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TESTIMONY BEFORE THE LITTLE HOOVER COMMISSION

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On behalf of Health Access California, the statewide health care consumer advocacy coalition, I appreciate the opportunity to testify before the Little Hoover Commission on how to improve publicly-funded health care. In examining this topic, we appreciate the Commission's comprehensive approach.

Broad reform needed: Whether it is rising costs, growing enrollments, or uneven quality, these aren't Medi-Cal problems. These are health care problems. Medi-Cal, for example, provides care to one-fifth of California's population, and finances the care for many more, who are the sickest, the poorest, and the most vulnerable. Yet it does it at a lower cost than the private sector and a lower cost than any other Medicaid program in the nation. The best reforms for Medi-Cal, Healthy Families, or other public programs, are those that seek to deal with the health care crisis as a whole.

Building on what works: In formulating or evaluating health care reform proposals, it is crucial to preserve and strengthen what works in our current health care system. This system rests on two pillars—employers voluntarily providing health coverage to (some of) their workers and their families, and public insurance programs that commit (with gaps in both policy and practice) to cover those not served by employers: seniors, people with disabilities, low-income children and in some cases their parents.

Consider these numbers: Most Californians—over 18 million—get health coverage through employer-based coverage. Over 10 million of the state's 36 million residents receive coverage through public insurance programs like Medi-Cal and Medicare.

In contrast, only about one million purchase health coverage as individuals, either because it is unaffordable or unavailable. As individuals, people don't the have power of group purchasing to get the best deal possible, and buying coverage as an individual is often unaffordable. Unlike in group coverage, individuals are simply at the mercy of insurers, who often deny them coverage outright because of their health status or so-called "pre-existing conditions."

The Problem of the Uninsured: Our system fails to insure over six million Californians, one in five of those under 65. Californians are more likely to be uninsured than residents of all but four states. The uninsured live sicker, die younger, and are one emergency away from financial ruin. The uninsured don't get needed care, including preventative screenings, ongoing treatment for chronic conditions, and emergency care, resulting in severe health impacts.[1] The uninsured are more likely to die prematurely than insured patients with similar problems.[2] Financially, nearly half of the uninsured reported having unpaid bills or being in debt to a health provider.[3] Nearly half of all personal bankruptcies are the result of health problems or large medical bills.[4]

But let's remember: Over 80% of the uninsured are workers or the dependents of workers.[5] They are not uninsured by choice—over 85% of the uninsured are not eligible for coverage from an employer.[6] And most of them have limited incomes and cannot afford coverage on their own.

So this is the major failure of our health care system. The individual market doesn't work. So is it the failure of employers to cover their workers, or is it the failure of the public programs to not provide expansive enough outreach, enrollment, eligibility, or retention?

Employers scale back*:* Some employers are scaling back coverage or dropping benefits entirely—and as competing employers follow, California may have large sectors of our economy in which employers have opted out of providing coverage. Nationally, the percentage of workers receiving coverage from their employer in 2004 was 61%, down from 65% in 2001, with at least 5 million fewer jobs providing health insurance in the three years.[7] Our state has one of the worst rates of employers offering coverage. Employers are increasing employee cost-sharing, reducing benefits, and limiting the percentage of their workforce that is eligible for any health benefits As employers scale back coverage or drop it altogether, competing employers are pressured to follow suit, leaving even more people underinsured or uninsured.

Public programs step in: In terms of making sure that people have health insurance, public programs like Medi-Cal and Healthy Families have been the success stories amidst these gloomy numbers. The number of uninsured children has recently decreased. Even when employer-based coverage for children was declining, the number of children uninsured at some point during the year decreased from 1.5 million children in 2001 to 1.1 million in 2003.[8] While the number of uninsured adults went up, public insurance programs, including Medi-Cal, Healthy Families, and various county initiatives, picked up the slack. These public insurance programs have been success stories, covering the sickest and frailest in our society at a cheaper cost.

Medi-Cal responded to the recent recession by enrolling many people who lost coverage, and now covers over 6.5 million. It adapted to new health crises, such as providing treatment to people with AIDS. Moreover, Medi-Cal's costs per person have risen at a slower rate than those for private insurers, and Medi-Cal offers the lowest per person cost and more benefits than Medicaid programs in the nation's other 49 states.

Budget cuts loom**:** The irony is that despite these successes—particularly the caseload growth responding to the recession and employers dropping coverage, these public insurance programs have been targeted for cuts and reductions. Both the previous and current Governor have proposed significant health cuts that would have denied coverage to hundreds of thousands of children, seniors, and people with disabilities, and additional policy changes would have restricted access to care for millions more. While that moment has passed in California, there are threats and proposed cuts at the federal level, including the President's recently released budget.

Simply put, Medi-Cal, Healthy Families, and other public programs cannot be sustainable in the long term without 1) a policy of setting a standard for employer-based coverage on the job, much like the minimum wage does for pay, to prevent more families from falling onto these programs; or 2) a policy that captures some financing from employers who do not provide coverage to all their workers, to fund these programs.

Financing Mechanisms: That's why we see the commonality in each of the comprehensive proposals on the table, whether by Governor Schwarzenegger, Speaker Nunez, Senate President Perata, or Senate Health Committee Chair Kuehl, that would either set such a standard, or require some shared financial responsibility from employers and their workers. Senator Kuehl would replace the employer-based system with a publicly-financed one, replacing employer and individual premiums with a progressive tax system, that likely would provide significant savings for many who pay now, but at probably some cost for those who don't. Speaker Nunez and Senate President Perata would set a standard at a level to provide coverage to a worker, or they

would pay into a purchasing pool. In this way, it would capture financing from those that don't contribute their fair share.

The Governor sets a standard of 4% of payroll for employers over 10 workers who do not provide coverage to their workers. We appreciate that the Governor has acknowledged the need for a standard for employers, but the level is similar to setting a minimum wage at $4 (four dollars).The average contribution of an employer to health benefits is 8-12%. A company frequently invoked in these debates, Wal-Mart, which provides coverage to just 45% of their workers, pays 7.7% of its payroll for healthcare. Setting the employer contribution at 4% of payroll would not assist many uninsured workers in large companies, including those that make their workers wait one, two or more years before getting benefits. Nor would it provide fairness and a level playing field to those employers that do provide coverage, but compete against those who provide little or nothing. It would only bring in limited contributions from those mid-size employers that offer no benefits whatsoever.

Another issue with the Governor's proposal is that beyond the low standard it sets for the employer contribution, it caps the employers' required contribution, whereas the mandate on individuals is not capped, it is unlimited and will grow with rising health costs. Over time, this shifts burden of health coverage from the group to the individual.

Affordability: We think any discussion of affordability must start with affordability for the consumer. Many proposals for affordability have been thinly-veiled efforts to simply shift costs and burdens from employers or insurers onto individual patients and families: the trends in this category that we oppose include higher deductibles and cost-sharing, reduced benefits, and mandates to simply buy products with little regard to ability to pay, the power of group purchasing, a shared contribution from employers or government, or assurance of a benefit of real value.

In fact, many of these trends increase costs not only for the consumer, but for the system as a whole. High deductibles discourage patients from getting the needed care, including preventative, disease management, and even emergency treatments that save money in the long run. Individual mandates to simply buy products take away the individual consumers' only bargaining power outside of a group: the power to say "no."

We don't oppose an individual contribution to a social insurance system. We have supported models such as Medicare, an employer-based system where workers have a requirement to contribute a fair amount, or even a public program expansion financed by a fee, tobacco tax, or other revenue source. All take into account ability to pay, don't place financial barriers in the way of patients getting the care they need, and ultimately are based on a group health care model.

We do appreciate the focus on affordability in the various health proposals, those that focus on root causes. This includes efforts at prevention and wellness; public health efforts, and better disease management. This includes using information technology to better streamline systems, to provide more transparency and disclosure of the cost and quality of care, and to ultimately reduce high-cost/low-quality care. We have a list on our website, at:
http://www.health-access.org/expanding/cost_controls.html

Senator Kuehl's proposal goes the farthest, in seeking major administrative savings through a single-payer system, both through better planning and global budgeting to radically reduce the costs of administration and profit. This administrative savings would not just of the insurers, but also that of the doctors and hospitals in having to deal with the multiplicity of different health plans. Governor Schwarzenegger's proposal would take a step by limiting the amount--15%--that hospitals and health plans would spend on administration and profit. The proposals of Speaker Nunez and Senator Perata would set up purchasing entities to at least streamline and standard benefits, so that consumers could make reasonable comparisons, and hopefully the overall system would be simpler.

There are other savings from the health industry to be gained in bulk purchasing and bargaining, which is why these proposals are best when they bring people together to share the risk and cost of health coverage through either public or private group plans—and they are at the worst when they force individuals to take on this burden and risk alone.

Universality: Finally, what all the plans recognize is what the Governor calls the "hidden tax," that there is a cost to all of us in having a large uninsured population. Put another way: we all pay more if McDonald's pays less. To the extent that we have a system where we all contribute, employers, workers, and taxpayers that contribute no longer have to subsidize those that don't. A universal system, where everyone pays according to their ability to pay, but then everyone gets a benefit, would be the most sustainable, both financially and politically.

A system that covers most, and ideally all, of the uninsured would also allow several of the cost-control options cited above to be more feasible. If everybody is covered, it would be easier to implement public health campaigns and measures. The system would have an incentive to be geared toward prevention, since everybody will be covered in one way or another (now, many insurers don't invest in prevention because that patient may not be under their care in a few years). Planning and budgeting would be easier.

For public programs, universality would mean a sea-change. No longer would we have programs that seek to enroll more people, but are scared about "crowd out," or enrolling too many people. We could vastly simplify the outreach, enrollment, and retention procedures that are now needlessly burdensome. An application for Medi-Cal would rival a mortage application, with everything from an assets test to income documentation. For example, we now require Medi-Cal applicants to fill out semi-annual reports, for the express purpose of having some recipients fall off the program, to generate budget savings. We could finally increase eligibility for broad programs like Medi-Cal and Healthy Families, rather than disease-specific programs, and take those expansions to be a more full safety-net. The Governor, for example, has proposed to expand Medi-Cal to include those adults under the poverty level who do not have children at home—and who right now are excluded from the program. With the goal of covering all Californians, these programs could finally be on a footing where they could succeed, and not be punished for it.

Systems of Delivery: We do believe that there will always be some who are left out of the health care system. For them, and for all of us, we need to preserve our system of public hospitals and community clinics in California. We oppose the Governor's proposal to take $2 billion from public hospitals, since we all rely on these institutions, for their emergency rooms and trauma centers, to provide and lead the way on specialty care, for medical education, and to deal with vulnerable populations and those with specific needs.

We are encouraged by the model in San Francisco, which incorporated a "universal access" model, where the safety-net institutions are a vital part of health reform, and the access provided is through the providers there. It was partially possible because of the investment that that county had made in its public system, one that is not commensurate in other parts of the state.

We also acknowledge that Medi-Cal and other public programs use both public and private systems of delivery, and we believe that in order for the system to work, these providers need to be fairly compensated. We are supportive of the proposal by Governor Schwarzenegger to increase Medi-Cal rates to a level commensurate with Medicare rates. The biggest issue with the Medi-Cal system for patients is access to providers, and for providers it is the low level of reimbursement, and we need to correct both issues.

Finally, government has a role to play as a regulator, to set the ground rules for both employers, but also for insurers and providers. Let me take one example, about how rules for insurers and providers in the

overall market can have a beneficial impact on public programs, public hospitals, and the health system as a whole.

Right now, the Department of Managed Health Care is considering new draft regulations and holding hearings on the implementation of AB2179(Cohn) c.797 of 2002, a bill sponsored by Health Access California to ensure patients have *timely* access to care. The hearing notice is here: http://www.dmhc.ca.gov/library/reports/news/aron.pdf

This rules will provide great relief to patients, but for the system as a whole. As the DMHC sets standards for health plans so that insured patients can get appointments for urgent care, or a specialist, in a timely fashion, that means less people will be forced to go to overcrowded, more expensive, and less appropriate emergency rooms.

Even though we are right to reduce ER use by the uninsured by extending coverage, the bulk of ER visits are from the *insured*. And there's a portion of ER visits by the insured that happen because the patient simply can't get into see a doctor in a timely manner, and simply can't wait for an appointment. So they end up going to sit out the wait in the emergency room, even though a doctor's office would be a better (and cheaper) place to get care. New regulations can help fix this, both so that those with coverage get the care they need *when* they need it, but also to help relieve problems throughout the system, like ER overcrowding.

Come together by sharing risk: Let me finish by re-iterating the central principle for health care reformers is to focus on what works, which is pooling people together to share risk. We value health insurance because we know that one of these years, by circumstance, emergency, or age, we will be in the small percentage of people who will require major medical care. Rather than take the individual risk, we know it is more affordable and efficient to get insurance in a larger group—and the larger the group, the stronger our health care can be. By principle, the more people are covered, the healthier we are, the healthier our public programs are, as is our health system as a whole. Thank you.

ENDNOTES

[1] "No Health Insurance? It's Enough to Make You Sick." American College of Physicians-American Society of Internal Medicine, November 1999.
[2] "Care Without Coverage," Institute of Medicine, May 2002
[3] "Paying for Health Care When You Are Uninsured," Access Project, 2000
[4] "Medical Problems and Bankruptcy Filings," Norton's Bankruptcy Advisor, 2000.
[5] California Health Interview Survey (CHIS), UCLA Center for Health Policy Research
[6] California Health Interview Survey (CHIS), UCLA Center for Health Policy Research
[7] Annual Employer Health Benefits Survey by the Kaiser Family Foundation/HRET, September 2004.
[8] California Health Interview Survey (CHIS), UCLA Center for Health Policy Research

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This paper, and more information on every policy proposal and bill mentioned herein, including a health policy blog updated daily, is available at our website: http://www.health-access.org