



# LITTLE HOOVER COMMISSION

August 16, 2006

**TO:** Health Care Advisory Panel Participants

**FROM:** Stuart Drown  
Executive Director

**SUBJECT:** Summary of July 27, 2006 Advisory Panel Meeting

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Thank you for participating in the Commission's advisory panel meeting on July 27, 2006. The meeting was intended to provide an overview of the core challenges associated with improving access to health care in California.

This document is intended to capture the information presented during the meeting. The information presented here does not represent the perspectives or conclusions of the Little Hoover Commission. Rather, this summary is intended to provide a record of the meeting along with an opportunity for participants to clarify or amplify those issues discussed.

As part of its project on health care, the Commission has scheduled public hearings for Thursday, September 28, 2006 and Thursday, November 16, 2006 in the State Capitol. The Commission also will convene additional advisory panel meetings throughout the fall.

## Advisory Panel Meeting – July 27, 2006

The Commission convened an advisory panel on health care. Participants included federal, state and local officials, legislative staff, health care advocates, providers and others. Five themes emerged during the meeting:

- Market-based and publicly-funded health care are interrelated.
- Barriers to health care and insurance are diverse.
- Despite health insurance, care can be inaccessible.
- Aged and disabled enrollees consume the bulk of Medi-Cal funds.
- Rising health care costs limit affordability.

## Overview of access to health care

Chris Perrone from the California HealthCare Foundation provided an overview of health coverage and financing in California. Mr. Perrone's presentation can be accessed from the Commission's Web site at [www.lhc.ca.gov](http://www.lhc.ca.gov).

Participants suggested that public programs cannot infinitely expand without affecting private insurance markets. Yet they cautioned that the State has no single entity responsible for managing the interface between public and private health insurance. Some suggested the State must promote opportunities for the uninsured to obtain privately-funded coverage.

**Barriers to health care and insurance are diverse.** Nearly 20 percent of Californians lack health insurance. Although lower income residents are more likely to be uninsured, income is not the only variable in determining whether an individual is insured. Nearly 30 percent of the uninsured earn more than \$50,000 per year; half of those individuals earn \$75,000 or more. Similarly, while being employed increases the likelihood of being insured, not all workers have insurance. Of all uninsured individuals in California, more than 80 percent are employed. Approximately half of the uninsured residents in the State are Latino; a quarter are white. Participants noted that, in comparison to other states, California has more low-income residents, more uninsured residents and more undocumented residents.

There are several reasons for lack of insurance. Many Californians qualify for publicly-funded coverage but are not enrolled. Many can afford and would like to buy private coverage, yet are denied insurance because of pre-existing medical conditions. Still others cannot afford to buy private insurance, yet are ineligible for publicly-funded coverage because of their income level or immigration status. Additionally, another subset choose to not purchase insurance because it is considered to be a poor value or it is not a priority.

Participants provided information on several of California's state-funded programs. Lesley Cummings, the executive director of the Managed Risk Medical Insurance Board, presented information on Healthy Families, Access for Infants and Mothers, and the Major Risk Medical Insurance Program. Included in the materials that Ms. Cummings distributed was a document that illustrates the eligibility criteria for each of these programs. That document is available on the Commission's Web site.

Although California's investments in publicly-funded health care programs have been significant, participants noted that eligibility criteria – structured around age, parental status and income – result in gaps in coverage.

Participants advised there is no simple, encompassing solution that will enable all who lack insurance to gain insurance. Because the reasons why individuals lack insurance vary, multiple solutions are needed to ensure access to coverage and care.

**Despite health insurance, care can be inaccessible.** More than 6 million residents are uninsured. But this figure does not adequately indicate whether Californians have access to quality care. First, many with insurance fail to receive the care they need. Second, many without insurance are able to access care.

Those who are insured often face barriers to care. Participants explained that one barrier is the low rates of physician participation in Medi-Cal. There are 70 primary care physicians per 100,000 people in California, but only 46 primary care physicians who participate in Medi-Cal per 100,000 beneficiaries. For medical and surgical specialists, the rates are even lower with 50 to 60 percent fewer specialists available to Medi-Cal beneficiaries than to the general population.

Those who lack insurance can access care through emergency rooms, public hospitals, county clinics and other sources. California counties and hospitals spend approximately \$3.4 billion dollars per year providing health care to the uninsured. In the U.S., caring for the uninsured costs approximately \$39 billion annually.

Participants discussed the proposal for universal health care in San Francisco and explained that the proposal creates access – but not insurance – for all residents. Participants noted that similar programs in Contra Costa, Santa Clara and San Mateo provide access to health care regardless of insurance status.

Participants emphasized the need to focus not only on access to insurance, but on access to care. Additionally, participants raised concerns over the quality of care provided and the associated costs.

**Aging and disabled enrollees consume the bulk of Medi-Cal funds.** Research indicates that while enrollment increases have occurred primarily for children and their parents, the majority of Medi-Cal expenditures pay for care for seniors and people with disabilities. Over 75 percent of Medi-Cal beneficiaries are children and parents, accounting for 37 percent of expenditures. Seniors and persons with disabilities represent 23 percent of the Medi-Cal population, but account for 63 percent of Medi-Cal expenditures.

Participants projected that Medicare Plan D could change the cost distribution in Medi-Cal, with fewer Medi-Cal dollars paying for prescription drugs for seniors. Yet participants cautioned that as the State's population ages, Medi-Cal costs for the aged are likely to increase.

**Rising health care costs limit affordability.** In 2005, family health insurance premiums for a lower-cost plan were 66 percent of California minimum wage earnings compared to 7 percent in 1970. Participants noted that along with costs, the benefits covered also have increased, particularly the use of new cost-intensive technologies and medications. Costs are divided about equally between hospital care, physician services and all other expenses. Consumers are paying a smaller share of health care costs, but the amount consumers spend has increased dramatically. Annual out-of-pocket spending rose to \$788 per capita in 2004 from \$119 per capita in 1970.

The State's Medi-Cal costs per beneficiary, however, are the lowest in the nation. Participants noted that the State has artificially kept costs down by providing one of the lowest provider reimbursement rates in the nation. Participants noted that the Medi-Cal program is characterized by tradeoffs like this one, which has allowed Medi-Cal to cover large numbers of uninsured, but also has compromised access to quality care.