

**Summary – AB 1x1 (Nunez)**  
**Health Care Security and Cost Reduction Act**

The Health Care Security and Cost Reduction Act (Act), AB 1x1 (Nunez), and a companion statewide ballot initiative anticipated for the November 2008 ballot, represent comprehensive and sweeping reforms to California's ailing health care system. The Act would significantly reduce the numbers of the uninsured through public program expansions and increased employer participation in the health care of workers; organize and improve the health insurance market for individuals; advance innovative strategies to reduce health care costs and improve quality; and protect California's budget through dedicated revenues that make the proposal self-financing. Once fully implemented, approximately 70% of California's 5.1 million uninsured, most of whom are low-income working individuals and their families, including 800,000 children, will no longer be uninsured for health care.

**MAJOR PROVISIONS OF THE ACT**

**Coverage expansions.** Brings health care coverage to approximately 70% of California's 5.1 million uninsured, most of whom are low-income working individuals and their families, including 800,000 children. The public coverage expansions are accomplished as follows:

- All children in families at or below 300% of the federal poverty level (FPL) (\$51,500 for a family of three in 2007) will be eligible for Medi-Cal or the Healthy Families Program, regardless of their immigration status. Expanded coverage for children, unlike all other provisions in the Act which generally are effective in July 2010, takes effect July 1, 2009; and,
- Single adults who do not have access to employer coverage and parents at or below 250% FPL (\$43,000 for a family of three) will be eligible for free or very low cost coverage through Medi-Cal or the adult equivalent of Healthy Families through the new statewide purchasing program. Share of costs for this coverage are capped at no more than 5% of income, and adults below 150% FPL would pay no premiums and have no cost sharing.

**Statewide Pooled Purchasing.** Establishes a state-administered health care purchasing program, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), to be administered by the Managed Risk Medical Insurance Board (MRMIB). MRMIB currently manages several existing health care coverage programs, including the Healthy Families Program, and is directed by a publicly accountable board with both gubernatorial and legislative appointees. MRMIB will provide coverage for individuals in the expanded public programs with incomes between 100-250% FPL. MRMIB will also provide an array of coverage choices for employees whose employer chooses to pay a fee rather than pay for health care directly by offering employees at least three different coverage options: a plan that meets the minimum mandated benefits, a mid-range coverage product and a high-range comprehensive benefit plan.

**Employer contributions.** Ensures that California businesses compete on a level playing field by placing on the November 2008 ballot the requirement that all employers meet a minimum spending level on health care for their workers, equal to 1-6.5% depending on the payroll of the employer. In addition, employers will be required to establish Section 125 tax-free accounts so that employees can pay for health benefits on a pretax basis, lowering payroll-related taxes for

**Summary – AB 1x1 (Nunez)**  
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both employers and employees.

**Individual Mandate.** Requires every California resident to have and maintain health care coverage and provides a combination of public program expansions, subsidies, tax credits and other tax breaks to make the coverage affordable. MRMIB will establish the minimum benefits required to meet the individual mandate, referred to as minimum creditable coverage, which must include at least medical, hospital and preventive care and the coverage health plans and insurers must provide under existing law. The Act requires MRMIB to balance the need for minimum coverage that protects individuals and families from catastrophic health care costs, with the need for premiums to be affordable so that Californians can reasonably comply with the mandate. Individuals subject to the mandate can purchase more benefits and coverage than the minimum required and will have improved access to all types of products as a result of major insurance market reforms included in the Act.

**Exemptions from the Mandate.** Exempts from the individual mandate those individuals and families with incomes at or below 250% FPL if their share of the premiums for the lowest benefit is more than 5% of income. In addition, MRMIB will be authorized to give both temporary and permanent exemptions for individuals and families above 250% of the FPL for whom MRMIB determines coverage is not affordable or presents a hardship. MRMIB is required to consider the effect on the person or family with regards to total out of pocket costs, including premiums, co-pays, co-insurance and deductibles, in addition to other factors such as housing, utility, child care and transportation expenses. In addition, hardship exemptions could be granted in the event of expenses from a natural disaster, sudden loss of income or other extraordinary circumstances.

**Affordability protections.** The Act emphasizes making coverage both available and affordable and includes a combination of public program expansions, subsidies, tax credits and other tax breaks to assist Californians and ensure that they do not face unreasonably high cost sharing. Affordability protections include:

- Expansions of eligibility for public coverage that ensure the lowest income Californians will have coverage with little or no cost sharing.
- Moderate income families, 250-400% of FPL (\$43,000-69,000 for a family of three), in Cal-CHIP without employer sponsored health insurance will have access to refundable tax credits if their share of costs for health coverage exceeds 5.5% of their family income.
- States legislative intent to enact legislation that authorizes tax credits for early retirees between the ages of 50 and 64 who are ineligible for the tax credit in amounts up to \$50 million annually.
- Employers will be required to establish Section 125 tax-free accounts so that employees can pay for health benefits on a pretax basis, lowering payroll-related taxes for both employers and employees.

**Summary – AB 1x1 (Nunez)**  
**Health Care Security and Cost Reduction Act**

- Low-income persons with incomes up to 250% FPL (\$43,000 for a family of three) are exempt from the individual mandate if the cost of premiums for minimum coverage exceeds 5% of their family income. Additionally, anyone, regardless of income, can seek a temporary or permanent exemption from the individual mandate based on hardship and affordability through MRMIB.
- Prohibits hospitals from “balance billing” insured patients who receive emergency services and post-stabilization care (except for copayments and deductibles) at a hospital that does not contract with the patient’s health plan.

**Insurance Market Reforms.** Requires every health plan and insurer in the state (carriers) to accept for coverage all applicants who are subject to the mandate, regardless of their health status or claims history, and establishes this "guaranteed issue" requirement with strict rating rules relating to differences for age, geography, family size and health status. Under the Act, no individual subject to the mandate can be denied health insurance coverage. Other elements of the market reforms include:

- Carriers will be obligated to spend at least 85 cents of every premium dollar collected on health care and health benefits, ensuring value for consumers and purchasers by placing limits on rising administrative costs.
- Regulators will establish five coverage choice categories for all individual market products, from the minimum benefit to the most comprehensive benefits, and carriers will have to offer benefits in each category.
- There will be one standardized HMO and one standardized PPO product in each coverage choice category, offered by each carrier, so that consumers will be better able to make "apples to apples" benefit and price comparisons.

**Cost Containment.** By covering many of the uninsured, the Act reduces the existing cost shift from uncompensated health care costs. The cost shift raises health care costs, health insurance premiums and the costs of government health care programs. In addition, the Act brings in \$4.6 billion in new federal funds that help pay for the public program expansions, helping to fund Medi-Cal physician rate increases, and, combined with the \$2.3 billion in additional revenues generated by the hospital fee, Medi-Cal hospital rate increases. Increasing Medi-Cal rates is another strategy to improve access to health care and to reduce cost shifting to private purchasers, individual consumers and employers.

Other cost containment elements include:

- Requirement for health care service plans and health insurers to spend 85% of premium dollars on health care.
- Cost savings for both employers and employees through the establishment of Section 125 plans that shelter health care premiums from state and federal tax.

**Summary – AB 1x1 (Nunez)**  
**Health Care Security and Cost Reduction Act**

- Programs to improve the prevention and management of high cost and chronic diseases, including diabetes specific programs, tobacco cessation, and obesity prevention.
- Expanded use of electronic records and methods to reduce paperwork, limit medical errors and improve the quality of health care delivery, including electronic personal health records and e-prescribing.
- Comprehensive, system-wide accountability and transparent public reporting of costs and quality for all elements of the health care system, including hospitals, physicians, health professionals and health plans, so that consumers and purchasers can evaluate the costs and quality of their health care choices. The California Health Care Cost and Quality Transparency Committee is charged with developing a comprehensive plan for statewide common measurement of costs and quality to reduce duplication and ensure meaningful measurement and reporting.
- Establishes a task force on nurse practitioner scope of practice to develop a recommended scope of practice for nurse practitioners, and requires the Department of Consumer Affairs to report its recommendations to the Legislature and promulgate regulations adopting the task force's recommended scope of practice.

**Safety Net Protection.** The Act enhances the financial stability and viability of California's public and private safety net through coverage expansions for uninsured persons now receiving care from safety net providers on an uncompensated basis and by substantially increasing revenues to physicians, hospitals and community clinics serving Medi-Cal and uninsured persons. Safety net protections include:

- A Medi-Cal rate increase to private and district hospitals of over \$1.6 billion.
- Public hospitals will also gain in excess of \$400 million in additional funds through Medi-Cal rate increases in the first year alone, which will continue to grow over time. In addition, counties with public hospitals will be able to develop a local coverage option for newly covered low income adults providing their health care through county and community clinic delivery systems. The goal is to ensure that county systems do not lose patients to other private delivery systems in the transition to expanded coverage.
- Expands access to community clinic services for uninsured persons.

**Implementation Trigger**

AB 1x1 makes implementation of the reforms in the bill contingent on a finding by the Director of the Department of Finance that sufficient funds will exist in the Health Care Trust Fund created by the bill, federal funds will be available to implement the legislation, and needed federal approvals have been or are anticipated to be obtained. In addition, the public program expansion and newly created pool, other than coverage for children, will not take effect until July 1, 2010.

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**ELEMENTS OF THE 2008 NOVEMBER BALLOT INITIATIVE**

Through a companion ballot initiative filed with the Attorney General on December 28<sup>th</sup> and anticipated for voter approval on the November 2008 ballot, this reform package ensures that adequate financing is in place before the reforms take effect in 2010 and that the entire package will be self-sustaining through dedicated revenues.

The initiative will specifically provide for an employer fee, the hospital provider fee, the tobacco tax, the county share of cost, and financial oversight protections to ensure that the fund stays solvent.

The total financing package includes: employer, hospital and employee contributions, increased tobacco taxes, additional federal funds, and revenues returned to the state by counties for those low-income persons newly enrolled in coverage and no longer in need of county funded health care services.

Specifically, the ballot initiative:

- Establish an employer contribution on total payroll, paid on wages capped at the Social Security wage limit, with the following breakdown by employer payroll size:
  - Firms with payrolls up to \$250,000 = 1% contribution
  - Firms with payrolls \$250,000 - \$1 million = 4% contribution
  - Firms with payrolls \$1 million - \$15 million = 6% contribution
  - Firms with payrolls in excess of \$15 million = 6.5% contribution
- Impose a 4% fee on hospitals based on net patient revenues;
- Require county share of cost payments for previously uninsured persons enrolled in public coverage;
- Increase tobacco taxes by \$1.75 per pack; and,
- Establish strict financial oversight of operations created in the Act by establishing a trigger mechanism requiring the Legislature to make the statutory changes needed to address any fiscal imbalance, or in the event the Legislature fails to do so, makes inoperative new programmatic elements contained in the bill.