



May 23, 2012 - Capitol Desk

## **Kaiser Balks at Joining Healthy Families Conversion to Medi-Cal**

by David Gorn

The planned switch of Healthy Families children into Medi-Cal could leave as many as 43,000 children looking for new health care providers if the state can't convince Kaiser Foundation Health Plan to join the effort.

That number would grow to 189,000 children if the state eventually converts all Healthy Families children to the Medi-Cal program.

On Tuesday, the Senate budget subcommittee for Health and Human Services rejected a plan to move the entire Healthy Families population of 875,000 kids to Medi-Cal all at once, instead starting with a pool of roughly 200,000 "bright line" children -- beneficiaries who are at or below 133% of federal poverty level.

An accurate number of the Kaiser bright-line children in the Healthy Families program is still being researched by Kaiser, but judging from the ratio of Kaiser's overall participation, about 43,000 of the 200,000 bright-line children are covered by Kaiser. Kaiser has 189,000 of the overall 875,000 children in Healthy Families.

Kaiser remains worried about an eventual conversion of all Healthy Families children to Medi-Cal, according to Marc Brown, media relations manager for Kaiser Permanente Northern California.

"While we support a balanced approach to restoring the state's fiscal stability," Brown said, "Kaiser Permanente has concerns about the proposed elimination of the Healthy Families program."

Norman Williams, deputy director of public affairs for the Department of Health Care Services, said the two sides are still working to get Kaiser on board.

"We are aware of the concern and we would certainly like Kaiser to participate," Williams said. "If that does not happen, we would move children into other plans in a seamless manner, and we would work to do it as efficiently as possible."

Read more: <http://www.californiahealthline.org/capitol-desk/2012/5/kaiser-conundrum-40-000-kids-to-move.aspx?p=1#ixzz1vhoSAiYm>

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Agenda Item 4  
5/23/12 Meeting

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## U.S. sets deadline for proposals on state healthcare exchanges

Wed, May 16 2012

WASHINGTON (Reuters) - The Obama administration forged ahead with healthcare reforms on Wednesday, announcing a November 16 deadline for state governments to submit proposals showing how they intend to operate health insurance exchanges in 2014.

The Department of Health and Human Services released a detailed blueprint of the legal and operational requirements states must meet in their proposals if they expect to win federal approval to begin operating regulated insurance markets, in whole or in part, by January 1, 2014, when the 2010 law is scheduled to come into full force.

President Barack Obama's embattled Patient Protection and Affordable Care Act calls on states to establish exchanges that would offer federally subsidized health coverage to an estimated 16 million people who currently do not have health insurance. The exchanges would allow consumers to purchase their insurance from an easy-to-understand menu of competing plans, at premiums set on a sliding scale according to the buyer's income.

But progress at the state level has been uneven, with many states waiting to see how healthcare reform fares in a U.S. Supreme Court ruling anticipated in June that could overturn the law. The main case before the court was brought by 26 states that believe the reforms exceed the federal government's constitutional powers.

Healthcare reform also faces a political test in the November 6 election, which falls 10 days ahead of the new filing deadline for healthcare exchanges. Obama's re-election bid is being challenged by presumptive Republican presidential nominee Mitt Romney, who has vowed to repeal healthcare reform if elected.

Health and Human Services Secretary Kathleen Sebelius told reporters that 34 states, including some that want healthcare reform overturned, and the District of Columbia now have accepted federal grant money to help establish the insurance exchanges.

The administration announced another \$181 million in grant awards for Illinois, Nevada, Oregon, South Dakota, Tennessee and Washington.

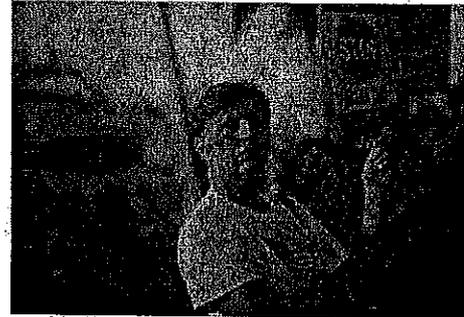
"What this shows is that states are making real progress in delivering quality, affordable health coverage to their residents and they want to be up and running by January 2014," Sebelius said.

Only about 15 states have actually moved to establish exchanges, either through legislation or executive order.

The administration also released guidelines for assisting states that could be unable to offer full exchange services by 2014 and for establishing federal exchanges in states that are unwilling to participate.

Officials said the administration would partner with state governments in two areas: certifying health insurance providers for the exchanges and helping consumers apply for coverage and enroll in an appropriate plan.

(Reporting by David Morgan; Editing by Bill Trott)



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uninsured patients end up footing a higher bill for uncompensated care. That takes away resources they could be spending on hiring better doctors, upgrading medical equipments or making a whole host of investments that could improve health outcomes. Worse care, for all patients treated at the facility, ensues.

On the flip side, increasing insurance coverage could have positive spillover effects, improving quality of care even for the already-insured. “Taken together, my results suggest that policies aimed at addressing the issue of uninsurance may have additional benefits to insured patients residing in the same communities,” Deysal concludes. That means the Affordable Care Act, which is expected to extend coverage to 32 million Americans, could have some fringe benefits for those already covered.

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Cost and Quality would oversee the transition to the new payment and delivery system with a board including consumer, government and industry representatives.

2. The plan establishes a specific cap for health-care spending that would be linked to the Gross State Product minus .5 percent.
3. The state could impose a 10 percent tax on hospitals if they charged more than 20 percent of the state median price for a given service and couldn't justify that higher price. (Two earlier reports by Attorney General Martha Coakley found that certain hospitals exploited their market clout to charge higher-than-justified prices). Hospitals would pay this penalty into a distressed hospital fund for institutions that serve a high proportion of poor and vulnerable patients.
4. Accountable care organizations would take on greater prominence, though the bill stresses that joining an ACO would be voluntary for patients and providers. The bill defines the size of an ACO as bigger than 15,000 people and no larger than 400,000. Patients would have the right to appeal decisions made by their ACO doctors, and have the right to a second opinion.
5. The state's medical establishment would continue its shift toward global payments and away from fee-for-service systems. The measure would "transition the industry to adopt alternative payment methodologies such as global payments and bundled payments for acute and chronic conditions."
6. Electronic health records would be required for all providers by 2017.
7. Greater transparency would be attained through detailed pricing available to consumers on the Web, as well as greater disclosure of out-of-pocket costs to patients up front.
8. The measure stresses greater coordination of care through primary care, and the establishment of "patient-centered medical homes" so that patients could have a single point of coordination for all types of care.
9. New rules on medical malpractice would create a 180-day cooling off period while both side try to negotiate a settlement. Also, the measure would allow providers to freely offer an apology to a patient.
10. Under a provision called "smart tiering" patients might pay more for more expensive services.
11. The bill would make several changes to Medicaid, including increasing MassHealth rates paid to providers.
12. Funding for workforce training and development are included in the measure, and a provision would forgive loans to primary care doctors who practice in rural or underserved areas.



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## Fewer jobs means more spending on U.S. Medicaid

Fri, May 4 2012

(Reuters) - Millions of people turned to the Medicaid health insurance program for the poor during the 2007-2009 recession as families coped with job losses and drastic drops in income, pushing Medicaid spending up by an average of 6.6 percent per year, according to a study released on Friday.

The study by the nonprofit Kaiser Foundation found that state and federal spending on the program, which states administer with partial reimbursements from the U.S. government, grew to \$400 billion in 2010 from \$330 billion in 2007.

That represents an average annual increase of 6.6 percent - far outstripping the 1.3 percent rate at which Medicaid spending rose from 2005 to 2006.

For medical services alone, such as acute care and prescription drugs, spending grew 6.9 percent annually on average over three years, reaching \$358 billion in 2010.

The spending spike could be especially worrisome for states, which suffered the largest revenue collapse in decades from the combination of the recession, housing downturn and financial crisis. With less money coming in, almost all had to slash spending and increase taxes, along with using millions of additional dollars the federal government pumped into their Medicaid systems through the 2009 economic stimulus plan.

Now the stimulus aid is gone, and revenues have only recently begun recovering, which will make it hard for some states to cover the elevated costs. In some states, Medicaid can take up a third of the budget, and for almost all it eats up more than a fifth of spending.

Last month, Illinois Governor Pat Quinn called for saving \$1.35 billion a year on his state's Medicaid spending by reducing people's eligibility for the program, saying that if Illinois does not act quickly its entire Medicaid system would collapse.

He is not alone in trying to cut spending through barring people from signing up for the program. Arizona has frozen enrollment.

The National Conference of State Legislatures said in a report on Thursday that 10 states are over budget on Medicaid this year. A think tank that tracks states' budgets, the Center on Budget and Policy Priorities, found that at least 20 states have made "identifiable, deep cuts in healthcare this year."

The study by Kaiser's Commission on Medicaid and the Uninsured found that the cost increase during the recession came almost entirely from enrollment growth. Eight million people joined the program from June 2007 to June 2010.

"During periods of economic downturn, people lose employment and income and are more likely to qualify for Medicaid; thus, program enrollment increases more rapidly as economic conditions worsen," it said.

When broken down per person, annual Medicaid spending growth was smaller than the rises in national expenditures on health per capita and increases in private health insurance premiums per enrollee, the report said.

It also found that families accounted for most of the enrollment surge. Family enrollment in Medicaid increased by an average of 7.2 percent per year between 2007 and 2010. In contrast, between 2004 and 2007 "growth in family enrollees was fairly flat" at 0.4 percent.

"Once the recession began, families' enrollment growth jumped from 3.3 percent at the early part of the period to over 9 percent as the recession deepened," Kaiser said.

The recession officially ended in 2009, but worries about the economy remain, especially because the recovery remains slow. The Labor Department reported on Friday that U.S. employers cut back on hiring in April and more people stopped looking for work. The unemployment rate reached a three-year low of 8.1 percent due to people dropping out of the labor force.

(Reporting by Lisa Lambert in Washington and Karen Pierog in Chicago; editing by Mohammad Zargham)

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## Potential Savings through Prevention of Avoidable Chronic Illness among CalPERS State Active Members

April 2012

Timothy A. Waidmann, Barbara A. Ormond, Brenda C. Spillman

### Introduction

The high and rising prevalence of chronic disease represents a substantial burden on the medical care system and a major cost for society, leaving aside its toll on individuals. Evidence comes from varied sources and is based on a range of methods. The burden is presented as rising rates of obesity,<sup>1</sup> increased prevalence of diabetes,<sup>2</sup> greater incidence of disability,<sup>3</sup> and the rising cost of medical care<sup>4</sup> and other disease-related costs.<sup>5</sup> And, while the age-adjusted mortality from coronary heart disease and stroke has fallen, the aging of the population and rising obesity portend increases in both incidence and prevalence of cardiovascular disease in the near future.<sup>6</sup>

The rise in obesity has been well documented in both the professional literature and the popular press. The Congressional Budget Office reports that medical spending on obese adults is 38 percent higher than on their normal-weight counterparts.<sup>7</sup> Absenteeism has been shown to be higher among severely obese working women.<sup>8</sup> Ormond and colleagues estimated the excess medical spending associated with uncomplicated diabetes and hypertension alone at \$180 billion annually, with nearly three-quarters of this cost borne by private payers and individuals.<sup>9</sup> The cost of cardiovascular disease in medical treatment and lost productivity has been estimated at \$400 billion per year, of which about one-quarter comes from lost productivity.<sup>10</sup>

There is widespread recognition that many of the most common chronic conditions could be largely prevented through changes in lifestyle-related behaviors such as reduced use of tobacco, improved diets, and increased physical activity.<sup>11</sup> The results from the Diabetes Prevention Program (DPP) argue strongly for the efficacy of lifestyle change in preventing the progression of pre-diabetes to diabetes,<sup>12</sup> and follow-on studies support the sustainability of the health gains.<sup>13</sup> Furthermore, recent studies have shown that the DPP protocol can be successfully implemented in a nonresearch setting at about one-tenth the cost of the original intervention.<sup>14</sup>

The debate about whether the benefits of prevention outweigh its costs continues.<sup>15</sup> The controversy stems

in part from what is considered "prevention." Recent research focusing specifically on workplace wellness programs, however, has found that every dollar invested in these programs can reduce medical care costs by \$3.27 and costs associated with absenteeism by \$2.73.<sup>16</sup> Earlier research showed even greater returns using less strict criteria for study inclusion.<sup>17</sup> Goetzel and colleagues cite studies of programs at specific organizations, noting that most show positive financial returns but cautioning that program design and implementation are important components in successful programs.<sup>18</sup>

Chronic disease has complex etiologies and treatment protocols, and estimating medical costs associated with particular diseases is methodologically tricky. The estimated costs seen in the literature represent a range that depends in part on what costs are included or excluded, how diseases are classified, and over what time period costs are calculated. Most estimates rely on national data, and extrapolations to smaller jurisdictions or entities are subject to adjustment for local factors such as the demographic makeup of the population, insurance coverage, and local medical practice patterns and costs.

Despite these obstacles in quantifying the burden, the literature overwhelmingly supports the notion that the burden of chronic disease is large and growing. Often the costs are attributed broadly to society; some research is more specific, with medical costs assigned to different types of insurance. But there is little direct evidence available for the entities that might have the most to gain from reducing the costs imposed by chronic disease on the magnitude of their specific burden and the potential gains from reducing it. For example, state investments in prevention of chronic disease for their Medicaid populations may be offset by reduced Medicaid costs for care. Employers, both private and public, stand to gain from reduced medical care and health insurance costs and from reduced worker absenteeism and other improvements in efficiency associated with a healthier workforce.<sup>19</sup>

From an employer's perspective, the size of the burden associated with chronic disease represents the potential gain from reducing it and so gives an indication of how much it would be reasonable to invest

in prevention. Two factors influence the return on such investments: how effective prevention programs are in reducing chronic disease and how much such programs cost. The expansion of workplace wellness programs offers implicit evidence that many employers believe that prevention is a worthwhile investment. The state of Oregon has recently established a "Health Engagement" model for state employees.<sup>20</sup> Pitney Bowes has a long-standing prevention and wellness program for its employees.<sup>21</sup> America's Health Insurance Plans has developed online wellness programs that subscribers can purchase.<sup>22</sup> And entrepreneurs, such as Advancing Wellness,<sup>23</sup> have begun offering programs for employers that prefer not to develop their own. The striking range of these efforts suggests that employers see a benefit in such programs.

The California Public Employees' Retirement System (CalPERS) health program covers nearly 1.3 million active and retired state, local government, and school employees and their family members.<sup>24</sup> It spent almost \$7 billion in 2011 to purchase health benefits for the State of California (which can be considered a single employer) and for more than 1,100 local and government agency and school employers. The program offers three health maintenance organization (HMO) plans, three self-funded preferred provider organization (PPO) plans, and three plans for members of several employee associations.<sup>25</sup>

## Empirical Framework

The analyses conducted for this report are designed to estimate the burden of preventable chronic disease on CalPERS State Active members and to describe the distribution of that burden by demographic characteristics, across geographic areas, across agencies and departments within state government, and across the health plans offered by CalPERS. State Active members are current California state employees and their dependents.

To calculate these burdens, we estimate the per capita effect of two clusters of preventable chronic disease. With well-targeted interventions, the prevalence of Cluster I conditions—hypertension and type 2 diabetes without the presence of related comorbidities—has been shown to be modifiable in a relatively short period (one to two years).<sup>26</sup> The second cluster, Cluster II, adds heart disease, stroke, and renal disease either alone or in combination with hypertension and diabetes. Because the risk of onset for the diseases in the second cluster is closely linked to the prevalence of the first cluster conditions, interventions targeted at Cluster I will likely have downstream effects on Cluster II. We assume these Cluster II effects can be expected in a slightly longer time horizon (five to ten years). Using regression analysis of the all payments made to providers by CalPERS on behalf of individual members over the full year, we calculate the fraction of those payments that are uniquely associated with each

cluster of diagnoses. The resulting estimates give the fraction of these payments that would be eliminated in the absence of each cluster, holding constant all other factors, including other illnesses. These proportions can be interpreted as the share of expenditures that are amenable to reduction through proven prevention strategies targeting diet, exercise, and smoking behavior.

## Data

Data for these analyses are derived from individual annual summary records of health care spending, demographics, and diagnoses for each State Active employee and his/her dependents covered by CalPERS between 2004 and 2008. The data exclude state retirees and their dependents, public agency active employees and their dependents, and public agency retirees and their dependents.

Data on state employee race and ethnicity were provided by the California State Controller's Office (SCO); no race/ethnicity data were available for dependents. To combine these records, Thomson Reuters (TR), the administrator of the CalPERS Health Care Decision Support System, generated a random identifier for each state employee and sent a finder file containing the random identifier and the employee's Social Security number to SCO. SCO then added data on employee race/ethnicity and a salary range indicator, removed the Social Security number, and returned the file to TR, which matched the SCO records to the CalPERS records. In this way, no personal identifiers were provided to the research team. The resulting data files contained 2,691,551 records. The large sample size results in highly precise estimates, as evidenced by the narrowness of the confidence intervals also shown in the table.

## Method

The outcome variable was total CalPERS spending during the year paid to providers on behalf of the member. Ordinary least squares regression (OLS) was used to estimate the unique contribution of each explanatory factor in the model to total health spending. The key explanatory factors in the regression model were indicators for the Cluster I and Cluster II conditions. We also controlled for other factors that have been shown to contribute to variation in health spending. These include age; sex; employment tenure in four categories—< 1 year, 1–5 years, 5–10 years, > 10 years; race/ethnicity in seven groups—American Indian, Asian, black, Filipino, Hispanic, non-Hispanic white, other, and missing.<sup>27</sup> To control for geographic differences in health care prices, we included 28 indicators for residing in each of the metropolitan statistical areas in the state. Finally, to control for changes over time in medical practice and prices, we included indicators for each year.

We defined "excess expenditures" for a condition as CalPERS health expenditures on behalf of a member

with the condition beyond that predicted for someone without the condition but with other characteristics unchanged. The estimates for excess expenditures for each disease indicator in this model are shown in table 1. For example, a person with diabetes (only) has estimated excess annual spending averaging \$2,863 more than someone with none of the target conditions. In the remaining tables, we label excess spending attributable to the Cluster I and Cluster II conditions as the "Preventable Costs."

The calculations presented in the rest of this report are made by multiplying these estimates by the number of members with the listed diagnoses in each subgroup (e.g., by age/sex, race/ethnicity, county, agency/department, or health plan).

## Results

Overall, our analysis finds that of the \$1.6 billion spent by CalPERS in 2008 on the health care services used by its State Active members, \$362 million (22.4%) was attributable to Cluster I and II chronic diseases that are amenable to prevention through changes in diet and physical activity. As a guide to targeting interventions to effect such changes, our analysis also pinpointed groups of members—identifiable by demographic characteristics, agency/department, county of residence, and health plan—with notably high or low shares of spending due to these conditions.

## Demographics

Table 2 shows the total payments made by CalPERS and the portion of those payments that is attributable to

**Table 1: CalPERS State Active Excess Expenditures (Per Person Per Year) of Selected Preventable Conditions**

Condition	Annual Excess Expenditure Per Person
<b>Cluster I</b>	
Diabetes only	\$2,863
Hypertension only	\$1,595
Diabetes and Hypertension only	\$3,920
<b>Cluster II</b>	
Diabetes with Heart, Cerebrovascular, or Renal Disease	\$21,181
Hypertension with Heart, Cerebrovascular, or Renal Disease	\$14,576
Diabetes, Hypertension, and Heart, Cerebrovascular, or Renal Disease	\$24,215
Heart, Cerebrovascular, or Renal Disease without Diabetes or Hypertension	\$10,743

the preventable conditions we include, by sex and age. One striking finding in this table is the much larger share of spending on preventable causes for males (27.9%) than for females (18.2%). While total CalPERS spending on females (\$914 million) exceeds that on males (\$702 million), the difference in the share attributable to preventable chronic disease makes the amount of preventable costs larger among men (\$195 million) than women (\$166 million). The age pattern of this disparity suggests that part of this difference in shares is due to the portion of total spending on women that is due to childbirth. However, the share of male spending on preventable causes exceeds that of women in every age group except for children. The second pattern that emerges from this table is the increasing fraction of medical spending on preventable causes that is

**Table 2. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, by Sex and Age, 2008**

Sex / Age	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total</b>	<b>555,770</b>	<b>2,908</b>	<b>1,616,103</b>	<b>6.5%</b>	<b>15.9%</b>	<b>22.4%</b>	<b>362,047</b>
0-19	181,369	1,475	267,582	0.5%	4.6%	5.1%	13,565
20-29	60,494	2,137	129,262	1.7%	7.2%	8.8%	11,417
30-39	77,484	2,625	203,406	4.8%	10.4%	15.2%	30,913
40-49	105,362	3,285	346,161	8.1%	15.9%	24.0%	83,168
50-59	98,793	4,553	449,793	9.8%	20.7%	30.5%	137,121
60-69	29,726	6,438	191,363	9.2%	29.5%	38.7%	74,007
70+	2,542	11,226	28,537	5.8%	35.7%	41.5%	11,856
<b>Female</b>	<b>285,226</b>	<b>3,205</b>	<b>914,013</b>	<b>5.3%</b>	<b>13.0%</b>	<b>18.2%</b>	<b>166,462</b>
0-19	88,693	1,532	135,845	0.4%	4.4%	4.9%	6,222
20-29	31,274	2,807	87,786	1.2%	6.5%	7.7%	6,742
30-39	42,063	3,425	144,065	3.1%	8.9%	12.0%	17,262
40-49	56,637	3,825	216,634	5.9%	13.4%	19.3%	41,906
50-59	52,209	4,604	240,347	8.7%	17.9%	26.6%	63,909
60-69	13,501	5,999	80,998	9.4%	24.1%	33.4%	27,065
70+	849	9,821	8,338	7.1%	28.4%	35.5%	2,956
<b>Male</b>	<b>270,543</b>	<b>2,595</b>	<b>702,090</b>	<b>8.0%</b>	<b>19.3%</b>	<b>27.9%</b>	<b>195,585</b>
0-19	92,676	1,421	131,737	0.5%	4.8%	5.3%	6,943
20-29	29,220	1,419	41,476	2.7%	8.6%	11.3%	4,675
30-39	35,421	1,675	59,341	8.8%	14.2%	23.0%	13,651
40-49	48,725	2,658	129,527	11.8%	20.1%	31.9%	41,262
50-59	46,584	4,496	209,446	10.9%	24.0%	35.0%	73,212
60-69	16,225	6,802	110,365	9.1%	33.4%	42.5%	46,943
70+	1,692	11,938	20,199	5.3%	38.8%	44.1%	8,900

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

**Table 3. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, by Race and Ethnicity, 2008 (Employees Only)**

Race / Ethnicity	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total</b>	<b>224,465</b>	<b>3,500</b>	<b>785,635</b>	<b>8.9%</b>	<b>19.5%</b>	<b>28.4%</b>	<b>222,851</b>
Native American	1016	3,773	3,833	9.3%	20.3%	29.6%	1,136
Asian	19,379	2,612	50,625	10.7%	23.5%	34.2%	17,304
African American	23,285	3,700	86,149	11.1%	18.3%	29.3%	25,283
Filipino	9,790	3,020	29,566	15.8%	22.7%	38.5%	11,379
Latino	45,249	2,928	132,471	11.7%	18.4%	30.1%	39,908
Pacific Islander	629	4,340	2,730	10.6%	16.2%	26.7%	730
Non-Hispanic White	110,639	3,867	427,797	7.2%	19.2%	26.4%	112,967
Other	5,732	3,457	19,814	8.0%	19.5%	27.5%	5,448
Unknown	8,746	3,733	32,651	6.2%	20.4%	26.6%	8,696

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

associated with age. Where "preventable" spending by women and men in their 30s is 12.0 and 23.0 percent of total spending, respectively, the shares for those in their 60s are 33.4 and 42.5 percent, respectively.

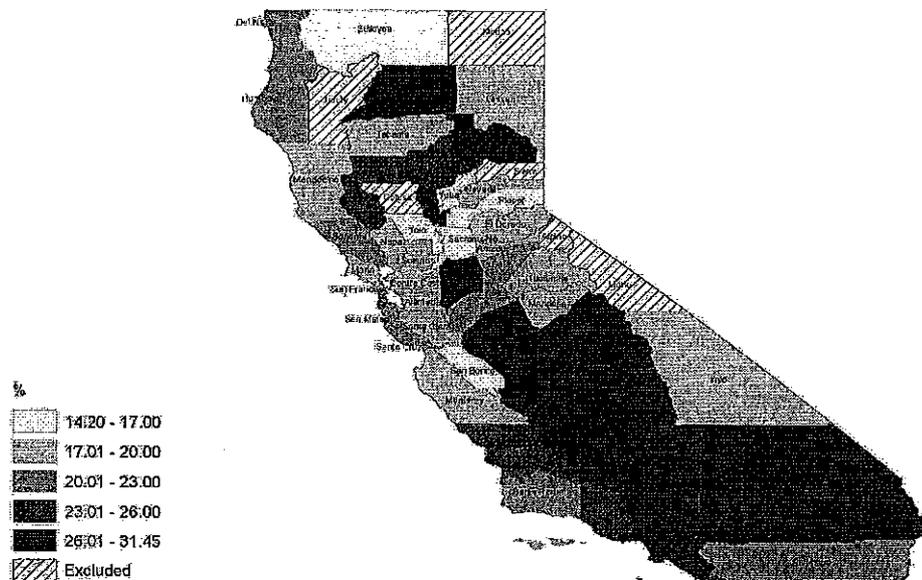
Table 3 shows the same calculations by race and ethnicity. The groups with the highest shares of spending that is attributable to preventable causes are Filipinos (38.5%) and Asians (34.2%), and the groups with the lowest such shares are non-Hispanic whites (26.4%) and Pacific Islanders (26.7%). However, the largest portion of preventable expenditures (\$113 million) was spent on behalf of non-Hispanic white employees because of their greater representation in the state workforce.

### Geography

A second set of analyses examined geographic differences in expenditures on the included preventable illnesses. Table 4 displays these calculations by county of residence of CalPERS members. Figure 1 displays the total share of expenditures attributable to Cluster I and II diseases.

The counties with the highest total spending on these conditions were Sacramento (\$63.7 million), Los Angeles (\$43.8 million), San Bernardino (\$19.7 million), Orange (\$16.7 million), and San Diego (\$16.1 million), where there are the largest numbers of CalPERS members. The share of all expenditures that are

**Figure 1. Percent of CalPERS expenditures attributable to diseases targetable by lifestyle interventions, by county, 2008**



Note: We exclude counties with less than \$1,000,000 total CalPERS payments.

**Table 4. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, by County of Residence, 2008**

County	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total</b>	<b>555,770</b>	<b>2,908</b>	<b>1,616,103</b>	<b>6.5%</b>	<b>15.9%</b>	<b>22.4%</b>	<b>362,047</b>
Alameda	13,967	3,388	47,321	6.0%	13.9%	19.9%	9,415
Alpine	44	2,538	112	*	*	*	*
Amador	2,286	2,985	6,824	5.9%	13.6%	19.5%	1,330
Butte	6,385	3,110	19,860	6.4%	18.6%	25.0%	4,958
Calaveras	1,284	3,638	4,672	5.5%	16.3%	21.8%	1,018
Colusa	221	4,267	943	*	*	*	*
Contra Costa	9,119	3,228	29,434	5.9%	14.0%	19.9%	5,866
Del Norte	3,394	3,693	12,535	5.2%	14.9%	20.1%	2,520
El Dorado	6,939	3,214	22,301	5.0%	12.8%	17.8%	3,969
Fresno	22,113	2,524	55,813	7.3%	19.6%	26.9%	15,011
Glenn	335	4,159	1,393	4.9%	18.7%	23.6%	329
Humboldt	4,530	2,653	12,017	7.2%	15.1%	22.3%	2,681
Imperial	7,893	1,976	15,599	10.5%	19.9%	30.4%	4,743
Inyo	692	3,865	2,674	6.5%	11.7%	18.3%	489
Kern	22,052	2,174	47,940	8.5%	21.2%	29.7%	14,219
Kings	8,433	2,508	21,149	8.6%	19.4%	28.1%	5,937
Lake	693	3,209	2,224	5.4%	17.7%	23.1%	514
Lassen	6,002	2,793	16,766	4.8%	12.9%	17.8%	2,982
Los Angeles	59,104	2,406	142,223	9.0%	21.9%	30.8%	43,841
Madera	4,062	2,418	9,824	7.7%	23.8%	31.5%	3,090
Marin	1,941	3,563	6,915	3.2%	15.4%	18.6%	1,289
Mariposa	466	2,561	1,193	4.1%	15.3%	19.4%	232
Mendocino	1,018	3,368	3,429	5.8%	12.5%	18.3%	627
Merced	2,842	2,914	8,282	7.6%	22.4%	30.0%	2,484
Modoc	270	1,920	518	*	*	*	*
Mono	193	3,909	754	*	*	*	*
Monterey	7,867	4,054	31,896	6.8%	12.9%	19.7%	6,298
Napa	3,809	3,273	12,466	4.9%	12.6%	17.6%	2,194
Nevada	1,374	3,135	4,307	5.9%	13.0%	18.9%	815
Orange	20,409	2,786	56,855	8.0%	21.4%	29.4%	16,728
Placer	12,972	3,826	49,629	3.2%	11.0%	14.2%	7,050
Plumas	398	3,055	1,216	4.0%	22.1%	26.1%	317
Riverside	25,266	2,457	62,071	7.1%	15.6%	22.7%	14,097
Sacramento	112,369	3,350	376,450	4.9%	12.0%	16.9%	63,715
San Benito	473	3,352	1,585	5.0%	12.0%	17.0%	269
San Bernardino	31,560	2,348	74,109	8.4%	18.2%	26.6%	19,730
San Diego	25,020	2,641	66,074	6.8%	17.6%	24.4%	16,147
San Francisco	7,064	2,912	20,570	6.6%	15.8%	22.4%	4,608
San Joaquin	10,207	2,955	30,160	7.3%	19.1%	26.4%	7,950
San Luis Obispo	16,886	2,905	49,052	6.7%	17.8%	24.5%	12,025
San Mateo	4,844	3,235	15,669	7.5%	15.1%	22.6%	3,544
Santa Barbara	2,366	3,252	7,694	6.4%	14.4%	20.8%	1,602
Santa Clara	9,508	3,465	32,947	6.1%	13.8%	19.9%	6,559
Santa Cruz	1,772	3,493	6,190	4.6%	15.9%	20.5%	1,268
Shasta	4,312	2,342	10,100	7.5%	18.6%	26.0%	2,628
Sierra	77	4,130	318	*	*	*	*
Siskiyou	1,073	3,121	3,348	3.7%	11.4%	15.2%	509
Solano	14,477	3,184	46,089	6.2%	11.1%	17.3%	7,958
Sonoma	7,955	3,311	26,336	5.0%	15.3%	20.2%	5,327
Stanislaus	5,355	2,790	14,940	5.6%	17.3%	22.9%	3,417
Sutter	2,389	3,183	7,603	5.7%	24.3%	29.9%	2,276
Tehama	927	3,015	2,795	6.2%	12.0%	18.2%	509
Trinity	236	1,608	380	*	*	*	*
Tulare	15,099	2,556	38,591	7.9%	22.6%	30.4%	11,749
Tuolumne	1,862	3,003	5,591	5.2%	14.7%	19.9%	1,114
Ventura	6,238	2,856	17,815	7.9%	17.8%	25.7%	4,576
Yolo	9,739	3,531	34,392	4.2%	11.7%	15.9%	5,475
Yuba	1,633	3,532	5,768	4.6%	10.6%	15.2%	879
Other Place (incl. other states)	3,963	2,620	10,383	7.6%	18.0%	25.6%	2,656

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

\* Due to potentially unreliable estimates, we exclude counties with less than \$1,000,000 total CalPERS payments from these calculations.

attributable to preventable illness, excluding counties with less than \$1 million in total CalPERS expenditures, ranged from 14.2 percent in Placer to 31.5 percent in Madera. The five counties with the largest proportions were Madera (31.5%), Los Angeles (30.8%), Tulare (30.4%), Imperial (30.4%), and Merced (30.0%). Counties with the lowest proportions were Placer (14.2%), Siskiyou (15.2%), Yuba (15.2%), Yolo (15.9%), and Sacramento (16.9%).

#### Department/Agency

Table 5a displays these calculations across the 19 largest agencies/departments covered by CalPERS. The three departments with the largest shares of total expenditures for the selected preventable diseases, counting both employees and dependents, are the Department of Developmental Services (27.3%), the California State University system (26.1%), and the Department of Mental Health (25.5%). The three departments with highest total expenditures on preventable disease are the Department of Corrections (\$83.0 million), the California State University system (\$54.1 million), and the Department of Transportation (\$33.7 million). The departments with the lowest percentage of expenditures on these illnesses are the California Highway Patrol (16.4%), the Department of Forestry and Fire Protection (16.7%), the Department of Justice (19.1%), and the Department of Water Resources (19.2%).

To aid in determining the desirability of using workplace prevention interventions in these agencies and departments, we have also made these calculations for employees separately from their dependents, shown in tables 5b and 5c. For employees (table 5b), the average share of total spending attributable to preventable illness statewide is 28.4%. The departments with the highest shares for employees are the Departments of Developmental Services (37.4%), Transportation (32.1%), and Corrections (31.8%). The departments with the lowest shares are the Franchise Tax Board (22.7%), the Department of Health Care Services (24.0%), and the Department of Public Health (24.1%).

For dependents (table 5c), the average share attributable to preventable disease is 16.8%, smaller than the 28.4% for employees. Rankings of departments also show somewhat different patterns. The department where dependents have the highest share of spending attributable to preventable causes is the Department of Health Care Services (22.3%), which has one of the lowest shares for employees. The Cal State System (22.1%) and the State Compensation Insurance Fund (21.3%) also have relatively high shares for dependents. The departments with the lowest shares for dependents are the Department of California Highway Patrol (11.1%), the Department of Forestry and Fire Protection (11.3%), and the Departments of Justice and Water Resources (13.4% each).

**Table 5a. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, for Largest Departments and Agencies, for Employees and Dependents, 2008**

Department / Agency	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total</b>	<b>555,777</b>	<b>2,908</b>	<b>1,616,103</b>	<b>6.5%</b>	<b>15.9%</b>	<b>22.4%</b>	<b>362,047</b>
Board of Equalization	7,435	2,805	20,857	6.7%	13.6%	20.3%	4,238
California State University System	75,899	2,727	206,939	6.7%	19.4%	26.1%	54,069
Dept of California Highway Patrol	30,039	2,552	76,656	4.2%	12.2%	16.4%	12,574
Dept of Corrections	139,811	2,628	367,420	6.8%	15.7%	22.6%	82,950
Dept of Developmental Services	11,267	3,226	36,351	7.8%	19.5%	27.3%	9,909
Dept of Forestry and Fire Protection	15,074	2,290	34,525	4.7%	12.0%	16.7%	5,749
Dept of General Services	6,365	2,934	18,674	6.5%	16.6%	23.1%	4,318
Dept of Health Care Services	5,438	3,571	19,417	6.3%	16.9%	23.2%	4,511
Dept of Justice	9,491	3,160	29,996	5.1%	14.0%	19.1%	5,721
Dept of Mental Health	20,897	3,004	62,779	7.8%	17.8%	25.5%	16,030
Dept of Motor Vehicles	17,055	3,157	53,846	7.5%	15.1%	22.6%	12,164
Dept of Public Health	5,524	3,697	20,422	5.7%	15.1%	20.8%	4,247
Dept of Social Services	7,355	3,460	25,445	6.5%	14.7%	21.1%	5,382
Dept of Transportation	49,392	2,881	142,290	7.1%	16.6%	23.7%	33,743
Dept of Water Resources	6,086	3,018	18,366	5.8%	13.3%	19.2%	3,519
Dept of Youth Authority	6,581	2,969	19,540	6.8%	14.6%	21.4%	4,187
Employment Development Dept	14,332	3,700	53,026	6.8%	16.4%	23.2%	12,321
Franchise Tax Board	9,729	2,904	28,257	6.5%	13.6%	20.0%	5,660
State Compensation Insurance Fund	15,498	3,262	50,560	7.2%	16.9%	24.1%	12,189
Other Agencies	102,509	3,226	330,738	5.7%	15.0%	20.7%	68,566

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

**Table 5b. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, for Largest Departments and Agencies 2008 (Employees Only)**

Department / Agency	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total (Employees)</b>	<b>224,466</b>	<b>3,500</b>	<b>785,635</b>	<b>6.9%</b>	<b>19.5%</b>	<b>28.4%</b>	<b>222,851</b>
Board of Equalization	3,182	3,518	11,194	8.3%	16.1%	24.4%	2,732
California State University System	34,105	3,321	113,272	8.2%	21.2%	29.4%	33,331
Dept of California Highway Patrol	9,989	2,417	24,146	8.7%	19.2%	27.9%	6,728
Dept of Corrections	49,614	3,155	156,539	10.9%	20.9%	31.8%	49,778
Dept of Developmental Services	4,453	3,733	16,621	11.5%	25.9%	37.4%	6,212
Dept of Forestry and Fire Protection	6,358	1,681	10,688	9.4%	19.1%	28.5%	3,045
Dept of General Services	2,726	3,364	9,171	9.4%	19.7%	29.1%	2,671
Dept of Health Care Services	2,509	4,423	11,097	7.2%	16.8%	24.0%	2,658
Dept of Justice	4,068	3,813	15,510	7.0%	17.4%	24.4%	3,780
Dept of Mental Health	8,704	3,763	32,757	10.3%	20.2%	30.5%	9,979
Dept of Motor Vehicles	7,093	4,121	29,229	9.9%	17.3%	27.1%	7,929
Dept of Public Health	2,549	4,442	11,324	6.7%	17.4%	24.1%	2,733
Dept of Social Services	3,272	3,773	12,344	8.7%	18.6%	27.3%	3,375
Dept of Transportation	18,675	3,614	67,491	10.0%	22.0%	32.1%	21,631
Dept of Water Resources	2,377	3,275	7,785	8.5%	18.5%	27.0%	2,101
Dept of Youth Authority	2,505	3,899	9,767	9.4%	18.0%	27.4%	2,674
Employment Development Dept	6,402	4,789	30,660	8.2%	18.0%	26.2%	8,021
Franchise Tax Board	4,143	3,804	15,760	7.5%	15.2%	22.7%	3,575
State Compensation Insurance Fund	6,650	4,253	28,282	8.4%	17.9%	26.3%	7,444
Other Agencies	45,091	3,814	171,996	7.3%	17.4%	24.7%	42,453

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

**Table 5c. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, for Largest Departments and Agencies, 2008 (Dependents Only)**

Department / Agency	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total (Dependents)</b>	<b>331,312</b>	<b>2,507</b>	<b>830,469</b>	<b>4.1%</b>	<b>12.6%</b>	<b>16.3%</b>	<b>139,197</b>
Board of Equalization	4,253	2,272	9,663	4.9%	10.7%	15.6%	1,507
California State University System	41,794	2,241	93,667	4.9%	17.2%	22.1%	20,738
Dept of California Highway Patrol	20,050	2,619	52,509	2.1%	9.0%	11.1%	5,846
Dept of Corrections	90,197	2,338	210,881	3.8%	11.9%	15.7%	33,172
Dept of Developmental Services	6,814	2,895	19,730	4.7%	14.1%	18.7%	3,697
Dept of Forestry and Fire Protection	8,716	2,735	23,837	2.5%	8.8%	11.3%	2,704
Dept of General Services	3,639	2,611	9,503	3.7%	13.6%	17.3%	1,647
Dept of Health Care Services	2,929	2,840	8,320	5.1%	17.2%	22.3%	1,853
Dept of Justice	5,423	2,671	14,486	3.1%	10.3%	13.4%	1,941
Dept of Mental Health	12,193	2,462	30,022	5.0%	15.1%	20.2%	6,050
Dept of Motor Vehicles	9,962	2,471	24,617	4.7%	12.5%	17.2%	4,235
Dept of Public Health	2,975	3,058	9,098	4.5%	12.2%	16.6%	1,515
Dept of Social Services	4,083	3,209	13,101	4.4%	10.9%	15.3%	2,007
Dept of Transportation	30,717	2,435	74,799	4.4%	11.8%	16.2%	12,112
Dept of Water Resources	3,709	2,853	10,580	3.8%	9.5%	13.4%	1,417
Dept of Youth Authority	4,076	2,398	9,772	4.2%	11.3%	15.5%	1,513
Employment Development Dept	7,930	2,820	22,366	5.0%	14.2%	19.2%	4,300
Franchise Tax Board	5,586	2,237	12,497	5.2%	11.5%	16.7%	2,085
State Compensation Insurance Fund	8,848	2,518	22,279	5.6%	15.7%	21.3%	4,746
Other Agencies	57,418	2,765	158,742	4.1%	12.4%	16.5%	26,113

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

**Table 6. CalPERS State Active Health Expenditures Attributable to Chronic Diseases Targetable by Lifestyle Interventions, by Health Plan, 2008**

Health Plan	Number of Persons Covered	Average Spending per Person (\$)	Total CalPERS Payments (\$000)	Share Attributable to Preventable Diseases			Preventable Costs (\$000)
				Cluster I <sup>a</sup>	Cluster II <sup>b</sup>	Total	
<b>Total</b>	<b>555,777</b>	<b>2,908</b>	<b>1,616,103</b>	<b>6.5%</b>	<b>15.9%</b>	<b>22.4%</b>	<b>362,047</b>
Blue Shield Access+	129,955	3,311	430,292	6.9%	18.1%	25.0%	107,541
Blue Shield NetValue	65,875	3,141	206,915	7.2%	18.2%	25.4%	52,600
CAHP	20,789	2,376	49,395	3.6%	12.9%	16.5%	8,128
CCPOA	32,616	2,000	65,243	7.6%	15.5%	23.2%	15,128
Kaiser	209,416	2,528	529,386	5.6%	9.3%	14.9%	78,787
PERS Choice	90,934	3,353	304,888	7.0%	22.4%	29.5%	89,843
PERS Select	2,521	2,468	6,222	7.0%	17.4%	24.4%	1,520
PERSCare	3,192	7,050	22,503	6.6%	30.0%	36.7%	8,252
PORAC	454	2,768	1,257	4.2%	15.4%	19.6%	247

a. Uncomplicated hypertension and/or diabetes

b. Heart disease, cerebrovascular disease, or renal disease, with or without hypertension or diabetes

## Health Plan

Finally, table 6 disaggregates expenditures across the nine health plans available to employees within CalPERS<sup>28</sup> in 2008. There may be opportunities for individual plans within the CalPERS system to increase member participation in prevention programs, as UnitedHealth has done by reimbursing providers of lifestyle coaching to improve diet and increase physical activity to reduce type 2 diabetes among their members. Therefore, we identify plans with the most to gain from supporting members' efforts to improve their health. Kaiser, the largest plan offered by CalPERS in terms of total payments, has the lowest share of expenditures going to preventable illness. Thus, it is only the third largest in terms of excess dollars spent on members with preventable illness (\$78.8 million). Blue Shield Access+ has the highest expenditures (\$107.5 million) on preventable illness. The plan with the highest proportion spent on these illnesses is PERSCare (36.7%), followed by PERS Choice (29.5%).

## Discussion

This analysis provides parameters that could be useful to CalPERS in setting priorities and targeting initiatives to improve its members' health while restraining medical care cost growth. Our excess spending estimates measure the potential benefits that could accrue to CalPERS from reduced medical care costs. They suggest that even a 1 percent reduction among State Active members in the prevalence of the common conditions we include in our analysis ultimately could save \$3.6 million per year. The literature suggests that actual reductions of 5 percent to 15 percent are feasible,<sup>29</sup> depending on how well-designed and targeted interventions are, indicating potential savings of \$18 million to \$54 million annually.

Our estimates are conservative because they do not include other diseases that may be affected by interventions to improve diet, increase exercise, and

reduce smoking, and we do not capture medical costs associated with "predisease," or reduced severity of the conditions we include. Interventions available to the whole CalPERS population, or even to those at high risk for disease onset, could affect these other costs, as well as those associated with diagnosed disease.

The estimates also do not include any savings from productivity gains in a healthier workforce. Other research suggests that other benefits, such as improved productivity at work and reduced absenteeism costs, could be nearly as large, as noted above. These benefits would largely accrue to state government and other CalPERS employers.

Finally, these estimates are also conservative because they are limited to current employees and their dependents and exclude retirees. Even if interventions are targeted only at active employees, those receiving the intervention who are close to retirement will likely have lower rates of health spending in retirement. While we do not have direct evidence in these data on the health of CalPERS retirees compared to workers at similar ages, we can make informed speculation as to the size of this impact. Higher per capita spending and the larger share of spending on preventable disease at older ages (table 2) suggest that savings from prevention efforts among retirees could be substantial and that prevention activities for active employees have the potential to reduce the cost of retiree health care in the long run.

It is beyond the scope of this report to identify which interventions might be most appropriate for the various CalPERS populations. Different interventions have different costs and benefits. The Community Preventive Services Task Force web site has a carefully selected list of effective interventions.<sup>30</sup> In addition, the reviews cited in the introduction to this report provide analysis of programs and extensive bibliographies to help guide program decisions.<sup>31</sup> The most effective interventions are those that are carefully tailored to the target population. The breakdowns of the CalPERS population

by demographics, geography, health plan, and agency/department provide ways for CalPERS to make decisions about programs that will best suit the target populations.

The populations with the highest share of spending related to preventable conditions have the potential to yield the greatest return on investment in prevention. However, populations with low shares of spending on preventable conditions may also provide valuable information about prevention by shedding light on what works. For example, health plans or employers with low shares of spending on preventable conditions may already have in place wellness promotion benefits or workplace programs that support employees' health. CalPERS members in counties with low shares may

have greater access to fitness opportunities or recreation activities. By identifying such characteristics, CalPERS may better understand what might benefit other health plans, employers, or geographic areas. In this sense, this analysis provides a starting point for CalPERS as it seeks to understand and promote ways to improve the health of its members and so help limit the growth of medical care costs.

The rates of effectiveness demonstrated by the YMCA implementation of the Diabetes Prevention Program are consistent with prevalence reductions of 15%. <http://www.thecommunityguide.org/worksite/index.html> See especially Baicker et al. 2010 (footnote 16) and Goetzel et al., 2008 (footnote 18).

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27. Because the race and ethnicity data are obtained from the State Controller's Office, we have this information for employees but not for dependents. Thus a large portion of observations are reported as having "Unknown" race and ethnicity.
28. Note that the three plans for Association members are not available to all CalPERS members.
29. The rates of effectiveness demonstrated by the YMCA implementation of the Diabetes Prevention Program are consistent with prevalence reductions of 15%.
30. The Community Guide, Worksite Health Promotion, available at <http://www.thecommunityguide.org/worksite/index.html>
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*The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.*

### **About the Authors and Acknowledgements**

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# STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

With passage of the Affordable Care Act, the stakes for children's coverage perhaps have never been higher. Children and youth potentially have much to gain in coverage for themselves and especially for their parents. At the same time, they also have much to lose as attention shifts, and gaps or unintended consequences of reforms focused primarily on adults surface. To examine these issues and options for keeping children's coverage strong in the future, NASEHP initiated discussions with both Medicaid expansion and separate CHIP program directors. This *State Health Policy Briefing* highlights themes for ongoing discussions. Focus on your key considerations for children's coverage that NASEHP and most CHIP directors believe policymakers should take into account in making policy decisions that may affect children's coverage.

NATIONAL ACADEMY  
for STATE HEALTH POLICY

# Briefing

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## Keeping Children's Coverage Strong in the Context of the Affordable Care Act: Perspectives from State Children's Health Insurance Leaders

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More than 9 out of 10 children in the United States are insured' — an accomplishment that owes much to the bipartisan creation and successful implementation of the state-federal Children's Health Insurance Program (CHIP). Beginning in 1997 and continuing through today, CHIP focused the nation's and the states' attention on providing good health insurance coverage for children. CHIP has provided coverage for millions of previously uninsured children and driven successes in increasing enrollment of lower income eligible children in its older and larger sister program, Medicaid. Due to efforts over the past 15 years or more, some states now are close to having nearly all their children covered by public or private health insurance. With the passage of the Affordable Care Act (ACA), the stakes for children's coverage have perhaps never been higher. Children and youth potentially have much to gain in coverage for themselves and especially for their parents. At the same time, they also have much to lose as attention shifts, and gaps or unintended consequences of reforms focused primarily on adults surface.

To examine the issues and options for keeping children's coverage strong in future, the National Academy for State Health Policy (NASHP) initiated discussions with both Medicaid expansion and separate CHIP program directors through a workgroup of 16 states, as well as at an annual convening in October 2011 attended by 35 state directors. Since shortly after enactment of CHIP, with the support of the David and Lucile Packard Foundation, NASHP has reported on and supported states' work in increasing health insurance coverage for children through CHIP, Medicaid, and public-private strategies.<sup>2</sup>

CHIP directors from states with varying CHIP program types, populations, geography, political leanings, and fiscal situations worked with NASHP from early 2011 to early 2012 to inform this brief. The workgroup's primary goal was to facilitate a process through which CHIP directors could share their perspectives and identify common and diverging points of view regarding key policy questions and options for meeting children's coverage needs in the context of ACA implementation and beyond. This brief reflects key perspectives of most CHIP directors, but does not reflect the views of any one or all states.

Both state and federal policymakers will continue making policy decisions about the ACA, as well as more broadly about health care priorities, budgets, and costs in 2012 and beyond. Many of these decisions will have major implications for children's coverage, and by extension, for children's health and well-being. The purpose of this brief is to highlight four key considerations for children's coverage that NASHP and most CHIP directors believe policymakers should take into account when making health policy decisions that may affect children's coverage. Recognizing that health care reform policies and systems are very much in process, NASHP and state officials intend to continue to contribute further information and analyses of issues and options to inform decision-making as it affects children's coverage.

### **1. The nation's focus on children's coverage during the past 15 years has yielded tremendous success that we do not want to put at risk.**

CHIP was created in 1997 to provide quality health coverage for children in families that earned too much to qualify for Medicaid but did not have access to affordable private coverage. In many ways, it was a forerunner for and an incremental step toward the coverage provisions for uninsured adults in the ACA. CHIP gave states the option to expand their Medicaid programs, create new coverage programs within broad federal parameters, or combine both approaches.

Over the years, the CHIP program has succeeded in increasing children's health insurance coverage. CHIP has been overwhelmingly successful in reducing the number of low-income uninsured children, spurring enrollment not only in CHIP, but also in Medicaid. In 1997, before states began implementing CHIP programs, 23 percent of children at or below 200 percent of the Federal Poverty Level (FPL) were uninsured.<sup>3</sup> By 2010 the rate had fallen to 10 percent,<sup>4</sup> and 85 percent of children eligible for these programs were enrolled.<sup>5</sup> Furthermore, CHIP and Medicaid helped reduce the uninsured rate among children of color, with the greatest impact on Hispanic children. From 1997 to 2010, the rate of uninsured Hispanic children dropped from more than one in three to less than one in five. Among African-American children, the rate dropped from nearly 22 percent to under 12 percent.<sup>6</sup> The most recent data indicate that CHIP covers 8 million children and Medicaid covers nearly 36 million.<sup>7</sup> Together, these programs cover more than half of all children nationally.<sup>8</sup> It is notable that recent gains in CHIP and Medicaid coverage for children occurred at the same time as private market coverage, particularly employer-based coverage, continued to erode.<sup>9</sup>

CHIP also has succeeded in improving access, utilization, and outcomes of care.<sup>10,11</sup> For example, in 2010, 36 states reported that more than 95 percent of children in CHIP aged 12-24 months had at least one visit to a primary care physician (PCP), comparable to children with private insurance.<sup>12</sup> A 2012 Medicaid and CHIP Payment and Access Commission report to Congress noted that children enrolled in Medicaid and CHIP have better access to care compared to uninsured children. Medicaid and CHIP children are more likely to have a usual source of care, a well-child visit in the past year, and seen a specialist in the past year, and less likely to have had their medical care delayed.<sup>13</sup>

State-focused studies also demonstrate the positive impact CHIP has had on care management, for example for children with asthma. A study demonstrated that children with asthma who were newly enrolled in the New York CHIP program had fewer emergency department visits and asthma-related hospitalizations, and had better access to a usual source of care after being enrolled for a year.<sup>14</sup> A study of the Alabama CHIP program provided similar results and found an associated cost savings due to improved disease management resulting from continuous enrollment for three years.<sup>15</sup>

In addition, CHIP enrollment has been found to improve school performance. Studies have shown that children enrolled in CHIP demonstrated improvements in their ability to pay attention in

class, school attendance, reading scores, and participation in school and normal childhood activities.<sup>16</sup>

While CHIP's enactment can be viewed as an incremental step toward addressing the broader problem of the uninsured, it also was driven strongly by a focus on meeting the specific needs of children. Supporters recognized the particular vulnerability of children and the value of investing in health coverage that could promote their healthy growth and development and prevent conditions that could affect adult health and productivity. Continuing to recognize and explicitly address children's unique vulnerabilities and health care needs is imperative to maintaining and achieving further progress in ensuring children have coverage that provides access to quality care that promotes healthy growth and development.

## **2. Key policy and operational issues in health reform implementation raise uncertainties for children's coverage in future.**

While the ACA holds the promise of major coverage gains for the currently uninsured, many details remain to be worked out to develop new policies, systems, and processes to implement the law's provisions. Federal and state officials understandably are focusing heavily on enrollment of newly eligible populations, who are primarily adults. These efforts should have a beneficial impact on children, both directly in improved systems and indirectly in improved coverage and access for their parents. Studies have shown that gains in coverage for parents result in gains in coverage for children and that the health of the parent is a major determinant in the physical and mental health of the family.<sup>17,18</sup> However, with the focus on the newly eligible comes the risk of unintended consequences for the currently eligible and currently enrolled — particularly children.

Some of the concerns for children's coverage center around a set of issues related to the affordability of subsidized coverage in the new insurance exchanges, especially when compared to CHIP. In a study of 17 states, the median actuarial value of CHIP plans ranged from 98 to 100 percent, meaning that families in these states paid, on average, up to 2 percent out of pocket.<sup>19</sup> While CHIP now provides affordable coverage for eligible children, if CHIP is not funded beyond 2015 and if identified issues around affordability of exchange coverage are not remedied, the lack of affordable options for families is likely to result in a decline in coverage of children.

One concern is that proposed rules for determining premium subsidies do not take into account the other premiums fami-

lies need to pay, including those for CHIP. As a result, those families who qualify to purchase insurance through exchanges beginning in 2014, and who live in the 30 states where CHIP premiums apply, could be subjected to "premium stacking," meaning they may need to pay premiums for CHIP as well as for the health plan they select in the exchange.<sup>20</sup>

The other concern about affordability of subsidized exchange coverage is that under proposed rules, only the cost for insuring the employee, rather than the whole family, is considered in determining if employer-sponsored insurance (ESI) coverage is affordable. The proposed exchange eligibility rule defines affordable ESI as not exceeding 9.5 percent of household income.<sup>21</sup> Thus, if an employee has to pay more than 9.5 percent of income for a family premium, the employer coverage will still be considered affordable and the employee will be ineligible for premium tax credits. The average cost of ESI family coverage is about 30 percent of median household income.<sup>22</sup> An estimated 3.9 million dependents, including spouses as well as children, will be excluded from receiving premium tax credits that are intended to increase the affordability of exchange coverage.<sup>23</sup>

There are also other specific concerns for children's coverage in the transition to new exchange and Medicaid policies and systems. As a result of new Medicaid eligibility rules aimed at simplification, in 2014 some children will move from CHIP to Medicaid and some from Medicaid to CHIP. This shifting creates the potential for some children to get "lost in the cracks" during this transition. Estimating exactly how many children may move and in which way is challenging, given current variation in state policies as well as the various family situations of children, which are more complicated than for adults. These situations can involve stepparents, child custody agreements, different insurer service areas for custodial parents, seasonally-employed parents, non-parental guardians, and mixed-status families in which a parent is not lawfully present but has citizen children. Even without these situations, most parents who are eligible for subsidized coverage in exchanges will have children eligible for Medicaid and CHIP.<sup>24</sup> Ensuring that new policies and systems do not create new gaps or complicate—rather than simplify and streamline—coverage is a major challenge for states and the federal government. Such a challenge requires sufficient time to plan, test and evaluate new systems before relying on them fully, particularly where vulnerable children are concerned.

States faced significant design and implementation challenges even with the much smaller and more focused new CHIP program 15 years ago. Many states opted at first to operate Medicaid expansion CHIP programs, allowing them to use an

existing program structure, while they took the time necessary to design and implement the separate programs that today operate in 40 states. The ACA extended CHIP funding until September 2015, raised the CHIP federal match in 2016, and required state maintenance of CHIP and Medicaid children's eligibility and enrollment policies through September 2019, signaling an intent for CHIP and Medicaid coverage for children to remain in place through the transition to new systems. Based on their experience in policy and systems development, and on concerns about when and how these uncertainties will be resolved, many CHIP directors believe it may be important to ensure continuation of the program until and unless it is clear that other coverage alternatives are working smoothly to provide children with affordable, quality coverage comparable to what they receive under CHIP.

Federal policies have recognized that full implementation of the ACA requires some interim approaches and extended timelines to support successful state implementation. CMS has allowed an additional two years beyond the start of expanded eligibility—through 2015—for states to obtain higher Medicaid matching funds for eligibility systems development.<sup>25</sup> Additionally, federal rules that allow for conditional health insurance exchange approvals and for federal-state partnership approaches provide states with more options and time for full implementation of exchange requirements.<sup>26</sup>

CHIP implementation experience demonstrates that building new programs presents unanticipated challenges and that change is harder than expected. As focus shifts to covering a large newly eligible adult population, it is important to ensure that children's coverage gains are built on and not lost either in the transition to or during the ongoing implementation of new coverage policies and systems. Gaining assurance that new coverage options, eligibility rules, enrollment systems, policies and procedures, benefits, plans and provider networks are all working well for children will take some time. This need to test and adjust new policies and systems as needed argues for extending CHIP funding beyond September 2015 to ensure that children have an effective, trusted option in place as the bugs are worked out in new and expanded options.

### **3. State flexibility in design and administration remains key to keeping children's coverage strong while integrating it with new coverage options.**

In addition to its focus on the needs of its target population and its explicit aim of increasing insurance coverage, another CHIP hallmark is the flexibility it accords states. This flexibil-

ity allowed states to tailor programs based on their cultures, populations, health care delivery systems, and finances. This flexibility also enabled many states to innovate in aspects of program design and implementation—in outreach, enrollment, affordability, benefits, plans, and provider networks. Many of these innovations have been adopted by state Medicaid programs, and are relevant to expanding Medicaid coverage for adults, developing health insurance exchanges and qualified health plans, and creating Basic Health Programs in states electing this latter option.<sup>27</sup>

Continued flexibility is needed to allow states to effectively maintain and further children's coverage gains in the context of new individual and family coverage requirements, options, policies, and systems. States will vary in the ways in which they implement new coverage expansions and options, and the timetables on which they phase in optional changes over time. These timelines should allow for careful advance planning as well as implementation assessment of how children's coverage needs are met, whether through Medicaid, separate CHIP programs, exchanges, or other options.

Safeguarding children's coverage and maintaining the program structures that are working now will be important through the transition to new coverage options. At the same time, these new options may provide the opportunity to consider innovative ways to maintain and improve children's coverage in future. For example, states have raised the possibility of using CHIP funds to "buy in" or subsidize coverage for children through health insurance exchange plans, similar to programs that currently allow employers or families to "buy in" to CHIP or Medicaid programs, or programs where CHIP or Medicaid assist families with premiums for private coverage. Such cross-program and public-private strategies would seem important to explore in the context of new coverage options for individuals and families. Another option might be to design Basic Health Programs, currently a state option for adult coverage, to serve children as well. Yet another idea generated among CHIP directors was the possibility of offering separate CHIP plans through health insurance exchanges. While parameters and standards would need to be set, allowing such state flexibility via waivers or new statutory options could yield innovative ways to achieve CHIP purposes and make further progress in covering children while implementing new systems that will provide coverage for families.

Such flexibility should extend to review and where needed, adjustment, in current CHIP policies and processes. For example,

in a context of near universal coverage, the common CHIP policy of requiring a waiting period before otherwise eligible children can enroll may need to be reexamined. As of January 2012, 40 state CHIP programs had waiting periods ranging from 1 to 12 months.<sup>28</sup> Waiting periods were put in place in an effort to discourage families from dropping private coverage. There is little evidence to support that waiting periods are effective in deterring families from dropping affordable private coverage for CHIP coverage.<sup>29</sup>

The flexibility accorded to states in designing their CHIP programs has contributed to their success in substantially reducing the number of uninsured children in the United States over the past 15 years, as well as in innovating new approaches to health insurance coverage. Continued state flexibility similarly could pave the way for developing, testing, and instituting innovative and effective approaches for integrating children's coverage with new options for families.

#### **4. Continued support for CHIP and Medicaid children's coverage through full implementation and assessment of new policies and systems is essential.**

Although the ACA extended CHIP program funding through September 2015, increased federal CHIP matching funds effective 2016, and required state maintenance of CHIP and Medicaid coverage for children until October 2019, substantial uncertainty exists about the future of CHIP post ACA implementation. This uncertainty, as well as the focus on implementation of ACA, can have an impact now as well as in future, slowing if not stalling state progress in covering eligible but uninsured children, as well as in making other program improvements such as improved dental coverage, that were included in CHIP reauthorization.

A 2011 analysis concluded that full implementation of the ACA could reduce the number of uninsured children by 40 percent, as well as the ranks of uninsured parents by 50 percent. However, if support for CHIP and Medicaid coverage for children is not sustained through continued funding for CHIP beyond 2015 and maintenance of Medicaid and CHIP eligibility levels and enrollment policies, the uninsurance rate

for children might be higher than it was before the ACA.<sup>30</sup>

Although funding for CHIP currently extends only until 2015, the ACA provisions related to CHIP and Medicaid coverage for children suggest intent to continue the CHIP program and Medicaid and CHIP coverage policies through a transition period of more than five years, until 2019, following implementation of new coverage options and systems in January 2014. Nonetheless, economic and political pressures have and could in the future generate policy proposals that could run counter to that intent, with potentially negative consequences for children's coverage. Most CHIP directors believe it is important to maintain the program and sufficient funding for children's coverage at least through a transition period long enough to work through the policy and operational issues of implementing new coverage programs and systems. Doing so could help states maintain and achieve further progress in providing children with the coverage they need as a foundation for growth and development into healthy, productive adults.

#### **CONCLUSION**

CHIP and Medicaid have been exceedingly successful in finding uninsured children and providing them with quality, affordable coverage. CHIP directors are clear that a strong focus on the coverage needs of children must continue in a post-reform world, and that focus should transcend political or policy debates. State flexibility in ACA, Medicaid, and CHIP implementation is essential to maintaining and furthering progress in covering children, as well as to informing and working through the design and operational issues in implementing new, as yet untested coverage mechanisms through exchanges. Maintaining CHIP and financing for CHIP and Medicaid children's coverage through the transition to full ACA implementation will help ensure that states can continue to build on the successes achieved in covering children, as they also forge ahead in covering new populations. CHIP directors look forward to continuing work with their state and federal partners to plan for children's coverage that is easily accessible, affordable, and meets children's unique health care needs.

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## **ENDNOTES**

1 Federal Interagency Forum on Child and Family Statistics, *America's Children: Key National Indicators of Well-Being, 2011* (Washington, DC: Federal Interagency Forum on Child and Family Statistics, 2011), 21.

- 2 NASHP's role has included conducting and reporting on four comprehensive surveys of both Medicaid expansion and separate CHIP programs' characteristics and activities, developing other analytic and descriptive briefs and reports on state children's coverage programs and initiatives; convening an annual meeting of state CHIP directors, hosting regular conference calls and a listserv, facilitating federal-state dialogue, and serving as an information resource for state and federal program administrators and policymakers, advocates, researchers, and other stakeholders.
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