

Member Q & A
AB 1x1 (Nunez) – As amended December 17, 2007

How do low-income Californians fare under this bill?

At its core, AB 1x1 protects low income working families by providing comprehensive coverage for either free or very low cost for those under 250% of the federal poverty level. It offers, for the first time, comprehensive coverage to the childless adults up to 250% of federal poverty – this is a population that no matter how poor, have always been left behind by federal Medicaid rules. It also protects middle class families without employer sponsored insurance with incomes between 250% - 400% (\$43,000 - \$69,000 for a family of 3) by capping their premiums at 5.5% of income for a mid-level plan offered in the pool. Families could use that premium offset upfront every month or take it at the end of the year as a tax credit, and they could use it towards any plan they wished.

How can we be sure that all individuals subject to the mandate to have health coverage can afford the coverage?

AB 1x1 protects Californians from unaffordable coverage. Families with incomes below 250% of the federal poverty level (\$43,000 for a family of 3) are eligible for very low cost, comprehensive insurance equivalent to Healthy Families coverage where premiums are capped at 5% of their income. Families with incomes below 150% of the federal poverty level (\$26,000 for a family of 3) would have free comprehensive health care – absolutely no cost sharing.

AB 1x1 exempts individuals and families from the individual mandate if the person or family has an income at or below 250% of the federal poverty level and the person or family's share of premium exceeds 5% of his or her family income. Additionally, anyone regardless of their income can seek an exemption from the individual mandate for either affordability or hardship reasons. The Managed Risk Medical Insurance Board (MRMIB), which currently runs the successful Healthy Families Program, and will operate the state health insurance purchasing pool established in AB 1x1, is required to take into account the effect of total out of pocket costs, including premiums, co-pays and deductibles, when considering ability to afford insurance. An individual is also exempt from the individual mandate if he or she has been in California for six months or less.

In addition:

- Children in families with incomes at or below 300% FPL will be eligible for Medi-Cal (with no premiums) or Healthy Families (with premiums of no more than \$25 per month);
- Advanceable, refundable tax credits will be available for persons with incomes of 250-400% of FPL (\$43,000-69,000 for a family of three) if their share of premium exceeds 5.5% of their family income;
- Additional tax credits will be available for early retirees; and,
- All employers will be required to offer their employees a Section 125 tax account to allow employees, regardless of their wage levels or income, to pay their share of health care with pre-tax dollars, reducing payroll taxes for both employees and employers.

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Is it true that there is no floor on how little coverage will be available to satisfy the mandate?

No. AB 1x1 directs the MRMIB to set the floor for what coverage will be the minimum necessary to meet the individual mandate requirements. MRMIB has more than 15 years experience in arranging for and providing comprehensive health coverage for Californians, including the state's Healthy Families program. AB 1x1 requires MRMIB to determine benefits for the individual insurance market which must at least include coverage for physician, hospital and preventive services and, at minimum, include the existing coverage requirements under law (such as mental health, and other mandated services that HMOs and health insurers currently have to provide coverage). AB 1x1 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 AB 1x1. Minimum coverage is the floor, not the ceiling. AB 1x1 would effectively ban "junk" individual insurance, and prohibit insurers from selling anything that didn't meet the minimum standard.

Will the minimum policy be the only benefit available to individuals buying their own coverage?

No. AB 1x1 better organizes the individual health insurance market and requires regulators to 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 every carrier, so that consumers will be better able to make "apples to apples" benefit and price comparisons. 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 AB 1x1. Every individual subject to the individual mandate will have guaranteed access to every individual market product regardless of any preexisting health condition or prior claims history.

Is it true that if you do not buy insurance within 62 days after the requirement kicks in, the Franchise Tax Board is authorized to collect premiums determined by the Managed Risk Medical Insurance Board by garnishment of wages or mortgage liens?

No. The Franchise Tax Board isn't authorized to do anything to enforce the individual mandate until the Legislature decides what is appropriate. Before implementation of the individual mandate, the Legislature must appropriate funds to implement the various requirements associated with the mandate. AB 1x1 requires MRMIB to adopt regulations through a public regulatory process, implement a statewide education and awareness program six months prior to the mandate taking effect, establish multiple entry points for enrolling in coverage, and notify the Legislature on how the mandate will be implemented.

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How does AB 1x1 affect currently insured employees who are not low income?

AB 1x1 does nothing to change or reduce benefits or coverage for employees whose employer currently provides coverage. The benefit categories and the minimum standards for coverage in AB 1x1 apply only to those individuals who are choosing to buy their own coverage as an individual, in the individual health insurance market, either because they are self-employed or health coverage is not offered to them through their job. The reasons that employers voluntarily provide health coverage to their workers now -- to attract and retain loyal employees, to ensure a healthy and productive workforce and to compete for the best, most qualified workers -- will remain a real part of the labor market and economy. Just as the existence of a minimum wage does not drive all wages to the minimum but rather sets a meaningful floor, so the individual mandated benefit levels will serve as a minimum from which employers can develop competitive benefits for their own employment sector and type of workers. In addition, employers and employees will have their costs for health care reduced through Section 125 pretax accounts that reduce payroll taxes for workers and employers.

Is it true there are no caps on what the employee would pay, only for the employer.

No. Employees are protected too. Through an expansion of public coverage, parents, caretaker relatives and adults without minor children who do not have employer-sponsored coverage with incomes at or below 150% of the federal poverty level would pay no premiums and would have no out-of-pocket costs. Individuals with incomes between 150-250% of the federal poverty level would have their premiums capped at no more than 5% of family income. AB 1x1 exempts individuals and families from the individual mandate if the person or family has an income at or below 250% of the federal poverty level and the person or family's share of premium exceeds 5% of his or her family income.

Individuals at all income levels will pay their share of health care premiums with pre-tax dollars, yielding significant savings.

How does AB 1x1 protect the health care safety net and ensure the financial stability of public hospitals?

Hospitals, including public hospitals, will receive significant increases in their reimbursement rates under the Medi-Cal program. In addition, AB 1x1 includes a local coverage option to ensure that county systems are able to maintain a stable patient base so that the specialty treatments provided by public hospitals, such as burn and trauma centers, remain available. The local coverage option gives county systems the exclusive right to be the providers of the new coverage for low-income, childless adults under 100% of the federal poverty level for five years.

How does AB 1x1 affect collective bargaining agreements related to health care?

The accompanying ballot initiative specifically protects all collective bargaining agreements. AB 1x1 establishes a floor similar to the minimum wage, requiring all employers to contribute a minimum amount to health care for their workers on a sliding fee scale from 1-6.5% depending

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on payroll. Labor negotiators have a stronger starting point from which to bargain for health care than is true today. As is true for the minimum wage, having a minimum does not cause all employers to move to the minimum but ensures a basic level of benefit.

In the ballot initiative, employers with collective bargaining agreements that require the employer to make health care expenditures on behalf of bargaining unit employees at least equal to the minimum spending requirements in AB 1x1, the employer will be deemed to be in compliance with the spending requirement in AB 1x1.

How do we know that there will be enough revenues? What protects the General Fund?

AB 1x1 and the initiative contain language making the implementation of the reforms contingent on a finding by the Director of the Department of Finance that sufficient funds and the required federal approvals are in fact available. Thus, the reforms which are scheduled to take effect beginning July 1, 2010, will occur only if sufficient revenues are available.

All through the year, the Legislature and the Administration have been working with economist John Gruber at MIT to model and price the reforms and the various versions of the reforms. The modeling has incorporated conservative assumptions on both the expenditure and the revenue side. We believe that we have done the due diligence to craft a responsible, self-financing proposal.

Why doesn't AB 1x1 include all the funding for it?

Unfortunately, the funding for AB 1x1 requires a two-thirds vote of the Legislature and Republicans in the Legislature refuse to vote for it. Therefore, it is necessary to have the voters approve the funding in a separate initiative. SB 840, the single payer initiative which the Legislature passed last year (and the Governor vetoed) would also have required a separate bill or initiative to fund it.

Can we be assured of the federal funds we are counting on for the program? How does the current federal State Childrens' Health Insurance Program (SCHIP) funding issue affect the plan?

The federal funds anticipated to support the reforms are modeled based on existing federal laws and the federal Center for Medicaid and Medicare Services (CMS) has said that California can expect to draw down federal funds as contemplated by the cost modeling for the public program expansions.

Given the current challenges with SCHIP funding at the federal level, to be conservative, the modeling does not assume increased SCHIP funds for the expansion population.

What is the impact of the county share of costs on county budgets?

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Counties are only being asked to share in the cost for the population that they currently receive state revenues for and which will now become the responsibility of the state, through the coverage expansion. Counties will only pay based on the number of low income persons that actually enroll in new coverage. The county share of costs will be capped on a county by county basis so counties know and can budget for their maximum total exposure with this fee. In addition, counties with public hospitals will benefit from increased Medi-Cal reimbursement rates and the local coverage option that gives county systems the exclusive right to be the providers of the new coverage for low-income, childless adults under 100% of the federal poverty level for five years.

How does AB 1x1 address rising health care costs?

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.
- 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.

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- 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 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.

Are we creating a new expensive state bureaucracy to administer this plan and the new programs?

No. The statewide purchasing program will become an additional duty of the existing for MRMIB. MRMIB currently administers the Healthy Families Program, the Access for Infants and Mothers Program for low income pregnant women and their children, and the Major Risk Medical Insurance Program for medically uninsurable persons. MRMIB has a track record of working with public and private health plans to make coverage options available for targeted populations. MRMIB is administered by a board composed of gubernatorial and legislative appointees and conducts deliberations and decision-making in public.