Healthy California:
A Proposal for Universal Health Insurance Coverage in California

Health Care Options Project
California Health and Human Services Agency

E. Richard Brown, PhD
UCLA Center for Health Policy Research
and UCLA School of Public Health

Richard Kronick, PhD
Department of Family and Preventive Medicine
UCSD School of Medicine

UCLA Center for Health Policy Research
10911 Weyburn Avenue, Suite 300
Los Angeles, CA 90024
http://www.healthpolicy.ucla.edu/

April 8, 2002
(revised)

Introduction

The lack of health insurance for more than 6.2 million California residents underscores the need for universal coverage.[1] But the lack of universal coverage creates problems for other constituencies as well. Throughout the state, hospital trauma centers and emergency rooms — the only source of needed medical services for many uninsured residents — are overwhelmed with uncompensated care; their continuing red ink and the dwindling numbers of emergency rooms put all Californians at risk.[2] In the absence of provisions to ensure universal coverage, private health insurance plans and public programs alike experience churning enrollments, creating uncertainty that makes it difficult to manage risk and make long-term investments in the health of enrollees.[3] The resulting chaotic market conditions contribute to insolvency of health plans, threaten safety net providers of care, and drive some health professionals from practice. And just when we saw progress in rising rates of employment-based health insurance coverage, escalating costs and slackening employment are once again threatening to expand the ranks of the uninsured.[4]

We propose a mixed public-private financing system to achieve universal coverage through a two-stage process. With full implementation, this combined approach will cover all citizens and legal immigrants in California and assure access to health services for all residents. Many Californians will continue to obtain employer-sponsored coverage as they do now, but all citizens and legal residents will be able to obtain publicly sponsored coverage through Healthy California, a program built on the foundation of Healthy Families and Medi-Cal. The proposed reform is summarized here and described in more detail below.

The first stage is designed to significantly expand coverage and, very importantly, create the framework that is necessary for Stage 2, in which comprehensive coverage is extended to all

citizens and legal immigrants in California. In the first stage, to be implemented soon after enactment and lasting for three years, Medi-Cal and Healthy Families will be integrated into a new program called "Healthy California." The new program will include all persons currently eligible for Medi-Cal through the children and families program, Healthy Families, and some other programs. In addition, after a federal section 1115 waiver is obtained, it will include adults without custodial children whose family incomes do not exceed 150% of poverty. A state standard for benefit packages (SSBP) will be established; it will approximate the Healthy Families benefits. The administrative capabilities for the full expansion of Healthy California in Stage 2 will also be developed during this first stage.

In the second stage, implemented three years after enactment, enrollment in Healthy California will be opened to all citizens and legal residents in the state, and a "pay-or-play" premium requirement will be implemented. In order to cover all eligible persons, coverage through Healthy California will be available without premium payment at the time of enrollment. Employers and employees will each pay a percentage of payroll for any employee or employee's dependent who is not covered by employer-sponsored insurance, Medicare, or CHAMPUS. Self-employed persons will pay a similar income-adjusted premium. The pay-or-play premium payment will finance coverage under Healthy California and encourage the continuation of employer-sponsored coverage for those who are currently satisfied with this arrangement. The first and second stages will be financed, in part, by maximizing federal matching funds for Medi-Cal and Healthy Families.

Why a Public-Private Financing System?

A pay-or-play approach utilizes both public and private sources of financing for health insurance coverage. There are at least two reasons why we propose this model rather than a purely public financing approach.

First, most Californians are satisfied with their current health care coverage — despite some very significant concerns that many people have with their health plans. In a survey conducted in 1997 for the California Managed Health Care Improvement Task Force, 76% of insured adults in California reported that they are satisfied with their health plan, including 33% who are very satisfied — despite the fact that 42 percent of insured adults reported having problems with their health plans, some of them serious ones.[5] To the extent that Californians are satisfied with their health plans, they will be less likely to support policy changes that require them to replace that plan with an untested government program. For the 11% of the general public who report believing that the health system "needs to be completely rebuilt," this proposal offers the option to join a new public program that is open to all Californians.

Second, converting the current mix of financing to an entirely public system would be a major health care reform — and such reform proposals have not fared well in American politics. Social insurance models have significant strengths,[6] but since the enactment of Medicare, neither social insurance proposals nor other proposals that require the replacement of privately financed health care coverage with publicly financed coverage have survived the political process in the United States.

Compared to parliamentary democracies that have developed national health insurance systems, the U.S. political system, institutions, and culture pose significant challenges to enacting major reforms.[7] In the United States, political power is divided between three branches

— the executive, legislative, and judiciary — rather than concentrated, making it more difficult for the government to push through controversial reforms. In parliamentary democracies, the government represents a parliamentary majority party or coalition, concentrating political power and offering fewer opportunities for blocking legislation that the government supports.

U.S. political parties are weak institutions; they lack coherence and a means of enforcing their policy platform, even when they have majority control. These weaknesses open the door wide to interest group influence in the policy process. The influence of interest groups has been greatly enhanced by the growing dominance of expensive television advertising in political campaigns and the dependence of parties and candidates on large donations from interest groups.[8]

In addition to these political barriers that affect national efforts to enact major reforms, states that try to enact universal coverage outside a national framework face additional political and economic barriers. The Employee Retirement Income Security Act of 1974 (ERISA) limits states' abilities to regulate employer health and welfare benefit programs.[9] The existence of the federal Medicare program limits a state's ability to create a coherent system of financing and delivery for all state residents. Competition among states for capital and labor impose greater constraints on tax policy than exist at the federal level, and state constitutional requirements for balanced budgets constrain state fiscal options. Limited state fiscal resources pose a daunting challenge to efforts to fund universal coverage using only state resources.

Purely publicly financed systems share with mixed and privately financed systems challenges in assuring that resources are sufficient, equitably allocated, and efficiently used to produce quality care. Programs that are supported entirely by public funds depend on political decisions for their funding, while privately financed systems depend on market forces for their

funding. Each method runs the risk of underfunding and inequitable and inefficient use of resources. [10]

All these factors compel us to propose reforms that finance health insurance with a mix of public and private funding and that offer Californians more than one option for obtaining health care coverage. This approach takes maximum advantage of federal funding streams to augment and expand the financing base for universal coverage in California.

Stage 1

In Stage 1, California will integrate the Medi-Cal children and families program, the Healthy Families Program, and Access for Infants and Mothers (AIM) into a new program called "Healthy California" (HC). The new program will create a seamless administrative mechanism that will enable eligible persons to be covered by HC with funding from any federal-match program (such as Medicaid and SCHIP) for which they may be eligible. Including AIM will enable persons currently covered under this state-funded program to qualify for federal matching payments to the state.

Second, California will establish a state standard for benefit packages (SSBP), which will approximate the benefits currently offered by Healthy Families (the benchmark for benefits in stages one and two) and which will apply to all enrollees in HC and state employees. All persons who would currently meet Medi-Cal eligibility provisions will receive any additional benefits now provided by that program; this supplementary benefits package will be called "Healthy California+Plus."

Third, in addition to covering children and their parents currently eligible for Medi-Cal or Healthy Families, and pregnant women and infants up to 300% of poverty who are currently eligible for Medi-Cal or AIM, HC will will cover uninsured adults without children living at

home who have incomes up to 150% of poverty, a group that currently has no opportunity to be covered by public programs despite their lack of access to job-based insurance. Premium payments and crowd-out protections will be the same as those for adults under the recently approved expansion of the Healthy Families program to the parents of eligible children. Finally, during the three years of Stage 1, MRMIB will develop the administrative infrastructure that will be needed to implement Stage 2.

Eligibility and Enrollment

All children and their parents who would be eligible for Medi-Cal, Healthy Families, or AIM will be eligible for HC, based on eligibility provisions in effect on January 1, 2002. Eligible persons will include children and parents with children living at home whose family incomes do not exceed 250% of the federal poverty guidelines (FPG). (These "poverty guidelines" are used to administer eligibility in federal programs and differ somewhat from the "poverty threshold" used by the Census Bureau.) Parents up to 200% of the FPG will be eligible under provisions recently approved by the U.S. Department of Health and Human Services (DHHS); HC will cover parents to 250% of the FPG — the same level as their children — when California receives federal approval for this policy that was enacted by the state in 2001.

Pregnant women and infants who are not now eligible for Medi-Cal or Healthy Families and whose family incomes do not exceed 300% of poverty also will be eligible; they currently are eligible for AIM, which is funded only by state dollars. By including them in HC, California will receive a federal match for their costs. In addition, all adults without children living at home and whose family incomes do not exceed 150% of poverty also will be eligible; they would be made eligible under a new 1115 waiver that California will seek from the DHHS.

A person's signed declaration of income will be used to determine eligibility for HC, verified by administrative records already available electronically and with monitoring and audits after eligibility has been determined. Federal law allows this easier paperless system, which 12 other states have adopted for their Medicaid or separate SCHIP programs or both — including states as different from each other as Alabama, Washington, Vermont, Florida and Michigan.[11] An applicant's assets will not be used to determine eligibility for HC. Citizenship and immigration status will similarly be established by a signed declaration with any verification conducted through administrative systems after enrollment. Exhibit 1 describes the groups that will be eligible for HC:

Exhibit 1. Eligibility for Healthy California in Stage 1

	Healthy California Eligibility		
	Age	**Income**	**Eligibility Under Current Programs**
Infants	Under age 2	Up to 300% FPG	• Infants up to 200% FPG: MC • Infants 200%-300% FPG: AIM
Children	Through age 18	Up to 250% FPG	• Ages 1-5 & up to 133% FPG: MC • Ages 6-18 & up to 100% FPG: MC • Ages 0-1 & 200%-300% FPG: AIM • Ages 1-5 & 134%-250% FPG: HFP • Ages 6-18 & 101%-250% FPG: HFP
Parents with Children Living at Home	Ages 19-64	Up to 250% FPG	• Up to 100% FPG: MC • 101%-250% FPG: HFP
Non-Disabled Adults Without Children Living at Home	Ages 19-64	Up to 150% FPG	• Adults without custodial children and not fitting other categories are not eligible for any program
Pregnant Women	—	Up to 300% FPG	• Pregnant woman up to 200% FPG: MC • Pregnant woman 200%-300% FPG: AIM

Note: FPG = federal poverty guidelines; MC = Medi-Cal family and children's program; HFP = Healthy Families Program; AIM = Access for Infants and Mothers

Benefits

California will establish a state standard for benefit packages (SSBP), which will approximate the benefits currently offered by Healthy Families. This SSBP will serve as the

benchmark for benefits in Stages 1 and 2. These benefits, shown in Exhibit 2, will apply to all enrollees in HC and to state employees.

All persons who would be eligible for Medi-Cal under current provisions (i.e., those in effect in 2001) will receive any additional benefits now provided by that program, a supplement called "Healthy California+Plus." This extended benefits package will be funded by Medi-Cal, but administration of the benefits, including assuring that eligible enrollees receive the benefits to which they are entitled, will be the responsibility of the Healthy California program.

Exhibit 2. Benefits Under the Healthy California Program

Physician Services	Office, Home visits $5 per visit* Allergy test, treatment $5 per visit*
Preventive Care	Periodic health examinations (including well baby care) No charge (including office visits) Variety of voluntary family planning services No charge (including office visits) Vision and hearing testing No charge (including office visits) Immunizations No charge (including office visits) Sexually transmitted disease tests No charge (including office visits) Confidential HIV/AIDS counseling and testing No charge (including office visits) Annual pap smear exams No charge (including office visits) Health education Services No charge (including office visits)
Prescription Drugs	30-34 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs $5 per prescription* 90-100 day supply of maintenance drugs $5 per prescription* While in the hospital No charge FDA approved contraceptive drugs and devices No charge

Exhibit 2. Benefits Under the Healthy California Program (Continued)

Hospital	Inpatient care No charge
Emergency Health Care Services	24-hour emergency care to diagnose and treat sudden, serious and unexpected illness, injury or condition. NOTE: Out-of-network emergencies are covered if health plan determines them to be medically necessary. $5 per visit
Prenatal Care/Pregnancy	Prenatal and postnatal care, inpatient and newborn nursery care No charge
Medical Transportation	Emergency medical transportation No charge
Diagnostic X-ray and Laboratory Services	Inpatient and Outpatient No charge
Durable Medical Equipment	Medical equipment appropriate for use in the home; oxygen and oxygen equipment; insulin pumps and all related necessary supplies No charge
Mental Health	Plan provides for mental health coverage including the diagnosis and medically necessary treatment of serious mental illness. Benefits include outpatient services; inpatient hospital services; partial hospital services and prescription drugs. $5 per visit for outpatient services*
Alcohol and Drug Abuse	Inpatient: As medically appropriate to remove toxic substances from the system Outpatient: 20 visits per benefit year (Some plans may choose to increase the number of visits in a benefit year if medically necessary.) No charge for inpatient services $5 per visit for outpatient services*
Physical, Occupational, Speech Therapy	Short-term therapy for a period not exceeding 60 consecutive calendar days per condition following the date of the first therapy session. Additional therapy beyond the 60 days is provided if medically necessary. No charge for inpatient services $5 per visit for outpatient services*
Home Health Care	Must be prescribed as directed by the attending physician or other appropriate authority designated by the plan. No charge
Skilled Nursing Care	Inpatient: Skilled nursing care: 100 days each benefit year No charge
Vision	Eye examinations once every 12 months $5 per examination* Prescription glasses once every 12 months $5 per glasses, frames or lenses*
Dental	Preventive care teeth cleanings, topical fluoride once every 6 months or as needed No charge Fillings as needed No charge Sealants as needed for permanent 1st and 2nd molars only No charge X-rays No charge

Exhibit 2. Benefits Under the Healthy California Program (Continued)

Optional Health Benefits	Acupuncture—20 visits per benefit year $5 per visit
	Chiropractic—20 visits per benefit year $5 per visit
	Biofeedback—8 visits per benefit year $5 per visit
	Elective Abortion—Health plans vary No charge

Note: The benefits in this table are identical to those in the Healthy Families Program
* Enrollees in Healthy California+Plus will not be charged copays that exceed those currently allowed by the Medi-Cal no-share-of-cost program.

Financing

This stage will be financed, in part, by maximizing federal matching funds for Medi-Cal and Healthy Families. A 50% federal match will be provided for all children and adults who would qualify for Medi-Cal under provisions in effect on January 1, 2002. All children and their parents whose incomes exceed Medi-Cal eligibility levels but are not higher than 250% of poverty would generate a 65% match up to the maximum total California allocation under the SCHIP program. Under terms of the current waiver, California is expected to fully draw down its SCHIP allotment.

The costs of coverage will be offset, in part, by the savings that accrue from enhanced public influence over the rate of growth in health care costs. Private-sector premiums are increasing rapidly, and are expected to continue to do so for the next few years. The state will need to substantially increase Medi-Cal and Healthy Families spending in the coming years in order to maintain access to high quality care. The increased bargaining leverage provided by a unified Medi-Cal/Healthy Families program and the increased leverage anticipated for HC in Stage 2 will allow the state to argue credibly to the federal Centers for Medicare & Medicaid Services (CMS) that it will restrain the rate of growth of per capita costs under the waiver to a rate below the baseline rate that would occur in the absence of the waiver. Healthy California

will enable the state to reduce the rate of growth for the integrated Medi-Cal/Healthy Families program by an estimated 2% per year below the rate that would occur without the waiver.[12] This 2% per year savings will finance part of the additional cost of covering non-custodial adults.

An additional tax will be levied on tobacco products to help fund the state costs for coverage in Stage 1.

Administration

One of the barriers to enrolling children in California's public coverage programs is the complexity that low- and moderate-income working families face negotiating multiple programs as they to try to piece together coverage for the entire family. The family and its health care also suffer from the fragmentation of coverage because some family members may be covered by Medi-Cal while others are enrolled in Healthy Families and others are in AIM. The new Healthy California program will administratively integrate Medi-Cal, Healthy Families, and AIM, creating a coverage program that appears seamless to enrollees. Despite the integration, however, eligibility and benefits will continue as they are currently, except for the expansions and administrative modifications noted in this proposal.

Healthy California will be administered by the Major Risk Medical Insurance Board (MRMIB), which will determine eligibility for the Medi-Cal program as it does for Healthy Families and AIM. MRMIB brings several strengths to its responsibility to administer HC. It is focused exclusively on providing health insurance coverage with no competing responsibilities. It is governed by a board that is accountable to elected officials but is buffered from direct political review of every policy decision. And it has a track record of relatively rapid and effective implementation of new coverage programs.

MRMIB's role in Medi-Cal will be authorized by a memorandum of understanding (MOU) with the Department of Health Services. Under the new program, eligibility will be determined by MRMIB's state employees, based on simplified application forms and mail-in, Web-based, and other non-stigmatizing application processes. County welfare workers *may* determine a person eligible for the HC program to enable them to fully serve their public-assistance clients. (County welfare workers will continue to determine eligibility for Medi-Cal aid categories that will not be integrated into HC.) MRMIB will develop an electronic income verification system, as described earlier.

MRMIB will also conduct outreach to and education of potentially eligible persons, expanding current efforts now undertaken in collaboration with the Department of Health Services. MRMIB will utilize a wide range of organizations and agencies in conducting this outreach to maximize the likelihood that eligible persons will learn about and apply to the HC program; these should include schools, employers, community-based organizations, and churches and other faith-based organizations. The Governor shall report to the Legislature on the achievements of MRMIB in enrolling all eligible persons and shall propose explicit rewards for MRMIB management and staff for achieving enrollment targets.

MRMIB also will be accountable for the quality of the HC program, any health plans with which it contracts, and health care services provided under the program. To enable it to perform this responsibility, MRMIB will establish an Office of Quality Assessment with an advisory board that includes consumers, physicians, nurses, other health professionals, and academic experts. MRMIB will have the authority to collect relevant data from all health plans and providers who receive funding from the HC program, and it will issue reports at least annually on consumer satisfaction and other measures of quality of the HC program, health

plans, and health services. MRMIB also will ensure that culturally competent services, including translation services, are widely available and accessible and that safety-net providers are enabled to participate in the HC program, either through contracted health plans or through direct contracting for services.

Relationship to federal law

The state will need to seek an 1115 waiver to obtain federal matching funds for adults without children living at home. In addition, creating a distinction in benefits for enrollees whose federal funding comes from Medicaid may require a waiver. Specifically, we propose that Healthy California enrollees who would be eligible for Medi-Cal under rules in place on January 1, 2002 will receive the Healthy California benefits package, plus the more expansive Medi-Cal benefits package through the Healthy California+Plus program (financed with 50% federal matching payments). However, Healthy California enrollees who would not have been eligible for Medi-Cal under January 1, 2002 rules will receive the Healthy California benefits but not the expanded benefits, a distinction that may require a waiver.

The transfer of administrative responsibility for the specified Medi-Cal program provisions to MRMIB merely requires an MOU between the agencies. Most other changes can be implemented under a revision of California's state plan.

Stage 2

Stage two will achieve universal coverage through a pay-or-play approach, which will establish a solid floor for employer-sponsored health insurance and offer the Healthy California program as an alternative for employers, employees, and others who prefer it.

Eligibility and Enrollment

All citizens and legal residents who are not covered by Medicare, CHAMPUS, or a "qualifying" employer-sponsored insurance plan (which must provide the SSBP) will be able to enroll in Healthy California without paying a premium. To enroll in HC, a resident will simply submit an enrollment application with the names and social security numbers of family members wanting to enroll. The applicants will need to sign a declaration that they are legal residents in California and that they are not covered by employer-sponsored coverage, Medicare, or CHAMPUS. After their application for HC is accepted, they will choose from among the health plans available in their geographic area.

If enrollees in HC subsequently obtain qualifying employer-sponsored coverage, they will be required to inform HC of this coverage, and coverage in HC will be terminated. Insurers will be required and large employers will be encouraged to set up automated systems in which information on new enrollees will be sent to HC, which will then match the private-coverage enrollment information with the HC enrollment files. HC enrollees who are also covered by employer-sponsored insurance will be contacted to clarify and correct the duplicate coverage.

In Healthy California, there will be no waiting period between having employer-sponsored or privately purchased coverage and enrolling in Healthy California, unlike the waiting period that affects some enrollees in the current Healthy Families Program. Moreover, ALL enrollees in Healthy California will be eligible for comprehensive benefits without any spend-down currently required of "share-of-cost" eligibles in Medi-Cal.

Although it would be desirable to assure coverage to ALL California residents, it seems political challenging to extend Healthy California to immigrants who are here without legal status. Many undocumented workers will receive coverage through their employer, but many will not have that option. The estimated number of persons who will not be covered by either

Healthy California or an employer plan is sufficiently small (less than 900,000, compared to well over 6 million in 2001[13]) that local governments, nonprofit health plans (such as the Alameda Alliance for Health and Kaiser-Permanente), and philanthropic foundations that currently subsidize coverage for undocumented immigrants will be able to provide needed assistance. Furthermore, although the number of uninsured will decrease by 86%, the HC program will continue to channel to safety net providers the current levels of federal and state safety-net support. These provisions should adequately subsidize health services for persons, such as noncitizens without documentation of their immigration status, who currently rely on safety net providers and who may not be covered by Healthy California.

Although Healthy California will not initially include Medicare beneficiaries, MRMIB will be directed to develop a proposal to provide supplemental coverage for the elderly and other Medicare enrollees. Coverage for this group will supplement the benefits that Medicare now provides, much as Medicaid does for very low-income elderly persons, private Medicare supplemental insurance does for many of the more affluent elderly, and Medicare HMOs do for many others.

Benefits

HC will offer the "SSBP" package of benefits, similar to the Healthy Families benefit package. MRMIB will provide the benefits either by contracting with HMOs or by directly contracting with providers. The board of MRMIB will have the flexibility to determine the most effective methods of provider payment. We anticipate that in urban areas of the state MRMIB will choose primiarly to contract with health plans, just as Healthy Families does now. In rural areas, direct contracts with providers may well be a preferred option. Further, the health plan

market is clearly in flux, and even in urban areas MRMIB may quickly find that direct contracting with providers is a preferable approach..

In areas of the state in which multiple plans are available in Healthy California, the benefits will be standardized across plans, but premiums may vary as a result of differences in network and other factors. In each geographic region, HC must fully pay for the "33rd percentile" plan. (The 33rd percentile plan is defined as follows: Sort the plans from least to most expensive; the 33rd percentile plan is the least expensive plan for which it is true that one-third of total enrollees in a region are enrolled in that plan or a plan that is less expensive.) If enrollees choose to join a plan that is more expensive than the amount contributed by HC, the enrollee pays the difference between the contribution and the premium.

The contribution by HC will be risk-adjusted for the characteristics of the enrollees in each plan — that is, MRMIB will pay a larger contribution to plans with older or sicker HC enrollees than it does to plans with younger enrollees.

As in Stage 1, all persons who would be eligible for Medi-Cal under current provisions will receive any additional benefits now provided by that program through "Healthy California+Plus."

Financing

Financing for HC will come from several sources, each of which is described below:

- Maximizing federal matching funds for Medi-Cal and Healthy Families;
- Premium payments made by employers and employees on behalf of employees who are not covered by qualifying employer-sponsored coverage, Medicare, or CHAMPUS; and
- Comparable premium payments made by Californians who declare self-employment and unearned income and who were not continuously covered by qualifying employer-sponsored coverage, Medicare, or CHAMPUS during the tax year.

- Reducing administrative costs;
- An additional tobacco tax and a small increase in the income tax; and

Maximizing federal matching funds for Medi-Cal and Healthy Families

Under existing Medicaid statute, there is substantial opportunity to expand federal matching funds. Under Section 1931 of the Medicaid statutes, California is allowed to stipulate the amount of income and assets that it can choose to disregard when determining whether a family with children qualifies for Medi-Cal. California used this authority in 2000 to expand Medi-Cal to all families with incomes below 100% of the FPG. Under Healthy California, the state will build on this precedent to gain federal matching funds for *all* families with children enrolled in HC, disregarding all income and assets when determining whether a family enrolled in Healthy California is eligible for federal matching funds. By using this authority, California will receive 51% of the financing from the federal government for all families with children enrolled in HC, with payroll tax payments to HC used as the state match.

Premium payments made by employers and employees on behalf of employees who are not covered by qualifying employer-sponsored coverage, Medicare, or CHAMPUS

All employers will pay a Healthy California premium payroll tax to the state as a percentage of each employee's wages, but employers who choose to "play" (i.e., to provide health benefits) will receive a credit for the full amount of this tax under two conditions: (1) if the actuarial value of the benefits is equivalent to the value of the SSBP benefits, and (2) if the employee accepts the benefits offered.

Employers who do not offer qualifying coverage to employees

Employers who do not meet these conditions will not receive the credit. The tax will be progressive, starting at a low percentage of income, as shown in Exhibit 3 below. Small

employers (with fewer than 25 full-time employees) with low-wage workers will make a lower premium tax payment than larger employers.

Exhibit 3. Employer and Employee Premium Payroll Tax

Worker Wage Level	Payroll Tax Rate		
	Small, Low-wage Employers[a]	Other Employers	Employee
First $10,000	2.0%	4.0%	1.3%
Next $20,000	3.9%	5.9%	2.0%
Next $30,000	7.9%	7.9%	2.6%
Over $60,000	10.0%	10.0%	3.3%

[a] Includes employers with less than 25 workers and average payroll under $25,000

In addition, workers whose employer does not meet these conditions would pay a premium payroll tax on their earnings (approximately one-third of the employer amount), as shown in Exhibit 3.[14] The employee contribution will be withheld from payroll by the employer and sent to HC along with the employer share.

Like social security, there will be a maximum liability for the premium tax. This maximum liability will be $700 per worker per month.

Employers whose employees have qualifying coverage

Employers who offer qualifying insurance to their employees will be able to receive a full credit on the premium tax on behalf of any workers in which all family members are covered by qualifying insurance, Medicare, or CHAMPUS. In order to receive the credit, employers must certify the coverage as "qualifying" by showing that it is actuarially equivalent to the SSBP.[15] An employer who wishes to be designated as providing qualifying coverage must designate which classes of workers are offered coverage, and which are not (e.g., consistent with current

federal law, an employer can choose to offer coverage to full-time, permanent workers, while not offering coverage to part-time workers, seasonal workers, or new hires during their first few months on the job).

Employers (and employees) will pay the premium tax on the wages of all workers. For classes of workers that are offered coverage, the employer and employee can claim a credit on the wages of workers in households where every member of the household is covered by an employer-sponsored plan, Medicare, or CHAMPUS. Largely consistent with current insurance practice, the employer can obtain the credit if he/she files a "declination statement" for each person to whom coverage is offered if either the employee or any member of the employee's household does not accept the employer's offer. The declination form, signed by the employee, must state, for each member of the household not covered by the employer, whether the person is covered by another employer's qualifying coverage, by CHAMPUS, or by Medicare. If the declination form shows that there are any uncovered members of the household, then the employer and employee will not receive the credit on their tax.

To enroll in the public program, the employee merely needs to sign a simple declaration stating that s/he does not have qualifying coverage (as we describe in a later section); discrepancies between an employee's declaration and other evidence (e.g., no employer declination on file) will be reconciled afterward and through annual income tax filings. As we have learned from the experience with Medi-Cal in California and Medicaid and SCHIP programs nationwide, keeping the verification process out of the enrollment process and conducting the verification in the background is essential to enabling Healthy California to enroll ALL eligible persons.

A System that Maximizes Employer and Employee Choice

We are proposing a system with both employer and employee choice. First, employers may choose whether to offer qualifying coverage. Employers who offer qualifying coverage will receive a full credit on the HC tax paid on the wages of workers by the employer's health plan. Employers who do not offer qualifying coverage will not receive a credit on the HC tax paid on the wages of all workers, nor will their workers receive a credit. If an employer chooses to offer qualifying coverage that is actuarially equivalent to the SSBP to certain classes of workers, the employer is free to determine how much to contribute. Second, workers whose employer offers health benefits will then choose whether to accept the employer's offer. If workers do not accept the employer's offer and have any uninsured persons in their family, then neither the employer nor the employee will receive the credit.

The incentives in this arrangement will encourage employers to "play" if the composition of their workforce makes it financially advantageous to pay for benefits, and the incentives will encourage them to "pay" the premium tax if they decide that is more advantageous. But workers also decide whether it is in their own and their family's interest to accept any health plan offered by their employer.

Any pay-or-play proposal will lead to some adverse selection against the public-sector risk pool: employers with relatively older or relatively sicker workers will be more likely to choose to pay, while employers with younger, healthier workers will be more likely to play. Our proposal has the potential for additional selection problems, since it is possible that employers with predominately healthy workers but a few unhealthy ones will be able to encourage the few workers with high health care needs to enroll in Healthy California, while maintaining the healthy workers in the employer-sponsored plan. While we acknowledge this possibility, we do not think it will be a large problem, especially in medium and large size firms. Under current

federal law, employers who offer benefits are subject to "non-discrimination" rules, requiring the offer to be made equitably to all workers within a given class of workers. California should consider whether additional state level non-discrimination rules are needed to discourage "dumping" of unhealthy employees into the Healthy California pool.

Despite such risks, the HC program will reduce any tendencies toward gaming of the system by employers, who might try to make their offered health plan unattractive to workers. As The Lewin Group analysis of this proposal concludes, "if the employer makes the coverage so unattractive that their employees do not enroll, the employer still pays the tax for these workers" because the firm would be refunded the tax only for those workers who have qualified coverage.[16]

A strength of our proposal is that we expect that employers who offer coverage will continue their current practice of paying a larger share of individual premiums than of family premiums. This will encourage single individuals to remain with employer-sponsored plans, while there may be some movement of families into Healthy California. Since the state will be receiving at least a 50% match from the federal government for all Healthy California families with children, in addition to the employer and employee paid premium tax, this pattern will benefit the state, employers, and families by maximizing federal support for these groups.

Employees with multiple jobs

Some workers have more than one employer. If an employee has two employers, neither of whom offers qualifying coverage, and the worker makes $10,000 from each, then each employer would pay 4.0% of the $10,000 ($400 each, or $ 800 in total), and the worker would pay $130 from the wages of each employer ($260 in total). If the worker had made $20,000 from a single employer, then the second $10,000 would have been taxed at 5.9% from the

employer and 2.0% from the employee. Thus, two $10,000 jobs rather than a single $20,000 job results in a tax liability of $1,060 rather than $$1,320. We do not see this as a large problem, and do not propose trying to grab "underpayments" from people (and their employers) in two jobs. If a large problem develops in which employers are creating new structures to break a single $40,000 per year job into the appearance of four $10,000 per year jobs in order to reduce tax liability, then corrective action from the state would be required.

A different problem may occur if a worker has two jobs for employers who pay the tax and the worker makes, for example, $60,000 in each. Then the total tax paid would be above the maximum liability that would exist if the worker had a single job making $120,000. In this situation, the worker will receive a refund on the overpayment as part of the annual tax reconciliation, just as workers can receive refunds on social security overpayments if they have two jobs.

Comparable premium payments made by Californians who declare self-employment and unearned income and who were not continuously covered by qualifying employer-sponsored coverage, Medicare, or CHAMPUS during the tax year

Some Californians will be eligible to enroll in HC (that is, they are not continuously covered by qualifying employer-sponsored coverage, Medicare, or CHAMPUS), but will have made no or low premium contributions through the payroll premium tax withholding process because they have no or small levels of wage income. In order to foster equity and financial stability, the California income tax system will be changed to require a health insurance contribution from people who are eligible to enroll in HC, have self-employment or unearned income (e.g., rents, interest and dividends, capital gains, royalty income, partnership income, etc.), and who did not earn sufficient wage or salary income to contribute the $700 per worker per month, prorated for the number of months uncovered.

To administer this requirement, an additional schedule will be added to the California income tax return. Tax filers with self-employment or unearned income will be required to state whether they were continuously covered by qualifying coverage (employer-sponsored, Medicare, or CHAMPUS) throughout the tax year. (Potentially, those providing qualifying coverage could be required to provide a statement, similar to a 1099 form, indicating that coverage had been supplied, and the number of months and SSNs of those who were covered.) Tax filers with one or more household members who were not continuously covered by qualifying coverage will pay a HC insurance premium as a tax on their self-employment and unearned income. The tax will be set at the sum of the employer and employee HC insurance premium rates. If household members were covered by a qualifying plan for part of the year, the HC insurance premium liability will be prorated for the uncovered period. Filers will have a maximum liability, equal to the maximum liability on employers and employees who pay rather than play. To the extent that employer and employee HC insurance premiums had been paid on wage income for household members, these payments will be subtracted from the household's maximum liability and will lower the amount that might be owed on self-employment and unearned income. Tax filers making payments on self-employment income will be treated as small businesses for the purpose of computing the employer portion of the liability; further, as in all two-worker households, the maximum liability for the employee portion for individuals (and couples) is $174 per month.

In addition to these revenue sources, Healthy California will offset some costs of coverage with savings in administrative costs, which The Lewin Group estimates will run about 6.2%, well below average administrative costs of private health insurance. We think it is likely, in addition, that provider administrative costs will decline in response to Healthy California's

simplified financing and eligibility system. Finally, it is likely that an additional tobacco tax will be needed and a small increase in the income tax.

Administration

As with Stage 1, this stage of the Healthy California program will be administered by MRMIB, which will contract with health plans and/or directly with providers of services. The agency will be responsible for all aspects of implementation, including conducting an extensive outreach campaign to inform all Californians of the new program and its provisions — an outreach and education campaign that needs to target the general population as well as employers and employees. MRMIB will be responsible for enrolling eligible persons in the program and for ensuring that those eligible for Healthy California+Plus receive the additional benefits to which they are entitled.

MRMIB will continue to be responsible for assuring the quality of the HC program, contracted health plans, and health care services for which it provides payment. Its quality assurance role will continue to include a special focus on assuring that culturally competent services, including translation services, are widely available and accessible and that safety-net providers are enabled to participate in the HC program. MRMIB will collect relevant data from all health plans and providers who receive funding from the HC program, and it will issue reports at least annually on consumer satisfaction and other measures of quality of the HC program, health plans, and health services.

Relationship to federal law

We believe that the construction of this proposal minimizes the risk of it being successfully challenged under ERISA. By imposing a HC "tax" on all employers and offering a

credit on that tax for those who meet certain specified conditions, the proposal avoids a direct conflict with ERISA, as noted by Patricia Butler:[17]

> In contrast to broad employer mandates…tax laws are probably less likely to face ERISA litigation. First, states could defend them as minimal intrusions on employer plan administration — employers who dislike the conditions could choose to design their plans accordingly and forgo the tax benefit. Furthermore, because tax incentives offer benefits and are purely voluntary, as a practical matter they are less likely to be challenged in court.

We believe this proposal also minimizes the need for additional waivers beyond the one required for Stage 1. Section 1931 of the Medicaid statutes enables California and other states to gain federal matching funds for all families with children without requiring a waiver from CMS (although the state plan must be approved by CMS).

However, waivers may be required for other provisions of our proposal. A waiver may be required to modify the benefits of Healthy California enrollees whose costs are subsidized by federal Medicaid dollars but who would not receive the expanded benefits of Healthy California+Plus because they would not have been eligible for Medi-Cal under rules in place on January 1, 2002, an issue already addressed in Stage 1.

Further, as discussed above, Healthy California enrollees choosing a plan more expensive than the 33rd percentile plan will be required to pay additional premium, possibly requiring a federal waiver. We expect that other requirements of federal Medicaid law would need to be waived in order to successfully implement our proposal. However, the waivers required will not increase federal financial exposure (the main concern of federal administrators), but in most cases either decrease it or leave it unchanged. The major federal financial exposure is created by the structure of Section 1931, which allows states to disregard all income and assets when determining eligibility for matching funds. As a practical matter, federal executive and legislative cooperation are likely to be needed in order to successfully implement our proposal.

Insurance and Risk

The state will contract with health plans to deliver the benefits in the HC benefits package. MRMIB will use risk arrangements that best serve the interests of enrollees and that promote the development of long-term positive relationships between the state, health plans, and providers. In the early years of implementation, this will likely include substantial risk sharing between the state and health plans, given uncertainty about the size and composition of HC enrollment. MRMIB will contract directly with provider groups and bypass health plans if that seems most advantageous to assure good access and quality for HC enrollees, to minimize administrative costs as a share of total health expenditures, and to control costs.

Conclusion

The proposal has some very significant advantages. First, it will achieve universal coverage by building on existing coverage mechanisms. The proposal creates a level playing field among employer-sponsored plans for employers and employees who are satisfied with them, and it expands public programs now in place (mainly Medi-Cal and Healthy Families) into a new streamlined Healthy California program for those with little or no access to employer-sponsored coverage as well as those who are dissatisfied with that coverage. The Healthy California program provides choice to *all* Californians — choice of where to obtain health insurance coverage, choice of plans in which they can enroll, and, through this wide array of coverage options, choice of the physician and other providers from whom they will receive health care.

Second, the proposed reform creates no financial barriers or disincentive to enrollment in HC. Employers and employees will pay a tax on wages of persons who are not covered by employer-sponsored qualifying coverage, regardless of whether the employee actually enrolls in

HC. Since enrollment in HC is free at time of enrollment, we expect that almost all those eligible will actually enroll (given appropriate marketing and outreach efforts). Since eligible persons will be making payments towards coverage through payroll withholding or the tax system regardless of whether they actually enroll, we expect virtually all eligible Californians to enroll, thus achieving universal coverage of all citizens and legal immigrants through qualifying employer-sponsored plans or through the HC program.

The Lewin Group estimates that approximately 900,000 Californians would be uninsured under Healthy California. While this is still more uninsured persons than any of us would want, it is a very large decrease from the current level of 6.3 million uninsured, and a relatively small fraction of the nearly 35 million Californians.

The proposal also establishes clear responsibility for quality assurance, meeting the needs of California's ethnically diverse population for culturally competent services, assuring persons with disabilities or chronic conditions that they will have good access to services and receive quality care, and enabling safety-net providers to continue to serve California's communities.

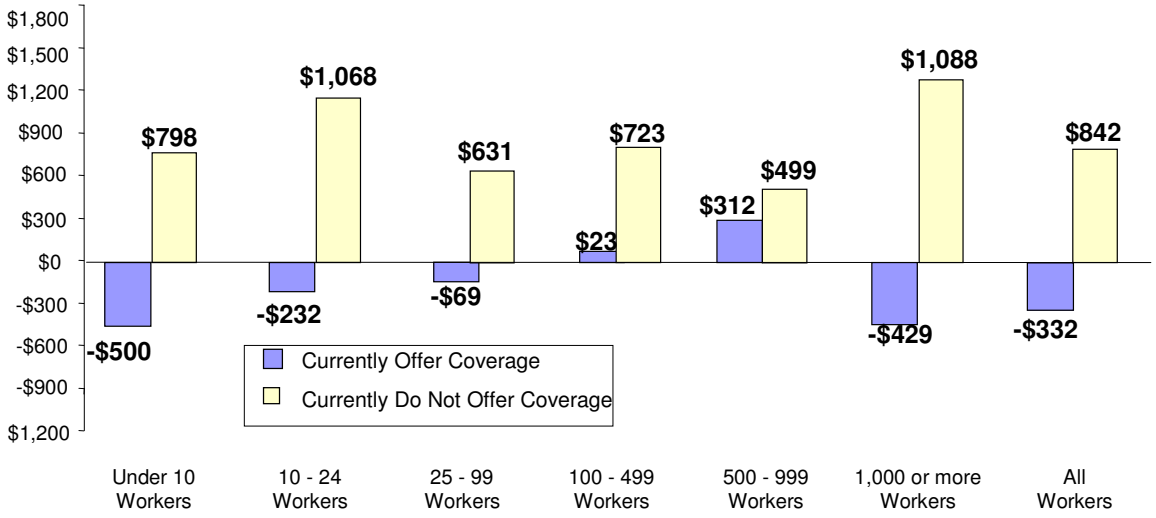
But Healthy California will not only ensure universal coverage of all citizens and legal immigrants while offering more options to employers and employees and enhancing the stability and quality of care. It will also generate substantial savings for households and no net increase in payments for employers. The Lewin Group, which analyzed all proposals commissioned by the Health Care Options Project of the California Health and Human Services Agency, has estimated that, when fully implemented, Healthy California will save the state's households a total of $4.2 billion through reduced health insurance costs, more covered services, and fewer out-of-pocket costs. All households with annual incomes under $150,000 will save money; the savings for each income group is shown in Exhibit 4.[18]

Exhibit 4. Change in Average Spending Per Family under Healthy California in 2002: After Wage Effects (includes Households Headed by Persons Under Age 65) [a/]

a/ Assumes Full Implementation in 2002
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Lewin Group also estimated that firms that now offer coverage will save a total of $3.3 billion, and that savings will accrue to nearly every size firm that currently struggles with paying for health benefits (see Exhibit 5 for the estimated savings by firm size).[19] Firms that currently do *not* offer coverage will pay more, evening the playing field among them. However, all firms — including those that currently cover their workers and those that do not — will pay only in proportion to the costs of their payroll and will be protected from excess costs and cost increases. Firms that do not currently offer coverage are estimated to pay an additional $3.4 billion. Combining the results for employers that currently offer with those that do not, Lewin projects virtually no change in total employer liability.

Exhibit 5. Change in Private Employer Health Spending Per Worker by Firm Size and Current Insuring Status Under the Healthy California Program: Before Wage Effects [a/]



a/ Assumes Full Implementation in 2002
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

At first blush, it may not seem feasible that California could achieve universal coverage while reducing payments from households and with no net change in payments from employers. This result is made possible largely by taking advantage of existing federal Medicaid law to greatly increase federal contributions to health care in California, and also by assuring that all residents contribute a fair and affordable share.

Acknowledgements

We appreciate the consultation provided to us by Lucien Wulsin, Jr., Patricia A. Butler, and Lucy Quacinella, all of whom graciously offered their feedback and suggestions on specific components of the proposal. Julia Prentice also provided valuable research assistance. Despite the generous assistance, the authors and not our consultants are responsible for all errors and misinterpretations.

[1] Brown ER, Alex S, and Becerra L, *Uninsured Californians Decline to 6.2 Million; 2 Million Are Eligible for Medi-Cal or Healthy Families*, Fact Sheet, Los Angeles: UCLA Center for Health Policy Research, February 2002.

[2] Jennifer Warren, "State Urged to Intervene in Hospitals' Urgent Care: Emergency rooms are closing because of financial losses," *Los Angeles Times*, Jan. 18, 2001; Sharon Bernstein, "Emergency Room Losses Mount," *Los Angeles Times*, Nov. 7, 2001; Lisa Rapaport, "Report Exposes ERs' Critical Lack of Space," *Sacramento Bee*, Nov. 7, 2001; Tony Fong, "Emergency Rooms in State Report $325 Million in Losses," *San Diego Union-Tribune*, Nov. 7, 2001; and [Editorial], "Wounded Trauma Centers," *Los Angeles Times,* June 13, 2001.

[3] Lawrence Casalino, "Canaries in a Coal Mine: California Physician Groups and Competition," *Health Affairs*, 2001; 20 (4): 97-108; and James C. Robinson, "Physician Organization In California: Crisis And Opportunity," *Health Affairs*, 2001; 20 (4): 81-96.

[4] Jon Gabel, Larry Levitt, Jeremy Pickreign, et al., "Job-Based Health Insurance In 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, 2001; 20 (5): 180-186; Todd Gilmer and Richard Kronick, "The Calm Before the Storm: Expected Increases in the Number of Uninsured," *Health Affairs*, 2001, November/December.

[5] Helen H. Schauffler and Lee D. Kemper, Survey Brief: *Task Force Survey Finds 76% of Insured Californians Satisfied, 42% Report Problems*, Sacramento: California Center for Health Improvement, January 1998.

[6] Victor R. Fuchs, J.S. Hahn. "How Does Canada Do It? A Comparison of Expenditures for Physicians' Services in the United States and Canada," *New England Journal of Medicine* 323 (1990): 884-890; Robert G. Evans, J. Lomas, Morris L. Barer, et al., :Controlling Health Expenditures—the Canadian Reality," *New England Journal of Medicine* 320 (1989): 571-577; U.S. Congressional Budget Office, *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates*, CBO Staff Memorandum. Washington, DC: U.S. Congressional Budget Office, April 1993; Steffie Woolhandler, David U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine* 324 (1991): 1253-1258; General Accounting Office (GAO), *Canadian Health Insurance: Lessons for the United States.* GAO/HRD-91-90. Washington, DC: U.S. GAO, June 1991; and G.J. Hayes, S.C. Hayes, T. Dykstra, "Physicians Who Have Practiced in Both the U.S. and Canada Compare Systems," *American Journal of Public Health*, 83 (1993): 1544-1548.

[7] See Carol S. Weissert and William G. Weissert, *Governing Health: The Politics of Health Policy*, Baltimore, MD: Johns Hopkins University Press, 1996; Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics*, New York: W.W. Norton, 1996; James A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government*, New York: Basic Books, 1990; and Vicente Navarro, "Why Some Countries Have National Health Insurance, Others Have National

Health Services, and the U.S. Has Neither," *Social Science and Medicine*, 28 (1989): 887-898; and D.J. Rothman, "A Century of Failure: Health Care Reform in America," *Journal of Health Politics, Policy and Law*, 18 (1993): 271-286.

[8] Anthony Corrado, Thomas E. Mann, Daniel Ortiz, Trevor Potter, and Frank Sorauf (eds.), *Campaign Finance Reform: A Sourcebook*, Washington, DC: The Brookings Institution, 1997.

[9] Patricia A. Butler, *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles*, New York: The Commonwealth Fund, October 2000.

[10] John K. Iglehart, "Revisiting the Canadian Health Care System," *New England Journal of Medicine* 342 (2000): 2007-2012; and Karen Donelan, Robert J. Blendon, Cathy Schoen, Karen Davis, and Katherine Binns, "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs*, 18 (May-June 1999): 206-216.

[11] Donna Cohen-Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures — Findings from a 50-State Survey*, Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, October 2000.

[12] The Lewin Group, "The Healthy California Program: Summary and Estimated Cost and Coverage Impacts," Final Second Round Estimates, Washington, DC: March 27, 2002.

[13] Lewin Group, "The Healthy California Program: Summary and Estimated Cost and Coverage Impacts," Final Second Round Estimates, Washington, DC: March 27, 2002.

[14] This proposal assumes that attorneys can define the employee paid mandatory health insurance contribution as a pre-tax contribution to health insurance under IRS regulations. If the state does not succeed in making this legal case, then we propose an amendment to the IRS code to treat this payment as pre-tax for federal (and state) income tax purposes. If this amendment does not pass, then we would propose that the entire premium contribution be made by the employer, rather than split between employer and employee, in order to take maximum advantage of federal tax laws.

[15] Employers would need to demonstrate that the coverage they offer is actuarially equivalent to, at a minimum, the PPO package offered by Healthy California. MRMIB would establish policies for demonstrating actuarial equivalence, and would have the authority to review employers' and insurers' certifications.

[16] The Lewin Group, "The Healthy California Program: Summary and Estimated Cost and Coverage Impacts," Final Second Round Estimates, Washington, DC: March 27, 2002.

[17] See Butler, *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles*, October 2000. A more skeptical assessment of the prospects for avoiding an ERISA challenge can be found in Weinberg JK, "ERISA and State Health Care Reform," paper

prepared for the Health Care Options Project of the California Health and Human Services Agency, January 28, 2002.

18 Estimates of household savings and the exhibit are in "The Healthy California Program: Summary and Estimated Cost and Coverage Impacts," Final Second Round Estimates by The Lewin Group, Washington, DC: March 27, 2002.

19 Estimates of employer savings and the exhibit are in "The Healthy California Program: Summary and Estimated Cost and Coverage Impacts," Final Second Round Estimates by The Lewin Group, Washington, DC: March 27, 2002.