



**THE CALIFORNIA HEALTH CARE OPTIONS PROJECT:
FINAL REPORT**

**Prepared for:
The Health Resources and Services Administration
U.S. Department of Health and Human Services**

**Prepared by:
The California Health and Human Services Agency**

September 2002

ACKNOWLEDGMENTS

The California Health and Human Services Agency would like to acknowledge the support of the following individuals, without whom the success of the Health Care Options Project would not have been possible.

Project Management Team

Genie Chough, California Health and Human Services Agency
Gary Claxton, Georgetown University, Institute for Health Care Research and Policy
Peg Gerould, California Research Bureau David Maxwell-Jolly, California Health and Human Services Agency

Authors of the Options Papers and Comparative Analyses

E. Richard Brown, PhD, UCLA and Rick Kronick, PhD UCSD
Bob Brownstein, Working Partnerships USA
Katie Horton, Peter Harbage, and Jennifer Ryan, Health Policy R&D
James G. Kahn, PhD UCSF and Don McCanne
Helen H. Schaffler, PhD, UC Berkeley
Ellen R. Shaffer, PhD, MPH
John F. Sheils, The Lewin Group
Judy Spelman, RN, Health Care for All-California
Claudia Williams, AZA Consulting
Lucien Wulsin, Jr., Insure the Uninsured Project

Advisory Group

Lupe Alonso, Children's Advocacy Institute
Jeanne Cain, California Chamber of Commerce
Jack Christy, American Association of Retired Persons
Lori Dangberg, Alliance of Catholic Health Care
C. Duane Dauner, California Healthcare Association
Robert P. David, Hospital Council, Northern Div.
Anne Eowan, Association of California Life and Health Insurance Companies
Barbara Glaser, CA Health Care Association
Rebecca Gudeman, National Center for Youth Law
Dorel Harms, California Health Care Association
Mandy Johnson, Community Clinic Association of Los Angeles County
Maura Kealey, Service Employees International Union
David B. Lamkin, Santa Barbara Regional Health Authority
Earl Lui, Consumers Union
Terry Mack, Health Plan of San Joaquin
Susan Maddox, California Children's Hospital Association
Burt Margolin, California Primary Care Association
Lia Margolis, Latino Coalition for a Healthy California
Pete Martineau, Congress of California Seniors
Maria Mason, MD, American Cancer Society
Sarah Mercer, Mexican American Legal Defense and Education Fund

Michael W. Murray, California Association of Health Insuring Organizations
Carolyn Negrete, Older Women's League
Doris Isolini Nelson, Health Care for All – California
Sara Nichols, California Nurses' Association
Caitlin O'Halloran, California State Association of Counties
Harold Owens, Harold Owens
Melinda Paras, Health Access
Bill Powers, Congress of CA Seniors
Ashley P. Ratcliffe, Individual/Consumer
Ursula Rolfe, CA Physicians' Alliance
Jeff Shelton, Health Net
Terri Thorfinnson, California Primary Care Association
Carla Woodworth, California Physicians Alliance

Review Team

Teri Barthels, Department of Mental Health
Dan Carson, Legislative Analyst's Office
Michael Dimmit, Assemblymember Tony Cardena's Office
Mike Genest, Senate Republican Consultants
Peter Hansel, Senate Office of Research
Steve Kessler, Department of Finance
Antonio Linares, Department of Managed Health Care
Gil Ojeda, UC Berkeley California Policy Research Center
Dan Pellissier, Assemblymember Keith Richman's Office
Richard Popper, Managed Risk Medical Insurance Board
Mark Quillici, Public Employees' Retirement System
Shar Schroepfer, Department of Health Services
Sean Tracy, Department of Insurance
Kristy Wiese, Department of Consumer Affairs

Technical Advisory Committee

Linda Bilheimer, The Robert Wood Johnson Foundation
Jose Escarce, RAND Center for Health Care Finance Policy Research
Paul Gertler, UC Berkeley
Larry Levitt, Kaiser Family Foundation

CONTENTS

EXECUTIVE SUMMARY.....	2
SECTION 1: UNINSURED INDIVIDUALS AND FAMILIES.....	6
SECTION 2: EMPLOYER-BASED COVERAGE	18
SECTION 3: THE HEALTH CARE MARKETPLACE	22
SECTION 4: OPTIONS FOR EXPANDING COVERAGE	25
SECTION 5: CONSENSUS BUILDING STRATEGIES	67
SECTION 6: LESSONS LEARNED AND RECOMMENDATIONS TO STATES	73
SECTION 7: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT	75
ENDNOTES	
APPENDIX I: BASELINE INFORMATION	
APPENDIX II: LINKS TO RESEARCH AND METHODOLOGIES	
APPENDIX III: PUBLIC PROCESS EVALUATION	
APPENDIX IV: TWO-PAGE SUMMARIES OF THE NINE OPTIONS PAPERS	

EXECUTIVE SUMMARY

Background

In October 1999, the Governor signed Senate Bill 480 (Chapter 990, Solis). This law calls upon the Secretary of the California Health and Human Services Agency (CHHS) to examine options for providing health care coverage to Californians – approximately 6.3 million of whom lack coverage. The State legislation calls for a process that involves both public and private sector stakeholder groups in examining the various reform options.

To implement SB 480, CHHS applied for and received a one-year State Planning Grant of \$1.2 million from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services on February 28, 2001, establishing the Health Care Options Project, designed to meet the requirements of SB 480. The grant provided an opportunity to develop and update ideas and options on how to expand coverage in California.

Goal of the Health Care Options Project

The goal of HCOP was to guide the State in a systematic exploration of different approaches to achieving expanded coverage by engaging in an in-depth examination of a range of reform options. An ambitious undertaking of HCOP was to provide policy makers and the public with detailed information about the costs and coverage impacts of different approaches to extending access to coverage. By using sophisticated economic modeling, the HCOP was able to estimate for each of the proposals how many people would become covered, the characteristics of the people that would be covered, the changes in their out-of-pocket costs, and the financial impacts on public and private payers, including employers. The options were then reviewed using a public process.

Purpose of this Report

This report, which follows the format required by HRSA, is being transmitted to both the federal government and State Legislature to share the findings from HCOP. More importantly, this report provides policy makers and both public and private stakeholders with the necessary tools to use in future policy discussions and any future actions they may take aimed at reducing the uninsured population in the State.

Summary Findings

The HCOP had three major components, all of which have been successfully completed:

- 1. Data and Research Synthesis.** The first component of the project identified existing sources of data and research that could be made available for analytic efforts. This task was performed primarily by the California State Library, which developed an extensive bibliography on issues relating to health coverage and also commissioned six background papers from California scholars which address important issues relating to access to health care and coverage in California. As required for this report, Sections 1, 2 and 3 include some of this research, and the bibliography as well as additional commissioned papers can be found at the HCOP website, www.healthcareoptions.ca.gov.

The results of the syntheses were made available to the health policy experts developing reform options for the next component of the project. The State Library and other State Departments also assisted the health policy experts with individual requests for data and information as they developed the options to be analyzed and with the contractors that performed the analyses.

- 2. Development and Analysis of Options for Expanding Coverage.** The second component of the project was the development and analysis of different options for expanding coverage in California.

To identify reform options for analysis, CHHS conducted a competitive process to solicit reform proposals from health policy experts. Bidders were required to develop a detailed proposal for analysis and to work with the contractor performing the economic analysis. The State selected nine proposals, including a broad range of approaches, such as: individual and employer premium subsidies and tax credits, public program expansions, pay-or-play approaches and single-payer systems. In some cases more than one approach was included in a reform option. Section 4 includes the information required for this report on the options. In addition, two-page summaries as well as the full options papers developed by the health policy experts can be found at the HCOP website, www.healthcareoptions.ca.gov.

A competitive process was used to identify a contractor with experience in microsimulation modeling to conduct an economic analysis of the reform options developed by health policy experts. The State selected the Lewin Group from among the bidders. Their final report provides a detailed discussion of the cost and coverage implications of each of the proposals. To assist readers in comparing reform options, each option is modeled as if it were fully implemented in 2002. A ten-year budget for each proposal also is presented. Substantial additional analysis also is provided in the report, including information about changes in individual out-of-pocket costs (by demographic category), changes in costs to employers (by size), and changes in costs for safety-net programs. The final report, including separate appendices providing additional analysis of each option, can be found at the HCOP website, www.healthcareoptions.ca.gov.

The State selected a second contractor, AZA Consulting, to conduct a more qualitative analysis of the reform options. The report looked at potential impacts of the reform options in four areas: access, utilization and continuity of care; quality and appropriateness of care; safety net; and vulnerable groups. In performing the analysis, the contractor identified key questions and issues in each area of interest and reviewed how each proposal addressed the questions and issues identified. The final report, including a matrix that shows how each proposal performs along each area of interest, can be found at the HCOP website, www.healthcareoptions.ca.gov.

- 3. Public Input Process.** As described in greater detail in Section 5, the final component of the HCOP was an extensive process for public education and input. (An evaluation of the public input process is included in Appendix III.) To ensure ongoing public participation

throughout HCOP, CHHS used various mechanisms to obtain stakeholder input, including public review and comment on key documents and participation in the culminating policy option symposia.

In the early stages of the project, the draft solicitations for the reform options and the modeling contractor were developed through an interagency process that included State representatives named in state legislation, Senate Bill 480, legislative staff, and health care experts. The draft solicitations also were published for public review and comment. In addition, to encourage greater participation from stakeholders, CHHS invited a cross-section of stakeholders to join an Advisory Group. The Advisory Group included members representing health care providers, associations, insurers, health planners, consumers, businesses, local government, and labor interests, as well as legislative staff. The Advisory Group provided important ongoing input to CHHS at several stages of the project, including the selection of the health policy experts and modeling contractor and the design and format for the symposia. The Advisory Group also met with the modeling contractor to discuss the design and assumptions used for the economic analysis of the coverage options.

The State sponsored a series of four symposia throughout the state – in Los Angeles, Fresno, Oakland, and Sacramento -- to provide an opportunity for stakeholders and the public to review and ask questions about the health reform options and the analyses and to provide feedback to the health policy experts developing the options and contractors performing the analyses. The experts developing the reform options received a summary of the comments and questions asked at the symposia and had an opportunity to revise their reform options in light of the public input.

Data Sources

Several rich sources of data about health insurance and access to health care are available to policy makers and others in California, including: an annual survey of California employers conducted by the Henry J. Kaiser Foundation and the Health Research Education Trust, and the 2001 California Health Interview Survey -- a significant new population-based survey of over 55,000 Californians which was conducted as a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services and the Public Health Institute. As a result, the HCOP did not focus on new data collection efforts, as projects conducted by other states have. Information from these surveys and other private data collection efforts are the bases for the responses in Section 1.

Conclusion

Overall, the HCOP succeeded in setting the stage for the continuing public policy debate in California about how to extend coverage to the State's remaining 6.3 million non-elderly who lacked coverage during 2001. The HCOP succeeded in providing policy makers and the public with detailed information about the cost and coverage impacts of a broad array of reform approaches. The HCOP included unprecedented, rigorous analyses of both incremental approaches and broad systemic changes, and provides a rich source of information to inform future efforts.

Since the project was not designed to achieve consensus recommendations or to identify preferred options, HCOP did not result in any preferred policy options. As a result, the State is unable to make specific recommendations for federal action. We would note, however, that meaningful reforms at the State level might entail greater flexibility from the federal government. For example, several of the reform options developed by the health policy experts under this project would require new flexibility under federal programs (such as Medicare and Tri-Care) so that the populations that they cover could be incorporated into new programs developed at the State level. In several other cases, reform options that require employer participation also may need federal relief from the preemption provisions of ERISA. If States are to take the lead in developing creative approaches that significantly expand the number of people with insurance, they may need access to existing federal funds and the flexibility to adapt existing program rules to accommodate new State institutions and approaches.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

California is fortunate that several surveys available to policy makers and others in California provide rich sources of data about health insurance and access to health care. As a result, unlike projects in other states, CHHS did not propose to conduct new data gathering on the uninsured in California as part of the HCOP. The information about the incidence of insurance provided in this section is from existing data sources. The primary data source for questions 1.1 to 1.3 is an analysis by the UCLA Center for Health Policy Research of the 2001 California Health Interview Survey (Brown et al, 2002). The California Health Interview Survey (CHIS) is a survey of over 55,000 randomly selected California households covering a broad range of public health concerns, including insurance status, public program eligibility and enrollment, and access to, and use of, health care services. (Brown et al, 2002.) Detailed information on the survey can be found at www.chis.ucla.edu. Where information from the California Health Interview Survey is not available, relevant information from the Current Population Survey is provided. Readers should be cautioned, however, that the results of the two surveys differ dramatically in some areas, including the overall number of uninsured in California (data from the March 2001 Current Population Survey shows about 6.3 million non-elderly uninsured in 2000; the 2001 California Health Interview Survey shows about 3.6 million non-elderly uninsured throughout the 12 months preceding the survey and 4.5 million non-elderly uninsured at a point in time in 2001. (Brown et al, 2002.) Given these significant differences, findings from one survey (such as rate of uninsurance by income) should not be applied to the findings of the other survey.

According to the California Health Interview Survey, about 85% of non-elderly Californians had health insurance in 2001 when the survey was conducted. Almost two-thirds of them were covered by employer-sponsored coverage (their own or through a family member) and another 5% were covered by privately purchased insurance. Medi-Cal covered about 14% of the non-elderly while the Healthy Families program covered about 2%. (Brown et al, 2002.)

Of the non-elderly, people with low incomes, particularly Latinos, had high incidences of uninsurance. About 30% of the non-elderly below poverty and about 26% of those between one and two-times poverty were uninsured in 2001. Among poor non-elderly Latinos, almost 37% with incomes below poverty and about 32% with incomes between one and two-times poverty were uninsured, the highest percentages of any racial group. At the same time, Latino children make up a significant portion of those that are eligible but not enrolled in public programs: estimates show that about 73% of children eligible for, but not enrolled in, Medi-Cal are Latino - as are about 67% of the children eligible for, but not enrolled in, the Healthy Families program. (Brown et al, 2002.)

Non-citizens also had a high incidence of uninsurance. Of non-elderly adults in 2001, about 32% of those with green cards were uninsured, while over one-half of those without green cards were uninsured. About 40% of non-citizen children lacked health insurance. (Brown et al, 2002.)

1.1 What is the overall level of uninsurance in your State?

In 2001, about 4.5 million (15.2%) non-elderly Californians did not have health insurance at the time of the survey. An additional 1.7 million (5.8%) non-elderly Californians with health coverage at the time of the survey were uninsured for some period during the preceding 12 months. About 3.6 million (12.2%) non-elderly Californians were uninsured for the entire 12 month period prior to the survey. (Brown et al, 2002.)

1.2 What are the characteristics of the uninsured?

Income:

The poor and near poor were most likely to be uninsured in 2001. Table 1 shows the rate of uninsurance for non-elderly Californians by income.

Table 1: Rate of Uninsurance By Income

	Below Poverty	101% - 200%	201% - 300%	Above 300%
Percent of Uninsured	30%	26.2%	15.1%	5.8%

Source Brown et al, 2002

In addition, the probability of having coverage throughout the year rises with income. For adults, about 52% of adults with incomes under poverty and about 60% of adults with incomes between one and two-times poverty were insured for the entire 12 months preceding the survey. The comparable percentage for adults with incomes between two and three-times poverty is about 75% and for adults with even higher incomes the comparable percentage is about 88%. (Brown et al, 2002.) A similar pattern holds for children: about 75% of children in families with incomes below poverty were insured for the entire 12 months preceding the survey, while almost 96% of children in families with incomes above 300% of poverty were insured throughout the same period. (Brown et al, 2002.)

Age:

Young adults were more likely than other age groups to be uninsured in 2001. Table 2 shows the rate of uninsurance of people in different age categories.

Table 2: Rate of Uninsurance in Different Age Categories

	< 11	12-17	18-24	25-34	35-44	45-54	55-64
Percent of Group Without Insurance	8.6%	11.7%	27.4%	21.9%	15.5%	12.2%	10.9%

Source Brown et al, 2002

Gender:

Pooled data from the March 1999 and March 2000 Current Population Surveys show that about 20% of female Californians and about 21% of male Californians were uninsured. About 52% of uninsured Californians were males over this period. (State Health Facts Online.)

Family composition:

Based on data from the Current Population Survey, children living in families headed by a single parent were more likely to be uninsured than children living in families headed by married couples in 1999. Twenty-five percent of children in single-parent families were uninsured, compared to 16% of children in married-couple families. (Brown et al, 2001.)

Among adults, single people (including single parents) were much more likely to be uninsured in 1999 than married couples. Table 3 shows the rate of uninsurance of non-elderly adults Californians in different family types.

Table 3: Rate of Uninsurance for Adults in Different Family Categories

	Single Adult	Single Parent	Married Couple W/O Children	Married Couple With Children
Percent of Group Without Insurance	32%	30%	16%	19%

Source Brown et al, 2001

Health status:

The uninsured were less likely than those with private health insurance to report that they were in excellent or very good health status. In 2001, about 36% of uninsured non-elderly adults reported that their health status was very good or excellent, compared with about 61% of non-elderly adults with employer-based coverage and about 69% of non-elderly adults with privately purchased coverage. Non-elderly adults covered by Medi-Cal or Healthy Families were even less likely (27%) than the uninsured to report themselves to be in very good or excellent health. (Brown et al, 2002.)

The picture is similar for children: about 46% of uninsured children reported that their health status was very good or excellent, compared with about 75% of children with employer-based coverage and about 80% of children with privately purchased coverage. About 54% of children covered by Medi-Cal or Healthy Families reported themselves to be in very good or excellent health. (Brown et al, 2002.)

Employment status (including seasonal and part-time employment and multiple employers):

In 2001, about 65% of non-elderly Californians were insured through employment based coverage. (Brown et al, 2002.) About 14.5% of workers were uninsured, accounting for just over one-half of uninsured non-elderly adults. (Brown et al, 2002.)

The prevalence of job-based coverage varied across a number of factors, including race, age, citizenship, education, industry, income and employment status. For example, about 75% of adult non-elderly Whites had job-based insurance, compared with about 47% of Latino, 64% of African American and 66% of Asian American non-elderly adults. Younger adult workers were far less likely to have job-based insurance than older workers: about 51% of workers between ages 18 and 24 had job-based insurance compared with 62% of workers between ages 25 and 34 and around 70% of workers in other age groups. U.S. Citizens also were more likely to have had job-based coverage: about 72% of non-elderly workers born in the United States had job-based insurance compared with about 49% of non-citizens with green cards and about 30% of non-citizens without green cards. (Brown et al, 2002.)

Looking at education, only about 34% of workers with less than a high school education had job-based coverage, while almost 81% of workers who were college graduates had such coverage. Looking at industry, only about 40% of adult non-elderly agricultural workers had job-based coverage; the comparable percentage for construction workers was about 57%, for workers in manufacturing it was about 81%, for workers in retail trade it was about 57% and for workers in business and repair it was about 67%. Income also was closely correlated with job-based coverage: only about 20% of non-elderly adult workers with income under poverty and only about 44% of workers with incomes between one and two-times poverty had job-based insurance. By comparison, about 67% of adult non-elderly workers with incomes between two and three-times poverty and almost 84% of such workers with incomes over three-times poverty had job-based coverage. Hours worked also was an important factor: about 75% of non-elderly adult full-time workers had job-based coverage, compared with only about 57% of part-time workers. (Brown et al, 2002.)

Availability of private coverage (including offered but not accepted):

In 2001, most adult non-elderly workers were offered health insurance, and most workers that were offered coverage accepted it. Table 4 shows the percentage of workers offered coverage, the percentage of workers that were eligible for coverage that was offered, and the percentage of employees that accepted coverage that was offered to them.

Table 4: Percent of California Workers Offered Coverage, Eligible for Coverage, and Enrolling in Coverage, Employees Ages 18-64

	Offered Coverage	Eligible for Coverage Offered at Work	Enroll When Eligible
California	83.4%	90.8%	84.4%

Source Brown et al, 2002

Offer rates varied significantly across factors such as race, age, industry, work status, citizenship and education, contributing to the differences in the prevalence of job-based coverage. For example, almost 89% of white non-elderly adult workers were offered health insurance at work, while the comparable percentage for Latino workers was only about 70%. Offer rates varied significantly across industries, ranging from an offer rate of 93% for educational services down to about 54% for agricultural workers. The number of hours worked was also correlated with offer rates: about 64% of non-elderly adult workers working 0-20 hours were offered coverage at work, compared to over 87% of such workers working 40 or more hours. Looking at income, offer rates varied from about 49% for non-elderly adult workers with incomes under poverty to over 92% for such workers with incomes above three-times poverty. Looking at education, offer rates varied from about 58% for non-elderly adult workers with less than a high school education to over 93% for such workers with a college degree. (Brown et al, 2002.)

Availability of public coverage:

In 2001, 4.65 million children and non-elderly adults were covered by Medi-Cal or the Healthy Families program, or about 16% of non-elderly Californians. Another estimated 355,000 uninsured children were eligible but not enrolled in Medi-Cal, and an additional 301,000 uninsured children were eligible for but not enrolled in Healthy Families. Among adults, about 413,000 parents and about 52,000 other adults were eligible for but not enrolled in Medi-Cal. (Brown et al, 2002.)

Latino children made up the lion's share of uninsured children eligible but not enrolled in both programs (about 73% of children eligible for, but not enrolled in, Medi-Cal and about 66% of children eligible for, but not enrolled in, Healthy Families). (Brown et al, 2002.) White children were the next largest group: about 17% of children eligible for, but not enrolled in, Medi-Cal and about 21% of children eligible for, but not enrolled in, Healthy Families were White. Children from other racial categories were very likely to enroll in these programs if eligible. (Brown et al, 2002.)

The State recently received a federal waiver to extend eligibility in the Healthy Families Program to parents of eligible children in families with income up to 200% of poverty. An estimated 281,000 parents will be eligible for coverage from this expansion. (Brown et al, 2002.)

Race/ethnicity:

Whites and African Americans had much lower rates of uninsurance among non-elderly Californians in 2001 than other racial/ethnic groups. Latinos had by far the highest rate of uninsurance. Table 5 shows the rate of uninsurance for non-elderly Californians in different racial/ethnic groups.

Table 5: Rate of Uninsurance for People in Different Racial/Ethnic Groups

	White	Latino	Asian American	Native Hawaiian & Pacific Islander	African American	Amer Indian & Alaska Native	Other and Multiple Race
Percent w/o Insurance	8.6%	28.3%	13%	12.9%	9.5%	17.8%	16.3%

Source: Brown et al, 2002

Immigration status:

Children who are citizens and whose parents are U.S. born citizens were much more likely to be insured in 2001 than children with naturalized or non-citizen parents. Non-citizen children had a very high rate of uninsurance. Table 6 shows the rate of uninsurance for children by citizenship status.

Table 6: Rate of Uninsurance for Children By Citizenship Status

	Child & Both Parents U.S. Born Citizens	Citizen Child Naturalized Parent	Citizen Child Parent Non-Citizen w/ Green Card	Citizen Child Parent Non-Citizen w/o Green Card	Non-Citizen Child
Percent of Group Without Insurance	4.5%	13.8%	16.3%	15.1%	39.9%

Source: Brown et al, 2002

Table 7 shows the rate of uninsurance for non-elderly adults by citizenship status.

Table 7: Rate of Uninsurance for Adults By Citizenship Status

	Born in U.S.	Naturalized Citizen	Non-Citizen With Green Card	Non-Citizen Without Green Card
Percent of Group Without Insurance	11.3%	16.6%	32.3%	51.2%

Source: Brown et al, 2002

Geographic location (as defined by State -- urban/suburban/rural, county-level, etc.):

The level of uninsurance differed significantly by region in 2001, with the Greater Bay Area (8.9% of the non-elderly and excluding San Francisco and Sonoma Counties) and the Sacramento Area (9.1% of the non-elderly) having the lowest levels of uninsurance and Los Angeles County (19.8% of the non-elderly) having among the highest levels of uninsurance. (Brown et al, 2002.) Uninsurance rates for each county are reported in the findings of the 2001 California Health Interview Survey. (Brown et al, 2002.)

Duration of uninsurance:

As presented above, in 2001 about 4.5 million (15.2%) non-elderly Californians did not have health insurance at the time the survey was taken. An additional 1.7 million (5.8%) non-elderly Californians with health coverage were uninsured for some period during the preceding 12 months. About 3.6 million (12.2%) non-elderly Californians were uninsured for the entire 12 month period prior to the survey. (Brown et al, 2002.)

- 1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

As described above, the HCOP analyzed a range of reform options developed by academic and other health policy experts. Each chose to target their reform option based on their values and their views about policy and politics in California.

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

As discussed above, CHHS did not propose to conduct new data gathering on the uninsured in California as part of the HCOP. The following responses are based on existing research of the uninsured in California where available.

A primary component of the HCOP was the economic modeling of reform proposals developed by different authors. To conduct the economic modeling, the State relied upon The Lewin Group, a nationally known consulting firm with extensive experience analyzing the health care system and the costs of health care. The model used by The Lewin Group incorporates information from national and California surveys, as well as other data needed to understand health coverage and spending in California. The Lewin model contains assumptions that address some of the questions posed in this section. For example, the model has assumptions about what amount individuals are willing to pay for health insurance. Often these assumptions vary based on factors such as income, health status and the like. A full description of the methodology for the Lewin model is available at www.healthcareoptions.ca.gov.

- 1.4 What is affordable coverage? How much are the uninsured willing to pay?

There is no one right answer for what uninsured people are willing to pay for coverage, in part because their attitudes about the value of having health insurance vary, and in part because they face very different costs for insurance, depending on such factors as their age, income, health status, and whether they are offered coverage at work. A survey of the non-poor uninsured conducted by the California HealthCare Foundation, however, found that a significant portion of the respondents (34% to 68%) overestimated the cost of purchasing non-group coverage. Based on the amounts that respondents indicated that they would be willing to pay, the research found that about one-quarter of the respondents were able to afford a typical \$10 co-payment plan within the amount that

they were willing to pay and that about one-half were able to afford a typical \$40 co-payment plan within that amount. (California HealthCare Foundation, 1999.)

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Using CHIS data, UCLA researchers have been able to look at this question. Parents of uninsured children who were estimated to be potentially eligible for the Healthy Families Program (HFP) or Medi-Cal were asked to identify barriers to enrollment. They identified the following:

- 20% (HFP) and 32% (Medi-Cal) believed they were not eligible, mostly because they thought their income was too high.
- 14% (HFP) and 8% (Medi-Cal) didn't know if they or their children were eligible.
- 23% (HFP) and only 0.3% (Medi-Cal) didn't know the coverage existed.
- 2% (HFP) and 13% (Medi-Cal) identified program characteristics as a barrier (either that the paperwork was too difficult or they didn't like or want welfare).
- 4% (both HFP and Medi-Cal) said they didn't believe in or didn't need health insurance.
- 37% (HFP) and 43% (Medi-Cal) identified a wide range of other reasons which were not differentiated.

1.6 Why do uninsured individuals and families disenroll from public programs?

Some become ineligible. Enrollees become ineligible for HFP if: family income exceeds eligibility thresholds, the child "ages out," a family obtains insurance through an employer or switches to Medi-Cal. Some families' coverage *lapses* either because they do not complete the annual renewal process or they fall behind in their premium payments.

A recent 7-state retention and disenrollment survey of SCHIP leavers issued by the National Academy for State Health Policy found that states overestimate the incidence of lapsing because significant numbers of parents who appear to have "lapsed" have actually made a judgment that their child is no longer eligible for the program.

- 61% of California parents contacted for the survey of past enrollees were found ineligible for participation in the survey because they said they left for reasons which, if true, would make them ineligible for HFP. Of these, 51% said they got private insurance, 26% said they were no longer income eligible, 13% reported that their child had moved to Medi-Cal, 4% said their child had aged out and 5% had other reasons.
- The remaining 39% constitute the survey's "true" lapsed. Of these:
 - Most give HFP high ratings.
 - Most (78%) did not mean to leave HFP.
 - The biggest reason that those who did not renew at annual eligibility determination gave was that they forgot (34%).

- Most (62%) find the renewal process easy, but 1/3 do not.
- 49% feel that the program asks for too much paperwork.
- 32% said they were not told about renewal.
- o The biggest reason given by those who lapsed because of non-payment of premium was that they forgot (39%).
 - 36% said they didn't have the money.
 - Most (91%) feel that the premium is affordable, however 1/3 say they have trouble paying some months.
- o None indicated that guilt or embarrassment about having their child in HFP was a factor.
- o Data do not support that "healthier" children are more likely to leave HFP.
- o One third of lapsed families report long waits hearing back from HFP about enrollment or some other issue.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

Information from the 2001 California Health Interview Survey shows that for eligible employees that did not participate in the health plan offered by their employer, 72% did not participate because they were covered by another plan, 19% did not participate because the coverage was too expensive, 6% either traded coverage for higher wages or did not want the coverage that was offered, and 3% did not participate because they did not value health insurance. (Brown et al, 2002.)

A survey of California employers conducted by the Henry J. Kaiser Family Foundation and the Health Research & Educational Trust asked employers about the most common reasons that employees declined their firms' offers of health insurance. Almost 60% of employers said that the that most common reason that employees declined coverage was because they were covered elsewhere, while 10% of employers responded that employees declined coverage because they could not afford their share of the premium. About 14% of employers stated that they did not know why employees declined, and about 15% percent cited other reasons. Only 2% of employers thought that employees declined coverage because they did not want it or did not feel that they needed it. (KFF and HRET, 2002.)

In a 1999 national survey of workers supported by the Commonwealth Fund, about one-half of lower-wage workers who declined coverage cited high costs and/or inadequate benefits as the reason they declined. Among higher-wage workers, the availability of health insurance through a family member was a more common reason for declining coverage. (Duchon et al, 2000.)

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

CHHS does not have information specific to California on this issue. In a 1999 national survey of workers supported by the Commonwealth Fund, workers were asked which

would be the best approach: having employers continue to be the main source of coverage, having the government become the main source of coverage, or having workers buy coverage directly from insurers. About one-half of adults chose employer-sponsored coverage as the best of the three choices. Of workers who were currently covered by a public plan, about an equal percentage supported employer-sponsored coverage (29%) and direct purchase of insurance (31%). About 73% of adults with employer-sponsored coverage thought employers generally did a "good job" in choosing insurance plans. (Duchon et al, 2000.)

1.9 How likely are individuals to be influenced by:

Availability of subsidies?:

CHHS does not have research information on this issue. Several of the reform proposals developed for this project used premium subsidies to encourage individuals to become covered, and the potential effects of these different subsidy schemes on coverage are analyzed in the results of the economic modeling for each of the proposals. The Lewin model contains assumptions that address both employer and employee responsiveness to subsidies. A full description of the methodology for the Lewin model is available at www.healthcareoptions.ca.gov.

Tax credits or other incentives?:

CHHS does not have research information on this issue. One of the reform proposals developed for this project used premium subsidies to encourage employers to offer coverage and to encourage uninsured individuals to purchase coverage, and the potential effects of these subsidy schemes on coverage are analyzed in the results of the economic modeling of that proposal. The Lewin model contains assumptions that address both employer and individual responsiveness to subsidies.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

A survey of the non-poor uninsured identified several reasons that people who do not purchase health insurance give for their lack of coverage. Cost, of course, was the primary reason. In addition, as described above, a significant portion of the non-poor uninsured overestimate the cost of coverage, and may be able to purchase it for an amount that they are willing to pay. Other reasons cited by respondents included the fact that the respondent was in good health (48%), that the respondent was waiting until they worked for an employer that offered insurance (37%), that the respondent can get needed care for less than the cost of insurance (33%), that the respondent did not feel that he or she needed insurance (25%), that the respondent had never thought about purchasing it individually (25%) and that the respondent did not know enough about buying coverage (25%). Over 40% of respondents agreed with a statement "Health insurance is not a very good value for the money", while almost 40% agreed with a statement "Going to public or free clinics for my medical care is just fine with me." (California HealthCare Foundation, 1999.)

In addition to these perceptions about the value of health insurance, there are additional obstacles that affect some people. Under California law, people with health problems can be denied health insurance coverage in the non-group market. The State offers coverage to uninsurable people through a high-risk pool, but premiums are higher than in the standard insurance market that makes coverage even less affordable for people with modest incomes.

1.11 How are the uninsured getting their medical needs met?

Information from the 2001 California Health Interview Survey shows that about 46% of uninsured non-elderly adults report having no usual source of care and about 25% report that a clinic or community-based hospital is their usual source of care. In contrast, about 82% of people with employer-based insurance report that a doctor's office or an HMO is their usual source of care; only about 8% report that a clinic or community-based hospital is their usual source of care and only about 9% have no usual source of care.

California has a substantial infrastructure of public and private health care institutions that provide health care to the poor. Looking just at public expenditures, spending for categorical programs for uninsured people with specific health care needs (such as the Ryan White Care Act) was about \$3.9 billion in Fiscal Year 01-02 and spending for noncategorical safety-net institutions was \$4.6 billion in Fiscal Year 01-02. (Kahn and Gardner, 2001.)

Despite this effort, research indicates that uninsured people have less access to health care than people who are insured. For example, among low-income children, 10.3% of uninsured children reported an unmet medical or surgical need in 1997, as compared to 1.6% of children with private coverage and 2.4% of children with public coverage. In that same year, 28% of uninsured children and about 46% of uninsured adults reported having no usual source of health care. (Haley and Zuckerman, 2000.) Uninsured non-elderly adults with diabetes, high blood pressure and heart disease also are less likely than the insured with those conditions to be taking medication for their disease. (Brown et al, 2002.)

1.12 What is a minimum benefit?

Each of the reform proposal authors defined the appropriate benefit level for his or her proposal. The approaches varied, with some approaches providing for all Californians to receive comprehensive benefits with little or no cost-sharing while others relied upon the types of coverage that are generally available in the market today. The benefit package for each proposal can be found at www.healthcareoptions.ca.gov.

One proposed approach (Cal-Health) provides for the creation of a standard uniform benefit package that would be designed to be less expensive than coverage currently available on the market. The product would cover a comprehensive set of services; the

savings generally would be achieved by applying rather significant cost sharing to use that exceeds a defined number of days or visits For example, a policy provided to younger purchasers would cover 5 hospital days in a year, with additional hospital days subject to a \$2000 deductible and 70% co-insurance.

- 1.13 How should underinsured be defined? How many of those defined as “insured” are underinsured?

As discussed above, each of the reform proposal authors defined the appropriate benefit level for his or her proposal. CHHS does not have any information on the concept of underinsurance.

SECTION 2. EMPLOYER-BASED COVERAGE

As discussed above, CHHS did not propose to conduct new data gathering on the uninsured in California as part of the HCOP. Information for the responses to the questions in this section is taken from existing data sources. The primary data source is the 2001 California Health Benefits survey conducted by the Henry J. Kaiser Family Foundation and the Health Research & Educational Trust. (KFF and HRET, 2002.) Information from this survey also was used by The Lewin Group in its the economic modeling of the coverage expansion proposals.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

The Kaiser and HRET survey reported that in 2001 66% of California employers offered health benefits to their employees in 2001, compared with a nationwide offer rate of 65%. The percentage of California employers that provide coverage rose rapidly in the past few years, from 48% in 1999 to 66% in 2001.

Employer size (including self-employed):

The percentage of California employers offering health benefits varied significantly by firm size, with only 61% of firms with 3-9 workers offering coverage compared with 95% of firms with 200-999 workers and 98% of forms with more than 1000 workers offering coverage. (KFF and HRET, 2002.)

Industry sector:

The percentage of California employers offering health benefits also varied by industry sector. Table 8 shows the offer rates for different industry sectors in 2001.

Table 8: Percentage of Employers Offering Coverage by Industry Sector

	Manufacturing, Transportation, Utilities, Communications	Health, Finance	Retail, Wholesale	Service	Mining, Agriculture, Construction
Percent Offering Health Benefits	75%	79%	56%	66%	59%

Source: KFF and HRET, 2002

Employee income brackets:

The wage level of employees also was correlated with employer offering of health benefits. Only 35% of lower wage firms (for example, firms in which at least 35% of workers earned less than \$20,000) offered benefits, while 75% of higher wage firms (for

example, firms in which less than 35% of workers earned less than \$20,000) offered health benefits.

Percentage of part-time and seasonal workers:

California employers also were less likely to offer health benefits to part-time and temporary workers than to full-time workers. Only 11% of firms offered health benefits to part-time workers, while 49% of firms offered health benefits to part-time workers.

Geographic location:

CHHS does not have information on this issue.

For those employers offering coverage, please discuss the following:

Cost of policies:

The average monthly premium for group health insurance coverage in California in 2001 was \$521. This varied by type of insurer; with an average of \$464 monthly for HMO coverage, \$601 monthly for PPO coverage, and \$543 monthly for point of service plans.

Health insurance premiums in California rose by an average of 9.9% between 1999 and 2000. The level of increase also varied by type of plan, with an average increase of 8.9% for HMOs, 10% for PPOs, and 11.7% for point of service plans.

The change in premiums between 2000 and 2001 in California also varied by firm size. There was very little variation in the average increases seen by firms with less than 300 employees saw increases that averaged 11% to 11.5%. Firms with between 300 and 1000 employees saw slower growth, with an average premium increase of 10%. Premiums for firms with more than 1000 employees increase by 8.6%.

Level of contribution:

The average monthly contribution in California by employers in 2001 was \$176 for single coverage and \$407 for family coverage. The average monthly worker contribution in that year was \$21 for single coverage and \$114 for family coverage.

Percentage of employees offered coverage who participate:

For firms in California that offered coverage to their employees in 2001, on average about 79% of the employees were eligible for to participate in the coverage arrangement. Of those employees eligible to participate, about 84% do.

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

- 2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Most California firms offer health benefits to their workers. Overall, about 66% of California firms offered health benefits in 2001. When firms that do not offer health benefits are asked for the most important reason for not covering their employees, about 60% cite high premiums, about 36% say it is because their employees are covered elsewhere, about 30% say that the firm cannot qualify for group coverage at group rates, about 27% say that they can attract good workers without offering insurance, and about 26% say that the administrative hassle of offering benefits is too great. (California HealthCare Foundation, 1999.)

- 2.3 What criteria do offering employers use to define benefit and premium participation levels?

CHHS does not have information on this issue.

- 2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

CHHS does not have information on this issue.

- 2.5 What employer and employee groups are most susceptible to crowd-out?

CHHS does not have information on this issue.

- 2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?:

Individual or employer subsidies?:

Additional tax incentives?:

The economic model used by the Lewin Group to analyze the impacts of the different reform proposals considered by this project includes explicit assumptions about how employers and individuals would react to subsidies and tax incentives. Those assumptions are discussed in the final report and technical appendix prepared by the Lewin Group, which can be found at www.healthcareoptions.ca.gov.

California already has an active purchasing pool, originally called the Health Insurance Pool of California, now called Pacific Health Advantage. Several of the reform options would make use of this mechanism or its administrator to expand coverage.

- 2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

The reform options developed by the health policy experts for this project considered several alternatives to encourage employer participation, including premiums subsidies (both direct and as tax credits) and required contributions (such as the pay-or-play approach). One option also provided for a lower-cost benefit package that could be offered to small employers to increase affordability of coverage. The estimates of the effectiveness of these approaches can be found in the final report prepared by the Lewin Group.

SECTION 3. THE HEALTH CARE MARKETPLACE

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

As discussed above, CHHS did not propose to conduct new data gathering on the uninsured in California as part of the HCOP. Information for the responses to the questions in this section is taken from existing data sources.

The design of the HCOP provided for proponents of different approaches to increases health insurance coverage to develop those proposals sufficiently so that the potential effects of each approach on access to coverage, utilization and costs could be calculated and compared through economic modeling

- 3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

The HCOP did not make any judgments on the adequacy of existing coverage, nor did it attempt to define it. The authors of each of the coverage expansion options was required to specify the level of coverage that individuals would receive under their approaches, and the economic modeling produced results that look at how each approach would affect costs, including out-of-pocket costs, and utilization of services.

- 3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

CHHS does not have information on this issue.

- 3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

Californian workers and their families are less likely to be covered by a self-funded health plan than workers nationally. (KFF and HRET, 2002.) Of California workers covered through an employer-sponsored plan in 2001, 27% received that coverage through a self-funded health plan. Nationally, 47% of workers covered through a plan offered by their employer were in self-funded health plans. (KFF and HRET, 2002.) One of the reasons for the difference is that Californian workers are much more likely to have coverage through an HMO than workers nationally. In California in 2001, 48% of workers were covered by HMOs, while only 23% of workers nationally had HMO coverage. (KFF and HRET, 2001.) The prevalence of HMO coverage may help explain why health care premiums in California are lower than the national average. (KFF and HRET, 2001.)

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

The HCOP project did not explicitly consider this issue. Several of health care options developed by proposal authors would expand the state's role as a health care purchaser, in some cases significantly. Three of the proposals would implement a single-payer approach to health coverage, with the state occupying the central role as a single-purchaser of health coverage for all Californians. In one proposal the state also would purchase all health care facilities and practices and would be the provider of health care as well. In several other proposals, public programs would offer comprehensive health coverage options that would act as an alternative to employer-sponsored coverage. These proposals are discussed below.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

The HCOP commissioned the development of nine different approaches to expanding coverage. Most, but not all, of these reform options would require some changes in existing laws or regulations. For example, several of the approaches propose an expansion of California's waiver for its Medi-Cal and Healthy Families Programs so that additional adults or children could be covered. Some reform proposals also would integrate federal and state funding under Medicare, Medicaid, and other public programs into new state programs that would provide to Californians. Under several options, employers would be offered the option of continuing to offer employer-sponsored insurance or making a required contribution to new state programs. Such an approach could be challenged as state regulation of an employee benefit plan under the preemption clause of ERISA, although the authors of those proposals believe that they would withstand scrutiny. Numerous other changes to state laws and regulations are envisioned under the proposals. Each reform proposal contains a discussion of the changes to existing laws and regulations that would be necessary to bring them into effect. Summaries and detailed reform proposals can be found at www.healthcareoptions.ca.gov.

3.6 How would universal coverage affect the financial status of health plans and providers?

The HCOP did not attempt to quantify specific impacts on health plans and providers under the various reform proposals that were developed by the reform proposal authors. In most cases, the reform proposals would expand insurance coverage, which should help reduce the uncompensated care burdens of providers. In a few cases, proposals would increase provider reimbursement rates, at least in the short run, which also would assist providers. Several of the proposals (particularly the proposals that would establish single-payer health systems) would limit the growth of health care spending over the long term in California, which probably would reduce revenues for some providers over the longer term. At the same time, these proposals also would substantially reduced administrative costs for providers and in some cases for health plans.

The effects on the various reform proposals on health plans are mixed. Several of the proposals would eliminate most of the existing private health plans, although non-profit health plans would be able to continue to operate within some of the new arrangements that are proposed. Other proposals would establish competing insurance arrangements that might attract enrollees away from existing health plans. Several of the more incremental reform proposals would build on existing coverage arrangements, which would result in more people being able to afford coverage through private health plans.

Each of the reform proposals contains a detailed discussion of how the proposed approach would affect the current health care market.

3.7 How did the planning process take safety net providers into account?

The authors of the reform proposals were asked to consider affects on safety-net providers as part of their reform proposals. In addition, the economic modeling conducted under the project took into account current public spending on safety net providers and how it would change under the different reform approaches. Finally, the potential impact on safety-net providers was one of the parameters considered in the qualitative analysis of the different reform approaches. That analysis can be found at www.healthcareoptions.ca.gov.

3.8 How would use change with universal coverage?

Expanding insurance coverage would generally increase the use of health care services. The Lewin model that was used to analyze the impacts of the different reform approaches makes assumptions about how service use will increase when coverage is expanded. In general, the model assumes that people who are uninsured and become insured modify their use so that their use is the same insured people with similar characteristics. The modeling also made explicit assumptions about how changes in cost-sharing and increasing access to primary care would affect use. These assumptions are discussed in the final report and technical appendix prepared by the Lewin Group, which can be found www.healthcareoptions.ca.gov.

3.9 Did you consider the experience of other States with regard to: Expansions of public coverage? Public/private partnerships? Incentives for employers to offer coverage? Regulation of the marketplace?:

The HCOP commissioned reform proposals from policy experts and interested parties. The authors of the different reform proposals looked to various sources in developing their proposals, including experiences in other states and in other countries. For example, several proposals considered the experience of other states in looking for ways to expand enrollment in existing public programs. In some cases, the authors of the single-payer proposals drew on experiences from other countries. In addition, the economic analysis the impacts of the different reform proposals considered relevant experiences from other states, such as the successes other states have had in expanding outreach and enrollment in their Medicaid and SCHIP programs.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. Those states that have not reached a consensus on a coverage expansion strategy may answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

- 4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

As discussed above, the HCOP was not designed to achieve consensus recommendations or to identify preferred options; rather, the goal of the HCOP was to provide policy makers and the public with detailed information about the cost and coverage impacts of a broad array of reform approaches. Nine health reform options developed by independent health policy experts were analyzed under the project. The information below summarizes key points of the proposals, but cannot capture all of the important detail included by the health policy experts that developed them. Readers should refer to the detailed description of these options for a more complete discussion of how they would operate. Two-page summaries as well as full options papers are available at www.healthcareoptions.ca.gov.

The nine health reform option proposals are:

- The Single Payer Option, developed by James G. Kahn and others, University of California at San Francisco. This reform proposal would replace current health financing arrangements with a single, publicly financed health insurance program that would cover all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people.
- Cal Care: A Single Payer Health Care System for California, developed by Judy Spelman and others; Health Care for All. This reform proposal also would replace current health financing arrangements with a single, publicly financed health insurance program that would cover all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people. This proposal differs from the previous proposal in some areas of benefits and administration.
- The California Health Service Plan, developed by Ellen Shaffer. This reform proposal also would replace current health financing and delivery arrangements with a single, publicly financed health care program that would provide health services to all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people. Under this proposal, health care services would be provided through the public sector by hospitals and other facilities operated by the state and through health care professionals employed

by the state.

- The California PacAdvantage Premium Program, developed by Katie Horton and others. This reform proposal would make subsidized coverage available to small employers and their employees with incomes below 350% of poverty through the state's existing non-profit small purchasing pool.
- Healthy California, developed by Rick Brown, UCLA, and Rick Kronick, University of California San Diego. This reform proposal would make coverage available to all citizens and legal residents through a new public program called Healthy California. In stage one a federal waiver would be sought to cover low-income adults and to integrate existing public programs into the new Healthy California. The income thresholds for current public programs also would be relaxed to permit the state to achieve federal matching payments for all families that enroll in the program. In the second stage, a pay-or-play premium requirement for employers would be instituted to help finance the system.
- CHOICE Option, submitted by Helen Halpin Schaffler and Sara B. McMenam, University of California at Berkeley. Under this reform option, a public program (CHOICE) would be created to offer coverage to working Californians and their dependents. Employers would pay a payroll tax to help fund health coverage for their workers, but would receive a refund for workers who chose to be covered through coverage offered by the firm. Workers (and their dependents) could enroll in CHOICE by paying premium that varies with their wages. Workers and their dependents who are enrolled in Medi-Cal or Healthy Families also could enroll in CHOICE. In addition, the proposal includes an outreach initiative aimed at individuals eligible but not enrolled in existing public programs.
- The Managed Care Expansion Plan, submitted by Working Partnerships, USA. Under this reform option, subsidies for coverage would be gradually phased-in over 15 years to California residents under 400% of poverty. Coverage would be provided through the managed care plan models currently serving Medi-Cal enrollees.
- The Managed Care Expansion Plan, submitted by the Insure the Uninsured Project. This reform option would use a combination of strategies to reduce the number of uninsured, including an 1115 waiver to cover low-income adults, providing coverage to Medi-Cal and Healthy Families enrollees through employer plans when it is cost-effective, a refundable tax credit targeted to employers with low-income employees, and a refundable tax credit or voucher for individuals not offered employer-provided coverage.

For each option identified, complete questions 4.2 through 4.15 (if relevant to your State's planning process):

OPTION: Single Payer Option, developed by James G. Kahn and others, University of California at San Francisco. This reform proposal would replace current health financing arrangements with a single, publicly financed health insurance program that would cover all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people.

4.2 What is the target eligibility group under the expansion?

The single payer program proposed in this option would provide coverage to all California residents (after a 3-month waiting period for most services; a 3-year waiting period for long-term care services).

4.3 How will the program be administered?

An elected health commissioner, a state board, and regional boards would administer the program. The boards would be public and would be composed of elected and appointed members, including representatives of health care providers, consumers and employers. The commissioner and boards would be responsible for financial management of the health care system, establishing eligibility and benefits, negotiation reimbursement and other necessary functions.

4.4 How will outreach and enrollment be conducted?

Any person with documentary evidence of state residence would be eligible for the program. Outreach would be accomplished through a concerted campaign involving public service advertising, workplace benefits information, and enrollment at health care providers offices and facilities and at government offices.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

The single payer program would not require premiums.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The program would provide a comprehensive benefit package, including long-term care services (other than room and board charges). The full package is outlined in detailed description of the plan at www.healthcareoptions.ca.gov.

Enrollees would be responsible for a \$5.00 co-payment for each ambulatory visit and for each prescription filled and for a \$100 co-payment for each hospital admission. Enrollees

meeting Medi-Cal or Healthy Families income eligibility guidelines would be exempt from cost-sharing. There would be no cost-sharing for preventive services.

- 4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

The proposed approach would provide coverage to all State residents. The estimated cost of the program (assuming full implementation in 2002) would be \$129.6 billion. This would represent a reduction in total health spending for the state of \$7.6 billion. Private employer spending would increase by \$12.4 billion in that year, while families on average would see savings of \$658 (which would vary with family income and other factors).

The costs estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

- 4.8 How will the program be financed?

Financing for the proposed program would come from:

- Redirecting existing public spending for health care, including state spending and federal spending in California for programs including Medicare, Medi-Cal, Healthy Families, Tri-Care, Indian Health Service, Federal Employees Health Benefits Program, Veterans Administration, federal and state categorical programs and state safety-net programs;
- Redirecting private funds intended for health care, such as retiree benefits;
- Billing any public and private programs that are not incorporated into the single payer system for services provided;
- Tobacco tax.
- Payroll tax of 8% on employers, with an exemption for firms with less than \$75,000 in gross income;
- Personal income tax on heads of households of 0.3%;
- State income tax surcharge of 0.3% on net taxable income in excess of \$250,000 annually; and
- Co-payments for selected services.

- 4.9 What strategies to contain costs will be used?

Under the proposed single payer program proposal, costs would be contained through the establishment of a global budget for the health care system, with corresponding regional budgets that would be specified by sector (such as fee-for-service providers, capitated providers, health facilities). Growth in overall spending under the system would be constrained to the rate of growth of state gross domestic product. To help keep costs within the budget, the health commissioner would approve large capital expenditures,

establish a formulary for prescription drugs, and be authorized to negotiate with prescription drug manufacturers and suppliers of medical supplies and equipment.

4.10 How will services be delivered under the expansion?

Services would be delivered by public and private health care providers or through integrated delivery systems.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The proposed single payer system is intended to supplant existing financing arrangements.

4.13 How will crowd-out will be avoided and monitored?

The proposed system is intended to supplant existing financing arrangements, so there is no effort to avoid crowd-out.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public

forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

A variety of ongoing efforts include:

- Development of a simplified and colorful 4-page mail-in application for Medi-Cal and HFP, and a similar four page mail-in application for Medi-Cal only individuals. The applications are available in 11 languages.
- Creation of Health-e-App, an on-line electronic application for Community Based Organizations, which provides immediate response to applicants about their potential eligibility for Medi-Cal or HFP.
- Increased efforts for coordination between Medi-Cal and HFP are making it much easier for families to navigate through the programs.
- Development of a bridging program between HFP and Medi-Cal and vice versa, to ensure the families a smooth transition from one program to the other.
- Continuous communication and sharing of draft policy documents between the State and the counties, to ensure simplification of processes at the county level.
- Collaboration with advocate groups in the development of policy and procedures.
- Use of more than 27,000 trained application assistants throughout the State that provide free help to families in their own language to complete an application for HFP and/or Medi-Cal.
- Proposal to use Child Health and Disability Prevention (CHDP) Program as a gateway to comprehensive health care for children. The Governor's revised budget (May 2002) provides funding to augment the CHDP program to develop an electronic pre-enrollment application for Medi-Cal and HFP. Under this plan, pre-enrolled children will be immediately eligible for medical care through Medi-Cal or HFP.
- Elimination of need for families to have face-to-face meetings with a Medi-Cal eligibility worker to enroll.
- Collaboration of HFP/Medi-Cal for Families (MCF) campaign with other state and federal outreach campaigns and foundations to help increase enrollment. During FY

2001-2002, the campaign has collaborated with Covering Kids - Robert Wood Johnson Foundation, Insure Kids Now Campaign, the California Endowment, the David and Lucile Packard Foundation, the Kaiser Family Foundation, and the California Children and Families Commission to supplement outreach and enrollment efforts. These efforts will continue.

OPTION: Cal Care: A Single Payer Health Care System for California, developed by Judy Spelman and others; Health Care for All. This reform proposal also would replace current health financing arrangements with a single, publicly financed health insurance program that would cover all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people. This proposal differs from the previous proposal in some areas of benefits and administration.

4.2 What is the target eligibility group under the expansion?

The single payer program proposed in this option would provide coverage to all California residents (demonstration of residency for 3-months with intent to remain for most services, 2 years of residency for long-term care services).

4.3 How will the program be administered?

The proposed Cal Care program would be administered by a single state health agency, headed by an elected state health commissioner, which would among other things develop a global budget for health spending, develop sector global budgets, perform state-wide health services planning, adopt and modify the benefits package, and oversee licensing and accreditation. Each county would have a branch of the county agency that would, among other things, perform regional health planning, negotiate fees and budgets with providers based on state budget limits, establish and oversee local capital budgets, and establish an office of consumer advocate.

4.4 How will outreach and enrollment be conducted?

California residents would be able to enroll at multiple sites, including internet sites. Those in Medi-Cal, Medicare, Healthy Families, HMOs, and other group programs would be enrolled in the system *en masse*. Newborns and those attaining US citizenship while residing in California would be enrolled automatically. Community, school and media outreach programs would inform people about how to enroll. Demonstration projects will help identify effective enrollment techniques. People will be able to enroll at multiple sites, including internet sites.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

The Cal Care program would not require premiums.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The program would provide a comprehensive benefit package based on the Kaiser Permanente benefit package for large employers, with additional services provided to people who meet Medi-Cal and Health Families eligibility criteria. Additional benefits,

including long-term care services (other than room and board charges) alternative medicine and dental care, would also be provided. (The full package is presented in the detailed description of the plan).

There would be no co-payments generally for services. There would be a \$25 co-pay for specialty care visits that were not referred from a primary care physician.

- 4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

The proposed approach would provide coverage to all State residents. The estimated cost of the program (assuming full implementation in 2002) would be \$134.7 billion. This would represent a reduction in total health spending for the state of \$3.7 billion. Private employer spending would increase by \$0.2 billion in that year, while families on average would see savings of \$473 (which would vary with family income and other factors).

The costs estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

- 4.8 How will the program be financed?

Financing for the proposed program would come from:

- Redirecting existing public spending for health care, including state spending and federal spending in California for programs including Medicare, Medi-Cal, Healthy Families, Tri-Care, Indian Health Service, Federal Employees Health Benefits Program, Veterans Administration, federal and state categorical programs and state safety-net programs;
- Payroll tax of 6.1% on employers and 3.6% on employees (with the first 7,000 of income exempt from the tax);
- An income tax surcharge of 2.8% on specified non-payroll income;
- Tobacco tax of \$1.00 per pack or product.
- A ¼ cent increase in the sales tax; and
- Alcohol tax sufficient to raise \$2 billion in 2002.

- 4.9 What strategies to contain costs will be used?

Under the Cal Care proposal, costs would be contained through the establishment of a global budget for the health care system, disaggregated by sector (such as fee-for-service providers, capitated providers, health facilities). Capital costs would be separately budgeted. Growth in overall spending under the system would be constrained to the rate of growth of state gross domestic product. To help keep costs within the budget, the State Health Agency would engage in state-wide health care planning and would negotiate with manufacturers and suppliers of pharmaceuticals, medical supplies and other health care products and use its purchasing power to negotiate lower prices.

4.10 How will services be delivered under the expansion?

Services would be delivered by public and private health care providers or through integrated delivery systems.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The proposed single payer system is intended to supplant existing financing arrangements.

4.13 How will crowd-out be avoided and monitored?

The proposed system is intended to supplant existing financing arrangements, so there is no effort to avoid crowd-out.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

See previous response to 4.19.

OPTION: The California Health Service Plan, developed by Ellen Shaffer. This reform proposal also would replace current health financing and delivery arrangements with a single, publicly financed health care program that would provide health services to all Californians. Savings from reduced administrative costs and other cost-savings features would help finance the extension of coverage to previously uninsured people. Under this proposal, health care services would be provided through the public sector by hospitals and other facilities operated by the state and through health care professionals employed by the state.

4.2 What is the target eligibility group under the expansion?

The single payer program proposed in this option would provide coverage to all California residents (residency for at least 3-months).

4.3 How will the program be administered?

The proposed California Health Service Plan (CHSP) would be administered by a new agency, the California Health Services Administration, which would set policy for and coordinate the work of the agencies administering the system. These agencies would include the California Health Services Program, which would deliver health care services to state residents, the California Department of Public Health, which would monitor vital statistics and implement programs to address determinants of poor health, and the California Office of Statewide Health Planning and Development, which would collect data and support strategic planning activities.

4.4 How will outreach and enrollment be conducted?

Individuals would be initially informed of their right to health care benefits, and enrolled in the program, through public announcements including: online outlets, the media, schools, workplaces, government offices, health care delivery sites, and community based organizations. Certified Application Assistants, trained to enroll applicants into the Healthy Families program, and others would conduct outreach and enrollment at least during the first two years of the CHSP program. Newborns would be automatically enrolled.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

The CHSP program would not require premiums.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The program would provide a comprehensive benefit package, including long-term care services (other than room and board charges) and dental services. (The full package is outlined in detailed description of the plan).

There would be no co-payments generally for services.

- 4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)

The proposed approach would provide coverage to all State residents. The estimated cost of the program (assuming full implementation in 2002) would be \$129 billion. This would represent a reduction in total health spending for the state of \$7.5 billion. Private employer spending would increase by \$7.9 billion in that year, while families on average would see savings of \$813 (which would vary with family income and other factors).

The costs estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

- 4.8 How will the program be financed?

Financing for the proposed program would come from:

- Redirecting existing public spending for health care, including state spending and federal spending in California for programs including Medicare, Medi-Cal, Healthy Families, Tri-Care, Indian Health Service, Federal Employees Health Benefits Program, Veterans Administration, federal and state categorical programs and state safety-net programs;
- Payroll tax of 7.41% on employers and 2.5% on employees; and
- Tobacco tax of \$1.00 per pack or product.

- 4.9 What strategies to contain costs will be used?

Under the proposed CHSP, could be constrained by setting and enforcing budgets for specific categories of services (such as primary care, inpatient and outpatient hospital care, and pharmaceutical drugs), with separate funds for capital expenses, research, and training. Providers could not offer covered services privately. Salaries and facility budgets would be negotiated with providers in appropriate groups. Financial and non-financial incentives would be implemented to encourage productivity and quality. The state agency would act as a group purchaser, negotiating rates for prescription drugs bought in bulk. Formulary and generic drugs will be encouraged. The annual growth in program costs would be constrained to growth in state gross domestic product.

- 4.10 How will services be delivered under the expansion?

Services would be delivered by the public sector. Health care providers would work for the public sector and would not be permitted to provide services outside of the proposed program.

- 4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

- 4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The proposed single payer system is intended to supplant existing financing arrangements.

- 4.13 How will crowd-out will be avoided and monitored?

The proposed system is intended to supplant existing financing arrangements, so there is no effort to avoid crowd-out.

- 4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

- 4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

- 4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary

factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

See previous response to 4.19.

OPTION: The California PacAdvantage Premium Program, developed by Katie Horton and others. This reform proposal would make subsidized coverage available to small employers and their employees with incomes below 350% of poverty through the state's existing non-profit small purchasing pool.

4.2 What is the target eligibility group under the expansion?

The proposed reform program would provide subsidies to small employers (2-50 employees) to help fund the premiums of participating workers with family incomes below 350% of poverty. Firms that had not offered health insurance to their employees for at least six months would be eligible to participate, and could receive subsidies for workers who had been uninsured for at least six months. In addition, firms that already offer coverage through PacAdvantage would be eligible to receive a subsidy for their employees. To be eligible for a subsidy, employees would have to work at least 20 hours per week and not be eligible for public coverage.

4.3 How will the program be administered?

The proposed program would be administered by PacAdvantage, California's non-profit small business purchasing pool, which is managed by the Pacific Business Group on Health. Policy oversight would be provided by the state Major Risk Medical Insurance Board, which operates the Healthy Families program and the state's high risk pool for uninsurable individuals.

4.4 How will outreach and enrollment be conducted?

Enrollment in the proposed program would be through PacAdvantage. Outreach efforts would include: a paid media campaign to place ads in newspapers, trade press and television; a media campaign in which the state would promote the program through newscasts, radio talk shows and public events; a grassroots outreach program which would send representatives to Chambers of Commerce, business groups and other interested organizations; and, an initiative to extend outreach to enrollment brokers.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Under the proposal, small employers would receive a subsidy based on the income level of participating employees, and they would be required to limit the employee's share of the premium to a percentage of the total premium that would vary with employee income. The subsidy to the employer would vary from 55% of premium for employees with incomes below twice poverty to zero for employees with incomes above 350% of poverty. The maximum employee share of the premium would vary from 10% for employees with income below twice poverty to 40% for employees with incomes above 350% of poverty, although employers could pay a larger share of the premium if they desire to. The following table demonstrates how the premium would be shared among the subsidy, the employer and the employee under the proposed subsidy arrangement:

Employee Income Level (percent of poverty)	Subsidy	Employer Share	Employee Share*	Total
350+	0	60	40	100
300-349	25	40	35	100
250-299	35	40	25	100
200-249	45	40	15	100
Below 200	55	35	10	100

* Maximum share that the employee can be charged under the arrangement. Employers can pay a greater share of the premium of the premium if they wish.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

Under the proposal, employers would be encourage to offer one existing products offered to small employers and their employees through PacAdvantage. Employers would have the option of offering dental, vision and chiropractic/acupuncture coverage; dental and vision riders would be required under the program.

Employers choosing not to offer a PacAdvantage product would be required to certify that the product selected was either identical or actually equivalent to one of the following:

- The most popular commercial HMO in the State;
- A plan offered in California through the Federal Employee Health Benefit Program; or
- The richest PacAdvantage plan offered in the employers' area.

The details of the benefits available through PacAdvantage are included in the description of the proposed reform at www.healthcareoptions.ca.gov.

4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)

The proposed program would cover 112,000 uninsured people if fully implemented in 2002, at an estimated additional public cost of \$189 million (net of savings to safety-net programs). Changes in private spending were not estimated.

The costs estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

4.8 How will the program be financed?

The proposed program would be funded by an estimated 20% increase in tobacco and alcohol taxes.

4.9 What strategies to contain costs will be used?

Under the proposal, coverage would be provided under existing insurance arrangements available to small employers, including managed care arrangements.

4.10 How will services be delivered under the expansion?

Services would be delivered through existing insurance arrangements available to small employers.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The proposed program would take advantage of state's existing non-profit purchasing pool for small employers. Coverage would be delivered through existing insurance arrangements available to small employers.

4.13 How will crowd-out will be avoided and monitored?

The proposed program would be limited to small employers that have not offered coverage in the previous six-months (other than through PacAdvantage) and to employees who had been uninsured for six months (other than through PacAdvantage). Individuals eligible for public coverage would not be eligible for subsidized coverage; the enrollment application would include screening questions to identify people eligible for public coverage.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Not applicable.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

See previous response to 4.19.

OPTION: Healthy California, developed by Rick Brown, UCLA, and Rick Kronick, University of California San Diego. This reform proposal would make coverage available to all citizens and legal residents through a new public program called Healthy California. In stage one a federal waiver would be sought to cover low-income adults and to integrate existing public programs into the new Healthy California. The income thresholds for current public programs also would be relaxed to permit the state to achieve federal matching payments for all families that enroll in the program. In the second stage, a pay-or-play premium requirement for employers would be instituted to help finance the system.

Note: the Healthy California Program is proposed to take effect in two stages: an initial stage that would focus on those currently eligible for public programs and other lower-income populations and a second stage that would make coverage available to all citizens and legal residents. The information below describes the program as fully implemented. More detail on the each stage and their costs is available in the detailed option description and in the final report of the modeling contractor.

4.2 What is the target eligibility group under the expansion?

The target group for this proposal would be all citizens and legal residents of California. Many undocumented immigrants would continue to receive coverage if they work for an employer maintains its employee benefit plan.

4.3 How will the program be administered?

The new Healthy California program would be administered state Major Risk Medical Insurance Board, which would conduct outreach to potentially eligible persons, determine eligibility of applicants, and monitor and assure quality.

4.4 How will outreach and enrollment be conducted?

The Healthy California proposal calls for the Major Risk Medical Insurance Board would conduct an extensive outreach campaign to inform all Californians of the new program. The enrollment process would require only that applicants provide the names and social security numbers of family members wanting to enroll and that they sign a declaration that they are legal residents in California and that they are not covered by employer-sponsored coverage, Medicare, or CHAMPUS. Verification would occur after enrollment. Enrollees would need to inform the program administrator if they became covered under an employer-sponsored plan. People who choose to be covered by an employee benefit plan offered by their employer would enroll as they do today.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

The proposed Healthy California is a pay-or-play model of health coverage. Employers would be required to pay a payroll tax to the new program, but would receive a credit against the tax if the employer offers a qualifying employee benefit plan and a worker decided to join it.

The payroll tax would vary by firm size and would be graduated with payroll:

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

The maximum liability for the payroll tax would be \$700 per month (including both the employer and employee share. People with unearned or self-employment income would be required to pay both the employer and employee share of the tax (unless they were otherwise insured).

Individuals for whom the payroll tax is paid would be automatically enrolled in the proposed program, and would be able to choose a private health plan for coverage. They would be able to enroll in any plan with a premium up to the 33rd percentile of premiums in their area without paying more; they choose a more expensive plan, they would be required to pay the difference.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

Under the proposal, a standard uniform benefit package would be created with benefits approximating those currently offered in the Healthy Families program. Medi-Cal eligible people also would receive additional benefits now provided by that program. The cost-sharing would be similar to the point-of-service plans now provided to state workers in California, but would be waived or phased-out for people covered under current state programs (such as Medi-Cal, Healthy Families, Access for Infants and Mothers, state high risk pool). A more specific discussion of the benefit package is included in the description of the proposed reform at www.healthcareoptions.ca.gov.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

Assuming full implementation in 2002, the proposal would reduce the number of uninsured by almost 5.7 million people; about 900,000 people would remain uninsured. Net new State spending would be \$22.4 billion under the Healthy California proposal.

Overall, employers would pay about \$14 billion in payroll taxes for the Healthy California program assuming full implementation in 2002. Firms that currently provide coverage would see average savings of \$322 annually per worker under the proposal, while firms that currently do not insure their workers would see new costs of \$842 per worker.

Families on average would see a savings of \$242 under the CHOICE proposal. All age groups would see a reduction except those over age 65, who would see an average increase of \$158.

The cost estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

4.8 How will the program be financed?

The proposed Healthy California program would be financed by:

- Employer and employee payroll taxes; taxes on unearned and self-employment income
- Federal matching payments for Healthy California enrollees eligible for Medi-Cal of Healthy Families;
- Extension of income eligibility under Medi-Cal to all parents and children (for example, all income is waived);
- An increase in the tobacco tax of \$1.00 per pack.

The proposal also calls for a new side agreement to be negotiated under NAFTA with Mexico to create a Social Integration Fund to help finance health insurance coverage in CHOICE for Mexican citizens working in California.

For modeling purposes, the HCOP assumed that if these sources of funding were insufficient, there would be an increase in the State income tax. The modeling assumes that an income tax increase of \$2.5 billion would be needed to cover the unfunded share of this proposal.

Detailed discussion of the financing of this proposal is contained in the final report from the Lewin Group at www.healthcareoptions.ca.gov.

4.9 What strategies to contain costs will be used?

Services under the proposal would be delivered by competing private health plans contracting with the new program. Enrollees would be required to pay out-of-pocket the total cost for premiums for higher cost plans.

4.10 How will services be delivered under the expansion?

Services would be delivered through private health plans contracting with the new program.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

Coverage now provided under existing state programs would be integrated into the new Healthy California program. The program would be administered by the Major Risk Medical Insurance Board, which administers several existing state programs.

4.13 How will crowd-out will be avoided and monitored?

In the first stage of the program, coverage would be extended to low-income childless adults under a Medicaid waiver. For these enrollees, crowd-out protections similar to those currently applied in the Healthy Families program would apply.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and

survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Not applicable.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

Under the proposed program, the eligibility process would be greatly simplified, as described above. See answer to 4.4.

OPTION: Cal-Health Option, submitted by Helen Halpin Schaffler and Sara B. McMenamin, University of California at Berkley. This option would extend eligibility in the Healthy Families programs for parents of eligible children and seek a waiver of the federal budget neutrality requirement to cover childless adults in Medi-Cal and Healthy Families. An outreach initiative and simplified enrollment procedures for existing public programs also are proposed.

4.2 What is the target eligibility group under the expansion?

The proposed option would expand eligibility under the Healthy Families program to parents of children eligible for Healthy Families up to 250% of poverty. If funds were available, the option also would extend Medi-Cal eligibility to childless adults with incomes up to 133% of poverty and to extend coverage under Healthy Families to childless adults with incomes between 133% and 250% of poverty. To help fund the coverage extension to childless adults, California would request that the federal government not apply the budget neutrality requirement typically applied to Medicaid waivers.

This option also proposes an outreach initiative and simplified enrollment procedures for individuals currently eligible for Medi-Cal and Healthy Families. In addition, to assist those who do not qualify for state coverage programs, the proposed option would create a lower-cost standard benefit policy that could be offered by insurers to individuals with incomes above 250% of poverty and to small businesses (2-50 employees).

4.3 How will the program be administered?

The state would administer the proposed Cal-Health program and would create a working group to advise it on how to streamline and simplify enrollment in Medi-Cal and Healthy Families.

4.4 How will outreach and enrollment be conducted?

The Cal-Health proposal would create a single simplified enrollment process for determining eligibility and enrollment in Medi-Cal and Healthy Families.

Outreach activities would be targeted at health care facilities and schools. Each school would inform parents about Cal-Health at least annually and would accept applications for enrollment. Health care facilities would be required to inform uninsured patients about the program and would be permitted to temporarily enroll patients in Medi-Cal or Healthy Families if they meet initial screening requirements. Providers who enroll patients at the point of service would receive payment for services delivered.

The Managed Risk Medical Insurance Board and the state Department of Health Services would also conduct a pilot project to assist small businesses in learning about insurance

products, their costs, administering employer-sponsored insurance, and enrolling eligible individuals in state coverage programs.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Under the proposals, enrollees in Medi-Cal would be subject to Medi-Cal cost-sharing requirements and enrollees in Healthy Families would be subject to that program's cost-sharing requirements.

The proposed option also calls for the development of a lower-cost standard benefit package that insurers would offer to individuals and small employers who may have difficulty affording coverage in the current market. The package would cover a comprehensive range of services, but would impose deductibles and coinsurance after individuals had used a specified amount of services (e.g., a \$2000 deductible and 30% coinsurance after fifth hospital day in a year). Separate packages would be developed for people below and above age 65. See the detailed description of the proposed option for more details on the standard benefit package www.healthcareoptions.ca.gov.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

See answer to 4.5.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

Assuming full implementation in 2002, the proposal would result in 385,000 new enrollees in Medi-Cal and Healthy Families (117,000 due to the enrollment expansion for parents to 250% of poverty and 268,000 due to outreach initiatives).

The net cost of the proposed reform option assuming full implementation in 2002 would be \$157 million, comprised of \$197.6 million in federal costs and \$40.6 million in savings for California. The estimates assume that California would not receive a waiver of budget neutrality to permit coverage to be extended to childless adults.

The costs estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

4.8 How will the program be financed?

To help finance the proposed approach, 70% of the average per capita funding for safety-net programs would be transferred from those programs to Cal-Health for each uninsured person that enrolls in Cal-Health. Development of an automated eligibility system also is estimated to produce \$194.4 million in savings (assuming full implementation in 2002), of which \$100 million would be realized by the federal government and \$94.4 million would be realized by the State.

4.9 What strategies to contain costs will be used?

Under Cal-Health, new enrollees would enroll in the Medi-Cal and Healthy Families, the cost containment features of those programs (such as managed care) would apply. The lower-cost standard benefit package would make lower-cost insurance products available to currently uninsured people through the use of novel cost-sharing arrangements.

4.10 How will services be delivered under the expansion?

Services would be delivered through the existing Medi-Cal and Healthy Families programs. The lower-cost standard benefit package would be offered by existing health plans.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The Cal-Health proposal extends coverage through existing programs (such as Medi-Cal and Healthy Families). The lower-cost standard benefit package would be offered by existing health plans.

4.13 How will crowd-out will be avoided and monitored?

Individuals would not be eligible for the expanded coverage for parent coverage unless they had been uninsured for at least six months, with exceptions for involuntary coverage loss or change of jobs.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and

survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

The proposed reform would include an outreach initiative and simplified streamlined enrollment for existing programs through a single, new program. See discussion in 4.4 above.

OPTION: CHOICE Option, submitted by Helen Halpin Schaufli and Sara B. McMenamin, University of California at Berkeley. Under this reform option, a public program (CHOICE) would be created to offer coverage to working Californians and their dependents. Employers would pay a payroll tax to help fund health coverage for their workers, but would receive a refund for workers who chose to be covered through coverage offered by the firm. Workers (and their dependents) could enroll in CHOICE by paying premium that varies with their wages. Workers and their dependents who are enrolled in Medi-Cal or Healthy Families also could enroll in CHOICE.

In addition, the proposal includes an outreach initiative aimed at individuals eligible but not enrolled in existing public programs.

4.2 What is the target eligibility group under the expansion?

The target population for the proposed reform option would be uninsured Californians. In particular, the proposed program would target working uninsured families, those eligible for public programs but not enrolled, and currently insured people whose coverage is not affordable, does not assure continuity, or does not provide sufficient choice of providers.

The following would be eligible to enroll in the CHOICE program:

- Workers and their non-working dependents (defined as having worked 3 out of the previous 12 months, people eligible for COBRA, and people receiving unemployment benefits);
- Workers and their non-working dependents eligible for enrolled in Medi-Cal or Healthy Families;
- Non-workers can buy into the CHOICE program by paying the full premium.

In addition, under the proposal the State would apply to the federal government for a waiver to permit Medicare beneficiaries to receive benefits through CHOICE by paying a premium based on income.

4.3 How will the program be administered?

Under the proposal, the Major Risk Medical Insurance Board would administer the CHOICE program and would coordinate with the State Department of Health Services to streamline and simplify enrollment in Medi-Cal and Healthy Families, and on the regulation of providers, quality assurance, data reporting, media and community outreach. MRMIB would provide for centralized claims processing, provider payment, utilization review, quality management and other administrative functions.

4.4 How will outreach and enrollment be conducted?

Under the proposal, enrollment in the CHOICE program would be conducted through employers.

The State would conduct a media campaign and extensive community outreach campaign to enroll eligible people in the CHOICE, Medi-Cal and Healthy Families programs. The CHOICE program would work with the State Department of Health Services to ensure that people seeking health services would be informed about public programs, including CHOICE, Medi-Cal and Healthy Families. Uninsured people could submit applications for these programs at the time of seeking care, and health care providers would be permitted to make eligibility determinations using an automated system. Health care providers would receive payment for patients enrolled in this manner.

The CHOICE program also would work with employers so that workers were informed about their eligibility.

Outreach activities also would be targeted at schools. Each school would inform parents about the CHOICE, Medi-Cal and Healthy Families programs at least annually and would accept applications for enrollment.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Under the CHOICE proposal, all employers would pay a payroll tax of 5.5% on the wages of their first through their 50th worker, and a payroll tax of 6.5% on the wages of additional workers. The employer would receive a refund for workers who elect to be covered under an employee benefit plan offered by the employer.

Workers who enroll in the CHOICE program would make a premium payment that varies their wages:

- Up to 150% of poverty: no premium
- Between 150% and 250% of poverty: monthly premium of 0.5% of wages for each worker plus an additional 0.5% of monthly wage for each non-working dependent, capped at 2% of monthly wage for each worker in a family.
- Between 250% and 350% of poverty: monthly premium of 1.5% of wages for each worker plus an additional 0.5% of monthly wage for each non-working dependent, capped at 2% of monthly wage for each worker in a family.
- Above 350% of poverty: monthly premium of 2% of wages for each worker plus an additional 0.5% of monthly wage for each non-working dependent, capped at 2.5% of monthly wage for each worker in a family.

No payment would be required for wages that exceed the maximum taxable amount for Social Security (about \$80,000 in 2001).

Self-employed people would pay the payroll tax as if they were an employer and would also pay the worker premium for their family. Workers and their family members who are eligible for Medi-Cal or Healthy Families would pay the premiums, if any, required

under those programs. Non-workers could join CHOICE by paying an actuarially fair premium for coverage.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

Under the proposal, the CHOICE program would offer the services now covered by the Kaiser Foundation Health plan for large groups.

There would be no cost-sharing for preventive care under the proposal. Additional cost-sharing requirements would vary with income, with no cost-sharing for enrollees with wages below 150% of poverty. For those with higher wages, there would be a \$10 co-payment for outpatient services, and there would be a four-tiered co-payment for prescription drugs. CHOICE enrollees also eligible for Medi-Cal or Healthy Families would pay the cost-sharing as required by those programs.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

Assuming full implementation in 2002, the proposal would reduce the number of uninsured by almost 4.7 million people; about 2 million people would remain uninsured. Net new State spending would be \$47.8 billion under the CHOICE proposal.

Overall, employers would pay about \$32 billion in payroll taxes for the CHOICE program assuming full implementation in 2002. Firms that currently provide coverage would see average savings of \$481 annually per worker under the proposal, while firms that currently do not insure their workers would see new costs of \$1,360 per worker.

Families on average would see a savings of \$187 under the CHOICE proposal. All age groups would see a reduction except those over age 65, who would see an average increase of \$351.

The cost estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at www.healthcareoptions.ca.gov.

4.8 How will the program be financed?

The proposed CHOICE program would be financed by:

- Employer payroll taxes and participant premiums.
- 70% of the average per capita funding for safety-net programs would be transferred to the CHOICE program for each uninsured person that enrolls in CHOICE.
- Recapture of current State funding for the AIM program for pregnant woman.
- Federal matching payments for CHOICE enrollees eligible for Medi-Cal of Healthy Families.

- Tax on soda of \$0.10 per 12 ounces.
- A sales tax increase of ¼ percent.
- An increase in the State assessment on traffic fines (from 170% to 607%).
- An increase in the tobacco tax of \$1.00 per pack.

The proposal also calls for a new side agreement to be negotiated under NAFTA with Mexico to create a Social Integration Fund to help finance health insurance coverage in CHOICE for Mexican citizens working in California.

For modeling purposes, the HCOP assumed that if these sources of funding were insufficient, there would be an increase in the State income tax. The modeling assumes that an income tax increase of \$777 million would be needed to cover the unfunded share of this proposal.

Detailed discussion of the financing of this proposal is contained in the final report from the Lewin Group at www.healthcareoptions.ca.gov.

4.9 What strategies to contain costs will be used?

The proposed approach contains several strategies to contain costs, including: using electronic processing for all administrative functions; bulk purchasing of pharmaceuticals and medical equipment; coordination administration of CHOICE with other public programs; and permitting self-determination of income, residency and work (with random paperless verification).

4.10 How will services be delivered under the expansion?

Under the proposal, enrollees in CHOICE would have the option of selecting between a statewide CHOICE Network, which would offer services on a fee-for-service basis or through a participating organized delivery system.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The CHOICE program would permit working individuals and their non-working dependents to switch from the public or private coverage that they currently have and enroll in CHOICE.

4.13 How will crowd-out will be avoided and monitored?

The proposal does not contain provisions to address crowd-out.

- 4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

- 4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals.

- 4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

The proposed reform would include an outreach initiative and simplified streamlined enrollment for people that want to enroll in CHOICE or existing programs.

OPTION: The Managed Care Expansion Plan, submitted by Working Partnerships, USA. Under this reform option, subsidies for coverage would be gradually phased-in over 15 years to California residents under 400% of poverty. Coverage would be provided through the managed care plan models currently serving Medi-Cal enrollees.

4.2 What is the target eligibility group under the expansion?

The target population for the proposed reform option would be uninsured Californians with incomes below 400% of poverty who are not eligible for public coverage and who have been uninsured for at least six months. Exceptions to the waiting period would be made for people in substandard coverage.

4.3 How will the program be administered?

Under the proposal, the Major Risk Medical Insurance Board would administer the new program and would be responsible for: certification of health plans; development of standards for applications, eligibility, enrollment and disenrollment; development of standards for adequacy of existing plans; data collection and distribution; establishment of reimbursement rates and disbursement of funds; determination of eligibility levels based on available funding and cost projections; and overall program administration and oversight. County health plans would be responsible for developing provider networks; design of applications and enrollment processes consistent with state standards; health education; member communications, grievances, cultural and linguistic services; quality assurance and utilization review; and data collection required by the state.

Under the proposal state and county agencies would share responsibility for outreach and publicity efforts.

4.4 How will outreach and enrollment be conducted?

Under the proposed reform, marketing and enrollment activities would be conducted in each county by the institutions that manage the program. Individuals would be permitted to enroll directly in the program, or their employer can enroll all of its workers and pay a share of the premium. Marketing activities directed to businesses would address tax and administrative issues, and special outreach efforts would be made to temporary staffing firms. Preventive health classes and other services would be offered to attract employer participation. Further, because the program would be phased-in and enrollment would be limited, employers would have an incentive to participate early in the program.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Enrollees would pay a premium that varies with family income. Employers could pay all or some of the premium for their employees. The sliding-scale fees would be:

-- Adults up to 100% of poverty: no premium

- Adults between 100% and 250% of poverty: 1.5% of annual household income.
- Adults between 250% and 400% of poverty: 2.5% of annual household income.
- The premium for children would be \$9.00 per month per child (up to 3 children).

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The benefits under the proposal would be the same as the current Healthy Families benefit package. Preventive care services would be available without cost-sharing, and co-payments for other services would range from \$5.00 to \$10.00 monthly, with an annual maximum of \$250. Prescription drug co-payments would range from \$0 to \$5.00 and would be included in the annual out-of-pocket limit.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

Assuming full implementation in 2002, the proposal would reduce the number of uninsured by about 1.9 million people. Net new State spending would be \$3.6 billion under the proposal.

The cost estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at

4.8 How will the program be financed?

The proposal would phase-in the coverage expansion over 15 years and would fund it within existing revenue streams. For modeling purposes, the HCOP assumed that existing revenues were not available, and the health care experts designing proposals were asked to identify new sources of revenue. For this proposal, financing would come from:

- a ½ cent increase in the sales tax.
- raising the income tax rates for taxpayers in higher income brackets.

4.9 What strategies to contain costs will be used?

To ensure that services are provided in a cost-effective manner, they would be provided through the existing managed care plans that serve the Medi-Cal program.

4.10 How will services be delivered under the expansion?

Under the proposal, services would be delivered through the managed care plan models currently serving Medi-Cal enrollees. Where possible, enrollees in the new program would be enrolled on public managed care plans. A complete description of California's system of managed care for Medi-Cal and how this proposed program would operate in counties with different managed care structures is provided in the detailed description of this health reform option, available at www.healthcareoptions.ca.gov.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

As discussed above, the proposed program would be administered by the Major Risk Managed Insurance Board, which has experience administering existing state programs, and services would be provided through existing managed care plans serving the Medical program.

4.13 How will crowd-out will be avoided and monitored?

The proposal contains several provisions to address crowd out. Eligibility would be limited to individuals who have been uninsured for at least six months (or covered by substandard coverage) and who are not eligible for other public or job-based coverage. People who lose coverage involuntarily would not be subject to the waiting period. Employers would be permitted to enroll their employees in the program only if the employer had not offered coverage for at least six months. In addition, the sliding-scale premium structure is intended to make the program less attractive to higher income people with insurance.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals. The authors of this proposal note that, because it is phased-in over a period of years, annual evaluations would be able to correct problems as they occur.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts

and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

This proposal would not address those eligible for existing public programs.

OPTION: The Managed Care Expansion Plan, submitted by the Insure the Uninsured Project. This reform option would use a combination of strategies to reduce the number of uninsured, including an 1115 waiver to cover low-income adults, providing coverage to Medi-Cal and Healthy Families enrollees through employer plans when it is cost-effective, a refundable tax credit targeted to employers with low-income employees, and a refundable tax credit or voucher for individuals not offered employer-provided coverage.

4.2 What is the target eligibility group under the expansion?

The target population for the proposed reform option would be uninsured Californians with incomes up to \$35,000 for individuals and \$70,000 for families. Different strategies would target different populations:

- Childless adults below 200% of poverty would be covered through an 1115 waiver expanding eligibility under the Medi-Cal and Healthy Families programs.
- Families eligible for the Medi-Cal and Healthy Families programs that have access to employer-provided insurance would be enrolled in those plans when cost effective.
- A refundable tax credit of 50% of total premium would be provided to small employers (2-10 workers) where at least one-third of the workers earned less than twice minimum wage. The tax credit would apply only to the premium attributable to the lower-wage workers.
- Refundable tax credits would be provided for those with incomes below \$35,000 (\$70,000 for families).

4.3 How will the program be administered?

The proposed reform approach would rely on different strategies to reach different populations.

- New coverage provided under the 1115 waiver expansion would be administered by the agencies that currently administer the Medi-Cal and Healthy Families programs.
- The State Department of Managed Health Care would regulate conduct in the non-group insurance market, including new reforms (for example, guaranteed issuance of coverage; limits on rate variation) proposed.
- The State Employment Development Department would distribute refundable tax credits to eligible small employers and would distribute refundable tax credits to eligible individuals that are working or are receiving unemployment insurance benefits. The State Franchise Tax Board would administer the refundable tax credits offered to individuals who are self-employed or not employed.
- The Healthy Families program would distribute premium subsidies to eligible low-income families receiving benefits through employers.

This proposal contains a number of provisions that would simplify the interactions between the Medi-Cal and the Healthy Families programs and between state and local responsibilities. In particular, the proposal would draw a bright line between Medi-Cal and Healthy Families at 133% of poverty. The proposal also would shift some functions away from county health departments, either to the State or to local managed care initiatives, including the county responsibility for providing indigent care. The details of these provisions can be found in the detailed description of the reform option, which can be found at www.healthcareoptions.ca.gov.

4.4 How will outreach and enrollment be conducted?

Under the proposal, outreach and enrollment would be conducted by the agencies administering the different strategies. See answer to 4.3.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Under the proposal, what enrollees pay would differ across different strategies. Generally, what enrollees would pay would vary with income:

- Low-income adults (below 133% of poverty) enrolling under the new waiver in Medi-Cal would pay nothing.
- Low-income adults (between 133% and 200% of poverty) enrolling under the new waiver in Healthy Families would pay 10% of the premium cost.
- Low-wage workers (wages below twice the minimum wage) working for employers receiving the new refundable employer tax credit would pay up to 50% of premium costs.
- Lower wage individuals receiving the refundable tax credit would pay about 20% of income at 200% of poverty and would pay more as income rises. The subsidy amounts would vary by age because non-group premiums vary by age.

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The benefits provided under the proposal would vary under the different strategies targeted to different groups:

- Low-income adults (below 133% of poverty) would receive the Medi-Cal benefit package.
- Low-income adults (between 133% and 200% of poverty) would receive the Healthy Families benefit package.
- People receiving tax credits would receive at least the required HMO basic benefit package, plus coverage for prescription drugs.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

Assuming full implementation in 2002, the proposal would reduce the number of uninsured by about 2.7 million people. Net new State spending would be \$6.7 billion under the proposal.

The cost estimates for this reform proposal were estimated using the Lewin Group Health Benefits Simulation Model. A detailed discussion of the cost estimate is at

4.8 How will the program be financed?

The program would be financed in the following ways:

- Budget neutrality under the 1115 waiver would be achieved by: enrolling the disabled population managed care plans; reducing benefits for optional eligibility groups to a level similar to the Healthy Families benefit package; imposing co-payments for optional services; reallocating disproportionate hospital share payments.
- State and county funding for safety-net programs would be shifted to the new program as the uninsured enroll.
- A tax on health care providers.
- Funds now used for the State's High Risk Pool would be transferred to the program.

4.9 What strategies to contain costs will be used?

Under the proposal, services provided to low-income adults would be provided through managed care plans serving Medi-Cal and Healthy Families.

For individuals receiving tax credits (directly or at work), the proposal would encourage the use of purchasing pools to reduce the costs of insurance. The tax credit levels would be based on premiums for less costly plans and would require individuals to pay more to enroll in more costly plans. This structure encourages individuals to choose lower cost plans.

4.10 How will services be delivered under the expansion?

Services provided to low-income adults would be provided through the managed care plans serving the Medi-Cal and Healthy Families programs. Services provided to individuals receiving tax credits would be provided through private health plans offering coverage in the small group and non-group markets. The proposal calls for market reforms in the non-group market that would make coverage available on a guaranteed issuance and guaranteed renewable basis, and that would permit rate adjustments only for family size, age, geography, health status (up to 25% at enrollment) and plan selection. The formation of purchasing groups also would be encouraged.

4.11 What methods for ensuring quality will be used?

The provisions of each of the reform options relating to quality are described and discussed in the report from AZA Consulting, which can be found on the HCOP website at www.healthcareoptions.ca.gov.

- 4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

The proposed expansion of coverage to low-income adults would be within the existing Medi-Cal (up to 133% of poverty) and Healthy Families (133% to 200% of poverty) programs. The tax credits would subsidize coverage in existing private health plans in the small group and non-group markets, although insurance reform would change practices in the non-group market. Individuals now enrolled in the State's high risk pool would move to non-group market (where coverage would be more affordable), and funding would be transferred to the new programs. Similarly, some existing state and local funding for the safety-net would be transferred to the new programs as uninsured people become newly covered.

- 4.13 How will crowd-out will be avoided and monitored?

Crowd-out generally is not addressed by the proposal.

- 4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

This level of detail was not required of the reform proposals.

- 4.15 How (and how often) will the program be evaluated?

This level of detail was not required of the reform proposals. The authors of this proposal note that, because it is phased-in over a period of years, annual evaluations would be able to correct problems as they occur.

- 4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

As discussed above, it was not the goal of the HCOP to select or recommend options for expanding coverage. The projected solicited alternative approaches from policy experts and interested parties, developed a comparative analysis of the proposals that were received, and presented the options and the analyses to the public in a series of public forums. The options and analyses are now available to the state legislature and to the public for their consideration as appropriate.

- 4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

See response to 4.16.

- 4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

See response to 4.16.

- 4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

This proposal contains a number of provisions that would simplify the interactions between the Medi-Cal and the Healthy Families programs and between state and local responsibilities. In particular, the proposal would draw a bright line between Medi-Cal and Healthy Families at 133% of poverty. These provisions should make eligibility and enrollment simpler, and may make it easier for entire families to enroll in the same program or health plan. The details of these provisions can be found in the detailed description of the reform option, which can be found at www.healthcareoptions.ca.gov.

SECTION 5. CONSENSUS BUILDING STRATEGY

- 5.0 HCOP called for the development of options for expanding health care coverage through a process by which representatives of health care consumers, providers, insurers, health care workers, advocates, counties, and all other interested parties are engaged in discussion and debate of the issues faced by the state. The project also required interagency participation of agencies and departments that can contribute to the effort.

To ensure ongoing public participation throughout HCOP, CHHS used various mechanisms to obtain stakeholder input, including public review and comment on key documents and participation in the policy option symposia. Stakeholders included interested parties, such as providers, association, insurers, health plans, consumer, businesses, labor, as well as legislative, State and county department staff. The following was the HCOP strategy for maximizing public input throughout the project.

- **Mass Mailings:** A database of approximately 1,000 names was established and used to disseminate information on the project and invite interested individuals to attend public meeting and comment on the Solicitations for Proposals (SFP).
- **SFP Process:** Rather than commission a single entity, CHHS used the SFP process – an open and competitive process – to solicit a series of five to ten papers that describe reform options for extending health care coverage throughout California. Soliciting approaches from a range of authors will capture multiple stakeholder perspectives on how best to extend coverage.
- **Public Meetings:** In order to receive public input on the SFPs, CHHS held public meetings to review and comment on drafts. In addition, the SFPs were posted on the Internet, and the public was invited to comment via email.
- **Advisory Group:** A cross-section of stakeholders were invited to join an Advisory Group, including: providers, associations, insurers, health planners, consumers, businesses, local government, and labor interests, as well as legislative staff. The role of the Advisory Group was to provide policy input to HCOP on selecting health care options to be explored, the micro-simulation model, and the symposia. Please see Section 5 for a list of members.

In addition, CHHS relied upon the Advisory Group for ideas to improve the project as it progresses. The following are some examples of how CHHS was able to respond to such suggestions.

- *Travel funds:* CHHS worked with the Kaiser Family Foundation which provided funds to support travel costs so that independent consumers could attend public meetings, including the Advisory Group meetings and the symposia.
- *Early input on the model:* CHHS invited the Advisory Group to comment on assumptions underlying the micro-simulation model, originally scheduled for

mid-December. In response to the group's concerns that this was too late in the process, CHHS worked with the contractor developing the model to move up the meeting to early November.

- *Public comment on the draft options papers:* The federal grant award was originally scheduled to expire in March 2002, and the final draft option papers were due soon after the first four symposia. The Advisory Group expressed concern that this timing would not allow for sufficient input on the options papers. As a result, upon submission of the drafts, CHHS posted them on the HCOP website for advance review and comment prior to the symposia.
- *Qualitative analysis:* Many Advisory group members raised concerns that the micro-simulation model could not analyze and compare less quantifiable aspects of health care coverage, such as issues related to quality, access, and safety. In response, CHHS hired an expert to conduct a cross-paper analysis on these issues. This report will be ready for the symposia, where it can be used to inform the public participants of these important issues.
- **Statewide Symposia:** The CRB, in partnership with the CHHS, organized and conducted a series of five statewide symposia to provide a forum for the Advisory Group, experts, Legislative staff, and other stakeholders to critically examine and provide input to the options and analyses.
- **Website:** CRB created www.healthcareoptions.ca.gov which hosts up to date information, including: SFPs, draft reform papers, background papers, model methodology, announcements, and other related materials. The website was also used to receive public input on the project.

Furthermore, HCOP was conducted with substantial input at each stage of the process, as described in the timeline below.

March 2001: Establish the Review Team to ensure an interagency process including State representatives named in SB 480, legislative staff, as well as a Technical Advisory Committee representing experts on health care, to assist in drafting two SFPs.

April 2001: Posted the draft SFPs on the Internet and held a public meeting seeking review and comment on the drafts.

June 2001:

- Released the SFPs. Part I solicits authors of five to ten papers describing various reform options for expanding health care coverage. Part II solicits a contractor to produce an extensive quantitative and comparative analysis of the reform options proposed in Part I.

- Mailed nearly 1,000 letters announcing the SFP release, launched www.healthcareoptions.ca.gov -- a website dedicated to the project, and posted an SFP advertisement in the State Contract Register.
- Held a Bidders' Conference to provide an overview of the SFPs and respond to questions regarding SFP instructions and requirements for potential proposers.

July 2001: Received proposal submissions for reform options and micro-simulation models.

August 2001:

- Invited a cross-section of stakeholders to join an Advisory Group to ensure public participation during the selection process and throughout the project.
- At the first forum, the Advisory Group provided meaningful feedback on selecting option papers and model submissions. Based on the Advisory Group's recommendations, selected nine authors of reform option papers posted Notices of Intent to Award.
- At the second Advisory Group meeting, received suggestions about the format of the symposia and assist in the development of outreach strategies to ensure maximum public input. CHHS was particularly interested in hearing suggestions about how to ensure that the project fully analyzes issues such as quality, access and impact on the safety net that cannot be easily measured using a micro-simulation model.

October/November 2001: Acted upon recommendations received by the Advisory Group to: (1) post draft option papers on the HCOP website prior to the symposia to ensure adequate time for review and comment, and (2) hire an expert to conduct a cross-paper analysis on to analyze the qualitative aspects of health coverage, such as issues related to quality, access and the safety net.

January/February 2002: Received public input on the options through four statewide symposia.

March 2002: Compile the comments and feedback received at the four symposia and disseminate to authors to consider as they drafted their final reports.

April 2002: Hold final public forum to present final papers and report on input received to the state Legislature, other policy makers, and the public.

- 5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The governance structure for the HCOP was consistent with the general approach outlined in Senate Bill 480 (Chapter 990, Solis), signed by the Governor in October 1999.

Decision-making authority was lodged with the Secretary of Health and Human Services, with input and advice from a wide range of experts, state officials, and stakeholders. The specific charge to the Secretary was to establish a process for developing options to provide health care coverage to Californians. In doing so, the Secretary was to review the results of previous studies and gather information on methods of financing and delivering health care coverage. The Secretary chose to achieve the goals outlined by the legislation by commissioning the development of multiple options for expanding health care, comparing and analyzing the options using a mathematical model, and soliciting public input on the results before compiling them into a report to the Governor and the Legislature.

In creating the HCOP, the Secretary first convened a small group of researchers and foundation staff who had carried out similar efforts to seek their advice on the project design. This consultation provided valuable advice on the best ways to develop options that would be comparable and capable of analysis through economic modeling and on approaches to selecting a modeling contractor.

The second group of advisors used by the Secretary was referred to as the "Review Team" (RT). This body, which included various state and legislative staff, provided advice on the contents of the solicitation documents and the initial design of the public input process. The members of the RT included representatives of health agencies specified by SB 480, key legislative staff and consultants, and an official of the University of California President's Office. RT advice was sought at two key points in the process -- review of the initial draft of the solicitation document and selection of the authors who would develop the final options. Advice on the draft solicitation was given in the course of a public meeting of the RT chaired by the Undersecretary of Health and Human Services. A second, non-public meeting was convened to allow RT members to hear from and question authors of draft proposals. During later stages of the HCOP, RT members participated in the option development and public processes on an individual basis, but were not required to convene again as an advisory body.

After considering advice received during the meeting of the RT, the Secretary also created a public Advisory Group (AG) to advise him on the selection of the reform option authors and on the design and implementation of the public input process. Please see the Acknowledgments for the list of Advisory Group members. This group comprised representatives of provider organizations, county health systems, business, consumers, seniors, health care advocates, labor, and other stakeholder groups. They provided input on the selection of reform option authors, the methods and the output of the comparative analyses of the options, and the design of the public input process. As the public process was implemented, members of the AG were active in recruiting presenters and participants and in publicizing the HCOP process.

The HCOP governance structure with centralized decision-making at the Cabinet Secretary level enhanced by a multi-interest advisory process proved to be highly effective. The model was sufficiently flexible to allow improvements the design and

timing of the HCOP, but was structured enough to ensure that all goals and objectives of the HCOP were met.

- 5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

The primary method used to obtain input on the reform options developed for the HCOP was a series of four symposia held throughout the state in January and February 2002. The symposia were arranged for and overseen by the California Research Bureau, a component of the California State Library. Brochures describing the symposia and the registration process were sent to a mailing list of approximately 900 persons. Attendance ranged from about 75 persons in the Fresno site to 250 in Oakland. Overall, approximately 600 people attended these events.

Each symposium involved presentations by the authors of the nine reform options and discussion of qualitative and quantitative comparisons of the options with the consultants who conducted them. Pre-registration materials let the participants know that draft option papers would be posted on the project website prior to the symposia. This allowed people to become familiar with the details of the options prior to attending the sessions.

Each symposium also included comments from four local or statewide stakeholders (providers, labor, county health departments, etc.) on the impact of uninsurance and the proposed options on their particular stakeholder group. The afternoon sessions of each event were set aside for small, facilitated, breakout groups with each of the authors.

Question and answer sessions were held after the author and consultant presentations. In addition, participants were encouraged to provide written questions and comments. In the course of the four events approximately 450 written questions and 550 comment forms were collected, transcribed and forwarded to the authors for their consideration as they completed the final drafts of their proposals

- 5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, website development)?

Given the complexity of the issues involved in health care reform, a decision was made to implement a public education program early in the HCOP process. The California Research Bureau entered into a contract with a team of faculty from California State University, Northridge, to write a series of background papers on California's health care environment and the challenges of expanding coverage to the state's six million uninsured. Six papers were written covering the health care market, a description of the state's uninsured population, employer-based coverage and several special population issues. These papers were supplemented by a comprehensive bibliography on universal health care and related issues that was compiled by staff of the California State Library.

While the background materials were being developed, a project website was created. Initially, the site contained a description of the project, the background papers and

bibliography, the author and modeler solicitation documents, and a set of links to related sites. As other materials were developed -- draft option papers, announcements of upcoming symposia, presentations from the various symposia, etc., -- they were posted on the site. An e-mail address for the project was published on the site. Over 100 persons were added to the HCOP mailing list in response to e-mail requests. The project also received numerous e-mails requesting information on the project or assistance with obtaining documents. The public also used the e-mail system to submit input or questions on the reform options. All of these messages were forwarded to the appropriate author(s) for consideration and response.

- 5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

Expanding health care coverage consistently has been an interest of policy-makers and the public in California for many years. Policy researchers at UCLA track census data on health insurance coverage and publish new estimates of the uninsured annually. These publications inevitably spark wide media coverage and renewed discussions among policy-makers of the need to expand coverage. Over the past 10 to 12 years, California has worked consistently at incremental expansion of coverage using approaches such as purchasing pools for small employers, subsidized coverage for high-risk individuals, and expansions of public programs. The current administration has made expansion of coverage for children and low-income parents a high priority.

The HCOP has re-vitalized the discussion of health care coverage in California and has provided the most comprehensive set of data on the topic ever made available to state policy-makers. This data will be immediately useful in the Legislature's deliberations on Assembly Bill 32 and Senate Bill 1414, two bills that would implement reform options developed for HCOP. The current economic situation in the state is likely to postpone any major reform efforts; however, the energy created by the process guarantees that coverage expansion will continue to be pushed in future years when there will be funding and the political will to pursue either incremental or universal strategies.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

- 6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

As discussed above, the HCOP did not involve any new data collection activities. However, the economic model that was used to analyze the different reform options was calibrated to reflect California demographic and economic circumstances. The health care experts who developed the reform options were able to interact with the modeler and were provided a detailed understanding of the potential cost and coverage results of their proposed approaches. The health care experts were then able to modify their proposals to better achieve their desired policy goals.

- 6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

See answer to 6.1.

- 6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

See answer to 6.1.

- 6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

See answer to 6.1.

- 6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

As discussed above, the results from the 2001 California Health Interview Survey were released recently. CHHS and others in the health policy community are just beginning to understand the results of this major effort, and it is unclear at this time what additional information is needed. The State will continue to work with the academic, policy and research community to identify information gaps and find ways to get the information that we need.

- 6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The State learned that microsimulation modeling can be a valuable tool in analyzing different health care reform options, and that applying consistent assumptions to different approaches improves the ability of policy makers and others to compare potential impacts across a range of different and important policy parameters.

- 6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

The HCOP provided policy makers and stakeholders with a rich source of detailed information about the potential impacts of different reform approaches. The modeling not only estimated the number of newly insured under different reform scenarios, but also delineated who would benefit from the proposed changes and who would pay for them (public and private dollars). In particular, the information on the estimated changes to what employers would pay under different reform scenarios should assist them to participate in future discussions in a more informed manner.

- 6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The success of the HCOP in developing and analyzing alternative approaches to expanding coverage suggest that other states should consider using microsimulation modeling to provide policy makers and the public with detailed information about the impacts that proposed would have on costs and coverage. Microsimulation modeling can provide types of information that are not often available in state debates, including information on changes in out-of-pocket costs and employer contributions and potential savings in safety-net programs. Microsimulation analysis also informs policy makers in much greater detail than is typically available about who would benefit and who would pay more under proposed reform approaches.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

As discussed above, the HCOP did not identify any preferred or recommended reform approaches. Several of the health reform options analyzed under the HCOP, however, would require waivers or changes in federal law. These include:

- Several of the reform options (Health California, Insure the Uninsured Project, Cal Health) would request federal waivers under Med-Cal and SCHIP in order to extend coverage to childless adults.
- Two of the reform options (Health California, CHOICE) would impose a pay-or-play type requirement on employers. In each case, the reform proponents do not believe that changes to the ERISA preemption provisions would be needed, but there is a possibility that ERISA could be a barrier to these approaches.
- Several of the reform options (Single Payer Option, Cal Care, California Health Service Plan) would integrate enrollees in Medicare, Tri-Care and other federal coverage programs into new public programs operated by the State. In these options, the State would receive the existing federal funding and would provide an expanded set of services to the enrollees. Federal law would need to be changed to accommodate these arrangements.
- One of the reform options (CHOICE) would request a demonstration waiver under Medicare to permit Medicare beneficiaries to join a State coverage program to receive their Medicare and supplemental benefits and pay a premium that would vary with income.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

The HCOP did not accept or reject any options.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

The State does not have any recommendations at this time.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

The federal government should continue to support in depth analysis, though microsimulation modeling and other approaches, of different options for reform so that

policy makers and the public can be as informed as possible about the potential impacts of those options.

ENDNOTES

ER Brown, N Ponce, T Rice, SA Lavarreda. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2002.

ER Brown, N Ponce, T Rice, *The State of Health Insurance in California: Recent Trends, Future Prospects*. Los Angeles, CA: UCLA Center for Health Policy Research, 2001.

ER Brown, A Shana, L Becerra. *Number of Uninsured Californians Declines to 6.2 Million – 2 Million Are Eligible for Medi-Cal or Healthy Families*, Health Policy Fact Sheet, Los Angeles, CA: UCLA Center for Health Policy Research, March 2002.

State Health Facts Online, <http://www.statehealthfacts.kff.organization>. Henry J. Kaiser Family Foundation.

To Buy Or Not To Buy, A Profile of California's Non-Poor Uninsured, Oakland, CA: California HealthCare Foundation, 1999.

J Kahn, A Gardner. *Health Care Safety Net Spending in California: Funding Trends and County Strategies*, San Francisco CA: Institute for Health Policy Studies, UCSF, June 2001.

J Haley, S Zuckerman. *Health Insurance, Access, and Use: California, Tabulations from the 1997 National Survey of America's Families*, Washington D.C.: Urban Institute, July 2000.

L Duchon, C Schoen, E Simantov, K Davis, C An. *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century*, New York, N.Y.: The Commonwealth Fund, January 2000.

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population: 33,871,648 (U.S. Census 2000 Summary File).

Number and percentage of uninsured (current and trend): About 4.5 million Californians, or 15.2% of the population, was uninsured at a point in time in 2001. (The State of Health Insurance in California: Findings from the California Health Interview Survey).

Average age of population: Median age is 33.3 years (U.S. Census 2000 Summary File).

Percent of population living in poverty (<100% FPL): According to the U.S. Census Bureau, 16% of Californians lived in households with incomes below poverty in 1997. Percent of population 18 years and older: 62.7% (U.S. Census 2000 Summary File).

Percent related children under 18 years old: 19.4% (Census 2000 Supplementary Survey, U.S. Census).

Primary industries: California has a large and diverse economy. Major industries include manufacturing, construction, finance, and agriculture.

Number and percent of employers offering coverage: The Kaiser Family Foundation survey of California employers found that 66% of California employers offered health benefits to employees in 2001.

Number and percent of self-insured firms: CHHS does not have information on the number or percentage of employers that self-fund. Information from the Kaiser Family Foundation survey of California employers indicates that 27% of insured workers were in self-funded plans in 2001. This compares with 47% of insured workers nationwide.

Insurance market reforms: California has enacted several reforms to improve its health insurance markets. In the small group market, California has enacted reforms that require insurers to issue coverage to small employers without regard to health status and to limit premium variation based on health-status related factors. The State also developed a purchasing cooperative that offers coverage to small employers; in 2000 operation of the the cooperative was transferred to the Pacific Business Group on Health. In the non-group market, California operates a high risk pool that provides coverage to individuals who are unable to private get non-group coverage because of their health.

Eligibility for existing coverage programs (Medicaid/SCHIP/other): Pregnant woman and children under 1 year of age are eligible for Medi-Cal if they are in families with incomes at 200 percent of poverty or below. Children ages 1 through 5 are eligible for Medi-Cal if they are in families with incomes below 134% of poverty. Children ages 6 through 18 are eligible for Medi-Cal if they are in families with incomes at poverty or below. Children in families with incomes

above Medi-Cal eligibility but below 200 percent of poverty are eligible for the Healthy Families program.

Use of Federal waivers:

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Indicate the website addresses for any additional sources of information regarding your State’s research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

As referenced throughout this report, deliverables and reports related to the Health Care Options Project are available at the project website, www.healthcareoptions.ca.gov. Specifically, the “Document Library” of the website includes:

- Two-page summaries
- Full options papers for each of the nine proposal
- The quantitative analyses conducted by The Lewin Group
- The qualitative analysis conducted by AZA Consulting
- Prior reports to the State Legislature and federal government
- Background papers on health care coverage in California
- Process evaluation report conducted by Public Sector Consultants

APPENDIX III: PUBLIC PROCESS EVALUATION



State of California
Health Care Options Project

Public Process Evaluation
Final Report

April 19, 2002

Submitted by

Public Sector
Consultants, INC.

Public Sector

Consultants, INC.

April 19, 2002

Ms. Peg Gerould
Assistant Director
California Research Bureau
900 N Street, Suite 300
P.O. Box 942837
Sacramento, CA 94237-0001

SUBJECT: HCOP FINAL REPORT

Dear Ms. Gerould:

Public Sector Consultants, Inc. is pleased to present its Final Report concerning the public process component of California's Health Care Options Project. Our report also includes the results of the participant surveys conducted at each of the four symposia. These are the last of the deliverables that we were contracted to provide as part of our independent public process evaluation services to the California Research Bureau (Contract L-1814).

We thank you for this opportunity to provide our services and hope that we have served you and the project well.

Sincerely,
PUBLIC SECTOR CONSULTANTS, INC.

Fredrick A. Schwartz
President

STATE OF CALIFORNIA
Health Care Options Project
Public Process Evaluation Final Report

PURPOSE OF THIS REPORT

This is the second and final report to the organizers of the Health Care Options Project (HCOP) regarding the approach and quality of the public discussion and debate engendered by the project. This report is to be included with the final report that the California Health and Human Services Agency (CHHS) intends to submit to the Legislature and federal government concerning the project's outcomes.

Public Sector Consultants, Inc. (PSC) submitted a Baseline Report outlining the goals, concerns, and suggestions of a wide variety of HCOP stakeholders on October 10, 2001. This report examines the success of the HCOP effort at meeting baseline expectations and the overall value the project had in fostering debate and discussion of the options to expand health insurance coverage to all citizens.

This report is submitted by PSC to the California Research Bureau (CRB), which is acting as an agent of CHHS. PSC was contracted by CRB to fulfill a federal grant-related requirement to obtain an independent review of the quality of the public process associated with the project.

This report documents PSC's independent review. The review consisted of the following activities:

- Attend symposia to obtain first-hand observations.
- Discussions and interviews with project sponsors.
- Interviews with stakeholders and proposal authors.
- Surveys of symposia participants.

SUMMARY OF FINDINGS

Stakeholders, symposia attendees, and proposal authors uniformly agreed that the HCOP process included public discussion, debate, and input in a meaningful way. These results are affirmed in the results of the surveys conducted at each of the symposia. Some observers expressed opinions qualified by their perspectives concerning the political context in which HCOP took place, but nonetheless were generally positive about the efforts and responsiveness of CHHS and the CRB, the HCOP process, and the project's outcomes.

SUMMARY OF THE BASELINE REPORT'S FINDINGS

For its October 10 Baseline Report, PSC reviewed project materials and conducted 12 interviews of policymakers and stakeholders serving on the State Review Team or Stakeholder Advisory Group to establish a baseline of expectations concerning the public discourse component of the HCOP. Interviewees included a range of stakeholders, from community activists to provider associations. Policymakers spanned the political spectrum. Expectations and concerns were equally diverse. There were, however, three common themes presented in the report.

Valuable intellectual product. There was consensus that the HCOP had the potential for creating a valuable work product that could inform long-term policy planning.

Pragmatic expectations. While some interviewees, particularly those representing the advocacy groups, expressed the hope that legislation representing either significant or incremental change might be introduced as a result of the HCOP, several observers cited the state's current economic outlook and political context when they articulated their limited expectation that the final options and models might inform ongoing discussion.

Iterative process. Interviewees representing the full spectrum of constituencies and political interests agreed that the public comment and debate concerning the assumptions behind the options and models should have an impact on the final work products. Several expressed disappointment concerning the constrained timeframes that were in place in October, citing the likelihood that neither the proposals nor the final report could fully incorporate public input through the symposia process. Others indicated a strong interest in seeing the process evolve as an iterative effort that uses the initial work products as the basis for ongoing discussions that might include blending elements of different proposals.

PSC also documented a number of specific suggestions for organizing and structuring the symposia that emerged from the Baseline Report interviews.

DETAILED FINAL REPORT FINDINGS

Context and Challenges. The CHHS and CRB faced many challenges in developing an effort responsive to the requirements of SB 480 and the federal government's State Planning Grant for a process of public debate and discussion concerning the options for expanding health care coverage. Perhaps the greatest was to find a way to make the debate as inclusive of a wide range of perspectives as possible given the current political and fiscal context.

Both SB 480 and the State Planning Grant from the federal Health Resources and Services Administration frame the debate as one of identifying options for expanding health care coverage or insurance. SB 480 in particular was supported by a coalition of activist groups that embrace the single payer reform model. Thus, from the outset, HCOP had difficulty attracting the interest of several key constituencies, including insurance firms, large employers, small businesses, and some types of care providers.

The lack of participation of these major stakeholders was evident from both the composition of the Advisory Group and participation at the symposia, including the final briefing at the Capitol, and was a source of disappointment to the people interviewed for this report. All, however, recognize the current challenges in California and the difficulty of bringing together a full range of stakeholders and perspectives, and none believed project organizers could have overcome these obstacles. Several affirmed the likelihood that non-involved groups will pay close attention to any legislation or initiative efforts that evolve from the HCOP work products.

On the other hand, the approach that CHHS chose—supporting the development of a range of well-researched and fully modeled proposals for reform—inherently brought many of the non-participants into the process through their contributions to the research and assumptions, including some contributors from across the political and institutional spectrum who asked not to be credited. Similarly, the modeling efforts were also based on research and assumptions concerning the likely behavior of key stakeholders such as employers, assumptions that can be debated and revised as discussion continues.

On balance, CHHS and the CRB expended great effort to meet the expectations of active HCOP participants and ensure the quality of the work products.

Organizers' Responsiveness. PSC finds that CHHS and the CRB were highly responsive to the concerns of Review Team and Advisory Group members. In particular, CHHS vigorously sought and was ultimately successful in obtaining an extension of the state and federal deadlines for submitting the final report. This was in direct response to the concern of active stakeholders that initial deadlines would not allow for input from the public process to be incorporated in the final proposals and report.

Project organizers also responded to stakeholders' concerns by changing timeframes to allow the Advisory Group members and the public to review and comment on proposal drafts, which were posted on the project's Web site. One group, Health Access, took this opportunity to formally review and grade the draft proposals to provide authors with another layer of feedback from the perspective of its coalition members.

CHHS also responded to stakeholders' concerns that the economic modeling proposed for the project would fail to account for variations in outcomes related to quality as opposed to cost, and brought on Claudia Williams of AZA Consulting to provide a qualitative comparison to supplement the economic modeling.

Similarly, the CRB was very responsive to members of the public and active HCOP stakeholders in organizing the symposia and responding to requests.

Some of the CRB's key efforts included:

- Personal responses to a wide range of e-mail and telephone inquiries and numerous requests for paper copies of documents.
- Development of a symposium format that balanced knowledgeable response to proposals from expert panelists with opportunities for symposia participants to ask questions and provide input.
- Development of support materials summarizing complex information in an accessible comparative format.
- Special symposium accommodations for advocacy groups representing low-income constituents, such as waiving standard no-show and cancellation fees.
- Providing tables and opportunities for stakeholder groups attending the symposia to distribute materials and gather signatures.

Satisfaction with the HCOP Process. PSC developed and evaluated the results of surveys distributed to participants at the four major symposia in Fresno, Sacramento, Oakland, and Manhattan Beach. The surveys were intended to assess participants' satisfaction with the project, both as a forum for education and an opportunity to discuss and debate the options for expanding health care coverage.

Survey results were very positive, with high scores in response to the questions soliciting feedback on the quality of handouts, the value of the public process in providing an understanding of the options for expanding health care coverage, and the opportunity to express one's views. With one of the two highest scores, participants affirmed that the HCOP process provided an open public discussion of the options.

Detailed survey results follow. The first nine questions required a rating on a one to five scale, with one representing the highest score and five the lowest. Two additional questions were open-ended. The survey was conducted and scored using approved psychometric testing standards.

Question	Fresno Responses Received	Fresno Response Average	Sacto Responses Received	Sacto Response Average	Oakland Responses Received	Oakland Response Average	Manhattan Beach Responses Received	Man. Bch. Response Average	Overall Response Average
1. Before the symposium, I previewed the health care expansion options at the HCOP website.	35	2.1	43	1.8	80	1.7	58	1.9	1.9
2. Handouts were understandable, complete and concise. †	35	1.8	41	2.1	79	2.0	57	1.7	1.9
3. Local issues regarding expansion were addressed. ‡	31	2.4	39	3.6	75	2.9	54	2.7	2.9
4. The public process provided an understanding of the options for expanding health care coverage in California. ‡	33	1.6	43	1.7	77	2.0	57	1.6	1.7
5. I understand the options now. §	34	1.7	45	1.6	79	1.7	57	1.4	1.6
6. I came to the symposium with an opinion about which option would be best. ‡	36	2.5	45	3.1	76	2.3	59	2.7	2.7
7. After the symposium, my opinion about the best option...	34	2.8	42	3.1	77	2.8	56	2.6	2.8
8. I had the opportunity to express my views during the symposium. ‡	32	1.8	41	2.0	74	2.1	54	1.6	1.9
9. An open public discussion of the options has occurred. ‡	32	1.5	42	1.5	76	1.8	55	1.7	1.6

* 1=Yes, 2=No, 3=Didn't know about Web site

† 1=Completely True, 5=Not True at All

‡ 1=Excellent, 2=Good, 3=Neutral, 4=Fair, 5=Poor

§ 1=Much Better, 2=Somewhat Better, 3=Neutral, 4=More Confused, 5=Already Understood Well

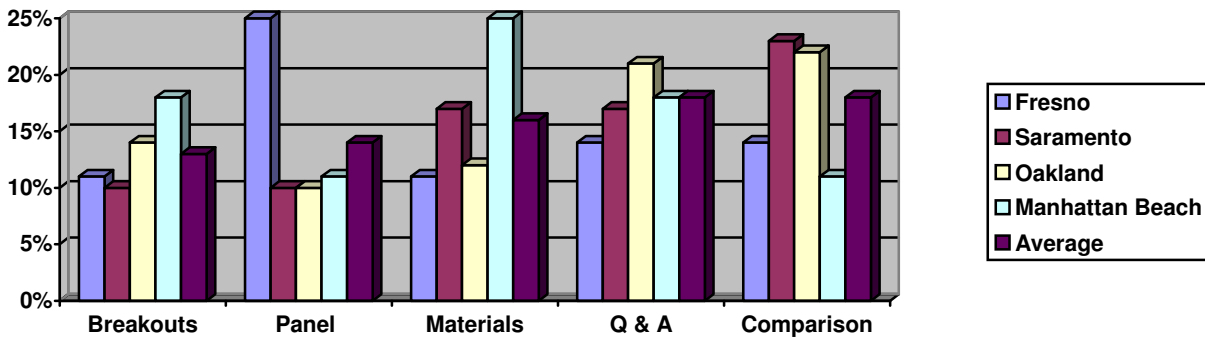
** 1=Changed, 2=Partially Changed, 3=Stayed the Same, 4=Still Undecided, 5=Never had an Opinion

Survey Question #10—Please describe what aspects of the symposia you found most helpful. Of the eight categories of response that made up the majority of comments, five were most frequent. In the order in which the symposia were held (Fresno, Sacramento, Oakland, Manhattan Beach), the most frequent responses concerning helpful aspects were:

The Panel Discussion	10%, 10%, 25%, 11% (Average 14%)
Q & A Periods	21%, 17%, 14%, 18% (Average 18%)
Materials Provided	12%, 17%, 11%, 25% (Average 16%)
Model Comparison	22%, 23%, 14%, 11% (Average 18%)
Breakouts	14%, 10%, 11%, 18% (Average 13%)

This information is graphically represented below.

GRAPH: MOST HELPFUL ASPECTS OF SYMPOSIA



Typical responses to this question included comments such as “the comparison of several models was invaluable...,” “Breakout groups were extremely helpful,” “...having printed copies of the materials,” and “The questions and answers.”

Survey Question #11—Please make suggestions for how the symposium could have been improved.

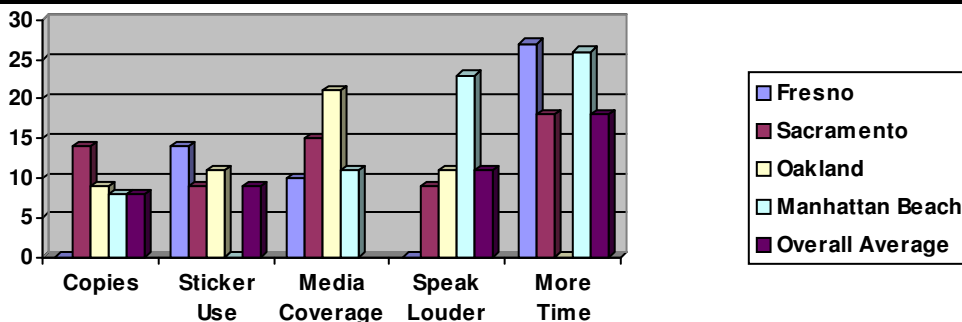
Five responses stood out as the main replies. The responses are listed as a percentage by symposium.

More Media Coverage	9%, 0%, 15%, 21% (Average 11%)
Provide Copies of All Materials	0%, 14%, 9%, 8% (Average 8%)
More Time for Symposium	27%, 18%, 0%, 26% (Average 18%)
Disliked Colored Sticker Use	14%, 9%, 11%, 0% (Average 9%)
Speak Louder	0%, 9%, 11%, 23% (Average 11%)

Samples of the most common suggestions for improvements included: “The dots were not a useful system,” “Please, more time for presentation and questions,” “Speak louder!!!” and “Provide handouts of each issue ahead of time.”

This information is graphically represented below.

GRAPH: SUGGESTIONS FOR IMPROVING THE SYMPOSIA



Impact of public feedback on the proposals. At the final briefing in the Capitol, several proposal authors spoke of the high quality and value of the feedback they received from the public throughout the project and the symposia process. Public feedback had a substantive impact on the proposals of the authors interviewed for this report, including driving additional research with the federal government concerning feasible alternatives.

Outcomes. There was general consensus that the HCOP process picked up momentum as the drafts were released and reviewed, and each of the symposia took place. The final briefing at the Capitol was well attended, particularly by many of the active stakeholders from the first four symposia. HCOP organizers also arranged to have the final briefing televised over the California Channel, or Cal-SPAN, providing an opportunity for a much broader audience of policymakers, legislative staff, stakeholders, and members of the general public to learn about the project and obtain copies of the final reports from the Web site. While press coverage was modest, the project did receive both print and broadcast coverage.

One of the proposals was developed to support pending legislation (AB32) and another, with modifications, was picked up during the HCOP process (SB1414). Single payer activists indicate that they hope to develop legislation around a blend of the three proposals in that category, or create momentum for a citizen referendum on the issue.

In addition, word of the HCOP process and proposals has spread among health policymakers in other states. One author reports several requests for speaking engagements and an exploratory conversation about the potential for a countywide pilot based on the proposal.

Conclusion. The California Health Care Options Project succeeded in providing a forum for meaningful debate and discussion concerning the options for expanding health care coverage. The structure of the project, incorporating rigorous research and analysis of a range of options, and the process developed to educate and solicit feedback from the public, worked together to create strong intellectual products to serve as the basis for continuing dialogue.

APPENDIX IV: TWO-PAGE SUMMARIES OF THE NINE OPTIONS PAPERS

HEALTHY CALIFORNIA: A PROPOSAL FOR UNIVERSAL HEALTH INSURANCE COVERAGE IN CA

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

Major Objectives the Healthy California Program Will Achieve

- Healthy California will **cover all citizens and legal immigrants residing in California** and give each of them a **choice of public or private coverage**.

Many will continue to obtain employer-sponsored coverage, as they do now. However, all legal residents in California will be able to obtain publicly sponsored coverage through Healthy California — with no premium payment at the time of enrollment.

- Healthy California will **maximize federal matching dollars** available to California.

Healthy California will be built on a foundation of the Healthy Families and Medi-Cal programs, integrated into a new, streamlined program in Stage 1 — but without the onerous eligibility application process now required.

- By using a pay-or-play approach, California **reduces barriers that federal law and politics pose** to other universal coverage proposals.

The pay-or-play approach avoids the barrier that ERISA poses to state reforms that try to require employers to help pay for coverage. By maximizing federal matching funds and using the pay-or-play approach — mixed public-private financing, Healthy California minimizes the amount of revenue that must be shifted from employment-based payments to taxes.

Target Populations and Eligibility

- All citizens and legal immigrants residing in California are eligible for Healthy California.
- Many undocumented immigrants will continue to receive coverage through employers who “play” or continue to receive care from private providers or the health care safety net.

Mechanism for Expanding Coverage

- In Stage 1, a federal waiver will enable the state to cover low-income adults without custodial children. Integration and streamlining of public programs will encourage all eligible children and adults to enroll.
- In Stage 2, **employers** would have to **choose** whether to “**play**” (provide private coverage) or “**pay**” (pay a premium as a percentage of payroll to the state program). **Employees choose** whether to **accept their employer’s coverage**, if it is offered. All Californians not covered by other qualifying insurance will be eligible to **enroll in Healthy California** — without premium payment at the time of enrollment.

Delivery System and Administration

- Healthy California will be administered by the Major Risk Medical Insurance Board (MRMIB). MRMIB will conduct outreach to potentially eligible persons, determine eligibility of applicants, and monitor and assure quality, including ensuring that culturally competent services are available.
- MRMIB may contract with HMOs and directly with health care providers. Healthy California will also offer a PPO network option for a modest additional charge.

Health Benefits

- Healthy California will establish a state standard for benefit packages (SSBP), approximating the Healthy Families benefits as the benchmark. All residents will receive these benefits whether covered through Healthy California or through qualifying job-based insurance.
- Those who would currently be eligible for Medi-Cal will receive expanded benefits through “Healthy California+Plus.” In addition to these additional benefits, they will not be charged copays that exceed those currently allowed by the Medi-Cal no-share-of-cost program.

Financing Mechanism

- In Stage 1, Healthy California will maximize federal matching funds for Medi-Cal and Healthy Families, and cap the rate of growth in spending to two percentage points less than currently projected under Medi-Cal and Healthy Families. Other sources of funding are being identified.
- In Stage 2, Healthy California will, in addition to Stage 1 financing, make all families eligible for federal match without regard to income and assets, receive payroll premium tax payments from employers and employees for all workers not covered through the workplace, and reduce administrative costs. Other sources of funding are being identified.

THE MANAGED CARE EXPANSION PROGRAM

A Project of Working Partnerships USA:

B. Brownstein, S. Zimmerman, L. Auerhahn, S. Muller, M. Elliot, W.K. Lum

Formatted

Major Objectives:

The Managed Care Expansion Program (MCEP) seeks to provide affordable health insurance to low income, uninsured California residents primarily through a long-term, incremental expansion of public managed care programs. This approach is based on the view that both fiscal and political considerations make a large scale, rapid and fundamental change in health insurance options unlikely. At the same time, the MCEP seeks to attempt to improve the fiscal stability and sustainability of “safety net” institutions in the health care delivery system.

Target Populations

The MCEP will target uninsured Californians with annual incomes of 400% or less of the Federal Poverty Level. An eligible applicant must: be a California resident; be under the age of 65; be ineligible for other public health insurance programs including Medi-Cal and Healthy Families; and must have been uninsured for at least six months prior to enrollment (with the exception of those losing job-based insurance due to layoffs) *or* have access only to a substandard health insurance program. Undocumented immigrants will be eligible for coverage. The target population of the MCEP is estimated at approximately 3.2 million adults and 350,000 children.

Mechanism for expanding coverage

The MCEP will build on existing public sector institutions currently engaged in providing coverage through the Medi-Cal and Healthy Families programs. The reliance on public institutions is based on the dual goal of ensuring quality of service and supporting safety net providers. Because of regional differences and varying patterns of existing institutional frameworks, the specific form that the MCEP will take will be tailored to each county’s infrastructure and demographics.

In counties that currently have a managed care system in place (such as Two-Plan and COHS counties), the existing system will be expanded. In Geographic Managed Care counties, plans will be offered the opportunity to bid to participate in the MCEP program for the county. If necessary, more than one plan may be chosen in order to provide coverage for all of the disparate communities in the county. In counties with other Managed Care models, the state will negotiate with the county to agree on an appropriate structure. In each Fee-For-Service county the state will assess whether the MCEP is feasible. Where managed care is not feasible and unlikely to improve the quality of care, FFS will remain and MCEP providers will receive reimbursement rates equal to those of Healthy Families. In all cases, MCEP plans must include traditional and safety net providers in the provider network.

Delivery System

The MCEP plans will market insurance coverage based on the number of new participants authorized by the state budget decisions. The program will initially cover the lowest income Californians and incrementally reach those approaching 400% of Federal Poverty Level. The Managed Risk Medical Insurance Board (MRMIB), already experienced with oversight of similar programs, will administer the MCEP.

Health Benefits

The MCEP benefits package will mirror the Healthy Families benefits package for both children and adults. Coverage will include:

- a) Inpatient, outpatient, medical and surgical services
- b) Prescription drugs, X-ray services, speech therapies
- c) Mental health, dental and vision care

To encourage public use of preventive care, preventive services would be free to all users. Co-payments will range from \$5 to \$10 monthly for all other services, with an annual maximum of \$250. Prescription drug co-payments range from \$0 to \$5 and are included in the annual \$250 maximum.

Financing mechanism

Approximately 83% of the cost of the MCEP will be paid by the state. To contain these costs, the MCEP will implement a sliding scale through which individuals or their employers contribute to premium costs. Sliding scale payments will not exceed two and a half percent of annual household income, thereby limiting the extent to which payments are a barrier to enrollment. The MCEP sliding scale fees are as follows:

- Adults with household incomes under 100% of FPL pay no fee.
- Adults with incomes between 100% and 250% of FPL pay 1.5% of annual household income.
- Adults with incomes between 250% and 400% of FPL pay 2.5% of annual household income.
- Parents pay \$9 per month for each enrolled child up to a maximum of \$27 per month.

Formatted: Bullets and Numbering

The incremental financing strategy for MCEP is designed to significantly expand health coverage while recognizing constraints on the state's fiscal capacities. In a model financing plan, increased allocations of state funds to the MCEP would be appropriated at approximately the same level for each of the next 15 years. With the estimated cost of \$5.94 billion annually to cover the entire target population (without factoring in inflation), this would require an annual funding increment of approximately \$396 million (as of 2000, in 2000 dollars). The actual cost to the state may be considerably lower, however, as this estimate reflects the maximum cost based on 100% enrollment, which is higher than enrollment estimates currently predict. For example, one prediction estimates 70% enrollment, which would result in a final cost of approximately \$4.16 billion annually, with \$277 million annual increments.

Thus, the MCEP plan attempts to provide the Governor and State Legislature with the ability to move slowly and consistently towards achieving universal health insurance in California without fundamentally restructuring the state's health care delivery system.

THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP) Health Policy R&D: Peter Harbage, Katie Horton, Jennifer Ryan

Program Goal

The California PacAdvantage Premium Program (CPPP) is designed to continue and supplement the significant efforts at providing health coverage to uninsured families in California. CPPP seeks to help small businesses make health insurance available to employees and their families. Small businesses face unique challenges in offering health insurance as compared to large businesses. Coupled with PacAdvantage, the state's existing non-profit small business purchasing pool, CPPP would offer premium assistance to employers and employees in paying for the costs of group health coverage.

Eligibility for CPPP

Employees

CPPP would make subsidized coverage available to workers with family incomes below 350 percent of the federal poverty level (\$61,775 for a family of four in 2001):

- Individuals could be part-time employees, but must be working at least 20 hours per week.
- Applicants must have been uninsured for the previous six months before enrollment (unless employed by a firm already offering coverage through PacAdvantage); and
- Families must be ineligible for Medi-Cal and Healthy Families (as determined by a screening at the time of application).

Employers

Small businesses with between 2 and 50 employees could participate in CPPP, provided they:

- Meet the requirements for participation in PacAdvantage/CPPP;
- Have not offered health coverage (other than through PacAdvantage) in the previous 6 months;
- Purchase and offer coverage that is actuarially equivalent to the CPPP benchmark benefit package.

Premium Subsidy

Subsidies would be provided on a sliding scale based on the family's income level (expressed as a percentage of the federal poverty level):

Employee Income Level	Subsidy	Employer	Employee*	Total
350+	0	60	40	100
300 - 349	25	40	35	100
250-299	35	40	25	100
200 - 249	45	40	15	100
Below 200	55	35	10	100

Benefit Package and Cost Sharing

Employers would have two options for ensuring the purchase of a quality health insurance product. They could:

- Utilize the existing PacAdvantage purchasing pool, which would include a choice of nine different health plans in various parts of the state. CPPP employers would also have the option of providing dental, vision and other ancillary services.
- Purchase a benefits package that is actuarially equivalent to one of three benchmarks – any plan available through the most popular commercial HMO in the state; the federal employees health benefit plan as offered in California (FEHBP); or the richest PacAdvantage plan in the employers' area.

Cost sharing would be determined according to the requirements of the selected health plan. There would be no specific limits beyond those on the premiums. (It should be noted that because families must be screened for Medi-Cal and Healthy Families eligibility before enrolling in CPPP, most families would be at income levels between 250 and 350 percent of the FPL.)

Administration and Financing

PacAdvantage (managed by the Pacific Business Group on Health) would have responsibility for the daily operations of CPPP, with policy oversight and assistance from the Managed Risk Medical Insurance Board (MRMIB). This logical partnership would blend two successful and experienced entities to ensure an efficient and accountable premium assistance program.

CPPP would be financed by a combination of funding sources including an increase in taxes on tobacco and possibly alcoholic beverages. An outreach campaign would also be targeted at obtaining donations from foundations or other private funding sources.

Transition/Implementation Issues

One of the strongest aspects of CPPP is its inherent connection to the existing structure of PacAdvantage. The fundamental aspects of PacAdvantage would remain in tact and serve to strengthen the ability of small businesses to offer health coverage for their employees.

Establishing an income-based enrollment process (with the help and experience of MRMIB) along with establishing a strong outreach and marketing plan would be two important challenges for the program. However, the absence of a federal regulatory burden would make the program both practically and politically viable and would provide a great opportunity for innovation and significant progress toward covering California's uninsured population.

SINGLE PAYER HEALTH PROGRAM FOR CALIFORNIA
Kahn JG, Bodenheimer T, Grumbach K, Farey K, Lingappa V, McCanne D

1. Major objectives

- provide universal coverage through universal eligibility;
- cover all individuals in a single financing pool;
- provide a comprehensive benefit package;
- maintain overall health care spending at or below current (projected) levels, but use substantial administrative savings to fund expanded services;
- leave clinical decision-making with providers and patients, by using global financing rather than individual provider utilization review to control spending;
- improve quality of care through improved data and analysis of health care patterns and outcomes;
- foster advances in public health and prevention and in innovative technologies through earmarked funding; and
- improve public responsiveness of the health care system through public hearings and accountability to the electorate.

2. Target populations and eligibility

Single payer has no specific target populations; a primary principle is to provide **universal coverage**. This inclusive approach permits maximum administrative savings, and assures broad support for the system.

Eligibility is based on residence in California. All state residents are eligible for coverage after a 3-month waiting period; longer length-of-residency restrictions apply for certain services (e.g., long-term care 3 years). Individuals lacking legal immigration status (i.e., “undocumented”) are included if they can document residence. Emergency services are covered during the waiting period.

3. Mechanism for expanding coverage

Coverage is expanded by **documenting evidence of residence** in the state (e.g., employment papers, official correspondence, etc). **Implementation** is by a concerted campaign involving public service advertising, workplace benefits information, enrollment at health care providers and at government offices (e.g., social service agencies and the DMV), etc. Expanded coverage will be achieved quickly due to broad and simple eligibility rules; lack of public assistance stigma; absence of requirement for regular recertification; lack of significant financial burden to participants; and presumptive eligibility of impaired individuals.

4. Delivery system, administration and regulatory approach

The delivery system is predominantly **private providers**, with a small number of county providers. There are two major sectors: **fee-for-service** and **capitated integrated delivery systems**. Providers and individuals must choose to participate in one sector or the other.

Administration of the single payer system is by an elected health commissioner, public state board, and regional boards (including individuals representing providers, consumers, and employers). This structure is responsible for financial management of the system; establishing eligibility and benefits; negotiating reimbursement; and other functions. There are advisory groups, such as on immigrant issues, quality assurance, and clinical guidelines.

Current state **regulatory mechanisms** not supplanted by single payer provisions remain in place, e.g., agencies that oversee provider care quality, licensing, and financial soundness are largely unaffected. Coordination is anticipated with the single payer system, e.g., data collected on health care utilization and outcomes.

5. Benefits and copays

The benefit package is **comprehensive, with flexibility for cost-control** purposes. Specifically, **all medical care deemed medically appropriate** by the patient's health care provider, including: inpatient and outpatient care, diagnostic tests, prescription medications, durable medical equipment, podiatry, chiropractic, dialysis, medical transportation, rehabilitation, language interpretation, preventive care, long-term care services (institutional, home-based, and day treatment), mental health care, and dental and vision benefits.

There are **copays** of \$5 outpatient and medications, \$100 inpatient, room & board long term care. Individuals who meet Medi-Cal/Healthy Families income rules are exempted. Preventive care is exempted.

6. Financing mechanism

- **Current public health care spending:** public insurance (e.g., Medi-Cal and Healthy Families), federal insurance and service programs (e.g., Medicare, CHAMPUS, Indian Health Service, Veteran's Administration, Federal Employees Health Benefits Program); categorical programs (e.g., Ryan White CARE Act); state health care safety net funds (e.g., Realignment); and county safety net funds to the extent not needed for safety net services;
- **Private funds** intended for health services (e.g., part of retirement packages), to the extent covered individuals participate in the single payer system;
- **Billing** for services delivered to individuals covered by other programs.
- **Payroll tax** of 8% on employers (private and public), exempting firms with annual gross incomes of less than \$75,000. These are likely to replace employer and employee payments now made to private insurers.
- **Personal income tax** for heads of households subject to California income tax, of about 0.3% of taxable income, and a state income surtax of 0.3% on net taxable income in excess of \$250,000.

CAL-HEALTH
Helen H. Schauffler, Ph.D.

Cal-Health is based on Assembly Bill 32 (AB 32), which was introduced by Assembly Member Richman, Senator Figueroa, and Assembly Member Chan in December 2000. In 1999, 66% of California's uninsured were in families with annual incomes below 250% of the federal poverty level, representing 4.5 million Californians. Cal-Health will increase eligibility for health insurance coverage for all Californians with incomes below 250% of poverty, and will make private insurance more affordable for persons with incomes above 250% of poverty by permitting health plans to offer a low-cost standard uniform benefit package (SUBP) in the individual and small group market.

Objectives and Target Populations: The objectives of Cal-Health are:

- 1) To provide the uninsured with an easy, one-step streamlined process for enrolling in health insurance by coordinating the administrative functions of Healthy Families and Medi-Cal and providing for accelerated enrollment in these programs under Cal-Health. Existing Medi-Cal and Healthy Families income and resource methodologies, other eligibility rules and applications, enrollment, retention and seamless bridging procedures will be simplified, streamlined, and coordinated under Cal-Health.
- 2) To target outreach through schools and health care facilities. Every pre-school and public elementary and secondary school will inform the parent or primary care taker of every enrolled child at least once a year about Cal-Health and an application may be submitted at the school. All licensed hospitals, clinics and other health care facilities will inform all uninsured patients seen or admitted about Cal-Health and may enroll them at the site of care using an automated enrollment system with paperless verification. Providers who enroll uninsured adults and children at the point of service will be reimbursed for services. It is estimated that the state will realize approximately \$94 million in administrative savings from accelerated enrollment.¹
- 3) To expand eligibility to parents under the Healthy Families program to those with family incomes between 200% FPL and 250% FPL. If fully implemented in 2002, it is estimated that 66,000 parents would newly enroll along with 51,000 of their children.²
- 4) To create an standard uniform benefits package (SUBP) that will be more affordable than the current products available in the market, which private carriers may sell in the individual market for those with incomes above 250% of poverty and to small businesses. (50 or fewer employees). It is estimated that 59,000 Californians would be newly covered by the SUBP.³
- 5) To expand coverage to low-income, non-custodial adults through the Medi-Cal program for persons with incomes at or below 133% of FPL and who are not currently eligible for other programs, and through Healthy Families for persons with incomes between 133% and 250% of FPL and who are not currently eligible for other programs. If the federal waiver is approved, 1.7 million Californians would be newly covered by this expansion.

Eligibility: There will be NO assets test for adults and children in Cal-Health. Persons covered by employer-sponsored health insurance in the six months prior to application for coverage will not be eligible for Cal-Health.

Administration and State Regulation: The state will administer the Cal-Health program and will coordinate Cal-Health with Healthy Families and Medi-Cal. Cal-Health will create a single,

¹ The Lewin Group, HSBM 2002.

² The Lewin Group, HSBM 2002.

³ The Lewin Group, HSBM 2002.

simplified and streamlined process for the determination of eligibility and enrollment with one portal for entry for all Californians eligible for either program, which will reduce administrative costs. There are two major Federal and State legal or regulatory changes that are required to implement the Cal-Health program. The first is that the state will need a federal waiver to expand the Healthy Families program to parents with incomes up to 250% of FPL. Second, the state will need to obtain approval for a unique federal waiver request that would waive the long-standing requirement of budget neutrality to the federal government to expand Medi-Cal and Healthy Families to low-income non-custodial adults. In addition, by expanding eligibility for the Medi-Cal program, which is currently determined by the counties, this option imposes a state-mandated local program by expanding the scope of those duties.

Health Benefits: Persons enrolled in Healthy Families will have health care coverage for the services mandated by the Healthy Families program. Similarly, persons enrolled in Medi-Cal will have access to the health care services mandated by the Medi-Cal program. Persons who purchase private coverage with the SUBP will have coverage for hospitalization, outpatient visits, preventive care, ambulance services, dialysis care, maternity care, mental health care, emergency and out-of-area care, family planning, hospice care, health education, imaging, lab tests and special procedures, reconstructive surgery, and transplants. In addition, coverage with limits will be offered for physical, occupational and speech therapy, multidisciplinary rehabilitation, and home health care. Two SUBPs will be offered: one for persons who are 19-34 years, which reflects their lower health care needs and utilization, and one for persons who are 35-64, which reflects their greater health care needs and utilization.

Financing Mechanisms: Financing for this option will come from both the state and federal governments for Medi-Cal and Healthy Families. As the previously uninsured population enrolls in Cal-Health, 70% of the average per capita cost of safety net funding for medical care per uninsured person will be transferred to help finance the state and federal share of Cal-Health (this will not include Federal DSH funds). Over time, the funding levels for the safety net to provide care to uninsured persons will increase as it retains both its current funding levels for persons who remain uninsured plus 30% of the funding from those who were previously uninsured and have enrolled in Cal-Health. Over time, this option assumes that the State's need to directly subsidize the health care safety net providers, including county health programs, community clinics, and DSH hospitals, will decline and that these providers will receive a more stable and generous source of revenue through insurance payments, as Cal-Health will significantly increase the number of previously uninsured individuals seeking medical care in these facilities.

Impact of Cal-Health on Costs and Coverage: If the federal waiver for non-custodial adults is NOT approved, Cal-Health will extend new coverage to 444,000 Californians at a net savings to the state of \$40 million.⁴ If the federal waiver for non-custodial adults IS approved, Cal-Health will extend new coverage to 2.12 million Californians at a total net cost to the state of \$857 million.⁵

⁴ The Lewin Group, HSBM 2002.

⁵ The Lewin Group, HSBM 2002.

CHOICE

Helen H. Schauffler, Ph.D.

Objectives: The objectives of the CHOICE Program are to 1) cover approximately 95% of California residents, regardless of legal status, 2) increase enrollment in Healthy Families and the Medi-Cal for those who are eligible but not enrolled, through mass media campaigns, extensive community outreach, and accelerated enrollment, 3) to increase patient choice of physicians and health care facilities to a statewide fee-for-service network and organized delivery systems (ODS) , 4) to make health insurance more affordable for individuals and families, and employers, 5) to provide a reasonably comprehensive standard set of benefits to all enrolled Californians, 6) to provide fair payment to all health care providers in the CHOICE Network using Medicare payment rates, regardless of the patient's source of financing, 7) to increase efficiency in the administration of health insurance coverage by improving the quality of health care, bulk purchasing pharmaceuticals and medical equipment, and streamlining administration, and 8) to maintain and improve the health of the people of California and to meet their medical care needs by: providing coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition, returning medical care decision-making to health care providers and their patients, and holding health care providers in the CHOICE Network and ODS contracting with the CHOICE Program accountable for quality and costs.

Target Population: The primary target populations include: working Californians and their non-working dependents, and those who are eligible for public programs but not enrolled. Californians under age 65 who reside and work in the state and their non-working dependents, regardless of race, age, gender, religion, ethnicity, sexual orientation, immigration status, health status, or income will be eligible to enroll in the CHOICE Program. Workers include full-time, part-time, seasonal, contractual and the self-employed. The target population also includes persons enrolled in publicly funded health insurance programs, including Medi-Cal, Healthy Families, AIM, MRMIP, and Medicare for the elderly (under a CMS demonstration program).

Eligibility: Non-elderly (0-64) Californians who meet three criteria are eligible to enroll in the CHOICE Program: 1) presently reside in California with the intent to remain, 2) ages 0-64 and not covered by Medicare, and 3) meet one of the following criteria: a) worked in California (or the non-working dependent(s) of eligible workers) for at least 3 months out of the last 12; b) eligible for COBRA health benefits; and c) receiving state unemployment benefits. Individuals and families who enroll in CHOICE will have coverage for one full year, with annual renewal guaranteed, conditional on continued payment of the income-based share of the premium. Worker premiums are collected through automatic payroll deduction. Individuals can self-certify their eligibility with paperless verification and may allow an application for enrollment to be submitted by a health care provider while they are in a hospital, clinic, or other health facility.

Mechanisms for Expanding Coverage: The CHOICE Program reforms California's health care system through the voluntary actions of individuals and employers based on their preferences and economic incentives. All Californians eligible to enroll in CHOICE will have two options for coverage: 1) get their medical care from any licensed health care professional or facility that elects to participate in the statewide fee-for-service network for provision of covered services, and 2) enroll in any state licensed ODS (including group-model HMOs, County Organized Health Systems (COHS), or non-commercial Local Initiative (LI) plans) that elects to contract with the CHOICE Program. In addition, the CHOICE Program will work with DHS in contacting hospitals, and outpatient facilities, as well as preschools, and public elementary and secondary schools to ensure that persons seeking medical care, and who are eligible for state programs (Medi-Cal, Healthy Families, AIM), enroll and receive health insurance benefits. It is

estimated that within one year of adoption of the CHOICE program 71% of the non-elderly population will enroll in CHOICE and 94.4% of all California residents will have coverage.⁶

Financing: The CHOICE Program is fully funded. Existing sources of financing include state funds for MRMIP and AIM; the State and Federal share-of-cost for those eligible for Healthy Families and the Medi-Mdi-Cal; the Medicare+Choice capitation payment for the elderly; 80% of the per capita savings in the State's direct subsidies for indigent medical care resulting from coverage of persons previously uninsured (does not include Federal DSH payments and increases per capita State funding to the counties for indigent medical care for those who remain uninsured). New sources of financing include a wage-based worker monthly premium, a quarterly employer marginal payroll tax that varies by firm size and total payroll (with a refund for workers covered by an employer-sponsored plan); three public health taxes (on tobacco, soda, and moving violations); a 0.25% increase in the state sales tax; a 1.25% increase in the state income tax; and funding from the proposed NAFTA Social Integration Fund for Mexican citizens working and residing in California.

Administration and Regulation: MRMIB will administer the CHOICE Program. The CHOICE Program involves no state mandates of individuals, no new Federal waivers, and no ERISA waiver. Rather, it restructures current payment mechanisms to cover currently uninsured Californians. Eligibility requirements for income, residency, and work will be determined by a self-certification process with paperless verification and no assets tests. The CHOICE program will contract directly with licensed health care professionals and facilities in the statewide CHOICE Network whose performance will be assessed on quality and cost. The State will offer tax incentives to insurance carriers and health plans to partner with large multi-specialty groups in exclusive arrangements to form new group model HMOs. Regulation of the coverage offered by employers will not be affected by this proposal. The Departments of Managed Care and Insurance will continue to regulate health care service plans and disability insurers, respectively.

Benefits: CHOICE provides coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition. The Kaiser Foundation Health Plan standard benefit package in the large group market is the initial benchmark for health benefits under the CHOICE Program. New benefits will be added over time by determining which treatments are most effective in maintaining and improving health, as well as which are relatively cost-effective in improving health outcomes. CHOICE offers a more rational framework determining what benefits will be covered. Benefits will be selected conscious of the trade-offs between cost, quality, access and choice. An independent panel of experts will be established to advise the CHOICE Program on the treatments or drugs which should be added or removed from the standard benefit package.

Quality: Physicians participating in the statewide CHOICE Network and participating ODS will be required to report on both quality and cost metrics, and to participate in quality studies. In addition, CHOICE enrollees will be provided information on Centers of Excellence for specific conditions to improve their quality of care. ODS, health care facilities, and physicians participating in the CHOICE Program will be offered financial incentives for improving their performance on quality indicators, preventive care and disease management.

⁶ The Lewin Group, HBSM 2002.

CALIFORNIA HEALTH SERVICE PLAN

Ellen R. Shaffer, PhD, MPH

Major Objectives

Through the California Health Service Plan, the public would both finance and administer the health care delivery system. Providers would be employed by the state to provide health services to all California residents. Savings would be sufficient to cover all California residents for comprehensive services.

Accountable public authorities that involve communities and health care workers in decision-making would integrate fragmented sources of financing, coordinate the delivery of services, and improve population health. The plan's objectives are:

- **Improve population health and quality of care**
 - Designate public authorities accountable for achieving, documenting and reporting improvement
 - Involve health care workers and communities in strategic planning
- **Coordinate and integrate delivery system**
 - Public owns health facilities, employs health care workers
 - Allocate health care resources where needed
 - Independent "base closure" committee to determine hospital capacity
 - Greater support for current "safety net" providers
- **Align relationships among providers, patients and payers to create valued outcomes**
 - Financial incentives
 - reimburse health care workers by salary; incentives tied to performance
 - encourage ethical professionalism
 - Organizational incentives: Involve health care workers and communities in setting quality targets, and other aspects of decision-making
- **Focus on supply side (providers, payors) to control costs**
 - Sharply reduced administrative waste: single payment source; no billing from hospitals or clinicians
 - Annual spending increases limited to increase in Gross Domestic Product
 - Increase percent of primary care physicians from current to 33% to 55%, reduce percent of specialists
- **Stable, progressive funding**
- **Universal coverage**

Target populations and eligibility

- Universal coverage, including the undocumented
- Residence requirement: 3 months
 - Emergency services covered in the interim
 - Reciprocal coverage for short term visitors with other sources of insurance

Mechanism for expanding coverage

Legislation to enact California Health Service Plan would authorize the state to finance and provide services to all Californians. Outreach programs would encourage enrollment.

State and local health departments would engage in strategic health planning, cooperating with providers and communities to improve health status.

Delivery system administration and regulatory approach

The California Health Services Administration would set policy for and coordinate the work of:

- California Health Service (CHS): delivers hospital and home health services, and most primary care.
 - Office of Accountability develops operational standards, advocates for patients.
 - Office of Reimbursement sets payment rates and pays providers
 - Office of Community Health Services provides home health services, and community outreach and health education for vulnerable populations
- Department of Public Health (DPH): sets policy for and coordinates population health and public health programs.
- Office of Statewide Health Planning and Development (OSHPD) collects and reports data to support strategic planning by CHS and DPH.

Patient advisory boards provide patient perspectives on organizational, access, and quality issues, and educate and communicate with patients. Members are elected at the community level, subject to conflict of interest rules, and work half time for the board.

Benefits

Inpatient and outpatient hospital care; prescription drugs; durable medical equipment; mental health; dental care; vision care; limited home health care; care coordination. Office visits to health care professionals working in salaried group practices, including physicians, advanced practice nurses, physician assistants, mental health and social service providers, dentists, chiropractors, acupuncturists, podiatrists, and allied health professionals.

Financial models shows costs for the plan both with and without coverage for long term care and eyeglasses. Alternative medicine provided by practitioners outside of group practices would not be covered, but could be available privately.

Copayments

There are no individual copayments. Copayments are likely to reduce use of both necessary and unnecessary services, especially for low-income residents. The system relies on supply-side financial incentives, and organizational features including increased availability of primary care and allocation of capital resources, to assure appropriate and affordable utilization.

Financing

Stable, progressive funding, with the least burden on individuals and employers with lowest incomes.

- Payroll tax
- Tobacco tax
- Income tax to supplement if needed (not projected to be necessary)

"CAL CARE" SINGLE PAYER PROPOSAL
Principal Authors: Judy Spelman, RN and Health Care for All-California

What is Single Payer?

- ❖ Single Payer is a universal health finance and administrative system. The State of California establishes a health insurance plan that covers all California residents. The plan replaces all other health insurance plans, public and private. The plan is funded by taxes instead of insurance premiums. Plan is administered by single state agency.
- ❖ Universal care is affordable because money saved by streamlining administration is shifted to health services.
- ❖ Universal care is sustainable over time because the rate of growth of health care spending is limited to the rate of growth of California GDP.
- ❖ Universal care is sustainable over time because cost inflation is controlled through global health care budgets with spending ceilings, state purchasing power to win discounts on pharmaceuticals, medical supplies and emphasis on primary and preventive care.
- ❖ Quality of care for all is improved through equitable distribution of resources including high technology, state wide health care planning, coordinated data collection and analysis, return of decision making to medical practitioners and linkage of health research and innovation to California's health care needs.

Cal Care: Major Objectives and Policies

Universal Coverage

All California residents covered from cradle to grave.
No exclusions for "pre-existing" conditions.
Insurance not lost with job change or job loss.

Sound Finance

Universal coverage for less than we now spend on healthcare through savings on administration, purchasing discounts and statewide health planning.

High Quality Care

Doctors decide on appropriate care, not insurance companies or the government.
Everyone chooses his or her own doctor.
Enforceable quality of care standards, including cultural and linguistic standards.
Special needs of people with disabilities met.
Health professional safe-staffing ratios.
Consumer advocate in each county.
Incentives to increase supply of nurses, including on-site child care.
Well-funded, coordinated development of advanced health technology.
"Risk-adjusted" budgets ensure adequate funds for high quality care.

Affordable Care

All Californians pay fair share. Health care costs for most Californians reduced.
No increase in costs when you are ill.

Good for Business

Business opportunities through public-private partnerships.
Business opportunities through expansion of market by 7 million Californians.
Levels playing field: Makes health payroll tax an operating expense for all businesses.
Stabilizes health system inflation.
Maintains prevailing wages and working conditions in public-private partnerships.

Delivery System

Delivery of care is private. All current providers may participate
Patient choice of provider. Includes Kaiser, other HMOs as well as individual providers.

Benefits

Comprehensive benefits: No co-pays. Includes: preventive, outpatient, hospital, emergency, podiatry, hospice, skilled nursing facility, personal behavioral therapies such as stress management, smoking, substance abuse cessation and obesity control, specialists with referral, mental health parity, durable medical equipment, dental, vision, long term, in home care, reimbursement to family caregivers, alternative and complementary care, full pharmaceutical coverage reform of Workers' Compensation. No loss current benefits.

Governance

Elected State Health Commissioner. Appointment through public process of State Health Commission members and County Health Officers. Single State Health Agency administers system. Consumer Advocate in each county. Public accountability.

Finance

Current federal, state and county health dollars, payroll tax (6.1% employer; 3.6% employee), tobacco tax (\$1.00 per pack), alcohol tax (15cents/can beer; 32 cents/bottle wine; 48 cents/bottle champagne; \$5.00/bottle distilled spirits) sales tax (1/4 cent) and surcharge on non-payroll income (2.8%).

Transition: Two-year transition period

INSURING CALIFORNIA'S UNINSURED

**Lucien Wulsin, Jr., Peter Long, Roohe Ahmed, Megan Hickey, Jan Frates,
Van Ta, Talia Silverman**

Insure the Uninsured Project proposes that California begin to cover its 6.8 million uninsured through both public and private initiatives. Under our proposal California's lowest income uninsured will be covered by expanding Medi-Cal and Healthy Families; those with higher incomes will have improved access to and better affordability of private coverage.

- §1115 waiver to cover low-income adults,
- Seamless coverage for those enrolled in public programs,
- Refundable tax credit to increase the offer rate for employers with low-wage workforces and purchasing credit to increase take up by low-wage workers,
- Refundable tax credit/voucher and insurance reforms to increase coverage of the flex workforce (temporary, part time, seasonal, contract workers and the self-employed) who are not typically offered coverage through an employer.

This would give all California residents who cannot afford health coverage opportunities to secure affordable coverage through their employer, the individual market and/or public programs. It would lay the foundation for universal coverage if California can develop the political consensus for a single payor system or for a combination of individual and employer mandates to achieve universal coverage.

Major Objectives:

- Increase in low-wage working adult coverage
- Increase in small employer offering
- Increase in opportunities for affordable private coverage
- Increase in federal financing of care for California's uninsured
- Improvements in delivery systems for uninsured
- Increased flexibility and support for pioneering safety net clinics and hospitals
- Increased coverage opportunities for immigrants
- Programmatic simplification

Target Populations:

The proposal seeks to finance coverage of the uninsured with annual incomes up to \$35,000 for an individual and \$70,000 for a family.

1. Below 133% of the federal poverty level (FPL) [up to \$11,900 for an individual], we expand Medi-Cal coverage through a Medicaid waiver.
2. Between 133 and 200% of FPL (between \$15,440 and \$23,220 for a family of two), we expand Healthy Families and affordable private coverage.
3. Above 200% of FPL we propose increasing private coverage.

Mechanisms for Expansions:

We would expand public and private coverage through a federal waiver, refundable tax credit, premium subsidies and increased use of group purchasing.

1. *Medi-Cal and Healthy Families managed care coverage for low income adults.*
 - In *Two Plan* counties, adults with incomes below the poverty level would choose between the county Local Initiative and its commercial competitor.
 - In *Geographic Managed Care* counties, adults with incomes below the poverty level would choose among contracting managed care plans.
 - In *County Organized Health System* counties, adults with incomes below the poverty level would be eligible for the COHS.
 - In *Small Counties* without mandatory managed care, adults with incomes below the poverty level would be eligible for Medi-Cal fee-for-service coverage.
 - Low income adults with incomes above the poverty level would be eligible for Healthy Families plans.
2. *Employment-based coverage for uninsured low-wage workers and families.*

This proposal uses refundable tax and purchasing credits to increase small employers offering and low-wage workers accepting coverage.
3. *Purchasing pools, individual market reforms and vouchers for flex workers.*

Flex workers (nearly half of uninsured workers) are in jobs not typically offered health coverage by an employer. This proposal would use insurance market reforms and a sliding scale premium subsidy to increase flex workers' coverage through the individual market and group purchasing entities.

Health Benefits Package:

1. Medi-Cal benefits for low income adults below 133% of FPL.
2. Healthy Families benefits for low income adults over 133% of FPL
3. Knox Keene basic benefits plus prescription drugs for persons with tax subsidies.

Financing:

Federal matching for adults

The proposal seeks a federal §1115 waiver to cover adults without Medicaid or Healthy Families linkage. We recommend that California meet the federal waiver's cost neutrality test by implementing managed care for disabled adults, consolidating and simplifying coverage and, to some extent, transforming Medi-Cal's institutional subsidies into coverage.

State and county financing for care to low income adults shifted

This proposal shifts state and county financing, which pays for care for low income adults, to purchasing coverage as individuals enroll in the new program.

Taxes

We do not see a need for a tax increase to finance our proposal, as we propose to use current state and county and new federal funding to finance the expansion. To the extent that new revenues are required, we believe that a small tax on providers and health plans would generate more than adequate revenues. This approach succeeded in financing expansions in other states such as Minnesota, Florida and Tennessee.