

MANAGED RISK MEDICAL INSURANCE BOARD
STATE LEGISLATIVE REPORT

February 9, 2011

NO CHANGES FROM PRIOR MEETING

Bill	Summary
AB 43 (Monning)	Medi-Cal: Eligibility
Version: I-12/6/2010	Would require the Department of Health Care Services to change Medi-Cal eligibility requirements to comply with the Medicaid expansions provided for in the federal Affordable Care Act beginning in 2014. The expansions are intended to include all non-elderly, non-pregnant and non-Medicare eligible individuals with adjusted incomes that do not exceed 133 percent of the federal poverty level. <i>Among other changes, the Medicaid expansion will change the income eligibility level for children ages 6 to 18 from 100 percent to 133 percent FPL and therefore change HFP income eligibility standards.</i>
Sponsor: Author	
Status: Introduced	
AB 52 (Feuer)	Health Care Coverage: Rate Approval
Version: I-12/6/2010	Would declare the intent of the Legislature to require that all health care service plans obtain approval from the Department of Managed Health Care and all health insurers obtain approval from the Department of Insurance in order to increase a premium, co-payment or deductible. The bill declares that the Affordable Care Act requires the federal government to work with the states to establish an annual review process of "unreasonable rate increases" and cites a Kaiser Family Foundation report finding that states with robust and transparent rate review processes have greater power to protect consumers from large rate increases.
Sponsor: Author	
Status: Introduced	
AB 62 (Monning)	Medi-Cal: Hospitals: Quality Assurance Fee
Version: I-12/7/2010	Would extend the quality assurance fee currently imposed on general acute care hospitals through October 15, 2015. The fee, first authorized in 2009 and approved by the Centers for Medicaid and Medicare Services in 2010, allowed the Department of Health Care Services to use the increased federal match provided by the American Reinvestment and Recovery Act for supplemental reimbursements to hospitals and managed health care plans and to provide \$80 million per quarter for health care coverage for children.
Sponsor: Author	
Status: Introduced	
AB 70 (Monning)	California Health and Human Services Agency: Public Health: Federal Grant Opportunities
Version: I-12/16/2010	Would require the California Health and Human Services Agency to direct the appropriate departments to apply for federal grants provided for by the Affordable Care Act and the Healthy, Hunger-Free Kids Act of 2010. Community Transformation Grants under the Affordable Care Act are to be awarded to state and local governmental agencies and community-based organizations to promote evidence-based community preventive health activities, including programs to increase healthy eating, physical activities, food security, smoking cessation, mental health and safety.
Sponsor: Author	
Status: Introduced	

SB 7 (Steinberg)**Medi-Cal: Hospitals: Quality Assurance Fee**

Version: I-12/6/2010

Sponsor: California
Hospital Association

Status: Introduced

Would extend the quality assurance fee currently imposed on general acute care hospitals through June 30, 2011. The fee, first authorized in 2009 and approved by the Centers for Medicaid and Medicare Services in 2010, allowed the Department of Health Care Services to use the increased federal match provided by the American Reinvestment and Recovery Act for supplemental reimbursements to hospitals and managed health care plans and to provide \$80 million per quarter for health care coverage for children.

SB 36 (Simitian)**County Health Initiative Matching Fund**

Version: I-12/6/2010

Sponsor: San Mateo
County

Status: Introduced

Would expand eligibility in the County Health Initiative Matching Fund program, also known as C-CHIP, to children in families with incomes between 300 and 400 percent of the federal poverty level. Participating counties would be allowed the option of whether or not to expand the income eligibility requirements. It would also expand eligibility requirements to include children who, although they have met the requirements for HFP, are unable to enroll when enrollment caps are utilized due to budget limitations. ***No state funds would be used to support these expansions. An identical bill, SB 1431, was passed by the Legislature in 2010, but vetoed by the Governor.***

SB 42 (Alquist)**Health Care Service Plans: Shared Savings Agreements**

Version: I-12/8/2010

Sponsor: Author

Status: Introduced

Would require Accountable Care Organizations and other risk-bearing organizations that enter into shared savings agreements with the United States Department of Health and Human Services to (1) file such agreements with the Department of Managed Health Care and (2) file any other documents DMHC deems appropriate for a determination of whether the ACO is subject to regulation under the Knox-Keene Health Care Service Plan Act of 1975. These types of entities are expected to increase because the Affordable Care Act provides for certain payments to ACOs that are able to meet quality performance standards and savings benchmarks.

SB 51 (Alquist)**Health Care Coverage: Benefit Limits: Medical Loss Ratio**

Version: I-12/15/2010

Sponsor: Author

Status: Introduced

Would require Health Care Service Plans and Health Insurers to comply with the Affordable Care Act's prohibition on lifetime limits and restricted annual limits. The bill would also require those same entities to comply with the Affordable Care Act's requirement to provide rebates to enrollees in plans that fall below the 85 percent and 80 percent medical loss ratios for large group coverage and small group / individual coverage, respectively.



February 14, 2011

WHY A BASIC HEALTH PLAN OPTION FOR CALIFORNIA

Background:

Section 1331 of the Affordable Care Act (ACA) provides for a state option to establish a separate program of coverage for persons with incomes between 134% - 200% of the FPL. It is estimated that there will be about 920,000 persons eligible in this income bracket. These persons would become eligible for the Basic Health Plan and would not be eligible to participate in the Exchange.

Section 1331 requires that the Basic Health Plan have a benefit structure that is less costly to participants than the Exchange. The Exchange subsidies are tied to the Silver level of the essential benefit which has a participant payment level of 30% of the cost of the coverage. The Basic Health Plan is required to have a benefit level that costs participants 10% of the cost of coverage for lower income persons and 20% for higher income participants.

The ACA provides for federal payment for the cost of coverage in the Basic Health Plan up to 95% of the cost of coverage in the Exchange. Premium rates and provider compensation would need to be at levels that would incur costs below this 95% of Exchange threshold to prevent state costs. The ACA requires that there be competition between health plans participating in the program.

REASONS FOR CALIFORNIA TO CONSIDER THE BASIC HEALTH PLAN OPTION

- ***Lower Costs for Consumers.*** Lower-income Californians would pay less for premiums and other out-of-pocket costs compared to the Exchange.
- ***Ensure Continuity of Care.*** Basic Health Program would be better equipped to prevent gaps in coverage as lower-income individuals and families are more likely to transition between coverage programs due to income fluctuations.
- ***Build on Existing Infrastructure.*** The Basic Health Program could be administered by MRMIB, as the program components are similar to the Healthy Families program. At the local level, many counties have built support for this population as part of the Coverage Initiative and the 1115 Waiver.
- ***Leverage Safety Net Providers.*** Safety net providers continue to deliver high quality care to lower-income Californians and are best positioned to meet the health needs of the population eligible for the Basic Health Plan.