



Assembly Health Committee

OVERVIEW *(Revised 10/17/07)*

Health Care Security and Cost Reduction Act

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

Legislative Counsel RN # 07 29963

- **Individual Mandate.** Requires, effective July 1, 2010, every California resident to obtain health coverage for themselves and their dependents that meets a minimum level of coverage, established in regulation by the Secretary of Health and Human Services (Secretary). Requires the Secretary to establish methods to inform individuals of their obligation, and available public coverage, as well as methods to ensure that uninsured individuals secure minimum coverage, (mandate enforcement). Makes the coverage mandate contingent on the Secretary's implementation of such education and enforcement mechanisms. Requires the minimum benefit plan established by the Secretary to cover medical, hospital, and preventive services. Allows specified existing public and private coverage to qualify as meeting the minimum benefit requirement for purposes of the mandate.
- **State Purchasing Program.** Establishes a state-level purchasing program, the Health Care Security and Cost Reduction Program (Program), to be administered by the Major Risk Medical Insurance Board (MRMIB). Requires the Program to offer both subsidized and unsubsidized coverage to residents who do not have employer-sponsored health coverage.
- **Low-income assistance.** Provides subsidies for eligible low-income persons in the Program and limits premium contributions based on income, as a percent of the Federal Poverty Level (FPL), as follows: 100-150% FPL -- No contribution; 151-250% FPL -- Limited to 5% of income; and, 250-350% FPL – Offers an advanceable tax credit equal to that portion of the premium for minimum coverage that exceeds 5% of adjusted gross income.
- **Public Program Expansions.** Expands the Healthy Families Program to include all children up to 300% FPL, and Medi-Cal to eligible children under 19, regardless of immigration status. Extends Medi-Cal coverage to 19 and 20 year olds, parents up to 250% FPL and childless adults up to 100% FPL. Eliminates the Medi-Cal asset test. Limits coverage for children ages 19-20, parents and childless adults to a new benchmark plan equivalent to subsidized coverage offered through the Program, as determined by MRMIB.
- **County Participation.** Makes subsidized coverage in the Program and coverage of childless adults under 100% FPL contingent on counties contributing an unspecified amount to the cost of coverage for individuals currently relying on counties for health care. Permits counties with public hospitals, under a new Local Coverage Options (LCO) program, to enter into at risk contracts with the state for coverage of low-income childless adults.
- **Medi-Cal Provider Rates.** Increases Medi-Cal hospital and physician rates. Requires physicians to be reimbursed at no less than 80% of Medicare rates, private and district hospitals at Medicare rates and public and UC hospitals at costs up to federally allowable levels.

- **Guaranteed Issue of Private Individual Coverage.** Requires health plans and insurers to offer, accept and renew individual private coverage regardless of the age, health status or claims experience of applicants ("guaranteed issue and renewal"). Guaranteed issue is contingent on implementation of the individual mandate enforcement activities delegated to the Secretary.
- **Insurance Market Rules.** Establishes rating rules for individual coverage. Market rules include, among other elements: limits to be developed by the Director of Managed Health Care (DMHC) and the Commissioner of Insurance (Commissioner) on age rating, focused on the ratio of the rate differential for persons aged 30-35 and those 60-64; limits on geographic rating factors similar to the rules that apply in the small employer coverage market; and gradual phase out over six to eight years of any rating factor based on health status or perceived health risk. During the first three years, the proposed rate bands for health risk (standard rates plus or minus 20%) mean that the highest risk person will pay 50% more than the healthiest person in the same age and geographic category. Establishes five tiers of individual coverage and generally limits individuals to moving up one tier per year, except at a qualifying event, such as loss of minimum coverage, marriage, divorce, birth of a child, or death of the primary subscriber.
- **Medical Loss Ratio in Private Health Insurance.** Requires private health plans and insurers to spend 85% of after-tax revenues on health care, calculated across all of a carrier's products. Excludes from health care costs administrative costs, but includes disease management, training and informational materials, telephone advice and payments to providers based on performance.
- **Tax Deductibility of Health Coverage.** Requires all employers to establish Section 125 accounts to allow employees to pay for health coverage with pre-tax dollars. Provides a tax deduction related to health savings accounts in conformity with federal tax laws.
- **Other Cost Containment.** Specific elements aimed at reducing costs include: requiring prescribers and pharmacies to handle prescriptions electronically by 2010; promoting expanded use of nurse practitioners, nurse midwives, and physician assistants; establishing programs to improve management of chronic conditions, including diabetes and obesity prevention; developing electronic personal health records in state-administered health coverage programs; enhancing transparency of health care cost and quality data and information; and mandating availability of public and private "Healthy Action Incentives and Reward Program" coverage plans that reward individuals and employer groups for healthy lifestyles and behaviors.
- **Financing.** States legislative intent to finance the plan with contributions from employers, individuals, federal, state and local governments and health care providers. Financing elements include: increased federal Medicaid and State Children's Health Insurance Program funds; unspecified revenue from counties based on enrollment in coverage of low-income adults now served by counties; a 4% fee on hospital patient revenues; employer fees ranging from 0 to 4% of payroll, based on employer size and payroll, with all employers of 10 or more employees paying 4%; premium payments by individuals in both publicly subsidized and private coverage; funds obtained through licensing the State Lottery; and other state savings from increased numbers of covered persons.
- **Contingent Implementation.** Makes the proposal contingent on a finding by the Director of Finance that sufficient financial resources are available.