Cross-Cutting Analysis of Coverage Reforms
Qualitative Analysis

Report Prepared for the
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INTRODUCTION

The nine coverage reform options offer a wide range of alternative strategies to cover the uninsured from single payer approaches that will produce fundamental shifts not only in coverage but also in the organization of the health care system itself, to approaches that build more incrementally on our current system of employer-based coverage. Each of the proposed reform options affords the promise of increased coverage. And all of the proposals, by providing coverage, are therefore likely to improve access to care and even quality of care since research shows that the insured have better access to care, experience fewer delays in seeking care and receive better quality of care than the uninsured.

This paper will not focus on these common and shared improvements, but instead will address how differences among proposals might produce varying results. This paper analyzes the proposed reforms, pointing to their differences, and suggesting how these alternative designs might affect or contribute to the outcomes of interest.

This is a challenging task first since we have scant knowledge about what health delivery structures produce desired outcomes and second because authors describe the health care organization of proposals to varying degrees.

This report is organized into four sections, each focusing on one of the main impact areas outlined by the Health Care Options Project advisory group. These areas of impact are: access, utilization and continuity of care; quality and appropriateness of care; safety net; and vulnerable groups. Each section of the report includes an initial discussion of the topic, followed by a description of the questions to be examined across proposals. At the end of each section is a brief overview of how different types of proposals affect or contribute to the outcomes of interest. For this overview proposals are sorted into two groups; single payer proposals and other reforms. The logic of this grouping is that single payer plans produce a more radical departure from the status quo with inherently different sorts of changes than other proposals, which generally build on and extend from our current health care system. Two of the more

Universal Challenges for Proposals: Resource Allocation and Reimbursement

Resource Allocation: The basic struggle of expending limited resources efficaciously and efficiently is at the core of each reform proposal. However, the nature of this struggle varies greatly depending on the approach. As was outlined by proposal authors Brown and Kronick, programs that are privately financed (or that depend in large measure on employer-based health care) tend to resolve these issues through market forces while publicly financed reforms address these issues through a political process. Each approach has inherent flaws and inefficiencies.

Reimbursement methods are a powerful force for directing the behavior of health care providers. As has been shown by our own history, fee-for-service payments have a tendency to produce over-utilization of services as providers' income is based on the number of services provided. By contrast, capitated payments can lead to underutilization of services, since providers receive the same income whether they deliver few or many services. Placing physicians on salaries is another option which does not create the same perverse incentives as fee-for-service or capitated payments but may lower physician productivity. Each of these approaches has limitations and flaws. Much work is being done to explore how to combine and hybridize these approaches in ways that promote productivity, appropriate health care and efficiency, but these strategies are still in their infancy.

comprehensive plans (the Schauffler CHOICE reform and the Brown and Kronick proposal) are grouped with the other reforms although in some respects their scope and impact is comparable to the single payer plans.

This overview analysis can be used to compare overall approaches, but will clearly gloss over important differences among proposals. To assess these details readers can turn to the matrices found in Attachment A, which analyze the strategies proposed in each proposal and their possible impact on the outcomes under examination.

IMPACT ON ACCESS, UTILIZATION AND CONTINUITY OF CARE

Providing health coverage is a means of improving access to and utilization of health care services. It is not an end unto itself. This section of the report will analyze the likely impact of the proposals on access to care. This topic is divided into six sub-issues reflecting the continuum of access issues from initial enrollment to access to services.

Ease of enrollment. Stringent and burdensome application processes dampen enrollment and can contribute to the stigmatization of public coverage programs. Conversely, enrollment approaches that streamline the eligibility processes, allow for phone-in and shortened application forms, and reduce reliance on county welfare offices to administer the application process will improve enrollment and retention. Strategies that automate or create a relatively passive and one-time process for enrollment – similar to that found in the Medicare program or for employer-based coverage – will also tend to produce better enrollment results than approaches requiring proactive and repeated steps on the part of the applicant. Meanwhile coverage reforms that create a simple, clear-cut and understandable overall approach to getting and maintaining insurance – such as that produced by most single payer plans – will have better results in encouraging and maintaining enrollment than approaches relying on many different routes to coverage all with different rules and requirements. A final issue is that approaches enrolling everyone in the same program (Medicare) appear to be more popular and generally accepted than programs covering only those with low-incomes (Medicaid).

Following are the questions to be examined across the proposals:

- How complicated is the enrollment process?
- Is enrollment a one-time requirement, or does it involve multiple interactions?
- To what extent does the reform simplify the overall approach to coverage?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Single payer proposals tend to have simple one-time enrollment processes. Still, there is some risk of barriers to timely coverage depending on paper-work requirements and mode of enrollment. Unifies and simplifies overall coverage approach.	Complexity of enrollment varies in other reforms. Continuation of multiple coverage options is confusing and dampens enrollment. This poses less of a problem for proposals with single alternative to private coverage. Multiple enrollment iterations required.

Usual source of care. Having a usual source of care is associated with better access to care, higher likelihood of receiving preventive services and better health outcomes.[1] Both public and private coverage appear to produce very good results in encouraging the establishment of usual sources of care for enrollees. More than 85% of non-elderly enrollees in both public and private coverage have a usual source of care.[2] Coverage programs can encourage the establishment and maintenance of a usual source of care in a variety of ways including requiring that enrollees select a primary care provider either at enrollment or some other sensible juncture, providing special payments for providers who perform usual source of care functions for enrollees (similar to the primary care case management monthly payments some states use for Medicaid), and providing incentive payments to primary care providers based on their performance delivering preventive care services.

In addition to ensuring that enrollees have a medical home and that providers are appropriately incented to serve as usual sources of care, policymakers may also need to address access barriers created by providers' organization of care. These barriers (which include lack of nighttime and weekend hours, long wait times and difficulty making an appointment) seem to depress demand for a usual source of care.[3] One potential way to address these is to hold providers to minimum standards regarding wait times and provider access.

A final issue is whether coverage is continuous or not since people with consistent coverage are more likely to have a usual source of care than those experiencing breaks in coverage.[4]

Following are the questions to be examined across the proposals:

- Are there mechanisms or incentives to establish a usual source of care?
- Are providers encouraged to reduce access barriers?
- How likely is it that enrollees will experience insurance transitions?

Overview analysis of proposals:

Single Payer	Other Reform Approaches

No clear difference in establishment of usual source of care by type of approach. Coverage is the main predictor of having a usual source of care. However, approaches that provide continuous coverage will perform better in helping people maintain a medical home. Single payer plans are generally more likely than other types of proposals to produce continuous coverage.

Benefits. As people often realize when they first experience a major health problem, having coverage does not necessarily translate into having access to needed services. The benefits covered by health insurance vary widely. Generally Medicaid and large employers offer the richest packages of benefits. Workers employed by smaller employers (who are also more likely to be poor) and persons who purchase individual coverage tend to have more meager benefits, often without services like vision care,

dental care and drug coverage. This has created a tiered system with those at the top and bottom of the income scale enjoying better and richer benefits than those in the middle.

Following are the questions to be examined across the proposals:

- What is the range of benefits offered by the proposal?
- Is there still a risk of tiered benefits?
- Are services such as dental, prescription drugs and vision care covered?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Single payer plans offer broad range of benefits although with variability in offer of dental and vision care. Significant shift from status quo is the uniformity of benefits.	New coverage provided by other reforms offers broad benefits. Benefits in existing private and public coverage vary. Those at top and bottom of income scale have richer benefits than those in middle.

Cost Sharing. Cost-sharing includes premium payments and point-of-service payments such as copayments or coinsurance. Premiums tend to lower coverage rates since some people decline insurance rather than pay premiums. This issue is addressed below in the discussion of gaps in coverage. Point-of-service cost-sharing, by contrast, has an impact on access to services once a person is covered. Copayments lead to reduced use of services with a greater impact on persons with low-incomes. [5] Research has shown that lower cost-sharing is associated with better health outcomes for low-income groups and the delivery of more preventive care. [6] Policymakers can design and target cost-sharing so that negative effects are minimized. This can be accomplished by exempting preventive services and low-income groups from cost-sharing, using sliding scale copayments and providing caps on out-of-pocket spending.

Following are the questions to be examined across the proposals:

- Does the proposal include point-of-service cost-sharing?
- Are preventive services or low-income groups exempted?
- Is there a cap on out-of-pocket spending?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
While any type of reform can include cost-sharing, the proposed single payer approaches do not. These proposals eliminate risk of reduced utilization from cost-sharing.	Some proposals include point of service cost-sharing for new coverage. All retain varying degrees of cost-sharing in existing private coverage. Cost-sharing may lower use of services with greater impact on poor and sick.

Access to Providers. While Medicaid has tended to provide rich benefits, enrollees have sometimes had difficulties gaining access to these services because of the limited number

of providers participating in the program. Problems with provider access have been particularly acute for dental care and in rural areas. A primary reason for limited provider participation in Medicaid is low reimbursement rates. Medicaid managed care has generally increased provider participation by offering improved reimbursement rates.

Conventional commercial plans have tended to offer higher rates and have enjoyed correspondingly larger provider networks than the traditional Medicaid program. But enrollees in commercial managed care plans may still experience problems finding an available or desired provider due to narrow provider networks. Plans sometimes have restricted provider panels in order to control costs and utilization or because providers do not want to participate in the networks.

Following are the questions to be examined across the proposals:

- Will reimbursement rates change?
- What are the restrictions on enrollees' choice of providers including specialists?
- Are there other approaches to assure access to providers?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Single payer plans generally offer free choice of providers and large networks. Some, but not all, improve reimbursement rates.	Other reforms mostly rely on existing Medi-Cal or Healthy Families plans, which have reasonably broad networks but include limitations on access to specialists. Some, but not all, improve reimbursement rates.

Gaps in Coverage. An unfortunate hallmark of our current coverage system is the prevalence of temporary gaps in coverage. These coverage gaps are created when someone switches jobs, becomes ineligible for public coverage due to family status or income, or works for an employer who drops coverage. Research evidence shows that insured people who experience a gap in coverage have poorer access to care and are less likely to have a usual source of care than those with continuous coverage.[7] Gaps in coverage are more likely to occur in a system that relies on multiple, intersecting paths to insurance than in a health care system, such as that outlined in most single payer strategies, where coverage has been expanded but also unified and simplified and where the link to the employer for health coverage has been removed.

Following are the questions to be examined across the proposals:

- Does the proposal retain the current features of our system with multiple paths to coverage?
- Do people have a waiting period before they are eligible for coverage?
- Are certain groups excluded from coverage?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
With a unified approach to coverage, single-payer plans generally eliminate gaps in coverage resulting in better continuity of coverage and improved access to and continuity of care. All have one-time waiting period.	Because of multiple, intersecting paths to coverage gaps remain for most other proposals. These are partly addressed in some plans by 12 months continuous coverage, high-income cut-offs and short waiting periods.

IMPACT ON QUALITY AND APPROPRIATENESS OF CARE

Preventive Care. One of the sharpest critiques of the US health care system is its focus on high technology care at the expense of primary and preventive care. Nevertheless, the situation has improved over the last two decades. The introduction in 1992 of the Resource Based Relative Value System (RBRVS) payments for physicians (developed for Medicare and adopted by other payers) improved payment for consultation relative to procedure focused visits, creating incentives for the delivery of primary and preventive care. Meanwhile managed care plans have tended to cover preventive services more readily than fee-for-service plans so the increased prevalence of managed care has translated into better access to preventive services. Coverage within the fee-for-service sector has also improved – from 1988 to 2000 the proportion of fee-for-service plans offering coverage for well-baby care increased from 45% to 78% .[8]

Yet while coverage of preventive care has increased, many argue that our health care system remains inadequately focused on primary and preventative care. Our knowledge of how to implement disease management, secondary prevention for those with chronic diseases, and behavioral change interventions to prevent the further development of chronic diseases is rudimentary. Indeed, it is widely acknowledged that physicians are poorly trained and reimbursed to provide preventive health care.

Changing the orientation of our health system is a complex undertaking. We have excelled in developing and disseminating advanced technological solutions to health problems. These interventions are highly demanded by US health care consumers. It may be possible to modulate this demand as some research shows that consumer choices are changed by the introduction of decision-tools presenting the risks and benefits of different interventions. Nevertheless, even if physician behavior and reimbursement changed overnight, consumer demand would likely counteract this, at least to some degree.

Following from this discussion, a minimum threshold question is whether a proposal covers preventive and primary care services. A secondary, but equally important question is whether these services are exempted from cost-sharing, since this will tend to increase demand for and utilization of these services. A final, and more complex issue is whether and how the proposal might invest more resources in preventive care and strengthen the ability of the health care system in general to promote behavior change and self-care.

Following are the questions to be examined across the proposals:

- Are preventive and primary care services covered?
- Are these services exempted from cost-sharing?
- Does the proposal shift resources to preventive care?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
All single payer plans cover preventive services with no cost sharing. Some plans shift resources to preventive care by changing provider mix and providing incentives for delivery of preventive services.	All cover preventive care services and most exempt from cost-sharing. These proposals do not generally include strategies to shift resources to preventive care.

Health Care Quality. Little is known about how to produce wholesale improvements in health care quality. Yet there is agreement that the US health care system suffers from significant health care quality problems and that fundamental changes are needed. Some of the problems were highlighted in a recent Institute of Medicine report that found widespread incidence of serious medical errors in hospitals and other health care settings.[9] Interestingly, this is a problem shared by other Western countries. Almost 40% of physicians in Canada and more than half of physicians in the United Kingdom (compared to 30% of US physicians) report that hospitals perform fairly to poorly finding and addressing medical errors.[10]

The significant geographic disparity in the utilization of intensive services such as hip replacements also highlights our nation's health care quality problems. For if physicians were following evidence-based practices we would expect to see comparable practice patterns across different areas.

In conceptualizing a system to improve quality of care two initial issues need to be considered; how to create better information systems to track quality of care and how to produce and disseminate performance information that will have an impact on health care quality.

Regarding the first issue, the US, like most other countries, lacks an information system that allows providers to track the delivery of care across settings or permits policymakers to evaluate the performance of providers. Our medical records are largely paper-based and dispersed. A principal source of aggregated and electronic patient-level data is medical claims, but these have been largely eliminated with the advent of managed care and do not include the clinical information needed to evaluate quality of care. Addressing these problems and improving our information systems is a clear priority.

On the second issue, while nearly all experts call for the development of improved information on provider performance, we still have too little knowledge about how this information translates into health quality improvements. Much effort has been spent in the last two decades developing health plan performance indicators. Yet while this information can be helpful, plan level do not give consumers the information they need to

select an appropriate provider. In light of this, quality experts have called for the development of provider performance measures. However, our few experiments producing and disseminating information on provider quality have not necessarily led to increased use by consumers of well-performing providers at the expense of those with poorer performance.[11] Nevertheless, reporting provider performance may still have an impact on quality of care by affecting provider behavior. Evidence from the CABG reporting efforts in Pennsylvania and New York and Cleveland's hospital performance reporting system, Cleveland Health Quality Choice, suggest that providers use the information to analyze and improve their own performance. Developing better provider performance measures and disseminating these data is a priority, but we need to learn more about how this information can be used to drive improvements in health care quality.

Despite these uncertainties, quality experts seem to be in agreement on the new capabilities that are needed, if not on how to develop them. To begin with we need better information systems and technology that allow for provider-level performance measurement. Important components of the system include the ability to collect needed data electronically and a mechanism for automated order entry to reduce medical errors.[12] Of equal importance is the development of quality guidelines and best practices, an approach to disseminate these to providers, strategies to track provider performance with respect to these optimal practices, and interventions to reward providers who perform well. A final critical requirement is the establishment of accountable entities within the health care system. Since health care is produced at a system, not at an individual level, the accountable entity should not be individual physicians but should consist of an aggregation of providers into appropriate networks of care.[13]

Following are the questions to be examined across the proposals:

- Does the proposal include efforts to improve information infrastructure?
- Does the proposal provide an accountable entity?
- Is there infrastructure and funding to produce quality standards and evidence-based guidelines, preferably in collaboration with physicians?
- Is information about provider performance disseminated to providers and to the public?
- Are there mechanisms for value-based purchasing or rewarding better performing providers?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Critical advantage of single payer plans is the opportunity to standardize data collection and quality measurement. These plans also have leverage to implement value purchasing and to develop organizational incentives. Proposals pursue these opportunities to varying degrees. There is a lack of an accountable entity in some proposals.	These proposals tend to continue current quality measurement efforts, but do not make major advancements in data collection and information technology or value-based purchasing. There is a lack of an accountable entity in some proposals.

Patient Education and Shared Patient Provider Education. The importance of patient education and patient involvement in medical decision-making has been underscored by the US consumerist health movement and by the increasing recognition that our nation's most serious health problems can only be addressed through significant behavior change on the part of consumers.

A number of approaches could be considered. First, strengthening the public health system and incorporating public health, as opposed to individual health, approaches to behavior change will be important. Major changes in US behaviors and attitudes have occurred over the last decade on issues ranging from seat-belt use, to baby sleep position, breastfeeding and smoking through multi-faceted and aggressive public education campaigns. Second, encouraging and adequately reimbursing primary care and preventive care services can encourage more effective patient education since primary care visits are often the locus for behavior changes and prevention interventions. Third, direct reimbursement of behavior change and care management initiatives which could range from smoking cessation programs to heart-healthy diet interventions and reimbursement of e-mail communication between chronic care patients and their providers would increase use of these important services. Fourth, the organization of health care can facilitate or deter shared patient-provider decision-making. Providers and patients alike are frustrated by the barriers created by managed care. Finding ways to lessen this direct third party involvements while giving consumers a voice in policy-development may result in a more responsive health care system and better relationships between providers and patients.

Following are the questions to be examined across the proposals:

- Are public health approaches to health education and behavior change incorporated into proposals?
- Are behavior change and self-care interventions supported through reimbursement?
- Are existing barriers between patients and providers diminished?
- Do consumers have a voice in important policy decisions?

Overview analysis of proposals:

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Single Payer	Other Reform Approaches
Single payer plans may provide more autonomy for physicians and their patients. These proposals introduce more community involvement and health planning, but do not generally increase public health approaches or reimbursement for behavior change.	These proposals make few changes to existing patient education and behavior change approaches. Some proposals do not rely on managed care – resulting in more physician autonomy.

Medical Innovation. The United States medical system, for all its flaws, has been possibly the world's most productive in the development of new technology, drugs and other forms of medical innovation. These developments have been facilitated by our market-based health care system and reflect the strongly held societal value for technological progress and advancement. [14] Technological advances have greatly contributed to reduced mortality in the last two decades for a variety of conditions including prematurity and heart disease. According to one analysis, 43% of the decline in deaths from coronary heart disease between 1980 and 1990 is attributable to better medical treatment and technology, 25% is attributable to primary prevention (reduction in risk factors), and 29% is attributable to secondary prevention (prevention of cardiac events).[15]

So, what impact would health care reforms likely have on innovation and the diffusion of medical technology? This question points us back to the issue of how costs will be controlled under different health care reform proposals, because technology growth is strongly tied to reimbursement and utilization prospects for new developments. Generally speaking, reforms that build on our current coverage system will likely not strongly effect medical innovation or technology development, unless they are paired with aggressive efforts to control costs, which may have a dampening effect. These reforms will not make fundamental changes to our market-based system of health care, in which the competition has often centered on access to medical technology. This may not be an unqualified good, however, since our health care system is marked by overutilization of many procedures and proliferation of underused equipment and facilities.

By contrast, in a single payer system technology use and distribution will be managed through more centralized and political processes, with the goal of limiting overutilization of expensive technologies. This is often accomplished through global budgets for hospitals with a separate budget and approval process for capital investments, including technology. The result is to disincent hospitals from competing through the purchase of new technology and to reduce the market for new technology.[16] This will likely have a dampening effect on the development of more costly and technologically advanced approaches and may lead to shortages of high technology equipment and services and waiting times for some non-emergency services.[17]

Following are the questions to be examined across the proposals:

- How does the proposal approach the issue of cost-control and technology diffusion?

- Is there an approval process for technology investments?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
With use of capital budgets and approval process, single payer plans may reduce demand for and supply of some technologically advanced interventions.	These proposals do not generally alter technology reimbursement and competition and therefore will not change current patterns of technology development and diffusion.

IMPACT ON THE SAFETY NET

The term "safety net" generally refers to the mix of public and private providers whose patient populations include a disproportionate share of low-income or uninsured patients (and a correspondingly small proportion of patients covered by Medicare or private insurance). Using this definition, the safety net includes public hospitals, community health centers, many academic medical centers and a variety of other providers. The "safety net" is not a well-defined or necessarily organized system of care.

Funding streams for safety net providers. One of the main functions of safety net providers is to provide health care services for those lacking coverage or who cannot access other providers because of cost and other barriers to care. Safety net providers rely on a variety of targeted funding streams to cover the costs of caring for these patients. In California these funding streams include Medi-Cal DSH funds, county indigent care funding, Realignment funds and Proposition 99 funds.

If a coverage approach truly is designed to cover everybody all the time – it could be argued that there is no need for designated safety net providers or earmarked charity care funding. However, each of the nine coverage reforms has gaps – creating a residual group of people who will lack coverage. This residual group includes populations categorically excluded from the expansion proposals, people choosing not to opt into coverage because of its cost or other reasons, and those who are waiting to become eligible. Because of this persistent residual uninsured group, there is a need for continued funding for uninsured care. This need will vary depending on the size of the uninsured population.

Following are the questions to be examined across the proposals:

- To what degree is targeted funding for indigent care preserved?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Mostly, single payer plans eliminate targeted charity care funding creating potential access issues for residual uninsured group. Future of safety net providers unclear, but with small residual uninsured group less need for dedicated providers.	Most scale back charity care funding, although some leave funding unchanged. Greatest risk posed by proposals that greatly reduce funding but retain large residual uninsured group.

Preferred contracting status for safety net providers. In addition to direct funding for uninsured care, the financial stability of safety net providers as sources of last resort care can be reinforced by providing special contracting status or preferential treatment to safety net providers. Many states have done this in Medicaid managed care programs by requiring health plans to include safety net providers in their provider networks. Some have argued that these approaches unfairly advantage this group of providers who do not necessarily provide better care than private sources. Others maintain that the continued viability and stability of these providers is a critical public policy goal as long as there is a significant group of people remaining uninsured and because safety net providers offer unique and important capabilities that should be maintained. These capabilities include ER and trauma capacity, culturally competent providers and outreach infrastructure.

Following is the question to be examined across the proposals:

- Does the proposal include a special or preferred contracting status for safety net providers?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Generally, single payer plans offer no preferential treatment for safety net providers. At least one proposal relies on the Medi-Cal provider infrastructure, which favors safety net providers.	Other reforms vary greatly from plans that rely only on safety net providers to those that would expand in private sector with no prominent role for safety net providers. Some rely on Medi-Cal and Healthy Families, which favor safety net providers.

IMPACT ON VULNERABLE GROUPS

Certain groups are more likely to experience barriers to health care access than others. These groups include immigrants and ethnic minorities, for whom cultural differences and language barriers can create access problems, and rural populations, who are more likely to experience geographic access barriers. Another important vulnerable group is people with special health care needs. Problems in the health care system are magnified for this high need group since they use more health services than the average person. This section of the report analyzes potential access issues for these three vulnerable groups.

Immigrants and ethnic minorities. Immigrants and ethnic minorities encounter intersecting access barriers when seeking health care. First of all, certain immigrant groups, most notably Latinos, are much less likely to have insurance coverage than the general population. This is due to ineligibility for public coverage, employment patterns and possibly lower demand for coverage. One issue of first-order importance, therefore, is whether reform proposals envision covering all immigrants, regardless of immigration status.

But even when covered, some immigrant and ethnic groups encounter substantial barriers to care. A recent study found that 19% of Latinos did not seek needed care in the last year because of the lack of availability of a Spanish-speaking provider or interpreter.[18] The same study found that the main barrier providers faced in better accommodating Spanish-speaking patients was cost.

Despite wide-spread recognition of these problems very little is known about what strategies are most effective to provide culturally competent and linguistically appropriate care at the health system level. Clearly, though, reform proposals that in addition to covering immigrant groups also reimburse translation services, provide training in how to deliver services more appropriately or track and monitor providers' performance with respect to these issues can be expected to have better outcomes.

Following are the questions to be examined across the proposals:

- Are undocumented immigrants covered?
- Are translation and interpretation services reimbursable?
- Does the proposal include other strategies to improve cultural competency and linguistic appropriateness of services?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
No clear difference by proposal type. Most proposals provide some coverage for undocumented immigrants. Most do not provide special reimbursement for translation or other needed services. There is no blueprint to establish culturally competent and linguistically appropriate care at health care system level.	

Persons with special health care needs. Problems of fragmentation and discontinuity of care in the medical system disproportionately affect persons with special health care needs and lead to sub-optimal care and access barriers. One of the hoped-for outcomes of managed care was better coordination and continuity of health care for this group. Most would agree that managed care (as it has been implemented) has not generally produced this result. However a loose and unorganized care system, likely to result from a return to fee-for-service financing and dismantling of managed care, may not produce better results.

Unfortunately, not enough is known about what care system might really work best for persons with special health care needs. Proponents of disease management point to

improved outcomes and care processes resulting from disease management for some diseases, but others are concerned that disease management sometimes focuses too heavily on pharmaceutical approaches rather than on integration and continuity of care. Some argue improving primary care services should be a principal strategy. But it is not clear that additional primary care improves outcomes for those with acute needs.[19] Others point to studies demonstrating that specialists are better than generalists at managing the care of particular chronic illnesses and advocate more direct access to specialists.[20] Finally, most analysts agree that point-of-service cost-sharing can have a particularly negative impact on this high use population – unless it is combined with maximum out-of-pocket payment limits.

So, what can be learned from synthesizing this conflicting information on health care for persons with special health care needs? Thoughtful construction of the benefits package, cost-sharing and access to specialists all have the potential to improve care - especially in cases of under-treatment. However, overtreatment and inappropriate treatment are also major issues for this group. An evidence-based approach to the overall benefits package can partially address this issue, but does not help a provider make the difficult decision about whether a given treatment will help a particular individual at a certain point in time. Strategies that develop and disseminate evidence-based protocols and disease management approaches, screen and identify people for these, and track the performance of providers in following these best-practice approaches, may well hold the most promise. A final important issue is risk-adjustment of plan and provider payment rates to address the tendency by plans and providers to avoid higher risk individuals.

Following are the questions to be asked across proposals:

- Is there point-of-service cost-sharing? Is there a cap on out-of-pocket payments?
- Do enrollees have direct access to specialists or a means to establish standing referrals?
- What restrictions on access derive from managed care requirements?
- Is there an approach to develop and implement disease management or care management for particular conditions?
- Are capitation rates or provider budgets risk adjusted?

Single Payer	Other Reform Approaches
Single payer plans generally include ready access to specialists, covered services without cost sharing and few managed care requirements. It is unclear how care will be coordinated and managed without managed care or some other entity to organize health care delivery.	Proposals that build on employer-based coverage raise concerns regarding cost-sharing without caps, variable benefits, and uncertain access to specialists. It is unclear how care will be coordinated and managed without managed care.

Rural populations. People living in rural areas are disproportionately poor and sick, so they encounter the access problems experienced by these vulnerable groups. In addition, they are more likely to experience geographic access barriers because while 20% of

Americans reside in rural areas only 9% of physicians practice there.[21] Low reimbursement rates are a factor contributing to the inadequate supply of physicians in rural areas. Rural physicians get a larger share of their practice revenue from Medicaid and Medicare, which have tended to reimburse at lower rates than private payers.[22]

Managed care and other care delivery approaches that employ restricted provider networks may exacerbate access problems for rural populations unless there are provisions for seeking out-of-network care or requiring plans to contract with rural providers. For this reason, among others, some states relying on Medicaid managed care have retained a fee-for-service system in rural areas.

More comprehensive approaches for improving rural access might include provisions for redistributing providers based on geographic need to achieve a more equitable distribution of providers. It is difficult to anticipate how effective these approaches will be, but they may well improve, if not resolve, rural access issues.

Following are the questions to be examined across the proposals:

- Do enrollees have a free choice of providers?
- Are reimbursement rates improved?
- Does the proposal cover transportation?
- Are there other strategies to increase provider capacity in rural areas?

Overview analysis of proposals:

Single Payer	Other Reform Approaches
Single payer plans offer the potential to address underlying workforce supply issues through direct intervention in placement of providers. The lack of managed care and referral requirements facilitate access. Non-emergency transportation generally not funded. Low reimbursement still an issue for some proposals.	Other reforms have little impact on rural access issues except possibly through less reliance on managed care in some proposals. Non-emergency transport not funded. Low reimbursement still an issue for some proposals.

[1] See the following:

Ettner SL. The timing of Preventive Services for Women and Children. *American Journal of Public Health.* 1996; 86(12):1748-1754.

Moy E, et al. Access to Hypertensive Care. *Archives of Internal Medicine.* 1995; 155:1497-1502.

O'Malley AS, et al. Continuity of Care and the Use of Breast and Cervical Cancer Screening Services in a Multiethnic Community. *Archives of Internal Medicine.* 1997;157:1462-1470.

Sox CM, et al. Insurance or Regular Physician: Which is the Most Powerful Predictor of Health Care? *American Journal of Public Health.* 1998; 88 (3): 364-370.

Turner BJ, et al. Delayed Medical Care After Diagnosis in a US National Probability Sample of Persons Affected with Human Immunodeficiency Virus. *Archives of Internal Medicine.* 2000; 160:2614-2622.

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Attachment A

Assessment of Individual Reforms and Their Potential Impact on Outcomes

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Prepared for the California Health Care Options Project

	Brownstein	Brown and Kronick	Harbage
Ease of enrollment Proposal	Enrollment process not specified. Process will likely involve demonstrating income, resident status, ineligibility for public programs and lack of insurance for six months. Focused marketing effort at the county level targeted at employers, temporary staffing firms and other groups. Enrollment in existing public and private coverage as in status quo, but with simplified income-based not categorical public coverage.	Written application for Healthy California (HC) requiring signed declaration of legal residence (and income for those wishing to apply for wrap-around benefits), SSN for applicants and signed declaration that applicants do not have employer-based coverage. Enrollment in employer-based coverage as in status quo.	Individual enrollment process through one-page application. Will likely require documentation of income, demonstration of lack of coverage for 6 months or evidence of meeting exemption, and other information required to screen for Healthy Families and Medi-Cal. Enrollment in existing public and private coverage as in status quo. Program envisions a multi-faceted outreach campaign.
Impact	*Unclear what enrollment process issues might be although number of requirements suggest it may be a complicated process. Targeted marketing of this type of program successful in Santa Clara County. Premiums likely a barrier to enrollment in public programs (logistics of payment and unwillingness to pay). Some potential for stigma in MCEP since income-eligible program - mitigated by increasing eligibility to 400% of FPL but possibly exacerbated by use only of safety net providers. Continuation of multiple intersecting coverage and fragmentation of current system, but with some simplification through income-based eligibility.*	*Although enrollment process streamlined still modest risk that eligibles will not enroll in HC because of paperwork requirements. Continuation of both private coverage and Healthy California, much simpler than today, but there is still modest risk of fragmentation.*	*The enrollment and eligibility process may be complicated since both the employer and the employee must be involved. Risk that eligibles will not enroll in CPPP because of paperwork requirement and possibility of stigma since low-income only program. This stigma may be reduced by use of private coverage. Continuation of multiple intersecting coverage and fragmentation of current system.*
Usual source of care Proposal	No specified process for establishing usual source of care in MCEP. Status quo in existing public and private coverage. Both Medi-Cal and Healthy Families have mechanism for establishing a usual source of care.	No specified process for establishing usual source of care. Status quo in private coverage.	No specified process for establishing usual source of care. Process for establishing usual source of care will vary by employer and plan. Status quo in existing private and public coverage.
Impact	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*	*As today, some subset of covered will not establish a usual source of care. In addition, transition from employer coverage to HC may disrupt usual source of care.*	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal	MCEP will have current Healthy Families benefits, which include dental and vision care. Status quo benefits for those in existing private and public coverage. Medi-Cal will retain rich benefits, which include support services.	Benefits will vary in private coverage although will need to match the actuarial value of HC. HC will have current Healthy Families benefits, which include vision and dental with access to enhanced services including support services for low-income.	Benefits will vary in new private coverage although will need to match the actuarial value of one of 4 benchmarks. Status quo benefits for those in existing public and private coverage. Medi-Cal will retain rich benefits, which include support services.
Impact	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale (Those with high incomes may have richer benefits through employer - those with low-incomes will have access to the full Medi-Cal benefit package.) Benefits still variable in private coverage.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage although will need to meet actuarial value of HC.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage. New coverage will meet actuarial value of benchmark.*
Cost sharing Proposal	Cost sharing per status quo in existing employer based and public coverage. MCEP has fairly nominal ($5-$10) copays for all services with an out-of-pocket limit of $250.	HC has nominal ($5) copays for outpatient services and prescription drugs – but not for inpatient or preventive care. No out-of-pocket limit. Cost sharing in existing employer based coverage cannot exceed HC levels.	Cost sharing per status quo in CPPP (based on existing private plans) and in existing private and public coverage.
Impact	*Modest copays in MCEP will depress use of some services including preventive care. This is mitigated by out-of-pocket limit. Risk of access barriers from cost-sharing in private coverage where copayments and deductibles will vary.*	*Exemption of preventive services from copays for HC will mitigate risk of cost-sharing, although modest copays will depress use of some services. This could be addressed by adding an out-of-pocket limit.*	*Copayments and deductibles will vary and have the potential to limit access to services.*
Access to providers *Proposal*	MCEP Will rely on current Medi-Cal managed care provider system. Reimbursement rates per status quo. Provider access per status quo for existing private and public coverage.	No specific provisions related to provider availability, network capacity, provider choice or access to specialists. Author makes indirect reference to the possible need to increase reimbursement rates stating that public coverage funding will have to increase in order to maintain access to care. Provider access per status quo for existing private coverage. MRMIB may use direct contracting for services. Employees can choose between available employer plan and HC.	No specific provisions related to provider availability, network capacity, provider choice or access to specialists. Reimbursement rates per status quo. Provider access per status quo for existing private and public coverage.
Impact	*Risk that safety net capacity will be insufficient or poorly distributed for populations with different demographics than those now enrolled. Current problems related to distribution and availability of providers, relatively low reimbursement for public coverage and limits on direct access to specialists continue.*	*Current problems related to distribution/availability of providers and limits on direct access to specialists continue. Possibility of improved access to providers for those in HC from potentially higher reimbursement rates.*	*Current problems related to distribution and availability of providers, relatively low reimbursement for public coverage and limits on direct access to specialists continue. Some protection afforded by insurance laws which mandate a certain level of access to providers, but problems still occur.*
Gaps in coverage Proposal	Gaps from 6-month waiting period for MCEP, insurance transitions due to employer-based coverage, ineligibility for MCEP due to income and inability to pay premiums. Waiting period only applies to voluntary termination of coverage by employer/employee, laid-off workers eligible immediately.	No gaps in coverage envisioned, unless a person has failed to enroll in HC.	Gaps in coverage for subset of population caused by 6-month waiting period for enrollment in CPPP, requirement that only small employers can participate, and insurance transitions related to employer-based coverage and inability to pay premiums.
Impact	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*	*Minimal anticipated access risk or threat to continuity of care from gaps in coverage.*	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Ease of enrollment Proposal	Enrollment process not specified – but will likely involve only documenting state residence for three months or longer. Proposal envisions public service campaign to encourage enrollment.	Enrollment process not specified – but involves proof of residence, demonstration of working status, mechanism for verifying income and paying premium. Coverage for one year with renewal guaranteed with payment of premium. Enrollment in existing public and private coverage as in status quo. Media campaign and community outreach to enroll eligibles.	Simplifies and streamlines the application process for public coverage by eliminating assets test, 12 months eligibility for some groups, simplifying the application, launching outreach and implementing presumptive eligibility for all groups. Enrollment in existing public and private coverage as in status quo but with simplified income-based not categorical eligibility.
Impact	One-time only enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.	*Some enrollment barriers will be present for CHOICE because of need to meet eligibility requirements. Mitigated by one-time eligibility. Continuation of multiple intersecting coverage and fragmentation of current system, but with a consistent alternative choice for those who work.*	*These strategies may result in greater enrollment and retention in public programs although still some risk of barriers to enrollment and risk of stigma since low-income only program. Continuation of multiple intersecting coverage retains fragmentation of current system, although with some simplification through income-based eligibility.*
Usual source of care Proposal	Individuals will formally designate a provider at enrollment if they select a prepaid provider. No specified process for selecting a usual source of care if fee for service providers used.	Enrollees in CHOICE select a PCP whose performance is monitored regarding delivery of preventive services and disease management. Enrollees may change their PCP at beginning of any month. Status quo for those in private and public coverage. Both Medi-Cal and Healthy Families have mechanism for establishing a usual source of care.	Both Medi-Cal and Healthy Families have mechanism for establishing usual source of care. Status quo in existing private coverage.
Impact	*Modest risk, as today, some enrollees will not establish a usual source of care. Little to no risk of insurance transitions.*	*Focus on establishing and monitoring usual source of care in CHOICE may result in better establishment and performance of usual source of care. Enrollees will be able to avoid insurance transitions by remaining in the CHOICE plan.*	*As today, some subset of covered will not establish a usual source of care. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal	Benefits including transportation for disabled, language interpretation, education and screening services, and long term care.	Uses the Kaiser plan large group benefits as benchmark. In CHOICE, benefits include vision care and health education but not dental care or other supportive services. Status quo benefits for those in private and public system. Medi-Cal will retain rich benefits, which include support services.	Benefits in the expanded public program relatively rich (current Health Families and Medi-Cal which include dental and vision). Status quo benefits in existing public and private coverage. Medi-Cal will retain rich benefits, which include support services. Limited benefits and very high deductible for the new employer coverage program.
Impact	*Access to care facilitated by broad definition of benefits including interpretation. However, services only covered if deemed medically necessary – unclear how or who will define this.*	*For CHOICE, broad benefits. Benefits only covered if deemed medically necessary – unclear how or who will define this. Risk of tiered system with richer benefits for those at top and bottom of income scale. Benefits still variable in private coverage.*	*Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still very variable in private coverage.*
Cost sharing Proposal	Nominal $5 copays for outpatient services and prescription drugs, and $100 for hospital stays, with no out-of-pocket limit.	Cost sharing per status quo in existing employer based and public coverage. For CHOICE no copayments for poor and for preventive services in network. Higher income enrollees have $10 copay for outpatient, $35 for ER visits and 4-tier copayment schedule for prescription drugs with no out-of-pocket limit.	Cost-sharing per status quo in existing employer-based and public coverage. Assume Medi-cal and Healthy Families expansions will embrace current cost-sharing policies. New employer coverage may have cost sharing with no cap and a very high deductible.
Impact	*Modest copays in MCEP will depress use of some services including preventive care. This is mitigated by exemption of persons who qualify for Medi-Cal.*	*Exemption of low-income enrollees and preventive services from copays will mitigate risk although copays will depress use of some services. This could be mitigated by adding an out-of-pocket limit. Risk of access barriers from cost-sharing in private coverage where copayments and deductibles will vary.*	*Copayments and deductibles will vary and have the potential to limit access to services.*
Access to providers *Proposal*	Patients who opt into “managed care” (providers are prepaid) must remain in network. Patients who choose fee-for-service providers will have choice of providers including direct access to specialists. Reimbursement at current average.	Providers will be paid at Medicare rates. Enrollees have direct access to providers including specialists. Status quo access for those in current private and public coverage.	Status quo for access to providers. No change envisioned to reimbursement rates.
Impact	*Provider access for low-income may increase since reimbursement rates will be better than current Medi-Cal rates. With free choice of providers, eliminates limitations on direct access to specialists. Current problems related to distribution of providers continue.*	*Provider participation in CHOICE likely better than today because of improved reimbursement rates. Enrollees in CHOICE will have ready access to providers with no restrictions or referral requirements. Access problems may continue in current private and public programs. Current problems related to distribution of providers continue.*	*Current problems related to distribution and availability of providers, relatively low reimbursement for public programs and limits on direct access to specialists continue. Provider access problems may arise for disabled population in Medi-Cal who transition to managed care*
Gaps in coverage Proposal	No gaps in coverage except resulting from one-time three-month waiting period.	Gaps in coverage for subset of the population caused by insurance transitions related to employer-based coverage, inability to pay premiums and employment requirements.	Gaps caused by waiting period for Healthy Families, insurance transitions related to employer-based coverage, ineligibility due to high income and inability to afford premiums for public as well as private coverage.
Impact	*Minimal access risk or threat to continuity of care from gaps in coverage.*	*Some risk of discontinuity of care and disruption in usual source of care from coverage gaps, although mitigated by simplified coverage system.*	*Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Shaffer	Spelman	Wulsin
Ease of enrollment Proposal *Impact*	Author does not specify the details of the enrollment process, but would likely involve only documenting state residence for six continuous months. The CHS administrator charged with developing efficient mechanisms for assuring eligibility and enrollment. Media and outreach campaign envisioned. *One-time enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.*	Author outlines enrollment process including simplified enrollment, automatic enrollment of newborns, and enrollment at point of contact with healthcare system. Enrollment at multiple locations, community outreach and media announcements envisioned. *One-time only enrollment and little paperwork will address most enrollment barriers. Little risk of stigma because everyone covered by one program.*	Enrollment process not specified for public coverage. Assume current rules continue but with simplified income-based not categorical eligibility. No need for new application when people move between Healthy Families and Medi-Cal. *As today, some risk of enrollment barriers in public programs. Potential for stigma since low-income only program. Continuation of multiple intersecting coverage and fragmentation of current system. Much simplification of enrollment in public coverage because of income-based (rather than categorical) eligibility and consolidation of multiple programs into two – Healthy Families and Medi-Cal.*
Usual source of care Proposal *Impact*	Author states that each person will have a primary caregiver, but does not specify a process or incentives for establishing or maintaining one. Care coordination assigned to each group practice. *Establishing a usual source of care for every enrollee is a goal of the program, however it is somewhat unclear how this will be established and reinforced.*	The author states that the plan will include system-wide primary care case management and referral. At enrollment, and at all points of interaction with healthcare system, there will be a mechanism for linking enrollees with a usual source of care. *Iterative process for establishing usual source of care will reinforce establishment of a medical home.*	Proposal does not affect status quo in private or public coverage. Both Medi-Cal and Healthy Families have mechanism for establishing usual source of care. *As today, some subset of covered will not establish a usual source of care. No plan to address this. In addition, insurance transitions will disrupt usual source of care.*
Benefits Proposal *Impact*	Uniform benefit package includes dental, vision, home health, acupuncture and chiropractic care. Support services such as transportation and translation/interpretation not reimbursed. *Broad benefits. Potential for modest access problems, especially for low-income due to lack of support services.*	Uniform benefit package includes limited vision, dental, and long term care as well as alternative medicine services. Implementation of a closed formulary for prescription drugs. Translation/interpretation and transportation are covered services along with behavior change interventions such as weight control, nutrition counseling and exercise classes. *Broad benefits, coverage of behavior change, and inclusion of translation and transportation should have a positive impact on access especially for low-income group. Depending on implementation - closed drug formulary could have a negative impact on access to prescription drugs.*	Benefits will vary depending on the type of coverage, although only plans meeting minimum bar of benefits (which does not include vision or dental) will be eligible for tax subsidies. Those in Medi-Cal and Healthy families will maintain current program benefits (including dental and vision and support services for Medi-Cal) but current optional Medi-Cal groups will transition to Healthy Families coverage. *Risk of somewhat tiered system with richer benefits for those at top and bottom of income scale. Benefits still very variable in private coverage. Loss of Medi-Cal benefits (including support services) for some low income groups transitioning to Healthy Families.*
Cost sharing Proposal *Impact*	No copayments or deductibles in current plan. *No limitation on access to care from cost-sharing.*	No copayments or deductibles in plan. *No limitation on access to care from cost-sharing.*	Copays for those in public coverage will be at current levels, which are relatively nominal. *Modest copays in public coverage and for Knox Keene plans (only Knox Keene qualify for tax subsidies) and will depress use of some services including preventive care. Copayments and deductibles in other private coverage will vary.*
Access to providers Proposal *Impact*	Assumption that most if not all providers will participate in the plan. Enrollees will have free choice of providers for services with no limits on access to specialists. Proposal includes plan to redistribute providers to create more access in underserved areas and increase number of primary care providers relative to specialists. *Enrollees will generally have ready access to providers with no restrictions or referral requirements. Rebalancing primary care and specialist capacity will likely increase availability of primary care and may reduce availability of specialty care. Provider shortages would be monitored by patient representatives. Plan recognizes and addresses need to increase rural access with large-scale efforts to assign providers to underserved areas.*	Assumption that most if not all providers will participate in the plan. Primary care case management system will include a required referral for access to specialty care, but with the option of specialty management of certain conditions. The budget, and presumably provider reimbursement, will increase at the rate of GDP plus population growth. The overall approach will include a mechanism for tracking distribution of resources to identify inequities. *Enrollees will have ready access to providers although with possibility of referral requirements. The presumed limitation on growth rate of reimbursement to GDP plus population growth may mean lower overall reimbursement growth relative to other areas of country without these limitations. This could affect the CA provider supply. Alternatively, simpler administration, more control over decision-making and risk-adjustment might attract providers. Plan will use financial incentives to create better distribution of providers.*	Status quo for access to providers. No change envisioned in reimbursement rate. *Current problems related to distribution and availability of providers, relatively low reimbursement rates for public coverage and limits on direct access to specialists will continue. Provider access problems may arise for disabled population in Medi-Cal who transition to managed care.*
Gaps in coverage Proposal *Impact*	No gaps in coverage except resulting from one-time six-month waiting period for new residents. *Minimal access risk or threat to continuity of care resulting from gaps in coverage.*	No gaps in coverage except resulting from one-time three-month waiting period. Those not eligible because of waiting period will be provided services if they present for care. *Minimal access risk or threat to continuity of care resulting from gaps in coverage.*	Gaps caused by waiting period for Healthy Families (although there are exceptions for all but those voluntarily dropping coverage), insurance transitions related to employer-based coverage, ineligibility due to high income and inability to afford premiums. Increase of public program eligibility will decrease transitions for low-income group. *Risk of discontinuity of care and disruption in usual source of care from coverage gaps.*

	Brownstein	Brown and Kronick	Harbage
Preventive Care Proposal	As in Healthy Families, preventive services covered in MCEP but may be subject to cost-sharing. Status quo for coverage of preventive care in private and public coverage.	Wide range of preventive services are covered and are not subject to cost-sharing. Status quo for coverage of preventive services in private coverage except plan has to meet actuarial value.	Preventive services not necessarily covered. If covered, may be subject to cost-sharing.
Impact	*This play would result in increased coverage and utilization of preventive services, but use may be depressed due to cost-sharing, but would not necessarily result in a shift of resources toward primary and preventive care.*	*This plan would result in increased coverage and utilization of preventive services. Would not result in a shift of resources toward primary and preventive care.*	*Use of private managed care entities may increase use of preventive services, since managed care more likely to cover these benefits than fee-for-service coverage. Varies by plan.*
Quality of Care Proposal	No specific quality of care strategies outlined. Author states that the county plans will be responsible for quality assurance and that quality control will be addressed by using safety net institutions, which have charitable missions. The accountable entity for quality improvement could be the contracting health plans. Status quo for quality in existing public and private coverage.	The implementing agency, MRMIB, will create an office of quality assessment with an advisory board to include all system stakeholders. This office will collect data from health plans and providers and issue reports. Status quo for quality in private coverage. The accountable entity for quality improvement will be the health plan.	Pac-Advantage has quality improvement efforts. Status quo for quality in private and public coverage.
Impact	*This proposal would not directly change or influence the quality of care in the health care system. Reliance on Medi-Cal contracting mechanisms may positively influence quality of care since these programs have more mechanisms to track and monitor quality than is typically found in private coverage, although it does not appear MCEP will use this infrastructure. Not clear that safety net providers offer better quality of care than other providers.*	*The author includes some of the elements of a quality continuum, although difficult to assess the scope. Based on description would likely be comparable to the level of quality information and improvement efforts in the Medi-cal program.*	*This proposal would not substantially change or influence the quality of care in the health care system.*
Patient Education Proposal	Status quo for patient education. County management of plan implementation may provide more opportunities for consumer input.	Status quo for patient education. Covers a number of behavior change interventions such as smoking cessation drugs and substance abuse treatment.	Status quo for patient education.
Impact	*This proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*	*Again, this proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Healthy Families may positively influence patient education since contracted plans may have more mechanisms to promote patient education than is found in private coverage. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*	*Again, this proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Continuation of managed care approaches throughout system will maintain existing third party intervention in the patient/provider relationship.*
Innovation Proposal	Status quo for innovation and technology.	Status quo for innovation and technology.	Status quo for innovation and technology.
Impact	*No changes anticipated from this program.*	*No changes anticipated from this program.*	*No changes anticipated from this program.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Preventive Care Proposal *Impact*	Covers preventive services although subject to cost-sharing. Earmarked funding to advance public health and prevention. *This plan would result in increased coverage and utilization of preventive services, although use may be somewhat depressed due to cost-sharing. Would not necessarily result in a shift of resources toward primary and preventive care, although does provide some amount of set-aside funding.*	CHOICE covers preventive care services with exemption from cost-sharing. Evidence-based benefits will focus on primary prevention and early disease identification and treatment. Primary care providers will be held accountable for preventive care utilization of their patients. Not clear how this will be enforced or incented. Electronic claims will be used to track provider performance on quality of care including delivery of preventive services. Status quo for private and public coverage. *This plan would result in increased coverage and utilization of preventive services and greater emphasis on primary and preventive care, especially if provider incentives are effective. There could be a shift of resources to primary and preventive care if the evidence-based benefits motivate substantial changes in practice.*	Preventive services covered in private and public coverage options. Not clear if covered in new scaled-back employer offerings. Status quo for cost-sharing. *This plan would lead to increased coverage and utilization of preventive services although use may be somewhat depressed due to cost-sharing.*
Quality of Care Proposal *Impact*	The author states that the plan will improve quality of care through improved data and analysis of health care patterns and outcomes. The author does not specify how this will be accomplished. Not clear how plan could hold individual physicians accountable for quality of care. No other alternative accountability entity. The plan will include a stakeholder advisory group addressing quality and clinical guidelines. *Based on the information provided it is difficult to assess what the interventions would be or how they might affect quality of care.*	CHOICE participating providers will be required to provide data on quality and participate in quality studies. Electronic clearinghouse for claims processing. Incentives for patients to use high quality/low cost providers but no specification of these. Also states that high quality providers will be "recognized". Proposal would implement centers of excellence for certain high cost procedures for which there is a link between volume and quality. CHOICE will only contract with providers meeting minimum standards. *For the CHOICE program, the author incorporates most of the elements of the quality continuum from improving information and data to tracking performance, publishing and disseminating quality information and creating mechanisms for performance-based contracting through the centers of excellence. Still, it is very difficult to evaluate the effectiveness and likely impact of these approaches.*	Status quo for quality. *This proposal would not directly change or influence the quality of care in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence quality of care since these programs have more mechanisms to track and monitor quality than are found in private coverage.*
Patient Education Proposal *Impact*	Will remove the third party intervention between doctor and patient present in today's health care system. This may result in more open communication and better relationships between providers and patients. Behavior change interventions included on list of covered services. Outreach and education services are funded. *Improved outlook for patient/provider relationship. Budget based facility payment may provide new opportunities for population and public health approaches, however not clear how these changes might be triggered and organized. Author does not specify increased investment in public health approaches to health education but does finance some individual behavior change interventions.*	Emphasis on provider accountability for preventive care and focus on disease management and self-care will likely translate into greater emphasis on patient education. CHOICE providers also required to launch patient education efforts and reminders to encourage appropriate care. Author states that there will be promotion of health education including all media taking into account individual characteristics such as language, disability and cultural perspective. The program will also invest in educational products allowing patients to make informed selection of treatment options. Status quo for those in private or public coverage. *The proposal emphasizes patient education, incenting providers to deliver patient education and prevention services and using a variety of public health oriented community education approaches to behavior change. While they are not explicitly covered, it is possible that direct behavior change interventions (weight loss, smoking cessation) would be funded under the disease management program. Within CHOICE, would remove the third party intervention between doctor and patient.*	Status quo for patient education. *Again, this proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence patient education since these programs have more mechanisms to promote patient education than are found in private coverage. Continuation of managed care approaches throughout system will maintain existing intervention in the patient/provider relationship.*
Innovation Proposal *Impact*	Separate capital budget. Capital spending in excess of $750,000 requires approval. All capital improvements funded through the capital budget will remain the property of the state of California. Earmarked funding for innovative technologies. *With use of capital budgets and approval process, along with presumed limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although other types (those linked to health goals) may be increased.*	Proposal includes an evidence-based benefits approach. *Possibility of lowered availability of some high technology services due to evidence-based approach to benefits. This approach could also promote the development of more cost-effective innovations.*	Status quo for innovation and technology. No changes anticipated from this program.

	Shaffer	Spelman	Wulsin
Preventive care Proposal *Impact*	Covers preventive services with no cost-sharing. The program aims to achieve a higher ratio of primary to specialty physicians. DPH and OSHPD track and address determinants of poor health. *This plan would result in increased coverage and utilization of preventive services and a shift in resources toward primary and preventive care through changing the physician mix.*	Covers preventive services with no cost-sharing. Health services budget includes funding for prevention and education. The approach includes financial incentives to assure broad implementation of population-health and prevention strategies. *This plan would result in increased coverage and utilization of preventive services. Required use of primary care doctors as first point of contact and increased reimbursement for these physicians likely to increase primary and preventive care use.*	Preventive services covered in private and public coverage options. Status quo for cost-sharing. *This plan would result in increased coverage of preventive services, but use may be depressed due to cost-sharing.*
Quality of Care Proposal *Impact*	The author states that the CHS will have the ability to increase the collection and dissemination of clinical information, but does not specify how this will be done except indicating that results will be shared with peers and public. Hospitals will develop processes to improve patient-safety. CHS will include a provider-led initiative to develop evidence-based guidelines and group practices will select quality measures for clinical improvement. The medical groups provide a ready accountability unit, although not clear what the carrots and sticks would be to generate better quality. *The author includes some elements of the quality continuum including developing quality standards in collaboration with physicians. Quality performance information will be disseminated to the public. The capabilities of the information system are not specified. There would not be a means to reward or offer preferential contracting to better performing providers.*	The proposal includes a number of quality of care initiatives including electronic data interchange, electronic patient records, physician performance data, development and tracking of standards of care/best practice standards in conjunction with clinical advisory groups, peer review of provider practices, public access to performance information and system to monitor results. *This author includes many of the elements of the quality continuum. Many of these have been successfully implemented, but they have never been collectively introduced at a system level. Given the complexity of this proposition, it is difficult to evaluate the effectiveness and likely impact of this approach.*	Status quo for quality. Existing quality improvement efforts in private and public programs would continue. Health plan could be the accountable entity for a quality improvement effort. *This proposal would not introduce new mechanisms for improving health care quality. Reliance on Medi-Cal and Healthy Families may positively influence quality of care since these programs have more mechanisms to track and monitor quality than is found in private coverage.*
Patient Education Proposal *Impact*	Will remove the third party intervention between doctor and patient. This may result in more open communication and better relationships between providers and patients. CHS would also use patient advisory groups in each community to set program objectives. Patient representatives are elected, paid and staffed. The Department of Public Health would be responsible for implementing public health programs with the Office of Community Health Services charged with community outreach and health education. A goal for clinician practices is to maximize patient involvement in treatment decisions. This is accomplished through consumer participation in setting quality goals, use of care coordinators and implementation of patient decision-making boards. *Improved outlook for patient/provider relationship. Author assigns public health responsibilities to a division of HHS responsible for direct service delivery which may result in integration of public health and direct health care services. Transition to salary based physician payment for physicians and budgets for facilities affords the opportunity for increased attention to population and public health approaches, however not clear how these changes might be triggered and organized. The Department of Public Health is given increased authority under the plan. Proposal does not finance behavior change interventions.*	Will remove the third party intervention between doctor and patient. This may result in more open communication and better relationships between providers and patients. Each county will have a consumer advocate office, a county health officer and regional boards of county health system stakeholders. A number of behavior change interventions are covered. Health planning could involve public health approaches to health care improvement. Health services budget includes funding for prevention and education. *Improved outlook for patient/provider relationship. Author funds increased investment in health planning and prevention and education. Proposal also finances individual behavior change interventions, which will likely increase use of these services. Budget based facility payment may provide new opportunities for population and public health approaches, including funding for training primary care doctors in population-health.*	Status quo for patient education. *Again, this proposal would not directly change or influence patient education and patient/provider decision-making in the health care system. Reliance on Medi-Cal and Healthy Families may positively influence patient education since these programs have more mechanisms to promote patient education than are found in private coverage. Continuation of managed care approaches throughout system will maintain existing intervention in the patient/provider relationship.*
Innovation *Proposal* *Impact*	Separate capital budget. Office of Reimbursement assigned to manage allocation process, although details not specified. *With use of capital budgets and approval process, along with presumed limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although other types (those linked to health goals) may be increased.*	Construction, renovation and major equipment would be financed by regional global capital budgets. Author states that maintaining the number and diversity of producers to encourage innovation research is a priority. System of public/private partnerships to incent innovation linked to health goals. *With use of capital budgets and approval process, along with limits on spending growth, this approach may reduce demand for and supply of some technologically advanced interventions, although other types (those linked to health goals) may be increased.*	Status quo for innovation and technology. No changes anticipated from this program.

	Brownstein	Brown and Kronick	Harbage
Preservation of safety net funding Proposal	No change to charity care funding except to count new MCEP enrollees in formula for DSH payments.	No change to charity care funding.	No change to charity care funding.
Impact	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase. MCEP likely to generate significant additional resources for safety net.*	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase.*	*Current mechanisms for charity care funding remain in place – presumption that resources available for each uninsured person would remain constant or increase.*
Contracting position of safety net providers Proposal	The contracting mechanism for MCEP will be quite similar to that for Medi-Cal managed care except that all enrollees residing in two-plan counties will be enrolled in the local initiative (e.g., they will not have the choice of a commercial plan) which contracts mainly with safety net providers. Local initiatives exist in 12 California counties covering more than half of the state's population.	No specified mechanism for contracting with safety net providers.	No specified mechanism for contracting with safety net providers.
Impact	*Safety net providers will have a highly favored contracting position under the MCEP program. Current favored contracting position of safety net providers in Medi-Cal/SCHIP remains.*	*Enrollees with employer-based coverage may not have access to safety net providers. Those in the public program will likely have access to these providers but there are no stated mechanisms to favor or prioritize them in the contracting process. Safety net providers' particularly advantageous contracting position under Medi-Cal would be eliminated since Medi-Cal will be merged with Healthy Families to form Healthy California.*	*Enrollees with employer-based coverage may not have access to safety net providers, unless employers choose the purchasing pool option. Current favored contracting position of safety net providers in Medi-Cal/Healthy Families remains.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Preservation of safety net funding Proposal	Eliminates most dedicated funding for charity care (DSH, Realignment, and state categorical programs such as Ryan White) and allocates these funds to expansions. Also eliminates county charity care funds "to the extent not needed for residual safety net services care" – but not clear how this is evaluated.	Eliminates DSH. Continues same level of payment per capita for state and county indigent care ($1,400).	For each uninsured person who becomes covered under the proposal, 70% of the funding for uninsured care (Realignment, county indigent care but not DSH) would be allocated to cover expansions.
Impact	*Significant reduction in the amount of dedicated funding available for charity care, although includes mechanism for evaluating whether funding still needed. The residual uninsured group likely to be very small.*	*Reduction in the amount of dedicated funding available for charity care but gauged to track decrease in uninsured.*	*Some reduction in safety net funding, but gauged to track decrease in uninsured.*
Contracting position of safety net providers Proposal	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position.	Safety net providers will have a favored contracting position since Medi-Cal's COHS plans and LI plans are among the few plans offered contracts.	Safety net providers will have a favored contracting position to some degree within the public program expansion since Medi-Cal offers preferential contracting to these providers.
Impact	*Safety net providers will not have a favored contracting position for new enrollees and will lose their current favored position under Medi-Cal and S-CHIP. This may result in a movement away from these providers.*	*Safety net providers will have a favored contracting position under the CHOICE program.*	*Safety net providers will have a moderately favored contracting position under this proposal.*

	Shaffer	Spelman	Wulsin
Preservation of safety net funding Proposal	Eliminates all, or nearly all (DSH, Realignment, county uninsured funds) dedicated government funding for charity care. Wraps this funding into financing for new coverage.	Eliminates all dedicated government funding for charity care. These resources wrapped into financing for Cal Care.	Increases federal match for current charity care funding. These resources (current spending and match) used to expand coverage. DSH as a source of uninsured funding is eliminated. Other sources of funding for uninsured services (Proposition 99 and Realignment) reduced proportionately with decrease in uninsured.
Impact	*Significant reduction in the amount of dedicated funding for charity care for any residual uninsured group. This group likely to be very small.*	*Elimination of dedicated funding for charity care for any residual uninsured group. This group likely to be very small.*	*Reduction in the amount of dedicated funding for charity care, but gauged to track decrease in uninsured.*
Contracting position of safety net providers Proposal	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position.	Safety net providers will likely be included in the networks/plans under the single payer system but will not have a favored contracting position. School clinics would be funded under Cal-Care.	Safety net providers will have a favored contracting position to some degree within the public program expansion since Medi-Cal offers preferential contracting to these providers.
Impact	*Safety net providers will not have a favored contracting position for new coverage and will lose their current favored position under Medi-Cal and Healthy Families. This may result in a movement away from these providers.*	*Safety net providers will not have a favored contracting position for new enrollees and will lose their current favored position under Medi-Cal and Healthy Families. This may result in a movement away from these providers.*	*Safety net providers will have a favored contracting position under this proposal.*

	Brownstein	Brown and Kronick	Harbage
Immigrants and ethnic minorities Proposal	Undocumented immigrants are covered. County plans will be responsible for cultural and linguistic services.	Undocumented immigrants not covered. No specific coverage of translation/interpretation service.	Undocumented immigrants can participate in CPPP. No specific coverage of translation/interpretation.
Impact	*Main advantage of plan is providing coverage regardless of immigration status. Those covered will benefit from linguistic services and capabilities of safety net providers in providing culturally competent services.*	*Undocumented immigrants likely to remain uninsured. Author states that part of the quality assurance role will involve assuring the availability of culturally competent services. Not clear how this will be accomplished. Lack of funding and reimbursement for translation/interpretation could be problematic.*	*Plan will provide coverage regardless of immigration status, although cost of coverage may still be barrier to immigrant enrollment. Lack of funding and reimbursement for translation//interpretation could be problematic.*
Persons with special health care needs Proposal	Care provided through managed care with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Not clear from description of benefits how comprehensive or rich they will be. Author does not include a disease management or care management approach for people with special health care needs. Out-of-pocket cap on cost-sharing. Plan payments are not risk-adjusted.	Care provided through managed care with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Disabled persons currently enrolled in Medi-Cal will transition from fee for service to managed care. Public enrollees meeting former Medi-Cal eligibility will retain Medi-Cal benefits. Others will have Healthy Families benefits. No out-of-pocket limit on cost-sharing in public program. Cost-sharing per status quo in private coverage. Option for PPO rather than managed care network for a higher price in HC. Plan payments are not risk-adjusted.	No specific provisions related to persons with special health care needs. Cost-sharing per status quo. Benefits will need to meet one of 4 benchmarks.
Impact	*Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.) within the MCEP and private coverage and continued variability of benefits in employer coverage may generally limit access to services for people with special health care needs. Poor and disabled protected by continuation of Medi-Cal and Healthy Families programs. No mechanism in MCEP to manage care of persons with special health care needs, although may be able to use the approaches already developed for Medi-Cal.*	*Disabled group transitioning to managed care may experience transition issues and potentially reduced access to services. Poor disabled protected by continuation of Medi-Cal benefits. Those enrolled in HC will benefit from disease and care management experience of Healthy Families contracted health plans. Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.), and variability of benefits in employer coverage may generally limit access to services for people with special health care needs.*	*Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.), and variability of benefits in employer coverage may generally limit access to services for people with special health care needs. Poor disabled protected by continuation of Medi-Cal and Healthy Families programs. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs.*
Rural populations Proposal	For MCEP fee-for-service maintained in rural areas that cannot support managed care and reimbursement rates improved from current Medi-Cal levels in these areas. Implementation through counties may allow for more sensitive and appropriate interventions to address rural health access issues. Provider access per status quo for those in private plans.	No particular provisions to address rural health care issues.	No particular provisions to address rural health care issues.
Impact	*The higher reimbursement rates and opt out from managed care for rural areas will address potential access issues for those in MCEP. Use of managed care in private coverage may exacerbate rural access issues. Lack of reimbursement for transportation could pose issues.*	*Healthy Families opts out of managed care in some rural areas. This will address potential rural access for those in HC. Lack of reimbursement for transportation could pose issues. For those in private coverage provider access per status quo in rural areas. Use of managed care in private coverage may exacerbate rural access issues.*	*Provider access per status quo in rural areas. Lack of reimbursement for transportation could pose issues. Use of managed care in private coverage may exacerbate rural access issues.*

	Kahn	Schauffler (CHOICE Option)	Schauffler (Cal-Health)
Immigrants and ethnic minorities Proposal	Undocumented immigrants are covered, along with translation services.	Undocumented immigrants are covered. No specific coverage of translation/ /interpretation service. Reliance on plans (including Kaiser) which author indicates have been effective providing culturally competent and linguistically appropriate care.	Undocumented immigrants are not covered by public program expansions but can participate in affordable plan offerings. Funding of translation/interpretation and services to assure culturally competent and linguistically appropriate care available for those in Medi-Cal expansion – but no assurances for those with other coverage.
Impact	*Main advantages of plan are providing coverage regardless of immigration status and reimbursing translation services. Acculturation to health system may be easier in single player health system.*	*Main advantage of plan is providing coverage regardless of immigration status. Lack of funding and reimbursement for translation/interpretation could be problematic.*	*Substantial subgroup of immigrants likely to remain uninsured because of limited mechanisms to cover them. New plan offerings may offer some relief, but would not be appropriate for persons with acute or chronic health car needs. Lack of funding and reimbursement for translation/interpretation could be problematic in private coverage.*
Persons with special health care needs Proposal	Patients can choose any provider. Comprehensive benefits and no cost-sharing. Budgets will be adjusted for case mix and to account for population need. Risk-adjustment to providers in groups, hospitals and IHDS. Managed care will be an option for patients through IHDS, but use of them not required.	Within CHOICE patients can choose any provider with no referral requirements for specialty care. Author envisions special disease management for those with certain conditions, presumably also allowing specialist primary care management. Patient incentives if disease management program maintained. Author does not specify what these would be. Cost-sharing waived or reduced for those participating in disease management programs. However, no out-of-pocket max and cost-sharing still per status quo for those remaining in public and private coverage. Dental benefits not covered. Capitation payments to plans will be risk-adjusted.	Author does not directly address this area.
Impact	*Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package particularly beneficial for persons with special health care needs. However, Cost-sharing may limit access to services for people with special health care needs. Depending on how implemented, requirement to document medical necessity may create barriers to services. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs. Risk-adjustment of budgets may disincent cherry-picking behavior and facilitate better care for persons with special health care needs.*	*Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Disease management will provide a care management mechanism for those with particular illnesses. Unclear how well this will work outside the framework of a health plan. Cost-sharing may still pose access issues for persons with special health care needs in employer coverage or those in the CHOICE program who do not participate in disease management. Depending on how implemented, requirement to document medical necessity may also create barriers to services. One group that may potentially be excluded from coverage are those who are near-disabled and unable to work. Lack of dental benefits has potential to be very problematic for persons with certain medical conditions such as HIV/AIDS. Risk-adjustment of budgets may disincent cherry-picking behavior and facilitate better care for persons with special health care needs. Poor disabled protected by continuation of Medi-Cal and Healthy Families.*	*Those enrolled in Medi-Cal and Healthy Families will benefit from relatively rich benefit package and disease and care management experience of contracting health plans. Status quo for all coverage groups for limits on access to specialists and services resulting from managed care. People with special health care needs face uncertain benefits and access in employer coverage, particularly if they opt for the new scaled back coverage option. Adults with special health care needs and incomes over 250% of FPL may remain uninsured. Potential barriers from cost-sharing. Lack of care management or disease management mechanism may create inappropriate or disjointed care for persons with special health care needs. Cost-sharing, managed care requirements (gatekeeping, preauthorization, etc.) and continued variability of benefits in employer coverage may generally limit access to services for people with special health care needs.*
Rural populations Proposal	Proposal envisions free choice of providers. Transportation not a covered service except for the disabled. Possibility to address rural health care issues by adjusting reimbursement rates.	No particular provisions to address rural access issues. Proposal envisions free choice of providers. Transportation not a covered service, except to the extent covered for Medi-Cal eligible population.	No particular provisions to address this area.
Impact	*Free choice and better reimbursement of providers will facilitate rural access, although provider distribution still potentially problematic. Lack of reimbursement for transportation could pose issues.*	*Free choice of providers and better reimbursement will facilitate rural access, although provider distribution still likely problematic. Lack of reimbursement for transportation could be problematic.*	*Lack of reimbursement for transportation could pose issues. Healthy Families and Medi-Cal opt out of managed care in some rural areas. This will partly address rural access.*

	Shaffer	Spelman	Wulsin
Immigrants and ethnic minorities Proposal *Impact*	Undocumented immigrants are covered. Translation and interpretation services not specifically covered, although author states that cultural competence in care delivery is an objective. Not clear how that will be pursued. Local and regional health planning functions are put into place. The Department of Health (including the Office for Multicultural Affairs and Office for Women's Health) has service delivery functions for special populations. *Main advantage of plan is providing coverage regardless of immigration status. Lack of funding and reimbursement for translation/interpretation could be problematic. With more organized care system and regional input and planning, potential to better match patient populations with services they need. Acculteration to health system may be easier in single player health system.*	Undocumented immigrants are covered. Translation a covered benefit. The author outlines an approach to improve cultural and linguistic considerations that includes adoption of standards including cultural competency training, availability of interpreters and translation of written materials. To address public charge fears, enrollee information would not be shared with the INS. *Main advantages of plan are providing coverage regardless of immigration status, covering translation and introducing a system-wide strategy for addressing cultural competency. Acculteration to health system may be easier in single player health system.*	Undocumented immigrants covered in the tax credit portion of the reform, but they cannot get coverage through the other components. Funding of translation/interpretation and services to assure culturally competent and linguistically appropriate care generally present in Medi-Cal. *Substantial subgroup of immigrants likely to remain uninsured because of limited mechanisms to cover them. Lack of funding and reimbursement for translation/interpretation in private coverage could be problematic. Author states that it will be important to deliver good, clear information to vulnerable groups and that plans and providers will need to improve language and cultural access. Not clear how this will be accomplished.*
Persons with special health care needs Proposal *Impact*	Specialists can provide primary care services for persons with complex conditions. Patients can choose any provider. Budgets will account for population need and case mix. Case managers/patient navigators will help coordinate care. *Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package and lack of cost-sharing particularly beneficial for persons with special health care needs. Possibility of primary care management by specialists. Direct access to specialty care unless redistribution and recalibration of specialty/primary care ratios or budget based interventions create more limited specialist access. No developed disease management program, although focus on coordination through case managers. Potential for better coordination of care by group practices.*	Patients can choose any provider, although presume that patients who choose an integrated delivery systems will need to remain in network. Author indicates that specialists can provide primary care for persons with special health care needs. Uniform and broad benefits and no cost-sharing. Budgets for facilities and integrated delivery systems (as well as global budgets) will be risk-adjustment. Risk adjustment methodologies outlined. *Free choice of providers will allow those with special health care needs to seek specialty as well as preventive care. Comprehensive benefit package and lack of cost-sharing particularly beneficial for persons with special health care needs. Possibility of primary care management by specialists. Specialist referrals may be needed in some cases. Lack of specialized care management or disease management approach for persons with special health care needs have potential to create inappropriate or disjointed care. Risk-adjustment of budgets may disincent cherry-picking by providers and facilitate better care for persons with special health care needs.*	Care for publicly insured and likely privately insured provided through managed care (except in rural counties) with attendant restrictions on access to services. Enrollees will likely not have direct access to specialists. Disabled persons currently enrolled in Medi-Cal will transition from fee-for-service to managed care. Plan payments are risk-adjusted in some if not all of Medi-Cal managed care program. Guaranteed issue for individual coverage. *Those enrolled in Medi-Cal and Healthy Families will benefit from relatively rich benefit package and disease and care management experience of contracting health plans. Disabled group transitioning to managed care may experience transition issues and potentially reduced access to services. People with special health care needs face uncertain benefits and access in employer coverage, particularly if employers adopt the minimum benefits (no dental or vision care) for tax subsidy eligibility. Adults with special health care needs and incomes over 133% of FPL may remain uninsured. Cost-sharing may still pose significant access barriers.*
Rural populations Proposal *Impact*	Mechanism to redistribute providers to achieve equitable geographic access. Local input through patient groups into health planning process. Proposal envisions free choice of providers. Transportation not a covered service. *Potential to improve rural access through redistribution of providers and health planning. Free choice of providers will facilitate rural access. Lack of reimbursement for tranportation could be problematic.*	Proposal envisions free choice of providers, although referrals may be needed for specialists. Transportation listed as a covered service. Author states that the distribution of provider and hospital service will be monitored, and financial incentives introduced to improve provider distribution. Weighted budget formulas can address rural service shortages. The proposal includes development of a referral system for people in rural areas. *Free choice of providers, weighted budgets and referral system will facilitate rural access.*	Proposal doubles the CMSP funding. *Provider access per status quo in rural areas. Lack of reimbursement for transportation could pose issues. Medi-Cal and Healthy Families opts out of managed care in some areas. This will partly address access issues. Additional funding for rural areas through increase in CMSP funds.*

Cross-Cutting Analysis of Coverage Reforms
Qualitative Analysis

Claudia Williams

AZA Consulting

Presented at the Final California Health Care Options Project Symposium

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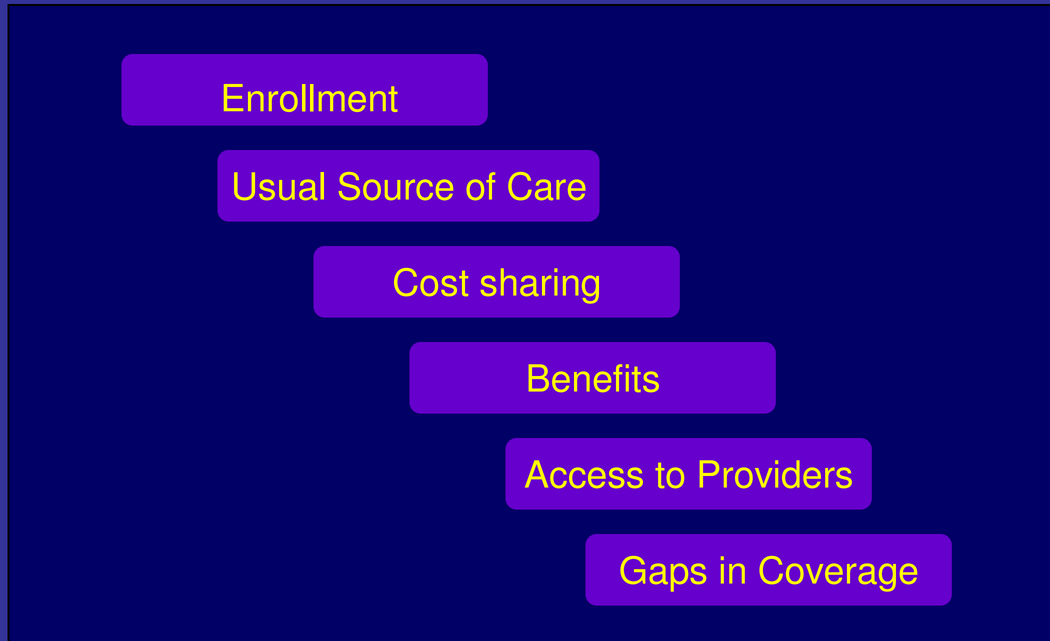
Analytic Framework

ACCESS TO CARE

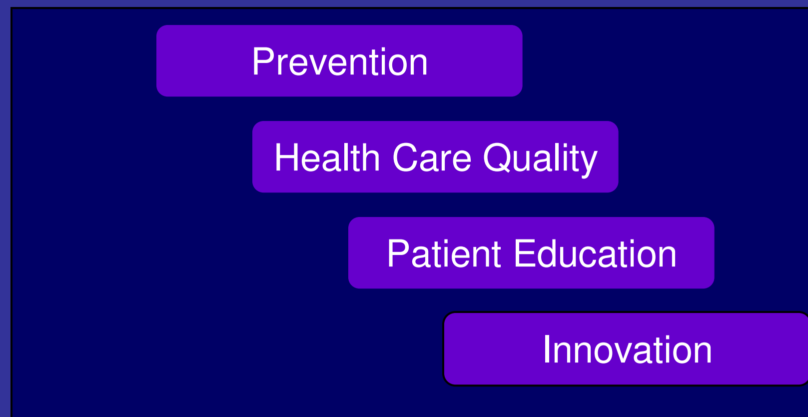


VULNERABLE GROUPS

- Immigrants/Minorities
- Rural Populations
- People with Special Needs
- Uninsured (Safety Net)

WHAT ACCESS?

QUALITY AND APPROPRIATENESS OF CARE



WHAT QUALITY?

For this analysis, reforms were sorted into two groups – "single payer plans" and "other reform approaches".

Two more comprehensive plans are grouped with other reforms but may have an impact comparable to single payer plans.

Single Payer Plans	Other Reform Approaches
• Kahn • Shaffer • Spelman	• Brown and Kronick* • Brownstein • Harbage • Schauffler (Cal-Health) • Schauffler (CHOICE) * • Wulsin

* Comprehensive plans

Impact on Access, Utilization and Continuity of Care

	Single Payer Plans	Other Reform Approaches
Ease of Enrollment	Single payer proposals tend to have simple one-time enrollment processes. Still, there is a modest risk of barriers to coverage depending on paper-work requirements and mode of enrollment. Unifies and simplifies overall coverage approach.	Complexity of enrollment varies in other reforms. Continuation of multiple coverage options is confusing and dampens enrollment. This poses less of a problem for proposals with single alternative to private coverage. Multiple enrollment iterations required.
Usual Source of Care	Coverage is the main predictor of having a usual source of care so proposals that expand coverage more will have a larger impact. In addition, approaches that provide continuous coverage will perform better in helping people maintain a medical home. Single payer plans are generally more likely than other types of proposals to produce continuous coverage.	

Impact on Access, Utilization and Continuity of Care

	Single Payer Plans	Other Reform Approaches
Benefits	Single payer plans offer broad range of benefits although with variability in offer of dental and vision care. Significant shift from status quo is the uniformity of benefits.	New coverage provided by other reforms offers broad benefits. Benefits in existing private and public coverage vary. Those at top and bottom of income scale have richer benefits than those in middle.
Point of Service Cost-Sharing	While any type of reform can include cost-sharing, most of proposed single payer approaches do not. These proposals eliminate risk of reduced utilization from cost-sharing.	Some proposals include point of service cost-sharing for new coverage. All retain varying degrees of cost-sharing in existing private coverage. Cost-sharing may lower use of services with greater impact on poor and sick.

Impact on Access, Utilization and Continuity of Care

	Single Payer Plans	Other Reform Approaches
Access to Providers	Single payer plans generally offer free choice of providers and large networks. Some, but not all, improve reimbursement rates.	Other reforms mostly rely on existing Medi-Cal or Healthy Families plans, which have reasonably broad networks but include limitations on access to specialists. Some, but not all, improve reimbursement rates.
Gaps in Coverage	With a unified approach to coverage, single-payer plans generally eliminate gaps in coverage resulting in better continuity of coverage and improved access to and continuity of care. All have one-time waiting period with access to care in interim.	Because of multiple, intersecting paths to coverage gaps remain for most other proposals. These are partly addressed in some plans by 12 months continuous coverage, high-income cut-offs and short waiting periods

Impact on Quality and Appropriateness of Care

	Single Payer Plans	Other Reform Approaches
Preventive Care	All single payer plans cover preventive services with no cost sharing. Some plans shift resources to preventive care by changing provider mix and providing incentives for delivery of preventive services.	All cover preventive care services and most exempt from cost-sharing. These proposals do not generally include strategies to shift resources to preventive care.
Health Care Quality	Critical advantage of single payer plans is opportunity to standardize data collection and quality measurement. These plans also have leverage for value-purchasing and to develop organizational incentives. Proposals pursue these opportunities to varying degrees.	These proposals tend to continue current quality measurement efforts, but do not make major advancements in data collection and information technology or value-based purchasing. There is a lack of an accountable entity in some proposals.

Impact on Quality and Appropriateness of Care

	Single Payer Plans	Other Reform Approaches
Patient Education	Single payer plans may provide increased autonomy for physicians and their patients. These proposals introduce more community involvement and health planning, but do not necessarily increase public health approaches or reimbursement for behavior change.	These proposals make few changes to existing patient education and behavior change approaches. Some proposals do not rely on managed care – resulting in more physician autonomy.
Medical Innovation	With use of capital budgets and approval process, along with limits on spending growth, single payer plans may reduce demand for and supply of some technologically advanced interventions.	These proposals do not generally alter technology reimbursement and competition and therefore will not change current patterns of technology development and diffusion.

Impact on the Safety Net

	Single Payer Plans	Other Reform Approaches
Funding for Safety Net	Mostly, single payer plans eliminate targeted charity care funding creating potential access issues for residual uninsured group. Future of safety net providers unclear, but with small residual uninsured group less need for dedicated providers.	Most scale back charity care funding, although some leave funding unchanged. Greatest risk posed by proposals that greatly reduce funding but retain large residual uninsured group.
Contracting Position Of Safety Net Providers	Generally, single payer plans offer no preferential treatment for safety net providers. At least one proposal relies on the Medi-Cal provider infrastructure, which favors safety net providers.	Other reforms vary greatly from plans that rely only on safety net providers to those that would expand in private sector with no prominent role for safety net providers. Some rely on Medi-Cal and Healthy Families, which favor safety net providers.

Impact on Vulnerable Groups

	Single Payer Plans	Other Reform Approaches
Immigrants and Ethnic Minorities	No clear difference by proposal type. Most proposals provide some coverage for undocumented immigrants. Most do not provide special reimbursement for translation/interpretation or other needed services. In certain cases, providers are required by law to provide these services. There is no blueprint to establish culturally competent and linguistically appropriate care at health care system level.	
People with Special Health Care Needs	Single payer plans generally include ready access to specialists, covered services without cost sharing and few managed care requirements. It is unclear how care will be coordinated and managed without managed care or some other entity to organize health care delivery.	Proposals that build on employer-based coverage raise concerns regarding cost-sharing without caps, variable benefits, and uncertain access to specialists. It is unclear how care will be coordinated and managed without managed care.

Impact on Vulnerable Groups

	Single Payer Plans	Other Reform Approaches
Rural Populations	Single payer plans offer the potential to address underlying workforce supply issues through direct intervention in placement of providers. The lack of managed care and referral requirements facilitate rural access. Non-emergency transportation not necessarily funded. Low reimbursement still an issue in certain cases.	Other reforms have little impact on rural access issues except possibly through less reliance on managed care in some proposals. Non-emergency transport not funded. Low reimbursement still an issue for some proposals.