Health and Human Services Policy Committee

Thursday, May 31 ▪ 10:30 a.m. – Noon
Regency Ballroom E-F ▪ Hyatt Regency Sacramento
1209 L Street ▪ Sacramento, CA

Supervisor Kniss, Santa Clara County, Chair
Supervisor Woodrow, Alpine County, Vice Chair

This policy committee meeting is an in-person meeting only
and is being held as part of the CSAC 2012 Legislative Conference.

10:30 a.m.	I.	**Welcome and Introductions** *Supervisor Liz Kniss, Santa Clara County*
10:35 – 10:45 a.m. **ACTION ITEM**	II.	**Governor's Ballot Measure** *Kelly Brooks-Lindsey, Senior Legislative Representative*
10:45 – 11:35 a.m. **ACTION ITEM**	III.	**Federal Health Reform Implementation: Eligibility & Benefits** *Cathy Senderling McDonald, County Welfare Directors Association* *Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty* *Sarah Muller, California Association of Public Hospitals and Health Systems*
11:35 – 11:55 a.m.	IV.	**2012-13 Budget Update** **- May Revision Budget** **- Care Coordination Initiative** **- 2011 Realignment Implementation** *Kelly Brooks-Lindsey, CSAC Senior Legislative Representative*
11:55 – Noon **ACTION ITEM**	V.	**Consider Frequency of HHS Policy Committee Meetings** *Supervisor Liz Kniss, Chair*
	VI.	**Adjournment**

ATTACHMENTS

Attachment One..................... **CSAC Memo: Constitutional Protections for Realignment – <u>ACTION ITEM</u>**

Attorney General's Title and Summary of *The Local Schools and Public Safety Protection Act of 2012 Version 3* (March 16, 2012)

Legislative Analyst's Office Letter on *The Local Schools and Public Safety Protection Act of 2012 Version 3* (March 16, 2012)

Public Policy Institute of California Statewide Survey (April 2012)

Los Angeles Times/USC Dornsife Survey: Strong Majority Backs Brown's Tax Initative, *Los Angeles Times* (March 25, 2012)

Los Angeles Times Editorial: California's Dueling Tax Plans (May 3, 2012)

Attachment Two.......................CSAC Memo: Health Care Reform: Designing Eligibility Systems for 2014 Essential Health Benefits (SB 951, AB 1453) Basic Health Plan (SB 703) – <u>ACTION ITEM</u>

Text of SB 951 (Hernandez)

Senate Health Committee Analysis of SB 951

Text of AB 1453 (Monning)

Assembly Health Committee Analysis of AB 1453

California Health Benefits Exchange Overview of Essential Health Benefits

Text of SB 703 (Hernandez)

Assembly Health Committee Analysis of SB 703

Mercer Report: State of California Financial Feasibility of a Basic Health Program (May 2011)

Attachment Three………………..CSAC Memo: 2012-13 State Budget Update - May Revision

CSAC Health and Human Services section of the May Revision Budget Action Bulletin (May 14, 2012)

CSAC, UCC and CHEAC Budget Letter on Public Hospital Funding (May 17, 2012)

Attachment Four…………………..CSAC Memo: Coordinated Care Initiative

Attachment Five…………………..CSAC Memo: 2011 Realignment Update: Implementation

CSAC Realignment Implementation Letter to the Legislature (May 8, 2012)

CSAC, CMHDA, CADPAAC, and CWDA Joint Comments on the HHS Programmatic Trailer Bills (May 15, 2012)

Reader's Guide to the 2011 Realignment Superstructure Trailer Bill

Attachment Six…………………….CSAC Memo: Establish Policy Committee Meeting Schedule – <u>ACTION ITEM</u>

Attachment One

CSAC Memo: Constitutional Protections for Realignment – ACTION ITEM

Attorney General's Title and Summary of The Local Schools and Public Safety Protection Act of 2012 Version 3 (March 16, 2012)

Legislative Analyst's Office Letter on The Local Schools and Public Safety Protection Act of 2012 Version 3 (March 16, 2012)

Public Policy Institute of California Statewide Survey (April 2012)

Los Angeles Times/USC Dornsife Survey: Strong Majority Backs Brown's Tax Initative, Los Angeles Times (March 25, 2012)

Los Angeles Times Editorial: California's Dueling Tax Plans (May 3, 2012)

May 21, 2012

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

To: CSAC Administration of Justice Policy Committee
CSAC Government Finance and Operations Policy Committee
CSAC Health and Human Services Policy Committee

From: Elizabeth Howard Espinosa, CSAC Senior Legislative Representative
Eraina Ortega, CSAC Legislative Representative
Kelly Brooks-Lindsey, CSAC Senior Legislative Representative

Re: **Constitutional Protections for Realignment – ACTION ITEM**

Recommendation: Adopt and forward a SUPPORT position for *The Schools and Local Public Safety Protection Act Version 3* to the CSAC Board of Directors.

Overview. The CSAC Board of Directors has indicated that obtaining a constitutional guarantee of revenues to support the 2011 realigned programs, as well as protecting counties from costs associated with future changes to those programs, remains a top priority of the Association in 2012.

This memo is intended to provide the relevant information to the CSAC policy committees with jurisdiction over relevant policy areas to assist in considering a SUPPORT position for *The Schools and Local Public Safety Protection Act Version 3*, which contains the Constitutional protections sought by counties.

The Schools and Local Public Safety Protection Act Version 3 is the Governor's hybrid measure that is jointly sponsored by the California Federation of Teachers. Governor Brown has directly pledged to the CSAC Executive Committee that if the hybrid measure fails in November of this year, he will not hesitate to bring back another ballot measure to provide the 2011 Realignment funding guarantees and protections sought by California counties.

The Governor has also committed to an ongoing dialogue with counties regarding implementation issues for realigned programs, as well as other issues of statewide concern. We continue to have an active and constructive dialogue with Administration officials on the implementation of 2011 Realignment.

Process. Once the Governor announced his new hybrid measure on March 15, the CSAC Officers indicated that they required a thorough review of the new measure. In accordance with the State Ballot Proposition Policy found in the CSAC Policy and Procedures Manual (page 12), the officers subsequently referred the measure to three policy committees: Administration of Justice, Government Finance and Operations, and Health and Human Services.

Each policy committee is scheduled to review the Governor's measure, Version 3, on May 31 during the CSAC Legislative Conference in Sacramento. The policy committees will then forward their recommendations to the CSAC Executive Committee for a recommendation to the full CSAC Board of Directors. The Board of Directors will then consider the policy committee position recommendations and adopt a position on *The Schools and Local Public Safety Protection Act Version 3* at their regularly scheduled meeting on September 6. The state's General Election will be held two months later, on November 6, 2012.

Timeline. At a special Board of Directors meeting on January 5, Board members voted to suspend all efforts by CSAC to qualify an independent ballot measure seeking 2011 Realignment funding protections, leaving the measure filed by Governor Brown in December 2011 (*The Schools and Local Public Safety Protection Act of 2012*) as the only available vehicle to achieve those constitutional protections.

On January 19, the CSAC Executive Committee considered the Governor's proposed ballot measure and voted to recommend to the Board of Directors that CSAC take a SUPPORT position on the measure.

On February 23, the CSAC Board of Directors voted to adopt a SUPPORT position on *The Schools and Local Public Safety Protection Act of 2012*. The California State Sheriffs Association (CSSA) and the Chief Probation Officers of California (CPOC) had also voted to take a SUPPORT position on *The Schools and Local Public Safety Protection Act of 2012* prior to the CSAC Board of Directors meeting.

On March 15, the Governor announced that he was joining with the California Federation of Teachers (CFT) – which was also gathering signatures for their own tax measure to raise revenue for schools – to support a new measure, titled "*The Schools and Local Public Safety Protection Act Version 3*," also referred to as the "Millionaire's Tax Measure." The coalition backing the new hybrid measure is called Californians Working Together. A copy of the Attorney General's Title and Summary is attached. At the time of the compromise on the hybrid measure, CFT abandoned its original school tax measure.

When he formed the compromise with CFT, Governor Brown indicated that he would continue to circulate his original petition to ensure that at least one of the measures would qualify. Subsequent to that announcement, though, the Governor determined that the compromise measure had sufficient support to qualify for the ballot and he suspended signature gathering on his original measure. This development left the compromise measure as the only vehicle available to counties to obtain constitutional protections for 2011 Realignment.

On May 4, the Governor and CFT submitted signatures to registrars in counties across California to qualify the new hybrid measure for the November 6 ballot.

Comparing the Measures. While the Governor's new hybrid measure combines some language and policy from both his and the CFT's original initiatives, the new measure includes the same structure as the Governor's first initiative, including the following features:

1. Funds are dedicated to education.
2. Assists in balancing the state budget.
3. Offers critical 2011 Realignment protections for counties, including:
    a. The identical Constitutional protections contained in the Governor's original measure (and those negotiated in the original SCA 1X).
    b. Guaranteed funding for the realigned programs.
    c. Protections from state and/or federal encroachment.

The bulk of the changes to the Governor's original measure are found in the tax rate structure[1]. The new measure makes changes to the Personal Income Tax (PIT) rate and changes the length of time that the new PIT rates will remain in effect. Additionally, the new measure proposes a sales tax rate lower than the Governor's original ballot proposal. The following chart details the changes:

		Governor's Measure	**March 15 Hybrid Measure**
Personal Income Tax Provisions	INCOME FOR SINGLE (JOINT) FILER		
	$250,000 ($500,000)	1%	1%
	$300,000 ($600,000)	1.5%	2%
	$500,000 ($1,000,000)	2%	3%
	LENGTH OF TAX	5 years	7 years
Sales Tax Provisions			
	RATE	½ cent	¼ cent
	LENGTH OF TAX	4 years	4 years

[1] Please note that none of the tax changes affect the revenues dedicated to 2011 Realignment.

A copy of the Legislative Analyst's Office letter regarding the blended measure is attached.

Since virtually all of the income earners impacted by the proposed temporary increase in personal income taxes itemize their dedications on state and federal tax returns, a significant portion of the increase in state taxes paid through this provision would be offset by a reduced federal tax liability.

The revenues raised by the temporary taxes are in addition to the funding guarantee for the realigned programs, which comes from existing sales and use tax and Vehicle License Fee (VLF) fund sources. The revenues generated from these temporary taxes in the Governor's hybrid measure are exclusively dedicated to school entities (K-12 education and community colleges) and are subject to the Proposition 98 calculation. The revenues raised by the measure are deposited directly into a newly created fund and allocated to schools, bypassing the Legislature. This feature essentially means that these revenues are first to fill the "bucket" of the state's annual Proposition 98 calculation, thus saving the state about half of that amount **which can then be used for other state General Fund purposes.**

In addition to the temporary increase in taxes for education, the measure provides a constitutional guarantee of the funding dedicated to the 2011 realignment (an amount equal to 1.0625% of the state sales tax and certain vehicle license fees) as well as the protections of those programs sought in early 2011 in legislative measure SCA 1X.

Tax Increases and CSAC Policy. It has long been CSAC policy to support a balanced approach to resolving the chronic state budget deficit and under that policy CSAC has supported increased revenues in the past. For instance, in 2009 the CSAC board supported an increase in the gas tax when the Legislature proposed to permanently divert the entire local share of the Highway User Tax Account (HUTA) to fund debt service and provide $1 billion a year in General Fund relief. This tax increase generated an additional $750 million per year.

Governor Brown inherited a combined $26.2 billion budget deficit when he took office in 2011 and recent projections indicate a $15.7 billion state budget deficit for the next 18 month period, despite significant cost cutting in the 2011-12 state budget. The Governor's proposed 2012-13 budget is balanced through a combination of budget cuts and the proposed tax increases. If the tax increases are not supported, triggers cuts — primarily in education — would automatically kick in. The temporary taxes contained in the Governor's ballot measure are about half of the taxes that would have been extended by SCA 1X. CSAC voted 45-4 to support SCA 1X due primarily to the fact that it contained the constitutional protections sought as part of realignment, as does the Governor's proposed measure.

Through his proposed budget, the Governor projects that these taxes would be temporary and that growth in the state's economy would produce future tax revenues sufficient to offset the loss of the temporary taxes when they expire.

Beginning in 1991, the State of California has relied upon temporary tax increases to assist the state in recovering from severe recessions. In 1991, Governor Wilson proposed, and the Legislature enacted taxes by adding incremental tax rates of 10 and 11 percent on upper income levels. These rates expired after five years in 1996. In addition, a temporary ½ cent sales tax was imposed, set to expire in 1993. Even those increased tax revenues, though, did not prevent the state from diverting $4.3 billion of local property taxes in 1992-93 and 1993-94 to a state Education Revenue Augmentation Fund (ERAF) to fund part of the state's obligation to K-14 education as the recession lingered. Those diversions are permanent and have grown to more than $7.3 billion annually.

Also in 1991, CSAC supported an increase in the sales tax (½ cent) and an adjustment to the depreciation schedule of the Vehicle License Fee which generated $1.98 billion that was then designated to the 1991 realignment programs. Both of those tax sources remain in effect today and generate approximately $4 billion for California counties to use on those programs.

In part to offset the impacts of those tax diversions, in 1993 the Legislature placed Proposition 172 on the ballot. This measure offered voters the opportunity to continue the ½ cent sales tax that was to expire at the end of 1993 and dedicated the funding from the ½ cent sales tax to public safety. CSAC supported Proposition 172; it passed by a strong margin and remains in effect today.

In 2009, under Governor Schwarzenegger, the Legislature adopted temporary income tax rates at the higher level, a temporary 1 cent increase in the sales tax, and a temporary Vehicle License Fee rate increase, a portion of which was dedicated to local public safety. These temporary taxes were in place for two years and expired at the end of June 2011. These were the taxes that would have been extended for five years under last year's SCA 1X.

SCA 1X of 2011						
	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**
General Fund *(in billions)*	$102.137	$103.373	$91.547	$87.335	$91.48	$85.937

State Budget Cuts. There is no question that California and the rest of the nation have been wracked by one of the worst and most prolonged economic recessions since the Great Depression. The impact first hit California in 2008 and has been felt in every budget since.

In response, California has made significant cuts in state expenditures. It is difficult to make an apples-to-apples comparison of budget gaps and deficits as those figures change continuously. However, an analysis of the actual budget figures for the state's general fund in the last several fiscal years reveals that the State of California has made real reductions in spending, while demand for services has continued to climb.

The 2011-12 Budget cut General Fund spending as a share of the economy to its lowest level since 1972-73. State Supplementary Payment grants were reduced to the level in effect in 1983. CalWORKs grants were reduced to below the level in effect in 1987. State support for its universities and courts was cut by about 25 percent and 20 percent, respectively. The Adult Day Health Care program, redevelopment agencies, Williamson Act subventions, Home-to-School Transportation, and the refundable child care and dependent tax credit were all eliminated. The Department of Corrections and Rehabilitation's expenditures will be reduced by approximately 18 percent once realignment is fully implemented. K-14 education funding remains $9 billion below the 2007-08 funding level.

The Governor has proposed further cuts to K-14 education should his measure fail in November. Furthermore, such a failure would exacerbate the structural deficit that has plagued the state since 2000.

The Governor's Campaign. The Governor and CFT were able to collect more than 1 million signatures in less than two months and submit them to county registrars of voters. Nearly 300,000 of the signatures gathered were through a grassroots volunteer process.

As of this writing, the Governor and the CFT have raised more than $12 million in support of their new measure. We anticipate significant funding from business, labor and education groups in support of the Governor's efforts. The Governor has in fact indicated a broad range of supporters, from labor to business interests.

To date, the following groups, among others, have made financial contributions to the combined Governor/CFT campaign:

- The California Federation of Teachers
- American Federation of Teachers
- The California Teachers Association
- The California School Employees Association
- The California Medical Association
- Assembly Speaker John Perez's campaign committee
- Service Employees International Union Local 1000
- United Domestic Workers of America California Medical Association

Competing Campaigns. An important factor that will influence the Governor and CFT's success on the ballot will be the extent to which they can clear the field of other tax initiatives, most importantly the remaining measure to raise personal income tax rates.

Sponsored by the *Our Children, Our Future* coalition, the remaining tax measure campaign is funded almost entirely by Molly Munger, a civil rights attorney in Los Angeles and the daughter of Charles Munger, a partner of Warren Buffett's. Ms. Munger's proposal increases the PIT rates on all but the lowest income bracket, beginning in 2013 and ending in 2024. The additional marginal tax rates would be higher as taxable income increases. For income of PIT filers currently in the highest current tax bracket (9.3% marginal tax rate, excluding the mental health tax), additional marginal tax rates would rise as income increases. The current mental health tax (Proposition 63) would continue to be imposed.

In 2013-14 and 2014-15, all revenues raised by this measure (estimated to be between $10 and $11 billion per year) would be allocated for schools and Early Care and Education (ECE) programs (85 percent for schools, 15 percent for ECE). Beginning in 2015-16, total allocations to schools and ECE programs could not increase at a rate greater than the average growth in California personal income per capita in the previous five years. The measure also prohibits its revenue from replacing state, local, or federal funding that was in place prior to November 1, 2012. All revenue collected by the measure and allocations made to schools are excluded from the calculation of the Proposition 98 minimum guarantee. Ms. Munger has contributed $8.7 million to this campaign as of this writing.

The *Our Children, Our Future* coalition began submitting signatures to the Registrars of Voters in counties on May 3.

Counties should note that Ms. Munger's measure does not contain the constitutional protections for counties for 2011 Realignment. Within the last week, Ms. Munger has indicated an interest joining with the Brown coalition to promote both measures under the shared goal of saving California's public schools.

Polling on the Governor/CFT measure. Recent polling (April 25) by the Public Policy Institute of California (PPIC) indicates that 54 percent of likely voters say they would vote for the Governor's new measure (39 percent would vote no) when they are read the new ballot title and a brief summary. A copy of the survey is attached.

However, the electorate appears divided on the method to raise revenue, with 65 percent of likely voters favor raising the top rate of state income tax paid by the wealthiest Californians, while only 46 percent support raising the state sales tax. Both tax increases are included in the new measure.

Please also note that a strong majority of likely voters (78 percent) oppose cuts to public schools, which Governor Brown has said would be the state's only choice should his initiative fail in November.

A USC Dornsife/Los Angeles Times poll on March 25 found that 64 percent of those surveyed said they supported the Governor's revised measure. An article about the survey is attached.

An earlier PPIC poll, held in January 2012 and measuring voter support for the Governor's original measure, found 72 percent of adults and 68 percent of likely voters favored the proposed temporary tax increases.

In December of 2011, CSAC conducted a poll of the Governor's original measure and found that 62 percent of those polled support a plain language description of the measure. The ongoing cuts to public education are the most persuasive arguments. In this same poll, a range of 65 percent to 71 percent of likely voters expressed concerned about funding for K-14 education.

Recommendation: *The Schools and Local Public Safety Protection Act of 2012 Version 3* remains the only viable vehicle for California Counties to obtain the constitutional protections and guaranteed funding for realigned programs, which remains the top priority of the Association. While the measure polls well as of this writing, competing measures could weaken its chances of passage. Association support of the measure is important to garner the votes necessary to pass the measure. Furthermore, Association support is very important should the measure fail and it becomes necessary for the Governor to follow through on his commitment to take a realignment protections measure to the electorate in a future election. For these reasons, it is recommended that the CSAC policy committees with relevant jurisdiction adopt and forward to the CSAC Executive Committee **a SUPPORT position** on *The Schools and Local Public Safety Protection Act of 2012 Version 3.*

Attachments

I. Attorney General's Title and Summary (March 16, 2012)

II. Legislative Analyst's Office Letter on *The Schools and Local Public Safety Protection Act of 2012 Version 3 (March 16, 2012)*

III. PPIC Statewide Survey (April 2012)

IV. Article on USC Dornsife/Los Angeles Times Poll (March 25, 2012)

V. LA Times Editorial Supporting the Brown/CFT Measure (May 3, 2012)

The Attorney General of California has prepared the following title and summary of the chief purpose and points of the proposed measure:

TEMPORARY TAXES TO FUND EDUCATION. GUARANTEED LOCAL PUBLIC SAFETY FUNDING. INITIATIVE CONSTITUTIONAL AMENDMENT. Increases personal income tax on annual earnings over $250,000 for seven years. Increases sales and use tax by ¼ cent for four years. Allocates temporary tax revenues 89 percent to K-12 schools and 11 percent to community colleges. Bars use of funds for administrative costs, but provides local school governing boards discretion to decide, in open meetings and subject to annual audit, how funds are to be spent. Guarantees funding for public safety services realigned from state to local governments. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local government: **Increased state revenues over the next seven fiscal years. Estimates of the revenue increases vary—from $6.8 billion to $9 billion for 2012-13 and from $5.4 billion to $7.6 billion, on average, in the following five fiscal years, with lesser amounts in 2018-19. These revenues would be available to (1) pay for the state's school and community college funding requirements, as increased by this measure, and (2) address the state's budgetary problem by paying for other spending commitments. Limitation on the state's ability to make changes to the programs and revenues shifted to local governments in 2011, resulting in a more stable fiscal situation for local governments.** (12-0009)

LAO

70 YEARS OF SERVICE

March 16, 2012

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed constitutional amendment related to the funding of local governments and schools and temporary taxes (A.G. File No. 12-0009).

BACKGROUND

State's Fiscal Situation

California's Recent Budget Problems. The General Fund is the state's core account that supports a variety of programs, including public schools, higher education, health, social services, and prisons. The General Fund has experienced chronic shortfalls in recent years due to trends in state spending and revenues. State budgetary problems since 2008-09 have been caused by a number of factors, including a severe economic recession that caused state revenues to decline sharply. To deal with the state's budgetary shortfalls, policymakers have reduced program expenditures, temporarily raised taxes, and taken a variety of other measures including various forms of borrowing from special funds and local governments.

Ongoing Budget Deficits Projected. The state's budget shortfalls are expected to continue over the next five years under current tax and expenditure policies. In November 2011, the Legislative Analyst's Office (LAO) estimated annual budget deficits of greater than $5 billion through 2016-17, including a budget shortfall of roughly $13 billion in 2012-13. In January 2012, the Department of Finance (DOF) estimated a budget shortfall of $9.2 billion in 2012-13 and annual budget deficits of less than $5 billion thereafter. These estimates will be updated in May 2012—based on updated information about state revenues and expenditures—when the Governor releases the May Revision to his proposed 2012-13 state budget.

Taxes and Revenues

The General Fund is supported primarily from income and sales taxes paid by individuals and businesses.

Income Tax. The personal income tax (PIT) is a tax on income earned in the state and is the state's largest revenue source. Tax rates range from 1 percent to 9.3 percent depending on a taxpayer's income. Higher tax rates are charged as income increases, such that the 1 percent of tax filers with the most income now pay around 40 percent of state income taxes. An additional 1 percent rate is levied on taxable incomes in excess of $1 million with the proceeds dedicated to mental health services rather than the General Fund.

Sales Tax. California's sales and use tax (SUT) is levied on the final purchase price of tangible consumer goods, except for food and certain other items. The SUT rate consists of both a statewide rate and a local rate. The current statewide rate is 7.25 percent. Approximately half of the revenue derived from the statewide rate is deposited into the General Fund, while the remainder is allocated to local governments. Localities also have the option of imposing, with voter approval, add-on rates to raise revenues for cities, counties, or special districts. As a result, SUT rates in California differ by county and locality, with an average rate of about 8.1 percent.

State School Funding

In 1988, voters approved Proposition 98. Including later amendments, Proposition 98 establishes a guaranteed minimum annual funding level—commonly called the minimum guarantee—for K-14 education (consisting of K-12 schools and community colleges). The minimum guarantee is funded through a combination of state General Fund appropriations and local property tax revenues. With a two-thirds vote in any given year, the Legislature can suspend the Proposition 98 guarantee for one year and provide any level of K-14 funding it chooses.

Minimum Guarantee Often Affected by Changes in State Revenues. In many years, the calculation of the minimum guarantee is highly sensitive to changes in state General Fund revenues. In years when General Fund revenues grow by a large amount, the guarantee is likely to increase by a large amount. Conversely, in years when General Fund revenues decline by a large amount, the guarantee is likely to drop by a large amount. In these years, however, the state typically generates an associated "maintenance factor" obligation that requires the state to accelerate future growth in Proposition 98 funding when General Fund revenues revive. Another type of Proposition 98 obligation is known as "settle-up." A settle-up obligation is created when the state ends a fiscal year having appropriated less than the finalized calculation of the minimum guarantee. Typically, the state pays off settle-up obligations in installments over several years.

2011 Realignment Legislation

Shift of State Program Responsibilities. The state and local governments in California operate and fund various programs. These programs are funded through a combination of state, federal, and local funds. The specific responsibilities and costs assigned to state and local governments vary by program. As part of the 2011-12 state budget plan, the Legislature enacted a major shift—or "realignment"—of state program responsibilities and revenues to local governments. The realignment legislation shifts responsibility from the state to local governments (primarily counties) for several programs including court security, adult offenders and parolees, public safety grants, mental health services, substance abuse treatment, child welfare programs, and adult protective services. Implementation of this transfer began in 2011.

Dedication of Revenues to Cover Program Costs. To fund the realignment of these programs, the 2011-12 state budget dedicates a total of $6.3 billion in revenues from three sources into a special fund for local governments. Specifically, the realignment plan directs 1.0625 cents of the statewide SUT rate to counties. Under prior law, equivalent revenues were deposited in the General Fund. In addition, the realignment plan redirects an estimated $462 million from the 0.65 percent vehicle license fee (VLF) rate for local law enforcement programs. Under prior law, these VLF revenues were allocated to the Department of Motor Vehicles for administrative purposes and to cities and Orange County for general purposes. The budget also shifts $763 million on a one-time basis in 2011-12 from the Mental Health Services Fund (established by Proposition 63 in November 2004) for support of the Early and Periodic Screening, Diagnosis, and Treatment Program and Mental Health Managed Care program.

Exclusion of Revenues From Proposition 98 Calculation. A budget-related law, Chapter 43, Statutes of 2011 (AB 114, Committee on Budget), stated that the 1.0625 cent SUT realignment revenues were to be excluded from the Proposition 98 calculation. This provision of Chapter 43, however, was made operative for 2011-12 and subsequent fiscal years contingent on the approval of a ballot measure by November 2012 that both (1) authorizes the exclusion of the 1.0625 cent sales tax revenues from the Proposition 98 calculation and (2) provides funding for school districts and community colleges in an amount equal to the reduction in the minimum guarantee due to the exclusion. If these conditions are not met, Chapter 43 creates a settle-up obligation for the lower Proposition 98 spending in 2011-12 to be paid over the next five fiscal years.

State-Reimbursable Mandates

State Required to Reimburse Local Governments for Certain Costs. The California Constitution generally requires the state to reimburse local governments when it "mandates" a new local program or higher level of service. In some cases, however, the state may impose requirements on local governments that increase local costs without being required to provide state reimbursements.

Open Meeting Act Mandate. The Ralph M. Brown Act (known as the Brown Act) requires all meetings of the legislative body of a local agency to be open and public. Certain provisions of the Brown Act—such as the requirement to prepare and post agendas for public meetings—are state-reimbursable mandates.

PROPOSAL

The measure amends the Constitution to permanently dedicate revenues to local governments to pay for the programs realigned in 2011 and temporarily increases state taxes.

2011 Realignment Legislation

Guarantees Ongoing Revenues to Local Governments for Realigned Programs. The measure requires the state to continue allocating SUT and VLF revenues to local governments to pay for the programs realigned in 2011. If portions of the SUT or VLF dedicated to realignment are reduced or eliminated, the state is required to provide alternative funding that is at least equal to the amount that would have been generated by the SUT and VLF for so long as the local governments are required to operate the realigned programs.

Constrains State's Ability to Impose Additional Requirements After 2012. Through September 2012, the measure allows the state to change the statutory or regulatory requirements related to the realigned programs. A local government would not be required to fulfill a statutory or regulatory requirement approved after September 2012 related to the realigned programs, however, unless the requirement (1) imposed no net additional costs to the local government or (2) the state provided additional funding sufficient to cover its costs.

Limits Local Governments From Seeking Additional Reimbursements. This measure specifies that the legislation creating 2011 realignment (as adopted through September 2012) would not be considered a state-reimbursable mandate. Therefore, local governments would not be eligible to seek reimbursement from the state for any costs related to implementing the legislation. Similarly, the measure specifies that any state regulation, executive order, or administrative directive necessary to implement realignment would not be a state-reimbursable mandate.

State and Local Governments Could Share Some Unanticipated Costs. The measure specifies that certain unanticipated costs related to realignment would be shared between the state and local governments. Specifically, the state would be required to fund at least half of any new local costs resulting from certain changes in federal statutes or regulations. The state also would be required to pay at least half of any new local costs resulting from federal court decisions or settlements related to realigned programs if (1) the state is a party in the proceeding, and (2) the state determines that the decision or settlement is not related to the failure of local agencies to perform their duties or obligations.

Open Meeting Act Mandate

The measure specifies that the Brown Act would no longer be considered a state-reimbursable mandate. Localities would still be required to follow the open meeting rules in the Brown Act but would not be eligible to seek reimbursement from the state for any associated costs.

Tax Rates

Increases Income Tax Rates on Higher Incomes for Seven Years. Under current law, the maximum marginal PIT rate is 9.3 percent, and it applies to taxable income in excess of $48,209 for individuals; $65,376 for heads of household; and $96,058 for joint filers. This measure temporarily increases PIT rates for higher incomes by creating three additional tax brackets with rates above 9.3 percent. Specifically, this measure imposes:

- A 10.3 percent tax rate on income between $250,000 and $300,000 for individuals; $340,000 and $408,000 for heads of household; and $500,000 and $600,000 for joint filers.
- An 11.3 percent tax rate on income between $300,000 and $500,000 for individuals; $408,000 and $680,000 for heads of household; and $600,000 and $1 million for joint filers.
- A 12.3 percent tax rate on income in excess of $500,000 for individuals; $680,000 for heads of household; and $1 million for joint filers.

These tax rates would affect roughly 1 percent of California PIT filers due to the high income threshold. The tax rates would be in effect for seven years—starting in the 2012 tax year and ending at the conclusion of the 2018 tax year. (The additional 1 percent rate for mental health services would still apply to income in excess of $1 million.)

Increases SUT Rate for Four Years. This measure temporarily increases the state SUT rate by 0.25 percent. The higher tax rate would be in effect for four years—from January 1, 2013 through the end of 2016. Under the measure, the average SUT rate in the state would increase to around 8.4 percent.

State School Funding

Permanently Removes Realigned Sales Tax Revenues From Proposition 98 Calculation. The measure amends the Constitution to explicitly exclude the 1.0625 cent sales tax revenues directed to realignment programs from the Proposition 98 calculation.

New Tax Revenues Deposited Into New Account for Schools and Community Colleges. The measure requires that the additional tax revenues generated by the temporary increases in PIT and SUT rates be deposited into a newly created Education Protection Account (EPA). Appropriations from the account could be used for any educational purpose and would count towards meeting the Proposition 98 minimum guarantee. Of the monies deposited into the account, 89 percent would be provided to schools and 11 percent would be provided to community colleges. The EPA funds for schools would be distributed the same way as existing general purpose per-pupil funding, except that no school district is to receive less than $200 in EPA funds per pupil. Similarly, the EPA funds for community colleges would be distributed the same way as existing general purpose per-student funding, except that no community college district is to receive less than $100 in EPA funds per full-time equivalent student.

Fiscal Effects

Realignment Programs

Provides More Certainty to Local Governments. This measure would change the state's authority over the 2011 realignment. After September 2012, the state could not impose new requirements to 2011 realignment resulting in increased costs without providing sufficient funding. Also, the state would share certain new costs related to federal law or court cases. Consequently, the measure reduces the financial uncertainty and risk for local governments under realignment. Any impact would depend on how the state would have acted in the future absent the measure, as well as what, if any, actions are taken by the federal government or courts.

Limits State's Ability to Change 2011 Realignment. With regard to the state, the measure would have the related impact of restricting the state's ability to make changes resulting in new costs to local governments in the 2011 realignment without providing additional funding to local governments. The state could also bear additional costs associated with new federal laws or court cases beyond the funds provided by 2011 realignment.

State Revenues

Significant Volatility of PIT Revenues Possible. Most of the income reported by California's upper-income filers is related in some way to their capital investments, rather than wages and salary-type income. In 2008, for example, only about 37 percent of the income reported by PIT filers reporting over $500,000 of income consisted of wages and salaries. The rest consisted of capital gains (generated from sales of assets, such as stocks and homes), income from these filers' interests in partnerships and "S" corporations, dividends, interest, rent, and other capital income. While upper-income filers' wage and salary income is volatile to some extent (due to the cyclical nature of bonuses, among other things), their capital income is *highly* volatile from one year to the next. For example, the current mental health tax on income over $1 million generated about $734 million in 2009-10 but has raised as much as $1.6 billion in previous years. Given this volatility, estimates of the revenues to be raised by this initiative will change between now and the November 2012 election, as well as in subsequent years.

Revenue Estimates. The volatility described above makes it difficult to forecast this measure's state revenue gains from high-income taxpayers. As a result, the estimates from our two offices of this measure's annual revenue increases vary. For the 2012-13 budget, the LAO currently forecasts this measure would generate $6.8 billion of additional revenues, and DOF forecasts $9 billion of additional revenues. (This essentially reflects six months of SUT receipts in 2013 and 18 months of PIT receipts from all of tax year 2012 and half of tax year 2013.) In the following five fiscal years, the LAO currently forecasts an average annual increase in state revenues of $5.4 billion, and DOF currently forecasts an average annual increase in state revenues of $7.6 billion. In 2018-19, the measure's PIT increase would be in effect for only six months of the fiscal year before expiring and generate lesser amounts of state revenue.

Proposition 98

The measure affects the Proposition 98 calculations. In the near term, the effect of the temporary tax increases would more than offset the state savings generated by the exclusion of the realignment SUT revenues. The change in the minimum guarantee, however, would depend on a number of factors, including the amount of revenue raised by the measure, year-to-year growth in General Fund revenues, and the way in which Proposition 98 maintenance factor obligations are paid. By excluding the realignment SUT revenues from the Proposition 98 calculations beginning in 2011-12, the state would no longer have a 2011-12 settle-up obligation. As a result, the state would not need to pay hundreds of millions of dollars annually from 2012-13 through 2016-17.

State Budget

Deposits New Revenues in the EPA. The new PIT and SUT revenues would be deposited in the EPA. The measure dedicates EPA funds for spending on schools and community colleges and counts them towards the Proposition 98 minimum guarantee.

New Revenues Available to Balance State Budget. As described above, the measure would increase the Proposition 98 minimum guarantee in the near term. At the same time, the measure would put new tax revenue into the EPA, which would be available for meeting the state's Proposition 98 obligation. The EPA funds would be sufficient to fund the increase in the

minimum guarantee as well as pay part of the minimum guarantee currently funded from the General Fund, thereby freeing up General Fund monies to help balance the state budget.

Long-Term Budget Effect Uncertain. The measure's tax increases are temporary. Depending on future budget decisions and the state of the economy, the loss of these additional tax revenues could create additional budget pressure when the proposed tax increases expire.

Summary of Fiscal Effect

This measure would have the following major fiscal effects:

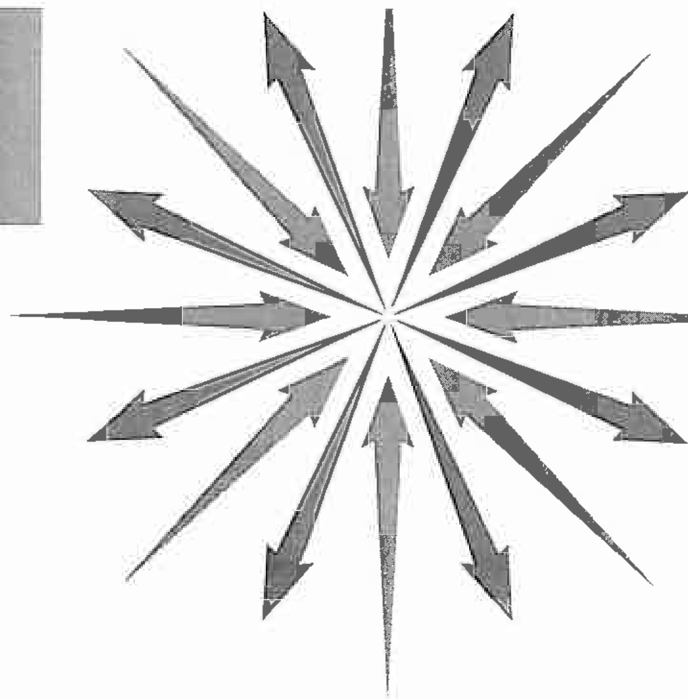
- Increased state revenues over the next seven fiscal years. Estimates of the revenue increases vary—from $6.8 billion to $9 billion for 2012-13 and from $5.4 billion to $7.6 billion, on average, in the following five fiscal years, with lesser amounts in 2018-19.
- These revenues would be available to (1) pay for the state's school and community college funding requirements, as increased by this measure, and (2) address the state's budgetary problem by paying for other spending commitments.
- Limitation on the state's ability to make changes to the programs and revenues shifted to local governments in 2011, resulting in a more stable fiscal situation for local governments.

Sincerely,

Mac Taylor
Legislative Analyst

Ana J. Matosantos
Director of Finance

PPIC STATEWIDE SURVEY



APRIL 2012

Californians & education

Mark Baldassare

Dean Bonner

Sonja Petek

Jui Shrestha

CONTENTS

About the Survey	2
Press Release	3
Fiscal Attitudes and Policy Preferences	6
General Perceptions	16
Regional Map	22
Methodology	23
Questionnaire and Results	25

in collaboration with
The Dirk and Charlene Kabcenell Foundation
and the Stuart Foundation

PPIC PUBLIC POLICY INSTITUTE OF CALIFORNIA

ABOUT THE SURVEY

The PPIC Statewide Survey provides policymakers, the media, and the public with objective, advocacy-free information on the perceptions, opinions, and public policy preferences of California residents. Inaugurated in April 1998, this is the 125th PPIC Statewide Survey in a series that has generated a database of responses from more than 264,000 Californians. This survey is conducted with funding from The Dirk and Charlene Kabcenell Foundation, the Stuart Foundation, and The Silver Giving Foundation. Its goal is to inform state policymakers, encourage discussion, and raise public awareness about K–12 public education issues. This is the eighth annual PPIC Statewide Survey since 2005 to focus on this topic.

California has the largest K–12 public education system in the nation. According to the California Department of Education and the Education Data Partnership (Ed-Data), the state served more than six million students in 1,050 school districts and about 9,900 public schools during the 2010–11 school year. California also has a highly diverse student population: More than half are economically disadvantaged (57%), a quarter are English learners (23%), and 10 percent have developmental, physical, emotional, or learning disabilities. Latinos (51%) make up the largest racial/ethnic group of students, followed by whites (27%), Asians (12%), and blacks (7%).

Governor Brown has placed K–12 public education at the center of his 2012–13 budget proposal. After several years of cutbacks, the governor would like to provide additional funding to the state's school districts by temporarily increasing the personal income tax on upper-income earners and by temporarily raising the state sales tax. He is seeking voter approval through a citizen's initiative on the November ballot. Should the initiative fail, the governor's budget proposal calls for automatic multibillion dollar cuts to K–12 education. Meanwhile, the governor has called for two key education reforms: increased flexibility at the local level on spending state funds and the targeting of resources to schools with the neediest students.

In this context, this survey report presents the responses of 2,005 California adult residents on:

- Fiscal attitudes and policy preferences, including priorities for state spending; preferences for the governor's tax initiative and automatic K–12 spending cuts, and for raising specific taxes to provide additional funding for schools; whether the state budget situation is a problem for schools; concerns about teacher layoffs and shortening the school year; preferences for raising revenues for local schools; and attitudes toward reforms—increasing local flexibility and targeting resources to schools with more low-income students and English learners.
- General perceptions, including approval ratings of the governor and legislature overall and of their handling of K–12 education; perceptions of California's ranking in per pupil spending and student test scores compared to other states; concerns about the teacher shortage in lower-income areas and about English learners' test scores; perceptions of their local public schools; and opinions of public school parents about their children's schools.
- Time trends, national comparisons, and the extent to which Californians may differ in their perceptions, attitudes, and preferences based on their political party affiliation, likelihood of voting, region of residence, race/ethnicity, whether they have children attending a California public school, and other demographics.

This report may be downloaded free of charge from our website (www.ppic.org). For more information about the survey, please contact survey@ppic.org. Try our PPIC Statewide Survey interactive tools online at http://www.ppic.org/main/survAdvancedSearch.asp.

PPIC
Statewide
Survey

CONTACT
Linda Strean 415-291-4412
Andrew Hattori 415-291-4417

NEWS RELEASE

EMBARGOED: Do not publish or broadcast until 9:00 p.m. PDT on Wednesday, April 25, 2012.

Para ver este comunicado de prensa en español, por favor visite nuestra página de Internet: http://www.ppic.org/main/pressreleaseindex.asp

PPIC STATEWIDE SURVEY: CALIFORNIANS AND EDUCATION

Worried About School Funding, Most Favor Tax Increase—For the Rich

LIKELY VOTERS RELUCTANT TO RAISE OWN TAXES, BUT 54 PERCENT SUPPORT BROWN INITIATIVE

SAN FRANCISCO, April 25, 2012—California's likely voters favor raising the state income taxes of the wealthiest state residents to provide more money for public schools, but most oppose increasing the state sales tax for this purpose. These are among the key findings of a statewide survey on K–12 education released today by the Public Policy Institute of California (PPIC).

The survey finds that 65 percent of likely voters favor raising the top rate of state income tax paid by the wealthiest Californians (34% oppose). By contrast, 46 percent support raising the state sales tax (52% oppose). Temporary increases in both of these taxes are components of Governor Jerry Brown's proposed November ballot initiative to deal with the state's multibillion-dollar budget gap.

Asked specifically about Brown's initiative, 54 percent of likely voters say they would vote for it (39% would vote no) when they are read the ballot title and a brief summary. Direct comparisons with earlier PPIC surveys on this question are not possible because the initiative has changed. However, likely voters' support was about the same in March when they were read the identical ballot title and a similar summary (52% yes, 40% no). Today, Democrats and Republicans are sharply divided on the measure (75% Democrats yes, 65% Republicans no), with independents more likely to say they would vote yes (53%) than no (43%). Public school parents support the measure by a wide margin (60% yes, 36% no).

If voters reject his initiative, Brown says there will be automatic cuts to public schools. A strong majority of likely voters (78%) oppose these cuts—a view held across parties.

The survey also asked about another idea being proposed to provide more money for education: an overall increase in state personal income taxes. The majority of likely voters (57%) oppose this tax increase (40% favor).

"Most likely voters favor the governor's tax initiative, although they express much stronger support for raising taxes on the wealthy than increasing their own taxes for public schools," says Mark Baldassare, PPIC president and CEO.

There is a strong partisan split among likely voters on the specific tax increases to provide more money for public schools. Most Democrats favor increasing the state income tax on high earners (89%), the state sales tax (64%), and personal income taxes overall (56%). Most independents favor raising income taxes on the wealthy (63%), but not the state sales tax (43% favor) or personal income tax (42% favor). Support is low among Republicans for raising any of these taxes to fund schools (36% support higher taxes on the wealthy, 25% support state sales tax increase, 21% support personal income tax increase).

DESPITE CONCERNS ABOUT FUNDING, MOST BALK AT RAISING LOCAL TAXES

An overwhelming majority of likely voters (72%) say the state budget situation is a big problem for public schools, and 67 percent say the quality of education is a big problem. When they are asked to choose among the four main areas of state spending, most (58%) say that K–12 education is the area they most want to protect from spending cuts (17% higher education, 15% health and human services, 7% prisons and corrections). And most (59%) say the current level of state funding for their local public schools is not adequate.

Likely voters are worried about steps that schools have taken to deal with decreased funding: 67 percent say they are very concerned about schools laying off teachers and 62 percent are very concerned about having fewer days of school instruction.

When public school parents are asked about the impact of budget cuts, a large majority (81%) report that their child's public school has been affected a lot (36%) or somewhat (45%) by recent state budget cuts. Most (58%) say they are very concerned about teacher layoffs at their child's school, with Latino parents (65%) much more likely than white parents (47%) to feel this way.

But just as most likely voters balk at raising their own state taxes to aid public schools, they are reluctant to increase their local taxes. Asked whether they would vote yes on a bond measure to pay for construction projects for their local school district, 53 percent say they would vote yes—but this is less than the 55 percent threshold needed to pass such a measure. If there were a local ballot measure that increased local parcel taxes to benefit schools, 51 percent would vote yes; this falls short of the two-thirds' approval required for passage of a parcel tax.

FEW SAY THAT MONEY ALONE WILL SOLVE PROBLEMS

How can school quality be improved? Just 6 percent of likely voters say increased funding alone will lead to significant improvement. Forty-eight percent say that using funds more wisely will significantly improve schools, and a similar share (46%) say both are needed.

"While many Californians believe that the state's budget situation is a big problem for public schools, few think that money alone is the answer," Baldassare says. "Most continue to say that significant improvements in the quality of education will take place when we spend money more wisely."

MOST PREFER LOCAL CONTROL OVER STATE FUNDS FOR SCHOOLS

The governor is proposing two other K–12 education reforms: giving school districts more flexibility in deciding how to spend state funds and giving districts with more low-income students or English learners more money than other schools.

Likely voters favor the idea of spending decisions made closer to home. Asked who should have the most control over spending decisions—local schools, local school districts, or state government—an overwhelming majority prefer local control (53% districts, 36% schools, 6% state). This majority holds across parties, regions, and demographic groups. But there are some differences: Los Angeles residents are less likely than others to choose local school districts (40% vs. about half in other regions) and more likely to choose state government (21% vs. about 10% in other regions). Among ethnic groups, Latinos (24%) are more likely than Asians (17%) or whites (7%) to favor state government control.

After being informed that some state funding provided to K–12 schools is earmarked for specific programs or goals, the vast majority of likely voters (81%) say they would favor giving local districts more flexibility over how that money is spent. How confident are they that school districts would spend the money wisely? Most (75%) are at least somewhat confident (18% very confident).

SUPPORT FOR DIRECTING MONEY TO NEEDIEST STUDENTS

Brown's proposal to target resources to low-income students and English learners has drawn support from many experts and school leaders, and generated controversy over its impact on districts with fewer of these students.

As they have in past PPIC surveys, most likely voters (79%) say that school districts in lower-income areas of the state have fewer resources—including good teachers and classroom materials—than those in wealthier areas. Fifty-four percent of likely voters say that if new funding were to become available, more of it should go to the districts with more low-income students. They are much less likely (40%) to support the idea of giving more funding to districts with more English learners.

Responses are the same when likely voters are asked to consider the possibility that giving more money to schools with more needy students means that other districts would get less: 53 percent would give more money to districts with more low-income students and 40 percent would give more money to districts with more English learners.

BROWN'S JOB APPROVAL RATING HOLDS STEADY

As the governor tries to build support for his tax initiative, 47 percent of likely voters approve of his job performance (40% disapprove, 12% don't know). This is similar to March (46% approve, 38% disapprove, 16% don't know) and April 2011 (46% approve, 32% disapprove, 21% don't know). Brown gets much lower marks for his handling of K–12 education: 23 percent approve, 54 percent disapprove, 23 percent don't know. The state legislature fares poorly on both measures: Just 15 percent of likely voters approve of the way the legislature is doing its job, and just 10 percent approve of its handling of K–12 education.

MORE KEY FINDINGS

- **One in four know how California ranks on spending, test scores**—page 18

  Twenty-seven percent of likely voters correctly state that California is below average in its spending per pupil and in student test scores compared to other states.

- **Concerns about teacher shortage, English learners**—page 19

  Most likely voters are very concerned that schools in lower-income areas have a shortage of good teachers compared to schools in wealthier areas (62%) and that English learners score lower on standardized tests than other students (53%).

- **Local public schools get good grades**—page 20

  Half of Californians (52%) give a grade of A (17%) or B (35%) to their local public schools, similar to adults nationwide in a 2011 Phi Delta Kappa/Gallup poll. Public school parents are slightly more positive, with 24 percent giving A's and 36 percent giving B's to their schools.

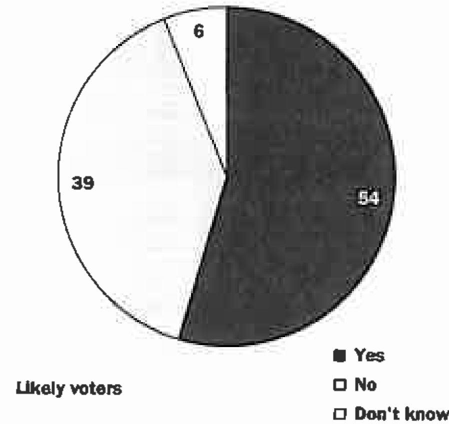
This PPIC survey is conducted with funding from The Dirk and Charlene Kabcenell Foundation, the Stuart Foundation, and The Silver Giving Foundation.

FISCAL ATTITUDES AND POLICY PREFERENCES

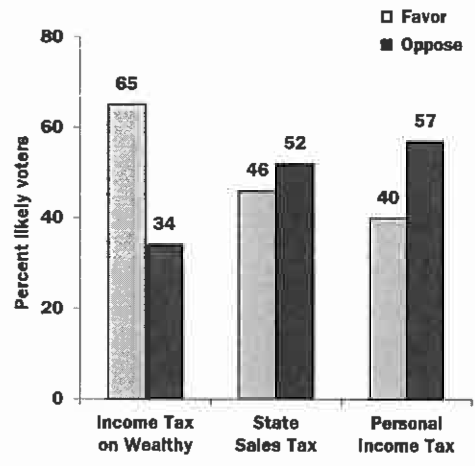
KEY FINDINGS

- Of California's largest areas of spending, K–12 education is the one that likely voters most want to protect from cuts. *(page 7)*
- Fifty-four percent of likely voters favor Governor Brown's proposed tax initiative that would provide additional funding for K–12 public schools. Strong majorities oppose the automatic cuts to education that could result from the measure's defeat. *(page 8)*
- The governor's initiative would temporarily raise income taxes on top earners—65 percent of likely voters favor this idea in general to provide additional K–12 funding. The initiative would also temporarily increase the sales tax, but 52 percent of likely voters oppose this idea in general. Forty percent favor raising state personal income taxes for K–12 education. *(page 9)*
- Two thirds of likely voters believe the state budget situation is a big problem for K–12 schools, but many believe that money also needs to be spent more wisely. *(page 10)*
- State residents are seriously concerned about schools laying off teachers or shortening the school year to deal with lower funding levels. *(page 11)*
- Six in 10 adults—but only about half of likely voters—would support bond measures or parcel taxes to raise revenues for their local public schools. *(page 12)*
- When asked about proposed school reforms, likely voters strongly support giving local school districts more flexibility over spending decisions, and just over half favor targeting funds to districts with more low-income students. Four in 10 support the idea of targeting funds to districts with more English learners. *(pages 13–15)*

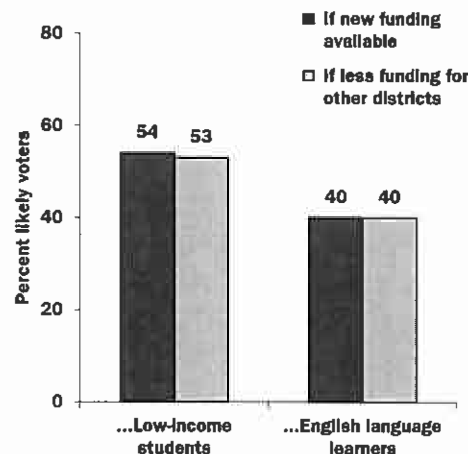
Vote on Governor Brown's Proposed Tax Initiative, with Ballot Title and a Summary



Raising Taxes to Provide Funding for K–12 Public Education



Support for Targeting Money to School Districts That Have More...



STATE BUDGET

As local public schools face funding uncertainties again this year, nearly all likely voters (96%) and all public school parents likely to vote (100%) believe the state budget is at least somewhat of a problem. Eighty percent of likely voters consider the budget situation a big problem, similar to our survey findings in March (78%), January (78%), and last December (83%). Sixty-four percent of likely voters and 70 percent of public school parents likely to vote say that local government services, such as those provided by city and county government and public schools, have been affected a lot by recent state budget cuts. At least six in 10 likely voters in March (66%), January (60%), and last December (65%) said their local services had been affected a lot by recent state budget cuts. Today, majorities of likely voters across political party groups, demographic groups, and state regions share the view that local governments have been affected a lot by recent state budget cuts.

"Would you say that your local government services—such as those provided by city and county governments and public schools—have or have not been affected by recent state budget cuts? (*If they have*: Have they been affected a lot or somewhat?)"

Likely voters only	All Likely Voters	Party			Public School Parents
		Dem	Rep	Ind	
Affected a lot	64%	67%	61%	64%	70%
Affected somewhat	26	24	26	28	23
Not affected	6	5	8	6	6
Don't know	5	5	5	3	1

When read the four major areas of state spending—K–12 public education, health and human services, higher education, and prisons and corrections—58 percent of likely voters and 64 percent of public school parents say K–12 public education is the area they would most like to protect from spending cuts. Since this question was first asked in June 2003, a majority of likely voters have always said K–12 education is the area they would most like to protect. Most likely voters across regions and party, age, education, and income groups say K–12 education is the area they would most like to protect from cuts.

"Some of the largest areas for state spending are K–12 public education, higher education, health and human services, and prisons and corrections. Thinking about these four areas of state spending, I'd like you to name the one you most want to protect from spending cuts."

Likely voters only	All Likely Voters	Party			Public School Parents
		Dem	Rep	Ind	
K–12 public education	58%	66%	51%	48%	64%
Higher education	17	13	18	26	15
Health and human services	15	16	13	15	11
Prisons and corrections	7	3	13	7	10
Don't know	4	2	5	4	–

How would Californians prefer to deal with the state's multibillion dollar gap between spending and revenues? Majorities of likely voters (58%) and public school parents (57%) would include taxes in the solution, with most preferring a mix of spending cuts and tax increases. Fewer than four in 10 likely voters (36%) and public school parents (39%) prefer to deal with the state's budget gap mostly through spending cuts. Most Democrats prefer a solution that includes tax increases (58% mix of cuts and taxes, 22% mostly tax increases), while most Republicans prefer mostly spending cuts (62%).

GOVERNOR'S PROPOSED TAX INITIATIVE

Governor Brown and others have proposed a tax initiative to deal with the state's multibillion dollar budget gap. The initiative calls for a temporary increase in both the state sales tax and the state personal income tax on wealthy Californians. When read the ballot title and a brief summary, 54 percent of likely voters say they would vote yes on the initiative, 39 percent say no, and 6 percent say they are undecided. While direct comparisons are not possible, likely voters' support for an earlier version of the governor's proposed tax initiative was about the same when read the identical ballot title and a similar ballot summary in March (52% yes, 40% no). Likely voter support was higher in questions that predated the ballot title in our December 2011 survey (60% in favor) and January 2012 survey (68% in favor). Today, while 75 percent of Democrats would vote yes, 65 percent of Republicans would vote no. Independents are more likely to say they would vote yes (53%) than no (43%). At least half of men (51%) and women (57%) support the proposed tax initiative. Support is similar across income groups but far higher among Latinos (70%) than whites (49%). Public school parents support the tax initiative by a wide margin (60% yes, 36% no).

"Governor Brown and others have proposed a tax initiative for the November ballot titled the 'Temporary Taxes to Fund Education. Guaranteed Local Public Safety Funding. Initiative Constitutional Amendment.' ...If the election were held today, would you vote yes or no on the proposed tax initiative?" *

Likely voters only		Yes	No	Don't know
All Likely Voters		54%	39%	6%
Public School Parents		60	36	4
Party	**Democrats**	75	16	9
	Republicans	31	65	4
	Independents	53	43	4
Gender	**Men**	51	44	5
	Women	57	36	7
Race/Ethnicity	**Latinos****	70	25	5
	Whites	49	43	8
Household Income	**Under $40,000**	57	36	7
	$40,000 to under $80,000	56	38	6
	$80,000 or more	54	41	5

*For complete text of question, see page 26.
**Small sample size for Latino likely voters.

Governor Brown's budget proposes automatic spending cuts to K–12 public schools if the tax initiative is rejected. Seventy-eight percent of likely voters, 77 percent of public school parents, and strong majorities across parties are opposed to the automatic spending cuts. Among those who would vote yes on the proposed tax initiative, 84 percent oppose the automatic spending cuts.

"If voters reject the proposed tax initiative on the November ballot, Governor Brown's budget proposes that automatic spending cuts be made to K–12 public schools. Do you favor or oppose these automatic spending cuts to K–12 public schools?"

Likely voters only	All Likely Voters	Party			Vote on Governor's Proposed Tax Initiative	
		Dem	Rep	Ind	Yes	No
Favor	19%	12%	23%	29%	14%	28%
Oppose	78	85	75	69	84	70
Don't know	3	3	2	3	2	2

RAISING STATE TAXES TO SUPPORT K–12 EDUCATION

Support varies among California's likely voters when it comes to the specific tax increases that some are proposing to provide additional funding for K–12 education: raising the top rate of the state income tax paid by the wealthiest Californians (65% favor, 34% oppose), raising the state sales tax (46% favor, 52% oppose), and raising personal income taxes (40% favor, 57% oppose).

Majorities of Democrats are in favor of raising the state income tax on the wealthiest Californians (89%), increasing the state sales tax (64%), and raising state personal income taxes (56%) to provide additional funding for K–12 education. A majority of independent likely voters favor raising the state income tax on the wealthiest Californians (63%), but only about four in 10 are in favor of increasing the state sales tax (43%) or the state personal income tax (42%). In contrast, Republican likely voters express little support for raising income tax rates among the wealthy (36%), raising the state sales tax (25%), or raising state personal income taxes (21%).

Majorities of men and women, Latinos and whites, and likely voters in all income groups favor—although to varying degrees—raising taxes on the wealthiest Californians to provide funding for K–12 education. Responses are more variable when it comes to the other two tax proposals. Latinos are much more likely than whites to favor raising the state sales tax (59% to 42%) and state personal income taxes (51% to 34%). Across income groups, both proposals (sales tax, personal income tax) lack majority support—with one exception: 52 percent of middle-income families (between $40,000 and $80,000) support raising the state sales tax.

Strong majorities of likely voters who say they would vote yes on the governor's tax initiative say they are in favor of raising taxes on the wealthiest Californians (88%), raising the state sales tax (69%), and raising state personal income taxes (65%) to provide additional funding for K–12 education. There is little support for any of these proposals among those who would vote no on the governor's tax initiative.

Likely voters only: *Percent saying "favor"*		Raising the top rate of the state income tax paid by the wealthiest Californians	Raising the state sales tax	Raising state personal income taxes
All Likely Voters		65%	46%	40%
Public School Parents		64	53	37
Party	**Democrats**	89	64	56
	Republicans	36	25	21
	Independents	63	43	42
Gender	**Men**	56	43	41
	Women	72	48	39
Race/Ethnicity	**Latinos**	81	59	51
	Whites	59	42	34
Household Income	**Under $40,000**	74	44	45
	$40,000 to under $80,000	64	52	40
	$80,000 or more	61	43	39
Vote on Governor's Proposed Tax Initiative	**Yes**	88	69	65
	No	32	13	9

STATE FUNDING AND EDUCATIONAL QUALITY

Consistent with their concern about the state budget, 90 percent of Californians say that the state's fiscal situation is at least somewhat of a problem for California's K–12 public schools; and 65 percent of all adults and 72 percent of likely voters consider it a big problem. Strong majorities across political groups; majorities across age, education, income, and regional groups; and 62 percent of public school parents say that the budget situation is a big problem for California's K–12 public schools.

"How much of a problem is the overall state budget situation for California's K–12 public schools today? Is it a big problem, somewhat of a problem, or not much of a problem?"

	All Adults	Party			Likely Voters
		Dem	Rep	Ind	
Big problem	65%	70%	65%	70%	72%
Somewhat of a problem	25	24	23	21	20
Not a problem	6	3	5	6	5
Don't know	4	3	7	2	4

Most Californians (87%) believe that the quality of education in California's K–12 public schools is at least somewhat of a problem, and over half (58%) consider it a big problem. Nor is this something new: For the last seven years (since April 2005), at least half of Californians have said the quality of K–12 education is a big problem. Likely voters (67%) are more likely than residents in general (58%) and public school parents (53%) to say that quality is a big problem. More than six in 10 across parties say that the quality of education is a big problem in California's K–12 public schools.

So how do Californians think funding should be altered to significantly improve the quality of education in public schools? About four in 10 adults (44%) say that existing funds need to be used more wisely, while the same percentage (44%) support a dual approach: using funds more wisely and increasing the funding for K–12 public schools. Only 9 percent believe that simply increasing state funding would significantly improve educational quality. Findings have been similar since April 2008. (For example, last April, 43 percent said use funds more wisely, 41 percent favored the dual approach, and 13 percent believed that simply increasing the funding would be sufficient.) The preferences of likely voters are similar to those of all adults: 48 percent say funds should be used more efficiently, 46 percent say increase the funding and use it more wisely, and 6 percent say that simply increasing the funding would be sufficient. A majority of Democrats (56%) believe a dual approach is needed, while a majority of Republicans (59%) think that using existing funds more wisely is sufficient. Independents are divided (49% do both, 46% use funds more wisely). As for public school parents, 45 percent say use funding more wisely, 11 percent say increase funding, and 39 percent say do both to improve quality.

"To significantly improve the quality of California's K–12 public schools, which of the following statements do you agree with the most? We need to use existing state funds more wisely, we need to increase the amount of state funding, or we need to use existing state funds more wisely and increase the amount of state funding."

	All Adults	Party			Likely Voters
		Dem	Rep	Ind	
Use funding more wisely	44%	34%	59%	46%	48%
Increase funding	9	8	5	4	6
Do both	44	56	35	49	46
Don't know	3	2	1	1	1

SPECIFIC SPENDING CUTS IN SCHOOLS

California's public schools have taken numerous steps in recent years to cope with their declining funding, including laying off teachers and providing fewer school days. A majority of adults are very concerned about public schools laying off teachers and offering fewer days of classroom instruction (66% and 54%, respectively). Concern was similar last year—laying off teachers (68%), fewer days of instruction (56%). Concern about laying off teachers was somewhat higher in 2010 (73%).

"There are a number of ways for the state's K–12 public schools to cut spending to deal with decreased state and local funding. For each of the following, please tell me if you are very concerned, somewhat concerned, not too concerned, or not at all concerned. How about ...?"

	Laying off teachers	Having fewer days of school instruction
Very concerned	66%	54%
Somewhat concerned	25	31
Not too concerned	5	9
Not at all concerned	3	5
Don't know	1	1

Across parties, demographic groups, and regions and among public school parents, there is more concern about teacher layoffs than fewer days of classroom instruction. Concern about laying off teachers is higher among Democrats (75%) than independents (66%) or Republicans (58%), and concern about fewer days of instruction is also higher among Democrats (63%) than independents (54%) or Republicans (53%). Women are more likely than men to be very concerned about both teacher layoffs (72% to 60%) and a shorter school year (59% to 50%). Whites (67%), Latinos (64%), and Asians (59%) are all very concerned about teacher layoffs; fewer are very concerned about shortening the school year—whites and Latinos (55% each), Asians (47%). At least half of residents across the state's major regions say they are very concerned about schools laying off teachers and having fewer days of classroom instruction.

Percent saying "very concerned"		Laying off teachers	Having fewer days of school instruction
All Adults		66%	54%
Likely Voters		67	62
Public School Parents		69	57
Party	Democrats	75	63
	Republicans	58	53
	Independents	66	54
Gender	Men	60	50
	Women	72	59
Race/Ethnicity	Asians	59	47
	Latinos	64	55
	Whites	67	55
Region	Central Valley	67	50
	San Francisco Bay Area	67	61
	Los Angeles	68	55
	Other Southern California	62	55

RAISING LOCAL REVENUES FOR SCHOOLS

Given the state's recent budget cuts, some school districts may be looking for ways to raise revenue at the local level in this year's elections. Two of the ways districts can raise local revenue are through bond measures to pay for school construction projects and through local parcel taxes. School bond measures require approval by 55 percent of voters; parcel taxes require approval by two-thirds of the voters.

Six in 10 state residents (62%) and just over half of likely voters (53%) say they would vote yes if their local school district had a bond measure on the ballot. Potential "yes" votes were similar in 2011 (60% all adults, 53% likely voters), in 2010 (63% all adults, 54% likely voters), and in 2009 (60% all adults, 54% likely voters).

Two in three Democrats (67%) say they would vote yes, as would 51 percent of independents. Republicans are divided (45% yes, 48% no). Support is highest among Los Angeles residents (65%), followed by those in the Other Southern California region (61%), the Central Valley (59%), and the San Francisco Bay Area (57%). Support is the same among men and women (62% each), but much higher among Latinos (80%) than among Asians (59%) or whites (49%). Support declines as age, education, and income increase, and support for such a bond measure is higher among renters (69%) than homeowners (55%). Two in three public school parents (68%) say they would support a bond measure for school construction projects.

"If your local school district had a bond measure on the ballot to pay for school construction projects, would you vote yes or no?"

	All Adults	Party			Likely Voters
		Dem	Rep	Ind	
Yes	62%	67%	45%	51%	53%
No	32	28	48	41	40
Don't know	6	5	8	7	6

Sixty percent of Californians and 51 percent of likely voters say they would support a measure on their local ballot that would increase parcel taxes to provide more funding for local public schools. Support was similar in 2011 (59% all adults, 54% likely voters) and in 2010 (57% all adults, 52% likely voters) but slightly lower in 2009 (54% all adults, 49% likely voters).

Support for local parcel taxes differs across parties: 69 percent of Democrats and 56 percent of independents say they would vote yes, 57 percent of Republicans say they would vote no. Support is similar across regions, with about six in 10 residents saying they would vote yes (63% San Francisco Bay Area, 61% Central Valley, 61% Los Angeles, 59% Other Southern California region). Latinos (72%) and Asians (65%) are much more likely than whites (51%) to support a local parcel tax. Support is higher among younger age groups, among those with a high school diploma or less, and among those with household incomes of less than $40,000 compared to others, as well as among parents of public school children (65%). Renters (75%) are far more likely than homeowners (48%) to support such a parcel tax.

"What if there was a measure on your local ballot to increase local parcel taxes to provide more funds for the local public schools? Would you vote yes or no?"

	All Adults	Party			Likely Voters
		Dem	Rep	Ind	
Yes	60%	69%	40%	56%	51%
No	34	24	57	38	44
Don't know	6	7	3	7	6

LOCAL FLEXIBILITY

In accord with the goal of realigning certain responsibilities from the state to the local level, the governor has proposed eliminating most categorical funding programs, thus increasing the flexibility of local school districts in deciding how to use state funds.

Most Californians (82%) want control over school spending decisions to reside at the local level, either within school districts (48%) or within the schools themselves (34%). Since we first began asking this question in 2008, very few residents have said they believe that the state government should control school spending decisions (15% or less since 2008, 14% today). Among likely voters, preference for local control is even higher (53% districts, 36% schools, 6% state government). Three in four public school parents prefer local control (47% districts, 29% schools, 18% state government).

Overwhelming majorities across parties, regions, and demographic groups prefer that school districts or local schools have the most control in deciding how state funding is spent in local public schools. Still, there are some differences between groups. For example, although more than seven in 10 residents across regions want some form of local control, Los Angeles residents are less likely than others to prefer local school districts (40% vs. about 50% in other regions) and more likely to select state government (21% vs. about 10% in other regions). Similarly, despite a strong preference among racial/ethnic groups for local control, Latinos (24%) are more likely than Asians (17%) or whites (7%) to choose state government.

"Who do you think should have the most control in deciding how the money from state government is spent in local public schools—the local schools, the local school districts, or the state government?"

	All Adults	Region				Public School Parents
		Central Valley	San Francisco Bay Area	Los Angeles	Other Southern California	
Local schools	34%	33%	33%	33%	37%	29%
Local school districts	48	53	52	40	49	47
State government	14	12	12	21	10	18
Other/Don't know	4	3	3	5	5	6

After being informed that some of the funding the state provides to K–12 public school districts is earmarked for specific programs and goals, the vast majority of Californians (79%), likely voters (81%), and public school parents (83%) say that they would favor giving local school districts more flexibility in deciding how this funding is spent. Support for such flexibility is widespread across parties (80% Republicans, 77% both Democrats and independents) and widespread across regions and demographic groups as well, especially among white residents (83% whites, 74% Latinos, 72% Asians).

"As you may know, some of the funding the state provides to K–12 public school districts is earmarked for specific programs and goals. Would you favor or oppose giving local school districts more flexibility over how state funding is spent?"

	All Adults	Region				Public School Parents
		Central Valley	San Francisco Bay Area	Los Angeles	Other Southern California	
Favor	79%	80%	79%	79%	76%	83%
Oppose	15	16	14	17	16	13
Don't know	6	4	7	5	8	4

LOCAL FLEXIBILITY *(CONTINUED)*

If the state were to give local school districts more flexibility over how state monies are spent, a majority of Californians (68%) are at least somewhat confident that the districts would spend this money wisely. However, about one-third of those polled are less confident (22% not too confident, 9% not at all confident). Solid majorities of likely voters, public school parents, and Californians across parties, regions, and demographic groups are at least somewhat confident that school districts would use the money wisely, although fewer than one in five in any group are very confident. Confidence is higher among residents in the Central Valley (75%) and the Other Southern California region (73%) than in the San Francisco Bay Area (66%) and Los Angeles (61%). Whites (72%) and Asians (78%) are more likely than Latinos (60%) to express at least some confidence. Confidence is higher among college graduates (78%) than among residents with less education (67% some college, 63% high school or less), and higher among upper-income residents (80%) than among those in the middle- (68%) and lower- (62%) income brackets. Among those who prefer that school districts have the most control over how state funding is spent in local schools, 73 percent are confident (13% very confident, 60% somewhat confident) that districts would spend the state money wisely.

"If the state were to give local school districts more flexibility over how state funding is spent, how confident are you that local school districts would use this money wisely? Are you very confident, somewhat confident, not too confident, or not at all confident?"

	All Adults	Region				Public School Parents
		Central Valley	San Francisco Bay Area	Los Angeles	Other Southern California	
Very confident	14%	17%	11%	10%	18%	14%
Somewhat confident	54	58	55	51	55	54
Not too confident	22	20	21	26	19	25
Not at all confident	9	4	11	11	7	7
Don't know	1	1	2	1	1	1

RESOURCE EQUITY

The governor is also proposing that school districts with more low-income students or English language learners receive more funding than other schools. Although many researchers and school leaders support this idea, there is some controversy over the baseline amount of funding per student and how this reallocation of funding would affect districts with fewer low-income students or English learners.

Most Californians (82%) believe that school districts in lower-income areas of the state have fewer resources than school districts in wealthier areas. At least 75 percent of Californians have held this view since this question was first asked in April 2005. Eight in 10 likely voters (79%) and public school parents (80%) believe resource differences between districts exist. More than two in three Californians across parties, regions, and demographic groups express this view.

"Do you think that school districts in lower-income areas of the state have the same amount of resources, including good teachers and classroom materials, as school districts in wealthier areas, or not?"

	All Adults	Race/Ethnicity			Public School Parents
		Asians	Latinos	Whites	
Yes	13%	11%	11%	15%	14%
No	82	76	85	79	80
Don't know	6	13	4	5	6

RESOURCE EQUITY *(CONTINUED)*

Democrats and independents (87% each) are more likely than Republicans (68%)—and Latinos (85%) are slightly more likely than whites (79%) or Asians (76%)—to say that resources are not equal across districts. At least eight in 10 residents across all income and education groups say that resources are not equal between districts in lower-income areas and those in wealthier areas.

If the state were to have new money available for school districts, a strong majority of Californians (68%) say that districts with more low-income students should get more of the new funding. Fewer (52%) say that more funding should be given to districts with more English learners. Among likely voters, support is much lower for giving more money to districts with either type of student (low-income 54%, English learners 40%). More Democrats (72%) and independents (65%) than Republicans (42%) say that the additional funds should go to schools with more low-income students. Similarly, more Democrats (50%) and independents (49%) than Republicans (38%) say that the additional funding should go to schools with more English learners. Solid majorities of Latinos and Asians support targeting funds to both low-income students and English learners; among whites, a slim majority support the idea for low-income students, and a slim majority oppose it for English learners.

"If new state funding becomes available, do you think school districts that have more ... should or should not get more of this new funding than other school districts?"

		All Adults	Race/Ethnicity			Public School Parents
			Asians	Latinos	Whites	
Low-income students	**Should**	68%	75%	85%	53%	73%
	Should not	27	18	12	41	24
	Don't know	5	6	3	6	3
English language learners	**Should**	52	62	73	35	59
	Should not	41	35	24	54	36
	Don't know	7	3	4	11	5

Even if the redistribution of funding meant less funding for other school districts, support for needier districts is nearly identical to the support expressed if only new state funds were available, both among Californians (67% for low-income, 51% for English learners) and among likely voters (53% for low-income, 40% for English learners). Across parties and racial/ethnic groups, support for targeting funds, even in the case of less funding for other districts, is similar to support in the case of new funding, except that there is lower support among Asians for targeting funds to English learners.

"If it means less funding for other school districts, do you think school districts that have more ... should or should not get more funding from the state?"

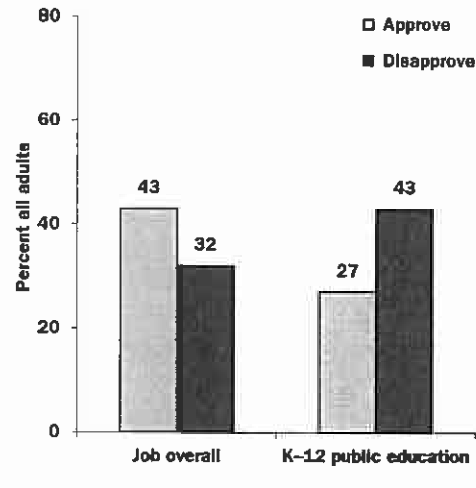
		All Adults	Race/Ethnicity			Public School Parents
			Asians	Latinos	Whites	
Low-income students	**Should**	67%	74%	82%	53%	66%
	Should not	28	24	14	40	29
	Don't know	5	2	4	7	4
English language learners	**Should**	51	52	74	35	57
	Should not	42	40	22	56	36
	Don't know	7	8	4	9	7

GENERAL PERCEPTIONS

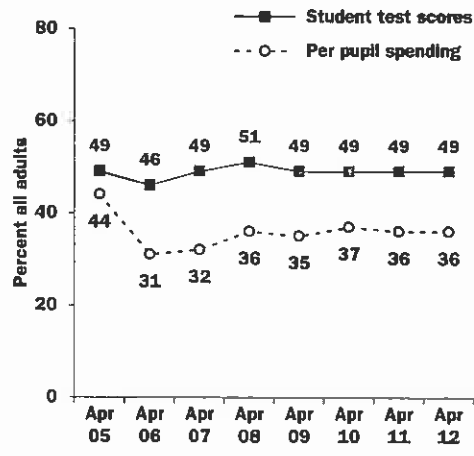
KEY FINDINGS

- Just over four in 10 Californians continue to express approval of Governor Brown's overall job performance; positive ratings drop considerably for his handling of the K–12 public education system. Majorities disapprove of the legislature overall and on education. *(page 17)*
- Many Californians are unaware that California is below average in per pupil spending compared to other states. Half say that California's student test scores are lower than those in other states, and indeed California ranks near the bottom. *(page 18)*
- Majorities of Californians across regions and demographic groups are very concerned about the shortage of good teachers in lower-income areas. To a lesser degree, Californians are also very concerned about the state's English learners scoring lower than others on standardized tests. *(page 19)*
- Similar to past years, half of Californians give positive grades of "A" or "B" to the quality of their local public schools. Still, only 17 percent say "A" and 63 percent say state funding for their local public schools is not enough. *(page 20)*
- Eight in 10 public school parents say their child's public school has been affected by state budget cuts (36% a lot, 45% somewhat). But levels of concern about teacher layoffs at their child's school vary considerably across income levels and between Latino and white parents. *(page 21)*

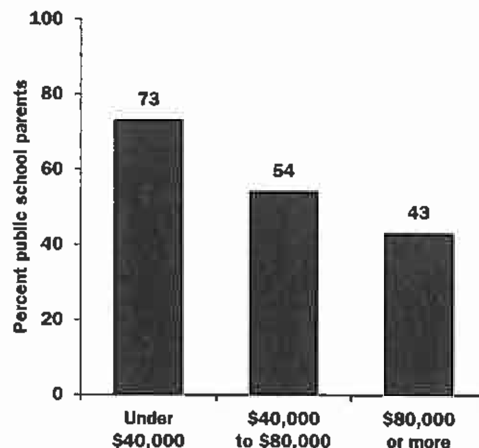
Approval Ratings of Governor Brown



Percentages Saying California Ranks Below Average Compared to Other States



Percent Very Concerned about Teacher Layoffs at Child's Public School, by Income Level



APPROVAL RATINGS OF STATE ELECTED OFFICIALS

As Governor Brown attempts to collect signatures and build support for a tax initiative on the November ballot, 43 percent of adults and 47 percent of likely voters approve of his overall job performance. Approval among both groups is similar to last month (40% adults, 46% likely voters) and to last April (40% adults, 46% likely voters). Two in three Democrats (65%) approve, while nearly six in 10 Republicans (58%) disapprove. Independents are more likely to approve (45%) than disapprove (32%). Approval is highest in the San Francisco Bay Area (55%) and lowest in the Other Southern California region (33%).

When it comes to Governor Brown's handling of K–12 education, 27 percent of adults and 23 percent of likely voters approve of his job performance. His approval on this issue was similar last year (24% adults, 25% likely voters). Approval is low across parties (36% Democrats, 10% Republicans, and 21% independents). Fewer than one in three across regions and across age, education, and income groups approve of his handling of K–12 education. Latinos (36%) are more approving than Asians (27%) or whites (21%), and three in 10 public school parents (31%) approve of the governor's handling of K–12 education.

"Overall, do you approve or disapprove of the way that Jerry Brown is handling...?"

		All Adults	Party			Likely Voters
			Dem	Rep	Ind	
His job as governor of California	Approve	43%	65%	24%	45%	47%
	Disapprove	32	20	58	32	40
	Don't know	25	15	18	23	12
The state's kindergarten through 12th grade public education system	Approve	27	36	10	21	23
	Disapprove	43	38	61	47	54
	Don't know	30	26	29	32	23

Twenty-five percent of adults and 15 percent of likely voters approve of the way that the California Legislature is handling its job. Approval among adults is similar to March (25%) and to last April (21%).

On the issue of the state's K–12 education system, 22 percent of adults and 10 percent of likely voters approve of the California Legislature. Approval of the legislature's handling of K–12 education was similar last April (18% adults, 9% likely voters). At most, one in four across parties and regions approve. Latinos (43%) are far more likely than Asians (16%) or whites (9%) to approve of the legislature on K–12 education.

"Overall, do you approve or disapprove of the way that the California Legislature is handling...?"

		All Adults	Party			Likely Voters
			Dem	Rep	Ind	
Its job	Approve	25%	26%	11%	21%	15%
	Disapprove	58	56	80	66	73
	Don't know	16	18	10	12	12
The state's kindergarten through 12th grade public education system	Approve	22	17	8	14	10
	Disapprove	56	59	69	64	69
	Don't know	22	24	23	21	21

PERCEPTIONS OF CALIFORNIA'S RELATIVE EDUCATION RANKINGS

Thirty-six percent of Californians think that the state's per pupil spending for K–12 public education is below average compared to other states, while one in four say the state's spending is average and 27 percent say it is near the top or above average. According to the National Education Association's *Rankings and Estimates* report (December 2011), California ranked below average—37th among the 50 states and the District of Columbia—in per pupil spending in the 2010–11 school year. Californians' views on per pupil spending have been similar since 2008; more Californians said it was below average in April 1998 (47%) and February 2000 (51%). Democrats (42%) are more likely than independents (35%) and Republicans (31%) to say spending is below average. Across racial/ethnic groups, the belief that per pupil spending is below average is most widely held among whites (38%), followed by Latinos (33%) and Asians (27%). Fewer than four in 10 adults across regions think per pupil spending is below average (38% Los Angeles, 38% San Francisco Bay Area, 36% Central Valley, and 31% Other Southern California region). Among public school parents, 43 percent say state spending is below average, as do 41 percent of those who consider the state budget situation to be a big problem for K–12 education.

"Where do you think California currently ranks in per pupil spending for K–12 public schools? Compared to other states, is California's spending near the top, above average, average, below average, or near the bottom?"

	All Adults	Race/Ethnicity			Public School Parents
		Asians	Latinos	Whites	
Near the top/Above average	27%	26%	23%	29%	20%
Average	25	31	32	20	27
Below average/Near the bottom	36	27	33	38	43
Don't know	12	17	12	12	10

More Californians know how the state actually ranks in student test scores. Half of Californians (49%) say scores are below average compared to other states, while 31 percent say they are average and 12 percent say they are near the top or above average. According to 2011 test scores compiled by the U.S. Department of Education's National Center for Education Statistics, California ranked near the bottom in both math and reading scores for fourth- and eighth-graders. Californians' perceptions of student test scores have been fairly similar since we first asked this question in 1998. Across parties, at least half of voters think test scores are below average (51% Democrats, 55% independents, 59% Republicans). Across regions, about half of residents think test scores are below average. Whites (59%) are much more likely than Latinos (40%) and Asians (35%) to say scores are below average.

One in four Californians (24%), likely voters (27%), and public school parents (24%) correctly state that both per pupil spending and test scores in California are below average compared to other states.

"Where do you think California currently ranks in student test scores for K–12 public schools? Compared to other states, are California's student test scores near the top, above average, average, below average, or near the bottom?"

	All Adults	Race/Ethnicity			Public School Parents
		Asians	Latinos	Whites	
Near the top/Above average	12%	17%	13%	10%	10%
Average	31	39	41	24	39
Below average/Near the bottom	49	35	40	59	42
Don't know	8	8	6	8	8

TEACHER SHORTAGE AND ENGLISH LANGUAGE LEARNERS

Most Californians (87%) are concerned (64% very, 23% somewhat) that schools in lower-income areas have a shortage of good teachers compared to schools in wealthier areas. Only 12 percent say they are not concerned (8% not too, 4% not at all). Six in 10 public school parents (60%) and likely voters (62%) say they are very concerned. The percentage saying very concerned was similar in April 2011 (65%) and April 2010 (60%), and lower in earlier years (54% in 2008 and 2007, 57% in 2006).

About seven in 10 Democrats (71%) and independents (67%) say they are very concerned about this issue, while less than half of Republicans (48%) say so. Majorities across income groups are very concerned; those earning under $40,000 (67%) and $40,000 to under $80,000 (68%) are more likely to be very concerned than those with incomes of $80,000 or more (58%). Among racial/ethnic groups, Latinos (73%) are most likely to say they are very concerned, compared to 61 percent of Asians and 56 percent of whites. Renters (71%) are more likely than homeowners (59%) to express concern. At least six in 10 across regions, age groups, and education levels say they are very concerned that schools in lower-income areas have a shortage of good teachers compared to schools in wealthier areas.

"How concerned are you that schools in lower-income areas have a shortage of good teachers compared to schools in wealthier areas?"

	All Adults	Household Income			Public School Parents
		Under $40,000	$40,000 to under $80,000	$80,000 or more	
Very concerned	64%	67%	68%	58%	60%
Somewhat concerned	23	22	20	28	28
Not too concerned	8	7	8	8	7
Not at all concerned	4	3	4	5	3
Don't know	1	1	1	1	1

When asked about English language learners scoring lower on standardized tests compared to other students, 56 percent of Californians say they are very concerned and 27 percent say they are somewhat concerned. Only 16 percent are not concerned about this issue. Concern among public school parents (56% very, 27% somewhat) and likely voters (53% very, 25% somewhat) is similar to that among all adults. Latinos (64%) are more likely than Asians (55%) and whites (50%) to be very concerned. About six in 10 of those earning less than $80,000 say they are very concerned, compared to 48 percent of those earning $80,000 or more. The percentage saying they are very concerned is similar across parties. But 25 percent of Republicans say they are not too or not at all concerned, compared to 19 percent of independents and 12 percent of Democrats. The share saying they are very concerned today was the same last year (56%) but much lower in earlier years (42% in 2008, 44% in 2007, 43% in 2006).

"How concerned are you that English language learners in California's schools today score lower on standardized tests than other students?"

	All Adults	Race/Ethnicity			Public School Parents
		Asians	Latinos	Whites	
Very concerned	56%	55%	64%	50%	56%
Somewhat concerned	27	34	28	26	27
Not too concerned	9	4	4	13	6
Not at all concerned	7	5	3	9	8
Don't know	2	2	1	2	2

RATING LOCAL PUBLIC SCHOOLS

Most Californians continue to give positive ratings to their local public schools. Half of Californians (52%) give their local public schools a grade of A (17%) or B (35%). Twenty-seven percent give a grade of C, 12 percent a D, and 4 percent an F. Similar shares of adults nationwide gave A's (14%) or B's (37%) to their local public schools in a June 2011 Phi Delta Kappa/Gallup poll. At least half of Californians have given an A or B grade for the quality of their local public schools each year since April 2005.

Public school parents are slightly more positive, with 24 percent giving a grade of A compared to 17 percent of all adults. Across regions, at least 49 percent give high grades to local public schools, with residents in the Other Southern California region (59%) giving more positive ratings than others. Among racial/ethnic groups, Asians (63%) are more likely than Latinos (53%) and whites (51%) to give a grade of A or B to their local public schools. Among those saying the quality of K–12 education in California's public schools is a big problem, 42 percent give their local public schools a grade of A or B.

"Overall, how would you rate the quality of public schools in your neighborhood today? If you had to give your local public schools a grade, would it be A, B, C, D, or F?"

	All Adults	Region				Public School Parents
		Central Valley	San Francisco Bay Area	Los Angeles	Other Southern California	
A	17%	15%	21%	16%	17%	24%
B	35	35	29	33	42	36
C	27	31	29	28	23	23
D	12	9	11	15	10	10
F	4	5	4	3	2	4
Don't know	5	3	6	4	6	3

Solid majorities of Californians (63%) and California's public school parents (66%) think that the current level of state funding for their local public schools is not enough. One in four adults say state funding is just enough (26%) and only 7 percent say it is more than enough. Fifty-nine percent of likely voters say that state funding is not enough. The share of adults saying state funding is inadequate is slightly higher today than it was last April (56%), and similar to April 2010 (62%). About half of Californians held this view from 2005 to 2009. Across regions, San Francisco Bay Area residents (67%) are the most likely, and those in the Other Southern California region (59%) the least likely, to say state funding for their local public schools is inadequate. At least six in 10 across racial/ethnic groups say funding is inadequate, with Latinos (67%) most likely to express this view. Across parties, seven in 10 Democrats (71%) say funding is not enough, compared to fewer independents (55%) and Republicans (48%). Renters (69%) are more likely than homeowners (59%) to say state funding is inadequate. Among those giving grades of A or B to their local public schools, 56 percent say funding is not enough.

"Do you think the current level of state funding for your local public schools is more than enough, just enough, or not enough?"

	All Adults	Region				Public School Parents
		Central Valley	San Francisco Bay Area	Los Angeles	Other Southern California	
More than enough	7%	6%	7%	6%	9%	5%
Just enough	26	24	22	30	29	26
Not enough	63	64	67	62	59	66
Don't know	4	5	4	2	4	4

PARENTS' PERSPECTIVES

The vast majority of parents of public school students report that their child's public school has been affected a lot (36%) or somewhat (45%) by recent state budget cuts. Just 16 percent say their child's school has not been affected and 3 percent are unsure if there has been an effect. Public school parents likely to vote express similar views (39% a lot, 47% somewhat). The share saying their child's school has been affected a lot was similar last year (35%), slightly higher in 2010 (43%), and lowest in 2009 (28%).

Similar shares of Latino (37% a lot, 46% somewhat) and white public school parents (35% a lot, 47% somewhat) say their child's school has been affected by recent state budget cuts. (The sample size for Asian public school parents is not large enough for separate analysis.) More than one in three parents across income groups say their child's public school has been affected a lot by state budget cuts. Parents with a college degree (35%) and those without one (37%) are similarly likely to say their child's school has been affected a lot. Women (42%) are more likely than men (30%) to express this view.

"Would you say your child's public school has or has not been affected by recent state budget cuts? (*If it has:* Has it been affected a lot or somewhat?)"

Public school parents only	All Public School Parents	Household Income			Race/Ethnicity	
		Under $40,000	$40,000 to under $80,000	$80,000 or more	Latinos	Whites
A lot	36%	37%	42%	34%	37%	35%
Somewhat	45	49	44	43	46	47
Not affected	16	10	13	20	14	16
Don't know	3	3	–	3	3	3

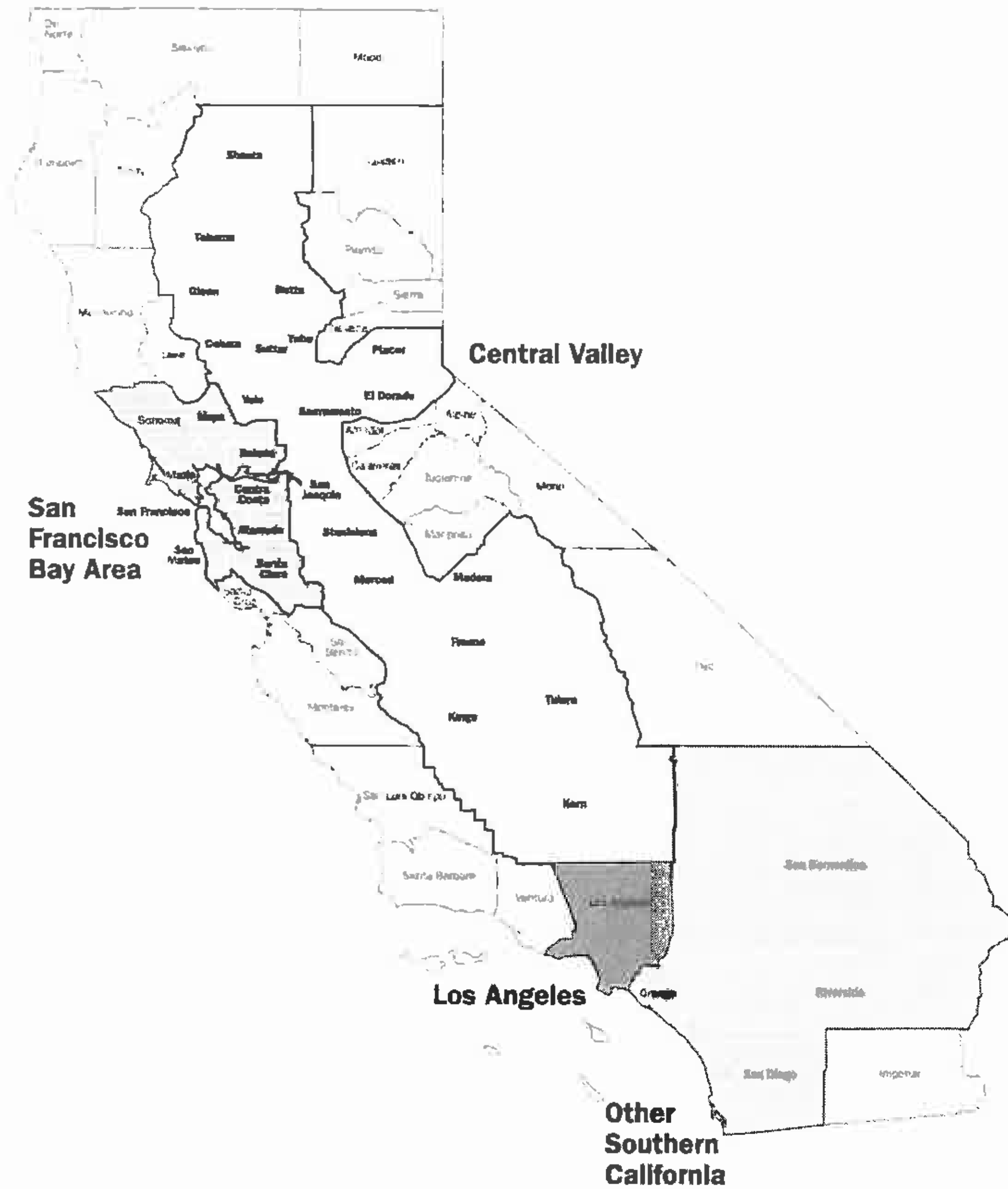
Teacher layoffs have been discussed as an effect of further cuts to state funding for K–12 education. When asked about concern over teacher layoffs in their child's public school, nearly all public school parents (87%) express concern. Fifty-eight percent say they are very concerned and 29 percent are somewhat concerned; only 13 percent say they are not too or not at all concerned.

Differences emerge between parents in various demographic groups. Sixty-two percent of public school parents who did not complete college say they are very concerned about teacher layoffs, compared to 44 percent of parents with a college degree. Among racial/ethnic groups, Latino public school parents (65%) are much more likely than white parents (47%) to say they are very concerned. Public school parents earning less than $40,000 (73%) are much more likely than middle-income parents (54%)—and far more likely than upper-income parents (43%)—to say they are very concerned. Public school parents who are under 45 years old (62%) are more likely than older parents (50%) to say they are very concerned about teacher layoffs at their child's public school.

"How concerned are you about teacher layoffs at your child's public school—very concerned, somewhat concerned, not too concerned, or not at all concerned?"

Public school parents only	All Public School Parents	Education		Race/Ethnicity	
		Not a College Graduate	College Graduate	Latinos	Whites
Very concerned	58%	62%	44%	65%	47%
Somewhat concerned	29	26	36	29	31
Not too concerned	8	8	10	4	13
Not at all concerned	5	4	10	2	9

REGIONAL MAP



METHODOLOGY

The PPIC Statewide Survey is directed by Mark Baldassare, president and CEO and survey director at the Public Policy Institute of California, with assistance from Sonja Petek, project manager for this survey, and survey research associates Dean Bonner and Jui Shrestha. This survey on *Californians and Education* is supported with funding from The Dirk and Charlene Kabcenell Foundation, the Stuart Foundation, and The Silver Giving Foundation. We benefit from discussions with PPIC staff, foundation staff, and other policy experts, but the methods, questions, and content of this report were determined solely by Mark Baldassare and the survey staff.

Findings in this report are based on a survey of 2,005 California adult residents, including 1,603 interviewed on landline telephones and 402 interviewed on cell phones. Interviews took an average of 18 minutes to complete. Interviewing took place on weekday nights and weekend days from April 3 to 10, 2012.

Landline interviews were conducted using a computer-generated random sample of telephone numbers that ensured that both listed and unlisted numbers were called. All landline telephone exchanges in California were eligible for selection, and the sample telephone numbers were called as many as six times to increase the likelihood of reaching eligible households. Once a household was reached, an adult respondent (age 18 or older) was randomly chosen for interviewing using the "last birthday method" to avoid biases in age and gender.

Cell phones were included in this survey to account for the growing number of Californians who use them. These interviews were conducted using a computer-generated random sample of cell phone numbers. All cell phone numbers with California area codes were eligible for selection, and the sample telephone numbers were called as many as eight times to increase the likelihood of reaching an eligible respondent. Once a cell phone user was reached, it was verified that this person was age 18 or older, a resident of California, and in a safe place to continue the survey (e.g., not driving).

Cell phone respondents were offered a small reimbursement to help defray the cost of the call. Cell phone interviews were conducted with adults who have cell phone service only and with those who have both cell phone and landline service in the household.

Live landline and cell phone interviews were conducted by Abt SRBI, Inc. in English and Spanish according to respondents' preferences. Accent on Languages, Inc. translated the survey into Spanish, with assistance from Renatta DeFever.

With assistance from Abt SRBI, we used recent data from the U.S. Census Bureau's 2007–2009 American Community Survey (ACS) through the University of Minnesota's Integrated Public Use Microdata Series for California to compare certain demographic characteristics of the survey sample—region, age, gender, race/ethnicity, and education—with the characteristics of California's adult population. The survey sample was closely comparable to the ACS figures. Abt SRBI used data from the 2008 National Health Interview Survey and data from the 2007–2009 ACS for California both to estimate landline and cell phone service in California and to compare the data against landline and cell phone service reported in this survey. We also used voter registration data from the California Secretary of State to compare the party registration of registered voters in our sample to party registration statewide. The landline and cell phone samples were then integrated using a frame integration weight, while sample balancing adjusted for any differences across regional, age, gender, race/ethnicity, education, telephone service, and party registration groups.

The sampling error, taking design effects from weighting into consideration, is ±3.4 percent at the 95 percent confidence level for the total sample of 2,005 adults. This means that 95 times out of 100, the results will be within 3.4 percentage points of what they would be if all adults in California were interviewed. The sampling error for subgroups is larger: For the 1,310 registered voters, it is ±3.7 percent; for the 823 likely voters, it is ±4.3 percent; for the 620 public school parents, it is ±6.2 percent. Sampling error is only one type of error to which surveys are subject. Results may also be affected by factors such as question wording, question order, and survey timing.

We present results for four geographic regions, accounting for approximately 90 percent of the state population. "Central Valley" includes Butte, Colusa, El Dorado, Fresno, Glenn, Kern, Kings, Madera, Merced, Placer, Sacramento, San Joaquin, Shasta, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba Counties. "San Francisco Bay Area" includes Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma Counties. "Los Angeles" refers to Los Angeles County, and "Other Southern California" includes Orange, Riverside, San Bernardino, and San Diego Counties. Residents from other geographic areas are included in the results reported for all adults, registered voters, and likely voters; but sample sizes for these less populated areas are not large enough to report separately.

We present specific results for non-Hispanic whites and for Latinos, who account for about a third of the state's adult population, constitute one of the fastest-growing voter groups, and whose children comprise about half of California's public school students. We also present results for non-Hispanic Asians, who make up about 14 percent of the state's adult population. Results for other racial/ethnic groups—such as non-Hispanic blacks and Native Americans—are included in the results reported for all adults, registered voters, and likely voters; but sample sizes are not large enough for separate analysis. We compare the opinions of those who report they are registered Democrats, registered Republicans, and decline-to-state or independent voters; the results for those who say they are registered to vote in another party are not large enough for separate analysis. We also analyze the responses of likely voters—so designated by their responses to voter registration survey questions, previous election participation, intentions to vote in the June primary, and current interest in politics.

The percentages presented in the report tables and in the questionnaire may not add to 100 due to rounding.

We compare current PPIC Statewide Survey results to those in our earlier surveys and to those in a national survey by Phi Delta Kappa/Gallup. Additional details about our methodology can be found at http://www.ppic.org/content/other/SurveyMethodology.pdf and are available upon request through surveys@ppic.org.

QUESTIONNAIRE AND RESULTS

CALIFORNIANS AND EDUCATION

April 3–10, 2012
2,005 California Adult Residents: English, Spanish

MARGIN OF ERROR ±3.4% AT 95% CONFIDENCE LEVEL FOR TOTAL SAMPLE
PERCENTAGES MAY NOT ADD TO 100 DUE TO ROUNDING

1. First, overall, do you approve or disapprove of the way that Jerry Brown is handling his job as governor of California?

   43% approve
   32 disapprove
   25 don't know

2. Do you approve or disapprove of the way that Governor Brown is handling the state's kindergarten through 12th grade public education system?

   27% approve
   43 disapprove
   30 don't know

3. Overall, do you approve or disapprove of the way that the California Legislature is handling its job?

   25% approve
   58 disapprove
   16 don't know

4. Do you approve or disapprove of the way that the California Legislature is handling the state's kindergarten through 12th grade public education system?

   22% approve
   56 disapprove
   22 don't know

[questions 5–10 reported for likely voters only]

5. ***[likely voters only]*** Next, some of the largest areas for state spending are: ***[rotate]*** (1) K–12 public education, (2) higher education, (3) health and human services, ***[and]*** (4) prisons and corrections. Thinking about these four areas of state spending, I'd like you to name the one you most want to protect from spending cuts.

   58% K–12 public education
   17 higher education
   15 health and human services
   7 prisons and corrections
   4 don't know

6. ***[likely voters only]*** Do you think the state budget situation in California—that is, the balance between government spending and revenues—is a big problem, somewhat of a problem, or not a problem for the people of California today?

   80% big problem
   16 somewhat of a problem
   2 not a problem
   1 don't know

7. ***[likely voters only]*** Would you say that your local government services—such as those provided by city and county governments and public schools—have or have not been affected by recent state budget cuts? (***If they have:*** Have they been affected a lot or somewhat?)

   64% affected a lot
   26 affected somewhat
   6 not affected
   5 don't know

8. *[likely voters only]* As you may know, the state government currently has an annual general fund budget of around $85 billion and faces a multibillion dollar gap between spending and revenues. How would you prefer to deal with the state's budget gap—mostly through spending cuts, mostly through tax increases, through a mix of spending cuts and tax increases, or do you think that it is okay for the state to borrow money and run a budget deficit?

   36% mostly through spending cuts
   12 mostly through tax increases
   46 through a mix of spending cuts and tax increases
   2 okay to borrow money and run a budget deficit
   2 other *(specify)*
   2 don't know

9. *[likely voters only]* Governor Brown and others have proposed a tax initiative for the November ballot titled the "Temporary Taxes to Fund Education. Guaranteed Local Public Safety Funding. Initiative Constitutional Amendment." It increases the personal income tax on annual earnings over $250,000 for seven years and increases the sales and use tax by a quarter cent for four years. It allocates temporary tax revenues, 89 percent to K–12 schools, and 11 percent to community colleges. It guarantees funding for public safety services realigned from state to local governments. Increased state revenues of about $5.4 to $9 billion annually would be available to pay for the state's school and community college funding requirements, as increased by this measure, and to address the state's budgetary problem by paying for other spending commitments. If the election were held today, would you vote yes or no on the proposed tax initiative?

   54% yes
   39 no
   6 don't know

10. *[likely voters only]* If voters reject the proposed tax initiative on the November ballot, Governor Brown's budget proposes that automatic spending cuts be made to K–12 public schools. Do you favor or oppose these automatic spending cuts to K–12 public schools?

   19% favor
   78 oppose
   3 don't know

Next,

[rotate questions 11 and 12]

11. How much of a problem is the quality of education in California's K–12 public schools today? Is it a big problem, somewhat of a problem, or not much of a problem?

   58% big problem
   29 somewhat of a problem
   9 not much of a problem
   4 don't know

12. How much of a problem is the overall state budget situation for California's K–12 public schools today? Is it a big problem, somewhat of a problem, or not much of a problem?

   65% big problem
   25 somewhat of a problem
   6 not much of a problem
   4 don't know

13. To significantly improve the quality of California's K–12 public schools, which of the following statements do you agree with the most? *[rotate responses 1 and 2]* (1) We need to use existing state funds more wisely, *[or]* (2) We need to increase the amount of state funding, *[or]* (3) We need to use existing state funds more wisely and increase the amount of state funding.

   44% use funds more wisely
   9 increase state funding
   44 use funds more wisely and increase funding
   3 don't know

There are a number of ways for the state's K–12 public schools to cut spending to deal with decreased state and local funding. For each of the following, please tell me if you are very concerned, somewhat concerned, not too concerned, or not at all concerned.

[rotate questions 14 and 15]

14. How about laying off teachers as a way to deal with decreased funding?

66% very concerned
25 somewhat concerned
5 not too concerned
3 not at all concerned
1 don't know

15. How about having fewer days of school instruction as a way to deal with decreased funding?

54% very concerned
31 somewhat concerned
9 not too concerned
5 not at all concerned
1 don't know

Changing topics,

[rotate questions 16 and 17]

16. How concerned are you that schools in lower-income areas have a shortage of good teachers compared to schools in wealthier areas? Are you very concerned, somewhat concerned, not too concerned, or not at all concerned about this issue?

64% very concerned
23 somewhat concerned
8 not too concerned
4 not at all concerned
1 don't know

17. How concerned are you that English language learners in California's schools today score lower on standardized tests than other students? Are you very concerned, somewhat concerned, not too concerned, or not at all concerned about this issue?

56% very concerned
27 somewhat concerned
9 not too concerned
7 not at all concerned
2 don't know

On another topic,

[rotate questions 18 and 19]

18. Where do you think California currently ranks in per pupil spending for K–12 public schools? Compared to other states, is California's spending near the top, above average, average, below average, or near the bottom?

13% near the top
14 above average
25 average
20 below average
16 near the bottom
12 don't know

19. Where do you think California currently ranks in student test scores for K–12 public schools? Compared to other states, are California's student test scores near the top, above average, average, below average, or near the bottom?

2% near the top
10 above average
31 average
30 below average
19 near the bottom
8 don't know

20. Next, overall, how would you rate the quality of public schools in your neighborhood today? If you had to give your local public schools a grade, would it be A, B, C, D, or F?

17% A
35 B
27 C
12 D
4 F
5 don't know

21. Do you think the current level of state funding for your local public schools is more than enough, just enough, or not enough?

7% more than enough
26 just enough
63 not enough
4 don't know

[rotate questions 22 and 23]

22. If your local school district had a bond measure on the ballot to pay for school construction projects, would you vote yes or no?

62% yes
32 no
6 don't know

23. What if there was a measure on your local ballot to increase local parcel taxes to provide more funds for the local public schools? Would you vote yes or no?

60% yes
34 no
6 don't know

24. Who do you think should have the most control in deciding how the money from state government is spent in local public schools—***[rotate order]*** (1) the local schools, (2) the local school districts, ***[or]*** (3) the state government?

34% the local schools
48 the local school districts
14 the state government
2 other *(specify)*
2 don't know

25. As you may know, some of the funding the state provides to K–12 public school districts is earmarked for specific programs and goals. Would you favor or oppose giving local school districts more flexibility over how state funding is spent?

79% favor
15 oppose
6 don't know

26. If the state were to give local school districts more flexibility over how state funding is spent, how confident are you that local school districts would use this money wisely? Are you very confident, somewhat confident, not too confident, or not at all confident?

14% very confident
54 somewhat confident
22 not too confident
9 not at all confident
1 don't know

27. Changing topics, do you think that school districts in lower-income areas of the state have the same amount of resources—including good teachers and classroom materials—as school districts in wealthier areas, or not?

13% yes, same amount of resources
82 no, not same amount of resources
6 don't know

[rotate blocks: questions 28, 29 and questions 30, 31]

[rotate questions 28 and 29]

28. If new state funding becomes available, do you think school districts that have more low-income students should or should not get more of this new funding than other school districts?

68% should
27 should not
5 don't know

29. If new state funding becomes available, do you think school districts that have more English language learners should or should not get more of this new funding than other school districts?

52% should
41 should not
7 don't know

[rotate questions 30 and 31]

30. If it means less funding for other school districts, do you think school districts that have more low-income students should or should not get more funding from the state?

67% should
28 should not
5 don't know

31. If it means less funding for other school districts, do you think school districts that have more English language learners should or should not get more funding from the state?

51% should
42 should not
7 don't know

[questions 32–34 reported for likely voters only]

Next, here are some ideas that have been suggested to raise state revenues to provide additional funding for K–12 public education. For each of the following, please say if you favor or oppose the proposal.

[rotate questions 32 to 34]

32. How about raising state personal income taxes to provide additional funding for K–12 public education?

40% favor
57 oppose
3 don't know

33. How about raising the state sales tax to provide additional funding for K–12 public education?

46% favor
52 oppose
2 don't know

34. How about raising the top rate of the state income tax paid by the wealthiest Californians to provide additional funding for K–12 public education?

65% favor
34 oppose
1 don't know

35. Next, some people are registered to vote and others are not. Are you absolutely certain that you are registered to vote in California?

67% yes *[ask q35a]*
33 no *[skip to q36b]*

35a. Are you registered as a Democrat, a Republican, another party, or are you registered as a decline-to-state or independent voter?

45% Democrat *[ask q36]*
31 Republican *[skip to q36a]*
3 another party *(specify) [skip to q37]*
21 independent *[skip to q36b]*

36. Would you call yourself a strong Democrat or not a very strong Democrat?

54% strong
43 not very strong
3 don't know

[skip to question 37]

36a. Would you call yourself a strong Republican or not a very strong Republican?

51% strong
45 not very strong
3 don't know

[skip to question 37]

36b. Do you think of yourself as closer to the Republican Party or Democratic Party?

22% Republican Party
50 Democratic Party
20 neither *(volunteered)*
8 don't know

37. How closely are you following news about candidates for the 2012 presidential election—very closely, fairly closely, not too closely, or not at all closely?

26%	very closely
37	fairly closely
24	not too closely
13	not at all closely
–	don't know

38. Would you consider yourself to be politically:

[read list, rotate order top to bottom]

10%	very liberal
20	somewhat liberal
32	middle-of-the-road
21	somewhat conservative
13	very conservative
3	don't know

39. Generally speaking, how much interest would you say you have in politics—a great deal, a fair amount, only a little, or none?

22%	great deal
38	fair amount
31	only a little
8	none
1	don't know

[D1–D4a: demographic questions]

D4b. *[public school parents only]* Would you say your child's public school has or has not been affected by recent state budget cuts? (*If it has:* Has it been affected a lot or somewhat?)

36%	affected a lot
45	affected somewhat
16	not affected
3	don't know

D4c. *[public school parents only]* How concerned are you about teacher layoffs at your child's public school—very concerned, somewhat concerned, not too concerned, or not at all concerned?

58%	very concerned
29	somewhat concerned
8	not too concerned
5	not at all concerned
–	don't know

[D5–D17: demographic questions]

PPIC STATEWIDE SURVEY ADVISORY COMMITTEE

Ruben Barrales
President and CEO
San Diego Regional Chamber of Commerce

Angela Blackwell
Founder and CEO
PolicyLink

Paul Brest
President
The William and Flora Hewlett Foundation

Mollyann Brodie
Senior Vice President
Kaiser Family Foundation

Bruce E. Cain
Executive Director
University of California Washington Center

James E. Canales
President
The James Irvine Foundation

Jon Cohen
Director of Polling
The Washington Post

Russell Hancock
President and CEO
Joint Venture Silicon Valley Network

Sherry Bebitch Jeffe
Senior Scholar
School of Policy, Planning, and Development
University of Southern California

Robert Lapsley
President
California Business Roundtable

Carol S. Larson
President and CEO
The David and Lucile Packard Foundation

Monica Lozano
Publisher and CEO
La Opinión

Donna Lucas
Chief Executive Officer
Lucas Public Affairs

Lisa Pitney
Vice President, Government Relations
The Walt Disney Company

Dan Rosenheim
News Director
KPIX-TV

Robert K. Ross, M.D.
President and CEO
The California Endowment

Most Reverend Jaime Soto
Bishop of Sacramento
Roman Catholic Diocese of Sacramento

Cathy Taylor
Vice President and
Editorial Commentary Director
Orange County Register

Raymond L. Watson
Vice Chairman of the Board Emeritus
The Irvine Company

Carol Whiteside
President Emeritus
Great Valley Center

The PPIC Statewide Survey Advisory Committee is a diverse group of experts who provide advice on survey issues. However, survey methods, questions, content, and timing are determined solely by PPIC.

PPIC BOARD OF DIRECTORS

Gary K. Hart, Chair
Former State Senator and
Secretary of Education
State of California

Mark Baldassare
President and CEO
Public Policy Institute of California

Ruben Barrales
President and CEO
San Diego Regional Chamber of Commerce

María Blanco
Vice President, Civic Engagement
California Community Foundation

Brigitte Bren
Chief Executive Officer
International Strategic Planning, Inc.

Robert M. Hertzberg
Partner
Mayer Brown, LLP

Walter B. Hewlett
Chair, Board of Directors
William and Flora Hewlett Foundation

Donna Lucas
Chief Executive Officer
Lucas Public Affairs

David Mas Masumoto
Author and Farmer

Steven A. Merksamer
Senior Partner
Nielsen, Merksamer, Parrinello,
Gross & Leoni, LLP

Kim Polese
Chairman
ClearStreet, Inc.

Thomas C. Sutton
Retired Chairman and CEO
Pacific Life Insurance Company

PPIC | PUBLIC POLICY INSTITUTE OF CALIFORNIA

The Public Policy Institute of California is dedicated to informing and improving public policy in California through independent, objective, nonpartisan research on major economic, social, and political issues. The institute's goal is to raise public awareness and to give elected representatives and other decisionmakers a more informed basis for developing policies and programs.

The institute's research focuses on the underlying forces shaping California's future, cutting across a wide range of public policy concerns, including economic development, education, environment and resources, governance, population, public finance, and social and health policy.

PPIC is a private operating foundation. It does not take or support positions on any ballot measures or on any local, state, or federal legislation, nor does it endorse, support, or oppose any political parties or candidates for public office. PPIC was established in 1994 with an endowment from William R. Hewlett.

Mark Baldassare is President and CEO of PPIC.
Gary K. Hart is Chair of the Board of Directors.

Short sections of text, not to exceed three paragraphs, may be quoted without written permission provided that full attribution is given to the source and the copyright notice below is included.

Copyright © 2012 Public Policy Institute of California
All rights reserved.
San Francisco, CA

PUBLIC POLICY INSTITUTE OF CALIFORNIA
500 Washington Street, Suite 600
San Francisco, California 94111
phone: 415.291.4400
fax: 415.291.4401

www.ppic.org
survey@ppic.org

PPIC SACRAMENTO CENTER
Senator Office Building
1121 L Street, Suite 801
Sacramento, California 95814
phone: 916.440.1120
fax: 916.440.1121

latimes.com

USC DORNSIFE/TIMES POLL

Strong majority backs Jerry Brown's tax-hike initiative

Sixty-four percent of those surveyed said they supported the measure that the governor hopes to place on the November ballot. It would hike the sales tax and levies on upper incomes to help raise money for schools and balance the state's budget.

By Anthony York, Los Angeles Times

7:11 PM PDT, March 25, 2012

Reporting from Sacramento

California voters strongly support Gov. Jerry Brown's new proposal to increase the sales tax and raise levies on upper incomes to help raise money for schools and balance the state's budget, according to a new USC Dornsife/Los Angeles Times poll.

Sixty-four percent of those surveyed said they supported the governor's measure, which he hopes to place on the November ballot. It would hike the state sales tax by a quarter-cent per dollar for the next four years and create a graduated surcharge on incomes of more than $250,000 that would last seven years. A third of respondents opposed the measure.

Brown's new plan, rewritten recently amid pressure from liberal activist and union groups that had a competing proposal, relies on a larger share of revenue from upper-income earners than his original measure. Correspondingly, it leans less upon sales taxes, which are paid by all California consumers. The poll shows that taxing high earners is overwhelmingly popular.

"These poll results illustrate that Brown was very smart to put together this initiative the way he did," said Dan Schnur, director of the Jesse M. Unruh Institute of Politics at USC.

Shirley Karns, 74, an independent voter from the Northern California town of Lakeport who backs the governor's new plan, said the wealthy should pay more.

"Those who have an unbelievable amount more than those who do not should contribute more," she said. "And on the sales tax, the more you buy, the more you pay. It's pretty tough on low-income people who have to pay an extra nickel here and there,

but we've got to get the money from somewhere."

Brown reached a deal with a coalition led by the California Federation of Teachers to tweak his tax measure. In exchange, the group dropped its rival proposal — also aimed at the November ballot — which would have increased levies exclusively on incomes of more than $1 million.

The poll found that the now-defunct plan remains more popular than the governor's tax mix. And the findings carry other warning signs for Brown's campaign. Less than half — 49% — of those surveyed said California's books should be balanced by a combination of cuts and tax hikes. Nearly as many — 45% — said the state's taxes are already too high and the estimated $9-billion budget gap should be closed with cuts in government services.

"It shows this is a tough environment to pass tax increases," said Stan Greenberg of the Democratic polling firm Greenberg Quinlan Rosner, which conducted the survey in conjunction with the Republican company American Viewpoint.

Views of the governor's initiative are split along party lines. Eighty percent of Democrats approved of it, while just 38% of Republicans expressed support. The measure also has the firm backing of independents — voters who state no party preference, who are more than 20% of the California electorate and whose support Brown will likely need to pass his measure. Three-quarters of independents said they liked Brown's idea.

Voters are unenthusiastic about a separate revenue proposal that would hike income levies on most California taxpayers to raise money for schools and early childhood education programs and help pay down the state debt. The measure, backed by Pasadena attorney Molly Munger and the California State PTA, was supported by just 32% of those surveyed; 64% opposed it.

"Whenever people feel they may have to pay the taxes themselves, there's a clear move against it," said pollster Linda DiVall of American Viewpoint.

Jennifer Tran, a 25-year-old community college student and waitress from Chino Hills who is a registered Republican, says she has seen the impact of state budget cuts. Classes are harder to get into, and the price for courses has increased. But she is opposed to any new tax proposal because she doesn't trust Sacramento lawmakers to spend the money wisely.

"Are they going to do what they promise or just come up with different programs and laws we don't need and more unnecessary spending?" she said.

About half of respondents approve of the job Brown is doing as governor. He received positive reviews from 49%, while 35% said they disapproved of his performance and 15% had no opinion. Asked for a more general impression, 51% said they regarded Brown favorably and 35% did not.

The poll also measured support for two initiatives on the June ballot: a cigarette tax hike of $1 per pack that would raise an estimated $850 million annually for cancer research, and a proposal to change the state's term limits law.

Sixty-eight percent said they favored Proposition 29, the tobacco tax, compared to 29% who opposed it.

Support is more tenuous for an adjustment of the term limits that voters imposed on state legislators in 1990. Proposition 28 would reduce the overall amount of time a lawmaker can serve in Sacramento from 14 years to 12, but would allow all 12 years to be spent in one legislative house. Current law limits Assembly members to three two-year terms and state senators to two four-year terms.

A bare majority, 51% of those surveyed, said they would like such a change. Thirty-two percent opposed it. The proposal has stronger support from Republicans — 58% were in favor — while just 48% of Democrats liked the idea.

Voters narrowly rejected a similar proposal in 2004 that was backed by Democratic lawmakers and Gov. Arnold Schwarzenegger.

The USC Dornsife College of Letters, Arts and Sciences/Los Angeles Times poll surveyed 1,500 registered California voters from March 14 through 19. The sampling error is 2.9 percentage points.

latimes.com/news/local/la-me-state-poll-20120326,0,7626225.story

anthony.york@latimes.com

Copyright © 2012, Los Angeles Times

May 3, 2012

latimes.com

Editorial

California's dueling tax plans

If both Jerry Brown's and Molly Munger's tax hike proposals appear on the November ballot, it's likely neither will pass — meaning even deeper education and services cuts in the future.

Gov. Jerry Brown has been arguing almost since the day he took office in 2011 that voters should approve a tax increase to help the state solve its long-running fiscal problems. But to Brown's dismay, the November ballot may ask voters to choose between two tax hikes — one that he has proposed, and one that wealthy civil-rights attorney Molly Munger and the California PTA are backing. Such a clash would make it less likely that voters would approve either one. That might delight anti-tax activists, but it's a worst-case scenario for public schools, universities, courts and the state's tattered safety net.

Both proposals have their pros and cons, but only one would significantly improve the state's fiscal situation for years to come. That's Brown's, which combines a four-year, quarter-cent-on-the-dollar increase in the state sales tax with a seven-year surtax of 1% to 3% on Californians with taxable incomes over $250,000. Although the money from Brown's proposal would flow into a new fund for public schools and community colleges, it would free up more than $3 billion a year to help close the persistent gap in the state's budget.

Munger's proposal, dubbed the "Our Children, Our Future" initiative, would raise income taxes on most Californians for 12 years, ranging from 0.4% at the low end of the income scale to 2.2% for single taxpayers with more than $2.5 million in taxable income. For the first four years, 70% of the money would go to public schools and preschool programs, and 30% would be dedicated to paying down bond debt for schools, children's hospitals and other general obligations. After that, all of the money would be dedicated to schools and early childhood care and education programs.

Supporters of Munger's plan argue that it's the more honest of the two initiatives. In her proposal, all of the revenue sent to schools would be in addition to the amounts they're guaranteed from the general fund. Although Brown's proposal would significantly increase school and higher-education budgets, it would allow the state to put less money from the general fund into schools and more into other programs.

Brown has acknowledged as much, but the initiative itself isn't so clear. Its title is "The Schools and Public Safety Protection Act of 2012," and it states: "The new tax revenue is guaranteed in the Constitution to go directly to local school districts and community

colleges." But it also notes, "State money is freed up to help balance the budget and prevent even more devastating cuts to services for seniors, working families and small businesses."

The governor also emphasizes that his proposal is important to public safety, and it is — indirectly. At Brown's urging, the Legislature agreed last year to shift responsibility for certain types of felons from the state to county criminal justice systems. The initiative would amend the state Constitution to guarantee that local governments receive funding from state sales, use and vehicle taxes for those new duties, rather than leaving it up to the annual budget process. Without that kind of assurance, counties could find themselves with a diminishing amount of state aid to handle the felons left on their doorstep, increasing the risk of earlier releases from custody with less supervision.

Polls show that the voters are more likely to support a tax increase if the money goes to schools and public safety than to other state services, which explains why the governor's initiative is being sold the way it is. Yet as important as those priorities are, they are not the only obligations the state must meet. The belt-tightening in recent years has moved well past the stage of trimming the easy targets of "waste, fraud and abuse." Instead, lawmakers have been slashing medical care for the poor and the elderly, diminishing support for state colleges and universities, shutting parks and cutting early childhood programs and welfare benefits.

By offering temporary help on bond payments, the "Our Children, Our Future" plan would ease the budget problems for a few years, albeit to a lesser extent than Brown's would. After that, however, it would lock away the additional tax revenue for the sole purposes of public schools and preschool programs. As much as schools could use the money, that sort of ballot-box budgeting is one reason the state is in the fiscal mess it's in today.

Munger is poised at the point of no return. On Wednesday the "Our Children, Our Future" campaign filed its first set of petitions with election officials in Los Angeles County; it expects to have enough signatures gathered by next week to qualify for the November ballot. Already the group has been running advertisements that implicitly criticize Brown's proposal, and a spokesman said he expects the campaign to continue trying to convince voters that its plan is the better one for education.

It's conceivable that having two tax initiatives on the ballot will help persuade voters that Sacramento really does need more revenue after years of budget cuts, and a majority of them will rally behind one or the other. But it's far more likely that the dueling campaigns will split support for a tax increase, sending both to defeat and causing more deep cuts to the very schools Munger aims to protect. Brown's proposal is a better fit for the state's needs today. Munger should stand down.

latimes.com/news/opinion/editorials/la-ed-tax-ballot-measures-20120503,0,1751108.story
Copyright © 2012, Los Angeles Times

Attachment Two

CSAC Memo: Health Care Reform:

- **Designing Eligibility Systems for 2014**
- **Essential Health Benefits (SB 951, AB 1453)**
- **Basic Health Plan (SB 703) – ACTION ITEM**

Text of SB 951 (Hernandez)

Senate Health Committee Analysis of SB 951

Text of AB 1453 (Monning)

Assembly Health Committee Analysis of AB 1453

California Health Benefits Exchange Overview of Essential Health Benefits

Text of SB 703 (Hernandez)

Assembly Health Committee Analysis of SB 703

Mercer Report: State of California Financial Feasibility of a Basic Health Program (May 2011)

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

May 21, 2012

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Health Care Reform:
Designing Eligibility Systems for 2014
Basic Health Plan (SB 703) – ACTION ITEM
Essential Health Benefits (SB 951 and AB 1453)

Staff Recommendation: Adopt a SUPPORT position for SB 703.

Background. As 2014 approaches, California's counties and the Legislature are beginning the difficult work of redesigning eligibility and health care benefit systems. In this agenda item, Committee members will hear from three policy experts on the most recent developments in the areas of eligibility, the creation of an Essential Health Benefits, and the opportunities embodied in the adoption of a Basic Health Plan (SB 703).

We are asking the Health and Human Services Policy Committee to approve a SUPPORT position on SB 703. The other two topics are for information purposes at this time.

Designing Eligibility Systems for 2014

Speaker: Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association. Ms. Senderling-McDonald can be reached at Csend@cwda.org.

As counties look toward the implementation of the federal Affordable Care Act, a number of opportunities and challenges emerge. From a county human services department perspective, these fit under a set of overarching principles that build on the current integrated service delivery system and leverage current service options for customers that include in-person, online, phone and mail to ensure an efficient, effective and cost-effective eligibility operations structure post-2014.

Below are the key priorities developed by CWDA regarding eligibility systems in 2014 and beyond:

Principles
- No Wrong Door
- Applicant/Client Choice
- Coordinated Service Delivery
- Effective Client Service
- Efficient
- Cost Effective

Assumptions
- County human services departments will play a significant role in eligibility operations.
- More horizontal integration between health and human services is better than less.
- The state IT structure (a.k.a. "CalHEERS") will be up and running timely.

- CalHEERs and the county systems (a.k.a. "SAWS") will be able to communicate with each other.
- The Health Benefit Exchange will seek to minimize its own staffing costs, out of necessity.
- On-going case management will be simpler (use available data from other systems, allow for some difference in income, etc.)

Opportunities
- Counties benefit from successful implementation of health care reform
- Take advantage of ACA to drive simplifications across health and human services programs
- Take advantage of modernized technology to help manage workload and provide services

Key Goals
- Work together with county, state, community partners to pre-enroll as many as possible
- Maintain and build upon the current "no wrong door" structure and preserve horizontal integration across health and human services programs
- Offer excellent service to all customers across the economic spectrum
- Build on past success to create a "culture of coverage"

Essential Health Benefits

Speaker: Elizabeth Landsberg, Director of Legislative Advocacy, Western Center on Law and Poverty. Ms. Landsberg can be reached at elandsberg@wclp.org.

Another issue regarding ACA implementation is the creation of an Essential Health Benefits (EHB) package. The ACA requires states to choose essential benefits in 10 categories, including:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

California will need to create the Essential Health Benefits package. Currently, there are two legislative vehicles that would create an EHB package. Senator Ed Hernandez has introduced SB 951, and Assembly Member William Monning has introduced AB 1453. Both men are the chairs of the Senate and Assembly Health Committees, respectively. Both measures would establish the Kaiser Small Group Health Maintenance Organization (HMO) plan contract as California's Essential Health Benefits benchmark plan.

At the time of this writing, SB 951 was passed by the Senate on May 7 and is pending in the Assembly. Assembly Bill 1453 passed the Assembly on May 14 and is pending in the Senate.

Materials: Text of SB 951 with Senate Health Committee analysis; Text of AB 1453 with Assembly Health Committee analyses; California Health Benefits Exchange Overview of Essential Health Benefits (January 2012).

Basic Health Plan (SB 703) – ACTION ITEM

Speaker: Sarah Muller, Director of Government Affairs and Communications, California Association of Public Hospitals and Health Systems. Ms. Muller can be reached smuller@caph.org.

The Affordable Care Act allows states to create a health care benefit program for individuals with income between 134% and 200% of the Federal Poverty Level (FPL) that is outside of the Health Benefits Exchange. Called a Basic Health Plan (BHP), the federal government will pay for 95% of the costs of coverage for the estimated 920,000 people who would be eligible. The goal of the BSH is to provide an incentive for low-income populations to enroll in a health care plan, thereby increasing their health and reducing the cost of uninsured and uncompensated care on health systems and hospitals.

The BHP provides an opportunity to:

- Provide low-income Californians with equal or better benefit levels,
- Less expensive health plan premiums, and
- Lower cost-sharing than would be available to them in the Exchange using exclusively federal dollars, according to a Mercer Government Human Services Consulting (Mercer) financial feasibility analysis.

Adopting the BHP option will likely lead to more individuals receiving health care coverage as a result of lower premiums, greater ability to access health care because of the lower cost-sharing, increased compliance with the federal individual mandate, and a reduction in uncompensated care for health care providers.

Because federal BHP financing is based on the amount spent on premium tax credit and cost-sharing subsidies for commercial Exchange products, the BHP also provides an opportunity to increase funding to certain health plans and providers to amounts that would exceed rates paid to health plans and health care providers through Medi-Cal. The Mercer feasibility analysis estimates rates paid to providers in the BHP would be 20% to 25% higher than Medi-Cal rates, which will improve the financial viability of safety net providers who will continue to serve the remaining uninsured after full implementation of federal health care reform. The BHP option also provides participants with a product with a higher medical loss ratio (85% instead of 80%) than in the Exchange, which allows consumers to get more value out of their premium dollar. Finally, establishing a BHP could also reduce state GF Medi-Cal costs by making it more likely that individuals who qualify for share-of-cost Medi-Cal, because they incur medical costs significant enough to enable them to "spend down" to Medi-Cal eligibility, will shift to the federally-funded BHP.

There are several issues to consider in the creation of a Basic Health Plan. The first is the potential for incurring state costs, i.e. the 5% that is not covered by the federal government.

If the state will incur costs for the BHP population, it would create additional pressure on the state General Fund. Also, there have been concerns raised about the BHP competing with or siphoning off clients from the Health Care Exchange (HBEX).

The Legislature continues to discuss the issue. Senator Ed Hernandez has introduced SB 703, which is currently on the Assembly Appropriations Committee's Suspense File due to concerns about possible state costs. The legislation is also on hold pending more direction from the federal government.

In an attempt to study the issue, the California HealthCare Foundation has contracted with Mercer Consulting to examine the feasibility of a BHP in California. Mercer's first report was issued in May of 2011 (attached); a follow-up report is expected at the time of this writing (May 2012).

Because of the potential benefits to the populations currently served by counties, CSAC staff is seeking direction from the Health and Human Services Policy Committee to develop a SUPPORT position for SB 703. Current supporters of the measure include the Local Health Plans of California (sponsor), the California Association of Public Hospitals and Health Systems, the Congress of California Seniors, and Santa Clara County.

Materials: Text of SB 703 and Assembly Health Committee analysis; Mercer Report: State of California Financial Feasibility of a Basic Health Program (May 2011).

AMENDED IN SENATE APRIL 16, 2012

AMENDED IN SENATE MARCH 26, 2012

SENATE BILL **No. 951**

Introduced by Senator Hernandez

January 5, 2012

An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 951, as amended, Hernandez. Health care coverage: essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires

health care service plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and declares the
2 following:
3 (a) Commencing January 1, 2014, the federal Patient Protection
4 and Affordable Care Act (PPACA) requires a health insurance
5 issuer that offers coverage to small employers or individuals, both
6 inside and outside of the California Health Benefit Exchange, with
7 the exception of grandfathered plans, to provide minimum coverage
8 that includes essential health benefits, as defined.
9 (b) It is the intent of the Legislature to comply with federal law
10 and consistently implement the essential health benefits provisions
11 of PPACA and related federal guidance and regulations, by
12 adopting the uniform minimum essential benefits requirement in

state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.

SEC. 2. Section 1367.005 is added to the Health and Safety Code, to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser ~~Small~~ *Foundation Health Plan* Group HMO *thirty-dollar ($30) deductible* plan contract ~~(product~~ *(federal health product identification* number 40513CA035) as ~~of December 31, 2011,~~ *this contract was offered during the first quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric *services, including oral and* vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health~~

~~services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the plan contract covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.* Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011.~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric oral and vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental, orthodontic, or vision services covered under the plan contract identified in paragraph (1).*

(4) Any other benefits required to be covered under this chapter.

~~(d)~~

(b) When offering, issuing, selling, or marketing a health care service plan contract, a health care service plan shall not indicate or imply that the plan contract covers essential health benefits

unless the plan contract covers essential health benefits as defined in this section.

~~(e)~~

(c) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

~~(f)~~

(d) A plan contract subject to this section shall also comply with Section 1367.001.

~~(g)~~

(e) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

~~(h)~~

(f) Subdivision (a) shall not apply to any of the following:

(1) A plan contract that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA.

~~(i)~~

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

~~(j)~~

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.

1 SEC. 3. Section 10112.27 is added to the Insurance Code, to
2 read:
3 10112.27. (a) An individual or small group health insurance
4 policy issued, amended, or renewed on or after January 1, 2014,
5 shall, at a minimum, include coverage for essential health benefits.
6 For purposes of this section, "essential health benefits" means all
7 of the following:
8 (1) (A) The benefits and services covered by the Kaiser ~~Small~~
9 *Foundation Health Plan* Group HMO *thirty-dollar ($30) deductible*
10 plan contract ~~(product~~ *(federal health product identification* number
11 40513CA035) as ~~of December 31, 2011~~ *this contract was offered*
12 *during the first quarter of 2012*, including, but not limited to, all
13 of the following:
14 (i) The items and services covered by the plan contract within
15 the categories identified in subsection (b) of Section 1302 of
16 PPACA, including, but not limited to, ambulatory patient services,
17 emergency services, hospitalization, maternity and newborn care,
18 mental health and substance use disorder services, including
19 behavioral health treatment, prescription drugs, rehabilitative and
20 habilitative services and devices, laboratory services, preventive
21 and wellness services and chronic disease management, and
22 pediatric *services, including oral and* vision care.
23 ~~(ii) The items and services covered by the plan contract within~~
24 ~~the following categories: acupuncture services, chiropractic~~
25 ~~services, skilled nursing facility services, hospice care, bariatric~~
26 ~~surgery, nonsevere mental illness services, substance abuse~~
27 ~~services, smoking cessation counseling, alcoholism treatment,~~
28 ~~applied behavior analysis therapy for autism, smoking cessation~~
29 ~~drugs, pain medication for terminally ill patients, rehabilitative~~
30 ~~services, habilitative, physical, and occupational therapy, speech~~
31 ~~therapy, orthotics and prosthetics, prosthetic devices for~~
32 ~~laryngectomy, special footwear for persons suffering from foot~~
33 ~~disfigurement, surgically implanted hearing devices, home health~~
34 ~~services, HIV/AIDS services, osteoporosis services, and diabetes~~
35 ~~education.~~
36 *(ii) Mandated benefits pursuant to statutes enacted before*
37 *December 31, 2011.*
38 (B) The services and benefits described in this paragraph shall
39 be covered to the extent they are medically necessary. Scope and
40 duration limits imposed on the services and benefits described in

this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the health care service plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the policy covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012*. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011.~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric oral and vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental, orthodontic, or vision services covered under the plan contract identified in paragraph (1).*

(4) Any other benefits required to be covered under this chapter.

~~(d)~~

(b) When offering, issuing, selling, or marketing a health insurance policy, a health insurer shall not indicate or imply that the policy covers essential health benefits unless the policy covers essential health benefits as defined in this section.

~~(e)~~

(c) This section shall apply regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

~~(f)~~

(d) A health insurance policy subject to this section shall also comply with Section 10112.1.

~~(g)~~

(e) This section shall not be construed to prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

~~(h)~~

(f) Subdivision (a) shall not apply to any of the following:

(1) A policy that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA.

~~(i)~~

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

~~(j)~~

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) "Small group health insurance policy" means a group health care service insurance policy issued to a small employer, as defined in Section 10700.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California
2 Constitution.

O

97

SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 951
AUTHOR: Hernandez
AMENDED: March 26, 2012
HEARING DATE: April 11, 2012
CONSULTANT: Trueworthy

SUBJECT: Health care coverage: essential health benefits.

SUMMARY: Designates the Kaiser Small Group HMO as California's benchmark plan to serve as the essential health benefit (EHB) standard, as required by federal health care reform.

Existing federal law:

1. Requires, under the federal Patient Protection and Affordable Care Act (ACA), health plans and health insurers that offer coverage in the small group or individual market to ensure that coverage includes the EHB package.

2. Requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing state law:

1. Establishes the Department of Managed Health Care (DMHC) to license and regulate health care service plans (health plans) and establishes the Department of Insurance to provide for the regulation of health insurers.

2. Requires health plan contracts and health insurance policies to cover various benefits.

3. Establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

This bill:

1. Requires individual and small group health plans and health insurance policy contracts, both inside and outside of the Exchange, to cover EHBs, as defined.

2. Defines EHBs as the benefits and services covered by Kaiser Small Group HMO, including the categories identified in the ACA.

3. Requires the services and benefits to be covered to the extent they are medically necessary, and prohibits the scope and duration limits from exceeding the scope and duration limits imposed on those services by the plan contract.

4. Requires habilitative services to be provided for the same services as the plan contract provides for rehabilitative services and under the same terms and conditions of the plan contract for rehabilitative services.

Continued---

5. Requires the same services and benefits for pediatric oral care as provided by a specified federal plan to be provided as an EHB.

6. Prohibits plans from indicating or implying a contract or policy meets the EHB standard unless it covers EHBs, as defined.

7. Exempts self-insured group health plans, large group market health plans, or grandfathered health plans.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1. **Author's statement.** Keeping in mind federal guidance issued to date and federal health care reform, SB 951 uses the following principles to guide the selection of California's benchmark EHB: recognize the importance of existing state-mandated benefits and incorporate as many state mandates as possible; protect California's commitment to reproductive services; embrace the consumer-oriented regulatory framework in place at the DMHC; and maintain affordability for consumers. Using these principles and through a process of comparison, SB 951 designates the Kaiser Small Group HMO to serve as the state's benchmark plan.

2. **Background.** Effective January 1, 2014, federal law requires Medicaid benchmark and benchmark-equivalent plans, plans sold through the Exchange and the Basic Health Program (if enacted), and health plans and health insurers providing coverage to individuals and small employers to ensure coverage of EHBs, as defined by the Secretary of the Department of Health and Human Services (HHS). HHS is required to ensure that the scope of EHBs is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

   Under federal law, EHBs must include 10 general categories and the items and services covered within the following categories:
   - Ambulatory patient services.
   - Emergency services.
   - Hospitalization.
   - Maternity and newborn care.
   - Mental health and substance use disorder services, including behavioral health treatment.
   - Prescription drugs.
   - Rehabilitative and habilitative services and devices.
   - Laboratory services.
   - Preventive and wellness services and chronic disease management.
   - Pediatric services, including oral and vision care.

3. **EHB Bulletin.** On December 16, 2011, the HHS Center for Consumer Information and Insurance Oversight released an EHB Bulletin proposing that EHBs be defined using a benchmark approach. This gives states the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." If a state does not choose a benchmark health plan, the default benchmark plan for the state would be the largest plan by enrollment in the largest product in the small group market.

EHBs must include coverage of services and items in all 10 statutory categories listed above, but states would choose one of the following benchmark health insurance plans:

- One of the three largest small group plans in the state by enrollment—in California, these options are Anthem PPO licensed by CDI, Kaiser HMO licensed by DMHC, or Anthem PPO licensed by DMHC;
- One of the three largest state employee health plans by enrollment—in California, these options are CalPERS Blue Shield Basic HMO, CalPERS Choice, or CalPERS Kaiser HMO;
- One of the three largest federal employee health plan options by enrollment, which are Government Employee Health Association, Blue Cross and Blue Shield (BCBS) Basic, or BCBS Standard; or
- The largest HMO plan offered in the state's commercial market by enrollment, which is the Kaiser Large Group Commercial HMO.

4. **Frequently Asked Questions for Essential Health Benefits bulletin.** HHS issued a Frequently Asked Questions for Essential Health Benefits bulletin to provide additional guidance on HHS's intended approach in defining EHB. The bulletin outlines three categories of benefits not included in many of the health insurance plans – 1) pediatric oral services; 2) pediatric vision services; and 3) habilitative services. The bulletin describes rules to ensure coverage of these categories, and SB 951 implements these rules related to pediatric oral services and habilitative services. Specifically, SB 951 requires a plan to cover pediatric oral services at par with the largest federal plan by enrollment, the federal BCBS Standard Option Service Benefit Plan. The bill also requires habilitative services to be covered at parity with rehabilitative services provided by the Kaiser Small Group HMO.

5. **Milliman analysis.** In January 2012, the Exchange retained consulting firm, Milliman, to analyze and compare the health services covered by the 10 EHB California benchmark plan options. Milliman found all the plans to be comprehensive and found there to be only a very small cost difference between the optional plans.

6. **Related legislation.** SB 961 (Hernandez) would require a health plan contract to comply with federal requirements in the individual market. *SB 961 is pending before the Senate Health Committee.*

   SB 1321 (Harman) would require the Exchange to select the plan with the lowest EHB cost to be the set benchmark for the definition of EHBs. *SB 1321 is pending before the Senate Health Committee.*

   AB 1453 (Monning) would select the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard, as required by federal law. *AB 1453 is pending before the Assembly Health Committee.*

   AB 1461 (Monning) would require a health plan contract to comply with federal requirements in the individual market. *AB 1461 is pending before the Assembly Health Committee.*

7. **Prior legislation.** SB 51 (Alquist), Chapter 644, Statutes of 2011, establishes enforcement authority in California law to implement provisions of the ACA related to

medical loss ratio requirements on health plans and health insurers and enacts prohibitions on annual and lifetime benefits.

SB 900 (Alquist), Chapter 659, Statutes of 2010, and AB 1602 (Perez), Chapter 655, Statutes of 2010, established the California Health Benefit Exchange.

8. **Support.** The California Psychiatric Association supports the inclusion of all significant diagnoses in the Diagnostic and Statiscal Manual of the American Psychiatric Association within the EHBs. The California Association for Behavioral Analysis writes in support of SB 951 stating that it makes clear, consistent with the requirements of state and federal law, that applied behavior analysis for autism is a covered benefit in the benchmark benefit package. The California Speech-Language Hearing Association writes in support of the bill including speech therapy and other habilitative services.

9. **Support with concern.** The Council of Acupuncture and Oriental Medicine Association write they are pleased to see SB 951 recognize acupuncture as an EHB, but they are concerned SB 951 will only apply to acupuncture for treatment of pain and nausea.

   Western Center on Law and Poverty supports the approach of SB 951 selecting a Knox-Keene licensed plan to serve as the state's EHB benchmark standard. However, they are requesting an amendment to explicitly say plans cannot substitute coverage of services even if such substitutions are actuarially equivalent. Western Center on Law and Poverty also writes they want to ensure that the Kaiser Small Group HMO plan is not the basis for structuring cost-sharing models for individual and small group markets.

   Health Access writes they strongly support the requirement for an EHB standard and supports the selection of a Knox-Keene plan. However, Health Access is concerned SB 951 does not include the necessary statutory underpinning to assure consumers regulated under the Insurance Code have the same benefits as those with coverage regulated under the Knox-Keene Act. Health Access is seeking an amendment to ensure the bill as drafted is not construed to put the burden on the consumer to demonstrate that care is medically necessary.

10. **Selection of EHB benchmark plan.** Federal guidance states that if a state selects a benchmark plan that does not include all state-mandated benefits, the state must pay the costs of those mandated benefits. Given the impact this could have on the state's budget it is appropriate for the Legislature to select the benchmark plan. Further, given that the EHB benchmark plan impacts plans outside of the Exchange, it is reasonable for the Legislature to select to the benchmark plan.

    The Kaiser Small Group HMO includes all state mandates which will protect the state budget and many of the items and services are covered within the 10 required categories requiring very few supplements from different plans.

    Further, according to a recent data analysis complied by Milliman, "the range in estimated plan costs due to the chosen EHB benchmark is about 2.36% (101.87% to 104.23%)." Given this very small difference, cost does not appear to be an influential factor.

11. Amendments to be taken in Committee.

a. **Listing of benefits.** The listing of certain benefits and services covered by the Kaiser Small Group HMO and not all of the benefits and services covered by this plan is confusing and unnecessary. To eliminate confusion, the author has agreed to ***strike out Page 3, Lines 34 – 40 and Page 4, Lines 1-6.***

b. **Mandated benefits.** The PPACA requires states to defray the costs of state-mandated benefits and requires any state-mandated benefit enacted by December 31, 2011, to be a part of the EHB. To provide clarity, the author has agreed to ***insert on Page 4, after Line 6: "Mandated benefits pursuant to statutes enacted by the Governor before December 31, 2011."***

c. **Pediatric oral and vision care.** SB 951 supplements pediatric oral care with the federal BCBS Standard Option Service Benefit Plan. However, this is not the benchmark plan option provided by the federal guidance to use as a supplemental plan. SB 951 is silent on vision care which can be supplemented by the same plan. The author has agreed to ***strike out on Page 4, Lines 19-22: "federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011."*** and ***insert: "Federal Employees Dental and Vision Insurance Program with the largest national enrollment as of the first quarter of 2012."***

SUPPORT AND OPPOSITION:

Support: California Academy of Child and Adolescent Psychiatry
California Association for Behavioral Analysis
California Psychiatric Association
California Speech-Language Hearing Association
Council of Acupuncture and Oriental Medicine Associations (with concerns)
Health Access (with amendments)
Planned Parenthood Affiliates of California
Western Center on Law & Poverty

Oppose: None received.

-- END --

AMENDED IN ASSEMBLY APRIL 17, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1453

Introduced by Assembly Member Monning

January 5, 2012

An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1453, as amended, Monning. Essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides the essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful

97

violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and declares the
2 following:
3 (a) Commencing January 1, 2014, the federal Patient Protection
4 and Affordable Care Act (PPACA) requires a health insurance
5 issuer that offers coverage to small employers or individuals, both
6 inside and outside of an American Health Benefit Exchange, with
7 the exception of grandfathered plans, to provide minimum coverage
8 that includes essential health benefits, as defined.
9 (b) It is the intent of the Legislature to comply with federal law
10 and consistently implement the essential health benefits provisions

of PPACA and related federal guidance and regulations, by adopting the uniform minimum essential benefits requirement in state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.

SEC. 2. Section 1367.005 is added to the Health and Safety Code, to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser Small Group HMO plan contract (product number 40513CA035) as ~~of December 31, 2011,~~ *this contract was offered during the first quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health~~

~~services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the plan contract covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under th~~e federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012*. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by th~~e federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012*.

(4) Any other benefits required to be covered under this chapter.

(b) When offering, issuing, selling, or marketing a health care service plan contract, a health care service plan shall not indicate or imply that the plan contract covers essential health benefits unless the plan contract covers essential health benefits as defined in this section.

(c) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

1 (d) A plan contract subject to this section shall also comply with
2 Section 1367.001.
3 (e) This section shall not be construed to prohibit a plan contract
4 from covering additional benefits, including, but not limited to,
5 spiritual care services that are tax deductible under Section 213 of
6 the Internal Revenue Code.
7 (f) Subdivision (a) shall not apply to any of the following:
8 (1) A plan contract that provides excepted benefits as described
9 in Section 2722 of the federal Public Health Service Act (42 U.S.C.
10 Sec. 300gg-21).
11 (2) A plan contract that qualifies as a grandfathered health plan
12 under Section 1251 of PPACA.
13 (g) This section shall be implemented only to the extent that
14 federal law or policy does not require the state to defray the costs
15 of benefits included within the definition of essential health benefits
16 under this section.
17 (h) For purposes of this section, the following definitions shall
18 apply:
19 (1) "Habilitative services" means health care services that help
20 a person keep, learn, or improve skills and functioning for daily
21 living.
22 (2) "PPACA" means the federal Patient Protection and
23 Affordable Care Act (Public Law 111-148), as amended by the
24 federal Health Care and Education Reconciliation Act of 2010
25 (Public Law 111-152), and any rules, regulations, or guidance
26 issued thereunder.
27 (3) "Small group health care service plan contract" means a
28 group health care service plan contract issued to a small employer,
29 as defined in Section 1357.
30 SEC. 3. Section 10112.27 is added to the Insurance Code, to
31 read:
32 10112.27. (a) An individual or small group health insurance
33 policy issued, amended, or renewed on or after January 1, 2014,
34 shall, at a minimum, include coverage for essential health benefits.
35 For purposes of this section, "essential health benefits" means all
36 of the following:
37 (1) (A) The benefits and services covered by the Kaiser Small
38 Group HMO plan contract (product number 40513CA035) as ~~of~~
39 ~~December 31, 2011,~~ *this contract was offered during the first*
40 *quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the health care service plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the policy covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under th~~e federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of~~

1 ~~December 31, 2011~~ *Federal Employees Dental and Vision*
2 *Insurance Program dental plan and vision plan with the largest*
3 *national enrollment as of the first quarter of 2012.* Scope and
4 duration limits imposed on the services and benefits described in
5 this paragraph shall be no greater than the scope and duration
6 limitations imposed on those benefits by the ~~federal Blue Cross~~
7 ~~and Blue Shield Standard Option Service Benefit Plan available~~
8 ~~to enrollees through the FEHB as of December 31, 2011~~ *Federal*
9 *Employees Dental and Vision Insurance Program dental plan and*
10 *vision plan with the largest national enrollment as of the first*
11 *quarter of 2012.*
12 (4) Any other benefits required to be covered under this part.
13 (b) When offering, issuing, selling, or marketing a health
14 insurance policy, a health insurer shall not indicate or imply that
15 the policy covers essential health benefits unless the policy covers
16 essential health benefits as defined in this section.
17 (c) This section shall apply regardless of whether the policy is
18 offered inside or outside the California Health Benefit Exchange
19 created by Section 100500 of the Government Code.
20 (d) A health insurance policy subject to this section shall also
21 comply with Section 10112.1.
22 (e) This section shall not be construed to prohibit a policy from
23 covering additional benefits, including, but not limited to, spiritual
24 care services that are tax deductible under Section 213 of the
25 Internal Revenue Code.
26 (f) Subdivision (a) shall not apply to any of the following:
27 (1) A policy that provides excepted benefits as described in
28 Section 2722 of the federal Public Health Service Act (42 U.S.C.
29 Sec. 300gg-21).
30 (2) A health insurance policy that qualifies as a grandfathered
31 health plan under Section 1251 of PPACA.
32 (g) This section shall be implemented only to the extent that
33 federal law or policy does not require the state to defray the costs
34 of benefits included within the definition of essential health benefits
35 under this section.
36 (h) For purposes of this section, the following definitions shall
37 apply:
38 (1) "Habilitative services" means health care services that help
39 a person keep, learn, or improve skills and functioning for daily
40 living.

1 (2) "PPACA" means the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148), as amended by the
3 federal Health Care and Education Reconciliation Act of 2010
4 (Public Law 111-152), and any rules, regulations, or guidance
5 issued thereunder.
6 (3) "Small group health insurance policy" means a group health
7 insurance policy issued to a small employer, as defined in Section
8 10700.
9 SEC. 4. No reimbursement is required by this act pursuant to
10 Section 6 of Article XIII B of the California Constitution because
11 the only costs that may be incurred by a local agency or school
12 district will be incurred because this act creates a new crime or
13 infraction, eliminates a crime or infraction, or changes the penalty
14 for a crime or infraction, within the meaning of Section 17556 of
15 the Government Code, or changes the definition of a crime within
16 the meaning of Section 6 of Article XIII B of the California
17 Constitution.

O

Date of Hearing: April 10, 2012

ASSEMBLY COMMITTEE ON HEALTH
William W. Monning, Chair
AB 1453 (Monning) – As Amended: March 29, 2012

SUBJECT: Essential health benefits.

SUMMARY: Establishes the Kaiser Small Group Health Maintenance Organization (HMO) plan contract as California's Essential Health Benefits (EHB) benchmark plan. Specifically, this bill:

1) Requires an individual or small group health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014 to, at a minimum, include coverage for EHBs, which means all of the following:

   a) The benefits and services covered by the Kaiser Small Group HMO plan contract as of December 31, 2011, including, but not limited to, all of the following:
      i) The items and services covered by the plan contract within the categories identified in the Patient Protection and Affordable Care Act (ACA), including but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric vision care; and,
      ii) The items and services covered by the plan contract within the following categories: acupuncture services; chiropractic services; skilled nursing facility services; hospice care; bariatric; surgery; nonsevere mental illness services; substance abuse services; smoking cessation counseling; alcoholism treatment; applied behavior analysis therapy for autism; smoking cessation drugs; pain medication for terminally ill patients; rehabilitative services; habilitative, physical, and occupational therapy; speech therapy; orthotics and prosthetics; prosthetic devices for laryngectomy; special footwear for persons suffering from foot disfigurement; surgically implanted hearing devices; home health services; HIV/AIDS services; osteoporosis services; and, diabetes education.

   b) The service and benefits to be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in 1) a) above.

   c) Habilitative services to be covered under the same terms and conditions applied to rehabilitative services identified in the plan contract identified in 1) above. Defines "habilitative services" as health care services that help a person keep, learn, or improve skills and functioning for daily living.

   d) The same services and benefits for pediatric oral care covered under the federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011.

Makes scope and duration limits imposed on the services and benefits no greater than the scope and duration limitations imposed on those benefits by the federal Blue Cross and Blue Shield Standard Options Service Benefit Plan available to enrollees through the FEHB.

e) Any other benefits required to be covered by health plans and disability insurers.

2) Prohibits a health plan or health insurer from indicating or implying that the health plan contract or health insurance policy covers EHBs when offering, issuing, selling, or marketing a health plan contract or health insurance policy unless the plan contract or policy covers EHBs.

3) Applies the provisions of this bill regardless of whether the plan contract or policy is offered inside or outside the California Health Benefit Exchange (Exchange).

4) States that a plan contract or health insurance policy subject to this bill shall also comply with state and federal requirements with regard to annual and lifetime limits on the dollar value of benefits.

5) States that this bill shall not be construed to prohibit a plan contract or policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under the Internal Revenue Service Code, as specified.

6) Exempts a plan contract or health insurance policy that provides excepted benefits under the Public Health Service Act, and a plan contract or health insurance policy that qualifies as a grandfathered plan from some provisions of this bill.

7) States that this bill shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of EHBs.

EXISTING LAW:

1) Regulates health plans pursuant to the Knox-Keene Health Services Act of 1975 (Knox-Keene) at the Department of Managed Health Care (DMHC) and health insurers pursuant to the insurance code at the California Department of Insurance (CDI).

2) Defines "basic health care services" under Knox-Keene as:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and diagnostic and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage, including services through the 911 emergency response system; and,
   g) Hospice care, as specified.

3) Establishes a variety of covered mandated benefits applicable to health plans and health insurers including benefits relating to breast cancer testing and treatment, cancer screening

tests, cervical cancer screening, mammography, mastectomy and lymph node dissection length of stay, cancer clinical trials, prostate cancer screening, diabetes management and treatment, HIV/AIDS, Osteoporosis, Phenylketonuria, health parity for severe mental illness, and behavioral health treatment for autism and related disorders.

4) Establishes the Exchange to compare and make available through selective contracting health coverage to individuals and small businesses as authorized under the ACA.

5) Requires, under the ACA, a health insurance issuer that offers health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package, as specified.

6) Requires the federal Secretary of Health and Human Services (HHS) to define EHBs, except that such benefits are required to include at least the following general categories and the items and services covered within the categories:
   a) Ambulatory patient services;
   b) Emergency services;
   c) Hospitalization;
   d) Maternity and newborn care;
   e) Mental health and substance use disorder services, including behavioral health treatment;
   f) Prescription drugs;
   g) Rehabilitative and habilitative services and devices;
   h) Laboratory services;
   i) Preventive and wellness services and chronic disease management; and,
   j) Pediatric services, including oral and vision care.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, a bulletin issued by the Center for Consumer Information and Insurance Oversight (CCIIO) suggests that states are permitted to select a single benchmark to serve as the EHB standard for qualified health plans operating inside the state exchange and plans offered in the individual and small group markets, with an exception for grandfathered plans. For 2014 and 2015, states have been given the choice among 10 options. If a state does not choose a benchmark plan, CCIIO will use the largest product in the state's small group market as the default. The author states CCIIO believes this approach will give states time to provide a transition period to coordinate their benefit mandates while minimizing the likelihood that the state would be required to defray the costs of mandates in excess of the EHB. The federal HHS Agency intends to assess the benchmark process for the year 2016 and beyond.

   The author asserts that with this guidance in mind, the choice of the benchmark plan is based on the following principles: a) Recognition of the importance of existing state mandated benefits and incorporation of as many state mandates as possible; b) Protection of California's commitment to reproductive services; c) Embracing the consumer oriented regulatory framework in place at the DMHC; and, d) Maintaining affordability for consumers. Through a process of comparison to these principles other plans were eliminated and the Kaiser Small Group HMO was chosen. The author believes, based on the

information available, the Kaiser Small Group HMO represents the best benchmark plan choice for Californians. The Kaiser Small Group HMO covers all of California's mandates and includes vision exams. The contract covers reproductive services, is licensed at DMHC as a Knox-Keene plan and complies with all of the consumer rights and protections that go along with that, and while the cost differentials among all of the options are not significant, this plan falls in the middle.

2) BACKGROUND. On December 16, 2011, the HHS CCIIO released an EHB Bulletin proposing that EHBs be defined using a benchmark approach. This gives states the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." If a state does not choose a benchmark health plan, the default benchmark plan for the state would be the largest plan by enrollment in the largest product in the small group market, which is also the Kaiser HMO. EHBs must include coverage of services and items in all 10 statutory categories, but states can choose among the following benchmark health insurance plans:
   a) One of the three largest small group plans in the state by enrollment, in California these options are Anthem PPO licensed by CDI, Kaiser HMO licensed by DMHC, or Anthem PPO licensed by DMHC;
   b) One of the three largest state employee health plans by enrollment, in California these options are CalPERS Blue Shield Basic HMO, CalPERS Choice, or CalPERS Kaiser HMO;
   c) One of the three largest federal employee health plan options by enrollment, which are Government Employee Health Association, Blue Cross Blue Shield (BCBS) Basic, or BCBS Standard; or,
   d) The largest HMO plan offered in the state's commercial market by enrollment, which is the Kaiser Large Group Commercial HMO.

3) MILLIMAN ANALYSIS. In January 2012, the Exchange retained Milliman Inc., to analyze and compare the health services covered by the 10 EHB California benchmark plans. Milliman found all the plans to be comprehensive and found there to be only a very small cost difference between the plan choices. Milliman set as the baseline the minimum coverage for all services available in the 10 plans. This was set at 100%. Each plan was compared to the baseline and given a differential percentage. According to the analysis, the range in estimated plan costs associated with the EHB benchmark plan options is about 2.36% (101.87% to 104.23%). Given this very small range, cost differences between the options do not appear to be an influential factor.

4) SUPPORT. Many organizations have expressed support for this bill. The California Speech-Language Hearing Association supports the speech therapy and other habilitative services provisions of this bill. The California Psychiatric Association supports this bill because it includes severe and non-severe mental illness as well as substance abuse as EHBs. The Service Employees International Union of California believes the Kaiser Small Group HMO is a solid choice for California. The California Pan-Ethnic Health Network is pleased that the plan is governed by the Knox-Keene Act because it ensures a comprehensive package of medically necessary basic health services. The California Association for Behavior Analysis believes this bill provides much needed clarity on the minimum coverage which must be offered beginning 2014, particularly with regard to behavioral health treatment, which includes applied behavior analysis for autism or pervasive developmental disorder. The Congress of California Seniors supports efforts to create a benchmark listing of EHBs for

California health plans as required by ACA. Planned Parenthood Affiliates of California indicates that their preliminary analysis of the Kaiser Small Group HMO is positive, including that preventive services such as family planning counseling, well woman exams, cancer screenings, and prenatal care are specifically identified as covered services with no cost sharing. Consumers Union supports the codification of EHB standard based on upon the most popular small group plan in California.

5) SUPPORT WITH CONCERNS. While acknowledging that guidance is still not out on cost-sharing, the Western Center on Law and Poverty (Western Center) wants to ensure that the cost-sharing components of the Kaiser Small Group HMO plan are not adopted in the EHB standard because $400 per day hospital inpatient co-pays shouldn't be the basis for structuring cost-sharing. Western Center is also concerned that this bill does not explicitly address benefit substitution and insurer flexibility. Western Center requests an amendment to say that plans cannot substitute coverage of services even if such substitutions are actuarially equivalent. Planned Parenthood is also concerned about cost sharing and substitution of benefits. The Council of Acupuncture and Oriental Medicine Associations is pleased that this bill recognizes acupuncture as an EHB and requires acupuncture for treatment of pain and nausea in the individual and small group market but feels this is limiting and prevents acupuncture for neuromusculoskeletal and smoking abstinence.

Health Access California (HAC) supports establishing EHBs and believes that the decision that is made will remain in place for several decades. HAC supports the Kaiser Small Group HMO selection at this time. However, HAC remains concerned that the Insurance Code framework in existing law allows insurers to impose dollar and visit limits on outpatient care or hospital stays, deny access to prescription drugs for which there is no therapeutic equivalent or substituting one benefit for another. HAC seeks an amendment to require the following provision to be included in the Health and Safety Code 1367.005 and Insurance Code 10112.27:

> ~~The services and benefits described in this paragraph shall be covered to the extent they are medical necessary.~~ Medically necessary or appropriate services and benefits described in this section shall be covered, subject to cost sharing approved by the director and any limitation consistent with this paragraph.

HAC also requests an enhancement of the definition of habilitative to include services for degenerative conditions such as multiple sclerosis, ALS, Alzheimer's and other conditions for which current medical science can slow the rate of decline or minimize but does not allow individuals to "keep, learn or improve skills and functioning." HAC suggests the following amendment:

Habilitative services: means health care services that help a person keep, learn, or improve skills and functioning for daily living and that help a person to slow, minimize or reduce the loss of skills and functioning for daily living.

HAC also requests amendments in legislation this year to add consumer protections to the Insurance Code related to network adequacy, access to specialists, out of network emergency room care, balance billing for out of network emergency service, timely access to care, prior approval of changes to cost sharing and covered benefits, and standards for prescription drug coverage.

6) RELATED LEGISLATION.

a) SB 1321 (Harman) - requires the Exchange to select the plan with the lowest EHB cost to be the set benchmark for the definition of EHBs. SB 1321 is pending before the Senate Health Committee.

b) SB 951 (Ed Hernandez) – selects the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard, as required by federal law. SB 951 is pending before the Senate Health Committee.

c) AB 1738 (Huffman) requires health plan contracts and health insurance policies issued, amended, renewed, or delivered on or after January 1, 2013, to provide coverage for two courses of treatment in a 12-month period for tobacco cessation preventive services rated "A" or "B" by the United States Preventive Services Task Force, and would prohibit plans and insurers from charging a copayment, coinsurance, or deductible for those services. AB 1738 is pending in the Assembly Health Committee.

d) AB 1800 (Ma) requires, commencing January 1, 2013, a health plan contract, and a health insurance policy offering outpatient prescription drug coverage, to provide for a limit on annual out-of-pocket expenses for all covered benefits, except as specified, and specifies that this limit shall not exceed federal limits. AB 1800 is pending in the Assembly Health Committee.

e) AB 1000 (Perea) requires a health plan contract or health insurance policy that provides coverage for cancer chemotherapy treatment to establish limits on enrollee out-of-pocket costs for prescribed, orally administered, nongeneric cancer medication. AB 1000 is pending in the Senate Health Committee.

f) AB 154 (Beall) requires health plans and health insurers to cover the diagnosis and medically necessary treatment of a mental illness, as defined, of a person of any age, with specified exceptions, and not limited to coverage for severe mental illness as in existing law. AB 154 is pending in the Senate Health Committee.

g) AB 171 (Beall) requires health plans and health insurers to cover the screening, diagnosis, and treatment of pervasive developmental disorder or autism. AB 171 is pending in the Senate Health Committee.

h) AB 137 (Portantino) requires health plan contracts and health insurance policies that are issued, amended, delivered, or renewed, on or after July 1, 2013, to provide coverage for mammography for screening or diagnostic purposes upon referral by a health care professional, based on medical need, regardless of age. AB 137 is pending in the Senate Health Committee.

i) AB 369 (Huffman) prohibits health plans and health insurers that restrict medications for the treatment of pain from requiring a patient to try and fail on more than two pain medications before allowing the patient access to the pain medication, or its generic equivalent, prescribed by his or her physician. AB 369 is pending in the Senate Health Committee.

7) AUTHOR'S AMENDMENTS.

a) Listing of benefits. The listing of certain benefits and services covered by the Kaiser Small Group HMO and not all of the benefits and services covered by this plan is confusing and unnecessary. To eliminate confusion, the author has agreed to Strike-out Page 3, Lines 26-29 and Page 4, Lines 1-13.

b) Mandated benefits. The ACA requires States to defray the costs of State-mandated benefits and requires any State-mandated benefit enacted by December 31, 2011 would be a part of the EHB. To provide clarity the author has agreed to insert on Page 4, after Line 14: "Mandated benefits pursuant to statutes enacted before December 31, 2011."

c) Pediatric Oral and Vision Care. This bill supplements pediatric oral care with the federal Blue Cross and Blue Shield Standard Option Service Benefit Plan. However, this is not the benchmark plan option provided by the federal guidance to use as a supplemental plan. This bill is silent on vision care which can be supplemented by the same plan. The author has agreed to on Page 4, Lines 25-35, Strike out: "federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011." and Insert: Federal Employees Dental and Vision Insurance Program with the largest national enrollment as of the first quarter of 2012.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association for Behavior Analysis
California Black Health Network
California Communities United Institute
California Pan-Ethnic Health Network
California Psychiatric Association
California Speech-Language Hearing Association
Congress of California Seniors
Consumers Union
Planned Parenthood Affiliates of California
Service Employees International Union California

Opposition

None on file.

Analysis Prepared by: Teri Boughton / HEALTH / (916) 319-2097

Overview
Essential Health Benefits in the Affordable Care Act

Deborah Reidy Kelch

January 26, 2012

California Health Benefit Exchange Board Meeting

Essential Health Benefits

Minimum floor of benefits in coverage for:

- Qualified health plans for individuals and small groups in the Exchange
- Non-grandfathered individual and small group coverage outside of the Exchange
- Persons newly eligible for Medicaid (133% of poverty and below)
- Persons enrolled in a Basic Health Option, if established by states

10 Benefit Categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Federal Essential Health Benefits Bulletin

Intended regulatory approach:

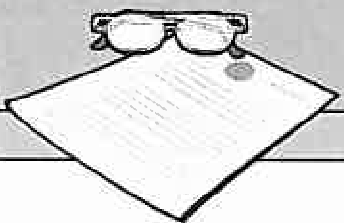
- Each state selects a benchmark plan
- Selected benchmark serves as a reference plan reflecting "both the scope of services and any limits offered by a typical employer plan"
- Plans chosen based on enrollment data first quarter two years prior to the coverage year (1st quarter 2012 for Jan 2014)
- Benchmark chosen in the third quarter of year two years prior (2012 for 2014)

Benchmark options (10 options):

- **Small group** – largest plan by enrollment in the three largest small group products
- **State employee** – largest three state employee plans by enrollment
- **Federal employee** – any of the largest three national FEHBP plans by enrollment
- **Commercial HMO** – largest insured commercial non-Medicaid HMO in the state

Health Benefit Plan Design

1) Benefit design
   - Covered services
   - Cost-sharing
   - Terms and conditions of coverage
2) Delivery system design
   - Provider network
   - Medical Management
   - Payment and Reimbursement
3) Customer service and administrative services



Benefit Design Elements

(For illustration purposes)

1 Covered Services

- Covered benefits, drugs and devices and benefit definitions
- Quantitative limits or exclusions
- Key Terms affecting coverage
  - Definition of medical service
  - Medical necessity
  - Experimental, investigational
  - Cosmetic

2 Cost-sharing

- Deductibles, co-payments, co-insurance, out-of-pocket maximums
- Covered services with no cost sharing (e.g., prevention)
- How enrollee cost-sharing accrues to the out-of-pocket maximum and deductibles

3 Coverage Terms

- In-network / out-of-network provider
- Prior authorization or pre-service review
- Specified settings, sites or levels of care where service is covered
- Provider type or license
- Primary care coordination / specialty referral conditions

Next Steps

1) Comments on federal proposal from California and other stakeholders

2) Continue to get clarification from federal Department of Health and Human Services, including Medicaid-specific guidance

3) Verify the appropriate benchmarks in compliance with the federal choices

4) Compare the benefits and coverage terms

5) Ensure that the 10 categories in the Affordable Care Act are included

6) Understand and evaluate the implications of choosing each benchmark

AMENDED IN ASSEMBLY JULY 12, 2011

AMENDED IN ASSEMBLY JUNE 28, 2011

AMENDED IN SENATE MAY 31, 2011

AMENDED IN SENATE MARCH 30, 2011

AMENDED IN SENATE MARCH 24, 2011

SENATE BILL No. 703

Introduced by Senator Hernandez

February 18, 2011

An act to add Part 6.25 (commencing with Section 12694.1) to Division 2 of the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 703, as amended, Hernandez. Health care coverage: Basic Health Program.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and employers. Existing state law establishes the California Health Benefit Exchange within state government. The federal Patient Protection and Affordable Care Act also authorizes the establishment of a basic health program under which a state may enter into contracts to offer one or more standard health plans providing a minimum level of essential benefits to eligible individuals instead of offering those individuals coverage through an Exchange, if specified criteria are met.

Existing law establishes the Managed Risk Medical Insurance Board (MRMIB) and makes it responsible for administering the California

Major Risk Medical Insurance Program and the Healthy Families Program to provide health care coverage to certain residents of the state who are unable to secure adequate coverage, subject to specified eligibility requirements.

This bill would establish in state government a Basic Health Program, to be administered by MRMIB. The bill would require MRMIB to enter into a contract with the United States Secretary of Health and Human Services to implement the Basic Health Program, and would set forth the powers and the duties of MRMIB relative to determining eligibility for enrollment, setting premiums for coverage, and selecting participating health plans under the Basic Health Program, subject to requirements under federal law. The bill would require the board to permit enrollment in the Basic Health Program on January 1, 2014. The bill would create the Basic Health Program Trust Fund for those purposes and would make moneys in the fund subject to appropriation by the Legislature, except that if the annual Budget Act is not enacted by a certain date, the bill would authorize the board to transfer specified funds from the trust fund to health plans in order to comply with certain requirements, thereby making an appropriation. The bill would require the Basic Health Program to be funded by federal funds, private donations, premiums paid by eligible individuals, and other non-General Fund moneys available for that purpose. Notwithstanding those provisions, the bill would authorize the board to obtain loans from the General Fund for initial start-up expenses, to be repaid by July 1, 2016, and would establish a procedure for continued coverage of individuals under the California Health Benefit Exchange if costs of the Basic Health Program exceed moneys available from specified sources. *The bill would require the board to request an evaluation of the Basic Health Program and to seek funding for the evaluation from an unspecified independent nonprofit private foundation.*

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Part 6.25 (commencing with Section 12694.1) is
2 added to Division 2 of the Insurance Code, to read:

1 PART 6.25. BASIC HEALTH PROGRAM
2
3 12694.1. It is the intent of the Legislature to establish a Basic
4 Health Program option to implement the option contained in
5 Section 1331 of the federal Patient Protection and Affordable Care
6 Act (PPACA). The Legislature finds and declares that Section
7 1331 of PPACA creating the Basic Health Program does the
8 following:
9 (a) Requires eligible individuals and their dependents enrolled
10 in the Basic Health Program be provided a health plan containing
11 the essential health benefits at a monthly premium price that does
12 not exceed the amount of the premium that the eligible individual
13 would have been required to pay if the individual had enrolled in
14 the applicable second lowest cost silver plan offered to the
15 individual through the California Health Benefit Exchange.
16 (b) (1) Prohibits the cost sharing an eligible individual is
17 required to pay under the Basic Health Program from exceeding
18 the cost sharing required under a platinum plan for individuals
19 with a household income at or below 150 percent of the federal
20 poverty level for the size of the family involved.
21 (2) Prohibits the cost sharing an eligible individual is required
22 to pay under the Basic Health Program from exceeding the cost
23 sharing required under a gold plan for an individual with a
24 household income above 150 percent of the federal poverty level
25 but at or below 200 percent of the federal poverty level for the size
26 of the family involved.
27 (c) Requires the medical loss ratio for products in the Basic
28 Health Program to be 85 percent, instead of 80 percent, in the
29 individual and small group market.
30 12694.15. For purposes of this part, the following definitions
31 shall apply:
32 (a) "Basic Health Program" means the program authorized by
33 Section 1331 of PPACA.
34 (b) "Board" means the Managed Risk Medical Insurance Board.
35 (c) "County organized health system" means a licensed health
36 care service plan established pursuant to Section 14087.51 or
37 14087.54 of the Welfare and Institutions Code or Chapter 3
38 (commencing with Section 101675) of Part 4 of Division 101 of
39 the Health and Safety Code.

1 (d) "Department" means the State Department of Health Care
2 Services.
3 (e) "Eligible individual" shall have the same meaning as set
4 forth in subdivision (e) of Section 1331 of PPACA.
5 (f) "Essential health benefits" shall have the same meaning as
6 set forth in Section 1302 of PPACA.
7 (g) "Fund" means the Basic Health Program Trust Fund
8 established by Section 12694.955.
9 (h) "Health plan" means a private health insurer holding a valid
10 outstanding certificate of authority from the Insurance
11 Commissioner or a health care service plan, as defined under
12 subdivision (f) of Section 1345 of the Health and Safety Code,
13 licensed by the Department of Managed Health Care.
14 (i) "Local initiative" means a licensed health care service plan
15 established pursuant to Section 14018.7, 14087.31, 14087.35,
16 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions
17 Code.
18 (j) "Patient Protection and Affordable Care Act" or "PPACA"
19 means Public Law 111-148, as amended by the federal Health
20 Care and Education Reconciliation Act of 2010 (Public Law
21 111-152), and any amendments to, or regulations or guidance
22 issued under, those acts.
23 12694.2. The Basic Health Program is hereby created and shall
24 be administered by the Managed Risk Medical Insurance Board.
25 12694.25. The board shall enter into a contract with the United
26 States Secretary of Health and Human Services to implement a
27 Basic Health Program to provide coverage to eligible individuals.
28 12694.26. The board shall permit enrollment in the Basic
29 Health Program on January 1, 2014.
30 12694.3. (a) The board shall administer the Basic Health
31 Program in conjunction with the Healthy Families Program, and
32 shall provide an eligibility and enrollment process that allows an
33 individual, or his or her natural or adoptive parent, legal guardian,
34 caretaker relative, foster parent, or stepparent with whom the child
35 resides, to enroll in the Basic Health Program at the same time an
36 individual, or his or her natural or adoptive parent, legal guardian,
37 caretaker relative, foster parent, or stepparent with whom the child
38 resides, applies for enrollment in the Healthy Families Program.
39 An individual may enroll in the same health plan, or a different

1 health plan, than his or her child or children who are enrolled in
2 the Healthy Families Program.
3 (b) In implementing the requirements of this section, and
4 consistent with the requirements of Section 1331 of PPACA, the
5 board may do all of the following:
6 (1) Determine eligibility criteria for the Basic Health Program.
7 (2) Determine the participation requirements of eligible
8 individuals applying for coverage in the Basic Health Program.
9 (3) Determine the participation requirements of participating
10 health plans.
11 (4) Determine when the coverage of eligible individuals begins
12 and the extent and scope of coverage.
13 (5) Determine, through negotiation with health plans, premium
14 and cost-sharing amounts.
15 (6) Collect premiums.
16 (7) Provide or make available subsidized coverage through
17 participating health plans.
18 (8) Provide for the processing of applications and the enrollment
19 of eligible individuals.
20 (9) Determine and approve the benefit designs and cost sharing
21 required by health plans participating in the Basic Health Program.
22 (10) Enter into contracts.
23 (11) Employ necessary staff.
24 (12) Authorize expenditures from the fund to pay program
25 expenses that exceed eligible individual premium contributions
26 and to administer the Basic Health Program, as necessary.
27 (13) Maintain enrollment and expenditures to ensure that
28 expenditures do not exceed amounts available in the fund, and, if
29 sufficient funds are not available to cover the estimated cost of
30 program expenditures, the board shall institute appropriate
31 measures to reduce costs.
32 (14) Issue rules and regulations, as necessary. Until January 1,
33 2016, any rules and regulations issued pursuant to this subdivision
34 may be adopted as emergency regulations in accordance with the
35 Administrative Procedure Act (Chapter 3.5 (commencing with
36 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
37 Code). The adoption of these regulations shall be deemed an
38 emergency and necessary for the immediate preservation of the
39 public peace, health, and safety or general welfare. The regulations

1 shall become effective immediately upon filing with the Secretary
2 of State.
3 (15) Make application assistance payments to individuals who
4 have successfully completed the requirements of a Certified
5 Application Assistant in the Healthy Families Program and who
6 successfully enroll eligible individuals in Basic Health Program
7 coverage.
8 (16) Exercise all powers reasonably necessary to carry out the
9 powers and responsibilities expressly granted or imposed by this
10 part and Section 1331 of PPACA.
11 12694.35. In implementing this part, eligibility for coverage
12 under, and the benefits, premiums, and cost sharing in, the Basic
13 Health Program, shall meet the requirements of Section 1331 of
14 PPACA. The board may determine the benefits, if any, to offer
15 Basic Health Program participants that are in addition to the
16 essential health benefits package required by Section 1302 of
17 PPACA, including benefits provided through specialized health
18 care service plans, as defined in subdivision (o) of Section 1345
19 of the Health and Safety Code, and specialized health insurance
20 policies, as defined in Section 106, to the extent that PPACA
21 authorizes the inclusion of such plans or policies in the Basic
22 Health Program. To the extent authorized by federal law, the board
23 shall determine whether benefits provided through specialized
24 health care service plans and specialized health insurance policies
25 are made available through the Basic Health Program as part of a
26 benefit package made available through health plans~~,~~ or as an
27 additional product to be purchased by individuals receiving
28 coverage through the Basic Health Program.
29 12694.4. The Basic Health Program shall be administered
30 without regard to gender, race, creed, color, sexual orientation,
31 health status, disability, or occupation.
32 12694.45. (a) The board shall use appropriate and efficient
33 means to notify eligible individuals of the availability of health
34 coverage from the Basic Health Program.
35 (b) The board, in conjunction with the department, shall conduct
36 a community outreach and education campaign to assist in
37 notifying eligible individuals of the availability of health coverage
38 through the Basic Health Program. The board and the department
39 shall seek federal funding and funding from private entities,
40 including foundation funding, for this purpose. The department

1 and the California Health Benefit Exchange shall include
2 information on the availability of coverage through the Basic
3 Health Program in all eligibility outreach efforts, and the board
4 shall also include information on the availability of coverage in
5 the Medi-Cal program and the California Health Benefit Exchange.
6 (c) The board shall use appropriate materials, which may include
7 brochures, pamphlets, fliers, posters, and other promotional items,
8 to notify families of the availability of coverage through the Basic
9 Health Program.
10 12694.5. (a) The board shall ensure that written enrollment
11 information issued or provided by the Basic Health Program is
12 available to program subscribers and applicants in each of the
13 Medi-Cal threshold languages.
14 (b) The board shall ensure that telephone services provided to
15 program subscribers and applicants by the Basic Health Program
16 are available in all of the languages identified as Medi-Cal
17 threshold languages.
18 (c) The board shall ensure that interpreter services are available
19 between eligible individuals and participating health plans in the
20 Medi-Cal threshold languages. The board shall ensure that
21 subscribers are provided information within provider network
22 directories of available linguistically diverse providers.
23 (d) The board shall ensure that participating health plans,
24 specialized health care service plans, and specialized health
25 insurance policies provide documentation on how they provide
26 linguistically and culturally appropriate services, including
27 marketing materials, to subscribers.
28 12694.55. No participating health plan, specialized health care
29 service plan, or specialized health insurance policy shall, in an
30 area served by the Basic Health Program, directly, or through an
31 employee, agent, or contractor, provide an applicant with any
32 marketing material relating to benefits or rates provided under the
33 Basic Health Program, unless the material has been reviewed and
34 approved by the board.
35 12694.57. The board may do the following:
36 (a) Amend existing Healthy Families Program contracts to allow
37 the parents of children enrolled in the Healthy Families Program
38 to enroll in the same plan as their child or children through the
39 Basic Health Program.

1 (b) Require, as a condition of participation in the Basic Health
2 Program, health plans to participate in the Healthy Families
3 Program.
4 12694.6. (a) The board may establish geographic areas,
5 consistent with the geographic areas of the Healthy Families
6 Program, within which participating health plans may offer
7 coverage to subscribers.
8 (b) Nothing in this section shall restrict a county organized
9 health system, a health plan, or a local initiative from providing
10 services to Basic Health Program subscribers in their licensed
11 geographic service area.
12 12694.65. (a) Notwithstanding any other provision of law, the
13 board shall not be subject to licensure or regulation by the
14 Department of Insurance or the Department of Managed Health
15 Care.
16 (b) A participating health plan, specialized health care service
17 plan, or specialized health insurance policy that contracts with the
18 Basic Health Program and is regulated by the Insurance
19 Commissioner or the Department of Managed Health Care shall
20 be licensed and in good standing with its respective licensing
21 agency. In its application to the Basic Health Program, an applicant
22 shall provide assurance of its standing with the appropriate
23 licensing agency.
24 12694.7. (a) The board shall contract with a broad range of
25 health plans in an area, if available, to ensure that subscribers have
26 a choice of health plans from among a reasonable number and
27 different types of competing health plans. The board shall develop
28 and make available objective criteria for health plan selection and
29 provide adequate notice of the application process to permit all
30 health plans a reasonable and fair opportunity to participate. The
31 criteria and application process shall allow participating health
32 plans to comply with their state and federal licensing and regulatory
33 obligations, except as otherwise provided in this part. Health plan
34 selection shall be based on the criteria developed by the board.
35 (b) (1) In its selection of participating health plans, the board
36 shall take all reasonable steps to ensure that the range of choices
37 of health plans available to each applicant shall include health
38 plans that include in their provider networks, and have signed
39 contracts with, traditional and public and private safety net
40 providers.

1 (2) A participating health plan shall annually submit to the board
2 a report summarizing its provider network. The report shall
3 provide, as available, information on the provider network as it
4 relates to all of the following:
5 (A) Geographic access for the subscribers.
6 (B) Linguistic services.
7 (C) The ethnic composition of providers.
8 (D) The number of subscribers who selected traditional and
9 public and private safety net providers.
10 (c) (1) The board shall not rely solely on a determination by
11 the Department of Managed Health Care or the Insurance
12 Commissioner of a health plan network's adequacy or geographic
13 access to providers in the awarding of contracts under this part.
14 The board shall collect and review demographic, census, and other
15 data to provide to prospective local initiatives, health plans, or
16 specialized health plans, and identify specific provider contracting
17 target areas with significant numbers of uninsured individuals with
18 incomes that would make them eligible for the Basic Health
19 Program. The board shall give priority to those health plans, on a
20 county-by-county basis, that demonstrate that they have included
21 in their prospective plan networks significant numbers of providers
22 in these geographic areas.
23 (2) Targeted contracting areas are those ZIP Codes or groups
24 of ZIP Codes or census tracts or groups of census tracts that have
25 a percentage of eligible individuals that is greater than the overall
26 percentage of eligible individuals in that county.
27 (d) In each geographic area, the board shall designate a
28 community provider plan that is the participating health plan that
29 has the highest percentage of traditional and public and private
30 safety net providers in its network. Subscribers selecting such a
31 health plan shall be given a premium discount in an amount
32 determined by the board.
33 (e) This section shall also apply to a specialized health care
34 service plan, as defined in subdivision (o) of Section 1345 of the
35 Health and Safety Code, and a specialized health insurance policy,
36 as defined in Section 106, to the extent that the inclusion of that
37 plan or policy in the Basic Health Program is authorized by
38 PPACA.
39 12694.75. (a) After two consecutive months of nonpayment
40 of premiums by an eligible individual enrolled in the Basic Health

1 Program, and a reasonable written notice period of not less than
2 30 days is provided to the eligible individual, the eligible individual
3 may be disenrolled from the Basic Health Program for the failure
4 to pay premiums. The board may conduct or contract for collection
5 actions to collect unpaid family contributions.
6 (b) Subject to any additional requirements of federal law,
7 disenrollments shall be effective at the end of the second
8 consecutive month of nonpayment.
9 12694.8. The Basic Health Program may place a lien on
10 compensation or benefits, recovered or recoverable by a subscriber
11 or applicant, or from any party or parties responsible for the
12 compensation or benefits for which benefits have been provided
13 under a plan contract or policy issued under this part.
14 12694.85. The board shall establish and use a competitive
15 process to select participating health plans and any other
16 contractors under this part. Any contract entered into pursuant to
17 this part shall be exempt from Chapter 2 (commencing with Section
18 10100) of Division 2 of the Public Contract Code, and shall be
19 exempt from the review or approval of any division of the
20 Department of General Services.
21 12694.855. (a) A health care provider that is provided
22 documentation of an individual's enrollment in the Basic Health
23 Program shall not seek reimbursement or attempt to obtain payment
24 for any covered services provided to that individual other than
25 from the participating health plan covering that individual.
26 (b) Subdivision (a) shall not apply to any cost sharing required
27 for covered services provided to the individual under his or her
28 participating health plan.
29 (c) For purposes of this section, "health care provider" means
30 any professional person, organization, health facility, or any other
31 person or institution licensed by the state to deliver or furnish
32 health care services.
33 12694.9. To the extent permitted by federal law, an eligible
34 individual enrolled in the Basic Health Program shall continue to
35 be eligible for the program for a period of 12 months from the
36 month eligibility is established.
37 12694.95. The board shall do all of the following:
38 (a) Make use of a simple and easy to understand mail-in and
39 Internet application process.

(b) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, cost sharing, and coinsurance, under the individual's health plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific product or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(c) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(d) Maintain an Internet Web site through which eligible individuals may obtain standardized comparative information on those health plans.

(e) Utilize a standardized format for presenting health benefits plan options offered through the Basic Health Program, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(f) Establish a process to inform individuals who lose eligibility ~~for~~ *under* the Basic Health Program of the availability of coverage through Medi-Cal and the California Health Benefit Exchange, and to transmit their eligibility-related information to those programs electronically to facilitate enrollment.

12694.955. (a) The Basic Health Program Trust Fund is hereby created in the State Treasury for the purpose of this part. All federal funds received pursuant to Section 1331 of PPACA shall be placed in the Basic Health Program Trust Fund. Moneys in the fund shall be used for the purposes of this part, upon appropriation by the Legislature, except that if the annual Budget Act is not enacted by June 30 of any fiscal year preceding the fiscal year to which the budget would apply, the board may transfer federal funds and premium payments from the Basic Health Program Trust Fund to health plans contracting with the board to ensure that individuals receiving coverage through the Basic Health Program are able to comply with the requirement to maintain minimum essential coverage as described in Section 1501 of PPACA. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

1 (b) Notwithstanding any other provision of law, moneys
2 deposited in the fund shall not be loaned to, or borrowed by, any
3 other special fund or the General Fund, a county general fund, or
4 any other county fund.
5 (c) The board shall establish and maintain a prudent reserve in
6 the fund.
7 (d) Notwithstanding Section 16305.7 of the Government Code,
8 all interest earned on the moneys that have been deposited into the
9 fund shall be retained in the fund and used for purposes consistent
10 with the fund.
11 (e) Subject to approval by the Department of Finance, and upon
12 notification to the committees of each house of the Legislature
13 that consider the budget and the committees of each house that
14 consider appropriations, the board may obtain loans from the
15 General Fund for all necessary and reasonable start-up and initial
16 expenses related to the administration of the fund and the Basic
17 Health Program. The board shall repay principal and interest, using
18 the pooled money investment account rate of interest, to the
19 General Fund no later than July 1, 2016.
20 12694.957. (a) The board shall ensure that the establishment,
21 operation, and administrative functions of the Basic Health
22 Program do not exceed the combination of federal funds, private
23 donations, premiums paid by eligible individuals, and other
24 non-General Fund moneys available for this purpose. Except for
25 loans authorized pursuant to subdivision (e) of Section 12694.955,
26 no state General Fund money shall be used for any purpose under
27 this part.
28 (b) The board shall negotiate contracts with health plans to
29 provide or pay for benefits to enrollees under this part. Each
30 contract entered into pursuant to this part shall require the
31 participating health plan to assume full risk for the cost of care for
32 the contract period. The board shall not contract with any
33 participating health plan if such a contract would result in costs
34 exceeding the funds available for purposes of this part, as described
35 in subdivision (a). The requirements of this subdivision shall also
36 apply to contracts with specialized health care service plans, as
37 defined in subdivision (o) of Section 1345 of the Health and Safety
38 Code, and specialized health insurance policies, as defined in
39 Section 106, to the extent that the inclusion of such plans or
40 policies in the Basic Health Program is authorized by PPACA.

1 (c) In the event that the board reasonably expects that the cost
2 of the Basic Health Program will exceed the available funds
3 specified in subdivision (a), coverage for eligible individuals shall
4 continue until the annual redetermination of each eligible
5 individual, after which time the board shall immediately transfer
6 the eligible individual to coverage in the California Health Benefit
7 Exchange. To the extent permitted by federal law, the board shall
8 contract with the federal government to allow federal funds made
9 available under paragraph (3) of subdivision (d) of Section 1331
10 of PPACA, relating to 95 percent of the premium tax credits under
11 Section 36B of the Internal Revenue Code of 1986, and the
12 cost-sharing reduction under Section 1402, to be used for the costs
13 of the board in implementing and administering this part.
14 *12694.959. (a) The board shall request an evaluation of the*
15 *Basic Health Program. The board shall seek funding for the*
16 *evaluation from an independent nonprofit private foundation.*
17 *(b) The purpose of the evaluation is to determine the extent to*
18 *which the Basic Health Program has achieved objectives to provide*
19 *low-income Californians with equal or better benefit levels, and*
20 *less expensive premiums and lower cost sharing than would be*
21 *available in the California Health Benefit Exchange. In addition,*
22 *the evaluation is intended to assess the impact of the Basic Health*
23 *Program on all of the following:*
24 *(1) The viability of the California Health Benefit Exchange*
25 *(Exchange).*
26 *(2) Providers, health plans, and insurers that serve the Medi-Cal*
27 *program and the Healthy Families Program.*
28 *(3) Continuity of care and coverage for individuals moving from*
29 *the Medi-Cal program to the Basic Health Program and from the*
30 *Basic Health Program to the Exchange.*
31 *(c) Components of the evaluation may include, but are not*
32 *limited to, the following:*
33 *(1) A determination of the extent to which individuals served*
34 *through the Basic Health Program have lower premiums,*
35 *additional benefits, or lower cost sharing than they would*
36 *otherwise have received in the Exchange.*
37 *(2) A determination of the extent to which individuals served*
38 *through the Basic Health Program have a choice of quality health*
39 *coverage options and adequate provider access and networks.*

1 *(3) A determination of the extent to which Basic Health Program*
2 *administrators have been able to coordinate the contracting of*
3 *health plans and health insurance or the purchasing of other*
4 *services with the Medi-Cal program, Healthy Families Program,*
5 *and the Exchange.*
6 *(4) A determination of the extent to which the Exchange is*
7 *attracting competitive health plan participation and offers premium*
8 *rate structures, and a determination as to the impact the inclusion*
9 *of the Basic Health Program population would have on the*
10 *Exchange.*
11 *(d) The evaluation shall include, but is not limited to, all of the*
12 *following:*
13 *(1) Enrollment in the Exchange and enrollment in the Basic*
14 *Health Program, including actual enrollment as compared to the*
15 *estimated number of individuals eligible for the Exchange and the*
16 *Basic Health Program, the number of individuals enrolled in the*
17 *Exchange with family incomes between 300 percent and 400*
18 *percent of the federal poverty level, and the number of individuals*
19 *enrolled in the Exchange with family incomes above 400 percent*
20 *of the federal poverty level.*
21 *(2) The average cost per person of the individuals enrolled in*
22 *the Exchange as compared to the average cost per person of*
23 *individuals enrolled in the Basic Health Program.*
24 *(3) The impact of the Basic Health Program on the funding*
25 *available for Exchange administrative costs.*
26 *(4) The impact of the Basic Health Program on premiums in*
27 *the Exchange and the impact of the Exchange on premiums in the*
28 *Basic Health Program.*
29 *(5) The impact of the Basic Health Program on the Exchange's*
30 *ability to selectively contract with health plans.*
31 *(6) The average premium and average cost sharing per person*
32 *enrolled in the Basic Health Program and the Exchange.*
33 *(7) The number of plans participating in the Basic Health*
34 *Program and the Exchange, including whether and to what extent*
35 *health plans in the Medi-Cal program participate in the Basic*
36 *Health Program in counties with Medi-Cal managed care.*
37 *(8) The number of individuals enrolling in the Basic Health*
38 *Program who, in the month immediately preceding Basic Health*
39 *Program enrollment, were enrolled in the Medi-Cal program.*

1 *(9) The number of individuals enrolled in the Medi-Cal program*
2 *who, in the month immediately preceding Medi-Cal enrollment,*
3 *were enrolled in the Basic Health Program.*
4 *(10) The number of individuals enrolled in the Exchange who,*
5 *in the month immediately preceding Exchange enrollment, were*
6 *enrolled in the Basic Health Program.*
7 *(11) The number of individuals enrolled in the Basic Health*
8 *Program who, in the month immediately preceding enrollment in*
9 *the Basic Health Program, were enrolled in the Exchange.*
10 *(12) The average amount of federal funding received by the*
11 *state per person by year, broken down by federal funding for*
12 *premiums and federal funds for cost-sharing subsidies, for*
13 *individuals enrolled in the Basic Health Program.*
14 *(13) Whether implementation of the Basic Health Program has*
15 *resulted in diminished access to health care providers for Medi-Cal*
16 *beneficiaries or diminished provider participation in the Medi-Cal*
17 *program.*
18 *(e) The Legislature hereby requests the results of the evaluation*
19 *to be furnished to the appropriate policy and fiscal committees of*
20 *the Legislature by July 1, 2017.*
21 *(f) The California Health Benefit Exchange, the Basic Health*
22 *Program, the Medi-Cal program, and the Health Families Program*
23 *shall provide, in a timely manner, the data necessary for the*
24 *evaluation requested by this section.*

O

Date of Hearing: July 5, 2011

ASSEMBLY COMMITTEE ON HEALTH
William W. Monning, Chair
SB 703 (Ed Hernandez) – As Amended: June 28, 2011

SENATE VOTE: 25-14

SUBJECT: Health care coverage: Basic Health Program.

SUMMARY: Creates the Basic Health Plan (BHP), administered by the Managed Risk Medical Insurance Board (MRMIB), which will serve individuals with income up to 200% of the federal poverty level (FPL) who would otherwise be eligible for subsidies in the California Health Benefit Exchange (Exchange). Specifically, this bill:

1) States legislative intent to establish a BHP to implement the option contained in the federal Patient Protection and Affordable Care Act (PPACA). Finds and declares that the BHP:
   a) Requires eligible individuals and their dependents enrolled in the BHP to be provided a health plan containing essential health benefits (EHBs) at a monthly premium price that does not exceed the amount of the premium that the eligible individual would have been required to pay if the individual had enrolled in the applicable second lowest cost silver plan offered to the individual through the Exchange.
   b) Prohibits the cost sharing an eligible individual is required to pay under the BHP from exceeding the cost sharing required under a platinum plan for individuals with a household income at or below 150% FPL for the size of the family involved.
   c) Prohibits the cost sharing an eligible individual is required to pay under the BHP from exceeding the cost sharing required under a gold plan for an individual with a household income above 150% FPL but at or below 200% FPL for the size of the family involved.
   d) Requires the medical loss ratio for coverage products in the BHP to be 85%, instead of 80% as required for products in the individual and small group market.

2) Defines "health plan" as a private health insurer holding a valid outstanding certificate of authority from the California Department of Insurance (CDI) or a health care service plan licensed by the Department of Managed Health Care (DMHC).

3) Requires MRMIB to enter into a contract with the United States Secretary of the Department of Health and Human Services (DHHS) to implement the BHP to provide coverage to eligible individuals and permits enrollment on January 1, 2014.

4) Requires MRMIB to administer BHP in conjunction with the Healthy Families Program (HFP), and to provide an eligibility and enrollment process that allows an individual, or his or her natural or adoptive parent, legal guardian, caretaker relative, foster parent, or stepparent with whom the child resides, to enroll in the BHP at the same time an individual, or his or her natural or adoptive parent, legal guardian, caretaker relative, foster parent, or stepparent with whom the child resides, applies for enrollment in HFP for the child. Permits an individual to enroll in the same health plan, or a different health plan, than his or her child or children who are enrolled in HFP.

5) Provides MRMIB authority to take actions in conjunction with administering the BHP, including the following:
   a) Determine eligibility criteria, requirements for coverage and health plan participation, premiums, and cost-sharing amounts;
   b) Collect premiums and provide or make available subsidized coverage through participating health plans;
   c) Provide for the processing of applications and enrollment of eligible individuals;
   d) Determine and approve the benefit designs and cost sharing required by health plans;
   e) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the fund, and, if sufficient funds are not available to cover the estimated cost of program expenditures, requires MRMIB to institute appropriate measures to reduce costs;
   f) Issue rules and regulations, and until January 1, 2016, provide emergency regulation authority; and,
   g) Make application assistance payments to individuals who have successfully completed the requirements of a Certified Application Assistant in HFP and who successfully enroll eligible individuals in BHP.

6) Authorizes MRMIB to determine benefits, if any, to offer BHP participants that are in addition to the EHB packages required by PPACA, including benefits provided through specialized health care service plans and specialized health insurance policies, to the extent PPACA authorizes the inclusion of such plans or policies in the BHP.

7) Requires MRMIB, in conjunction with state Department of Health Care Services (DHCS), to conduct a community outreach and education campaign to assist in notifying eligible individuals of the availability of coverage through BHP.

8) Requires DHCS and the Exchange to include information on the availability of coverage through the BHP in all eligibility outreach efforts, and MRMIB to also include information on the availability of coverage in the Medi-Cal Program and Exchange.

9) Requires MRMIB to ensure that written enrollment information issued or provided, and telephone services provided, by the BHP are available to program subscribers and applicants in each of the Medi-Cal threshold languages.

10) Requires MRMIB to ensure that subscribers are provided information within provider network directories of available linguistically diverse providers, and participating health plans, specialized health plans and specialized insurance policies, provided documentation on how linguistically and culturally appropriate services are provided, including marketing materials, to subscribers.

11) Requires MRMIB to contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice of health plans from among a reasonable number and different types of competing health plans.

12) Requires MRMIB to take all reasonable steps to ensure that the range of choices of health plans available to each applicant includes health plans that include in their provider networks, and have signed contracts with, traditional and public and private safety net providers.

13) Requires a participating health plan to annually submit to MRMIB a report summarizing its provider network, including information on geographic access for subscribers, linguistic services, the ethnic composition of providers, the number of subscribers who selected traditional and public and private safety net providers.

14) Prohibits MRMIB from relying solely on a determination by DMHC and the CDI of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this bill.

15) Requires MRMIB to collect and review demographic census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, and identify specific provider contracting target areas with significant numbers of uninsured individuals with incomes that would make them eligible for the BHP.

16) Requires MRMIB to give priority to those health plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic target areas.

17) Requires MRMIB to designate a community provider plan (CPP) in each geographic area that is the participating health plan that has the highest percentage of traditional and public and private safety net providers in its network. Requires that subscribers selecting such a health plan be given a premium discount in an amount determined by MRMIB. Includes specialized health plans and insurance policies in this provision and provisions 11) through 16) above.

18) Continues enrollment for an eligible individual enrolled in the BHP for a period of 12 months from the month eligibility is established, to the extent permitted by federal law.

19) Authorizes MRMIB to disenroll an eligible individual enrolled in BHP after two consecutive months of nonpayment of premiums, and a reasonable written notice period of not less than 30 days. Authorizes MRMIB to conduct or contract for collection actions.

20) Requires MRMIB to make sure of a simple and easy to understand mail-in and Internet application process, provide for the operation of a toll-free telephone hotline to respond to requests for assistance, maintain an Internet Website, utilize a standardized format for presenting health benefits plan options, as specified, and establish a process to inform individuals who lose eligibility for the BHP of the availability of coverage through Medi-Cal, and the Exchange and to transmit their eligibility-related information to those programs electronically to facilitate enrollment.

21) Requires MRMIB in the event that MRMIB reasonably expects that the cost of BHP will exceed the available funds, to transfer individuals at their annual redetermination to coverage in the Exchange.

EXISTING FEDERAL LAW:

1) Establishes federal PPACA, which among other private market insurance reforms, authorizes states to establish an American Health Benefit Exchange by January 1, 2014, that makes qualified health plans available to qualified individuals and employers.

2) Provides states an option to establish BHP to enter into contracts to offer one or more health plans providing at least EHBs, as specified, to eligible individuals in lieu of offering such coverage in the Exchange.

3) Requires, as part of the BHP, the state to establish to the satisfaction of DHHS, that the amount of the monthly premium an eligible individual is required to pay for coverage under a standard health plan (in BHP) for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay if the individual had enrolled in the applicable second lowest cost silver plan, as specified, offered to the individual through an Exchange; that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150% FPL; and, the cost-sharing required under a "gold plan" in the case of an eligible individual with household income between 150% FPL and 200% FPL and the benefits provided under the standard health plans offered through the program covers at least the essential health benefits (EHBs).

4) Defines EHBs to include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care, and requires the Secretary of DHHS to further define EHBs, and ensure that the scope of EHBs is equal to those provided under a typical employer plan.

5) Provides for premium assistance credits for the purchase of health insurance in the Exchange. Credits are calculated on a sliding scale capped at 2% of income for those at or above 133% FPL and phasing out at 9.8% for those at 400% FPL. The premium credit is based on the second lowest-cost silver plan.

6) Provides assistance based on standard out-of-pocket (OOP) limits of $5,950 for individuals and $11,900 for families. Limit is reduced to one-third for those with income between 100% and 200% FPL, to one-half for those with income between 200 and 300% FPL and two-thirds for those with income between 300 and 400% FPL.

EXISTING STATE LAW:

1) Establishes HFP, administered by MRMIB, to provide health coverage through health plans to eligible children in families with income up to 250% FPL.

2) Establishes the CPP in HFP, whereby in each geographic area, MRMIB designates a CPP that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Requires subscribers selecting such a plan to be given a family contribution discount. Pursuant to regulation, traditional and safety net providers are determined by MRMIB for each county based on providers participating in the Child Health and Disability Prevention Program, outpatient hospital based clinics, Federally Qualified Health Centers (FQHCs), rural, community and free clinics participating in the Medi-Cal Program, and specified public and private hospitals participating in the Medi-Cal Program

such as county hospitals, non-profit community hospitals, hospitals operated by the University of California, and designated children's hospitals.

3) Authorizes MRMIB to pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the HFP application, and the applicant is enrolled in HFP as a result of the application.

4) Provides for the licensure of health plans, through the DMHC, under the Knox-Keene Health Care Service Plan Act of 1975, and for the licensure of health insurers, through the CDI, under the Insurance Code.

5) Provides for the DHCS, which administers the Medi-Cal Program, a health care services and coverage program for low-income families, pregnant women, children, individuals with disabilities, the elderly, and individuals in long-term care.

6) Establishes the Exchange in state government, and specifies the duty and authority of the Exchange. Requires the Exchange to determine the minimum requirements health plans must meet for participation in the Exchange, the standards and criteria for selecting health plans to be offered in the Exchange, to provide, in each region of the state, a choice of qualified plans, at each of the five levels of coverage contained in federal law (platinum, gold, silver, bronze, and catastrophic).

FISCAL EFFECT: According to the Senate Appropriations Committee:

Fiscal Impact (in thousands)

Major Provisions	2011-12	2012-13	2013-14	Fund
Start-up funding:	unknown, likely in the millions of dollars annually			General*
Ongoing cost to operate BHP:	likely in the billions of dollars annually			Federal/** Private

*Permits a General Fund (GF) loan to be repaid by July 1, 2016, with interest.
**BHP funded by federal funds and subscriber premiums.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill will create affordable health care coverage for hundreds of thousands of people without asking for a single dime more from California's taxpayers. The BHP will provide low-income Californians with equal or better benefit levels, less expensive health plan premiums, and lower cost-sharing than would be available to them in the Exchange using exclusively federal dollars, according to a Mercer Government Human Services Consulting (Mercer) financial feasibility analysis. Adopting the BHP option will lead to more individuals receiving health care coverage as a result of lower premiums, greater ability to access health care because of the lower cost-sharing, increased compliance with the federal individual mandate, and a reduction in uncompensated care for health care providers. Because federal BHP financing is based on the amount spent on premium tax credit and cost-sharing subsidies for commercial Exchange products, the BHP also provides an opportunity to increase funding to certain health plans and providers to amounts that would exceed rates paid to health plans and health care providers through Medi-

Cal. The Mercer feasibility analysis estimates rates paid to providers in the BHP would be 20% to 25% higher than Medi-Cal rates, which will improve the financial viability of safety net providers who will continue to serve the remaining uninsured after full implementation of federal health care reform. The BHP option also provides participants with a product with a higher medical loss ratio (85% instead of 80%) than in the Exchange, which allows consumers to get more value out of their premium dollar. Finally, establishing a BHP could also reduce state GF Medi-Cal costs by making it more likely that individuals who qualify for share-of-cost Medi-Cal, because they incur medical costs significant enough to enable them to "spend down" to Medi-Cal eligibility, will shift to the federally-funded BHP.

2) FEDERAL HEALTH CARE REFORM. On March 23, 2010, President Obama signed the PPACA (Public Law [PL] 111-148), which was amended on March 30, 2010 by the Health Care and Education Reconciliation Act of 2010 (PL 111-152), together these laws are referred to as PPACA. The law includes many provisions including a restructuring of the small and individual group insurance market, setting minimum standards for health care coverage, providing financial assistance to certain individuals and small employers, and enabling and supporting states to establish Health Benefit Exchanges where individuals and small business can shop for insurance and premium credits and cost sharing subsidies will be determined.

3) BENEFIT CATEGORIES. PPACA establishes five benefit categories—bronze, silver, gold, platinum, and catastrophic - all of which will have the EHB package. Policies cannot be sold in the small-group and individual market or Exchanges that do not meet the actuarial standards (percentage of medical expense paid by insurer) for the benefit categories established by PPACA. All carriers selling in the individual and small-group markets are at least required to offer silver and gold plans.
   a) The bronze package will represent minimum creditable coverage with an actuarial value of 60% (i.e., covering 60% of enrollees' medical costs) with out-of-pocket spending limited to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies.
   b) The silver benefit package will have an actuarial value of 70% and the same out-of-pocket limits.
   c) The gold package will have an actuarial value of 80% and the same out-of-pocket limits.
   d) The platinum package will cover 90% of costs with the same out-of-pocket limits.
   e) A catastrophic benefit package can be made available for adults younger than age 30, similar to HSA-eligible, high-deductible plans, with the EHB package, the cost of preventive services will be excluded from the deductible as under current HSA law, three primary care visits, and cost-sharing to HSA out-of-pocket limits.

4) PREMIUM TAX CREDITS AND SUBSIDIES. Depending upon income, PPACA provides premium tax credits, lower cost-sharing and lower maximum out-of-pocket (OOP) limits. Beginning 2014, advanceable, refundable tax credits will be available in the Exchange. Tax credits are based on the premium for the second lowest cost silver plan in an Exchange in the area where the person is eligible for coverage. Premiums are capped on a sliding scale depending upon income: a person with income up to 133% FPL has a cap of 2% of their income; a person with income up to 200% FPL has a cap of 6.3%; and, a person with income up to 400% FPL has a cap of 9.5%. As an example, a person with income at 200% FPL ($21,780 in 2011) would have a premium cap of $1,372 (6.3% of income), so if the second lowest cost silver plan premium was $4,000, there would be a premium credit of $2,628 (the

difference between the $4,000 premium and the $1,372 cap). Credits are based on annual income. A year-end reconciliation through the Internal Revenue Service could result in a refund to the enrollee or repayment up to a maximum safe harbor of $300 for an individual and $600 for a family at or below 200% FPL, and a scaled repayment for those with incomes up to 500% FPL.

People who qualify for premium credits and are enrolled in an Exchange silver level plan will also be eligible for assistance with cost-sharing requirements. In addition to the maximum OOP caps ($5,950 per individual and $11,900 per family), cost-sharing subsidies will further reduce OOP maximums by two-thirds for income between 100 and 200% FPL; by one-half for income between 200 and 300% FPL; and, by one-third for income between 300 and 400% FPL.

5) BHP. PPACA allows states to establish a BHP to support coverage of low-income individuals not eligible for Medicaid (Medi-Cal in California). BHP eligible individuals are people with income under 200% FPL who would otherwise be eligible for premium credits in the Exchange. Under the BHP, DHHS will transfer to the state for each fiscal year for which one or more standard health plans are operating within the state the amount equal to 95% of the premium tax credits, and cost-sharing reductions, that will be provided for the fiscal year to eligible individuals enrolled in the Exchange. States must assure that cost sharing requirements do not exceed those of a platinum Exchange plan (90% actuarial value) for individuals with income under 150% FPL and those of a gold plan (80% actuarial value) for other BHP enrollees. To qualify, enrollees must be U.S citizens or lawfully present immigrants under age 65, have income that does not exceed 200% FPL, not qualified for Medicare, Medicaid, or Children's Health Insurance Program (CHIP), and not offered employer sponsored insurance that meets PPACA standards for affordability and comprehensiveness. The University California Los Angeles (UCLA) Center for Health Policy Research estimates there are approximately 829,000 individuals in California who would be eligible for BHP, including 46,000 legal immigrants.

6) BHP FEASIBILITY. At the request of the California HealthCare Foundation, Mercer assessed the financial feasibility of the BHP option in terms of whether the BHP could potentially be implemented in California at existing Medi-Cal managed care payment rates. The results indicate that California may be able to implement BHP at no cost to the state GF. Mercer estimates that the average 2014 federal BHP monthly subsidy would be between $441 and $497 per member per month (PMPM). Using conservative estimates, Mercer estimates the average monthly BHP premium cost to be between $294 and $353 PMPM. Mercer acknowledges that these estimates are speculative and that there are many provisions and details of PPACA that are still unknown. Another report by the Institute for Health Policy Solutions (IHPS) points out that the federal subsidy amounts are highly sensitive to the benchmark plan in the Exchange and that IHPS and the Congressional Budget Office have estimated a lower premium amount ($392 PMPM), which means federal funding available for BHP could be hundreds of millions of dollars less than is assumed by estimates to date (i.e., Mercer).

7) IMPACT ON CONSUMERS. If the BHP uses Medi-Cal providers and plans, it could provide continuity for populations switching between Medi-Cal and the BHP. It could also provide coverage at a lower cost than Exchange coverage, assuming Medi-Cal provider rates. Savings would be passed on to BHP enrollees in the form of lower premiums, cost-sharing,

or additional benefits. BHP enrollees would not be subject to year-end reconciliation. To the extent that HFP plans participate, parents and their children could enroll in the same plan. On the other hand, BHP enrollees would not be able to enroll in the Exchange, may be limited in their choice of mainstream health plans, and would not be eligible for tax credits. In addition, there may still be disruption in coverage as income fluctuates (at slightly higher income levels) and people move between BHP and the Exchange.

8) IMPACT ON SAFETY NET. Traditional and safety net providers are those providers who typically serve Medi-Cal, low-income, and uninsured patients. They include public hospitals and primary care clinics, including FQHCs. California, through its Medi-Cal Managed Care Program has three models of managed care delivery; two of those models, Local Initiatives and County Organized Health Systems have networks that include and in some cases are required to include traditional and safety net providers. The BHP, as contemplated in this bill, creates discount premiums for a plan designated a CPP, which obtains that designation based on the percentage of traditional and safety net providers in its network. To the extent the BHP preserves a patient base and revenue stream for traditional and safety net providers, those providers will benefit. FQHCs, however, are not guaranteed higher Prospective Payment System (PPS) rates as they are in Medi-Cal and the Exchange, and may be disadvantaged. Because of historically low reimbursement rates, provider access and financial solvency is a concern in Medi-Cal and may be a factor in the ability of Medi-Cal plans and providers to compete in the Exchange, but may not be an issue in BHP.

9) IMPACT ON EXCHANGE. Mercer estimates approximately 1.8 million would enroll in the Exchange (even with a BHP). Mercer suggests that the BHP population could represent a less healthy (and more costly) risk profile than the remaining Exchange population above 200% FPL because people with lower incomes tend to have more health issues. The level of premiums and cost-sharing in BHP and in the Exchange will have a direct impact on the risk of the population that enrolls in either place. Higher premium and cost-sharing levels increase the level of adverse risk and lead to higher enrolled population risk, because only those people who really need coverage will be willing to pay for it, especially at higher premium and cost-sharing levels. Lower premiums and cost-sharing levels, as would be offered in the BHP as compared to what the same population would get in the Exchange, could result in better risk in BHP because lower income people with more health issues would not be in the Exchange risk pool. Mercer indicates that plan participation, consumer choice, and risk dynamics for the Exchange population are complicated and beyond the scope of their analysis.

The IHPS report indicates that the BHP would substantially reduce the size of the Exchange's core tax credit population by more than half. IHPS uses estimates developed by the Urban Institute that indicate that there are over 2.3 million Californians with income up to 400% FPL, and a half of them have income under 200% FPL and would be eligible for BHP. IHPS states that this reduction in the Exchange population would greatly diminish the Exchange's ability to attract and offer high-value health plans that would compete for three out of four individual market purchasers.

Based on the 2009 California Health Interview Survey, a chart prepared by the UCLA Center for Health Policy Research indicates in the potential BHP eligible population 67% self-report their health status as good or better, and 33% indicate they have a chronic condition (any physical or mental condition that limits daily activities). This compare to the 87% of the

potential Exchange eligible population who self-report their health status as good or better, and 20% indicate they have a chronic condition.

10) SUPPORT. The California Association of Health Insuring Organizations (CAHIO) believes BHP is a better option compared to the Exchange because it can offer a more affordable benefit than the Exchange. CAHIO identifies many advantages to establishing BHP as an extension of HFP, such as, MRMIB already has a competitive health plan selection process, appropriate plan oversight, it would reduce administrative start-up expenses, and could maintain the family unit as existing HFP plans are more likely to participate in BHP. The Local Health Plans of California (LHPC) supports the BHP because LHPC believes it will offer a better benefit at lower cost to low-income working families, the BHP will provide continuity and convenience of unified care for parents and children who are in HFP, it will allow safety net providers and their health plan networks to preserve their patient base and revenue streams, and the BHP has the potential to raise the level of compensation for those providers participating in HFP and provide a more sustainable funding base.

11) SUPPORT IF AMENDED. The California Primary Care Association requests amendments to ensure that FQHCs receive PPS reimbursement in the BHP. The Western Center on Law and Poverty (Western Center) supports this bill because they believe, based on the Mercer study, that premiums and cost sharing for this low-income group will be much lower than it would be in the Exchange. However, Western Center believes the BHP should be administered by DHCS or the Exchange in order to provide seamless transitions for this population with volatile income. The Service Employee International Union requests amendments to house the BHP in the Exchange and address adverse selection scenarios that could make the Exchange or BHP pool unsustainable.

12) SEEKS AMENDMENTS. Health Access California has a strong policy preference that BHP be operated by the Exchange. Maternal and Child Health Access (MCH) requests an amendment that this bill "shall not diminish the right of a woman to pregnancy-related care under the Medi-Cal Program under Welfare and Institutions Code sections 14132(u) and 14134.5." MCH wants to preserve pregnancy related benefits and protections on cost-sharing and due process for women with income up to 200% FPL who qualify for Medi-Cal pregnancy services. MCH raises questions about whether these women would be eligible for BHP for non-pregnancy services and if so, questions, how the programs would coordinate. The American Federation of State, County and Municipal Employees, AFL-CIO (AFSCME) seeks amendments to put BHP in the Exchange. AFSCME believes the Exchange will be undermined and have less bargaining power without the BHP population, covering some, but not all parents of HFP children further complicates things, and that MRMIB has privatized (enrollment) providing poor customer service.

13) OPPOSITION. The California Right to Life Committee opposes any health care program that includes abortion and family planning services with tax payer dollars, and any health care programs that would include minors who could obtain these services without parental notification or consent. The Orange County Board of Supervisors thinks that as many individuals and groups as possible should be served in a competitive, private sector market and that government programs should focus on serving our lowest income individuals who would otherwise be unable to secure coverage.

14) POLICY QUESTIONS.

a) Should the impacts of pulling a significant federal subsidy population out of the Exchange to create a separate health coverage program be measured and monitored over time? Mercer, Urban Institute, IHPS and others have anticipated some of the potential impacts of creating a BHP on the Exchange but there is no certainty in any of those studies. Should California create a BHP it may be useful to conduct an evaluation over a period of time after the program has experience with enrollment, plan participation, federal subsidies, etc., to determine the long-term viability of the program and impact on the Exchange. A sunset of the program could accompany the evaluation to give policymakers an opportunity to revisit the utility of the BHP.

b) Is MRMIB the best entity to administer the BHP? While MRMIB has demonstrated many accomplishments establishing and operating health coverage programs, there are potentially greater advantages to locating the BHP at either DHCS or the Exchange. At present, there is uncertainty about the future of the HFP. A recent proposal by the Governor would have transferred HFP to Medi-Cal to be operated as a Medi-Cal expansion. In addition federal authorization of CHIP is time limited. There may be advantages in leveraging purchasing power of the Medi-Cal program or selective contracting of the Exchange that should be taken into consideration.

c) Is there urgency to making a policy decision about the BHP at this time? Federal rules are expected on the BHP this fall which may help California evaluate with more confidence the tradeoffs associated with implementing a BHP.

REGISTERED SUPPORT / OPPOSITION:

Support

Local Health Plans of California (sponsor)
California Association of Health Insuring Organizations
California Association of Public Hospitals and Health Systems
California Chiropractic Association
Congress of California Seniors
Disability Rights Legal Center
Molina Healthcare of California
Planned Parenthood Affiliates of California
Santa Clara County

Opposition

American Federation of State, County and Municipal Employees, AFL-CIO
California Right to Life Committee, Inc.
Orange County Board of Supervisors

Analysis Prepared by: Teri Boughton / HEALTH / (916) 319-2097

June 28, 2011

State of California

Financial Feasibility of a

Basic Health Program

MERCER

Prepared with funding from the
California HealthCare Foundation

Mercer

Contents

1. Executive Summary.....1

2. Introduction.....4
   - Background.....4

3. Project Scope and Approach.....6

4. Analysis and Findings.....7
   - Demographic Characteristics of the Uninsured Population Eligible for the Exchange.....7
   - Conclusion on Financial Feasibility.....20

5. BHP Impact on the Exchange.....21
   - Impact on Exchange Risk.....21
   - Impact on Exchange Self-Sustainability.....22
   - Impact on The Exchange's Ability to Selectively Contract.....22
   - Other Considerations.....23

Executive Summary

Mercer Government Human Services Consulting (Mercer), assessed the financial feasibility of the Basis Health Program (BHP) option, as defined in the Patient Protection and Affordable Care Act (ACA) in California. The feasibility determination, prepared with funding from the California HealthCare Foundation (CHCF) is based on whether the BHP option could potentially be implemented in California at existing Medi-Cal managed care payment rates at no cost to the State (i.e., entirely funded by federal subsidies).

The task of assessing the feasibility of the BHP option in the State of California is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in California and the subsets likely to enroll in the BHP and Health Benefit Exchange (Exchange)
- Estimate the Silver-Level benefits and premiums likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the State BHP based on the estimated Silver-Level benefits offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population up to 200% of the Federal Poverty Level (FPL) at existing Medi-Cal managed care provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

The results of the analysis outlined above indicate that the State of California may be able to implement the BHP option at no cost to the state general fund. Mercer estimates the average 2014 federal BHP monthly subsidy to be between $441 and $497 PMPM. Using our conservative assumptions with respect to health status and costs, Mercer estimates the average monthly BHP premium cost to cover this population to be between $294 and $353 PMPM with very low premiums and cost-sharing levels. Based on these

estimates, under any scenario there is a projected excess of BHP subsidy over BHP costs. In addition, it appears that there would be enough excess funding to allow the State to implement the BHP option at provider reimbursement rates near, or possibly even exceeding, Medicare payment levels.

These estimates are speculative at this early stage with so many provisions of the ACA undefined and specifics of the BHP undetermined. However, the relatively large gap between the estimated premium subsidy and projected health care cost to cover the BHP population is consistent with findings from other studies (non-California specific) on this topic. In fact, three other studies (by Milliman, the Urban Institute and the Community Service Society (CSS)) have analyzed the BHP option and come up with similar results as to the financial feasibility of the BHP. In California, the excess of the federal subsidies over the resulting costs of a BHP could be used to increase provider reimbursement rates, reduce member premiums and cost-sharing (even further than already assumed), expand benefits, and extend outreach to enroll a greater share of this low-income population.

Mercer and CHCF are not advocating for or against the BHP option. The results of this study simply indicate this may be a viable option for the State to consider as it decides how best to implement the many provisions of the ACA. While the results of the analysis do show this to be financially feasible, clearly, implementation of a BHP would not be without some element of risk to the State.

In addition to the question of financial feasibility of a BHP option, the CHCF asked Mercer to address some of the potential impacts that adopting a BHP could have on the Exchange in California. Specifically, the following potential areas of impacts were considered:

- Impact on Exchange risk
- Impact on Exchange self-sustainability
- Impact on the Exchange's ability to selectively contract

Impact on Exchange Risk

The level of premiums and cost-sharing in a BHP and in an Exchange population (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. That is to say, higher premium and cost-sharing levels increase the level of adverse risk among the enrolled population. With the assumption that a BHP option would only be implemented with reduced premiums and cost-sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP than the risk of the same population subgroup that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange. However, one could argue that with less disposable income at the lower income (FPL)

levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. Therefore, it is reasonable to be concerned about removing some Exchange eligible members from the pool of members from which the Exchange may be funded. Our estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number for California is likely to be larger than any other state's gross Exchange enrollment. Therefore, from a purely fiscal perspective, the somewhat reduced Exchange population should not pose a significant issue with respect to being able to achieve self-sustainability.

Impact on the Exchange's Ability to Selectively Contract

California's Exchange enabling legislation has authorized the Exchange to use selective contracting. This was most likely set up this way to create some level of competition among licensed health plans for a place in the Exchange. Such competition can be used to drive higher quality and potentially lower costs (or improved efficiency). Therefore, it is reasonable to be concerned as to whether removing some Exchange eligible members from the pool will lower the "demand" to be part of the Exchange.

As mentioned previously, the estimate of Exchange membership (net of BHP) is still approximately 1.8 million. This net number is approximately twice the size of California's Healthy Families Program (HFP) population. MRMIB currently has 24 licensed health plans under contract and competing for the HFP membership of less than 900,000. A group of 1.8 million people constitutes a large pool of potential membership. We cannot speak to the specific size that will ultimately attract the State's desired level of demand for participation in the Exchange. However, if the estimate of Exchange enrollment net of BHP is reasonable, the somewhat reduced Exchange population should not create a dramatic difference with respect to being able to drive competition for selective contracting.

2

Introduction

Mercer assessed the financial feasibility of the BHP option, as defined in the ACA, in California. The analysis was prepared with support from CHCF. The feasibility determination is based on whether the BHP option can be implemented in California at existing Medi-Cal managed care payment rates at no cost to the State (i.e., entirely funded by federal subsidies). Medi-Cal was selected as the benchmark because this program's provider reimbursement rates are typically lower than reimbursement rates of the HFP, or of commercial health plans. Therefore, feasibility is first tested at this lowest level, with further analysis available with respect to other payment levels.

Background

Under the ACA, Medicaid eligibility will be increased to 133% FPL in 2014 (138% FPL, including the 5% income disregard). The ACA defines health care premium and cost-sharing subsidies for individuals below 400% FPL for purchasing mandatory health care through products offered in the state's Exchange. The BHP option creates a separate state run health program to cover individuals up to 200% FPL, who are not eligible for other government programs. If the BHP option is elected by a state, BHP eligible individuals would not have coverage available through the state Exchange.

The criteria that individuals eligible for coverage under the BHP must meet are as follows:

- Income up to 200% FPL
- U.S. citizen or lawfully present immigrant
- Under age 65
- Not be eligible for coverage under Medicaid (Medi-Cal), Medicare, Children's Health Insurance Program (CHIP) or Military/CHAMPUS-TRICARE
- Not have access to Employer-Sponsored Insurance (ESI) that meets certain ACA standards (comprehensive and affordable)

Therefore, the two groups of individuals that would be covered by a BHP are:

- Adults with modified adjusted gross income (MAGI) between 133% and 200% FPL
- Lawfully present individuals with income below 133% FPL, not eligible for Medi-Cal or HFP because of immigration status

The ACA includes the following requirements related to a BHP option:

- Cover the minimum essential benefits (not yet fully defined)
- Member premiums must not *exceed* premiums charged for the second lowest cost Silver-Level plan offered through the Exchange
- For individuals up to 150% FPL, cost-sharing cannot *exceed* Platinum-Level (10%)
- For individuals 151% to 200% FPL, cost-sharing cannot *exceed* Gold-Level (20%)
- Plan offered is either a managed care system or offers similar benefits of care management [e.g., Fee-For-Service (FFS) + Enhanced Primary Care Case Management (EPCCM) may work]
- To the extent feasible, the consumer is offered a choice of options
- Plan medical loss ratio can be no less than 85%
- Plan selection through a competitive process

Section 1331 of the ACA provides for financing of BHPs in two ways. The federal government will pay states a premium subsidy of 95% of what it would have paid for the BHP members (premium credit) under the Exchange. In addition, the federal government will pay states a cost-sharing subsidy, based on the cost-sharing subsidy available under the Exchange. These subsidies vary by income as defined by the ACA in relation to the FPL.

3

Project Scope and Approach

The task of assessing the feasibility of the BHP option in the State of California is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in California and the subsets likely to enroll in the BHP and Exchange
- Estimate the Silver-Level benefits and premiums (second lowest price) likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the state BHP, based on the estimated Silver-Level premium and cost-sharing offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population up to 200% FPL at existing Medi-Cal managed care provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

Each of these steps is discussed in more detail, along with results, in the following section (Analysis and Findings) of this report. There have been other studies done and reports published on the BHP option, including the aspect of financial feasibility. However, CHCF is interested in examining the financial feasibility of the BHP option specifically for California. It is important to note that the analyses performed included the assumption that there would not be modifications to existing program eligibility requirements, other than those required by law. Therefore, the assumption used was that eligibility and coverage for Medi-Cal, HFP and the Access for Infants and Mothers Program (AIM) would remain at least at their current levels, in addition to the new coverage requirements of ACA.

4

Analysis and Findings

Demographic Characteristics of the Uninsured Population Eligible for the Exchange

The primary data source used by Mercer for estimating the size and demographic characteristics of the population eligible for the Exchange was the Census Bureau annual Current Population Survey (CPS) dataset, which breaks down the population of all fifty states. California-specific CPS data for 2007 – 2009 was used as the base, or starting point, of the demographic analysis. We compared the results of this analysis to multiple other California-specific studies and/or data sources and found very comparable results.

Mercer's estimate of the total Exchange and BHP *eligible* population is 4,454,000. It is important to understand that not everyone who is eligible for the Exchange or a BHP option will enroll. As a point of reference, the October 2010 issue of Health Affairs estimated that approximately 18.5% of Californians eligible for Medi-Cal or the HFP have not enrolled. These programs have little to no premiums required of their members. Therefore, it is reasonable to assume an even higher percentage of eligible members would not enroll in a BHP option or Exchange, which will both have some premium requirements for members.

There are three tables displayed on the following pages that show estimated enrollment for the Exchange (net of BHP), the BHP population, and then finally, the combined total enrollment for all Exchange-eligible populations. The assumptions that drive these enrollment estimates are addressed in the bullet points that precede each table.

In estimating the size of the Exchange eligible and enrolling population (net of BHP), Mercer incorporated the following working assumptions:

- The Exchange risk pool (net of BHP) will consist entirely of adult individuals and families with incomes above 200% FPL
- There would not be any children below 250% FPL, due to maintenance of effort requirements for CHIP
- Individuals with existing government-provided health benefits – Medicare and Military/CHAMPUS-TRICARE – will remain in these programs and will not be eligible for, or covered by, the Exchange
- The number of individuals with ESI will not change significantly with the implementation of the ACA in 2014
- Virtually all individuals between 200% and 400% FPL, with privately purchased individual policies, will migrate to the Exchange to take advantage of federal premium and cost-sharing subsidies
- Relatively few individuals above 400% FPL will enroll in the Exchange; instead they may enroll in non-Exchange offered products
- An assumed 70% of the eligible 200 – 400% FPL group will enroll and only 25% of those greater than 400% FPL will enroll (due to the fact that the over 400% FPL group will receive no government assistance under the Exchange)

Table 1 below displays the estimated Exchange (Net of BHP) eligible population assumed to *enroll* in the Exchange.

Table 1 – Total Population Estimated to Enroll in the Exchange

	200% – 400% FPL		400% FPL and Above		
	Females	**Males**	**Females**	**Males**	**Total**
Average **Adult Age**	**40.8**	**38.9**	**44.8**	**43.2**	**40.6**
0-18	107,190	124,784	22,061	28,262	**282,297**
19-24	88,855	102,498	10,561	14,645	**216,559**
25-34	136,834	180,862	23,008	35,179	**375,883**
35-44	111,072	132,757	22,682	31,378	**297,889**
45-54	142,436	134,659	34,757	39,393	**351,245**
55-64	101,394	82,950	34,100	36,162	**254,606**
Total	**687,781**	**758,510**	**147,169**	**185,019**	**1,778,479**

The working assumptions related to the BHP eligible and enrolling population are as follows:

- The BHP risk pool will consist entirely of adults, ages 19 through 64, with incomes up to 200% FPL
- Children up to 200% FPL will be covered by the HFP or Medi-Cal, and will not be enrolled in the BHP
- Legal immigrants with residency status less than five years will be eligible for the BHP, including those below 133% FPL, who are currently ineligible for federally funded Medicaid benefits
- Individuals with existing government-provided health benefits – Medi-Cal, HFP, Medicare and Military/CHAMPUS-TRICARE – will remain in these programs and will not be eligible for, or covered by, the BHP

- The number of individuals with ESI will not change significantly with the implementation of the ACA in 2014 (assuming some employers will drop coverage while others will add coverage)
- Virtually all individuals up to 200% FPL, with privately purchased individual policies, will migrate to the BHP due to the incentives of minimal premiums and low levels of cost-sharing
- Assume 70% of the BHP eligible population will actually enroll

Table 2 below displays the estimated BHP eligible population assumed to *enroll* in the BHP option.

Table 2 – Total Population Estimated to Enroll in the BHP

	< 150% FPL		150% – 200% FPL		
	Females	**Males**	**Females**	**Males**	**Totals**
Average Age	39.0	39.9	42.9	39.9	**40.8**
19-24	16,584	14,026	24,568	39,276	94,454
25-34	25,360	25,911	46,260	76,201	**173,732**
35-44	22,768	22,988	65,237	59,968	**170,961**
45-54	19,301	25,355	65,034	50,555	160,245
55-64	13,513	12,694	49,645	48,174	124,026
Total	**97,526**	**100,974**	**250,744**	**274,174**	**723,418**

Table 3 below, displays the total Exchange and BHP eligible population estimated to *enroll* in the Exchange and the BHP combined. It is important to understand that the figures in this table do not reflect our estimate of the number of people that would enroll in the Exchange absent a BHP. This is because we would assume a smaller percentage of individuals up to 200% FPL would actually enroll in the Exchange, as compared to a BHP, due to the higher premiums and cost-sharing requirements.

Table 3 – Total Population Estimated to Enroll in the BHP and Exchange Combined

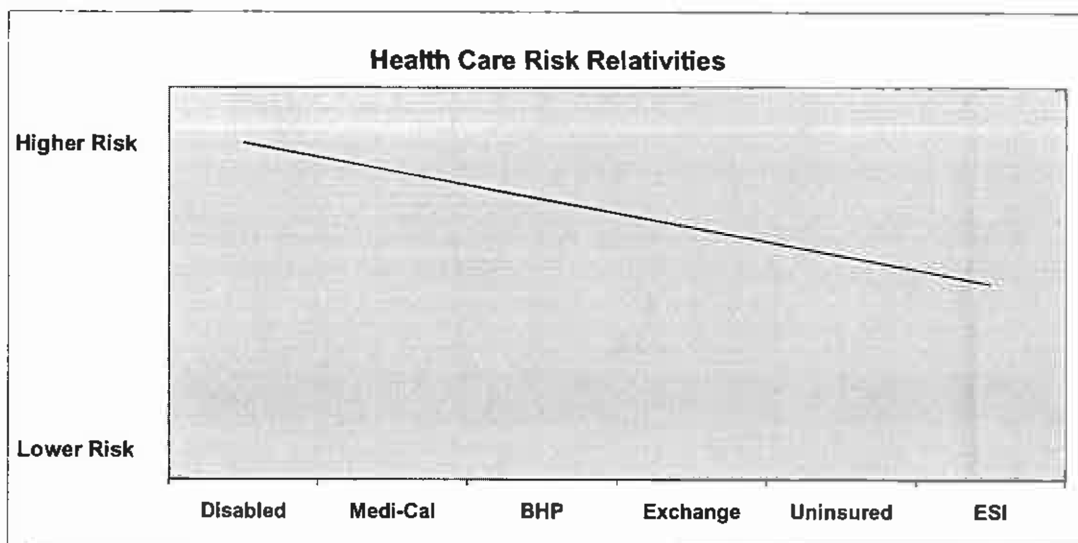
	Females	**Males**	**Total**
Average **Adult Age**	**41.6**	**39.8**	**40.6**
0-18	129,251	153,046	**282,297**
19-24	140,568	170,445	**311,013**
25-34	231,462	318,153	**549,615**
35-44	221,759	247,091	**468,850**
45-54	261,528	249,962	**511,490**
55-64	198,652	179,980	**378,632**
Total	**1,183,220**	**1,318,677**	**2,501,897**

Relative Health Status of Populations

Generally, health status improves as income increases, resulting in decreasing average health care costs. Conversely, health status declines as income decreases resulting in increasing health care costs. Relative health status also improves for those who are employed, both because employed individuals have higher incomes than the unemployed and because they are healthy enough to work.

Since Medicaid (Medi-Cal) represents the lowest income population, this population group is assumed to have the highest health care risk and utilization levels, with the disabled Medicaid population generating higher costs than the non-disabled Medicaid population. The uninsured population represents a mix of relatively healthier individuals, who view purchasing coverage as uneconomical, and those with existing health conditions representing additional risks that cause health insurers to typically deny coverage or make the premiums unaffordable. This mix has been shown to reflect an overall average health status that is better than the Medicaid population – with lower average health care risk and utilization – but is somewhat worse than the ESI covered population.

These assumed health care cost relativities, as illustrated in the graph below, are consistent with the self-reported health status scores collected as part of the CPS dataset. While these self-reported scores are subjective and do not easily convert to a numerical rating scale, they confirm the generally held actuarial assumptions and support developing projected health care costs under the ACA from these income relativities.



Silver-Level Benefits and Premiums Offered in the Exchange

Section 1331 of the ACA authorizes the BHP and defines the premium and cost-sharing subsides based on the "Essential Health Benefits", yet to be fully defined by the Secretary of Health and Human Services (HHS). Because the concept of Essential Health Benefits is modeled on the Federal Employee Health Benefits Program (FEHBP), Mercer estimated the 2014 Silver-Level premiums based on a typical FEHBP plan of benefits.

The Silver-Level of benefits is defined by the ACA as having an actuarial value of 70%, meaning that 70% of the total health benefit costs (excluding plan administration, risk and profit charges) are paid by the plan, with the remaining 30% paid by the member through per service cost-sharing in the form of deductibles, coinsurance and copayments. Mercer defined the level of member cost-sharing and estimated the premium using its proprietary Uninsured Model, which uses a national, commercial employee benefit and cost database, adjusted for the California health care market.

To project future health care costs from the base data, Mercer used current annual commercial health care unit cost and utilization trends for the 18 distinct Categories of Service (COS) employed in the Uninsured Model to project costs for the target year of 2014.

A demographic profile is defined as the relative distribution of a population by age and gender. The Exchange demographic profile used to estimate the Silver-Level premiums in 2014 was developed from the population in the CPS dataset in the 200% and above FPL income levels.

Mercer adjusted this demographic profile slightly by assuming that younger people, who are less likely to have ongoing health care needs, will be slightly (or somewhat) less likely to comply with the federal mandate to purchase coverage through the Exchange, while older people, conversely, are slightly (or somewhat) more likely to have ongoing health care needs, and be more likely to comply with the federal mandate to purchase coverage through the Exchange. Therefore, while we assume an average of 70% of the Exchange eligible population between 200% and 400% FPL will enroll, we assume that only 60% of the youngest age brackets will enroll and 80% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled population by about one year.

We also assumed the population that enrolls in the Exchange will be primarily in the 200% — 400% FPL income bracket because they are eligible for the premium and cost-sharing subsidies. Those with incomes exceeding 400% FPL will not have any subsidies available to them under the Exchange and may be able to find more attractive coverage options outside the Exchange, thus, we assume that only 25% of individuals above 400% FPL will purchase coverage through the Exchange. The demographic profile of the uninsured Exchange eligible population expected to enroll and pay

premiums is 53% male, with an average age of 41 and estimated to be 1.8 million, as shown in Table 1 earlier in this section.

In addition to adverse selection due to age, the enrolled population in the Exchange will experience adverse selection in all age brackets at both extremes of the health spectrum. Less healthy individuals with above average health care risk will select against the insurers in the Exchange by enrolling at premium levels insufficient to cover the health care risks they present (i.e., they will enroll), while some of the healthier individuals with little to no health care risk will opt-out of the Exchange and avoid the unnecessary and unreasonably high health care premiums (i.e., they will not enroll).

This adverse selection, which will increase the average risk levels of the members who purchase coverage in the Exchange, will be somewhat offset by the fact that the BHP premium and cost-sharing subsidies will be based on the second lowest Silver-Level premium offered in the Exchange. As with any other product or service in the marketplace, Mercer anticipates that there will be a range of premiums offered at the Silver-Level by the health insurers participating in the Exchange, some of which will overestimate the resulting risk pool (at higher premium levels), while others will underestimate the resulting risk pool (at lower premium levels). Thus, it's possible that the BHP premium and cost-sharing subsidies, based on the second lowest Silver-Level premium offered in the Exchange, will underestimate the ultimate risk level and be lower than the average. Consequently, to be conservative, Mercer developed the BHP subsidy estimate by not including an adverse selection risk loading into the projected 2014 Silver-Level premium estimate.

In order to create a range of possible premium and cost-sharing subsidies, two different pricing scenarios were utilized (lower and higher). The key differences between these scenarios were varying the annual trend and administrative loading percent that were applied as well as varying the cost-sharing subsidy calculation. The two different sets of annual trends (weighted across all categories of service) were 7.9% for the lower scenario and 8.9% for the higher scenario, on a PMPM basis. The health plan administrative loading was set at 12% (lower) and 15% (higher). Finally, to further differentiate scenarios, we utilized 95% (lower) and 100% (higher) for the cost-sharing subsidy calculation. See the discussion below on the issue of 95% versus 100% for the cost-sharing subsidy.

The resulting Silver-Level premiums for the year 2014, priced for the demographics above, as calculated by the Uninsured Model, are $441 PMPM for the lower scenario and $486 PMPM for the higher scenario.

The 2011, CalPERS statewide health insurance premium rates for single employee coverage, range from $448 PMPM to $850 PMPM (midpoint of $649 PMPM) and the 2011, non-postal FEHBP premium rates range from $438 PMPM to $814 PMPM (midpoint of $626 PMPM). The rates for these plans typically reflect actuarial values in excess of 90% (higher actuarial value equates to lower member cost-sharing, compared to the 70% Silver-Level projected for the Exchange). Reducing the actuarial values of

these plans (CalPERS and FEHBP) to the 70% Silver-Level, produces premiums comparable to the $441 and $486 PMPM estimates when projecting them forward three years to 2014. These comparisons and discussion were included to demonstrate a reasonableness check of Mercer's independent Exchange premium estimate.

Federal BHP Premium and Cost-Sharing Subsidy Calculations

The BHP federal premium and cost-sharing subsidy formula is not clearly defined. Section 1331(d)(3)(A)(i) of the ACA defines it as, "... equal to 95 percent of the premium tax credits ..., and the cost-sharing reductions under section 1402 ..." which can be interpreted as either

- 95% x [Premium Subsidy + Cost-Sharing Subsidy] or
- 95% x Premium Subsidy + 100% x Cost-Sharing Subsidy

The Premium Tax Credit is defined mathematically as:

The Premium (for the second lowest Silver-Level Benefit Plan) – the member share of premium, as determined by the applicable premium offset percentage (based on income as defined in Section 1401(b)(3)(A)(i) and as specified in Table 4 below).

Table 4 – Premium Offset Percentages (of Income)

	Low-End Premium Offset %	High-End Premium Offset %	Cost-Sharing (Actuarial Value)
100% — 133% FPL	2.00%	3.00%	94%
133% — 150% FPL	3.00%	4.00%	94%
150% — 200% FPL	4.00%	6.30%	87%
200% — 250% FPL	6.30%	8.05%	73%
250% — 300% FPL	8.05%	9.50%	
300% — 400% FPL	9.50%	9.50%	

Section 1402(c)(2), defines the additional cost-sharing subsidy as "... the issuer of a qualified health plan ... shall further reduce cost-sharing under the plan in a manner sufficient to — (A) in the case of an eligible insured whose household income is ... not more than 150% of the poverty line ... increase the plan's share of the total allowed costs of benefits provided under the plan to 94% of such costs; ... in the case of an eligible insured whose household income is more than 150% but not more than 200% of the poverty ... increase the plan's share of the total allowed costs of benefits provided under the plan to 87% of such costs." Mercer interprets this language to mean that those between 100% and 150% FPL have plans with an effective actuarial value of 94% (paying an average of 6% cost-sharing) and those between 150% and 200% FPL have plans with an effective actuarial value of 87% (paying an average of 13% cost-sharing). See Exhibit 1, on the following page, for cost-sharing percentages by benefit level.

Exhibit 1 – Cost-Sharing Percentages by Benefit Level

Bronze	Silver < 150% FPL	Silver 150% - 200% FPL	Gold	Platinum
40% Of Health Care Cost Paid By Member	6% Of Health Care Cost Paid By Member	13% Of Health Care Cost Paid By Member	20% Of Health Care Cost Paid By Member	10% Of Health Care Cost Paid By Member
	24% Of Health Care Cost Paid by Federal Cost-Sharing Subsidy	17% Of Health Care Cost Paid by Federal Cost-Sharing Subsidy		
60% Of Health Care Cost Paid By Plan	70% Of Health Care Cost Paid By Plan	70% Of Health Care Cost Paid By Plan	80% Of Health Care Cost Paid By Plan	90% Of Health Care Cost Paid By Plan

Mercer estimates the 2014 FPL for a single adult will be $12,196, which would generate the Exchange premium offset amounts shown in Table 5 below.

Table 5 – Estimated Exchange Premium Offset Calculation

One Adult	$ Income	Premium Offset %	Annual	Monthly
100% FPL	$12,196	2.00%	$ 244	$ 20
138% FPL	$16,830	3.29%	$ 554	$ 46
144% FPL	$17,502	3.65%	$ 640	$ 53
150% FPL	$18,294	4.00%	$ 732	$ 61
175% FPL	$21,343	5.15%	$1,099	$ 92
200% FPL	$24,392	6.30%	$1,537	$128

Figures in the table are rounded

The 138% level is used in this table since FPL levels below this will be covered by Medi-Cal (133% FPL + 5% income disregard). The number of people estimated below this income level (legal immigrants not currently eligible for Medi-Cal) is very small. Since 144% FPL is midway between the lower BHP population income segment of 138% — 150% FPL and 175% FPL is midway between the upper BHP population income segment of 150% — 200% FPL, Mercer used the 144% and 175% midpoints to represent the average of each population segment for pricing purposes.

Using this Exchange demographic profile, the weighted net federal BHP premium and cost-sharing subsidies range from about $441 PMPM to $497 PMPM. Calculations are shown in Tables 6 and 7, below.

Table 6 – Calculation of the Estimated BHP Subsidy (Lower Scenario)

	< 150% FPL	150% – 200% FPL	Combined
Total Projected Health Care Cost	$554	$554	$554
- 30% Member Cost-Sharing	$166	$166	$166
= 70% Plan Covered Health Care Cost	$388	$388	$388
+ 12% Administrative Loading	$ 53	$ 53	$ 53
= Silver Level Premium PMPM	$441	$441	$441
- BHP Premium Offset	$ 53	$ 91	$ 81
= Gross Premium Subsidy	$388	$350	$360
x 95% = Net Premium Subsidy	$368	$332	$342
Gross Cost-Sharing Subsidy	$133	$ 94	$105
x 95% = Net Cost-Sharing Subsidy	$126	$ 89	$100
Total Estimated BHP Net Subsidy PMPM	$494	$421	$441

Figures in the table are rounded

Table 7 – Calculation of the Estimated BHP Subsidy (Higher Scenario)

	< 150% FPL	150% – 200% FPL	Combined
Total Projected Health Care Cost	$593	$593	$593
- 30% Member Cost-Sharing	$180	$180	$180
= 70% Plan Covered Health Care Cost	$413	$413	$413
+ 15% Administrative Loading	$ 73	$ 73	$ 73
= Silver Level Premium PMPM	$486	$486	$486
- BHP Premium Offset	$ 53	$ 91	$ 81
= Gross Premium Subsidy	$433	$395	$405
x 95% = Net Premium Subsidy	$411	$375	$385
Gross Cost-Sharing Subsidy	$142	$101	$112
x 100% = Net Cost-Sharing Subsidy	$142	$101	$112
Total Estimated BHP Net Subsidy PMPM	$553	$476	$497

Figures in the table are rounded

Estimated 2014 BHP Expenses

Like the Exchange demographic profile, the BHP demographic profile used to estimate the BHP premium and cost-sharing, was developed from the population in the CPS dataset in the up to 200% FPL income levels. Mercer adjusted the BHP demographic profile to a greater extent than the Exchange demographic profile because the lower income level of the BHP population provide greater incentives for younger, healthier individuals to avoid unnecessary expenses on their limited incomes.

While we assume an average of 70% of the BHP eligible population will enroll, we assume that only 50% of the youngest age brackets will enroll, while 90% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled BHP population by about two years.

The demographic profile of the uninsured BHP eligible population expected to enroll and pay premiums is 52% male with an average age of 41 and estimated to be 0.7 million, as displayed in Table 2 previously.

To estimate the BHP Expenses in 2014 for this population, Mercer used the Calendar Year (CY) 2009 Medi-Cal Managed Care encounters and related FFS experience from the membership of a large subset of Medi-Cal plans that reported the most reliable and complete encounter data. As was done for the Exchange rate assumptions, Mercer developed two different scenarios (lower and higher) to show a range of potential BHP costs.

The following assumptions were used for the higher BHP cost scenario:

- Health status increases with income, as noted previously. Since the BHP eligible population sits just above the Medi-Cal population on the income scale, the BHP health care risk should be slightly better than the Medi-Cal experience
- The Medi-Cal populations that best reflect the health care risk of the BHP eligible population are the adults in the Adult & Family Category of Aid (COA) group and the Disabled Medi-Cal Only (i.e., non-dual eligible) COA group
- Incidence of disability increases as income levels decrease. The current Medi-Cal mix of the adult population is about 80% from the Adult & Family COA group and 20% non "share-of-cost" Disabled Medi-Cal Only COA group. To be very conservative, Mercer assumed the disabled health status risk composition of the BHP eligible population would approach the Medi-Cal mix, so a 15% Disabled blend was used with 85% Adult & Family experience
- The State would establish minimal premium and cost-sharing levels, similar to, or slightly above the current HFP levels, to help maximize enrollment and not discourage access to vital health care services
- Since the current HFP monthly premiums are $4 for the lowest income Category A (up to 150% FPL) and $16 for income Category B (up to 200% FPL), Mercer priced a $10 monthly premium for the less than 150% FPL income group and a $20 premium for the 150% — 200% FPL income group
  - Since Mercer calculated the current HFP Category A cost-sharing level to equate to about a 98% actuarial value and the Category B cost-sharing level to equate to about a 96% actuarial value, Mercer priced the less than 150% FPL income group BHP plan with a 98% actuarial value and the 150% — 200% FPL income group BHP plan with a 96% actuarial value
- Again, for conservatism, health care cost and utilization trends for the five year period from CY 2009 to the first year of the BHP, CY 2014, will be approximately 1/2% above the upper bound of the range of Mercer estimates used in the pricing of 2011 — 2012 Medi-Cal managed care rates

- The administrative loading (including profit/risk/contingency) for the BHPs would represent 12% of the premiums, which is higher than current Medi-Cal managed care payment levels (to be conservative)

After the CY 2009 encounter data for the relevant Medi-Cal managed care health plans were extracted by COA and COS for ten distinct age and gender brackets, they were adjusted for known reporting anomalies. FFS health care costs for benefits not provided by the Medi-Cal managed care health plans, but covered under Medi-Cal FFS (e.g., AIDS and psychotropic drugs) were added to the total to develop complete costs for covering these Medi-Cal members. This was done to better represent the ultimate essential benefits to be defined under ACA.

Once the CY 2009 Medi-Cal MCO data were completed and adjusted to the statewide levels used for rate setting and the FFS costs were added, the resulting data were projected forward five years, using the current Medi-Cal unit cost and utilization trends to develop estimated CY 2014 health care costs for both the Adult & Family and Disabled COAs. These costs were then loaded with a 12% factor for administration, profit and risk/contingencies to develop final, estimated statewide MCO premiums for females and males in each of five age brackets for both COAs.

The adult female Medi-Cal membership in the 19-44 age brackets significantly overrepresent maternity costs due to Medicaid eligibility rules. In many cases, women become eligible for Medicaid, not only because of their income, but because of a combination of their incomes and pregnancy status. Consequently, the female age 19-44 Medi-Cal health care risk is much higher than the normal, commercially covered populations, where the incidence of pregnancies is not unnaturally inflated. Under current Medi-Cal eligibility rules, almost all pregnant women below 200% FPL are eligible for coverage. As an added measure of conservatism, Mercer calculated the projected BHP health care costs with 25% of the Medi-Cal pregnancy experience included. It is important to note that if actual BHP maternity experience is greater than what was included in the cost base, it will mean that the State is achieving corresponding savings by removing the maternity experience from Medi-Cal. Therefore, we believe this 25% figure is very conservative.

The resulting premiums by age bracket were then combined in the ratio of 85% Adult & Family COA and 15% Disabled COA to develop blended rates. The projected membership by age and gender for both BHP income categories were then multiplied by the estimated BHP demographic mix to develop a weighted, estimated gross BHP rate of $373 PMPM.

Mercer then calculated the impact of the $10 and $20 member premiums for the less than 150% FPL and 150% — 200% FPL income brackets, respectively, assuming that only 50% of the premiums will ultimately be collected (to be conservative). Added to this, Mercer applied the 2% cost-sharing paid by the less than 150% FPL income group and the 4% cost-sharing paid by the 150% — 200% FPL income group, to reduce the $373

PMPM gross BHP rate to a net cost to the State of $353 PMPM for the BHP, as shown in Table 8, below.

Table 8 – Estimated BHP Premium Rates (Higher Scenario)

Pregnancy Costs Included	< 150% FPL	150% – 200% FPL	Combined
Gross MCO Premium	$369	$374	**$373**
Gross Member Contribution	$10	$20	**$17**
Collection Offset Percentage	50%	50%	**50%**
Net Member Contribution	$5	$10	**$9**
Member Cost-Sharing	$6	$13	**$11**
Net MCO Cost to State	**$358**	**$351**	**$353**

Figures in the table are rounded

Because this scenario reflects compounded conservatism of several assumptions, Mercer developed an alternate lower cost scenario that has a higher probability, with the following adjustments:

- The Medi-Cal mix of the population will be 90% Adult & Family and 10% Disabled, instead of the 85%/15% mix used in the most conservative scenario
- Health care cost and utilization trends for the next five year period from CY 2009 to the first year of the BHP, CY 2014, will be at the midpoint of the range of the Mercer estimates used in the pricing of 2011 – 2012 Medi-Cal managed care rates
- The administrative loading for the Medi-Cal MCOs operating similar BHPs would represent 10% of the premiums, instead of 12%
- Only 10% of the pregnancy costs will be included in the premium rates, instead of the 25%
- 75% of the premiums will be collected, instead of the 50% assumption

This lower scenario produces a weighted, estimated gross BHP rate of $316 PMPM. The impact of the same member premiums and cost-sharing referenced above, reduces the $316 PMPM gross BHP rate to a net cost to the State of $294 PMPM for the BHP, as shown in Table 9, below.

Table 9 – Estimated BHP Premium Rates (Lower Scenario)

Pregnancy **Costs Removed**	< 150% FPL	150% – 200% FPL	Combined
Gross MCO Premium	$312	$318	**$316**
Gross Member Contribution	$ 10	$ 20	**$ 17**
Collection Offset Percentage	75%	75%	**75%**
Net Member Contribution	$ 8	$ 15	**$ 13**
Member Cost-Sharing	$ 5	$ 11	**$ 9**
Net MCO Cost to State	**$299**	**$292**	**$294**

Figures in the table are rounded

Surplus/(Deficit) of Estimated Federal BHP Subsidies over BHP Premiums

In calculating the CY 2014 BHP premium subsidy and BHP cost estimates, Mercer employed conservative assumptions on both sides. The actual Exchange subsidies may be higher due to the risk profile of the likely actual Exchange enrolled population and the pent-up demand this previously uninsured population will bring with it. Similarly, the risk profile of the likely BHP enrolled population should have lower average costs than the current Medi-Cal enrolled population, and should have a lower incidence of disability and pregnancy than was used in the BHP cost estimates.

In order to reflect the most conservative scenario, Table 10, below, calculates the difference between the lowest estimated BHP subsidy and the highest cost BHP estimate. This reflects the minimum potential difference (excess) of BHP subsidy and BHP cost estimates. The table also reflects the maximum potential difference resulting from the subsidy and cost estimates.

Table 10 – Calculation of the Estimated BHP Subsidy Surplus/(Deficit)

	Minimum Difference PMPM	Maximum Difference PMPM
Estimated Monthly Federal Subsidy	$441	$497
Net Estimated Monthly BHP Costs	$353	$294
Difference = Excess	$ 88	$203

The $88 PMPM gap between the estimated premium subsidy and BHP costs for the most conservative scenario represents about 25% of the $353 Net BHP costs, which allows for a large margin of error in these estimates and assumptions. For the more aggressive scenario, the $203 PMPM gap represents almost 70% of the Net BHP costs. The size of these gaps should not be affected by the actual number of Californians with incomes less than the 200% FPL level and eligible for the BHP, although it will be affected by the relative risk profile of the percentage that decides to enroll.

Another factor worth noting is that the federal BHP subsidies do not include state mandated benefits, which must be funded entirely by the states. By using the actual Medi-Cal costs to develop the estimated BHP rates, the current California mandated benefits are already included on the cost side of the ledger. Given that California has one of the larger sets of state mandated benefits, an expansion of the definition of Essential Health Benefits could have the impact of increasing the federal BHP premium subsidies without adding any costs to the BHP rates, as these benefits may already be included in the current Medi-Cal costs.

Conclusion on Financial Feasibility

Under any scenario based on the estimated subsidy and costs modeled in this analysis, the result is that it would be financially feasible for California to offer a BHP option at Medi-Cal provider reimbursement levels, with no costs to the State. These results are consistent with estimates and projections included in other papers written on the BHP option that were not specific to California (e.g., Milliman, the Urban Institute, and CCS).

Since the ACA does not allow a state to retain or use excess funding for anything but the BHP, there appears to be room under each scenario to offer a BHP at reimbursement rates above current Medi-Cal levels. The following bullets offer a point of reference for the current Medi-Cal reimbursement levels for the three most significant COS (Hospital Facility, Physician, and Pharmacy).

- An analysis of data from the 2008 California Office of Statewide Health Planning and Development (OSHPD) Hospital Annual Disclosure Reports estimates Medi-Cal managed care hospital per diem reimbursement rates to be approximately 89% of Medicare reimbursement levels. Based on this same data source, Medi-Cal managed care per diem rates are approximately 43% of Commercial inpatient rates
- A 2009 CHCF nationwide survey of Medicaid physician reimbursement rates found California physician fees to be approximately 56% of the Medicare fee schedule. Based on Mercer's experience, commercial physician reimbursement tends to run anywhere from 100% to 130% of Medicare. Taking the average of this range (115%) would put Medi-Cal physician reimbursement at approximately 49% of commercial reimbursement levels
- Based on Mercer's experience, Medi-Cal managed care prescription drug reimbursement levels are roughly equivalent to Medicare and commercial levels

For purposes of this discussion, we will assume that these three COS are representative of all reimbursement levels for Medi-Cal. That is to say, we will assume that all COS roll up to one of these three, broad COS (Hospital – Facility, Physician – Professional and Pharmacy). On a weighted basis, this would mean that current Medi-Cal reimbursement levels are approximately 81% of Medicare rates (the weighting of 89% facility, 56% professional and 100% pharmacy).

Under the most conservative scenario, there is an excess of approximately 25% funding (i.e., 25% higher estimated subsidy than the estimated net BHP costs). Therefore, even under this scenario, our model projects that there is enough room to raise BHP reimbursement levels from current Medi-Cal (assumed to be 81% of Medicare) to 100% of Medicare for Facility and Pharmacy and 90% for Physician/Professional services.

Under the less conservative scenario, there was an excess of approximately 70% funding (i.e., 70% higher estimated subsidy than the estimated net BHP costs). If this scenario plays out, there would appear to be enough room to raise BHP reimbursement levels to 110% of Medicare for Facility, 100% for Pharmacy and 125% for Physician/Professional.

BHP Impact on the Exchange

This section of the report addresses some of the potential impacts that adopting a BHP option could have on the Exchange in California. Specifically, the following potential areas of impacts are discussed:

- Impact on Exchange risk
- Impact on Exchange self-sustainability
- Impact on the Exchange's ability to selectively contract

Finally, we close with a host of "Other Considerations" related to the analyses performed and included in this report.

Impact on Exchange Risk

As illustrated by the Health Care Cost Relativities graph in the previous section, the BHP population in the up to 200% FPL income group (BHP group) should represent a less healthy (and more costly) risk profile than the remaining Exchange population above 200% FPL. In addition, the level of premiums and cost-sharing in a BHP and in an Exchange population (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. Specifically, higher premium and cost-sharing levels increase the level of adverse risk and lead to higher enrolled population risk. With the assumption that a BHP option would only be implemented with reduced premiums and cost-sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population, up to 200% FPL, would be better under a BHP than the risk of the same population subgroup that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange.

However, one could argue that with less disposable income at the lower income (FPL) levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP. On the other hand, at higher income levels the subsidy is considerably lower than at lower income levels. Therefore, the motivation to participate within the Exchange versus the outside market is much lower for the healthiest segment of the Exchange population. Plan participation, consumer choice and risk dynamics for the Exchange population are complicated and beyond the scope of this analysis.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. There will be no federal funds available for states to use for the ongoing operations of the Exchanges after this date. Therefore, it is reasonable to be concerned about removing some Exchange eligible members from the pool of members from which the Exchange may be funded. Based on the population estimates included in the previous section, the BHP population is approximately 723,000 members. However, the estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number for California is likely to be larger than any other state's gross Exchange enrollment (California's total population is 48% larger than the next closest state – Texas). From a purely fiscal perspective, the somewhat reduced Exchange population should not pose a significant issue with respect to being able to achieve self-sustainability.

Impact on The Exchange's Ability to Selectively Contract

California's Exchange enabling legislation has authorized the Exchange to use selective contracting. While the details regarding how this selective contracting will occur are still under development, ultimately it means that not every willing health plan will be allowed to participate in California's Exchange. This was most likely set up this way to create some level of competition among licensed health plans for a place in the Exchange. Such competition can be used to drive higher quality and potentially lower costs (or improved efficiency). Therefore, it is reasonable to be concerned as to whether removing some Exchange eligible members from the pool will lower the "demand" (i.e., competition) to be part of the Exchange.

As mentioned previously, the estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number is approximately twice the size of California's HFP population. MRMIB currently has 24 licensed health plans under contract and competing for the HFP membership of less than 900,000. A group of 1.8 million people constitutes a large pool of potential membership. We cannot speak to the specific size that will ultimately attract the State's desired level of demand for participation in the Exchange. However, if the estimate of Exchange enrollment net of BHP is reasonable,

the somewhat reduced Exchange population should not create a dramatic difference with respect to being able to drive competition for selective contracting.

Other Considerations

As illustrated in Table 5 in the previous section, the income band spanning 138% and 200% FPL is a rather narrow range of only $7,562 annually. Sommers and Rosenbaum, in the February 2011 issue of Health Affairs, published a study which showed that over the course of a year, approximately 50% of the people at this income level will experience earnings fluctuations which will move them above or below the 138% FPL BHP eligibility threshold, rendering them ineligible for the specific coverage they have, and requiring them to re-enroll in the coverage for the income category they move to. This churning of coverage will also likely exist above or below the 200% BHP upper income eligibility threshold, requiring them to disenroll from the BHP and enroll in the Exchange (or vice versa). We did not attempt to model this phenomenon and have not made any adjustment to our analysis to account for this.

By using the Medi-Cal provider reimbursement rates in the CY 2009 data, we have not modeled the increased reimbursements for primary care providers (PCPs) to the Medicare levels mandated by the ACA for CY 2013 and CY 2014. As the law currently stands, these PCP reimbursement rates will revert to their current levels starting in 2015, however, some states are contemplating leaving the PCP reimbursement rates intact after 2014.

The ACA currently requires Exchange participating health plans to offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as part of their provider networks. In addition, payment for these FQHCs and RHCs is to be at the prospective payment rates used by the states' Medicaid programs. In California, these payment rates tend to be significantly higher than regular physician Medi-Cal and even commercial payment levels. As the ACA stands today (before regulations are published), these requirements do not exist for a BHP option. Mercer did not make any adjustment to the estimated BHP or Exchange health care costs to account for this requirement.

All estimates in this report are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any estimates or projection must be interpreted as having a likely range of variability from the estimate. Mercer has prepared these projections exclusively for the California HealthCare Foundation. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. The estimates and projections included in this report are not a guarantee of results which might be achieved.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA and Health Care Education and Reconciliation Act (HCERA) have been issued, including clarifications and technical corrections and without

guidance on complex financial calculations that may be required. Accordingly, these estimates are not Actuarial Opinions. The State of California is responsible for all decisions related to the policy direction of the Exchange and a BHP option. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios and not solely on the basis of the estimates illustrated here.

Because of numerous uncertainties about the health care marketplace in 2014, the analyses and findings contained in this report are preliminary and subject to change for many reasons, including, but not limited to:

- Uncertainties regarding the ACA
  - Key terms and provisions in the law remain undefined, or not yet fully defined, more than a year after it was enacted, such as the definition of the "Essential Health Benefits" that will be required for all products offered in the Exchange, and which will drive the BHP premium and cost-sharing subsidies
  - Key terms and provisions of the law conflict. For example, Section 1331(a)(2)(A)(ii) defines the BHP cost-sharing subsidies to be a minimum of Platinum-Level benefits (90% actuarial value) for individuals between 100% – 150% FPL and Gold-Level benefits (80% actuarial value) to individuals between 150% – 200% FPL, while Section 1402(c)(2) defines the additional cost-sharing subsidies to be a minimum of 94% actuarial value for individuals between 100% – 150% FPL and 87% actuarial value to individuals between 150% – 200% FPL
  - Key terms and provisions of the law are unclear, such as the precise definition of "actuarial value" and the formula for the BHP cost-sharing subsidy (100% or 95%)
- Decisions about how the State would structure a BHP, such as the premiums and cost-sharing levels, which will impact the risk profile of those who enroll, and how the state decides to legislate and regulate the health care marketplace under the ACA
- Uncertainties regarding consumer behavior under the ACA, for example:
  - What will be the level of compliance with the federal insurance mandate?
  - Will those above 400% FPL, not eligible for premium subsidies, purchase health care in the Exchange, or migrate to other products outside it, leaving the Exchange with a potentially lower income and less healthy risk pool?
  - How will the 90-day grace period for non-payment of premiums and the lack of a penalty for re-enrollment affect coverage persistency and premium payments in a BHP and/or in the Exchange?

MERCER

Mercer (US) Inc.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500

Consulting. Outsourcing. Investments.

Attachment Three

CSAC Memo: 2012-13 State Budget Update - May Revision

CSAC Health and Human Services section of the May Revision Budget Action Bulletin (May 14, 2012)

CSAC, UCC and CHEAC Budget Letter on Public Hospital Funding (May 17, 2012)

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

May 21, 2012

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: 2012-13 State Budget Update – May Revision

Background. The Governor released his May Revision Budget for 2012-13 on Monday, May 14. The state Department of Finance has also released most of the attendant trailer bill language at the time of this writing.

Attached is the CSAC summary of Health and Human Services impacts in the May Revision Budget.

The full May Revision Budget and trailer bill language can be found at www.dof.ca.gov. An analysis by the Legislative Analyst's Office can be found at www.lao.ca.gov.

The pertinent Assembly and Budget Subcommittees are meeting to discuss and take action on the Governor's Budget. CSAC staff anticipates that the subcommittees will have completed their hearings by May 31.

Materials. We have attached several documents that pertain to the Governor's budget proposals and established CSAC policy for review by the members of the Health and Human Services Policy Committee. CSAC staff will also provide updated budget materials at the in-person policy committee meeting during the CSAC Legislative Conference on May 31, 2012.

- CSAC Health and Human Services section of the May 14 May Revision Budget Action Bulletin (BAB)
- CSAC, UCC and CHEAC Budget Letter on Public Hospital Funding (May 17, 2012)

May Revision Budget – May 14, 2012
CSAC Health and Human Services Summary

The Governor's May Revision Budget includes $1.2 billion in cuts to health and human services out of $8.3 billion total proposed cuts for the 2012-13 fiscal year. The California Health and Human Services Agency's total budget for 2012-13 is $103.9 billion, of which $25.5 billion is state General Fund and $78 billion in federal and other funds.

Medi-Cal

Coordinated Care Initiative. The Governor proposes a number of changes to the Coordinated Care Initiative (CCI) in the May Revise. The Administration is proposing to phase-in long-term care benefits as each county transitions into managed care. The Administration is reducing the number of counties in phase one from 10 to 8 (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) and to delay implementation from January 1, 2013 to March 1, 2013. Sacramento and Contra Costa counties, along with the other counties with existing Medi-Cal managed care plans, will be in the second phase of CCI implementation in 2014

Counties will continue to assess and authorize hours for the In-Home Supportive Services (IHSS) program. Consumers will continue to select and direct their provider. The Administration is proposing a county-specific maintenance of effort to hold county expenditures to the estimated level that would been incurred absent the CCI. As CCI is implemented, collective bargaining will eventually transition to the state. The Administration does not provide additional detail about collective bargaining changes, nor does the CCI trailer bill address it.

The modified CCI proposal saves $663.3 million in 2012-13 (as in January the savings are from the Medi-Cal payment deferral) and $887 million when fully implemented. The CCI savings are contingent on securing a six-month stable enrollment period and 50 percent shared savings from the federal government.

Hospital Payment Changes. The Administration proposes to reduce supplemental payments to private hospitals, eliminate public hospital grants and eliminate increases to managed care plans for supplemental payments to designated public hospitals. All told, these changes save $150 million General Fund in 2012-13 and $75 million in 2013-14. The May Revisions also proposes to delay the transition to a new diagnosis related group-based payment methodology for hospitals by six months (from January 1, 2013 to July 1, 2013).

Unexpended Federal Waiver Funds. The May Revision proposes to split unexpended federal funds from the Medi-Cal Section 1115 Bridge to Reform Waiver equally between the state and designated public hospitals. The proposal saves $100 million General Fund in 2012-13 and $9 million in 2013-14.

Non-Designated Public Hospital Payment Changes. Non-designated public hospitals have historically been funded similar to private hospitals (50 percent General Fund, 50 percent federal funds), rather than like designated public hospitals (no state General Fund; local funds are used to draw down federal match) for inpatient Medi-Cal fee-for-service. The Administration is proposing to align non-designated hospital funding with designated hospitals funding methodology for inpatient Medi-Cal fee-for-service. The proposal generates $75 million in General Fund savings in 2012-13 and ongoing. The Department of Health Care Services will be seeking additional federal funds for these hospitals. Please not the non-designated public hospitals are primarily district hospitals.

Nursing Homes. The Administration is proposing to rescind the 2012-13 nursing home rate increase while continuing the collection of fee revenue. The state would retain the fee revenue for a General Fund benefit of $47.6 million. Existing law also requires DHCS to set aside 1 percent of nursing home payments for supplemental payments based on quality measures. The Administration is proposing to sweep the 1 percent for a General Fund benefit of $23.3 million.

First 5 Funding. The Administration is proposing that $40 million of state First 5 Commission funds be used for Medi-Cal services for children age birth through 5. This decreases Medi-Cal General Fund by $40 million.

Medi-Cal Caseload Adjustment. The Administration is projecting a decrease in Medi-Cal caseload, which results in a $200 million General Fund savings in 2011-12 and $700 million General Fund in 2012-13.

Provider Payments. The Administration is adjusting the May budget to reflect court rulings that have prevented the implementation of provider payment reductions. The May Revision includes an additional $245.5 million in 2011-12 and $174.6 million in 2012-13.

Co-Payments. The federal government rejected the Administration's 2011-12 budget proposal to implement co-payments. The Administration is adjusting the May budget to reflect the increased costs from the proposal not being implemented - $555.3 million in 2012-13. Additionally, the Administration is proposing new co-payments of $15 for non-emergency room visits and $1 and $3 co-payments for pharmacy based on drug status and how medications are dispensed to achieved $20.2 million in General Fund savings in 2012-13.

Healthy Families Program (HFP)

The May Revision continues to anticipate the shift of 875,000 Healthy Families Program (HFP) participants into Medi-Cal starting in October of this year. However, the savings anticipated have dropped from about $64 million to about $49 million. This is due to an increase in the estimated per-member per-month average cost of a Medi-Cal beneficiary from $76.86 to $83.91. This new estimate includes the costs for mental health managed care benefits for this population. Further, the Administration has been forced to drop the January proposal to increase premium and copayments in HFP to save $42 million because it was blocked by the federal government.

CalWORKs

The Administration makes some policy changes to the January proposal to "redesign" the CalWORKs program into two tracks, but the basic structure introduced in January remains, including:

CalWORKs Basic. This track would serve as the entry-point for the welfare-to-work program and would be operational by October of this year. The eligibility time limit for this phase would be 24 months, with an assessment of the recipients' progress after 12 months. For six months following the October 2012 implementation of the CalWORKs Basic program, all currently aided eligible adults will be eligible for welfare-to-work services and child care. The budget has increased the county single allocation by $35.6 million to provide some of these services. Additionally, families who are sanctioned for more than three months would be disenrolled from the program.

CalWORKs Plus. If a CalWORKs Basic participant maintains unsubsidized employment at specified levels (30 hours for adults and 20 hours for those with children under age 6), they would move to the CalWORKs Plus program. This program would become operational in April of 2013 and reward participants with a higher grant level by allowing them to utilize a higher income disregard (first $200 earned and 50 percent of subsequent income). Participants would be eligible for this program for up to 48 months, and if they reach the time limit but continue to work specified amounts, they would retain the higher earned income disregard.

Child Only Grants. The income support program of child only grants will continue under the name of Child Maintenance Program, but grants will be cut by 27 percent, or about $70 a month, beginning in October of this year. Also, families on the Child Maintenance Program will be subject to annual eligibility determinations and required to have children in the program seen annually by a doctor.

Work Participation. Furthermore, under the proposed restructuring, low-income families who are CalFresh recipients or child care subsidies – but not on CalWORKs – and meet work participation requirements may receive $50 bonus payments.

The May Revision includes some changes to the above policy proposals, including counting any combination of state-allowable work activities in the first 24 months and federally allowable activities for up to 48 months toward work participation, instead of counting only paid employment. Further, the May Revise also abandons the proposal to retroactively count previously exempt and sanctioned months toward the adult recipient's 48-month time limit.

Child Care

In January, the Governor had proposed nearly $500 million in changes and reductions for subsidized child care programs in California. In the May Revision, the Governor remains committed to saving the state $452.5 million in child care costs, but has altered some of the above proposals, including:

- Allow education and training activities, not just paid employment, to count toward eligibility for child care services for up to two years. This will cost the state $180.1 million in 2012-13.
- Reduce reimbursement rates for voucher-based programs by $184.2 million by reducing the reimbursement rate ceiling from the 85th percentile to the 40th percentile of the private pay market. License-exempt providers would be reimbursed based upon 71 percent of the lowered licensed ceilings.

The new proposals will eliminate 29,600 child care slots, while the previous plan would have eliminated 54,800.

In Home Supportive Services (IHSS)

The Governor continues to focus on the IHSS program for state savings, noting in the May Revision that costs for IHSS are "...considerably higher than in 2011 Budget Act." One aspect of this plan, the Coordinated Care Initiative, is covered in the Medi-Cal section of this document. Other proposals include:

Reducing Hours by 7 Percent. The May Revise includes a proposal to reduce total authorized IHSS hours by 7 percent across the board to save $99 million General Fund in 2012-13. This would be effective August 1, 2012. This is on top of the 20 percent across the board reduction that the courts prevented the state from implementing in the fall of 2011. The 7 percent reduction is proposed to be permanent and ongoing.

Eliminating Domestic Services. The Governor is maintaining his January proposal to eliminate domestic services and related services for IHSS consumers living with other adults who are not participants in the IHSS program, unless those adults are found to be unable to perform such services. This reduction in domestic services also applies to children in the IHSS program who reside with their parents, and the state assumes budget savings of $164 million in the current year if implemented by July 1 of this year. This proposal would affect 254,000 IHSS recipients.

IHSS Provider Tax. The federal government has not approved the IHSS provider tax approved in the 2011-12 budget. The delay in implementation has resulted in lost General Fund savings of $57.3 million in 2011-12 and $95.4 million in 2012-13. The Administration is assuming the tax will be implemented October 1, 2012.

Please note that the Governor has been prevented from implementing the December 2011 Trigger Cuts through a court injunction and Legislative action. The 2012-13 May Revision again includes a set-aside to fund the IHSS program in light of this reality.

Child Support

Suspend County Share. In January, the Governor asked to suspend the County share of child support collections and redirect it to the state's General Fund. He maintains that proposal for a state savings of $32 million General Fund in 2012-13.

Reduce Funding to Local Agencies. In May, he also proposes to decrease the funding for Local Child Support Agencies (LCSAs) by $14.7 million in 2012-13 to save $5 million General

Fund. This is a significant cut to the local agencies, and, as a result, the Administration has said that the LCSA's will no longer be required to prepare cases for state hearings. They would, however, still have to continue their required complaint resolution process and refer cases for state administrative review.

Reduce Automation Funding. The Governor also wants to reduce funding for the California Child Support Automation System (CSSAS) again in 2012-13, this time by $1 million. The current 2011-12 budget reduced CCSAS funding by $5.5 million. The 2012-13 reduction would be achieved by sweeping remaining CCSAS reappropriation dollars, and would reduce the ongoing project maintenance and operations budget by $2.9 million.

Public Health

AIDS Drug Assistance Program. The Governor maintains his proposal to increase the client share of cost for the AIDS Drug Assistance Program (ADAP), but with a significant change: private insurance clients would be exempted from the share of cost because it would exceed their out-of-pocket costs for private insurance. The Governor also proposes a 90-day implementation delay to make billing system modifications. With these changes, the ADAP cost-sharing proposal is estimated to save the state $10.7 million in 2012-13.

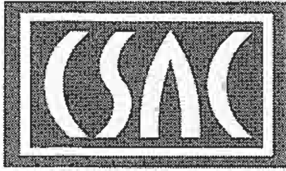
Further, the Governor anticipated a net increase in funding for ADAP due to a combination of factors, including a delay in ADAP clients enrolling in the county Low-Income Health Programs, increased federal Ryan White funding, a decrease in Safety Net Care Pool funds, and an increase in the projected drug rebate collection rate.

Mental Heath

The May Revision includes an increase of $15 million in the Mental Health Services Fund as part of a $60 million commitment toward the California Reducing Disparities Project in 2012-13.

LEADER Replacement System

The May Revision includes $36.5 million ($15.3 General Fund) in 2012-13 to replace the existing Los Angeles Eligibility, Automated Determination, Evaluation and Reporting System (LEADER).



URBAN
COUNTIES
CAUCUS

California State Association of Counties | Urban Counties Caucus | County Health Executives Association of California

May 17, 2012

The Honorable Mark DeSaulnier, Chair
Senate Budget & Fiscal Review Subcommittee #3 on
Health and Human Services
State Capitol, Room 5035
Sacramento, CA 95814

RE: **Governor's May Revision FY 12/13 – Public Hospitals**

Dear Senator DeSaulnier:

The California State Association of Counties (CSAC), Urban Counties Caucus (UCC) and the County Health Executives Association of California (CHEAC) are writing to express our concerns regarding proposals in the Governor's May Revision that would have an adverse impact on county hospitals and health systems. While we appreciate the very serious budget challenges the state is facing, the proposed reductions to public hospitals would undermine the ability of our public hospital system to serve the vulnerable populations that rely on these services. Specifically, we have concerns about the following proposals:

Hospital Payment Changes. The Administration proposes to eliminate $61.5 million in funding made available to public hospital systems through the hospital fee, which supports access to care for low-income Californians. These funds were intended to provide partial relief from insufficient Medi-Cal reimbursement, and their loss will further exacerbate declines in other funding for public hospitals.

Redirection of Unexpended Federal Waiver Funds. The May Revision also proposes to retain $109 million over two years in Redirected Safety Net Care Pool Funds intended to cover care for the uninsured. (These are federal funds that would otherwise reimburse public hospitals for a portion of the county funds that have already been expended to provide services to low-income Californians. Since no state general funds have been used to provide these services, and public hospitals already only receive $.50 for every dollar spent on these services, counties object to the state retaining these federal funds.

These proposals would further stress our county hospital and health systems, and we urge your reconsideration.

Sincerely,

Kelly Brooks-Lindsey
CSAC Legislative Representative

Jolena Voorhis
UCC Executive Director

Judith Reigel
CHEAC Executive Director

cc: Senator Elaine K. Alquist, Member, Senate Budget & Fiscal Review Subcommittee #3
Senator Bill Emmerson, Member, Senate Budget & Fiscal Review Subcommittee #3
Michelle Baass, Consultant, Senate Budget & Fiscal Review Subcommittee #3
Kirk Feeley, Republican Consultant, Senate Budget & Fiscal Review Subcommittee #3

Attachment Four

CSAC Memo: Coordinated Care Initiative

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

May 21, 2012

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: 2012-13 Budget Update: Coordinated Care Initiative

Background. The Governor's January budget contains a number of major policy changes within the Medi-Cal program aimed at improving care coordination, particularly for people receiving both Medi-Cal and Medicare.

- Dual Eligible Demonstration Projects: California is one of 15 states competitively selected by the federal Center for Medicare and Medicaid Services (CMS) to design "person-centered approaches to better coordinate care for Medicare-Medicaid enrollees." SB 208 (Chapter 714, Statutes of 2010) specifically authorizes pilot projects for integration of services to dual eligibles in four counties. Transitioning the dual eligible population into Dual Integration Demonstration projects presents challenging issues for the state and for counties. There are multiple complex issues that are distinct and inter-related and must be addressed up front in order to develop successful pilot programs.

  Existing law allows up to 4 demonstration sites to improve care coordination for individuals receiving both Medi-Cal and Medicare – known as dual eligibles. The Administration is proposing to expand the number of demonstration sites to 8. Projects are to begin March 1, 2013. The Duals Demonstration Project would expand the managed care benefits to include the In-Home Supportive Services (IHSS) program, as well as Multipurpose Senior Services Programs (MSSP), Community-Based Adult Services, and skilled nursing facility services.

(continued on next page)

The following is the list of the applications for the Dual Demonstration by county:

County	Managed Care Type	Application(s)
Alameda	Two-Plan Model	Alameda Alliance for Health Anthem Blue Cross
Los Angeles	Two-Plan Model	L.A. Care SCAN Health Plan Health Net
Orange	County Organized Health System	CalOptima
Riverside	Two-Plan Model	Inland Empire Health Plan Molina Healthcare SCAN Health Plan
San Bernardino	Two-Plan Model	Inland Empire Health Plan Molina Healthcare SCAN Health Plan
San Diego	Geographic Managed Care	Care 1st Community Health Group Health Net Molina Healthcare SCAN Health Plan*
San Mateo	County Organized Health System	Health Plan of San Mateo
Santa Clara	Two-Plan Model	Anthem Blue Cross Santa Clara Health Plan

**SCAN was not selected as a plan in San Diego County.*

On April 4, the Administration announced selection of the 4 counties authorized in current law – Los Angeles, Orange, San Diego and San Mateo.

As envisioned by the Governor, an additional 22 counties would have duals demonstration projects begin in 2014. The project would then be expanded to all counties in 2015.

The Administration prepared a project proposal, which was released for public comment, and submitted the proposal to the federal Center for Medicare and Medicaid Services (CMS). CMS will have 30 days to review and make changes the proposal. The state is hoping to have CMS approval by the end of June.

CMS is currently working with 15 states on Dual Demonstration projects. Thus far four other states, including New York, have asked to start their demonstration projects in 2014. The demonstration projects are going to require a high degree of coordination and information sharing across Medicaid and Medicare programs.

Related Proposals.

- Managed Care Expansion: The Administration is also proposing to expand managed care to the 28 counties currently without a Medi-Cal managed care plan beginning in June 2013.

- Long Term Care Services and Supports: The Administration is proposing to enroll all Medi-Cal beneficiaries (regardless of whether they are in a duals project) into managed care. The Administration is also proposing to make IHSS a managed care benefit, phasing the implementation to align it with the phase-in of the Duals Demonstration Project.

Budget Impacts.

Medicare Shared Savings. The Administration estimates $42 million in General Fund savings in 2012-13, $412 million in General Fund savings in 2013-14, and growing savings in out-years. To determine the Medicare Shared Savings, the Administration made the following assumptions (among others):

- The state will share savings 50:50 with the federal government.
- Inpatient hospital utilization will drop by 15 percent in 2012-13, 20 percent in 2013-14, 20 percent in 2014-15, and 20 percent in 2015-16.
- Skilled Nursing Facility (SNF) utilization will drop by 5 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16. This applies only to those enrollees not currently in a SNF.
- Physician utilization will increase by 4 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16.
- Pharmaceutical utilization will increase by 2 percent in 2012-13, 2 percent in 2013-14, 2 percent in 2014-15, and 2 percent in 2015-16.

CMS has indicated its intent to share Medicare savings with the state; however, it is unclear how these savings will be split. Almost half of the out-year savings (over $400 million General Fund) is attributable to sharing savings with Medicare. If CMS does not agree to share savings 50:50 with the state, there could be a major reduction in the savings achieved with this proposal.

General Fund Savings from Medicare Shared Savings (in millions)

	2012-13 (six months)	**2013-14**	**2014-15**	**2015-16**
Medicare Shared Savings	$42.1	$412.7	$556.1	$651.9

These assumptions are generally based on DHCS' rate development experience for Medi-Cal only SPDs transitioning from fee-for-service into managed care and reflect a two-year phase-in of savings for hospital and physician utilization.

Furthermore, DHCS assumes 1) managed care plans need time to gain experience with this new Medicare rate structure before they can achieve full savings, 2) a number of months of increased care coordination may need to take place before savings are achieved, and, 3) most of the savings from SNF utilization for this population are reflected in the proposal to integrate LTSS into managed care.

These project savings are similar to the experience of the Health Plan of San Mateo (HPSM) when it coordinated its care for high-risk Medicare Special Needs Plan members in 2008. According to HPSM's application to become one of the demonstration projects, it indicated

that its coordination of services for high-risk Medicare Special Needs Plan members revealed:

- A 45 percent decrease in the percent who had at least one non-psychiatric
- hospitalization;
- A 31 percent decrease in the percent who had at least one emergency room visit;
- An 11 percent decrease in the average length of stay; and
- A 42 percent decrease in the number of emergency room visits per member.

County Perspective. CSAC, along with the County Welfare Directors Association and the California Association of Public Authorities, offered a number of recommendations to inform the state's thinking about designing the ideal models for serving dual beneficiaries in the four pilot counties. Following are the critical recommendations to be considered.

Person-centered planning: IHSS should remain an entitlement to participants in the Duals Demonstration. IHSS consumers should retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select other individuals to also participate in their care planning.

IHSS Provider Wages and Benefits: In accordance with SB 208 and the waiver authority granted under the federal demonstration project, the Duals Demonstration should recognize the Public Authority as the employer for purposes of collective bargaining for individual providers. Additional training opportunities should be made available through the local Public Authority to IHSS consumers and providers under the Duals Demonstration.

Relationships to County IHSS Agencies: Integrating Entities should be required to contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS Administration. Integrating Entities should demonstrate their ability to work collaboratively with the County to define the level of services to be provided by the County. At minimum, county IHSS social worker staff will assess and authorize IHSS services and participate actively in local care coordination teams. Other options include having IHSS county staff perform care coordination on behalf of the Integrating Entity, and/or contracting with the County to establish local integration hubs that bring medical and social service providers together to coordinate care based on consumer needs.

In addition, IHSS services should continue to be authorized according to established statutory and regulatory guidelines, and include processes that allow information on the care needs of the clients to be shared between the County and the Integrating Entity and to ensure that services are aligned with the consumer's plan of care.

Financing. All pilot counties will continue to participate financially in IHSS costs. It is critical to not disrupt the current 1991 Realignment structure to prevent unwanted Proposition 98 challenges that, if successful, could cause the unintended consequence to shift funds away from current health, mental health and social service programs. There are various financial structures that could be established between the county and the Integrating Entity that would preserve the existing financing structure while ensuring counties partner financially in the demonstration. Given the unknown financial impact to county budgets, pilot counties'

costs in the demonstration should be negotiated and agreed to by the local Board of Supervisors to ensure that counties do not bear increased cost under the pilot.

CSAC sent a joint letter in March with CWDA, CAPA, Western Center, AARP, Disability Rights California and other consumer groups outlining our concerns with the Administration's aggressive timeframe and the overall proposal.

Counties are not opposed to the demonstration projects – we understand the importance of better coordinating and integrating care. However, expanding the duals project before getting data, outcomes and evaluation on the demonstration project is premature.

Further, moving IHSS into managed care presupposes the outcome of the pilots. The Legislative Analysts' Office (LAO) also released a report in February outlining a number of concerns that mirrors counties' concerns. The LAO report is attached.

County Share. The Administration is proposing that the county share of IHSS be part of the rates for the health plans. The Administration wants Department of Finance to negotiate a Maintenance of Effort (MOE) level for each county. The MOE would be based on how the IHSS program would have grown (caseload and utilization) absent the demonstration. The MOE would change if there are changes other than caseload and utilization changes (i.e. wages and/or benefits changes).

Additionally, the Administration and CMS are having discussions about how to align financing and outcomes in the behavioral health system. The state is exploring creating performance pools that would allow plans and counties to share in savings related to better coordinated care and better outcomes (such as reduced hospitalizations). At this point, this option that would be negotiated locally between county mental health and the health plans. However, there is not a lot of detail about how behavioral health will be addressed in the projects – other than behavioral health is part of the demonstration.

The Department of Health Care Services recently erected a Website to inform consumers and stakeholders on the status and process related to the Care Coordination Initiative. Please visit www.CalDuals.org for more information.

Attachment Five

CSAC Memo: 2011 Realignment Update: Implementation

CSAC Realignment Implementation Letter to the Legislature (May 8, 2012)

CSAC, CMHDA, CADPAAC, and CWDA Joint Comments on the HHS Programmatic Trailer Bills (May 15, 2012)

Reader's Guide to the 2011 Realignment Superstructure Trailer Bill

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

May 21, 2012

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: 2011 Realignment Update: Implementation

Background. In the May Revision, the Administration revised the funding allocations by program with updated caseload information and proposed trailer bill language to create a permanent funding structure for 2011 Realignment. The trailer bill was released on May 15; a revised version was released on May 17.

The updated allocation chart reflects changes to the base for the following programs in 2011-12:

- The allocation for Substance Abuse Treatment programs has increased by $3.9 million, from $179.7 to $183.6 million. These funds will be included in the Behavioral Health Subaccount beginning in 2012-13.
- The allocation for Foster Care, Child Welfare and Adult Protective Services increased by $5.1 million from $1,562.1 million to $1,567.2 million. These funds will be included in the Protective Services Subaccount beginning in 2012-13.

Additional changes include:

- The 2011-12 allocation for Existing Community Mental Health Programs is $1,083.6 million, which represents the amount that will be allocated to the Mental Health Account pursuant to the formula in statute for 2011-12. This amount is greater than the $1,068.8 million that is now estimated to have been available for Mental Health in 2011-12 under 1991-92 Realignment.
- The 2012-13 allocation for Existing Community Mental Health Programs is $1,120.6 million, which represents the amount that is estimated to otherwise have been available for Mental Health is 2012-13 under 1991-92 Realignment. Although this is less than the $1,164.4 million reflected in the Governor's Budget, Mental Health programs have a dedicated growth account in the new ongoing funding structure. These programs will also continue to receive any Mental Health growth resulting from 1991-92 Realignment.
- The allocations for Early and Periodic Screening, Diagnosis and Treatment program and the Mental Health Managed Care program have increased by $48.1 million, from $732.8 to $780.9 million. Please recall that the 2012-13 funding level establishes the base for these programs and these programs will be included in the Behavioral Health Subaccount beginning in 2012-13.
- The allocation for Foster Care and Child Welfare Services now changes from year-to-year from 2012-13 through 2014-15. This reflects the costs for counties to expand foster care benefit eligibility up to age 21 as authorized by Chapter 559, Statutes of 2010 (AB 12) for a cumulative increase of $53.9 million. These funds are included in the Protective Services Subaccount and will be phased in over a three-year period beginning in 2012-13.

Below is an updated funding chart. Compared to the program allocation and funding chart included in the January Budget, the 2011-12 and 2012-13 funding level for several programs has increased.

2011 Realignment Funding
($ in millions)

Program	2011-12	2012-13	2013-14	2014-15
Court Security	$496.4	$496.4	$496.4	$496.4
Public Safety Programs	489.9	489.9	489.9	489.9
Local Jurisdiction for Lower-level Offenders and Parole Violators				
Local Costs	239.9	581.1	759.0	762.2
Reimbursement of State Costs	989.9	-	-	-
Realign Adult Parole				
Local Costs	127.1	276.4	257.0	187.7
Reimbursement of State Costs	262.6	-	-	-
Mental Health Services				
EPSDT	-	584.2	584.2	584.2
Mental Health Managed Care	-	196.7	196.7	196.7
Existing Community Mental Health Programs	1,083.6	1,120.6	1,120.6	1,120.6
Substance Abuse Treatment	183.6	183.6	183.6	183.6
Foster Care and Child Welfare Services				1,621.1
Adult Protective Services	55.0	55.0	55.0	55.0
Existing Juvenile Justice Realignment	97.1	98.8	98.8	98.8
Program Cost Growth	-	221.7	456.6	1,014.7
TOTAL	**$5,592.3**	**$5,889.8**	**$6,303.6**	**$6,810.9**
1.0625% Sales Tax	5,152.9	5,434.7	5,840.3	6,339.8
Vehicle License Fee Funds	439.4	455.1	463.6	471.1
TOTAL Revenues	**$5,592.3**	**$5,889.8**	**$6,303.6**	**$6,810.9**

Materials. We have attached a number of documents, including:

- CSAC Realignment Implementation Letter (May 8, 2012)
- CSAC, CMHDA, CADPAAC and CWDA joint comments on the HHS programmatic Trailer Bills (May 15, 2012)
- Reader's Guide to the 2011 Realignment Superstructure Trailer Bill

California State Association of Counties

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

May 8, 2012

The Honorable Members
California State Senate
State Capitol
Sacramento, CA 95814

The Honorable Members
California State Assembly
State Capitol
Sacramento, CA 95814

Re: **Implementation of 2011 Realignment**

Dear Senators and Assembly Members:

On behalf of the California State Association of Counties (CSAC), we write to express our commitment to successful implementation of 2011 Realignment. We sincerely appreciate your partnership with counties to construct a realignment plan that balances state needs, county needs, and the needs of the Californians we mutually serve.

In 2011, counties identified many risks with embarking on a realignment that would shift nearly $6 billion in additional responsibilities to counties. However, Governor Brown's principles for realignment – including an emphasis on local control and flexibility – coupled with his commitment to proceed with a constitutional amendment, guaranteeing funding and protecting the realigned programs from increased costs, helped bring counties to a place of support for realignment.

As you know, when the Legislature passed the 2011 Realignment package, the funding structure was solely for the 2011-12 fiscal year. We have been working with counties and the Administration to craft a permanent fiscal structure, allocate funds among accounts and subaccounts, allocate funds among counties, and craft appropriate local flexibilities. That work is ongoing. Counties are working closely with the Legislature to put a permanent structure into place. As realignment discussions proceed, counties would like to highlight our priorities to ensure 2011 Realignment is implemented successfully.

Constitutional Protections

The framework for the 2011 Realignment would not be workable without the constitutional amendment and its accompanying protections. Counties sought constitutional protections that offered appropriate revenue stability and predictability, program certainty and flexibility, and an acceptable level of fiscal risk. The constitutional amendment includes many important elements outlined below.

Revenue Protection and Predictability. The constitutional amendment guarantees ongoing funding for the realigned programs, while giving the Legislature flexibility to change the revenue source(s) in the future – as long as they are replaced with revenues equal to or greater than what the specified portions of sales and use tax and Vehicle License Fees would have produced. The funds are continuously appropriated.

Federal law changes. Counties must receive funding for federal law changes – including federal statutes, regulations or directives. It is too great a risk for counties to assume in full the entire responsibility for future federal law changes under the proposal where counties will assume a 100 percent share of cost for many federal entitlement programs.

Judicial decisions. Similarly, judicial outcomes that create new programs, higher levels of service, or additional costs also pose a significant financial risk to counties. Counties must receive funding for judicial outcomes that impose costs; of course, if the outcome is the result of a county action or inaction, we accept responsibility. Again, it is simply too great a risk for counties to take under realignment with counties assuming a 100 percent share of cost for many federal entitlement programs.

State Legislation. The constitutional amendment creates an obligation for the state to pay for higher costs resulting from new legislation. If the Legislature does not appropriate funds, counties are relieved of the responsibility to provide the enhanced service. One of the counties' lessons learned from the 1991 Realignment is that realigned programs change over time. One such example is the In-Home Supportive Services (IHSS) program. In 1991, the IHSS program was a state-only program with a non-unionized workforce. Today, IHSS is a federal Medicaid program with a collective bargaining mandate. While the changes to the IHSS program over the last 20 years have greatly increased access to the program, the changes also increased costs to a degree not originally envisioned when the 1991 realignment fiscal structure was developed.

Local Control and Flexibility

Our members strongly believe in Governor Brown's principle of bringing government closer to the people. Governor Brown outlined a number of principles underpinning his public safety realignment, including providing more flexibility at the local level, reducing duplication and overlap, and building on previous success.

There is a strong commitment among counties to improving public safety outcomes. Counties genuinely believe that we can do better than the state has done in providing services to the population leaving state prison and to reducing recidivism. The Legislature provided appropriate flexibilities to allow counties to implement the public safety realignment in a manner that best addresses local needs.

The Legislature cannot offer similar flexibilities with the health and human services programs included in 2011 Realignment because many of these programs are federal

entitlement programs, with strict federal requirements. The fiscal structure becomes critical on the health and human services side because the Legislature cannot relax federal rules. The Administration has proposed two subaccounts on the health and human services side – a Protective Services Subaccount (social services programs) and a Behavioral Health Subaccount (mental health and alcohol and drug programs). Counties will have the flexibility to allocate funds among the programs within each subaccount.

Additionally, the structure on the health and human services side replicates a flexibility found in the 1991 Realignment – the ability to transfer 10 percent of funds across subaccounts once per year. It is absolutely critical that this flexibility be part of the 2011 Realignment. It will allow counties to move funds in situations where caseloads may be declining within one subaccount, while increasing in the other subaccount.

There are additional places where the Legislature can offer limited flexibilities on the health and human services side, including making some of the social services programs optional. Counties are supportive of this flexibility and look forward to engaging with the Legislature and other stakeholders in these discussions.

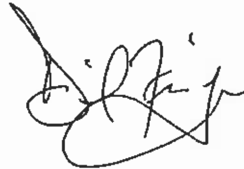
There also appears to be additional interest in expanding the role and scope of state oversight of the health and human services programs. While counties understand that the state must demonstrate to the federal government appropriate oversight mechanisms since the state is the single state agency, very little has changed with the programs – other than the source of funding. The state has existing oversight mechanisms for all of the health and human services programs. It is not clear what authority state departments currently lack that would impede their appropriate oversight of counties. Further, health and human services programmatic realignment trailer bills need to approach the state-county relationship and the state's oversight role in a consistent manner across the realigned programs. Some advocacy organizations may suggest that separating the programs into separate subaccounts is an answer to state oversight. Putting all the funding streams back into their original silos does nothing to increase state oversight and would create an administrative nightmare and time-consuming operational complexities at the county level – which, ultimately, would drain resources that should be dedicated to program delivery. Counties will be engaging the Legislature and the Administration about the appropriate state oversight mechanisms in discussions over budget trailer bill language.

In conclusion, CSAC remains committed to ensuring successful implementation on the 2011 Realignment. We will continue to work with the Administration and the Legislature in a cooperative manner to address these and other critical issues as they arise. To be clear, the 2011 Realignment will fail without appropriate local control and flexibility and without constitutional protections. We look forward to crafting a permanent realignment structure that addresses outstanding county concerns.

Counties are committed to a partnership to reshape government that offers services and supports for all Californians. Once again, thank you for your demonstrated commitment to the partnership between the State and counties.

Respectfully,

Mike McGowan
President, CSAC
Yolo County Supervisor

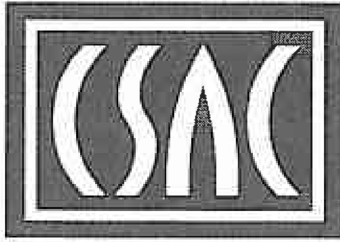


David Finigan
1st Vice President, CSAC
Del Norte County Supervisor

John Gioia
2nd Vice President, CSAC
Contra Costa County Supervisor

John Tavaglione
Immediate Past President, CSAC
Riverside County Supervisor

cc: Governor Jerry Brown
Nancy McFadden, Executive Secretary, Office of Governor Brown
Ana Matosantos, Director, Department of Finance
Diane Cummins, Special Advisor to the Governor
Craig Cornett, Chief Fiscal Advisor, Senate President Pro Tempore Steinberg
Keely Bosler, Staff Director, Senate Budget and Fiscal Review Committee
Seren Taylor, Director, Senate Republican Fiscal
Chris Woods, Budget Director, Assembly Speaker Pérez
Christian Griffith, Chief Consultant, Assembly Budget Committee
Eric Swanson, Director, Assembly Republican Fiscal



May 15, 2012

The Honorable Mark DeSaulnier
Chair, Senate Budget & Fiscal Review Subcommittee No. 3
State Capitol, Room
Sacramento, CA 95814

Re: Realignment Trailer Bill Language – Comments

Dear Senator DeSaulnier:

The California State Association of Counties (CSAC), the California Mental Health Directors Association (CMHDA), the County Alcohol and Drug Administrators Association of California (CADPAAC), and the County Welfare Directors Associations (CWDA) are writing to express our interest in ensuring consistency among each of the health and human services programmatic Realignment 2011 trailer bills that were released on April 27 (Issues 1004, 1005, and 1006).

Since the Department of Finance released the three health and human services programmatic trailer bills, we have endeavored to closely review each in order to understand relevant policy implications. However, during our review, it became clear that the three measures lacked a cohesive approach to the state-county relationship and the state's oversight role across the realigned programs, which we believe is critical to successfully implementing 2011 Realignment. Below is a description of the issues we believe the Administration and Legislature must address in the Realignment 2011 programmatic trailer bills for health and human services.

County Role in Federal Waivers and State Plan Amendments
Counties recommend that all three trailer bills include language requiring the administering state departments to consult with counties prior to submitting federal waivers or state plan amendments. Currently, the alcohol and drug trailer bill (#1005) requires prior consultation with counties on proposed federal waivers and state plan amendments pertaining to Drug Medi-Cal (Welfare and Institutions Code Section 14124.24 (b). However, the other two trailer bills do not contain similar language.

Counties recommend that a similar provision be included in appropriate code sections in the other two trailer bills. Under Realignment 2011, where counties are responsible for 100% of the share of cost for federal programs, it is imperative that we are at the table when policy and/or fiscal changes to these programs are proposed. In fact, the Governor's May Revision indicates that the state is committed to *assisting counties* if federal state plan amendments, waivers, or other flexibilities are needed in assisting counties to meet their responsibilities for realigned programs.

Rule-Making Authority

With respect to the state departments abilities to implement regulations and administrative policies related to the realigned programs, we found significant inconsistencies across the three trailer bills on the proposed methods and timelines of that rule-making authority. In most cases, the trailer bills would give the state departments broad authority to implement realignment legislation via All County Letters (ACLs) or similar instructions, and then to adopt regulations thereafter. However, the three departments give themselves different timelines:

- The alcohol and drug trailer bill (#1005) allows the state to adopt regulations until July 1, 2014.
- The social services trailer bill (#1006) allows the state a 24-month timeline on rule-making authority, beginning the clock once an All County Letter is released.
- The mental health trailer bill (#1006) does not even specify a timeline for the implementation of pertinent regulation and policy.

DHCS provides itself sweeping authority to utilize non-regulatory methods to establish requirements and sanctions. Specifically, two of the Administration's mental health trailer bills (#1006 and #614) authorize DHCS to impose monetary sanctions – and to choose not to renew its contract — if a county Mental Health Plan fails to comply with statutes, regulations, or "similar instructions." Additionally, the trailer bills would authorize DHCS to use regulations or "other similar instructions" in the establishment of a process for resolution of disputes about claims or recoupments of funds. We believe legislative and regulatory methods – not administrative directives – should be used to describe and authorize the imposition of administrative remedies that could result in the loss of counties' financial resources for realigned Medi-Cal Specialty Mental Health services. The state's legislative and regulatory rulemaking processes offer transparency and provide vital opportunities for public notice and participation. The rulemaking authority provided in the alcohol and drug trailer bill (#1005) is far preferable (Section 11798 subdivision l).

In the interest of efficiently implementing 2011 realignment with a consistent approach across the realigned health and human services programs, counties respectfully request clear parameters around the state's rule-making authority, including the mode and methods of rule-making, notification procedures, and a date certain for policy implementation. This will assist the state and counties by providing a clear roadmap for implementation of this ambitious shift of programs.

Financial Authorities
The state departments provide themselves authority to collect state-imposed penalties by siphoning funds out of 2011 realignment funds. This is completely inappropriate. The 1991 realignment structure does not provide the state with any authority to access realignment funds. The Governor's constitutional amendment clearly designates the realignment funds as local revenues. Counties object to providing mechanisms in statute for the state to access these local funds for fines, penalties or overpayments. Additionally, all references to penalty sharing or transference in the programmatic trailer bills should be deleted because penalties are addressed in the fiscal structure trailer bill.

Oversight of Programs
There appears to be interest in expanding the role and scope of state oversight of the realigned health and human services programs. While counties understand that the state must demonstrate to the federal government appropriate oversight mechanisms since the state is the single state agency, Realignment 2011 has changed very little about the programs – other than the source of funding. The state already maintains a comprehensive statutory framework for oversight mechanisms for each of the realigned health and human services programs. It is not clear what oversight authority the state currently lacks that would impede its appropriate oversight of county-run realignment programs.

The proposed trailer bill makes significant changes to the existing California Child and Family Services Review (C-CFSR), established under AB 636 (Steinberg, Statutes of 2001). Counties have several concerns with the use of performance thresholds as a device to judge county performance for a number of reasons. First, differences across counties make performance thresholds difficult to predict and plan for. Second, setting thresholds can be misleading and drive performance in undesired ways. Improvement in one measure may also have a negative impact on another measure. For example, improvements in the timeliness to reunification measure may have a negative impact on re-entries. Finally, achievement of performance targets can be undermined when other federal and state programs that support child welfare families are cut, such as CalWORKs, Medi-Cal, Developmental Services, housing supports, and mental health.

The C-CFSR system can and should continue to be used to facilitate state oversight. Counties currently set improvement targets and the state now monitors county outcome performance on a continuous basis. If a county persistently fails to implement the action steps it identifies in its System Improvement Plan (SIP), the state currently provides the county with technical assistance to help achieve its SIP plan. The AB 636 process should also be the mechanism where the state and counties identify any changes to the county's SIP to ultimately bring the county into compliance. The existing C-CFSR process must be the driver for the child welfare accountability system, with the county continuing to work with the state to establish targets for improvement.

Finally, all language that would expand the state's oversight and/or auditing authority related to non-realigned programs should be removed from all trailer bills. It is inappropriate for a department to be seeking to increase its authority with respect to non-realigned programs in the context of the realignment legislation.

CSAC and counties remain committed to ensuring successful implementation of 2011 Realignment, including securing the necessary constitutional protections for counties in this new landscape. In the meantime, we are working diligently to ensure that the implementing legislation and trailer bill language is intelligent, efficient, consistent, and implementable. To that end, we respectfully request that the Administration and Legislature consider making the above suggested changes to draft trailer bill language. These changes will reduce uncertainty, avoid complications, and increase efficiency for both the state and counties in the coming years.

We will continue to work with the Administration and the Legislature in a cooperative manner to address these and other critical issues as they arise. We look forward to crafting a permanent realignment structure that addresses outstanding county concerns and ensures the success of the 2011 Realignment.

Sincerely,

Kelly Brooks-Lindsey
CSAC, Legislative Representative

Patricia Ryan
CMHDA, Executive Director

Tom Renfree
CADPAAC, Executive Director

Frank Mecca
CWDA, Executive Director

cc: Members, Senate Budget & Fiscal Review Subcommittee No. 3
Michelle Baass, Consultant, Senate Budget & Fiscal Review
Jennifer Troia, Consultant, Senate Budget & Fiscal Review
Joe Stepinshaw, Consultant, Senate Budget & Fiscal Review
Diane Van Maren, Consultant, Senate President Pro Tempore Steinberg
Myesha Jackson Consultant, Senate President Pro Tempore Steinberg
Kirk Feely, Consultant, Senate Republican Fiscal
Chantele Denny, Consultant, Senate Republican Fiscal
Diane Cummins, Special Advisor, Department of Finance
Michael Wilkening, Undersecretary, California Health & Human Service Agency
Vanessa Baird, Deputy Director, Behavioral Health, Department of Health Care Services
Will Lightbourne, Director, Department of Social Services
Michael Cunningham, Acting Director, Department of Alcohol and Drug Programs
Kathy Gaither, Chief Deputy Director, Department of Mental Health

Section	Purpose
	CREATING THE FUNDS

Govt Code §30025
pp. 1-12
	Creates the funds at the state level for 2012-13 and beyond.
	
	As of September 30, 2012, abolishes the accounts and subaccounts created in the Local Revenue Fund 2011 at the state level in 2011-12, except the Mental Health Account, the Undistributed Account and the Reserve Account. As of December 31, 2012 the Undistributed Account and the Reserve Account are abolished.
	
	Local Revenue Fund 2011 with the following permanent structure for account, subaccounts and special accounts:
	
	Support Services Account
	▪ Protective Services Subaccount
	▪ Behavioral Health Subaccount
	▪ County Intervention Support Services Subaccount
	
	Law Enforcement Services Account
	▪ Trial Court Security Subaccount
	▪ Enhancing Law Enforcement Activities Subaccount
	    ➢ Enhancing Law Enforcement Activities Special Growth Account (i.e., local public safety subventions)
	▪ Community Corrections Subaccount
	▪ DA/PD Subaccount
	▪ Juvenile Justice Subaccount
	    ➢ Youthful Offender Block Grant Special Account
	    ➢ Juvenile Reentry Grant Special Account
	
	Sales and Use Tax Growth Account
	▪ Support Services Growth Subaccount
	    ➢ Protective Services Growth Special Account
	    ➢ Behavioral Health Growth Special Account
	▪ Law Enforcement Services Growth Subaccount
	    ➢ Trial Court Security Growth Special Account
	    ➢ Community Corrections Growth Special Account
	    ➢ DA/PD Growth Special Account
	    ➢ Juvenile Justice Growth Special Account

<table>
<tr><th>Section</th><th>Purpose</th></tr>
<tr><td></td><td>Provides for the transfer of funds from 2011-12 accounts and subaccounts to the permanent accounts, subaccounts, and special accounts on September 15, 2012. Old accounts are deleted on September 30, 2012.

Similarly, changes the account structure at the local level. The County Local Revenue Fund 2011 includes the following:

Support Services Account
▪ Protective Services Subaccount
▪ Behavioral Health Subaccount
▪ Support Services Reserve Subaccount (local option)

Law Enforcement Services Account
▪ Trial Court Security Subaccount
▪ Enhancing Law Enforcement Activities Subaccount
▪ Community Corrections Subaccount
▪ DA/PD Subaccount
▪ Juvenile Justice Subaccount
    ➢ Youthful Offender Block Grant Special Account
    ➢ Juvenile Reentry Grant Special Account
▪ Innovation Subaccount (funds deposited in 2015-16)

Transferability. Includes transfer (called reallocation) provisions similar to 1991 between the Protective Services and Behavioral Health Subaccounts [paragraphs (f)(1)(D)(i-v). The language mirrors Welfare & Institutions Code § 17600.20. Clarifies the reallocation is for one fiscal year and is not a permanent funding source.

Local Reserve. Board of Supervisors may optionally create a Support Services Reserve Subaccount. The Reserve Subaccount is capped at 5% of the total funds allocated to the Protective Services and Behavioral Health Subaccounts in a given fiscal year. Funds are to be used only for programs funded by the two subaccounts. Requires documentation to be submitted to the Controller annually. [paragraphs (f)(1)(F)(i-ii)].

Provides for the transfer of funds from 2011-12 county accounts and subaccounts to the permanent accounts, subaccounts, and special accounts on September 15, 2012.</td></tr>
</table>

Section	Purpose
	Creates a Local Innovation Subaccount in the local Law Enforcement Services Account. Boards of Supervisors have the authority to spend funds in the Local Innovation Subaccount as they would funds in any of the other law enforcement subaccounts, with the exception of the Enhancing Law Enforcement Activities Subaccount. Adds Medi-Cal specialty mental health services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and mental health managed care, to the programs within the Behavioral Health Subaccount. Clarifies that the existing 10% county match for EPSDT growth is not an eligible expense from the Behavioral Health Subaccount. Provides all funds from the state Reserve Account be disbursed by December 1, 2012. Provides all funds from the Undistributed Account be disbursed by December 1, 2012.
Govt Code § 30026 p. 12	Clarifies that the newly created Community Corrections Subaccount and the Community Corrections Growth Special Account shall be used to fund AB 109.
	MANDATES, PROTECTIONS, ETC.
Govt Code § 30726.5 pp. 12-17	This section generally includes a number of the provisions from the constitutional amendment negotiated with the Brown Administration. There is some additional language, as well. (a) Identical to constitutional amendment (b) New language. The Administration is trying to clarify that if anything in 2011 Realignment is declared a mandate that the funds provided for are intended to cover the costs of the mandate. The subparagraphs are intended to direct counties to use funds from the accounts and subaccounts to pay for mandates unless the Subaccount funding is insufficient. (c) Identical to constitutional amendment (d) Similar to constitutional amendment. Adds cross-reference back to (b). (e) Similar to constitutional amendment. Adds cross-reference back to (b). (f) New language. Requires that if a Board of Supervisors adopts significant cuts to optional or discretionary programs, then they shall do so in a noticed public meeting. Defines significant cuts as 10% in one year or 25% over three years. This section applies to behavioral health programs or adult protective services. For the other optional or discretionary services funded from the Protective Services Subaccount, counties shall follow the public notification articulated in statute [in the DSS realignment TBL]. (g) This section creates the shares of cost for the HHS programs without enactment of the constitutional amendment. Also clarifies that counties are to use 2011 Realignment funds before using county General Fund on realigned programs if they are determined to be state mandates.

Section	Purpose
	(h) Creates the shares of costs for the HHS programs if the constitutional amendment is enacted. (i) Provides direction to the Controller about posting revenues and disbursements related to 2011 Realignment. (j) Clarifies that 2011 Realignment does not affect rights provided by federal entitlement programs. 2011 Realignment does not place additional restrictions on eligibility, coverage or access to services and care for any federal or state entitlement. (k) Continues counties' existing 10% match on EPSDT growth and clarifies that the match shall come from a funding source other than the Local Revenue Fund 2011. (l) Provides that if the constitutional amendment passes, all subdivisions except (f), (h) and (i) are eliminated.
	ALLOCATING FUNDS TO THE STATE ACCOUNTS
Govt Code §30027 pp. 17-18	Allocates funds to the appropriate state accounts and subaccounts in 2011-12 and clarifies that the fiscal year includes the cash received in July and August 2012.
Govt Code §30027.5 pp. 18-21	Provides for the allocation of funds for the 2012-13 fiscal year to state accounts, subaccounts, and special accounts. ▪ Allocates $93,379,252 in sales tax to the Mental Health Account of the Local Revenue Fund 2011. ▪ Allocates $489.9 million in VLF to the Enhancing Law Enforcement Activities Subaccount. ▪ Allocates sales tax to the Support Services (64.1975% or $2.604 billion) and Law Enforcement Services Accounts (35.8025% or $1.452 billion). ▪ If revenues come in below projections, the funds are disbursed proportionally between the Support Services and Law Enforcement Services Accounts. ▪ If revenues come in above the base amount for each account, the funds are deposited into the Sales and Use Tax Growth Account. ▪ If there are not sufficient VLF revenues to provide $489.9 million to the Enhancing Law Enforcement Activities Subaccount, then sales tax revenues from the Local Revenue Fund are used to make up the difference. ▪ Allocates funds to the Law Enforcement Services Account and its corresponding Subaccounts and Special Accounts. ➢ 34.1721% up to $496,429,000 to Trial Court Security Subaccount ➢ 58.0217% up to $842,900,000 to Community Corrections Subaccount ➢ 1.0050% up to $14.6 million to the DA/PD Subaccount ➢ 6.8012% up to $98,804,000 to Juvenile Justice Subaccount ▪ Allocates funds to the Support Services Account and its subaccounts. ➢ 37.0264% up to $964,500,000 to the Behavioral Health Subaccount ➢ 62.9736% up to $1,640,400,000 to the Protective Services Subaccount
Govt Code §30027.6 pp. 21-23	Provides for the allocation of funds for the 2013-14 fiscal year to state accounts, subaccounts, and special accounts.

Section	Purpose
	▪ Requires DOF to submit a schedule to the Controller that includes prior year base and growth calculations and revised allocations. ▪ Allocates $93,379,252 in sales tax to the Mental Health Account of the Local Revenue Fund 2011. ▪ Allocates $489.9 million in VLF to the Enhancing Law Enforcement Activities Subaccount. ▪ Allocates sales tax to the Support Services and Law Enforcement Services Accounts. ➢ Support Services = amounts allocated in the prior FY + $20.368 million + total support services growth ➢ Law Enforcement = amount allocated in the prior FY + $158.5 million + Trial Court Security and Juvenile Justice Growth Special Accounts in 2012-13 ▪ If revenues come in below projections, the funds are disbursed proportionally between the Support Services and Law Enforcement Services Accounts. ▪ If revenues come in above the base amount for each account, the funds are deposited into the Sales and Use Tax Growth Account. ▪ If there are not sufficient VLF revenues to provide $489.9 million to the Enhancing Law Enforcement Activities Subaccount, then sales tax revenues from the Local Revenue Fund are used to make up the difference. ▪ Allocates funds to the Law Enforcement Services Account and its corresponding Subaccounts and Special Accounts. ➢ 30.8105% up to totals received in 2012-13 to Trial Court Security Subaccount ➢ 61.9960% up to $998.9 million to Community Corrections Subaccount ➢ 1.0613% up to $17.1 million to DA/PD Subaccount ➢ 6.1322% up to totals received in 2012-13 to Juvenile Justice Subaccount ▪ Allocates funds to the Support Services Account and its subaccounts. ➢ 36.7391% up to total amount received in 2012-13 for Behavioral Health Subaccount ➢ 63.2609% up to the total amount received in 2012-13 plus $20.368 million
Govt Code §30027.7 pp. 24-26	Provides for the allocation of funds for the 2014-15 fiscal year to state accounts, subaccounts, and special accounts. ▪ Requires DOF to submit a schedule to the Controller that includes prior year base and growth calculations and revised allocations. ▪ Allocates $93,379,252 in sales tax to the Mental Health Account of the Local Revenue Fund 2011. ▪ Allocates $489.9 million in VLF to the Enhancing Law Enforcement Activities Subaccount. ▪ Allocates sales tax to the Support Services and Law Enforcement Services Accounts. ➢ Support Services = amounts allocated in the prior FY + $15.333 million + total support services growth ➢ Law Enforcement = amount allocated in the prior FY - $66.1 million + Trial Court Security and Juvenile Justice Growth Special Accounts in 2012-13 ▪ If revenues come in below projections, the funds are disbursed proportionally between the Support Services and

Section	Purpose
	Law Enforcement Services Accounts. ▪ If revenues come in above the base amount for each account, the funds are deposited into the Sales and Use Tax Growth Account. ▪ If there are not sufficient VLF revenues to provide $489.9 million to the Enhancing Law Enforcement Activities Subaccount, then sales tax revenues from the Local Revenue Fund are used to make up the difference. ▪ Allocates funds to the Law Enforcement Services Account and its corresponding Subaccounts and Special Accounts. ➢ 32.1286% up to totals received in 2013-14 to Trial Court Security Subaccount ➢ 60.4543% up to $934.1 million to Community Corrections Subaccount ➢ 1.0226% up to $15.8 million to DA/PD Subaccount ➢ 6.3945% up to totals received in 2013-14 to Juvenile Justice Subaccount ▪ Allocates funds to the Support Services Account and its subaccounts. ➢ 36.5258% up to total amount received in 2013-14 for Behavioral Health Subaccount ➢ 63.4742% up to the total amount received in 2013-14 plus $15.333 million
Govt Code §30027.8 pp. 26-29	Provides for the allocation of funds for the 2015-16 fiscal year and every fiscal year after to state accounts, subaccounts, and special accounts. ▪ Requires DOF to submit a schedule to the Controller that includes prior year base and growth calculations and revised allocations. ▪ Allocates $93,379,252 in sales tax to the Mental Health Account of the Local Revenue Fund 2011. ▪ Allocates $489.9 million in VLF to the Enhancing Law Enforcement Activities Subaccount. ▪ Allocates sales tax to the Support Services and Law Enforcement Services Accounts. ➢ Support Services = amounts allocated in the prior FY plus Support Services Growth Subaccount deposits ➢ Law Enforcement Services = amounts allocated in the prior FY plus Law Enforcement Services Growth Subaccount deposits ▪ If revenues come in below projections, the funds are disbursed proportionally between the Support Services and Law Enforcement Services Accounts. ▪ If revenues come in above the base amount for each account, the funds are deposited into the Sales and Use Tax Growth Account. ▪ If there are not sufficient VLF revenues to provide $489.9 million to the Enhancing Law Enforcement Activities Subaccount, then sales tax revenues from the Local Revenue Fund are used to make up the difference. ▪ Allocates funds to the Law Enforcement Services Account and its corresponding Subaccounts and Special Accounts.

Section	Purpose
	➢ Totals received in the prior year to Trial Court Security Subaccount and Growth Special Account ➢ Totals received in the prior year to Community Corrections Subaccount and Growth Special Account ➢ Totals received in the prior year to DA/PD Subaccount and Growth Special Account ➢ Totals received in the prior year to Juvenile Justice Subaccount and Growth Special Account If there are insufficient funds, Controller allocates funding based on the proportional share each subaccount received in the previous fiscal year. ▪ Allocates funds to the Support Services Account and its subaccounts. ➢ Total received in the Behavioral Health Subaccount and Growth Special Account in the prior fiscal year ➢ Total received in the Protective Services Subaccount and Growth Special Account in the prior fiscal year If there are insufficient funds, Controller allocates funding based on the proportional share each subaccount received in the previous fiscal year.
Govt Code §30027.9 pp. 29-34	**Growth Allocations.** 2012-13 For 2012-13, allocations from the Sales and Use Tax Growth Account: 65% to the Support Services growth Subaccount and 35% to the Law Enforcement Services Subaccount. 2013-14 For 2013-14, first allocate Sales and Use Tax Growth funds to the Support Services Account and the Law Enforcement Services Account the "amounts necessary to provide full base funding or the appropriate level of funding as described in this act." If there are insufficient funds to fully fund the subaccounts, distribute on the same proportion as the two accounts received from the Local Revenue Fund 2011 in 2013-14. Once a prior year base shortfall is addressed, allocate 65% to the Support Services growth Subaccount and 35% to the Law Enforcement Services Subaccount. Defines the "amount necessary to provide the appropriate level of funding" for the Law Enforcement Services Account as: ▪ The greater of the amounts that either the predecessor of the Trial Court Subaccount received in 2011-2 OR the total amount the Trial Court Subaccount and its Growth Special Accounts received in 2012-13, plus ▪ The greater of the amounts that either the predecessor of the Juvenile Justice Subaccount received in 2011-2 OR the total amount the Juvenile Justice Subaccount and Its Growth Special Accounts received in 2012-13, plus ▪ The maximum amount permitted to be allocated to the Community Corrections Subaccount, plus ▪ The maximum amount permitted to be allocated to the DA/PD Subaccount.

Section	Purpose
	Defines the "amount necessary to provide the appropriate level of funding" for the Support Services Account as: ▪ The maximum amount permitted to be allocated to the Behavioral Health Subaccount, plus ▪ The maximum amount permitted to be allocated to the Protective Services Subaccount. <u>2014-15</u> For 2014-15, first allocate Sales and Use Tax Growth funds to the Support Services Account and the Law Enforcement Services Account the "amounts necessary to provide full base funding or the appropriate level of funding as described in this act." If there are insufficient funds to fully fund the subaccounts, distribute on the same proportion as the two accounts received from the Local Revenue Fund 2011 in 2014-15. Once a prior year base shortfall is addressed, allocate 65% to the Support Services growth Subaccount and 35% to the Law Enforcement Services Subaccount. Defines the "amount necessary to provide the appropriate level of funding" for the Law Enforcement Services Account as: ▪ The greater of the amounts that either the Trial Court Subaccount and its growth special account received in a single fiscal year since 2012-13 OR the amount applicable predecessor account received in 2011-12, plus ▪ The greater of the amounts that either the Juvenile Justice Subaccount and its growth special account received in a single fiscal year since 2012-13 OR the amount applicable predecessor account received in 2011-12, plus ▪ The greatest amount received by the Community Corrections Subaccount in a single year since 2012-13, plus ▪ The greatest amount received by the DA/PD Subaccount in a single year since 2012-13. Defines the "amount necessary to provide the appropriate level of funding" for the Support Services Account as: ▪ The greater of either the maximum amount that could be allocated OR the largest amounts actually received by to the Behavioral Health Subaccount and its special growth account in a single year since 2012-13, plus ▪ The greater of either the maximum amount that could be allocated OR the that should have been allocated to the Protective Services Subaccount. <u>2015-16</u> For 2015-16 and beyond, first allocate Sales and Use Tax Growth funds to the Support Services Account and the Law Enforcement Services Account the "amounts necessary to provide full base funding as described in this act." If there are insufficient funds to fully fund the subaccounts, distribute on the same proportion as the two accounts received from the Local Revenue Fund 2011 in the fiscal year at issue. Once a prior year base shortfall is addressed, allocate 65% to the Support Services growth Subaccount and 35% to the Law Enforcement Services Subaccount.

Section	Purpose
	Defines the "amount necessary to provide the appropriate level of funding" for the Law Enforcement Services Account as: ▪ The greater of the amounts that either the Trial Court Subaccount and its growth special account received in a single fiscal year since 2012-13 OR the amount applicable predecessor account received in 2011-12, plus ▪ The greater of the amounts that either the Juvenile Justice Subaccount and its growth special account received in a single fiscal year since 2012-13 OR the amount applicable predecessor account received in 2011-12, plus ▪ The greatest amount received by the Community Corrections Subaccount and its growth special account received in a single fiscal year since 2014-15 OR the highest amount he Subaccount or its applicable predecessor received since 2012-13, plus ▪ The greatest amount received by the DA/PD Subaccount and its growth special account received in a single fiscal year since 2014-15 OR the highest amount he Subaccount or its applicable predecessor received since 2012-13. Defines the "amount necessary to provide the appropriate level of funding" for the Support Services Account as: ▪ The greater of either the maximum amount that could be allocated OR the largest amounts received by the Behavioral Health Subaccount and its special growth account in a single year since 2012-13, plus ▪ The greatest of the following 3 options: (1) maximum amount that could be allocated, (2) amount that should have been allocated, or (3) highest amount received by the Protective Services Account and its growth special account in a single year since 2012-13. **Law Enforcement Growth Allocations** 2012-13 ▪ 10% to Trial Court Security Growth Special Account ▪ 5% to DA/PD Growth Special Account ▪ 10% to Juvenile Justice Growth Special Account ▪ 75% to Community Corrections Growth Special Account Beginning in 2013-14, for Trial Court Security and the Juvenile Justice Account base + growth = new base. The DA/PD and Community Corrections Growth subaccounts, base + growth = new base starting in 2015-16. **Support Services Growth Allocations** 2012-13 From the Support Services Growth Subaccount allocate: ▪ 5% to the Mental Health Subaccount (1991)

Section	Purpose
	▪ 40% for child welfare services to the Protective Services Growth Special Account ▪ 42.03% to the Protective Services Growth Special Account ▪ 12.97% to the Behavioral Health Growth Special Account 2013-14 Designates starting 40 percent of Supportive Services Growth is dedicated to child welfare services until a full $200 million is reached. From the Support Services Growth Subaccount allocate: ▪ 5% to the Mental Health Subaccount (1991) ▪ 40% for child welfare services to the Protective Services Growth Special Account ▪ 21.81% to the Protective Services Growth Special Account ▪ 33.19% to the Behavioral Health Growth Special Account Defines how growth is counted for determining base. DOF certifies that $200 million has been allocated for child welfare services and notifies the Controller. Once the $200 million is paid to child welfare services, allocate from the Support Services Growth Subaccount as follows: ▪ 5% to the Mental Health Subaccount (1991) ▪ 45% to the Protective Services Growth Special Account ▪ 50% to the Behavioral Health Growth Special Account
Govt Code §30027.9.1 pp. 34-35	**County Intervention Support Services Subaccount** ▪ Allows Department of Health Care Services to notify the Controller, DOF and a county that said county is failing to perform a federal Medicaid program (applies to Drug Medi-Cal and specialty mental health services) to the extent federal Medicaid funds are at risk. The Controller then deposits the county's revenues for the program in question into the County Intervention Support Services Subaccount. ▪ This section is intended to cover a case where a county exercises its right of first refusal for specialty mental health services or a county refuses to perform Drug Medi-Cal or is performing inadequately (beneficiaries are not receiving entitled services). ▪ DHCS will have access to those funds in the County Intervention Support Services Subaccount. ▪ DHCS notifies the Controller to stop putting funds into the County Intervention Support Services Account

Section	Purpose
Govt Code §30027.9.2 p. 35	▪ The language from this section originated in the constitutional amendment. The constitutional amendment says that 2011 Realignment legislation will define the method for determining the amount that counties would otherwise receive if the revenue source changes. Also includes continuous appropriation language. ▪ In the constitutional amendment, this section has the priority order of payments. That language can only be put in the constitution – not in statute. Hence, it is not included in the TBL.
Govt Code §30028 pp. 35-36	Defines how Juvenile Justice Account funds are allocated to the subaccounts prior to 2012-13.
Govt Code §30028.1 p. 36	Defines how funds are allocated to the Juvenile Justice Subaccount and to its Special Accounts in 2012-13 and beyond.
Govt Code §30028.5 pp. 36-37	Defines how funds are allocated to the Health and Human Services Account in 2011-12 and repeals this section on January 1, 2014.
	ALLOCATING FUNDS FROM THE STATE FUNDS TO LOCAL FUNDS
Govt Code §30029 pp. 37-43	Clarifies that the 2011-12 fiscal year includes the cash received in July and August of 2012. Repeals this section on January 1, 2014.
Govt Code §30029.05 pp. 43-52	▪ Establishes process for allocating funds to counties in 2012-13 and beyond. ▪ Allocates Mental Health Account funds to the Mental Health Subaccount of the Sales Tax Account in the Local Revenue Fund (1991) on the 20th of each month. ▪ Allocates Trial Court Security Subaccount funds on a county-by-county basis. ▪ Allocates Local Community Corrections Subaccount funds on a county-by-county basis for 2012-13 and 2013-14. Beginning in 2014-15, funds shall be allocated pursuant to a schedule developed by DOF in consultation with CSAC. ▪ Allocates the DA/PD Subaccount funds on a county-by-county basis for 2012-13 and 2013-14. **Beginning** in 2014-15, funds shall be allocated pursuant to a schedule developed by DOF in consultation with CSAC. ▪ Allocates funds to the Enhancing Law Enforcement Activities Subaccount. ▪ Specifies the allocation out of the Enhancing Law Enforcement Activities Special Growth Account to specified local public safety programs.
Govt Code §30029.07 52-55	▪ Specifies that the funds in the Special Growth Accounts at the state level shall be allocated to the corresponding subaccounts at the local level. The funds will be allocated pursuant to a schedule developed by DOF with criteria, in consultation with CSAC. ▪ Beginning in 2015-16, requires each county treasurer to deposit 10% of funds received that fiscal year from each of the following into the Local Innovation Subaccount: Trial Court Security Growth Special Account, Community Corrections Growth Special Account, DA/PD Growth Special Account and Juvenile Justice Growth Special Account. ▪ $200 million for child welfare services will be allocated monthly, per statute (percentages still need to be filled in). ▪ Sets aside a portion of the Protective Services Growth Subaccount to counties who meet spending thresholds that

Section	Purpose
	would have allowed the county access to the CWS Augmentation fund. Exempts counties under 50,000 from the expenditure requirement. ▪ Includes a statutory allocation for the CWS Augmentation by county (percentages still need to be filled in). ▪ Specifies that in 2012-13, 90% of the Protective Services Growth Special Account shall be allocated in the same proportion as the 2012-13 base funding. In 2013-14 and beyond, allocate in the same proportion as the base funding is allocated for that fiscal year. DSS, after consulting with CSAC shall provide a schedule to the Controller. ▪ For 2012-13, the Community Corrections Growth Special Account shall by allocated by the Controller pursuant to a schedule provided by DOF. DOF shall consider a number of factors articulated in paragraphs (e)(1-7).
Govt Code §30029.1.1 pp. 55-56	Allocations out of the Juvenile Justice Subaccount to counties.
Govt Code §30029.2 pp. 56-57	Repeals the 2011-12 HHS allocations on January 1, 2014.
Govt Code §30029.2.1 pp. 57-59	▪ Specifies the county-by-county allocations out of the Protective Services Subaccount in 2012-13 (percentages need to be filled in), includes a 59th county for purposes of contracting back for state programs. ▪ Designates an amount for state contracts. ▪ Specifies the county-by-county allocations process of the Protective Services Subaccount in 2013-14 and beyond, pursuant to a schedule.
Govt Code §30029.2.2 p. 59	Behavioral Health Subaccount shall be allocated pursuant to a schedule provided by DOF in consultation with CSAC.
Govt Code §30029.2.3 pp. 59-60	**Contracting.** A county or counties may contract back with state for Drug Medi-Cal or agency adoptions. Counties may contract with another county, joint powers agreement or county consortium for any program, service or activity. Exempts state contracts from the Public Contract Code
Govt Code §30029.2.4 pp. 60-61	**Contract Special Account.** Allows a county to contract with DSS for specified state services on behalf of all counties. The designate county receives the allocation as the 59th item in the allocation schedule. If full funding is not provided, DSS can reduce the contract.
Welfare &Institutions Code §1954 (p. 61)	Repeals the section appropriating Youthful Offender Block Grant funds, given that Govt Code §§30028.1 and 30029.1.1 define allocation methodology for 2012-13 and beyond..
Welfare &Institutions Code §17600.05 p. 62	**Mental Health Growth Subaccount.** Creates a Mental Health Growth Subaccount in the 1991 Realignment structure to receive growth funds from the 2011 Realignment. Clarifies that the growth deposited in the Mental Health Growth Subaccount shall not be used for calculating 1991 growth.
Welfare &Institutions	▪ Transfers $93,379,252 into the CalWORKs MOE Subaccount monthly.

Section	Purpose
Code § 17601.20 pp. 62-63	▪ Clarifies that the deposits into the Mental Health Subaccount shall not be used for calculating 1991 base or growth.

Attachment Six

CSAC Memo: Establish Policy Committee Meeting Schedule – ACTION ITEM

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

May 21, 2012

To: CSAC Health and Human Services Policy Committee

From: Supervisor Liz Kniss, Committee Chair
Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Establish Policy Committee Meeting Schedule – ACTION ITEM

Staff Recommendation: Adopt a quarterly meeting schedule for the CSAC Health and Human Services Policy Committee.

Background. The CSAC Health and Human Services Policy Committee continues to lead the way on county health and human services policy issues. In the past few years, with federal health care reform, the federal Section 1115 Medicaid Waiver, 2011 Realignment and ongoing state budget cutbacks, the Committee has met regularly to examine significant issues.

We anticipate the Policy Committee's continued direction in 2012 and beyond as counties brace for health care reform and continue to implement 2011 Realignment.

To that end, Committee Chair Liz Kniss has suggested establishing a quarterly meeting schedule for the Committee as follows:

- February Meeting – via phone
- CSAC Legislative Conference in May – in person
- August Meeting – via phone
- CSAC Annual Meeting in November – in person

Establishing a quarterly meeting schedule will allow participants to schedule the meetings in advance, help ensure our continued robust participation rate, and position the Committee to weigh in at key times during the policy process. For these reasons, staff recommends approval of the above meeting schedule.