

## **ITUP RECOMMENDATIONS**

- Universal coverage, basic benefits, controlled costs
- Model -- shared responsibility, all pay, all covered, all enroll
  1. Expand eligibility for Medi-Cal for uninsured with incomes under 100% of FPL
    - Secure federal 1115 waiver
    - Use county funds as the match
  2. Expand eligibility for Healthy Families for uninsured adults with incomes between 100% and 200% of FPL
    - Use federal §1931b for parents
    - Secure federal 1115 waiver
    - Use county funds as match
  3. Public/private model for uninsured with incomes up to 300% of FPL
    - Three way responsibility: employers 1/3<sup>rd</sup>, employees 1/3<sup>rd</sup> and public funding 1/3<sup>rd</sup>
    - Use employment based or individual coverage or public coverage at individual's option
    - Individual pays incremental difference for more costly options
  4. Private model for uninsured with incomes over 300% of poverty
    - 50/50 split between employers and employees, individual pays the incremental difference for more costly options
- Financing – all pay, maximize federal contributions
  - Individuals pay sliding fee scale premiums based on percent of income up to full share of premium at 300% of FPL
  - Employers pay a percent of wages up to full share of premium
  - Employees pay a percent of wages up to full share of premium
  - Existing federal, state and local financing for care to the uninsured is phased in, as uninsured enroll in coverage
  - Federal match for uninsured children and parents up to 300% of FPL
  - Federal match for uninsured adults, seek and secure §1115 waiver
  - Federal tax subsidies for employment based coverage
  - Employer and employee contributions structured so they can qualify as state match
  - Seek additional federal funding for California's programs
  - Provider tax/fee of 1%, if needed
  - Options/incentives to evolve from employment based financing towards consumption based financing (?)
- Cost containment – relief for employers and employees

- Managed competition: individuals pay for incremental costs of more expensive plans and benefits
  - Reporting and transparency of plan premiums, provider prices, quality indicators and cost benefit ratios
  - Electronic medical records
  - 24 hour coverage
  - Primary care gatekeepers for referrals to specialty services
  - Tiered reimbursement based on clinical and cost effectiveness of benefits
  - Chronic disease case management
  - Income adjusted cost sharing
  - Consolidation of complex, specialty care in centers of excellence
  - Bulk purchasing of medical supplies and prescription drugs
  - Improved funding for neighborhood-based wellness care and centers
  - Improved funding for after hours urgent care centers to relieve burdens on costly hospital emergency rooms
- Covered benefits -- basic for all; option to buy up for all
    - Hospital, medical, diagnostic, preventive and prescriptions
    - Sliding scale premiums, co-pays and deductibles
    - Individuals can choose to pay for incremental costs of extra benefits and more costly plans
    - Just Coverage (?)
- Reimbursement reforms – changing incentives
    - Pay for performance (?)
    - Reward efficiency, effectiveness and quality, penalize poor quality and ineffective services
    - Eliminate “charges”
    - Medical education component in all payors’ rates
    - Negotiated trade-off among state, health plans and providers -- increase in public reimbursement and decrease in private insurance rates and premiums
    - All payor hospital rate setting in rural and other markets with insufficient market infrastructure for competition
- Regulatory reforms – access to basic coverage and essential services
    - Guaranteed issue and renewal and age adjusted rating in the individual market
    - Guaranteed issue and renewal in the mid-size market
    - Guaranteed access to hospital emergency and trauma services through hospital licensure requirements
- Safety net providers – evolution
    - Guaranteed access to all plans covering uninsured and low income publicly insured patients, no additional reimbursement rate guarantees, phased down guarantee of market share minimum (?)
    - Flexibility in hospital reimbursement to allow transformation of delivery models
    - Authority to develop regionally organized delivery of care and services
    - Flexibility in county governance

- Counties – match
  - County match equals existing spending on uninsured plus growth factor in realignment
  - County funds follow county patients enrolled in coverage
  - County option for minimum enrollment guarantees
  - Repeal of counties' §17000 obligation to provide/pay for medical care
  
- Administration – simplify
  - Consolidate and radically simplify public programs
  - Eliminate over-lapping responsibilities
  - Move all eligibility towards on-line and replace local redundancy
  - Purchasing pools and standardized on-line applications for private coverage
  - Transparent, easily accessible on line information on plan and provider prices and quality