

**ASSEMBLY BILL 8 (NUNEZ)
As Enrolled**

PAY OR PLAY REQUIREMENTS: (effective 1/1/10)

- AB 8 would require an employer to either spend an amount equivalent to at least 7.5% of Social Security wages (capped at \$97,500 in 2007) on health care or pay an equivalent amount to the new California Health Trust Fund. Employers make separate elections for full time and part-time employees. Full time is defined as working 120 or more hours/month.
 - According to estimates produced by Jonathon Gruber, an MIT economist, who has been producing estimates for all California health care reform proposals: 21.2 million lives would be covered by playing employers and 4.9 million by paying employers.
 - Employers of in-home support workers are exempt from the requirement that employers purchase or pay for coverage. Employers required by any collective bargaining agreement under the Labor Management Relations Act to make health care expenditures are deemed to have satisfied the “pay or play” requirement for those employees whether or not they meet the 7.5% threshold for full-time and part-time employees separately or in the aggregate.
 - Employers must make their first election by July 1 2009. The first election to pay the fee is for a two year period. Subsequent elections must be made on or before September 15th annually. Employers must pay the fee or start making the health expenditures on October 1, 2009
- Qualifying health care expenditures that satisfy the 7.5% expenditure requirement include: contributing to a health savings account, reimbursing employees for health care expenses, establishing programs to assist employees attain and maintain health and healthy lifestyles (such as on-site health fairs and clinics), disease management programs, or buying health care coverage from a health plan or insurer.
- Employees are required to “take-up” coverage. Dependents are not.
 - AB 8 provides for exceptions to the “take-up requirement” when an employee has other coverage.
 - Employees are not required to enroll in Cal-CHIPP or employer provided coverage if they demonstrate they have individual coverage that was in place when the law becomes effective or any time that they have other group or public coverage. Employees of “pay” employers can also be exempt if they have public coverage.
 - Those exempt from the take-up for Cal-CHIPP can purchase it if they choose.
 - AB 8 provides an exemption from the take-up requirement if coverage is unaffordable.
 - Employees of playing employers are exempt if the cost for annual health expenditures would exceed 5% of their annual wages, taking into account their potential cost-savings for participating in a Section 125 plan;
 - Employees of paying employers are exempt if the cost of their coverage for a product with a maximum out of pocket of \$1,500 is greater than 5%.

Comment: 4802.3

- Employers are required to provide notice to their employees of the availability of subsidized coverage, the requirement to take-up coverage and the exemptions.
- AB 8 would prohibit employers from attempting to avoid the requirements of law by designating an employee as a contractor or temporary worker, reducing a worker's hours, or firing and rehiring a worker.

Comment: 4829

ESTABLISHMENT OF POOL FOR PAYING EMPLOYERS: (effective 1/1/10)

- Employees (and their dependents) working for employers electing to pay the 7.5% fee would receive their coverage through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as of January 1, 2010.
- The Employment Development Department (EDD) would collect fees from paying employers and deposit them in the California Health Trust Fund.
 - EDD, in consultation, with MRMIB is, required to deposit funds so that they are available for timely enrollment of subscribers.
 - The bill authorizes a General Fund loan for EDD expenses occurring prior to January 1, 2011. Loan proceeds are subject to appropriation in the annual budget act.
 - EDD may require reimbursement for all direct costs incurred related to the provision of any and all information related administering and enforcing Cal-CHIPP with funds collected by MRMIB for the program.
 - EDD can charge penalties when an employer does not pay timely.
- If an employee were interested in subsidized coverage (see Public Coverage Section below) he or she could apply for it. If eligible, they would select a Cal-CHIPP Medi-Cal plan or Cal-CHIPP Healthy Families plan (depending on family income).

Comment: 12699.217

Comment: 1095.1

- Gruber estimates that of the 4.9 million lives covered under the pay mechanism 4.2 million would be subsidized and 0.7 million would be unsubsidized,

- MRMIB would offer:
 - Unsubsidized Cal-CHIPP participants "various" benefit plan designs that (1) comply with Knox-Keene Act requirements plus prescription drug coverage and (2) have cost-sharing levels that promote prevention and health maintenance. The products are to have varying benefit levels, deductibles, coinsurance and annual limits on out-of-pocket expenses.
 - Subsidized Cal-CHIPP participants a Cal-CHIPP Healthy Families or Medi-Cal Cal-CHIPP plan.
 - For children (in either HFP or MC) and caretaker relatives who are Medi-Cal eligible, the benefits must be comparable to the benefits in the regular HFP and Medi-Cal programs. The Board is to contract with DHCS to provide the Medi-Cal program.
 - For caretaker relatives in HFP, the benefits must be Knox-Keene plus drugs and satisfy federal requirements.
 - The Board is also directed to offer a "low cost" plan for childless adults with incomes at or under 300% FPL.
- For prescription drugs, MRMIB is authorized to contract with a health plan, contract with a pharmacy benefit manager, procure drugs through the Department of General Services drug procurement program, or any combination thereof. If it chooses to

Comment: 12699.203

contract with a pharmacy benefit manager or to procure drugs through DGS MRMIB
|allow other state and local governmental entities and labor organizations or other
collective bargaining entity to participate in the program

Comment: 12699.206.1

- Health plans and insurance carriers with more than a million lives are required to submit a good faith bid to MRMIB for participation in Cal-CHIPP.
- MRMIB is required to negotiate with Medi-Cal managed care plans.
- Employees and their dependents would retain eligibility in Cal-CHIPP for two months even if their employer failed to pay the required fee. The Board may allow an employee to pay directly for up to an additional 36 months.
- The bill authorizes a General Fund loan for Cal-CHIPP expenses.
- The Board is authorized to establish eligibility rules and processes but is encouraged to consider using existing eligibility processes for determining HFP and MC eligibility, including eligibility determinations made by counties.
- AB 8 would authorize MRMIB to adjust the fee paid to Cal-CHIPP by employers by October 31st of each year and adjust subscriber premiums after considering the costs of health care typically paid for by employers and employees in California,

SECTION 125 PLANS

- Under Section 125 of the Internal Revenue Code, employers can allow employees to pay their portion of health insurance premiums on a pre-tax basis. AB 8 would require all employers to establish a Section 125 Plan, unless prohibited by law.
 - o Employees save money because their income for taxable purposes is reduced by the amount spent on health insurance premiums. Savings accrue from reductions in Federal Insurance Contributions Act (FICA) taxes, federal income taxes and state taxes.
 - Worker savings would range from 17.65% to over 42% of worker premium payments, depending on income and family structure.
 - o Employers experience a reduction in their taxable payroll and therefore pay less in FICA taxes.
 - Employer savings would equal 7.65% of the workers' premiums paid through the Section 125 plan (this is the employer's share of FICA on the amount by which taxable salary is reduced).
- Penalties would be levied on employer failing to establish a cafeteria plan.

PUBLIC COVERAGE EXPANSIONS FOR LOW-INCOME CHILDREN AND CARETAKER RELATIVES

CHILDREN'S COVERAGE (effective 7/1/08)

- AB 8 would expand income eligibility for the Healthy Families Program (HFP) from 250% of federal poverty level (FPL), to at or below 300% FPL, (from \$42,925 for a family of three to at or below \$51,500 for a family of three).
 - o Children in families with incomes of 250% FPL to 300% FPL would pay monthly

premiums of \$22 to \$25 per child, up to a maximum family monthly premium of \$75.

- AB 8 would make full-scope Medi-Cal and HFP available to children regardless of their documentation status.
- AB 8 would establish a Medi-Cal floor at 133% of the federal poverty level (at or below \$22,836 for a family of three) for all children ages 1 to 18.
 - Under AB 8, all children ages 1 to 18 with incomes below 133% FPL would be eligible for Medi-Cal. All children aged 1 to 18 with incomes between 133% and 300% FPL would be eligible for the HFP. Current law would not change for infants 0 to 1 (allows families with income up to 200% FPL in Medi-Cal).
- Children already in the Healthy Families program whose parents work for “pay” employers would be moved into the Cal-CHIPP HFP at their annual eligibility review or earlier, upon request.

Comment: 12693.621

COVERAGE of CARETAKER RELATIVES (effective 7/1/08)

- AB 8 would expand eligibility in Medi-Cal and HFP to low-income, working parents of children with family incomes between 100% (at or below \$17,170 for a family of three) and 300% of FPL.
- Parents with family incomes between 100% to 133% would receive coverage through Medi-Cal. Those with incomes between 133% to 300% FPL would enroll in a HFP benchmark benefit package.

HORIZONTAL EQUITY **Effective 7/1/08**

- AB 8 would require Carriers providing coverage to play employers to collect the employer premium for any employee in Medi-Cal or HFP and transmit it to MRMIB to offset costs for Cal-CHIPP HFP or Cal-CHIPP Medi-Cal coverage.
- Carriers are required to notify employees of the availability of subsidized coverage in their evidence of coverage documents.

INSURANCE MARKET REFORMS

Individual Market Reforms (effective 7/1/08)

- MRMIB would develop a list of medical conditions to determine a person's eligibility for MRMIP. The purpose of the list is to identify the 3% to 5% of people who are the most expensive to treat.
 - MRMIB would design a health status questionnaire which carriers would have applicants fill out to identify persons with the list of conditions established above. While there is no explicit date by which these activities must be done, they have to be completed prior to the 7/1/08 provision immediately below.
- Starting 1/1/09, carriers would have to sell coverage on a guaranteed issue basis to any person that does not have one of the conditions on the list. Any person that does have such a condition will be referred to the high risk pool. These persons are "automatically eligible" for MRMIP. Effective 7/1/08

- By 9/1/08, the regulators jointly will adopt regulations establishing 5 classes of benefits that carriers must guarantee issue and renew to anyone other than the 3% to 5% of individuals identified as high-risk by the questionnaire. They are to approve carrier's products by ninety days after the regulations are promulgated.
 - Each class shall reflect a reasonable continuum between the class with the lowest and highest benefits with each class having an increased level of benefits.
 - Each class shall have one baseline HMO and one PPO.
 - The regulators must assure that the plans provide for reasonable benefit variation.
- Subscribers can change classes of benefits, as follows:
 - During the month of birth, the subscriber can change one level up.
 - Movement to a lower class can be at any time.
 - After a significant life event, (such as divorce, death of spouse, adoption), subscriber may move up to any higher class.
- Rate variance is allowed for age, family size and geographic regions, all as determined by the regulators. Carriers are also allowed to provide health improvement discounts.

Mid-Size Employer Market Reforms (effective 7/1/08)

- AB 8 would extend protections to mid-size employers with 51 to 100 or employees, currently given to small employers (2 to 50 employees). (Note: The 7/18/07 version of AB 8 included employers up to 250 employees). Specifically, plans/insurers selling coverage to employers with 51 to 100 employees would be required to guarantee issue all health insurance products, publish rates, and use rate bands that limit the variation in premiums charged. Currently, a 10% variation is allowed for rates charged to employers that have 2 to 50. These rate bands would be phased out for employers with 2 to 50 and 51 to 100 employees as of January 1, 2010.

Minimum Medical Loss Ratios (effective 7/1/08)

- AB 8 would require the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) each to adopt a regulation by 7/1/08 requiring at least 85% of health plan and insurer revenue be spent on health care services, referred to as a "medical loss ratio." "Health care services" would be defined by regulations issued by the DOI and DMHC. The requirement applies across all markets.

ENROLLMENT SIMPLIFICATION (effective 7/1/08)

- Under current law, in order to be eligible for 1931(b) Medi-Cal coverage, a family's countable property cannot exceed certain dollar thresholds depending upon the number of people in the family. AB 8 eliminates the asset test to expand coverage. It would eliminate the requirement that certain adult Medi-Cal beneficiaries file a semiannual status report, but still requires beneficiaries to submit an annual reaffirmation indicating their ongoing eligibility for the program.

CALIFORNIA HEALTH BENEFITS SERVICE (effective 1/1/08)

- AB 8 would create California Health Benefits Service (CHBS) within the California Health and Human Services Agency to assist in creating and maintaining joint ventures among

“public” health plans such as county organized health systems and local initiatives and in contracting directly with providers in counties in which there is no public plan. In forming joint ventures, CHBS and participating health plans are to seek to contract with the 22 designated public hospitals, county health clinics, and community clinics. Any joint ventures CHBS establishes must be obtain a Knox-Keene license.

- The CHBS would be overseen by a 9-member board with three members representing local initiatives (appointed by the Governor, Senate and Assembly) two representing county-operated health systems (appointed by Governor and Senate), one each representing health care purchasers (appointed by Governor), consumers (appointed by Senate), health care providers and organized labor (both appointed by Assembly). The CHBS would hire an Executive Director, who would hire staff, as needed.
- CHHS would convene a workgroup consisting of MRMIB, DMHC, and DHCS to make recommendations about regulatory, statutory and financial barriers to 1) joint ventures between local initiatives and 2) directly contract with providers in counties with no prepaid publicly-run health plans. The working group shall report its findings by April 2008 to the executive director, the CHBS governing board, and the committees of jurisdiction in the Senate and Assembly.
- AB 8 requires that the DMHC Director provide regulatory and programmatic “flexibilities” to “facilitate” new licenses or modify existing licenses issued to local initiatives, county operated health systems or California Health Benefit Service “joint ventures” seeking to participate in CalCHIP or provide coverage in the individual and group market.

HEALTH CARE COST AND QUALITY TRANSPARENCY COMMISSION (effective 7/1/08)

- AB 8 would create a 13-member Healthcare Cost and Quality Transparency Commission (HCQTC) within CHHS charged with developing and maintaining a health care quality and cost containment plan that will result in transparent public reporting of safety, quality and cost efficiency information at all levels of the health care system.
- Members (volunteers) would be appointed by the Governor, Senate and Assembly, and they would include:
 - Representatives of academia/research, hospitals, a multi-specialty medical provider group, physicians/surgeons, large employers that purchase group coverage, labor unions, an employer that purchases group coverage or a nonprofit organization working with employers to enhance coverage affordability, consumers, health insurers or health care service plans, and small employers that purchase group coverage or a nonprofit labor-management purchaser coalition that works with employers and employees to enhance health care affordability.
 - Ex officio, nonvoting members: the HHS Secretary, the DMHC Director, the MRMIB Executive Director, and the Insurance Commissioner or their designees, and a designee of the California Public Employees’ Retirement System.
- It would be allowed to impose fees on data sources and data users, obtain grants and contributions, and impose civil and financial penalties on entities that fail to provide required data.
- By December 1, 2008 and annually it is to provide a report on patient safety and inpatient quality indicators. By 7/1/10 it is to publish a report about infections associated with acute care hospitals.

Performance Benchmarks and Best Practice Standards

- CHHS in consultation with the Board of Administration of the Public Employees' Retirement System will develop health care provider performance measurement benchmarks and incorporate these benchmarks into a common pay for performance model to be offered in every state-administered health care program, including, but not limited to, the Public Employees' Medical and Hospital Care Act, the Healthy Families Program, the Major Risk Medical Insurance Program, the Medi-Cal program, and Cal-CHIPP.
- CHHS, in consultation with the Board of Administration of the Public Employees' Retirement System, will develop and adopt best practice standards in the care and treatment of patients with high-cost chronic diseases. Upon adoption of the standards, each state health care program, including, but not limited to, programs offered under the Public Employees' Medical and Hospital Care Act, the Medi-Cal program, the Healthy Families Program, the Major Risk Medical Insurance Program, and the California Cooperative Health Insurance Purchasing Program, shall implement those standards.

EVALUATION (effective 1/1/08)

- AB 8 requires CHHS to undertake an evaluation to track and assess the effects of health care reform and the sustainability of Cal-CHIPP.
- A five-member advisory body with legislative and gubernatorial appointments would guide the assessment and, with CHHS, would establish a timeline for reporting data annually to the Legislature, including data about employer compliance and cost of health coverage in the state.
- The assessment would include, for example, the number of people receiving coverage through the purchasing pool, the cost and affordability of health care, the quality of health care services, the change in access and availability of health care throughout the state, and the impact of reforms on employers, employment, employer-based health coverage, and the county health care system, including uncompensated care and emergency-room use.