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REMOVING THE BARRIERS TO HEALTH COVERAGE
How Could Health Reforms Make Health Coverage More Affordable, Available, Automatic?

Health coverage should be **available** to everyone. It isn't.
Health coverage should be **affordable** for all, both to buy and to use. It isn't.
Health coverage should be **administratively simple** to get. It isn't.

It is because health coverage is not available, affordable, or automatic that so many Californians find themselves uninsured, and millions more are concerned that coverage won't be there for them when they need it.

Health reforms can go a long way toward removing these barriers that exist for each of the three basic ways that Californians get coverage: through
1) employers through on-the-job benefits,
2) public coverage programs like Medicare, Medi-Cal and SCHIP, and
3) the individual insurance market.

This paper summarizes the major barriers that Californians face in getting coverage, and evaluates health reforms based on those proposals.

BARRIERS IN THE STATUS QUO

Largely, our health system is built on two pillars of group coverage: employer-based coverage for working families; and public insurance programs for those without a connection to the workforce. But many are left out, and the third possibility, buying coverage as an individual, is not an option for many.

Employer health benefits: More than half--19 million Californians—get coverage through employers. For those who have it, it is often affordable (because it is often significantly subsidized by the employer) and automatic (you sign up at the job; any share-of-premium is deducted from your payment, effortlessly). But it's simply not available for many working families, and for those without a workforce connection.

Is it available? *Yes for 19 million Californians—but not for all*

*Employer-based coverage is provided to almost 60***%** of non-elderly Californians, who are employees or their dependents. It is the single most common way for Californians to get coverage. Almost two-thirds of adults who are employed are offered coverage on the job, are eligible for it and accept it.

However, *employer-based coverage is not available to everyone that works*. In fact, more than 80% of the uninsured are workers or their family members. Many working Californians (4.5 million) find that their employer doesn't offer coverage, or that they (or their family members) are not eligible for it. Even at companies that offer coverage, many may be ineligible because of waiting period or seniority, part-time status, job classification, or other reasons.

Also, *some Californians simply aren't in the workforce*, including early retirees (who don't yet qualify for Medicare), students, divorced spouses, and people between jobs. Self-employed people don't have the same access to guaranteed-issue group coverage, and many have to buy coverage as individuals.

Is it affordable? *For most employees, yes.*

In California, the median spending on premium and out-of-pocket costs for Californians with employment-based coverage is under 3% of income.

While *a substantial number of employers pick up most, if not all, of the tab for the cost of insurance premiums*, some employers do require workers to pay a significant share of the premium. And most plans provided by employers also expect other cost-sharing, including deductibles and co-payments. As a result, there are *some workers, particularly lower-income ones, who can't afford the cost of taking up the coverage, or find the coverage is not of value*, since they won't be able to afford to use the benefit, because of the cost-sharing

Even when an employer pays a smaller share of the premium, *buying health coverage through an employer also provides tax savings, increases group purchasing power, and helps to spread risk and cost throughout the employers' workforce*, making it more affordable.

Is it automatic? *Yes.*

One of the reasons that employer-based coverage is so prevalent is that it is automatic: you get a job, you sign up for health insurance benefits, and there's often somebody at work who can answer questions about benefits and plan options, and deal with issues should they arise.

Public programs: About one third of the state – more than 10 million Californians – get coverage through public programs: largely though Medicare, Medicaid (Medi-Cal), and SCHIP (Healthy Families). Medicare is a federal program that is largely universal for those over 65. For the purposes of California health reform, the focus is on the state versions of the two latter programs, Medi-Cal (with 6.5 million) and Healthy Families (with 800,000). These programs subsidize targeted lower-income populations to make coverage affordable, but are not universal for even the groups targeted.

Is it available? *For some—and not all who need it*

Public programs are offered for some populations that are less likely to have connection to the workforce: low-income children and their parents, seniors, and people with disabilities. However, the commitment to make coverage available to these populations is not complete in policy or in practice.

At the state level, Medi-Cal covers low-income seniors, people with disabilities, children, and in some cases, their parents. Healthy Families covers children in families with modest incomes, less than $34,000 a year for a single parent and child or $51,000 a year for a family of four.

However, *these programs have stringent eligibility requirements, and don't cover all of even the very poor, most particularly adults*: A non-elderly adult without a child under 18 at home or a qualifying disability is not eligible for Medi-Cal coverage, even if she is under the poverty level of $10,210/year. Undocumented Californians are largely excluded as well.

Other restrictions that limit eligibility for Medi-Cal include an assets test that prevents people from having any real savings, even enough to pay first and last months' rent. And while some programs allow some who are over the poverty line, these programs are limited and do not reach many of the working poor and middle-income population that need help.

In addition, Healthy Families is not a federal entitlement like Medi-Cal, and as such depends on block-grant state and federal funding—which means it could run out of money, forcing a waiting list or disenrollment of subscribers. While California law

provides that in any given year the budget will cover a shortfall, a major change in federal funding could force California to change this protection.

Is it affordable? *Yes.*

The public programs do offer a range of benefits with no cost-sharing or with small co-payments.

In the Healthy Families program for those children over the poverty line, premiums are limited to no more than $15 per child per month, and cost-sharing is limited to $250 per year. (Of course, there are always medical expenses that are not reimbursed.)

Is it automatic? *No.*

The many restrictions and complicated requirements drive away some of those who are actually eligible. Given the complexity of the rules, many people don't know they are eligible. Compared to Medicare where you sign up once when you are 65 or employment-based coverage where you sign up once when you get a new job, enrolling in Medi-Cal or other public programs is a chore, and one that must be repeated often.

Even when they are eligible*, the bureaucracy and paperwork to enroll can be discouraging*, including requiring a trip to the county welfare office. With the assets test and other requirements, a Medi-Cal application can be as burdensome as a mortgage application. Semi-annual status reports and other paperwork seem intended for the purpose of having people fall off the program.

Recent reforms have been successful in reducing the enrollment burden, such as doing outreach to children through schools and other social programs.

<u>The individual insurance market:</u> Those that are not eligible for group coverage through an employer or a public program are left to buy it as individuals, even though it is the most expensive, least efficient way to get coverage. Those that do so are a residual population, covering around than 2 million Californians, or less than 5% of the population. For most Californians, it is nether available, nor affordable, nor automatic.

Is it available? *For many Californians, no.*

Insurers have broad leeway to choose who gets to buy coverage and what coverage they get to buy. Often people are denied coverage because of "pre-existing conditions" which is a category that ranges from major health conditions such as diagnosed cancer or diabetes, to more minor conditions such as heartburn or childhood asthma, to single incidents of something as small as an ear infection or yeast infection, or simply taking a prescription medicine in the previous year. As a result, even those who are willing and able to pay any price for it may not be able to obtain coverage. While two million Californians buy coverage as individuals, insurers

refuse to disclose how many of the 6.5 million uninsured Californians have applied and been rejected by insurers.

Those who are denied have only one option, to see if they can get coverage through the state's Managed Risk Medical Insurance Program. This program provides subsidized coverage but it still has a higher premium than the overall market, as well as a capped benefit. The program has a limit on enrollment and sometimes has a waiting list and because of this has never been advertised.

Is it affordable? *No.*

The individual market is the most expensive way to get health coverage, and provides the least value for the money.

Individual consumers don't have the ability to negotiate with the insurers like large employers and public programs do. *Beyond the lacking the power of group purchasing, individuals get less value in the product, since insurers do more extensive marketing to sell to individuals, pay commissions to agents, and engage in extensive medical underwriting, which is not only a barrier but an added administrative cost.* A June 2007 Health Affairs study shows that the value of non-group coverage is less than that of employment-based coverage: with cost-sharing and benefit limits, an average non-group policy only covers 55% of a person's medical expenses while a group policy covers 84% of a person's medical expenses.

In California, insurers are allowed to charge different rates based on age, health status, and other factors. *Insurers can charge consumers what they want, discriminating most against the older and sicker.* While they compete to cover younger and healthier people, they also compete to *not* cover those who might actually need health care services.

Since there is no subsidy, assistance, or shared risk from either an employer or government, the cost of individual health insurance policies is simply prohibitive for many low-income, middle-income and older Californians.

Is it automatic? *Scarcely.*

Even for those who are eligible and can afford it, the process of getting coverage is difficult. *Shopping intelligently is difficult: since there are so many different benefit structures, it is hard to do even basic price comparisons*, or even be totally sure that a plan will provide the coverage that a person wants and needs. Those that take the plunge sometimes feel they need an agent or broker.

Either way, it usually takes self-motivation, strong interest, an ability to figure out a complicated marketplace, and the ability to pay a significant percentage of one's income.

2007 HEALTH REFORM MEASURES

This detailing of barriers in the current health insurance system provide a background for assessing how reforms in the Legislature would, or would not, address the problem.

AB8(Nunez/Perata): Would make coverage more available, affordable, and automatic in general for Californians, leading to coverage of 95% of Californians and 70% of the uninsured. The legislative leaders' bill would take strides toward removing the barriers to get employer-based coverage, public program coverage, or insurance in the individual market.

In particular, it would expand group coverage that is employer-based or publicly financed; it would also reform a smaller individual insurance market.

Employer-Based Coverage: Secured and Expanded, with a New Option

More Available:

A minimum employer contribution toward health care would encourage employers to make coverage more available.

AB8's 7.5% minimum employer contribution sets a floor for health benefits, much like the minimum wage does for pay. Those employers that don't offer any benefits would start to provide at least some coverage to their workers. Other employers who provide some coverage but less than the requirement would increase their contribution.

Employers will also be offered a new, affordable option of providing coverage to their workforce through a statewide purchasing pool, for 7.5% of payroll. In this way, more workers might be covered, for those who work for employers who offered benefits to some but not all their employees.

Also, AB8 has a two-pronged test, so that companies can choose to pay the fee for their part-time workers, and have their part-time workers covered—a population that often doesn't have the option of employer-based health care.

More Affordable:

AB8 says that no one who is offered health benefits by their employer can be required to take those benefits if that would cost more than 5% of their wages.

AB8's statewide purchasing pool provides a new, affordable option for employers, which through bulk purchasing and federal matching funds, may be able to provide coverage at a reduced rate, which could translate to savings for workers as well.

For those in the purchasing pool, the bill limits the share of premiums for workers under median income (300% of the federal poverty level, or $30K for an individual, $60K for a family of four) to at most five percent of income. Nobody of any income, in or out of the pool, would have to take up coverage if their health expenses were more than 5% of income.

For those families who would ordinarily qualify for public programs, but are offered coverage on the job, they might be able to benefit from "premium assistance,'' which allows them to receive the additional benefits from the public programs (beyond whatever the employer is offering).

Finally, employers would also be required to offer "Section 125" plans, so that workers' share of premium can be paid on a pre-tax basis, for a savings of 15-40%.

More Automatic:

AB8 includes a worker requirement to take up coverage, unless there is proof of having group coverage from another source, such as a spouse, or unless that worker's health costs would be over 5% of income.

Even those workers whose employer does not contribute to a health plan will be offered a "Section 125" plan, where they can automatically enroll in a health plan, as well as get pre-tax savings.

Those workers in the statewide purchasing pool may have the additional benefit of having their coverage be continuous and portable if they shift to other employers also paying into the pool.

<u>Public Programs:</u> Dramatically Expanded

More Available: Yes.

The proposal would greatly expand coverage for low-income children and their parents. AB8 includes covering all children up to 300% of federal poverty level, regardless of immigration status. It would also expand subsidized Medi-Cal coverage to (citizen and documented) parents up to 300% FPL (around 30K for an individual and $60K for a family of four).

The Governor's proposal also seeks to expand Medi-Cal to also include low-income adults without children at home—who currently are not eligible for Medi-Cal. With a revenue source to fund this expansion (which requires either a two-third legislative vote or a ballot measure), this could be incorporated into this proposal as well.

More Affordable: Yes.

For those newly eligible for Medi-Cal or Healthy Families, they would get coverage, more affordable than anything provided privately, in terms of both benefits and cost-sharing.

For those above the poverty line, there still would be limits on premiums and cost-sharing, based on income.

***More Automatic**:* Yes.

In a major improvement, AB8 and the Governor's plan would eliminate:
- The current asset test, which makes it hard for low- and moderate-income families to own a reliable car or have modest savings accounts.
- The deprivation test, which treats low-income two-parent families differently from one-parent families.
- Semi-annual status reports, which endangers coverage for families if they don't complete paperwork on time.

Each of these are significant administrative barriers to getting on coverage and staying on, and would be eliminated under both proposals.

<u>The Individual Market:</u> A Smaller, Reformed Market

***Available**:*

There would be limits on insurers' ability to deny coverage because of pre-existing conditions. The questionnaire used to ask people's health history would be shortened and standardized for all insurers, and insurers would no longer be able to deny people for minor conditions.

Those who would still be denied – about 3-5% of the market -- would have access to coverage through an expanded MRMIP, which would be subsidized by an assessment on those insurers who deny people coverage. The benefit for those in this pool would be improved.

***Affordable**:*

The folks left in the individual market are those, by definition, that don't qualify for even expanded public programs. Even though many of them would make more than median income, coverage will likely be very expensive to buy and to use.

Employed Californians, through Section 125 plans, could pay their premiums using pre-tax dollars, providing savings at 15-40%.

***Automatic**:*

Outside of work, no one would be automatically signed up for health insurance.

The market would be easier to navigate with a standardized benefit structure, made up of five classes, so consumers can make apples-to-apples comparisons.

<u>SB840 (Kuehl)</u>: Would create a universal, Medicare-like system for all Californians. The bill builds on what works in our health care system, by extending the benefit of group purchasing to the entire state, and by relying on a mix of contributions from employers, individuals, and government.

All Californians would be aggregated into one purchasing pool, and get coverage as a result. Contributions would reimburse the current network of private doctors and hospitals – as is done in Medicare now. To replace what we pay in premiums, deductibles, and out-of-pocket costs, employees would pay 3.87 percent of their income, and employers would pay 8.14 percent of payroll.

Available? Yes.

The bill would extend coverage to all Californian residents, as defined by the legislation.

Affordable? Yes.

People would pay a percentage of their income (a percentage that would ensure people's ability to pay), and it would be taken out as part of their taxes -- rather than paying based on type of job, or medical condition or any other individual characteristic. Estimates currently provide for an 8% employer payroll tax, and a 4% employee tax, with some exemptions.

Automatic? Yes.

With near-universal eligibility, and financing through taxes, sign-up becomes automatic. Like Medicare, there would be an easy, one-time sign-up (and that gets all but a handful of people to enroll).

For more information, contact Health Access California, the statewide health care consumer advocacy coalition, or visit our website, at http://www.health-access.org.