CHEAC Legislative Policy Guidelines:
Expansion of Health Care Coverage (2007)

Existing Role of Counties in the Provision of Health Care Services

In county health care systems, most of the recipients of health care are indigent or very low-income and face transportation, communication and other challenges in accessing health care services. Because of cultural and socio-economic differences, patients may manifest rare diseases, co-morbidities and social/behavior patterns that many private providers cannot or choose not to handle. County health care systems are both experienced and skilled in dealing with socio-economic and cultural variations and provide access to care in communities frequently underserved by private providers.

Counties are required to serve the medically indigent under Welfare and Institutions Code Section 17000. Each county may define that standard as appropriate to their own community in terms of income and assets and through a variety of delivery mechanisms. Counties may also serve the uninsured, those who don't have coverage but may have income and assets greater than the county indigent standard. Many uninsured are employed, but don't have access to employer sponsored programs, cannot afford them, or choose to go without coverage. Counties may serve undocumented persons, who usually are not eligible for most public programs.

The delivery of direct health care services is only part of the obligation counties have in promoting the health of their communities. Counties, and city health departments, also provide public health services which benefit their communities as a whole. In addition, counties provide jail health care and other health services, such as dental services, which may not be covered under an expansion.

In order to avoid disruption in the provision of these essential services, and to ensure the protection of safety net services during the transition to and after a coverage expansion is in place:

- Any transfer of indigent medical services funding away from the county should be accompanied by a commensurate transfer of responsibility, including the health care provisions of Welfare and Institutions Code Section 17000. Any remaining county responsibility for indigent medical care or care for residual uninsured populations must be sustained by adequate funding from non-county sources to provide reasonable access to quality services.

- Adequate and secure funding must be assured for other county health services, especially those that are state-mandated. Funding for core local public health activities (communicable disease control, epidemiology, public health laboratories, public health nursing, etc) must be protected.

- Health coverage proposals should consider the development of a partnership with the existing county health care systems in recognition of the important resources they provide for serving specialized segments of the population.

- Health coverage proposals should refrain from levying new taxes or fees on counties or county facilities to fund coverage expansions unless the proposal also includes an equivalent reduction in county costs.

- Coordination with and participation by counties for outreach activities for any new or expanded program should be maximized. This will permit the State and uninsured individuals to derive maximum benefit from such programs as local health departments are highly knowledgeable regarding local neighborhoods, families and cultures.

Key Health Care Reform Principles

Coverage

CHEAC believes that California should embrace coverage for all residents, irrespective of pre-existing conditions, or ability to pay.

Ideally, Californians will be assigned to a medical home. This should ensure regular checkups, preventive care, and management of any chronic health conditions. This population of covered individuals will have identifiable costs and their care can be managed in a cost effective manner. This can most easily be accomplished for those with employer-based coverage or those already enrolled in public benefit programs.

In contrast, for some individuals, such as the unemployed or self-employed, coverage won't begin until time of service. It is difficult to determine on an actuarial basis the cost of service for this population. This population may lose the advantage of preventive and regular primary care. The costs of care at entry will likely be higher than those who can be pre-enrolled.

- Incentives should be included for employers to retain and expand employee coverage and to include preventive care in their benefit level. Include "no crowd-out" provisions to ensure employers don't drop existing coverage for employees if that would result in a lower level of coverage for employees.

- Coverage for mental health and substance abuse services should be included at parity with the level allowable for other diagnoses.

- Expansion of Medi-Cal and/or Healthy Families programs should be supported to provide coverage for the uninsured population.

- Coverage should be extended to incarcerated persons and/or those under the custody of the county sheriff and chief probation officer – or secure their eligibility under the appropriate programs.

Access

- Coverage without access is no coverage at all. All licensed medical professionals should be considered providers under the plan.

- Reimbursement rates should be adequate to cover the cost of care, provide quality incentives and ensure provider participation. Medi-Cal reimbursement rates must be increased to incentivize providers to participate in the program.

- The state should encourage access to care in rural, remote, or underserved areas through programs such as loan repayment and tax incentives for providers.

- The plan should facilitate access through supportive programs such as subsidized transportation options, the availability of case managers, health care coaches/promotoras and advice lines to enhance management of patient care.

- Take into consideration that those covered by the plan will vary in culture and language. The plan should provide the necessary flexibility and trained personnel to communicate with and care for all populations including those unfamiliar with insurance programs.

Affordability

- Any mandated system must ensure that coverage is affordable. Cost sharing should be tied to income and assets.
- Consumers of health care should be cognizant of costs and the consequences of choices they make.
- Catastrophic care should be covered, and financially addressed through re-insurance and risk pools.
- No one should be driven into bankruptcy or defer seeking needed medical care due to health care costs.
- Preventive and primary care services should be the least expensive program components to ensure access to these aspects of care.

Prevention

- The coverage plan should provide a medical home and must include preventive services such as immunizations, pre-natal care and appropriate disease screenings.
- Health reform should include incentives for individuals to access regular preventive and primary care services and should recognize healthy behaviors and choices by consumers.
- Incentives should also be included for health care practitioners to provide case management and to promote primary and prevention services to ensure that medical conditions and illnesses are caught at the earliest and least costly stage.

Streamlining

- Existing state coverage programs should be consolidated with a streamlined application and enrollment process, with minimum, necessary, required documentation.
- Enrollment should be available through providers and point of service facilities and allow for self enrollment through the internet and mail. Penalties and/or sanctions should not be imposed upon counties for applications received from other sources that may contain inconsistencies.
- The services covered should be clearly identified, with a minimal need for billing, or prior authorizations.

Evaluation

- Any health reform proposal should include a periodic evaluation of the program and the progress made toward achieving its goals. This evaluation should utilize census data (when available) and gauge cultural relevance, adaptability and accessibility.

Approved by CHEAC General Membership April 5, 2007