

California wrestles with how to deal with impact of health care reform

3M people may have to be added to Medi-Cal

By Timm Herdt

Sunday, August 14, 2011

SACRAMENTO — Even as a new round of federal budget-cutting that could target Medicaid is poised to take place and Republicans in Congress continue their fight to block the implementation of health care reform, health policy experts in Sacramento are plowing through a thicket of issues that must be resolved before a historic expansion of insurance coverage can be implemented in 2014.

"Regardless of the ongoing debate around the country about the Affordable Care Act, implementation from the federal perspective is full speed ahead," said Richard Figueroa, health reform manager for the nonprofit California Endowment. "And most states have been gearing up on the theory that it's better for them to own it."

Already this month two of the state's leading health policy think tanks have issued detailed reports outlining various challenges and opportunities that will be presented by adding up to 3 million new beneficiaries to Medi-Cal and opening a Health Benefit Exchange that is expected to facilitate the purchase of partially subsidized private insurance for 2 million Californians.

One of the core questions to emerge is how best to accommodate the working poor, the low-income workers who earn too much to qualify for Medi-Cal, are least likely to have job-based insurance coverage and are most likely to now be uninsured.

Should those on the bottom rungs of this group be left to fend for themselves to purchase private insurance through the exchange, or should the state avail itself of a little-known provision in the federal act that allows it to create what is known as a Basic Health Program that would offer insurance under slightly different rules?

The question has divided policymakers, as Senate Health Committee Chairman Ed Hernandez, D-Los Angeles, is backing legislation that would put California at the forefront in creating a state-run basic health plan, while the operators of the exchange are opposing the legislation unless it is put on hold for at least a year.

If approved, the program would go into effect at the same time the new federal law and the health insurance purchasing exchanges become operative, on Jan. 1, 2014.

The bill, SB 703, is sponsored by Local Health Plans of California, an association of a dozen safety-net health care plans around the state. Executive Director John Ramey asserts creating a basic health plan would be a win-win-win proposition for California because it would provide better coverage at a better price to consumers, at less cost to taxpayers.

"What makes it possible is that California has an average-priced individual health insurance market and below-average Medi-Cal reimbursement rates," he said.

He believes a basic health plan, operated through a network of safety-net providers, can make insurance more affordable to consumers while also providing payments to providers that are above Medi-Cal rates.

The plan would be open only to those with incomes of between 133 percent and 200 percent of the federal poverty level, or between \$14,484 and \$21,780 a year for an individual.

Ramey estimates that plans purchased through the exchange would cost such individuals an average of \$200 a month, between premiums, copays and deductibles.

Directors of the Health Benefit Exchange say Hernandez and the bill's backers are getting too far out front, arguing the cost estimates are uncertain and federal regulators have yet to issue detailed guidelines on how the basic health programs would work.

The board voted last month to oppose the bill unless it is put on hold for at least a year.

Without the federal guidelines, no one can "fully understand the risks and benefits for states associated with this optional program," acting Administrative Officer Patricia Powers wrote in a letter to Hernandez.

Officials with the Health Benefit Exchange are concerned that the creation of a Basic Health Program in California could significantly reduce the pool of consumers who would purchase private plans through the exchange and potentially adversely affect the risk pool, which would make it more difficult for the exchange to negotiate for low prices.

An analysis by the nonprofit California Healthcare Foundation estimates the exchange could enroll about 2 million people in the individual insurance market after three years of operation, but that enrollment would be "considerably lower" if the Basic Health Program is established.

Hernandez said he understands the concerns of the exchange board but believes the creation of a more affordable option would actually improve the risk pool.

"Let's say we don't have a Basic Health Program," he said. "This segment of the population may not be able to afford it, and may forgo buying insurance until they actually need it."

Ramey said that for someone making \$2,000 a month, the prospect of having to pay a \$95 penalty for not complying with the individual mandate in the first year will seem more palatable than signing up for a plan that would cost them more than that each month.

Hernandez said he envisions the Basic Health Program as "Healthy Families for adults," referring to the children's health insurance program that is available for children in families of the working poor.

A key benefit is that, just as does Healthy Families, it would provide a higher reimbursement rate to doctors, hospitals and other medical providers than Medi-Cal, although lower than private insurance.

That would be an important benefit, he said, because it would produce more revenue for providers that work in low-income communities.

"I can speak from experience because I'm a provider," said Hernandez, who is an optometrist.

"Thirty percent of my patients are Medi-Cal patients, and for them I receive 30 cents on the dollar."

Figueroa of the California Endowment said one potential benefit of a Basic Health Program is that it would likely promote continuity of care for low-income patients. Because their incomes often fluctuate, they can go on and off Medi-Cal depending on their status at any given time. Advocates believe it is likely that the same providers these patients would see when covered by the higher-paying plan would continue to see them if they go back onto Medi-Cal, he said.

Figueroa, who expressed no opinion on the bill, said it is understandable why some would urge caution.

Since the federal regulations regarding Basic Health Programs are not yet out, he said, many of the estimates about premium costs, the level of federal subsidies and the provider reimbursement rates are "based on assumptions."

The fate of the bill is now in the hands of the Assembly Appropriations Committee, and Hernandez said he will continue to press for passage this year.



Los Angeles Times

Editorial

Putting health coverage within reach

The Basic Health Program being considered by California lawmakers would put insurance within reach of more of the working poor.

August 29,
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To bring health insurance to more Americans, the federal healthcare reform law calls for billions of dollars in subsidies for lower-income households. The law gives states an option, though, that could cut costs while also making the coverage more affordable. Called a Basic Health Program, it would serve as a transitional step between Medicaid and the private insurance plans. A bill by state Sen. Ed Hernandez (D-West Covina) to create such an option in California is pending. Lawmakers should approve it.

The program would give low-income families an alternative to the insurance exchange that California is creating for consumers not covered by employer-sponsored plans or MediCal. Although Washington will subsidize policies sold at the exchange to those earning up to four times the [federal poverty level](#), they may still cost too much for some of the working poor. For example, a single mother making \$600 a week in Los Angeles may be hard-pressed to afford the \$90 in monthly premiums and co-payments that the exchange's entry-level plans are expected to cost.

The Basic Health Program created by Hernandez's bill ([SB 703](#)) would bring monthly costs down to about \$30 for those earning less than twice the federal poverty level. At the same time, the coverage provided by the bill, which relies solely on federal funds, would cost taxpayers less than the subsidized private insurance plans at the exchange. That's because the Basic Health Program would pay doctors and hospitals less for their services than private insurers do. Those payments would still be higher than the notoriously low ones offered by MediCal, which should prompt more doctors and hospitals to participate and provide better access to care than MediCal.

Some state officials have suggested that the new program could undermine the exchange by reducing the total amount of premiums it collects and, potentially, leave it with older and costlier customers. But with an estimated 1.8 million people still under its purview, the exchange's risks and costs would be spread across one of the largest groups of customers in the country. Two new studies also suggest that the Basic Health Program wouldn't leave the exchange with a group that's costlier to insure. But if lawmakers want more certainty, they can require insurers to combine both groups into a single risk pool when calculating premiums.

When poor people without insurance require medical care, they tend to receive it in the least efficient and most expensive ways, with the costs borne by everyone else. That's one of the reasons it's important to extend coverage to as many people as possible. The Basic Health Program and the state's new insurance exchange share that goal, but the former would put insurance within reach of more of the working poor. That makes it an important part of the evolving healthcare system, and a good deal for taxpayers.

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Viewpoints: Controlling costs must be paramount in health care reform

Special to The Bee

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This is a critical time for the Affordable Care Act, the health care reform law passed by Congress last year. There is much at stake – for businesses, for consumers and for our economy. At the Bay Area Council, we believe the entire business community can and must play an active and vocal role in keeping cost control at the center of the health care reform bull's-eye.

Rising health care costs continue to be a scourge on our economy, sapping resources and capital, and hampering our efforts to put the Great Recession behind us and start creating jobs. While the current economic malaise has reduced the rate at which costs are increasing, spending on health care nationwide continues to outpace the economy. Projecting from the latest figures from the California HealthCare Foundation, California health care spending has risen by 225 percent over the past two decades.

Spiraling health care costs also put California and the United States at a severe competitive disadvantage in the global economy, where U.S. manufacturers spend \$2,726 more per worker annually on health benefits than our direct foreign competitors. Overall, our per capita spending on health care is double that of most other developed countries, but we don't have healthier people or healthier communities to show for our investment.

Reducing health care costs is one of the main goals of health care reform. And yet, there are early signs that the detailed work of implementing the Affordable Care Act may be straying from the course of controlling costs through improving medical quality and effective care. One example is a bill that we believe will diminish the power of competition to reduce health care costs and provide consumers with affordable insurance.

Senate Bill 703, authored by Sen. Ed Hernandez, D-West Covina, would effectively remove 700,000 people from a competitive marketplace, the new California Health Benefit Exchange. It moves them instead into a government-run, Medi-Cal-type program. This has the potential to shift more costs to California businesses and to raise the cost of insurance premiums for middle class consumers who purchase their insurance through the exchange. So far, the bill has received little public attention. Whether or not the bill moves this year, these crucial decisions need to be on the radar screens of businesses and of those who want to see the health care reform succeed.

While not all businesses in California supported the Affordable Care Act, it now is the law of the land. We want it to work by having our California health system get dramatically more efficient at producing health care. The innovation in the tech sector that revolutionized communication can be similarly harnessed in the health sector. California business models, purchasing strategies,

and medical and technological innovation are a critical component of the transformation of our system.

Passage of the Affordable Care Act was the first step. As hard as this is to believe given all of the political conflict it caused, passing the law may have been the easiest part. Now begins the hard work of implementing health care reform. The pace of implementation is only going to quicken over the next three years. Not getting on board now means abdicating any responsibility for the outcome. That's why the Bay Area Council has and will continue to be engaged in this critical task of working toward a system with universal access to quality, affordable health care.

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Viewpoints: Health plan would offer same benefits but lower premiums

Special to The Bee

Published Tuesday, Aug. 30, 2011

Overshadowed by the drama, delays and deal-making at the state Capitol in recent months, groundbreaking legislation that would position California at the forefront of national health care reform is under consideration by the state Assembly.

Passage of the bill would be a major achievement for the Legislature, which badly needs to chalk up a major achievement this year.

Written by Sen. Ed Hernandez, D-West Covina, Senate Bill 703 would provide more than 720,000 low-income Californians with quality health insurance coverage for as little as \$20 a month – with no additional cost to state taxpayers.

The federal Patient Protection and Affordable Care Act signed into law by President Barack Obama in 2010 allows states to create a state-run, federally financed basic health program for low-income individuals. It is targeted at low-income working adults with incomes just above Medicaid levels – \$15,000 to \$21,800 – as well as legal immigrants who are not eligible for Medicaid. These Medicaid-like plans would be a more affordable alternative to buying federally mandated insurance from the exchange – the new marketplace of plans from which uninsured Californians will buy their health insurance coverage.

Sponsored by Local Health Plans of California, the association of nonprofit plans that serve the state's highest populated counties, SB 703 also has earned broad support from health care stakeholders including the Service Employees International Union, Planned Parenthood, Molina Healthcare and the California Association of Public Hospitals.

Establishing the basic health program in 2014 will benefit consumers, the state, and health care providers – with benefits, premiums and out-of-pocket costs similar to the state Healthy Families Program.

According to an independent Mercer study funded by the California HealthCare Foundation, the basic health program would offer consumers the exact same benefits as offered by the exchange but with significantly lower premiums. In addition, the percentage of health care paid for by insurance, rather than consumers in the form of co-payments and deductibles, is also estimated to be significantly lower in the basic health program. The state would contract with health plans for coverage that meets essential health benefit requirements.

The Mercer study estimates that 70 percent of eligible Californians would buy these plans. These are individuals who would be required under federal law to purchase insurance ("the individual mandate"), but who may not be able to afford a policy offered by the exchange or can't afford health care due to cost-sharing that individuals must pay when receiving services.

Because premiums and cost-sharing in the basic health program are estimated to be less than in the exchange, more Californians will be able to afford insurance and have access to health care providers. In turn, compliance with the individual mandate will increase, and uncompensated care costs will decrease for health care providers.

Federal subsidies and premiums paid by people enrolled in coverage would cover the cost of the basic health program, according to the Mercer study. Beyond that, the study concludes that provider payments could be increased by 20 percent to 25 percent over current reimbursement rates for Medi-Cal providers – those who serve as the safety net for the poor and uninsured – at no extra cost to the state's general fund.

The success of health care reform may well depend on how California insures working individuals and families in a short time. There is no better opportunity than the present to establish a basic health program in California. It will give the state and health care providers a chance to launch and market the program, secure contracts and begin providing basic health care to nearly 750,000 uninsured Californians.

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Businesses, proponents take stand on basic health plan at Capitol

Los Angeles Business from bizjournals - by [Kathy Robertson](#), Sacramento Business Journal

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Business leaders took to the Capitol steps Monday to criticize legislation they say would reduce the market clout of California's health insurance exchange by allowing thousands of low-income workers to sign up with a different program.

Proponents of the proposed Basic Health Program — who called a press conference for the same time and place — say something has to be done for folks who can't afford the exchange, even with government subsidies.

The focus was Senate Bill 703, important but low-profile legislation hanging precariously before the Assembly Appropriations Committee as lawmakers muscle legislation to the governor's desk in the last weeks of the session. A hearing on the bill scheduled last week was postponed.

The bill would create a state-administered, federally financed program that offers basic coverage for as little as \$30 a month, beginning in 2014.

The program would be open to individuals with incomes between 133 percent and 200 percent below the federal poverty line who do not have access to employer-sponsored coverage and are not eligible for Medicaid. That means up to \$44,700 for a family of four.

The alternate plan could remove 700,000 people from the California Health Benefit Exchange, eroding purchasing power and possibly leading to higher rates for California businesses, said **Jim Wunderman**, president and chief executive officer at the Bay Area Council, a coalition of large and small businesses in nine Bay Area counties.

"We are hopeful it won't pass this year," Wunderman said.

The Basic Health Plan, allowed under federal health reform, makes coverage affordable to those who can't afford premiums in the exchange estimated to run \$150 to \$200 a month, countered **John Ramey**, executive director of **Local Health Plans of California**, sponsor of the bill. The association represents nonprofit public plans that serve Medi-Cal members in selected counties.

The proposed plan works because providers have agreed to take less reimbursement, Ramey said.

“We focus on low-income workers who will find the exchange — even with subsidies — out of reach,” he said. “There’s a lot at issue, but we could see it happen this year. If not, it would be much more difficult next year.”

Plan to expand benefits draws opposition

Posted By [Dan](#) On September 2, 2011 @ 10:22 pm In [California Health Report](#) | [No Comments](#)

By Joshua Emerson Smith

A network of doctors, community hospitals and public health plans is proposing a new, low-cost health plan for some of California's low-income residents.

But a state agency created to implement the federal health reform law is opposing the idea, saying the low-cost plan would undercut efforts to create a new insurance exchange from which millions of Californians will begin buying their coverage in 2014.

Senate Bill 703 would establish a "Basic Health Program" aimed at serving over 720,000 working adults in California, whose income is between 133 percent and 200 percent of the Federal poverty level: \$15,000 to 21,800 a year. The program would also serve legal immigrants who are not eligible for Medicaid.

Those are people the Health Benefits Exchange Board was counting on as potential enrollees in their program. The Exchange board recently came out in opposition to the bill, asking to postpone a vote until next year.

"The Basic Health Program could remove up to 70 percent of the people who are eligible for subsidies and generally healthy from the Exchange," said Patricia Powers, Acting Administrative Officer for the California Health Benefit Exchange. "This diminishes the Exchange's purchasing power and efficiencies to be gained from economies of scale. It may result in a less healthy remaining population overall."

However, many people will not be able to afford insurance through the Exchange and without the Basic Health Program will opt out of the system completely, said Tim Valderrama, spokesman for author of the bill Ed Hernandez (D - Senate District 24).

"While the Basic Health Program removes lives from the Exchange, California will still have either the largest or one of the largest exchange populations in the country," he said. "If exchanges at all will work, California's will be large enough even with this population removed."

The Basic Health Program will cost a person roughly 30 dollars a month, according to two independent studies by Mercer and the Urban Institute. Estimates run from 150 to 200 dollars a month for insurance offered to the same population through the Health Exchange, which has been designed to offer products from commercial insurance companies.

The Basic Health Plan would be able to offer significantly lower rates because it would contract with California's network of community hospitals, doctors, and public health plans, which accept Medicaid reimbursements rates, said John Raimey, Executive Director of Local Health Plans of California, a lobby group representing non-profit health insurance providers.

"Low income working people is the population we serve," he said. "Our health plans are well acquainted with what their capacity for buying health insurance is and how much disposable income they have. Plus our provider networks are where these folks go to access coverage."

There has been talk of trying to fuse the Exchange and the Basic Health Program, but specifics are still unclear. Powers said shifting SB 703 to a two-year bill would allow time to better evaluate ways to address affordability and choice for people who qualify for the program.

"We need to examine alternatives such as an Exchange-based BHP that offers choices of public and commercial health plans, she said. "We need to think about optimum ways to assist people so that when their income fluctuates they do not have to change health plans or doctors. Especially because initial analyses show that people eligible for the BHP experience high income fluctuations and will be moving in and out of the program."

The benefit terms of state-run health plans, created under last year's health care overhaul, have yet to be defined by the federal government. The Basic Health Program is optional for states and would receive Federal reimbursements rates similar to the Exchange.

SB 703 has been passed out of the Senate and is currently in the Assembly Appropriations Committee.

Pre-existing plan lowers premiums

Sunday, August 14, 2011

SACRAMENTO —The state insurance pool established under the federal health care reform law to provide coverage to those with pre-existing medical conditions has lowered its premiums and made it easier for individuals to qualify for insurance.

California is one of 27 states that have established Pre-existing Condition Insurance Plans under the law. Those plans are designed to bridge the gap until Jan. 1, 2014, when all insurers will be prohibited from denying coverage based on pre-existing medical conditions.

Prices vary by region and age of the insured. For someone in Ventura County between 40 and 45, the cost of individual coverage will drop from \$304 to \$261 per month.

For someone between 50 and 55, the new monthly premium will be \$370, down from \$445.

Spokeswoman Jeanie Esajian said the plans are priced at no more than what it would cost a healthy person of the same age.

The new rates take effect in October, but those who enroll before then will receive credits for the difference that will be deducted from future premiums.

To qualify, individuals must have been without insurance for at least six months. Previously, they had been required to show that they had been denied coverage based on their medical history, but a change in policy now allows people to qualify if a doctor or other medical provider certifies that they have a condition that would likely disqualify them from market-priced private insurance.

About 4,000 Californians now receive coverage through the plan, well below its projected capacity.

Esajian said the requirement that individuals must have gone without insurance for at least six months is a barrier for some people. Those with chronic medical conditions who are now paying inflated premiums to obtain coverage, she said, "are reluctant to drop the insurance they have and go without for six months."

Those who have no insurance often balk at even the market-based premiums offered by the Pre-Existing Condition Insurance Plan, Esajian said. "If you haven't had insurance in a long time, even a well-priced plan can be a barrier."

For details on the plan and information on how to apply, go to <http://www.pcip.ca.gov>.

Timm Herdt



California Office of AIDS Expands Its Insurance Premium Assistance

By Jacques Chambers

Autumn 2011

For several years, the California Office of AIDS has been paying health insurance premiums for qualified beneficiaries under the CARE/HIPP Plan. That program was greatly expanded effective July 1, 2011. It increases the financial requirement so that more will be eligible. It also increases the amount of monthly premiums it will pay and the program is no longer time limited. For the first time, it will also pay partial premiums for plans whose premium exceeds their new limit of \$1,339 per month for non-ADAP clients and \$1,938 per month for ADAP clients.

Since Medicare Drug Coverage was started in 2006, it has also had a program under AIDS Drug Assistance Program (ADAP) to pay the premiums for Medicare Part D beneficiaries on ADAP.

Now it is adding a new program for people who have not been able to get health insurance. It will begin paying premiums for the new Pre-Existing Conditions Insurance Plan (ADAP) created under the new Affordable Healthcare Act (ACA).

For more information on obtaining assistance in enrolling in these plans, contact your local Aids service organization or see the Office of AIDS Web site at www.cdph.ca.gov/programs/aids/Pages/OAIAS.aspx.

Enrollers are currently being trained to not only enroll you in the premium assistance plans under the new rules, but for those that are eligible for the PCIP health coverage, they will be able to enroll you in the health plan itself as well as set up the premium payment program.

PCIP is a health insurance plan available now to "uninsurable" individuals. Since the federal ACA does not require health insurance companies to accept anyone for coverage regardless of their health until 2014.

Waiting until 2014 to get health insurance is a very long wait for someone with a pre-existing condition and no health insurance. To solve that dilemma, the Act provides for temporary programs called Pre-Existing Conditions (health) Insurance Plan (PCIP). The Plan is temporary and will last only until insurance companies are required to cover anyone who requests coverage in 2014.

There is a PCIP plan in each state, and California has set up one of the first programs. However, there are strict limitations on who can purchase this insurance.

These programs were designed not just to help people who cannot purchase health insurance, but they were also planned as a method to help move some of the "uninsurable" people not having current coverage into the market to ease the pressure of everyone applying for coverage at once when 2014 arrives. Because these plans have not been well advertised, however, enrollments have been much lower than expected.

The plans:

- Cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. All covered benefits are available, even to treat a pre-existing condition.
- Don't charge a higher premium just because of the medical condition.
- Don't base eligibility on income.

To be eligible for these PCIP plans:

- You must be a citizen or national of the United States or reside in the US legally.
- You must have been without health coverage for at least the last six months. Please note that if you currently have insurance coverage that doesn't cover your medical condition or are enrolled in a state high risk pool, you are not eligible for the Pre-Existing Condition Insurance Plan. Also, people on full Medi-Cal are not eligible for PCIP, while people with Share-of-Cost Medi-Cal may be eligible for coverage.
- You must have a pre-existing condition or have been denied health coverage because of your health condition.

Obviously, the requirement of having been without health insurance at least six months severely limits who can enroll in these plans, but the purpose of the program was to start making coverage available to people without insurance, not draw people from the current health insurance market.

In order to qualify for coverage, you will need to provide one of the following documents:

- A letter from a doctor, physician assistant, or nurse practitioner dated within the past twelve months stating that you have or had a medical condition, disability, or illness. This letter must include your name and medical condition, disability, or illness and the name, license number, state of licensure, and signature of the doctor, physician assistant, or nurse practitioner.

-OR-

- A denial letter from an insurance company licensed in your state for individual insurance coverage (not health insurance offered through a job) that is dated within the past twelve months. Or, you may provide a letter dated in the past twelve months from an insurance

agent or broker licensed in your state that shows you aren't eligible for individual insurance coverage from one or more insurance companies because of your medical condition.

-OR-

- An offer of individual insurance coverage (not health insurance offered through a job) that you did not accept from an insurance company licensed in your state that is dated within the past twelve months. This offer of coverage has a rider that says your medical condition won't be covered if you accept the offer.

-OR-

- If you are under age 19 an offer of individual insurance coverage (not health insurance offered through a job) that you did not accept from an insurance company licensed in California that is dated within the past twelve months. This offer of coverage must show a premium that is at least twice as much as the Pre-Existing Condition Plan premium (the monthly payment you make to an insurer to get and keep insurance) for the Standard Option in your state.

The plan provides preventive care (paid at 100%, with no deductible) when you see an in-network doctor and the doctor indicates a preventive diagnosis. For other care, there is a deductible before PCIP pays for your health care and prescriptions. After you pay the deductible, you will pay 20% of medical costs in-network for coverage in and out of the hospital, in doctor's offices, x-rays and lab tests, and coverage for prescription drugs. The maximum you will pay out-of-pocket for covered services in a calendar year is \$5,950 in-network/\$7,000 out-of-network. There is no lifetime maximum or cap on the amount the plan pays for your care.

More information on the PCIP program can be found at www.pcip.gov.

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August 19, 2011 - Capitol Desk

Budget Trailer Bills Might Rescue Healthy Families Program

by David Gorn

When faced with running a large children's program on about \$390 million less than you had before, how many beneficiaries will you be forced to drop?

That's the question facing the Healthy Families program, which is considering a substantial disenrollment of the 870,000 children currently in the program.

The answer, according to Senate member Mark Leno (D-San Francisco), lies in two bills -- ABX1 21 and SBX1 9, budget trailer bills left over from the previous session.

"Going back to May and June and even before that, going back to the governor's proposed budget," Leno said, "that budget not only proposed the extension of the gross premium tax, but it also raised copays for people in Healthy Families."

That package of give-and-take was only partially passed, he said.

"The Legislature did approve the rise in copays, but did not extend the gross premium tax."

It's that managed-care tax that was funding a large portion of the Healthy Families program. Leno said it's on the table again, and that the Legislature will take it up -- quickly, since the current session only lasts a month.

"We will be addressing this before the end of our session," Leno said.

"The question will be," he added, "will our Republican colleagues go along with it?"

The trailer bills need to pass by a two-thirds vote. According to Alicia Trost of Senate President pro Tem Darrell Steinberg's office (D-Sacramento), that will be an easier sell now than at last session's budget deadline, especially if the health plans being taxed agree with the levy.

"We are reaching out to the health plans, to let them know what's at stake here with Healthy Families," Trost said. "And we intend to pass the budget trailer bill."

On the Assembly side, Bob Blumenfield (D-Woodland Hills) said that pulling health care coverage from hundreds of thousands of poor children is something no legislator wants.

"This is a scary situation with a simple solution," Blumenfield said. "The problems facing Healthy Families can be solved by putting politics aside and doing what's best for California's kids. It's been a tough road so far, but I'm committed to building the will to back a solution."

Leno said hard financial times for the state means harder financial times for the state's poor.

"At this time of severe financial crisis on these poor families and poor children, the impact would be so significant and so severe, that I really hope we would pass this," Leno said. "These are children. These aren't Republican children and Democrat children, they're children."

No timetable has been set for when the budget trailer bills will hit the legislative floor for a vote. The current session ends Friday, Sept. 9.



September 09, 2011 - Capitol Desk

Legislature Passes Healthy Families Money, Mulls DMHC Move

by David Gorn

Among the raft of bills that floated through the Legislature in the final days of session were two big health-related ones:

- The Assembly, after trying and failing by one vote to pass ABX1 21 by Bob Blumenfield (D-Woodland Hills), yesterday took up the measure again and this time passed it, 61-9; and
- An Assembly bill, AB 922 by Bill Monning (D-Carmel), is designed to expand and move the Office of the Patient Advocate. It took on an amendment that also moves its parent agency, the Department of Managed Health Care. Those agencies currently reside under the Department of Business, Transportation and Housing.

ABX1 21 is designed to fund a large chunk of the Healthy Families budget by extending by a year a tax on Medi-Cal managed care organizations. Those MCOs actually support the tax extension.

"This is a bill with industry support, so we're in the rare situation of not taxing anyone who is not wanting to be taxed," Blumenfield said when he introduced the legislation.

ABX1 21 was approved by the Senate earlier, and now moves to the governor's desk. It missed approval previously on the Assembly floor by one legislative vote. If the bill had not passed, the state was contemplating a massive shift of children off the Healthy Families program.

"We finally reached a bipartisan breakthrough to narrowly avert disaster," Blumenfield said. "Low-income parents across California have been sick with worry for months, not knowing if at any moment the state would revoke their children's insurance. This has been a very scary situation with a simple solution. By signing this bill, the governor can alleviate the fears of these parents."

The bill to move the Office of the Patient Advocate under the umbrella of the California Health and Human Services Agency makes sense, Monning said, because of pending implementation of the Affordable Care Act, which the OPA will be involved in.

That same reasoning was applied to the parent agency of OPA, the Department of Managed Health Care, according to the floor analysis.

"The move is meant to create a clear internal chain of command for the Administration," according to the floor analysis. "DMHC's actions should be vetted through the Health and Human Services Agency, which is focused on consumers and implementation of the Affordable Care Act (along with other aspects of healthcare delivery and regulation), rather than BT&H, which has no expertise in federal health care reform and its requirements."

Monning, who is chair of the Assembly Committee on Health, said that the request for the amendment to also move the DMHC came from the Brown administration. "The request was made to transfer the department," Monning said. "It has been one of the interests of the [CHHS] Secretary and the administration, that we have a more accountable and streamlined system."