VI. Policy Review and Recommendations

This section is written in two parts. The first part summarizes the legislation that was enacted or vetoed in the 1999 session of the California Legislature with respect to increasing access to care, mandated coverage of benefits, and managed care reform. The second part presents our policy recommendations for the 2000 session of the California Legislature to continue the expansion of access to comprehensive, affordable health insurance that promotes the health of all Californians.

A. 1999 Legislative Session: State Health Policy Review

Helen H. Schauffler, Ph.D., and Jennifer Mordavsky, MPH

As part of Governor Gray Davis’ first budget, significant changes were made in 1999 to both the Healthy Families Program and Medi-Cal to extend eligibility for health insurance to low-income children in California. In addition, the Governor signed a bill to study and report on options for achieving universal health insurance coverage for all Californians.

A number of mandating new benefits were also enacted in 1999 to increase access to specific services, including mental health parity for severe mental illness, contraceptive coverage, cancer screening, breast cancer diagnosis and treatment, diabetes supplies, and hospice care.

Significant gains were also realized in reforming California’s managed health care system, including legislation addressing independent, external review of health plan decisions, health plan liability, second opinions and other consumer protections, and standards addressing the financial solvency of medical groups.

In all, it was a very good year for both increasing access to insurance for California’s uninsured children, as well as extending consumer protections and important benefits to California’s insured managed care population.

1. Increasing Access to Health Insurance

The two most important health insurance coverage bills signed into law by Governor Davis were the budget bill (AB 1107), which expanded coverage for the Healthy Families Program and Medi-Cal, and SB 480, which calls for a process, study, and written report to the Legislature on the options for achieving universal health insurance coverage in California.

However, Governor Davis also vetoed several bills that would have increased access to health insurance coverage for low-income Californians, including a bill to study the feasibility of consolidating Medi-Cal, the Healthy Families Program, and the Access for Infants and Mothers (AIM) Program into a single program with a single public insurance purchasing pool, and a bill requiring the use of the tobacco settlement for health purposes, among others.

Governor Davis signed the following bills into law:

**AB 1107 (Cedillo and Budget Committee)—Healthy Families and Medi-Cal:**

- Expands coverage for the Healthy Families Program to include families with an annual or monthly household income greater than 200% of the federal poverty level by use of an income disregard provision for incomes between 200% and 250% of the federal poverty level, and specified Medi-Cal income deductions for incomes over 250% of the federal
The State of Health Insurance in California, 1999

poverty level. The Health Care Financing Administration approved this change effective November 23, 1999.

• Modifies eligibility under the Healthy Families Program to include children less than 12 months of age in families with incomes above 200% of poverty.

• Permits a minor to apply for coverage under the Healthy Families Program on behalf of his or her child, and on behalf of himself or herself if emancipated or not living with a natural or adoptive parent, legal guardian, or caretaker relative, foster parent, or stepparent.

• Permits a family contribution sponsor to pay all of the annual required family contributions for the Healthy Families Program at the time of application, but would not permit a family contribution sponsor to receive the free months of coverage provided to applicants. Requires the Managed Risk Medical Insurance Board (MRMIB) to determine who may act as family contribution sponsors and to provide a mechanism for sponsorship.

• Permits children enrolled in the Healthy Families Program who have a California Children’s Services (CCS) program-eligible medical condition, and whose families do not meet the financial eligibility requirements of the CCS program, to receive CCS program benefits. Exempts these families from the annual CCS enrollment fee. Waives county expenditures for services to these children, and makes corresponding changes in the Healthy Families Program, requiring the state to pay the expenditures from designated state and federal funds.

• Requires the Department of Health Services (DHS), by July 1, 2000, to create and implement a simplified application package for children, families, and adults applying for Medi-Cal. Requires the department, by July 1, 2000, to revise the quarterly reporting form for Medi-Cal beneficiaries to be as simple as possible to complete.

• Requires DHS, in conjunction with MRMIB, to award contracts to community-based organizations to help families learn about, and enroll in, Medi-Cal, the Healthy Families Program, and other health care programs for low-income children.

• Permits initial treatment up to 90 days prior to the effective date of coverage under the Healthy Families Program.

• Provides that a child who is a qualified alien, as defined in federal law, and who is otherwise eligible for participation in the Healthy Family Program, shall not be denied eligibility based on the child’s date of entry into the United States. This bill would not require federal financial participation for qualified aliens in the 1999-2000 budget year, but would require participation in subsequent fiscal years.

**SB 480 (Solis)—Study of Universal Coverage:** Requires the Secretary of the California Health and Human Services Agency to submit a report to the Legislature, on or before December 1, 2001, concerning the results of the process established to examine the options for providing universal health care coverage.

Governor Davis vetoed the following bills:

**Vetoed SB 1047 (Murray)—Study of Single Public Insurance Program and Pool:** Would have required the California Health and Human Services Agency, on or before January 1, 2000, to analyze and
submit a report to the Legislature regarding, among other things, the feasibility of consolidating Medi-Cal, the Healthy Families Program, and AIM into a single program administered by the State Department of Health Services, and the feasibility of creating a single public insurance purchasing pool to allow for maximum patient choice.

**Vetoed SB 111 (Figueroa)—Medi-Cal Eligibility:** Would have provided that, to the extent federal financial participation was available, any child under 19 years of age who met all other applicable eligibility requirements, would be eligible for Medi-Cal benefits if his or her family income did not exceed 133% of the federal poverty level.

**Vetoed AB 100 (Thomson)—Use of Tobacco Settlement for Health Related Purposes:** Would have created the Thomson, Dunn, and Escutia Tobacco Settlement Fund in the State Treasury, as a repository, commencing July 1, 2000, for the state’s share of all funds received from the tobacco litigation Master Settlement Agreement of 1998. Would have provided that, upon appropriation by the Legislature, moneys in the Tobacco Settlement Fund should be used for health related purposes.

**Vetoed AB 469 (Papan)—Voluntary Enrollment in Medi-Cal Managed Care:** Would have provided that enrollment in a Medi-Cal managed care plan would be voluntary for beneficiaries who were eligible for benefits under the federal Supplemental Security Income for the Aged, Blind and Disabled Program and eligible low-income infants and children, in areas specified by the Director of Health Services for expansion of the Medi-Cal managed care program.

2. Mandated Benefits

The California Legislature enacted a number of bills mandating the coverage of specific benefits, including mental health benefits for the severely mentally ill, contraceptive coverage, cancer screening, breast cancer diagnosis and treatment, diabetes supplies, and hospice care. Each of these is described below.

Governor Davis signed the following bills:

**AB 88 (Thomson)—Mental Health Coverage:** Requires an HMO contract or health insurance policy issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions.

**AB 39 (Hertzberg) and SB 41 (Speier)—Coverage for Contraceptives:** Requires every group and individual HMO contract and health insurance policy that is amended, renewed, or delivered on or after January 1, 2000, to provide coverage for a variety of Federal Food and Drug Administration (FDA) approved prescription contraceptive methods. Provides exemptions for religious employers.

**SB 5 (Rainey)—Breast Cancer Coverage:** Requires HMO contracts that are issued, amended, delivered, or renewed on or after January 1, 2000, to provide coverage for screening for, diagnosis of, and treatment for breast cancer. Prohibits the denial of enrollment or coverage solely due to a family history of breast cancer or because of one or more diagnostic procedures for breast disease where breast cancer has not developed or been diagnosed. Requires coverage of screening and diagnosis of breast cancer consistent with generally accepted medical and scientific evidence upon the referral of an enrollee’s or insured’s participating physician. Also, requires that an HMO contract provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse midwife, or participating physician.
SB 64 (Solis)—Diabetes Supplies: Requires health plans to cover supplies, insulin, medications for, and the training and education required for self-management of diabetes.

SB 205 (Perata)—Coverage for Cancer Screening Tests: Requires that all HMO contracts that are issued, amended, delivered, or renewed on or after July 1, 2000, be deemed to provide coverage for all generally medically accepted cancer screening tests.

SB 349 (Figueroa)—Mental Health Screenings: Requires coverage for psychiatric emergency medical conditions. This bill provides additional screening, examination, and evaluation of a patient to determine whether a psychiatric emergency medical condition exists.

SB 148 (Alpert)—PKU Coverage: Requires health plans to cover the special formulas and specially formulated foods needed by those with phenylketonuria (PKU) when the costs of the formulas exceed the costs of a normal diet.

3. Managed Care Reform

One of the most comprehensive packages of managed care reform bills in the country was enacted by the California Legislature and signed into law by Governor Gray Davis in the 1999 legislative session. The most significant pieces of this reform package include bills to provide all enrollees in HMOs with an independent, external review of health plan decisions to delay, deny, or modify care; the creation of a State Department of Managed Care to regulate the industry; liability for health plan decisions; consumer protections, including the right to a second opinion, confidentiality of medical records, and disclosure of utilization review procedures and criteria; and standards for the financial solvency of medical groups.

Governor Davis signed the following bills:

a. Independent Review

AB 55 (Migden, Thomson, Schiff)—Independent Medical Review: Requires every HMO contract that is issued, amended, renewed, or delivered in California on or after January 1, 2000, to provide an enrollee, effective January 1, 2001, with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan or by one of its contracting providers, if the decision was based on a finding that the proposed services are not medically necessary. Establishes, commencing January 1, 2000, an independent medical review system, whereby requests for reviews shall be conducted by an independent medical review organization. An enrollee will not pay any application or processing fee. Additionally, requires that the costs of the independent medical review process be paid by an assessment on health care service plans. Also, provides for a similar independent medical review system to be established in the Department of Insurance for review of similar decisions by disability insurers.

SB 189 (Schiff, Migden)—Contractors for Independent External Review: Requires the Department of Corporations to contract with one or more impartial, independent, accredited entities for purposes of the external, independent review process, rather than the plan or insurer. Requires the plan or insurer to reimburse the department for costs associated with the contract. Requires health care service plans to provide subscribers and enrollees with written responses to grievances, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the...
plan’s grievance process for 30 days. Also, requires the department to respond to each grievance in writing within 30 days. Expands the current law regarding external review for experimental treatments.

b. Accountability in Managed Care

AB 78 (Gallegos)—Department of Managed Care: Transfers responsibility for the implementation of programs for the provision of managed health care by the Department of Corporations to the Department of Managed Care in the Business, Transportation, and Housing Agency. The new agency will be devoted exclusively to the licensing and regulation of health care service plans. Establishes, in the Department of Managed Care, an Advisory Committee on Managed Care to assist and advise the Director of the Department of Managed Care on various issues. Also, establishes in the department an Office of Patient Advocate to provide educational material to plan enrollees and to render advice and assistance to enrollees.

c. Health Plan Liability

SB 21 (Figueroa)—Health Plan Liability: Requires that an HMO or managed care entity, for services rendered on or after January 1, 2001, have a duty of ordinary care to provide medically appropriate health care service to its subscribers and enrollees where the health care service is a benefit provided under the plan. Makes an HMO or managed care entity liable for any and all harm legally caused by the failure to exercise ordinary care in arranging for the provision of, or denial of, health care services in specified circumstances. Requires that a person may not maintain a cause of action against an HMO unless he or she has exhausted the procedures provided by any applicable independent medical review system or independent review system, with certain exceptions.

d. Consumer Protections

AB 12 (Davis)—Second Opinion: Requires HMOs to provide or authorize a second opinion by an appropriately qualified health care professional, if requested by an enrollee or an insured, or a participating or contracting health professional who is treating an enrollee or insured. Requires an authorization or denial to be provided in an expeditious manner, and prescribes the conditions under which a second opinion must be rendered within 72 hours. The enrollee may go outside the medical group if the second opinion requested is of a specialist’s treatment recommendation.

SB 59 (Perata and Ortiz)—Utilization Review: Requires all Medical Directors of health plans to hold a California medical license. Requires HMOs to disclose the process, its contracting provider groups, or any entity with which the plan contracts for services, uses to authorize, modify, or deny health care services, to health care providers, enrollees, or to any other person or organization upon request. Revises the criteria or guidelines used by plans to authorize, modify, or deny health care services. Further, requires that those decisions be made within specified timeframes.

AB 285 (Corbett)—Telephone Advice Services: Requires all HMOs and health insurers that provide, operate, or contract for telephone medical advice services to require that the staff employed to provide the services hold a valid license, registration, or certification, in any of specified health professions. Requires that a physician and surgeon be available to the telephone medical advice service on an on-call basis at all times the service is advertised to be available.

SB 19 (Figueroa)—Medical Record Confidentiality: Amends the Confidentiality of Medical Information Act to prohibit the unauthorized selling, sharing, or use of medical information for any purpose not necessary to provide health care services. This bill amends the Knox-Keene Health Care
Service Plan Act of 1975 to require health care service plans to create policies and procedures and make them available upon request.

**AB 416 (Machado)—Mental Health Records:** Prohibits health care providers from releasing medical information regarding an individual’s participation in outpatient treatment with a psychotherapist without a written request to the provider and notice to the patient.

**AB 724 (Dutra)—Y2K Problems:** Deals with a variety of Year 2000 issues, including allowing individuals to obtain prescription drug refills earlier than normal under certain circumstances.

**SB 737 (Committee on Insurance)—HIPAA Clean-Up:** Enacts technical changes to the small group and large group laws relating to the definition of “late enrollee.” These changes were required by the federal Health Insurance Portability and Accountability Act.

Governor Davis vetoed the following consumer protection bills:

**Vetoed SB 1053 (Poochigan)—Out-of-Area Care:** Would have required health plans to permit enrollees to obtain covered services from contracting physicians outside the enrollee’s service area (and medical group or IPA) in certain serious cases if the enrollee cannot develop an acceptable relationship with the provider.

**Vetoed AB 351 (Steinberg)—Health Plan Mergers:** Would have created a separate, additional prior approval process at the Attorney General's office for health plan mergers and acquisitions that would subject mergers to state-level review under state law.

**Vetoed AB 217 (Wildman)—Medi-Cal HIV Payments:** Would have required DHS to establish risk-adjusted capitation rates that meet certain criteria for Medi-Cal beneficiaries infected with the HIV virus. Would also have required Medi-Cal managed care plans to pass on the “appropriate proportional amount” of the new risk-adjusted rates to providers.

**e. Fiscal Solvency of Medical Groups**

Governor Davis signed the following bills into law:

**SB 260 (Speier)—Financial Solvency:** Establishes the Financial Solvency Standards Board, within the Department of Managed Care, composed of eight members, one of whom is the Director of the Department of Managed Care and seven of whom are appointed by the director. Requires the board to take specified actions with regard to financial solvency and standards affecting the delivery of health care services. Requires the Director of the Department of Managed Care to adopt regulations on or before June 30, 2000, with respect to, among other things, a process for reviewing or grading risk-bearing organizations based on specified criteria, and requires the director to investigate and take enforcement action against an HMO that fails to comply with these prescribed requirements.

**AB 215 (Soto)—DOC Waivers and Limited Licenses:** On or after January 1, 2000, until January 1, 2002, the bill prohibits a license with waivers or limited license, from being issued to any person for provision of—or for the arranging, payment, or reimbursement for the provision of—health care services to enrollees of another plan under certain risk-assuming contracts. Also, prohibits any licensed HMO, on and after January 1, 2000, from contracting with any person, with certain exceptions, for the assumption of financial risk with respect to certain health care services and any other form of global capitation.
We anticipate that the Legislature will introduce legislation in 2000 to clean up some of the bills passed in the 1999 session, to expand eligibility for the Healthy Families Program, and to reform the individual health insurance market and expand the State’s high risk pool (MRMIP), and will also reintroduce some of the bills that were vetoed in 1999, such as the feasibility study of combining the Healthy Families Program, Medi-Cal, and AIM into a single program offering all eligible Californians a choice of health plans, and the use of the tobacco settlement for health related purposes.

B. Health Policy Recommendations for the 2000 Legislative Session

E. Richard Brown, Ph.D., and Helen H. Schauffler, Ph.D.

1. Cover the Uninsured

While the economy grew during the 1990s, the percentage of Californians with private health insurance obtained through employment did not grow significantly, and Medi-Cal coverage declined rapidly, pushing up the uninsured rate to a new high of 24.4%. The number of uninsured Californians reached 7.3 million in 1998, growing by 23,000 per month from 1997 to 1998.

The lack of growth in job-based insurance during an extended economic boom and the continuing decline of Medi-Cal coverage are cause for great concern. If the state and the nation do not address this problem when the economy is strong and fiscal resources are growing, it seems unlikely that they will do so when the economy and fiscal resources decline.

Ultimately, the United States will need to find a way to achieve universal coverage, as other economically developed countries have done. SB 480, enacted by the Legislature and signed by the Governor, calls for a study of alternative approaches to achieve universal health insurance coverage in California. The results of this study are likely to stimulate dialogue on cost-effective ways to reach this goal. Regardless of which approach California finally chooses, it is important for the state to set forth a policy goal to achieve universal health insurance coverage—affordable coverage that provides good access to high quality care that improves people’s health.

POLICY RECOMMENDATION

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

Reforms that have sought to expand private health insurance coverage by removing market barriers for small firms and increasing the portability of insurance for workers who change or lose their jobs have been helpful, but they have not eliminated underwriting practices experienced by individuals, the self-employed, and mid-size firms—practices that make health insurance unattainable or unaffordable. Market reforms that guarantee access to health insurance for all individuals and employers will not, by themselves, substantially increase the number of people with coverage.25 Expanding coverage to low- and moderate-income individuals and families will require subsidies that can come only from employers and/or government.

Medi-Cal (California’s Medicaid program) and the Healthy Families Program (California’s Children’s Health Insurance Program or CHIP), supported by a combination of federal and state funds, are effective vehicles for channeling government subsidies to individuals and families. California has yet

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to make maximum use of available federal matching funds to provide affordable coverage for families and individuals who need it. It makes enormous policy and fiscal sense to expand coverage through programs in which the federal government picks up half or two-thirds of the cost. The options described below could greatly expand coverage by maximizing use of federal options and funding under Medicaid and CHIP.

POLICY RECOMMENDATION

 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.

2. Fix Medi-Cal and the Healthy Families Programs for Children

As noted earlier, the stigma associated with Medi-Cal has discouraged many parents from enrolling their children. Medicaid’s welfare origins generated a guiding philosophy that seemed to be, “Keep out ineligible children,” resulting in elaborate application procedures and stigmatizing means tests in welfare offices. 26 Both California and the federal government have adopted a policy goal of covering all eligible children, but California has yet to implement administrative policies that will achieve this goal. Such a goal should focus on creating the simplest applications and procedures designed to enroll all children who are eligible, with errors cleaned up after the fact by administrative analysis, rather than by creating administrative barriers to enrollment. This approach should imbue and guide all aspects of the administrative procedures for determining program eligibility.

California has taken some important steps to simplify the joint application for children’s Medi-Cal and Healthy Families coverage, and to improve outreach. The original 28-page application booklet required applicants to complete a lengthy form, compute and document income, and document immigration status. The state has shortened and simplified the application to four pages in a 12-page application booklet, but it could join a number of other states that have adopted one- or two-page, greatly simplified applications that encourage enrollment and eliminate verification of all information except immigrant status for noncitizens. 27 The state has also increased the participation of community-based organizations, churches, schools, and other community agencies in outreach and enrollment campaigns. The May 1999 change in INS policy should reassure immigrant families that they will incur no risk of being classified as “public charges” for enrolling their children or themselves in public health insurance programs, if the policy change is effectively communicated by trusted, community-based organizations and leaders.

POLICY RECOMMENDATION

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 BY MORE FULLY ENGAGING
COMMUNITY-BASED ORGANIZATIONS, CHURCHES, AND SCHOOLS IN OUTREACH AND ENROLLMENT.

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3. Expand Medi-Cal and the Healthy Families Programs for Children

California could cover more children by maximizing use of federal funds already available to the state—funds that will match **two federal dollars for every dollar of state spending**. California could cover nearly all citizen and legal immigrant uninsured children by drawing on approximately $2 billion in additional federal funds that have been allocated to it for expansion of children’s health insurance coverage—funds that might be reallocated to other states if they are not used.\(^{28}\)

In 1999, California increased maximum income eligibility in the Healthy Families Program from its original level of 200%. California could cover nearly all citizen and legal immigrant uninsured children up to 250% of the poverty guidelines (about $41,700 for a family of four in 1999). The 1999 reforms also allowed applicants to use the same income deductions as in the Medi-Cal program—provisions that will add about 215,000 children to eligibility. These are important expansions, but California could further expand enrollment of children under current income eligibility policies.

California could, as legislative leaders proposed in 1999, increase income eligibility for children up to 300% of poverty (up to about $50,000 for a family of four), by expanding “income disregards” up to this level or by using the provisions of section 1902(r)(2) or section 1931 of the Social Security Act.\(^{29}\) This expansion would enable the state to cover nine out of ten of those who are citizens or legal immigrants. Seven other states now cover children with family incomes over 200% of poverty, including four that cover those with incomes up to 300% of poverty.\(^{30}\)

**POLICY RECOMMENDATION**

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

In addition, California could institute what some have called “express-lane eligibility”—extending eligibility for Medi-Cal and Healthy Families to children who are already qualified for free or reduced-price school lunch programs, food stamps, or the Supplemental Food Program for Women, Infants and Children (WIC). The state also could extend children’s Medi-Cal eligibility to 12 months before recertification is needed, as California has done with the Healthy Families Program; this policy change would eliminate the onerous requirement for more frequent recertification, which unnecessarily reduces program participation and adds administrative cost.

**POLICY RECOMMENDATION**

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

We estimate that, even if all these recommended reforms were adopted, approximately 10% of uninsured children would remain without subsidized coverage options. We need to know more about

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\(^{28}\) Senate Budget and Fiscal Review Committee, Subcommittee No. 3 on Health, Human Services and Veterans Affairs, March 8, 1999.


why these children with family incomes above 300% of poverty are not insured: Is the barrier lack of access to employment-based health insurance, which usually is needed to make health insurance affordable to middle-income families? Is the barrier lack of available and affordable alternatives to job-based insurance, or lack of knowledge about existing options? Appropriate options could be developed with a more detailed understanding of the factors that contribute to this lack of coverage. Regardless of the particular nuances of the problem for this group, the state should work with schools, religious organizations, and a variety of community-based organizations to conduct a well-designed education campaign that informs families about the availability of alternative sources and the costs of health insurance coverage.

POLICY RECOMMENDATION

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

4. Expand Existing Programs to Uninsured Adults

California also has opportunities to make effective and efficient use of Medi-Cal to provide subsidies that would assist its 5.3 million uninsured adults, who are predominantly low- and moderate-income workers or dependents of workers. Many of these adults have uninsured children who are eligible for the Healthy Families Program or Medi-Cal. In 1999, California expanded eligibility for adults whose children are eligible for Medi-Cal—from about 80% of the poverty guidelines to 100%. To increase parents’ eligibility, California joined ten other states that cover parents with incomes up to or above the poverty level under provisions of section 1931 of the Social Security Act, which allow states considerable flexibility in setting income eligibility for family Medicaid coverage. The state could use these provisions to cover more parents of children eligible for Medi-Cal or the Healthy Families Program. Expanding coverage to working adults using federal matching funds would offset state costs with savings generated by reducing state and county expenditures on indigent medical care.

POLICY RECOMMENDATION

- 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.

In addition to opening up existing children’s coverage programs to their parents, California could restructure Medi-Cal and the Healthy Families Program and open them to people who do not meet the requirements of public assistance programs (like being in a family with dependent children, a disabled non-elderly adult, or over age 65). With a Medicaid section 1115 waiver, the state could enable any uninsured families or individuals who meet eligibility criteria under current programs to enroll at no cost or low cost to them, and allow those who do not qualify for current programs to buy into them by paying an income-adjusted premium. Four states now enable families above the Medicaid or CHIP income eligibility levels to buy into their programs.

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31. To Buy or Not to Buy: A Profile of California’s Non-Poor Uninsured, California HealthCare Foundation, 1999.
POLICY RECOMMENDATION

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

Expanding children’s and adults’ income eligibility for Medi-Cal and the Healthy Families Program and restructuring them is an effective method to expand affordable coverage, drawing in federal contributions for all enrollees who are eligible for them, obtaining contributions from enrollees based on their ability to pay, and supplementing these with state, and possibly employer, contributions. California’s costs for such coverage would be offset partially by further savings in indigent care spending.

5. Reform Medi-Cal Managed Care

There are several problems that we identified in our report last year, *The State of Health Insurance in California, 1997*, that Medi-Cal managed care plans identified as significant barriers to implementing the program and to providing quality health care for Medi-Cal enrollees. These include lack of continuous eligibility and lack of health plan lock-in. It is difficult, if not impossible, for Medi-Cal plans to deliver high quality care to enrollees who frequently lose their eligibility status or switch plans. Such churning limits the ability of plans and providers to provide continuity of care and to deliver comprehensive and appropriate care.

POLICY RECOMMENDATIONS

- **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.**

6. Take Health Care Out of Welfare

Many of the problems associated with Medi-Cal and the Healthy Families Program are a legacy of Medicaid’s welfare-based origins, which generally require stigmatizing means tests, usually conducted in welfare offices. These humiliating procedures have kept many eligible people from seeking Medi-Cal coverage. To make these programs acceptable to a larger number of working families, California should end the role of welfare agencies in reviewing and processing applications for public health care programs. This non-welfare approach was adopted with the enactment of the Healthy Families Program under former Governor Pete Wilson to avoid the stigma associated with Medi-Cal. Avoiding this unnecessary review by welfare agencies would also save administrative costs for eligibility determination that could help offset the costs of expanded coverage.

California could transfer all responsibility for eligibility determination to the California Department of Health Services, which could create a special unit that would process—expeditiously—all applications for the state’s public health care programs. Consolidating the application review and

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approval process for Medi-Cal and other health care programs administered by the department would provide a less costly, more efficient system that could determine a person’s or family’s eligibility for all such programs. If this unit is established with adequate staffing and information systems and is operated in a client-centered manner, it could also process applications for the Healthy Families Program, which is administered by another agency.

POLICY RECOMMENDATION

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

7. Integrate Public Coverage Programs to Form a Seamless System

California has several different programs to provide health care coverage to its residents: Medi-Cal, California Children’s Services (CCS), and Child Health and Disability Prevention (CHDP), all administered by the Department of Health Services, and the Healthy Families Program, Access for Infants and Mothers (AIM), and the Managed Risk Medical Insurance Program (MRMIP), administered by the Managed Risk Medical Insurance Board (MRMIB). These programs have different eligibility criteria and target different, but often overlapping, population groups. Besides Medi-Cal and the Healthy Families Program, which have been described earlier, CHDP pays for mental and physical health screening of children up to age 21 with family incomes up to 200% of poverty, including many children who would not be eligible for Medi-Cal or the Healthy Families Program, and treatment of conditions identified during screening. AIM provides subsidized coverage to pregnant women with incomes 200%–300% of poverty and their infants. CCS covers children up to age 21 with serious disabling conditions if their families have annual incomes below $40,000 or if the costs of care exceed 20% of adjusted gross income. MRMIP subsidizes health insurance coverage for people who have been turned down by private health plans and insurers due to a pre-existing condition.

These programs benefit millions of Californians, but their patchwork character fragments coverage for families and individuals who must navigate multiple programs. Families may have one child who is eligible for Medi-Cal, another for the Healthy Families Program, a mother who is eligible for AIM, and a father who is not eligible for any public or job-based health insurance program. Family members covered by one program may find themselves in one health plan with its contracted providers, while other family members must choose from a different list of providers because they are covered by a different program. And some family members, who may themselves have chronic health problems, are left with no coverage options.

This patchwork disrupts continuity of coverage and health care for eligible persons as their circumstances change, even when they are eligible for another program. Many lower-income families, who find themselves eligible for a program, such as the Healthy Families Program, in one year, may experience a loss of income in the next year and find themselves eligible for a different program, such as Medi-Cal. Many low-income families and individuals also experience large gaps in coverage. This patchwork system increases administrative costs for multiple bureaucracies needed to administer different programs, rules, applications, and eligibility determination processes. It also is a frustrating experience for families and individuals who must deal with so many bureaucracies and imposes unnecessary costs in time lost from work.

California could integrate Medi-Cal, the Healthy Families Program, MRMIP, and AIM to create a seamless system. A Medicaid section 1115 waiver, in addition to enabling California to expand coverage
to new groups, would provide the flexibility needed to integrate and simplify the eligibility criteria and process.

Structural integration of the programs would have many benefits. Families and individuals would apply with one application, and all family members would be covered within the same visible program (even if funding came from separate federal programs). Enrollees would not need to switch programs or lose coverage when their circumstances change (if they still fall within the coverage limits of any included programs). Such integration also would provide broader and more continuous coverage and greater opportunities to obtain federal funding for many beneficiaries. Finally, it would substantially reduce administrative costs by unifying eligibility and other administrative functions. According to the California Legislative Analyst’s Office, simplifying application rules and procedures, ending welfare office review, and integrating these programs would save an estimated $127 million each year in administrative costs alone.  

POLICY RECOMMENDATION

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

8. Preserve the Public Health Safety Net

It is important that the state and counties continue to fund and maintain a strong safety net of public health and community clinics, and public hospitals, which provides high quality care to the substantial number of Californians who will remain uninsured, even if all of the above recommendations for increasing access were adopted and fully implemented.

We found that nearly one in three uninsured adults in California in 1999 did not seek medical care when they needed it, and that uninsured adults were much less likely to receive preventive services that have been demonstrated to reduce the prevalence of disease and premature death. Lack of health insurance should not mean lack of access to care. It is critical that all Californians have access to medical care when they need it.

In addition, a large proportion of the uninsured population is Latino and/or immigrants who require care that is culturally sensitive. Public health and community clinics and public hospitals have a long tradition of serving this population and delivering culturally competent care.

Unless, or until, California guarantees access to health insurance coverage to all of its people, the safety net has an important role in providing medical care to and in promoting the health of and preventing disease among the uninsured population.

POLICY RECOMMENDATION

- 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.

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9. Incentives for Employers to Offer Affordable Coverage to Low-Wage Workers

Another option that could encourage some employers to offer health benefits to their low-wage employees is the approach of the “living wage.” Some three dozen cities and counties throughout the nation have enacted living wage ordinances that require municipal contractors to pay wages above the federal or state minimum wage. Many of these ordinances offer contractors incentives to provide health insurance, as well. For example, Los Angeles City requires contractors to pay at least $8.50 an hour or at least $7.25 an hour plus $1.25 in health benefits. Adopting the living wage as a statewide policy for state contractors and, perhaps, for all employers may be an effective way to expand health insurance coverage, as well as earnings, of low-wage workers, the most vulnerable group in the labor market.

POLICY RECOMMENDATION

❖ 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.

California faces a difficult challenge to extend coverage to its more than seven million uninsured residents, but improving and expanding existing programs and maximizing the state’s use of available federal funds can go far toward this goal by making affordable coverage available to the great majority of them.

10. Reform the Individual Market and Expand the State’s High Risk Pool

Two million of the 5.3 million uninsured adults in 1999 sought to purchase health insurance in California’s private, individual health insurance market, but either did not purchase it due to the cost or were denied coverage. Eighty-three percent of these individuals (1.66 million) rate themselves as healthy, 64% (1.28 million) are employed or self-employed, and 49% (980,000) have incomes over 200% of FPL. The reason given by 94% for remaining uninsured is the high cost of coverage. The number of participants in California’s individual insurance market has the potential to more than double, if individual health insurance policies were more accessible and affordable. However, recent trends in the rapidly escalating price of premiums in the individual market suggest that access may be diminishing rather than increasing.

As we reported in The State of Health Insurance in California, 1997, insurers in California may deny coverage to individuals based on pre-existing medical conditions such as rheumatoid arthritis, chronic headaches, heart disease, cancer, and stroke, among others. Of the HMOs operating in California’s individual market in 1996, 85% reported using chronic illness or some other pre-existing condition, 77% used smoking status, and 69% used HIV/AIDS to deny coverage to individuals and families in the individual market.

Without a requirement to guarantee-issue coverage, health insurers have no incentive to cover unhealthy individuals when they are able to deny coverage or price them out of the market. However, with no limits on how high premium prices in the individual market can go, guarantee-issue health insurance alone does little to increase access, as recent studies of the Federal Health Insurance Portability and Accountability Act (HIPAA) have revealed. Even though premium rates are relatively lower in California than the rest of the country, they still represent a high percentage of the incomes of low-wage workers. Thus, to truly increase access, premium subsidies will be required to help low-income

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individuals and families defray the costs of health insurance in the individual market. Mechanisms such
as rating bands could also be used to increase access to individuals and families previously shut out of
the individual market due to poor health status. Of the 13 other states that have guarantee-issue in the
individual market, 12 have also implemented rating restrictions.

Establishing health insurance purchasing pools in the individual market is another method to
expand both access and choice. Purchasing groups simplify the process of obtaining coverage, spread
risk, and extend choice of health plans to consumers.

POLICY RECOMMENDATIONS

- Reform the private, individual health insurance market to guarantee-issue health 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 MRMIP.

- 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.

Another group that requires assistance in purchasing private insurance is self-insured
individuals, particularly those in single-employee firms. The small group reforms that California enacted
guarantee-issue and renewal of health insurance for small firms down to two employees, but continue to
exclude the “onesies.” Among uninsured self-employed workers in single-employee firms, 40% have
never had health insurance coverage. Single-employee firms should either be treated like other small
businesses or included in individual market reforms.

POLICY RECOMMENDATION

- 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).

One concern expressed by the health insurance and managed care industries in California about
guaranteeing the issuance and renewal of health insurance in the individual market is that only those
who are ill and relatively high cost will purchase insurance. They argue that without an individual
mandate to purchase insurance or expanding the MRMIP pool to accommodate all those who are
considered uninsurable or “bad risks,” the adverse selection that might result would increase the cost of
premiums for everyone in the individual market, potentially having the opposite effect of that
intended—increasing the number of individuals who are uninsured, instead of reducing the number.

One of the only fallbacks for individuals who have been denied or terminated from their health
insurance coverage or who have been priced out of the market due to a pre-existing health condition is
the State’s high risk pool, MRMIP. However, recent increases in benefits, health care cost inflation, and
stagnant State appropriations have left this program with grossly insufficient capacity to meet the current
demand. In 1999, it is estimated that the program had the capacity to serve only 7-13% of the uninsured
individuals in California who may be eligible. For those who are on the MRMIP waiting list, but who
cannot afford to buy an unsubsidized “look-alike,” or who can not afford even the subsidized MRMIP
premiums, there is no other recourse. Both expanding the capacity of MRMIP and subsidizing MRMIP
premiums for low-income, eligible individuals will require increased and/or new revenues for the program.

POLICY RECOMMENDATION

- 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) through either an increase in the annual state appropriation, new fees and/or taxes levied on insurance carriers, HMOs, and providers, use of a portion of the tobacco settlement funds, or a combination of the above.

We also found that less than one-third of small employers in the state were familiar with their group purchasing options—Pacific Health Advantage (formerly the HIPC) and California Choice. While participation of small firms in group purchasing has been growing steadily over the last four years, less than 2% of small firms currently participate in group purchasing arrangements in California. To increase participation in group purchasing, small firms need to be made aware of their options and the benefits of group purchasing for their employees.

POLICY RECOMMENDATION

- 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.

11. Adopt Information Systems and Quality Assurance for All Health Plans

Nearly all of the policy recommendations to reform California’s managed health care system that we made in our annual report last year resulted in successful legislation. However, two of our recommendations, to create a comprehensive, publicly available, statewide health data system on California’s health plans and provider networks, and to establish minimum standards for quality assessment and assurance for all health insurers, health plans, and providers, have not yet resulted in legislation.

The creation of the new Department of Managed Care and an Office of Patient Advocate in the Business, Transportation and Housing Agency presents an important opportunity to define and implement systems for the collection, analysis, and dissemination of information on California’s managed care system to benefit purchasers, consumers, regulators, as well as the plans and providers. In addition, it is critical that all parts of California’s health care system be held to the same standards and expectations of high quality to prevent the possibility of harm and maximize good health outcomes for all individuals who use health care services in the state, regardless of the type of insurance coverage they have.

POLICY RECOMMENDATION

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

Over the past four years, HMO enrollment has increasingly been concentrated in a handful of health plans. This is the result of growth in HMO enrollment in these plans, as well as multiple health plan acquisitions and mergers. Continued consolidation in the industry may result in anti-competitive conditions that create a state of oligopoly. The State needs to carefully review all future proposed mergers and acquisitions to preserve a competitive health plan marketplace in California.

POLICY RECOMMENDATION

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

In addition, we found that most HMO enrollees do not have coverage for treatments for nicotine dependence that have been demonstrated to be both effective and highly cost-effective in helping smokers to quit. The clinical practice guideline developed and published by the Agency for Health Care Policy and Research specifically recommends that treatment for tobacco dependence be covered by all health insurance. At a minimum, such coverage should include nicotine replacement therapy and all other pharmacotherapy approved by the FDA for the treatment of nicotine dependence, as well as counseling (individual face-to-face, group, and telephone) for smoking cessation.

POLICY RECOMMENDATION

- 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.

12. Promoting the Health of All Californians

Uninsured adults in California have poorer health status, greater health risks, and less access to recommended preventive care than insured adults. In addition, Californians who are employed in small firms, who work part-time, or who are out of work have poorer health status and less access to preventive care than other adults. They are also less likely to have access to worksite health promotion.

The primary avenue for improving the health of these populations is the public health system. The important role that the public health system plays in ensuring the health of our communities should be reflected in adequate funding of public health programs.

POLICY RECOMMENDATION

- Provide that a defined proportion of California’s 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.

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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.

Local and state health departments have had little involvement working with private health plans in California. It is instructive to note that the Department of Health Services requires, in its contracts with Medi-Cal managed care plans, the development of memorandum of understanding between the plans and local public health agencies. Private purchasers, such as CalPERS and PBGH, and public purchasers, such as MRMIP, could have an enormous impact on the extent of collaboration between the two systems, if they required similar agreements in their contracts with health plans. There are a number of other policy tools that can be used to increase integration of health promotion and disease prevention into managed care that should be encouraged for both public and private purchasers of health insurance.

POLICY RECOMMENDATIONS

- Encourage private and public 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.

- 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, tobacco use, 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.