BILL ANALYSIS

(Without Reference to File)

ASSEMBLY THIRD READING
AB 1 X1 (Nunez)
As Amended December 17, 2007
Majority vote

HEALTH 12-5 APPROPRIATIONS 12-5

Ayes:	Dymally, Bass, Berg, De La Torre, De Leon, DeSaulnier, Eng, Hayashi, Hernandez, Jones, Ma, Salas	Ayes:	Leno, Caballero, Davis, DeSaulnier, Huffman, Karnette, Krekorian, Lieu, Ma, Nava, Solorio, De Leon
Nays:	Nakanishi, Emmerson, Gaines, Huff, Strickland	Nays:	Walters, Emmerson, La Malfa, Nakanishi, Sharon Runner

SUMMARY : Enacts the Health Care Security and Cost Reduction Act (Act), a comprehensive health reform proposal, 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. Requires the Managed Risk Medical Insurance Board (MRMIB) to administer Cal-CHIPP. Establishes various health cost containment measures and private insurance market reforms. The author has indicated that financing of major elements of this bill will be subject to voter approval of an initiative on the November 2008 statewide ballot. Specifically, this bill :

Coverage Expansions

1)Expands eligibility for public coverage programs for low-income persons as follows:

a) Effective July 1, 2009, 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) Effective July 1, 2010, extends coverage to 19- and 20-year olds and to low-income parents and caretaker relatives up to 250% FPL. Coverage for adults with incomes at or below 100% FPL would be covered under Medi-Cal. Adults with incomes 100-250% FPL and for childless adults with incomes 100-250% FPL will be provided in a benchmark plan pursuant to new federal Medicaid rules under the federal 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 (CCHFP);

c) Establishes cost-sharing limits for adults 19 and older eligible for subsidized coverage based on income, as described in #1) b) above, as a percent of FPL, as follows: for persons up to 150% FPL - no premium contribution or out-of-pocket costs and for persons 150-300% FPL - premiums not to exceed 5% of income, net of applicable deductions;

d) Requires, effective July 1, 2010, 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 DHCS to use the methodology for the federal poverty programs for pregnant women and children, but excludes from the determination of eligibility for this new program income disregards currently 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 four years that the LCO is available. After five years of operation of an LCO in a county, permits newly eligible individuals to choose to enroll in the LCO, the county organized health system or one of the two-plan Medi-Cal managed care contractors in that county. Permits LCOs to offer a limited network of providers with approval by DHCS and the Department of Managed Health Care (DMHC);

e) 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;

f) Eliminates, effective 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,

g) Requires 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 MRMIB to coordinate with DHCS to seek FFP for CCHFP coverage. 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 the parent or caretaker relative of

a child, who is made eligible for Medi-Cal or HFP by this bill despite their immigration status, to sign under penalty of perjury an attestation that the child is not described in any of the categories enumerated on the attestation for which federal financial participation for full-scope services is available.

4)Authorizes DHCS to make statewide eligibility determinations for any group or subgroup of Medi-Cal applicants, except for aged, blind, or disabled persons, either directly or by contract with counties or an agent or agents.

5)States legislative intent to establish a mechanism for the state to defray the costs of an enrollee's public program participation, including taking advantage of other opportunities for coverage of that enrollee. Requires the DMHC, the California Department of Insurance (CDI), and DHCS to evaluate options and to report recommendations to the Joint Legislative Budget Committee by July 1, 2009. Requires, 90 days after their report, DMHC, CDI, and DHCS to implement policies, procedures, and requirements described in their report.

6)Establishes the California Health Benefits Service Program (CHBS) within DHCS to expand cost-effective health coverage options to purchasers governed by the Act. Requires the program to: a) identify barriers or incentives that should be addressed to facilitate geographic expansion of, or the establishment and maintenance of joint ventures between health plans that contract with, or are governed, owned, or operated by, a county board of supervisors, a county special commission, a county organized health system or a county health authority, as well as the County Medical Services Program; b) report findings to the Legislature by January 15,

2009; and, c) provide technical assistance to support expansions and joint ventures. Creates the CHBS Stakeholder Committee (Committee), comprised of 10 members: six appointed by DHCS; two by the Speaker of the Assembly; and, two by the Senate Rules Committee. Requires the Committee to meet at least quarterly to provide input to CHBS and assist CHBS in carrying out its responsibilities. Requires DHCS, with input from the Committee, to update the Legislature on implementation of CHBS.

7)Authorizes DHCS to enter into contracts with joint ventures, described in #6) above, to provide medical services to specified populations. Requires health plans within such joint ventures to seek to contract with designated public hospitals, county health clinics, community health centers, and other traditional safety net providers.

8)Requires licensure under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), the licensing framework for health plans in California, including Health Maintenance Organizations (HMOs), for all joint ventures established pursuant to #6) above, prior to commencement of enrollment. Permits the Director of the DMHC to provide regulatory and program flexibility 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.

9)Modifies the Expanded Access to Primary Care (EAPC) program by: a) expanding income eligibility from 200% FPL to 250% FPL for persons who do not have third party coverage and who do not qualify for public health care coverage programs; b) requiring beneficiaries to choose a primary care medical home; and, c) requiring DHCS to issue a primary care card on determination of a person's eligibility for the program. EAPC currently provides reimbursement to certain primary care clinics, on a per visit basis, to defray the costs of outpatient visits for uninsured persons at or below 200% FPL.

10)States legislative intent to implement a transition plan by July 1, 2010, that will allow payment of premiums and cost-sharing burdens under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Purchasing Program and Individual Mandate

1)Requires, commencing July 1, 2010, requires every California resident to enroll in and maintain minimum health care coverage (individual mandate), as determined by MRMIB, for

himself or herself and his or her dependents. Exempts an individual from this requirement if MRMIB determines that the cost for a minimum policy (minimum creditable coverage) is not affordable for that individual or would constitute an undue hardship. Also exempts from the individual mandate any person or family with family income at or below 250% FPL when the person's or family's share of premium for minimum creditable coverage exceeds 5% of family income, or if the individual has been in California for less than six months and is not eligible for guaranteed issue health coverage. States that MRMIB must consider affordability, protection from catastrophic costs, and prevention in establishing standards for minimum creditable coverage.

2)Requires MRMIB, by March 1, 2009, to set the standards for minimum creditable coverage in the individual market and for purposes of the individual mandate. Requires minimum creditable coverage to at least include coverage for physician, hospital, and preventive services and to be, at a minimum, inclusive of existing coverage requirements under law. Requires MRMIB, in defining minimum creditable coverage, to consider protection of individuals and health purchasers from catastrophic medical costs, the extent to which cost sharing would deter an enrollee from obtaining appropriate and timely care, and affordability, taking into account deductibles, coinsurance, copayments, and total out-of-pocket

costs, and the extent to which the resulting premium cost would prevent an individual from obtaining coverage at a reasonable price. Requires MRMIB to consider the extent to which and under what circumstances benefits offered by a bona fide church or organization whose principles include healing entirely by prayer or spiritual means may be included in, or qualify as, meeting the requirement to maintain minimum creditable coverage.

3)Establishes Cal-CHIPP as a state purchasing program, or health insurance purchasing pool, administered by MRMIB, to provide or make available health care coverage for eligible persons through participating health plans, defined as health insurers regulated under CDI or health care service plans licensed by DMHC, (collectively "carriers"). Establishes the duties, authority and responsibility for MRMIB in the operation of

Cal-CHIPP. Makes Cal-CHIPP operational on January 1, 2009, and requires MRMIB to provide health care coverage through Cal-CHIPP beginning July 1, 2010.

4)Establishes eligibility standards for enrollment in Cal-CHIPP and the rights and remedies of enrolled persons. Establishes two categories of Cal-CHIPP enrollees, CCHFP enrollees, and those who are not eligible for CCHFP:

a) CCHFP coverage for eligible enrollees is subject to the following:

i) To be eligible for CCHFP coverage an individual must meet all of the following criteria:

(1) Be a legal resident of the state;

(2) Be 19 years of age or older;

(3) Have family income 101-250% FPL; and,

(4) Not be offered employer-sponsored insurance or have been offered only coverage where the employer does not make any financial contribution toward the premium;

ii) Includes benefits to meet the requirements of Knox-Keene, plus prescription drugs, combined with enrollee cost-sharing levels that promote prevention and health maintenance, including appropriate cost-sharing for physician office visits, diagnostic laboratory services, and maintenance medications to manage chronic diseases. Requires MRMIB, in determining enrollee and dependent cost-sharing for CCHFP, to consider whether those costs would deter an enrollee from obtaining appropriate and timely care; and,

iii) Premiums and cost sharing as follows:

(1) For individuals with family income less than or equal to 150% FPL, no premiums or out-of-pocket costs; and,

(2) For individuals with family income 151% to 250% FPL, premiums not to exceed 5% of family income, net of applicable deductions;

b) Coverage for individuals authorized in this bill to receive health coverage through Cal-CHIPP, but who are not eligible for subsidized coverage in CCHFP, is subject to the following:

i) Residents of the state are eligible if they satisfy at least one of the following criteria:

(1) Be an employee or a dependent of an employee of an employer who elected to pay into the California Health Trust Fund (Fund);

(2) Be an employee paying the full costs of coverage through an employee tax savings plan where the employer designates Cal-CHIPP in the cafeteria plan; or,

(3) Be eligible for a state health coverage tax credit established in this bill;

_____ ii) Benefits offered will include at least three different coverage options, a plan that offers the same benefits as the minimum coverage for the individual market, a mid-range coverage product (category three of the five coverage choice categories to be developed by DMHC and CDI for all individual coverage products sold in the state) and a high-range comprehensive benefit plan (category five). Authorizes MRMIB to offer dental and vision coverage if specified conditions are met; and,

_____ iii) Premiums will equal the full cost of the coverage choice made by the enrollee. Enrollees eligible for the state health care tax credit may reduce their premiums by the value of the credit. Authorizes MRMIB to provide an additional contribution equal to 20% of the premium of a minimum benefit product to employees with incomes at or above 250% FPL whose employers pay into the Fund.

5)Makes available a tax credit from January 1, 2010 through December 31, 2014, for individuals and families with incomes

of 250-400% FPL ($43,000-69,000 for a family of three) who receive coverage under Cal-CHIPP, if their share of costs for health coverage for a mid-range coverage product (category three) exceeds 5.5% of their family income. Limits the tax credit to a specified maximum amount for a family based on family size and age which phases down as income increases. States legislative intent to make this tax credit advanceable. States legislative intent to authorize a tax credit for individuals between the ages of 50 and 64 whose income exceeds 400% FPL and which would be limited by and contingent on an appropriation of not more than $50 annually.

6)Permits MRMIB to take specified actions to provide prescription drug coverage to Cal-CHIPP enrollees, including using direct procurement (bulk purchasing). If MRMIB develops a bulk purchasing program, authorizes MRMIB to allow participation in that arrangement by other state and local government entities or a board or plan administrator providing health care pursuant to collective bargaining with a labor organization. Specifies that health care service plans licensed by DMHC must meet all related Knox-Keene requirements when participating in prescription drug arrangements developed by MRMIB.

7)Requires MRMIB to collect and disseminate, as appropriate, information on the quality and cost-effectiveness of Cal-CHIPP participating carriers.

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

9)Specifies the definitions and administrative duties and responsibilities applicable to Cal-CHIPP and the administration of Cal-CHIPP by MRMIB.

10)Authorizes carriers participating in Cal-CHIPP to contract with agents or brokers to provide marketing and servicing of health benefits offered through the program with commissions set and paid by the participating carrier and the agent or broker.

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 minimum creditable coverage. 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 individual 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)Requires MRMIB to pay the cost of health care coverage on behalf of a previously uninsured individual who has been without health care coverage for a period of at least 62 days, and is enrolled in minimum creditable coverage by MRMIB, and to establish methods to recoup from the individual the cost of that coverage.

Health Insurance Reforms

1)Requires carriers, on and after July 1, 2010, to spend no less than 85% of after-tax revenues on health care benefits, as specified, excluding administrative costs, establishing a minimum "medical loss ratio (MLR)." Requires DMHC and CDI to jointly adopt regulations to implement this requirement. Authorizes a carrier to average costs across all products in calculating MLR, including the products of affiliated companies, regardless of whether or not they are under the jurisdiction of DMHC or CDI. Authorizes DMHC and CDI to exempt from the MLR requirement new products in the first two years, providing the products are substantially different from the carrier's previously existing products.

2)Requires all carriers who sell individual private coverage to offer, accept and renew such coverage to all individual applicants in the carrier's service area (guaranteed issue and renewal). Makes guaranteed issue contingent on implementation of the individual mandate requirement. Exempts from the guaranteed issue requirement carriers that do not have sufficient health care delivery resources, as specified, providing that specified conditions are met, and health plans that do not offer coverage to individuals in the commercial market and whose membership and revenues are primarily from persons eligible for Medicare or Medi-Cal, as specified.

3)Notwithstanding #2) above, authorizes carriers to reject an application for coverage from persons meeting the following criteria:

a) New residents in the state for the first six months, unless they are eligible for coverage under the federal Health Insurance Portability and Accountability Act (HIPAA) or can demonstrate at least two years of prior coverage; and,

b) Individuals exempt from the individual mandate pursuant to this bill either because of their income level, unless they can demonstrate prior creditable coverage, or because they have received an affordability or hardship exemption from MRMIB.

4)Prohibits any preexisting condition exclusions, waivered conditions, or enrollment waiting periods once guaranteed issue is implemented, except for those persons who fail to comply with the individual mandate for more than 62 days, for whom a carrier may impose a preexisting condition exclusion of up to 12 months, as specified.

5)Prohibits health plans and insurers from rescinding any individual plan contract or policy after it is issued. Prohibits carriers from compensating individuals employed by or contracted with the carrier based on the number of persons for whom coverage is rescinded or the financial savings to the carrier associated with the rescission of coverage.

6)Establishes rating rules for individual guaranteed issue individual coverage. Requires individual rates to be

determined based on a standard risk rate for the benefit plan chosen, and authorizes separate rate differentials, for age, geographic location (risk category) and perceived health risk (risk adjustment factor), as determined by carriers, subject to the following:

a) Limits geographic rating categories to nine or fewer regions, and includes restrictions on how the regions are designed similar to the geographic rating limits now imposed on small employer guaranteed issue coverage;

b) Limits age rating to 12 categories, compared to seven age ranges currently permitted for small employer coverage. Requires CDI and DMHC to jointly establish a maximum limit on the ratio between rates for individuals in the 60-64 years category and those in the 30-35 years category;

c) Limits "risk adjustment factors" (rate increases or discounts for health status or health risk) to no more or no less than 20% of standard average rates for the first two years; no more or no less than 10% for the second two years, and eliminates such risk adjustment factors at the end of four years;

d) Limits changes to risk adjustment factors at the time of renewal to no more than five percentage points;

e) Requires premiums to be in effect for no less than 12 months and requires guaranteed renewal, with specified limitations and exceptions, such as when an individual moves out of the carrier's service area, fails to pay the premium, engages in fraud or intentional misrepresentation, or engages in fraud or deception in the use of the carrier's services;

f) Requires carriers, and their agents or brokers, to make specified disclosures related to individual rights, guaranteed issue and renewal requirements and other specified requirements in law and regulation; and,

g) Requires carriers to make specified filings with DMHC and CDI to demonstrate compliance with these rules.

7)Authorizes carriers to require individuals to provide health

status or health history information as necessary to apply the risk adjustment factors permitted under #6) above, but requires the carriers to use a standardized form and evaluation process developed by DMHC. Authorizes carriers to ask individuals to voluntarily provide such information after the effective date of coverage for purposes of providing care management services.

8)Requires DMHC, in consultation with the Insurance Commissioner (IC) and MRMIB, to develop by March 1, 2009, a standardized form and uniform evaluation to be used by all carriers in determining any risk adjustment factor authorized, as in #6) c) above.

9)Requires CDI and DMHC to jointly develop and consistently enforce a system to categorize all health plan contracts and health insurance policies into five coverage choice categories, by April 1, 2009, with the lowest level incorporating the mandatory minimum creditable coverage. Requires at least one standard HMO and one standard Preferred Provider Organization (PPO) in each category. Requires carriers to offer coverage in all five choice categories, including at least one standard product in each choice category, and if the plan or insurer offers a specific type of benefit plan in one category - HMO, PPO, Exclusive Provider Organization (EPO) or point of service - to offer the same type in all five categories. Requires prices for a carrier's products to reflect a reasonable continuum between the coverage choice categories and prohibits rates from being lower in one category than prices for coverage in a lower category.

10)Establishes the qualifying events that must be met in order for an individual, having purchased coverage in one of the five coverage choice categories, to be able to move up to a higher class of benefits, as specified. Limits the ability of individuals to move up to higher coverage choice categories, except at the anniversary date of the contract, and at certain qualifying events, (such as the death of the subscriber, marriage, divorce, birth of a child, etc.) and provides that individuals not experiencing a qualifying event can only move up one choice category per year.

11)Prohibits on and after March 1, 2009, CDI and DMHC from

approving new products that do not meet the standards for minimum creditable coverage, as the minimum is defined by MRMIB. Prohibits on and after March 31, 2009, carriers from offering any individual plan or policy that does not meet the minimum, except as provided below.

12)Grandfathers and allows carriers to continue coverage indefinitely that does not meet the standards for minimum creditable coverage, for any individual enrolled prior to March 1, 2009, without increasing benefits to minimum levels, but prohibits those products from being offered to new enrollment. Deems such existing coverage as meeting the individual mandate requirement. Requires rates for grandfathered products to comply with the rating rules under #6) above.

13)Requires, no later than two years following implementation of guaranteed issue, the Director of DMHC and the IC to make a finding related to the relative risk profile in individual coverage, compared to the risk profile in Cal-CHIPPP, and to establish a reinsurance program, as specified, if specific risk profile differentials are identified. Provides that reinsurance to compensate for adverse risk selection of more than 5% and up to 10% will be paid through a broad-based assessment on carriers, and risk selection differentials of more than 10% will be paid by funds in the Fund established by this bill, subject to appropriation.

14)Requires the Office of Patient Advocate (OPA) to develop and maintain on its Internet Web site OSHDP reports and data to assist the public in choosing health plans, hospitals, medical groups, and other providers and requires carriers to make available detailed specified information regarding coverage and benefits for purposes of inclusion on the OPA Web site.

15)Effective July 1, 2009, requires all carriers to offer to include and communicate the availability of a "Healthy Action Incentives and Reward Program" (Healthy Action plan), as defined, for group and individual health coverage. Requires Healthy Action plans to provide, where appropriate, health risk appraisals and enrollee access to an appropriate health care provider, as necessary, to review and address the results of the health risk appraisal, and to, in addition, where appropriate, include follow-up through a Web-based tool or a

nurse hotline either in combination with a referral to a provider or separately. 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." Permits employers, and requires California Public Employees' Retirement System (CalPERS) and Medi-Cal, to provide Healthy Action plans. 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.

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, 2012, 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 to patients a written receipt of the information that is transmitted to the pharmacy and specifies the content of the receipt.

4)Requires carriers 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 CalPERS Board, by January 1, 2010, 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 CalPERS 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. Permits MRMIB to provide PHRs for HFP enrollees.

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 authorization from the enrollee or insured.

9)Expands the authority of medical assistants (MAs) to administer medications and perform other tasks, pursuant to written instructions by a physician, when the physician is not onsite, under specified conditions.

10)Establishes a nine-member task force, including six voting members (three from the Medical Board of California and three from the Board of Registered Nursing), and three non-voting ex officio members (the Director of the Department of Consumer Affairs (DCA) and two academics) to develop a recommended scope of practice for nurse practitioners (NPs) by June 30, 2009, and requires DCA to promulgate regulations that adopt the task force recommendations by July 1, 2010. Sunsets this task force on July 1, 2011.

11)Requires the Office of Statewide Health Planning and Development (OSHPD) to collect clinical data and publish risk-adjusted outcome reports for percutaneous coronary interventions, including utilization of angioplasty and

stents. Requires OSHPD to report by hospital annually and by physician biannually, and to consult with the existing clinical advisory panel.

12)Establishes a new California Health Care Cost and Quality Transparency Committee (Transparency Committee) for the purpose of statewide data collection, common measurement and analysis of health care costs, quality and outcomes. States that the Transparency Committee will consist of 16 specified members, 10 appointed by the Governor and six by the Legislature. Requires the Transparency Committee to meet at least once every two months, and to develop, update, and submit to the Secretary of the California Health and Human Services Committee (CHHSA) a detailed Health Care Cost and Quality Transparency Plan, with specified strategies for public reporting of safety, quality and cost efficiency information on the health care system, to issue annual reports on the plan's implementation and to conduct a full review every three years. Requires the Transparency Committee to appoint at least one technical committee and one clinical panel, as specified. Once the plan is recommended to the Secretary, the Secretary will have 60 days to accept the plan or return it to the Transparency Committee with recommended modifications. Requires the Secretary, once he or she has accepted the Plan, to implement it, as specified. Requires OSHPD to identify a fee schedule for users of collected data and other financial resources to implement this provision. Requires the Secretary to report to the Legislature every six years after implementation, commencing January 1, 2014, on whether the Transparency Committee should be continued and whether changes to the Transparency Committee should be made.

13)Adds to the current responsibilities of the OPA, which currently maintains a Web site that provides public information on health plan and medical group performance and quality, the requirement to provide to the public reports and data obtained by OSHPD, to assist the public in selecting health plans, hospitals, medical groups, nursing homes, and other providers.

14)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.

15) 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.

16) 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.

17) Requires DPH 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.

18) 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 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.

19) 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) Increases, commencing July 1, 2010, and to the extent that federal funds are received, and state funds are appropriated, increases Medi-Cal reimbursement rates for physicians, podiatrists, and non-physician medical practitioners to an unspecified percent of similar rates in the federal Medicare program, not to exceed 100% of federal Medicare rates. Requires DHCS to establish rates for services, which Medicare

does not cover, that are DHCS' best estimate of a rate that is the same unspecified percent of the rate Medicare would pay for such services if covered. Establishes criteria for the reimbursement of physician services in Medi-Cal subject to the rate increase, including the location of the service, the claims process and the records providers must maintain.

2)Authorizes DHCS to set aside up to 25% of the Medi-Cal rate increases required in #1) above for payments linked to performance measures and performance improvement, and requires

DHCS to consult with stakeholders in the development of those measures. Specifies performance measures that DHCS may consider and requires DHCS to integrate the Medi-Cal measures with the pay-for-performance programs required in all state programs pursuant to this bill.

3)Includes within the provisions of the Act, the Medi-Cal Hospital Rate Stabilization Act which establishes a new methodology for hospital payment rates in Med-Cal and increases the rates of reimbursement for participating hospitals as follows:

a) Private and District Hospitals . Establishes and increases Medi-Cal rates for private and non-designated public hospitals (primarily district hospitals) so that reimbursement levels are set at the same annual aggregate level that the federal Medicare program would pay for inpatient and outpatient services (otherwise known in federal law as the "upper payment limit" (UPL)) and requires that rates be adjusted annually commensurate with Medicare rate increases. The methodology established by this bill essentially establishes the base rate of total funds currently received by the affected hospitals from Medi-Cal, including supplemental payments, with some exclusions, and adjusts the base rates by the percentage necessary to bring total aggregate Medi-Cal payments to hospitals up to the UPL. Private and district hospitals would also continue to receive supplemental federal reimbursement, known as disproportionate share payments, consistent with existing law;

b) Public Hospitals . Increases inpatient and outpatient rates for designated public hospitals, defined as the University of California and county public hospitals, so that payment rates, paid on either a per diem or a per discharge basis, are based on the hospital's allowable costs, as specified, established for the 2009-10 fiscal year and adjusted by the medical component of the federal Consumer Price Index. Designated public hospitals would also continue to receive supplemental federal reimbursement, known as disproportionate share payments, consistent with existing law, as well as funds from the existing Safety Net Care Pool (SNCP), pursuant to California's Medicaid Hospital Financing Waiver, but SNCP

funds would be provided at a reduced level, capped annually at $100 million statewide for all eligible hospitals. Establishes the system for cost reporting, reconciliation and establishment of rates for designated public hospitals. Makes rate increases paid to designated public hospitals contingent on the payment by counties of a contribution toward the costs cost of care through a county share of cost; and,

c) Medi-Cal Managed Care (MCMC) Plans . Requires DHCS to increase Medi-Cal reimbursement rates for MCMC plans by the actuarial equivalent of the increased rates paid to hospitals and providers. Requires the MCMC plans to expend 100% of the related rate increases received in the form of increased provider rates to the classes of providers and the hospitals receiving the rate increases established by this bill, subject to the limits of federal law.

4)Repeals the hospital rate setting system established in this bill within five years, effective January 1, 2016, unless a subsequent statute extends the provisions. Establishes specific contingencies for adjustments of the rates because of errors or data problems. Requires DHCS to consult with the hospital community, as defined, and other stakeholders, in the development of any and all methodologies for the reimbursement rates established under #3) above, requires DHCS to seek federal approval for the methodology and makes payments

contingent on the receipt of federal funds.

_____ 5)Makes inoperative all other provider rates as of July 1, 2010, including rates for hospital services negotiated by the California Medical Assistance Commission.

_____ 6)Makes the new hospital rates and rate methodologies inoperative in the event of a final judicial determination or a determination by the federal Centers for Medicare and Medicaid Services that any element of the Medi-Cal Hospital Rate Stabilization Act cannot be implemented.

_____ 7)Requires DHCS, to the extent feasible, to develop a case mix adjustment factor to apply to inpatient hospital rates to take into account the relative costs in treating different types of cases, as specified.

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8)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].

9)Requires DHCS to make periodic payments to county LCOs for low-income childless adults on a per member per month basis, as determined by DHCS consistent with the methodology for other MCMC plans. Requires DHCS to offer contract provisions to LCOs that limit the financial risk of the LCO and provides for the state to share in profits or losses above or below specified risk thresholds DHCS establishes. Requires providers of out-of-network emergency services for LCO enrollees to accept payments as payment in full if the rates comply with federal laws related payments for those services.

10)Makes Medi-Cal MC plans subject solely to regulation by DHCS, and not subject to regulation by DMHC or another state agency, in the areas of advertising and marketing, member materials, evidences of coverage, disclosure forms, and product design. Requires DHCS and DMHC to develop a joint filing and review process for medical quality surveys.

11)Increases state funding for health care benefits for In-Home Supportive Services (IHSS) workers by 25 cents per hour (from 60 cents to 85 cents per hour). Increases state funding by two additional 25 cent increments contingent on estimated General Fund revenues exceeding by at least 5% the prior year's revenue.

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; 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 tax on each pack of cigarettes; 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 the Fund in the State Treasury. Specifies how MRMIB may spend monies in the Fund.

6)Requires all employers with one or more full-time equivalent employees to establish Section 125 accounts to allow employees to pay premiums for health coverage with pre-tax dollars.

Implementation

1)Makes the implementation of this Act contingent on a finding by the Director of Finance that the financial resources necessary to implement the Act are available. States that this Act shall become operative upon the date that the Director of Finance files a finding with the Secretary of State (SOS) that all of the following circumstances exist:

a) Sufficient state resources will exist in the Fund;

b) Required federal approvals for program changes have been obtained or can reasonably be expected to be obtained by the time those programs are implemented; and,

c) Required federal resources will be available based on the anticipated schedule of review and approval of applicable state plan amendments and waivers.

2)Requires the Director of Finance to transmit the findings described in #1) above to the Legislature at least 90 days prior to their filing with the SOS.

3)States that, if any operative date specified in the Act is later than the date of the filing of the finding described in #1) above, that later date will apply. States that #1) above does not prevent the appropriation of funds to support activities necessary to prepare for the implementation of the Act prior to the filing with the SOS.

Evaluation

Requires the Secretary of CHHSA to complete, or contract for, a detailed, comprehensive evaluation of the reforms included in the Act, as specified, and to submit the first assessment to the Legislature on or before March 1, 2012, and every two years thereafter. Establishes the components of the evaluation.

Other

Declares this Act to be a comprehensive health care reform effort, that no provisions are severable, and that if any provision of the Act is held invalid, the entire Act will become inoperative.

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 (MRMIP), 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 : According to the Assembly Appropriations Committee:

1)Costs . The total annual cost of this coverage expansion is an estimated $14.4 billion (all funds) when enrollment reaches maximum levels. Major costs contained in this bill include:

a) Annual Cal-CHIPP costs of $6.4 billion to support low-income workers and employees of employers who choose to pay fees into the Fund;

b) Annual costs of $2.4 billion to expand Medi-Cal and HFP to children up to 300% FPL and adults up to 250% FPL;

c) Annual costs of $4 billion for Medi-Cal FFS, managed care, hospital, and physician rate increases;

d) Annual reduced tax revenues of $730 million due to a reduction of state personal income tax collections associated with employee use of Section 125 plans and tax credits provided to specified low- and moderate-income families; and,

e) Annual administrative and programmatic costs of approximately $900 million to various state agencies to support programmatic and administrative aspects of the requirements of the bill.

1)Financing . According to the author, the financing required to support the reform package will be presented to voters in a statewide ballot in November of 2008. The author indicates proposed financing will be designed to be revenue neutral with respect to the state General Fund. Several major financing provisions are expressed in legislative intent in the bill and include:

a) A requirement for employers to pay a health care fee equal to 1% to 6.5% of annual Social Security wages in the prior calendar year depending on size of firm payroll. This spending requirement will be reduced to the extent employers make health expenditures for employees and their dependents during the same time period. This requirement will generate an estimated $2.6 billion in annual contributions to Cal-CHIPP;

b) An increase in the tobacco excise tax of up to $2 per pack. This increase will generate an estimated $1.5 billion in special fund revenues;

c) A requirement for hospitals to pay an annual fee based on net patient revenues. This requirement will generate an

estimated $2.3 billion in annual special fund revenues that will be paid to support Medi-Cal rate increases to hospitals and other health care providers; and,

d) A requirement that specified local health care funds are shifted from counties to the state to support the expansion

of health coverage for individuals serviced by the county safety net. This requirement will generate $1 billion in annual revenues.

1)Financing Components Not Subject to Voter Approval . There are several major sources of financing that will not appear on the ballot, but are generated by requirements and provisions of the bill These include:

a) Annual employee contributions to Cal-CHIPP of $2.1 billion;

b) Annual FFP of $4.6 billion to support public program expansion of Medi-Cal and HFP and to increase provider Medi-Cal rates; and,

c) Annual Medi-Cal and Healthy Family savings of $500 million from a net movement of individuals from these public programs to other forms of coverage.

COMMENTS : This bill is the result of more than 14 months of legislative deliberations, public hearings, and stakeholder meetings. 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 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. These provisions were ultimately amended into
AB 2 X1 with no author. 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. This bill (AB 1 X1) was introduced and amended in Special Session and heard in public hearings by both the Assembly Health Committee and the Assembly Appropriations Committee.

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, 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 70% of Californians 5.1 million uninsured, including all low-income children regardless of immigration status.

According to the California HealthCare Foundation (CHCF), an average of 6.6 million Californians were uninsured 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 Medicaid, and 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 contribution 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% of FPL. 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.

According to CHCF, health care spending in California reached $169 billion in 2004, or 11% of the state's economy. Current projections indicate that health care spending could exceed 20% of the gross domestic product by 2025. According to a recent survey by the Kaiser Family Foundation, one in four Americans say their family had a problem paying for health care sometime during the past year, and 28% say someone in their family has delayed health care in the past year due to lack of insurance.

CHCF reports that approximately 40% of uninsured workers are employed by small businesses, and the number of uninsured workers in mid-size firms continues to rise. From 1999 to 2005, premiums for employer-provided health insurance in California increased by 112%, while the general cost-of-living increased by 29%. Average premium increases in California in 2006 were 8.7%, more than twice the California inflation rate of 4.2%, and higher than the national rate of increase of 7.7%. At the same time, over one-third of employers offering any kind of health insurance coverage, and nearly half of employers with less than 200 employees, experienced premium increases of over 10%.

This bill makes changes to the market rules affecting individual health insurance and revises eligibility for MRMIP for medically

uninsurable persons. While the majority of those with health insurance obtain that coverage on the job, individual coverage is the main alternative for those who are not covered through employment and are ineligible for publicly subsidized health coverage. In today's individual market, health insurers typically deny coverage or charge higher rates to individuals with pre-existing serious health conditions, such as cancer or heart disease. In addition, individuals with any previous health service use, even for conditions that no longer exist or with chronic conditions that are successfully being treated (such as mental illness, diabetes, or asthma), are also generally denied coverage. A September 2006 Commonwealth Fund national survey found that 89% of working-age adults who sought coverage in the individual market during the past three years ended up never buying a plan. A majority (58%) found it very difficult or impossible to find affordable coverage. One-fifth (21%) of those who sought to buy coverage were turned down, were charged a higher price because of a pre-existing condition, or had a health problem excluded from coverage. This bill requires all carriers to guaranteed issue and eliminates their ability to deny coverage for most persons, except for those who are not subject to the individual mandate. In addition, this bill establishes strict rating limits related to premium rate ups for health status and eventually phases out the ability of carriers to charge more for persons because of their health status or claims experience.

An August 2007 Field Poll found that 69% of California voters are dissatisfied with the state's health care system. Moreover, the percentage of voters who say they are "very dissatisfied" with the system has more than doubled since December 2006 when Field Poll last surveyed voters on health care reform. The poll found that 50% of Democratic voters are "very dissatisfied" with the health care system, along with 34% of Republicans and 37% of Independents.

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

1)A fee on employers equal to a specified percentage of payroll

payable to the Fund, which may be reduced by the amount the employer expends on health care for workers. Employers would pay on a sliding scale basis based on their payroll. Employers with payrolls of up to $250,000 would pay a fee equivalent to 1% of Social Security wages (capped at $97,500 in 2007), employers with payrolls between $250,000 and $1 million would pay a fee equal to 4% of Social Security wages, employers with payrolls between $1 million and $15 million would pay a fee equal to 6% of Social Security wages, and employers with payrolls above $15 million would pay a fee equal to 6.5% of Social Security wages;

2)A tobacco tax increase, likely between $1.50 and $2.00 for a package of cigarettes, and an equivalent increase on 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 programs through voter-approved Proposition 99; and, 50 cents for early childhood education through voter-approved Proposition 10;

3)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 FFS Medi-Cal payments to hospitals and MCMC 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; and,

4)County payments to the state representing a county's share of cost for previously uninsured persons that were the county's responsibility but under this bill will be enrolled in public coverage.

The Service Employees International Union State Council (SEIU) supports this bill, arguing that it will make health care more secure for everyone by controlling costs, improving quality and providing health coverage to almost four million uninsured Californians. SEIU states that, unlike today, where insurers and HMOs can and do deny coverage for any reason, under this bill they would be required to sell health insurance to anyone

who wants to buy it, regardless of pre-existing conditions. SEIU also argues that this bill covers three quarters of the uninsured, sets a standard for health benefits similar to the minimum wage, gives small businesses not just a break but an affordable alternative for coverage, subsidizes coverage for low- and moderate-income families, and provides cost containment through bulk purchasing of prescription drugs, a public insurer, public disclosure of cost and quality data regarding doctors, hospitals and insurers and places limits on insurer profits and overhead. In addition, SEIU argues that this bill moves California from dead last in Medi-Cal funding for doctors and hospitals, by increasing Medi-Cal rates for doctors, hospitals, and HMOs that serve Medi-Cal beneficiaries. SEIU notes that it has previously opposed individual mandate proposals that required Californians to have insurance whether they could afford it or not. However, this bill provides subsidies for those below 400% FPL ($40,840 for an individual, $82,600 for a family of four) and affordability and hardship exemptions for those with higher incomes.

The 100% Campaign, a coalition of Children Now, Children's Defense Fund, and The Children's Partnership, and PICO California support this bill because it extends health coverage to all children at or below 300% FPL, except that they would like to see the coverage for children take effect in January 2009 rather than July 2009.

Support and opposition received for a prior version of this bill include the following:

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 certain changes to this bill related to eligibility and affordability. The American Cancer Society (ACS) writes that the ideal system would establish health insurance that is affordable, available, adequate, and

administratively simple and that this bill most effectively meets ACS' criteria. The Children's Health Initiative of Greater Los Angeles supports this bill because it represents a

unique opportunity to provide health coverage to thousands of uninsured children and their families, but also would like to see an interim financing solution for the existing local children's health initiatives.

Those with support-if amended positions on this bill, including the American Federation of State, County and Municipal Employees, Health Access, Consumers Union, the California Medical Association, the California Hospital Association, the Congress of California Seniors, Planned Parenthood Affiliates of California, the California Academy of Family Physicians, and the Latino Issues Forum, raise various concerns, including defining the minimum set of benefits, making coverage affordable, assuring long-term stability and predictability in financing hospitals, avoiding relaxed licensing standards and expanded provider staffing ratios, adequacy of Medi-Cal reimbursement rates, and specifying the language of the proposed initiative.

Opponents of this bill include the California Nurses Association (CNA), the League of Women Voters (LWV), the Foundation for Taxpayer and Consumer Rights (FTCR), the California School Employees Association (CSEA), Blue Cross, Health Net, the Association of California Life and Health Insurance Companies, the Chamber of Commerce, the California Manufacturers and Technology Association, and the National Federation of Independent Businesses. CNA, LWV, CSEA and FTCR argue that the health insurance provided will not be universal, affordable, or high quality, and that bare bones coverage plans will be forced on Californians and employers who will have absolutely no control over the price. Insurers who are opposed argue that guaranteed issue and modified community rating will destabilize the insurance market, placing those currently insured in the individual market at risk of significant premium increases, and 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. Business groups who are opposed argue that 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.

Those with oppose-unless-amended positions include Kaiser Permanente (Kaiser), the California Association of Health Underwriters (CAHU), the Pharmaceutical Research and Manufacturers of America (PhRMA), the California State

Conference of the NAACP, and the Union of American Physicians and Dentists. Kaiser argues that guaranteed issue without a full individual mandate will not work, Cal-CHIPP needs more specificity, and best clinical practice standards should not be subject to bureaucratic rulemaking. CAHU opposes this bill unless it is amended to do the following: eliminate Cal-CHIPP or assure that it is voluntary; define minimum coverage; 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. PhRMA opposes this bill unless it is amended to remove MRMIB's prescription drug bulk purchasing and aggregate negotiating authority, arguing it will limit access to needed drugs. The NAACP also argues this bill will limit access to needed drugs.

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