

INFORMATIONAL HEARING

October 31, 2007
10:00 a.m.-3:00 p.m.
State Capitol, Room 4202

Governor Arnold Schwarzenegger's Revised Health Care Plan

Health Care Security and Cost Reduction Act

(As proposed by Governor Schwarzenegger – 10/9/07)

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(Text available online at: <http://gov.ca.gov/pdf/gov/HCR-RN0729963.pdf>)

CONTEXT

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, to establish a single-payer style health reform program in California. Senate and Assembly Republicans subsequently announced alternative health care reform strategies and introduced multiple bills in both houses to enact the proposals. AB 8 and SB 48 moved through the legislative process, and were publicly heard and voted on in multiple legislative hearings. The two bills were merged into AB 8 in July 2007, and AB 8 was passed by the full Senate and Assembly on September 7, 2007 and sent to the Governor. On September 11, 2007, the Governor signaled his intention to veto AB 8, and called an extraordinary special session of the Legislature to consider and act upon legislation to comprehensively reform California's health care system. On October 9, 2007, the Governor released the first public draft of legislative language to implement his plan, which included several additions and modifications from the plan outline released in January of this year. With the release of draft legislative language, the Governor also declared his intention to pursue a statewide ballot initiative to accompany the legislation, primarily to seek voter approval for the financing elements of his reform plan. On October 12, 2007, the Governor vetoed AB 8.

This background document analyzes the Governor's proposed draft legislative language.

PROPOSAL SUMMARY

The Governor's proposal establishes the Health Care Security and Cost Reduction Act (Act). The Governor's overall reform plan also depends on voter passage of a statewide ballot initiative, for which no language is available, intended primarily to seek voter approval for the financing elements of the plan. The Act provides that all provisions, dates and policy changes proposed are contingent on the Director of Finance making a finding that sufficient revenues are available.

I. Coverage Expansions

- 1) Effective July 1, 2010, expands eligibility for public coverage programs for low-income persons as follows:
 - a) Covers all children at or below 300% of the Federal Poverty Level (FPL), regardless of their immigration status. Expands eligibility in the Healthy Families Program (HFP) from 251% to 300% FPL; sets HFP premiums for children with family incomes of 251% to 300% FPL at \$22-25 per month per child, with a maximum of \$66-75 per month per family; and, eliminates federal citizenship and immigration eligibility requirements for children 18 and under in Medi-Cal or HFP.
 - b) Extends Medi-Cal coverage to 19- and 20-year olds up to 250% FPL, as specified. Extends coverage for low-income parents, caretakers of children on Medi-Cal or HFP, and childless adults between 100-250% FPL. Subsidized coverage for parents and caretaker adults otherwise not eligible for Medi-Cal and childless adults 100-250% FPL would be provided in a "benchmark plan," pursuant to new federal Medicaid rules under the Deficit Reduction Act (DRA) of 2006, through the Health Care Security and Cost Reduction Program (Purchasing Program) established in the Act. The DRA allows states to vary the benefit designs they offer to some groups using federal Medicaid funds.
 - c) Establishes cost-sharing limits for adults 19 and over eligible for subsidized coverage based on income, as described in 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 individuals and families 151-250% FPL -- No more than 5% of income, net of applicable deductions. Includes HFP premiums when calculating the above premium limitations.
 - d) Requires 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 the Purchasing Program, 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, requires the methodology for the federal poverty programs for pregnant women and children be used, but excludes from the determination of eligibility for this new program income disregards available under those programs, and provides that federal Medicaid rights, including the right to retroactive eligibility, do

not apply to this program unless a federal Medicaid waiver requires otherwise. Requires DHCS to seek federal funding for this program but does not make the coverage contingent on receipt of federal financial participation (FFP).

- e) Requires the Managed Risk Medical Insurance Board (MRMIB), which will administer the Purchasing Program, to determine the subsidized benefit plan and requires subsidized coverage to meet the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) and to also include prescription drug benefits. Requires MRMIB to combine the benefits with employee 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. (Knox-Keene is the existing body of law regulating health care service plans, and required basic benefits include inpatient and outpatient hospital, physician, preventive care, diagnostic lab and X-ray, home health, emergency, including out-of-area emergency and ambulance services, and hospice care.)
 - f) Effective July 1, 2010, eliminates the Medi-Cal assets test, which currently applies to certain Medi-Cal eligibility categories, to the extent that FFP is available.
 - g) Sunsets July 1, 2010 the requirement that certain adult Medi-Cal beneficiaries file semiannual status reports and instead requires them to file semiannual address verification, provided FFP is not jeopardized.
 - h) Requires the Department of Health Care Services (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 develop documentation requirements for HFP applicants newly eligible because of the elimination of immigration status as eligibility criteria, and specifies those program decisions that may be appealed to MRMIB by persons receiving coverage through the Purchasing Program.
 - 4) Requires MRMIB to coordinate with DHCS to seek FFP for subsidized health care coverage, including any federal Medicaid waivers that will be required, and to enter into appropriate inter-agency agreements to facilitate MRMIB's administration of Medi-Cal subsidized plans through the Purchasing Program. Makes subsidized coverage subject to the terms and conditions of any waiver or state plan amendment to the extent that FFP is obtained. Requires MRMIB to apply citizenship, immigration and identity documentation requirements to the extent required to obtain FFP for those persons eligible for federal funding. Requires

DHCS to maximize federal funds for the cost of subsidized coverage established under the Act.

- 5) Authorizes counties to make determinations of eligibility for HFP and for subsidized coverage under the Purchasing Program. 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.
- 6) States legislative intent to establish a mechanism for the state to defray the costs of an enrollee's public program participation by taking advantage of other opportunities for coverage of that enrollee.
- 7) Makes all coverage expansions for persons aged 19 and over, and the elimination of immigration status as an eligibility criteria for children in Medi-Cal, subject to implementation of education and enforcement activities required to be developed by the Secretary of Health and Human Services (Secretary) for the purposes of enforcing the individual mandate described below.

COMPARISON TO AB 8 (Nunez): AB 8 also covers children up to 300% FPL regardless of immigration status, but makes the coverage effective earlier, July 1, 2008. Covers parents up to 300% FPL rather than 250%, and also eliminates the Medi-Cal asset test for certain adults. The coverage expansions for parents effective January 1, 2010 would also be provided through a benchmark plan in a statewide purchasing program, known as the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), and would cover Knox-Keene benefits plus prescription drugs. AB 8 requires MRMIB to establish benefits and set premiums for low-income adults below 300% FPL in Cal-CHIPP at 0-5% of income, depending on the income level. Requires health plans and insurers (collectively "carriers") to collect the employer premium contribution for Medi-Cal and HFP eligible employees and transmit that amount to MRMIB. AB 8 does not include a public coverage program for low-income childless adults.

II. Purchasing Program and Individual Mandate

- 1) Requires, effective July 1, 2010, every California resident to maintain health coverage for themselves and their dependents, at least equal to a minimum level of coverage established in regulation by the Secretary, or other coverage that the Act provides will satisfy the mandate, such as any employer-sponsored coverage, thereby imposing an individual mandate on all California residents.
- 2) Makes the coverage mandate in #)1 above contingent on implementation of specified public education and mandate enforcement activities by the Secretary. Requires the Secretary to establish methods to inform individuals of their obligation and available public coverage. Grants broad authority but does not require the Secretary to establish methods to ensure that uninsured individuals obtain the minimum coverage, which may include paying the cost of minimum coverage for an uninsured individual and then recouping those costs from the individual, with interest. Authorizes the Secretary to enter agreements with the Franchise Tax Board (FTB) to use FTB's civil authority and procedures to collect funds owed that were

advanced, and requires, to the extent possible, individual mandate enforcement activities to be based on existing reporting processes regarding the employment and tax status of individuals and other existing mechanisms.

- 3) Requires FTB, the Department of Motor Vehicles, the Employment Development Department and other appropriate state agencies to cooperate with the Secretary and other responsible entities in undertaking these individual mandate enforcement activities and implementing these provisions. In addition, authorizes the Secretary to contract with private vendors for enforcement purposes. Implementation of these provisions is contingent upon an appropriation in the Budget Act or another statute.
- 4) Requires the minimum benefit plan established by the Secretary to cover medical, hospital, and preventive services. Also defines as minimum coverage for purposes of the mandate specified existing public and private coverage programs, such as Medicare, Medi-Cal and HFP, any employer-sponsored health care coverage, group health coverage, student health insurance and county-sponsored health care coverage for low-income persons, as specified.
- 5) Effective January 1, 2009, establishes the Purchasing Program, to be administered by MRMIB, and requires the Purchasing Program to offer both subsidized and unsubsidized coverage effective July 1, 2010. Establishes the duties, authority and responsibility for MRMIB in the operation of the Purchasing Program.
- 6) Makes California residents with incomes above 250% FPL eligible for unsubsidized coverage in the Purchasing Program as follows: employees paying the full cost of coverage through a cafeteria plan (Section 125 plan) where the employer designates the Purchasing Program as the Section 125 plan; persons eligible for a state tax credit based on the cost of health insurance administered by MRMIB; or employees of an employer that does not offer health coverage with at least some portion of the cost paid by the employer.
- 7) States legislative intent to establish a tax credit that will be available to a taxpayer who meets all of the following criteria: is not eligible for publicly subsidized coverage; receives unsubsidized coverage through the Purchasing Program; has adjusted gross income of 250-350% FPL; and is not eligible for employment-based group health coverage directly or through their spouse. States that the tax credit is advanceable and refundable and that the amount of the tax credit will equal that portion of the standard premium for minimum coverage on July 1, 2010, that exceeds 5% of the individual's adjusted gross income. For purposes of the tax credit, adjusts the premium level annually based on the United States Medical Consumer Price Index.
- 8) Requires unsubsidized coverage, at a minimum, to include one product that offers the same benefits as the minimum health care coverage mandated for individuals, and one product each in categories three and five, from the five choice categories established by the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) as part of the health insurance market reforms. Requires unsubsidized coverage to be subject to the insurance market reforms discussed below. Permits MRMIB to make available unsubsidized dental and vision coverage for individuals along with health coverage

through the Purchasing Program, as specified.

- 9) Requires premiums for unsubsidized health, dental and vision coverage to be commensurate with the cost of obtaining that coverage from participating plans plus the associated administrative costs.
- 10) Requires the Purchasing Program's participating health, vision, and dental plans to be regulated by, and in good standing with, either CDI or DMHC. Requires participating health plans to utilize efficient practices to control costs. Includes provisions to protect confidentiality of information concerning Purchasing Program applicants, enrollees and family members, as specified. States that MRMIB is not subject to regulation as a health plan or insurer by either CDI or DMHC consistent with existing law.
- 11) Makes it an unfair labor practice for an employer to refer an employee or dependent of an employee to the Purchasing Program 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 the Purchasing Program.
- 12) Authorizes but does not require school districts to provide an information sheet to specific 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.

COMPARISON TO AB 8: AB 8 does not include a requirement for individuals to have or maintain health insurance independent of whether they have employer-sponsored health coverage. AB 8 establishes Cal-CHIPP as a statewide purchasing program also administered by MRMIB and requires MRMIB to establish benefits at least equivalent to benefit levels mandated under Knox-Keene, plus prescription drugs. Instead of an individual mandate, AB 8 contains an employee "take up" requirement, which requires employees whose employer elects to pay to participate in Cal-CHIPP to sign-up for coverage, unless the employee's cost for coverage in Cal-CHIPP, as measured by the costs of a plan with a maximum out-of-pocket cost of \$1,500 annually, would exceed 0-5% of their income. Where employers elect to make health care expenditures rather than pay an equivalent fee, employees would have to accept the expenditures, unless they have other coverage or their share of costs for the employer-offered benefit exceeds 5% of their income. AB 8 requires MRMIB to establish premium contributions for low-income persons in Cal-CHIPP not to exceed 5% of family income for persons up to 300% FPL.

III. Health Insurance Reforms

- 1) Requires all carriers who sell individual private coverage to offer, accept and renew such coverage to all individuals [regardless of the age, health status or claims experience of applicants] (guaranteed issue and renewal). Guaranteed issue is contingent on implementation of the individual mandate enforcement activities delegated to the Secretary. Makes conforming changes to existing guaranteed renewal provisions and includes specified

exceptions for specialized types of plans and carriers with insufficient capacity to serve new enrollees.

- 2) Prohibits any preexisting condition exclusions, waived conditions or enrollment waiting periods once guaranteed issue is implemented and prohibits health plans and insurers from rescinding any individual plan contract or policy after it is issued.
- 3) Establishes rating rules for individual guaranteed issue coverage. Individual rates will be determined based on a standard risk rate for the benefit plan chosen, plus separate rate differentials, because of the individual's age, geographic location (risk category) and perceived health risk (risk adjustment factor), as determined by plans and insurers, 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 than 120% and no less than 80% of standard rates for the first three years; no more than 110% or less than 90% for the second three years, and eliminates such risk adjustment factors at the end of six years, unless the DMHC or CDI extends their use for up to an additional two years. During the first three years, the proposed rate bands for health risk (standard rates plus or minus 20%) mean that the highest risk person will pay 50% more than the healthiest person in the same age and geographic category;
 - d) 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;
 - e) 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,
 - f) Requires carriers to make specified filings with DMHC and CDI to demonstrate compliance with these rules.
- 4) Upon implementation of guaranteed issue, prohibits carriers from offering any individual plan or policy that does not meet the minimum coverage requirement determined by the Secretary, except as provided below, and requires the Secretary to make the minimum benefit determination by January 1, 2009. Prohibits CDI and DMHC from approving new products that do not meet the minimum after that time.
- 5) Grandfathers and allows continuation of coverage that does not meet the minimum benefit standard for any individual that buys such coverage prior to January 1, 2009, and deems the

existing below minimum coverage as meeting the mandate requirement. Prohibits the Insurance Commissioner and Director of the DMHC from approving for offer or sale any new benefit design that was not approved prior to that date which does not meet or exceed minimum health care coverage requirements. Provides that a below minimum product purchased after January 1, 2010 will be considered to meet the mandate for the term of the contract or 12 months, whichever is sooner. The Act appears to allow carriers to continue to offer below minimum products between January 1, 2009 and January 1, 2010.

- 6) 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 March 31, 2010, with the lowest level incorporating the mandatory minimum. Requires every health plan or insurer to offer coverage in all five categories and if the plan or insurer offers a specific type of benefit plan in one category – Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), 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 in a lower category.
- 7) 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.
- 8) Requires DMHC, in consultation with CDI, to develop and implement no later than July 1, 2010, through the period following one year after the elimination of health status rating in the individual market, mechanisms to assist carriers in managing the risk of guaranteed issue, if the mechanisms can improve access to individual coverage. Requires the mechanisms to collect data on carrier enrollment, prices and risk mix and to include strategies to normalize risk among plans, including a requirement to develop a reinsurance mechanism for individual market carriers.
- 9) Requires the OPA to develop and maintain on its Internet web site a uniform benefits matrix of all available individual health plan contract and insurance policies and specifies the information to be included.
- 10) Requires private carriers to spend 85% of after-tax revenues on health care, calculated across all of a carrier's products. Excludes from health care costs administrative costs, but includes disease management, training and informational materials, telephone advice and payments to providers based on performance.
- 11) Effective July 1, 2009, requires all carriers to offer, for both individual and group coverage, at least one "Healthy Action Incentives and Reward Program" (Healthy Action plans) as a benefit design, and also as a supplement for every contract or policy. Requires Healthy Action plans to provide for health risk appraisals and a follow-up with a licensed health professional. Requires Healthy Actions Plans to include any of a series of specified incentives or rewards for enrollees and insured persons to "become more engaged in their

health care and to make appropriate choices that support good health." Programs for which incentives may be provided include smoking cessation, physical activity or nutrition. Incentives may include premium reductions, differential copayments or cash payments. Rewards may include nonprescription pharmacy products, exercise classes, gym memberships and weight management programs.

- 12) Requires any carrier that offers Healthy Action 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.
- 13) Permits employers to provide Healthy Action plans which can include monetary incentives and reduced premiums for nonsmokers and smoking cessation. Provides that employer provided Healthy Action plans should not be construed as unlawful bribes or kickbacks, and provides for implementation only to the extent allowed under federal law.
- 14) Requires DHCS to include a Healthy Actions plan as a covered Medi-Cal benefit.
- 15) Exempts Healthy Incentives and Rewards Program offerings from laws prohibiting unlawful kickbacks, bribes, or inducements for enrollment or participation, to the extent permitted by federal law and not otherwise held to be invalid in court.

COMPARISON TO AB 8: AB 8 does not include an individual mandate and does not require carriers to accept all individual applicants regardless of health status, but only allows carriers to exclude the 3-5% of persons who are the most expensive to treat and who are automatically eligible for guaranteed coverage through the Major Risk Medical Insurance Program (MRMIP) for medically uninsurable persons. AB 8 requires MRMIB to develop a standardized health questionnaire for use by carriers in the individual market so as to identify the 3-5% of persons who will be eligible for coverage in MRMIP. AB 8 also requires CDI and DMHC to jointly establish five tiers of coverage and imposes similar limits on the ability of individuals to move up to a higher class of benefits. AB 8 extends current market rules applicable to firms of 2-50 employees, including guaranteed issue and rating limits, to firms of 51-100 employees, and completely eliminates health rating in employer plans for those 2-100 by January 1, 2010.

IV. 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 no later than January 1, 2010, and requires specified state licensing Boards and Committees that oversee the health professions to enforce compliance with this provision.
- 2) Defines "electronic prescribing" (e-prescribing) as prescription-related information transmitted between the point of care and the pharmacy using electronic media. Requires pharmacies and prescribers to share available specified information either directly or through an intermediary.

- 3) 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.
 - 4) Requires prescribers using e-prescribing to offer a written receipt of the information that is transmitted to the pharmacy and specifies the content of the receipt.
 - 5) Requires health plans and insurers to make the most current prescription drug formularies available electronically to prescribers and pharmacies.
 - 6) Requires DHCS to identify best practices related to e-prescribing standards and make recommendations for statewide adoption of e-prescribing by January 1, 2009.
 - 7) 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.
 - 8) Requires the Public Employment Retirement System (Cal-PERS) Board, by January 1, 2009, and authorizes MRMIB and DHCS, to provide or arrange for electronic personal health records (PHR) for PERS members, HFP enrollees, and Medi-Cal beneficiaries, respectively. Requires a PHR to provide access to real-time, patient-specific information about covered benefits and cost sharing, and permits PERS, MRMIB, and DHCS 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.
 - 9) Authorizes carriers to provide electronic notice to enrollees and insureds in order to comply with specific statutory or regulatory notice requirements that are otherwise required to be provided by mail, if the notice complies with specified requirements, including that the plan or insurer obtains written authorization from the enrollee or insured.
- 1) Extends to Nurse Practitioners (NPs), Physician Assistants (PAs), and nurse midwives the same authority granted to physicians to supervise medical assistants (MAs), and allows MAs to perform tasks or supportive services, pursuant to written instructions by a physician, NP, nurse-midwife, PA or licensed podiatrist, even when the supervisor is not onsite, under specified conditions.
 - 2) Expands from four to six the number of NPs, and from two to six the number of PAs, that a physician may supervise at any one time.
 - 3) Establishes an eight-member task force (three members of the Medical Board of California, three members of the Board of Registered Nursing, and two non-voting ex officio academic members) to develop a recommended scope of practice for NPs by June 30, 2009, and

requires the Director of the Department of Consumers Affairs to promulgate regulations that adopt the task force recommendations by July 1, 2010.

- 4) Establishes a new California Health Care Cost and Quality Transparency Committee (Committee), with specified appointed members, to be administered by a lead agency designated by the Secretary, for the purpose of statewide data collection, common measurement and analysis of health care costs, quality and outcomes, rather than relying on existing state agencies. Requires the Committee to meet monthly until January 1, 2011, and to develop a health care cost and quality transparency plan within one year of its first meeting, and authorizes but does not require the Secretary to implement recommendations in the plan.
- 5) Requires the Office of Statewide Health Planning and Development (OSHPD) to establish a clinical data collection program and to publish risk-adjusted outcome reports for percutaneous coronary interventions, such as angioplasty and the use of stents. Requires OSHPD to report by hospital and at least every other year, by hospital and physician, and to consult with the existing clinical advisory panel.
- 6) Adds to the current responsibilities of the OPA, which currently provides public information on health plan and medical group performance and quality, the requirement to provide to the public reports and data obtained by the lead agency designated by the Secretary under # 4) above, through mechanisms including but not limited to the Internet, for the purpose of assisting the public in making informed selections of health plans, hospitals, medical groups, nursing homes and other providers.
- 7) Establishes the Comprehensive Diabetes Services Program (CDSP), administered by the 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 federal financial participation 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.
- 8) Requires 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 # 8) above, as specified.
- 9) Requires CHHSA, in consultation with Cal-PERS and provider groups, to develop provider performance benchmarks to advance a common statewide framework for quality measurement and reporting, including measures approved by national quality measurement entities. Authorizes CHHSA to incorporate benchmarks into a common pay for performance

model to be offered in every state-administered health coverage program.

- 10) 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.
- 11) Requires Department of Public Health, subject to a budget act appropriation, to use scientifically appropriate methods to track and evaluate obesity-related health indicators, including physical activity, diet, and community environment, as specified, to evaluate and compare obesity projects and programs, and to study the health and economic consequences of obesity. Requires DPH to develop an Obesity Prevention Campaign, to be known as "California Living," and to link the campaign with community-level efforts, assist schools to promote fresh foods and whole grains, and provide technical assistance to help employers integrate wellness programs and policies into employee benefit plans and worksites.
- 12) Establishes the Community Makeover Grant program to be administered by DPH, for the purpose of awarding grants to local health departments (LHDs) as local lead agencies in the promotion of active living and healthy eating. Requires grants to LHDs to be based proportionally on population and to be expended for specified purposes, including, among other things, creation of a community infrastructure; coordination among local partners, including schools; and for local grants to promote physical activity for children, improve access to healthy foods, and better utilize community recreation facilities. Authorizes DPH to provide training, consultation and technical assistance to local programs or to contract for those services to another state, federal or auxiliary organization.

COMPARISON TO AB 8: AB 8 establishes a 13-member new California Health Care Cost and Quality Transparency Commission, with specified appointed members and independent staffing and responsibility, instead of under the auspices of an existing state agency as proposed in the Act, for the similar purposes of statewide data collection, common measurement and analysis of health care costs, quality and outcomes. AB 8 requires California Health and Human Services Agency (CHHSA) to conduct a professional review of best practice standards related to the care and treatment of patients with high cost chronic diseases, and to develop a pay for performance provider payment program, as specified, and requires implementation of both in all state-administered health coverage programs. Provides greater specificity on the cost-effective practices MRMIB must impose on carriers participating in Cal-CHIP. Establishes the California Health Benefits Service, administered by a nine-member board, within the California Health and Human Services Agency, to solicit and assist local initiatives and county organized health systems currently providing health care in Medi-Cal and HFP to form public joint ventures to provide coverage for individuals and ultimately employers.

V. Provider Reimbursement

- 1) Commencing July 1, 2010, increases Medi-Cal reimbursement rates, to the extent that federal funds are available, as follows:
 - a) Physicians. Requires physicians and physician groups in Medi-Cal to be paid no less than 80% of federal Medicare rates and requires DHCS to establish estimated rates not less than what Medicare would pay for services which are generally not covered by Medicare;
 - b) Private and District Hospitals. Establishes Medi-Cal rates for private and non-designated public hospitals (primarily district hospitals) at the same annual aggregate level that the federal Medicare program would pay for inpatient and outpatient services (otherwise known in federal law at the "upper payment limit") and to adjust the rates annually commensurate with Medicare rate increases;
 - c) Public Hospitals. Increases rates for designated public hospitals, University of California (UC) and county public hospitals, so that payment rates would be on a per diem or per discharge basis set at 100% of the hospitals allowable costs in 2006-07, adjusted annually by the increase in Medicare rates to private hospitals, or the annual rate of growth in costs by the individual hospital, whichever is less. 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; and,
 - d) Medi-Cal Managed Care (MCMC) Plans. Requires DHCS to increase Medi-Cal reimbursement rates for Medi-Cal managed care plans by the actuarial equivalent of the increased rates paid to hospitals and requires the plans to expend 100% of the related rate increases received in the form of increased hospital rates. States legislative intent to increase MCMC plan rates to reflect physician rate increases, to the extent practicable;
- 2) Establishes the system for cost reporting, reconciliation and establishment of rates for designated public hospitals and repeals the rate setting system within five years, effective January 1, 2016.
- 3) Authorizes DHCS to set aside an unspecified percentage of the Medi-Cal rate increase for physicians for payments linked to performance measures and performance improvement, as specified.
- 4) Prohibits a hospital, in the event a patient has coverage for emergency health care services and post stabilizing care, and the hospital does not have a contract with the patient's carrier, from billing the patient for emergency and post stabilizing care, except for applicable copayments and cost shares. Provides that the noncontracting hospital and the health plan or health insurer retain the right to pursue all current legal remedies [regarding payment or reimbursement].

- 5) Under a new Local Coverage Option (LCO), permits the DHCS to enter into at-risk-contracts with counties that have public hospitals, at the county's option, for the purpose of covering low-income, as specified.
- 6) Makes Medi-Cal managed care 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.

COMPARISON TO AB 8: AB 8 does not include provisions for provider rate increases.

VI. Financing

- 1) States legislative intent to finance the Act with contributions from employers, individuals, federal, state and local governments and health care providers. [The Governor has indicated his intention to pursue a ballot initiative containing the financing elements.]
- 2) Financing elements in the intent language include: increased federal Medicaid and State Children's Health Insurance Program (SCHIP) funds; unspecified revenue from counties based on enrollment in coverage of low-income adults now served by counties; a 4% fee on hospital patient revenues; employer fees ranging from 0 to 4% of payroll, based on employer size and payroll, with all employers of 10 or more employees paying 4%; premium payments by individuals in both publicly subsidized and private coverage; funds obtained through licensing the State Lottery; and other state savings from increased numbers of covered persons.
- 3) States legislative intent to establish a mechanism whereby counties contribute to the cost of providing coverage to individuals currently relying on counties for medical services. Makes coverage for childless adults at or below 100% contingent on this county contribution.
- 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 California Health Trust Fund (Fund) and makes it continuously appropriated to MRMIB for providing coverage under the Program. Specifies how monies in the fund may be spent.
- 6) In addition to other specific contingencies outlined in the Act, makes implementation of the Act contingent on a finding by the Director of Finance that sufficient financial resources to

implement specific sections are available. Makes the Act operative on the date the Director files a finding with the Secretary that specified conditions are met as outlined in the Act.

- 7) Requires all employers with two or more full-time employees to establish Section 125 accounts to allow employees to pay premiums for health coverage with pre-tax dollars.
- 8) Conforms state law with federal tax law to allow for a state income tax deduction related to health savings accounts.

COMPARISON TO AB 8: Implementation of AB 8 does not depend on subsequent passage of a statewide ballot initiative. AB 8 does also rely on increased federal Medicaid and SCHIP funds to fund some portion of costs for the public program expansions proposed. Effective January 1, 2009, AB 8 requires employers to elect to either: a) make health care expenditures, defined as any amount paid by an employer to or on behalf of its employees and dependents to provide health or health-related services or to reimburse the costs of those services, for its full-time or part-time employees, or both; or, b) pay an equivalent amount to the California Health Trust Fund established in the bill, and establishes the amount of the employer's financial obligation as 7.5% of Social Security wages paid by the employer for full-time employees working 30 or more hours per week and 7.5% of Social Security wages paid by the employer for part-time employees working less than 30 hours per week. Exempts expenditures subject to collective bargaining agreements, as specified. AB 8 also requires employers to establish Section 125 plans for their employees.

VII. Evaluation

- 1) Requires the Secretary to complete, or contract for, an 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.

COMPARISON TO AB 8: AB 8 also requires CHHSA to conduct an evaluation of the reforms with evaluation components that are very similar but not completely identical to those proposed in the Act, including that AB 8 requires an assessment of health care quality not included in the evaluation proposed in the Act.

BACKGROUND

- 1) PURPOSE OF THIS PROPOSAL: According to the Schwarzenegger Administration, the Act would ensure access to health coverage for all. Background materials for the Governor's plan state that the Act guarantees that every Californian can purchase insurance, promotes affordability of coverage and requires every Californian to carry a minimum level of health care insurance.
- 2) CALIFORNIA'S UNINSURED. 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 Medi-Cal, and an estimated 8.7% purchase coverage through the individual insurance market.

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

Thirty-eight percent of the uninsured in California have incomes below \$25,000 annually, and 54% of the uninsured have annual incomes below 200% of the 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.

- 3) COVERAGE FOR CHILDREN. According to the CHCF, an average of 1.3 million children in California remained uninsured over the three year period 2003 – 2005. Children comprise 20% of the state's total uninsured population, and 71% of California's uninsured children are in families where the head of household works full-time, full year. Over half of all uninsured children were eligible for either HFP or Medi-Cal, but remained unenrolled. The balance of uninsured children was ineligible for these programs, largely due to income limitations or immigration status. According to CHCF, in 2003, although employers were the primary source of health coverage for children (covering 53% of children), approximately 26% of children under age 19 were enrolled in Medi-Cal and 6% were enrolled in HFP.
- 4) EXISTING PUBLIC COVERAGE PROGRAMS As a result of both state and federal laws, eligibility rules for California's Medicaid program, Medi-Cal, are complex and based on multiple factors primarily related to income, property, household composition, residency, age and/or health condition. There are currently more than 170 "aid codes," or eligibility categories, in Medi-Cal. Generally speaking, low-income citizen children are eligible for Medi-Cal as follows: infants in families with incomes less than 200% FPL, one to five year olds at 133% FPL or less; and six to nine year olds at 100% FPL or less. Low income adults can be eligible for Medi-Cal under a variety of programs primarily designed for disabled persons or parents of low-income children. Generally speaking, adults between the ages of 21 and 65, without children, who are not pregnant, blind or disabled, and who do not have one of several specific health care needs outlined in statute (such as dialysis, tuberculosis, breast and cervical cancer treatment, etc.) are not currently eligible for Medi-Cal. HFP currently covers children in families with incomes over 200% FPL but less than or equal to 250% FPL. HFP applies income deductions that are applicable to children under Medi-Cal in determining that a family's income does not exceed 250% FPL for purposes of HFP eligibility. FFP is not available for undocumented persons in Medicaid or SCHIP.
- 5) FPL: THE FEDERAL POVERTY GUIDELINES. The table below includes the FPL for 2007 as developed according to formula by the federal Department of Health and Human

Services. The federal poverty guidelines, or percentage multiples of them (such as 125%, 150%, or 185%), are used as an eligibility criterion by a number of federal and state programs.

2007 Federal Poverty Guidelines					
Persons in Family or Household	48 Contiguous States and D.C.	150%	200%	250%	300%
1	\$10,210	\$15,315	\$20,420	\$25,525	\$30,630
2	13,690	20,535	27,380	34,225	41,070
3	17,170	25,755	34,340	42,925	51,510
4	20,650	30,975	41,300	51,625	61,950
5	24,130	36,195	48,260	60,325	72,390
6	27,610	41,415	55,220	69,025	82,830
7	31,090	46,635	62,180	77,725	93,270
8	34,570	51,855	69,140	86,425	103,710
For each additional person, add: \$3,480					
SOURCE: <i>Federal Register</i> , Vol. 72, No. 15, January 24, 2007, pp. 3147-3148					

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

Proponents of the individual mandate argue that such mandates respond to a legitimate concern about "free riders," uninsured persons who nonetheless receive treatment when they get sick, in emergency rooms and through other uncompensated or reduced cost care, resulting in additional costs being passed on to taxpayers and individuals with insurance. Proponents argue that those most likely to go without health insurance are the young and relatively healthy and that for these young, healthy individuals, going without health insurance is often a logical economic decision. The problem with their choice, proponents argue, is that it leads to a form of adverse selection. Removing the young and healthy from the insurance pool results in higher insurance premiums for those who choose to be insured because the remaining insurance pool is older and more costly to insure. Finally, proponents argue that in the context of an individual mandate it is possible to impose stricter rules on insurance carriers, requiring them to guarantee issue of coverage to everyone, because concerns about potential adverse selection are reduced. Opponents of an individual mandate argue that individuals, including young and healthy persons, are most likely uninsured because they cannot afford to buy meaningful coverage or are being denied private coverage because of pre-existing health conditions. Opponents argue that imposing a mandate does nothing by itself to significantly improve affordability and that the majority of uninsured persons will need some form of subsidy or government-sponsored health plan in order to comply with a mandate. Opponents also argue that requiring individuals to buy coverage on their own is inefficient and reduces the purchasing clout typically associated with buying group health insurance. Opponents are also concerned that a mandate can only be enforced through punitive and costly penalties or expensive government bureaucracies that come at the expense of the programs that actually provide health coverage. Finally, some opponents of the mandate view the requirements as unacceptably providing the health insurance industry with a captive market that must seek out and purchase their product.

- 8) MEDICAL LOSS RATIOS. In health insurance, a medical loss ratio (MLR) is the ratio of medical benefits to premiums – in other words, the amount of premium revenues a carrier spends on the actual costs of medical care services, versus administration, profit and where applicable, shareholder dividends. MLRs are presented as a percentage – the percent of premium revenues spent on medical care. Except for Medicare-related coverage plans, the only existing MLR requirement is the regulatory standard imposed on individual health insurance policies regulated by CDI, which are required to return 70% of the premium in the form of medical benefits. Health plans under DMHC jurisdiction are limited to no more than 15% for administrative costs, but this standard does not affect how much must be spent on medical care in the same way as MLR.
- 9) SECTION 125 PLANS. Under Section 125 of the Internal Revenue Code, enacted by Congress in 1978, employers can give their employees the opportunity to pay for benefits on a pretax basis. In a Section 125 plan, sometimes called a cafeteria plan, an employee is allowed to pay for his/her group health premiums, other qualified insurance premiums, unreimbursed medical costs (such as prescriptions and copayments), child and dependent care costs and more, all with tax-free dollars. Both employees and employers save on taxes because Section 125 plans reduce taxable wages, including the amount of wages on which employers must pay Social Security and Medicare taxes.

POLICY ISSUES AND QUESTIONS

Coverage Expansions

- 1) Premium Assistance. The Act includes intent language to "establish a mechanism for the state to defray the costs of an enrollee's public program participation by taking advantage of other opportunities for coverage of that enrollee." This may be intended as placeholder language for some type of premium assistance program. Premium assistance programs help to pay premiums for private coverage, such as paying a low-income persons share of costs for employer-sponsored coverage. The Administration may wish to clarify the purpose of this language.

Individual Mandate

- 2) Individual Mandate. The Act requires all California residents to be enrolled in and maintain minimum health coverage. In 2007, the Legislature has not voted on any legislation containing a similar individual mandate and AB 8 (Nunez) did not impose a health insurance mandate on all Californians. Although there are many policy and legal considerations relating to the individual mandate, one policy consideration is the affordability of health coverage for persons subject to the mandate. What are the public program expansions, tax credits or subsidies necessary to ensure that all Californians, particularly individuals and families with low and moderate incomes, can afford to comply with a legal mandate to maintain health coverage?
- 3) Tax credit for low income persons. The draft language expresses legislative intent to offer an advanceable and refundable tax credit for persons at relatively low incomes, (250-350% FPL), based on the "average standard risk rate" for minimum coverage, and only for that portion of the premium that exceeds 5% of a taxpayer's adjusted gross income. However, the language makes it unclear how the average standard rate would be determined for this purpose. If a person has a higher rate because of age, or lives in a higher cost area, the tax credit they receive could be significantly less than their actual costs of minimum coverage. Is the proposed tax credit based on an average rate across all age and geographic categories, or would it be related to the average rate for a person in their age or geographic category?
- 4) Mandate enforcement. The Act provides very broad authority to the Secretary relating to implementation and enforcement of the individual mandate, including the ability to enroll individuals in minimum coverage and recoup the costs with interest, access information about individuals from any state agency, including using the civil and procedural authority of the FTB, and contracting with an external private vendor for all enforcement activities. Is the delegation of this level of responsibility to the Secretary with broad and vague language appropriate? What should be the incentives or the penalties, if any, for failure to meet the individual mandate?
- 5) Mandate trigger. The Act makes the individual mandate contingent on implementation of education and enforcement activities by the Secretary. However, the language requires the educational activities, but only authorizes the enforcement related activities. What specific

activities would need to be implemented for the mandate to become effective? What process would be established to ensure that all consumers understand the effective date and requirements they must meet?

- 6) Minimum benefit plan. The Act requires the minimum benefit plan established by the Secretary to cover medical, hospital, and preventive services. This minimum benefit set could exclude many services required under Knox-Keene, as well as benefits that most Californians have come to expect in health insurance policies. Depending on the Secretary's interpretation of the specific language in the Act, potentially excluded services include basic diagnostic laboratory and X-ray services, outpatient hospital services, emergency and out-of-area emergency care and services, and outpatient prescription drugs. Moreover, the Act defines as minimum coverage any employer-sponsored coverage and other coverage alternatives whether or not they meet the minimum established by the Secretary. What additional guidance or direction should the Legislature give to the Secretary, if any, to ensure that the minimum mandated benefit provides adequate coverage for essential health care services? Should there be some standardization among the coverage that must be offered, such as at least one common benefit plan in each choice category offered by all carriers, to permit purchasers to comparison shop among carriers? If state policy is to require every resident to have minimum coverage, how does allowing alternative coverage that does not meet the mandate advance that policy?

Health Insurance Reforms

- 7) Grandfathering of existing low benefit coverage. The Act proposes to grandfather existing low benefit plans that will not meet the new minimum coverage requirements determined by the Secretary. One rationale for doing so is that individuals with existing low-cost coverage (such as policies with very high annual deductibles and copayments, limited hospital or physician visits, no maternity coverage, etc.) would end up paying more for coverage as a result of reform. However, under current market rules, which allow carriers to selectively insure only persons they perceive as low-risk and low-cost, individuals covered in these plans today are often the youngest and healthiest persons. Allowing the young and healthy to stay out of the new market created by the Act could make premiums for the remaining individuals who buy coverage significantly higher as a result of the adverse risk mix in the new market. How can the Legislature balance concerns about the potential health insurance rate increases for some healthier, younger groups with the need to also make coverage available and affordable for older persons and those with preexisting conditions and chronic health care needs? In addition, the language in this section needs clarification since the Act prohibits carriers from selling below minimum plans after January 1, 2009, but then appears to allow for such policies sold after January 1, 2010 to be temporarily grandfathered. The Legislature may wish to ensure that below minimum benefit plans cannot be sold at all after January 1, 2009 to reduce the incidence of carrier marketing designed to insure the largest number of young, healthy persons in grandfathered low benefit plans prior to the start of the reforms.
- 8) Health status rating. The Act requires guaranteed issue of all products in the individual market and sets the rating rules for the coverage, including allowing carriers to price products taking into account the age, geographic location and health status of individual applicants. In

an individual mandate context, should there be at least some products that individuals subject to the mandate can purchase without higher premiums because of their health status, for example, the minimum mandated benefit, or at least one benefit plan in each of the lowest two choice categories? What is the rationale for the six-to-eight year phase out of health rating in the individual market? With an individual mandate in place shouldn't the time period be significantly shortened because everyone, both healthy and high risk persons, is required to be in the market, hopefully resulting in a more manageable risk mix?

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

Technology and Cost Containment

- 10) E-prescribing. The Act requires prescribers and pharmacies to be able to transmit and receive electronic prescriptions, but does not require health plans, insurers or other payers to provide all of the eligibility and coverage information, other than formulary information, the prescribers and pharmacies must be able to receive. In order to facilitate adoption of e-prescribing, should payers also be required to provide real-time eligibility and coverage information electronically? Is the January 1, 2010 deadline for all prescribers and pharmacies to meet the requirement realistic, especially for smaller and rural providers?
- 11) California Diabetes Program and Obesity Prevention programs. The existing California Diabetes Program (CDP) was established within the former Department of Health Services now DPH and is primarily funded by the federal Centers for Disease Control and Prevention. In the 2005 Budget, the Legislature mandated that CDHS create a strategic plan to guide a statewide response on obesity. How do the proposed new programs and activities in the Act compare with existing programs administered by DPH and DHCS? Is there a potential for overlap and duplication?
- 12) Changes to NP and PA Supervision. The Act allows one physician to supervise a combined total of 12 NPs. Is this the intent? While expanding the use of NPs and PAs may be an appropriate strategy to include in health care reform, is the significant expansion proposed in the Act justified? What standards, protections or training requirements might be necessary to ensure that the expansion can be implemented while protecting patient safety?

Provider Reimbursement

- 13) Safety Net Funding. The Act proposes a new rate methodology for Medi-Cal payments to public hospitals, including a \$100 million limitation on public hospital access to the existing Safety Net Care Pool established as part of California's hospital financing waiver. What is the overall impact on public hospitals and the county safety net from all of the elements of the Act, including the requirement that counties pay a share of cost to the state? What will be the potential impact on other county administered and funded programs such as social services and mental health?
- 14) Hospital Fee. The Governor's plan calls for a 4% hospital fee which in turn provides revenues to support the Medi-Cal rate increases proposed in the Act and a portion of the cost of the coverage expansions. Under a fee proposal combined with Medi-Cal rate increases, some hospitals would pay more in fees than they receive in additional Medi-Cal payments and some hospitals would receive a net increase in revenues. The Act does not spell out the structure and distribution of the hospital fee. The Administration may wish to provide additional information about the proposed fee and the impact on hospitals across the state.

Financing

- 15) Financing. The Act includes only intent language on the financing anticipated to support the Act. The Governor has stated his intention to pursue a ballot initiative to secure the funding, including the employer fee, the hospital fee and revenues from the lottery. How can the Legislature evaluate the Act and the financing component without specific proposed statutory language? What portions of the Act should be in statute and what should be in a proposed initiative? What are the implications of pursuing financing for this comprehensive reform proposal through a ballot initiative as proposed by the Governor?
- 16) County Share of Cost. As health reform provides health coverage to previously low-income uninsured persons, counties could potentially face reduced demand for county health care programs and services currently provided to low-income uninsured persons. In this context, what is the appropriate timing, process and level for county revenues to be included in financing the coverage expansions aimed at individuals they currently serve? The Act includes intent language requiring that counties contribute an unspecified amount to the state to support the costs of care for previously uninsured persons who may have been receiving services through county health care programs and facilities. The Administration may want to clarify the intent of this section.
- 17) Contingencies. The Act includes several provisions that delay implementation until certain benchmarks are met. The Act in its entirety depends on the Director of Finance making a finding that sufficient revenues are available, presumably upon successful passage of the ballot initiative to raise revenues. What portions of the Act should depend on key benchmarks and what portions might be possible regardless, for example, specific proposals to reduce or control health care costs?

Technical issues and questions.

In addition to the policy questions and issues raised by this analysis, there are significant technical clarifications and possible amendments that appear to be necessary to clarify or accomplish the stated intent and purposes of the Act. Should this draft language be introduced as legislation, these technical challenges and clarifications would need to be addressed and the proposed policy changes evaluated by the Legislature once clarified.