

The California Universal Coverage Initiative

In January 2007, California Gov. Arnold Schwarzenegger issued a health care reform proposal to achieve universal coverage in the state. The proposal relies on an individual mandate to encourage the take-up of private, market-based coverage by uninsured state residents. The plan also expands Medicaid coverage and provides premium subsidies to make private coverage more affordable for low-income individuals and families. The state will rely on an insurance purchasing pool to facilitate the purchase of health insurance products and administer premium assistance for employer-sponsored insurance (ESI) to lower-income individuals. The state is relying on contributions from many health care stakeholders – including hospitals, physicians, employers, and individuals – to help fund the plan.

Proposal in Brief

Target population: All uninsured residents.

Sources of Coverage: Affordable, private insurance; Medicaid expansions.

Coverage Incentives: Individual mandate; premium subsidies; employer responsibility.

Financing: Federal Medicaid funding; assessments on employers, physicians, and hospitals; state and local funding; individual premium payments.

Timing: Not yet known.

PROPOSAL SUMMARY

Individual Mandate: The California proposal requires all state residents to have health care coverage. The minimum level of coverage required under the proposal is a \$5,000 deductible plan with maximum out-of-pocket limits of \$7,500 per person and \$10,000 per family. After the mandate takes effect, residents who do not have this level of health insurance would lose their personal withholding on their state income taxes. Health insurers must guarantee individuals access to coverage in the individual market, spend at least 85 percent of premiums on patient care, and make healthy lifestyle benefits available (see page 2).

The Purchasing Pool: California would create a purchasing pool that would offer individual health insurance products that provide the mandated minimum coverage. Individuals earning up to 250 percent of the federal poverty level (FPL) will be eligible for subsidized coverage through the purchasing pool. Small businesses would not be permitted to purchase coverage through the state pool. Insurance products offered by the purchasing pool would be required to offer benefit designs that encourage the use of preventive care and discourage unnecessary emergency department visits.

Premium Assistance: For low-income individuals not eligible for California's Medicaid program, Medi-Cal, the purchasing pool would administer premium subsidies to residents with incomes between 100-250 percent of FPL. The plan does not specify a schedule of premium subsidies.

Medicaid Expansions: Medi-Cal is currently limited to adults who have children but, under this proposal, would be extended to all adults earning up to 100 percent of FPL. The state would also expand Medi-Cal coverage to children, regardless of their immigration status, with family incomes up to 300 percent of FPL, or about \$60,000 a year for a family of four. Children with documented residency are currently covered if their family's income is up to 250 percent of FPL.

Employer Participation: All California employers with 10 or more workers that do not offer health insurance will be required to contribute 4 percent of payroll toward the cost of employee health coverage. Companies with fewer than 10 employees are exempt from the 4 percent

California Quick Facts

Population:

35.8M (US total: 292.9M)
Largest state

No. and Percent Uninsured:

6.8M; 19% (US: 46.6M; 16%)
4th highest uninsured rate

Median Household Income:

\$51,647 (US: \$46,037)
12th highest

Undocumented Immigrants:

About 2.4M; 7% (US: 9.3M; 3%)
Largest number of
undocumented immigrants

Avg. Annual Cost of Employer-Sponsored Insurance (individual per year):

\$3,534 (US: \$3,705)
11th lowest annual cost

Medicaid Enrollment:

10.0M; 28% (US: 55.0M; 19%)
Second largest pop. covered

Medicaid Coverage of Working Parents:

107% FPL (US avg: 87% FPL)

Sources: Kaiser State Health Facts; Urban Institute Estimates of Undocumented

contribution. All employers will be required to set up Section 125 plans for employees in order for employees to use tax-free income toward health insurance premiums.¹

Provider Participation: Doctors will contribute 2 percent of revenues and hospitals 4 percent of revenues to the cost of the universal coverage initiative. These revenues will be deposited into a Health Care Services Fund to finance Medi-Cal expansions, public programs, low-income insurance subsidies, increased Medi-Cal payment rates for providers and plans, and programs to promote prevention, health and wellness. In addition, health plans and hospitals would be required to spend 85 percent of premium and health care dollars on patient care.²

OTHER KEY COMPONENTS

Wellness, Prevention, & Care Coordination:

The proposal establishes “Healthy Actions Incentives/Rewards” programs and mandates that all health plans offer benefit packages that include incentive or reward programs. Enrollees in commercial plans, including California Public Employees’ Retirement System (CalPERS), would earn incentives for the adoption of a healthier lifestyle by receiving premium reductions.

Beneficiaries enrolled in Medi-Cal or California’s State Children’s Health Insurance Program (SCHIP), Healthy Families, would earn rewards such as gym memberships

or subsidized enrollment in weight management programs. Additionally, the proposal would create an extensive Medi-Cal diabetes prevention and care management program that would include screenings, prevention education, and self-management programs. The proposal also creates a media campaign to help curb obesity and increases access to smoking cessation services.

Quality: The California proposal includes provisions to increase quality in health facilities and the Medi-Cal program while promoting greater transparency of quality and pricing data.

Health Facility Quality – The proposal requires new health facility safety measures and reporting requirements to reduce medical errors and hospital acquired infections by 10 percent over four years. It also calls for the implementation of evidence-based measures to improve health facility quality and the creation of an academic curriculum designed to improve patient safety and streamline health care costs. The proposal does not define what entities would be included in its definition of a health facility.

Medi-Cal Quality – Proposed reforms to improve Medi-Cal quality and efficiency include increased physician, hospital, and health plan rates to ensure a stable provider network. Additionally, Medi-Cal payments would be linked to specific performance measures related to quality of care, efficiency, and health information technology (HIT) adoption. California also

would apply for a federal Section 1115 Medicaid waiver to support innovative financing and delivery of Medi-Cal services.

Transparency – The proposal would create a new Internet consumer resource on health plan performance through the Office of the Patient Advocate’s Web site, while working to strengthen the ability of the Office of Statewide Health Planning and Development to collect, integrate, and distribute data on health outcomes, costs, utilization, and pricing.

Health Information Technology (HIT): The California proposal calls for extensive HIT adoption over the next several years. Features of the initiative include:

- 100 percent electronic health data exchange in the next 10 years.
- Universal e-prescribing by 2010.
- Support for uniform, interoperable standards and HIT adoption.
- Use of standardized Personal Health Records (PHR) in the short term that are accessible via internet and smart cards,³ are portable between health plans, and provide consumers access to a core set of data for their personal use.
- Creation of a county-level pilot of an electronic medical record system specifically to create an integrated network of care for mental health clients.
- Development of public/private partnerships to meet the financing of HIT-related projects.
- Expansion of broadband capabilities to facilitate the use of telemedicine.

BUDGET ESTIMATES

The governor estimates that the proposal will cost approximately \$12 billion annually. It would cost the state and federal government approximately \$5.5 billion each and local governments approximately \$1 billion.

NEXT STEPS FOR IMPLEMENTATION

The California Assembly has not yet approved the governor’s proposal, and it is not yet clear whether it will do so. Republicans and business groups have come out against the mandated employer contribution, while Democrats are concerned about the requirement that health plans provide insurance to anyone who seeks coverage, as that could push premiums up significantly.

SOURCES

http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.
<http://gov.ca.gov/index.php?fact-sheet/5190/>.

¹ Internal Revenue Code Section 125 makes it possible for employers to offer their employees a choice between cash salary and a variety of non-taxable benefits (qualified benefits). A qualified benefit includes health care, vision and dental care, group-term life insurance, disability insurance, adoption assistance and certain other benefits (Internal Revenue Service, 2007). These plans are also called cafeteria plans.

²This provision would functionally limit administrative spending by health plans and hospitals.

³ Smart cards are mass data storing devices that are typically the size of a credit card. Smart cards carry data in an electronic memory, which is secured against being read by anyone unless the individual has the correct PIN and an authorized reader system. Even when the reader system is given the enabling code the card may be configured to reveal only some of the data it holds depending on the classification of the user. For example, a smart card may be configured to reveal different data to a psychiatrist than it would reveal to other types of providers (Neame, 1997).