DECEMBER 23, 2010

Health Reform 9-Month Status Report:

Californians Take Advantage of New Options & Benefits; More Patient Protections Go Into Effect

The start of the new year brings new options and benefits for health care consumers under the new federal health law passed earlier this year. December 23, 2010 marks the nine-month mark since President Barack Obama signed the Patient Protection and PPACA (ACA), a historic comprehensive federal health care reform law. Since then, California has enacted several key consumer protections and other bills to implement the federal law.

Several patient protections and other elements of that federal law began to take effect on September 23rd. The start of 2011 provides an opportunity to review how California consumers are beginning to benefit, what new patient protections are in place or coming soon, and how California is proceeding with efforts to implement and improve upon the new federal law.

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SIGNIFICANT PROGRESS TO DATE

Over the next ten years, the new ACA will put in place policies to provide new consumer protections and new oversight and rules for insurers; make coverage affordable for individuals, families, and small businesses; and encourage efforts to tame the costs of health care, with benefits for both our economy and our federal deficit.

Some provisions began immediately on March 23, while many others kicked-in six months later on September 23rd, and additional benefits will be implemented between now and 2014, when the bulk of reforms are instituted.

Californians are already beginning to benefit from reform, including gaining additional consumer protections from the most abusive insurance company practices; feeling more secure about their current coverage; and receiving help to afford coverage.

*On September 30th, Governor Schwarzenegger signed about a half-dozen bills recently passed by the California State Legislature, both bringing state law into compliance with ACA and in some cases (marked with a *) extending consumer protections and benefits beyond federal requirements. In addition to reflecting the unique needs of the state and the support for more robust reform, certain elements may serve as models for other states beginning the process of implementing PPACA.*

This report details the provisions in federal and state law that have taken effect as of September 23, 2010, the 6-month anniversary of ACA's signing, and those coming soon, due to the federal law or to pending state legislation. Those bills that the Governor Schwarzenegger signed will be in force on January 1, 2011.

PHASING IN PATIENT PROTECTIONS

INSTILLING CONFIDENCE IN COVERAGE

Even insured families wonder if their coverage will be there for them when they need it. Health reform helps provide more financial security to families by ending insurer provisions and practices that leave insured patients uncovered for the care they need.

*** Ending Unjustified Rescissions:** On April 28th, the national association of health insurers wrote to Congress indicating they would stop the practice of rescissions, where coverage is retroactively denied after the patient had been paying premiums for months. In California, rescissions had already decreased to

single-digits due to increased media and regulatory oversight.

On September 23rd, the federal law set an ongoing and clear standard for any insurer to revoke coverage based on problems in the patient's initial health questionnaire.

The California legislature passed and Governor Schwarzenegger signed AB2470 (De La Torre) to implement the new federal standards for rescission. California would improve upon federal law with requirements that insurers continue coverage pending determination of rescission.

Ending Annual and Lifetime Caps on Coverage: Over 2.2 million Californians report having medical debt, and 75% of them *were insured* at the time that they incurred the debt. This is in part because many plans had a cap on the amount they would pay toward benefits in a year or over the course of a lifetime. Once an individual reached that limit, they were responsible for the balance of medical costs in a year or for the rest of their life.

As of September 23rd, the ACA required that plans begin phasing out annual limits and bans all lifetime limits to ensure that consumers no longer have to fear running out of insurance.

California legislation, SB890 (Alquist), vetoed by Governor Schwarzenegger, would have to implement into state law the restrictions on annual and lifetime caps on coverage; However, state regulators still have the ability to enforce federal law.

Choice of Providers, Direct Access to Ob/Gyn Care Beginning September 23, 2010 consumers were guaranteed the right to choose their primary care provider from any available physicians in their network. In addition, consumers are now able to access Pediatricians and Obstetricians/Gynecologists without having to first get a referral from their primary care provider. *This has been existing California law for over a decade.*

No Prior Authorization for Emergency Services: The ACA states that insurers are no longer allowed to require consumers to get prior authorization for emergency services, and new plans can not require higher cost sharing for out of network emergency care. *California law has provided this protection for over a decade.*

Right to Appeal Decisions to Deny Care: The ACA includes patient rights in relation to insurance company decisions to deny care and coverage. Consumers are guaranteed the ability to appeal coverage determinations or claims to their insurance company and if necessary, appeal to an external third party. *California law has provided similar protections for over a decade.*

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ACCESS TO COVERAGE REGARDLESS OF HEALTH STATUS

*** Guaranteed Issue for Children with Pre-Existing Health Conditions:** On September 23rd, federal law began prohibiting insurers from denying children up to age 19 for coverage due to pre-existing conditions, or denying treatment associated with the pre-existing conditions. An estimated 576,500 children in California have pre-existing conditions that could lead to denial of coverage. This provision will help ensure access to coverage for vulnerable children and protect their families from medical debt and bankruptcy due to medical bills.

Many California health plans initially responded to this requirement by no longer selling "child-only" policies in the individual market. However, due to a new California law, the major insurers are expected to begin selling such products again as of January 1, 2011, under the new market rules.

AB2244 (Feuer), signed by Governor Schwarzenegger, will go into effect on January 1, 2011, and will help provide more access and affordability for children with pre-existing conditions. Insurers that don't sell "child-only" policies as of January 2011 will be barred from selling new products in the individual market for five years.

This will provide more meaningful access by limiting insurers' ability to charge sick children more than twice the premiums for healthy children, families will be able to buy reasonably priced policies for children with pre-existing conditions either in an "open enrollment" period or when the child's circumstance changes. The bill phases out the cost difference allowed until 2014, when insurers will be required to charge children (and adults) the same regardless of health status. The regulators are finalizing guidance, with the law going into effect January 1, 2011.

*** New Options for Adults with Pre-existing Health Conditions:** An estimated 6.5 million Californians under the age of 65 have pre-existing health conditions, and up to 396,000 have been denied coverage from insurance companies at any cost. These denials have been for both major and minor conditions.

For those with pre-existing conditions that don't have access to group coverage through an employer or a public health insurance program, the only option left in California was the Major Risk Medical Insurance Program (MRMIP). But MRMIP has recently had a waiting list despite never advertising, being expensive, and offering a benefit capped at only $75,000 a year.

Under PPACA, insurers will no longer be able to deny coverage for pre-existing conditions by 2014 and beyond. Until then, a new option, alongside this existing MRMIP "high-risk pool," has just recently opened up enrollment. Anew California Pre-existing Condition Insurance Plan (PCIP) began its operations on October 20th.

Under two bills passed and signed into law earlier this year, AB1877(Villines) and SB227(Alquist), the new PCIP will draw down up to $761 million in federal dollars available to California to cover adults with preexisting conditions through 2014 when guaranteed issue regulations and the exchange goes into effect.

This high risk pool program, governed by California's Managed Risk Medical Insurance Board (MRMIB) that runs the state's MRMIP pool as well, will serve up to 30,000 Californians that are otherwise "uninsurable." This quadruples the capacity of our current high-risk pool, which is limited to 7,100 people and $40 million of funding. California's PCIP started providing coverage in late October, and has nearly 1,000 enrollees as of Mid-December.

SECURING AND EXPANDING COVERAGE OPTIONS

*** Expanding Coverage to Low-Income Californians:** In 2014, the new federal law expands Medicaid coverage to all citizens up to 133% of the federal poverty level, and streamlines and improves this crucial safety-net program in other ways. The expansion would be 100% federally funded for the first three years, and required state participation would be no more than 10% afterwards.

The federal law also allows states to expand coverage earlier, before 2014, under the existing 50-50% Medicaid matching rate for California. California's Medicaid program, Medi-Cal, currently covers over 7 million low-income children, parents, seniors, and people with disabilities—and while a state-based expansion is untenable given the state budget crisis, a new waiver allows California counties to take advantage of this opportunity and begin to expand coverage early.

Two California bills, AB342 (Perez) and SB208 (Steinberg) authorize the Medi-Cal waiver negotiated between the state and federal governments to help build the bridge to full federal health reform implementation, most notably by accelerating the expansion of Medi-Cal coverage of childless adults using county funds.

Among many other aspects, the waiver would allow counties to get federal matching funds to extend basic coverage to adults under the poverty level. This could potentially mean up to a half-million Californians getting coverage well in advance of 2014, and meaning these Californians will be ready, on day one of 2014, to get full Medi-Cal coverage.

The waiver, which in part relies on funding and authority from the PPACA, also provides new funding opportunities for our state budget and our state safety-net, including public hospitals, to prepare for the law's changes in 2014.

*** New Information to Assist Consumers Choosing Coverage on** July 1st, the U.S. Department of Health and Human Services unveiled a new and evolving website that will help consumers figure out their current (and future) choices in

the health insurance marketplace. The department also released funds targeted to help provide assistance to consumers.

Over the next several years, California will set up a new health insurance exchange, which will provide a more consumer-friendly market for health coverage and in 2014 will provide significant subsidies for low and moderate income families to afford coverage.

California enacted the first-in-the-nation state legislation to create an exchange (post reform passage) with AB1602 (Perez) & SB900 (Alquist/Steinberg), which created the governance and operations of an insurance marketplace to provide information, access, and subsidies to consumers. Improving upon federal requirements, the exchange will act as an active purchaser negotiating for the best price and values for consumers and small businesses, and provide streamlined, apples-to-apples choices for purchasers. Governor Schwarzenegger is expected to announce his two appointments (of five board members) on January 1, 2011.

*** Security for Californians on Medi-Cal and Healthy Families:** Over 8 million Californians have more security that they will keep the coverage they have under Medi-Cal or Healthy Families, due to "maintenance of effort" requirements in both PPACA as well as the economic recovery act.

These provisions prohibit California from moving ahead with proposed eligibility and enrollment cuts in these programs that would have denied coverage to potentially millions of Californians (although other cuts are still proposed within these programs). The law also provides the opportunity for more federal funds for California, as is being negotiated in a new Medi-Cal waiver between the state and federal governments.

New Coverage Options for Young Adults: Some young adults are now newly getting coverage under their parent's plans. Previously, over 30% of young adults did not have health insurance, while 47% reported being uninsured at some point last year. Federal law now requires that employers providing dependent coverage extend that coverage to dependents up to the age of 26. This is estimated to impact over 4 million young adults nationwide and 196,000 in California.

Governor Schwarzenegger signed SB1088 (Price) which will conform state law to federal law with regard to this new option for children up to age 26. CALPERS reports that 27,000 young adults are getting such coverage among its membership alone.

Providing Public Health Insurance Options: Beyond the stalled federal debate about a national public health insurance option, California has had county-based managed care plans as options in our Medi-Cal program for many years.

Governor Schwarzenegger Schwarzenegger vetoed SB56 (Alquist), which would

allow county-based plans to form joint ventures and expand their networks to create public health insurance options that can be viable choices in the new exchange. These plans may go ahead on this idea anyway.

Resources for Clinics, Workforce Development, Prevention Efforts, and More: The U.S. Department of Health and Human Services has announced grant programs worth millions of dollars in investment, including support for community clinics; $250 million in efforts to increase clinicians and other primary care providers; $250 million in strategies to encourage health and health prevention, including funding public health infrastructure, research and tracking, and public health training.

As the process moves forward, California communities and institutions will be the recipient of hundreds of millions of dollars of these funds in the next few months.

MAKING HEALTH CARE MORE AFFORDABLE

*** Scrutinizing Rate Hikes** Anthem Blue Cross' proposed 39% rate hikes in 2009 highlighted the importance of greater scrutiny and transparency of insurance rates. The rates were not made public until subscribers who got a 30-day notice went to the media; and even with the red-hot presidential spotlight on these increases, the Department of Insurance needed to go to an outside actuary that eventually found problems with the math. The new federal law has awarded grants to states, up to $1 million to start, to provide resources to conduct further actuarial reviews of insurance rates.

The Governor Schwarzenegger signed SB1163(Leno) into law, requiring insurers to make rate increases public with 60 days notification, and to provide more information to the Department of Managed Health Care and the Department of Insurance for review. The regulators are finalizing guidance. Filings are required as of January 1, 2011.

Helping Small Businesses Cover Their Employees: Small businesses now have an incentive to cover (or continue to cover) their workers. While many small business owners say they would like to provide insurance to their workers, the cost can be prohibitive. Californians are less likely than Americans in other states to be offered employer based coverage. In a 2009 survey of California small business owners, 55% reported that they did not provide coverage for their workers, 97% of them said they could not afford to.

Effective immediately upon passage of the health reform law, small businesses were able to take advantage of tax credits up to 35% of premiums. 503,000 California small businesses may be eligible for tax credits.

Making Prescription Drugs More Affordable for Seniors: Seniors who currently fall into the coverage gap or "donut hole" in the Medicare Part D prescription drug coverage program have started receiving rebate checks in the amount of $250. From 2011 forward, more provisions will go into effect that moves toward the complete closure of the "donut hole".

California will benefit more than any other state as California seniors who fall into the donut hole spend $381,636 out-of-pocket for prescription drugs. 80,000 checks have been mailed to date, and more will go out as even more seniors reach the coverage gap. Approximately 382,000 California seniors will receive checks.

Help with Coverage for Early Retirees: About $5 billion have been allocated toward a new reinsurance program to provide financial assistance to employers and union-based plans around the country, assisting in the costs of covering early retirees ages 55-65, including the 430,000 Californians who retired before they were eligible for Medicare. Reinsurance has been successfully used by a number of states to lower premiums for small businesses. Savings for the plans will be required to be used to lower costs for the enrollees.

Over 100 California employers, union trusts, and others have received funding under this early retiree program.

Free Preventive Care for Seniors: Preventive services such as colorectal cancer screenings, mammograms, and annual wellness visits are available to seniors enrolled in Medicare without any copayments, coinsurance, or deductibles. This will mean savings to 4.5 million seniors in California.

Free Preventive Services through Private Health Plans: 31 million Americans are estimated to benefit from the requirement that new private health plans offer preventive services with no cost share for consumers. Many screenings, immunizations, and other preventive services are now available to consumers with no copayments, coinsurance, or deductibles.

The California legislature has passed, and the Governor Schwarzenegger signed, AB2345 (De La Torre) which would put the federal regulations into California law.

NEW YEAR, NEW BENEFITS - 2011

California legislation that passed in 2010 will go into effect on January 1, 2011. These include the bills to start the set-up of the exchange (AB1602/SB900), and conforming to federal rules on young adult coverage (SB1088) and no cost-sharing for preventive care (AB2345). This is especially true for the two additional bills where California is going beyond federal law, where both the Department of Insurance and Department of Managed Health Care are finalizing guidance prior to

January 1, 2011:

- Rate Review: SB1163 (Leno) will require insurers to provide additional notice to consumers of rate hikes, and to file their rate hike requests with regulators, with their justification made public.
- Access for Children with Pre-Existing Conditions: SB2244 (Feuer) will require insurers to sell policies to children with pre-existing conditions, and to limit the premium for such children signing up in an open enrollment period.

In additon to the state laws signed by the Governor Schwarzenegger, a number of additional federal benefits will also begin January 1, 2011, 2011.

Medical Loss Ratios: Insurers will be required to spend more of your premium dollars actually providing health care, rather than administration and profit. In the large group market, 85% of premiums must go to care and in the individual and small group markets, 80% will have to go to care. If these Medical Loss Ratio's (MLRs) are not met, insurers will be required to provide rebates to consumers.

Medicare Part D Donut Hole: The next step in closing the Medicare Part D Donut hole will allow seniors to get 50% discounts on prescription drugs starting 2011.

Primary and Preventive Care for Seniors: The federal law establishes a free annual wellness visit and personalized prevention plans for Medicare beneficiaries.

Community Health Centers: New funding will be available for community health centers, $1 billion in 2011 increasing to $3.6 billion in 2015, with additional $1.5 billion annually for infrastructure renovation.

Workforce Development in Primary Care: The federal law provides a 10% Medicare bonus payment for primary care physicians; allows unused residency training slots to be redistributed to increase primary care training in underserved areas; and addresses health care workforce shortage through a variety of loans, grants, and scholarships toward training programs.

Prevention and Public Health: Insurers will need to cover tobacco cessation programs for pregnant women; chain restaurants and vending machines will need to display calorie information for each menu item; and a five-year $200 million grant program will encourage small employers to initiate wellness programs.

Addressing Costs: The new federal law appropriates $50 million for state tort reform demonstration projects; imposes $2.5 billion fee on pharmaceutical manufacturers according to market share; and establishes a Center for Medicare & Medicaid Innovation to pursue payment and delivery reform models.

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CONCLUSION: Much Accomplished, Much More to Do

Californians are taking advantage of the new options and benefits of the new federal health law. More improvements to the state's health system will become available in January 2011, and there's much to do in anticipation of the biggest changes from the federal health reform law that kick in on January 2014.

California has taken the lead among states in implementing federal health reform. Some of the new state legislation simply conforms state law to new federal standards, but other efforts have taken advantage of the opportunities to improve upon the federal requirements. California's efforts to implement the federal law early and aggressively serve multiple purposes: first, to ensure that Californians get the benefits and protections they are entitled to as soon as possible; secondly, these efforts allow for a smoother transition from the current insurance market and for California to have the time to adjust to new rules for insurers and new expectations for consumers. Finally, by starting early, California can be sure to be ready on day one in 2014 to take full advantage of new eligibility rules, federal funds, and new protections.

In 2014, the implementation will include new rules preventing insurers from denying any patient due to pre-existing conditions, a dramatic expansion of coverage to over four million Californians through 100% federally funded expansions of Medi-Cal, and the new availability of affordability subsidies for low and moderate income families.

Health Access will continue to produce updated reports to document the progress to both inform Californians about what they may be entitled to, and to alert policymakers to additional actions needed to implement and improve health reform, all toward the goal of an improved and more affordable health system. We also hope to provide a model for consumer oriented implementation and improvement of health reform law that may be useful to other states.

This report was prepared by Linda Leu and Anthony Wright of Health Access, a statewide coalition of consumer, community, ethnic, senior, labor, faith, and other organizations that has been dedicated to achieving quality, affordable health care for all Californians for over 20 years. To follow up, contact lleu@health-access.org.

Please visit our website at www.health-access.org and read our daily blog at blog.health-access.org.

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APPENDIX: Bills Passed by the Legislature

Creating a Consumer-Friendly & Transparent Individual Insurance Market & Exchange

Bill	Description	Status
AB 1602 Perez	**CREATING A NEW EXCHANGE:** Would specify the operations of the California Health Benefit Exchange which would be an independent state agency tasked in negotiating for the best prices and values for consumers and providing information regarding health benefit products. *Improving on federal reform:* The Exchange is an Active purchaser, protects against adverse selection.	***Signed***
SB 900 Alquist/ Steinberg	**RUNNING A NEW EXCHANGE:** Would establish governance of the Exchange by a 5 member board appointed by the Governor Schwarzenegger and Legislature. The board will serve the individuals and small businesses seeking health care coverage through the Exchange. *Improving on federal reform:* Creates independent state agency with conflict of interest protections.	***Signed***

Setting Minimum Benefit Standards

Bill	Description	Status
SB 890 Alquist/ Steinberg	**TRANSITIONING TO A MORE TRANSPARENT & STANDARDIZED MARKET:** Standardizes and simplifies the individual insurance market, so that consumers can understand their coverage choices, make comparisons based on actuarial value, and have the security that coverage does not have lifetime and/or annual caps. Also conforms to federal law on medical loss ratios, ensuring that 80-85% of premium dollars go to patient care, rather than administration and profit. *Improving on federal reform:* Standardizes individual health insurance early, additional disclosure.	*Vetoed*
AB 1825 De La Torre	**ENSURING MATERNITY CARE:** Would phase-in a requirement that all health plans cover maternity services. *Improving on federal reform:* Early implementation of coverage of maternity care.	*Vetoed*
AB 1600 Beall	**REQUIRING MENTAL HEALTH PARITY:** Would require most health plans to provide coverage for the diagnoses and treatment of a mental illness. *Improving on federal reform:* Early implementation of coverage of mental health services.	*Vetoed*

Reviewing Insurance Company Rates

Bill	Description	Status
SB 1163 Leno	**PROVIDING TRANSPARENCY ON RATES:** Would require 60 days public notice of rate hikes and requires health plans to provide to the public information about their rate methodology. *Improving on federal reform:* Requires review of all rate hikes in individual and small group market, rather than just "unreasonable" increases. Also, collects additional information on underlying cost increases.	***Signed***
AB 2042 Feuer	**PROHIBITING MID-YEAR RATE HIKES:** Insurers and HMOs cannot change or increase premiums, cost sharing or benefits more often than once a year. *Improving on federal reform:* Federal law silent.	*Vetoed*

Regulating Underwriting and Providing Access for Those with Pre-Existing Conditions

Bill	Description	Status
AB 2244 Feuer	**ACCESS AND AFFORDABILITY FOR CHILDREN WITH PRE-EXISTING CONDITIONS:** Requires guaranteed issue, eliminates all pre-existing condition exclusions, and limits premium increases based on health status, phasing in modified community rating for children under age 19 in the individual market. *Improving on federal reform:* Rating rules of 2 to 1 in open enrollment.	***Signed***
AB 2470 De La Torre	**REGULATING RESCISSIONS AND MEDICAL UNDERWRITING:** Set standards for rescission, the insurance industry's practice of terminating coverage as if the coverage had never been issued. *Improving on federal reform:* Continues coverage pending determination of rescission. Provisions regulating notice.	***Signed***
AB 2540 De La Torre	**POSTCLAIMS UNDERWRITING:** Enacts a fine for rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting before issuing the policy or certificate or after a claim has been filed. *Improving on federal reform:* Fines for insures who violate rescission.	*Vetoed*

Other Consumer Protections and Health Reform Implementation

Bill	Description	Status
SB 1088 Price	**ALLOWING YOUNG ADULTS TO STAY ON THEIR PARENTS' COVERAGE:** Would require group health, dental, and vision plans to allow dependent children to continue on their parents' coverage through age 26. *Improving on federal reform:* Requires notice and disclosures.	***Signed***
AB 2345 De La Torre	**COVERING PREVENTIVE SERVICES:** Requires insurers to eliminate cost-sharing for some preventive services such as pap smears, mammograms, other cancer screenings, and immunizations. *Conforms to federal reform.*	***Signed***
SB 56 Alquist	**FACILITATING PUBLIC HEALTH INSURANCE OPTIONS:** Would authorize county-organized health plans and other county-based local initiatives to form joint ventures in order to create integrated networks of public health plans that pool risk and share networks, subject to the requirements of the Knox-Keene Act. *Improving on federal reform:* Builds on federal reform.	*Vetoed*
AB 542 Feuer	**NO PAY FOR NEVER EVENTS:** Creates a process for ending Medi-Cal payments for never events (events that should never happen, such as surgery on the wrong body part), and requires insurers to stop paying for never events. *Improving on federal reform:* Requires stakeholder process for developing the standards.	*Vetoed*

Federal Medicaid Waiver

Bill	Description	Status
AB 342 Perez **SB 208** Steinberg	**MEDI-CAL WAIVER:** The state's 1115 Medicaid Waiver would draw down up to $2 billion in federal funding to assist our safety net providers to expand coverage to new medically indigent populations. The waiver would also move seniors and people with disabilities to Medi-Cal managed care. The waiver is intended as a bridge between the existing Medi-Cal program and the full access expansion that will happen in 2014 as a result of federal reform. *Improving on federal reform:* Moving toward Medicaid coverage of adults without children at home before 2014.	***Signed***

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