Policy Critique

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Author Note

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In the U.S. social welfare system, managed health care is a significant portion of federal and state budgets allocated for welfare. These programs have grown steadily over the past few decades to become the primary way through which a lot of Americans obtain health care and insurance. The slower growth of private or employer-based health premiums is usually attributed to managed care provided by state and federal programs; however, the transition to these health plans have not been without criticism. In the state of California, the Medi-Cal program is the main health care insurance and management program which provides affordable care for low-income adults, families, people with disabilities, and seniors, while helping them transition to managed care. The paper will explore the history of the Medi-Cal welfare policy in California, and examine the various criticisms leveled at it from groups with competing views, exploring their alternatives to it. It will further identify the values, beliefs, and assumptions that underlie the welfare policy and evaluate it from the perspective of those it directly impacts. 306

# History of the Policy

The Medi-Cal program, in the state of California, is the largest state-based health care program in the U.S. Nearly one-third of California’s residents are insured through Medi-Cal, which remains the key source of covering individuals across the state, especially low-income families and people with disabilities. The program further covers beneficiaries of the federal sponsored Medicare program among older adults. Since a few decades, California’s social welfare policy regarding Medi-Cal has been one which encourages transition from a fee-for-service delivery system and payment towards managed care. The FFS allows those covered by Medi-Cal to see any health care provider who accepts the service, who are then reimbursed by the program. In the case of managed care, the state’s policy is to provide the same Medi-Cal benefits in exchange for capitation payments or a monthly premium for the qualifying individual.

California adopted this welfare policy in the early 1970s creating a unique structure for its managed care program, which was developed keeping into account the different financing systems and model of health care delivery within its different counties. The transition has been successful and has included nearly 10 million covered adults, seniors, children, and disabled people into a managed care program that make up nearly three-fourths of the overall enrolled beneficiaries (Tatar, Paradise, & Garfield, 2016). During the 1980s, Country Organized Health System (COHS) programs started as the first managed care programs under Medi-Cal at the county level. All citizens who were beneficiaries of Medi-Cal had to enroll in their respective counties' COHS plans, including people with disabilities and senior adults. More COHS plans were introduced by the early 1990s as managed care programs were further expanded under Medi-Cal under different programs, such as the Central California Alliance and the Partnership Health Plan.

Overall, Medi-Cal which is short for the California Medical Assistance Program is the largest health care assistance and managed care program in the state which serves a range of beneficiaries such as seniors, children in foster care, low-income families, childless adults with low incomes, pregnant women and people with disabilities. Low-income is usually defined at a certain percentage of the federal poverty level for different categories. The benefits which come as part of the program include emergency services, visits to physicians, newborn and maternity care, hospitalization, treatment for substance use disorders, mental health, vision care, dental care, as well as long-term support and care. In May 2015, nearly 32.4% of the state's population was covered by Medi-Cal (DHCS, 2016).

# Policy Criticism and Competing Views

The criticism of the Medi-Cal program stems from groups and individuals of various perspectives. Among the most prominent criticism comes from those who are either supportive of the policy in general but consider the program to be expanding too much and thus impacting other welfare programs due to budget allocation, or criticism comes from groups who are generally dismissive of state’s being responsible for social welfare in general. This form of criticism is usually directed at the policy itself highlighting various inefficiencies within these programs while criticizing revenue generation in the form of higher taxes to fund these program

Health care welfare programs that take up a significant portion of the state’s budget are criticized for their potential to cause a negative impact on the state’s long-term economic growth. When the state spends a considerable portion of its revenue on Medi-Cal, this leads to increased tax burdens, reduced employment, reduced private savings, and fiscal crises and fragility. Moreover, it creates an environment where everyone feels entitled to subsidized health services even when they are covered by other insurance programs. Another criticism of the program is the conflict between achieving low costs and high-quality care. The managed care policy leads to problems for consumers because reducing costs is often prioritized over quality health care and patient needs. At times, these have led to downgrading qualifications of the hired personnel to save money or pre-determined cut-off dates for patients. For instance, the programs have given women who gave birth a time limit on their hospital stay due to cost considerations (Jerry Marx, 2010). Furthermore, subsidizing payments and delivery impacts competition and promotes inefficiency as there is less incentive to reduce medical errors and wasteful care.

Another criticism leveled at the program is that its spending growth is leading to reduced spending on higher education funds allocated for the CSU and UC. Medi-Cal spending is outgrowing state revenue generation due to reduced federal support and growth of healthcare costs, to the extent where one-sixth of California’s welfare budget is now being allocated for Medi-Cal, thus the criticism to contain its expanding budget (Brian, 1975). Furthermore, there is criticism leveled from the cost-benefit perspective, because a great deal of the spending provides little value in terms of patient outcomes (CATO, 2017).

The policy alternative to Medi-cal is a prefunded system in which workers are encouraged to invest their income and the amount they are now paying as taxes, in their personal accounts which would be dedicated to meet their health needs after retirement. They can invest these funds into profitable avenues or augment them with other savings, while the state could make voluntary contributions to those accounts. Furthermore, private insurance is to be encouraged to cover health care costs. These would create more market competition and create an incentive for innovation and efficiency and thus lead to lower taxes and health care costs.

# The underlying beliefs and values guiding policy formation

There are a number of beliefs and values which contributed to California's health policy. Firstly, social welfare is essentially a form of social altruism that ensures their survival of society's weak members and holds the social fabric together, preventing it from fracturing along political, social or economic-stress lines. It also helps enforce social control and creates conditions that reduce the likelihood of revolt from the poor sections of the society as a result of the unequal distribution of privilege and wealth (Karger & Stoesz, 2018). A liberal welfare policy is favored by most social workers and serves the expectations of the public who demand greater benefits and services from the government. The policy is also influenced by healthcare-associated consequences and distress, in order to reduce the ill person from falling into poverty by paying for expensive health care, offsetting the lack of opportunity they had to generate a suitable income. A supply of collective resources to help individuals sustain their wellbeing and health is more favorable, especially for people living in poor conditions. Those who have less individual resources should be allowed to draw on the society’s collective resources, and make use of quality services to improve their health and well-being, like other members of the society (Lundberg, 2009). Programs such as Medi-Cal improved access to health coverage for such people and reduced insurance premiums at the same time.

# Impact of the Policy on the affected People

Although certain challenges exist to make health programs adequate to serve the needs of the beneficiaries, the program has visibly brought a number of benefits, especially to the low-income strata. A number of criticisms leveled at the program can be addressed by engaging all stakeholders in the planning process, while ensuring that beneficiaries are provided assistance with regards to their options and right. Data analytics and information systems for performance improvement and oversight could make the managed care transition better and reduce inefficiencies within the system.

As part of Medi-Cal's expansion from the implementation of the ACA, nearly 2 million people in the state have gained access to health insurance and provided them with a range of health and economic benefits. This expanded coverage has led to a visible reduction in mortality rates and improved employment and education outcomes. In contrast, less coverage leads to a greater financial impact for health care institutions which affects even those who are insured. Therefore expanding coverage to include other members of the society such as undocumented migrants would reduce overall costs and financial impact, even if it requires an initial investment (McConville, Hill, Ugo, & Hayes, 2019).

Moreover, people who are otherwise not able to afford proper health care are provided coverage and thus insulated from its high costs. People are provided with preventing screenings and services, along with free annual checkups at no cost which helps prevent many illnesses that could produce a strain on the health care system if treated at a later stage. Those who are terminally ill find access to quality end-of-life care while reducing readmissions for those recovering. Thus, by helping people afford the high cost of illnesses, the Medi-Cal social welfare policy plays a key role in the health security and financial security for the people of California.

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