Health Care Coverage/Reform Proposals

Comparison of Key Features

California Hospital Association

May 24, 2007

Key Features	Governor Schwarzenegger	Speaker Núñez (AB 8)	President Pro Tem Perata (SB 48)	Senate Republican Caucus (Cal CARE)	Assembly Republican Caucus Proposal	Senator Kuehl (SB 840)
Who is covered	All Californians.	All Californians within 5 years, with first priority coverage for all children. Some provisions are contingent on subsequent funding legislation and/or federal waivers.	Working Californians and their dependents. Medi-Cal and Healthy Families programs would be expanded to cover all eligible children and additional adults. Some provisions contingent on subsequent legislation.	Would not mandate coverage. Much of the Senate Republican Caucus proposal is reflected in SB 236 (Runner, Ackerman, Aanestad, and Cox) as amended on April 19, 2007.	Would not mandate coverage. Would give Californians unable to purchase coverage due to pre-existing medical conditions the opportunity to purchase health savings accounts and high deductible plans	All California residents, including those who are temporarily out of state. Residency is based upon physical presence in the state with intent to reside. Visitors to California are not covered.
How people are covered	Employment-based coverage, a partially subsidized purchasing pool, individual coverage mandate and expanded eligibility for Medi-Cal and Healthy Families.	Employment-based coverage, *Cal-CHIPP*--a purchasing pool, a benchmark plan or policy offered group members and dependents eligible for coverage through Medi-Cal or Healthy Families programs and expansion of eligibility for those programs.	Employment-based coverage, the *Health Care Connector*--a purchasing pool, individual coverage, and expanded eligibility for Medi-Cal and Healthy Families. Individual mandate to carry coverage, with limited exceptions.	Seeks to increase access to affordable coverage through tax incentives, regulatory relaxation, market changes and redirection of safety-net funding.	Seeks to increase access to affordable coverage and/or care through tax incentives, regulatory relaxation and market changes. Various provisions aim to increase access to care rather than increase coverage.	The California Universal Healthcare System (CUHS), administered by the California Universal Healthcare Agency (CUHA), acts as a single payer for all covered services, negotiating or setting fees and paying claims for services.

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

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Benefits	Knox-Keene-benefits and prescriptions, with maximum deductible of $5,000. Maximum out-of-pocket limits of $7,500 person and $10,000 per family.	To be determined by the Managed Risk Medical Insurance Board (MRMIB) consistent with the requirements of AB 8.	Coverage would have several standardized options (with varying out-of-pocket costs) to be determined by MRMIB.	No mandated coverage or benefits. Would allow plans and insurers increased flexibility in coverage options.	Would eliminate existing requirements on plans and insurers to offer specified “mandated” benefits.	Comprehensive benefits, including 100 days of post-acute skilled-nursing care, but not long-term nursing home care. State may expand or reduce benefits.
Employers	Employers with 10 or more employees who choose not to offer health coverage for employees and their dependents would pay 4% of payroll to purchasing pool. Employers would be required to establish “Section 125” plans to allow employees to use pre-tax income to pay health coverage premiums.	Employers would be required to make health care expenditures for their employees and dependents of at least 7.5% of social security payroll or pay an equivalent amount to the California Health Trust Fund for their employees, who with some exceptions would be required to enroll in Cal-CHIPP. Employers would be required to establish pre-tax “Section 125” plans for employees.	Employers would be required to spend 7.5% of social security payroll on health care expenditures for their employees and their dependents or, alternatively, pay to the Connector a health care fee in an equivalent amount. Employees of employers electing to pay the fee would secure health coverage through the Connector. Employers electing to use the Connector would be required to collect a required employee contribution.	No employer mandate. Employers would be encouraged to establish “Section 125” plans to allow employees to use pre-tax income for health expenses. Would provide employers tax incentives to offer health coverage.	No employer mandate. Would encourage increased use of “Section 125” plans. Employers who offer coverage would be allowed to purchase policies that cover both non-work-related medical care and workers’ compensation. Would provide for small businesses to join together to purchase group health coverage.	Would replace employer-based coverage with universal tax-funded health coverage. Employers would pay taxes to support the public system.
Individuals	Individual and employee mandates. All Californians would be required	Employees and their dependents would obtain coverage offered by their employer or through	Starting Jan. 1, 2011, employed Californians would be required to maintain a minimum	No individual mandate. Proposes using market demand to	No individual mandate. Proposes using market demand to	All California residents would be covered by the single state-administered tax-

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	to have minimum coverage described above in "Benefits". Individual and employee mandate would be enforced through wage withholding and the tax code. For low-income people, options include enrollment in public programs or subsidized private coverage through the purchasing pool.	Cal-CHIPP if their employer elected to pay the fee rather than make qualifying expenditures. Employees of employers electing to pay a fee instead of making health expenditures would be enrolled in Cal-CHPP. Employee cost-sharing requirements are not addressed.	policy of health care coverage for themselves and their dependents, but would exempt individuals whose family income is less than 400% of the federal poverty level and those whose only source of income is from retirement income. Employee contributions for coverage through the Connector would be withheld and paid to EDD. Taxpayers would be required maintain coverage would lose tax exemptions if they fail to show proof of health coverage	increase available coverage options by allowing plans and insurers increased flexibility in coverage, including co-payments, deductibles, networks and benefits. Would provide individuals tax incentives to purchase health coverage. Proposes a ballot measure to redirect Proposition 99 tobacco tax revenues to provide health coverage for children.	increase available coverage options by allowing plans and insurers increased flexibility in coverage, including co-payments, deductibles, networks and benefits. Would create an insurance exchange to increase insurance security when an individual changes jobs. Would make all medical expenses deductible from state income tax.	supported single payer system. Individuals would pay means-based premiums, deductibles and co-payments as determined by a state agency. Any eligible individual could receive services from any willing professional provider.
Health plans and insurers **Health coverage market reforms**	Must guarantee access to coverage in individual market (guaranteed issue and age-adjusted rating). 85% of premiums must be spent on patient care. Must make "Healthy Actions" benefits	Would enact several health insurance market reforms to be operative July 1, 2008, including requirements for limited guaranteed issue, simplified benefit designs, modified small employer coverage and other	Would enact health coverage market reforms relative to small employers By Jan. 1, 2011, plans and insurers would be required to offer individuals health benefit plans on a guaranteed issue basis. Would create a related	Would encourage HSA-eligible High Deductible Health Plans (HDHPs). Would require CalPERS to offer HDHPs and HSAs to state employees. Would reduce restrictions on health plan and insurance	Would encourage HSA-eligible HDHPs. Would require CalPERS to offer HDHPs and HSAs to state employees. Would remove restrictions on health plan and insurance prod-	All health coverage would be provided through the public system (CUHS). Would prohibit health care service plan contracts or health insurance policies for services covered by CUHS.

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	available to promote healthy behaviors.	related changes. Would require several uniform benefit designs in and outside of Cal-CHIPP. Would require plans and insurers to offer a benchmark plan or policy at a rate negotiated with and approved by MRMIB that is available to group members and dependents eligible for coverage through Medi-Cal or Healthy Families programs, or to otherwise arrange for coverage through Cal-CHIPP. Plans and insurers would be required to expend at least 85% of dues, fees and premiums for health care services. Would extend existing MRMIB Public Records Act exceptions to Cal-CHIPP negotiations.	reinsurance mechanism. Would standardize application and prescribe permissible rating practices. Plans and insurers would be required to expend at least 85% of dues, fees and premiums for health care services.	products and increase flexibility for coverage rates in the small group market.	ucts, eliminate minimum benefit requirements and allow out-of-state plans and insurers to offer coverage in California. Would create a pilot program for Medi-Cal enrollees to receive coverage through health savings accounts and high deductible plans.	
Hospitals	Would increase Medi-Cal inpatient payments to 100 percent of Medicare	Expansion of coverage should decrease uncompensated care and in-	Expansion of coverage should decrease uncompensated care and in-	Would make increasing Medi-Cal rates a budget priority over the next	Would increase Medi-Cal payments. Would prioritize	The state would exercise extensive regulatory control over all aspects of

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	rates and Medi-Cal outpatient rates to 80 percent of Medicare outpatient rates, with some of the increase paid for by current safety-net funding. Substantial reduction in uncompensated and under-compensated care. Hospitals would be required spend 85% of revenues on patient care costs and to pay 4% of revenues as a "coverage dividend". The proposal would provide an aggregate positive net benefit, but the impact on individual hospitals would vary. See also "Cost containment and affordability" below.	appropriate emergency department use. Does not include a Medi-Cal rate increase. Would require development of benchmarks and pay-for-performance in every state administered health coverage program (including public employees, Healthy Families, MRMIP, Medi-Cal and Cal-CHIPP. States intent to require all health care providers to adopt standard electronic medical records by Jan. 1, 2012.	appropriate emergency department use. Does not include a Medi-Cal rate increase. See "Cost containment and affordability" below.	8 years. Would "realign" Medi-Cal benefits to more closely mirror private health care benefits. Would redirect hospital Medi-Cal DSH funds to primary care clinics. Would reallocate First Five funds for children's health coverage. State tax credit to purchase health information technology (HIT). Loan program for non-profits to purchase HIT.	seismic upgrades of hospitals using science-based reforms to focus resources on "worst first" buildings. Would increase funding for clinics to reduce use of emergency rooms by non-emergency patients.	health care delivery, including establishing state and regional budgets, setting payments, approving operating and capital budgets, setting compensation for providers and health system executives, limiting increases in state, regional and facility-specific expenditures. Integrated health care systems could elect to operate on a capitated or non-capitated operating budget instead of fee-for-service payments. Compensation for health system employees would be negotiated between the state agency and employee unions.
Physicians	Significant increase in Medi-Cal payments. Physicians would be required to pay 2% of patient reve-	Would require development of benchmarks and pay-for-performance in every state administered health cover-	See "Cost containment and affordability" below.	Would make increasing Medi-Cal rates a budget priority over the next 8 years. Would "realign"	Would increase Medi-Cal rates for physicians. Would enact state tax credits for physicians who pro-	The state agency would set fees and make payments to physicians for covered medical services.

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	nues to help fund health coverage.	age program (including public employees, Healthy Families, MRMIP, Medi-Cal and Cal-CHIPP. States intent to require all health care providers to adopt standard electronic medical records by Jan. 1, 2012. See "Cost containment and affordability" below.		Medi-Cal benefits to more closely mirror private health care benefits. Would reallocate First Five funds for children's health coverage. State tax credit to purchase HIT. Low-interest loan program for non-profits to purchase HIT.	vide charity care. To encourage convenient care at health clinics in neighborhood retail settings, would eliminate the bar on a physician supervising more than four nurse practitioners.	Fee-for-service providers would choose a representative to negotiate with the state agency. The state would set binding rates if agreement is not reached. Group medical practices that provide comprehensive, coordinated services could choose to be paid on a capitated or non-capitated operating budget.
Cost Containment & Affordability	Would promote fitness and healthy lifestyles, place caps on plans' administrative costs, eliminate cost-shifting, and require hospitals to spend 85% of revenue on "patient care costs". Would simplify benefit plans, reduce medical errors, develop health information technology, reward good healthy behaviors, reconsider state mandates, including the seismic man-	Would encourage fitness, wellness, and health promotion programs that promote safe workplaces, healthy employer practices and individual efforts. Would require pay-for-performance in every state administered health coverage program (including public employees, Healthy Families, MRMIP, Medi-Cal and Cal-CHIPP. Would require monitoring of the	Would require contracts with nonprofit groups or foundations and other organizations to track and assess the effectiveness of the reforms enacted by SB 48. The assessments must include: compliance rates, sustainability and solvency, cost and affordability, the health insurance market, effect on employers and employment, employer based health cov-	Would expand clinics to reduce emergency room use. Would increase transparency of pricing information. Would revise seismic mandate to focus first on hospitals most at risk. State tax credit to purchase health information technology (HIT). Low-interest loan program for non-profits to purchase HIT.	Would expand clinics to reduce emergency room use. Would revise the seismic mandate to focus on the "worst first".	Global budget, regional budgets, regulation of prices and fees, regulation of hospital budgets, elimination of private health plans and insurers, bulk purchasing and cap on program growth. Extensive cost control authority and measures are specified in subdivision (c) of Section 140203 on page 32 of the bill as introduced.

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	date, and reduce regulatory barriers to efficient health care delivery.	progress on increasing coverage.	erage, county health, health professions, quality and other issues.			
Public programs (state/federal)	Medi-Cal rates to be significantly increased. Medi-Cal and Healthy Families would be expanded to cover up to 300 percent of FPL. Medi-Cal would be expanded to cover poor adults.	Healthy Families and Medi-Cal would be expanded to cover children and their parents up to 300 percent of FPL. Would cover all children without regard to citizenship or immigration status, creating a state-only element of the programs.	Subject to future appropriation of funds, Healthy Families and Medi-Cal would be expanded. Would cover all children without regard to citizenship or immigration status, creating a state-only element of the programs.	Would make increasing Medi-Cal rates a budget priority over the next 8 years. Would “realign” Medi-Cal benefits to more closely mirror private health care benefits. Would reallocate First Five funds for children’s health coverage.	Would create a Medi-Cal pilot program using health savings accounts and high deductible plans.	A new government-administered single-payer health insurance system would replace all private health insurers and all existing government insurance programs, including Medicare. The system would be allowed to contract for claims administration and other functions.
Health care safety net and “county indigents”	State would become responsible for all Californians except undocumented adults. State would redirect most of the safety-net pool funds and half of county match. $2 billion is left with counties and safety-net providers.		The state would be required to assess the impact of the reforms on the county health care safety net system including a review of the amount of uncompensated care and emergency room use.	Part of existing hospital safety-net funding would be redirected to community clinics.	Would increase resources for medical clinics serving the poor by requiring foundations created by the conversions of not-for-profit hospitals and health care service plans to spend 90 percent of their investment income on clinics.	Coverage would be virtually universal, so in theory there would be no indigent patients for whom counties would be legally responsible.

Sources:

- AB 8 (Núñez), as amended May 17, 2007 and related Assembly committee analyses.
- SB 48 (Perata), as amended May 16, 2007 and the related Senate committee analyses.
- SB 840 (Kuehl) as amended April 30, 2007and the related Senate committee analyses.
- SB 236 (Runner) as amended April 19, 2007.
- Descriptive materials issued by Speaker Núñez, by President Pro Tem Perata, by Governor Schwarzenegger, by the Senate Republican Caucus, by the Senate Office of Research and by the Assembly Republican Caucus.

Note: This side-by-side is for broad comparison purposes. The proposals are complex — this format cannot fully reflect all of their significant details and implications. Refer to legislative committee analyses for detailed descriptions and analysis. This document may be updated as the proposals evolve.