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This memo is an informational update on the Governor's and Legislature's efforts to date on comprehensive health care reform. It was distributed at today's County Administrative officers meeting.

Background

Currently, health care reform is a two-track process – a bill, AB 1 X1 (Núñez), and a ballot initiative. AB 1 X1 was set to be heard by Senate Health Committee on January 23, pending the analysis by the Legislative Analyst's Office on the long-term fiscal impacts. From Senate Health Committee, the bill would likely proceed to Senate Appropriations and then to the Senate Floor. If the measure is amended in the Senate, it would have to be returned to the Assembly for concurrence. From there, it would be sent to the Governor for action. Please note that the initiative contains language that requires AB 1 X1 to be "substantially similar" to the December 17, 2007 version of the bill. It is unclear whether the Senate will amend the measure.

The ballot initiative was submitted to the Attorney General's Office on December 28. The Legislative Analyst has until February 7 to provide their analysis for the title and summary. Presumably, signature gathering could begin in early to mid-February. The ballot initiative is intended for the November 2008 ballot.

Key Provisions of AB 1 X1

AB 1 X1 would enact the California Health Care Security and Cost Reduction Act.

<u>Expansion of the Medi-Cal and Healthy Families programs.</u> The proposal expands Medi-Cal and Healthy Families Program (HFP) for children and Medi-Cal for adults.
Children. Expands Healthy Families coverage to children up to 300% of the federal poverty level (FPL). The children's expansion would be effective July 1, 2009. Eliminates federal citizenship and immigration eligibility requirements for children 18 and under in Medi-Cal or HFP.
Adults. Effective July 1, 2010, extends coverage to 19- and 20-year olds and to low-income parents and caretaker relatives up to 250% FPL. Coverage for adults with incomes at or below 100% FPL would be covered under Medi-Cal. Adults with incomes 100-250% FPL and for childless adults with incomes 100-250% FPL coverage will be provided in a benchmark plan pursuant to new federal Medicaid rules under the federal Deficit Reduction Act (DRA) of 2006, which allows states to vary the benefit designs they offer to some groups using federal Medicaid funds.

<u>Creation of a statewide purchasing pool (the California Cooperative Health Insurance Purchasing Pool – CalCHIPP).</u> The new purchasing pool, CalCHIPP, will provide subsidized coverage to individuals and families with incomes between 100 and 250 percent of FPL. The Managed Risk Medical Insurance Board (MRMIB) will administer CalCHIPP. Coverage offered through CalCHIPP must meet Knox-Keene

(the body of law regulating health plans in California) mandates plus specified prescription drug coverage. Additionally, CalCHIPP must offer a specified choice in plans.

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

Creation of an individual mandate to purchase health insurance. Requires all California residents, who have lived in the state at least six months, to enroll in and maintain minimum coverage. MRMIB is required to define what constitutes minimum coverage by March 1, 2009. The minimum health coverage would be required to include the same scope of services as required under the Knox-Keene Act, plus prescription drugs.

Exemptions:

- People with incomes below 250% FPL whose cost for the required coverage exceeds 5% of their income can opt out of the individual mandate requirement.
- Allows MRMIB to grant limited temporary or permanent exemptions to people who demonstrate they are facing significant financial hardship or otherwise cannot afford coverage. Includes victims of natural and manmade disasters in examples of temporary hardship.

In-Home Supportive Services (IHSS) program. The Act specifies that IHSS recipients are not the employer for purposes of the employer fee.

Additionally, the Act includes language to require the public authority to provide health care benefits through a trust fund if the employee representatives request it during collective bargaining.

The Act also provides for $0.75 increase in state sharing in health benefits. Under existing law, the state shares in benefits up to $0.60/hour. The new language would increase that to $1.35 via a three-year staged implementation. The first $0.25 would occur in the first year that the Act is in effect (presumably 2010). The next two $0.25 increments would begin in a subsequent fiscal year in which state General Fund revenues grow at least 5% year over year, based on the May Revise estimate.

Public hospital issues. Increases inpatient and outpatient rates for designated public hospitals, defined as the University of California and county hospitals, so that payment rates, paid on either a per diem or a per discharge basis, are based on the hospital's allowable costs established for the 2009-10 fiscal year and adjusted by the medical component of the federal Consumer Price Index.

The measure also provides for a Local Coverage Option (LCO). Childless adults in counties with LCOs would access health services through the LCO exclusively for the first four years that services are available. In the fifth year, enrollees would have the ability to opt out of the LCO in the first 30 days of enrollment.

Eligibility processing. Creates a work group, including counties, labor, legislative staff and the state, to discuss options related to eligibility administration for the new programs. Requires the Legislature to enact the work group's recommendations and requires the budget to include funding.

Creation of a medical loss ratio requiring insurers to spend at least 85 of premiums on medical care. Requires health care service plans and health insurers to expend no less than 85 percent of revenues obtained from subscribers and enrollees on patient care.

Financing Provisions. The Act includes language that states notwithstanding any other provision of this Act, the implementation of the provisions of the Act shall be contingent on a finding by DOF that the financial resources necessary to implement those provisions are available. That finding must contain all of the following:

- Sufficient state resources will exist to implement;
- Required federal approvals for program changes have been obtained/can be obtained; and
- Required federal resources will be available to implement.

Various other provisions, including modification of the individual and group insurance markets and expansion of preventive health programs.

Outstanding Concerns with AB 1 X1

Counties have numerous concerns with the requirement that health benefits for IHSS providers be administered through a union trust. This language is contained in Section 60, Welfare and Institutions Code Section 12306.1 (g). Specifically, this paragraph states that if the employee representative of In-Home Supportive Services workers wants health benefits provided through a trust fund, "the public authority or non-profit consortium *shall* agree to those terms."

This new paragraph circumvents the local agency collective bargaining process in current law. Under existing state law, public authorities negotiate health benefits for IHSS providers. The entire health benefit is subject to negotiation – the number of hours worked in order to qualify for benefits, employee cost sharing in premiums and co-pays, benefits, etc. Counties are very concerned about the precedent of the State dictating to local agencies how to provide benefits that are currently collectively bargained. Furthermore, this language may lead to other employee representatives seeking similar legislation for their members.

The language is constructed in way that leads counties to conclude that the public authority must agree to whatever terms the union puts on the table in regards to the trust. Issues such as provider networks and benefits would not be subject to the collective bargaining process. Currently a number of counties provide health benefits to IHHS providers through a county-run health plan. These plans typically include a network of county facilities – hospitals and clinics. To the extent county facilities are

excluded, paragraph (g) will affect the bottom line of county hospitals and health systems and may affect the quality of and access to care for other county employees and residents.

Counties are concerned that we will lose the ability to bargain over the health benefits offered through the trust – in effect paying for these benefits without any way to ensure that they are administered efficiently.

There may be cases where providing health benefits through a union trust makes sense. Alternatively, there may be cases where health benefits can be provided more cost-effectively and with higher quality achieved through a different structure. For example, the city and county of San Francisco currently provides health benefits through its own health plan and county provider network. This system of providing health benefits to IHSS providers is estimated to be approximately $16 million less than if provided through a similar commercial insurance product. In another example, counties can currently include IHSS providers in their county employee pools; counties would lose a significant share of their purchasing power for health benefits if IHSS workers received their benefits through a trust.

Counties attempt to ensure fairness in benefits provided to employees, regardless of their participation in a union. Not all IHSS providers are members of a union. If a trust mechanism were mandated, how would benefits be provided to non-union IHSS providers?

Local conditions should dictate whether a trust is utilized for health benefits – not the State. Counties are very concerned with the precedent of a state-specified benefit violating the tenets of Myers-Milias-Brown.

Key Provisions of the Ballot Initiative

Sufficiency of Funds. At least twice a year the Director of Finance must review available funds and determine whether they are sufficient to support the continued operations of all the new programs. If the Director determines funds are insufficient in either current or the following two years, he or she must notify the Legislature. The Legislature then has 180 days to pass legislation to address the imbalance, or all provisions become inoperative.

County Share of Cost. Counties are required to pay 40% of the costs of providing coverage to childless adults under 100% FPL in the new Medi-Cal program as well as childless adults and certain parents under 150% FPL who are in the state purchasing pool.

Total county contributions are capped at $1 billion, adjusted annually by the increase or decrease in Realignment revenues. The legislature must pass future legislation designating specific county caps, with recommendation from the Department of Finance (DOF), in consultation with an association representing all counties, by April 1, 2009.

If any of the expansion programs included in the county share of cost are eliminated or reduced, the state shall correspondingly reduce the county cap "in an amount directly proportional to the health care coverage costs previously incurred by the state in the prior year for those individuals whose eligibility is reduced or eliminated."

Counties are authorized to use Health Realignment funds to pay their share of cost.

If a county fails to remit payment with 45 days of receiving notification of the amount owed, the state may withhold either (1) sales tax allocations to the Health Realignment Account or (2) "any other revenue to which the county would otherwise be entitled and to which access is not precluded by the California Constitution or federal law."

A county may annually submit a request to DOF for modification of its share of cost if it experiences "financial distress due to high demand for county-funded health care services by medically indigent persons and an actual level of savings attributable to implementation of the Health Care Security and Cost Reduction Act that is significantly below anticipated savings". The modification request must include an independent audit. The DOF has 45 days to make a determination on the modification request.

Tobacco Tax. The Tobacco Tax is increased by an amount equivalent to $1.75 per pack, with limited backfill provisions for Proposition 99 and Proposition 10. The Proposition 99 backfill is limited to education and research programs, as well as breast cancer and asthma programs currently receiving funding. Proposition 10 is backfilled EXCEPT for funds allocated in 2007-08 by the State Children and Families Commission for children's health insurance provided by local commissions. The First Five Association is estimating that approximately $19.5 million would be exempted from the backfill – $15.6 million in local funds and $3.9 million state funds.

Employer Fee. Employers are required to spend between 1% and 6.5% of wages on health care expenditures for employees based on payroll size. Employer expenditures can include the purchase of health insurance, the operation of "healthy lifestyle" or disease management programs, pharmacy benefit programs, or contributions to health savings accounts.

Hospital Fee. Acute care hospitals, except for rural hospitals of less than 50 licensed beds, are required to pay a fee equal to 4% of their net patent revenue. Revenue from this source can be used only for hospital and managed care rate increases.

IHSS. The initiative as filed includes language that says that IHSS consumers' responsibilities as employers are met pursuant existing Welfare and Institutions code section 12302.2. This is the existing law that makes the state responsible for paying unemployment insurance, payroll, etc. The language is incomplete as the underlying Welfare and Institutions Code Section needs to be correspondingly amended to

include health payments. The Administration and Speaker's staff indicate that this is an issue for clean-up in future legislation.

Interim Children's Coverage. The DOF is authorized to provide a one-time General Fund loan up to $25 million (to be repaid later from health reform revenues) by January 1, 2009, to eligible county children's initiatives to eliminate any caps on enrollment and waiting lists in the county programs.

Future Legislative Changes. Changes to the hospital fee provisions and the sufficiency of funds provisions within the initiative can be made only with a two-thirds vote of the Legislature. The other provisions, including the county share of cost, can be changed with a majority vote measure.

Severability. If any provision of the initiative is found to be invalid or unconstitutional by a court, the remaining provisions shall NOT be affected. This means the county share of cost, tobacco tax and hospital fee could remain in effect even if the employer requirement is thrown out in court. The Legislature could then modify the program provisions of AB 1 X1 to retain only portions of the original program.

Outstanding Concerns with the Ballot Initiative

The primary concerns with the ballot initiative center on the county share of cost.

The share of cost proposal will impact different counties differently. Generally, counties with public hospitals may be better off because these counties will be getting additional revenues through the provider rate increases and the local coverage option.

The key question for counties is how many people remain without insurance and continue to access county indigent services for care. Counties want to be sure that they would have sufficient revenues after paying the share of cost to continue to provide services to the residual population and to continue to provide public health services.

The $1 billion formula does not guarantee that this balance will be achieved and was not derived from any estimates about remaining county services and responsibilities.

The Governor's January budget proposals will affect health care reform and raises new concerns for counties. These proposals will affect the residual services offered by counties and eligibility for those services. For example, the proposal to eliminate adult dental services will impact county indigent programs. Many counties are required to provide dental services in their indigent programs. If some of these Medi-Cal recipients meet county indigent program standards, they could end up getting dental services at the county.

Additionally, the proposal to increase status reporting to quarterly makes it harder for recipients to remain on Medi-Cal and will result in people losing their coverage.

Some of these individuals may access county indigent programs. Making it harder to remain on public coverage raises concerns for us. Cuts to county eligibility staff for Medi-Cal and California Children's Services will mean that it may take longer to process applications and allow children and families to access services.

Our final apprehension with the county share of cost is that the share of cost can be changed by a simple majority vote of the Legislature in the future. There are no guidelines for future changes, such as whether counties have sufficient remaining revenues to provide other mandated services.

Staff Comments
In testifying before Senate Health Committee on January 23, CSAC will articulate the concerns noted above with both the bill and the ballot initiative.