

LITTLE HOOVER COMMISSION



HEALTH CARE POLICY ANALYSIS

LITTLE HOOVER COMMISSION

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State of California

LITTLE HOOVER COMMISSION

September 8, 1993

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The Honorable Pete Wilson
Governor of California

The Honorable David Roberti
President Pro Tempore of the Senate
and Members of the Senate

The Honorable Willie L. Brown Jr.
Speaker of the Assembly
and Members of the Assembly

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable James Brulte
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

Health care reform appears to be at the top of the national agenda, but what form it will take and how soon it will occur are impossible to predict. Nonetheless, many states such as Oregon, Colorado and Vermont, are moving forward with their own concepts. They do so knowing that President Clinton is sympathetic to state government systems and that the National Governors Association -- under a proposal by California's Governor Wilson -- are pressing for state flexibility.

California, however, shows little signs of taking the comprehensive, policy steps that are necessary to position it for health care reform. Barriers to a rational approach to health care include financial constraints and political sensitivities. The Little Hoover Commission, in the attached policy analysis, has examined some of these "barriers" and has found that misconceptions often impede progress more than reality. For instance, the fear that mixing state workers with Medi-Cal recipients in the same insurance pool may increase costs and water down benefits for the state workers is undercut by an examination of the facts: Medi-Cal recipients have a richer benefit package by far and their per-person cost under managed care contracts is far less.

The Little Hoover Commission believes the State needs to begin down the path of health care reform by definitively answering three key policy questions:

- 1. What population will the State be responsible for in terms of bargaining for health care coverage?**

Milton Marks Commission on California State Government Organization and Economy

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Positioning California for Health Care Reform

The federal proposal to set the national framework for reforming health care remains in the "trial balloon" stage seven months into the Clinton presidency: A variety of concepts are being floated for scrutiny by the public with no real assurance that any will end up in the final package of solutions. Even less assured is the eventual outcome -- if any -- once the President's proposal is presented to Congress and all interested parties begin the long process of lobbying to adjust the bits and pieces that make up the whole. Already dissipating is the early euphoric belief that fixing the country's dysfunctional health care system is inevitable now that national attention is focused on the problem. "What," "when" and even "if" are still key questions.

Nevertheless, two signals have been sent consistently and clearly:

- * The basic element of any, eventual federal reform will be universal coverage with a common benefit package.
- * States will have wide flexibility to establish their own direction within goal-oriented parameters set by the federal government. In fact, such flexibility is already available through an explicit commitment by the federal administration to expedite Medicaid waivers for innovative state programs.

California needs to address key policy questions to prepare for health care reform

The Little Hoover Commission believes that with this information in hand, California should begin the long process of answering key policy questions and setting mechanisms in place that will prepare the State for health care reform. Yet there are few outward signs in California that steps are being taken to position the State for change, although many other states are already moving toward reform. Guided by a broad-based advisory committee (please see **Appendix A** for its membership) and based on research and two public hearings (please see **Appendix B** for witness list), the Commission has created this issue paper to urge state policy makers to create a framework for health care reform. Following a brief background on what other states are doing and California's status, the issue paper will outline key policy questions that the State should

*Present study is
outgrowth of 1990
Commission report
on Medi-Cal issues*

*Oregon is one
of several states
already moving
forward with reform*

address and recommend mechanisms for deciding and implementing new policies.

The Commission's present health care study is an outgrowth of its 1990 report on the Medi-Cal system. In a section of that report entitled Future Directions, the Commission recommended that the State explore ways to maximize its purchasing clout through leveraged bargaining -- a concept very similar to what is now being advocated under the name "managed competition." The report also recommended monitoring Oregon's prioritization experiment closely to see if there are potential benefits for California in using similar mechanisms.

While most of the Commission's recommendations regarding Medi-Cal in other sections of the 1990 report have been adopted, little has been done to reorganize the State's overall approach to health care. Other states, however, have moved toward consolidating and reforming their health care delivery systems. None of the innovative programs is yet operational, so results cannot be examined. However, each of the states is further along than California by virtue of setting up frameworks within which change will occur. The following is a thumbnail sketch of the different approaches taken by several states:

Oregon: With a game plan adopted by the Legislature in 1989 and finally approved by the federal government in March 1993, Oregon expects to see its new system of medical care coverage in place by January 1994. Its key elements are 1) expansion of the population covered by Medicaid to include everyone below the federally set poverty level (adding about 120,000 people to the present pool of 245,000); 2) limitation of services covered to treatments that are ranked according to beneficial effects and delineated by what the State feels it can afford; 3) cost control through the greater use of managed care and preventive measures; and 4) coverage for about 300,000 workers who are now uninsured beginning in July 1995, with employers providing coverage similar to Medicaid's or paying a fee into a state pool that will provide coverage for the workers.

Oregon has faced substantial criticism for creating a plan that will deny some types of health care for the poor -- not on the basis of the lack of effectiveness of a particular treatment but because of funding limitations in

the state budget. In expectation that the federal government's health care reform plan will mandate the form and contents of a common benefit package, the Commission will not assess the pros and cons of Oregon's choices in this issue paper.

This does not mean, however, that the Commission found Oregon's experience irrelevant to California. Of key importance was Oregon's ability to build consensus across a broad spectrum of interests within the state for its comprehensive approach. Using a gubernatorial-appointed 11-member Health Services Commission composed of five physicians, four consumers, a social worker and a public health nurse, Oregon conducted formal hearings, collected input from 47 community meetings and reviewed results of a telephone survey. The high-profile process served to both minimize political posturing and maximize public education about choices and values.

Colorado: Calling its plan "ColoradoCare," Colorado is spending almost \$700,000 on a feasibility study for a system that would ensure universal health care coverage for everyone up to age 65 (when Medicare would take over). Under the plan, the money now spent on health care -- private employer insurance premiums, the \$1 billion allocated for Medicaid and the \$32 million spent on a state indigent care program -- would be put into a single pool, along with new taxes to be levied on employers and employees. A menu of insurance plans would be available for each resident to choose from annually, and the state would pick up the tab, paying a single, flat rate for each person covered.

Similar to the Canadian system, Colorado's plan is a single-payer approach that minimizes costly paperwork, a managed care mode that will control quality and cost of treatments, and a managed competition model that uses a large pool of beneficiaries to spread risk and maximize bargaining power for a low, universal rate. An ambitious schedule requires the study to be completed and implementing legislation introduced by January 1994.

Florida: Although Florida's political leadership has touted its new plan as the first universal access to health care in the nation, the claim is far too broad for the piecemeal approach the state has taken. Basically, the plan -- which is awaiting federal Medicaid waiver approval -- allows low-income residents to buy into the Medicaid plan with a sliding-scale fee and sets up a basic-

*Colorado is pursuing
single-payer approach
with a menu of plans
for all residents*

*Florida's plan
would allow working
poor to buy into
Medicaid program*

*Vermont wants
a single pool
covering everyone
by October 1994*

*New Jersey will
use payroll tax
and sliding
scale of fees*

*West Virginia is
taking steps to
combine state workers
with Medicaid*

benefits insurance program that small businesses may purchase to insure their employees.

If the federal government agrees, the added costs of caring for the expanded population base will be covered by an exemption for Florida from a federal law requiring states to pay "reasonable" rates to nursing homes, dropping Medicaid coverage of prescription drugs and placing more Medicaid recipients in managed care plans.

Vermont: By 1994, the state's Health Care Authority is required to develop options for providing universal access and a common benefit package, using either a single-payer Canadian-style system or a multi-payer system with uniform procedures. As cost containment measures, the Authority has the power to regulate hospital growth, require the use of common claim forms and limit other costs.

By creating a pool that includes all residents, the Authority is expected to use the leverage power of large numbers to bargain effectively for low prices. The system is required to be in place and operational by October 1994.

New Jersey: The state's SHIELD program will provide coverage beginning in 1994 for low-income families not on Medicaid and moderate-income people not covered by private insurance. Costs will be covered by sliding-scale fees and payroll taxes on employers. Services will be provided exclusively in managed care systems to control costs and quality of care.

West Virginia: Since 1990, West Virginia has been moving slowly toward pooling its government workers and Medicaid recipients to take advantage of greater bargaining power and to provide uniformity of health care. To be included were programs run by six agencies: the Public Employees Insurance Agency, Workers' Compensation Fund, Office of Medical Services, Bureau of Human Resources, Bureau of Public Health and the State Board of Rehabilitation. A 1991 study concluded that the data collection and billing systems were so disparate that only a phased-in approach to consolidation would work.

Steps are now underway to establish a claims clearinghouse and create a common claimant file. The

Legislature is expected to reauthorize the concept of pooling the populations this year but the eventual implementation date is uncertain.

N*ew York:* New York is two years into a seven-year program to place half of all Medicaid recipients into managed care systems (the other half will remain in fee-for-service health care). In New York City alone, where 700,000 recipients will be affected, cost savings are expected to reach \$50 million annually.

M*innesota:* MinnesotaCare taxes doctors, hospitals and other care providers to expand coverage to those not now covered by insurance, Medicaid or Medicare. Those people may buy a state-subsidized health insurance package, paying premiums on a sliding scale based on income.

Taxing providers, of course, adds to medical inflation. Some of that is offset, from the state's perspective, because the increased tab is partially covered by federal funds in the Medicaid program.

The Commission notes that many of the concepts being pursued by the states described above are not foreign to California. In a fragmented, uncoordinated way, California is employing many of the same mechanisms for different populations for which it has health care responsibility. For instance, Medi-Cal is expanding managed care for its recipients; the Public Employees Retirement System (PERS) makes aggressive use of managed competition; and the State has created a small-business insurance pool.

Below is a summary of the various approaches that California uses to fulfill its health care responsibilities in a cost-effective manner while ensuring adequate care:

* Medi-Cal covers almost 5 million people. The State uses bargaining clout that derives from the number of recipients in several different ways:

- 1) The California Medical Assistance Commission (CMAC) bargains on behalf of Medi-Cal for all in-patient hospital services. Since its creation in 1982 (partially in response to a Little Hoover Commission recommendation), CMAC has saved the

New York is targeting cost containment with managed care

Minnesota is taxing providers to expand coverage with subsidized plans

California already uses a variety of techniques to bargain for care

State more than \$2 billion by containing hospital cost increases.

- 2) The Department of Health Services bargains on behalf of Medi-Cal for pharmaceutical purchases, lowering costs that were the highest in the nation at the time of the Commission's 1990 Medi-Cal review.
- 3) The Department of Health Services and CMAC together negotiate with providers to establish managed care and primary care case management systems. For the past decade, only about 10 percent of Medi-Cal recipients have been covered by managed care services because of federal restrictions and concern for giving recipients freedom of choice. With legislative approval in 1992, the State is moving forward with a plan to place about half of the recipients into managed care by fiscal year 1994-95. Because of opposition from the health care industry and Medi-Cal advocates, however, the Department has delayed implementation and restructured its efforts. The movement into more managed care for Medi-Cal recipients is also threatened by legislative proposals that would curtail the Department's plan.

* PERS bargains for health care that covers, as of July 1993, almost 900,000 former and present state and local government employees and their families. With an annual premium volume of more than \$1.3 billion, PERS has gained national recognition for holding down prices through tough negotiations with the 19 health maintenance organizations and six other insurers that provide coverage. In 1990, premium increases were 21 percent. By standardizing coverage packages and beginning with a bargaining stance that there should be no price increase, PERS held increases to 3.1 percent in 1992 (compared to 13.2 percent throughout the state for private industry) and 2 percent in 1993 (compared to 14 percent nationally).

* The Major Risk Medical Insurance Board (MRMIB) creates health-care purchasing pools to bargain for

insurance on behalf of small businesses in the State. Businesses employing between five and 50 workers are eligible to select from among 18 health plans at rates up to 23 percent lower than those offered to state employees through PERS.

Thus different portions of state government are having varying degrees of success in achieving low costs and high quality care. But the State is not working from a common blueprint that takes advantage of the large number of health care recipients under its wing and that brings bargaining expertise into a single, powerful unit. To create such a blueprint, the State needs to begin by answering some key policy questions.

*State needs to
create blueprint
after answering
policy questions*

1. What population will the State be responsible for in terms of bargaining for health care coverage?

As detailed above, the State already is the chief purveyor of health care coverage for:

- * 900,000 state and local government workers and retirees. Under PERS, health care is provided to 185,987 state workers, 86,643 retirees and 357,038 dependents. About 800 local government agencies -- cities, counties, school districts and special districts -- buy into the PERS system for an additional 96,548 workers, 21,363 retirees and 151,177 dependents.
- * 5 million Medi-Cal recipients. Almost three-quarters of the recipients are families (typically women and children receiving Aid to Families with Dependent Children); another 15 percent are the non-elderly disabled; and just over 10 percent are the elderly who either are in long-term care or are poor enough to have out-of-pocket Medicare costs covered.
- * 3,000 employees of small businesses. Although the State's small-business health care pool only became operational on July 1, 1993, already 250 firms have signed up, with anticipated growth to 50,000 employees by July 1994.

The State needs to decide what additional populations -- if any -- it should be responsible for. The benefits of enlarging the State's responsibility are that bargaining on behalf of more recipients would spread risk

*State could
choose to cover
uninsured and all
government workers*

*State may wish
to pool all people
it currently is
responsible for*

over a larger pool and also would increase the purchasing clout of the State.

The downside is the huge increase in costs if the State assumes responsibility for populations that have no funding source attached to them. Among the possible choices are:

- * ***The uninsured.*** Typically the working poor or impoverished males with no dependents, the uninsured population in California is usually estimated at 6 million. Some health care experts believe the number includes about one-third who are simply between insurance as they change jobs and another one-third are those who could buy their own insurance with discretionary income if they chose to do so.
- * ***All local government, special district and school employees.*** Sweeping all public employees into a state-sponsored system would increase the current 900,000 PERS pool by 2 million people.
- * ***All 32 million Californians.*** Like Canada, Vermont and Colorado, California could choose to treat all of its residents as a single pool. Private employers who now pay health insurance premiums would, instead, send their premiums to a single state fund, which would also hold Medi-Cal and state employee allocations. A common benefit package and a variety of provider mechanisms would then be offered to each person in the pool, regardless of income, job or family status.

Without adding any new populations, the State also could choose to streamline its efforts on behalf of its current health care recipients, adopting a single approach for state workers and retirees, Medi-Cal recipients and private, small business buy-ins. In the past, both myths and regulatory barriers have kept the State from unifying these separate responsibilities -- a step that would allow the State to maximize its leverage and apply the same expertise to all populations. Among the myths and barriers (which are described in more detail in separate sections below) are:

- A) ***State worker benefits would have to be watered down*** if they were combined with the Medi-Cal population.

- B) *The cost of care for the Medi-Cal population is much higher*** because they are so radically different from the State's other insureds.
- C) *PERS after-retirement requirements*** block some public agencies from participating.
- D) *The federal government's strict requirements*** for serving the needs of Medi-Cal recipients make change almost impossible.



While the Medi-Cal program may be held in poor regard by the average working Californian covered by employer health insurance, the perception stems from the bureaucratic buzz-saw that greets applicants, the lack of access because of the few providers willing to take Medi-Cal reimbursement and the complicated approval system for out-of-the-ordinary treatment (see the Commission's 1990 "A Prescription for Medi-Cal" for more details). The disdain for Medi-Cal could not possibly stem from an accurate assessment of the coverage given to recipients since Medi-Cal offers one of the richest benefit packages in the nation -- partially because of federally mandated services and partially because of California's decision to provide almost all optional services allowed by the federal government.

Despite this, the California State Employees Association (CSEA) testified to the Commission at a public hearing that one of its major concerns is that state workers would lose benefits and coverage if they were combined with the Medi-Cal population.

The Medi-Cal package covers more treatment options and services than the coverage provided to state workers through PERS, even when the state workers' dental and vision plans are considered along with their health insurance coverage. A side-by-side comparison of Medi-Cal services and those provided under PERS's health-maintenance-organization contracts shows that basic physician and hospital services are covered without limit. The major differences are indicated in the chart on the next page:

***A. Comparison of
health benefits
for Medi-Cal,
state workers***

<i>Comparison of Benefits Offered by Medi-Cal and PERS</i>		
Benefit	Medi-Cal	PERS Plans
Co-Pays	Provider may collect \$1; hospital may collect \$5 for non-emergency use of emergency room.	\$5 for most services and drugs; \$15 to \$50 for emergency room if not hospitalized
Inpatient Mental Health	No limit	Up to 30 days
Home Health Care	Yes	No
Skilled Nursing Care	Yes, including custodial care	Limited to 100 days of medically necessary care after hospitalization
Speech/Physical/Occupational Therapy	Twice a month for as long as needed	Limited to 60 calendar days per condition
Outpatient Mental Health	Twice a month for as long as needed	\$20 per visit, 20 visits per year
Acupuncture	Yes	No
Chiropractic	Yes	No (except for 4 plans)
Disposable Medical Supplies	Yes	Only in hospital setting
Adult Day Health Care	Yes	No
Dialysis	Yes (portion not covered by Medicare)	No
Podiatry	Yes	No
Intermediate Care for Developmentally Disabled	Yes	No
Second Opinions	Yes	No
Transportation Services	Yes	Ambulance only
Unreplaced Blood	Yes	No
Modification of house, automobile for medical problem	Yes	No

Source: Department of Health Services, PERS

As indicated previously, one reason the Medi-Cal benefit package is so rich is that California has chosen to provide most of the optional services the federal government has offered to subsidize, even though it requires additional, substantial out-of-pocket expenses for the State. The following chart shows the

optional services. A check mark indicates services provided to state workers, either through PERS or vision and dental plans.

<i>Optional Services in California Medi-Cal Program</i>					
Medi-Cal	PERS	Medi-Cal	PERS	Medi-Cal	PERS
Nursing Facilities (under 21)		Speech, Hearing and Language Disorders	√	Christian Science Sanitoriums	
Optometry	√	Prescribed Drugs	√	Podiatry	
Chiropractic		Inpatient Psychiatric (under 21)	√	Emergency Hospital Services	√
Psychology	√	Prosthetics	√	Personal Care	
Nurse Anesthetists	√	Eyeglasses	√	Transportation	√
Clinic Services	√	Preventive Services		Case Management	√
Dental	√	Rehabilitative Services	√	Hospice Care	√
Physical Therapy	√	Dentures		Respiratory Therapy	√
Occupational Therapy	√	Christian Science Nurses		ICF/MR Services	

Source: Department of Health Services

The above data indicates that state policy makers have been generous in meeting the needs of Medi-Cal recipients, while state workers, who rely on collective bargaining for the scope of their health coverage, have received a more limited package. It is, therefore, difficult for the Commission to envision how state worker benefits would erode if they were joined with a population that is now covered by a richer benefit package (although the previously noted problems with Medi-Cal access and bureaucratic barriers would need to be addressed to ensure that they did not carry over into a common pool).

*B. Comparison of
costs for state
workers, Medi-Cal
families*

The common perception is that the Medi-Cal population is sicker and more costly to care for than the general population. Prior Commission reports on skilled nursing facilities and the Medi-Cal system as a whole reflect this -- but only for a small segment of Medi-Cal recipients. The elderly who receive skilled nursing facility services and the severely disabled who have round-the-clock care are sicker and more costly, but they are, in general, not provided service under managed care systems. For the Medi-Cal population covered by managed care, statistics show that the State purchases services more cheaply for Medi-Cal recipients, the population profile is not significantly different from that covered by PERS, and the rate of usage of services is only incrementally higher.

There are five health maintenance organizations that currently cater to both Medi-Cal and PERS: Kaiser North, Kaiser South, Cigna, AmeriMed (a division of Foundation) and FHP. The five serve 221,682 Medi-Cal recipients and 442,318 PERS customers. The table on the next page compares the rates that each of the plans charges Medi-Cal with the PERS rate for one person and the PERS per-person rate if the employee and two dependents are covered.

Each company charges Medi-Cal seven different rates depending on how a person is qualified for Medi-Cal assistance. The average rate shown on the chart was computed by dividing the total capitation payment by the number of people covered, thus spreading the risk over the entire population just as PERS does. The AFDC rate -- the lowest charge by each of the plans -- is included in the chart for comparison purposes because the Department of Health Services says that typically 95 percent of the client base in managed care is covered by the AFDC rate.

<i>Comparison of Capitated Rates for Medi-Cal and PERS</i>				
Health Plan	Medi-Cal		PERS	
	AFDC Rate	Average Per Person	Rate for One Employee	Per-Person Rate if Three Covered
Kaiser North	\$65.59	\$95.10	\$159.29	\$141.23
Kaiser South	\$76.74	\$112.62	\$163.06	\$149.47
Cigna	\$86.20	\$104.97	\$162.54	\$135.99
FHP	\$70.89	\$131.54	\$152.55	\$137.29
AmeriMed (Foundation)	\$78.58	\$88.63	\$164.10	\$143.31

Source: Department of Health Services, PERS

It should be reiterated that the packages of health care are not the same; the Medi-Cal package -- which is being purchased for a cheaper price -- requires a higher level of service for recipients. The low prices for the Medi-Cal services are not so much the result of hard bargaining by the State as they are the outcome of federal policies that over the years have required capitated fees to be no higher than what the same covered population would cost if fee-for-service care were used. Since California's Medi-Cal reimbursement rates are among the lowest in the nation, the capitated rates correspondingly have been held down.

The health care industry has complained that the artificially low rates -- both for fee-for-service and for managed care -- have forced them to shift costs, causing other health care purchasers to pay higher bills. Yet with the loss of 500,000 jobs (many of them covered by health insurance) during California's recession, the health care industry appears eager to have the steady income represented by Medi-Cal capitated rates, even at low prices. The Department of Health Services, in the midst of a drive to place more people in managed care systems, is finding no shortage of bidders.

The population that Medi-Cal places in managed care is similar to that covered by PERS. This is because Medi-Cal's most difficult and costly patients are rarely covered by managed care systems. Custodial care in skilled nursing facilities is used by about six percent of Medicaid recipients nationally, incurring about 30 percent of the expenditures in the system. But

Managed care populations are similar for Medi-Cal, PERS

*Doctor utilization
rates are also
similar for
Medi-Cal, PERS*

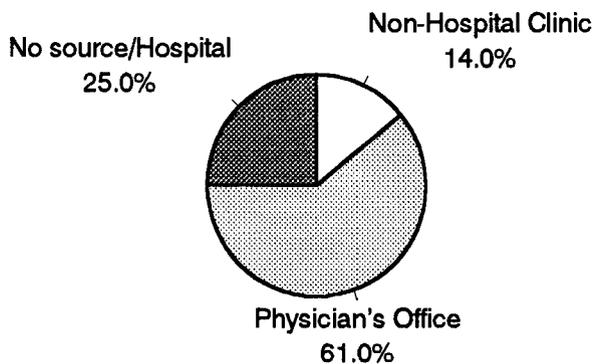
custodial care in nursing homes is not included in the coverage provided by managed care contracts. And for the most part, severely disabled people who require extensive, specialized services are cared for outside of managed care systems.

Thus, Medi-Cal's managed care population is somewhat different than the system's overall population. While families make up about three-quarters of Medi-Cal recipients overall, they account for about 95 percent of the people in Medi-Cal's managed care plans. This compares to a PERS population of 790,750 active workers and their families and 108,006 retirees, about a 88 percent/12 percent split between those raising families and the older generation.

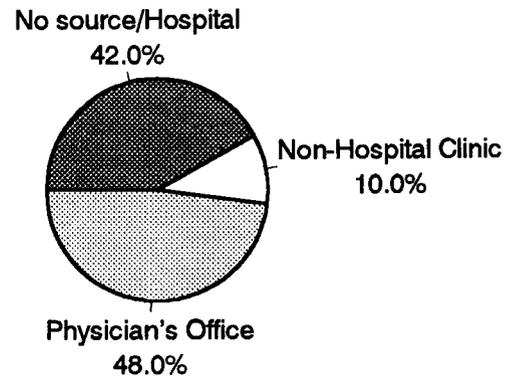
Another way to compare the populations is to examine utilization rates -- how often people use services. Nationally, the "non-poor" (usually people with health insurance) visit a doctor 5.3 times per year, people on Medicaid go 5.7 times per year, and people with neither insurance nor Medicaid go only 3.9 times per year. In PERS, the usage is about 5.7 physician visits per year. Although utilization figures within managed care plans are not tracked by the Department of Health Services, the plans themselves monitor usage. Cigna, with 111,453 Medi-Cal clients, showed a total of 119,880 physician services for the three months from January through March 1993. On an annualized basis that represents 4.3 visits per year for each person.

The Cigna figure, however, is skewed by only looking at physician visits. One perception about Medi-Cal recipients that is true is that they use hospital emergency rooms for primary care, although they are less likely to do so than the uninsured population. The chart on the next page compares the two using national figures from 1987.

Usual Source of Care for the Nation's Medicaid Beneficiaries



Medicaid Beneficiaries



Uninsured Population

Source: Kaiser Commission on the Future of Medicaid, 1991

As the chart indicates, 61 percent of Medicaid recipients usually go to a doctor's office for care, 14 percent use a clinic and 25 percent have either no usual source of care or go to an emergency room. Forty-eight percent of people who are uninsured have a regular doctor and 10 percent use a clinic, but 42 percent either have no usual source of care or use emergency rooms.

The Cigna quarterly figures show 22,927 emergency room visits and 411 clinic visits. If those figures are added to physical visits, the annualized utilization rate rises to 5.14 -- still below the national figure and the PERS figure.

Thus, all of the statistics indicate that Medi-Cal recipients get a richer benefit package that costs less than PERS coverage. In addition, Medi-Cal recipients in managed care systems use the services at roughly similar rates to PERS members.

*C. PERS rules
keep some agencies
from signing up
for health care*

PERS has held health care cost increases to a minimum for the past two years. Recognizing that their success flows in part from growth that gives them mass purchasing power, PERS officials have said they want to expand the number of public agencies beyond state government that buy into the system. From the perspective of the public agencies, the PERS plans are attractive because the cost is low, health care quality high and overhead charges by PERS are minimal.

But an artificial barrier that keeps many school districts and local governments from participating, according to PERS experts, is the PERS requirement that the employing agency contribute to health care costs when the worker retires. This means that public agencies must set aside funds for each employee to pay a stipend toward health insurance premiums after retirement. Because the requirement represents a significant long-term cost, many agencies forgo the bargain-basement PERS offerings -- and PERS loses the ability to bring a larger pool of workers to the table for bargaining clout.

Among proposals to work around the barrier is one to set up a second PERS pool that public agencies could join without committing to contributing to retirement health care costs.

*D. Federal barriers
to creativity
appear to be
weakening*

The first reflexive cry of state health care experts when change is proposed is that the federal government has hemmed in options so tightly that little can be done to take a new approach to Medi-Cal. However, other states have won waivers for innovative approaches to Medicaid -- most notably and recently Oregon, which has created an entirely new framework for the program by concentrating on effective, beneficial treatments. California itself operates under several Medicaid waivers and options, including county-run managed care systems in Santa Barbara and San Mateo counties, in-home medical care, AIDS treatment and specialized senior citizen services.

In addition, the federal administration has expressly indicated a willingness to fast-track alternative systems that promise better coordination and delivery of care. While the federal government is a barrier to the State moving on the health care front independently, the Commission believes that favorable signs may make it worthwhile to move beyond "business as usual" in determining what populations the State will take care of and how it can best manage health care services -- which

leads to the next policy question that should be answered by the State.

2. How can health care services be monitored to ensure that quality, effective care is delivered -- and unnecessary, non-beneficial care is precluded -- within a cost containment environment?

No matter how large the population is that the State decides to include in its responsibilities, the State's duties will have to go beyond merely bargaining for care and paying the bills. Over the past few decades, the health care industry has shown that managed care, with its per-person monthly rates and stringent checks on service use, can translate into inadequate care in the hands of the unscrupulous more interested in profit than good service. Experts also have concluded that while managed care cuts down on some unnecessary services, it is not the silver bullet that will put an end to waste in the health care system. In both instances -- ensuring the quality of care and eliminating waste -- knowledgeable oversight holds the key to success.

The responsiveness of an oversight mechanism is directly related to the linkage to consumer interests and concerns. PERS, for instance, tracks utilization rates and frequency of procedures, comparing each health care provider against the others to understand the quality and amount of care being delivered. But PERS officials believe it is the PERS board, dominated by representatives of those who use the health care services, that ensures quality care and provides redress for problems. No similar board exists for Medi-Cal recipients, who instead may take their problems to court with the assistance of non-profit legal organizations or who may find a sympathetic ear among local legislators.

Not only a consumer orientation is needed, however. Oversight also clearly requires expertise that allows careful weighing of data so that well-informed decisions can be made about services to be covered and new technology to be incorporated. For instance, Blue Shield of California has a specialized committee that is instrumental in determining what procedures should be added to the basic benefit package, walking the line between what is medically beneficial and/or necessary and what drives up costs without improving the condition

Another key question: How to ensure quality care

*Different models
offer ways
to define
necessary care*

of patients. Oregon, as described previously, brought together a commission balanced between health care experts and consumers to determine what constitutes essential services, as opposed to services that are either not vital or unnecessary.

Such a committee approach could be especially valuable in refining a common benefit package that will meet health care needs efficiently rather than simply providing any type of service, whether or not it is beneficial to a specific patient. While the federal government may set the parameters for a common benefit package, it may well be left up to states to define services. Several models exist:

- * ***The Macro Approach.*** Health care services are covered based on broad general categories, such as in-patient hospital care, maternity care and prescription drugs. There may be some limitation, such as a set number of days of hospital care, but the limitations are unrelated to specific medical needs of patients. An example of this model is PERS' health care plans, which provide almost unlimited physician and hospital care. The "gatekeeper" function of the primary care physician in the managed care mode serves to control -- to some degree -- which services will be used and when. But overall, there are relatively few restrictions in what is covered.

- * ***The Micro Approach.*** This approach uses the concept of linking medical diagnoses and conditions to covered treatment. For instance, if a patient has diabetes, insulin makes the disease manageable; therefore, insulin is a covered benefit. Oregon's prioritization efforts focused on linking treatments to conditions, arraying them in order of beneficial effect. Although many believed the process would be herculean and ultimately impossible, Oregon took more than 10,000 diagnoses recognized nationally by medical experts and collapsed them into 709 condition-treatment pairs (i.e., lower back pain/surgery or appendicitis/appendectomy). The benefit of this approach is that a health care is only covered if the condition is expected to improve through the use of the treatment. The problem is that it is not specific enough to take into account the different degrees of patient response because of the variance in conditions.

- * ***The Clinical Guidelines Approach.*** This goes a step beyond the micro approach, attempting to link specific patient criteria and conditions to treatments that have proven to have beneficial outcomes. Such an approach requires the careful calibration of conditions and diagnoses, along with the thorough examination of the results of treatment options. To illustrate the difference between the micro and clinical guideline approaches: Under the micro system, arterial blockage may be treated by coronary bypass surgery. Under the clinical guidelines system, if coronary bypasses have proven to be beneficial only for people with arterial blockages greater than 50 percent, then a patient with lesser blockage would not be eligible for covered coronary bypass surgery.



While the clinical guidelines approach is the most resource and labor intensive in terms of weighing criteria and determining outcomes, it holds the most promise not only for avoiding unnecessary, costly care but also for improving the quality of care delivered. Numerous studies throughout the nation have shown that a patient may receive a particular form of treatment -- beneficial or not -- largely based on the medical community in which he lives and/or the type and extent of insurance coverage he has. The federal government is busy in this arena, with the Agency for Health Care Policy and Research already having created its first clinical guidelines for seven sets of conditions.

Building on the work begun by Oregon and the federal government, California has the opportunity to set up a system to refine medical coverage in ways that will promote effectiveness and efficiency. To win acceptance of such a system requires the State to address a third policy question.

3. **What attitudes, patterns of medical care usage and personal practices need to change to allow reforms to work without leaving affected populations with the perception that the quality of their medical care has diminished?**

Clinical guidelines approach offers best hope for effectiveness

*Final question:
What habits need
to change for
reform to work*

The crisis atmosphere surrounding health care has caused pundits to conclude that the nation as a whole is unhappy with their medical care and as a result are demanding a new system. Yet surveys show that more than three-quarters of Americans are happy with the health care they are receiving as individuals. Instead of revolting against poor treatment, they actually have two concerns: that at some point they will no longer be covered by a health care plan and that there are too many other people who are suffering because they have no health care insurance. One recent survey showed that people would be willing to pay more to see that the uninsured are provided with health care -- but only \$50 a year more. This dual attitude -- "I want to keep mine and I want others to have it too if it doesn't cost too much" -- sets the overall political framework for health care reform. In addition, there are other factors that affect how people feel about health care reform:

- * **Managed Care.** Thirty years ago, any attempt to place Medicaid recipients into managed care was viewed as restricting freedom of choice and dumping a helpless population into second-rate systems. But today many of the nation's workers have found themselves in managed care systems, with restricted choices, because of cutbacks by employers. In PERS, for instance, 75 percent of members are covered by health maintenance organizations. Nationally, almost 40 percent of workers now are in managed care, compared to only 11 percent in 1988. Managed care is becoming the accepted norm rather than a second-class system, as it was once perceived to be.

- * **High technology.** Viewing the medical establishment as magicians rather than skilled practitioners, Americans in search of miraculous cures tend to want any and all high-technology treatments. But not all high-technology innovations provide the right answers: A person with frequent headaches, for instance, can demand a specialized head scan, but his doctor is unlikely to know any more about the source of the headaches after the machine has been used. As more focus turns toward assessing beneficial outcomes of treatments, patients may become more easily convinced that throwing high technology at a condition will not necessarily solve it.

- * ***Failure to use appropriate care.*** As noted previously, both the uninsured population and Medi-Cal recipients are prone to use high-cost emergency rooms for care that could be routinely handled elsewhere. In addition, studies have shown that not enough use is made of practitioners other than physicians, such as nurse practitioners, who may provide beneficial care at a greatly reduced cost. Creating a climate where all patients know how to access the lowest, least expensive care that is appropriate for their condition would increase efficiency and effectiveness of medical resources.

- * ***Personal responsibility.*** Preventive care and avoiding detrimental habits can reduce health problems and associated long-range costs. For instance, for every \$1 spent on prenatal care, \$3.38 in costs associated with low-birth weight babies are avoided. The \$927 average cost of physician check-ups, immunizations and periodic tests for young children is far less than the cost incurred if a child has to spend a single day in the hospital. Not smoking or drinking to excess, exercising and eating healthy foods all are steps that could save billions of dollars in health care costs.

Addressing these issues by educating people about the impact of their actions is vital if health care reform is to be successful and to be viewed positively.

 alifornia should be positioning itself to implement comprehensive health care reform that is compatible with national mandates but designed to maximize efficient and effective care for the State's diverse population. To accomplish this, the Commission has three recommendations:

1. ***Create a temporary commission independent of the Executive and Legislative branches of government that will put forth a single plan for a California health care system.***

The commission should be small enough in size for workable exploration of issues, balanced between expertise and consumer orientation, insulated as much as possible from political considerations and sunsetted in a

***Commission
recommends
3 steps for
State to take***

reasonable length of time. The commission's goal would be to answer the three policy questions outlined in the report above, creating a health care system that would be placed before the Legislature for an up or down vote, without modification. The commission's process would include extensive public and professional input, as well as an evaluation of steps already taken by other states.

2. *Establish a unit within the Department of Health Services to advance knowledge about treatment outcomes and beneficial effects.*

Working in tandem with federal government and private efforts, the State should be pro-actively determining what treatments are effective and what treatments either have no effect or are detrimental. By examining treatment patterns that are related to medical communities rather than to patient conditions, the State can educate both practitioners and the public about services that are of questionable value. The State also will then have the expertise and research documentation to mold a common benefit package that covers beneficial treatment and precludes unnecessary care.

3. *Perform educational outreach to ensure that citizens know how to maximize their health care opportunities and to pave the way for acceptance of health care reform.*

Through educational outreach, the State can promote a common understanding of what a good health care system is: what it looks like, what services it should perform and how people can have quality access. Changing people's perceptions as well as their habits will contribute to the success of health care reform.

***Conclusion:
State should
move forward
with own reforms***

California cannot afford to wait for the federal government to solve health care problems. Instead, it should follow the example of other states, like Oregon, Vermont and Colorado, that are moving ahead to establish innovative frameworks for purchasing and delivering health care. The policy questions and recommendations outlined by the Commission are designed to move California into the 21st Century as a pro-active health care guardian, shedding the present reactive, in-the-trenches mentality. The Commission urges the Governor and the Legislature to move forward with health care reform.

APPENDIX A

Little Hoover Commission Health Care Advisory Committee

Elizabeth Hill, Legislative Analyst

Roger B. King, Deputy Director
Assembly Office of Research

Elisabeth Kersten, Director
Senate Office of Research

Assemblyman Burt Margolin, Chair
Assembly Health Committee

Senator Diane Watson, Chair
Senate Health and Human
Services Committee

Dr. Molly J. Coye, Director
Department of Health Services

Gary Macomber, Executive
Vice President
California Association of
Health Facilities

Dwayne Donner, Vice President
California Association of Hospitals

Robert H. Elsner, Executive
Vice President
California Medical Association

Francisco L. Castillon
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California Health Federation, Inc.

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Legal Aid Foundation of Los Angeles

Marianne O'Sullivan, Executive Director
Health Access

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Western Center on Law and Poverty

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American Association of Retired Persons

Eric Carlson
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California Rural Legal Foundation

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(continued on next page)

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California State Employees Association**

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California Medical Assistance Commission**

**Robert P. Marshall
Executive Vice President
California Pharmacists Association**

**Dr. Mary Pittman, President and Chief
Executive Officer
California Association of Public Hospitals**

**Mary Foley, President
California Nursing Association**

**Lawrence Lavin, Director
National Health Law Program**

**Robert MacLaughlan
Legislative Coordinator
Senior Legislature**

APPENDIX B

Witnesses Appearing at Little Hoover Commission Health Care Public Hearings

March 17, 1993, Sacramento

**Dr. Molly J. Coye, Director
Department of Health Services**

**Tom Elkin, Assistant Executive Officer
Public Employees Retirement System**

**Clifford Allenby, Chairman
Major Risk Medical Insurance Board**

**John Ramey, Executive Director
Major Risk Medical Insurance Board**

**Dr. David Hadorn
Researcher, RAND Corporation**

May 19, 1993, Los Angeles

**Paige Sipes-Metzler, Executive Director
Oregon Health Services Commission**

**John Golenski
Bioethics Consultation Group**

**Dr. Wade Aubry, Medical Director
Blue Shield**

**Maryanne O'Sullivan, Executive Director
Health Access**

**Mark Regan, Staff Attorney
National Health Law Program**

**Yolandi Solari, President
California State Employees Association**

LITTLE HOOVER COMMISSION FACT SHEET

The Little Hoover Commission, formally known as the Milton Marks Commission on California State Government Organization and Economy, is an independent state oversight agency that was created in 1962. The Commission's mission is to investigate state government operations and -- through reports, and recommendations and legislative proposals -- promote efficiency, economy and improved service.

By statute, the Commission is a balanced bipartisan board composed of five citizen members appointed by the Governor, four citizen members appointed by the Legislature, two Senators and two Assembly members.

The Commission holds hearings on topics that come to its attention from citizens, legislators and other sources. But the hearings are only a small part of a long and thorough process:

- * Two or three months of preliminary investigations and preparations come before a hearing is conducted.
- * Hearings are constructed in such a way to explore identified issues and raise new areas for investigation.
- * Two to six months of intensive fieldwork is undertaken before a report -- including findings and recommendations -- is written, adopted and released.
- * Legislation to implement recommendations is sponsored and lobbied through the legislative system.
- * New hearings are held and progress reports issued in the years following the initial report until the Commission's recommendations have been enacted or its concerns have been addressed.



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