Date of Hearing: November 14, 2007

ASSEMBLY COMMITTEE ON HEALTH X1
Mervyn M. Dymally, Chair
AB 1 X1 (Nunez and Perata) - As Amended: November 8, 2007

SUBJECT : Health care reform.

SUMMARY : Enacts the California Health Care Reform and Cost Control Act (Act) which creates the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a state health care purchasing program to provide coverage to specified employees, individuals eligible for new expanded public coverage and individuals who are newly eligible for a tax credit to defray health insurance costs. Establishes various health cost containment measures and private insurance market reforms. The author has indicated that several of the major financing elements of this bill will be subject to voter approval on the November 2008 statewide ballot. Specifically, this bill :

Coverage Expansions

1) Effective July 1, 2010, expands eligibility for public coverage programs for low-income persons as follows:

a) Covers all children at or below 300% of the Federal Poverty Level (FPL), regardless of their immigration status. Expands eligibility in the Healthy Families Program (HFP) from 251% to 300% FPL; sets HFP premiums for children with family incomes of 251% to 300% FPL at $22-25 per month per child, with a maximum of $66-75 per month per family; and, eliminates federal citizenship and immigration eligibility requirements for children 18 and under in Medi-Cal or HFP;

b) Extends Medi-Cal coverage to 19- and 20-year olds up to 250% FPL, as specified. Extends coverage for low-income parents and caretakers of children on Medi-Cal or HFP up to 300% FPL, and childless adults between 100-250% FPL. Subsidized coverage for parents and caretaker adults otherwise not eligible for Medi-Cal and childless adults 100-250% FPL would be provided in a benchmark plan pursuant to new federal Medicaid rules under the Deficit Reduction Act (DRA) of 2006, which allows states to vary the benefit designs they offer to some groups using federal Medicaid

funds. This benchmark plan would be provided under Cal-CHIPP and be known as the Cal-CHIPP Healthy Families plan;

c) Defines "Cal-CHIPP Healthy Families plan" to mean health care coverage provided through a health care service plan or a health insurer that provides for specified individuals' coverage that meets the requirements of federal law and that, at a minimum, provides the same covered services and benefits required under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) plus prescription drug benefits;

d) Establishes cost-sharing limits for adults 19 and older eligible for subsidized coverage based on income, as described in #b) above, as a percent of FPL, as follows: For persons up to150% FPL - no premium contribution or out of pocket costs; for persons above 150-300% FPL - no more than 5% of income, net of applicable deductions;

e) Requires the Department of Health Care Service (DHCS) to establish a new coverage program for childless adults who are citizens, nationals, or qualified immigrants with incomes up to 100% FPL, contingent on unspecified county contributions to the state required under the Act. Requires the coverage to be equivalent to subsidized coverage offered in Cal-CHIPP, but also specifically excludes long-term care services, nursing home care, personal care services, in-home supportive services and home- and community-based services. In determining income eligibility for the new program, requires the methodology for the federal poverty programs for pregnant women and children be used, but excludes from the determination of eligibility for this new program income disregards available under those programs. Requires individuals eligible under this provision, who live in a county where a Local Coverage Option (LCO) program is available, to be covered exclusively by that LCO for the first five years that the LCO is available;

f) Effective July 1, 2010, eliminates the Medi-Cal assets test, which currently applies to certain Medi-Cal eligibility categories, to the extent that federal financial participation (FFP) is available;

g) Sunsets July 1, 2010 the requirement that certain adult Medi-Cal beneficiaries file semiannual status reports and instead requires them to file semiannual address verification, provided FFP is not jeopardized. Requires DHCS to seek federal approval to make cost sharing determinations for public program beneficiaries enrolled in Cal-CHIPP on an annual basis; and,

h) Requires the DHCS to seek appropriate federal approval for expansion provisions. The coverage expansions for all populations except for low-income childless adults will require a Medicaid state plan amendment. The cost-sharing requirements are subject to a federal Medicaid waiver.

2)Continues confidentiality protections for all types of written and oral information concerning an applicant, subscriber, or household member made or kept by a public agency in connection with the administration of HFP, except for purposes directly connected with HFP or Medi-Cal, or when the individual gives written consent for that disclosure. Specifies those purposes that are directly connected to the administration of HFP and Medi-Cal.

3)Requires the Managed Risk Medical Insurance Board (MRMIB) to develop documentation requirements for HFP applicants newly eligible because of the elimination of immigration status as eligibility criteria, to the extent required to obtain FFP.

4)Requires MRMIB to coordinate with DHCS to seek FFP for subsidized health care coverage, including any federal Medicaid waivers that will be required, and to enter into appropriate inter-agency agreements to facilitate MRMIB's administration of Medi-Cal subsidized plans through Cal-CHIPP. Makes subsidized coverage subject to the terms and conditions of any waiver or state plan amendment to the extent that FFP is obtained. Requires MRMIB to apply citizenship, immigration and identity documentation requirements to the extent required to obtain FFP for those persons eligible for federal funding. Requires DHCS to maximize federal funds for the cost of subsidized coverage established under the Act.

5)Establishes the California Health Benefits Service (CHBS) within the California Health and Human Services Agency (CHHSA) to solicit and assist local initiatives and county organized health systems which currently provide health care under

Medi-Cal and HFP, to form joint ventures to create integrated networks of public health plans that would pool risk and share networks. Establishes a 9-member board to govern CHBS, as specified, and requires CHBS to appoint an executive director. Requires CHBS to report to the committees of jurisdiction in the Senate and Assembly by March 1, 2009, and annually thereafter, on implementation of CHBS and to make recommendations on resources and regulatory and legislative changes necessary to implement the joint ventures and to build and implement a system of health coverage throughout California.

6)Requires licensure under Knox-Keene for all joint ventures established pursuant to #5) above, prior to commencement of

enrollment. Requires the Director of the Department of Managed Health Care (DMHC) to provide regulatory and program flexibility as may be necessary to facilitate new, modified, or combined licenses of local initiatives, county organized health systems or the CHBS seeking licensure for regional or statewide networks to participate in Cal-CHIPP or to provide coverage in the individual or group markets. Requires the Director of DMHC to ensure that any public health plans established meet essential financial, capacity, and consumer protection requirements of Knox-Keene.

Purchasing Program and Individual Mandate

1)Requires every individual in this state to maintain a minimum policy of health care coverage, as determined by MRMIB, for himself or herself and his or her dependents. Exempts an individual from this requirement if the total cost for a minimum policy, including all out-of-pocket costs, exceeds 6.5% of the individual's family income or the individual has a significant financial hardship, as determined by MRMIB. States that MRMIB must consider affordability, protection from catastrophic costs, and prevention in establishing the minimum policy.

2)Establishes Cal-CHIPP as a state purchasing program, or health insurance purchasing pool, administered by MRMIB, to negotiate and contract with carriers to offer health coverage to eligible persons. Establishes the duties, authority and responsibility for MRMIB in the operation of Cal-CHIPP. Makes Cal-CHIPP operational on January 1, 2009 and requires Cal-CHIPP to provide health care coverage beginning July 1,

2010.

3)Specifies that all benefit plan designs in Cal-CHIPP must meet benefit levels mandated under Knox-Keene plus prescription drugs. Requires "a variety of" designs, which must include low-cost plans for Cal-CHIPP adult enrollees with family incomes below 300% FPL (at or below $51,500 for a family of three in 2007) who are ineligible for HFP or Medi-Cal.

4)Limits the amount of the Cal-CHIPP premium paid by an employee with a household income at or below 300% FPL, to no more than 0-5% of household income, depending on the income, after taking into account the tax savings the employee realizes by using a federal cafeteria plan offered by employers.

5)Establishes eligibility standards for enrollment in Cal-CHIPP and the rights and remedies of enrolled persons, including establishing that an individual, to be eligible for enrollment in Cal-CHIPP, must be a state resident, as specified, and one of the following: a) an employee, or dependent of an employee, of an employer who elects to pay into the California Health

Trust Fund (Fund); b) eligible for a Cal-CHIPP Healthy Families plan; or c) eligible for a state health care tax credit.

6) Requires each carrier with one million or more enrollees in California to submit a good faith bid to MRMIB in order to be a participating plan through Cal-CHIPP.

7) Permits MRMIB to take a variety of specified actions to provide prescription drug coverage to Cal-CHIPP enrollees, including contracting with a pharmacy benefit manager or using direct procurement (bulk purchasing).

8) Requires MRMIB to impose specified practices related to costs and efficiency on carriers contracting to provide coverage in Cal-CHIPP, including, among other things, reduction of medical errors, preventive care, and management of chronic diseases, incentives for healthy lifestyles, standardized billing, and rational use of technology. Require MRMIB to collect and disseminate, as appropriate, information on the quality and cost-effectiveness of Cal-CHIPP participating carriers.

9) Establishes standards to protect the confidentiality of Cal-CHIPP applicants, enrollees and household members.

10) Specifies the definitions and administrative duties and responsibilities applicable to Cal-CHIPP and the administration of Cal-CHIPP by MRMIB, including the requirement that MRMIB only adjust premiums at a public meeting of the board.

11) Makes it an unfair labor practice for an employer to refer an employee or dependent of an employee to Cal-CHIPP for the purpose of separating that employee or dependent from group health coverage provided by the employer or to change the employer-employee share-of-cost ratio or make modifications of coverage so that employees or their dependents enroll in Cal-CHIPP.

12) Requires MRMIB to work with state and local agencies, health care providers, health plans, employers, consumer groups, community organizations, and other appropriate stakeholders to establish point-of-service methods to facilitate enrollment of individuals who do not have or maintain a minimum policy of health care coverage. Also, requires MRMIB to establish and maintain an active statewide education and awareness program to inform all California residents of their health insurance obligation and their options for meeting the mandate.

13) Authorizes but does not require school districts to provide an information sheet to specified students regarding health insurance requirements and information about available

government programs. Requires MRMIB and the California Department of Education to develop a standardized information sheet for this purpose, as specified.

14)States legislative intent that MRMIB pay the cost of health care coverage on behalf of an individual who has been without health care coverage for a period greater than 63 days after the date of leaving employment where the individual had health care coverage, by enrolling him or her in minimum health coverage though Cal-CHIPP and then recouping from the individual the cost of that coverage.

Health Insurance Reforms

1)Requires DMHC and California Department of Insurance (CDI) to adopt regulations by July 1, 2009, defining and limiting administrative costs so that at least 85% of revenues received

by carriers must be spent on health care services rather than administration or profit, establishing a minimum "medical loss ratio." Requires, in addition, carriers to disclose to prospective purchasers the medical loss ratio for the carrier's preceding fiscal year, as specified.

2)On and after January 1, 2008, extends to employers with 51-100 employees (mid-size employers) the existing rating and underwriting requirements applicable to employers of two-50 employees (small employers) including, among other things, the requirement that carriers offer and sell all health coverage products available for mid-size employer groups to all applicant groups, without any exclusion due to medical underwriting, or any other criteria other than the employer's willingness to make the premium payments and meet reasonable participation requirements. Subjects the coverage to specific rating restrictions. Authorizes carriers to offer different benefit designs for small and mid-size employers.

3)Requires the director of DMHC and the commissioner of CDI to jointly develop regulations establishing five classes of individual health benefit plans which carriers selling individual coverage must make available. Establishes the qualifying events that must be met in order for an individual, having purchased coverage in one of the five classes, to be able to move up to a higher class of benefits, as specified. Requires DMHC and CDI to approve one baseline health maintenance organization (HMO) and one baseline Preferred Provider Organization (PPO) product in each of the five classes, that is the lowest cost product a health plan or health insurer would offer in that class.

4)Effective January 1, 2010, requires carriers to guarantee issue the five classes of approved benefit plans established pursuant to #3) above and discontinue selling other plans in

the individual market. Limits the rating categories carriers can use for individual health coverage to age, family size, geographic region, and health improvement discounts, as specified. Makes guarantee issue contingent on implementation of the individual mandate requirement.

5)Requires the Office of Patient Advocate (OPA) to develop and maintain on its Internet Web site a uniform benefits matrix of all available individual health plan contract and insurance policies and specifies the information to be included.

6)Effective July 1, 2009, requires all carriers to offer, for both individual and group coverage, at least one "Healthy Action Incentives and Reward Program" (Healthy Action plan) as a benefit design, and also as a supplement for every contract or policy. Requires Healthy Action plans to provide for health risk appraisals and a follow-up with a licensed health professional. Requires Healthy Action plans to include any of a series of specified incentives or rewards for enrollees and insured persons to "become more engaged in their health care and to make appropriate choices that support good health." Programs for which incentives may be provided include smoking cessation, physical activity or nutrition. Incentives may include premium reductions, differential copayments or cash payments. Rewards may include nonprescription pharmacy products, exercise classes, gym memberships and weight management programs.

7)Requires any carrier that offers Healthy Action plan incentives in the form of premium reductions to make the premium reduction standard and uniform for all groups and subscribers and to offer the incentives only after the enrollee or subscriber successfully completes the specified program or practice.

8)Permits employers to provide Healthy Action plans which can include monetary incentives and reduced premiums for nonsmokers and smoking cessation.

9)Requires DHCS to include a Healthy Action plan as a covered Medi-Cal benefit.

10)Exempts Healthy Action plans from laws prohibiting unlawful kickbacks, bribes, or inducements for enrollment or participation, to the extent permitted by federal law and not otherwise held to be invalid in court.

Technology and Cost Containment

1)Requires every prescriber and pharmacy in California to have the ability to transmit and receive prescriptions by electronic data transmission (e-prescribing) no later than

January 1, 2010, and requires specified state licensing boards and committees that oversee the health professions to enforce compliance with this provision.

2)Requires every e-prescribing system to comply with national standards for data exchange, state and federal confidentiality and data security requirements, and state record retention and reporting requirements, and to allow real-time verification of eligibility and covered benefits.

3)Requires prescribers using e-prescribing to offer a written receipt of the information that is transmitted to the pharmacy and specifies the content of the receipt.

4)Requires health plans and insurers to make the most current prescription drug formularies available electronically to prescribers and pharmacies.

5)Requires DHCS to identify best practices related to e-prescribing standards and make recommendations for statewide adoption of e-prescribing by January 1, 2009.

6)Requires DHCS to develop a Medi-Cal e-prescribing pilot program, contingent on FFP. Permits DHCS to provide e-prescribing technology, including equipment and software, to participating Medi-Cal prescribers.

7)Requires the California Public Employment Retirement System (CalPERS) Board, by January 1, 2009, to provide or arrange for electronic personal health records (PHR) for CalPERS members. Requires a PHR to provide access to real-time, patient-specific information about covered benefits and cost sharing, and permits PERS, to make the PHRs Internet-based. Permits, but does not require a PHR to incorporate other data, such as laboratory results, prescription histories, claims histories, and personal health information authorized or provided by the enrollee, at the enrollee's option. Requires the PHR to adhere to national standards for interoperability, privacy, and data exchange, or be certified by a nationally recognized certification body, and to comply with applicable state and federal confidentiality and data security requirements.

8)Authorizes carriers to provide electronic notice to enrollees and insureds in order to comply with specific statutory or regulatory notice requirements that are otherwise required to be provided by mail, if the notice complies with specified requirements, including that the plan or insurer obtains

written authorization from the enrollee or insured.

9)Extends to Nurse Practitioners (NPs), Physician Assistants (PAs), and nurse midwives the same authority granted to physicians to supervise medical assistants (MAs), and allows MAs to perform tasks or supportive services, pursuant to written instructions by a physician, NP, nurse-midwife, PA or licensed podiatrist, even when the supervisor is not onsite, under specified conditions.

10)Expands from four to six the number of NPs, and from two to six the number of PAs, that a physician may supervise at any one time.

11)Establishes an eight-member task force (three members of the Medical Board of California, three members of the Board of Registered Nursing, and two non-voting ex officio academic members) to develop a recommended scope of practice for NPs by June 30, 2009, and requires the Director of the Department of Consumers Affairs to promulgate regulations that adopt the task force recommendations by July 1, 2010.

12)Requires the Office of Statewide Health Planning and Development (OSHPD) to establish a clinical data collection program and to publish risk-adjusted outcome reports for percutaneous coronary interventions, such as angioplasty and the use of stents. Requires OSHPD to report by hospital and at least every other year, by hospital and physician, and to consult with the existing clinical advisory panel.

13)Establishes a new California Health Care Cost and Quality Transparency Commission (Commission) for the purpose of statewide data collection, common measurement and analysis of health care costs, quality and outcomes. Requires the Commission to identify by July 1, 2009 the existing data analysis, reporting and collection activities currently administered by OSHPD which are necessary to the Commission's activities and which shall be transferred to the Commission. States that the Commission will consist of 13 specified members, seven of whom would be appointed by the Governor and six by the Legislature. Requires the Commission to meet at least once every two months, and grants broad authority to the Commission, including permitting the Commission to determine the data elements to be collected, the reporting format and the use and reporting of any data submitted. Requires the

Commission, by December 1, 2009, to develop, implement, and update a health care quality and cost containment plan that provides for effective measurement of the safety and quality of an array of health care services provided to Californians. Establishes the Commission's duties and authority, fees and penalties, as specified.

14)Adds to the current responsibilities of the OPA, which currently provides public information on health plan and medical group performance and quality, the requirement to provide to the public reports and data obtained by the lead agency, through mechanisms including but not limited to the Internet, for the purpose of assisting the public in making informed selections of health plans, hospitals, medical groups, nursing homes and other providers.

15)Establishes the Comprehensive Diabetes Services Program (CDSP), administered by DHCS, for specified adult Medi-Cal beneficiaries who have been diagnosed with prediabetes or diabetes. Requires DHCS to define CDSP services, and provides that they may include: diabetes screening, visits by certified practitioners, culturally and linguistically appropriate life-style coaching and self-management training, and regular and timely laboratory evaluations by the primary care physician. Requires DHCS to seek FFP for CDSP and to contract with an independent organization for evaluation, including estimating the associated short- and long-term savings. Requires DHCS to develop and implement "incentives" for participating beneficiaries and "financial incentives" for participating Medi-Cal providers, as specified. Makes implementation contingent on an annual appropriation of state funds.

16)Requires the Department of Public Health (DPH) to maintain the California Diabetes Program, including but not limited to providing information on diabetes prevention and management to the public, including health care providers, and technical assistance to the Medi-Cal CDSP established in #14) above, as specified.

17)Requires DPH to identify the 10 largest providers of health care coverage in the state, based on their enrollment, and to publicize the smoking cessation benefits they provide. Requires DPH to evaluate the effects of providing the information, based on changes in beneficiary awareness and use

of smoking cessation benefits, other smoking related indicators, such as smoking rates, and changes in coverage for smoking cessation. To the extent funds are appropriated, requires DPH to increase efforts to reduce smoking through increased capacity of the California Smokers' Helpline and increased awareness of cessation benefits available through public and private plans.

18)Requires DPH, subject to a budget act appropriation, to use scientifically appropriate methods to track and evaluate obesity-related health indicators, including physical activity, diet, and community environment, as specified, to evaluate and compare obesity projects and programs, and to study the health and economic consequences of obesity. Requires DPH to develop an Obesity Prevention Campaign, to be known as "California Living," and to link the campaign with community-level efforts, assist schools to promote fresh foods and whole grains, and provide technical assistance to help employers integrate wellness programs and policies into employee benefit plans and worksites.

19)Establishes the Community Makeover Grant program to be administered by DPH, for the purpose of awarding grants to local health departments (LHDs) as local lead agencies in the promotion of active living and healthy eating. Requires grants to LHDs to be based proportionally on population and to be expended for specified purposes, including, among other things, creation of a community infrastructure; coordination among local partners, including schools; and for local grants to promote physical activity for children, improve access to healthy foods, and better utilize community recreation facilities. Authorizes DPH to provide training, consultation and technical assistance to local programs or to contract for those services to another state, federal or auxiliary organization.

20)Establishes CHHSA as the lead agency to conduct a professional review and development of best practice standards in the care and treatment of persons with high cost chronic diseases, such as asthma and diabetes, to be implemented in every state health coverage program, including the CalPERS, Medi-Cal, HFP, and Cal-CHIPP.

21)Requires the CHHSA to consult with CalPERS, and affected health provider groups, to develop performance benchmarks for

quality measurement and reporting into a common "pay for performance" model to be offered in every state-administered health care program, as specified, and advanced as a common statewide framework for quality measurement and improvement.

Provider Reimbursement

1)Commencing July 1, 2010, and to the extent that federal funds are available, increases Medi-Cal reimbursement rates for physicians to no less than 80% of federal Medicare rates. Also, requires DHCS to establish rates for physician services, which Medicare does not cover, that are DHCS' best estimate of a rate that is not less than 80% of the rate Medicare would pay for such services if covered.

2)Authorizes DHCS to set aside an unspecified percentage of the Medi-Cal rate increases required in #1) above for physicians for payments linked to performance measures and performance improvement, as specified.

3)Expresses legislative intent to increase Medi-Cal hospital inpatient and outpatient rates.

4)Prohibits a hospital, in the event a patient has coverage for emergency health care services and post stabilizing care, and the hospital does not have a contract with the patient's carrier, from billing the patient for emergency and post stabilizing care, except for applicable copayments and cost shares. Provides that the noncontracting hospital and the health plan or health insurer retain the right to pursue all current legal remedies [regarding payment or reimbursement].

5)Requires DHCS to make periodic payments to county LCOs for low-income childless adults on a per member per month basis, actuarially determined to be adequate to meet the full costs of services, as specified. Requires DHCS to establish payment rates that must be accepted by out-of-network Medi-Cal providers who provide emergency services to LCO enrollees.

Financing

1)States legislative intent to finance the Act with contributions from employers, individuals, federal, state and local governments and health care providers. [The author has indicated his intention to pursue a ballot initiative

containing the financing elements.]

2)Financing elements in the intent language include: increased federal Medicaid and State Children's Health Insurance Program (SCHIP) funds; unspecified revenue from counties based on enrollment in coverage of low-income adults now served by counties; a 4% fee on hospital patient revenues; employer fees ranging from 2 to 6.5% of payroll; premium contributions from currently offering employers when employees choose to enroll in public programs; premium payments by individuals in both publicly subsidized and private coverage; funds obtained through increasing the tobacco tax by two dollars per pack; and other state savings from increased numbers of covered persons.

3)Makes HFP coverage expansions contingent on funds appropriated in the state Budget or another statute.

4)Requires DHCS to seek any necessary federal Medicaid approval to obtain federal funds for coverage expansions to specified low income populations, Medi-Cal provider rate increases, and

other related provisions of the Act, and grants broad authority and "flexibility" to DHCS to utilize Medicaid state plan amendments, waivers, or any combination, and to make modifications to the proposed requirements, standards and methodologies in the Act, as necessary to obtain federal approval, except that the DHCS may not make otherwise eligible persons ineligible for Medi-Cal or HFP, increase cost sharing amounts above those proposed, reduce benefits proposed in the Act, or otherwise "disadvantage applicants or recipients in a way not contemplated" in the Act.

5)Establishes Fund and makes it continuously appropriated to MRMIB for providing coverage under the Program. Specifies how monies in the fund may be spent.

Other

1)For the period January 1, 2008 to December 30, 2011 authorizes DHCS to implement provisions of this bill through all county letters or similar instructions and MRMIB to adopt emergency regulations.

EXISTING LAW :

1)Establishes the Medi-Cal program, administered by DHCS, which provides comprehensive health benefits to low-income children, their parents or caretaker relatives, pregnant women, elderly, blind or disabled persons, nursing home residents, and refugees who meet specified eligibility criteria.

2)Establishes HFP, administered by MRMIB, to provide low-cost, subsidized health, vision, and dental insurance to uninsured children with family incomes up to 250% of the FPL, who are not eligible for no-cost Medi-Cal. Establishes the Access for Infants and Mothers Program (AIM), administered by MRMIB, to provide low-cost health insurance for pregnant women and their newborn infants.

3)Requires all carriers offering health coverage to small employers, to issue that coverage without any exclusion based on medical underwriting, requires renewal of all coverage for small employers, at the option of the small employer, as specified, and restrains within a rate band of plus or minus 10%, the ability of carriers to base initial and renewal premiums on the health status, occupation, or claims experience of the employees of a small employer. Limits rating factors for small employer coverage to specified age, geography and family size categories.

4)Establishes Major Risk Medical Insurance Program, administered by MRMIB, to provide health coverage for individuals unable to purchase private individual health coverage, because they have

been denied health coverage by at least one private health plan or are offered only limited coverage or coverage significantly above standard average individual rates, as determined by MRMIB.

5) Provides for the regulation of health care service plans by DMHC and regulation of disability insurers certificated to sell health insurance by CDI.

FISCAL EFFECT : Unknown

COMMENTS :

1) PURPOSE OF THIS BILL : According to the author, this bill enacts major health care reform in California and responds specifically to the Governor's veto message on AB 8 (Nunez), particularly to the Governor's concerns regarding

universality, an individual mandate and diversity of funding. The author states that this bill makes significant progress towards the goal of universal health insurance, by instituting a series of broad based reforms of the insurance market, expanding and simplifying public health insurance programs, improving health care quality and increasing cost effectiveness and value, emphasizing prevention and wellness, preserving choice, building and improving upon the existing public and private health systems, and creating a system of shared responsibility with employers, employees and government. The author emphasizes that this bill would expand health coverage to more than two-thirds of Californians 4.9 million uninsured, including all children.

2) FINANCING . The author has stated his intent to pursue financing elements of this plan in a ballot initiative for November 2008. The employer fee, hospital tax and tobacco tax would be subject to voter approval. More specifically, the author indicates that the ballot initiative would include:

a) An employer "pay or play" election to either make health expenditures or pay an equivalent amount to the California Health Trust Fund. Employers would pay on a sliding scale basis based on their payroll. Employers with payrolls of less than $100,000 would pay a fee equivalent to 2% of Social Security wages (capped at $97,500 in 2007), employers with payrolls of between $100,000 and $250,000 would pay a fee equivalent to 4% of Social Security wages, and employers with payrolls above $250,000 would pay a fee of 6.5% of Social Security wages;

b) Employers would elect to directly make health expenditures for all of their employees making above $25,000 per year, and all of their employees making less than $25,000 per year, or could elect to make health expenditures for one group of employees (for example,

employees with wages above $25,000 a year) and pay a fee for the other group of employees (for example, employees making less than $25,000 a year);

c) A tobacco tax increase of $2 for a package of cigarettes, and an equivalent amount for other tobacco products. The current state excise tax on tobacco products is 87 cents, with 10 cents going to the General Fund, 2 cents to breast cancer research and early detection services, 25 cents to health education, research, health care and environmental program through voter-approved

Proposition 99, and 50 cents for early childhood education through voter-approved Proposition 10;

d) A hospital fee of 4% of aggregate net patient revenue of hospitals. This is estimated to generate $2.3 billion in revenue, which would be matched by federal funds and returned to hospitals through Medi-Cal rate increases provided through fee-for-service Medi-Cal payments to hospitals and Medi-Cal managed care plan payments to hospitals totaling $3.4 billion. Hospitals would receive an additional $1.2 billion (total funds) that would pay for the hospital portion of public program expansions to low-income individuals;

e) A refundable tax credit for those with family incomes between 250-450% FPL who purchase health insurance through Cal-CHIPP. The tax credit would be an amount that would cover the premium costs above the amount an individual would spend on the minimum policy after they have spent 5% of their adjusted gross income on health insurance premiums.

3)CALIFORNIA'S UNINSURED . According to the California HealthCare Foundation (CHCF), an average of 6.6 million Californians were uninsured for some period over the three year period of 2003-2005. California has the largest number of uninsured residents in the United States and the seventh largest proportion of uninsured in the nation (20.8% of the population). Of those, 5.3 million were adults and 1.3 million were children. Fifty-five percent of Californians have employment based coverage, 16% get coverage through Medi-Cal, and an estimated 8.7% purchase coverage through the individual insurance market.

CHCF also reports that employer based coverage in California from 1987-2005 declined from 64.6% to 54.7%, with government sponsored coverage increasing from 15.7% to 18.7%, individually purchased coverage increasing from 6.8% to 8.7% and the percentage of uninsured increasing from 17.6% to 21.4%. CHCF reports the median employer premium contributions in California firms offering coverage in 2005 as a percentage of payroll was 7.7%.

Thirty-eight percent of the uninsured in California have incomes

below $25,000 annually, and 54% of the uninsured have annual incomes below 200%. Fifty-seven percent of the uninsured are Latino and Latinos are much more likely to be uninsured than

any other ethnic group. However, unlike Latinos and African Americans, whose high rates of being uninsured have either held steady or slightly declined for the last five years, the likelihood of being uninsured is now growing for Whites and Asians.

4)COVERAGE FOR CHILDREN . According to the CHCF, an average of 1.3 million children in California remained uninsured over the three year period 2003 - 2005. Children comprise 20% of the state's total uninsured population, and 71% of California's uninsured children are in families where the head of household works full-time, full year. Over half of all uninsured children were eligible for either HFP or Medi-Cal, but remained unenrolled. The balance of uninsured children were ineligible for these programs, largely due to income limitations or immigration status. According to CHCF, in 2003, although employers were the primary source of health coverage for children (covering 53% of children), approximately 26% of children under age 19 were enrolled in Medi-Cal and 6% were enrolled in HFP.

5)EXISTING PUBLIC COVERAGE PROGRAMS As a result of both state and federal laws, eligibility rules for California's Medicaid program, Medi-Cal, are complex and based on multiple factors primarily related to income, property, household composition, residency, age and/or health condition. There are currently more than 170 "aid codes," or eligibility categories, in Medi-Cal. Generally speaking, low-income citizen children are eligible for Medi-Cal as follows: infants in families with incomes less than 200% FPL, one to five year olds at 133% FPL or less; and six to nine year olds at 100% FPL or less. Low income adults can be eligible for Medi-Cal under a variety of programs primarily designed for disabled persons or parents of low-income children. Generally speaking, adults between the ages of 21 and 65, without children, who are not pregnant, blind or disabled, and who do not have one of several specific health care needs outlined in statute (such as dialysis, tuberculosis, breast and cervical cancer treatment, etc.) are not currently eligible for Medi-Cal. HFP currently covers children in families with incomes that are less than or equal to 250% FPL, but too high to qualify for Medi-Cal. HFP applies income deductions that are applicable to children under Medi-Cal in determining that a family's income does not exceed 250% FPL for purposes of HFP eligibility. FFP is not available for undocumented persons in Medicaid or SCHIP.

6)FPL: THE FEDERAL POVERTY GUIDELINES. The table below includes the FPL for 2007 as developed according to formula by the federal Department of Health and Human Services. The federal poverty guidelines, or percentage multiples of them (such as 125%, 150%, or 185%), are used as an eligibility criterion by a number of federal and state programs.

2007 Federal Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	150%	200%	250%	300%
1	$10,210	$15,315	$20,420	$25,525	$30,630
2	13,690	20,535	27,380	34,225	41,070
3	17,170	25,755	34,340	42,925	51,510
4	20,650	30,975	41,300	51,625	61,950
5	24,130	36,195	48,260	60,325	72,390
6	27,610	41,415	55,220	69,025	82,830
7	31,090	46,635	62,180	77,725	93,270
8	34,570	51,855	69,140	86,425	103,710

For each additional person, add: $3,480

| SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148 |

7) INDIVIDUAL HEALTH INSURANCE MARKET . While the majority of those with health insurance obtain that coverage on the job, individual coverage is the main alternative for those not covered through employment and are ineligible for publicly subsidized health coverage. CHCF reports that, over the three year period 2003-2005, an estimated 2.8 million people in California were covered in the individual health insurance market. According to the Kaiser Family Foundation, the individual insurance market can be a difficult place to buy coverage, especially for people who are in less-than-perfect health. Access to and the cost of coverage is very much dependent on a person's health status, age, place of residence, and other factors. Common circumstances leading people to seek such coverage include self-employment, early retirement, working part time, divorce or widowhood, or "aging off" a parent's policy. Insurance carriers in the individual market often decline to cover people who have pre-existing medical conditions, and even when they offer coverage, frequently impose severe limitations on the coverage for any expenses related to the pre-existing condition or charge more to individuals because of their medical history. This can price insurance out of the reach of many consumers in poor health or create significant gaps in coverage for individuals who end up with exclusions and limited coverage.

8) INDIVIDUAL MANDATE . An individual health insurance mandate is a legal requirement that every resident obtain adequate private health insurance coverage. People who don't receive coverage through government programs, their employer or some other group are required to purchase their own individual coverage, as in this bill. Proponents of the individual mandate argue that such mandates respond to a legitimate concern about "free riders," uninsured persons who nonetheless receive treatment when they get sick, in emergency rooms and through other uncompensated or reduced cost care, resulting in additional costs being passed on to taxpayers and individuals with insurance. Proponents argue that those most likely to go without health insurance are the young and relatively healthy and that for these young, healthy individuals, going without health insurance is often a logical economic decision. The

problem with their choice, proponents argue, is that it leads to a form of adverse selection. Removing the young and healthy from the insurance pool results in higher insurance premiums for those who choose to be insured because the remaining insurance pool is older and more costly to insure. Finally, proponents argue that in the context of an individual mandate it is possible to impose stricter rules on insurance

carriers, requiring them to guarantee issue of coverage to everyone, because concerns about potential adverse selection are reduced. Opponents of an individual mandate argue that individuals, including young and healthy persons, are most likely uninsured because they cannot afford to buy meaningful coverage or are being denied private coverage because of pre-existing health conditions. Opponents argue that imposing a mandate does nothing by itself to significantly improve affordability and that the majority of uninsured persons will need some form of subsidy or government-sponsored health plan in order to comply with a mandate. Opponents also argue that requiring individuals to buy coverage on their own is inefficient and reduces the purchasing clout typically associated with buying group health insurance. Opponents are also concerned that a mandate can only be enforced through punitive and costly penalties or expensive government bureaucracies that come at the expense of the programs that actually provide health coverage. Finally, some opponents of the mandate view the requirements as unacceptably providing the health insurance industry with a captive market that must seek out and purchase their product.

9)MEDICAL LOSS RATIOS . In health insurance, a medical loss ratio (MLR) is the ratio of medical benefits to premiums - in other words, the amount of premium revenues a carrier spends on the actual costs of medical care services, versus administration, profit and where applicable, shareholder dividends. MLRs are presented as a percentage - the percent of premium revenues spent on medical care. Except for Medicare-related coverage plans, the only existing MLR requirement is the regulatory standard imposed on individual health insurance policies regulated by CDI, which are required to return 70% of the premium in the form of medical benefits. Health plans under DMHC jurisdiction are limited to no more than 15% for administrative costs, but this standard does not affect how much must be spent on medical care in the same way as MLR.

10)SECTION 125 PLANS . Under Section 125 of the Internal Revenue Code, enacted by Congress in 1978, employers can give their employees the opportunity to pay for benefits on a pretax basis. In a Section 125 plan, sometimes called a cafeteria plan, an employee is allowed to pay for his/her group health premiums, other qualified insurance premiums, unreimbursed medical costs (such as prescriptions and copayments), child and dependent care costs and more, all with tax-free dollars. Both employees and employers save on taxes because Section 125 plans reduce taxable wages, including the amount of wages on which employers must pay Social Security and Medicare taxes.

11)SUPPORT . The California Public Interest Research Group

(CalPIRG) writes in support of this bill, arguing that this bill gives California consumers effective tools to get a fair price for health insurance, gives all consumers access to health insurance, regardless of whether they are sick or healthy, increases the number of Californians who have useful health insurance, and contains the rising cost of health care. At the same time, CalPIRG urges the following changes to this bill: Make all Californians eligible for Cal-CHIPP to help those who would otherwise lack access to affordable group coverage; create a link between a paying employer's contributions and their employees' benefits; include a rate band link to prevent insurers from defacto refusing to cover older Californians; establish a floor of basic benefits that satisfy the individual mandate; and, prohibit an individual from being disqualified from obtaining coverage better than the minimum offered, or from taking advantage of guarantee issue and community rating, if the individual has failed to comply with the individual mandate.

12)SUPPORT IF AMENDED . The Service Employees International Union (SEIU) supports this bill if amended to require that a specific and appropriate minimum benefit package, such as a standard HMO package plus prescription drugs, be available to an individual for less than 6.5% of heir income in order for them to be mandated to carry coverage. SEIU states that it is also working to resolve issues regarding the operation of the purchasing pool, the structure of the hospital provider fee, public hospital funding, and workforce training assistance, as well as other issues, including the specific language in a proposed ballot initiative to fund this bill. Health Access seeks amendments to address affordability and other issues.

On affordability, Health Access suggests that the exemption from the individual mandate which is now available to individuals when the cost of premiums and out of pocket expenses exceeds 6.5% of family income be "scaled" so that individuals with incomes up to 150% FPL have no mandate; those with incomes of 151-300% FPL are exempt from the mandate if costs exceed 1-3% of income; and those with incomes of 301-450% FPL are exempt if costs exceed 5% of income. Health Access also requests amendments to allow any individual not covered by group coverage to have access to Cal-CHIPP and to make Healthy Action plan coverage mandatory for individual insurance policies.

Consumers Union supports this bill if amended to add parameters for the minimum coverage required under the individual mandate, to clarify enforcement of the individual mandate, and to tighten some of the individual market reforms. The California Medical Association supports this bill if amended to address the following concerns: compromised quality of care due to relaxed licensing standards and expanding provider staffing ratios; unintended consequences of

pay-for-performance and reporting requirements; potentially weakened patient protections from reduced oversight of insurers; and the need for fine tuning electronic prescribing proposals. The Latino Issues Forum (LIF) supports this bill if amended. LIF expresses concerns regarding reductions to the safety-net through a county share-of-cost; the imposition of an individual mandate; and, the undefined minimum level of benefits. LIF recommends that MRMIB work with DMHC to determine benefit levels due to DMHC's in-depth knowledge of Knox-Keene benefits. The Congress of California Seniors supports this bill with the following suggested amendments: exempt from the individual mandate individuals whose premiums exceed 5% of income or whose premiums plus out of pocket costs exceed 6.5 % of income; specify that minimum level of coverage is Knox-Keene plus prescription drugs; tie the individual mandate to premium oversight (at a minimum require carriers to report costs and explain the basis for any premium increases); and make Cal-CHIPP available to all.

13)OPPOSITION . The California Nurses Association (CNA) is strongly opposed to this bill, stating that the health insurance provided will not be universal, will not be affordable, and will not be high quality while bare bones coverage plans will be forced on Californians and employers

who will have absolutely no control over the price. CNA argues that this bill does not provide health care to families, but provides covered lives to insurers who have already broken almost every moral (and often legal) imperative in the delivery of health care. CNA further points out that this bill does nothing to ensure patient choice of providers. CNA objects to the emphasis on self-help health care and so-called lifestyle strategies that miss the point of improving health outcomes. CNA takes issue with the "de-regulation of unlicensed medical assistants" proposed in this bill and the authorization for NPs and PAs to provide written instructions to unlicensed personnel who are operating at unlicensed sites. Finally, CNA suggests that all efforts should be redirected to dealing with the impending possible disenrollment of children from HFP as a result of the lack of federal action on the reauthorization of SCHIP. The California School Employees Association opposes this bill because it fails to provide adequate and affordable health care coverage for all Californians.

Blue Cross opposes this bill, stating that guarantee issue and modified community rating will destabilize the insurance market and place over 740,000 Blue Cross insureds at risk of significant premium increases. Instead, Blue Cross supports product and rating flexibility. Blue Cross also opposes this bill's limit on administrative costs, arguing that such a limit will reduce the incentive to develop new products, reduce insurer spending on marketing and broker commissions,

which Blue Cross claims promotes outreach to underserved communities and reduces the number of uninsured. Finally, Blue Cross argues that the new state purchasing pool may be underfunded and that establishing a public insurer may create an uneven playing field in the marketplace. Health Net opposes this bill, arguing that the individual mandate will not work because of the lack of enforcement and the large number of people who will be exempt from the mandate. As a result, Health Net argues that many people will drop coverage and not take up insurance unless or until they become ill, increasing the cost of coverage for those who remain. Health Net also argues that MLR provisions will reduce access to care, that insurers forced into the pool could be inadequately paid, that funding for the proposal is not included and there is no tie-in to an initiative, and that transparency provisions need more work.

The California Chamber of Commerce (Chamber) opposes this bill, stating the proposal would violate the Employee Retirement Income Security Act (ERISA) by imposing a tax on employers, a tax that employers, especially small employers cannot afford. In addition, the Chamber argues that funding referenced in this bill is inadequate to fully fund the entitlement programs included in the bill, putting significant pressure on the general fund. The Foundation for Taxpayer and Consumer Rights (FTCR) argues that there are gaps in this bill that represent drafting errors or gaps in promised protections. For example, FTCR points to the absence of a middle-class tax credit, an individual mandate that is not contingent on a ballot measure that would provide financing for this bill, and no defined minimum health care coverage benefit-which may well be unaffordable. FTCR argues that, because of the danger of enacting a health care bill that is less affordable and universal, and that provides less choice than the current system, the Legislature should limit itself to enacting universal health care for kids.

14)OPPOSE UNLESS ADMENDED . The California Association of Health Underwriters opposes this bill unless it is amended to do the following: eliminate the purchasing pool (Cal-CHIPP) or assure that it is voluntary and has no artificial advantages over the private market; define minimum coverage in statute; enforce the individual mandate; limit the individual mandate exemption to the cost of coverage; remove the 85% MLR; and enroll those uninsured Californians who are currently eligible for Medi-Cal and HFP before expanding these programs. The Pharmaceutical Research and Manufacturers of America oppose this bill unless it is amended to remove MRMIB's prescription drug bulk purchasing and aggregate negotiating authority under this bill.

15)CONCERNS . The Association for Los Angeles Deputy Sheriffs

expresses concern that the proposed tobacco tax (expressed as legislative intent in this bill) could violate the tobacco Master Settlement Agreement with significant general fund implications that could result in reduced funding for law enforcement. The National Minority Quality Forum writes to express concerns that MRMIB's prescription drug bulk purchasing authority may limit access to necessary medications. The Having Our Say coalition expresses concerns with the following: enforcement of the individual mandate; whether affordability measures are strong enough; workers' and

families' ability to maintain continuous coverage; establishing a minimum level of coverage based on Knox-Keene; and, the financing plan for the proposal.

16)PREVIOUS LEGISLATION . In December 2006, legislative leaders in both houses introduced legislation to reform California's health care system and to reduce the number of uninsured Californians, AB 8 (Nunez) and SB 48 (Perata). In January 2007, Governor Arnold Schwarzenegger announced his own plan to enact comprehensive health care reform. In February 2007, Senator Sheila Kuehl reintroduced SB 840, a bill previously vetoed by the Governor, to establish a single-payer style health reform program in California. SB 840 (Kuehl) passed the Senate but was held in the Assembly Appropriations Committee. Senate and Assembly Republicans subsequently announced alternative health care reform strategies and introduced multiple bills in both houses to enact their proposals. AB 8 and SB 48 moved through the legislative process, and were publicly heard and voted on in multiple legislative hearings. The two bills were merged into AB 8 in July 2007, and AB 8 was passed by the full Senate and Assembly on September 7, 2007 and sent to the Governor. On September 11, 2007, the Governor signaled his intention to veto AB 8, and called an extraordinary special session of the Legislature to consider and act upon legislation to comprehensively reform California's health care system. On October 9, 2007, the Governor released the first public draft of legislative language to implement his plan, which included several additions and modifications from the plan outline released in January of this year. With the release of draft legislative language, the Governor also declared his intention to pursue a statewide ballot initiative to accompany the legislation, primarily to seek voter approval for the financing elements of his reform plan. On October 12, 2007, the Governor vetoed AB 8.

17)RELATED LEGISLATION .

a) AB 2 X1 (no author) establishes the Health Care Security and Cost Reduction Act, which is intended to codify the Governor's health care reform proposal. The Governor's proposal specifies that all provisions, dates and policy

changes proposed are contingent on the Director of Finance making a finding that sufficient revenues are available. The Governor's proposal also depends on voter passage of a

statewide ballot initiative, for which no language is yet available, intended primarily to seek voter approval for the financing elements of the proposal.

b) AB 8 X1 (Villines) proposes multiple, diverse strategies to address health care costs and access, including: tax incentives and government programs to promote and facilitate consumer-directed health care and employer-sponsored insurance; allowing the sale of out-of-state health plans and policies not subject to any California law or regulation; increasing Medi-Cal provider reimbursement rates and creating an income tax credit for physicians who provide unreimbursed care for the uninsured; establishing a mechanism for financial aid for training physician assistants; and, requiring foundation conversions to provide direct medical care.

18) Policy Issues and Questions .

a) Minimum benefit plan . The Act requires all Californians to have a minimum policy of health care coverage, which is to be established by MRMIB. The Act states that MRMIB must consider affordability, protection from catastrophic costs, and access to preventive care in establishing the minimum policy. What additional guidance or direction should the Legislature give to MRMIB, if any, to ensure that the minimum mandated benefit provides adequate coverage for essential health care services ?

b) Individual market rates . The Act requires health plans and insurers to guarantee issue to all individual applicants without regard to health status or claims experience an age, geography and "health improvement discounts." How will the health improvement discounts be operationalized and are additional protections needed to ensure that such discounts do not become a way for health plans and insurers to charge favored rates in an effort to attract and enroll the highest number of younger and healthier groups and individuals?

c) Healthy Action Incentives and Rewards Plans . The language requiring carriers to establish these plans is unclear about what the products will be and how they will be priced. As just one example, it is not clear how a

Healthy Action "supplement" premium would be calculated. Would the purchaser pay for a supplement that subsequently reduced base premiums as a result of enrollee participation in specified activities? In addition, the language provides limited direction to DMHC and CDI to ensure that the new product offerings they approve do not allow carriers to circumvent the individual and group market rules currently in place and those proposed. For example, reducing premiums for employers based on high participation of their employees in gym memberships could have the unintended effect of reducing premiums more often for younger, healthier firms whose workers are willing and physically able to take up a gym membership. The Legislature may wish to provide additional direction to DMHC and CDI in their review and approval of these products.

d) E-prescribing. The Act requires prescribers and pharmacies to be able to transmit and receive electronic prescriptions, but does not require health plans, insurers or other payers to provide all of the eligibility and coverage information, other than formulary information, the prescribers and pharmacies must be able to receive. In order to facilitate adoption of e-prescribing, should payers also be required to provide real-time eligibility and coverage information electronically? Is the January 1, 2010 deadline for all prescribers and pharmacies to meet the requirement realistic, especially for smaller and rural providers?

e) California Diabetes Program and Obesity Prevention programs. The existing California Diabetes Program (CDP) was established within the former Department of Health Services now DPH and is primarily funded by the federal Centers for Disease Control and Prevention. In the 2005 Budget, the Legislature mandated that CDHS create a strategic plan to guide a statewide response on obesity. How do the proposed new programs and activities in the Act compare with existing programs administered by DPH and DHCS? Is there a potential for overlap and duplication?

f) Local Coverage Option. This bill requires DHCS to establish LCOs in counties with public hospitals as the coverage option for childless adults below 100% FPL. This bill makes the LCO the exclusive coverage option for these

adults. What protections are needed to ensure that eligible persons receive quality care, choice of providers and adequate access to geographically accessible health care?

g) Changes to NP and PA Supervision . The Act allows one physician to supervise a combined total of 12 NPs and PAs. Is this the intent? While expanding the use of NPs and PAs may be an appropriate strategy to include in health care reform, is the significant expansion proposed in the Act justified? What standards, protections or training requirements might be necessary to ensure that the expansion can be implemented while protecting patient safety ?

h) County Share of Cost . As health reform provides health coverage to previously low-income uninsured persons, counties could potentially face reduced demand for county health care programs and services currently provided to low-income uninsured persons. The Act includes intent language requiring that counties contribute an unspecified amount to the state to support the costs of care for previously uninsured persons who may have been receiving services through county health care programs and facilities. In this context, what is the appropriate timing, process and level for county revenues to be included in financing the coverage expansions aimed at individuals they currently serve?

i) Evaluation . AB 8 (Nunez) included an evaluation of the health care reform proposed by that bill. Should such an evaluation also be included in this bill?

j) Financing . The Act includes only intent language on the financing to support the proposed program. The author has stated his intention to pursue a ballot initiative to secure the funding, including the employer fee, the hospital fee and an increase in the tobacco tax. How can the Legislature evaluate the Act and the financing component without specific proposed statutory language? What portions of the Act should be in statute and what should be in a proposed initiative?

19) TECHNICAL ISSUES AND QUESTIONS .

a) On page 36, health insurance coverage would continue from the effective date through the last day of the month immediately preceding the subscriber's next birthday. What is the intent of this language? Should coverage, and the rates for that coverage, be in effect for at least one year?

b) On page 38, line 26, OPA is expected to disseminate information collected by the "lead agency." There is no other reference in this bill to the lead agency.

c) On page 94, lines 15-17, it appears this bill intends to make coverage for certain individuals contingent on establishment of a county share of cost. However the language cited is unclear. In addition, it appears that the citation to Section 14005.332 should be to Section 14005.333.

d) This bill increases the number of PAs that a physician can generally supervise from two to six. To do this without ambiguity, Business and Professions Code Section 3516.1, which limits the number of PAs a physician can supervise in a medically underserved area to four, should be repealed.

REGISTERED SUPPORT / OPPOSITION :

Support

California Public Interest Research Group

Support if Amended

American Federation of State, County and Municipal Employees
California Chamber of Commerce
California Healthcare Institute
California Hospital Association
California Medical Association
Congress of California Seniors
Consumers Union
Health Access
Latino Issues Forum
Planned Parenthood Affiliates of California
Service Employees International Union
Western Center on Law and Poverty

Opposition

Association of California Life and Health Insurance Companies
Blue Cross of California
California Chamber of Commerce
California Manufacturers and Technology Association
California Nurses Association
California School Employees Association
Foundation for Taxpayer and Consumer Rights
Health Net
National Federation of Independent Business
1 individual

Oppose Unless Amended

California Association of Health Underwriters
Kaiser Permanente
Pharmaceutical Research and Manufacturers of America

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