

State Innovations in Modernizing Health Insurance Coverage and Extending Coverage to the Uninsured

June 2008



THIS PAPER IS A PRELIMINARY DRAFT REPORT ON INNOVATIVE STATE EFFORTS TO REDUCE THE NUMBER OF AMERICANS WITHOUT HEALTH INSURANCE COVERAGE. THIS IS BY NO MEANS AN EXHAUSTIVE TREATMENT OF THE SUBJECT. WE ARE CONTINUING OUR SURVEY OF STATES AND WILL EXPAND AND UPDATE THIS REPORT AS RESPONSES ARE RECEIVED. ANY COMMENTS AND SUGGESTIONS WILL BE WELCOME.

Table of Contents

COMPREHENSIVE REFORMS	2
COVERAGE FOR CHILDREN	ERROR! BOOKMARK NOT DEFINED.
UNIVERSAL COVERAGE PROGRAMS FOR CHILDREN	ERROR! BOOKMARK NOT DEFINED.
EXPANDED DEPENDENT COVERAGE	ERROR! BOOKMARK NOT DEFINED.
INDIVIDUAL (NONGROUP) MARKET REFORMS	ERROR! BOOKMARK NOT DEFINED.
INDIVIDUAL MARKET GUARANTEED ISSUE	ERROR! BOOKMARK NOT DEFINED.
LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS	ERROR! BOOKMARK NOT DEFINED.
MERGED SMALL GROUP AND INDIVIDUAL MARKETS.....	ERROR! BOOKMARK NOT DEFINED.
RENEWAL OFFERING REQUIREMENTS	ERROR! BOOKMARK NOT DEFINED.
SMALL GROUP MARKET REFORMS	ERROR! BOOKMARK NOT DEFINED.
SMALL GROUP MARKET RATING RESTRICTIONS	ERROR! BOOKMARK NOT DEFINED.
INCLUSION OF “GROUPS OF ONE” IN SMALL GROUP MARKET.....	ERROR! BOOKMARK NOT DEFINED.
LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS	ERROR! BOOKMARK NOT DEFINED.
SMALL GROUP REFORM PACKAGES	ERROR! BOOKMARK NOT DEFINED.
POOLING	ERROR! BOOKMARK NOT DEFINED.
PURCHASING POOLS AND ALLIANCES FOR SMALL EMPLOYERS	ERROR! BOOKMARK NOT DEFINED.
PRESCRIPTION DRUG POOLS	ERROR! BOOKMARK NOT DEFINED.
HEALTH INSURANCE EXCHANGES	ERROR! BOOKMARK NOT DEFINED.
INDIVIDUAL MANDATE.....	ERROR! BOOKMARK NOT DEFINED.
EMPLOYER MANDATE/PAY-OR-PLAY.....	ERROR! BOOKMARK NOT DEFINED.
REINSURANCE	ERROR! BOOKMARK NOT DEFINED.
HIGH RISK POOLS.....	ERROR! BOOKMARK NOT DEFINED.
COST CONTAINMENT	ERROR! BOOKMARK NOT DEFINED.
SYSTEMIC COST CONTAINMENT	ERROR! BOOKMARK NOT DEFINED.
CHRONIC CARE/DISEASE MANAGEMENT	ERROR! BOOKMARK NOT DEFINED.
QUALITY MEASUREMENT	ERROR! BOOKMARK NOT DEFINED.
HEALTH PROMOTION.....	ERROR! BOOKMARK NOT DEFINED.
PAY FOR PERFORMANCE.....	ERROR! BOOKMARK NOT DEFINED.
ERROR REDUCTION	ERROR! BOOKMARK NOT DEFINED.
MANDATE REVIEW COMMISSIONS.....	ERROR! BOOKMARK NOT DEFINED.
MANDATE-LITE PLANS.....	ERROR! BOOKMARK NOT DEFINED.
MANDATED BENEFITS MORATORIA	ERROR! BOOKMARK NOT DEFINED.
MANDATED BENEFITS STUDIES	ERROR! BOOKMARK NOT DEFINED.
DATA COLLECTION.....	ERROR! BOOKMARK NOT DEFINED.
INSURER TRANSPARENCY	ERROR! BOOKMARK NOT DEFINED.
ACCESS TO CARE	ERROR! BOOKMARK NOT DEFINED.
CLINIC-BASED HEALTH CARE	ERROR! BOOKMARK NOT DEFINED.
COMMUNITY INITIATIVES	ERROR! BOOKMARK NOT DEFINED.
TELEMEDICINE	ERROR! BOOKMARK NOT DEFINED.
ADMINISTRATIVE SIMPLIFICATION	ERROR! BOOKMARK NOT DEFINED.
STANDARD FORMS AND PROCESSES	ERROR! BOOKMARK NOT DEFINED.
UNIFORM CREDENTIALING	ERROR! BOOKMARK NOT DEFINED.
PROVIDER CREDENTIALING	ERROR! BOOKMARK NOT DEFINED.
RATE AND FORM FILING.....	ERROR! BOOKMARK NOT DEFINED.

REGULATORY CHECKLISTS.....	ERROR! BOOKMARK NOT DEFINED.
STANDARDIZED PLANS	ERROR! BOOKMARK NOT DEFINED.
INFORMATION TECHNOLOGY.....	ERROR! BOOKMARK NOT DEFINED.
CONSUMER DRIVEN HEALTH CARE.....	ERROR! BOOKMARK NOT DEFINED.
HEALTH SAVINGS ACCOUNTS	ERROR! BOOKMARK NOT DEFINED.
PROVIDER COST DATA	ERROR! BOOKMARK NOT DEFINED.
SUBSIDIES	ERROR! BOOKMARK NOT DEFINED.
DIRECT SUBSIDIES	ERROR! BOOKMARK NOT DEFINED.
SUBSIDIZED PLANS	ERROR! BOOKMARK NOT DEFINED.
TAX CREDITS.....	ERROR! BOOKMARK NOT DEFINED.
MULTI-SHARE OR PUBLIC-PRIVATE PARTNERSHIP PROGRAMS	ERROR! BOOKMARK NOT DEFINED.
HEALTH REFORM STUDIES	ERROR! BOOKMARK NOT DEFINED.
STATE-BY-STATE INDEX	ERROR! BOOKMARK NOT DEFINED.

Comprehensive Reforms

Maine

Dirigo Health Reform

The first of the current crop of state reforms was Maine’s Dirigo Health Reform program. Enacted in 2003, and taking its name from the state’s motto (Latin for “I lead”), the program aimed to expand coverage to all Maine residents by 2009. It consisted of two coverage expansion initiatives: a new subsidized insurance plan for small businesses, individuals and the self-employed; and an expansion of MaineCare, the state’s Medicaid program, to parents up to 200 percent of the federal poverty level (up from 150 percent). These expansions were paired with the creation of the Maine Quality Forum, designed to increase the quality of medical care in the state, and various voluntary and regulatory cost containment measures.

DirigoChoice, the centerpiece of the program, offers health insurance coverage through a private carrier to small businesses, individuals, and the self-employed. Premiums and cost-sharing for individuals and the self-employed below 300 percent of the federal poverty level are set on a sliding scale. Those above 300 percent of the poverty level may enroll at full cost. Employers who pay 60 percent of the premium are also eligible to participate. Employees below 300 percent of the federal poverty level receive reduced premiums and cost-sharing. However, due to funding constraints, DirigoChoice terminated enrollment of new members requiring subsidies as of September, 2007.

In an effort to further reduce premiums, Dirigo Health Reform also implemented a number of cost-containment measures, such as strengthening the certificate of need process and limiting some capital investments, increased price transparency for health care providers, and voluntary caps on hospital costs and operating margins. In addition, the bill strengthened oversight, review and approval of small and large group insurance rates by the Superintendent of Insurance and implemented standardized annual reporting requirements for all carriers in the state, designed to allow easy comparison of loss ratios and profit across lines of business and across insurers.

Finally, the Dirigo Health Reform created the Maine Quality Forum, which is charged with promoting best practices, analyzing and publishing comparative quality data, promoting electronic technology,

promoting healthy lifestyles and reporting to consumers and the Legislature. Major projects have included: “In-a-Heartbeat,” designed to implement a statewide heart attack treatment protocol and minimize variations in practice, as well as educate Mainers on heart attack symptoms; and a hospital nurse-patient ratio study used to develop policy by the State Legislature. Additionally, the state produces a biennial State Health Plan. The most recent plan, released in 2008, includes a study on cost drivers and potential responses, including:

- Decrease variation in care delivery.
- Decrease utilization of emergency departments.
- Develop patient-centered medical home pilots.
- Promote electronic health information systems.

Subsidies to the DirigoChoice Health Plan were initially financed through “Savings Offset Payments” from insurers. These payments were intended to reflect lower reimbursement rates paid by carriers to providers who face reduced bad debt and charity care as a result of expanded access to health coverage from the MaineCare expansion and DirigoChoice program. However, determining methodologies for estimating and capturing savings has proven difficult and controversial; legal challenges have created funding constraints. In April of 2008, Governor Baldacci signed legislation to change this funding source to an ongoing surcharge on all paid claims, combined with taxes on beer, wine and soda and an allocation from the tobacco settlement fund.

Massachusetts

In 2006, Massachusetts adopted a health reform plan that has received a great deal of attention from the health policy community and the press. The main elements of the reform are the individual mandate, Commonwealth Connector health insurance exchange, a safety net expansion, new responsibilities for Massachusetts employers, insurance market reforms, and the Massachusetts Cost and Quality Council.

Individual Mandate

With the implementation of the health reform law, Massachusetts became the first state in the nation to require that all residents over the age of 18 have health insurance coverage. The mandate is enforced through the tax code, at first through loss of the personal deduction, which is worth approximately \$219 per individual. Beginning in 2008, a fine of up to 50 percent of the premium of the least costly plan available is assessed for each month that the individual is without coverage. That penalty in 2008 is \$672 for individuals 26 years old and younger and \$912 for individuals above the age of 26. The Connector Authority has exempted individuals for whom insurance is deemed not affordable because premiums exceed a given percentage of family income, those who have religious objections to purchasing health insurance, and those who have obtained a waiver in advance stating that no affordable product was affordable.

Until 2009, any policy sold in the state will meet the individual mandate requirement. After that date, coverage that fulfills the requirements of the individual mandate must meet minimum standards, including caps on deductibles, out of pocket limits, and requirements that policies provide first-dollar coverage of preventative care and have no daily cap on hospital benefits.

Employer Responsibilities

The Massachusetts Health Reform law included a provision requiring all employers with 11 or more employees who fail to make a fair and reasonable contribution to their employees' health coverage costs to pay a "Fair Share Contribution" of \$295 per full time employee per year. This payment is designed to reimburse the state for the costs of free care used by individuals whose employers do not provide coverage. Employers can avoid paying the contribution by offering a health plan with at least 25 percent employee take-up or by contributing at least 1/3 of the total premium. The legislation also implemented a new requirement that all employers offer Section 125 cafeteria plans, allowing employees to pay for health insurance and other items on a pre-tax basis.

Safety Net Expansions

The health reform legislation expanded MassHealth, the state Medicaid program to cover children up to 300 percent of the federal poverty level (up from 200 percent) and raised enrollment caps on existing Medicaid programs for adults. It also implemented comprehensive community-based outreach programs to reach people who are eligible for Medicaid, but have not enrolled. Finally, it increased Medicaid provider reimbursement rates to achieve greater participation, while tying future increases to specific quality, efficiency, and disparity reduction performance goals.

Commonwealth Connector

To help residents obtain insurance coverage, the health reform bill created the Commonwealth Connector, a new independent state agency to connect the uninsured with coverage. The Connector acts as a marketplace through which individuals and small businesses can purchase health insurance policies that have been vetted by the Commonwealth Connector Authority and are affordable and high quality. It aggregates contributions from employers (including contributions from multiple employers) and individuals and forwards them to insurers offering coverage through the Connector. The Connector also administers the Commonwealth Care subsidized insurance program, and is the only place where young adults can purchase specially designed low-cost policies.

Commonwealth Care Subsidized Insurance Program

Individuals who do not qualify for Medicaid, but have incomes below 300 percent of the federal poverty level, are eligible to receive coverage through the Commonwealth Care program. Plans are offered through the Connector by managed care organizations that participate in the Medicaid program and are certified by the Connector Authority as being affordable and high quality. Plans may not have deductibles. Premiums are set on a sliding scale based upon income; those below 100 percent of the federal poverty level pay no premiums. Enrollees may apply employer contributions towards the purchase of the Commonwealth Care plan if the employer participates in the Connector.

Market Reforms

The health reform legislation made a number of health insurance market reforms, including merging the individual and small group markets and the creation of new affordable health insurance plans specially designed for young adults. In July 2007, the small group and individual markets were merged, a change that will pool the risk of individuals with that of small groups. In order to compensate for somewhat higher utilization among individuals, carriers will be allowed to charge up to 10 percent more for individuals. Actuarial analysis of the merger estimates that it will result in a 24 percent reduction in premiums for individuals.

The reform bill also allows young adults to remain on their parents' insurance for two years past the loss of their dependent status, or until they turn 25, whichever occurs first. In addition, new plans will be offered through the Connector for individuals aged 19-26, which do not include all mandated benefits.

Health Care Quality and Cost Council

To further reduce costs and improve the quality of health care in the state, the reform legislation created the Massachusetts Health Care Quality and Cost Council. The council was given the responsibility to:

- Establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care;
- Demonstrate progress toward achieving those goals; and
- Disseminate comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.

Vermont

Catamount Health

Introduction

On May 25, 2007, Vermont Governor Jim Douglas signed into law Catamount Health, Vermont's Health Care Reform Plan.¹ Catamount Health is the product of collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants in Vermont's health care system. For Governor Douglas, the key goals of the plan are:

- universal access to affordable health insurance for all Vermonters;
- cost containment and improved quality through health care system reform; and
- promotion of healthy behavior and disease prevention across the lifespan of individuals.

Background - Health Care in Vermont.

Good data on the demographics of the uninsured in Vermont helped to focus policy development. 51% of the uninsured in Vermont are eligible for a Medicaid program but are not enrolled in the program. 22% of the uninsured in Vermont have household income greater than 300% of FPL and can afford to purchase health insurance. 27% of the uninsured in Vermont have household income under 300% FPL but are not eligible for a Medicaid program. As part of on-going reform efforts, Vermont continues to update information on the uninsured to get a better sense of this population's needs.

Vermont has had significant experience using its Medicaid waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300% FPL, to pregnant women with household income under 200% FPL, and to parents and caretakers with household income under 185% FPL. The Vermont Health Access Plan provides coverage for uninsured adults with household income under 150% FPL. As a result, Vermont has an

¹ Catamount Health is contained in three (3) separate legislative enactments: H8.61, H.895, and Sections 321-343b of H.881; <http://www.leg.state.vt.us>

uninsured rate of 9.8% compared with a national rate of 15.7%, and an uninsured rate for children of 4.9%.²

Per capita health care costs are lower in Vermont when compared to the U.S., but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last eight years.

Vermont's Health Care Reform Initiatives

Catamount Health

Catamount Health is a separate insurance pool created for the purpose of offering a low cost health insurance product for uninsured Vermonters. Lower costs are anticipated based on estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on reimbursement rates established in the law that are lower than commercial rates (but 10% higher than Medicare rates). A comprehensive benefit plan is provided by two private health insurance carriers and largely defined by statute. Catamount Health is modeled after a preferred provider organization plan with a \$250 deductible. Cost sharing does not apply to chronic care if an insured is enrolled in a chronic care management program. Further, cost sharing does not apply to preventive services. Catamount Health policies enrollment began on October 1, 2007, with coverage effective November 1, 2007.

Catamount Health Premium Assistance Program

A Vermont resident who has been uninsured for at least 12 months, who is not eligible for a public insurance program such as Medicaid, and who does not have access to employer-sponsored insurance may apply for financial assistance to purchase a Catamount Health policy. Individual premium contributions are income-sensitive; in FY 2009 these premiums will range from \$60 per month for individuals with household income under 175% FPL, to \$185 per month at 276-300% FPL, to the full cost of Catamount Health for individuals with household income over 300% FPL.

Employer Sponsored Insurance Premium Assistance Program

Adults currently enrolled in the Medicaid VHAP program who have access to an approved employer-sponsored insurance (ESI) plan are required to participate in the ESI plan, with public subsidies from the Premium Assistance Program. The transfer of Medicaid enrollees to ESI plans is hoped to result in financial savings for the Medicaid program. In addition, any Vermont resident who has been uninsured for at least 12 months, who has household income under 300% FPL, and who has access to an approved employer-sponsored insurance plan, is eligible for premium assistance to help them participate in the ESI plan.

Medicaid Access Initiative

Since the largest group of the uninsured are eligible for Medicaid but not enrolled, the Catamount Health legislation addresses ways to increase enrollment and retain beneficiaries. Catamount Health outreach has involved promotion of all available state programs, collectively referred to as Green Mountain Care. When a Vermonter calls the 1-800 number, they will be assisted so that they enroll in the appropriate program.

Medicaid Provider Reimbursement Increases

² Vermont Family Health Insurance Survey, 2005. Family Health Insurance Survey, 2005, preliminary reports can be found at: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf

Significant Medicaid provider underpayments can threaten access to care, and underpayments result in a cost shift to commercial plans that must be paid by commercial health insurance premiums. The Catamount Health legislation will increase Medicaid provider reimbursements in the following manner:

- Evaluation and management services are paid at 2006 Medicare rates in order to support primary care physician practices;
- Incentive payments are provided to health care professionals participating in the Medicaid care coordination program; and
- Reimbursement increases in the future will be tied to performance measures established by the Blueprint for Health - the Chronic Care Initiative.

The Blueprint for Health - The Chronic Care Initiative

Due to a combination of an aging population, increased prevalence of obesity, and poor lifestyle habits, the needs of Vermonters with chronic conditions (such as diabetes, cardiovascular disease, and depression) will be the primary driver of the demand for health care for the foreseeable future. Since the cost of treating individuals with chronic conditions (25% of Vermonters) accounts for about 75% of health care spending, Vermont has decided to invest significant public funds in the redesign of the health care system to improve the quality and cost-effectiveness of care for those with chronic conditions. The Blueprint, under the direction of the Vermont Department of Health, will focus on:

- Patient self-management;
- Provider practice change consistent with evidence-based standards for chronic care;
- Community activation and support to address physical inactivity and obesity, which are risk factors for many chronic diseases;
- A chronic care information system; and
- Health system design - the development of common performance measures and clinical guidelines for chronic conditions, and the linking of financing mechanisms and insurance reimbursement with the attainment of chronic care treatment goals.

In addition, the Office of Vermont Health Access has implemented a chronic care management program, consistent with the policies and standards established by the Blueprint for Health, for Vermonters who are insured under a Medicaid-funded program.

Health Information Technology

The Department of Banking, Insurance, Securities and Health Care Administration, in collaboration with the Vermont Information Technology Leaders (VITL - a public-private partnership) is developing a statewide, integrated, electronic health information infrastructure for the sharing of health information among health care facilities, health care professional, public and private payers, and patients.³ The Medication History Pilot Project will reduce the risk of adverse drug events, improve the quality of health care for many Vermonters, and save health care costs. The project will be used as the first step towards a comprehensive, state-wide health record system. In early 2008, the Legislature adopted the Vermont Health Information Technology Plan, a statewide plan to implement an integrated electronic health information infrastructure. This plan will be updated annually as technology and initiatives evolve and mature.

³ VITL - 18 V.S.A. section 9417; <http://vitl.net/ndex.htm>

Consumer Price and Quality Information System

A major factor in the success of consumer driven health care plans is consumer access to good price and quality information. Good information is especially important, as more benefit plans require higher levels of out of pocket spending by consumers. The Department of Banking, Insurance, Securities and Health Care Administration is in the process of developing and adopting rules to provide the public with transparent price and quality information for hospitals and physicians so that consumers are empowered to make economically sound and medically appropriate decisions.

The Multi-Payer Data Collection project

Health care providers, hospitals and insurers need a comprehensive health information system in order to improve the quality and cost-effectiveness of the health care system. Modeled after programs in Maine and New Hampshire, the Department of Banking, Insurance, Securities and Health Care Administration has designed the data collection program to collect claims payment data from all payers, including third party administrators and pharmacy benefit managers. The Department will start collecting test data in July 2008 and all payers will start filing data in October 2008.

Common Claims and Procedures

In 2007, the Legislature authorized the creation of the Common Claims Work Group involving numerous stakeholders including commercial insurers, hospitals, physicians, Vermont Medicaid, businesses, consumer advocates, the Vermont Department of Banking, Insurance, Securities and Health Care Administration. The work group issued a report on January 15, 2008 recommending numerous ways the claims administration system could be simplified. Some of these suggestions were formally enacted into statute in 2008. The Department of Banking, Insurance, Securities and Health Care Administration is in the process of adopting regulations designed to implement many of the work group's recommendations and simplify the claims administration process, and to lower administrative costs in the health care financing system. The Department is also in the process of contracting with an outside vendor to create the Vermont Claims Administrative Collaborative to seek collaborative electronic solutions to claims payment systems.

Adverse Event Reporting

The Vermont Department of Health has established a Patient Safety Surveillance and Improvement System, designed to improve patient safety, eliminate adverse events, and support quality improvement efforts by Vermont hospitals. Improved quality of care and cost savings are anticipated from implementation of the system. Additionally, hospitals must report incidences of any of the National Quality Forum's 28 serious reportable events and for each such event, the hospital must conduct a causal analysis, develop and implement a corrective action plan and file the causal analysis and corrective action plan with the Patient Safety Surveillance and Improvement System.

Community Health and Wellness Programs

Vermont has recognized that public health concerns such as those relating to overweight and poor nutrition are major drivers in the incidence of chronic disease incidence, and in increased medical inflation. The Community Health and Wellness grant program focuses the state's public health resources in promoting healthy behavior and disease prevention across the lifespan of the individual, including the promotion of good nutrition and exercise for children, community recreation programs, elderly wellness, lead poisoning abatement, obesity prevention, maternal and child health and immunization, and tobacco prevention and cessation programs. In 2008, the Legislature enacted additional legislation further refining and enhancing community health and wellness programs in Vermont.

Encouraging Wellness through Insurance Coverage Programs

The Catamount Health legislation authorizes the Department of Banking, Insurance, Securities and Health Care Administration to adopt regulations permitting health insurers to establish premium discounts or other economic rewards for insureds in Vermont's community rated nongroup market. Premium discounts will be available for those who participate in programs of health promotion and disease prevention, subject to approval of the Department. Additionally, in the group market, the Legislature has directed the Department to develop rules around offering a "slit-benefit" plan, wherein insureds would pay the same premium, but the participants cost sharing burden would be reduced if the insured agreed to take specified steps to enhance wellness. Rules implementing these programs are to be adopted no later than January 1, 2009.

California (Not Adopted)

In January 2007, Governor Arnold Schwarzenegger proposed a health care reform plan that aimed to cover all 4.8 million uninsured California residents by expanding safety net programs, creating a new subsidized health insurance purchasing pool, and by requiring all Californians to obtain health insurance subsidy. It would also have required all employers with at least 10 employees to make a contribution towards their employees' health insurance costs. The governor's proposal also targeted health promotion, affordability and cost containment.

During the 2007 regular session, the legislature adopted its own legislation, which was vetoed by the governor, prompting a special session in the fall to develop compromise legislation that the legislature could pass and the governor would sign. The resulting bill, ABX1 1 was adopted by the Assembly, but ultimately failed to make it out of committee in the Senate due to fiscal concerns.

Individual Mandate

ABX1.1 would have required most state residents to obtain coverage that met minimum standards set by the Managed Risk Medical Insurance Board. Exemptions would have been made for those with family incomes below 250 percent of the federal poverty level and for those who would have to pay more than 5 percent of their family income for coverage.

Safety Net Expansion

For those with low incomes, the bill would have expanded the California Medicaid and SCHIP programs. All children, up to 300 percent of the federal poverty level, would be eligible for either Medicaid or SCHIP. Parents up to 250 percent of the federal poverty level would also now qualify for coverage under one of the two programs. A new purchasing pool, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), would make both subsidized and unsubsidized coverage available for those with low incomes who do not qualify for Medicaid and those whose employers do not offer coverage.

Pay-or-Play Requirement

The legislation would have required all employers make minimum contributions to the cost of their employee's health coverage. Those that failed to make the required levels of contribution would be required to pay the balance into a fund to subsidize Cal-CHIPP coverage. The required contribution would have varied based upon the employer's payroll:

- 1% for firms with wages up to \$250,000
- 4% for firms with wages up to \$1 million
- 6% for firms with wages up to \$15 million
- 6.5% for firms with wages over \$15 million.

Insurance Market Reforms

To complement the individual mandate, ABX1 1 would have made a number of reforms to the small group and individual markets. It would have instituted modified community rating in both markets, allowing adjustments only for age and geography and would have required carriers to have a minimum loss ratio of 85 percent. In the individual market, the use of health status as a rating factor would have been phased out over a four-year period., and all individual market plans would have been guaranteed-issue by 2010.

An additional reform to the individual market would have required the California Department of Insurance and the Department of Managed Health Care to categorize all individual market plans into five coverage categories. The lowest level of coverage would consist of the minimum coverage required to satisfy the individual mandate, with higher levels consisting of greater coverage. All individual market carriers would have been required to offer at least one standard product in each tier. Enrollees would only be permitted to increase their coverage by one level each year unless there was a qualifying event, such as marriage, death of a family member, or the birth of a child.

Cost Containment and Quality Improvement

ABX1 1 would have established a Health Care Cost and Quality Transparency Commission to develop a statewide plan for reporting safety, quality, and cost efficiency data. The state would also establish efficiency and cost standards for health plans and best practices for the treatment of chronic conditions. It would also have implemented a new diabetes management program for Medicaid enrollees to reduce unnecessary hospitalizations and procedures that result from poor management of the disease.

Pennsylvania (Proposed)

Rx for PA

Providing Access to Affordable Health Care Coverage to Every Pennsylvanian.

Cover All Pennsylvanians (CAP) will make affordable basic health insurance available to eligible small businesses that do not presently offer health insurance to their employees and to the uninsured. This coverage will be offered through the private insurance market. In addition, more effective regulation of the insurance industry will ensure that small businesses and other consumers are not faced with skyrocketing costs for their health care coverage.

Expanding Access to Health Care in Appropriate Settings for the Best Cost.

Prescription for Pennsylvania will make more health care providers available to Pennsylvanians by enabling nurses, dental hygienists and other licensed health care providers to practice to the fullest extent of their education and training. With Pennsylvanians 11% more likely than the average American to go to the emergency room - often because they do not know where else to go for their primary health care needs - the plan will promote non-emergency settings for non-emergency care. The Prescription will increase the number of care centers in shortage areas and promote incentives for health care providers who offer services in the evenings and on weekends.

**Improving Quality by Delivering the Right Care, Right, the First Time and Promoting Wellness --
Strategies that Save Money While They Improve Lives.**

Prescription for Pennsylvania will focus on patient safety by eliminating hospital-acquired infections - saving thousands of lives and billions of dollars each year - and targeting avoidable medical errors and will promote a payment system that rewards wellness and does not pay for unnecessary or ineffective medical services. The plan will also improve the care received by the many Pennsylvanians suffering from chronic conditions such as heart disease, diabetes and asthma. And to help all Pennsylvanians stay healthy, the plan will support consumer incentives that reward healthy lifestyles.

