Date of Hearing: November 14, 2007

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

SUBJECT : Health care.

SUMMARY : Proposes multiple 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 insurance 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 benefits and assets from foundation conversions to support direct medical care.
Specifically, this bill :

Physician Assistants

1)Requires the Physician Assistant Committee within the Medical Board of California (MBC) to establish by regulation procedures for administering a license renewal program for physician assistants (PAs) in which PA licenses expire on the last day of the birth month of the licensee at the end of a two-year term, unless the license is renewed by application and payment of a prescribed renewal fee.

2)Establishes, in the Health Professions Education Foundation, the California Physician Assistant Scholarship and Loan Repayment Program (Program), and in the State Treasury, the California Physician Assistant Scholarship and Loan Repayment Program Fund (Fund), to provide scholarships and repay qualifying educational loans of PAs who agree to participate in medically underserved areas or community or free clinics.

3)Requires the MBC to collect voluntary contributions of twenty-five dollars ($25) or more from PA licensees at the time of license renewal, and transmit the funds to the Fund. Requires the Office of Statewide Health Planning and Development to adopt regulations for program implementation

and to submit an annual report to the Legislature, beginning on or before January 1, 2009, describing the experience of the Program, its effectiveness, and other information as specified.

Tax Credits

4) Allows a qualified employer to take against its "net tax" a tax credit equal to 15% of the amount paid for qualified health insurance for employees. Defines a qualified employer as an employer which has two to 199 employees, and either commenced business on or after October 1, 2008, or did not offer health insurance to employees in the previous five tax years. Specifies that "qualified health insurance" means a high deductible health plan (HDHP) or health savings account, as defined in federal law. Requires the Franchise Tax Board to report to the Legislature on employers using the credit, employees using HDHPs, and the total cost to the state. Requires the Legislative Analyst to report to the Legislature on the effectiveness of the tax credits in helping meet deductible medical expenses under HDHPs.
5) Changes the Revenue and Taxation Code to conform to the federal Internal Revenue Code (IRC) concerning HSAs by allowing a personal income tax deduction for funds deposited into a qualifying HSA by, or on behalf of, an eligible individual. Also brings state law into conformity with the IRC concerning Archer Medical Savings Accounts, health flexible spending arrangements, and health reimbursement accounts.

6) Allows a state personal income tax deduction, for purposes of computing a taxpayer's adjusted gross income (AGI), for the costs of medical care, as defined in the Internal Revenue Code, paid by a taxpayer for the taxpayer, his or her spouse, and their dependents.

7) Allows a credit in an amount equal to 50% of the "fair market value of uncompensated medical care" provided by a physician to an individual who resides in this state, is not covered by health insurance, and whose household adjusted gross income is less than the federal poverty level (FPL). Allows the credit in excess of a physician's tax liability in a single year to be carried over to subsequent tax years.

Health Opportunity Accounts

8) Requires the Department of Health Care Services (DHCS) to implement a Medi-Cal pilot project and do all of the following:

a) Submit, by July 31, 2008, a proposal to the federal government to participate in the federal Medicaid Demonstration Project for Health Opportunity Accounts (HOAs), which allow states to use federal Medicaid funds to deposit up to $2,500 per adult and $1,000 per child into an account that the enrollee may use to pay for out of pocket

medical expenses to meet the deductible of an approved health insurance product;

b) Select up to ten counties in which to implement the demonstration project;

c) Provide incentives for patients in the demonstration project to seek preventive services;

d) Reduce inappropriate use of health care services;

e) Ensure that the annual deductible is between 100% and 110% of the amount contributed to the HOA;

f) Ensure that all participating insurance plans offer all standard Medi-Cal benefits; and,

g) Allow participating individuals to use HOA funds for job training or tuition after one year of participating in the program.

9) Requires the California Public Employees Retirement System (CalPERS) Board of Administration, beginning January 1, 2008, to do the following:

a) Offer its members at least one HDHP option, which must be combined with a HSA that complies with federal law relating to HSAs;

b) Create the Public Employees Health Savings Fund, to which members who choose the HDHP will contribute through a salary or retirement deduction, and, requires contributions to be credited to a member-specific account;

c) Deposit into a participating member's account the difference between the HDHP premium and the weighted average of other plan premiums; and,

d) Disburse funds from a member's HSA to pay for qualified medical expenses, as defined in federal law.

Out of State Health Plans and Insurers

10) Allows a health plan or insurance carrier domiciled in another state and authorized to issue an essential health benefit plan and transact business in that state to offer, sell, or renew a health benefit plan in California, without a license issued by the Department of Managed Health Care (DMHC) or a certificate of authority issued by the Commissioner of the California Department of Insurance (CDI).

Mandated Benefits Waiver

11) Allows carriers to offer, sell, and renew health benefit plans and insurance policies that do not include specified required benefits, provided the applicant or policyholder waives those benefits by signing a disclosure form. Requires the Commissioner of CDI and the director of DMHC to prepare the disclosure form by July 1, 2008.

California Health Insurance Exchange

12) Requires the Managed Risk Medical Insurance Board (MRMIB) to establish the California Health Insurance Exchange (Exchange) for the purpose of allowing employers to transmit health insurance premium payments obtained by employees through a cafeteria plan for remittance to participating health plans or insurers for individual plan contracts and insurance policies. Authorizes MRMIB to:

a) Contract with professional service firms and to fix their compensation;

b) Contract with third-party billing and administrative services;

c) Contract with employers and carriers to administer the payment of premiums for health care coverage on and after

January 1, 2009; and,

d) Charge a fee to implement the Exchange.

13) Prohibits MRMIB from imposing terms or conditions with respect to rates or benefits. Establishes the California Health Insurance Exchange Fund in the State Treasury. Requires MRMIB to prepare, beginning two years after beginning operation of the Exchange and annually thereafter, a written report for the Governor and Legislature, as specified.

14) Requires DHCS to increase reimbursement rates for physician services under the Medi-Cal program, beginning January 1, 2009, to a level that equals 80% of the Medicare reimbursement rate for those same services, except for those physician services currently reimbursed at or above 80% of the Medicare reimbursement rate.

Conversion Foundations

15) Requires that 90% of the annual expenditure of charitable assets dedicated and transferred to a charitable, grant-making foundation as a result of a health care service plan (health plan) conversion from nonprofit to for-profit, be spent for health care services for citizens who

reside in California and who are not receiving health care services through a local, state, or federal program.

EXISTING STATE LAW :

1)Creates within the MBC the Physician Assistants Committee, and authorizes it to develop regulations for licensing PAs.

2)Establishes the Health Professions Education Foundation within OSHPD.

3)Establishes the Medi-Cal program, which is administered by DHCS and 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.

4)Provides for the licensure and regulation of health care service plans by DMHC under the Knox-Keene Health Care Service

Plan Act of 1975 (Knox-Keene) and regulation of disability insurers who sell health insurance (health insurers) by the CDI.

5)Requires a health care service plan to provide basic health care services, as defined, unless exempted from that requirement by the Director of DMHC, and to provide specified mandated benefits.

6)Requires that an insurer obtain from the Commissioner of CDI a certificate of authority to conduct business in the state, and that the insurer operate according to specific requirements, including offering specified mandated benefits in its health policies.

7)Requires a health plan intending to convert from nonprofit to for-profit status to secure approval from the director of DMHC and requires the director to find that the plan is in compliance with the requirements of the Knox-Keene Act, and requirements concerning the money set aside from the conversion, the functioning of the charitable organization, dedication of the organization's activities to meeting Californians' health care needs, and others.

8)Establishes MRMIB as an independent board with gubernatorial and legislative appointees, and charges MRMIB with a broad mandate to advise the Governor and the Legislature on strategies for reducing the number of uninsured persons in the state.

9)Requires MRMIB to administer specified state and local health coverage programs, including the Healthy Families Program, the

Access for Infants and Mothers Program and the Major Risk Medical Insurance Program, and charges MRMIB with negotiating and contracting with private health plans and insurers for health coverage to eligible persons consistent with the various program rules. Allows various tax credits designed to encourage socially beneficial behavior or to provide tax relief to those incurring specified expenses.

10) Allows an itemized deduction for expenses that are not compensated by insurance or otherwise for the medical care of the taxpayer, the taxpayer's spouse, or the taxpayer's dependents, to the extent those expenses exceed 7.5% of the taxpayer's AGI.

EXISTING FEDERAL LAW :

1)Under the federal Deficit Reduction Act (DRA), authorizes demonstration projects for up to ten states to use Medicaid funds to implement HOAs.

2)Allows an itemized deduction for expenses that are not compensated by insurance or otherwise for the medical care of the taxpayer, the taxpayer's spouse, or the taxpayer's dependents, to the extent those expenses exceed 7.5% of the taxpayer's AGI.

3)Defines the "net tax."

4)Allows a deduction for contributions to a qualifying health savings account by a taxpayer who also has a HDHP for medical coverage.

5)In Section 125 of the IRC, enacted by Congress in 1978, allows employers to give their employees the opportunity to pay for benefits on a pretax basis. In a Section 125 plan, allows an employee to pay for group health premiums, other qualified insurance premiums, unreimbursed medical costs (such as prescriptions and copayments), child and dependent care costs, and more, with pretax dollars.

FISCAL EFFECT : Unknown

COMMENTS :

1)PURPOSE OF THIS BILL : According to the author, the purpose of the bill is to maximize choice, reduce costs, and increase access. The author notes that Medi-Cal provided health coverage to approximately 6.6 million low-income, aged, and disabled beneficiaries at a total projected cost of $35 billion ($13.7 billion General Fund) for fiscal year 2006-07. According to the author, Medi-Cal expenditures comprised 13% of the state budget in 2000, but are projected to rise to 21% by 2015. Since 2000, General Fund expenditures on Medi-Cal

have risen by 44%. According to the author, this bill is needed for California to take advantage of DRA provisions that authorize demonstration projects for up to ten states to implement HOAs. The author reports that Medi-Cal will spend about $3,700 per enrollee in fiscal year 2006-07, and believes that depositing a portion of this into HOAs for a select

population of Medi-Cal beneficiaries on a voluntary basis is a viable option for California to address the lack of control individuals in public health care programs exercise over their use of services.

2)HOAs .

a) According to the Center on Budget and Policy Priorities (CBPP), research does not support the notion that Medicaid beneficiaries make excessive use of health care services, citing a recent study that found that adult Medicaid beneficiaries use about the same level of health care services as adults with private insurance. In addition, while Medicaid spending levels have increased significantly in the past decade, private insurance rates have risen even more. While General Fund expenditures on Medi-Cal have risen by 44% since 2000, employer sponsored health insurance premiums in California have increased by 85% in the same period.

b) CBPP reports that HOAs are likely to increase Medicaid spending because of provisions that allow Medicaid beneficiaries to keep their accounts when they leave Medicaid, use the funds for other than Medicaid benefits and pay nonparticipating providers up to125% of the standard Medicaid reimbursement fees. According to CBPP, as a result of these higher costs, the Congressional Budget Office expects that the demonstration project will actually increase federal Medicaid spending by $60 million over the first five years of the demonstration, and that nationwide expansion of HOAs would result in costs more than tripling over the second five years (2011-2015).

c) Another potential cost of HOAs is fraudulent billing. Because an HOA allows an enrollee to see non-Medi-Cal providers who have not gone through the Medi-Cal provider enrollment process, the risk of provider fraud is likely to be significantly higher than under the existing Medi-Cal program.

3)CONVERSION FOUNDATIONS . The conversion foundations currently operating in California support a variety of direct health care service programs, educational and research activities, through grant making activities and public policy analysis and research. Examples of some of these activities include the

following:

a) Health-e-App is the first fully automated Web-based application in the United States for enrolling low-income children and pregnant women in public health insurance programs. Health-e-App was developed by the California HealthCare Foundation (CHCF) in cooperation with the California Health and Human Services Agency. Subsequently, CHCF licensed Health-e-App to the state of California at no cost. Health-e-App is being implemented throughout California to enroll eligible applicants in the Healthy Families Program and Medi-Cal;

b) The California Health Interview Survey (CHIS) is a collaboration of the UCLA Center for Health Policy Research, DHCS, the California Department of Public Health, and the Public Health Institute. CHIS is a telephone survey of Californians that collects information on health issues, such as health status, health insurance coverage, access to care, chronic health conditions, cancer, dental health, neighborhood and housing, and hunger. The California Endowment (TCE) is a major funder of CHIS. TCE also provides funding for the AskCHIS query system, an on-line resource that provides access to CHIS data and information; and,

c) The Community Clinics Initiative (CCI) is a grant making program established by Tides Foundation and TCE to support community health clinics in California. CCI has made 693 grants totaling over $57.8 million to 185 clinics and clinic consortia in California over the past seven years of the program. Individual awards have enabled clinics to convert to electronic medical recordkeeping, improve or expand patient facilities, use software to share data among clinics in a network, or train staff. According to Tides Foundation, these enhanced capabilities allow clinics to better track health status, care for more patients, achieve diverse revenue sources, reduce administrative costs, expand opportunities for shared learning and advocate for community health needs.

4)HEALTH INSURANCE EXCHANGE . The Exchange is intended as a mechanism to assist employers to transmit pretax Section 125 payments to health insurers and health plans on behalf of their employees. This bill intends to make tax benefits for

health insurance more equitable by facilitating a tax benefit for purchasers of individual coverage, thus reducing the out of pocket premium cost and possibly helping to ensure that more Californians have adequate health insurance.

Under Section 125 of the IRC, both employees and employers save on taxes because 125 plans reduce taxable wages, including the amount of wages on which employers must pay Social Security and Medicare taxes. These plans are referred to by many names, including flexible spending accounts (FSA), choice spending accounts, section 125 plans, and/or reimbursement accounts. Section 125 offers several alternatives; three of the most common are: Premium Only Plans, Flexible Spending Accounts, and Cafeteria Plans. Cafeteria Plans are the most complex alternative because they change the way employees receive benefits. Instead of providing a determined set of benefits (such as a medical plan and $50,000 of life insurance), each employee is given an amount of "benefit dollars" roughly equal to the employer's expenditure for that person's benefits. The employee then chooses from a menu of benefits offered by the employer and determines those that best fit his or her needs.

Section 125 requires employers to establish a written plan that identifies the plan year and describes each benefit available, the eligibility rules, procedures for making a salary reduction election, how employer contributions (if any) are made, and the maximum amount of employer contributions. Internal Revenue Service rules also require annual compliance assurances and prohibit discrimination in favor of highly compensated employees.

5)CONSUMER-DIRECTED HEALTH CARE or HDHPs combined with HSAs . Consumer-directed health care (CDHC) is designed to reduce the cost of health insurance and health care by giving consumers financial incentives to treat their health care as a consumer product or service and involving them in purchasing decisions about their health care. CDHC involves two key components: HDHPs, and HSAs for tax advantages. Qualifying contributions to HSAs are made with pre-tax dollars; in other words, they are not subject to income taxes.

In CDHC, insurance premiums are lower but out-of-pocket costs for health care are increased. Thus, individuals have greater responsibility for paying for their health care, and this is

expected to make them more prudent, cost-conscious consumers. This increase in cost-sharing is expected to reduce inappropriate health care utilization and increase competition among health care providers. Ultimately, proponents expect

this cost-consciousness to drive health care costs down.

Studies show that enrollees in CDHC tend to have higher incomes and better health than those in other plans. A Government Accountability Office (GAO) study reports that about 51% of HSA participants reported incomes exceeding $75,000 but make up only 18% of tax filers, and that the average income of HSA users was $133,000, compared with $51,000 for all non-elderly tax-filers. The GAO found that those with higher incomes tend to make larger HSA contributions. About 40-45% of enrollees in HSA-eligible plans did not make tax-deductible contributions to their HSAs.

Consumers who have HDHPs typically spend about double on out-of-pocket costs compared with those with more traditional health plans. A CBPP study showed that in 2005, individuals in CDHC were 2.5 times more likely to spend more than 5% of their income on out of pocket medical costs. The GAO suggests that for low to moderate health care use, HDHPs appear to cost consumers less than more traditional Preferred Provider Organizations. People who use health care services more, however, tended to pay more with HDHPs.

Researchers using the RAND Corporation Health Insurance Experiment and actuarial pricing models suggested that if everyone were moved to CDHC, we might see a one-time reduction in use of 2-7.5%, or double that (4-15%) if not combined with HSAs or health reimbursement accounts. People who enrolled in CDHC did tend to decrease utilization of healthcare 1%-11% for some measures, but it is important to note that among those measures, the greatest decrease of 11% was for primary care visits. Another RAND Corporation study reports that those in HDHPs are more likely to delay or avoid getting care due to cost, not get prescriptions, not see specialists when needed, and skip tests and follow up. On the other hand, consumers in CDHC also appear to use more nurse hotlines, seek alternative treatment methods, and choose less expensive and less extensive treatment.

The GAO study participants were generally satisfied with CDHC, but another study found that only 44% of new enrollees were

satisfied with their HDHPs, and a third study found that those in HDHPs were much less likely to report being very satisfied or extremely satisfied than those in other plans.

6)TAX CREDIT FOR MEDICAL CARE .

a) Provisions of this bill would take state law out of conformity with federal law. Specifically, under this measure, California law would allow an "above-the-line" deduction for medical expenses, while federal law would continue to allow a "below-the-line" deduction subject to

the AGI limitation.

b) Tax provisions of this bill define the term "medical care" by reference to federal law, which defines medical care very broadly, including transportation essential to medical care, qualified long-term care services, and insurance payments.

7) PRIOR LEGISLATION .

a) AB 1040 (Duvall) allows a personal income tax deduction, for purposes of computing a taxpayer's AGI, for the costs of medical care paid by a taxpayer for the taxpayer, his or her spouse, and their dependents. AB 1040 was heard by the Assembly Committee on Revenue and Taxation on May 21, 2007 and died on the Assembly Revenue and Taxation Suspense File.

b) AB 1635 (Strickland) requires the Department of Health Care Services to submit a proposal to the federal government to participate in the federal Medicaid Demonstration Project for HOAs created pursuant to the federal Deficit Reduction Act of 2005. AB 1635 was heard in the Assembly Health Committee and failed on April 10, 2007.

c) AB 1072 (Gaines) requires MRMIB to establish the California Health Insurance Exchange for the purpose of allowing employers to transmit health insurance premium payments obtained through an employee benefits cafeteria plan established pursuant to federal tax law. AB 1072 was heard and passed in the Assembly Health Committee on April 24, 2007, and was held under submission in the Appropriations Suspense File on May 31, 2007.

d) AB 1592 (Huff) allows a credit equal to 50% of the "fair market value of uncompensated medical care" provided by a physician during the taxable year to an individual who is a resident, is not covered by a government-sponsored health program, and is at or below the federal poverty level. The author canceled the hearing of AB 1592 by the Assembly Revenue and Taxation Committee on May 14, 2007.

e) AB 245 (DeVore) conforms state revenue and taxation code to federal tax law with respect to HSAs for taxable years beginning on or after January 1, 2007. AB 245 was held under submission in the Assembly Revenue and Taxation Committee Suspense File on May 21, 2007.

f) AB 84 (Nakanishi) conforms to federal tax law with respect to health savings accounts (HSAs) for taxable years beginning on or after January 1, 2008. AB 84 was held

under submission in the Assembly Revenue and Taxation Committee Suspense File on May 21, 2007.

g) AB 1377 (Nakanishi) requires the PERS Board of Administration to offer a high deductible health plan and a health savings account option to public employees and annuitants, and establishes the Public Employees' Health Savings Fund, for payment of qualified medical expenses of employees and annuitants who elect to enroll in the high deductible health plan and participate in the health savings account option. AB 1377 was referred to the Assembly Public Employees, Retirement and Social Security Committee on March 22, 2007, but was not heard.

h) AB 1214 (Emmerson) allows health care service plan and health insurance carriers, on and after July 1, 2008, to issue, renew, or amend contracts without certain specified benefits that are otherwise required, provided that the applicant, contractholder, or policyholder has designated and waived the benefits specifically. AB 1214 was referred to the Assembly Health Committee on March 15, 2007 but was not heard, at the author's request.

i) AB 1644 (Niello) allows a carrier that is domiciled in another state and authorized to issue an essential health benefit plan and transact business in its domiciliary state to offer, sell, or renew in this state a health benefit

plan meeting certain unspecified requirements, without holding a license issued by the DMHC or a certificate of authority issued by the Insurance Commissioner, and exempts the essential health benefit plan from requirements otherwise applicable to plans and insurance policies providing health care coverage in this state. AB 1644 was referred to the Assembly Health Committee and was set for hearing on April 17, 2007, but was not heard, at the author's request.

j) AB 1312 (Emmerson) increases Medi-Cal reimbursement rates for physician services to 80% of the Medicare rate beginning January 1, 2009, and requires DHCS, prior to making a rate adjustment, to consider the ability of beneficiaries to access physician services by geography and specialty and to request data from OSHPD to allow DHCS to determine the extent of Medi-Cal physician shortages by geography and specialty. AB 1312 passed in the Assembly Health Committee and was set to be heard in the Assembly Appropriations Committee, but the hearing was postponed on May 31, 2007.

aa) AB 1572 (DeVore) requires that 90% of the annual expenditure of charitable assets dedicated and transferred to a charitable, grant-making foundation as a result of a

health care service plan conversion from nonprofit to for-profit, be spent for health care services for citizens who reside in California and who are not receiving health care services through a local, state or federal program. AB 1572 failed in the Assembly Health Committee on April 24, 2007.

bb) SB 1584 (Runner and Ackerman) of 2006 would have brought the California tax code into conformity with the federal tax code regarding HSAs, as it was with the Medical Savings Accounts that preceded HSAs. The Franchise Tax Board estimated that this bill would reduce State revenues by $9M in 2006-07, $15M in 2007-08, and $20M in 2008-09. SB 1584 was heard in Senate Health Revenue and Taxation Committee April 26, 2006 and held in committee.

8) RELATED LEGISLATION . AB 1 X1 (Nunez and Perata) enacts the California Health Care Reform and Cost Control Act which creates the California Cooperative Health Insurance Purchasing Program, 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.

9) POLICY ISSUES AND QUESTIONS :

a) Targeted Employer Tax Credit . As the bill is written, "qualified health insurance" means a HDHP or HSA. Usually a HDHP and HSA are meant to work together, and a HSA qualifies for tax credits only when combined with a qualifying HDHP. Did the author mean "HDHP and HSA" ?

b) CalPERS, CDHC . The January 1, 2008 start date does not allow the PERS Board enough time to comply with the requirements to establish a new fund and define or select a qualifying HDHP, and implement the new option for its members. In addition, if passed in Special Session, this bill will not take effect until after January 1, 2008. The author may wish to change the date of compliance for this section.

c) CDHC . Because of the financial disincentive to obtain health care services under CDHC, any proposal to encourage CDHC should require plans to exempt preventive health care and chronic disease management from the deductible requirement. This bill does not include such a provision. Should the Legislature consider a policy promoting CDHCs where prevention and primary care are fully paid for in out-of-pocket costs by the insured?

d) Mandated Benefits Waiver . There is no requirement that carriers provide a discount to applicants or plan members who opt to waive benefits as permitted by this legislation, and a person who would choose to waive a given benefit does so because he or she is unlikely to use that benefit even if it is available. Thus, this proposal would not improve risk pooling and is unlikely to yield cost savings. Should the Legislature impose additional requirements on the author's proposal to allow "benefit-lite" health care coverage? Does the Legislature want to exempt policies in California from important benefits such as are currently required in California law?

e) Out of State Health Plans and Insurers . To the extent that the Legislature deemed California's licensing and regulation of health plans and insurers important for protecting the health and economic well-being of the public, exempting some health plans and insurers from these restrictions would be unwise for California consumers and unfair to California health plans and insurers. These plans might provide consumers more choices, but would be difficult to compare with California plans and policies, and more importantly, would expose Californians to unacceptable risks. When these plans fail to provide needed coverage, patients will get sicker, be exposed to severe financial hardship, transfer costs to the public, or all of the above. The California Health Benefits Review Program noted that an exodus of California carriers to other states, and significant destabilization and insolvency in the health insurance market might result from a similar proposal.

f) Physician Tax Credit .

i) Must a physician provide services completely free of charge to claim the 50% credit?

ii) If a patient pays a small sum, below market value, for services, would the doctor be entitled to a credit based on the market value of the services minus the patient contribution?

iii) This bill only allows a credit when the patient served is a member of a household with a combined household adjusted gross income below the FPL. How exactly is a doctor to determine whether a particular patient meets this precise threshold ? Moreover, will doctors be required to provide this information to the Franchise Tax Board for auditing purposes ? Would this create additional administrative burdens regarding record retention ?

iv) Is it the author's intent to compensate physicians who treat underinsured as well as uninsured patients ?

v) This bill provides for an indefinite carryover of the credit until it is exhausted. The author may wish to provide that the excess credit shall only be carried over

for a specified number of years, given that credits are typically exhausted within eight years of being earned.

vi) The author may wish to include a sunset date to permit the Legislature to re-evaluate the tax credit's effectiveness.

g) Conversion Foundations. This bill prevents new foundations from supporting valuable health-related programs currently receiving foundation support. For example, CHIS does not provide health care services but has provided previously unavailable data and information on the health and health status of Californians. The development of Health e-App would be precluded because it is not direct services and because the system is used for populations applying for state coverage programs. This bill also prevents funds from being used for other than non-citizens so any provider, including a community clinic, providing services to undocumented persons would be unable to receive funds. In many instances, foundation funding has served as a bridge for the gaps where government funding is either insufficient or unavailable. Given the record of important, innovative health-related (but not direct health care service) uses to which conversion foundations have applied conversion dollars, does the Legislature want to limit the use of future conversion dollars to direct service programs for citizens ?

h) Health Insurance Exchange .

i) The author and supporters of this bill argue that Section 125 plans prove administratively burdensome for the employer to transmit each of those payments to individual and potentially numerous health plans, and that the Exchange will simplify and facilitate employer offerings of Section 125 plans. However, under this bill, employers must still keep track of the health plans employees choose and each individual's premium payment amount and transmit the information to MRMIB along with payment. Would an Exchange that instead offered multiple health benefit plans and insurers that individuals could select, and then billed an employer the payment amounts for each employee, come closer to accomplishing the author's intent?

ii) Individual coverage: The coverage paid for by the Exchange will essentially be individual market coverage, subject to the existing rules in that market, including the ability of health plans and insurers to medically underwrite and deny coverage to individuals with preexisting conditions and prior claims experience. How does the author anticipate that the Exchange would be able to improve the availability of coverage options for individual employees, beyond the assistance provided by the tax credit ?

iii) Financing: This bill does not provide start-up funding for the Exchange. Even if the Exchange were to ultimately be self-supporting through fees charged to participants start-up funding would be needed to establish the structure and administrative capacity to be able to offer the services of the Exchange before any fees or premiums were received.

iv) Aside from the tax incentive provided by the Section 125 plans, the Exchange would not likely affect affordability of health coverage in the individual market, and as the bill is written, prohibits MRMIB from imposing conditions with respect to rates or benefits. Would it make sense to allow MRMIB to form a risk pool and negotiate for group health insurance rates?

8) OPPOSITION .

a) Physician tax credit : Opponents state that the tax credit would result in a General Fund revenue loss with no specific economic benefits for California. This is revenue that could otherwise be used to finance the uninsured.

b) HSA conformity, HDHPs : Health Access opposes HSA conformity because HDHPs, it argues, jeopardize patient health by causing delays in needed care, failing to pay for preventive care and chronic disease management. The California Federation of Teachers also argues that these plans are of little value to low to moderate income working families.

c) Mandated Benefits Waiver . Health Access notes that the existing process for defining insurance mandates was adopted by the Legislature and takes into account

individual and population health concerns, as well as costs to consumers and HMOs and insurers. Health Access asks: what is the point of health insurance if it does not cover basic health care needs? Kaiser Permanente also argues that insurance only works when everyone is willing to pay a small amount for everyone's health care needs.

d) Out of State Insurers : According to Health Access, among the consumer protections that would be lost by allowing insurers that are not licensed in California are the right to a second opinion, the right to independent review of denials of care, and the ability to fine an insurer for denying care in the event that the denial caused death or harm. The California Federation of Teachers and California Labor Federation add that the measure would erode patient and quality protections, allowing carriers to offer "sub-par" products. Kaiser Permanente argues that all plans should comply with the same standards and that out-of-state competitors would undercut California carriers with cheaper coverage.

e) Increased Medi-Cal reimbursement for physicians : According to Health Access, this measure lacks the revenue needed to finance the reimbursement increase.

9) OPPOSE UNLESS AMENDED .

a) Kaiser Permanente opposes this bill unless provisions concerning out of state carriers and the mandated benefit waiver are deleted.

b) Health Access opposes this bill unless the following are deleted:

i) Provisions concerning tax law conformity for HSAs;

ii) Mandated benefit waiver;

iii) Provision concerning out-of state insurers;

iv) Provision concerning conversion foundations; and,

v) In addition, Health Access suggests inclusion of a revenue increase to fund the Medi-Cal reimbursement increase.

10) SUPPORT IF AMENDED .

Blue Cross of California supports this bill if the provision

concerning out-of state insurers is deleted.

REGISTERED SUPPORT / OPPOSITION :

Support

None on file.

Support if amended

Blue Cross of California

Opposition

American Federation of State, County and Municipal Employees
California Federation of Teachers
California Labor Fede
California Nurses Association
California School Employees Association
Consumers Union
Service Employees International Union

Oppose unless amended

California Association of Health Underwriters
Health Access
Kaiser Permanente

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