Introduction

The long-term objective of the Managed Care Expansion Plan (MCEP) is to provide affordable health insurance to all California residents with incomes equal to, or under, 400% of the Federal Poverty Level (FPL). In attempting to achieve this objective, the plan employs a number of strategic judgments.

1) To a great extent, the plan relies on the expansion of existing health insurance institutions and health care delivery systems rather than establishing totally new models. This approach is based on the view that both fiscal and political considerations make a large scale, rapid and fundamental change in health insurance options unlikely. In the alternative, an incremental approach may prove to be more feasible, offering less risk, engendering less resistance, and requiring less immediate cost. An incremental model can be most effectively designed if it is based on some subset of existing structures.

2) Within the existing health insurance framework, the plan has selected two components on which it seeks to build for an expanded program. The first of these is a reliance on public sector institutions. As will be noted below, a focus on public sector insurers offers advantages in terms of reliability and quality of services and economies of scale. Secondly, with the exception of rural areas, the plan relies on managed care, with the intent of encouraging the best of that approach in terms of an emphasis on preventive care, avoidance of unnecessary procedures, and reasonable cost controls.

3) At the same time that MCEP seeks to expand health coverage to uninsured California residents, it also attempts to improve the fiscal stability and sustainability of "safety net" institutions in the health care delivery system. Safety net hospitals and clinics play a critical role in guaranteeing quality care to those California residents who remain uninsured while progress towards universal coverage is slowly accomplished. Essentially, the safety net allows the existing health care delivery system to meet at least minimum levels of access to all persons in need during that extended period over which improvements to coverage can be implemented.

4) The MCEP is a long-term, phased in, strategy. One rationale for this approach is the deliberate intent to present the governor and legislature with a functional way to view the achievement of universal health insurance as a state priority that can compete, over time, with other state priorities, such as transportation and education. From this perspective, the state will have the option of either weighing this priority against others when economic cycles generate additional revenues or moving more rapidly through tax increases if decision-makers should conclude that an expedited pace of program implementation is desirable.

5) Although state resources are the primary source of funding for expanded health coverage under this model, the plan does require that either insurance recipients or their employers must pay a share of premium costs. Based on current projections of program costs, approximately 17% of the total statewide cost of premiums would be paid by private parties. This approach allows the MCEP to be compatible with innovative efforts to

encourage or assist employers to play a greater role in the provision of health insurance to lower income workers.

Statement of the Problem

Before proposing additional state funds for health insurance coverage, it is important to examine whether current economic structures and dynamics will, over time, resolve or reduce the scale of the problem – that is, the large number of Californians who lack coverage. The analysis below concludes that public intervention is, in fact, needed by examining both structural and cyclical economic factors that contribute to persistently high percentages of state residents lacking insurance, as well as the demographic factors specific to California that suggest the continuing presence of this problem.

Economic Factors Affecting Uninsurance

Without public intervention, it is likely that the number of uninsured Californians will increase. The large number of state residents who lack health insurance stems from a dependence on employment based insurance in an economy that increasingly fails to provide that benefit. During the last thirty years, changes in the basis for corporate growth and profitability have produced an emphasis on innovation and short product life spans. These dynamics, in turn, have impacted the nature of employment. Increasingly, the employer/employee relationship has been characterized by an increase in the amount of contingent work (part-time workers, temporary employees, self-employed individuals or independent contractors). These workers make up at least one-fifth of the workforce, and in some regions as many as one-third. Contingent workers are less likely to receive health insurance from an employer than full time permanent workers. Temporary workers are twice as likely to work for an employer who does not offer health benefits, and twice as likely to be ineligible for benefits offered by an employer compared with permanent workers[1].

In addition, even permanent job growth has tended to concentrate in sectors where employers are least likely to offer health insurance. The rapid rise of the service sector demonstrates this trend. In 1997, service employees were three times as likely as management and technical employees to work for an employer who does not offer job-based insurance. Forty percent of employees in the service sector worked for an employer who does not offer health benefits. Yet, this sector has been growing continuously over the last 15 years and is now the largest sector of the workforce in California. Service jobs also are chronically low wage positions. Employers with a majority of low wage employees are less likely to offer health insurance than those with a higher paid work force. In recent years, low wage positions have dominated job growth in the state. In 1999, 60% of all jobs in California on average paid less than $15 an hour, or $30,000 annually.

Compounding the long-term structural economic factors that reduce the availability of health coverage are cyclical dynamics. Under a system relying on employment-based insurance, a

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[1] State of California, Department of Finance, *California Current Population Survey Report: March 2000 Data.* Sacramento, California, March 2001.
<http://www.dof.ca.gov/HTML/DEMOGRAP/CPS-2000.doc>

downturn with attendant unemployment regularly results in a loss of coverage for numerous people. Recently, even as business profits are falling during a downturn, health costs have continued to rise, making hard pressed firms even less likely to offer insurance. Those who must change jobs may be forced to accept temporary employment or independent contractor status, thereby losing job-based health insurance. An employee's dependents, spouses and children are similarly vulnerable. Family coverage has proven to be cyclical: in the recent upturn of the late 1990's, women were increasingly covered as dependents; in 1999, women received job based coverage as dependents 28% of the time, versus a 14% rate for men. In the ensuing downturn employers have dropped family coverage. Therefore, for the working poor and especially for women, a public program with employer participation can provide substantial opportunities for reliable and affordable health coverage that our current employer based system is unlikely to offer even if levels of aggregate growth are impressive.

Demographic Factors Affecting Uninsurance

The demographic characteristics of the uninsured population in California also suggest that, absent public intervention; California will continue to have one of the highest rates of uninsured residents in the country, 10-15% higher than the national average. One reason is that the employers most prevalent in California are those least likely to offer health insurance. In 1999, 48% of California firms vs. 61% of US firms offered insurance; these lower rates of insurance are due in part to the high percentage of part-time agricultural jobs in California.

The ethnic composition of the state also influences the availability of employer-based health insurance. California has a higher percentage of Latinos than many other states (32.4% of California's population, up from 28.8% in 1996), and Latinos are much less likely than any other racial and ethnic group to have job-based coverage. At the same time, however, if Latinos are offered health insurance on the job, they have a higher take up rate than any other group. This data suggests that patterns of immigration, discrimination, and marginalization of ethnic groups in low wage jobs may all contribute to the persistence of the health insurance problem in California.

Impact of Uninsurance on Health Delivery System

Under current conditions in California, the lack of affordable health insurance produces serious impacts on the health care delivery system. A limited number of hospitals are required to allocate massive resources towards care for the uninsured. According to the California Association of Public Hospitals and Health Systems, 70% of expenses at public hospitals and other "open door" providers are the result of treating the uninsured.[2] While these providers account for just 6% of all hospitals in the state, they provide nearly 50% of the care to the state's uninsured population. This leaves public hospitals financially vulnerable. The relatively limited number of fully insured patients cannot produce significant excess revenues to permit a cost shift to help cover the care of those lacking insurance.[3]

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[2] *California's Uninsured and the Future of Open Door Providers: A Call for Investment in Our Communities' Health."* California Association of Public Hospitals and Health Systems. 4 October 2001. <http://www.caph.org/publications/odpreport.pdf>

[3] California Association of Public Hospitals and Health Systems, Ibid

The impact on the health delivery system is not only financial – the quality of care suffers as well. A key example is the case of emergency care. The economic burden of maintaining operational emergency rooms is so acute that many hospitals throughout the state are closing their E.R. facilities.[4] The presence of large numbers of uninsured persons certainly contributes to this problem. Emergency rooms are often the access point for medical care for the uninsured, as opposed to primary providers where preventive care could be initiated. With fewer E.R.s in operation statewide, fewer overall inpatient beds to move E.R. patients into after treatment,[5] and no new major public programs to increase health coverage opportunities for the uninsured, it is hardly surprising that a form of hospital gridlock occurs, forcing some E.R.s to go on "diversion," essentially closing hospitals to ambulances.

The current system also leaves uninsured families financially vulnerable. Families are less likely to receive preventive treatment that would reduce acute illnesses and the genuine need for emergency services[6] with consequent potentially long stays in the hospital to recover from otherwise routinely treatable conditions. Thus, the uninsured will experience less effective medical treatment and more expensive medical care at the same time.

Policy Proposal: The Managed Care Expansion Plan

The MCEP can be succinctly described in terms of its institutional framework, medical coverage, financing, and implementation phases.

a) Institutional Framework

Managed care plans are available to Medi-Cal recipients in California through a variety of organizational models. Primary options include: Two-Plan Model counties in which a public agency and a private firm selected by the state through competitive bid offer competing managed care programs to eligible clients; County Organized Health Systems (COHS) in which a local agency created by the County Board of Supervisors administers a capitated, comprehensive, health insurance program; and Geographic Managed Care (GMC) under which the State Department of Health Services contracts with several capitated managed care plans in the participating jurisdiction. Under MCEP, each of these existing models would be charged with expanding its coverage to include additional uninsured individuals. Although counties could choose to move from one model to another, the projections for MCEP assume counties will continue to use the model they currently employ.

The single exception to this approach is rural counties in the state in which approximately 6% of the population resides. Because of the difficulty of

[4] "Emergency Departments—An Essential Access Point to Care." *Trendwatch Vol.3. No.1* March 2001. 25 Sept. 2001
<http://www.ahapolicyforum.org/trendwatch/pdfs/TWMarch2001.pdf>
[5] *Trendwatch,* Ibid
[6] *Trendwatch,* Ibid

maintaining managed care systems in those areas, they will be allowed to provide expanded coverage through a fee-for-service model.

b) Medical Coverage

MCEP will provide health benefits identical to those offered under the existing Healthy Families program, including dental and vision care. Existing provider networks will be incorporated into MCEP. To the extent additional providers are required, it is anticipated the volume of patients with reasonable reimbursement rates generated by MCEP will sustain or improve provider capacity in safety net facilities and encourage additional participation by other hospitals and physicians.

c) Financing

Financial costs of the program will be divided between the state and either plan recipients or their employer. The state's share of premium subsidies will be the remaining amount after the individual or employer share has been paid. Individual or employer shares will be determined based on a sliding scale varying with household income. Total annual cost of achieving coverage for all uninsured adults with incomes below 400% of FPL is estimated to be $7.1 billion in 2000 dollars. Of this amount, approximately 83% or $5.9 billion would be paid by the state. However, the MCEP does not envision immediate implementation of full coverage. It assumes coverage would be achieved in phases with full coverage not achieved for at least 15 years. Therefore, initial state expenditures would be considerably lower.

d) Implementation Phasing

A 15 year "ideal case" model would be established indicating the resources needed to achieve 100% coverage by the end of that period. As available state fiscal resources vary over time, adjustments can be made to this case, either extending the period before 100% coverage is achieved or supplementing the state contribution in those years during which greater expansions of coverage are desired. To achieve the ideal case, approximately equivalent annual augmentations of state funds would be required each year. The annual expansion of coverage, therefore, would be limited to the number of uninsured whose premiums could be paid for within that allocation. Those households who are the most economically vulnerable would be the earliest targeted groups. In future years, coverage would be extended to those with higher incomes. Inflation would necessarily increase premium costs over time. On the other hand, the state share of premiums would decline over time since the sliding scale would require higher income individuals or their employers to absorb greater proportions of program costs.

Target Population

The Managed Care Expansion Program will target uninsured Californians with household incomes of 400% or less of the Federal Poverty Level. An eligible applicant must be a California resident; be under the age of 65; be ineligible for any other public health insurance programs including Medi-Cal and Healthy Families; and must have been uninsured for at least six months prior to enrollment. Exceptions would be made for adults eligible for sub-standard programs. The state would evaluate employer-based coverage to determine if the existing plan meets basic standards. Thus, working adults with programs requiring excessive payments, or programs that exclude significant areas of coverage, such as inpatient care, dental care, or mental health, would be eligible for the MCEP.

Although California's uninsured population is estimated to include 5 million adults and 1.8 million children, a smaller number would actually be served by MCEP. The goal of MCEP is to provide coverage only for persons who are not already eligible for an existing subsidized program. Thus, approximately 850,000 adults and 1.2 million children who are eligible for but not enrolled in Medi-Cal would not be covered[7], although outreach and enrollment programs for MCEP would include concerted efforts to enroll eligible applicants in Medi-Cal and Healthy Families as well. In addition, some 880,000 uninsured adults and 240,000 children belong to households with incomes greater than 400 percent of poverty. The state is not fiscally capable of subsidizing health insurance for households at this higher income level.

Once the impact of these eligibility limitations have been calculated, the target population (as of 1999) for coverage under MCEP is estimated at approximately 3.2 million adults and 348,000 children, totaling about 3.6 million eligible individuals. Of these eligible adults, about 690,000 have household incomes less than 100% of the federal poverty level, 1.68 million are between 100% and 250% FPL, and 866,000 fall between 250% and 400% FPL.

The majority of people in MCEP's target population are unlikely to have access to employment-based insurance because they are employed either in occupational sectors such as temporary work and agriculture that traditionally fail to offer job-based insurance, or they work at low-wage jobs in other sectors that also tend to not offer insurance. MCEP's marketing approach, to be described below, will attempt to meet the needs of these types of employers, encouraging them to pay their employees' share of the program's premium costs.

Benefit Package

[7] This estimate assumes that the state of California extends Healthy Families eligibility to parents of eligible children with household incomes below 200% of poverty. Thus, it includes the approximately 317,000 adults estimated to be eligible for Healthy Families under the proposed expansion.

The MCEP package will mirror the Healthy Families benefits package for both children and adults.

Coverage will include:

a) Inpatient, outpatient, medical and surgical services
b) Prescription drugs, X-ray services, speech therapies
c) Mental health, dental and vision care

To encourage public use of preventive care, preventive services would be free to all users. Co-payments will range from $5 to $10 monthly for all other services, with an annual maximum of $250. Prescription drug co-payments range from $0 to $5 and are included in the annual $250 maximum.

Administration

The MCEP will present some unique administrative challenges to the state that can best be served by the Managed Risk Medical Insurance Board (MRMIB). Because MCEP will be phased in over a 15-year period, at times expanding rapidly, it will require a flexible administrative unit. MRMIB can draw upon similar experiences with Healthy Families, which has grown consistently through marketing strategies since its inception. The focus of MRMIB is already on the uninsured and other vulnerable populations that MCEP will serve. A more detailed discussion of the distribution of responsibilities between state and county agencies is presented in the Proposed MCEP Framework section on page 13.

Institutional Framework

Justification for Organizational Model

The proposed institutional framework for the Managed Care Expansion Plan builds on the successes of current public health insurance models while attempting to solve some of the problems that these approaches have encountered. The MCEP commitment to managed care is based on the objective of encouraging patients to seek preventive and primary care, rather than enduring poor health until hospitalization or emergency care becomes necessary. By continuing to offer a variety of implementation models, the plan offers the flexibility needed to successfully serve California's geographically diverse populations. Decentralization, with local authorities responsible for implementation in each county, will promote community involvement and community control while still insuring state oversight, as well as helping the MCEP to establish mutually supportive relationships with each county's safety net institutions. An exclusive reliance on public sector organizations will also tend to support safety net and traditional providers. Finally, the proposed framework builds on the existing Medi-Cal county plans, minimizing additional bureaucracy and capitalizing on the resources already invested in making these plans work.

Current Medi-Cal Framework

Since MCEP relies on existing managed care programs, a brief summary of the main features of these models may be useful.

Under managed care Medi-Cal, the state contracts with insurers, which may be either non-profit county-organized organizations, i.e. COHSs or Local Initiatives, or commercial HMOs. All but one of the county-organized plans have an exclusively Medi-Cal membership; the membership of most of the commercial plans is majority non-Medi-Cal.

These entities then contract with providers, generally individual physicians or medical groups (medical groups further subcontract with individual physicians). A few of the county-organized plans (L.A. Care, a Local Initiative, and CalOPTIMA, a COHS) contract with HMOs that then subcontract with medical groups and/or physicians. Managed care plans may contract with physicians and medical groups on either a fee-for-service or a capitated basis; capitated contracts "downstream" risk from the plans to the providers.

Medi-Cal Managed Care models

Medi-Cal has three major managed care models: the Two-Plan model, implemented in 12 counties which account for 55% of the state population; the County Organized Health System (COHS), which functions in 6 counties and is California's oldest Medicaid managed care model; and Geographic Managed Care (GMC), used in only two counties. As of June 2000, about 2.5 million Medi-Cal eligibles were enrolled in a managed care program. Of these, approximately 1.78 million were covered by Two-Plan (1.09 million by a Local Initiative and 0.699 million by a Commercial Plan), 402,000 by COHS, 311,000 by GMC, and 2,200 by other managed care models.[8]

Prior to 1996, Medi-Cal operated predominantly on a fee-for-service basis. In that year, the state began a transition to managed care in order to improve preventive and primary care, reduce unnecessary hospitalizations, and increase cost-effectiveness.

Most states that have implemented Medi-Cal managed care administer it through a model similar to Geographic Managed Care in all counties. However, when DHS began to implement managed care, it realized that the varying conditions and priorities of the state's many counties would be better served by offering multiple models. Two-Plan was developed primarily to protect the safety net while still allowing for competition, while counties with less of a public health structure followed the COHS or GMC models, and those with small Medi-Cal populations or without an established managed care market used other models or remained exclusively fee-for-service. The Medi-Cal Policy Institute says, "Through its multiple models California 'manages its markets' in ways that attempt to preserve traditional and safety net providers and, at the same time, are sensitive to community differences and desires."[9]

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[8] *Managed Care Annual Statistical Report, April 2001.* Department of Health Services: Medical Care Statistics Section. 18 Sept. 2001. <http://www.dhs.cahwnet.gov/admin/ffdmb/mcss/publishedreports/annual/mcannual01/mcannual01.pdf>

[9] Hurley, Robert, Jodi Korb, Nelda McCall, Michael McCue, Andrew Petersons, and Pamela Turner. *Participation, Performance, and Perspectives in Medicaid and Medi-Cal Managed Care, September 2000.* Medi-Cal Policy Institute and the Center for Health Care Strategies. 5 Sept. 2001.

Two-Plan Model – In each county, a county-run Local Initiative competes for members with a Commercial Plan, which DHS chooses in a competitive bidding process. In 1998, Local Initiative enrollment was significantly higher than Commercial Plan enrollment in every Two-Plan county with a Local Initiative. All Local Initiatives together had a total enrollment of 996,526 (406,883 excluding L.A. County), while Commercial Plans' total enrollment was 530,889 (145,319 excluding L.A. County).[10]

Rates for Two-Plan are set by the state for each county and grouping of aid codes; price is not a component of the bidding process for Commercial Plans. Capitation rates for Local Initiatives are slightly higher than for Commercial Plans in most counties. Rates are generally higher in urban counties than in rural ones.

In December 1998, the lowest monthly Two-Plan capitation rate for CalWORKS beneficiaries was $61.29 for Omni (the Commercial Plan) in San Joaquin County, and the highest was $97.19 for Santa Clara Family Health (the Local Initiative) in Santa Clara County. Capitation rates paid to the plans are set by the state and are public. Initially, DHS chose counties for the Two-Plan model based on the number of eligible Medicaid beneficiaries in the county (at least 45,000) and the county's interest in participating. Competition in the Two-Plan model occurs for the bid award rather than at the plan-to-consumer market interface; this may have helped California to avoid the plan withdrawals that have plagued other states.[11]

In designing the Two-Plan model, California attempted to ensure support for safety net and traditional providers, which nationally have suffered financial losses and increased insecurity as a result of the transfer of Medicaid beneficiaries from fee-for-service to managed care. Local Initiatives under Two-Plan systems are required to contract with all traditional and safety net providers who want to participate. Commercial Plans are encouraged, though not required, to include safety net and traditional providers, and a plan's provider network – including participation of traditional and safety net providers and cultural competency of providers – is considered in the bidding process.

All local initiatives are state-licensed HMOs. The majority of the local initiatives are organizations governed by a Board of Directors which is appointed by each county's Board of Supervisors. Three counties slated for Two-Plan proved unable or unwilling to create a county-run Local Initiative; Stanislaus and Tulare contract with Blue Cross as the Local Initiative, and Fresno has two Commercial Plans and no Local Initiative.

County-Organized Health System (COHS) – This system is similar to a Local Initiative, but without a competing commercial plan – the COHS is the sole plan available for managed care Medi-Cal beneficiaries. COHSs do not need a Knox-Keene license, but they must be independent public entities that meet Knox-Keene requirements. One COHS may cover multiple

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<http://admin.chcf.org/documents/mcpi/pppreport.pdf>

[10] Korb, Jodi, Nelda McCall, Andrew Petersons, and Pamela Turner. *The Medi-Cal Managed Care Market 1996-1998, Sept 2000.* Medi-Cal Policy Institute. 22 Sept. 2001.
<http://admin.chcf.org/documents/mcpi/mcmcm.pdf>

[11] Ibid

counties; for example, the county-organized Partnership Health Plan of California covers both Solano and Napa. Most beneficiaries are automatically enrolled in the COHS when they sign up for Medi-Cal. Capitation rates are negotiated between the plans and the California Medical Assistance Commission and are confidential.

Santa Barbara and San Mateo Counties began operating COHS's in the 1980s. Four additional counties created or joined COHSs in the 1990s as part of Medi-Cal's strategic plan to move towards managed care. California has a federal waiver allowing it to operate five COHSs covering no more than 10% of all Medi-Cal beneficiaries; another waiver would be required to exceed these limits. COHS is not likely to expand because "DHS believes there is lack of beneficiary choice and insufficient inter-plan competition in this model, resulting in potential stagnation over time and an undue concentration in bargaining power."[12] In a 1998 survey, commercial plans opposed expansion of the COHS model (even if counties subcontracted with commercial plans), favoring a Two-Plan model and especially GMC.[13]

However, some counties with small Medi-Cal enrollments and a Two-Plan system are showing interest in converting to COHS, worrying that commercial plans will stop participating as Medi-Cal enrollment falls too low to make commercial participation viable. A COHS would also give these counties greater local control over Medicaid and other public health funding, allowing them to better coordinate uninsured and indigent care.[14]

Geographic Managed Care – In Geographic Managed Care, the state contracts directly with multiple private health plans (both non-profit and for-profit) to cover Medi-Cal recipients in that county. Participating health plans must be designated by the county through a formal process and agree to fulfill required conditions such as support of public health programs and quality improvement activities. Capitation rates are negotiated between the plans and the California Medical Assistance Commission and are confidential. GMC resembles the model of Medicaid managed care that has been implemented in most other states, but in California it is the smallest of the three major models.

DHS originally intended to implement GMC as the standard approach to Medi-Cal managed care, but in response to concerns that GMC would put safety net providers at a disadvantage and would be difficult to administer, DHS developed the Two-Plan model and facilitated COHS expansions. GMC was implemented in counties that had a large Medi-Cal population and a managed care infrastructure but preferred not to develop a Local Initiative or a county-organized health plan, in part due to their lack of a public hospital system. Only Sacramento and San Diego follow this model. The Sacramento program is entirely state-run, while San Diego county shares some responsibility and authority for San Diego's GMC.

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[12] Frates, Janice and Lucien Wulsin, Jr. *California's Uninsured: Programs, Funding and Policy Options,* Insure the Uninsured Project, 1997. http://www.work-and-health.org/itup/Programs,Funding,Policy.htm

[13] Hurley, Robert, Jodi Korb, Nelda McCall, Michael McCue, Andrew Petersons, and Pamela Turner. *Participation, Performance, and Perspectives in Medicaid and Medi-Cal Managed Care, September 2000.* Medi-Cal Policy Institute and the Center for Health Care Strategies. 5 Sept. 2001. <http://admin.chcf.org/documents/mcpi/pppreport.pdf>

[14] Hurley, Robert, et al. Ibid

Other Managed Care Models – Several small counties have created other models to implement Medi-Cal managed care, including Prepaid Health Plans, Primary Care Case Management, Fee-for-Service Managed Care, and combinations of these three models. The plans are used in counties that have insufficient resources, infrastructure, or Medi-Cal enrollees to implement one of the three major models. Generally, either the state contracts with providers directly through DHS, or a private health plan manages the program. Less than 1% of Medi-Cal managed care beneficiaries are enrolled under these models [15]

Fee-for-Service (FFS) Only – Thirty-two of California's counties (making up just 6 percent of the state's total population) operate on an exclusively fee-for-service basis. With most of these counties in rural areas, it has been argued that FFS is the most cost efficient health care model due to the low number of recipients.

Under the FFS model, each beneficiary is assigned a primary care provider who is paid only for services provided. Although Managed Care typically costs less per enrollee than FFS, low enrollments have driven private managed care models out of some rural areas, leaving FFS to dominate the market.

Rural communities primarily operate with a few, if any county hospitals or clinics. Most rural counties have some access to emergency and specialty care services; however, services are limited due to economies of scale. Emergency rooms are often occupied with non-emergency cases due to the high proportion of uninsured in rural areas. Even in areas where there is sufficient access to hospitals and clinics, many Medi-Cal and Healthy Families patients are often restricted in their choice of providers. Most independent physicians do not accept Medi-Cal patients, arguing that reimbursement rates are too low to cover the cost of their care.

The lack of managed care, according to many health care administrators, is due to the small population of these counties. Administrators argue that with such a low enrollment volume, managed care becomes too costly, and so many HMOs have left rural counties. Capitation rates are too low to cover the costs of specialty services due to the low volume of outpatient/preventive care patients. Some counties such as Monterey have managed care plans that operate in a limited capacity, primarily for outpatient services. However, Monterey, unlike many other FFS counties, has a well-established county health care system and a fairly large population.

Proposed MCEP Framework

The MCEP aims to build on the current Medi-Cal framework as much as possible, taking advantage of the research, experience and stakeholder input that went into its creation. This is advisable in order to maximize the return on the public investment in these models. In addition, the creation of dramatically different new models always carries with it the risk that these models will not function as expected, an experience the state has had to endure in the field of energy deregulation. Existing county plans will need to expand to accommodate the new program, but such an expansion appears to be well within their capabilities given the funding to accomplish it.

[15] Hurley, Robert, et al. Ibid

The CEO of one Local Initiative judges that "the impact in terms of provider services and ability to handle a new population would be minimal" on Local Initiatives and COHSs.[16] At the same time, MCEP's implementation is designed to try to better address the problems that have arisen from existing structures, such as the financial difficulties experiences by safety net providers under Medi-Cal managed care.

Based on these principles, the goal of the program is to serve as many enrollees as possible through publicly run managed care plans, while recognizing that regional differences will require frameworks appropriate to each county's infrastructure and demographics. In counties that currently have a managed care system in place, the existing system will be utilized, as follows:

- In Two-Plan Counties, MCEP beneficiaries will be enrolled in the Local Initiative. This allows the program to be implemented by a locally managed authority that has already functioned successfully for several years. Local Initiatives also appear to be preferred by enrollees; currently, every Local Initiative has a higher enrollment than its corresponding Commercial Plan. Finally, not including a Commercial Plan should ensure stronger protection for safety net and traditional providers, many of which have suffered under Medi-Cal managed care, as well as avoiding the problem of different Commercial Plans winning the bids for Medi-Cal and for MCEP, which would complicate administration.

- In COHS counties, beneficiaries will be enrolled in the COHS. As with Local Initiatives, this allows the MCEP to be implemented by a locally managed, already functional authority. Probably the greatest challenge that COHSs will face in running an MCEP plan is their lack of marketing experience, a difficulty that has become apparent with the advent of Healthy Families. The state will have to provide technical assistance to COHSs as needed to develop their marketing strategy, using as models the Local Initiatives that have successfully experienced growth in their client population.

- In Geographic Managed Care counties, plans will be offered the opportunity to bid to become the MCEP plan for that county. The bid will be awarded based on criteria similar to those used under the current Medi-Cal Commercial Plans bidding process, with emphasis on the inclusion of traditional and safety net providers in the plan's provider network. If necessary, more than one plan may be chosen in order to provide coverage for all of the disparate communities in the county.

- In those few counties with other managed care models, the state can negotiate with the county to agree on an appropriate structure.

- Rural counties that are exclusively or primarily fee-for-service will be the most difficult areas in which to implement the MCEP. In these counties, the state will have to make an individual determination whether managed care can efficiently be implemented, and if so, negotiate the design of an appropriate model. Where some form of public managed care already exists, the MCEP may be able to expand the current program. In the rural counties with larger populations, a managed care program is likely to prove more cost efficient and

[16] Brownstein, Bob. "Questions Regarding Universal Health Care." E-mail to Leona Butler. 17 Sept 2001.

provide better quality care than fee for service. In areas where only the fee-for-service model exists and creating a managed care system in the area would be infeasible, inefficient, or would not improve the quality of care, a fee-for-service system will be implemented as arranged with the county. Though fee for service may be more costly, only six percent of the state's population resides in counties that currently are exclusively fee-for-service, so the added expense, if any, will be small in relation to the overall program cost.

Roles of state and county agencies

The Managed Risk Medical Insurance Board (MRMIB) will be the state agency with primary responsibility for the program, as discussed below. The division of responsibilities between state and county authorities will be similar to that of Medi-Cal, though they will have more flexibility in this division since the program will not be bound by federal Medicaid regulations (for example, the state will not be required to adhere to Medicaid data collection and reporting requirements). The state authority will be responsible for:

- Certification of county health plans.
- Creation of standards for applications, eligibility, enrollment and disenrollment.
- Creation of standards to measure the adequacy of employer based plans to determine eligibility for MCEP of adults currently enrolled in these programs.
- Collection and distribution of data on enrollees.
- Establishment of reimbursement rates for each county.
- Disbursement of funds to counties.
- Determination on an annual basis of additional eligible individuals to be enrolled, based on available funding, number of current enrollees, and cost projections.
- Provision of overall program administration and monitoring.

The county plans will be responsible for:

- Development of a provider network that offers medical services and case management.
- Design of application forms and other administrative procedures in accordance with state standards.
- Health education.
- Cultural and linguistic services
- Member communication and grievances
- Quality assurance.
- Utilization management.
- Data collection as required by the state.

The state and the counties will share responsibility for outreach and publicity efforts, and the state will work to provide technical support for counties which need assistance in setting up or expanding their health plans. Division of responsibilities for other types of managed care (Primary Care Case Management, Prepaid Health Plans, and Fee-for-Service Managed Care), if implemented, and for state and counties will determine fee-for-service counties jointly.

Advantages of Publicly Run Managed Care Plans

Preserving Capacity of Safety Net Institutions

For several reasons, it is crucial that a new public health care program provide strong support for the safety net – providers and programs which serve large numbers of uninsured or underinsured patients. Considerable public investment has already been made in safety net institutions, including community hospitals, children's hospitals, and community and free clinics. In 1999, there were 92 government-operated hospitals and 715 community and free clinics in the state.[15] The physical plants of public hospitals have received large amounts of state funds, as well as leveraged federal resources. The physical plants of public hospitals have received large amounts of state funds, as well as leveraging federal resources. As much as 50% of all new public hospital construction in California, including seismic retrofits, new special care facilities, and other improvements, is financed by state and federal dollars.[17] Clinics are financed primarily by public funds, with government support accounting for approximately 77% of clinics' total revenues in 1999.[18] Directing additional public funding towards these providers will ensure a continued return on a substantial initial investment.

Safety net providers generally have a positive relationship with the local community, especially within those populations that would be eligible for the MCEP. Indeed, for many of the MCEP's potential enrollees, safety net institutions are already their primary source of care; 40% of inpatient care for the uninsured is provided by public hospitals and clinics, reporting over 1.6 million encounters with non-paying or self-paying patients in 1999.[19] Indeed, for many of the MCEP's potential enrollees, safety net institutions are already their primary source of care; forty percent of inpatient care for the uninsured is provided by public hospitals. Inclusion of safety net institutions in plans' provider networks would thus minimize the disruption and excess costs incurred when enrollees must switch from their accustomed provider. Safety net and traditional providers – public hospitals and community clinics in particular[20] – also tend to possess a high degree of cultural and linguistic competence, making them more effective in successfully treating patients.

Finally, continued support for safety net providers is necessary to ensure that they are able to continue caring for the remaining uninsured and underinsured patients. The MCEP will not generate the resources for 100% coverage for at least fifteen years. Even after full implementation of the MCEP, a substantial number of individuals will remain uninsured for a

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[15] *Annual Utilization Reports of Hospitals: California Acute Care Hospital Services Statewide Trends, 1990-1999.* State of California Healthcare Information Division Healthcare Information Resource Center. 28 Sept. 2001. <http://www.oshpd.state.ca.us/hid/infores/archive/hospital/util/hosagg99.pdf>

[17] Martin, Dennie. Telephone interview with Executive Director of the California Association of Public Hospitals and Health Systems. 17 Oct. 2001.

[18] State of California Healthcare Information Division Healthcare Information Resource Center: *Annual Utilization Reports of Hospitals*, Ibid

[19] State of California Healthcare Information Division Healthcare Information Resource Center: *Annual Utilization Reports of Hospitals*, Ibid

[20] *Minority Health: Medicaid Managed Care and Cultural Diversity in California, February 1999.* The Commonwealth Fund. 26 Sept. 2001. <http://www.cmwf.org/programs/minority/coye_culturaldiversity_311.asp>

variety of reason, just as many Medi-Cal and Healthy Families eligible remain unenrolled today. If large numbers of MCEP eligible were diverted to other providers, safety net providers' ability to maintain adequate service levels for the remaining uninsured could be seriously impaired.

In achieving the goal of supporting safety net institutions, publicly run managed care plans are more likely to be effective than privately run plans. Public Medi-Cal managed care plans are subject to stricter legal requirements concerning inclusion of safety net providers than are private Medi-Cal managed care plans, even when both plans serve the same population in a Two-Plan county.

Public plans may also be more likely in practice to encourage enrollees to seek care at safety net institutions. In many Two-Plan counties, including San Francisco, Contra Costa, Santa Clara, San Bernadino, Riverside, and San Joaquin, strong ties exist between the Local Initiative and public hospitals, providing financial stability for the safety net and consistency for patients. Contra Costa, in fact, administers its Local Initiative and public hospital under the same department, while Inland Empire (the Local Initiative for San Bernadino and Riverside) uses its annual surplus to fund a "supplemental payment pool" that offers grants directly to public hospitals in order to maintain the hospitals' fiscal stability.[21]

Economies of Scale

A framework which concentrates all MCEP enrollees in each county into a single insurance plan, rather than distributing them among multiple plans, would better position plans to take advantage of economies of scale. In particular, this arrangement provides a sufficient volume of patients to allow those organizations managing the county MCEP plans to serve public health insurance enrollees exclusively, as opposed to serving a small population of public enrollees and a much larger group of private insurance beneficiaries, as most commercial plans currently do.

The benefits of this specialization are demonstrated by the performance of managed care health plans enrolling Medi-Cal beneficiaries. Plans that exclusively or nearly exclusively serve Medi-Cal members financially outperform plans with only a small proportion of Medi-Cal members according to several measures, including administrative costs and operating margins. From 1996 to 1998, plans participating in Medi-Cal had lower administrative cost ratios than those that did not, with COHSs, which serve only Medi-Cal enrollees, having the lowest administrative costs of any type of plan. Further, plans' administrative cost ratios were lowest (.103) if 75% or more of their members were Medi-Cal enrollees, and highest (.143) if less that 25% were Medi-Cal enrollees.[22]

The comparative operating costs of managed care plans provide even stronger evidence for the economies of scale achieved by plans with large Medi-Cal enrollment. By 1998, California health plans participating in Medi-Cal had an average operating margin of +.004 while non-participating plans had a margin of -.058; participating plans' high performance is attributable in

[21] Martin, Dennie, Ibid.

[22] Korb, Jodi, Nelda McCall, Andrew Petersons, and Pamela Turner. *The Medi-Cal Managed Care Market 1996-1998, Sept 2000.* Medi-Cal Policy Institute. 22 Sept. 2001. <http://admin.chcf.org/documents/mcpi/mcmcm.pdf>

large part to Local Initiatives and COHSs, both of which enroll Medi-Cal patients exclusively. Both nationally and in California, it appears that plans with large numbers of Medicaid enrollees perform better financially than non-Medicaid plans, but plans with small numbers of Medicaid enrollees may not do so well, partly due to high administrative costs. Specifically, California plans whose membership was greater than 75% Medi-Cal performed better than those whose membership was less than 75% Medi-Cal, with average operating margins of +.019 for the former and -.006 for the latter. Plans with more than 50,000 Medi-Cal enrollees also performed better than those with fewer enrollees. [23]

In essence, California managed care plans with large or exclusive Medi-Cal membership (primarily Local Initiatives and COHS's) are financially outperforming nearly every other kind of plan, including private Medi-Cal plans with low numbers of Medi-Cal enrollees, non-Medi-Cal plans, and private managed care plans nationwide, despite their small size (mostly limited to one county) and the lowest Medicaid capitation rates in the country. If this dynamic holds true for other forms of public managed care, it will provide a strong rationale for allowing just one plan per county to participate in MCEP and to require that plan to serve public health insurance enrollees exclusively.

Quality Control

While the financial advantages of a public sector model are compelling, equally as important are quality control issues. Maintaining a high quality of care is the primary goal of public institutions – private institutions, however, must prioritize profit as well with a resulting impact on the quality of care.[24] In fact, Kaiser Permanente admitted that in past years it actively restricted patients' access to doctors in northern California by encouraging physicians to reduce their availability.[25] While safety net institutions are not invulnerable to external pressures to cut costs, their management and staff tend to emphasize their mission as providers of care as opposed to generators of an economic surplus[26].

Providers

Provider Capacity

A health insurance expansion of the magnitude proposed in this paper is likely to require an expansion in the capacity of health care providers to serve these newly insured patients. Currently, California is already facing provider capacity shortages in several areas, particularly general acute care hospital capacity, primary care physicians, and medical services in rural regions. Even where there are sufficient providers, Medi-Cal enrollees – and even private managed care members – often have difficulty finding a provider who accepts their insurance plan.

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[23] Korb, Jodi, et al. Ibid

[24] Associated Press. "Report: HMO Restricted Access." *Los Angeles Times*, 1 Sept. 2001. 10 Sept. 2001. <http://www.latimes.com/news/nationworld/wire/sns-ap-kaiser-permanente0901sep01.story>

[25] Perez, Vivian, and Herman Spencer. Telephone Interview with Clinic Administrators of Imperial County and Northern Inyo County, respectively. 4 Oct. 2001.

[26] Managed Care, Success or Failure. Letters to the Editor. JAMA Vol. 286 No. 13, October 3, 2001

California's current and projected capacity shortages are driven by fiscal shortfalls; hospitals are reducing available beds and physician groups are limiting the number of patients they will accept because patient revenues are not high enough for these providers to continue operating at their current capacity. These financial burdens fall especially heavily on safety net providers, which are the principle source of care for the uninsured and often for Medi-Cal patients. A primary goal of the Managed Care Expansion Program, in addition to insuring the uninsured, is to improve and stabilize the financial base of safety net providers.

The MCEP will use a three-pronged approach to address the need for provider capacity. First, each county's plan will be designed to support safety net and traditional providers by ensuring that they can maintain their patient base and associated DSH revenues as their patients enroll in the MCEP. Second, managed care plans will encourage preventive and primary care, which should reduce the patient load in hospitals and emergency departments while increasing the demand for clinics and primary care physicians. Finally, the provision of insurance with adequate reimbursement rates for the formerly uninsured will increase revenues for providers who currently serve uninsured patients, thereby providing more revenue per patient and enabling safety net providers to continue serving the remaining uninsured population.

The Managed Care Expansion Program, implemented through county-based public managed care plans and providing those plans with adequate funding per patient, will be a significant stride towards preserving and improving the capacity, quality and financial stability of California's safety net health care providers. It is important to note, however, that a single insurance program will not be able to solve all of the issues associated with California's health care provider system. Additional policy measures beyond the scope of this project will be needed to deal with these issues.

Capacity and Fiscal Issues of California's Hospitals

In 1999 there were 483 general acute care hospitals in California. 50.3% of these were non-profit hospitals, 17.3% government or district hospitals, and 32.4% investor (i.e. private for-profit) hospitals. Over half of all net patient revenue (51.6%) for acute care hospitals in 1998 came from public health care funds (either Medicare, Medi-Cal or county funding).

The number and total capacity of hospitals in California is falling. Between 1995 and 1998, available beds per person dropped from 2.50 per 1,000 people in 1995 to 2.33 in 1998, as the number of hospitals of all types decreased. [27] Occupancy rates in general acute care hospitals have risen from 43.7% in 1994 to 49.5% in 1999 (though they were higher in 1990-91).[28]

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[27] *California Statewide Perspectives in Healthcare.* Office of Statewide Health Planning and Development, 1998. 3 Oct. 2001.

[28] *Annual Utilization Reports of Hospitals: California Acute Care Hospital Services Statewide Trends, 1990-1999.* State of California Healthcare Information Division Healthcare Information Resource Center. 28 Sept. 2001. <http://www.oshpd.state.ca.us/hid/infores/archive/hospital/util/hosagg99.pdf>

In 1999, hospitals held a total of 84,327 licensed beds, down from 104,763 beds in 1990 and 103,675 beds in 1995.[29] Meanwhile, patient days fell from 15.7 million in 1990 to 12.4 million in 1996, then rose slightly to 13.4 million in 1999,[30] as total outpatient visits reached 39.5 million in 1998, up from 37.8 million in 1995. The overall utilization picture shows a slight reduction in hospitalizations per person and a larger drop in a patient's length of stay in the hospital, combined with a growing tendency to treat patients on an outpatient rather than an inpatient basis. However, rising occupancy rates suggest that these trends have not been enough to counteract the reduction in hospital capacity.

Safety net and traditional hospitals, in particular, are having difficulties maintaining capacity, service levels and financial solvency, largely due to their dependence on Medicaid revenues. Nationally, the transfer of Medicaid beneficiaries from fee-for-service to managed care has made revenues more insecure for safety net hospitals, both because Medicaid reimbursements are lower and because Medicaid patients are being lost to private or non-profit hospitals. This occurs at the same time that private payers are reducing their payment rates and the number of uninsured is rising (safety net hospitals disproportionately provide uncompensated care and sustain much larger losses than other hospitals on indigent care and programs).

The combination of these trends makes it financially difficult for safety net hospitals to maintain their current capacity and service levels, even while the need for safety net providers increases as the number of uninsured grows. The effect on safety net hospitals' capacity is demonstrated by high occupancy rates; in 1998 occupancy rates at government, district and non-profit hospitals, which are more likely to be safety net providers, were much higher (59.2% to 67.1%) than at investor hospitals (48.0%). Yet investor hospitals' average net income per day was higher than any other type (excluding LA County hospitals) and was three times the average income of government and district hospitals.[31]

Safety net hospitals have responded to these pressures by cutting costs or trying to increase revenues. One common strategy has been reducing staffing levels, especially nurses and non-clinical staff (food service, laundry, etc.), accompanied by attempts to substitute Licensed Practical Nurses for Registered Nurses. Hospitals are also reducing their numbers of budgeted beds and attempting to lower ER visits by referring non-urgent patients elsewhere. Some are cutting back on services, while other hospitals are merging or even shutting down.[32] While in some cases these strategies may improve efficiency, many of them result in a reduction of quality or availability of care to these hospitals' patients.

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[29] State of California Healthcare Information Division Healthcare Information Resource Center: *Annual Utilization Reports of Hospitals.* Ibid

[30] State of California Healthcare Information Division Healthcare Information Resource Center: *Annual Utilization Reports of Hospitals.* Ibid

[31] *California Statewide Perspectives in Healthcare.* Office of Statewide Health Planning and Development, 1998. 3 Oct. 2001. http://www.oshpd.cahwnet.gov/hid/infores/Perspectives/index.htm>

[32] Brennan, Niall, and Stuart Guterman, and Stephen Zuckerman. *Medicaid and the Uninsured. The Health Care Safety Net: An Overview of Hospitals in Five Markets.* The Henry J. Kaiser Family Foundation, April 2001. 28 Sept. 2001.
<http://www.kff.org/content/2001/2250/2251.pdf>

Case study: Los Angeles County

A drop in Medi-Cal patients has contributed to grave funding difficulties among safety net hospitals in Los Angeles County. In L.A. County, the primary safety net hospitals are those run by the LA County Dept. of Health Services (LACDHS). In 1998, these hospitals accounted for 30% of all Medicaid patient days in the county, but only 12% of total patient days – in other words, they treated almost 3 times their share of Medicaid patients. By contrast, private not-for-profit hospitals accounted for 66% of total patient days, but only 50% of Medicaid days. The LACDHS hospitals also accounted for more than their share of emergency room visits (17%).

In FY1999-00, the LACDHS's funding sources were:

Medi-Cal	**40%**
State	**22%**
County	**6%**
Other	**32%**

LACDHS has had difficulty keeping adequate funding throughout the last decade, due in large part to decreases in revenues from Medi-Cal, its largest funding source. In 1995 the system was "on the verge of financial collapse." It was saved by a Section 1115 waiver (a waiver from the U.S. Department of Health and Human Services allowing a state to develop a pilot program that expands Medicaid coverage to additional eligibility categories) that provided for $900 million in federal funding over 5 years.

During those 5 years, LACDHS began to face another funding crisis. Medi-Cal patients in the system had dropped dramatically due to a combination of welfare reform and Medi-Cal managed care (which shifted patients towards private providers), resulting in a loss of funding. From 1995 to 2000, the share of Medi-Cal revenues from direct service provision dropped from 55% to 38%. DSH payments did not rise to make up for this loss. Only federal funding from the waiver, which was renewed in 2000, kept Medi-Cal revenues from plummeting. By 2000, 17% of LACDHS's Medi-Cal revenues were coming from the waiver. Nevertheless, some hospitals may still be forced to cut programs; for example, Medi-Cal births have declined at Harbor-UCLA Hospital to the point where hospital officials fear they may be unable to maintain its residency-training program in Obstetrics and Gynecology.[33]

Impact of MCEP on Hospitals

Although Medi-Cal managed care was specifically designed to support safety net and traditional providers, it has not been completely successful at maintaining these providers' patient base, and thus has contributed to their financial difficulties. However, managed care remains a more efficient and effective means of providing quality medical care in most areas than fee-for-service. To avoid replicating this problem, the MCEP is structured to provide stronger

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[33] Brennan, Niall, and Stuart Guterman, and Stephen Zuckerman. *Medicaid and the Uninsured: The Health Care Financing Changes?* The Henry Kaiser Family Foundation, April 2001. 28 Sept 2001. <http://www.kff.org/content/2001/2250/2250.pdf>

protections for the safety net, as described above under "Institutional Framework." Specifically, in almost all the counties in which MCEP is implemented through a managed care program, that program will be publicly run and, as with Local Initiatives, will be required to include in its provider network all safety net and traditional providers who wish to participate.

In order to further ensure that MCEP does not deplete the financial resources of safety net hospitals, MCEP enrollees will continue to be counted in determining a hospital's allocation of Disproportionate Share Hospital (DSH) funds. The DSH program is currently an important source of funding for many safety net hospitals; it provides hospitals with additional resources based on the number of uninsured and Medi-Cal patients they treat, partially reimbursing the hospitals for the uncompensated care costs which they incur by treating these patients. Though reimbursement rates for MCEP patients should be generally higher than Medi-Cal, and certainly higher than what hospitals receive from uninsured patients, it is likely that MCEP reimbursements will still not cover the full cost of care for its patients. Inclusion of MCEP enrollees as DSH patients, as is done for Medi-Cal enrollees, will ensure that safety net hospitals do not suffer the loss of needed DSH funds.

Provision of managed care medical insurance to a large uninsured population will affect safety net hospitals (and, to some extent, all hospitals) in two ways. First, it should reduce hospital inpatient usage as more primary care and preventive care is provided. Second, by paying for formerly uncompensated care it should increase patient revenues received by hospitals – especially safety net hospitals that provide the bulk of uncompensated care. Hospitals thus may have fewer patients, especially patients entering through the emergency room, but will receive more revenue per patient. Overall, MCEP should improve the financial stability of safety net hospitals in California.

Capacity and Fiscal Issues of Emergency Departments in California

Emergency departments of hospitals are a crucial access point and source of care, especially for Medi-Cal enrollees and for uninsured, low-income, and rural populations. Nationally, over one third (34.2%) of visits to emergency departments are by people who are insured by Medicaid or uninsured, compared to less than one sixth (16.3%) of visits to physicians' offices.[34] Therefore, some emergency departments are also facing capacity and financial difficulties.

From 1990 through 2000, 50 of the state's emergency departments closed, nine of them in FY 2000, and 285 of the state's 355 hospital emergency rooms – in both urban and rural areas -- lost money in FY 1999[35]. Uncompensated emergency care alone accounted for a loss of $400 million for California hospitals in 1999.[36]

As hospitals have eliminated their emergency departments or closed down entirely, the remaining emergency departments are coming under increasing strain. They are increasingly

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[34] *Trendwatch*, Ibid.
[35] *Trendwatch,* Ibid.
[36] Seliger, Jerome, PhD. *Background on Health Care Coverage—The Health Care Market: The California Health Care Market, July 2001*. State of California: Health Care Options Project. 3 Sept. 2001. <http://www.healthcareoptions.ca.gov/csunmarket2.asp>

forced to go "on diversion", meaning that an ER stops accepting patients via ambulance. [37] Though increasing visits per emergency room is one factor in this system under stress, falling hospital capacity accounts for more ambulance diversions than ER capacity. With reductions in inpatient beds and hospital staffing levels, often there are no beds available for patients admitted through the ER, meaning that those patients have to stay in the ER. Decreasing hospital capacity is thus "causing gridlock throughout the entire system," especially in ERs.[38]

The MCEP employs two strategies, which together can help to improve this situation. First, through encouraging preventive and primary care, and allowing enrollees to access the health care system through points other than the emergency room, it should reduce emergency visits per person in California. This will occur both through a reduction in visits from uninsured patients who turn to the ER for non-urgent care because they have no other access point (in 1998, 36% of ER visits in the state were deemed non-urgent[39]), and a reduction in visits from patients with urgent conditions that could have been detected and treated much earlier had that patient had access to primary and preventive care. Second, if the program successfully addresses the lack of capacity in hospitals, essentially a fiscal problem, then it will reduce the "gridlock" described above.

Clinic Capacity in California

In contrast to hospitals and emergency departments, the number and capacity of primary care clinics in the state has grown dramatically over the past decade, from 494 clinics in 1990, to 604 in 1995, up to 715 in 1999. Patients treated has similarly increased, from 1.97 million in 1990 to 2.77 million in 1999 (compared to 3.0 million patients discharged from hospitals in 1999), along with a rise in total encounters from 5.92 million in 1990 to 9.33 million in 1996 and 9.44 million in 2000.[40] During the implementation of Medi-Cal managed care, Medi-Cal patients did not leave safety-net clinics for other providers in large numbers; 9.7% of Medi-Cal beneficiaries used safety-net clinics in 1997, down less than a percentage point from the 10.4% that used safety-net clinics in 1995. The implementation of Medi-Cal managed care thus does not appear to have negatively impacted the safety-net clinics' patient base (though drops in the overall number of Medi-Cal enrollees may have done so).[41]

Low-income patients make up a large majority of clinic visitors; in 1998, 60.6% of all California clinic patients had incomes below 100% FPL, with another 25.8% between 100-200%.[42] Medi-Cal has been clinics' largest single source of funds since 1991, and in 1999 it provided 24% of all clinic revenue.

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[37] *Trendwatch,* Ibid.
[38] *Trendwatch*, Ibid.
[39] *California Statewide Perspectives in Healthcare.* Office of Statewide Health Planning and Development, 1998. 3 Oct. 2001.
[40] *Annual Reports of Primary Care Clinics: California Primary Care Clinics Statewide, 1990-1999*. State of California Healthcare Information Division Healthcare Information Resource Center. 28 Sept. 2001. <http://www.oshpd.state.ca.us/hid/infores/archive/clinic/tables/cliagg99.pdf>
[41] Medicaid Managed Care's Impact on Safety-Net Clinics In California: Summary of Findings. *The Henry J. Kaiser Family Foundation, February 2000. 16 Oct. 2001.*
[42] Office of Statewide Health Planning and Development, Ibid.

Clinics are an increasingly important source of care, especially for low-income, uninsured, and rural populations. The MCEP should maintain or increase patient loads at clinics as well as providing a large new source of funding, enabling clinics to increase services offered, expand capacity as needed, and maintain a high quality of care. In addition, it is anticipated that higher premium payments to plans, along with the use of public rather than for-profit plans, will lead to higher reimbursement rates than providers receive under Medi-Cal. Reimbursement rates that more adequately compensate providers for the cost of care will be an important factor in supporting the funding base of clinics and other safety net providers.

Reimbursement Rates

Under managed care systems in California, reimbursement rates are negotiated and therefore differ from hospital to hospital. Hospitals in urban areas, where multiple insurance companies may compete to secure contracts with providers, have greater leverage in negotiating rates. In rural areas where competition is almost nonexistent, hospitals often struggle to negotiate reimbursement rates that adequately cover the costs of health care.

The reimbursement rates offered by different insurance companies range dramatically, as do the typical rates offered for different services. Many insurance companies provide significantly lower reimbursement rates for outpatient services than for inpatient care, thus providing a perverse incentive for hospitals to unnecessarily treat conditions on an inpatient basis. Preventive care has relatively lower reimbursement rates than to specialty care, again creating an incentive for doctors to perform unnecessary procedures to get the higher rate.

Medi-Cal's reimbursement rates are lower compared to all other providers on the market. For example, in one hospital Medi-Cal's reimbursement rates are 20% of bill charges for outpatient services and for 94% of charges for inpatient care. In the same hospital, Blue Shield pays 99% of bill charges for both outpatient and inpatient care.

Under the MCEP, managed care counties will each negotiate premium rates with the state. The resulting rates should be set sufficiently high to allow plans to reimburse providers for the reasonable cost of care; it is anticipated that these rates will be higher than those offered by Medi-Cal. In Fee-For-Service counties the MCEP will require that reimbursement rates to providers be equivalent to those provided by the Healthy Families program. Based on findings indicating low dentist participation in public programs, reimbursement rates for dentists will be raised and the program run on a fee-for-service basis, in accordance with Healthy Families policy[43].

Case Study: Family Health Plan

A brief review of the structure and capabilities of the local initiative in Santa Clara County, the Santa Clara Family Health Plan (SCFHP), may be useful in demonstrating the potential of these

[43] http://www.deltadentalca.org/dentist/programs.html; Distribution of Medicaid Dental Services in California, December 2000. A paper by the Center for California Health Workforce Studies at the UCSF Center for the Health Professions. Carolyn Manuel- Barkin, MPP, MPH, Elizabeth Mertz, MPA, Kevin Grumbach, MD

types of public agencies to undertake the tasks associated with operating the MCEP. In 1995, Santa Clara County elected to participate in the two plan model. By ordinance, the Board of Supervisors established the Santa Clara County Health Authority; the Authority is the institution that manages the SCFHP.

As a public agency, the Authority is open to public input and public review. A Board of Directors appointed by the County Supervisors governs it. Board membership includes the following designated positions: Board of Supervisors (2 seats), Santa Clara Valley Health and Hospital System (2 seats), Medical Association (2 seats), DSH Hospital (1 seat), Community Clinic (1 seat), Consumer Representatives (1 seat), Ancillary Provider (1 seat), At Large (1 seat), Santa Clara Valley Health and Hospital System Medical Staff (1 seat), and a Santa Clara County Representative (1 seat). The Authority has established both a Provider Advisory Committee and a Consumer Advisory Committee. Meetings of the Board are governed by the Brown Act.

The growth of the SCFHP during the past five years has been rapid. Eighty-two full time staff positions are budgeted for 2002. Key personnel include a physician medical director, registered nurses, a statistician, a health educator, and numerous administrative specialties. The plan's financial condition indicates it is well positioned to implement expanded programs. The Statement of Revenue and Expense for FY2000 showed premium revenue of $54,662,452 and costs and expenses of $48,960,728, yielding an excess of revenue over operating expenses of $5,701,724. SCFHP has been financially capable of both repaying the county for its start-up investment on schedule and generating a surplus that it contributes to a foundation established to promote the health of the community.

In 2001, the SCFHP is serving approximately 43,000 Medi-Cal, 8,2000 Healthy Families, and 5,800 Healthy Kids members. Healthy Kids is a unique insurance product created in Santa Clara County that provides health coverage to children from families with incomes below 300% of Federal Poverty Level who are ineligible for other subsidized programs. With the exception of the Healthy Kids program, for which SCFHP is the sole source of coverage, the local initiative must compete with private plans. For Medi-Cal, Blue Cross is the sole competition. For Healthy Families, SCFHP competes with Blue Cross, Blue Shield, Health Net and Kaiser. Currently, SCFHP's market share for these competitive products is 67%.

Provider networks available to SCFHP members are broad. The plan contracts with all eleven general acute care hospitals as well as three hospitals that offer acute psychiatric care in the Bay Area. As of October 2001, SCFHP maintained contracts with 569 PCP's and 1,543 specialists for its Medi-Cal members, 329 PCP's and 1,130 specialists for its Healthy Family members, and 257 PCP's and 974 specialists for the Healthy Kids members.

The SCFHP maintains a strong relationship with the safety-net providers in the county. It contracts directly with the Valley Health Plan, an HMO owned and operated by the Santa Clara Health and Hospital System, for all services rendered by the county hospital and affiliated clinics. More than forty percent of the Family Health Plan's memberships are actually assigned to a safety net PCP.

Although the SCFHP has never specifically projected the impacts associated with participate in the MCEP, the organization's ability to expand operations to cover previously uninsured adults can be evaluated by reviewing its plans for insuring Healthy Family adults in the county. SCFHP Budget estimates for FY2002 indicate the SCFHP could achieve enrollment of 19,500 adult members during that year while still generating a small revenue surplus

It should be recognized that the membership base of the MCEP would be different from Healthy Families' adults. SCFHP's expectations regarding Healthy Families' adults assumes only 20% of the new members will be over age 45. This projection is reasonable for a population that includes only people with children under 18, however MCEP membership will undoubtedly include a larger proportion of older individuals. To respond to the increased costs of providing services to this member base, MCEP premiums will vary in accordance with age, with rates for those who are ages 45 – 64 being nearly double the rates for those between ages 18 – 45. The higher premium rates will cover the higher costs of providing medical services to the older population. The administrative costs associated with older members are not expected to vary significantly from the costs of younger members.

Costs

Sliding Scale

The MCEP will implement a sliding scale requiring individuals or their employers to pay a portion of the premium cost. These payments will decrease the overall fiscal impact of the program to the state. Sliding scale premiums will be based on the enrollee's household income in order to keep payments at a level that individuals can afford and thus avoid discouraging enrollment with excessive costs. In effect, the MCEP's sliding scale will decrease the state's obligations and ensure that health insurance is affordable.

Minnesota, Wisconsin and Tennessee have pioneered the integration of sliding scale fees into their state programs, and overall they have proven to be successful in achieving high enrollment levels for lower income residents. In both Minnesota and Tennessee, sliding scale rates range from 0 to approximately 8.8% of household income. Data from these programs shows that once the higher end of the sliding scale is reached, few people enroll. In Minnesota, less than 10% of enrollees pay premiums greater than 5% of their incomes, while in Tennessee only 4% of enrollees pay the high premiums charged to those with incomes above 200% FPL. At these levels, enrollment declines because premium costs are perceived as economically unattractive.

The MCEP's sliding scale will be a slight variation on the Minnesota and Tennessee program. MCEP will adopt the TennCare's standard of enrolling only those individuals with incomes up to 400% FPL; however, the sliding scale rates defined in the MCEP model will rise less quickly than TennCare's in order to avoid an enrollment drop-off at higher income levels. The sliding scale fees implemented in the MCEP model will be as follows:

- Adults with household incomes under 100% of FPL pay no fee.
- Adults with incomes between 100% and 250% of FPL pay 1.5% of annual household income.

- Adults with incomes between 250% and 400% of FPL pay 2.5% of annual household income.
- Parents pay $9 per month for each enrolled child up to a maximum of $27 per month.

Sliding scale payments for the MCEP will not exceed two and a half percent of annual household income, thereby ensuring that the payments are not a barrier to enrollment. It is estimated that the annual sliding scale payments the state of California would expect to receive if all eligible individuals enrolled total $1,198,474,978.

Aggregate Costs

Currently, there are an estimated 3,232,710 adults and 347,630 children who are eligible for the MCEP program, for a total of 3,580,340 eligible individuals. (See *Appendix A*) If 100% of this target population were covered, the total annual cost of the MCEP is estimated at $7,141,576,862. Sliding scale payments from individuals and employers would total an estimated $1,198,474,978 annually, or 17% of the total cost. With the sliding scale, the net annual cost to the state of covering this entire population would thus be $5,943,101,884, for an average of $1660 annually per insured individual. (See *Appendix B*) If the program were phased in over fifteen years as described below, the annual incremental cost to the state – that is, the amount of new funding that would need to be allocated each year – would be $396,206,792. (See *Appendix C*)

Phasing

The state government financing strategy for MCEP would be designed to significantly expand health coverage while recognizing limitations on the state's fiscal capacities. The program would be phased in over a period of 15 years, initially offering coverage to those at relatively low-income levels and then expanding to individuals with higher incomes during subsequent years. At the same time, individual and/or employer shares of the costs of premiums will increase as the program reaches those with higher earning power.

By adopting a long-term incremental approach, the state's general fund can absorb the program's costs out of the cumulative growth in the state economy. While state revenues certainly vary with business cycles, the same future oriented patterns of economic expansion that are producing reductions in job based health coverage are generating a structurally stronger and larger state economy. Between FY1986-87 and FY2001-02, California's state budget increased by an average of over 6% a year. Assuming a 1% rate of growth was allocated to the MCEP, the additional resources available for the program in FY2015-16 would be over $11 billion dollars.

The incremental financing strategy would be designed to appropriate increased allocations of state funds to the MCEP at approximately the same level for each of the next 15 years. With the estimated cost of $5.9 billion annually for covering the entire target population, this would require an annual funding increment of approximately $396 million each year (as of 2000, in 2000 dollars). To accomplish this objective, each year's expansion in coverage would be based on a calculation of the subsidies required for covering an additional number of uninsured persons. The initial targets would be the most economically vulnerable Californians, those with

incomes less than 100% of Federal Poverty Level, and children below 400% of Federal Poverty Level. Public authorities would be issued marketing objectives in relation to the statewide goal. In future years, coverage would be expanded to those with higher incomes, at lower costs per person to the state since higher individual and/or employer shares of premium costs would be required.

For example, in the first year, coverage might be limited to eligible adults with incomes less than 100% of Federal Poverty Level and children at all eligible income levels, with a target enrollment of 23% of eligible adults and 33% of eligible children (126,185 individuals). In the following year, the target enrollment in each category could double, bringing the total to 47% of adults under 100% FPL and 66% of all eligible children. In year 3 all children could be covered, and by year 4 all adults below poverty could be covered and the program could begin to phase in coverage for adults between 100% and 250% FPL. Coverage could expand to this entire population by year 12. In the remaining three years, coverage could be expanded to adults between 250-400% FPL, thus offering insurance to the entire target population by year 15. (See Appendix C for details of a possible phasing strategy.)

These projections are greatly simplified, as they assume that the state budget increases by the same percentage each year. In reality, the budget's growth rate fluctuates with business cycles, and allocating $396 million in new funding to the MCEP might not be possible in years of revenue shortfalls that put serious constraints on all programs. On the other hand, in years when revenues are especially high, the state may choose to expand coverage more rapidly than scheduled. The design of the program allows acceleration or slowing of implementation as necessitated by fiscal constraints.

Although strains on state budget spending have grown considerably in the last decade, both the Wilson and Davis administrations have proven that large-scale programs requiring significant spending continue to be created or expanded. Gov. Wilson initiated a massive expansion in correction and law enforcement programs in the midst of a recession. Gov. Davis has dedicated large amounts of new funding for education and health spending. Although California under the Davis administration has, until recently, enjoyed a healthier economy, the key point is that structurally, the state budget can accommodate new programs in both deficit and surplus years. The fundamental advantage of this program is that it will not require a massive state investment up front. The MCEP simply puts universal health care on the table alongside every other critical state program. In years of economic prosperity, the state can allocate the needed resources to expand coverage. In years of fiscal crisis, the program will obviously deal with the vulnerabilities experienced by every state funded program. The key point is that it creates a framework for the state to achieve universal care in a fiscally realistic fashion. If the state should decide that new revenue must be generated through taxes, the advantage of this program remains the same.

Alternative Revenue Strategies

If the state chooses to expedite the implementation of the MCEP or if it wishes to fund other costly priorities as well as the MCEP, then moderate tax increases could be imposed to generate the necessary revenue. The strategy described below could generate 50% of the revenue needed

to fund the entire MCEP program, leaving the state general fund with the remaining 50% of the burden. Because this program is expected to expand slowly over a 15-year period, the state would not have to impose significant tax increases immediately. Tax increases could be adopted in phases in balance with the expansion of health coverage.

An MCEP tax strategy would be based on modifications to the current sales and income tax rates. As noted above, the total annual cost of the program is estimated to be $5.9 billion in 2000 dollars. Approximately $1.95 billion could be generated by increasing the sales tax by ½ cent. In addition, between $1 billion and $1.2 billion could be generated by income tax increases for taxpayers in the higher brackets. Specifically, the proposed new rates would be:

- 10% rate for Single-filing with income of $125,000 and above; Joint-filing with income of $250,000 and above
- 11% rate for Single-filing with income of $250,000 and above; Joint-filing with income of $500,000 and above.

Because implementation of the MCEP would be phased in, the timing of parts of these tax increases could be delayed until several years after the program's initiation. Taxes could be adjusted upwards at three times. First, a ¼ cent sales tax increase could be imposed in Year 1, generating $975 million (in 1999 dollars). Since this tax would generate more revenue than needed for the early years of the program, the revenue surplus could be deposited in a reserve fund. After 4 years, the combined revenues from the ¼ cent tax and reserve fund balance would be insufficient to cover increasing plan costs and the income tax adjustment would be required.

These revenues would carry the MCEP through Year 7 at which point the second ¼ cent sales tax could be imposed. This additional $975 million will generate enough total revenue to meet 50% of the $5.9 billion needed to fund the MCEP at 100% of capacity. If, at this time, the remaining costs have not been covered by general fund appropriations, then either final implementation would have to be delayed or additional tax increases would be required.

Fundamentally, this strategy will enable the state to control pressures on the general fund while not overwhelming California's taxpayers with unrealistic rate increases. Considering the likely pressures facing the state budget over the coming years, no other approach is realistic. Other cost savings can be achieved through bulk purchasing plans of pharmaceuticals. Such practice has been successful at the federal level with the Federal Supply Schedule bulk purchasing program.[44] In California, Byron Sher recently introduced SB 1315, a bill to take advantage of such a cost saving mechanism.

Marketing

Enrollment in the MCEP will be accomplished through marketing activities of the institutions in each county that manage the insurance program. Individuals will be able to enroll directly if they

[44] Estimates average a 42% discount from drug makers' factory prices. Sagar, Alan and Deborah Socolar. CUTTING PRESCRIPTION DRUG SPENDING BY PAYING FEDERAL SUPPLY SCHEDULE PRICES: SAVINGS IN EIGHT NORTHEAST STATES. 6 August, 2000.

choose to do so and will pay the sliding scale fee. Alternatively, an employer can agree to pay the fee and enroll all of the eligible workers at his or her business.

MCEP is designed to reduce the obstacles that often prevent businesses from providing health insurance to their employees. Small businesses, in particular, are unlikely to offer health insurance as an employee benefit. A major reason for this situation is the cost of premiums, which are often higher for small firms with small purchasing pools. In 1999, smaller firms experienced greater increases in their premiums than did large firms in both California and the United States[45]. With a substantial state subsidy, MCEP can make the cost of insurance reasonable for a firm with limited resources.

Businesses with low wage workers are also less likely to offer health coverage, and so would stand to benefit significantly from the MCEP. In California, firms with large numbers of low wage workers are even less likely to offer coverage than such firms nationally. In 1999, only 25% of firms in California with 35% or more of their employees making low wages offered health coverage. By comparison, 38% of such firms nationally offered coverage to low wage employees. Since MCEP fees are established in accordance with a sliding scale, it is precisely these firms with low wage workers which will be able to secure insurance for their employees at the lowest costs.

Surveys indicate businesses also often fail to provide health insurance because they lack information regarding the tax advantages of doing so, or because they wish to avoid the administrative burden of forming a group and managing a plan. MCEP marketing activities can provide answers to many of these questions, and the organization of MCEP can significantly reduce the firm's administrative responsibilities associated with health coverage.

Other incentives in the program can also encourage business participation. Local Initiatives or other plan operators can achieve both savings in marketing costs and savings in some forms of services, such as preventive health classes. By interacting with numerous employers at a central business location, plan operators will be allowed to offer discounted premiums to employers. In addition, the phasing of the program will encourage employer participation. As a long-term program, MCEP will only enroll limited numbers of the total potential eligible members each year. A firm that acts promptly is likely to secure insurance for its employees before the annual quota is reached. That firm would thereby enjoy the competitive advantage of having an insured workforce with consequent reductions in absenteeism and turnover as well as improvements in morale.

MCEP will encourage special outreach efforts to temporary staffing firms (SIC 7361 and 7363) to target temporary employees. Staffing agencies present unique challenges to programs attempting to increase health coverage for workers, as demonstrated by the fact that temporary employees are 50% less likely than permanent employees to receive health benefits. The ambiguous nature of the employment relationships surrounding contingent workers contributes to the problem. Temporary workers seem to have two employers, the client firm and the

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[45] Brown, Richard E., PhD., and Ninez Ponce, PhD., and Thomas Rice, PhD. *The State of Health Insurance in California, March 2001.* The California Wellness Foundation. 28 June 2001. <http://www.healthpolicy.ucla.edu/publications/TheStateofHealthInsinCalifFullReport2001.pdf>

placement agency, but in many cases neither provides them with access to benefits. Outreach efforts designed to assist traditional businesses may not prove to be of value. For example, programs focused on small businesses tend to miss temporary employment agencies. Because they are considered the employer of record, they carry large numbers of people on their payroll and fail to meet small business eligibility criteria. Marketing efforts to reach temporary workers may have to involve the creation of worker groups distinct from the staffing agencies themselves, possibly with the assistance of non-profit organizations or unions. These new associations may develop joint marketing campaigns with Local Initiatives in order to inform temporary workers of their opportunities under the MCEP.

The MCEP, then, will combine a phasing mechanism with a targeted marketing strategy to encourage employers to participate. The phasing mechanism encourages businesses to participate at the outset to benefit from the competitive advantage they gain over non-participating firms. At the same time, marketing plans can focus on businesses with the largest pool of uninsured low wage workers, small businesses, and temporary staffing agencies and/or associations of temporary employees.

Implementation Issues

Crowd Out

Any significant expansion of publicly subsidized health insurance must confront the potential challenge of crowd out, the possibility that employers or individuals will discontinue participation in private health plans in order to take advantage of the new low cost government program. The MCEP includes a number of mechanisms to respond to this issue. The primary device to discourage crowd out is eligibility restrictions. Coverage is limited to those who have been uninsured for more than six months or have access only to a sub-standard health insurance plan, do not have access to health insurance through their job, and do not qualify for any other public insurance program. Similar restrictions have been successful in limiting crowd out in other states, particularly Minnesota and Tennessee. Both of these states have imposed similar eligibility restrictions on their health insurance expansion programs, and both have experienced minimal degrees of crowd out. In addition, MinnesotaCare determined that only 3% of its enrollees had discontinued employer-sponsored coverage. On the other hand, Rhode Island's insurance program, which lacked eligibility restrictions, suffered from substantial crowd out in its early stages. Once eligibility controls were imposed, however, crowd out was significantly reduced.

Another component of the MCEP that reduces the attractiveness of crowd out is the presence of a sliding scale fee system. As workers' incomes increase, the non-subsidized portion of the insurance premium becomes closer to market rates, thereby reducing the economic benefit from discontinuing private coverage in favor of the public program.

Rural Counties

Rural communities in California face special obstacles to the task of providing adequate health care to their populations. Because they have small and lower density populations, they have fewer health care facilities. In addition, in the absence of the economies of scale, they have proven unable to sustain HMOs. Also, as health care costs increase, access to the most expensive services, dependent on volume, is declining in these regions. Many specialty services are disappearing, forcing rural residents to travel in order to obtain services.

Additional challenges confront low-income patients. Most rural counties operate on a fee-for-service basis, and Medi-Cal's reimbursement rates are especially low in these regions. At the same time, the agricultural employment base results in a high proportion of the population being uninsured with incomes under the federal poverty level. The result is a severe lack of access to health care. Private practices and some clinics often refuse Medi-Cal patients because of the low reimbursement rates, thus further limiting access to care. Safety net institutions find themselves hard pressed to cope with the resulting demands for service.

The MCEP will work with each rural county to find the best means of implementing the program. In counties where only FFS exists and a managed care model would be inefficient, the FFS model would be expanded. In managed care model counties the MCEP would simply expand the existing system. The MCEP will require that reimbursement rates be competitive with that of Healthy Families, thereby decreasing the problem of insufficient access to care. By emphasizing preventive and regular care, the MCEP will reduce the overall load on hospitals, funnel more patients into outpatient care and away from the already limited emergency rooms thus making positive changes to the safety net institutions. Revenue from MCEP patients will relieve rural hospitals and clinics from the burden of uncovered costs from the previously uninsured.

Marketing Skills

While a number of local initiatives in two plan counties now have substantial experience in designing and managing marketing activities for Medi-Cal and Healthy Families programs, in COHS counties, these capabilities may not yet have been developed. As part of the administration of the MCEP, the state should develop a best practices marketing guide and provide technical assistance for those institutions in need of support.

Monitoring and Evaluation

One of the advantages of an incremental strategy is that it provides an opportunity to evaluate the effectiveness of program components before massive resources have been committed. On an annual basis, the state should closely monitor the performance of MCEP with an emphasis on the following factors:

- number of enrollees
- costs
- adequacy of provider networks

- impact on safety net institutions
- utilization of health plans
- customer satisfaction.

All of these factors should be reviewed by county and by type of managed care organization.

Conclusion

The MCEP plan attempts to provide the Governor and the State Legislature with the ability to move slowly, but consistently, towards achieving universal health insurance in California without fundamentally restructuring the state's health care delivery system. The plan is designed to require state expenditures that are significant but not extraordinary either in relationship to the size of the state budget or the scope of tax increases that might be required. At the same time, it requires a major commitment of resources either from plans' participants or their employers and is compatible with a variety of mechanisms to encourage businesses to offer health insurance as an employee benefit. In a number of ways, the presentation of the plan may be of value to ongoing debates regarding access to health care in California and the state's role in the provision of insurance to the uninsured. The MCEP demonstrates that the opportunity to move forward towards universal coverage exists even if resources to achieve 100% coverage are not immediately available. Moreover, it offers a public policy objective against which the use of future state surpluses can be weighed. What the MCEP tells the taxpayers and decision makers of California is that whenever state surpluses are used for purposes other than health care, the opportunity cost is the provision of health insurance to the uninsured residents of the state.

Appendix A: Eligible Population Under the MCEP (2000)

	Income < 100% FPL	Income 100% - 250% FPL	Income 250% - 400% FPL	Income > 400% FPL	*Totals*
Number uninsured, ages 19-64	1,221,960	1,993,290	866,460	880,500	*4,962,210*
Uninsured Medi-Cal eligibles	(532,000)				
Uninsured Healthy Families eligibles		(317,000)			
Eligible for MCEP	**689,960**	**1,676,290**	**866,460**	**0**	***3,232,710***

Total uninsured children	1,849,000
Unins. kids >400% FPL	(240,370)
Unins. Medi-Cal eligibles	(726,000)
Unins. HF eligibles	(535,000)
Eligible for MCEP	**347,630**

Appendix B: Costs of the MCEP Including Sliding Scale

Cost Estimates for the Managed Care Expansion Plan					
	Number of Eligibles	Cost of Premium for Ages 19-64 [1]	Cost of Premium for Children [1]	Gross Annual Cost	*Net Annual Cost to State*
Total Eligible Children:	347,630		$325,256,533	$325,256,533	*$287,712,493*
Total Eligible Adults:	3,232,710				
Adults by Income:					
<100% FPL	689,960	$1,281,255,720.0		$1,281,255,720	*$1,281,255,720*
100-250%	1,676,290	$3,591,820,108.8		$3,591,820,109	*$2,997,692,644*
250-400%	866,460	$1,943,244,500.4		$1,943,244,500	*$1,376,441,027*
Total Eligible Individuals:	**3,580,340**		**Total Gross Annual Cost**	**$7,141,576,862**	
Adults with household incomes below 100% FPL pay $0 annually				$0	
Adults with household incomes 100-250% FPL pay avg. $354.43 annually [2]				-$594,127,465	
Adults with household incomes 250-400% FPL pay avg. $654.16 annually [2]				-$566,803,474	
Children's contribution, $9/month = $108/yr				-$37,544,040	
			Total Annual Sliding Scale Payments	-$1,198,474,978	
			Total Net Annual Cost to State	**$5,943,101,884**	*$5,943,101,884*
			Net Cost Per Enrollee	**$1,659.93**	

[1] Based on average premium costs for adults and children in each income bracket as given in Lewin Group report.

[2] Based on average premium contribution per adult in each income bracket as given in Lewin Group report.

Appendix C: Phase In

Total annual cost when phase-in is complete: **$5,943,101,884**

Option 1: Add 1/15th of final annual cost each year

Annual Increment $396,206,792

		approx. population covered:			
		children	adults		
	annual cost		<100% FPL	100-250% FPL	250-400% FPL
Year 1	$396,206,792	33%	23%	0	0
Year 2	$792,413,585	66%	47%	0	0
Year 3	$1,188,620,377	100%	70%	0	0
Year 4	$1,584,827,169	100%	100%	1%	0
Year 5	$1,981,033,961	100%	100%	14%	0
Year 6	$2,377,240,754	100%	100%	27%	0
Year 7	$2,773,447,546	100%	100%	40%	0
Year 8	$3,169,654,338	100%	100%	53%	0
Year 9	$3,565,861,130	100%	100%	67%	0
Year 10	$3,962,067,923	100%	100%	80%	0
Year 11	$4,358,274,715	100%	100%	93%	0
Year 12	$4,754,481,507	100%	100%	100%	14%
Year 13	$5,150,688,300	100%	100%	100%	42%
Year 14	$5,546,895,092	100%	100%	100%	71%
Year 15	$5,943,101,884	100%	100%	100%	100%

Note: This chart is illustrative of a phasing strategy. It does not include an inflation factor and actual state expenditures would vary depending on increased costs.

Appendix D: Federal Poverty Level

2002 HHS Poverty Guidelines		
Size of Family Unit	**48 Contiguous States and D.C.**	**400% FPL**
1	$8,860	**$35,440**
2	11,940	**$47,760**
3	15,020	**$60,080**
4	18,100	**$72,400**
5	21,180	**$84,720**
6	24,260	**$97,040**
7	27,340	**$109,360**
8	30,420	**$121,680**
SOURCE: *Federal Register*, Vol. 67, No. 31, February 14, 2002, pp. 6931-6933.		