. It is our hope that the symposia will provide a public forum for the Advisory Group, experts, Legislative staff, and other stakeholders to critically examine and provide input to the options and analyses. In August, an independent contractor was hired to evaluate the public input process. The results of this evaluation will be included in the final reports to HRSA and the Legislature.

SECTION 7: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

[THIS SECTION WILL BE INCLUDED IN FINAL DRAFT]

SECTION 8: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

[THIS SECTION WILL BE INCLUDED IN FINAL DRAFT]

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