California Speaks
A statewide conversation on health care

Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it? Who gets covered? What reforms are needed? How will we pay for it? What are the shared responsibilities? Which values will guide us? Who gets covered? Which values will guide us? How will we pay for it? How do we contain costs? What are the shared responsibilities? How much will it cost? How much will we pay for it?
CaliforniaSpeaks is a nonpartisan project created and led by AmericaSpeaks with generous funding from Blue Shield of California Foundation, The California Endowment and The California Wellness Foundation.

Additional funding for CaliforniaSpeaks has been provided by Alliance Healthcare Foundation, the Sierra Health Foundation and the San Francisco Foundation.

Contents

Our purpose and process .......................................................... 1
California’s health care situation ............................................... 2
How the health care system works ............................................. 4
Opportunities to strengthen the system ..................................... 6
Key elements of reform ......................................................... 8
    Topic 1: Employer responsibility ......................................... 10
    Topic 2: Government responsibility ..................................... 12
    Topic 3: Insurer responsibility ............................................. 14
    Topic 4: Individual responsibility ....................................... 15
    Topic 5: Controlling costs .................................................. 17
Reference: Current health care reform proposals ....................... 18
Keeping health care reform moving forward ............................. 20

AmericaSpeaks (www.americaspeaks.org) is a nonpartisan, non-profit organization with the mission of providing Americans with a greater voice in the most important decisions that affect their lives. AmericaSpeaks has engaged more than 130,000 citizens across the country on such topics as health care reform in Maine, shaping municipal budget priorities in Washington, D.C. and developing rebuilding plans for the World Trade Center site in New York City. Most recently, AmericaSpeaks convened thousands of New Orleanians to create their city’s recovery plan.
California’s health care situation

California has over 37 million residents. It has the 8th largest economy in the world, with goods and services valued at $1.7 trillion in 2006. Despite this dynamic environment and many great natural resources, California faces major challenges in providing health care for its residents:

- Spending on health care was $196 billion in 2004. And costs continue to grow faster than inflation.
- At this moment, about 4.9 million Californians do not have health insurance. Over 6.5 million Californians (over 20% of the population) had no coverage at some time during the past year.
- Even those with insurance feel insecure about it. In a recent survey, 77% of Californians were concerned about not being able to pay the costs of a major illness or injury.

<table>
<thead>
<tr>
<th>SOURCES OF HEALTH INSURANCE, 2005</th>
<th>Californians under 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employe-based</td>
<td>54%</td>
</tr>
<tr>
<td>Medi-Cal/Healthy Families</td>
<td>16%</td>
</tr>
<tr>
<td>Private purchased</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>20%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

How Californians get health insurance

How people get their insurance depends on their age. Medicare, the national health insurance program, covers most people age 65 or older (and some people younger than 65 who have disabilities), about 11% of Californians in total.

The focus of this health care reform discussion is on people under 65. A majority of these Californians get their insurance from their or a spouse’s employer. Others participate in federal and state funded programs like Medicaid (called Medi-Cal in California) or the Healthy Families program. The rest buy insurance on their own or go without.

While the individual market is a small part of the whole, it is a very important sector for people who work for themselves or for an employer that does not provide them with insurance, or who are not eligible for government programs. The “other” group on the chart includes people who get insurance from a union or trade association.

Fewer people covered by employers

The percentage of Californians receiving health care from an employer has decreased 10% in the past two decades.

Of people without insurance in 2005, 84% were in a family with someone who worked. New or part-time employees and people who work at small businesses are examples of workers who are less likely to have health care insurance.

Health insurance status can change quickly

Many people move back and forth between having insurance and not having insurance at different points in their life. They have a range of experiences with health care coverage:

- UNINSURED No health insurance coverage. Often go without care or need to use emergency room or safety net providers for health care services.
- UNDERINSURED May be covered for major medical emergencies with high deductibles; may not be able to afford needed care or drugs. May have medical condition that is excluded from their policy, or have medical expenses that go over the yearly limit.
- ADEQUATELY INSURED Confident that health insurance will continue and that it will be able to cover most expenses.

Even those with insurance may feel “insecurely insured.” A sudden illness, job lay off, divorce or any major life transition can make any of us vulnerable to losing coverage or having it decrease.

There is an important difference between having coverage and actually using health care services. Uninsured and underinsured Californians are less likely to seek or follow up on needed care and prescriptions because they cannot afford it, often creating medical problems that could have been prevented.

Health care providers: shifts in supply and demand

Many Californians face barriers to quality health care because the right mix of health care professionals is not available to serve them:

- The number of California physicians in primary care has dropped to 40% of all doctors. These generalists make about half the pay of specialists.
- Most of California, like the country as a whole, is facing a shortage of nurses.
- Higher caseloads and lower reimbursements have forced many medical practices to limit or stop care for uninsured patients and patients on Medi-Cal. This in turn increases pressure on emergency rooms from both insured and uninsured patients.
- Many overburdened emergency rooms have closed and more are likely to do so. When an emergency room is not available, everyone who needs emergency care suffers.
Introduction

How the health care system works

California's health care system depends on different sectors playing important roles in delivering, receiving and paying for health care. Each of these parts of the system is interrelated. A change in any one part will affect the others, for better or worse. Together, all parts of the system play a role in determining how healthy people are in California.

Government
- Regulates the health care system
- Provides coverage for vulnerable populations

Individuals & Families
- Use and pay for health care services
- Take personal actions that affect health

Employers
- Decide what kind and how much health care coverage will be provided to employees

Health Insurance Companies
- Contract with employers to provide group insurance for employees
- Offer policies to select individuals

Medical Providers
- Provide care for clients
- Connect with insurers to get patients and payment, or bill patients directly

Who pays for health care

Nationally, our total health care system is funded about 45% by government and 55% from private dollars from employers and individuals. The role of government support increased when national health insurance for seniors (Medicare) and certain categories of low-income people (Medicaid) was enacted in 1965.11 We all pay for California's health care system directly and indirectly.

- WE PAY AS TAXPAYERS for government funded and managed programs.
- WE PAY AS EMPLOYEES because wage increases by most employers are lower than in the past, in part to help make up for increased health care costs.
- WE PAY AS USERS OF HEALTH CARE for insurance and services.
- WE ALSO PAY AS CONSUMERS of other products because those companies often pass on their health care costs.

How insurance works for consumers

When you have health insurance, the organization providing the insurance agrees to pay part of your medical expenses if you need to visit a doctor's office or hospital. The amount of the bill paid by the insurance company depends on your policy, which has these parts:

- PREMIUM – the amount you have to pay each month for the level of coverage you choose
- CO-PAY – when you see the doctor, you also may have to make a co-payment such as $20 per visit
- DEDUCTIBLE – how much you have to pay out of your pocket ($500, for example) before the plan starts paying; once you've reached your deductible, the policy may pay a certain portion (80%, for example) of total costs

Most insurance in California is based on a “managed care” system with a specific network of providers, as in a health maintenance organization (HMO). In an HMO, a primary care physician decides when you get referred to specialists. Other policies let you have more direct choice of providers like PPOs (Preferred Provider Organization) and you typically pay more for that ability to choose.

When employers buy insurance for a group of people, they are bargaining in the “group market.” If someone does not have insurance through an employer or a current state program, his or her only health care coverage option is to purchase insurance through the “individual market.” Premiums in the individual market are usually higher than for the group market and are more difficult for many people to afford.

People can be denied a policy in the individual insurance market – even if they are willing and able to pay for it – based on their medical history, whether or not they are sick now. There is a state insurance program that lets people buy insurance who have been denied coverage elsewhere. The premium costs for this program are more affordable for many people.

How participation affects insurance costs

Most people cannot predict when they will need health care. They buy insurance to be prepared. All of the people buying insurance are paying into a “pool” of funds that will pay their medical bills when they need care. At any point in time, healthier people may pay into the pool more than they use, while sicker people may draw out more than they put in.

If the number of healthy people paying into the pool is larger than the number of people using medical care, then costs balance out. If too many healthy people leave the pool, the proportion of sick people increases. This change leads to higher insurance costs for those remaining in the pool since more people are spending money on health care rather than people paying in without drawing out.
Introduction

Opportunities to strengthen the system

The people of California are innovators. For example, the state is the center for much of the new research in health care technology and bio-medicine. Many of the top life sciences firms are located in California, along with world-class research hospitals. Exciting breakthroughs that could change the face of health care in the future are happening here.

On a day-to-day level, almost one million medical care workers in California are making a positive difference in millions of lives. Yet, we also have a health care system that:

- is inefficient with overlapping, complex administration
- is fragmented in how care is provided, with many people falling through the cracks
- does not control costs effectively
- leaves millions of residents underinsured as well as uninsured, and millions more feeling insecure about their insurance

These strains on the system are only going to get worse as the state could add another 7 to 10 million new people in the next twenty years, along with an aging population.

How our system compares to others

U.S. health care spending per person in 2004 was double or even triple the rate for other developed countries such as Canada, France and Spain.

<table>
<thead>
<tr>
<th>HEALTH CARE SPENDING PER PERSON, 2004*</th>
<th>$2,004</th>
<th>$2,508</th>
<th>$3,043</th>
<th>$3,120</th>
<th>$3,159</th>
<th>$3,165</th>
<th>$6,102</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.K.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In a study of health trends among 30 developed countries, the U.S. ranked first in access to medical technologies and specialists. Patients in our country have better cancer survival rates than many other countries and comparatively shorter waits for elective treatment. Yet, the U.S. did not compare favorably on many other measures. Our country was ranked ninth in life expectancy and 28th in infant mortality.

California is a leader in the science of health care. Now our challenge is to apply this innovative spirit in creating an affordable and accessible system of care.

Health care costs are growing faster than inflation

Health care costs in California have grown dramatically in the past twenty years and are now likely to be over $200 billion. In 2005, as in other recent years, health care insurance premiums in California grew much faster than wages or inflation.

Nationally, the fastest growing cost categories are prescription drugs (now at 11% of total health care spending, up from 5% twenty years ago) and administration which is about 7% of total spending.

Why health care costs are so high and growing

These are some of the interrelated factors that result in high health care costs:

- **GROWTH IN CHRONIC DISEASE**
  About 14 million California adults (38% of total) have chronic illnesses such as hypertension, heart disease and asthma. A child born in 2000 has a 36% risk of developing diabetes in his or her lifetime.

- **COMPLEX SYSTEM STRUCTURE**
  California has hundreds of insurers and thousands of policies. Poorly coordinated care and excess administration lead to higher costs.

- **LIMITED PARTICIPATION IN THE INSURANCE POOL**
  When fewer people have insurance coverage, the overall cost of insurance goes up because risk is spread across a small number of people.

- **CONFLICTING INCENTIVES**
  Providers can often make more money on specializing, issuing new drugs, and using expensive tests and devices instead of preventive care or other treatments that may be more cost effective.

- **HIGH COSTS OF END OF LIFE CARE**
  A high proportion of costs are spent to extend the life of critically ill patients and the aged. This requires expensive procedures and many forms of prescription medicines.

- **REGULATIONS**
  Some regulations can inadvertently increase the cost of care, such as requiring a physician to be on site for routine services that could be provided by a nurse.
This year and in years past, many different approaches have been proposed to reform California’s health care system. Broadly speaking, these approaches fit into three general categories:

<table>
<thead>
<tr>
<th>Set up a government-funded health care system</th>
<th>Build on current employer and government systems</th>
<th>Rely more on private health care markets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government becomes the payer of all health insurance (like Medicare, but for everybody), replacing the current network of insurance companies.</td>
<td>Require all state residents to have health insurance and require employers to contribute to employee health care coverage.</td>
<td>Maximize free market competition between insurance plans by promoting more individual choice.</td>
</tr>
<tr>
<td>The state (not insurance companies) reimburses doctors and hospitals for delivering care, providing a choice for all residents.</td>
<td>Make insurance affordable through government subsidies, plus new regulations on private insurers.</td>
<td>No requirement for individuals to have insurance.</td>
</tr>
<tr>
<td>Costs are controlled through the efficiencies of a single payment system, the purchasing power of a large “shared risk pool” of users and by regulation of providers.</td>
<td>Expand public health programs for the most vulnerable people in California.</td>
<td>Reduce regulations on insurers so providers can offer new kinds of products and services.</td>
</tr>
<tr>
<td>Create personal health savings accounts that let people use pre-tax dollars for health care needs.</td>
<td></td>
<td>Create personal health savings accounts that let people use pre-tax dollars for health care needs.</td>
</tr>
</tbody>
</table>

In the past year, multiple proposals have been introduced to the California legislature that correspond to these three approaches:

- A proposal to set up a government-funded health care system (Senate Bill 840) has been passed by the Senate and is moving through the Assembly. The Governor has vetoed similar bills in the past and has said he will do the same this year.
- A proposal that builds on the current employer and government systems is under consideration by the legislature (Assembly Bill 8). A competing package has been proposed by the Governor.
- Proposals relying on the private market have been introduced (e.g., Senate Bill 236), but have not been passed out of the legislature.

More information about the specific provisions of each of these proposals is provided on pages 18 and 19.

Two of these proposals are currently receiving the most legislative attention with prospects for becoming law in 2007: Assembly Bill 8 written by the Democratic leadership and a proposal by the Governor. In order to provide the public with the maximum opportunity to influence health care reform legislation this year, today’s discussions will focus on the options in these two proposals. Participants are encouraged to keep the other approaches in mind and consider the trade-offs involved.

CURRENT REFORM PLANS UNDER DISCUSSION

The Governor and the legislature are discussing different reform plans that look at how all of the pieces could work together to make a stronger health care system. The CaliforniaSpeaks meeting will focus on a few critical policy options that are central to these discussions.

**Topic 1** Should employers be required to either offer insurance to employees or pay into a group insurance fund? If so, how much should they pay?

**Topic 2** Should state government increase access to affordable health insurance for low and moderate income Californians?

**Topic 3** Should insurance companies be required to guarantee coverage to all applicants regardless of pre-existing conditions? Should there be a limit on insurance companies’ administration and profits?

**Topic 4** Should individuals be required to have health insurance? Should employees be required to do so if their employer offers it?

**Topic 5** What can each part of the system do to help control costs while improving health outcomes?

The figure below shows where the proposed policy options would fall within California’s health care system:
Employers in California choose whether to offer health care insurance for their employees. As they think about how much health care insurance to offer, they face a challenge in keeping costs low while attracting and retaining a productive and healthy workforce.

In 2005, 54% of Californians had health insurance through their or a spouse’s employer. That is down from 65% in 1987.22

About 70% of employers offer health insurance to their employees. Large businesses are more likely to offer insurance than small ones.23

In 2006, on average, California employers paid about 88% of individual premiums and 76% of family premiums. Employees paid the rest, plus any co-payments and deductibles. The share paid by employees has been increasing.24

**How employers are dealing with health care costs**

Escalating health care costs have put many employers in the position of limiting wage increases as they try to keep up with rising insurance premiums for their employees. Employers in 2005 were spending almost twice as much (97% more) on health insurance for employees than ten years earlier, while they increased wages only 39% over the same time period.25

According to a Union Bank of California survey of small businesses, 60% of those offering health care said that these costs were affecting their business. Businesses reported shifting costs to employees or reducing health care benefits.26

RAND reports that among California employers offering health insurance, half spend more than 7.7% of payroll for health care expenses and half spend less than that. Employers of low-wage workers (earning $9.50 or less) spend 20% of payroll on health care.27

**PROPOSED CHANGES**

Employers would be required to spend a minimum amount on employee health care either by offering health care coverage or paying a fee to the state for an insurance pool.

- The amount of the fee would be calculated based on the employer’s payroll. The specific amount is not set but initially could be between 4% and 7.5%. In return for the fee, the state would provide subsidies for insurance premiums of low-income employees.
- State tax law would be changed to line up with federal law so that employers and employees could set aside pre-tax income to help pay for health care expenses.
- Some businesses might be excluded, such as those with fewer than ten workers, those with payrolls less than $100,000 and start-up firms, as well as people who are self employed.

**Arguments for**

- Health care reform should build on our current employer-based system that is already working for a majority of Californians under 65.
- Many low-wage workers would now have access to health care insurance that was previously unaffordable.
- Businesses that offer insurance will no longer have to compete against other California companies that don’t.
- This requirement may lead more employers to offer health care directly to their employees.
- In other countries with government-sponsored “single payer” health care systems, employers contribute to health care coverage for employees.

**Arguments against**

- California employers will have a harder time being competitive. Some employers may be forced out of business or choose to leave the state.
- Employers will take the health care expense out of employee wages or pass the cost onto consumers.
- There is no cap on the fee of 4.0% or 7.5%. As health care costs keep rising, employers can get stuck with a mandate that keeps increasing.
- Employers who already offer insurance may choose to save money and reduce benefits by switching to the government-sponsored plan.
- Federal law prohibits states from intruding on employer benefits. Employers must be given choices in how to meet this kind of employer obligation.

**How the fee would work**

If an employer chooses not to provide health insurance directly to employees, then it would pay a fee based on Social Security wages for its employees. For example, a small business with a payroll of $100,000 would pay $7,500 (if 7.5% is the fee level that gets set).

In return, that company’s low-income employees would get state subsidies to help with the cost of coverage.

**Competing data about impact on employers**

There are different views about the economic impact of making health care insurance or the fee mandatory for employers.

- The National Federation of Independent Business (a small business association) found that if the proposal included all small businesses, over 249,000 jobs would be lost in the first five years.28
- U.C. Berkeley Labor Center found that employers’ short term operating costs would increase less than one percent in the beginning and would decline over time. This group forecast no negative effects in job creation and predicted positive effects on productivity.29
With the help of the federal government, the state government plays an important role in providing health coverage for vulnerable populations, like children, low-income Californians and the disabled, and in regulating the state’s health care system. The state also has a program that helps people who have been denied health insurance based on their medical history.

### Current publicly funded health insurance programs for Californians under 65

**MEDI-CAL** is California’s version of Medicaid, and provides low cost health services to eligible low-income and disabled people, including nursing home care for poor elderly residents. Currently, low-income people under age 65 without children and without disabilities are excluded from Medi-Cal.

**HEALTHY FAMILIES** offers insurance for children and teens from families with incomes between the Medi-Cal cutoff and 250% of the federal poverty level. The program provides subsidized health, dental and vision coverage.

The state determines how providers of services to Medi-Cal patients are reimbursed. The per-person cost of running the Medi-Cal program is lower than for other states, but this is primarily because providers are being reimbursed well below their actual costs. Because of this, some Medi-Cal patients have difficulty finding providers willing to serve them.

### Protecting vulnerable populations

In a 2005 survey of Californians without insurance, 43% of people said that the reason they did not have insurance was because they could not afford it (far and away the most common answer). Over half the people without health insurance had been without it for three or more years. 7

Young adults in the 19 to 29 age group are the most likely to be without insurance (41% are without). However, in the past four years, there has been a drop in the percentage of children and teens without insurance (from 31% down to 22%) due to increased enrollment in Medi-Cal and Healthy Families. 10

<table>
<thead>
<tr>
<th>2007 FEDERAL POVERTY LEVEL</th>
<th>INDIVIDUAL</th>
<th>FAMILY OF FOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% ($10,200)</td>
<td>$10,200</td>
<td>$20,700</td>
</tr>
<tr>
<td>200% ($20,400)</td>
<td>$20,400</td>
<td>$41,100</td>
</tr>
<tr>
<td>300% ($30,600)</td>
<td>$30,600</td>
<td>$62,000</td>
</tr>
<tr>
<td>400% ($40,800)</td>
<td>$40,800</td>
<td>$82,600</td>
</tr>
</tbody>
</table>

Rounded to nearest hundred.

### Health insurance and citizenship status

The reform proposals introduced by the Governor and legislative leadership do not offer any programs to provide coverage for undocumented adults who do not have insurance through their employers. Under discussion is whether undocumented children should be eligible for the state’s Medi-Cal and Healthy Families Program.

In the 2005 health survey, 63% of the Californians without insurance were U. S. citizens and another 15% were permanent legal residents with green cards. Non-citizens without green cards were 22% of the total of uninsured. 7 This category includes many legal residents, including temporary workers and students. While it is hard to determine total costs for undocumented residents in California, it is worth noting that:

- Undocumented workers have very restricted access to publicly funded health care programs; they are limited to emergency services, immunizations, pre-natal care, labor and delivery.
- Health care expenditures are 55% lower for immigrants than for U.S.-born individuals, primarily because immigrants are less likely to use health care services. 10

### PROPOSED CHANGES

**Expand eligibility for the Medi-Cal and Healthy Families programs.** Medi-Cal could be offered to individuals without children with incomes up to $10,500 (100% of the federal poverty level). The Healthy Families and Medi-Cal insurance programs could be expanded for children up to 300% of the federal poverty level, regardless of their citizenship status.

**Provide subsidies to low and moderate income people (e.g., up to 250% or 300% of the poverty level) to help pay for the cost of health insurance, based on a new large state purchasing pool to make premiums more affordable.** People would contribute based on their income, with a cap of no more than 5% or 6% of income for premiums (e.g. $2,500 to $3,000 for a family making $50,000). Under discussion is whether access to insurance from the group pool would also be allowed for employees not covered by employers, even if their incomes did not allow for the subsidies.

**Provide increased compensation for Medi-Cal providers, hospitals and health plans.** They would receive “fair” market rate compensation for services.

### Example of insurance subsidy

The sliding scale for how much the subsidized premium would cost ranges from 3% to 5% of income. As an example, people at 200% of the federal poverty level would pay 4% of income:

- An individual with income of $20,400 would pay $816 per year.
- Family of four with income of $41,300 would pay $1,652 per year.

### Arguments for

- State government has a responsibility to provide health coverage to low-income people through public programs. Individuals as well as families need help.
- State government can use its purchasing power to assist lower and moderate income people in securing health coverage.
- Businesses need the state to create this foundation; they cannot afford to provide health care for all low-wage workers.
- All children should receive health care services, regardless of their citizenship status.
- If Medi-Cal providers had adequate reimbursements, they would not have to charge other patients to make up for underpayments, and they would be more willing to serve Medi-Cal patients.

### Arguments against

- It is not the state’s responsibility for taking care of all or part of the uninsured population.
- We cannot afford to add any more burden to the state budget. Increasing Medi-Cal expenditures will reduce what we can spend on other priorities like education.
- The private market could do a better job of creating access to health care if there were reduced regulations.
- Health care for undocumented children would be an additional draw for more illegal immigration.
- How much the state can do is limited by the critical role that the federal government plays in financing and regulating health care and coverage.

### Thinking about government’s role in health care

In addition to the proposals listed above, government could play a larger role in health care through the creation of a “single-payer” system in which the government is the primary source of health care insurance for all Californians (see page 8). While the Senate has passed a proposal to create such a system, it is highly unlikely that such a reform will be adopted because the Governor has vetoed similar legislation in the past and has said he will do so again. Others think the government should have an even further reduced role in our health care system.
Health insurers play an important role by providing health coverage to individuals and families that belong to their plans.
- Insurers need to offer health packages that respond to market conditions while playing by the rules set by state insurance regulators.
- In order for insurers to stay in business, they must have the right number and mix of customers paying premiums to be able to pay for the cost of providing normal and extraordinary health care expenses for everyone in their plans.

Part of the money paid to health insurers goes to providing care for members and part of it goes to paying administrative costs. The journal Health Affairs reported in 2005 that administrative costs represented 25% of health care spending in California, with the bulk of that made up of billing and insurance-related functions.  

### The individual insurance market
California law permits insurers to choose who they will sell insurance to in the individual market. When people apply for insurance, they are screened for current and past health situations. Based on the screening results, insurers can reject people or charge higher premiums for conditions like cancer, heart disease or asthma, even if people no longer have that condition.

There is a state-run Major Risk Medical Insurance Program for people who have been turned down by health insurers. However, the premiums in the program (an average of $450 per month) are unaffordable for many people.  

### PROPOSED CHANGE #1

Requiring insurers to provide coverage to people in the individual market independent of their medical conditions (known as “guaranteed issue”).

**Arguments for**
- Insurance companies should not be able to discriminate against people with a pre-existing condition.
- Many healthy people are rejected for health insurance based on conditions they no longer have or for very minor reasons.

**Arguments against**
- Insuring individuals with any pre-existing condition will raise premiums for everyone else.
- Insurers should not be mandated to accept all consumers unless everyone is mandated to participate and that is enforced. Otherwise, some people will only purchase insurance when they get sick.

### PROPOSED CHANGE #2

Requiring insurers to spend at least 85% of premiums collected on reimbursements for medical care and no more than 15% for administration and profit.

**Arguments for**
- Administrative spending is growing faster than other categories of care. Putting a 15% lid on administrative costs and profits will help control future cost increases.
- Reducing administrative spending and total costs will make it easier to afford increased access to health care for more people.

**Arguments against**
- The 15% cap could reduce what expenses insurers are willing to cover and might lead to worse health outcomes.
- Insurers may “game the system” to meet the numbers and they will be discouraged from making long term investments, like better information systems, that would lead to real cost reductions.

---

### Topic 4

Individuals can receive health insurance through their employer, a public program, or by purchasing an individual policy. In most cases, individuals have to pay for some portion of their care depending on what kind of policy they have.

Some people choose not to get insurance because the costs are too high given the choices available to them. In a 2005 study of the uninsured in California, 43% of people said that the reason they did not have health insurance was because they could not afford it.

### Factors that increase insurance premiums

About 4.9 million Californians do not have insurance at any given point in time. The consequence of people not having insurance is that the overall costs to the health care system increase.

- **Shrinking Pool:** When the pool of people paying into the health care system gets smaller, the cost per person increases (as illustrated on page 5).
- **Cost Shift Effect:** When some people pay for insurance and others don’t, then costs rise because medical providers need to get paid for providing treatment to those who do not have insurance. Those costs are added onto the premiums of those who do have insurance.

Different economists have calculated the cost shift associated with two sources: unpaid medical bills of people without insurance and underpayments to Medi-Cal providers. Although there are differences in their analysis, estimates are that Californians are paying between 9% and 22% percent more for their insurance premiums due to these two factors.  

The cost shift associated with the uninsured alone has been estimated to increase family coverage by an extra $922 a year and individual coverage by $341 a year.

### ESTIMATES FOR COST SHIFT IMPACT ON PREMIUMS

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of uninsured</td>
<td>2%</td>
<td>11%</td>
</tr>
<tr>
<td>Impact of Medi-Cal underpayments</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
<td>22%</td>
</tr>
</tbody>
</table>

---

### PROPOSED CHANGE

All Californians would be required to have health insurance for themselves and their children.

- No-cost and low-cost comprehensive coverage would be available through public programs for the state’s lowest income citizens.
- Low and moderate income Californians would get subsidies to help pay for premiums.
- For people above the subsidy cut-off, the minimum required insurance level is a plan designed to cover major medical events with a $5,000 deductible, with an out of pocket spending cap per year of $7,500 for individuals or $10,000 for families. Preventative services would be covered without needing to get to the deductible level.
Arguments for

- Everyone should have the security of health insurance to protect against financial ruin from an unexpected emergency or high cost health care episode.
- If insurance is affordable and available for all, then individuals should be required to purchase it. It’s just like public schools for children. Everyone will eventually use the health care system, so everyone should pay into the system.
- With everyone participating, those with insurance will no longer have to pay for the costs of treating people without insurance.
- People will have greater access to preventative and wellness care which could bring down costs for everyone.
- Research shows that health care has broad social benefits, such as helping children learn better and families climb out of poverty.

Arguments against

- This shifts the risk of rising health care costs onto the backs of individuals, with no caps or controls on premium increases.
- Moderate income workers not eligible for financial assistance may not be able to afford the premiums or will get plans with high deductibles.
- There is little control on containing total medical costs. Putting more people into the existing private insurance market may reduce cost shifting between types of consumers but does nothing to reduce the total cost of care.
- It’s unfair to force middle income Californians to buy expensive private insurance if they do not have employer coverage, subsidies from a public program or access to a group plan.
- This is an infringement of individual liberties and will be very difficult to enforce.

Looking at the financial impact for individuals and families

- Current proposals would provide insurance subsidies for Californians with incomes up to three times the federal poverty level ($30,600 for an individual and $62,000 for a family of four). Californians with incomes above the subsidy level would either get insurance from employers or buy insurance on the private market.
- It is estimated that the minimum required insurance might cost an individual about $100 per month and more comprehensive insurance would be closer to $300 per month.
- There would be a potential negative impact for people if they have high medical bills with a minimum plan and a high deductible. However, without medical insurance, low and moderate-income individuals are at risk of completely losing their assets in the event of a major medical problem.
- High deductible plans cost less in premiums, but have higher total potential costs in the case of high medical expenses. This is an example for someone above the subsidy level with the kind of major medical problem that would otherwise lead to bankruptcy if uninsured:
  - An individual earning $40,000 per year could potentially pay 18% of their income (the $7,500 yearly cap) for health care if they had major medical expenses.
  - A family of four earning $80,000 per year could pay up to 12% of income (the $10,000 yearly cap).

Topic 5

Controlling costs

Increasing health care costs affect all of us. Health care costs in California have grown dramatically in the past 20 years and are now likely to be over $200 billion. Some of the key reasons for this growth are listed on page 7. In 2005, as in other recent years, health care insurance premiums in California grew much faster than wages or inflation. In less than ten years, spending on health care is projected to represent 20% of the national economy. A serious commitment to control spiraling health care costs is essential for the health of our economy as well as the health of our society. Significant control of health care costs will require actions from all parts of our health care system, including employers, government, insurers, providers, and individuals.

PROPOSED COST CONTROL MEASURES

In addition to the cost savings that would be anticipated if more people had health insurance (and hence lower average premiums) as covered in the previous topics, these are other cost control measures to consider:

PREVENTION & WELLNESS
Establish incentives and programs for wellness, fitness and prevention such as obesity and tobacco use reduction. Incentives and education can be provided by insurers, employers and state programs.

CHRONIC DISEASE MANAGEMENT
Improve chronic disease management programs, including use of “evidence-based care standards” to better coordinate care and create lower costs for patients with better outcomes.

IMPROVED AVAILABILITY OF DATA ABOUT COST, QUALITY AND EFFECTIVENESS
Provide better information and easier access to data on the cost, effectiveness and quality of hospitals, doctors, health plans, treatment options and prescription drugs. This would allow for more informed selection of best providers and treatments.

STREAMLINED ADMINISTRATION
Streamline administrative procedures including billing, eligibility process, electronic medical records, use of information technology and program administration.

PERFORMANCE-BASED COMPENSATION
“Pay for performance” for plans and providers to offer incentives for better quality, efficiency, and costs of care. For example, future increases for Medi-Cal providers could be based on the performance of the care provided versus just the numbers who were served.

GROUP PURCHASING
Provide group purchasing especially for individuals, small and mid-sized employers to allow for more leverage when bargaining with health plans.

REDUCED REGULATIONS
Reduce regulatory requirements and barriers to allow less costly providers and plans to provide services, promoting new point of service models and clinics. For example, allowing nurse practitioners instead of doctors to be in charge at a clinic providing routine services would allow for more retail clinics.
Four proposals have been introduced recently that represent significant alternative approaches to reforming California’s health care system. This is a summary of the major elements of each proposal.

### Assembly Bill 8 (Núñez/Perata) Compromise bill in Senate
- **Increased Coverage**: Estimated at 3.4 million additional uninsured covered (approximately 2/3 of Californians uninsured at a given point in time).
- **Individuals/Employees**: All employees working for a firm that pays a fee (instead of paying for employee health coverage directly) must enroll in the newly created state purchasing pool.
- **Subsidy/Affordability**: Premiums for employees under 300% of poverty level in purchasing pool would not exceed 5% of family income.
- **Employers**: “Pay or play” approach – employers required to pay 7.5% of Social Security wages (capped at $97,500) for employee health care expenditures or pay equivalent amount into a health trust fund for state purchasing pool.
- **Small Employers**: No exemption based on employer size (except for the self-employed).
- **Public Program Expansions**: Expands Healthy Families program for children (regardless of citizenship status) and families up to 300% of poverty level. Expands Medi-Cal to parents and children ages 5-18 living at or below 133% of poverty level.
- **Insurance Reforms**: By 2011, all health plans required to guarantee issue in the individual market and use community rating (premiums varying based on age and geography) for individuals without serious medical conditions. Individuals with serious medical conditions would be eligible for high risk pool (to be funded by an assessment on health plans).
- **Cost Containment**: Incentives for prevention, pay for performance, centralized assessment of new technology, evidenced-based prevention services, cap on administrative costs and profits (15%).
- **Costs and Sources**: $8.3 billion – Financed through employer/employee contributions, state funds, federal funds.

### Governor’s Plan Has not been introduced as legislation
- **Increased Coverage**: Estimated at 4.1 million additional uninsured covered (more than 3/4ths of Californians uninsured at a given point in time).
- **Individuals/Employees**: All Californians required to have coverage. To meet the requirement, a minimum benefit level of $5,000 deductible, with out-of-pocket maximums of $7,500 per person ($10,000 per family) must be maintained.
- **Subsidy/Affordability**: Individual/family contribution toward premium linked to income and ranges from 3% at 100-150% of poverty level to 6% at 201-250% of poverty level.
- **Employers**: Pay or play approach – employers required to pay 4.0% of Social Security wages (capped at $97,500) for employee health care expenditures or pay equivalent amount for state purchasing pool.
- **Small Employers**: Employers with fewer than 10 employees exempt. Employees subject to individual requirement.
- **Public Program Expansions**: Expands Healthy Families and Medi-Cal for children up to 300% of poverty level, regardless of citizenship status. Expands Medi-Cal for legal adult residents living at or below 100% of poverty level.
- **Insurance Reforms**: Health plans required to guarantee coverage to all Californians. Premiums may vary based on age and geography.
- **Cost Containment**: $300 million in new prevention programs, reduce regulatory requirements on health plans and promote new retail delivery models, 15% cap on administrative costs and profits.
- **Costs and Sources**: $12 billion Cost Estimate – Financed through employer/employee contributions, individual contributions, redirection of safety net funds, federal funds, 2% fee on physician and 4% fee on hospital revenues.

### Senate Bill 840 (Kuehl) Passed by Senate
- **Increased Coverage**: All Californians covered through newly created government-administered California Health Insurance System (CHIS).
- **Individuals/Employees**: Californians required to contribute a portion of income via taxes instead of paying for health care premiums, deductibles, co-pays, and other out of pocket costs such as prescription drugs.
- **Subsidy/Affordability**: First $7,000 of income would be exempt. Individuals would pay 3-4% of income between $7,000-200,000; 1% more on income over $200,000.
- **Employers**: Require employers to contribute via a new payroll tax at 8%. First $7,000 of payroll would be exempt.
- **Small Employers**: Not applicable. Same for all employers.
- **Public Program Expansions**: Consolidates funding for existing public programs into newly created Universal Health Care Fund.
- **Insurance Reforms**: CHIS becomes the primary policy for all Californians; insurers may sell supplemental policies.
- **Cost Containment**: Preventative care covered by CHIS. Caps administrative spending to 5% of total system wide spending and authorizes CHIS to create other forms of cost control.
- **Costs and Sources**: Legislation relies on an estimated $29 billion in administrative and other savings that are used to fund expanded coverage under CHIS.

### Senate Bill 236 (Runner) Not yet passed by Senate
- **Increased Coverage**: Not estimated. Emphasis on access to affordable care through expansion of community clinics and urgent care.
- **Individuals/Employees**: No Requirements.
- **Subsidy/Affordability**: None stated.
- **Employers**: Incentives to establish Health Savings Account contributions and federal tax benefits by creating plans that allow health care expenditures to be counted as income before taxes.
- **Small Employers**: Similar incentives and provide same tax treatment for self-employed who purchase insurance as larger employers.
- **Public Program Expansions**: Directs additional First Five funds to children’s health care and insurance initiatives. Requests that federal government cover the $2.2 billion cost of care for mandated health services to undocumented immigrants.
- **Insurance Reforms**: Encourages greater availability of benefit designs to allow plans greater flexibility to put more products on the market.
- **Cost Containment**: More hospital and provider pricing information available to consumers.
- **Costs and Sources**: Reallocation of existing funds to primary care and community clinics, First Five to children’s health initiatives.

**In addition to these four proposals, there are other bills sponsored by Assembly Republicans which relate to these key themes:**
- **Maximizing Choice**: Expanding availability of Health Savings Accounts by updating tax laws and expanding competition to provide more affordable health care choices by providing greater flexibility to out-of-state and in-state insurers.
- **Reducing Cost**: Creating a California Health Insurance Exchange to provide direct purchasing of insurance for workers and individuals, and guaranteeing the opportunity to purchase a health plan regardless of pre-existing conditions to prevent financial ruin.
- **Increasing Access**: Ensuring more convenient care at neighborhood health clinics, increasing the number of well-trained nurses through expansion of programs at colleges and universities and ensuring seismic retrofitting of California’s hospitals, performed on a “worst-first” basis.
Keeping health care reform moving forward

In the coming weeks, California’s elected leaders will consider the adoption of health care reform legislation based on the plans and proposals that have been put forth this year. CaliforniaSpeaks will present the priorities that have emerged from today’s discussion to the Governor and legislative leadership to make sure that your voices are heard in these final deliberations.

Reform efforts are more likely to succeed if there is a shared public voice supportive of change. These are steps you can take to help ensure that your priorities are heard by state lawmakers:

- Write a letter to the editor of your local newspaper
- Contact your elected representatives
- Educate your friends and family about what we talked about today
- Join a community group that supports the views you have
- Stay informed about what is happening

An easy to use tool for contacting your state representatives will be available at www.CaliforniaSpeaks.org after August 11. You can also use the “letter to the editor” guide being handed out during the statewide conversation.

To stay informed about the latest news in health care reform, visit: www.californiahealthline.org and www.calhealthcare.org.

ACKNOWLEDGEMENTS

CaliforniaSpeaks would like to thank Governor Arnold Schwarzenegger, leaders of the California Legislature and their staff for their support of this groundbreaking civic engagement effort. We also want to express our deep appreciation to the countless staff and volunteers who have made the statewide conversation possible.

CaliforniaSpeaks would also like to acknowledge Viewpoint Learning and the distinguished group of individuals who provided their guidance to help prepare the content for this discussion guide, along with our thanks to the many additional advisors who gave generously of their time.

Jonathan Gruber, Ph.D, Massachusetts Institute of Technology
Peter Harbage, M.P.P., Harbage Consulting
John Holahan, Ph.D., The Urban Institute
Robert E. Moffit, Ph.D, The Heritage Foundation
Marian Mulkey, M.P.H., M.P.P., The California Health Care Foundation
Steven Rosell, Ph.D., Viewpoint Learning
Lucien Wulsin, J.D., Insure the Uninsured Project, UCLA Center for Health Policy Research

FOOTNOTES

1 Centers for Medicare and Medicaid Services (from 2007 presentation by Governor’s Office)
2 Centers for Medicare and Medicaid Services (from 2007 presentation by Governor’s Office)
5 Findings from the 2005 California Health Interview Survey, UCLA, July 2007
6 Health Care Coverage for All Californians: A Citizen Dialogue, Viewpoint Learning, Spring 2006
7 Snapshot: California’s Uninsured; California HealthCare Foundation, 2006
8 Findings from the 2005 California Health Interview Survey, UCLA, July 2007
10 Kaiser State Health Facts, www.statehealthfacts.org
11 California HealthCare Foundation: Myths and Fact, www.calhealthcareform.org
12 Snapshot: Health Care Costs 101, California HealthCare Foundation, 2005
14 Kaiser State Health Facts, www.statehealthfacts.org
15 California 2025: Taking on the Future, Public Policy Institute of California, 2005
18 California Employer Health Benefits Survey 2005, Department of Finance
19 Snapshot: Health Care Costs 101, California HealthCare Foundation, 2007
20 Chronic Disease in California: Facts and Figures, California HealthCare Foundation, 2006
21 Chronic Disease in California: Facts and Figures, California HealthCare Foundation, 2006
22 Snapshot: California’s Uninsured, California HealthCare Foundation, 2006
23 California Employers Health Benefits Survey, California HealthCare Foundation, 2006
24 California Employers Health Benefits Survey, California HealthCare Foundation, 2006
25 Snapshot: Employer Health Insurance Costs in the United States, California HealthCare Foundation, July 2007
27 Senate Committee on Health Informational Briefing on Governor Schwarzenegger’s Health Insurance Proposal, February 15, 2007
30 Findings from the 2005 California Health Interview Survey, UCLA, July 2007
31 Findings from the 2005 California Health Interview Survey, UCLA, July 2007
32 Findings from the 2005 California Health Interview Survey, UCLA, July 2007
34 Chronic Disease in California: Facts and Figures, California HealthCare Foundation, 2006
35 The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals, Health Affairs, 24, no. 6 (2003)
36 California HealthCare Foundation: Myths and Facts, www.calhealthcareform.org
37 Multiple sources: New America Foundation, December 2006; California Foundation for Commerce and Education, June 2006; California Chamber of Commerce; analysis by Kenneth Thorpe of Emory University; Administration analysis of The Cost-Shift Payment “Hydraulic” Dobson et al. Health Affairs, 2006
38 The Cost-Shift Payment “Hydraulic”: Foundation, History, And Implications, Dobson et al. Health Affairs, 2006