Executive Summary

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A. Health Insurance Coverage

1. Overview of Health Insurance Coverage

California’s uninsured population increased by 276,000 in 1998 to 7.3 million. The growth of the uninsured population in California accounted for one-third of the increase in the number of uninsured in the entire U.S. – three times California’s share of the nation’s population. California continues to have higher rates of uninsured than the rest of the country.

- **Adopt a state policy committing California to achieve affordable coverage that provides good access to high quality care that improves people’s health.**

Job-based and privately purchased health insurance coverage remained flat from 1995 to 1998, despite California’s booming economy. California continues to have lower job-based health insurance coverage than the rest of the nation. Uninsured rates in California vary by a factor of three across counties, from a high of 32% in Los Angeles to as low as 11% to 15% in other counties. The decline in Medi-Cal coverage (California’s Medicaid program) accounted for the entire increase in California’s uninsured population from 1995 to 1998. Falling Medi-Cal coverage in nonworking families accounted for nearly half the increase in the number of uninsured between 1995 and 1998.

Young adults have the highest rates of uninsured (39%) compared to other age groups. Latinos (40%) and other people of color have higher uninsured rates compared to non-Latino whites (15%). Noncitizens also have very high uninsured rates (50%).

The vast majority of the uninsured in California (6 million out of 7.3 million) are in working families. Among working families, health insurance coverage changed little between 1995 and 1998, despite the rapid growth in the economy. Health insurance coverage declined between 1995 and 1998 for more than two million moderate-income working families. Two-thirds of the uninsured are poor or near-poor and will require substantial subsidies to make health insurance affordable.

- **Build on the 1999 reforms for children’s coverage by expanding eligibility of adults whose children qualify for Medi-Cal or the Healthy Families Program to the same income eligibility level as their children.**

- **Apply for a section 1115 waiver to restructure Medi-Cal and the Healthy Families Program to open them to low-income people who do not meet traditional categorical requirements.**

- **Adopt a “living wage” law that raises minimum wages and encourages employers to offer health benefits and that applies to state contractors and, perhaps, all employers.**

2. Women’s Coverage

Among 55- to 64-year-olds, women experience an uninsured rate that is one-third higher than men’s rate. Among Latinas, uninsured rates rose significantly from 39% in 1995 to 45% in 1998, and Medi-
Cal coverage fell. Job-based coverage remained relatively flat between 1995 and 1998 for women in all ethnic groups.

3. Children’s Coverage

On July 1, 1998, the Healthy Families Program and new Medi-Cal eligibility rules for children went into effect. However, the number of uninsured children increased to more than two million in California in 1998, despite these new opportunities for coverage. As of November 1999, 1.48 million uninsured children were eligible for Medi-Cal or the Healthy Families Program, but were not enrolled. Children’s Medi-Cal coverage fell from 25% in 1995 to 20% in 1998, while job-based coverage remained flat, pushing up the uninsured rates for children.

Most uninsured children are in working families and more than half have at least one parent who is a full-time, full-year employee. Nearly 90% of uninsured children have family incomes below 300% of the poverty guidelines. Like adults, Latino children have the highest uninsured rates. Half of noncitizen children and one third of citizen children with noncitizen parents are uninsured. The decline in Medi-Cal coverage increased the disparities in insurance coverage for immigrant and noncitizen children.

- **Build on the 1999 reforms for children’s coverage by further simplifying the application and eligibility process for Medi-Cal and the Healthy Families program and more fully engaging community-based organizations, churches, and schools in outreach and enrollment.**

- **Extend the 1999 reforms for children’s coverage by increasing income eligibility for the Healthy Families program to 300% of the poverty guidelines.**

- **Expand eligibility for children by (a) enabling those who are eligible for one mean-tested program with similar eligibility provisions to be considered eligible for Medi-Cal or Healthy Families and (b) increasing the duration of eligibility to 12 months before requiring recertification.**

- **Take the eligibility determination process for California’s public health care programs out of the welfare system.**

- **Integrate the Medi-Cal, Healthy Families, MRMIP, and AIM programs to create a seamless system of health care coverage.**

- **Work with schools, religious organizations, and community-based organizations to educate families about the availability and costs of health insurance.**

4. Duration and Causes of Uninsurance

Nearly half of the uninsured have been without coverage for more than five years or have never had coverage. The chronically uninsured are most likely to be male, Latino, and have incomes below 200% of poverty. More than one in three Latinos have never had health insurance coverage. Non-Latino whites, women, and adults between the ages of 18 and 29 are more likely to experience short-term lapses in health insurance coverage of less than one year. More than half of uninsured workers in small firms and among the self-employed are chronically uninsured and the proportion of chronically uninsured workers in small firms (2 to 50 employees) has grown from 41% to 51% from 1997 to 1999. Among workers who are self-employed in single-employee firms, 40% have never had health insurance coverage.

- **Extend the provisions of the small group market reforms that guarantee -issue and renewal of health insurance for small firms (2-50 employees) to include self-employed individuals in single-employee firms (1-50 employees).**
Affordability remains the most important barrier to accessing health insurance coverage for California’s uninsured population. Employers not offering coverage and employees losing coverage when they change or lose their jobs are other important barriers to coverage. Less than one-third of uninsured adults tried to find private coverage in the individual market in California in 1999. The longer individuals have been uninsured, the less likely they are to try to find private coverage.

- Reform the private, individual health insurance market to guarantee issue and renewal of insurance with rating bands for all individuals, using an expansion of MRMIP to minimize potential increases in the price of health insurance in the individual market, combined with premium subsidies for persons with incomes below 250% of the poverty level to purchase private coverage in the individual market, as well as through the MRMIP program.

- Provide that a defined proportion of the tobacco settlement received from the tobacco litigation Master Settlement Agreement of 1998 be used to fund the state’s share of expansions to Medi-Cal and the Healthy Families Program and to expand the state’s high risk pool (MRMIP), as well as to provide subsidies to low-wage workers to purchase individual health insurance.

5. Consequences of Lack of Health Insurance

Nearly one-third of uninsured, non-elderly adults in California report that in 1999 they did not seek medical care when they needed it because of the cost. Low-income adults and those in poor health were most likely not to seek needed care because of cost.

Uninsured adults are also less likely to receive recommended preventive care than those with health insurance coverage. Uninsured adults report higher rates of unhealthy behaviors, including higher rates of smoking and of being overweight, which put them at increased risk of future disease and premature death. Uninsured adults in California have poorer health status than the insured.

Adults with Medi-Cal coverage are two to three times more likely to report that they did not seek medical care in the last year when they needed it compared to adults with private health insurance coverage, most likely due to lapses in coverage during the year.

- Change the eligibility requirements for Medi-Cal so that all beneficiaries are eligible for Medi-Cal for one full year from their date of established eligibility.

- Change the enrollment procedures in Medi-Cal managed care plans so that beneficiaries are continuously enrolled in the health plan for one full year from their date of enrollment.

- Appropriate sufficient funding at the state and county levels to maintain a strong safety net of public health and community clinics, and public hospitals to provide high quality and culturally competent care to the uninsured population in California.

B. Employer-Sponsored Health Plans

1. Employer Offer and Take-Up Rates

Less than half of small firms (2 to 50 employees) in California offer their employees health insurance benefits. Even the largest firms (1,000 or more employees) in California are less likely to offer coverage compared to all large firms in the US. Workers in the wholesale and retail industries in California are the least likely to be offered coverage and least likely to accept coverage when offered compared to workers in other industries. Less than 30% of minority-owned firms offer health insurance
benefits to their workers. Firms with unionized workers are more likely to offer employees health benefits (77%) compared to only 37% of firms without unionized workers. Nearly all firms that offer coverage to employees also offer coverage to dependents. Fewer than half of firms that offer coverage include part-time workers as eligible for coverage.

Most firms that do not offer health benefits cite the high cost of premiums as an important reason. Many firms that do not offer coverage also report that their employees are covered elsewhere. Women- and minority-owned firms consider factors other than premium costs to be more important when choosing health plans for their employees. Less than half of all firms in California were familiar with the national quality initiatives of the National Committee for Quality Assurance (NCQA) or the Health Plan Employer Data and Information Set (HEDIS) quality measures.

2. Employee Choice of Health Plans

Most firms that provide employee health benefits offer coverage through an HMO. Very few firms offer traditional, indemnity health insurance coverage. Most firms that provide HMO or PPO coverage offer the choice of only one HMO or PPO. The larger the firm, the more likely it is to offer employees the choice of three or more health plans.

Only one-third of small firms that offer coverage provide employees with the choice of a PPO or indemnity plan that will pay for them to go to any doctor.

3. Premiums and Employee Contributions

HMOs offer the lowest total monthly premiums for employer-based coverage—$145 for single and $405 for family coverage. PPO plans are the most expensive with total monthly premiums averaging $218 for single and $555 for family coverage. The average monthly premium cost of employer-sponsored HMOs is about $145 for single coverage regardless of the size of the firm.

The average monthly employee contribution for HMO coverage is $18 for single and $115 for family coverage. For PPO coverage, the average monthly employee contribution is $25 for single and $128 for family coverage. Employers heavily subsidize the cost of coverage for their employees, contributing up to 88% for single coverage and 77% for family coverage.

4. Benefits Covered by Employer-Sponsored Health Plans

Nearly all Californians with job-based coverage, regardless of the type of health plan, are covered for prenatal care, well baby care, mammography screening, and both outpatient and inpatient mental health benefits. In general, employer-sponsored HMOs tend to cover a wider range of benefits and services compared to PPO and POS plans, but they impose more coverage limits.

HMOs place the greatest restrictions on the number of covered mental health visits compared to PPO and POS plans. Coverage of family planning services varies considerably by type of health plan. Californians enrolled in employer-sponsored HMO plans are more likely to have comprehensive coverage for contraceptives than enrollees in PPO or POS plans. Prescription drug coverage is universally provided in employer-sponsored plans, regardless of plan type. However, nearly half of all Californians in employer-sponsored HMOs have drug benefits that limit coverage to generic drugs only. Fewer than half of Californians with employer-sponsored coverage are offered benefits for treating tobacco dependence. Those with HMO coverage are most likely to be covered for bupropion (Zyban/Wellbutrin), nicotine patch, or a behavioral cessation program.
C. Health Insurance Plans in the California Market

1. Health Plan Product Market Analysis

Most insured, non-elderly Californians (74%) are enrolled in a private HMO or PPO plan. Less than two percent are enrolled in private indemnity health insurance. The remainder are in publicly-sponsored insurance programs, such as Medi-Cal and the Healthy Families Program. HMO enrollment is increasingly concentrated in just a few plans in California, with just four HMOs covering 69% of HMO enrollees in 1998.

- Create a separate, additional prior approval process at the Attorney General’s Office for health mergers and acquisitions that would subject mergers to statel-level review under state law.

HMO coverage is widely available in California, with at least three HMOs licensed to sell their plans in all but one county in California. HMOs responded to consumer concerns regarding access to specialists with more than three-quarters of HMOs offering products in 1998 that permitted members to go directly to specialists. Enrollee cost-sharing has increased in private HMOs from 1996 to 1998. Californians with group HMO coverage have lower office visit copayment requirements than those with individual policies.

The vast majority of Californians covered by private health plans have comprehensive benefits. However, HMO coverage limits for mental health and substance abuse treatment vary considerably across plans. Fewer than half of all HMO enrollees in California have coverage for nicotine replacement therapy or cessation programs to help them to quit smoking, and only 61% are covered for bupropion (Zyban/Wellbutrin).

- Require HMO contracts or health insurance policies issued, amended or renewed on or after January 1, 2001, to provide coverage for all FDA-approved pharmacotherapy for treating tobacco dependence.

2. Quality Assessment and Disease Management

HMO performance on HEDIS quality measures is variable and falls below recommended levels. Few HMOs offer incentives to providers or their members to improve their performance on HEDIS measures. Quality of care is not assessed for enrollees in PPO plans.

Health plans vary considerably in the disease management programs they offer. The only chronic conditions for which half or more of the HMOs in California have developed or are developing disease management programs are diabetes, asthma and congestive heart failure. There is very little standardization across disease management programs offered by California HMOs. Those conditions for which health plans are least likely to have developed disease management programs include osteoporosis, arthritis, HIV/AIDS, peptic ulcer, and prostate cancer. Health plan performance on managing heart disease and diabetes varies widely.

- Establish statewide minimum standards requirements for quality assessment and assurance for all health care service plans, health insurers, and provider groups, including, but not limited to, HMOs, POS plans, PPOs, EPOs, indemnity health insurers, medical groups, and IPAs.

- Create a comprehensive, publicly available, statewide, automated state health data system on California’s managed health care plans and network providers. The specific data elements requested of plans and providers should be reviewed and updated annually by the Department of Managed Care based on the advice of an Advisory Board composed of key stakeholders. The health data
program should collect reliable and valid data on health plan and network providers (including contracting IPA and medical groups) that can be used for planning, research, evaluation, and policy development purposes.

D. Purchasing Groups

Participation in group purchasing continues to grow, especially among small employers. In 1999, nearly two million Californians, representing about 11% of the insured population under age 65, got their health insurance coverage through a purchasing group. Negotiated premiums for HMO coverage in California’s employer purchasing groups rose between 8% and 10% in 1999.

As of July 1999, the administration of the HIPC for small employers was transferred to the Pacific Business Group on Health (PBGH) and its name was changed to Pacific Health Advantage. Enrollment in the Healthy Families pool has grown every month since the program started in July 1998 and exceeded 200,000 in December 1999. Limited funding for the state’s high risk pool, the Managed Risk Medical Insurance Program (MRMIP), means that it is not accessible to most Californians who have been denied private insurance coverage because of pre-existing health conditions.

> Increase the size of the MRMIP high risk pool to accommodate all those who are potentially eligible, along with increased subsidies for eligible low-income individuals (below 250% of poverty) by either increasing the annual state appropriation; levying new fees and/or taxes on insurance carriers, HMOs, and providers; using a portion of the Tobacco Settlement Fund; or a combination of the above.

Participation in group purchasing is still not an option for single-employee firms, individuals purchasing insurance in the private market, or mid-size firms (51 to 999) in California.

> Expand an existing, or develop a new, health insurance purchasing group for consumers in a reformed individual market, enabling individuals to have a wide choice of plans offered at group rates.

Less than one-third of small employers in California are aware of their group purchasing options through Pacific Health Advantage or California Choice.

> Increase small employer awareness of the availability and advantages of group purchasing in California to increase the rates at which small employers offer coverage to their employees.

E. Health Promotion and Public Health

1. Health Promotion in Health Plans

Nearly all Californians in HMOs have comprehensive preventive care benefits. However, most HMOs require cost-sharing for preventive care, which reduces access. HMO benefits for preventive services cover more screenings than guidelines recommend. Utilization of preventive services did not vary by type of health plan in 1999, despite its emphasis as a quality measure in HMOs.

More than 20% of HMOs have dropped health promotion programs targeting substance abuse, HIV/AIDS, STD, and injury prevention in the last year. Most HMOs rely on newsletters, preventive services reminders to patients and providers, and brochures to promote the health of their members. Utilization rates of health promotion programs are very low across all plan types.
Insured adults in the Medi-Cal program have the poorest health status. However, Medi-Cal recipients are the most likely to receive preventive counseling on health risks such as smoking, alcohol, and STDs.

- Define quality measures and performance standards for health promotion and disease prevention as part of the standard quality assessment and assurance system for all health plans. Include the tracking of specific health risks in the medical record and provision of preventive counseling at least once every three years for alcohol and drug use, injury prevention, STD and HIV/AIDS prevention, healthy diet, physical activity, and unintended pregnancy to the appropriate target groups, as defined by the US Preventive Services Task Force.

- Encourage all public and private purchasers to hold health plans, medical groups, and IPAs accountable for delivering appropriate health promotion and disease prevention services, as defined by the US Preventive Services Task Force by putting between 2% and 10% of premium or capitation payments at risk for meeting negotiated performance targets. The work of PBGH in developing and implementing performance guarantees can serve as a model for other purchasers.

- Require HMO contracts or health insurance policies issued, amended or renewed on or after January 1, 2001, to provide coverage for all health education and counseling services that have been demonstrated to be effective in reducing health risks and improving health.

2. Worksite Health Promotion

Workers in the manufacturing, retail, and service industries report higher rates of smoking and acute drinking than workers in other industries. Retail and service workers also report rates at or below average for having received routine check-ups in the last year. Workers in the service industry also report lower than average rates of blood pressure, Pap smear, and mammography screening. Receipt of preventive counseling and mammography rates increased from 1998 to 1999 across all industries. Workers in small firms report the lowest utilization of recommended preventive services.

Most HMOs subsidize worksite health promotion programs, however few California employers offer worksite health promotion programs. The larger the firm, the more likely it is to offer worksite health promotion. Only one percent of small firms and 33% of the largest firms in California offer any worksite health promotion. Only six percent of adults in California report having participated in a worksite health promotion program in the last year.

- Adopt policies, including tax incentives, to encourage employers to offer worksite health promotion programs.

3. Public Health and Managed Care

HMOs are not likely to collaborate with local or state health departments on health promotion activities. Where managed care and public health do collaborate, they are most likely to address childhood immunizations, smoking cessation, and nutrition interventions. Managed care and public health are least likely to collaborate to prevent HIV/AIDS, STDs, drugs, or alcohol use; to increase physical activity; or to measure quality. Uninsured adults in California are less likely to participate in health promotion programs offered in the community, as well as in any health promotion programs, despite their higher levels of health risk.

- Provide that a defined proportion of the tobacco settlement received from the tobacco litigation Master Settlement Agreement of 1998 be used to fund population-based health promotion and
disease prevention programs that have been demonstrated to be effective in reducing morbidity, disability and premature mortality in the population.

- Increase funding for local public health departments to provide the core functions of public health to protect all Californians against the threats of infectious disease and environmental hazards and to promote health and prevent disease in the population, regardless of health insurance coverage status.

- Encourage private purchasers of health insurance to build requirements for collaboration with local and state public health agencies into their contracts with health plans. Such collaboration may be most effective if the state identifies a few key areas for collaboration (e.g. smoking cessation, childhood immunizations, breast and cervical cancer screening, STD prevention) around which plans can collaborate on a statewide basis with state and local public health agencies.

- Require the Department of Health Services, working in collaboration with the health plans, to develop minimum standards for health promotion and disease management programs and encourage all purchasers to require health plans, as part of their contractual requirements, to meet the minimum standards.
Introduction

The State of Health Insurance in California, 1999, is the fourth in a series of annual reports that analyze trends in Californians’ access to health insurance; California employers’ experiences and practices in providing health benefits to their employees; the practices of managed care and other types of health plans available in California; the role that health insurance purchasing groups play in efforts to control costs, improve benefits and quality, and improve access to coverage; and the availability of health promotion programs and their integration into California’s health care system. The report includes a discussion of policy options that could improve Californians’ access to comprehensive, affordable health insurance that promotes their health.

The State of Health Insurance in California, 1999, was developed by the Health Insurance Policy Program, a joint effort of the University of California, Berkeley, Center for Health and Public Policy Studies and the UCLA Center for Health Policy Research. The Health Insurance Policy Program is funded by a grant from The California Wellness Foundation as part of the foundation’s Work and Health Initiative.

The body of the report is divided into the following six sections:

I. a discussion of Californians’ health insurance coverage, including an examination of the coverage of California residents; an overview of working families and their access to health insurance coverage; a discussion of women’s access to health insurance coverage; an overview of children’s access to health insurance coverage; an analysis of the duration and major reasons Californians are uninsured; and an analysis of the consequences of having no health insurance;

II. an examination of California employers who provide health benefits, focusing on offer, eligibility, and take-up rates; reasons employers don’t offer coverage; factors influencing employer choice of health plans and employee choice of health plans; the average premium costs and employee premium contributions; and benefits covered through employer-sponsored health plans;

III. comprehensive information on California’s private health insurance market, describing the types of insurance plans and products that are available; the number of managed care plans and their characteristics; quality initiatives in managed care plans; and disease management programs in HMOs;

IV. a description of the purchasing groups operating in California, including the specific groups that are operating, the populations they serve, the impact of their purchasing decisions, small employer awareness of group purchasing options, new developments, and gaps in the marketplace;

V. an examination of the health promotion and disease prevention programs of HMOs, worksite wellness programs, and the relationships between public health agencies and managed care; and

VI. a review of health policy in the 1999 legislative session in California, as well as a discussion of policy recommendations to improve access to and affordability of high quality health insurance that promotes health in California; to reform California’s individual and small group market and expand the state’s high risk pool; to increase access to group purchasing; and to strengthen California’s public health system and its integration with managed care.
A. Data Sources

This report presents data and information from five statewide surveys of California’s non-elderly population, employers, HMOs, health insurance carriers, and purchasing groups. The data were collected to assess Californians’ access to comprehensive, affordable health insurance and the availability of coverage that promotes health and prevents disease.

The report focuses on the non-elderly population (children and adults under age 65) because the problems of uninsurance and underinsurance are greatest for this population. Virtually the entire population age 65 and over has Medicare coverage, and the majority has additional private or public coverage that offers substantial financial protection against medical expenses.

The sources of the data for this report are (a more detailed description of data sources is in Appendix B):

- the March 1996-1999 Current Population Surveys (CPS) conducted by the U.S. Census Bureau, with California samples of approximately 14,000 households;
- the 1997 to 1999 California Department of Health Services Behavioral Risk Factor Surveys (BRFS) of 2,270 California adults, ages 18-64;
- the 1999 KFF/HRET/UC Berkeley California Employer Health Benefits Survey of 743 California firms with three or more employees;
- the 1996-1999 University of California, Berkeley, School of Public Health surveys of Knox-Keene licensed health care service plans (HMOs) and health insurers that sell comprehensive health insurance products (indemnity, PPO, and EPO) operating in California. In the 1999, we surveyed 27 HMOs and 14 health insurers (plans surveyed are listed in Appendix C, page 128); and
- the 1996-1999 University of California, Berkeley, School of Public Health surveys of six employer purchasing groups operating in California.