I. Health Insurance Coverage of Californians

In 1997, the number of uninsured non-elderly Californians increased to more than 7 million, growing at the rate of nearly 50,000 per month. The decline in coverage is largely attributable to a significant drop in the proportion covered by Medi-Cal and a drop in the proportion who purchase health insurance in the private market. While employment-based health insurance has increased slightly since 1995, it has not been enough to make up for the losses in coverage in other areas. The net result has been a substantial increase in the uninsured, despite the continued growth in California's economy in 1997.

The uninsured are predominantly low- and moderate-income working families and individuals who do not qualify for government sponsored health insurance, who work for employers who do not offer coverage, or who cannot afford the employee share of premium. Ethnic and racial minorities, especially Latinos, continue to bear higher risks of being uninsured. Young adults also have high rates of uninsurance, but even among adults ages 40-64, one in five is uninsured.

Employees overwhelmingly accept employment-based health insurance when it is offered to them. One out of five Californians (20%) works for an employer who did not offer health benefits to any employee. Among employees who were offered and eligible for coverage, nearly 90% accepted it. Approximately 8% did not accept coverage because they were covered through a family member. Only 3.8% of those who were offered and eligible for coverage refused it and remained uninsured.

Small employers (those with 3-9 employees) are the least likely to offer coverage for their employees. Employers reported that financial concerns were the important barriers to their offering coverage, such as the high cost of premiums and uncertain profits and cost of insurance.

Nearly three-quarters of firms that do not offer employee health benefits indicated that they would if 50% of the cost were subsidized, and 40% indicated they would if they received a 15% subsidy.

Almost half (45%) of the non-elderly adult population in California who were uninsured in 1998 have never had health insurance or have been without coverage for more than five years. The majority of the chronically uninsured are Latino (55%), men (60%), and have incomes below 200% of poverty. More than half of the uninsured workers in small firms and the self-employed are chronically uninsured.

Less than one-third (27%) of the uninsured have been without coverage for less than a year. The majority in this group are women (53%) and those with incomes greater than 200% of poverty.

The most important reason nearly all uninsured adults in California give for not having coverage is the high cost of health insurance.

Lack of health insurance has serious consequences for affected populations, including less access to preventive care and health promotion services, failure to seek medical care when needed and poorer health status. For example, among uninsured women, only 34% had received a mammogram in the last two years.
We recommend that the Legislature create a statewide, bipartisan Task Force to Assure Affordable Health Insurance for All Californians, broadly representative of a broad range of stakeholders, which would engage in an open and public process of developing a plan to guarantee access to affordable health insurance for all Californians. A report with specific policy recommendations would be due to the Governor and the Legislature on January 1, 2000.

a) Children's Health Insurance

Medi-Cal and the Healthy Families Program have the potential to cover more than 1 million of California’s 1.85 million uninsured children. At current rates of enrollment, the Healthy Families Program is unlikely to exceed 128,000 children at the end of its first year, out of an estimated 328,000 eligible children. Covering all eligible children will require the state to alleviate barriers to enrollment. Such barriers include, among others, an application that is long and complicated, insufficient outreach, and concerns of immigrant parents about adverse consequences if they enroll their eligible children in these programs. In addition, more than 400,000 children whose families earn over 200% of poverty remain uninsured and ineligible for assistance.

- Extend eligibility to the Healthy Families Program to uninsured children in families with incomes between 200% and 300% of the federal poverty guideline by disregarding income between 200% and 300% of poverty.

- Adopt presumptive eligibility for children applying to Medi-Cal, as the state has done with pregnant women.

- Extend children's Medi-Cal eligibility to 12 months, as the state has done with the Healthy Families Program.

- Use legal resources and political influence to persuade the federal government to exclude, clearly and unequivocally, Medi-Cal and the Healthy Families Program from the “public charge” issue.

- Use state funds from the tobacco lawsuit settlement or other sources to extend eligibility for the Healthy Families Program to uninsured legal immigrant children who entered the United States after August 22, 1996.

- Extend eligibility for the Healthy Families Program to the uninsured parents of the enrolled children, using a combination of contributions from family and employers, to cover the whole family with the amount required to cover just children under the Healthy Families Program.

- Review those features of the Healthy Families Program that make it more desirable to Medi-Cal eligible families and either adopt those features in the Medi-Cal program or replace the Healthy Families Program and Medi-Cal with a new unified program that is applicant-friendly and maximizes coverage.

- Improve the outreach and application process for uninsured children to increase enrollment of all eligible children in either the Healthy Families Program or Medi-Cal.

b) Individual Health Insurance Market

The percentage of the non-elderly Californians who have privately purchased individual health insurance is 4.8%, about 1.4 million people. Nine out of ten uninsured adults (93%) cited the high cost of coverage as an important reason they remained uninsured. Recent trends, however, in escalating premium prices in the individual market suggest access may be diminishing rather than increasing. In
addition, insurers in California can deny coverage to individuals based on pre-existing medical conditions.

- **Guarantee issue health insurance in the individual market, with modified community rating requirements including defined rate bands that limit what insurers may charge for coverage. Maintain pre-existing condition limitations, define a limited period of enrollment and coordinate the market rules in the individual and association markets. Implement a participation requirement for all insurers to promote competition among insurers and choice for consumers in the individual market.**

### II. Commercial Health Plans in the California Market

Approximately 70% of insured Californians under age 65 are enrolled in either a commercial HMO (47.7%) or PPO (22.3%) plan. Only slightly less than 13% are covered by indemnity health insurance, with the largest group (9.9%) composed of traditional Medi-Cal recipients, while a mere 2.8% of the non-elderly are covered through private indemnity health insurance. Increasingly, California’s insured population is concentrated in only a handful of health plans. In 1997, the four largest HMOs in California made up 68% of the non-Medicare HMO market or 9 million members.

The majority of HMOs operating in California are for-profit health plans, enrolling 54% of non-Medicare commercial HMO members. More than half (55%) of the commercial HMOs operating in California (12 plans) report that in 1997 they operated at a loss.

In the best-selling HMO plans, patient copayments have been increasing from $5 to $10 and from $10 to $15 per visit. Increased enrollee cost-sharing is troubling because high copayments for office visits act as economic disincentives for HMO members to receive regular check-ups and other health care services.

Coverage limits imposed on specific services in HMOs vary considerably from plan to plan for inpatient days for mental health and substance abuse treatment, outpatient mental health and substance abuse visits, chiropractic visits and in vitro fertilization treatments.

The majority of HMOs in California have responded to consumer concerns regarding difficulty in gaining access to specialists and plans’ ability to care for persons with chronic conditions by offering products that allow consumers direct access to specialists. HMOs have also developed and implemented disease management programs addressing asthma, diabetes and high risk pregnancy.

At present, there is no central database on California’s managed care plans that is available to researchers and policy makers. Health plans are inundated with requests from researchers and purchasers for data and the Department of Corporations does not enter the information plans report to it into a centralized, automated database.

In addition, none of the available state or federal health surveys of California’s population provides comprehensive information needed for policy analysis nor do they enable analysis at the county level.

- **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 state entity with responsibility for regulating 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 plans and network providers including contracting IPA and medical groups.

- Fund a new statewide health data survey to collect comprehensive health status, health insurance coverage, access to health services, and health risk information on the California population. It should include a large enough sample to be able to derive accurate estimates at the state, regional and county levels and to track changes over time.

a) Quality Assessment and Assurance

Most HMOs in California report that quality reporting and performance on HEDIS is not important in marketing their products to employers. Few plans report any efforts to induce either providers or patients to improve performance on quality measures.

All of the quality measurement and reporting for managed care is limited to HMOs and there is no parallel system operating to assess and report on quality of care in California’s PPOs, through which 22% of the non-elderly insured population is covered.

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

b) Mid-Size Group Market

A majority of all HMOs consider type of industry as a factor in initial underwriting for groups larger than 50. One-third or more of all HMOs consider automobile dealerships, health care organizations, hair salons, bars, fishing, car washes and restaurants to be substandard groups. Thus, for these industries, it may be difficult to find or afford health insurance to offer their employees. In addition, 15% or more of commercial HMOs exclude business associations, multiple employer trusts, temporary employment agencies, the mining industry, hair salons, bars and law firms.

- Guarantee issue and renew health insurance for mid-size firms (51-100 employees). Provide mid-size firms with the same protections as small firms including the use of defined rating factors and rate bands, price and coverage disclosure requirements and pre-existing condition exclusion limits.

- Prohibit health insurers and HMOs from underwriting groups over 50 employees using industry as a demographic.

c) Managed Care Reform

In 1997, approximately 6.7 million insured adult Californians reported that they had experienced a problem with their health plan in the last year: 1.75 million reported that they did not receive the most appropriate medical care or what they needed; 1.6 million reported that there were delays in getting needed care; and nearly half a million reported that they were denied care or treatment.

Large numbers of Californians reported serious health consequences as a result of experiencing these problems with their health plan, including 45% who reported that their health condition worsened as a result of this problem with their health plan, and 15% who reported that this problem with their health plan resulted in a permanent disability that negatively affected their activities of daily living.

Of the 6.7 million Californians who reported having a problem with their health plan in the last year, slightly over half (57%) of them tried to resolve their problem with their health plans. Only a
minority of those who had problems contacted their plan and a majority were not satisfied with the plan’s resolution of their problem.

- Create a new state entity for regulation of managed care plans currently regulated by the Department of Corporations and phase in the regulation of other managed care plans and health insurance plans presently regulated by the Department of Health Services and the Department of Insurance, as well as presently unregulated entities that bear financial risk, including medical groups and IPAs.

- Establish a process of independent review for consumers to appeal health plan decisions beyond their health plan’s internal appeal mechanism to an external, independent review organization (IRO) and/or to medical experts who have no professional, financial or material connection to the parties involved or interest in the outcome of the review. IROs should have the authority to make binding decisions about the appropriateness of the health care service in dispute. No filing fees or minimum dollar thresholds for services eligible for independent review should be imposed. Reviews should be completed within 30 days, except in emergency or life-threatening cases where decisions should be made within 24 hours.

- Consider establishing a process that would expand the liability of health plans for injury to enrollees that results from wrongful denials or delays of health services, as part of a comprehensive package of reforms to increase health plan accountability to consumers.

III. Medi-Cal Managed Care

There are several problems that Medi-Cal managed care plans identified as significant barriers to implementing the program and to providing quality health care for Medi-Cal recipients. 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 recipients who frequently lose their eligibility status or switch plans. Such turnover limits the ability of plans and providers to provide continuity of care and to deliver comprehensive and appropriate care.

- Provide continuous eligibility for all Medi-Cal recipients for 12 months, eliminating the requirement for recertification every three months.

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

IV. Purchasing Groups

The two most significant developments in group purchasing in California in 1998 were the awarding of a contract to privatize the Health Insurance Plan of California (HIPC) and transfer administrative responsibility from the Managed Risk Medical Insurance Board (MRMIB) to the Pacific Business Group on Health (PBGH); and the development of a purchasing pool for eligible children participating in the state’s new Healthy Families Program.

In 1998, the total population covered by the five employer purchasing groups operating in California was nearly 1.8 million Californians, representing 10.3% of all non-elderly Californians with employment-based insurance.
Since 1996, the total number of employers participating in group purchasing has grown by 50%, with the number of enrollees increasing by 22%. The growth has been even higher in small firms, with enrollment increasing by 61% over the last three years.

For the second year in a row, the HMO premiums negotiated between employer purchasing groups and health plans in California increased. The increases negotiated for HMO premiums ranged from 5% to 8%. A significant part of the increase can be attributed to the 11%-12% increases negotiated by Kaiser Permanente. However, the long-term impact of group purchasing has kept HMO prices in check. The cumulative effect of the most recent negotiations on HMO premiums has resulted in only a 2.6% increase over five years for the HIPC and a reduction of 5.42% over five years for PBGH.

Significant gaps remain in access to group purchasing and choice of health plans in several segments of the market. There is no pool for individuals, for Medi-Cal recipients or for single employee firms, and the only pool available for mid-size firms underwrites based on industry.

- Establish a statewide purchasing pool for mid-size firms (51-100 employees) that offers a standard benefit package.
- Expand an existing, or develop a new, health insurance purchasing group for consumers in the individual market.

V. Promoting the Health of All Californians

a) Health Promotion in California's Health Plans

Nearly all HMOs cover comprehensive preventive services in their best-selling products, but the majority require a patient copayment for preventive care. There were no differences in access to preventive care by type of health insurance coverage for the insured non-elderly population in 1998.

In the last two years, more than one-quarter of all HMOs, representing between 7% and 30% of all commercial HMO members, have stopped offering health promotion programs addressing substance abuse, HIV/AIDS prevention, mental health promotion and childhood injury prevention.

Only 3% to 4% of insured Californians report that they participated in any health promotion programs offered through their health plan in the last year.

Medi-Cal builds into its contracts with health plans requirements to cover health education programs and services and requirements to collaborate with public health agencies.

Commercial HMOs in California spend on average less than $2 per member per year on health promotion and health education programs and services.

Those Californians who have the least access to health care and the poorest health status are the least likely to have access to health information available on the Internet because they do not have access to a computer either at home or at work.

b) Worksite Health Promotion

There is a strong relationship between the conditions of work and health. There is a strong positive relationship between self-reported health status and having flexible work hours, being able to make one's own decisions at work, and having freedom to do work one's own way.

Workers in single employee firms report having the worst health status, while workers in large firms (more than 500 employees) report having the best health status.
Nearly two-thirds of HMOs subsidize worksite wellness programs. However, only 4% of the non-elderly population report having participated in a worksite health promotion program in the last year.

c) Health Plan Collaboration with Local Public Health Departments

Most of the collaboration between local health departments and managed care is with Medi-Cal managed care plans, with significantly less involvement by commercial health plans that do not serve Medi-Cal recipients.

The specific health promotion topics most likely to be addressed in collaborations between managed care and public health are childhood immunizations, smoking cessation, prenatal care, nutrition and injury prevention.

Californians covered by commercial indemnity health insurance (11%) are the most likely to have participated in a health promotion program in the last year offered in their community compared to only 5% or 6% of the population insured through Medi-Cal or commercial HMOs or PPOs.

❖ Increase funding for local public health departments to provide the core functions of public health and to support the safety net to ensure that those Californians who remain without health insurance have access to basic primary, preventive, acute and emergency services provided by either traditional safety net providers (public hospitals and community clinics) or through contractual agreements with private providers and health plans.

❖ Require the Department of Health Services, working in collaboration with health plans, to develop minimum standards for health promotion and disease management programs and require public purchasers to oblige health plans, as part of their contractual requirements, to meet 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, as defined by the U.S. Preventive Services Task Force.