THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM

Small Business and the Use of Premium Subsidies to Extend Health Insurance Coverage

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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.

THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP)

PART I: BACKGROUND

Over the past several years, California has made great strides in covering the uninsured. Despite a slow beginning, Healthy Families, the state's Children's Health Insurance Program (CHIP), had more than 511,000 children enrolled as of February 1, 2002.[1] In addition, enrollment increases in the Medi-Cal program, the state's Medicaid program, have also brought additional help to California's uninsured. Another important part of this effort has been Pacific Health Advantage, more popularly known as PacAdvantage, a program that has helped small businesses to purchase insurance for their employees. Despite the success of these combined efforts, over 6.3 million people in California remain uninsured.[2]

In California, as in the rest of the country, the vast majority of the insured receive coverage through their employer as an employment benefit. The health care system relies on employers to subsidize the cost of coverage, thereby making it more affordable for employees. However, in cases where employers themselves do not have the revenue to offer health insurance as a benefit, or they lack the expertise needed to interact in the complicated health care marketplace, employees of these businesses are often left to seek coverage on their own. In fact, many of California's uninsured fall into a large gap in the health insurance system – the gap between those who earn a salary too high to qualify for public insurance programs and those who do not have access to, or cannot afford, private insurance.

Due to cost and administrative barriers, small businesses find it particularly challenging to provide health care to their employees. While 99 percent of businesses nationally with 1000 or more employees offered health insurance in 2001, only 79 percent of small businesses (10 to 49 employees) did so.[3] Small businesses in California face similar challenges with only 61 percent of very small firms (3 to 9 employees) offering employer sponsored insurance (ESI).[4] As a result, about half of California's uninsured population consists of small business employees.[5] To help small businesses overcome obstacles to health insurance coverage, action is needed from both the public and private sectors.

The purpose of this paper is to outline how California's existing non-profit small employer purchasing pool – PacAdvantage – could be coupled with a premium assistance program to expand health coverage. Although not a new concept,[6] this is the first paper to detail how such a program, to be known as the California PacAdvantage Premium Program (CPPP), could subsidize the cost of quality health insurance for small businesses that did not previously offer ESI for uninsured employees. This subsidy could help ensure affordable health insurance coverage for the employee. Although CPPP would only provide assistance to the employed, this program's success would stem from the use of a public/private partnership that leverages private dollars for the purchase of health care, thereby maximizing use of ESI and avoiding the regulatory burden (as well as stigma) sometimes associated with public health program expansions.

MILLIONS OF CALIFORNIANS LACK INSURANCE

California ranks 4th of the 50 states and the District of Columbia in the percentage of uninsured between 16 and 64 years of age.[7] While there are numerous, complex reasons for this statistic, this paper addresses two primary issues:

- **Historically, public programs have not covered low-income, childless adults.** While Medi-Cal and Healthy Families offer assistance to millions of people, these programs do not provide assistance to all low-income adult workers. Although children in low-income families with incomes up to 250 percent of the Federal Poverty Level (FPL) can find assistance in California, parents of such children and childless adults historically have not been eligible for public coverage.

  Research shows that only 14 percent of California's roughly five million uninsured non-elderly adults are eligible for Medi-Cal.[8] Even now that the Centers for Medicare and Medicaid Services (CMS) has approved the state's pending Healthy Families waiver to cover the parents of eligible children up to 200 percent of the (net) FPL, only slightly more than 300,000 parents are expected to become eligible for the new program.[9]

- **Employees of small businesses in California have difficulty accessing the group market.** Given the difficulty and expense in obtaining insurance in the individual market, most individuals rely on their employer to purchase affordable coverage through the group market. However, accessing the group market is difficult for small employers where it is estimated that only 61 percent of California businesses with 3 to 9 employees offered health insurance in 2001 as compared to 95% of firms with 200 to 999 workers.[10] For employers with 10 to 49 workers, only 78 percent of employers in California offer insurance while 79 percent do so nationally.[11] California's parity with regard to ESI participation rates is new as of 2001 when the Kaiser Family Foundation found the ESI rate for all firms to be 66 percent in 2001, six points higher than 2000 and 18 points higher than 1999's 48 percent participation rate. Historically, California has had one of the lowest ESI rates in the country.[12] The reasons for this recent shift are not fully understood, although it is reasonable to assume that as premiums increase, participation could again decline. It is still the case that part-time works frequently do not have access to health coverage.

GENERALLY, EMPLOYERS WANT TO OFFER, AND INDIVIDUALS WANT TO HAVE, HEALTH INSURANCE

California's ESI rate among small employers is interesting given the expressed desire of employers to offer, and the desire of individuals to have, health insurance. In fact, through a variety of surveys, it seems California's small business owners believe that health insurance improves recruitment, increases productivity and reduces turnover.[13] Furthermore, a national survey funded by the California HealthCare Foundation in 1998 found that 54 percent of small business owners believe that it is their responsibility to provide health insurance--a result supported by other surveys.[14] A focus group study of small business owners in California conducted in 2000 concludes, "In all instances, [small] employers say they would like to be able to offer health insurance to their employees."[15]

According to additional research funded by the California HealthCare Foundation, about half of the uninsured in California would like to be covered by health insurance. In addition, a substantial portion of this population worries about their lack of health insurance.[16]

COST IS THE PRIMARY CONCERN FOR SMALL BUSINESSES AND INDIVIDUALS CONSIDERING ESI

Studies have shown that the two primary barriers to obtaining ESI are cost and a lack of credible, understandable information.

The 2001 Annual Health Benefits Survey by The Kaiser Family Foundation and Health Research Education Trust reveals that 73 percent of firms that do not offer insurance report that premium cost is a "very" or "somewhat" important factor in the decision-making process--the most important factor given.[17] This finding is supported by other studies, such as the California HealthCare Foundation's 1998 survey, which asked small business owners to select their top two reasons for not purchasing insurance. In this survey, 60 percent of small employers selected "we can't afford it," as the reason for not having ESI; 42 percent of respondents selected the next most common answer, "employees get it elsewhere."[18] Given that California's health insurance premiums for small businesses shot up 11.3 percent, with more than a third of small firms facing a 15 percent increase, it seems reasonable to assume that the perception of cost as a factor will only grow. These increases are more than double the 4.3 percent inflation rate from 2001.[19]

Through a focus group conducted in 2000, the California HealthCare Foundation supported these findings and additionally found that a lack of unbiased, easily understood information on health insurance contributed as a major barrier. The report concluded, "cost is the primary factor when deciding to offer coverage. If a small business can afford to sponsor an employee health plan without suffering a financial hardship, it is likely to offer it."[20] Many small business owners do not fully understand the health insurance market and are "skeptical" of information from insurance companies.[21] This lack of "credible" information can lead to inaction on the part of employers.

Even when small businesses can overcome these barriers and purchase insurance, individuals sometimes will not take the health insurance offered because it is perceived to be too costly to the individual. A survey conducted by the California HealthCare Foundation reports that 75 percent of the uninsured indicated that they could not afford coverage, the most common response given.[22] One reason for this finding could be that, on average, small employers require employees to pay a larger share of the insurance premium. Among individuals, there are certainly those who are uninsured by choice due to a lack of concern about their health coverage. Particularly for those who are healthy, expenditures on health insurance are often perceived as unnecessary. While a lack of motivation to purchase health insurance can be more of a factor than cost for some, surveys consistently cite cost as a leading factor of uninsurance.

Part II: PacAdvantage: Existing Program Offers a Sound Foundation

PacAdvantage, the nation's first purchasing pool for small business, is the result of the small business health insurance reforms enacted in California under Assembly Bill 1672. All plans sold to qualified small employers are sold on a guaranteed issue basis--eligible and participating employees cannot be turned down for health insurance coverage based on health, age, occupation or residence.

PacAdvantage allows small businesses to provide affordable health insurance to their employees. This non-profit small business purchasing pool has operated since 1992 and currently covers more than 11,000 small employers and 147,000 individuals.[23] PacAdvantage was formed to respond to basic health insurance needs. Through its purchasing pool, PacAdvantage provides purchasing power and affordability, a comprehensive benefits package and a choice of health plans. It offers one product that is available from several different companies. The employee selects a health plan based on quality, service and price.

Until 1999, the Managed Risk Medical Insurance Board (MRMIB), a governmental entity led by appointed officials in California, oversaw PacAdvantage. Then known as the Health Insurance Plan of California (HIPC), the state turned control of the purchasing pool over to the Pacific Business Group on Health (PBGH), an existing non-profit coalition of health care purchasers, following a competitive bidding process.

ELIGIBILITY

PacAdvantage serves small businesses and their employees living and working in California. The employee must be actively working for a qualified small employer on a full-time basis with a normal 30-hour workweek at the employer's place of business. Exceptions may be made for permanent part-time employees.

Dependents (spouse, domestic partner or any unmarried child under 23 years of age) of the employee may enroll but must choose the same health plan as the employee. If an employee is eligible for coverage and has health insurance through another employer-sponsored plan, Medicare or Medi-Cal, she may waive coverage with PacAdvantage but must also waive coverage for dependents.

ENROLLMENT

Once the employer's required waiting period and other eligibility criteria are met, an enrollment form must be completed and submitted to PacAdvantage. If approved, the effective date of coverage is the 1st of the next month. Each enrolled employee receives an ID card, provider network information and a document outlining how to use the plan selected (Evidence of Coverage or Certificate of Insurance). Additionally, trained PacAdvantage staff assist employees with questions. Furthermore, the vast majority of small businesses use the services of insurance agents or brokers who also assist the employer and employees.

Also, an annual open enrollment period allows employees to:

- Add dependents or switch categories of dependent coverage;
- Join PacAdvantage if an employee previously waived or initially declined to enroll in PacAdvantage;
- Change benefit options (ex. Standard, Plus or Preferred HMO), or choose another product (HMO, POS, Triple Coverage or PPO). (See Appendix A for select benefit and option information.);
- Add optional benefits such a dental, vision or chiropractic/acupuncture coverage; and
- Change health plans for any reason.

BENEFITS

PacAdvantage offers a consistent health care benefit across its plans including coverage for hospital and physician services, prescription drugs, mental health services and durable medical equipment. In general, benefits in each PacAdvantage health plan are designed to be the same although each may be administered differently. Copayments and deductibles will vary depending on plan choice. (Please see Appendix B.)

Employees have a choice of in or out-of network providers. Preferred provider organization (PPO), Point-of-Service (POS) and Triple Option coverage[24] options allow members to pursue out-of-network services. Additionally, PacAdvantage offers Flex Net, a fee-for-service plan available to California residents who do not reside within PacAdvantage managed care service areas in California. This indemnity plan reimburses patients for medical expenses incurred—after an employee pays for covered medical services, up to his deductible amount, the plan will pay 80% of usual, customary and reasonable charges for services used. While there are no pre-existing condition exclusions when an employee enrolls in an HMO, POS or Triple Coverage health plan participating in PacAdvantage, employees may be subject to a six-month preexisting condition exclusion period if an employee chooses a PacAdvantage PPO or Flex New plan.

Out-of-state coverage is limited to emergency services only, except, under specified circumstances, out-of-state dependent and guest privileges coverage. The employee is responsible for determining whether her plan offers this coverage.

COST SHARING

With a PacAdvantage HMO plan, an employee's payments are limited to a set fee per visit, or co-payment. The employee must visit the facilities and health care professionals designated by the plan. Employees are responsible for the costs of all non-emergency services received that are not authorized by the HMO health plan.

When an employee enrolls in a POS or Triple Coverage Plan through PacAdvantage, she may use the health plan's in-network providers and pay only the applicable co-payments for each service. When using the POS or Triple Coverage out-of-network component, a deductible applies, and the employee will pay the first $500 each year for services received on an out-of-network basis. After an

employee pays for qualifying medical expenses up to his deductible amount, the plan will pay 70% of its contracted or scheduled rate for the services used, or 70% of usual, customary and reasonable charges for the services used.

Like an HMO plan, an employee's payments in POS or Triple Coverage plans are limited to the co-payments when benefits are accessed through the health care professionals and facilities designated by the health plan. When accessing health benefits outside the plan's network of physicians and facilities, the 30% amount paid is based on the employee's health plan's more limited out-of-network fee schedule or contract payment rates. An employee is also responsible for all charges above the health plan's out-of-network fee schedule.

When selecting a PPO plan, an employee may choose to receive health care services from providers both inside and outside the PPO network. Some covered services and all out-of-network care are subject to an annual deductible before the plan begins to pay. After an employee has paid for qualifying medical expenses up to the deductible amount, the PPO will pay a percentage of the negotiated fee when an employee uses providers in the PPO network. If an employee receives services from a provider outside of the PPO network, the amount paid by the PPO will be significantly lower. (Please see Appendix B.) For out-of-network services, an employee will be responsible for paying the difference between provider charges and the health plan's rate of payment.

Part III: PacAdvantage Premium Program Operations and Policies

Extending from PacAdvantage's existing program, the CPPP is designed to be a simple, flexible and supportive means of assisting certain small businesses and their low-income employees with obtaining health coverage through the private health insurance market. The program's goal is to create a public/private partnership that would mitigate the two most significant barriers to small businesses obtaining ESI --cost and lack of information--so that state and private dollars could be used efficiently to pay for insurance coverage.

I. EMPLOYER ELIGIBILITY

California PacAdvantage Premium Program (CPPP) is designed to facilitate participation by employers and employees.

A. Policy Summary

To participate, employers must fulfill the crowd-out requirements (described in section III) as well as pass an annual review of all PacAdvantage participation requirements. The employer must have:

- 50 or fewer employees for more than 50 percent of the working days during the year;
- A majority of employees residing in California; and

- Fulfilled the definition of an employer as, "a person, firm, proprietary or non-profit corporation, partnership, public agency or association that is actively engaged in a business or service."[25]

To remain eligible, the employer must:

- Meet insurance participation take-up rate requirements; and
- Pay all premiums in a timely manner.

1. Size of Employer

As with PacAdvantage, the employer must have 50 or fewer employees for at least 50 percent of the working days during the year. In addition, the PacAdvantage re-qualification requirement that the firm have fewer than 100 employees was eliminated for CPPP because it is unnecessarily redundant with existing size requirements.

The 50-employee size restriction may be slightly larger than one might expect for a small business definition. According to EBRI data, nearly 35 percent of workers are in firms with fewer than 10 employees. Data also show that nearly half of all uninsured are employed by businesses with fewer than 25 employees.[26] However, the 50-employee size restriction is consistent with PacAdvantage as well as with the definition of a small employer specified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This definition also seems appropriate in light of California's low rate of small business participation in health insurance. In addition, the 50-employee size would increase the number of eligible entities and reduce the possibility of adverse selection.

2. Take-Up Rate Requirements

Under PacAdvantage, if the employer provides 100 percent of the premium, then 100 percent of the employees must participate. If the employer provides less than 100 percent of the contribution, than at least 70 percent of those eligible employees must join. Firms with only 2 or 3 eligible employees must have 100 percent participation.[27]

This requirement, designed to reduce adverse selection, has been imported to CPPP so as not to complicate PacAdvantage's existing insurance agreements. In addition, the participation requirements are similar to those that any small employer would face if purchasing insurance independently.

3. Other Possible Employer Qualifications

Other qualifications could be applied beyond those referenced above.

For example, the program could be designed exclusively for low-wage businesses--as defined either by the average salary of the employees or by the employer's revenue. For example, HealthChoice, the Wayne County, Michigan program, requires that half of the employees in participating firms earn less than $10 per hour.[28] Such a requirement could be well founded, as wage level seems to be a determining characteristic as to when ESI is offered. In 2001, only 35 percent of low-wage California employers (defined as those where at least 35 percent of the workers make $20,000 per year or less) offered insurance, while 75 percent of high-wage California employers offered insurance.[29] It could be argued that targeting firms by wage, and not size, would mean that those with the most need would receive support. However, the CPPP application does not ask for income information or other information for a number of reasons.

- **Ease of use**. While CPPP's subsidy would be significant, the availability of funding would not guarantee participation. Confusing rules, regulatory burden and unnecessary government interference could reduce employer participation. Every effort should be made to keep the employer application for CPPP concise and preferably no more than one page. In addition, a wage requirement for employers is not part of the PacAdvantage program, and it is useful to keep the rules as similar as possible.
- **Unintended consequences.** With each new requirement, it is possible that there may be some negative impact on the employer or the insurance industry. Therefore, this proposal attempts to minimize requirements as much as possible. For example, placing revenue limits on participating firms could create a disincentive to programmatic growth.
- **Avoid stigma.** Programs with burdensome requirements risk stigmatization. Such programs could be perceived as a "confusing government program." Some researchers have argued that means-tested public programs (such as Medicaid) may have a negative stigma while programs that are not means tested (such as Medicare) do not have such a stigma. For example, in the case of CPPP and using low-income requirements, small employers may not want to participate in a program that labels them as "low-wage".

- **Avoid resentment from excluded groups.** With each new eligibility requirement, there is another group of employers who may grow to resent the program as "unfairly" excluding them.

II. EMPLOYEE/DEPENDENT ELIGIBILITY

The overall goal of CPPP is to provide health insurance to working individuals and their dependents who are otherwise uninsured and ineligible for public insurance programs. Enrolled employers would be required to offer all employees the opportunity to have their eligibility determined.

A. Policy Summary

Eligibility, determined annually, would be contingent upon several requirements. To be eligible for the subsidy, individuals would be required to:

- Live in a family in which they, or a participating parent/guardian, work for a participating employer for 20 hours or more per week;
- Have a family income below 350 percent of the Federal Poverty Level;
- Be ineligible for Medi-Cal, Medicare, Healthy Families, Access for Infants and Mothers, or any other health insurance program sponsored by the state and/or federal government; and,
- Be less than 23 years of age (for dependents only).

To remain eligible, the employee/dependent would be required to:

- Remain working for a participating employer, or remain in a family with a participating parent/guardian; and,
- Pay all premiums in a timely manner.

CPPP would not be an entitlement program, and those individuals responsible for overseeing the program would have the ability to control enrollment in proportion with financial resources.

1. Part-time Employees Qualify

In order to increase the number of people eligible for assistance, CPPP would allow those individuals working at least 20 hours per week to qualify for the program.[30] Allowing a larger pool of persons to participate would help reduce the number of uninsured and, by increasing the number of individuals allowed to participate, would reduce the possibility of adverse selection.

2. Income Cap and Eligibility

Unlike the requirements for employer qualification, employees would be requested to meet an income test. Some programs, such as HealthChoice, allow any person in a qualified firm to participate. However, the cap at 350 percent of the Federal Poverty Level is needed in order to fulfill the program's goal of reaching low-income working families.

3. Screen and Enroll Policy

While CPPP is designed to help small businesses provide health insurance to eligible employees, it is important that individuals eligible for public health insurance programs (such as Medi-Cal and Healthy Families) receive the full benefit of those programs. The application form for CPPP would include basic questions about the employee's income, consistent with the information required for Healthy Families. Applicants would be allowed to "self-declare" their annual income for purposes of screening for potential eligibility for Healthy Families or Medi-Cal, and employees would be asked to provide a current pay stub for verification purposes at the time of enrollment. This effort would enable individuals to be enrolled in the appropriate program without delay. (Please See Appendix C.)

4. Ineligibility and Coverage through a Spouse

The proposal recommends that persons should be eligible for CPPP regardless of a spouses' insurance status. It is tempting to screen persons for eligibility in other private insurance products in an effort to reduce public expenditures. However, in cases where individuals have been uninsured for six months or more as required under the crowd-out policy, it seems reasonable to assume that the product available is deficient in some way--perhaps the cost is too high or the benefits are not sufficient. Therefore, access to CPPP would not be restricted on this basis.

5. Residency

The program would be open to any person who is legally employed in California by a certified employer.

III. CROWD-OUT REQUIREMENTS

While research findings have varied on the level of crowd-out that may occur in health insurance due to a given program, many analysts believe that it is a real phenomenon. In the extreme, crowd-out means that all new public spending simply replaces private dollars already being spent on health insurance without a decrease in the rate of the uninsured. In terms of programs such as the Children's Health

Insurance Program (CHIP), the concern regarding crowd-out is well founded as states expand coverage to higher income levels. If the government pays for health insurance, the motivation for private employers and individuals to pay for the same health insurance coverage is diminished.

A. Policy Summary

With certain exceptions, the crowd-out policy for CPPP is as follows:

- Employers: Must not have offered insurance (other than through CPPP) in the previous 6 months.
- Employees: Must be uninsured for the previous six months.

1. Strategies to Reduce Crowd-out

As part of the implementation process for the CHIP, the Centers for Medicare and Medicaid Services (CMS) required that states include a statement about crowd-out prevention in their CHIP plans. In some states, strong crowd-out provisions were critical for building political coalitions that could implement a program while other states fought the federal government on requiring any provisions at all.

A paper released by the Urban Institute's *Assessing the New Federalism* discusses the options used by states to limit crowd-out in the context of the CHIP program.[31] Some of the most commonly used options to prevent crowd-out include:

- **Monitor and respond as needed.** One approach is to simply monitor a given program and implement a crowd-out policy if data indicates that substitution is occurring. Such a policy is predicated on the basis that crowd-out will probably not occur, but if it does, definitive steps can be taken to stop it.
- **Ineligibility for program based on current insurance status.** The most common crowd-out prevention strategy is to ask about an individual's insurance status on the application for enrollment and to deny eligibility to those who are currently enrolled in a health insurance program. While this approach prevents a person from being enrolled in two programs simultaneously, it does not prevent an individual from being enrolled in a private program one day and then moving to a public program the next.
- **Look-Back Period**. Moving a step beyond current insurance status is to consider an individual's previous insurance status. For example, in CHIP, numerous states have required that children be ineligible for the program if they were enrolled in an insurance program during the previous 3 to 6 months, and at least two states set 12 months as the "look-back period." Considered the most comprehensive approach

for combating crowd-out, this policy also prevents those who are uninsured from obtaining insurance. California uses a 3-month look-back period for Healthy Families eligibility.

2. Rationale for CPPP's Crowd-out Policy

Although it may be controversial, CPPP would require a waiting period of six months for both employers and employees. Employers and employees should have a high level of motivation to obtain the premium subsidy. With regard to individuals, the crowd-out policy would also help ensure that resources are used to help those who are chronically uninsured, as opposed to those who may simply lack insurance for a brief time.

With a goal of only providing insurance to the previously uninsured, CPPP's look-back period of six months is recommended for several reasons:

- While still allowing many of the uninsured to participate, a six-month look-back period sends a strong message to individuals and employers that they should not drop existing health insurance coverage in order to enroll in CPPP. Research shows that, during any given month, 83.1 percent of the uninsured have been without coverage for 7 months or longer; as a result, the majority of the uninsured will still be to obtain coverage while discouraging individuals and businesses from dropping coverage.[32]
- A 12-month period would raise serious questions of fairness by requiring persons to be uninsured for a long period of time. New Jersey recently reduced the state's waiting period for CHIP from 12 to 6 months, and other states, such as Massachusetts, have received approval for waiting periods of six months. (Please See Appendix D.) There is little data to know the exact impact of a one-year waiting period, but what is known is that 12 months is a significant period of time to go without insurance. By implementing a six-month waiting period and carefully monitoring the program, it should be possible to minimize any funds lost to crowd-out.
- Controversy could come from both those who believe CPPP's six-month policy is too short and those who believe that it is too long. The controversy could stem from the look-back period's inherent inequity. Under a look-back period, those employers who "did the right thing" by paying additional money and purchasing insurance prior to CPPP are denied support. However, in the absence of a crowd-out requirement, there is the risk that any new public program may simply supplant existing

private spending without providing insurance to any new individuals. There are those who may also say the period is too short--that there are companies that may cancel their insurance and wait six months to provide insurance with the subsidy. The reason that this policy is controversial is that both views, to some unknown degree, are accurate. With careful monitoring, adjustments to the policy could be made as necessary.

3. Crowd-Out Exceptions

a) Exceptions for Employers -- There are two exceptions to the look-back policy for employers.

- **Previous participation in PacAdvantage Program.** If a company participated in the program and stopped participation for any reason, only later to find that it wanted to continue participating, the company would be free to do so during the six-month period.
- **Previously Offered a Sub-Standard Plan.** If the benefit plan offered during the look-back period does not fulfill CPPP standards, then the employer would be permitted to participate immediately without a waiting period.

b) Exceptions for Employees -- There are several exceptions to CPPP's look-back period for employees. This extra flexibility is allowed because the look-back period for employers would be a significant deterrent to crowd-out regardless of the restrictions on individuals. In addition, low-income employees are more likely to have their insurance status change for reasons beyond their control. In such cases, it seems unfair to penalize the individual by denying them insurance. If the following events are the reason for the lack of insurance, the employee could participate in CPPP:

- Previous insurance was obtained through a public program for which the individual is no longer eligible;
- Family member who provided insurance is no longer available (death, divorce);
- Previous job was lost (fired, laid off);
- Voluntarily changed jobs; or
- Previous insurance was obtained through COBRA.

c) Employees Who Change Jobs as an Exception -- The question could be raised whether a person with insurance who accepts employment with a CPPP-only employer could be denied coverage for the duration of the look-back period. Given that low-

income persons change jobs more frequently than those at higher levels, this question becomes very important.

Some might suggest that it is inequitable to force a person to wait six months to obtain insurance through CPPP simply because they had ESI through their previous employer. In addition, the labor market may become skewed as previously insured persons avoid the six-month look-back period by seeking out CPPP employers. While employers could simply enroll such persons into their insurance plan without the CPPP subsidy, employers might not be inclined to take on the additional cost. On the other hand, CPPP is intended to provide coverage only to previously uninsured persons; every dollar that goes to cover the previously insured is a dollar that cannot help the uninsured.

As part of the overall crowd-out policy evaluation process, this proposal recommends that the "change jobs" provision be specifically evaluated. Absent any evidence regarding crowd-out in a premium assistance program, it is difficult to render an informed decision. One means to obtain useable data might be to monitor the number of people who enroll in the program that were already insured from a previous job. It is doubtful that monitoring this reserve (the number of people who were denied enrollment based on insurance from a previous employer) would provide useful information because it would be impossible to know how many people declined to attempt enrollment knowing that they were not qualified. If a significant level of crowd-out is found under this provision after a six-month test period, MRMIB could discontinue this policy.

d) Flexibility to Change Look-Back Period -- Certainly, policymakers have the flexibility to set the crowd-out period for any length of time desired with 3 to 12 months being the most obvious range. As part of the program's evaluation process, careful attention should be paid to whether employers are dropping insurance to participate in the program. After such data is gathered, appropriate adjustments could be made.

IV. BENEFIT PACKAGE

A number of options exist for designing a health benefit package. These options range from broad flexibility, requiring that the plan only meet a basic definition for insurance in the Health Insurance Portability and Accountability Act of 1996, to specifying a single, specific benefit package. One CPPP goal is to provide a middle ground between these two options: a wide choice of plans available in the private market while ensuring access to quality health insurance.

A. Policy Summary

Employers should offer a quality health insurance product to their employees. CPPP would encourage employers to work through PacAdvantage, which offers at least nine different products available in various parts of the state. (Please see Appendix E.) Under PacAdvantage, employers have the option of offering dental, vision and chiropractic/acupuncture coverage; participation in CPPP would require that the dental and vision riders be purchased.

In the event that the employer decided to offer a non-PacAdvantage product, some entity would be required to certify that the selected product was either identical or actuarially equivalent to one of the following benchmarks:

- 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 responsibility for certifying that the product was either identical or actuarially equivalent could rest with the non-PacAdvantage participating health plan. Alternatively, the certification could fall to some existing state entity such as the State Insurance Commissioner.

In the event the employer decided to exercise their flexibility under the program by selecting a non-PacAdvantage plan, they would be required to pay a 10 percent surcharge on the cost of the premium each month.

1. Quality Health Insurance

One of the central tenets of CPPP is that the subsidy should only provide support for the purchase of quality health insurance. To achieve this standard with a minimum of burden on businesses, the program would work through the existing PacAdvantage structure and the associated insurance products. The benefit package would be designed to be consistent across all PacAdvantage plans but could be administered differently.[33] (Appendix A provides a comparison of key benefit information for PacAdvantage plans.) To add additional flexibility beyond the PacAdvantage options, a benchmark system could be used to allow businesses to select the plan of their choice.

2. Should Specific Benefits Be Provided Beyond those Required Under State Law?

There are a number of methods that could be used to provide CPPP employees with greater benefits.

- **Sub-categories of benchmark equivalence.** In addition to benchmarking against overall plans, specific sub-categories of services could be provided. For example, under the benchmark system developed in CHIP, general benchmarks are supplemented by specific sub-categories of actuarial equivalence. Plans used under CHIP must provide at least 75 percent of the value of the set benchmarks offering preventive benefits.

- **Using richer benchmarks.** Another alternative might be to use the Healthy Families or Medi-Cal benefits packages as the sole benchmark.

There are a number of reasons to warrant caution when requiring additional benefits in CPPP.

- **Using the PacAdvantage plans offers employers a manageable "menu" of options.** Small employers are particularly frustrated by how difficult it is to interpret the benefit packages of insurance plans. Under PacAdvantage, employers do not have to make any choices about the quality of individual benefit packages because employees are allowed to select from any of the PacAdvantage plans available in their area; interference with this process could lead to unnecessary frustration for employers.

- **Non-Interference with the existing market.** Having a richer benefit package could lead other plans to strengthen their packages, which may lead to an overall increase in premium prices or skew the market in other ways.

- **Additional Protection may be unnecessary.** While sub-category requirements that ensure preventive or well-child benefits could be important policy choices for a program specifically designed to cover children at more vulnerable levels of poverty, CPPP is designed to provide a more general level of care to a less vulnerable population without focusing on children specifically.

- **Crowd-out as a concern.** Medi-Cal and Healthy Families offer relatively rich benefits -- which are necessary and appropriate given their coverage of vulnerable populations. At higher income levels, private insurance companies generally do not offer a comprehensive benefit packages. As CPPP goes up to a fairly high level of income, a Medi-Cal-quality benefit package at a reduced price could induce crowd-out as employers try to obtain a more generous benefit package at a lower price.

- **Cost.** Despite a subsidy, a more comprehensive benefit package could result in increased premiums, ultimately decreasing the number of small businesses that might seek coverage due to cost.

3. Actuarial Equivalence

In order for a health plan to become a participating provider, the plan would be required to pay a flat fee to cover the cost of the actuarial analysis of the plan's benefit package in order to determine whether it is equivalent to one of the benchmarks. As this is premium assistance, there would be no opportunity to provide wrap-around coverage in cases where selected benefit packages do not meet the equivalence test.

V. EMPLOYEE CO-PAYS AND DEDUCTIBLES

CPPP cost sharing would match the cost sharing required by the selected PacAdvantage plan. If the employer selected a non-PacAdvantage plan, there would be considerable flexibility with regard to cost sharing levels.

A. Policy Summary

There would be no separate cost sharing limits beyond the premium. Employees would be responsible for any copayments, deductibles or other cost sharing required by the insurance plan.

1. Further Caps Not Needed

Although there would not be a specific cap, participants would still have some protection from excess cost sharing due to the copayment caps already built into most PacAdvantage plans. For non-PacAdvantage plans, actuarial equivalence would provide some protection as well. In addition, when considering cost sharing, it is important to keep in mind that while CPPP would be available to individuals with incomes from 0 to 350 percent of the poverty level, the majority of enrollees would likely be at higher incomes. As a result, cost sharing is likely to be a less important issue than it is in Medi-Cal and Healthy Families.

PacAdvantage offers a wide range of plans from which employees may choose, each with its own cost sharing requirements. Deductibles range from $0 for HMOs to $3,000 per family for the PPO30 option. A similarly large range of choices exists for copayments/coinsurance ranging from $5 per office visit under the HMO preferred option and 50% of the cost under the PPO30 option. (Appendix A provides a comparison of key cost sharing information for PacAdvantage plans.)

The value of the insurance product being purchased must equal the value of the benchmark in order to satisfy the actuarial equivalence test. Given the comprehensive nature of the benchmarks and given that the test must account for cost sharing, the ability of non-PacAdvantage plans to charge significant cost sharing should be limited.

VI. ASSISTANCE (SUBSIDY) LEVEL

The level of support available to participating employers and employees through the program is designed to encourage small employers to purchase insurance for their employees.

A. Policy Summary

The maximum subsidy for employers available under the program would be 55 percent. This level of support would be available for covered individuals who have incomes below 200 percent of the Federal Poverty Level (FPL). As shown in Figure 1, the subsidy decreases on a sliding scale basis and phases-out completely for individuals at, or above, 350 percent of the poverty level.

Figure 1

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

* The employee share is a maximum contribution; employers could choose to subsidize a larger amount.

1. Setting the Employer and Employee Contribution Level

As mentioned above, cost is the major reason for employers not offering ESI. This is true even though California's monthly premiums were approximately 10% lower than the national average in 2001. Indeed, two-thirds of California employers believe that the cost of their premiums is higher than in other states. The perception of cost will likely increase as premiums rise; in California, premiums for small businesses shot up 11 percent in 2001, with more than a third of small firms facing a 15 percent increase. Inflation only increased 4.3 percent in 2001.[34]

CPPP's goal would be to provide sufficient support to allow businesses and employees to purchase quality health insurance. Businesses not participating in the existing PacAdvantage program may have found the premium costs too high. Ideally, discounting the average percentage contribution by employees and then calculating the employer contribution would determine CPPP's subsidy level.

It is difficult to obtain recent data on employer contributions. Leading data sources do not report even the number of small employers that offer individual or family subsidies to their employees.[35] Similarly, Bureau of Labor Statistics data provides premium contribution data for employers in terms of dollar amounts, rather than percentages.

The Center for Policy Solutions at the University of California-Berkley, on behalf of the Institute for Health Policy Solutions and the California HealthCare Foundation, addressed this question using the 1999 California Employer Survey data. Researchers found that the median contribution made by small employers for family coverage was 68.4 percent, while large businesses contributed 78.6 percent. This same analysis also showed significant variation in contribution levels across all California employers, with 16.4 percent of employers contributing the full cost of coverage and 19.9 percent paying less than 60 percent of coverage.

The experience of two local demonstration programs is not necessarily instructive on the issue of subsidy levels.

- The HealthChoice program's premium payment is divided evenly among the employer, the employee and the subsidy. This approach allows employers to contribute the same amount as employees, which is not normally the case with ESI.
- Financially Obtainable Coverage for Uninsured San Diegans (FOCUS), a private effort in San Diego funded with the assistance of non-profit entities, employs a sliding scale approach with the employer contributing an average of 55 percent of the subsidy. FOCUS officials believe it is possible that they are "leaving employer dollars on the table" citing a 10 percent cost increase this year that did not result in any employers dropping the program.[36] However, FOCUS offers a relatively small benefit package at reduced cost because the Sharp Health Plan has negotiated reduced provider reimbursement for the program. Consequently, FOCUS may offer a significantly more inexpensive product than could be offered under PacAdvantage, and may tolerate paying 55 percent of the FOCUS premium, while it would not tolerate paying small business owners 55 percent of a PacAdvantage premium. In addition, a number of the FOCUS

program's participants are family-owned and operated businesses, and as a result, may demonstrate more tolerance for price increases than would other small employers.[37]

Based on the experience of other subsidy programs, a number of principles have been incorporated into CPPP's subsidy structure.

- Even affluent small employers can struggle to offer coverage because of cost and administrative barriers. As a result, the subsidy should act as an inducement for small employers to participate in CPPP.
- Employers should be able to easily understand their contribution requirements.
- As is the convention in the purchase of insurance, employees should make a greater contribution toward the purchase of insurance than employees.
- Low-income employees (those below 200 percent of the poverty level) should receive a significant subsidy.
- As employees earn increased incomes and become better able to provide for their own healthcare, their obligation under the program should gradually increase.

By setting a contribution level at almost half that for employees under 200 percent of the poverty level, CPPP would take a significant step toward eliminating cost as a barrier for small businesses. Even at higher income levels, CPPP would make a significant contribution toward the purchase of insurance.

2. The Sliding Scale As a Means to Combat Crowd-Out

CPPP's sliding scale approach would assist in combating crowd-out. By charging those at higher income levels more money, it would be less likely that those individuals would be as motivated to discontinue their current insurance and enroll in CPPP after the six-month period.

The demonstration programs examined seem to address crowd-out in different ways. In the case of HealthChoice, employees at the lowest income levels pay premiums consistent with what a person in an average small firm pays. FOCUS employs a sliding scale contribution so that as employees achieve higher income levels, the employer and employee contribute more toward the cost of the insurance. While the sliding scale approach adds complexity to the program, it may reduce crowd-out. Additionally, the sliding scale approach promotes fairness because those who are able to contribute more do so.

VII. OUTREACH

Experts on premium assistance programs emphasize that small employers need more than just financial support. As a result, CPPP would work with PacAdvantage to ensure that small businesses are provided the technical support and information they need to purchase insurance effectively and efficiently.

A. Policy Summary

The program's aggressive outreach campaign would include:

- A paid media campaign to place ads in newspapers, trade press and television;
- An earned 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.

The two model programs examined take different approaches to encourage enrollment. According to FOCUS officials, the program relied almost exclusively on word-of-mouth, along with some earned media, during the initial phase of the program. While FOCUS is now contacting firms to encourage participation, this effort is being done more for methodological reasons than out of a need to increase enrollment. FOCUS researchers want to ensure that there is a mix of different kinds of employers in the program. HealthChoice, on the other hand, has aggressively used flyers and television ads to encourage businesses to participate.

CPPP would heavily advertise the program's existence. Unlike FOCUS, which operates in a small, defined geographic area, there is no reason to assume that word-of-mouth would be enough to promote appropriate levels of enrollment in CPPP.

VIII. ADMINISTRATION

The state could designate the Pacific Business Group on Health (PBGH), operator of PacAdvantage, to oversee CPPP. By leveraging administrative efficiencies between the two programs, the state would maximize the use of proven work practices while avoiding duplication.

A. Policy Summary

While PBGH would be responsible for operations, the Managed Risk Medical Insurance Board (MRMIB) would oversee the policy issues surrounding the premium subsidy program. Together, the two entities would:

- Create processes that would ensure timely payment of subsidies;
- Determine eligibility of employers and employees;
- Ensure that employees and employers have the information necessary to participate in the program;
- Implement aggressive outreach programs to maximize the use of CPPP;
- Oversee trust fund stability;
- Work to obtain public and private grants to support the trust fund; and
- Educate the public on the importance of health insurance.

1. MRMIB as Policymaker

Selecting the MRMIB, to oversee the new premium assistance program is a logical way to capture administrative efficiencies. As a publicly accountable entity with five appointed members and expertise in developing policies that improve insurance coverage in California, MRMIB would be an appropriate entity to oversee CPPP. MRMIB's experience overseeing the Health Insurance Plan of California (HIPC), the state's small business purchasing pool now known as PacAdvantage, should serve CPPP well. Another benefit of MRMIB's oversight of CPPP should be improved coordination with existing programs that help California's working families such as Healthy Families, a program also overseen by MRMIB. This coordination could prove critical in the event that CPPP eventually seeks Federal funding through CHIP. (Please see Appendix F.)

Some may argue that MRMIB does not have the ability to shift from a culture of working with health providers and payers to a new system of paying employers to purchase insurance. In July of 1999, MRMIB turned control of PacAdvantage over to PBGH. Establishing CPPP with MRMIB as the oversight entity would effectively bring MRMIB back into an oversight role with of PacAdvantage. While MRMIB is clearly capable of the task, to fill the oversight role, MRMIB may need additional resources including additional staff to handle the administration of the new program.

2. PBGH as Administrator

Since July of 1999, PBGH has managed the state's small business health care purchasing pool. During this time, the number of participating employers increased from 7,700 to over 11,000.[38] Moreover, the number of brokers offering PacAdvantage also greatly increased. In order to leverage this success, the PBGH would manage CPPP. PBGH's infrastructure and expertise with small businesses could be invaluable for making the premium assistance program successful.

While the potential advantages of using PBGH seem to outweigh the potential disadvantages, policymakers should consider these issues carefully including the following:

a) Potential Benefits of Using PBGH to Oversee CPPP

- PBGH is a known quantity for many small businesses.
- PBGH already has expertise in addressing the health care needs of small businesses.
- Employers would appreciate having a single point of contact for the purchasing pool and subsidy.
- A joint program would maximize administrative efficiency by leveraging economies of scale.
- PBGH has a strong history of being able to work with employers.
- Impact on the PacAdvantage application process should be minimal. In addition to existing application questions, businesses would only be asked about crowd-out requirements to determine CPPP eligibility.

b) Potential Disadvantages of Using PBGH to Oversee CPPP

- PacAdvantage could be inadvertently stigmatized by adding a program for which only certain employers qualify.
- Oversight of a large spending program is a fundamentally new mission for PBGH that could require a different skill set than managing a purchasing pool.
- Legal and operational challenges could exist to giving PBGH responsibility for large sums of government funds.

3. Possible Alternatives to PBGH

a) Competitive Bid for Existing Pools -- An alternative approach could be to put management of the subsidy program out for competitive bid. CalChoice, operated by Word & Brown since 1994, is California's second purchasing pool.[39] While a competitive bidding process for PacAdvantage could yield more efficient operations, the pairing of the premium assistance program with PacAdvantage seems to offer inherent efficiencies that could not be obtained if two separate entities managed the program.

b) Entirely New Entity -- Policy-makers could develop a new, separate entity to manage the subsidy program. Indeed, it arguably would make sense for all of the policy and operation control to be housed in a single new entity free from bureaucratic history. The downside of such an approach is that it would require the creation of new administrative processes and additional funds. (Appendix G outlines an option for how the new entity could be created and managed.)

IX. FUNDING

A number of difficult policy choices exist regarding the creation of funding sources. Following is a brief discussion of funding options.

A. Policy Summary

A trust fund would be created to receive funding from the state, through an increase in the tobacco or the liquor tax, as well as donations from for-profit and non-profit private entities and individuals. Administrative costs would be funded by a 1.5 percent surcharge on premium payments made by participating small businesses.

1. Tobacco Tax

The primary contributor to the trust fund would be the state. Given the negative health affects of smoking and the political opposition to increasing income taxes, an increase in the existing tobacco tax could help to fund CPPP. In addition to funding expanded health insurance, other social goods, namely a decrease in the rate of smoking, would result from increasing taxes on tobacco. To fund the program, it is estimated that tobacco taxes would need to be increased by 20%.[40]

2. Liquor Tax

There have been various proposals in the state legislature to increase the tax, but it has not generated a sufficient amount of support thus far. To fund the program, it is estimated that liquor taxes would also need to be increased by 20%.[41]

3. Donations from Private Groups and Individuals

It is possible that a public relations campaign could generate at least some donations from private entities, foundations and individuals. CPPP, however, would not rely heavily on funding from such sources.

As the trust fund is not part of the state government, it would be permissible for the fund to accept donations from health care entities without any required offset in federal Medicaid dollars as is typically required when states accept donations of funds from health-related organizations.

B. Administrative Funding

CPPP is designed to fund its own administration with a 1.5 percent premium surcharge paid by participating small businesses.

C. Alternative Funding Sources

Section 1115 Demonstration -- Beyond the funding mechanisms discussed above, it may be possible to obtain Federal funding to support CPPP. This effort would require the state to receive a section 1115 waiver from the Federal government and operate the program through Medicaid or CHIP.

This approach could be aided by the fact that, in August 2001, CMS launched the Health Insurance Flexibility and Accountability (HIFA) initiative to streamline the Section 1115 waiver process. Section 1115 of the Social Security Act grants the Secretary of HHS broad authority to waive certain requirements of the Medicaid and CHIP programs. Historically, such waivers have been used by states to expand coverage to populations not otherwise eligible for these programs to make other program modifications. These demonstrations also include an evaluation component to look at the impact of such changes. The HIFA initiative (as explained in Appendix F) has eased many of the Federal requirements on premium assistance programs through Medicaid and CHIP. While there are considerable reasons for the state to consider seeking a CHIP waiver under HIFA for this project, the obstacles to obtaining a waiver remain substantial and should be considered in any decision to rely on this approach. (Please see Appendix I for a discussion of other possible mechanisms to access federal funds.)

X. IMPACT AND COST

For the Health Care Options Project, the California Health and Human Services Agency retained the Lewin Group to assess the impact of each proposal.[42]

According to the Lewin results, 112,000 previously uninsured persons would obtain coverage under CPPP if fully implemented in 2002. Of these, 107,000 would be workers and dependants at firms who were induced to offer coverage a due to the program's subsidy.

At the same time, PacAdvantage Premium would be available to employers currently offering coverage through PacAdvantage. Within this population, Lewin estimates that approximately 5,000 individuals who previously declined coverage would take up with the subsidy. In addition, a total of 76,000 persons current covered under PacAdvantage would also use the subsidy. This would bring the total number of persons covered under PacAdvantage to 193,000.

The program would be operated at a cost of $216 million if fully implemented in 2002. By 2012, it is estimated that spending would grow to $411 million.

The Lewin Group also conducted an extensive analysis of what would happen to coverage and cost levels if the subsidy level varied from the recommended level given in this paper. At a flat 70% subsidy level (with employers paying 20% and employees 10% of the premium), the total number of uninsured would be reduced by 147,000 at a cost of $354 million. At a 20% subsidy level (with employers paying 70% and employees paying 10% of the premium), the number of uninsured would be reduced by 64,000 at a cost of $67 million.

We encourage readers to consult the Lewin analysis directly for more detailed information regarding the impact of CPPP.

XI. OTHER POLICY ISSUES

The following section discusses other issues relevant to CPPP.

A. Grievance and Appeals Process

CPPP would not set any requirements regarding the plans. Such concerns would be left to traditional channels.

B. Insurance and Risk

CPPP would build on PacAdvantage. Existing procedures should help eliminate the already small possibility of adverse selection. Guarantee issue provisions requiring that all persons be allowed to enroll in insurance plans reduce this possibility. In addition, existing nondiscrimination laws prevent employers from creating two tiers of health plans.

C. Evaluation Criteria

Evaluating the success of CPPP should be based on four critical factors:

- Percentage of eligible employers who enroll;
- Percentage of eligible employees who enroll;
- Raw number of those who obtain coverage; and,
- Satisfaction survey.

PART IV: DISCUSSION AND CONCLUSION

CPPP would seek to reduce the number of uninsured by enabling small businesses to obtain subsidies for the purchase of quality private health insurance for employees and their dependents. Combining ideas from existing, successful local demonstration programs from around the country that work to reduce the cost of health insurance, CPPP would take a different approach from the Federal-state programs (such as CHIP) to expand coverage. Instead of creating a new government-run and funded insurance program, CPPP would work through PacAdvantage, the state's non-profit small business purchasing pool. By pairing CPPP with PacAdvantage, the state could leverage existing administrative structures that are already working successfully with small employers to promote ESI.

The process for obtaining the premium subsidy is designed to be efficient and simple for both the employer and employee. After a brief application process, eligible employers could receive as much as a 55 percent subsidy for the purchase of quality insurance on behalf of eligible employees. While the employer would be encouraged to select a plan from PacAdvantage, it would be possible to receive support for any insurance product that meets certain quality requirements. As part of this process, CPPP would provide information and guidance to small businesses on how to purchase health insurance.

WHY PACADVANTAGE PREMIUM COULD BE SUCCESSFUL

There are a number of reasons why CPPP is needed and why the program could successfully provide health benefits to uninsured Californians. CPPP would:

- **Build on the tradition of, and preference for, ESI.** Since the 1940s, the linkage of health insurance coverage to employment has become an accepted--if not expected--part of American society. One recent survey demonstrates that most Americans believe health benefits are part of employer compensation.[43] In fact, the Commonwealth Fund's National Survey of Worker's Health Insurance found that 56 percent of those surveyed preferred ESI to the 20 percent that preferred buying insurance directly from insurance companies.[44]

- **Progress logically from existing California programs.** CPPP would help further PacAdvantage's existing goal of promoting ESI by adding a subsidy to the other assistance provided.

- **Benefit from the lessons learned from local demonstration programs.** As discussed, many premium assistance programs have been tested around the country. Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) is a multi-year demonstration project launched in April 1999 by the Sharp Health Plan and non-profit foundations that offer subsidized health coverage to 2,000 persons associated with more than 200 small businesses. Another such program is Michigan-based HealthChoice that subsidizes the cost of insurance, with the county, employer and employee all paying one third of the premium cost. Over 20,000 individuals and 70 percent of the eligible businesses participate in the program.

- **Benefit from lessons learned in other States.** With several other states implementing premium subsidy programs, as discussed in Appendix D, California would have the experience of other states to guide policy formation.

- **Help fulfill the goals of welfare reform by supporting those who are employed.** CPPP would promote personal responsibility. Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the government places a greater emphasis on moving persons from welfare to work. For this effort to be fully successful, studies document that former welfare participants need strong social support systems, such as childcare and health care, in order to establish and maintain self-sufficiency.

- **Be consistent with the concept of public/private partnerships.** CPPP moves beyond proposing that the government serve as the sole source of funds and support for the uninsured (as Medicaid does) and instead, seeks to forge a partnership with the private sector that could be mutually beneficial.

- **Create a program free of Federal Medicaid and CHIP regulations.** By creating a program using state-only funds, California avoids the complex and cumbersome requirements that can sometimes accompany Federal funding. In addition, a state-only funding approach would allow the state to act immediately without waiting for Federal approval of waivers -- a process that has historically taken years.

- **Avoid stigma typically associated with public programs.** Historically, public insurance programs have often been stigmatized as "welfare" programs. While some states have been able to overcome this impression in recent years (particularly with CHIP), a non-state entity that works through employers to offer private health insurance coverage should reduce stigma's occurrence, thereby promoting enrollment.

- **Allow parents to obtain coverage through the same system as their children.** Based on analysis from several different research and case studies, one analyst recently concluded that extending public insurance programs to parents would "almost inevitably result in greater enrollment of children" eligible for such programs.[45] Evidence also exists that children in public insurance programs are more likely to receive preventive benefits when their parents are also enrolled.[46] In contrast to the historical approach of Medicaid and CHIP, CPPP would focus on helping the entire family as a unit.

- **Help small businesses achieve their goals.** Small businesses want to offer health insurance for their employees. This program would help remove identified barriers and give small businesses the resources they need to offer health insurance.

- **Leverage both private and public funds to maximize the number of persons covered.** By tapping into ESI and private funding, the government could maximize the number of dollars being used to pay for insurance.

- **Be politically feasible.** There is often political resistance to expanding public programs significantly. As an incremental approach that supports small businesses through a public/private partnership, CPPP could be well positioned to receive support from a wide-range of stakeholders.

- **Assist the immigrant population in a meaningful way.** The approach of using an employer and a non-profit organization to offer health insurance could be especially appealing in California where immigrant families are less likely to approach the government for benefits.

DESPITE OVERALL STRENGTH, PACADVANTAGE PREMIUM HAS LIMITATIONS

While there are a number of benefits to the CPPP approach, limitations exist. For example, this program is not designed to help the unemployed. Nor would the program assist workers whose employers do to participate. In addition, CPPP would not help those with incomes above 350 percent of the Federal Poverty Level. Furthermore, the program would not necessarily provide continuity of coverage for individuals who frequently change jobs (a common occurrence at lower income levels). CPPP is designed to provide subsidized health insurance for a targeted group of California's small employers and their employees. The goal is to create a manageable extension of PacAdvantage as an incremental step in reducing the number of uninsured.

Some may criticize the proposal by pointing out that it does not leverage support from the federal government, thereby leaving the state government to shoulder a greater financial burden than may otherwise be necessary. It is true that expansions under Medicaid and CHIP could bring significant Federal matching payments. In fact, many states operate premium assistance programs through Medicaid, and a small but growing number of states are operating programs through CHIP. (Please see Appendix D.) However, these states have historically faced a number of challenges that have limited the effectiveness of such programs. In addition, such approaches also bring complicated rules that are subject to change, as well as delays in obtaining approval. The state would not take on the financial responsibility of CPPP alone. Indeed, private businesses and employees would be responsible for 45 to 74 percent of the premiums under the program. Beyond the direct support from small businesses contributing toward the cost of insurance, private businesses, foundations and even individuals would have the ability to donate to the program.

APPENDIX A
BENEFIT INFORMATION FOR SELECT PACADVANTAGE PLANS

Appendix reprinted from 2000 PacAdvantage Handbook.

PAC ADVANTAGE BENEFIT SUMMARY PPO PLANS				
BENEFIT	**SAVER**		**PPO 30**	
	In-Network	Out-of-network	In-Network	Out-of-Network
Deductibles (individual/family)	$500 per individual/two per family		$1,000 per individual/$3,000 per family	
Lifetime Maximum Benefits	$5,000,000 combined		$5,000,000 combined	
Calendar Out-of-Pocket Maximum	$2,500 per individual		$3,000 per individual	$6,000 per individual
Professional Services	Not subject to deductible		Not subject to deductible	
Physician Office Visits	$20 2 visits individual/spouse, 4 visits dependents	50% 2 visits individual/spouse, 4 visits dependents	$30	%50
Preventive Care				
Preventive Child Care **(Age 2 through age 16)**	$20 2 visits individual/spouse, 4 visits dependents	Not covered	$30	Not covered
Preventive Adult Care **(Age 17 and older)**	$20 individual/spouse/ 4 visits dependents	Not covered	20%	Not covered
Prenatal Care	$20 individual/spouse/ 4 visits dependents	Not covered	$30	50%
Well-Baby Care (0-2 yrs.)	$20 individual/spouse/ 4 visits dependents	Not covered	$30	Not covered
Outpatient Services	Professional services subject to a $500 max benefit per year.			
Infertility Services	Not covered		20% $2,000 lifetime max.	50% $2,00 lifetime max.
Laboratory & Radiology	20% (Not subject to deductible)	50% (Not subject to deductible)	20%	50%
Outpatient Surgery	20%	Not covered	20% ($250 deductible per year)	50% ($250 deductible per year)
Hospitalization Services				
Inpatient Hospital Benefits	20% ($500 deductible applies to 1st admission)	50% ($500 deductible applies to 1st admission)	20% ($250 deductible applies to 1st admission)	50% ($250 deductible applies to 1st admission)
Skilled Nursing Care	20% Combined limit of 90 days	50% Combined limit of 90 days	20% Combined limit of 60 days	50% Combined limit of 60 days
Emergency Health Coverage				
Emergency Care Services	20% ($75 deductible applies to 1st admission)	20% ($75 deductible applies to 1st admission)	20% ($50 deductible applies to 1st admission)	20% ($50 deductible applies to 1st admission)
Ambulance Services	20%	50%	20%	50%

PAC ADVANTAGE BENEFIT SUMMARY PPO PLANS				
BENEFIT	**SAVER**		**PPO 30**	
	In-Network	Out-of-network	In-Network	Out-of-Network
(plus $50 deductible, if not admitted)				
Prescription Drug Coverage	$500 maximum per calendar year		N/A	Plus $100 deductible
Generic 30-34 Days	20%	50%	$15	50%
Brand 30-34 Days	20%	50%	$25	50%
Non-formulary 90 Days	Not covered		50%	Not covered
Mail Order				
Generic 90 Days	20%	Not covered	$30	Not covered
Brand 90 Days	20%	Not covered	$50	Not covered
Non-formulary 90 Days	Not covered		50%	Not covered
Durable Medical Equipment	Prosthetics and diabetes supplies only		20%	50%
Maximum benefit per year	N/A		$1,000 Combined	
Prosthetics	20%	50%	20%	50%
Maximum benefit per year	N/A		$200 Combined	
Mental Health Services				
Inpatient	20%	50%	20%	50%
Limits	Combined limit 30 days		Combined limit 30 days	
Outpatient	Not subject to deductible		20%	50%
Limits	$20 2 visits individual/spouse, 4 visits dependents	50% 2 visits individual/spouse, 4 visits dependents	20 visits per member per calendar year Maximum payable per visit $25	
Chemical Dependency Services				
Inpatient	20%	50%	20%	50%
Limits	Detox. only. $500 deductible applies to first admission		Combined limit 30 days	
Outpatient	Not covered		Not covered	
Limits	N/A		N/A	
Home Health Services				
Home Care	20%	50%	20%	50%
Limits	90 visits combined, $75 per day maximum		60 visits combined, $110 per day maximum	
Hospice Care	20%	50%	20%	50%
Limits	Lifetime maximum of $10,000		Lifetime maximum $5,000	

PAC-ADVANTAGE BENEFIT SUMMARY –HMO

BENEFIT	HMO STANDARD	HMO PLUS	HMO PREFERRED
Deductibles	$0	$0	$0
Lifetime Maximum Benefits	Unlimited	Unlimited	Unlimited
Yearly Out-of-Pocket Maximum (Individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Professional Services			
Physician Office Visits	$15	$10	$5
Preventive Care	$15	$10	$5
Prenatal Care	$5	$5	$5
Well-Baby Care (0-2 years)	$5	$5	$5
Outpatient Services			
Infertility Services	50%	50%	50%
Laboratory and Radiology	$0	$0	$0
Outpatient Surgery	$100	$75	$50
Hospitalization Services			
Inpatient Hospital Benefits	$250 per Admission	$100 per Admission	$0
Skilled Nursing Care	$100 per Admission	$0	$0
Emergency Health Coverage			
Emergency Care Services	$50, if not admitted	$50, if not admitted	$50, if not admitted
Ambulance Services	$0	$0	$0
Prescription Drug Coverage			
Generic 30-34 Days	$10	$10	$5
Brand 30-34 Days	$20	$15	$15
Mail Order			
Generic 90 Days	$20	$20	$10
Brand 90 Days	$40	$30	$30
Durable Medical Equipment			
Durable Medical Equipment	$0	$0	$0
Corrective Appliances and Prosthetics	$0	$0	$0
Mental Health Services			
Inpatient (max. 10 days/yr)	$100 per Admission	$0	$0
Outpatient (Max. 20 visits/yr.)	$20/ 20 visits or approved alternative	$20/ 20 visits or approved alternative	$20/ 20 visits or approved alternative
Chemical Dependency Services			
Inpatient (Detox. only)	$100 per Admission	$0	$0
Outpatient (subject to benefit year limit)	$20/ 20 visits or approved alternative	$20/ 20 visits or approved alternative	$20/ 20 visits or approved alternative
Home Health Services			
Home Care	$15	$10	$5
Hospice Care	$15	$10	$5

PAC ADVANTAGE BENEFIT SUMMARY – FLEX NET PLAN

BENEFIT	
Deductibles	$300 per person/900 per family
Lifetime Maximum Benefits	
Out-of-Pocket Maximum	$1,500 per person $4,500 per family
Professional Services	
Physician Office Visits	20%
Preventive Care Child (Age 2 to age 17) Adult (Age 18 and older)	20%
Prenatal Care	20%
Well Baby Care (0-2 yrs.)	20%
Outpatient Services	
Infertility Services	Not covered
Laboratory and Radiology	20%
Outpatient Surgery	20%
Hospitalization Services	
Inpatient Hospital Benefits	20%
Skilled Nursing Care (Up to 60 days per calendar year)	20%
Emergency Health Coverage	
Emergency Care Services	20%
Ambulance Services (Maximum 75 miles per incident)	20%
Prescription Drug Coverage ($300 deductible applies)	
Generic 30-34 Days	20% after $75 deductible
Brand Formulary 30-34 Days	20% after $75 deductible
Non-Formulary 30-34 Days	20% after $75 deductible
Mail Order ($300 deductible applies	
Generic 90 Days	20% after $75 deductible
Brand Formulary 90 Days	20% after $75 deductible
Non-Formulary	20% after $75 deductible
Durable Medical Equipment	
Durable Medical Equipment	20%
Corrective Appliances and Prosthetics	20%
Mental Health Services	
Inpatient (30 days/calendar year maximum combined with inpatient substance abuse benefits)	50%
Outpatient (20 visits/calendar year maximum combined with outpatient substance abuse benefits)	50% (maximum of %40 per visit)
Chemical Dependency Services	
Inpatient (30 days/calendar year maximum combined with inpatient mental benefits)	50% (maximum of $50 per visit) Detox: 3-day calendar year maximum
Outpatient (20 visits/calendar year maximum combined with outpatient mental health benefits)	50% (maximum of $50 per visit)
Home Health Services	
Home Care (100 visits maximum per calendar year)	20%
Hospice Care (180 days lifetime maximum)	20%(maximum of $150 per day)

PAC ADVANTAGE BENEFIT SUMMARY – POS PLANS

BENEFIT	IN-NETWORK	OUT-OF NETWORK
Deductibles	$0	$500
Lifetime Maximum Benefits	Unlimited	Unlimited
Yearly Out-of-Pocket Maximum (Individual/family)	$2,000/$4,000	$5,000/$10,000
Professional Services		
Physician Office Visits	**$10**	**30%**
Preventive Care	**$10**	**Not covered**
Prenatal Care	**$5**	**30%**
Well-Baby Care (0-2 yrs.)	**$5**	**30%**
Outpatient Services		
Infertility Services	**50%**	**Not covered**
Laboratory & Radiology	**$0**	**30%**
Outpatient Surgery	**$75**	**30%**
Hospitalization Services		
Inpatient Hospital Benefits	**$100 per Admission**	**30%**
Skilled Nursing Care	**$100 per Admission**	**30%**
Emergency Health Coverage		
Emergency Care Services	**$50, if not admitted**	**$50, if not admitted**
Ambulance Services	**$0**	**$0**
Prescription Drug Coverage		
Generic 30-34 Days	**$10**	**Not covered**
Brand 30-34 Days	**$15**	**Not covered**
Mail Order		
Generic 90 Days	**$20**	**Not covered**
Brand 90 Days	**$30**	**Not covered**
Durable Medical Equipment		
Durable Medical Equipment	**$0**	**Not covered**
Corrective Appliances and Prosthetics	**$0**	**Not covered**
Mental Health Services		
Inpatient (Detox. Only)	**$100 per Admission**	**30%**
Outpatient (subject to benefit year limit)	**$20/20 visits or approved alternative**	**Not covered**
Home Health Services		
Home Care	**$10**	**30%**
Hospice Care	**$10**	**30%**

APPENDIX B
COST SHARING INFORMATION FOR SELECT PACADVANTAGE PLANS

Appendix reprinted from 2000 PacAdvantage Handbook.

HEALTH NET PPO

Benefit	Saver		PPO 30	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Deductibles (individual/family)[47]	$500 per individual/two per family		$1,000 per individual/$3,000 per family	
Lifetime Maximum Benefits	$5,000,000 combined		$5,000,000 combined	
Calendar Out-of-Pocket Maximum	$2,500 per individual		$3,000 per individual	$6,000 per individual
Professional Services	Not subject to deductible		Not subject to deductible	
Physician Office Visits	$20 2 visits individual/ spouse, 4 visits dependents	$50%[48] 2 visits individual/ spouse, 4 visits dependents	$30	$50%[2]
Preventive Care Preventive Child Care (Age 2 through age 16)	$20 2 visits individuals/ spouse, 4 visits dependents	Not covered	$30	Not covered
Preventive Adult Care (Age 17 and older)	$20 2 visits individual/ spouse, 4 visits dependents	Not covered	20%	Not covered
Prenatal Care	$20 2 visits individual/ spouse, 4 visits dependents	Not covered	$30	50%
Well-Baby Care (0-2 yrs.)	$20 2 visits individual/ spouse, 4 visits dependents	Not covered	$30	Not covered
Outpatient Services[49]	Professional services subject to a $500 max. benefit per year.[50]			
Infertility Services	Not covered		20% $2,000 lifetime max.[51]	50% $2,000 lifetime max.[8]
Laboratory & Radiology[52]	20%[7] (Not subject to deductible)	50%[7] (Not subject to deductible)	20%	50%[2]
Outpatient Surgery	20%	Not covered	20% ($250 deductible per year)	50% ($250 deductible per year)
Hospitalization Services Inpatient Hospital **Benefits**[3,4]	20% ($500 deductible applies to 1st admission)	50%[2] ($500 deductible applies to 1st admission)	20% ($250 deductible applies to 1st admission)	50%[2] ($250 deductible applies to 1st admission)
Skilled Nursing Care[3]	20% Combined limit of 90 days	50% Combined limit of 90 days	20% Combined limit of 60 days	50% Combined limit of 60 days
Emergency Health Coverage Emergency Care Services	20% ($75 deductible, if not admitted)	20% ($75 deductible, if not admitted)	20% ($50 deductible, if not admitted)	20% ($50 deductible, if not admitted)
Ambulance Services (plus $50 deductible if not admitted)	20%	50%[2]	20%	50%[2]
Prescription Drug Coverage	$500 maximum per calendar year		N/A	Plus $100 deductible.[4]
Generic 30-34 Days	20%	50%[2]	$15	50%[2]
Brand 30-34 Days	20%[2]	50%[2]	$25	505[2]

HEALTH NET PPO

Benefit	Saver		PPO 30	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Non-formulary 30-34 Days	Not covered	Not covered	50%[2]	50%[2]
Durable Medical Equipment	Prosthetics and diabetes supplies only.		20%	50%[2]
Maximum benefit per year	N/A		$1,000 Combined	
Prosthetics[3]	20%	50%[2]	20%	50%[2]
Maximum benefit per year	N/A		$200 Combined	
Mental Health Services[53] **Inpatient**[3]	20%[54]	50%[6]	20%	50%[2]
Limits	Combined limit 30 days		Combined limit 30 days	
Outpatient	Not subject to deductible		20%	50%[2]
Limits	$20 2 visits individual/ spouse, 4 visits dependents	50%[2] 2 visits individual/ spouse, 4 visits dependents	20 visits per member per calendar year Maximum payable per visit $25	
Chemical Dependency Services				
Inpatient[3]	20%	50%[2]	20%	50%[2]
Limits	Detox only, $500 deductible applies to first admission.		Combined limit 30 days	
Outpatient	Not covered		Not covered	
Limits	N/A		N/A	
Home Health Services **Home Care**[3]	20%	50%[2]	20%	50%[2]
Limits	90 visits combined, $75 per day maximum		60 visits combined, $110 per day maximum	
Hospice Care[3]	20%	50%[2]	20%	50%[2]
Limits	Lifetime maximum of $10,000		Lifetime maximum of $5,000	

Some services require prior authorization or benefits may be reduced. Check with your health plan or refer to your Certificate of Insurance for more information. All services covered by your selected health plan are fully described in your Certificate of Insurance document that will be mailed to you once you are accepted into the program. All deductibles are calendar year. For exact terms and conditions of the health care benefits, provisions, exclusions and limitations of each plan, please refer to your Certificate of Insurance. The plan's Certificate of Insurance, if different from the benefits described here, will apply.

Services that have a copayment are not subject to the calendar year deductible.

APPENDIX C

PROCESS FOR OBTAINING AND MAINTAINING INSURANCE THROUGH PACADVANTAGE PREMIUM

1. Employer contacts CPPP about qualifying under the program.

2. Following the filing of a one-page application, CPPP issues an eligibility determination. All applications would be decided within 5 business days.

3. If qualified and if there is funding available, then CPPP would enroll the employer in the program. Otherwise, the employer would be placed on a waiting list.

4. Employers would then identify an insurance product that they would like to purchase. CPPP would provide support for this decision, including a list of insurance products already reviewed and qualified for subsidies.

    - If employer chooses a plan not yet reviewed and approved by CPPP, the employer would submit the desired plan to CPPP for approval. This review would be completed within 14 business days and free of charge to the employer.
    - If employer selects a qualified purchasing pool plan, then the employer would proceed immediately to the next phase.

5. To determine employee eligibility of the program, CPPP would provide one-page applications to be distributed to employees.

6. Employees would complete the application and send it directly to CPPP; a determination would be made within 5 business days.

7. Under the process, applicants (employees and dependants) would be screened to determine eligibility for California's other public health insurance programs. Using the same analysis procedures as Healthy Families, the screening process would result in three outcomes:

    - Eligible for CPPP. Applicants who meet CPPP's eligibility criteria would be enrolled immediately.
    - Likely Eligible for Public Health Insurance Programs. If the screening process shows that the applicant is likely to be eligible, they would be told that they cannot enroll in CPPP and, with permission, the information would be forwarded to the appropriate program for an eligibility determination. In order to enroll in CPPP, the applicant would need a denial letter from the program in question.
    - Ineligible for CPPP, Likely Ineligible for Government Programs. In these cases, the applicant would be given the opportunity to apply to a government program, but it would not be recommended. Individual would have the opportunity to enroll in the employer's program without the CPPP subsidy.

8. On a monthly basis, insurance companies would send a premium bill to both CPPP and participating employers. By a date certain, the participating employer would then send the employer and employee's portion of the premium to CPPP. (Employers would simply withhold the employee share for health insurance.)

    - Even if the employer payment is not received, CPPP would send payment of the full premium to the insurance company and grant a month grace period for bills to be paid. A 5 percent charge would be assessed on all late payments.
    - CPPP would make every effort to ensure payments are only made for current employees.
    - Incentives should be developed to encourage the use of electronic funds transfer.

9. Every year, the employer and employees would be required to re-certify eligibility.

10. Need to notify PBGH of changes in employee status, including income.

APPENDIX D

COMPARISON OF CHIP PREMIUM ASSISTANCE PROGRAMS

	MASSACHUSETTS	MISSISSIPPI	WISCONSIN	MARYLAND	NEW JERSEY	VIRGINIA	WYOMING
Eligibility Level	200% FPL for children 150% for parents	200% FPL	185% FPL	300 % FPL	350% for children 200% for parents and pregnant women	185% FPL	133% FPL
Employer Contribution	50 percent	50 percent	60 percent	50 percent	50 percent	40 percent	40 percent
Crowd-Out Strategy	Monitoring/ 3 month trigger	6 month waiting period	6 month waiting period	6 month waiting period	6 month waiting period	6 month waiting period	1 month waiting period + monitoring
Benefits	Each ESI plan must meet SCHIP benchmark package	Each ESI plan benefit package must be equivalent to a SCHIP benchmark.	Equivalent to the Medicaid benefit package. State provides wrap-around benefits if ESI plan does not offer all Medicaid benefits.	Benchmark-equivalent coverage -- Comprehensive Standard Health Benefits package.	Medicaid benefit package for children, state-defined benchmark equivalent for parents. State provides wrap-around if ESI plan does not include.	Equivalent to State employees benefit plan with wraparound coverage of certain services.	"Secretary-approved coverage" with somewhat limited benefit package.
Cost Sharing	$10 per child per month premium (max. $30); no cost sharing on well-baby/well-child, statutory 5% limit applies overall.	Sliding scale copayments for children with incomes above 150% FPL; state covers cost sharing for employer plan benefits for which Title XXI prohibits cost sharing.	Families with incomes above 150% FPL pay premiums equivalent to 3 percent of family income. No copayments.	Sliding scale premiums for families with incomes between 200-250% FPL and between 250-300% FPL. No copayments.	Co-payments according to a schedule for certain benefits. Annual co-payments cannot exceed 5 percent of family income. Prenatal and preventive services exempt.	Premiums not to exceed 5 percent of annual family income. No co-payments apply to participants in the premium assistance program.	Co-payments with an annual maximum of $200 per family.
Effective Date	July 1998	January 1, 2000	July 1, 1999	July 1, 2001	January 18, 2001	December 22, 2000	September 1, 2001

Based on Authors' Collection of Data

APPENDIX E

ANSWERS TO COMMON QUESTIONS ABOUT PACADVANTAGE COVERAGE PLANS

Appendix reprinted from 2000 PacAdvantage Handbook.

Questions PacAdvantage members ask	Aetna U.S. Healthcare	Blue Shield HMO/POS	Chinese Community Health Plan	Community Health Group	Health Net HMO/Triple Coverage	Kaiser Permanente North	Kaiser Permanente South	National HMO	Sharp Health Plan	UHP HealthCare	Universal Care – Champion Health	Universal Care HMO/POS	Western Health Advantage
Must routine care be accessed through a PCP in this plan?	Yes	Yes*	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Must dependents have the same PCP as the subscriber?	No	No	No	No	No	No	No	No	No	No	No	No	No
Must dependents choose a PCP from the same medical group as the subscriber?	No	No	Yes	No	No	No	No	No	No	No	No	No	No
How many times can a member change their primary care physician in one benefit year?	No Limit	No Limit	2*	No Limit	12	No Limit	No Limit	12	No Limit	12	No Limit	No Limit	12
Comprehensive physical exams are available to adults every (?) months in this plan?	12	Varies	12	Varies	Not Covered	12	12	12	Varies	Varies	12	12	Varies
Does the plan offer a prescription drug mail-in program?	Yes	Yes	No	Yes	Yes*	Yes	Yes	Yes	Yes	Yes*	Yes	Yes	Yes
Does the plan require physicians to prescribe pharmacy product from a list of drugs approved by the plan?	Yes*	Yes	No	Yes	No	Yes	Yes*	Yes	No*	Yes*	Yes	Yes	No
Does the plan require that generic drugs be substituted for brand name drugs, except when medically necessary?	No	Yes*	Yes*	Yes	Yes	Yes	Yes	Yes*	No	Yes*	Yes*	Yes*	Yes
Can women see an OB/GYN without referral from a PCP?	Yes*	Yes*	Yes	Yes*	Yes*	Yes	Yes	Yes	Yes*	Yes	Yes*	Yes*	Yes
Does the plan offer a process to speed up referrals to specialists?	Yes	If using Access Plus HMO Provider	No	Yes	Yes	Self-referral for certain specialty services	Self-referral for certain specialty services	Yes	Express referrals available for selected medical groups (prior authorization not required)	Yes	Yes	Yes	Yes

As of June 30, 2000, PacAdvantage plans reported													
Total number of California subscribers and dependents	502,751	941,798**	6,990	74,129	2,154,904	3,014,171	2,980,666	45,9494	86,044	94,649	160,287	267,071	50,000
Total number of primary care physicians (PCP)	9,635	10,287	71	583	11,616	1,444	1,135	478	507	1,147	53	6,146	362
Percentage of PCPs accepting new patients as of 7/1/00	85%	80%	92%	78%	83.6%	85%	85%	83%	94%	97%	100%	95%	75%
Percentage of primary physicians that are Board-certified	75%	60.49%	66%	79.4%	73.4%	84%	84%	53%	74%	65.9%	79%	795	81%
Percentage of specialty physicians that are Board-certified	75%	66.03%	76%	83%	76%	84%	84%	57%	80%	88%	82%	82%	78%

** The information on these pages was provided by each health plan.*
*** HMO members only.*

APPENDIX F

IMPLICATIONS OF HIFA CHIP WAIVER APPROACH

Premium Assistance through CHIP

Historically, federal policy has created a significant challenge for states attempting to create a premium assistance program through CHIP. In addition, of the states with such programs in operation, participation levels have been extremely low thus far. Indeed, after two years, Wisconsin's program has only enrolled 32 families.[55] However, since the initial policies were issued in1998, HHS has eased some of the restrictions, culminating in the final CHIP regulations and the Health Insurance Flexibility and Accountability (HIFA) initiative.

In January 2001, HHS eliminated several of the most critical barriers to using CHIP to subsidize ESI. This flexibility, coupled with benefits already offered by the CHIP program, make it superior to Medicaid in terms of how to approach premium assistance programs. For example, one early HHS requirement specified that employer contributions to ESI had to equal or exceed 60 percent. Several observers argued that this level was too high, not representative of the employer market in most states, and was unduly discouraging the use of ESI in CHIP. In addition, this flexibility comes on top of other benefits to CHIP, such as the enhanced match rate. (Appendix H discusses some of the key requirements for using ESI in CHIP.)

As of September 2001, seven states have developed premium assistance programs under CHIP. Of these states, Massachusetts is considered to be one of the most successful, although their program (MassHealth) currently only has 10,000 beneficiaries enrolled.[56] Four of the states -- Maryland, New Jersey, Rhode Island and Wyoming -- recently launched ESI programs --all prior to the HIFA guidance. (Appendix D provides a comparison of key elements in CHIP premium assistance programs.)

Which Approach to Use When Seeking Federal Dollars?

If Federal funds are sought for CPPP, CHIP should be considered as preferable to Medicaid for several reasons:

- All else being equal, CHIP offers a higher match rate (at 65 percent) than Medicaid (at 51 percent) along with greater overall program flexibility.
- Medicaid is an entitlement that will restrict CPPP's ability to control costs.
- Under a Medicaid waiver, budget neutrality -- a Federal policy requiring that the state cannot spend any more money under the waiver than it would have in absence of the waiver -- is very restrictive. The CHIP policy of "allotment neutrality" is much less complex and easier with which to comply.
- There has historically been a welfare stigma attached to the Medi-Cal program.

However, while CHIP is preferable to Medicaid, there are still a number of policy issues to consider that impact the use CHIP funds including:

SUPPORT FOR USING CHIP FUNDS

- The Federal government could reimburse state dollars spent on CPPP at 65 percent, thereby reducing the burden on the state.
- The specifications for CPPP seem to fulfill the HIFA requirements in many critical areas.
- According to the Federal government, California is expected to spend less than 30 percent of its CHIP allotment in 2006. Even after the approval of the parents' waiver for Healthy Families, the state should be able to achieve allotment neutrality with CPPP spending.[57]
- A premium assistance program through Healthy Families could help to:
  - Reduce Healthy Families expenditures by leveraging available employer dollars.
  - Reduce crowd-out in Healthy Families by encouraging employers to offer insurance, and work with the program instead of supplanting dollars altogether.

REASONS TO NOT SEEK CHIP FUNDS

- California may not be able to fulfill the waiver requirements. HIFA is primarily designed for populations under 200 percent of the poverty level, and CMS does not seem inclined to go beyond that level.[58] In fact, for waiver approval through HIFA, states must fulfill two separate requirements.
  - The state must demonstrate that expansion will not "induce individuals with private coverage to drop their current coverage." It seems likely that the crowd-out policy as proposed would fulfill this requirement.
  - The state must prove that, "focusing resources on populations below 200 percent of FPL is unnecessary because the state already has high coverage rates in this income range." While there is no further explanation of "high coverage rate", it seems unlikely that California could make such a showing at this time. In addition, according to the Kaiser Family Foundation, 40 percent of those under 200 percent of the poverty level in California are uninsured, while the national average is 34 percent.[59]
- Premium assistance programs through CHIP and Medicaid have had limited success.
- There is significant regulatory burden associated with the Federal government, despite HIFA's assertion that decisions will be reached in 90 days. While no state has yet applied for a waiver under HIFA, the Healthy Families for adults program has been pending at the Federal level since the start of the Bush Administration. In addition, there are other reporting requirements that would have to be fulfilled.
- Some modifications to CPPP would be required to obtain Federal approval. For example, although HIFA does not require a set employer contribution, it may be difficult to obtain approval for a 35 percent employer contribution. Although HIFA no longer requires a 60 percent employer contribution, it is not clear that such a small employer contribution could be considered cost-effective under any circumstances. [60]

Again, one of the primary obstacles to offering CPPP through Healthy Families expansion to 350 percent of the Federal Poverty Level Some policy-makers may want to consider offering CPPP through HIFA, even if only for the population at 200 percent of the poverty level or lower.

APPENDIX G

ALTERNATIVE GOVERNANCE MODEL FOR CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP)

There are a number of ways to design new management boards. In the event policymakers believe that a new, independent board should be created to manage the premium assistance program (as opposed to PacAdvantage or an existing state agency), the following provides a model for ensuring that the new board would create an efficient and accountable program.

Board Appointments

A 13-member board of directors would govern the new entity. The twelve members would select a chief executive officer who would serve as an ex-officio, voting director. The authority to make appointments would be apportioned in the following manner:

- Governor: 4
- Assembly Majority Party: 2
- Assembly Minority Party: 2
- Senate Majority Party: 2
- Senate Minority Party: 2

The board must have representatives from a range of communities. Of the board members, a representative of each of the following communities should be included:

- Uninsured advocates,
- Small business owners,
- CPPP enrollees (a person currently or previously insured through CPPP),
- Medical provider community; and
- Medical payers.

Terms of Service

Of the 12 members first appointed, five members would serve terms of two years and seven would serve terms of four years. Subsequent appointments would last four years. Members, except the executive manager could only serve two consecutive terms. Any member of the board of directors could be removed by the governor for malfeasance in office, failure to attend regularly called meetings, or for any cause that renders the member incapable of discharging their duties.

Authority

The board would have the general powers of an independent corporate entity and the authority to conduct all necessary duties. For decisions of the board to be effective, a majority of the board must support the measure through a recorded vote at a meeting at which a quorum is present.

APPENDIX H

EVOLUTION OF CMS REQUIREMENTS FOR PREMIUM ASSISTANCE PROGRAMS THROUGH CHIP

Incorporating the concept of premium assistance into public health programs was contemplated by the drafters of the original statute authorizing the State Children's Health Insurance Program (CHIP), however the legislative language contains very little specificity, leaving a great deal of room for interpretation by federal policy makers as they set forth on the task of implementing the new program.

On February 13, 1998, the Health Care Financing Administration released its first guidance for states wishing to utilize premium assistance in their CHIP programs. The guidance reflected the Clinton administration's policy that, in order to receive enhanced federal matching funds for the purpose of subsidizing employer coverage, states must ensure that employers contribute at least 60 percent of the cost of providing group health plan coverage for enrollees in their CHIP programs. This contribution level was determined as part of the calculations for meeting the "cost-effectiveness test" which required that the cost of providing the coverage to an entire family in CHIP could be no greater than the cost of covering the children only. It was assumed that a significant employer contribution is necessary to ensure cost effectiveness under the statute.

This policy was codified in the CHIP notice of proposed rulemaking (NPRM) that was published in the Federal Register on September 29, 1999.

SCHIP Final Rule

After a great deal of consideration of comments received on the proposed rule and discussion with states regarding the feasibility of finding employers to participate in premium assistance programs, even with the federal subsidy available, the federal government determined that the 60 percent employer contribution requirement was too rigid and prohibitive of employers' participation. In fact, in its negotiations with the states proposing premium assistance programs, it became clear that even a 50 percent contribution would be a "hardship" to most employers, especially low-wage and small employers.

The final rule removed the 60 percent contribution requirement in favor of a more general policy requiring states to establish a contribution level that is representative of the employer market in their particular state. The cost effectiveness test remains. To date, seven states have received approval from the Center for Medicare and Medicaid Services to use SCHIP funds to enroll eligible children in private coverage offered by employers.[61]

Finally, the Department of Health and Human Services' new HIFA initiative now requires states to pursue premium assistance programs and suggests a great deal of additional flexibility in terms of waiting periods to prevent substitution and the cost effectiveness test. (See Appendix F for more information on the HIFA initiative.)

Success?

Premium assistance programs have been a key component of states' efforts to expand coverage to parents, however because states with separate SCHIP programs do not have an easy way to administer required supplementation of employer plans, states have not had much success with enrolling families in SCHIP premium assistance programs to date, even with the additional flexibility provided by the final SCHIP regulations.

Massachusetts is the only state that has had considerable success in establishing a premium assistance program in combination with a section 1115 demonstration that blends Medicaid and SCHIP funds, although its 10,000 enrollees represent only a small in proportion or the states overall Medicaid and SCHIP program. New Jersey, Maryland and Rhode Island have recently implemented premium assistance programs and hope to emulate Massachusetts' success under their own 1115 waiver expansions.

While premium assistance is a more cost-effective way for states to expand coverage, especially to working families, the breadth of these programs will likely remain limited. Analysts note that some working families would not want to enroll in public coverage through Medicaid or SCHIP, but would accept help with enrolling in private coverage provided through their employer. Premium assistance is not intended to encourage employers to reduce or discontinue coverage because of the availability of public coverage, but the potential is there. This result has increasingly become a concern as states have expanded eligibility for their programs well into the "full-time worker" range. States have had to carefully structure their programs to maintain the expectations that employers will continue to provide a significant contribution toward health coverage for their employees.

APPENDIX I

BACKGROUND ON CALIFORNIA'S HEALTH INSURANCE PREMIUM PAYMENT PROGRAM UNDER SECTION 1906 OF THE SOCIAL SECURITY ACT

Section 1906 of the federal Medicaid statute enables states to pay the contribution necessary to enroll individuals in private health insurance, usually employer-sponsored coverage, as long as doing so is cost-effective (compared to the cost of providing regular Medicaid coverage). Enrollees must receive all of the benefits covered under the state's Medicaid plan; states usually do this by issuing a Medicaid card that can be used to access services not covered under the employer plan. These Health Insurance Premium Payment (HIPP) programs can be made available to families who are Medicaid eligible and have access to employer-sponsored private health insurance.

As Medicaid beneficiaries, participants in this program are entitled to receive all Medicaid benefits and are protected by Medicaid's significant cost sharing restrictions. If the employer plan does not meet these requirements, Medicaid provides "wrap-around" services whereby the state will fill any gaps in coverage with Medicaid funds.

The benefits of a HIPP program mirror those of premium assistance programs and would:

- Reduce state costs by leveraging employer contributions.
- Allow for coverage of working parents of Medicaid-eligible children who cannot otherwise afford their share of ESI.
- Allow an entire family to be covered under the same plan.
- Reduce stigma by enrolling families in ESI and not a Medicaid plan/HMO.
- Allow those enrolled in Medicaid whose income later increases to remain in the same ESI plan, thereby providing continuity of coverage

Medi-Cal and HIPP

The State of California uses the authority under section 1906 to enable Medi-Cal beneficiaries to purchase private or employer sponsored health insurance coverage when it is available. This authority benefits both the state and the beneficiary by deferring a large portion of the cost of coverage to private or employer health plans.

Enrollment in California's HIPP program is limited to certain Medi-Cal beneficiaries who:

- Have a high-cost medical condition such as pregnancy, HIV/AIDS or the need for an organ transplant;
- Have a Medi-Cal share of cost of $200 or less;
- Have private health insurance coverage or have access to coverage through an employer;[62]
- Are not enrolled in a Medi-Cal managed care plan or other county organized health plan.

Like many other states, California's statewide HIPP program has not had a great deal of enrollment success, in part due to the limited eligibility criteria. However, in addition to the statewide program, there are several other county-specific HIPP programs that enable enrollees in Medi-Cal managed care to buy into private coverage. Programs are currently operating in Orange, Napa, Solano, Santa Barbara, and Santa Cruz Counties. In addition, the state offers a program called CARE/HIPP for individuals with HIV/AIDS who are not eligible for Medi-Cal.

FOCUS

In April 1999, the Sharp Health Plan and the Alliance Healthcare Foundation teamed up to develop a premium assistance program in San Diego County targeted at small employers and their lower-wage employees. Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) provides coverage for employees and their families with incomes up to about 300 percent of the Federal Poverty Level ($52,950 for a family of four in 2001).[63] Employees must be working full time and be uninsured for the twelve months before application. As of December 7, 2001, there were 1,522 enrollees from 242 businesses participating in FOCUS.[64]

HIPP Has Limited Affect

Despite their relative success, HIPP programs and other premium assistance programs have historically been limited in scope and cannot realistically be expected to suffice as an option for universal coverage on their own. Most states are operating HIPP programs, but they are usually limited to very high-cost cases like cancer and HIV/AIDS patients. Only a few states (Iowa, Texas, Pennsylvania and Virginia) use HIPP programs to screen all Medicaid eligibles for access to employer-sponsored coverage. Even when used in this broader way, enrollment has remained very small, representing only 1 percent of states' total Medicaid program enrollment.[65]

There are several reasons for these small enrollment numbers. First, because of the nature of low-wage jobs, most Medicaid eligible individuals do not have access to health coverage through their employers. Further, it is difficult for states to identify the target population because there is not an existing relationship between employers and the state Medicaid agency, causing information sharing to be problematic. In addition, it is difficult for states to identify individuals who may have ESI, and the reality is that few working individuals can pass Medicaid's low-income requirements.

However, HIPP programs are a good example of an expansion opportunity because a significant number of HIPP enrollees are not otherwise Medicaid eligible and many are the working parents of Medicaid-eligible children who would be uninsured because they would not otherwise be Medicaid eligible, but could not afford to pay the premiums associated with private coverage.

APPENDIX J

LEGISLATIVE SPECIFICATIONS FOR THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP)

Purpose/Goal

The state would enable small business to obtain subsidies for the purchase of quality private health insurance for employees.

Operations

To achieve this goal, the state would enhance an existing public-private partnership, PacAdvantage, the state's small business purchasing pool operated by the Pacific Business Group on Health. CPPP would use existing PacAdvantage procedures and simply add a subsidy option for certain businesses on top of the program.

Administration

While PacAdvantage would be responsible for operations, California's Managed Risk Medical Insurance Board (MRMIB) would oversee the policy issues surrounding CPPP. Taken together, the two entities would work to:

- Determine eligibility of employers and employees.
- Ensure smooth operations and timely payment of subsidies.
- Ensure employees and employers have the information necessary to participate in the program.
- Oversee stability of the premium subsidy trust fund.
- Obtain public and private grants to support the trust fund.
- Implement aggressive outreach programs to maximize usage of CPPP.
- Educate of the public on the importance of health insurance.

Employer Eligibility

To participate, employers would be required to receive an annual certification that they fulfilled the crowd-out requirements as well as all PacAdvantage participation requirements, including that the employer has:

- 50 or fewer employees for more than 50 percent of the working days during the year.
- A majority of employees residing in California.
- Fulfilled the PacAdvantage definition of an employer as, "a person, firm, proprietary or non-profit corporation, partnership, public agency or association that is actively engaged in a business or service."

To remain eligible, the employer must:

- Meet insurance participation take-up rate requirements.
- Pay all premiums in a timely manner.

Employee Eligibility Policy

Eligibility, determined annually, would be contingent upon several requirements being true at the time of the determination. To be eligible for the subsidy, individuals would be required to:

- Live in a family where either they or a parent/guardian works for a participating employer 20 hours or more a week;
- Have a family income below 350 percent of the Federal Poverty Level;
- Be ineligible for Medi-Cal, Medicare, Healthy Families, Access for Infants and Mothers, Medicare, or any other health insurance program sponsored by the state and/or Federal government; and
- Be less than 23 years of age (for dependents).

To remain eligible, the employee/dependent must:

- Remain working for a participating employer/remain in a family with a participating parent/guardian.
- Pay all premiums in a timely manner.

CPPP would not be an entitlement program, and MRMIB would be able to control enrollment in response to changes in financial resources.

Crowd-Out Eligibility Policy

- Employers: Not offered insurance in the previous 6 months (with certain exceptions).
- Employees: Not been enrolled in insurance during the previous six months (with certain exceptions).

Benefit Package

Employers would be required to offer a quality health insurance product. To assure this, employers would be strongly encouraged to select one of the nine products offered through PacAdvantage. Under PacAdvantage, dental, vision and chiropractic/acupuncture coverage is optional; participation in CPPP requires that the dental and vision riders be provided.

In the event that the employer wishes to offer a non-PacAdvantage product, MRMIB would be required to determine that the selected product is either identical or actuarially equivalent to one of the following three benchmarks:

- 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.

While MRMIB would oversee determination of actuarial equivalence, the burden would fall on the plans to produce documentation justifying such certification. In the event the employer decides to exercise their flexibility under the program by selecting a non-PacAdvantage plan, the employer would have to add a 10 percent surcharge to the cost of the insurance subsidy.

Cost Sharing

There would be no separate cost sharing limits beyond the premium. Employees are responsible for any copayments, deductibles and other cost sharing as required by the selected insurance plan.

Assistance (Subsidy) Provided

The maximum subsidy available under the program would be 55 percent. This support would be available when the individuals covered are below 200 percent of poverty. The subsidy would decrease on a sliding scale and would phases out completely for individuals at or above 350 percent of poverty.

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

Outreach

This program would have an aggressive outreach campaign that would include:

- A paid media campaign that places ads in newspapers, trade press and television.
- An earned media campaign in which the state would promote CPPP through newscasts, radio talk shows and public events.
- A grassroots outreach program that would send representatives to Chambers of Commerce and business groups.

Funding

Payments for the subsidy would be collected through a trust fund. While donations could be given by private/non-profit entities, the vast majority of support for the fund would come from an increase in California's tobacco or alcohol tax. CPPP administrative costs would be funded by a 1.5 percent surcharge on premium payments made by participating employers.

Endnotes

[1] California Managed Risk Medical Insurance Board website, www.mrmib.ca.gov reviewed March 1, 2001.

[2] Richard Brown et al, "Stepping up to Universal Coverage," Los Angles, CA: UCLA Center for Health Policy, Revised October 2001.

[3] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," February 2002.

[4] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," February 2002.

[5] King, Brown & Partners, "Small Business Employer Sponsored Health Coverage Qualitative Report," Oakland, CA: California HealthCare Foundation, September 2000.

[6] While some analysts have previously suggested that a premium assistance program in combination with PacAdvantage may be a successful approach to reducing the number of uninsured, this is the first paper to detail how such a program could be implemented. Papers where this approach has been suggested include: Richard Brown, "California's Younger Adults Have High Uninsured Rates," Los Angles, CA: UC Health Insurance Policy Program Policy Alert, May 1999. Ed Neuschler and Rick Curtis, "Expanding Healthy Families to Cover Parents: Issues & Analyses Related to Employer Coverage," Washington, DC: Institute for Health Policy Solutions funded by the California HealthCare Foundation, January 2001.

[7] Kaiser Family Foundation, State Health Facts Online, accessed September 24, 2001. Analysis based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys.

[8] Richard Brown et al, "Uninsured Californians in Assembly and Senate Districts, 2000," Los Angles, CA: UCLA Center for Health Policy, May 2001, pg. 2.

[9] California Healthy Families Health Insurance Accountability and Flexibility wavier application for parent coverage, as downloaded from www.mrmib.ca.gov March 2000.

[10] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," February 2002.

[11] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," February 2002.

[12] Kaiser Family Foundation, State Health Facts Online, accessed October 17, 2001. Analysis based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys. Total US numbers are based on March 2000 estimates.

[13] King, Brown & Partners, "Small Business Employer Sponsored Health Coverage Qualitative Report," Oakland, CA: California HealthCare Foundation, September 2000. Sharon Silow-Carroll, "Enhancing Health Coverage for the Working Uninsured: Lessons from Six State and Local Programs," New York, NY: Commonwealth Fund, February 2001.

[14] William M. Mercer Inc., "Employer Sponsored Health Insurance: A Survey of Small Employers in California," Oakland, CA: California HealthCare Foundation, August 1999.

[15] California HealthCare Foundation, *Small Business Employer Sponsored Health Coverage*, Oakland, CA: California HealthCare Foundation, September 2000, Executive Summary.

[16] California HealthCare Foundation and Field Research, "To Buy or Not to Buy: A Profile of California's Uninsured," Oakland, CA: California HealthCare Foundation, 1999.

[17] Jon R. Gabel et al., "Annual Survey of Employer Sponsored Health Benefits," Menlo Park, CA: Kaiser Family Foundation and Health Research Education and Trust, Septmeber2001, page 41.

[18] William M. Mercer Inc., "Employer Sponsored Health Insurance: A Survey of Small Employers in California," Oakland, CA: California HealthCare Foundation, August 1999, pg. 12.

[19] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," February 2002.

[20] King, Brown & Partners, "Small Business Employer Sponsored Health Coverage Qualitative Report," Oakland, CA: California HealthCare Foundation, September 2000, pg. 7.

[21] King, Brown & Partners, "Small Business Employer Sponsored Health Coverage Qualitative Report," Oakland, CA: California HealthCare Foundation, September 2000, pg. 13.

[22] California HealthCare Foundation and Field Research, "To Buy or Not to Buy: A Profile of California's Uninsured," Oakland, CA: California HealthCare Foundation, 1999.

[23] Accessed at www.pacadvantage.org/content/about.asp on January 7, 2002.

[24] A Triple Coverage plan has HMO-like and out-of network components, but has an additional PPO component. The Triple Coverage plan has different benefit levels for each "tier" of coverage. The PPO tier has lower out-of-pocket costs than the out-of-network tier, but has higher out-of-pocket costs than the HMO.

[25] PacAdvantage Employer Handbook, July 1, 2001.

[26] Paul Fronstein, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," Washington, DC: Employee Benefit Research Institute Issue Brief, December 1998.

[27] For CPPP, the PacAdvantage policy must be modified somewhat to apply to CPPP. When determining if the employer is contributing 100 percent of the premium, the share should be considered to be the total insurance premium less the CPPP subsidy. In addition, when calculating the participation rate, CPPP will only include in the denominator those employees who work 35 hours or more a week in this calculation –not all eligible employees as in PacAdvantage. Given CPPP flexibility to allow those working 20 hours a week to participate, it is possible that some eligible employees may not feel that they earn enough to be able to afford insurance. Given the challenge of getting part-time employees to participate, such individuals should not be counted towards the take-up rate requirement.

[28] For more information on the Wayne County Program, please see Sharon Silow-Carroll, Stephen E. Anthony and Jack A. Meyer, "State and Local Initiatives to Enhance Health Coverage for the Working Uninsured," The Commonwealth Fund Task Force on the Future of Health Insurance, New York, NY, November 2000.

[29] Kaiser Family Foundation and Health Research and Education Trust, "2001 California Employer Health Benefits Survey," March 2002.

[30] PacAdvantage allows employers to choose to provide coverage to those with 20 to 29 hours of work a week.

[31] Amy Westpfhal Lutzky and Ian Hill, "Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP," Washington, DC: Urban Institute, June 2001.

[32] Ed Neuschler and Rick Curtis, "Expanding Healthy Families to Cover Parents: Issues & Analyses Related to Employer Coverage," Washington, DC: Institute for Health Policy Solutions funded by the California HealthCare Foundation, January 2001, pg. 13.

[33] PacAdvantage Employee Handbook, July 1, 2001, pg. 21.

[34] Kaiser Family Foundation and Health Research and Education Trust, "California Employer Health Benefits Survey," March 2002.

[35] Sarah Rosenbaum, Phyllis Borzi, and Vern Smith, "Allowing Small Business and the Self-Employed to Buy Health Care Coverage Through Public Programs," New York, NY: Commonwealth Fund, December 2000.

[36] Author's Conversation with Kathlyn Mead, President Sharp Health Plan.

[37] Author's Conversation with Kathlyn Mead, President Sharp Health Plan.

[38] Pacific Business Group on Health Press Releases, April 6, 1999 and August 2, 2001.

[39] Information from www.calchoice.com, Downloaded September 27, 2001.

[40] The California PacAdvantage Premium Program (CPPP): Summary and Estimated Costs and Coverage Impacts, Washington DC: The Lewin Group, February 8, 2002.

[41] The California PacAdvantage Premium Program (CPPP): Summary and Estimated Costs and Coverage Impacts, Washington DC: The Lewin Group, February 8, 2002.

[42] The California PacAdvantage Premium Program (CPPP): Summary and Estimated Costs and Coverage Impacts, Washington DC: The Lewin Group, February 8, 2002.

[43] *Listening to Workers,* New York, NY: Commonwealth Fund, January 2000.

[44] Richard Curtis, "Private Purchasing Pools to Harness Individual Tax Credits," New York, NY: Commonwealth Fund, December 2000.

[45] Jeanne Lambrew, "Health Insurance: A Family Affair – A National Profile and State-by-State Analysis of Uninsured Parents and Their Children," New York, NY: Commonwealth Fund, May 2001, pg. 7. She cites articles including: Joyclen Guyer and Cindy Mann, "Employed But Not Uninsured," Washington, DC: Center on Budget and Policy Priorities, February 1999. Leighton Ku and M. Broaddus, "Importance of Family-Based Insurance Expansions: New Research Findings about State Reforms," Washington, DC: Center for Budget and Policy Priorities, September 2000. Kenneth Thorpe and CS Florence, "Covering Uninsured Children and Their Parents: Estimated Costs and the Number of Newly Insured," New York, NY: Commonwealth Fund, July 1998.

[46] Elizabeth Gifford et al, "Encouraging Preventative Health Services for Young Children," Presentation at the Academy for Health Services Research and Health Policy Conference, Atlanta, Georgia, June 12, 2001.

[47] Two family members must satisfy their individual out-of-pocket maximum to satisfy the family out-of-pocket maximum.

[48] For prescription drugs and out-of-network services, member is responsible for coinsurance plus any amount in excess of covered expenses or limited fee schedule. The amount paid toward the balance of such a bill does not count toward a member's out-of-pocket maximum or deductible.

[49] These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a $50 deductible is required for each visit; for uncertified inpatient admissions, a $250 deductible is required for each inpatient admission.

[50] Professional services subject to a $500 maximum benefit per year. After Health Net has paid $500 for these services in a calendar year, no additional payments will be made for the remainder of the calendar year until the member's out-of-pocket maximum has been satisfied, after which these services will be payable at 100%. Fees in excess of the $500 maximum apply to the member's out-of-pocket maximum.

[51] Separate one-lifetime deductible $500.

[52] These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a $50 deductible is required for each visit; for uncertified inpatient admissions, a $250 deductible is required for each inpatient admission.

[53] For certain diagnoses, mental health benefits are the same as medical benefits for office and hospital copay/deductible, prescription drugs, and inpatient and outpatient visit limits. Check with your health plan or refer to your Certificate of Insurance for more information.

[54] Inpatient care in a hospital or skilled nursing facility for nonsevere mental illness. The maximum allowable each day is $175.

[55] Rick Curtis, President of Institute for Health Policy Solutions, Speaking at National Health Policy Forum, September 24, 2001.

[56] Jennifer Ryan, "Health Insurance Family Style," Washington, DC: National Health Policy Forum Issue Brief, pg. 5.

[57] Centers for Medicare and Medicaid Services, "Report in the Health Insurance Flexibility and Accountability Initiative, October 4, 2001.

[58] HIFA Policy Guidance, Centers for Medicare and Medicaid Services, July 2001. Dennis Smith, CMS Director for Medicaid and State Operations, Speaking at National Health Policy Forum, September 24, 2001.

[59] Kaiser Family Foundation, State Health Fact Online, Downloaded September 2001. Numbers attributed to Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys.

[60] One innovative solution to this problem might be to offer the Federal government the possibility of calculating the CHIP match as if the employer were contributing at a higher level, say 50 or 60 percent. This would have the affect of at least earning some federal dollars, while allowing the government to maintain the precedent of only matching higher employer contributions.

[61] As of November 30, 2001, Massachusetts, Wisconsin, Mississippi, Maryland, Virginia, New Jersey, and Wyoming had received approval to use SCHIP funds to conduct premium assistance programs, either through a state plan amendment, a section 1115 waiver or a combination of the two.

[62] Access to employer coverage includes COBRA and the state subsidy program Cal-COBRA, but excludes policies issued through the California Managed Risk Medical Insurance Board (MRMIB). The policy must not exclude coverage for the specific high cost medical condition.

[63] The FOCUS package closely resembles that of any standard commercial plan. Covered services include:

- 100 percent hospitalization;
- physician office visits, $5 copayment;
- outpatient prescription drugs, $15 brand name/$5 generic;
- Emergency Room, $50 copayment;
- Some mental Health and substance abuse coverage.
- Some services, such as chiropractic and infertility coverage, are not offered.

Under the plan, there is a $1500 per individual and $3000 per family cap on annual copayments.

[64] Conversation with Jeff Lazenby, Sharp Health Plan on December 7, 2001.

[65] Sharon Silow-Carroll, Stephen E. Anthony and Jack A. Meyer, "State and Local Initiatives to Enhance Health Coverage for the Working Uninsured," The Commonwealth Fund Task Force on the Future of Health Insurance, New York, NY, November 2000, 20.