



Continuing California's Commitment to the Remaining Uninsured

A Concept Paper on Extending County Low-Income Health Programs (LIHPs) to Provide Safety-Net Coverage for the Remaining Uninsured in California

EXECUTIVE SUMMARY

With the historic expansion of new coverage, the Affordable Care Act will reduce the number of uninsured by half to two-thirds—but as many as 3 to 4 million Californians will be left uninsured.

The majority of the remaining uninsured will be citizens or legal residents, who will be disproportionately Latino, African American, and Asian-Pacific Islander. Some will not be eligible due to income or immigration status, for missing open enrollment periods, or due to other gaps in the law.

This concept paper provides a framework on how to continue California's commitment to the remaining uninsured as the ACA is implemented, preserving our state's safety net of public hospitals, community clinics, and other key health providers, in a transparent, accountable, and fiscally responsible way.

Health Access Concept Paper

May 8, 2013





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Extending County Low-Income Health Programs (LIHPs) to Provide Safety-Net Coverage for the Remaining Uninsured in California

EXECUTIVE SUMMARY (CONTINUED)

California is at a pivotal moment in the next few weeks in deciding how we care for all our residents and families, including the insured, the newly covered, and the remaining uninsured.

- The implementation of the Affordable Care Act provides opportunities and challenges for the safety-net of public hospitals, clinics, and other providers.
- As a condition of Medi-Cal expansion, Governor Brown is insisting on a state-county realignment, one that threatens resources for the existing county safety-net and the remaining uninsured.
- A key innovation in delivering safety-net services better over the past few years—The Low-Income Health Programs—is set to expire at the end of this year without legislative action.

This paper proposes an approach to reassessing the state-county relationship on caring for the medically indigent while maintaining California's commitment to the remaining uninsured, and preserving needed capacity and infrastructure in our health care system.

We propose we continue and extend the LIHPs to the remaining uninsured. In order to have a strong health care system for all Californians, including those excluded from the ACA, we propose the following.

- Fully implement Medi-Cal expansion statewide, get the benefit of the federal funding that comes with it, and reduce the number of uninsured overall, as soon as possible.
- Preserve the state dollars that go to county health for 3 years, during peak demand for services by the newly insured, and when the newly eligible are 100% federally funded.
- Encourage counties to preserve and extend the LIHP infrastructure for the remaining uninsured.
 - After 3 years, maintain half of these "realignment" funds for public health, but tie the remaining portion of state funding to enrollment in the LIHP-like coverage programs.
 - Counties that show continued demand and commitment would continue to get these funds, while allowing the state to claim savings if and when the needs of the uninsured are reduced—but at a pace that is a data-driven.

A success story, LIHPs in 53 counties now cover over 550,000 otherwise uninsured Californians, virtually all of whom will become eligible for full Medi-Cal on January 1, 2014. While not full coverage, LIHPs offer more than episodic and emergency room care for the uninsured, providing a medical home with primary and preventative care services. Instead of letting the LIHPs expire, California should extend the LIHPs to the remaining uninsured—both continuing our commitment to all Californians, and using our dollars in the most effective and efficient way. This unique opportunity represents a viable way to fulfill the goal of providing access to care and coverage to Californians regardless of income or immigration status.

Introduction

The Affordable Care Act is the biggest expansion of health coverage in two generations, potentially reducing the number of uninsured by one-half to two-thirds, according to the Congressional Budget Office. Decisions made in Sacramento this year will determine how successful we are in enrolling as many Californians in coverage, and reducing the uninsured population, as much as possible. But in the best-case scenario, with millions of Californians newly insured and millions more with improved benefits and other consumer protections, [University of California CalSIM models estimate](#) that there may be three to four million remaining uninsured in our state.

The remaining uninsured is acknowledged by Governor Brown in his [Budget Summary](#):

The state will also need to consider how these changes would impact the remaining County obligations to provide care to those individuals who remain uninsured as well as public health programs.

The Legislative Analyst Office in its February 2013 "[Examining the State and County Roles in the Medi-Cal Expansion](#)" also recognizes the ongoing responsibility of counties to the remaining uninsured, but also suggests that if the Affordable Care Act now covers some (but not all) of the currently uninsured, some reassessment of state and county responsibilities and related funding is in order.

This conversation shouldn't be about just state-county financing or responsibilities, but the central question: *What is our commitment to, and how do we provide access to care for, the remaining uninsured?* California has a history and infrastructure to help in addressing the needs of the uninsured, from county safety-net systems to public hospitals and community clinics to the more recently created Low-Income Health Programs (LIHPs). California's implementation of the Affordable Care Act provides the opportunity to take advantage of these assets into the future.

The Remaining Uninsured: Who Are the Remaining Uninsured?

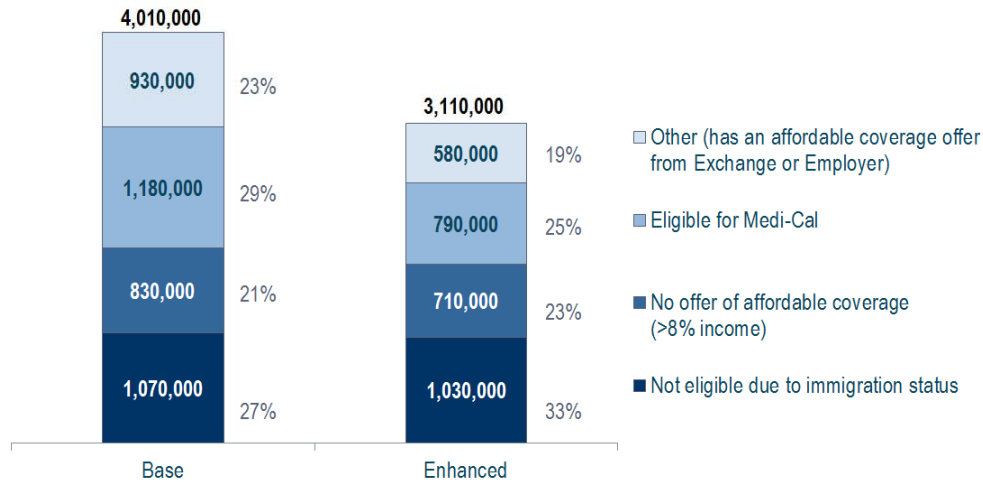
Recent estimates by a research team at [UC Berkeley](#) and [UCLA](#) indicate that there will be three to four million remaining uninsured, even after the first five years of ACA implementation in 2019.

	Base		Enhanced	
	Individuals	Percent of Remaining Uninsured	Individuals	Percent of Remaining Uninsured
Undocumented	1,073,000	28%	1,033,000	34%
Eligible for Medi-Cal or Healthy Families	1,130,000	29%	743,000	25%
Eligible for Exchange Subsidies	782,000	20%	429,000	14%
Eligible for Exchange without Subsidies	883,000	23%	820,000	27%
400% FPL or less	226,000	6%	211,000	7%
Greater than 400% FPL	657,000	17%	609,000	20%
Total	3,862,000		3,025,000	
Remaining uninsured exempt from individual penalty		54%		56%

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

3-4 Million Californians are Predicted to Remain Uninsured in 2019

Uninsured Californians under age 65, 2019



Source: UC Berkeley-UCLA CalSIM model, v1.8

The “uninsured” are not a single, static population: instead the uninsured include diverse populations, some of which churn on and off coverage. About half are uninsured for less than six months, and others are long term uninsured. The remaining uninsured includes:

- Around 1 million according to the UCLA California Health Interview Survey and the CalSIM model, will be undocumented Californians, who were expressly and unfortunately excluded from subsidized coverage or participating in the Exchange by the federal law. The undocumented, now about 20% of the uninsured, will be 27-33% of the remaining uninsured. Depending on decisions regarding immigration reform, many may be on a “path to citizenship” but excluded from federal help with coverage.
- The majority of the remaining uninsured will be citizens or legal residents.
- About a fifth to a quarter will be exempt from the individual mandate for reason of lack of an affordable coverage option.
- Some of the remaining uninsured will be family members of workers with job-based coverage, but who don’t get or qualify for family coverage or Exchange subsidies. (This has been known as the “kid glitch” or “family glitch.”)

- Because of the barrier to individual insurance coverage created by open enrollment periods, some individuals will fail to take up coverage during the open enrollment and will need care when they lack coverage.
- Even with special enrollment periods, some will drop off coverage during transitions in life and work, not sign up for new coverage in time, and need care before the next open enrollment period.
- Some will be eligible for Medicaid, but find it hard to complete the application, including with verification of income and immigration. Some will be homeless individuals and/or people with significant mental health and substance abuse needs, who may have issues in documentation or otherwise in going through the Medi-Cal eligibility process.
- Some will not get the word about the new options for coverage no matter the extent of outreach and education efforts.

Demographically, the remaining uninsured will be disproportionately from communities of color.

These are not mutually exclusive categories and some of these populations overlap. It is worth thinking about the uninsured in different ways because there will be different solutions for different populations and to reach some people, it may take multiple avenues to get them care, if not coverage.

Determining the cost of care for the remaining uninsured is not an easy task. We offer a rough estimate based on publicly available information. More careful analysis might result in an estimate that is higher (because of health status and deferred health needs of the uninsured) or lower (perhaps because the remaining uninsured are younger or otherwise healthier, and many would be eligible but not enrolled). Estimates of the remaining uninsured by CalSIM v.1.8 (see above) range from roughly 3 million to 4.5 million, depending on the aggressiveness of enrollment efforts, and the time it may take to find and enroll Californians in coverage. Under a low level of enrollment, California is estimated to have 4.5 million uninsured in 2014. Under an enhanced level of enrollment, there would be 3.7 million uninsured, and it would down to 2.9 million in 2016.

Those who would not be offered or eligible for affordable coverage options, by reason of ineligible status or income or immigration or other reasons, are estimated to be in the 1.4 to 1.6 million category. In addition, while many of the eligible but enrolled would be able to get signed up when they needed safety-net care, some might continue to experience barriers: we would assume that providers will attempt to enroll those who are eligible but will not always succeed in completion of an eligibility determination.

Any back-of-the-envelope estimate to cover this population with commercial or even much cheaper Medi-Cal coverage would be more than what is estimated to be spent now by counties. What counties spend now was artificially constrained in 1982 when counties accepted responsibility for medically indigent adults at 70% of what the state spent at that time with no cost-of-living adjustment (COLA) for future cost increases. While the 1991 realignment and 2001 State budget provided some relief, neither was intended to fully fund the needs of the uninsured.

The State Controller's office states that counties currently receive around \$1.4 billion in health realignment dollars, to fund safety-net services as well as crucial public health functions. The Governor's budget estimates that counties now spend \$3 to \$4 billion on care for the uninsured in total, although other estimates suggest that figure is significantly lower.

This calls for being cautious in reducing funding to counties in their ongoing responsibility to care for the uninsured, but also to be as efficient and effective as possible with those funds.

The Governor's proposal seeks to shift risk and costs of the Medicaid expansion in the Affordable Care Act to the counties, either by mandating the counties to implement the Medicaid expansion themselves (however unworkable that might be), or by having the counties accept additional human services responsibilities as part of a new realignment. A third, unstated alternative is for the State to re-evaluate and revise the current funding formula to claim a portion of these funds that go to counties to serve the medically indigent.

The Massachusetts Experience:

The severity of the uninsured crisis in California suggests that short-term savings will be hard to come by. While Massachusetts started its health reform efforts in a very different place than California, its experience is instructive. The 2006 Massachusetts health care reform law reduced, but did not eliminate, uncompensated hospital care. Massachusetts has an uncompensated care pool that reimburses hospitals for inpatient and outpatient care to the uninsured below 400%FPL.

In Massachusetts, as coverage expanded after 2006, the number of emergency room visits and outpatient care paid by the uncompensated care fund was cut in half, but not eliminated—even as the uninsured rate dropped by 80%. This is in the context of a state that started with half as many uninsured as well as a better-funded health care system and a much better-funded safety net for the remaining Medicaid population and the remaining uninsured.

Public Health:

A portion of the realignment funds counties get from the state are intended to support public health—from the tracking of diseases to the broader preventative efforts against tobacco use, youth smoking, teen pregnancy, and much more. This also includes the new efforts that the Affordable Care Act encourages, centered around community transformation grants to encourage walking and active lifestyles, to promote healthy eating, and to engage in other efforts that are policymakers' best shot at improving health and reducing health care costs.

With the new framework and opportunities under the Affordable Care Act, shifting resources away from crucial community health prevention activities could mean the counties could not only lose emergency preparedness capacity, but also lose opportunities for federal funding and advancing key public health

goals. In fact, this is the best time to increase investments in public health and leverage federal dollars and support.

Built Safety-Net Provider Capacity:

Many counties operate public hospitals and county outpatient clinics, support services through contracting with community clinics, and other built infrastructure and capacity with costs that remain in place even with a reduction in the uninsured. The doctors, nurses and janitors still expect to get paychecks, the energy bills still need to get paid. The hope is that the newly insured will continue to come to key safety-net providers, now as paying customers.

But there are real risks to the safety-net in this transition, from what happens if fewer than expected Californians are enrolled in the new coverage under the ACA, to the broader issue of what happens if the newly insured enrollees shun these safety-net providers. The expected sharp increase in the newly insured means, at the very least, that California will need all the capacity it can muster in the first few years of transition, starting in 2014. The ACA does make some investments for long-term development of capacity, and market forces will determine if public hospitals and community clinics are providers of choice and viable in the long term, but there is a public policy interest in ensuring the vitality of these safety-net providers in this transition.

Other Major Cuts to the Safety Net:

The federal government, which is funding 90-100% of the cost of the newly eligible in Medi-Cal, has already made its claim for any Medi-Cal savings. The Affordable Care Act, in order to help pay for the Medi-Cal expansion, reduced payments to DSH (Disproportionate Share) Hospitals by half (\$10 billion nationally) over the next several years, which is currently used to help cover uninsured costs. Public hospital systems in California receive the bulk of the DSH funding and having the state also claim additional county health resources that is also essential in caring for the uninsured would be further destabilizing on an already fragile system.

Timing:

A key variable in any negotiation between the state and counties is timing. If the state is asking counties to absorb the cost of the newly-eligible, that cost is zero for the first three years of ACA implementation, from 2014-16. As counties learn from their ACA experience and understand what savings (if any) materialize after the federal DSH cuts, they will be more prepared to engage in a process to shift appropriate level of funding and/or realignment over the course of several years, scheduled for 2017 and beyond, as the work of implementation the ACA busily continues.

For all these reasons, Health Access supports an urgent implementation of the Medicaid expansion—and that California needs to preserve the funding going to county health care in the crucial transition years. If there is a reduction, it should be timed to when the state begins a share of cost, and tied to what is actually happening on the ground in terms of enrollment and ongoing demand for safety-net services. We propose

that the continued use of Low-Income Health Programs for the remaining uninsured offer a convenient and policy-based way to help make such calculations.

LIHPs: Preserving This Innovative California Asset for Our State

When considering the uninsured today, California has a lot to be proud about in our adoption of the Low Income Health Programs (LIHPs)—and that work should be continued past 2014.

A California Success Story:

Today 53 counties (out of 58) provide access to care for uninsured “medically indigent adults” through a Low Income Health Program (LIHP). More than 550,000 uninsured Californians now have access to care through these programs. While these LIHPs provide more limited benefits and more limited access to providers than either Medi-Cal or commercial insurance, they are a significant step up from traditional safety-net care that all too often provides only emergency and episodic care.

Counties and LIHPs Are Not a Vehicle for Medi-Cal Expansion:

The Governor’s proposal suggests the possibility of using the county LIHPs as the vehicle for the Medicaid expansion, in lieu of a full statewide Medi-Cal expansion. Every analysis to date suggests this is unworkable. It took over two years to get 53 counties up-and-running, at various stages of eligibility and capacity. Five counties still refuse—making it unlikely a county-based Medicaid expansion could really be statewide. Moreover, every LIHP in the state would have to scale up and transform to meet the new federal guidelines—in areas from eligibility, enrollment process, network adequacy, and more. To have 58 counties go through these major changes simply couldn’t happen by later 2013, and likely not even for a while after. Finally the county-based Medi-Cal expansion would be separate from and not integrated with the statewide Medi-Cal program which currently has over 7 million enrollees, causing additional logistical issues. For all these reasons, the only viable choice is a statewide Medi-Cal expansion, not a county-based option.

Same Infrastructure, New Purpose:

A statewide expansion should result in virtually all the 550,000 (or more by December 2013) people covered by LIHPs being shifted into state-administered, federally funded Medi-Cal on January 1, 2014. Without any other action, these Low-Income Health Programs, and California’s investment in them, could disappear.

As those newly eligible for Medi-Cal get shifted into full coverage, the Low-Income Health Programs have a crucial role to play after January, redirected to provide access to care and coverage for the remaining uninsured. The LIHPs provide a medical home, preventative and primary care services, coordination of care, and financial security—all grounded in the county’s safety-net. Similarly, Healthy San Francisco provides an existing model that is not health insurance coverage but that provides access to care with a more limited set of benefits and a more limited network of providers than required for insurance coverage. The LIHPs and Healthy San Francisco are in effect self-insured by the counties which offer this access to care.

Through two Medicaid waivers, whether the approach has been called “Coverage Initiatives” or “Low-Income Health Programs (LIHPs),” California has fostered a new and more efficient and effective way to provide safety-net services. These systems of care recognized the value and cost-effectiveness of providing a medical home, but also grounding this relationship in the county’s safety-net.

The creation of the LIHPs reflects an investment in infrastructure of access to care for the currently uninsured. Rather than lose this investment on January 1, 2014, we propose that it be redirected to serve the remaining uninsured as many of those currently enrolled in the LIHPs transition to Medi-Cal or Covered California in 2014.

One part of addressing the needs of the remaining uninsured would be for the counties to continue to operate the Low Income Health Programs to provide access to care for the remaining uninsured. Health Access proposes this as an alternative to those proposals in the Governor’s budget.

Under this proposal, the state will encourage counties to continue their Low-Income Health Programs, for the purpose of serving the remaining uninsured, but have the LIHPs financed through existing county realignment dollars as well as other county health dollars. The more people the counties enroll in LIHPs, the more money the counties can get from the state for their safety-net and economy, within the constraints of the budget of existing realignment dollars.

It is important to note that some of the existing county-based programs already serve some individuals who are not anticipated to be covered through Medi-Cal or Covered California. For example, CMSP estimates that 20% of their current enrollees will remain after January 1, 2014. Healthy San Francisco, Healthy Way LA and other county-based programs also serve uninsured Californians who may not be eligible for or who may not enroll in coverage on January 1, 2014.

Finally, none of us know how quickly the uninsured who are not enrolled in LIHPs will take up coverage through Medi-Cal, Covered California, an employer or other sources. California’s experience with Healthy Families was that take-up was low and slow: many steps are being taken to assure that this experience is not repeated but we literally do not know how rapid take-up will be.

All counties should maintain some minimum funding for their public health efforts and basic safety-net infrastructure. By having a portion of state realignment funds tied to LIHP enrollment, this policy acknowledges where there is greater or less demand for care by the uninsured, or where counties have more restricted enrollment criteria. If and when increased enrollment efforts and changes in health and immigration policy reduce the number of uninsured, LIHP enrollment can serve as a useful metric to gauge continued demand for safety-net services, and to indicate if/when the state can claim savings from a county, or if/when that county needs to retain all or most of these safety-net funds.

In counties that do little for the uninsured or that adopt restrictive policies of based on income or immigration status, or other exclusions of the remaining uninsured from access to care, the state should use some of these resources to direct such resources to funding of community clinics, health centers, and non-county safety-net providers in counties where there are gaps in access. This could possibly use current or previous funding streams like EAPC for community clinics. If a county for policy or political reasons is not

going to cover all the remaining uninsured, then setting aside a portion of county realignment dollars to go directly to such providers is a backstop.

How Should California Provide Care for the Remaining Uninsured? Continuing California's Current Commitments

Our proposal establishes California's commitment to the remaining uninsured, allows for some state savings in future years, but that secures enough resources for a safety-net that survives and thrives, and provides for more accountability and transparency with regard to safety-net resources.

Health Access proposes the following elements of a solution for the remaining uninsured:

1. Confirming that California is undertaking a statewide Medi-Cal expansion, under the Affordable Care Act, along with an aggressive effort to enroll as many Californians as possible.
2. Preserving the state realignment dollars for the first three years, in which the federal government is funding the expansion at 100%, would allow for capacity building to meet the needs of the newly insured as well as the remaining uninsured during this peak.
3. Keeping those state dollars should be contingent on a maintenance of effort requirement to assure counties continue to spend at least what they are spending now, including their own county dollars, on the remaining uninsured, public health and related health needs.
4. Encouraging counties to redirect existing Low Income Health Programs to serve the remaining uninsured; Counties would be encouraged to maintain their LIHP-like or Healthy San Francisco-type programs using these state realignment dollars.
5. Ensuring, after three years, half of state realignment funds continue to go to counties to perform public health functions, as envisioned in the original 1991 realignment, as well as base 17000 safety-net responsibilities.
6. Linking the remaining portion of this funding stream to LIHP enrollment, so counties are funded in line with the demand and their commitment. The first three years provide time when counties have the opportunity to build their enrollment back up, but then the state can yield savings as the ACA is implemented and overall demand goes down.
7. Allocating some state savings to support safety-net institutions through a state funding stream.
8. Instituting accountability and transparency into the state-county relationship going forward.

Our Proposal:

No shift of funds away from counties makes sense without an assessment of whether the remaining funds are sufficient to provide care to the remaining uninsured, as part of a better understanding of the impact of health reform on counties. The counties should not get a blank check, however—there needs to be much greater accountability for these funds, and we propose that a portion of funding should be conditional on providing actual care and/or coverage.

1. Expand Medi-Cal Statewide: Reduce the Number of Uninsured Dramatically

Assuming the Medi-Cal expansion is statewide, counties will still have a crucial role in the enrollment—ultimately to reduce the number of uninsured.

As advocates, our first choice is that those who are eligible for coverage should be enrolled in that coverage. We support the efforts to further streamline and simplify the enrollment process in Medi-Cal and Covered California, as proposed in pending bills in the current legislative special session.

Since counties have a vested interest in enrolling individuals in Medi-Cal, counties should support enrollment activities, including funding the non-federal share of match for application counselors. Covered California, will fund navigators and insurance agents. While the ACA dedicates federal Exchange dollars to be used for the Exchange population, the state and counties should invest in helping enroll Medicaid eligible Californians.

Especially in 2013, the counties should put up the non-federal share of match for application counselors to help enroll those Californians who are or will be eligible for Medi-Cal to enroll in that program. With such efforts, California can achieve mass enrollment on January 1, 2014. In 2014 and beyond, counties will continue to have an incentive to do outreach, and at the least to screen all who come to an emergency room, public hospital, clinic, or otherwise for enrollment in coverage. The more Californians enrolled, the fewer remaining uninsured—and the more federal dollars come into the health system and economy of California and our counties.

2. Capacity Building: Use the First Three Years to Build Capacity

In 2014, 2015 and 2016, the federal government will fund 100% of the cost of the expansion population. These are precisely the years when the strain on the capacity of the health care system to serve the newly insured will be greatest. As such, we propose that these \$1.4 billion from the state for county health continue to fund county health services.

Many of the newly insured live in areas that have historically been underserved for health care. This is not a surprise: doctors, hospitals and other providers locate where there are paying customers. The uninsured get less care in a less timely manner: when they become insured, they have pent-up demand for care.

Upcoming UCLA research suggests this beginning burst of demand does decrease and moderate over time, but this suggests the need to be at top capacity for the first two-three years.

The 1115 waiver included DSRIP funding to help county hospital systems build their capacity. The Affordable Care Act included funding for community clinics to build capacity. CMS has invested in provider network and infrastructure development for primary care, specialty care, behavioral health and medical homes.

California will need that capacity, and more, to deal with the demands of the newly insured as well as the remaining uninsured in 2014 and beyond. Whatever realignment or reallocation is agreed to, we propose that it doesn't take place for a few years, to allow for the safety-net to have the resources to address the pent-up demand. Even in shifting DSH dollars to pay for the Medicaid expansion, the ACA recognizes that it should wait for a few years before claiming any savings. President Obama's proposed federal budget recommends delaying those scheduled cuts for another year, to further assess how enrollment and implementation is proceeding.

In 2017 and future years, the state will face a share of cost for the Medi-Cal expansion population, increasing from 5% to 10% in the year 2020, and so the state's desire for savings increases then. At the same time counties with public hospital systems will begin to experience the most significant federal DSH cuts. With all these variables, it would be hard to come up with a justifiable number for reallocation at this early date—what this proposal allows both the state and counties to get a better understanding of the impact of reform in the next three years, and provides a metric to claim state savings in 2017 and beyond.

3. Maintenance of Effort for Health, for Both the State and the Counties

Health Access supports maintaining the existing dollars for medically indigent care, and keeping health care dollars in health care, not allowing counties to use these dollars for other needs. The first element of our proposal is that if counties keep their state health care realignment dollars, there should be a maintenance of effort requirement which requires that at a minimum, counties spend on health care at least what they are spending now of their current dollars. Counties can't argue to keep all state funding if they claim savings from county health funds.

This proposal allows that if the actual demand goes down, the opportunity for savings by the state and counties goes up. If a particular county discovers that it has met the needs of the remaining uninsured, it would be appropriate to consider redirecting these dollars. Given the experience of counties like San Francisco and San Mateo as well as states like Massachusetts that have tried hard to meet the needs of the uninsured, we expect that even the most active counties will need several years to address unmet needs of the uninsured.

4. Redirecting the Low Income Health Programs to Cover the Remaining Uninsured

Counties would be given the option and encouragement to continue their Low Income Health Programs for the remaining uninsured. While not the comprehensiveness or expense of full coverage, the LIHPs would continue to be a more efficient and effective way to provide care, including primary and preventative services, than the emergency and episodic care of a traditional safety-net.

The counties would fund their LIHPs with their health realignment dollars and their own resources—no federal dollars would be available. If this proposal is adopted, California can explore if the next Medicaid waiver might seek some federal support for these populations. With more limited dollars, the focus is on providing cost-effective care and treatment beyond just emergency or episodic care. The Low-Income Health Programs would still continue to enroll people in a coverage-like plan, one with a medical home, and access to preventative and primary care.

5. Ensuring a Portion of Funds for Public Health

Counties would have the three years of continued funding to work to enroll their residents in Medi-Cal or Covered California, invest in infrastructure, and ultimately to build up enrollment in Low-Income Health Programs. After that period, we propose that a portion existing funding would be guaranteed for continued public health work and basic services. Consistent with the 1991 realignment that 54% go for public health services, we propose that perhaps half of the \$1.4 billion of these county health dollars should be guaranteed for public health. There should be a recognition in any formula of the obligation for public health, as well as meeting basic 17000 safety-net obligations.

6. Linking Funding to LIHP Enrollment, A Metric for State Savings and County Continuation of Funding

The rest of the \$1.4 billion in county health realignment funds would be dependent on enrollment in a LIHP or coverage-like LIHPs such as the unmatched Healthy Way LA or Healthy San Francisco programs.

Basing continued funding on enrollment provides a metric for both the actual demand and for a county's commitment to serve the remaining uninsured. Some counties may have a lower enrollment given the lack of demand in a given area, as the number of uninsured is reduced. Other counties may have a tight eligibility requirement in terms of income; may exclude the undocumented, or decide not to set-up or continue its LIHP. In these cases, where the demand or the commitment is shown not to be there, the state will claim more savings as a result.

Under this structure, no county is mandated to set up a LIHP, or to cover the undocumented, or do anything beyond their basic 17000 obligation. This sets up no additional entitlement for the state or counties. But it provides the support for counties who meet this commitment now including those with built infrastructure like public hospitals and clinics, and provides the financial incentive for those counties who want to serve this need in their community. No federal funds means more flexibility for counties, especially in eligibility and enrollment. Counties could go over 200% of the poverty level, putting in place a modest premium and cost-sharing structure for those individuals and families, like Healthy San Francisco.

This structure also serves the important policy goal of recognizing the difference in counties, their populations, and their different approaches to health care. In contrast, the Governor's proposal to realign a human service like child care or CALWORKS would treat disparate counties the same, even if their uninsured populations are markedly different sizes, if they are making progress on reducing the uninsured rate at different paces, and if they make very different commitments on health care in general. In the tradition of subsidiarity, this approach in this concept paper appropriately adjusts to the local circumstance.

7. Ensuring Basic Support for the Safety-Net Statewide

This proposal suggests a way to allow for state savings, meet the needs the remaining uninsured, and invest the local safety-net to serve this function. Rather than a statewide program to serve the remaining uninsured, a county-based approach would use existing infrastructure and ensure it was grounded in the local safety-net.

But by not explicitly mandating participation in a LIHP, there needs to be a California commitment to support the safety-net statewide. For counties that choose not to set-up or continue a LIHP, the state will get savings--and a portion of those state savings should go to support statewide safety-net funding streams to ensure some help for the remaining uninsured, targeted in reluctant counties.

California has had funding streams for community clinics and health centers, including Expanded Access to Primary Care (EAPC), Rural Health Services, Seasonal Agricultural Migration Services, and Indian Health Programs that have served to support safety-net providers of the uninsured, and a portion of any state savings should go to those or similar program. While we prefer that counties take this responsibility and commitment (it would be better for them financially, and it would provide a better medical home for their residents), California should have a basic commitment to a safety-net throughout the state.

8. Accountability and Transparency

The role of the state and counties would be clearer under such a plan. If counties are keeping these resources, healthcare advocates want to know that the money is meeting a tangible need, and the resources are going to health care, whether public health, or a medical home for Californian who remain uninsured.

This paper aligns with the Brown Administration proposals to move away from episodic care and encourage medical homes and integrated care approaches—as stated in the Let’s Get Healthy California Task Force goals, and in the ongoing work to shift seniors and people with disabilities into Medicaid managed care.

This proposal ensures the stated Brown Administration goal that government “not pay for the same person twice.” Enrollment in LIHPs would only occur if people are found not to be eligible for Medi-Cal, Covered California, or other coverage options—it would be a real indicator of the actual demand for continued safety-net services.

After the first few years, this proposal is likely to yield state savings to help with the out-year costs of the newly covered in Medi-Cal, but in a balanced and data-driven way that acknowledges the needs of the uninsured as well.

These goals are advanced while, in the spirit of subsidiarity, allowing counties flexibility to craft a LIHP that meets the values and needs of its residents. County realignment dollars come with increased accountability and transparency, but still allowing county variation and experimentation, while ensuring that health dollars are being spent in the most efficient and effective way possible.

Conclusion

The first choice of health advocates is to have no remaining uninsured—for all Californians to be eligible for quality, affordable health coverage. For the remaining 3-4 million uninsured, would it be possible? We support this goal, but barring unlikely changes at the federal level to the Affordable Care Act, any proposal would need to be at the state and local level: some counties using county funds, First Five funds and foundation funding were able to offer coverage to all children using a coverage model. But it took years to build these efforts. Rather than starting from scratch, we suggest using the infrastructure that already exists and that may disappear without action this year.

This proposal recognizes that LHPs provide a way to provide many of the benefits of coverage while also building upon and supporting the safety-net institutions that we need to maintain. It also recognizes different counties do very different things with regard to the remaining uninsured. All counties would need some money preserved for public health and basic provision of medical services—but those counties that do more get more resources, with the accountability and transparency that have been missing.

Under this proposal, the remaining uninsured have better and more effective care than just traditional safety-net services (that otherwise would also be at risk). Willing counties and the safety-net continue to get state realignment dollars for this purpose. The state gets more transparency and accountability and the ability to score savings in the near future. And without starting new programs and using existing infrastructure, California gets a health system more inclusive and responsive to the needs of all Californians.

For more information about this concept paper, contact:

Anthony Wright
Executive Director, Health Access
awright@health-access.org
916-497-0923 Ext 202

After its official release, the latest version will be available on our website at www.health-access.org

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HEALTH ACCESS SACRAMENTO OFFICE

1127 11th Street, Suite 234
Sacramento, CA 95814
Phone: 916-497-0923
Fax: 916-497-0921

HEALTH ACCESS LOS ANGELES OFFICE

1930 Wilshire Blvd., Suite 916
Los Angeles, CA 90057
Phone: 213-413-3587
Fax: 213-413-8631

HEALTH ACCESS OAKLAND OFFICE

414 13th Street, Suite 450
Oakland, CA 94612
Phone: 510-873-8787
Fax: 510-873-8789

www.health-access.org

Health Access is the leading voice for health care consumers in California. Founded in 1987, Health Access is the statewide health care consumer advocacy coalition advocating for quality, affordable health care for all Californians. [Our Agenda in 2012 and beyond](#) includes:

- **Expanding Coverage:** Implementing and improving upon health reform.
- **Fighting for a Fair Budget for the Future:** Protecting public investments to preserve access to care.
- **Protecting Consumers:** Ensuring consumer representation and protection.
- **Encouraging Prevention:** Promoting a healthier California.

