

To: ITUP Board Members, Workgroup and Conference Participants  
From: Lucien Wulsin, Jr.

**Section 1** Re-titled as Health Care Security and Cost Reduction Act

**Section 8** Delays operative date for mandatory e prescribing from 2010 to 2012

**Section 14** Secretary of Health and Human Services Agency assesses impacts of reform on labor markets, underground economy and reduction in racial and ethnic disparities in access and availability of health care

**Section 21** Deletes application of underwriting reforms to mid-sized employers of 51-100

**Section 22** Deletes extensive disclosure requirements to consumers from health plans

**Section 27.5 and 28 and 34.3-34.7** Bars performance bonuses to health plan employees or contractors for rescissions and claims denials

**Section 28.5** New individual policies after 3/1/09 must meet minimum creditable coverage

**Section 28.5** Individual policies must be upgraded so that lifetime benefit maximums meet minimum creditable coverage effective 7/1/10

**Section 28.5** Health plans can reject applications for individual coverage for those with hardship exemptions or those with low income and excessive premium cost exemptions from the individual mandate and can reject new California residents for their first six months of residency unless they have had two years of minimum creditable coverage or meet HIPAA requirements and apply with 62 days of loss of prior coverage

**Section 28.5** Insurance Commissioner and Director of DMHC must develop a re-insurance mechanism for the individual market if the incidence of bad risks exceeds the norms of those enrolled in CAL-CHIPP (but not the Healthy Families component of CAL-CHIPP). If the risk profile exceeds 5%, all plans must participate in paying for re-insurance of the risk differential. If the risk profile exceeds 10%, the California Health Trust Fund must pay for the risk differential.

**Section 31.1 to 31.6** EAPC (Early Access to Primary Care) for community clinics is expanded to cover uninsured up to 250% of FPL, require participating clinics to serve as a medical home for EAPC patients, requires issuance of a primary care card to eligible beneficiaries good for one year of eligibility and automated eligibility and payment mechanisms. State shall seek to maximize FFP.

**Section 40** Deletes disclosure of medical loss ratios for small groups

**Section 41** Deletes application of underwriting reforms to mid-sized employers of 51-100

**Section 42** Same changes as section 28.5 above but for insurers

**Section 42** No rescissions of individual coverage after 7/1/10, insurers may exercise other available legal remedies to recover damages other than rescission

**Section 47** Healthy Families coverage for uninsured children begins 7/1/09

**Section 52** Deletes counties ability to determine eligibility for Healthy Families or CAL-CHIPP

**Section 53** Re-assures plans and brokers they can contract with each other and agree on commissions

**Section 53** MRMIB and FTB coordinate in the administration of the refundable and advanceable tax credit. MRMIB reports annually to each subscriber on premiums and use of refundable, advanceable tax credits.

**Section 53** Those who are offered employer coverage for which their employer pays a portion are not eligible to enroll in CAL-CHIP Healthy Families

**Section 53** Deletes continuous appropriation. Funds must be appropriated by the Legislature

**Section 54** Board determines how to treat Christian Science and other faith-based healing

**Section 57.1** Establishes refundable tax credit for those with incomes between 250 and 400% of FPL whose premiums exceed 5.5% of income. Tax credit is a sliding fee scale between 300 and 400% of FPL. The maximum annual credit is set by age and family composition; it ranges from \$0 for single adults ages 19-29 to \$8722 for husband, wife ages 60-64 with children. Maximums are adjusted annually by the medical CPI (Consumer Price Index).

Section 57.1 The tax credit is linked to the actual cost of the subscriber's coverage through MRMIB or Category 3 (i.e. mid-range) coverage whichever is less.

**Section 57.1** Tax credits are only available to persons with no employer offered coverage or to their dependents if the employer pays no share of their coverage.

**Section 57.3** States legislative intent to offer a comparable tax credit for persons aged 50 to 64 with higher incomes and subject to a \$50 million annual appropriations cap

**Section 57.4** Fines and disqualifications for fraudulent or reckless behavior in relation to the tax credits

**Section 57.5- 57.6** MRMIB and FTB exchange all information necessary to program administration

**Section 57.7** Refundable tax credits paid from the following funds in order of priority: Health Care Trust Fund, Personal Income Tax Fund, General Fund (subject to Appropriation)

**Section 60** Deletes states ability to determine eligibility for Medi-Cal

New Section 60 Deletes restriction on state funding of costs of health coverage for IHSS workers and adds in 25¢ an hour for health benefits, adds in additional 50¢ and then 75¢ per hour if the state has a 5% budget surplus in the May Revisions Allows the union at its option to use a union trust fund to provide health benefits for IHSS workers rather than using the county health plan

**Section 68** MIAs not eligible for Medi-Cal if they have employer offered coverage to which the employer contributes

**Section 73** Extends from three to four years the period in which MIAs can be locked into a county health plan under the local coverage option. Requires the county health plan to include and reimburse licensed community clinics. Requires the county health plan to include non-county hospitals and doctors as necessary to comply with Knox-Keene requirements. Assessment whether county plans are meeting the benchmarks after three years and the county plan loses exclusivity if it fails to substantially comply. After four years, beneficiaries have a right to switch plans. After five years, new enrollees have a right to choose their own plan. DHCS and DMHC have the authority to permit a limited provider network for local coverage option counties.

**Section 76** \$25 million from the public hospital funds may be used for county developed health care worker re-training. Counties must develop and submit worker-retraining plans to OSHPD for review and comment.

**Section 77** Specifies that physicians being paid at higher than Medicare rates will not have their rates reduced.

**Section 79** Deletes the ability to implement coverage expansions with all county letters

**Section 84** Intent to transition Ryan White and other funding

**Section 84.5** Act is non-severable; invalidity of any provision of the Act by a court of law invalidates the entire program