

**Policy Brief**  
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# Health Reform 2007 Impact on the Valley



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## INTRODUCTION

California's Gov. Arnold Schwarzenegger has committed to making 2007 the year of health care reform for the state. This bold move has attracted national attention and sparked broad debate in California and the nation. Health care reform has typically been a political "no-win" situation because of the broad disagreements among advocates, health care stakeholders, and public officials about desired goals and methods for reform. The governor has taken up the challenge by proposing a comprehensive, shared responsibility proposal that mandates universal coverage. The proposal has elicited statements of concern from almost every special interest group while setting the bar quite high for competing proposals. Although the governor has yet to put his proposal in legislative language, it has remained a major player in California's health reform debate. California now finds itself in the spotlight, and how this debate plays out will likely have considerable influence on the national health reform debate that is rapidly becoming one of the most visible issues in the 2008 presidential race.

The San Joaquin Valley now has a unique opportunity to influence health policy and health care reform by giving a voice to the health disparities experienced by its residents and influencing the negotiations that are ongoing as the health reform debate heats up.

A number of events have given Valley residents opportunities to explore the proposals and provide input. Among these events were: a business health summit sponsored by Assembly Minority Leader Mike Villines on March 2, 2007; the Central Valley Health Policy Institute's annual conference *Health Reform 2007: Impact on the Valley* on March 22, 2007; the Town Hall Meeting sponsored by Assemblymember Juan Arambula and featuring Assembly Speaker Fabian Núñez on May 12, 2007; a Central Valley Regional Network meeting for the Latino Coalition for a Healthy California on June 1, 2007 to discuss Latino health issues; and a number of events sponsored by It's Our Healthcare! It's Our Health care is a coalition of consumer advocates, seniors, health advocates, communities of faith, and labor united in supporting the campaign for quality, affordable healthcare for every Californian and working to ensure that the voice of the people of California is heard in the debate over health care reform.

## BACKGROUND

Californians, like others in the United States, find themselves in a climate of increasing public concern regarding the cost, quality and availability of health coverage. California's size, world ranking economy, diversity and large number of unauthorized residents provide a unique set of challenges for health reform. In spite of the governor's bipartisan legislative successes in 2006, health care reform debates have been fashioned around decidedly partisan philosophies.

Republicans insist that the number and needs of the uninsured are exaggerated and that expanding public coverage is too expensive. Instead they propose increasing the flexibility of the insurance market while offering tax incentives and potentially less expensive plans with high deductibles. The Republicans propose that these plans will increase the affordability of insurance and effectively decrease the number of uninsured Californians while continuing to allow residents a choice in their insurance coverage. The Republicans also want to improve access by increasing Medi-Cal provider rates and supporting the "neighborhood clinic" model of primary care.

Democrats see the challenge of uninsured and under-insured Californians as one of several indicators of a failed private market for health care. They want to leverage federal resources while increasing employer and consumer responsibility for providing coverage to their employees. The governor has proposed a comprehensive plan that stresses shared responsibility. Whether or not that responsibility is equally shared has been a contentious issue for consumers, providers and employers.



Finally, SB 840, the single-payer health coverage bill, has enjoyed significant grass root support but fights strong opposition from insurers and businesses represented by the California Chamber of Commerce. The projected cost, stigma against “government control” and the overwhelming issues surrounding transition from a market-based to a single payer model are significant “road blocks” to this proposal.

Federal issues that are influencing California’s debate include the lack of comprehensive national immigration reform, the potential for ERISA challenges (see text box below) to proposals that promote an employer mandate and the assumption that federal funding will be available to match the proposed expansions of public coverage, as in the reform proposals from the governor, California State Senator Don Perata and California Assemblyspeaker Fabian Núñez.

Health care reform is not new to California. The Health Insurance Act of 2003 or Senate Bill 2 (SB 2) was an employer “pay or play” measure passed by the legislature and signed by Gov. Davis in 2003. SB 2 required large and medium-sized California employers to either pay a fee to the state (pay) to provide health insurance for their employees or to provide coverage directly to their employees (play). However, a coalition of business groups sponsored a referendum (Proposition 72) that sought to repeal the law prior to implementation. This action caused SB 2 to be placed on hold until the election in November 2004. SB 2 was subsequently defeated, although it did receive 49 percent of the vote.

Senator Sheila Kuehl first introduced single-payer legislation in 2003, and her SB 840 bill, that included finance language, passed in both legislative houses in 2006 but was vetoed by Gov. Schwarzenegger.

*The Employee Retirement Income Security Act (ERISA) was enacted in 1974 as a means of regulating fraud and mismanagement in private-sector employer and union pension plans. It also established standards, reporting and disclosure requirements for employee benefits, including healthcare. These benefit plans are exempt from state insurance laws. As a result, recent ERISA legal challenges have generally resulted in courts prohibiting states from requiring employers to provide healthcare coverage to employees*<sup>1-2</sup>

## AN OVERVIEW OF THE MAJOR HEALTHCARE PROPOSALS

### *Gov. Schwarzenegger’s Health Care Proposal*<sup>3-4</sup>

The governor’s plan focuses on “shared responsibility among employers, individuals, providers and government” and proposes to cover all currently uninsured Californians. The plan includes an individual and an employer “pay or play” mandate as well as mandated fees to be collected from health providers and hospitals. The plan also includes expanded eligibility for public health insurance programs for all children, regardless of documentation status, and single, childless and poor adults (up to 100 percent of the federal poverty level (FPL) or an income of \$10,210 per year or less) that are legal residents. Subsidized coverage would also be available for low-income individuals and families (up to 250 percent of the FPL, an income of \$25,525 or less per year for an individual or \$51,625 or less for a family of four) who are legal California residents. Cost containment strategies target prevention, health promotion and wellness programs. Insurance reforms include guaranteed issue (the requirement that the insurer accept anyone who applies for coverage, regardless of pre-existing conditions or health status) and a requirement that health plans must spend 85 percent of premiums on patient care or a medical loss ratio of 85 percent (the ratio between the cost to deliver medical care and the amount of money that was taken in by a plan). The plan estimates that it can be fully funded through reallocation of county funds, assessments on employers and providers, and streamlining of state programs.

### *AB 8: Assembly Speaker Fabian Núñez’s Health Care Coverage Legislation*<sup>5</sup>

This bill expands subsidized coverage to all children, regardless of documentation status in families with an income up to 300 percent of the FPL and expands subsidized coverage to parents up to 300 percent of the FPL. It also establishes a state purchasing cooperative, the California Cooperative Health Insurance Purchasing Program, funded by employer contributions for those employers who choose not to offer health coverage to their employees and their dependents. Employees working for an employer that pays into the cooperative must enroll in a cooperative coverage plan. The legislation has recently been amended to include the same insurance reform strategies (guarantee issue and 85 percent medical loss ratio) as the governor’s plan. The Núñez plan requires the California Health and Human

Services Agency to develop health care provider performance benchmarks and encourage fitness, wellness and health promotion programs. Núñez's plan also calls for the state to extend coverage, within five years, to the estimated 2.5 million unemployed, low-income or childless adults who lack insurance coverage.

***SB 48: Senate President Pro Tem Don Perata's Health Care Coverage Legislation***<sup>6</sup>

This legislation would require that all full-time and part-time working/taxpaying Californians and their dependents, in households earning above 400 percent of FPL (\$40,840 for an individual and \$82,600 for a family of four), have a minimum coverage policy. This minimum coverage is defined as benefits required of licensed California health plans plus prescription drug coverage. The plan creates a "Connector" or state purchasing pool that is funded by employer fees and employee premiums. Employers would be mandated to pay a certain percentage of employee wages for health care or pay into the Connector Trust Fund. Employee premiums would be no more than 5 percent of annual income. Employees under 400 percent of the FPL, or for whom policy costs would be higher than the 5 percent limit, would be exempt from the coverage mandate.

***SB 840: Senator Sheila Kuehl's California Universal Healthcare Act***<sup>7</sup>

SB 840 fundamentally alters the financing of health care in California, shifting the current employer based/multi-payer system to a single financing system. As proposed, the bill will: 1) provide comprehensive medical benefits to every California resident, 2) authorize participation of all licensed medical providers, 3) incorporate federal and other public programs into the universal system, 4) prohibit the sale of private health insurance, and 5) regulate health care costs. The program would be financed with current government health care funding for incorporated federal/county programs, a payroll tax to replace employer benefit plans and other taxes to replace insurance premiums. The measure would be governed by an appointed commissioner charged with establishing the universal system's budget, setting rates, establishing expenditure limits, developing a capital management plan, seeking all necessary waivers and exemptions, and establishing equitable distribution of services and financing. This bill contains the structure and policy for a universal single payer system while the financing provisions are in a companion measure, SB 1014 (Kuehl).<sup>8</sup> An actuarial analysis of a prior version of this legislation

by the Lewin Group found that the total health spending for California residents under the current system to be about \$184.2 billion for 2006, and that the single payer program would achieve universal coverage while reducing total spending in the state by a net \$7.9 billion.<sup>8</sup>

***Senate Republican Caucus Proposal: SB 236 "Cal CARE"***<sup>9</sup>

Cal CARE proposes that it will improve health care access for every Californian with more health care options and services that are more affordable and cost-efficient. It includes a number of specific strategies that address access, affordability and choice. It includes no employer or individual mandates and does not expand public health coverage. However, it does provide that funding for the California Families and Children Act of 1998 (Proposition 10) be directed totally towards funding local Children's Health Initiatives under the direction of First 5 California. Cal CARE also calls for an increase in Medi-Cal provider rates to move toward parity with Medicare rates over an eight year period. Cal CARE would require that Medi-Cal services be more closely aligned with private health care benefits (decreasing the scope of services), which would require a federal waiver. It promotes the Health Savings Account/High Deductible Health Plan as a strategy for increasing the number of California residents with health insurance. It also promotes tax credits for providers who offer care to the uninsured and dictates that funding currently allocated for state-only programs for the uninsured or underinsured be redirected to community health clinics. Additionally, the Senate Republican Caucus Proposal decreases the physician oversight requirement for nurse practitioners and physician assistants running primary care clinics in order to increase flexibility for establishing primary care clinics in underserved areas.

***Assembly Republican Caucus Health Care Reform Package***<sup>10</sup>

The Assembly Republican Health Care Reform Package is a series of 18 bills that, like the Senate Republican proposal, address maximizing choice, reducing cost, and increasing access. There are several strategies that overlap with Cal CARE including decreasing physician oversight on nurse practitioner-run clinics, increasing Medi-Cal rates for physicians and providing tax credits to physicians providing charity care. The package also strongly supports the Health Savings Account/High Deductible Plan as a strategy to increase affordability. However, it differs in a number of insurance reforms including creating a single group health

and worker's compensation policy, guaranteeing coverage for pre-existing conditions, and allowing out-of-state insurers to offer health benefit plans to Californians. The package also supports a bill to allow an individual to waive specified benefits currently required under state regulations as a strategy to decrease insurance plan costs. The bill includes language that would make it easier for small businesses to join together for the purpose of obtaining group rates from insurers.

State health reform measures also must be considered within the context of the national health policy debate. Critical to successful financing of SB 840 is to seek and receive a federal waiver so that current federal payments to the state for health care services continue. The waiver process may be contentious given the current administration's perspective on health reform. The governor's proposal and both Democratic proposals rely on expanding eligibility for public insurance. This will require an increased funding commitment and possibly regulatory changes from both the state and federal governments. The coverage expansion is within federal guidelines but the availability of funding may be in question. The governor's and the Republican proposals also call for increasing Medi-Cal reimbursement rates, which again raises concerns about the availability of funding. Additionally, the State Children's Health Insurance Program is up for reauthorization. It has previously been funded under a block grant and may not be adequately funded to support expansions of California's Healthy Families program.

## A SAN JOAQUIN VALLEY PERSPECTIVE ON HEALTHCARE REFORM

More than 150 people including consumers, advocates, providers, policy researchers and community leaders attended the Central Valley Health Policy Institute's *Health Reform 2007* conference. The conference provided extensive opportunity for individuals to ask questions, comment on proposals and voice issues of concern for the Valley with regard to health care reform. Issues raised at the conference provided the basis for this discussion of the San Joaquin Valley Perspective on health care reform. Input from other ongoing discussions of regional needs, including other health reform convenings, collaboration with the California Partnership for the San Joaquin Valley Health and Human Services workgroup partners and meetings with state health policy experts, also supported the identification of key regional issues critical to the health reform debate.

Based on this process of collecting regional, community and expert input on the elements of health reform proposed in California this year, 10 key regional health reform issues emerged. These issues can be grouped into three general categories: demographic issues, access issues and resource issues. Critical to the health reform discussion is that any or all of the elements of reform "do no harm" to Valley residents.

### *Health Reform 2007: Impact on the Valley*

*March 22, 2007*

#### *Speakers*

*John Capitman, Ph.D.*  
*Moderator*

*Executive Director, Central Valley Health Policy Institute*

*David Carlisle, M.D., Ph.D.*  
*Keynote Speaker*

*Director, Office of Statewide Health Planning and Development*

*Robin Podolsky, M.A.*

*Press Secretary for Senator Sheila Kuehl's District Office*

*Agnes Lee, M.P.P.*

*Principal Consultant, Senate Office of Research*

*Patricia Lynch*

*Vice President, State Government Relations Services, Kaiser Permanente*

*Julie Griffiths*

*District Director, Assemblyman Mike Villines, Assembly Republican Leader*

## DEMOGRAPHIC ISSUES

### Racial/Ethnic Diversity

The San Joaquin Valley is very diverse, with higher percentages of Latino and Asian residents compared to the state as a whole. More than 1 million Latinos reside in the region along with 111,000 “Other Asians” (Asians not of Chinese or Japanese descent), primarily of Laotian and Hmong ethnicities.<sup>11</sup> Given this diversity, it is important to Valley residents that health reform proposals include mandates to provide care that is both culturally respectful and linguistically competent. Senator Kuehl’s SB 840 legislation includes translation services as a benefit. It also instructs the Director of the Office of Health Planning to establish standards for culturally and linguistically competent care and pursue federal funding for the provision of a “language services” program. Benefits included in the Governor, Perata and Núñez plans will likely be similar to those mandated by the Knox-Keene Act (see text box, above right) which includes basic benefits and also lists the right of an enrollee to receive assistance in his or her primary language. Other aspects of promoting culturally responsive and respectful care are not addressed by these proposals.

### Large Numbers of Poor Residents

It is unclear whether the income limits on subsidized health care purchasing will disproportionately affect the Valley. What is clear is that the Valley is poorer than the state as a whole, with 1,700,000 residents or almost 50% of the region having incomes under 200 percent of the Federal Poverty Level (FPL). By comparison, 34 percent of all Californians

*The Knox Keene Act describes required basic benefits that must be offered by most Health Maintenance Organization (HMO) Plans and some Preferred Provider Organization (PPO) plans. Any plan licensed under the California Department of Managed Care must include physician services, hospital inpatient and outpatient care, diagnostic lab and radiology services, home health services, preventive health services, emergency health care, and hospice care. Knox-Keene does not require drug, vision or dental coverage.<sup>1</sup>*

are in this income band. The number of residents with incomes between 200 percent - 300 percent of the FPL includes 549,000 individuals or 15 percent of the regional population which compares to 13 percent of the entire state population in this income group. The Valley also has significantly more uninsured residents than the rest of the state. This increased percentage appears to be composed primarily of adults living below 100 percent of the FPL. There are 172,000 of these poor uninsured adults in the San Joaquin Valley.<sup>11</sup> Also it is probable that this number is underestimated due to the number of undocumented agriculture workers in the region.

Currently only parents with incomes under 100 percent of the FPL are eligible for Medi-Cal. The Governor’s plan to cover documented adults at 100 percent FPL would address the needs of the Valley as would SB 840. AB 8 would expand Medi-Cal eligibility to parents up to 133 percent of the FPL

Table 1

San Joaquin Valley and California Poverty Levels, 2005

Federal Poverty Levels (FPL)*	San Joaquin Valley		California	
	%	Number	%	Number
0-99% FPL	21.7	799,000	15.1	5,450,000
100-199% FPL	24.9	918,000	19.6	7,083,000
200-299% FPL	14.9	549,000	13.0	4,713,000
300% FPL and above	38.5	1,420,000	52.3	18,900,000

Source: 2005 California Health Survey<sup>11</sup>

\* In 2007, for a single person, an income of \$ 10,210 =100% of the FPL; \$15,315 = 150% of the FPL \$20,420 = 200% FPL; \$25,525 = 250% FPL; \$30,630 = 300% FPL; \$40,840 = 400% FPL.<sup>12</sup>

and provide a “benchmark” health plan for parents with incomes between 133 percent and 300 percent of the FPL. This “benchmark” plan would likely be similar to that of the current Healthy Families coverage. The bill also has intent language to cover childless adults under 300 percent of the FPL within five years. SB 48 also extends coverage that is identical to that of AB 8 to working parents with incomes up to 300 percent of the FPL, but has no provision for childless adults.

### ***High Unemployment Rates***

The San Joaquin Valley counties experience unemployment rates that are higher than two-thirds of other California counties.<sup>13</sup> Proposals such as AB 8 and SB 46 (Núñez and Perata) tie expanding coverage and affordable coverage products to employment status. They do not address seasonal employment or multiple employers and, as a result, these bills would have less impact on increasing coverage in the Valley than other parts of the state. The result for the Valley may be increases in local administrative costs and a decrease in continuity of care due to “churning,” a continuing process of enrollment and disenrollment as residents move in and out of employment.

The governor’s individual mandate would be enforced regardless of employment status, which could force more Valley residents into minimum coverage policies. Similarly, the elements of the Republican proposals that include high deductible plans linked to health savings accounts also are not responsive to the demographics of a population that is predominantly the working poor. SB 840 separates health coverage from employment and would more efficiently address employment characteristics unique to the valley.

### ***Large Numbers of Unauthorized/Undocumented Residents***

Although there are no credible surveys identifying the actual number of unauthorized immigrant adults in the San Joaquin Valley, it is probable that the Valley is home to a significant number given the availability of agriculture, construction and service jobs. This population’s health will continue to be the responsibility of counties and the Valley’s safety net system under all the health reform proposals, except SB 840. Any measures that propose to transfer current funding for the uninsured from safety net providers will increase the fragility of those systems and impact the health of unauthorized immigrants.

Responses to concerns regarding providing health care for

unauthorized residents in California are also poised along party lines. Both the Senate and Assembly Republican Caucus proposals emphatically refuse to cover either undocumented children or adults. SB 840 covers all individuals with the “intent” to reside in California, regardless of documentation status. In the middle ground are the proposals from Democratic legislative leaders and the governor’s proposal with the intent to cover all children regardless of documentation status, but not undocumented adults. Speaker Núñez’s proposal does include intent language to cover childless adults with incomes below 300 percent of the FPL within five years but it is not clear if this would include unauthorized immigrants.

The governor’s plan seeks to levy a hospital and provider fee (4 percent and 2 percent respectively) as a return on the increased Medi-Cal rates included in his proposal. His proposal also redirects \$2 billion currently in the safety-net care pool, and used by public hospitals for the provision of uncompensated health care for the uninsured, to the new purchasing pool. The governor is using these measures to fund his proposal. CalCARE also proposes transferring funding from safety net hospitals to primary care clinics. It would require that state-only program funding that provides health care to uninsured or underinsured individuals be targeted towards community clinics and health centers. State-only funding for hospital services to unauthorized residents may be then at risk.

An “employer mandate” (as defined in the Perata, Núñez and governor’s proposals) has a different meaning for employers that hire unauthorized immigrants in that the employer would be paying for health care that his/her workers generally could not access. Agricultural employers in the San Joaquin Valley would be particularly vulnerable to this “Catch-22” as they would not be able to admit to illegal hiring practices, their “undocumented” and uninsured workers would not be



eligible for new coverage, and yet, these employers would be required to pay into the system.

## ACCESS ISSUES

### *Disproportionate Number of Publicly Insured and Uninsured Residents*

The San Joaquin Valley suffers from both higher percentages of Medi-Cal enrollees per population and a higher number of uninsured residents, for all or part of the year, than the state as a whole and most other regions in the state.<sup>11, 14</sup> All of the proposals seek a decrease in the number of uninsured persons. The proposed strategies vary widely on their potential to impact the uninsured poor. The governor, Senate Republicans and Assembly Republicans hope to make health care insurance more affordable by allowing insurers flexibility. These proposals also rely heavily on high deductible health plans along with tax free health savings accounts as an effective strategy for increasing coverage. However, these plans are untenable for low and middle income individuals and families and other marginalized populations. High deductible health plans offer lower premiums in exchange for higher deductibles and are usually linked with a tax-free health savings account. Low and middle-income earners generally do not benefit from this tax subsidy due to their marginal tax rates and small income tax liability.<sup>15, 16</sup> The high deductible plans may encourage individuals and families to forego less expensive preventative care because these plans generally require the beneficiary to pay from around \$1000 per person to as much as \$10,000 out-of-pocket each year before coverage begins. For low and middle-income individuals and families this means that routine health care must compete with other monthly necessities such as food and rent.<sup>17-19</sup> The Governor, Senate Republicans and Assembly Republicans also propose increasing affordability by allowing insurers greater flexibility in the number/scope of benefits they are required to offer. This cost containment strategy has the potential for increasing out-of-pocket costs and decreasing access for needed services for unforeseen medical conditions that employers and/or individuals have “opted out” of coverage.

The governor’s proposal, although providing a subsidized purchasing pool for individuals with incomes from 100 percent-250 percent of the FPL, also includes a \$500 deductible/\$3,000 out-of-pocket maximum which, according to Health Access California calculations (personal communication with Hanh Quach of Health Access), could

add up to as much as 1/3 of a beneficiary’s income. The Perata/Núñez proposals expand subsidized coverage for families with incomes up to 300 percent of the FPL and also provide for more affordable options to working individuals/families above 300 percent of the FPL. Out-of-pocket costs such as deductibles and co-payments have not been determined in these plans although the Núñez plan does indicate that cost-sharing would be minimal for primary and preventive care.

Senator Kuehl’s single-payer plan imposes a 3.78 percent payroll tax on employees that is the full cost of the health coverage premium; however wages below \$7,000 will be exempt from the tax. Deductibles and co-payments for primary care are prohibited by the plan.

The elements of the Perata and Núñez legislation would result in health insurance coverage for approximately 69 percent of currently uninsured adults and children. The governor’s plan and SB 840 propose that all individuals will have insurance coverage albeit from very divergent strategies. The Governor’s individual mandate without exclusions will be difficult to enforce and does not provide for affordable, usable coverage for individuals and families above 250 percent of the FPL. It also does not include those individuals that are undocumented and not paying into the state tax system. SB 840 includes all individuals with intent to reside in California with premium costs that are progressive in that they are a percentage of taxable wage earnings. The Republican Senate and Assembly proposals offer no expansion of insurance coverage to Californians although aligning state tax credits with federal tax credits for health savings accounts and increasing insurer’s flexibility in plan design may result in the affluent uninsured opting to become insured.

### *Shortage and Maldistribution of Health Professionals/Lower Reimbursement Rates*

The San Joaquin Valley experiences greater shortages of health professionals than other regions in the state.<sup>20</sup> This challenge is compounded by the Valley’s rural environment and large numbers of publicly insured and uninsured residents. Medi-Cal reimbursement rates are lower than other areas in the state, creating a disproportionate burden on those professionals that do provide care to uninsured, underinsured and publicly insured patients. The Republican proposals most clearly address the maldistribution of health professionals. The Assembly Republican Caucus has sponsored a bill to relax the physician supervision requirements on nurse

practitioners who run clinics. This measure could effectively increase the number of clinics available in underserved urban fringe and rural neighborhoods (AB 1643). They have also sponsored a bill with the intent to raise Medi-Cal reimbursement rates for doctors (AB 1312) as well as a bill that creates a tax credit for uncompensated care provided by doctors (AB 1592). The Senate Republican proposal also includes strategies to decrease physician oversight on clinics managed by nurse practitioners and other physician extenders, such as physician's assistants. It also increases Medi-Cal rates for non-physician providers. The Senate Republicans would make increased Medi-Cal reimbursement rates a budget priority over the next eight years, bringing them towards parity with Medicare rates. The Governor's proposal would increase physician, hospital outpatient and inpatient and health plan Medi-Cal rates but also assesses a fee on hospitals and physicians of 4 percent and 2 percent of gross revenues respectively. The timeline for implementing the governor's provider rate increase, or the fee assessment on hospitals and physicians, is not outlined in the proposal.

It should be noted that increasing Medi-Cal reimbursement rates is highly dependent on federal financial participation, as the federal government matches state Medi-Cal spending dollar for dollar. Proposals under the current federal administration to cut Medicaid spending places this assumption in jeopardy.<sup>21</sup> Proposed statewide increases in provider Medi-Cal reimbursement rates also do not specifically address disparities in reimbursement rates experienced by providers in the San Joaquin Valley. SB 840 may have the most regional impact through the establishment of ten health planning regions within the state. Each planning region will have a regional planning director and medical officer with the responsibility to assess regional needs and the opportunity to advocate for resources to address those needs through negotiations with the state Health Commissioner. Providers may have an opportunity to increase their reimbursement rates through negotiations with the health commissioner. However, none of the proposals directly addresses or provides specific mechanisms to ensure that Medi-Cal reimbursement rates are equitable across California regions nor do they propose strategies that address the shortage of health professionals in the Valley, particularly in rural areas.

*Public health investments at the county level in California are supported through multiple federal, state and county sources. One of the largest sources of public health funding is derived from realignment. This mechanism, established in 1991, transfers a portion of local revenues from sales tax and vehicle license fees, as well as some state general funds to the counties, to fund a broad range of programs based on prior investments by the counties. These programs include community health and indigent health care services.<sup>23</sup>*

## RESOURCE ISSUES

### *Historical Underfunding of Public Health in the San Joaquin Valley*

There is consensus that the relatively lower tax base and high rates of poverty in the San Joaquin Valley have resulted in a long-term pattern of lower investment in public health than is experienced in other regions of the state. This disparity has been linked to inequities in realignment fund distribution (see text box above). An analysis of county public health spending found that the Valley counties were spending over 80 percent less, per capita, on residents living in poverty than other counties with only 5 percent of county budgets in the Valley allocated to public health.<sup>22</sup> Again regional inequities in funding have not been addressed in any of the proposals other than with SB 840. It is possible that through the establishment of health planning regions and strong regional leadership through the director and medical officer appointments, that regional inequities could be addressed.

### *Disproportionate Chronic Disease, Lack of Coordinated Care and Disease Management Programs*

The rates of both asthma and diabetes are higher in the San Joaquin Valley than in any other region in the state. California Department of Health statistics indicate that four of the Valley counties rank highest in the state for deaths due to diabetes.<sup>24</sup> Analysis of 2005 California Health Interview Survey data found that the San Joaquin Valley had a higher percentage of residents with asthma visit an urgent care provider or emergency room in the past 12 months when compared to every other region in the state.<sup>11</sup> Inadequate

management of chronic health conditions is linked to other regional health issues including health professional shortages, lower reimbursement rates, underfunding of public health services and a lack of long term care infrastructure. It is also impacted by the large immigrant population, lower levels of health literacy and poor air quality in the Valley.

Chronic disease management is an element of the Governor, Perata and Núñez proposals. These proposals focus on the potential for long-term health care cost savings that may be achieved through disease prevention and greater assumption of individual responsibility for health. None of these proposals addresses the underlying disparities in health status or the inadequacy of healthcare and the lack of preventive health services that plague Valley communities. Senator Sheila Kuehl's proposal also emphasizes preventive care and proposes no co-payments for other types of care for the first two years of the proposal. It is not clear whether there might be costs associated with chronic disease management in the future. The Kuehl proposal would also use funds that currently go to counties for chronic disease prevention and management programming as a funding component of the single-payer system. Counties would have the option of finding new funding sources to continue these efforts, which would have an unknown effect on San Joaquin Valley residents.

*The Major Risk Medical Insurance Program is a purchasing pool that serves people insurers refuse to cover due to pre-existing conditions and/or concerns about medical risk. Services are delivered through contracts with health insurance plans. Subscribers pay premiums that cover 62 percent of program costs with the remainder covered by state appropriation. The length of participation in the program is limited to 36 months. The program is managed by the Major Risk Medical Insurance Program (MRMIB) who also manages California's State Children's Health Insurance Program and Healthy Families.<sup>25</sup>*

Insurance reforms that guarantee coverage for pre-existing conditions, included in the Perata, Núñez and governor's proposals, may increase the opportunity for individuals with chronic disease to access disease management programs but, without insurance rate regulation, affordability may still be a problem. The weakening of coverage requirements for private insurance plans included in the governor's and the Senate and Assembly Republican proposals may result in increasing numbers of Californians whose health insurance does not provide adequate coverage for chronic disease management.

The Republican proposals have addressed guaranteed coverage for pre-existing conditions by increasing funding to the current state run high risk pool program, the Major Risk Medical Insurance Program<sup>25</sup> (see text box, below left) but costs for coverage through this program are still high with monthly premiums ranging from 125 percent to 137.5 percent of a plan's standard average individual rate.<sup>26</sup> Ironically, disease or case management services are not required of health plans providing coverage for individuals in this program.

#### ***Lack of Infrastructure for Long Term Care***

Long-term care for the frail aged and others with disabilities remains one of the most significant drivers of healthcare costs and public liability growth. California once led the nation in long-term care financing and delivery innovations intended to permit more elders and others with disabilities to remain in home and community settings. However, program development has not kept pace with the growth of this sector of the population.

The inadequacy of regional infrastructure to address the long term care needs of residents of the San Joaquin Valley is directly related to the rural nature and youth of the population. However, the region has experienced explosive growth in part due to in-migration by urban "baby boomers" from more expensive locations in the Bay Area or Los Angeles through equity transfers. As this group ages, the shortage of resources to address chronic health conditions and their impacts on functioning will reach "crises" proportions. SB 840 does identify rehabilitative care, hospice care, home health care and adult day care as covered services. Skilled nursing facility care is limited to 100 days, which is the length of time covered under Medicare. Proposals that include "Knox-Keene" basic benefits (Perata, Núñez and governor's

subsidized care) would be required to include hospice care equal to the provisions under Medicare Part A<sup>27</sup> and up to 100 home health visits per year. There are no provisions for skilled nursing care in the Perata, Núñez and governor's proposals. SB 840 has the potential to direct new attention to improving access to comprehensive community-oriented long term care services through its broad coverage and the development of regional health planning roles. However, as with the other proposals, SB 840 does not call for focusing new policies and resources on long-term care.

### ***Need for Integration of Behavioral Health/ Substance Abuse Services with Primary Care***

The issue of mental health care parity has been the subject of national debates, but has been somewhat overlooked in the health reform discussion in California. Behavioral health and substance abuse challenges are known to increase the risk of needing other health services, and poor management of behavioral health problems is often mentioned as a key factor in excessive use of emergency medical services. Historical patterns of mental health/substance abuse funding, primarily through realignment funds, have left San Joaquin Valley counties with inadequate resources to meet mental health needs. New funding through the 2004 Proposition 63 Mental Health Services Act is not expected to be sufficient to significantly reduce unmet need among the most severely mentally ill or among those who seek assistance in primary care settings.<sup>28-30</sup>

Medi-Cal funds mental health/behavioral health services in primary care and other settings. However, provider capacity and coverage limitations continue to produce access barriers. For example, safety net clinics in the Valley consistently voice concerns over lack of access to behavioral health services for both children and adults.

Additionally, regulatory barriers persist for publicly insured patients that disallow payment for same day mental health services after a primary care visit. Medi-Cal will also not reimburse for services provided by a Masters in Social Work (MSW) mental health provider. SB 840 is the only proposal that is openly inclusive of behavioral health and substance abuse services. Both the Perata and Núñez proposals do not specifically address these services, although the implication is that coverage will be comprehensive and include benefits currently required by licensed California health plans (Knox-Keene Act protections) which include some mental health coverage but no substance abuse treatment provisions.<sup>31</sup>

The governor's proposal indicates that subsidized coverage will include these "Knox-Keene" basic benefits. However, individuals not eligible for subsidized coverage may be vulnerable to diminished coverage for behavioral health as they look for affordable coverage in the private marketplace. The governor's and the Senate and Assembly Republican proposals open up the opportunity for insurers to decrease reimbursement for behavioral health and substance abuse services by easing the scope of services restrictions on insurers. None of the proposals identify specific strategies to improve the access to and the delivery of behavioral health and substance abuse services to Californians.

## **RECOMMENDATIONS/NEXT STEPS**

The nation is looking to states as "laboratories" of health reform. Modeling proposals will never adequately predict all costs, short and long-term health outcomes or unintended consequences. It is in the best interest of the region that we encourage thoughtful reform in the broadest of contexts and avoid piecemeal solutions that reflect the power of special interests. At a recent Families USA Health Action Conference, Senator Barack Obama pointed out that we are in the midst of an important historical moment on health care that we have not seen for over 40 years, since the Medicare bill was signed into law in 1965. "Plans that tinker and halfway measures now belong to yesterday."<sup>32</sup>

As the reform debate continues to weave its way through partisanship and special interests towards a compromise it is critical that stakeholders be wary of incremental legislation and support resolutions that are balanced and responsive to the needs of Valley residents, while doing no harm. None of the plans are specifically responsive to the array of unique San Joaquin Valley health needs. SB 840 comes closest to providing the opportunity to address inadequate and disproportionate funding of Valley health through the establishment of Health Planning Regions. However, most of the regional issues and concerns addressed here could be included in any of the proposals without major structural change. Despite broad philosophical differences each of the proposals includes some strategy or strategies that would improve either coverage, access or quality of health care for Valley residents.

Clearly it is important to keep in mind that all of the plans are subject to future appropriations of both federal and state

funds to expand coverage and improve access. For example, Speaker Núñez's bill states, "The premium assistance benefit shall only apply to individuals and their dependents when the State Department of Health Care Services determines that it is cost effective for the state."<sup>5</sup>

Other than SB 840, which does away with the insurance industry in its entirety, the proposals presented that do address regulation of insurers do not address the regulation of rates as a cost-driver. Skyrocketing pharmaceutical costs are also not addressed, although SB 840 proposes negotiated governmental bulk purchase of pharmaceuticals.

Addressing the San Joaquin Valley's unique concerns in healthcare reform could be an additional goal in the health reform debate. Below is a list of policy options that address the issues and concerns of Valley residents and could be incorporated in a state health reform program:

### **Demographic Issues**

1. Cultural respect and linguistic competency standards, that reflect the need and diversity in the Valley, should be incorporated into all health reform proposals. These standards must be developed and enforced based on a review of national and international best practices. Accountability should be built into pay-for-performance initiatives as they are developed for public insurance programs.
2. National or state immigration reform would both clarify and simplify the application of all of the health reform proposals. If any proposal other than Senator Kuehl's SB 840 legislation is implemented an unfair burden will be placed on Valley counties as their responsibility for providing health care for unauthorized/undocumented uninsured will continue. Reform proposals must adequately fund counties with a disproportionate share of unauthorized/undocumented residents.
3. It is critical to the success of any health reform measure based on shared responsibility that it articulates a feasible, detailed plan for implementing employer and individual mandates. It is not clear from any of the proposals whether funding mechanisms derived from either individual or employer contributions unfairly impact Valley businesses and residents. True costs for individuals must be assessed that include all out-

of-pocket health care costs, including co-payments, deductibles and non-covered services such as dental and vision. Health care costs that drive employers to decrease the number of employees or move out of California will not increase the economic "health" of Californians or increase the number of insured.

4. The considerable number of seasonal and possibly undocumented agricultural, service and construction workers in the Valley presents a coverage issue that is difficult for any of the proposals to address and traditional health coverage may not be viable in this industry sector. SB 840 separates coverage from employment but does not completely address the complexity of employment patterns for seasonal employees. Demonstration projects to explore creative models for coverage of agricultural/undocumented workers are needed. One possibility would be a public-private partnership where seasonal employers, such as farmers, contract with Federally Qualified Health Clinics or other local safety-net providers, to provide care for their workers. This strategy must be coordinated with models of transportable personal health records, such as the MiVia de Salud program (see text box below), for adequate health risk and chronic disease management.

*Mi VIA is an electronic and transportable, Personal Health Record (PHR) for migrant and seasonal agricultural workers. It was piloted in Sonoma County impacting over 1500 workers. The ability to store and download critical health information such as diagnosis, medications, allergies, chronic conditions, treatment plans and test results will enhance health outcomes and decrease duplication of services. Mi VIA allows patients, or any advocate whom they authorize, to download their information at any time or to have the information downloaded by a health care provider.<sup>33</sup>*

### **Access Issues**

1. Increasing provider reimbursement rates for Medi-Cal has been featured in several of the proposals to increase

access to healthcare for enrolled persons. Although providers support these efforts it is not a guarantee that more physicians would be willing to accept Medi-Cal patients. Historically increases in physician rates have not had an effect on Medi-Cal participation.<sup>34</sup> Increases must be adequate to incentivize provider participation in public insurance. Other negative perceptions of Medi-Cal participation, including the idea that Medi-Cal patients are difficult to care for and that paperwork is burdensome, must be addressed. Additional issues affecting enhanced reimbursement rates include the need for the state legislature to support reimbursement increases regardless of federal participation. Increased reimbursement should be for all providers, not just physicians, and implementation of increases must be timely.

2. The Republican Senate (Cal CARE) and Assembly (AB 1592) Caucuses have introduced measures providing tax credits to physicians and providers that provide charity care, however, the definition of “charity care” is somewhat restrictive and may be only marginal in impact. Adding strategies to the present proposals that support supplemental payments and/or measurable tax credits to providers, with a defined percentage of their practice serving the uninsured, have the potential for improving access for San Joaquin Valley residents.
3. Lack of access is also a reflection of the health professional shortages that are endemic to the San Joaquin Valley. A number of strategies to improve these shortages should be considered. The need for a regional medical school at UC Merced is apparent, however, it is a long term solution. Local health professional “pipeline programs” should be fully and consistently funded in the San Joaquin Valley. Health businesses should be financially supported through tax incentives or programmatic reimbursement to develop and sustain “work to career programs” for staff. Federal and state supported health professional programs throughout the state should have mandated internships and/or rotations to underserved rural and urban regions with measurable unmet health needs. Exploring creative demonstration projects that identify and implement feasible and sustainable economic development incentives for a wide range of health businesses should be supported.
4. The individual mandate proposed by the governor will likely force many Californians to purchase high deductible

plans, specifically those individuals and families above the income limit for the purchasing pool. It is critical that insurers be mandated to provide products in the high deductible plan market that, at a minimum, provide basic primary care, including screening and other preventive care measures that are subject to affordable deductibles and co-payments.

### **Resource Issues**

1. SB 840 has the potential for addressing regional needs with a restructuring of the state’s system of health care that includes the concept of “health planning regions.” All of the alternative proposals could include some version of regional health planning and flexible mechanisms that permit variations in reform implementation responsive to local conditions. The health planning regions will consist of contiguous counties that are grouped based on patterns of health care utilization, resources including workforce, health needs, geography and population and demographic characteristics. Governance for these planning regions will be appointed positions that include a regional planning director and a regional medical officer. The regional planning director can serve up to two eight-year terms and must reside in the region he or she serves. If this model were to be implemented questions might arise as to the authority this director would have in resource allocation, whether the Valley would be better served if the director was an elected position and would the planning region structure best meet the needs of Valley residents.
2. The reallocation of realignment funding must be reconsidered and a formula that considers unmet health needs in each county should be adopted. The San Joaquin Counties are considered “underequity” counties, with seven of the eight counties experiencing equity shortfalls that are more than ten percent of their total realignment allocations. Realignment funding was originally based on historical spending, caseloads and population as of 1991 or even earlier. Even though the goal of realignment was to address historical differences in funding allocations among counties, inequities persist based on the funding formula. The last revision of the realignment funding structure was in 1994-95 and, given the growth of the Valley and persistence of many unmet

health needs, revaluation of this funding stream is long overdue.<sup>23</sup>

3. SB 840 maintains that the state will assume financial responsibility for the health care programs currently provided by cities and counties in California. The Republican Senate proposal also proposes that state-only programs that provide services to underinsured or underinsured residents be redirected to community clinics and health centers. This potential transfer of funding from county public health programs needs to be carefully scrutinized for any unintentional consequences that will increase the vulnerability of Valley counties due to cuts in prevention program services, resulting in decreased access. These proposals do not make it clear which services, programs and populations will remain as County responsibilities.
4. The Medi-Cal Redesign proposal of 2006 established Acute and Long-Term Care Integration Health Plan Demonstration projects in three urban counties (Orange, Riverside and San Diego). These projects were designed to integrate primary, acute and long-term care for seniors and persons with disabilities. Unfortunately, other rural and urban/rural mix counties have not received the same opportunity.<sup>35</sup> The *Program for All Inclusive Care for the Elderly* or PACE (see text box,) was first introduced in San Francisco, but it has not yet been replicated in the Valley. Other states have begun developing and implementing Rural PACE programs but this rural model has not been introduced in California. Given the aging population it is imperative the health resources be allocated to exploring alternative models of integrated, community-based long term care. None of the proposals specifically address this need. A minimum requirement of all health plans and health reform proposals is reimbursement for community-based long term care case management even if they do not offer coverage for long term care services.
5. Given the evidence for high rates of unmet mental health and substance abuse service needs in the Valley and other state regions, mental health care parity should be sought in all healthcare reform efforts. High deductible Plans or strategies that allow insurers to decrease the scope of offered services must not be allowed to further decrease access to these services.
6. Based on interviews with clinic providers, access to mental health services is severely limited due to

shortages of licensed mental health providers. Master of Social Work and other “licensed-waived providers” can provide Medi-Cal reimbursable services if they are under the supervision of a licensed provider who has signed a plan of care document. Resources for exploring strategies to address health professional shortages must include mental health providers. Alternate models of employing these “licensed-waived” mental health providers including redefining “supervision” and allowing them to provide limited unsupervised services could be investigated through demonstration projects at Federally Qualified Health Clinics.

7. A significant barrier to integration of primary care with mental health/substance abuse treatment is the Medi-Cal reimbursement policy disallowing same day visits for mental health/substance abuse services. This policy has been cited by clinic providers as limiting their ability to provide appropriate care to their patients. Often providers are forced to take a loss on these same day services because transportation, work and child care issues prevent patients from returning for treatment on a subsequent day. Clearly, it is also a critical issue if a patient is in crises. Policy and/regulatory reform should

*The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.”<sup>36</sup>*

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