State Health Watch

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In This Issue

The uninsured: Policy-makers still cannot agree on a single solution

At the end of 2003, there was a flurry of reports on the problems of those without health insurance coverage for all or part of each year and what to do about them. The upcoming presidential campaign keeps the issue alive. Here is a summary of the reports and analyses that are likely to be the foundation for any policy changes.

All is not well in Stuart Altman's view of American health care and the uninsured. "The problem is getting worse, not better, on a lot of fronts," said Mr. Altman, Brandeis University professor of national health policy, at a November briefing of the Council on Health Care Economics.

"We're not making progress. We're going in the wrong direction. The number of uninsured is growing. And the parallel problem to the increasing number of uninsured is the increasing cost of health care. Whether we're looking at premium growth or expenditure growth, we're back to the 1980s in terms of increases in spending," he added.

Special Report: The Uninsured

Contrast that, Mr. Altman said, with the fact that for many decades

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NASHP: Medicaid buy-in programs increase as states find they can reduce the uninsured

A literature review, state survey, and expert meeting to look at the design and operation of Medicaid buy-in programs as a way to cover the uninsured have found that such programs have increased in both number and enrollment in recent years, and states have demonstrated that they can design and implement participant buy-in programs using existing waiver mechanisms.

Fiscal Fitness: How States Cope

Neva Kaye, the program director for the National Academy for State Health Policy (NASHP), authored the study for that organization. She says a debate on the role and purpose of Medicaid could help clarify what changes to the program would be beneficial for the future.

Ms. Kaye tells *State Health Watch* that among the many proposals being floated as ways to deal with the problem of the uninsured, expanding Medicaid buy-ins is very feasible, especially for use with low-income populations. She notes there would be a financial benefit in increasing the pool of Medicaid insured by allowing people to buy

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State Health Watch
The Newsletter on State Health Care Reform

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The uninsured

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now a vast majority of Americans, usually 75% to 85% of those polled, believe every American should have health insurance coverage.

To show how difficult it is to develop a solution that can win political support, Mr. Altman divides the country into rough quarters. The first, about 25%, believes there should be a single-payer system run by the government, whether it would look like Medicare, or like Canada and Great Britain.

The next group, also about 25%, believes in employer mandates, which has been the prevailing structure for most health insurance since World War II ended. The latest version of the employer mandate paradigm is California's Senate Bill 2 (**see related stories, pp. 7, 9**), which wants every employer to be responsible for covering all its workers. Small firms and those with low wage bases would be subsidized, but the basic theme is an employer mandate wrapped around a government plan for those not working.

Yet another group, according to Mr. Altman, opposes employer mandates because they distort the labor market or they leave inefficiencies. People in this group believe there should be tax and other incentives to encourage individual responsibility for their own health insurance.

The fourth group, perhaps 15% to 20%, is opposed to anything, according to Mr. Altman.

In a political context, he added, a substantial majority, perhaps 60% to 70% of those voting, is needed to pass any significant structural change, and thus it's easy for the opposition to form a coalition with any group whose idea is dead in the water and stonewall progress.

"We allow ourselves to say that if we can't have our own plan, we'd rather stick with the status quo," he said.

Mr. Altman said it's not likely that a solution will come until enough Americans feel personally threatened.

"Maybe," he theorized, "as the problem grows worse and affects more and more of the middle class, the likelihood of some form of government action will increase."

Paul Ginsburg, president for the Center for Studying Health System Change and vice president Len Nichols described the health care cost-coverage conundrum as the "care we want vs. the care we can afford.

"How we finance health care and our leaders' pervasive unwillingness to confront the difficult trade-offs inherent in containing health care costs and expanding health insurance to cover more Americans contribute to the seemingly intractable nature of the cost-coverage conundrum," they wrote in the center's annual report, suggesting that for any meaningful discussion, three key factors must be considered:

1. Cost-containment and quality improvement efforts are essential if Americans are to get a better value for the large sums of money spent on health care.
2. If we are to cover everyone, we cannot cover everything, and it's necessary to make informed choices about which medical services are more beneficial to patients than others.
3. Even if cost trends are slowed, considerable public funding will be needed to expand coverage to the uninsured, whether through tax subsidies, expansion of public coverage, or a combination.

What is striking over the years,

according to Mr. Ginsburg and Mr. Nichols, is "the consistency with which leaders in both the public and private sectors have avoided the idea that real cost containment involves real sacrifice — patients going without services that may provide some benefit or physicians, hospitals, and insurers settling for smaller incomes or profits."

It doesn't work, they said, for policy-makers to consider the health care cost problem in terms of waste, fraud, and abuse in hopes that if enough progress is made in those areas, there will be no need for difficult trade-offs.

More people can't afford care

They noted that, despite an aggregate economic capacity to pay for ever-greater health care spending, an increasing number of individuals can no longer afford health care when society acts as if medical care is a free service.

"In our view," they wrote, "a more clinically based form of rationing is needed to avoid pricing health care out of the reach of an increasing proportion of Americans. Though some deny it, we ration care today. The uninsured get much less care than the insured and suffer worse health outcomes because of it, and the insured with ample means get more care than the lower-income insured, although without clear differences in outcomes. The challenge is to ration in a way that is more efficient and more equitable."

Mr. Ginsburg and Mr. Nichols traced America's long history of rising health care cost trends and noted that even though other industrialized countries devote smaller percentages of their gross domestic product to health spending, their health care costs per capita grew at a rate remarkably similar to those in the United States, and all developed countries are spending an increasing share of the gross domestic product on health and increasingly are worried about cost control, according to the Organization for Economic Cooperation and Development (OECD).

Its commentary says employers' willingness to deal with cost control varies with the business cycle. When health care costs are rising rapidly, profits are low and labor markets are loose; employers have taken strong actions to control costs only to drop their efforts when the cycle turns.

Employers buying down benefits

With health insurance premium trends high and the economy weak, said Mr. Ginsburg and Mr. Nichols, employers respond by buying down the benefit structure of their plans by increasing patient cost sharing. While employers don't appear to be interested in revisiting restrictive managed care models, possibly because of the vehement employee opposition to such controls and the lack of visibility of costs to workers, they also are not optimistic that higher cost sharing alone can provide a long-term answer.

State and federal governments deal with costs through two distinct roles, Mr. Ginsburg and Mr. Nichols explained. They are managers of public insurance programs and also are regulators of the health care system. Medicare and Medicaid, they said, have aggressively controlled spending when imperatives to cut budgets were greatest, primarily by reducing provider rates. But rate reductions have been constrained by concerns about beneficiaries' access to providers and concerns about providers' financial viability, especially hospitals'. Benefit reductions have not been common, and there has been little interest in controlling utilization of services. Also, except for the 1970s, governments have not been very active in attempts to contain costs systemwide.

Restrictions in other countries

In contrast to what has happened here, according to Mr. Ginsburg and Mr. Nichols, OECD countries use a wider array of tools to limit resource use and expenditure growth.

"Until recently," they wrote, "cost sharing has not been used in these countries, often reflecting their social value of solidarity — equal access to something as critical as health care. Direct regulation of prices, involving unabashed use of government's sole-buyer power, and administrative limits on the acquisition and use of expensive technology are used in place of substantial patient cost sharing in these systems. A recent cost analysis concluded that rates of service use are lower in the U.S. than in OECD countries and that higher services prices and greater service intensity explain much of the higher U.S. spending rate."

With cost pressures likely to increase in this country in the next few years, Mr. Ginsburg and Mr. Nichols said policy-makers are likely to pursue ideas that promise to reduce costs, including federal support for an information technology infrastructure for hospitals and medical practices, plus an expanded role for disease management in Medicaid and Medicare.

"Many of these initiatives have merit because they may improve the quality of care," they wrote, "but we are skeptical about the magnitude of cost reduction. While there certainly will be instances where quality improvement will contain costs at the same time, we doubt that the net impact on costs will be commensurate with the magnitude of the affordability problems.

"More effective ways to cope with limited resources will depend on

political, professional, corporate, labor, and opinion leaders articulating the need to confront trade-offs among clinical effectiveness, costs, and equity. Once the rationing imperative is widely acknowledged, a broader and complimentary array of cost-containment tools can be brought to bear in the United States. These cannot and need not extend to the kinds of absolute limits on specific resources and consumer choices used by the centralized systems of most OECD countries. Rather, evidence-based practice guidelines and institutionalized technology assessment can help to inform private benefit package design and differential cost-sharing requirements. In contrast to systems that decide for the patient what services are unavailable because of limited clinical value, a system more compatible with American values would continue to allow broad patient and provider choices, coupled with extensive information about likely clinical value and higher cost sharing when the values are small."

Mr. Ginsburg and Mr. Nichols concluded that, in the end, Americans still will be devoting more of their income to health care than is the case today, but slowing that trend may keep mainstream health care accessible to more of the population. It also could give, they added, considerably more value for the health care dollars spent and help ensure that care will be distributed more equitably throughout society than if nothing is done.

[To access a webcast and transcript of the Council on Health Care Economics and Policy briefing, go to: www.kaisernetwork.org. Download the Ginsburg-Nichols commentary from www.hschange.org. Contact Mr. Ginsburg and Mr. Nichols at (202) 484-5261.] ■

Fiscal Fitness

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in, and also points out that these are programs that have been carried out for some time with good track records, and thus are ready to be broadened.

For purposes of this study, Medicaid buy-in programs were defined as any program in which participants pay a prospective fixed premium or other kind of fee, such as an enrollment fee, to participate in Medicaid. Medicaid programs in many states have experience charging and collecting premiums from participants, who typically have higher incomes than Medicaid participants who are not charged premiums. Most of the participants who pay premiums are in states with Section 1115 research and demonstration waivers that permit the states to waive the typical Medicaid prohibition on charging premiums. And some premium paying participants are working disabled people who ordinarily earn too much to qualify for Medicaid.

Many of the concerns related to Medicaid buy-in programs don't deal with specific issues involved in charging and collecting premiums, but rather to other elements in the Medicaid rules that cause barriers to the success of such programs, Ms. Kaye says.

The NASHP study reports the literature search conducted as part of the research found:

- As premiums increase, enrollment falls predictably, with the greatest enrollment occurring when premiums are set at 1% or 2% of the income of the target population.
- Those who enroll are different from those who don't, with those not enrolling having lower income, less education, and being members of a minority group.

Under federal law, according to Ms. Kaye, there are five authorities for state Medicaid agencies to charge premiums or enrollment fees — Section 1115 waivers, work incentives under the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999, Transitional Medical Assistance, certain pregnant women and infants, and medically needy pay-in spend-down options. The only one of these authorities not reported by any state was charging premiums to certain pregnant women and infants.

The survey of states found that 29 states reported 41 programs in which some or all participants must pay a premium or enrollment fee to participate in Medicaid. The majority (54%) of programs that charge premiums are Work Incentive programs. The majority of people (97%) who pay premiums or enrollment fees to participate in Medicaid do so under Section 1115 waivers.

A total of 471,856 Medicaid beneficiaries were in buy-in programs in May 2002. In most states with programs, buy-in participants represented only a small percentage of all Medicaid participants. In 32 of the 41 surveyed programs, buy-in participants represented less than 1% of total Medicaid enrollment in the state. The remaining nine programs had enrollment representing more than 1% of total Medicaid enrollment, and two programs (MinnesotaCare and TennCare) accounted for 70% of total buy-in participants nationwide.

Most programs that require participants to pay for Medicaid are fairly new, with 54% implemented in the last two years, Ms. Kaye says. The majority of programs that charge premiums or enrollment fees apply them to working people with disabilities. She adds that when the analysis is limited to Section 1115 waivers, which serve 97% of those

who must pay to participate, adults are the most likely group to be required to pay for participation.

Among all 41 programs, Medicaid agencies reported being most likely to begin charging premiums at 150% of the federal poverty level. Among work incentive programs, the most frequently reported threshold for premium payments also is 150% of the poverty level, with the second most frequent threshold level being "any who would not otherwise qualify for Medicaid."

In the Section 1115 waiver programs, the most frequently selected income threshold for premium payment was "anyone who not otherwise qualifies for Medicaid." Two of the programs begin charging premiums at differing levels of income for different groups of program participants. Programs most frequently reported using a sliding schedule based on income to determine individual payment level. The range in premiums charged was large, going from a low of $4 per child per month to a high of $1,375 per family per month. But Ms. Kaye's report says the range in incomes of the eligible population also was diverse.

Most states (36) use a state agency to collect premiums, while seven use an external contractor and two use local eligibility offices. States typically mail their bills two to four weeks before payment is due, and payment is due either a couple of weeks before or after coverage starts. Late notices typically are sent two weeks later. Some states follow-up with phone calls, and termination for nonpayment can occur from one week to four months later.

Programs most often said they charged buy-in participants to "offset the cost of the expansion" and to "promote personal responsibility." Some 32 of the programs rated their premium collection programs as successful, while five said they could not rate collections as either successful or unsuccessful. When asked to name the top two barriers to success, technical/billing systems/operations was named in 23 programs, client understanding as a barrier in 11 programs, failure to pay in five programs, and insufficient staff in three programs.

Ms. Kaye says that when 28 staff from various states were brought together by NASHP to discuss the potential of using Medicaid to collect premiums and help insure the uninsured, they soon found that while many states have experience and capability to charge and collect premiums and fees, there are other issues in Medicaid rules and regulations that need to be addressed before they can design truly effective programs for uninsured state residents who can afford to pay a premium.

For instance, Oregon is redesigning some aspects of its Medicaid program and considering cutting back on benefits. The state obtained a waiver in October 2002 to expand its coverage of adults from 100% of the federal poverty level to 150%. But it can afford to do that only by offering a benefits package comparable to small employer coverage, with fewer benefits and higher cost sharing than traditional Medicaid coverage. State officials have said they are worried about both crowd-out and adverse selection as a result of the expansion.

Minnesota charges premiums to those between 175% and 270% of the federal poverty level, with premiums ranging up to 7% of income. The state has found that enrollment is most attractive for older enrollees and people with health conditions. They are required to be uninsured for four months before joining the buy-in, to prevent them from dropping private coverage. The state has a rule that if an employer pays 50% or more of a person's coverage, he or she cannot join, but officials say they now are seeing more people who cannot afford the $200 to $300 per month to pay their share of private coverage. Officials also think there is a need to increase the $3 copayment on prescription drugs.

Few problems getting premiums

Officials in Minnesota report few problems in collecting premiums, and say the most efficient way appears to be making automatic deductions from bank accounts using debit cards. In coordinating Medicaid and employer coverage, they have found that employers do not want to be closely involved with their employees' public coverage and do not want to know what their employees' family incomes are.

Rhode Island officials reported they have found that more children enroll when parents also are eligible. The state has released a study of what happened to people who did not pay their RIte Care premium and were disenrolled. After the program began to charge premiums of $43 to $58 per family per month in January 2002 to enrollees earning between 150% and 200% of the federal poverty level, 82% still were enrolled in July 2002 and 18% had been dropped because of failure to pay. The survey showed that half of those who were disenrolled became uninsured. Those who did not pay and became uninsured were more likely to have a chronic condition and to use hospital emergency departments for primary care than were those who found other health care coverage.

To address a concern about potential crowd-out (people dropping private coverage to enroll in the state program), Rhode Island requires RIte Care enrollees who have employer coverage available to them to enroll in the employer's coverage. There is a premium assistance

program that pays subsidies directly to the enrollee to help pay the employee share of the premium. The state does not impose a mandatory period of uninsurance because it wanted its policies to promote health insurance coverage rather than separate people from coverage.

Rhode Island officials say changes need to be made in two federally imposed obstacles to more efficient coordination with employer coverage. First, they say, states need the authority to collect health insurance information from both large and small employers that now cannot be obtained because of Employee Retirement Income Security Act (ERISA) restrictions. And federal Medicaid eligibility rules should be simplified so there is one income level below which everyone qualifies for Medicaid and above which states may offer a commercial insurance-like package.

Mississippi officials identified another federal obstacle to premium assistance programs. When someone is found eligible for Medicaid premium assistance, the determination typically doesn't trigger an open-enrollment period in the employer plan. Instead, the applicant must be provided with regular Medicaid for the months before the employer's open enrollment period, and procedures must be put in place to switch the coverage during that open-enrollment period. Maryland officials said they had experienced similar problems, although Maryland law allows Medicaid and State Children's Health Insurance Program eligibility to create an open enrollment for small businesses, but does not cover large self-insured employers, which are exempted by ERISA.

Some states advised that the description of Medicaid health benefits should be simplified to make premium-assistance programs more successful. They said the level of detail specified by a Medicaid benefit package is not a good fit with current employer benefits packages. The mismatch in terminology and detail makes it complicated to define and offer wraparound coverage, and makes it difficult to explain the program to employers.

During the discussion, it was noted that many states have spent considerable time and effort to collect premiums from individuals and coordinate with employers, but in many cases the total value of the premiums collected was very low. This led to a discussion of whether collecting premiums was worth the effort or whether it would be better to impose a moderate copayment on something like prescription drugs rather than collect premiums.

Value of copayment doubted

Washington state has experience with that kind of trade-off. Officials there considered more substantial copayments on prescription drugs for public employees, but recognized a need to be cautious so that the copayment did not pose a financial barrier to people getting needed drugs. Also, when the state implemented a copayment on drugs for Medicaid in 1993, pharmacists ended up absorbing the costs if patients were unable to afford the copayment, and the copayment was discontinued within seven months.

Officials from Oklahoma reported their state is considering whether to create a program that expands coverage by charging premiums for some Medicaid recipients. They can't expand the program with a traditional Medicaid benefits package and would like to use a commercial insurance-like package and a single eligibility level based on income rather than on categories.

Utah has received a Section 1115 waiver to expand coverage with a primary care benefits package. The state's decision to have new populations pay an enrollment fee sent an important message from the legislature in support of personal responsibility, officials said. The state would prefer to cover new populations through their employers, but recognizes that while 75% of the uninsured are working, most of their employers do not offer coverage at all or do not offer affordable coverage. Crowd-out thus is not a significant concern because the target population has very little affordable private coverage available.

Those at the NASHP meeting said that one immediate change the federal government could make that would simplify Medicaid eligibility rules would be to stop locking out single adults without children who earn less than the poverty guidelines. In addition, much of the Medicaid budget goes to cover the prescription drug costs of people with Medicare, and some states said that the federal government could help state budgets considerably by paying for more drug coverage for Medicare beneficiaries.

States asked to discuss their experiences with the Ticket to Work program reported varying degrees of success. In New Jersey, the program has attracted a different population than was originally expected. While intended to provide affordable health insurance for physically disabled people who were working but had no coverage, it has turned out to serve many mentally ill participants in low-paying jobs.

In Minnesota, 6,000 people have enrolled in Ticket to Work. Officials say that for about half of them it was a less expensive option than other Medicaid participation would have been. They said there has been frustration over the inability to define "work," and the need to qualify some people who do relatively little,

often sporadic, work in their homes for their friends and neighbors. The Minnesota Ticket to Work program, they said, has to balance how much it helps higher income people with high health needs vs. lower income people with less intense chronic health problems. Minnesota's experience was contrasted with that in Washington state where the program was not included in the governor's budget this year and is likely to be cut.

One state official suggested that if Medicaid and Medicare paid the full costs of the care provided to their participants, private health insurance would be more affordable because there would be less cost-shifting and there would be fewer uninsured. Many of Medicaid's complexities come from trying to separate the deserving poor from the undeserving poor, and it would be simpler to have a national health care program for anyone under, for example, 150% of the federal poverty level.

According to Ms. Kaye, NASHP's work on that program is finished, although the organization is using lessons learned from it on a project on making Medicaid work for the 21st century. She says some congressional staffers have expressed interest in the concept of Medicaid buy-in, but it's not clear if anyone in Congress will champion this approach to reducing the number of uninsured. As Medicaid reform continues to be discussed, some states are saying they would like to be able to run buy-in programs without going through the waiver process. "They're saying that they've been carrying out the elements for quite a while; these are tried-and-true programs that are ready to go prime time."

[For more information, go to: www.nashp.org. Contact Ms. Kaye at (207) 874-6524.] ■

Many Californians lack health insurance for long periods, say UCLA researchers

Often considered a bellwether state in health policy, California is demonstrating the extent of the problem of lack of health insurance, but it also will be seeing how one possible solution could work.

A study of the health insurance situation in California by the University of California, Los Angeles (UCLA) Center for Health Policy Research, funded by the California Healthcare Foundation, found that 4.5 million Californians were uninsured for six months or longer in 2001, out of a total 6.3 million who lacked health insurance for all or part of the year.

A total of 3.3 million people were uninsured for longer than a year. Only 15% of the 6.3 million uninsured, less than 1 million people, were uninsured for three months or less.

Study author Richard Brown says the lack of health insurance coverage "is a long-term condition for more than 5 million Californians. It has real consequences for their access to health services and for their health."

'Pay or play'

Meanwhile, California is implementing the Health Insurance Act of 2003, a "pay-or-play" approach that requires California employers to pay a fee to the state to provide health insurance unless the employer provides coverage, in which case the fee is waived. (**See related story, p. 9.**) The legislation was one of the last bills to be signed by Gov. Gray Davis before he had to leave office as a result of the recall election.

Special Report: The Uninsured

Because so-called pay-or-play provisions are one of many that analysts say could address the nation's overall health insurance problems, attention will be focused on California's experience with this bill for lessons that can be applied elsewhere.

Some coverage not stable

Mr. Brown's survey found that some sources of coverage are less stable that others.

Among adults and children who were uninsured at the time they were interviewed, 25% had had health insurance coverage during the year but lost it. Some 9.1% of children who were uninsured at the time of the interview had been covered by Medi-Cal, the state's Medicaid program, but lost it, while 2.3% had been covered by the state's Healthy Families program, and 10.8% had been covered by job-based insurance before becoming uninsured.

Among adults who were uninsured when interviewed, only 3.6% previously had Medi-Cal and lost it, 7.2% had privately purchased health insurance or some other coverage, and 13.3% had job-based coverage before becoming uninsured.

Mr. Brown also found that the probability of retaining coverage throughout the year or lacking coverage for all or part of a year varied considerably depending on age group, income, ethnicity, citizenship status, level of English proficiency, and other social characteristics. The study found:

- Children younger than 12 were least likely to be uninsured all or part of the year, but nearly half were uninsured all year. Young

adults ages 18 to 24 were most likely to be uninsured at least some of the year, and half of them were uninsured all year. Their rates of uninsurance decrease throughout adulthood, however.

- Among children in families with income below the federal poverty level, 24.8% were uninsured for all or part of the year, including 14.4% of all poor children who were uninsured all year. In contrast, only 4.5% of children in families with income above 300% of the poverty level were uninsured.
- Among adults with family income below the poverty level, 48.6% were without coverage for some portion of the year, including 33% who were uninsured all year. As with children, among adults with family incomes above 300% of the poverty level, 12% were uninsured for some portion of the year.
- Among children, nearly 25% of Latinos were uninsured at least part of the year, including 13.8% uninsured all year, the highest rate among all ethnic groups. However, only 4.3% of Asian Americans and Pacific Islander children, 6.8% of American Indian/Alaska Native children, and 2.5% of African-American children were uninsured all year.
- Among adults, 43.5% of Latinos were uninsured at least some of the year, including 28.5% who were uninsured the whole year, also the highest rate among all ethnic groups.
- Among noncitizen adults without a "green card," 61.5% were uninsured all or part of the year, including 27% uninsured all year. In contrast, 22.6% of naturalized citizens and 17.6% of U.S.-born citizens were uninsured some part of the year.
- Children whose parents were both born in the United States are least likely to be uninsured for all or part of the year (7.7%). However, 23.4% of children whose parents are noncitizens without a green card and 46.2% of noncitizen children were uninsured all or part of the year, including 34.1% of noncitizen children who were uninsured all year.
- While 19.7% of Californians up to age 64 who speak English very well experienced some period of uninsurance, 44.8% of those with limited English proficiency lacked coverage all or part of the year, including 32.2% who were uninsured all year.

Mr. Brown reports that most of California's 13.6 million workers (78.6%) were insured continuously in 2001, but nearly 3 million (21.4%) were uninsured for some or all of 2001. More than 1.5 million workers (11%) were uninsured all year.

Disproportionate characteristics

Employees who experience at least some period of uninsurance were found to be disproportionately Latino, with limited English proficiency, single with no children, and have lower household incomes. Stability of coverage also varies significantly by labor market characteristics such as hourly wages, hours of work, size of firm, and industry type.

Thus, employees who earn low hourly wages, work less than full time, are employed in smaller firms, and work in certain industries tend to account for a disproportionate share of employees who experience uninsurance all or part of the year.

Are the levels of intermittent coverage reflected in the health status of Californians? Absolutely, according to Mr. Brown.

He says that nonelderly adults with all-year Medi-Cal coverage (including a small number in healthy families) reported the worst health status of any group, reflecting Medi-Cal's role in serving the disabled.

Among adult Medi-Cal beneficiaries, 39.6% reported being in fair or poor health, compared to 19.3% of those uninsured part of the year, 27.4% of those who were uninsured the entire year, and less than 11% of those with job-based or privately purchased coverage.

Among children, he says, 18.3% of those who were uninsured the entire year were reported to be in fair or poor health, compared to 14% of those uninsured part of the year and those who had Medi-Cal or Healthy Families coverage all year, and less than 5% of those with job-based or privately purchased coverage.

Less likely to have medical home

Mr. Brown's survey found that Californians who were uninsured all or part of the year were less likely to have a medical home, a usual source of care, were more likely to report experiencing delays in or not getting care, and were less likely to report taking medication for certain chronic conditions compared to those insured all year.

With respect to the relationship of insurance to delays in getting care or not receiving care at all, Mr. Brown reports that just more than 20% of those uninsured part of the year and just less than 20% of those uninsured all year reported delaying or not getting care, compared to less than 14% of those with continuous coverage.

Health insurance coverage also

was related to whether adults with chronic illnesses were taking prescription medications to help them control their condition.

According to the UCLA report, lack of coverage results from not having access to affordable health insurance and has some real consequences for the health of Californians and their access to health services.

There are at least two sources from which relief may be forthcoming, the report says. One is a growing movement at the local level in a number of counties to expand health insurance. Mr. Brown says that such initiatives are targeted at maximizing enrollment of uninsured eligible children into Medi-Cal, Healthy Families, and other programs, and also at expanding coverage options for those who do not qualify for federal and state programs.

Another promising approach

A second promising approach is included in Senate Bill 2, which was signed in October 2003.

Mr. Brown says that when it is fully implemented, the legislation will cover 698,000 workers and 372,000 spouses and children who were uninsured in 2001. Of the 4.52 million people who were uninsured at the time they were interviewed for the UCLA survey, 25% or 1.07 million would gain coverage.

"The magnitude of the problem of uninsurance and the added burden it places on state and local public resources, as well as on the individuals and families who are directly affected, underscore the urgency of California adopting and implementing policies to provide coverage to all its residents," Mr. Brown says.

(To download the complete report, go to: www.healthpolicy.ucla.edu.) ■

California implements 'pay-or-play' policy

One of the possible solutions to the nation's problem with lack of health insurance coverage for all is a "pay-or-play" program that puts the burden on employers to provide employees with health insurance or pay for insurance provided by the state. California will be implementing such a program as created in Senate Bill 2, which passed the legislature Sept. 12 and was signed by former Gov. Gray Davis Oct. 5, about six weeks before he left office.

A California Healthcare Foundation analysis of the bill showed the requirements will be phased in over several years. Eligible employees are those who have worked for an employer for three months and work at least 100 hours per month, meaning that many part-time workers will be covered. Firms with 200 or more California employees are to participate by providing coverage for both workers and their dependents beginning Jan. 1, 2006. Firms with 50 to 199 California employees join the system Jan. 1, 2007, providing coverage for workers but not for dependents. Firms with 20 to 49 employees are exempt unless the state provides a tax credit equal to 20% of the employer's net cost of the fee, and firms with fewer than 20 employees are completely exempt.

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Under the bill, firms will be required to pay a fee to a state fund for each eligible worker. Those firms that offer coverage that meets the minimum requirements of the bill will receive a credit against their fee.

A new State Health Purchasing Fund will be administered by the Managed Risk Medical Insurance Board, the group that already manages California's Healthy Families program. That board will set the fee and establish enrollee cost-sharing requirements such as deductibles, coinsurance, and copays.

Employers that want to offer their own coverage (the "play" in pay or play), can apply to the Employment Development Department for a credit against their fee. Coverage offered through the state Department of Managed Health Care will meet the requirement, as will coverage offered through the Department of Insurance, as long as the maximum out-of-pocket costs to participants don't exceed those offered through preferred provider organizations regulated by the Department of Managed Health Care. Accident-only, hospital indemnity, and other limited benefit plans will not qualify.

Employers and employees are required by law to share the coverage, with employers required to contribute at least 80%, and workers contributing the remaining share up to 20%. Worker contributions are capped at 5% of wages for low-income workers (up to 200% of the federal poverty level).

A 2002 survey of California firms by the Kaiser Family Foundation/ Health Research Educational Trust found that 94% of companies with 50 to 199 workers and 99% of those with 200 or more workers already offer health insurance coverage. The remaining firms will be required to pay the fee if they don't start to offer their own coverage.

Some other firms already offer health insurance, the researchers found, but will be required to increase their contributions to meet the 80% requirement. About 80% of firms with more than 50 workers contribute at least 80% of the premium for worker coverage. Under SB 2, the remaining 20% of companies would have to upgrade their

contribution to 80%. Only about half the companies with 200 or more workers pay the required 80% premium share for family coverage. The other half would have to increase their premium share.

There are conflicting estimates of the cost to California firms as a result of this law, ranging from $1.3 billion, from the California Medical Association, to $11.3 billion, from the Employment Policies Institute. The California Healthcare Foundation said that labor market effects are uncertain, with opponents of the plan predicting that many employers not currently offering health insurance will lay off workers or leave the state, while proponents say that the majority of such employers are in locally based service industries and that the new requirements level the playing field for firms already offering coverage.

While state agencies are working toward implementation of the program, opponents may challenge it on a variety of fronts:

1. a state lawsuit that claims the fee actually is a tax that did not receive the required two-thirds majority vote in the legislature;
2. a federal lawsuit that claims the law violates the Employee Retirement Income Security Act of 1974, a federal law that preempts states from regulating employer benefit plans;
3. a referendum to repeal the law being considered by the California Chamber of Commerce, which would need about 375,000 signatures to get on a ballot.

Also not known at this point is how Arnold Schwarzenegger, the new Republican governor, views the program's impact on his goal to revitalize the California economy.

[For copies of the legislation and links to other resources, go to: www.chcf.org. Call the foundation at (510) 238-1040.] ■

Covering many of the uninsured need not spike health care costs

Twelve to 40 million uninsured Americans could receive health care coverage at an increase to total national health spending of 1.5% to 3.7%, or $23 billion to $57 billion a year, according to new analysis from the Lewin Group.

"The bottom line is that significant progress in covering the uninsured is possible using a variety of different approaches that run the philosophical gamut," said Robert Wood Johnson Foundation senior vice president John Lumpkin. "Our problem is not that we don't know how to cover the uninsured, but that we lack the national will to do so."

The analysis was completed as part of the Economic and Social Research Institute's (ESRI) Covering America project. The foundation is funding the Covering America effort.

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The report did not identify a preference for any of the 10 proposals it puts forward and also didn't address the political/policy difficulties that are likely to face any of them. Rather, it explains the cost for each proposal and the number of Americans each would cover under five broad categories of change: incremental reforms, voluntary insurance pools, proposals that replace the current tax exclusion for employer-sponsored health insurance with tax credits, proposals that require employers to pay for coverage, and a tax-financed health care system.

The report highlighted that health reform involves trade-offs among different goals. Nearly all of the proposals combine coverage expansion with other objectives such as fairness to the currently insured, limiting the amount of new federal spending, increasing consumer choice, etc. Moving toward one goal, the authors say, often means moving away from another.

"While these trade-offs mean that there is no single best or problem-free solution to cover the nation's uninsured," said Jack Meyer, ESRI president, "these proposals are real options that could dramatically reduce the total number of people without health insurance. Many of the proposals from this project share the same building blocks as those put forth by candidates, members of Congress, and state leaders who also struggle with the same trade-offs shown in these proposals. This project makes it possible to compare very different approaches using a common methodology that can help policymakers and private-sector leaders forge effective proposals to cover the uninsured."

At an Oct. 31 briefing on the report, Meyer made a particular point of the relatively small increase in health care spending that would be needed to cover many of the uninsured.

"The reform plans evaluated by The Lewin Group would add from 1.5% to 3.7% to the more than $1.6 trillion the United States now spends on health care," he said. "This net cost of covering the uninsured is anywhere from a fourth to a half of the annual increase in our health care spending. If we do not reform the health care system, costs will continue to soar, inappropriate medical care will continue unabated, and the number of uninsured will continue to grow. These

problems feed on each other, as occurs when health spending increases well in excess of wages leads to increases in the number of uninsured."

Also noting the relatively small investment that would be needed was Center for the Study of Health System Change vice president Len Nichols, an author of one of the plans, who reacted at the ESRI briefing. "The total new spending required is relatively low," he said, "at least compared to what we're about to spend on drugs and compared to what we're maybe going to spend on the war before we're done. So at the end of the day, it doesn't look like all that much new money."

The Lewin Group report by John Shiels and Randall Haught stated that total health spending would change in response to the proposals for at least four reasons. First, previously uninsured people use more medical services once they have coverage. Second, previously insured people whose coverage is now more or less comprehensive change the amount of health care services they consume. Next, health care services are provided more or less efficiently. And, finally, provider reimbursement levels change.

"The first three contributors to new health spending are, in many ways, the most important," according to Mr. Shiels and Mr. Haught. "They represent the real resource cost of coverage expansion — the manpower, capital equipment, and other resources that are used to produce health services and are thus not available to produce other goods and services that people value. These costs represent other opportunities foregone because of the decision to expand the health sector."

The researchers said that another way to look at costs is to examine who pays the health care bill. While households ultimately bear all costs of financing health care, in the form of direct payments for health services, as part of the price of non-health goods and services, as reduced wages or other compensation, or as taxes, it is important to analyze how initial financing of the health care bill is shared among the various players. Mr. Shiels and Mr. Haught point out that even though many coverage expansion proposals produce only a relatively small increase in total health expenditures, they may cause large shifts in the distribution of health care financing among households, employers, and government for several reasons.

First, to make coverage more affordable for those who are currently uninsured, all the proposals provide subsidies to lower income people, high-risk individuals, or small or low-wage employers. The result is that the cost borne by government increases.

Also, most proposals provide government subsidies to people who already purchase health coverage without subsidies — the people who are covered by their employers or purchase coverage in the individual market but switch to the new public program or become eligible for subsidies.

The proposals assign initial costs quite differently to households, employers, and government, based on the trade-offs authors are willing to make and the objectives they seek to promote in addition to expanding coverage. Thus, household payments of health premiums and out-of-pocket health costs decline between $3 billion and $187 billion a year; for employers, the impact on health spending ranges between a $69 billion increase and a $77 billion annual savings; state and local health care spending would drop under most of the proposals, by as much as $28 billion and go up under a few of the plans by as much as $6 billion a year; and federal costs would grow between $34 billion and $552 billion annually.

The Lewin study said that in deciding how to structure major reforms, policy-makers must balance a number of goals, which could include covering a large number of people who otherwise would be uninsured, avoiding unfair treatment of those currently insured, limiting the extent of new federal spending, limiting growth in total national health spending, increasing consumer choices among health plans and health care providers, improving quality of care, and limiting the amount of federal spending going to people who already have coverage.

"Frequently, pursuing one goal involves trading off another," explained Mr. Shield and Mr. Haught. "For example, a number of proposals deliberately incur additional federal costs to accomplish goals other than expanded coverage."

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Thus, some tax credit proposals shift hundreds of billions of dollars in annual premium costs from currently insured, lower-income households to the federal government. This "horizontal equity" provides the same level of subsidy to all similarly situated low-income individuals, including both the uninsured and those who previously purchased coverage on their own. In addition, some proposals seek to limit future growth in national health care spending and to increase consumer choice through insurance pools that offer multiple health plan options, with federal premium subsidies, on terms that give consumers incentives to select less expensive coverage. Because such pools are not limited to the newly insured, but also serve numerous workers who previously received employer-sponsored coverage, some of the proposals, depending on how they are structured, may shift billions of dollars in annual health premium costs from employers to government.

In contrast, the authors said, other proposals prioritize the competing policy goal of limiting new government spending to just the uninsured, whenever possible. By reducing the shift of current private-sector costs to the public sector, such proposals spend fewer federal dollars on each newly insured person. "In sum," added Mr. Shiels and Mr. Haught, "there is no problem-free solution to the problem of the uninsured. Policy-makers must inevitably resolve trade-offs among competing, desirable objectives. The analysis suggests that policy-makers may face a basic trade-off between preserving a voluntary and nonguaranteed system of health insurance and maximizing the increased coverage that results from reform. Automatic enrollment mechanisms appear to increase the coverage gains from voluntary and nonguaranteed systems, but even policy-makers incorporating auto-enrollment strategies must decide whether to seek the additional increment of coverage that would result from mandates or legal guarantees of health coverage."

Here is the basic scoring Mr. Shiels and Mr. Haught developed for each of the 10 plans (listed by the last name of the lead author):

- **Feder** — cover about 12 million uninsured. Federal costs less offsets would be about $34.1 billion.
- **Pauly** — cover about 20.5 million people with a net federal cost of $89.7 billion.
- **Singer** — cover 11.8 million people with new federal spending net of offsets of $102.8 billion.
- **Gruber** — cover 14.5 million people with new federal spending of $190.5 billion.
- **Holahan** — cover 15.2 million people with new federal spending of $127.4 billion.
- **Hacker** — cover 37 million people with new federal spending of $241.9 billion. Average cost to firms that do not now offer coverage is estimated at $1,000 per worker. Firms that currently offer insurance would see savings averaging about $409 per worker.
- **Weil** — cover 37 million people with new federal spending of $160.9 billion. Average cost to firms that don't offer coverage now is estimated at $1,000 per worker. Firms that currently offer insurance would see savings averaging about $22 per worker.
- **Wicks** — cover 40.3 million people, achieving nearly universal coverage, with new federal costs less offsets of $230.8 billion.
- **Butler** — cover 26.9 million people with new federal spending of $236.1 billion.
- **Kronick** — cover virtually all Americans, except 1.6 million undocumented immigrants and lower-income nonworkers who are difficult to reach, with new federal spending of $551.7 billion, funded with payroll taxes and an increase in the personal income tax. Health spending in firms currently providing insurance would increase by about $197 per worker, while the cost to firms that do not now offer coverage would be about $1,760 per worker. While this proposal has the highest level of new federal spending, it has the lowest level of spending per new person covered.

Mr. Shiels and Mr. Haught said that many of the proposals considered in their study have never been attempted on a broad scale in this country, and there are few data on the likely outcomes of such programs. Also, programs that substantially restructure the health care financing system fundamentally could change consumer, employer, and provider incentives in ways that could have a significant impact on program costs.

(For more information, go to: www.rwjf.org; and www.esresearch.org.) ■