Preliminary Thoughts on California's Waiver Coverage Expansion Options: The Quick and the Dead

By Lucien Wulsin Jr.
Insure the Uninsured Project
www.itup.org

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Waiver Coverage Expansion Options

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Overview

The hospital financing and managed care waiver negotiated between the state of California and the federal government designates $180 million annually in years 3-5 of the waiver in federal financial participation that must be used on coverage expansions. This is a lower limit and does not preclude the state from allocating more of the new federal funding for coverage expansions.

There will be pushing, shoving and positioning of all parties to access the new funding. Those who access the new funding first are likely to retain it thereafter. So we sub-titled this piece the 'Quick and the Dead".

The following issues ought to at least be considered by parties seeking to design coverage expansions under the waiver. $180 million is only a very small down payment on covering the uninsured.

- Where should it be targeted to most immediately help cover the uninsured?
- Where should it be targeted as a building block to further increase coverage in subsequent expansions?
- How can it be used to leverage additional funding to increase coverage of the uninsured?
- How does it interface with the other provisions of the waiver?

In our view the funds are best targeted at increasing coverage rates for low wage uninsured workers, using safety net health plans as the delivery network, and permitting uninsuring employers the opportunity to buy into the offered coverage.

What Problem Are We Trying To Solve?

- **Low offer rates of low wage businesses (e.g. agriculture, child care, restaurants, construction, retail, garment industry, beauticians, gardeners)** [1]

Uninsured individuals in California are primarily (85%) low-wage workers and their family members. California's unusually high rates of uninsured residents as compared to comparable states are principally a function of very low offer rates for low wage workforces – 70% of workers are uninsured because their employer does not offer coverage.

Employers offer coverage because it keeps their employers healthy, on the job and effective at work. The overwhelming reason that uninsuring employers cite for the failure to offer coverage is "affordability". Private coverage is unaffordable for low wage workforces due to the highly regressive impacts of state and federal tax subsidies for employment based coverage.

Industries with unusually low offer rates are those that are labor intensive with high percentages of low wage, mostly non-unionized employers. One approach with the new federal funding is to fund pilot programs to partially subsidize coverage for low wage uninsured workforces, providing the employer and employee financially participate in the costs of their coverage. The goal is to identify the mix of incentives and other features that persuade uninsuring employers and uninsured employees to get coverage. Successful pilots can be most easily translated into further expansions.

The new federal funds can buy much more coverage if matched by employer and employee contributions. Successful pilots in Michigan have been designed with 1/3 employer funding, 1/3 employee funding and 1/3 public funding.

This idea has been tested many times, and the research confirms the obvious. With very large subsidies, more employers offer and more employees take-up coverage – for example the heavily subsidized county pilots for home care workers in California had strong take-up. With small subsidies, only a few employers take up the matching challenge and offer coverage. The most responsive uninsuring employers may be very small employers. In the FOCUS program in San Diego and SacAdvantage in Sacramento, most participants were very small employers (five employees or less). The results in terms of increased offer rates, however, have never approached the results projected by the proponents of this approach. One experienced plan administrator suggests that employers are appropriately wary that premium subsidies will dry up after a few years, leaving the employer with a tough financial challenge to replace the funds or a difficult personnel decision to terminate coverage.

The key design issues are 1) properly targeting those uninsured workers and uninsuring employers who will respond to the premium subsidy and 2) setting the subsidy at an amount sufficient to induce participation by the employer and employee without over-subsidizing the product.

- **Low wage worker take up rates (family coverage)[2]**

A much smaller percent of the uninsured (15%) are individuals who are offered coverage, but for a variety of reasons, primarily affordability, do not take up their employer's offer. As premiums have increased at double digit rates and those costs are passed through to employees, family coverage is becoming increasingly unaffordable for low wage workers and some national researchers are finding that the decline in employment based coverage is primarily associated with a large decline in the take-up rates for family coverage.

Subsidizing family coverage for low wage working families has several virtues and one major drawback. It builds on the employer contribution, keeps the whole family in a single plan, resolves financial hardships of low wage working families and saves spending for state health programs, Comparatively few employees drop family

coverage and become uninsured, so this approach (while saving state funds) is projected to cover very few of the uninsured.

- **Coverage for flex workers**[3]

Flex workers include part timers, temps, seasonal, self-employed and independent contractors. Flex workers are not typically offered coverage even at workplaces where full time workers are covered and thus building their coverage through the workplace is not a viable option. Flex workers may account for as much as 40% of uninsured workers.

ITUP researched possible approaches to increase coverage of flex workers and found low wage flex workers need both an efficient purchasing pool and a source of premium subsidy to make coverage both available and affordable. The Lewin analysis of SB 480 Option Papers found that purchasing pools and strong premium subsidies could dramatically increase coverage of low wage flex workers. More recently several Fortune 500 companies have joined forces to promote purchasing pools (but no premium subsidies) to cover their flex workforces.

- **Affordability for low wage, young and/or older workers**[4]

As discussed above, employment-based coverage for low wage workforces is often unaffordable due to the skewed and regressive tax policies that support employment based coverage. Low wage workers and young workers in entry level jobs are disproportionately uninsured. Uninsured young males however may use health services only *in extremis* and primarily in hospital emergency room settings, even with coverage. Covering young adults can be done at a very low cost provided it is coordinated with existing public coverage for perinatal services, but it has fewer short term and greater long term public health benefits than expansions of coverage for older workers. San Francisco Health Plan has recently offered subsidized coverage for young low wage adults, using its successful Healthy Kids program as the stepping stone.

Individual and small employer coverage for older workers is unaffordable because those premiums are age rated and typically two to three times as high (since we all experience more health problems as we age) as the premiums for younger workers. Older workers make up a small share of the uninsured. However, those with chronic illnesses disproportionately use county health programs and other safety net services. Expanding coverage for older workers has the most immediate beneficial impacts on health status, job retention and job performance. Coverage expansions targeted to uninsured, low wage, older workers could have three beneficial impacts: increasing their coverage, improving their health status, and reducing the demand on the most expensive components of county health services.

- **Safety net facilities funding and delivery problems (clinics, hospitals, counties, integrated delivery systems, care models and coverage models)** [5]

County health programs are responsible by state law to provide care to low income, uninsured adults. County health faces a multiplicity of problems; these include lack of adequate funding, high cost hospital and emergency room centered delivery systems, and lack of integration among primary care and specialty services. For example, in a number of counties, non-profit community clinics are not funded by their counties for care to the county's uninsured; whereas, in other counties, such as Los Angeles under its 1115 waiver, community clinics are well integrated into the county's delivery network and are heavily dependent on county funding.

There is widespread unevenness in eligibility and funding and wide disparities in access to services among county health systems, depending both on comparative funding in the county and also on the respective priorities of local decision makers. In general, those counties with more funding provide more services and coverage to the uninsured although in some counties uninsured residents are a low priority as compared to other local health needs. Some counties have been expanding eligibility while others have been limiting eligibility.

Counties with public facilities and some with private facilities operate on a "care" model that treats all uninsured patients on a first come first served basis and triages available funding and services. Many counties without public facilities use a fee for service coverage model based loosely on Medi-Cal, but heavily oriented towards reimbursing emergency and hospital based services for a discrete, defined group of uninsured eligible adults. Two counties, Contra Costa and Solano, stand out as having moved their county health programs towards a well-balanced, managed care model of coverage for uninsured adults, and others have made important improvements.

Counties with an emergency room oriented delivery system for the uninsured are not well positioned to compete in Medi-Cal managed care markets that require a primary care centered delivery system. Those county safety nets with an episodic delivery system for the uninsured will face challenges adapting to the demands for managing chronic illness as the disabled move into Medi-Cal managed care.

The new federal funding could be distributed on a competitive grant basis for those counties adopting or expanding a coverage model with accountability for achieving the promised coverage expansions with the funds allotted.

- **Inadequate access to/funding for outpatient services**[6]

Our research on 48 county health systems indicates that access to and use of outpatient services in county health programs is comparatively speaking far worse than access to and use of hospital and emergency services. It may be said that in health care "form follows funding", and DSH and SB 1255 funding that pay for care

to the uninsured in hospital settings have contributed to the imbalanced delivery system in place in many California counties today.

Utah, under then Governor, now HHS Secretary Mike Leavitt, used an 1115 waiver expansion to fund coverage of outpatient services to adults up to 150% of the Federal Poverty Level. As federal DSH program funds pay for uncompensated care in hospital settings, an outpatient coverage expansion would be complementary to increased hospital funding in the other provisions of the waiver. It could be linked to a legislative assurance that each California hospital receiving DSH funds would neither turn away nor over-bill a patient covered for outpatient services under this aspect of the waiver.

Los Angeles' 1115 waiver afforded one of California's 58 counties, albeit the nation's epicenter of the uninsured, federal matching funds and a unique opportunity to increase funding for primary care services to the uninsured. There is a need to learn from the experiences of the community clinics and the county under the Los Angeles waiver in designing any expansion of outpatient coverage.

Under an outpatient coverage expansion, the legislature would need to assure that state and county administrators do not de-fund existing financial commitments to outpatient services; otherwise there may be little or no net increase in coverage or funding for outpatient services.

- **Inter-county funding and access to care inequities (e.g. Central Valley, Southern California counties)[7]**

Funding for county health services is widely and sharply inequitable in California. Realignment formulas are based on 20+ year old distribution formulas that bear little or no relationship to the numbers of uninsured in any given county. DSH and SB 1255 financial distributions favor counties where the care to the uninsured is concentrated in a few institutions and disfavor uninsured residents in a number of very poor "under-equity" counties with high percentages of uninsured residents.

The new limited federal funds could be used to fund coverage expansions in "under-equity" counties or could fund coverage expansions in all counties, but with disproportionate catch-up funding allocated to those under-equity counties with high percentages of uninsured residents. It could be tied to achieving specified state minimums of eligibility and delivery of services.

- **Families, parents, adults without minor kids living at home, children[8]**

A coverage expansion under the waiver could be targeted to uninsured children, Healthy Families parents, or low wage adults without children living at home. It cannot be targeted to undocumented workers or children. In our view the most sensible expansion is coverage of uninsured low wage adults without minor children living at home because the state has other available options to pay for uninsured

children and parents that are not subject to the limited federal allocation for coverage expansion under the waiver.

California has federal waivers to cover Healthy Families parents and to cover uninsured children up to 300% of the federal poverty level, but has not implemented these waivers because the state government has not put up the matching funds for Healthy Families parents due to its fiscal crisis. Counties have not been able to put up the matching funds to cover Healthy Families parents because the state has never submitted the necessary paperwork to secure approval from the federal government. Furthermore Healthy Families spending is outrunning the federal allocation, leaving little or no funds in reserve to pay for expanded coverage to parents. Counties operating Healthy Kids programs report that they have not been able to access the federal match for children with incomes between 250 and 300% of the federal poverty level due to federal and state obstacles. Even if California spends all of its federal allocation of S-CHIP funding (2/1 match), it makes more sense for California to cover uninsured children and Healthy Families parents through a Medicaid 1931b expansion (1/1 match, but no federal cap) than through the provisions of this waiver. For these reasons, we think the funds ought to be used to expand coverage of low wage working adults without minor children living at home.

- **Workers or unemployed workers**

The federal funds could be used to expand coverage for workers (85% of the uninsured) or non-workers (15% of the uninsured) or both.

The non-worker category includes both the short-term unemployed as well as many individuals with chronic medical conditions or illnesses that limit their capacity to work. Some non-workers have applied for SSI but have not yet been determined as disabled. Many non-workers are unemployed, low-income individuals between jobs who cannot afford COBRA coverage. Unemployment is stressful to the health of working individuals resulting in preventable illnesses. Covering non-workers would benefit the unemployed worker (and society as a whole) by preventing their conditions from deteriorating resulting in permanent disability, assisting unemployed workers with maintenance of their health status, and assuring a timely return to work. Massachusetts covers unemployed workers by designating a very small percentage of the state's Unemployment Insurance tax for that purpose.

County health programs serve a proportionately higher incidence of the low-income non-workers. Coverage of non-workers is significantly more expensive as they have worse health status, a higher risk profile and greater utilization of costly services than do workers of the same age. Expanding coverage of non-workers minimizes the risks of crowd-out incentives for those with employment-based coverage.

Coverage of workers benefits the employers and employees by enhancing employees' productivity and job retention; it reduces days lost to preventable illness and enhances the worker's short and long term health status.

- **Short term or long term uninsured**

Over half of the uninsured are long term uninsured, meaning they are uninsured for an entire year. About 40% of the uninsured are short term uninsured, meaning they are insured part of the year and uninsured for part of the year. It is administratively easier and far less costly to keep an individual enrolled who is about to become uninsured than it is to do outreach, find and enroll an individual who is long term uninsured. The short term uninsured are higher income and more able to contribute towards the cost of their coverage than the long term uninsured. The long term uninsured may be in poorer health, more costly to treat and more likely to immediately benefit from coverage than the short term uninsured.

What Level(s) Of Government Are Involved And In What Role?

- **Local or regional (plans, counties, providers)**

Counties are responsible for care to low-income adults with no other health coverage. They provide care to about 1.5 million individuals at a cost of about $1.9 billion. Some counties operate their own hospitals and clinics to provide these services, while others pay private hospitals, doctors and non-profit community clinics to deliver these services. A few are hybrid models that operate county clinics and pay private hospitals. Some counties operate managed care plans to provide managed care services to Medi-Cal patients. Other counties operate regional programs for the uninsured, and more should be encouraged to do so to promote greater cost efficiency.

Are counties paying the match to access federal funds? Do they have available local funds to pay the match? Is new local funding to be the match, or is the match to be existing county spending on the uninsured? Can counties back out the existing funds they dedicate to coverage of the uninsured?

Some local governments have been the policy pioneers, developing new models of health coverage. The new funds could spark new rounds of local innovation in those counties. To put it in context, the proposed new funding is nearly three times what counties spend annually on local Healthy Kids programs for uninsured children.

Would the expanded coverage augment or displace or operate autonomously and independently from the current county health coverage? If county governments pay the match, then county governments will control the decision-making. Some local decision makers will use the new federal financing to augment coverage in their existing programs; others will use it to pioneer new programs, while still others will seek to use it to replace some existing county health funding that will be diverted to other pressing local priorities.

The federal waiver funds account for about 10% of existing county spending for the uninsured. It is unlikely that this small tail will "wag the dog" and transform a county's health system. Without state oversight, new funds may be used in some counties to pay for long-sought provider rate and employee pay increases rather than actually expanding coverage.

Would the coverage be offered through the county managed care plan and would that plan be the exclusive plan for coverage? County managed care plans have been the California pioneers in expanding coverage to the uninsured and have played a far larger role in this regard than their larger, better financed commercial competitors.[9] They have the added virtue of a mixed public-private delivery network with a major role for safety net providers. On the other hand, county managed care plans exist in only a limited number of counties, and not all fare well in head to head competition with commercial plans. In addition, many small counties have no managed care infrastructure in place.

In counties with public facilities, would public facilities be the exclusive source of care or be a part of a mixed public and private network? While the major public facilities are the dominant source of care for the uninsured in their communities, it may prove difficult to design a plan that attracts enrollment and financial contributions from uninsuring employers or uninsured employees for coverage that limits patient choice to public providers.

- **State (purchaser, financier, arbiter/decision maker, matchmaker)**

California state government plays a large role in financing care to the uninsured through payments to counties, to clinics, to health plans, hospitals and other local providers.

State government is often a funding conduit with little or no decision-making role for funds they allocate, such as realignment, CHIP and DSH. In its other roles, such as through MRMIB, it purchases coverage for the medically uninsurable, pregnant women and uninsured children. Through C-MAC, it plays a major under-the-radar role in negotiating and financing improvements in local delivery systems for low-income individuals. Through DHS, it expands coverage to uninsured individuals with certain illnesses or conditions such as forms of cancer, tuberculosis, AIDS or to uninsured pregnant women, children, working parents or disabled workers.

Most would welcome a state role as financier, paying a state match for the new federal funds. Without assuming a financing role, the state is likely to be a funding conduit and to play little or no decision-making role.

If state government pays the match, it must decide whether to administer the coverage expansion funds through DHS, MRMIB, C-MAC or the counties. For example MRMIB could create a mix and match purchasing pool similar to Dirigo in the State of Maine that would combine new federal funds, new state funds, and employer and

employee shares of premiums. MRMIB could purchase basic health coverage for low income working adults who pay a sliding share of the premium based on their income as the state of Washington does.

California could build on its existing DHS administered coverage of treatment for breast and prostate cancer to cover all forms of cancer for low and moderate income uninsured adults. While some will criticize covering the uninsured disease by disease because it fails to build a platform for extending coverage, this approach would give significant financial relief to counties and to hospitals and provide important peace of mind and security for cancer patients who all too often face extreme financial hardship while battling for their lives. Given the large funding (Prop 99, Prop 10 and tobacco litigation settlement) contributions to the state from smokers and tobacco companies, expansion of state programs to cover cancer treatments could be particularly appropriate.

C-MAC could be asked to administer a system of competitive three or five year grants for localities and others seeking to expand coverage to the uninsured. Communities with the greatest unmet need, most innovative proposed financing and delivery systems for the uninsured could be prioritized.

- **Federal (relationship to refundable tax credits)**

President Bush and Republicans in Congress propose a system of refundable tax credits to help the uninsured purchase individual coverage, probably through state purchasing pools. The President's proposal amounts to nearly $1 billion annually for California or five times the amount allocated under this waiver. While it is unclear whether this proposal will ever pass, if passed it will need a piggy bank/administrator/negotiator to turn annual refundable tax credits for low income uninsured individuals into monthly premium payments to health plans.

California could use the design flexibility inherent in the waiver funds to develop and pilot the administrative infrastructure, subsidies and program design for purchasing coverage for low wage workers, perhaps using MRMIB or Pac-Advantage as the administrative building block.

<u>How Much And What Kind Of Public And Private Sector Involvement Is Desired?</u>

- **Private employers**

In our view, the expansion should provide opportunities for uninsuring private employers to voluntarily contribute towards the cost of their employees' health coverage because most of the uninsured are workers and their spouses. That said, unless the program is designed to encourage, streamline and facilitate employer contributions, it is likely that few if any will participate. Furthermore, the opportunities for employer participation must be designed so as to minimize crowd out and avoid giving incentives for employers and employees to drop coverage.

Given the limited federal funding, state policy makers should use every avenue possible to augment it. Expectations of employer participation must be modest as that has been the result of most pilots.

If other matching opportunities or program designs are more promising (e.g. coverage for cancer treatments) and are incompatible with employer participation, the employer option should be abandoned.

- **Public and/or private health plans**

The advantage of selecting a single plan is simplicity of administration and the potential for negotiating the best price. The disadvantage of selecting a single plan is that plan competition for patients' choice can improve quality, provided of course that patients have adequate information about the plans and their provider networks to make informed choices. It is readily apparent from the wide variations in health plan premiums that different plans in different regions are the most successful in assembling cost effective delivery networks. With a limited budget, administrative costs should be minimized and only the most cost effective plan(s) and/or provider network(s) selected.

Some would argue for bypassing the health plans and contracting directly with those provider networks that are willing and able to absorb and manage financial risk and then use the administrative savings to increase coverage opportunities. It is not clear that there are many well-run provider networks willing and able to absorb and manage financial and medical risk of the uninsured in California.

To date, most innovation in extending coverage to the low income uninsured has come from the public health plans; however some private plans have led and pioneered as well.

- **Public and/or private doctors and hospitals**

In some communities, public hospitals and public doctors provide the bulk of care to the uninsured. They are the logical building block for expanding coverage of the uninsured. In other communities, a network of private doctors and private hospitals provide the bulk of care to the uninsured, and they are the logical building blocks. Should coverage expansion opportunities offer a mix of public and private sector providers? In our view, the fundamental test should be cost effectiveness and quality, rather than whether the provider is "public" or "private". If a coverage expansion does not offer a desirable network for subscribers, patients will not choose coverage, particularly if there is a monthly premium for coverage.

- **Purchasing pools**

Purchasing pools, such as MRMIB, PacAdvantage, or California Choice, offer opportunities for informed choice, negotiated prices and administrative efficiencies. On the other hand they can add to the costs of coverage, and pools have not demonstrated the success in negotiating prices anticipated by their most ardent proponents. The value of purchasing pools in a given proposal should be measured by what the proposal is trying to achieve. Pools would be most needed if the coverage expansion targets individual purchasers, uses multiple competing carriers and follows a premium assistance model. In order to be effective, pool(s) need a level playing field so that it does not become the bad risk pool for the worst health risks rejected by other carriers.

- **Public or private coverage**

Is the coverage expansion offering public coverage, private coverage or consumer choice between the two types of coverage? Public coverage (Medi-Cal or Healthy Families) has lower costs, few patient out of pocket expenditures, broader benefits, better acceptance of safety net providers and less acceptance by the private sector. Private coverage offers greater flexibility in benefits, more cost sharing, higher reimbursement rates and better participation by private doctors and hospitals with significantly less opportunities for safety net providers. Offering consumer choice allows the uninsured individual to afford to take-up employer offered coverage.

- **Individual premium contributions**

Must an individual pay a premium to be covered and how much of the premium is paid by the individual as opposed to subsidized? For low-income individuals, the higher the subsidy and the less the individual pays out of pocket for coverage, the stronger the participation. This does not mean that no premiums should be charged since there is a level of ownership and increased participation that comes with paying an affordable share of the premiums. The Healthy Families program has strong participation because its premiums are perceived as affordable while Oregon Health Plan experienced a huge fall-off in program participation after it adopted premiums that were experienced as unaffordable. In the private sector, participation by low-income workers and families has remained surprisingly strong, despite large increases in consumer cost sharing.

What Is The Organizing Principle Of The Coverage Expansion?

The target population to be covered may prove determinative of program's design.

- **Employers (Focus or SacAdvantage)**

California has had two subsidized premium pilots designed to increase coverage for low wage workers, using uninsuring small business as the platform to extend coverage. Both had similar sliding fee scale premiums based on the employee's pay scale. Both offered private coverage, but with low copays and little out of pocket exposure. Both experienced enrollment primarily from very small uninsuring businesses – five employees or fewer. SacAdvantage, using local brokers and plan choice through a purchasing pool, had much lower and slower response from employers than did FOCUS, which offered only a single plan and had a more streamlined, more grass-roots and less costly enrollment process.

Pilot programs in the Inland Empire and San Diego have tested whether information on the prices and tax advantages of health insurance for small businesses are sufficient to produce any increase in coverage and have concluded that they are not.

Western Growers Association and JL Levey and Associates have separately tested employers' responses to a model of low co-pays, no deductibles and a low annual maximum payment and Western Growers found some success with that model.

- **Low wage workforces (e.g. child care workers)**[10]

Coverage has been developed for low wage workforces such as child care workers, home care workers, agricultural workers, janitors and garment workers. A large public or private subsidy and an active and effective intermediary that would collect premiums, match them with subsidies, and determine and process eligibility are required to make this type of coverage expansion successful.

- **Individuals (Washington Basic Health Plan)**[11]

Washington Basic Health Plan instituted a sliding fee scale premium subsidy program for low wage individuals over a decade ago. The program was capped based on available funding. It included an option for employers to participate, but no incentives for them to do so, and so very few did. Individual participation was strong but diminished as premium subsidies declined at higher income levels until their share of premiums became unaffordable. The diminished participation of healthy higher income individuals also resulted in some adverse selection in the program.

- **Public programs (Healthy Families, Medi-Cal or county health), Safety net provider delivery networks, Safety net health plans**[12]

Rather than start a new administrative structure, coverage expansions can be built on existing public programs; the most logical are Healthy Families and MediCal or Local Initiatives and county health programs. If the state is paying the match, it may wish to use the building blocks of Healthy Families or Medi-Cal. Healthy Families may be more attractive since administrative costs are lower, program flexibility is greater and acceptance by plans, providers and consumers is stronger. On the other hand, participation and reimbursement rates of safety net providers are stronger in the Medi-Cal program.

If the counties and/or local managed care plans are paying the match, counties may wish to use either their county health programs or the local managed care plans to administer the coverage expansion. As discussed above, county health programs are a logical entity to expand coverage as this is where care to uninsured is now reimbursed; the challenges are how the state, federal or local government can be assured that the new funds are used to expand coverage as opposed to the myriad other program demands and how much change is reasonable to expect with the new funds at issue. It is possible to designate the local managed care entity to receive the new funding and ask it to expand coverage consistent with the most urgent local needs. This approach would include safety net providers, use a managed care structure and build on current pioneering efforts to cover uninsured children and other subgroups of the uninsured. However not all local governments have county operated managed care plans, and not all of those that exist have been leaders in expanding coverage. Few local managed care entities have any experience with the small employer market and would face major learning challenges designing a program that builds in opportunities for employer participation.

<u>How Is The Subsidy For Coverage Expansions Delivered?</u>

- **Public program expansions, buy ins and wrap-around**[13]

Half the care and half the costs of caring for the uninsured are already in the system; most of the funding for care to the uninsured is from public programs, but the funding is in hard to integrate bits and pieces in multiple programs. If given sufficient flexibility and strong direction by the legislature, public program administrators may be able to build coverage expansions through the public sector that do not double pay for the coverage expansion and thus are able to buy more coverage.

- **Subsidies for high risk cases (Arizona or New York)**[14]

New York, Arizona and New Mexico have sought, with some success, to increase coverage of the uninsured through uninsuring small employers by subsidizing coverage for the high end, most costly cases. This approach reduces premium costs to

the target market(s) without the policy challenges of deciding who to subsidize and how much and how to distribute and administer the subsidies. This approach is attractive to private employers, but leaves to the internal decision-making of the health plans and individual small employers whether any (and what type) expansion of coverage occurs.

Another approach is to offer catastrophic benefits only through a high deductible policy. While this approach drastically reduces premiums and allows for more uninsured to be covered, it produces little or no public health benefit. It does help hospitals with uncompensated care and relieves some burdens on counties for the most costly cases.

- **Limits on coverage (outpatient only or dollar limits)**

An outpatient only benefits package maximizes the funding for non-hospital services where hospital based services are otherwise reimbursed under other aspects of the program. The success of Cal-Kids confirms that the low-income uninsured will enroll and participate in a heavily subsidized outpatient only benefits plan. The corresponding failure of Blue Cross' MediFam product confirms that low wage working families will not pay the full cost of an outpatient only benefits package. Western Growers Association's success with its low co-pay, low deductible and low annual expenditure cap insurance policy for farm workers suggests that low wage employers may be willing to purchase coverage with a strong preventive component and little catastrophic coverage for their employees.

- **Premium assistance (to small employers or to individuals)[15]**

Premium assistance to individuals or small employers is yet another approach to distributing the subsidy. The subsidy goes directly to the individual or small employer who must then make a decision as to what coverage to purchase. Premium assistance also invokes consumer control and decision-making and often, but not always, implies greater consumer cost exposure. In the public program models, public administrators make most coverage, benefit and price decisions, and the consumer makes small co-payments and in some programs co-premiums. In the approach that subsidizes plans for high cost cases, commercial health plans make most of the critical operational decisions, including how much to reduce premiums; the consumer decides whether or not to purchase the subsidized product. Under premium assistance models, either the small business or the low-income individual ostensibly controls the decision-making and it is suggested that this will encourage market competition. While this model is very positive, the health coverage "market" also operates in an extra-ordinarily unequal context where plans, brokers and providers have enormous informational advantages and the uninsuring small business or uninsured low wage individual has little or no bargaining or negotiating leverage.

What Cost Containment Principles Are In Play?

Health care costs are rising at far too fast a pace to ignore the cost implications of the coverage expansion, State and federal budgets continue to have large, unresolved structural deficits and the new funds are temptation for budget and finance officials seeking to solve their operating deficits.

- **Leveraging existing or new funds**

The waiver permits the state or counties to fund the match with new or with existing funds. If new funds are to be used, this would double the impact of the waiver's coverage expansion, but where are the new funds coming from? If existing funds are to be used, are they state or local funds? What are the opportunities for either level of government to back out existing contributions negating the impacts of the waiver?

- **Multiple matching opportunities (Dirigo, State of Maine)[16]**

Coverage expansion can be designed to maximize multiple matching opportunities as Maine proposes to do in its Dirigo program. For example, if the federal government contributes $180 million, the state contributes $90 million, counties contribute $90 million, employers and employees contribute $180 million and California foundations contribute $90 million, then the total available to purchase coverage would be $630 million, not $180 million. If the cost of individual coverage is $1,500 annually for those under 30, the expansion could cover 420,000 young uninsured workers (less than 10% of the uninsured). To put this in context, the enrollment would be roughly 50% of anticipated Healthy Families enrollment.

- **Competitive bidding (Arizona)**

California could use a pure competitive bidding process for public and private plans willing to offer their best prices and most cost effective delivery networks to extend coverage of the uninsured.

- **Bulk purchasing (MRMIB, CalPERS or PBGH-PacAdvantage)**

California could use existing purchasing pools to negotiate the best price for coverage of the uninsured. The Legislature would need to clearly define the group to be offered coverage, as the costs for covering 60 year olds are nearly three times the cost of covering 20 year olds.

- **Managed care[17]**

The state has been moving most Medi-Cal patients into managed care, believing it provides better and more cost effective access. By comparison, very few counties use managed care for their uninsured indigent although those few who do so report favorable results.

- **Managed competition**

  Under managed competition principles, patients are offered a menu of coverage choices and pay the incremental costs of the more expensive plans. While promoting plan competition on price is an important cost control feature, it does add administrative costs and complexity. Low income subscribers appear to be very sensitive to cost differentials in the Healthy Families program, selecting the community provider plan for a cost differential of $3.00 per child per month. This suggests that managed competition could work very well if plans were interested in competing by lowering their premiums to serve the uninsured.

- **Public program reimbursement**

  Public programs are less costly than private coverage for the same benefits because public programs typically pay providers less for their services. This results in fewer private providers participating in public programs and in add-ons to pay safety net providers for their reasonable and necessary costs of care. Private coverage typically pays providers more than costs. High prices are the primary reason that the US spends far more on health care than other industrialized nations. Rising costs are prime contributor to the growing numbers of uninsured Americans.

- **Administrative cost efficiencies**

  Healthy Families is far less administratively costly than the far more complex Medi-Cal program. Local Healthy Kids programs have streamlined the state's application and enrollment process, further reducing administrative costs. Public managed care entities maintain that they operate at much lower overhead and administrative costs than their commercial competitors. County health program administrators maintain that they operate programs with far less costs going to administration than do managed care entities or the state Medi-Cal program. It is unclear whether 58 separate county efforts are more efficient than a single state expansion; however diversity, flexibility and local innovation are also important values. California has by dribs and increments achieved a health system for low-income individuals of labyrinthine complexity, we should resist the natural impulse to make it even more complicated.

<u>Recommendations</u>

As discussed, the coverage expansion funds can be used in many useful ways. We recommend targeting the new funds to increase coverage rates for low wage uninsured workers, using safety net health plans as the delivery network, and permitting uninsuring employers the opportunity to buy into the offered coverage because 1) these create important building blocks to increase coverage for the uninsured, and 2) they attract investments from other parties, multiplying the impacts of the new funds. We recommend that coverage be extended through a "mix and match" purchasing pool that is directed to build on rather than supplant existing state, federal and local funds for the uninsured.

Prepared by Lucien Wulsin, Insure the Uninsured Project www.itup.org

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[6] For background information, see Hickey and Wulsin, Counties, Clinics, Hospitals, Employers, Health Plans and California's Uninsured; ITUP, 1115 Waivers: A National Summary (November 2003) at www.itup.org and Frates and Wulsin, Clinics, Counties and the Uninsured Reports, Phases 1 and 2 (Insure the Uninsured Project 1999 and 2000).

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[14] See Silow Carroll, Stretching State Health Care Dollars During Difficult Economic Times

[15] See Chavira, Premium Subsidies for Low Wage Workforces

[16] See Adam Thompson, Governor's Office, State of Maine, presentation on Dirigo Health Plan at 8th Annual ITUP Conference (Feb. 18 2004)

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