

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

COVERAGE RESPONSIBILITY - INDIVIDUALS

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl*	Sen. Republicans
<p>Individual mandate – Requirement for individuals to have, maintain and demonstrate proof of health care coverage on their own, whether or not they have access to public or employer-sponsored coverage</p> <p>Employee mandate – Requirement that employees participate or "take up" coverage when offered by their employer and pay their share of premium costs, if any.</p> <p>Single payer health care – A type of health care financing system in which a single entity, typically a government-run organization, acts as the administrator (or "payer") to collect all health care fees and revenues, and pay out all health care costs. In practice, this means that the government collects revenues from taxes, business or other sources, creates an entity to administer a health coverage program and then pays providers for health care services and costs. Federal Medicare is a single payer system.</p>	<p><u>Employee mandate</u> with expanded public programs for low-income persons.</p> <p>Employees do not have to take up employer coverage if their share of premiums and out-of-pocket costs exceed a certain %age of family income (TBD).</p>	<p><u>Individual mandate</u> on workers, including the self-employed, with expanded public programs for low-income working persons.</p>	<p><u>Individual mandate</u> with subsidies for low-income persons through a state-administered purchasing program.</p> <p>Employees are not required to take up employer coverage that is offered to them but are required to demonstrate proof of coverage either through the employer or on their own.</p>	<p><u>Single payer</u> Establishes universal eligibility for all California residents, (physical presence in the state with intent to reside) in a state-administered health care coverage program, the California Health Insurance System (CHIS).</p>	<p>No individual or employee mandate. Gives those purchasing in the individual market the same tax benefit that is available for employment-based coverage.</p>

COVERAGE RESPONSIBILITY – EMPLOYERS

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Employer responsibility – The role that employers pay in contributing to health care or coverage for their workers</p> <p>Pay or Play – Employers choose to pay a fee to the state for the costs of health care or cover health care for their workers.</p> <p>Section 125 Plan – Employer-established savings account that allows employees to pay for their contributions to health care, child care and other approved expenses with pre-tax dollars. Also referred to as "cafeteria plans." Section 125 plans are authorized under federal law.</p> <p>Employee Retirement Income Security Act (ERISA) - A 1974 federal law that established standards, reporting and disclosure requirements for employer-funded pension and employee benefits, including health care. To date, employer self-funded health benefit plans operating under ERISA have been held to be exempt from most state insurance laws. Larger employers are more likely than smaller employers to operate ERISA self-funded plans. ERISA is a consideration for states seeking to impose requirements that employers contribute to health care for their workers.</p>	<p><u>Pay or play</u> Employers elect to provide health coverage for their employees and dependents or pay a fee (% of payroll TBD) to the state for coverage under the California Cooperative Health Insurance Purchasing Program. Exempts employers with less than 2 workers or payrolls less than \$100,000 or newly established firms.</p> <p>Requires all employers to establish Sec 125 plans for their employees.</p>	<p><u>Pay or Play</u> Employers elect to either provide health care coverage to employees and dependents equal to a % of the employer's Social Security wages (TBD) or, alternatively, allows employers to have that coverage provided through the state-administered "Connector" upon payment of a fee of an equivalent amount.</p> <p>No employer exemptions proposed.</p>	<p><u>Pay or Play</u> Employers with 10 or more employees who choose not to offer health coverage to their workers will contribute an amount equal to 4% of payroll toward the costs of employees' health coverage. Requires all employers to establish Sec 125 plans for their employees.</p>	<p><u>Single payer</u> Coverage under the program is not dependent on employment status. Employer health coverage for basic health care would not be required. Employers could provide additional coverage to workers</p>	<p><u>Health Savings Accounts</u> No employer coverage mandate. Offers incentives for employers to offer health insurance and to establish Sec 125 plans. Proposes tax credits for employers who contribute to HSAs.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

COVERAGE RESPONSIBILITY - PUBLIC PROGRAMS FOR LOW-INCOME FAMILIES

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Medi-Cal (Medicaid) – California's version of federal Medicaid provides comprehensive health benefits to low-income children, their parents or caretaker relatives, pregnant women, elderly, blind or disabled persons, nursing home residents and refugees who meet specified eligibility criteria. Medi-Cal is administered by the state Department of Health Services (DHS) and costs are shared about equally between the state General Fund and federal funds.</p> <p>Healthy Families Program (HFP) – California's version of the federal State Children's Health Insurance Program (SCHIP), administered by the Managed Risk Medical Insurance Board (MRMIB), provides health, dental, vision and basic mental health coverage for legal immigrant children from birth to age 19, who do not have private coverage or Medi-Cal in families earning up to 250% of the federal poverty level (FPL). Families pay a relatively low monthly premium and choose from a selection of private managed care plans. Funding for HFP generally is on a 2-to-1 federal/state matching basis.</p> <p>Access for Infants and Mothers (AIM) -- California's program that provides low cost health insurance coverage to qualifying uninsured, middle income pregnant women who do not have maternity coverage through Medicare, Medi-Cal or private insurance. Subscriber's pay 1.5% of their adjusted annual household income and the state and the Federal Government supplement the subscriber contribution to cover the full cost of care. In addition to premiums, AIM is funded by Proposition 99. AIM is administered by MRMIB.</p> <p>Children's Health Initiatives (CHIs) -- County programs that provide low cost health coverage, similar to benefits under the HFP, for uninsured children up to age 19 who are not eligible for HFP or no cost Medi-Cal.</p> <p>Federal poverty level (FPL) -- The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size. The FPL for a family of four in 2007 is \$20,650.</p>	<p>Parents with incomes up to 300% of the FPL would be eligible for Medi-Cal or Healthy Families.</p> <p>All children in families up to 300% of the FPL, regardless of immigration status, would be eligible for Healthy Families and/or Medi-Cal, depending upon income.</p> <p>Makes a commitment to cover childless adults with incomes below 300% of the FPL within five years.</p>	<p>Medi-Cal coverage would be expanded to cover working parents with incomes from 100-300% of the FPL.</p> <p>All children in families up to 300% of the FPL, regardless of immigration status, would be eligible for Healthy Families and/or Medi-Cal, depending upon income.</p> <p>Envisions using federal Medicaid and SCHIP funds to support subsidized coverage in the connector.</p>	<p>All children and documented adults below 100% of the FPL would be eligible for Medi-Cal, establishing a "bright line" of Medi-Cal eligibility for families.</p> <p>All children 100-300% of the FPL would be eligible for Healthy Families.</p> <p>Subsidies for individuals and families with incomes 100-250% of FPL are available only in a state purchasing cooperative, or pool, and persons eligible for the subsidy pay sliding scale premiums ranging from 3-6% of gross income.</p> <p>Undocumented adults without employer coverage and any persons temporarily uninsured would receive health care provided or paid for by counties. No change to existing county mandates or responsibilities.</p>	<p>All California residents, regardless of income, would be eligible for coverage under CHIS.</p> <p>Consolidates existing funding for public programs into one fund to provide coverage under CHIS.</p>	<p>No expansion of existing public programs.</p> <p>Reduces Medi-Cal benefits to mirror private health insurance.</p> <p>Proposes redirection of First Five tobacco tax revenues to fund children's health care initiatives, which requires voter approval.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

COVERAGE STRUCTURE - PRIVATE INSURANCE

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Individual insurance – Private coverage generally purchased by individuals who are self-employed or those who do not have employer-sponsored coverage. An estimated 6% of Californians have individual coverage.</p> <p>Group insurance – Private coverage generally available to groups, such as employer groups. The group market is generally divided into small groups (2-50 employees), mid-size (50-200) and larger employers (200+), with different rating and underwriting practices in each market segment. An estimated 55% of Californians are in employer-sponsored group plans.</p>	<p>Maintains private markets. Requires health insurers to use standard applications and offer three uniform benefit designs. Insurers must issue individual coverage to all applicants, except for persons with specified serious health conditions, as determined by MRMIB.</p>	<p>Maintains private markets. Requires insurers to issue coverage on a guaranteed basis, without any rate adjustments for health status, but only in the state-administered, "connector" purchasing program.</p>	<p>Maintains private markets. Insurers must issue policies to all individual applicants and premiums can only vary based on age, family size and geography. No changes to group markets proposed.</p>	<p>Prohibits the sale of any private health insurance policy, other than CHIS, for CHIS benefits. Permits insurers to sell supplemental policies for benefits not covered by CHIS. Allows for integrated delivery systems.</p>	<p>Maintains private markets. Permits greater range of premium rates in the small group market.</p>

COVERAGE STRUCTURE - PURCHASING POOL OR COOPERATIVE

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Health insurance purchasing cooperative (HIPC) or purchasing pool -- Public or private organizations that secure health insurance coverage for pool members, typically the employees of member employer groups.</p> <p>High risk pool – Health insurance purchasing programs organized by states (34 currently, including California) to provide coverage for individuals who have been denied health insurance because of a medical condition or history of health service use or whose premiums have been rated significantly higher because of their health status or claims experience. California's high risk pool is the Major Risk Medical Insurance Program (MRMIP) administered by MRMIB. Enrollment in MRMIP is limited to funds available. The program is currently funded at \$40 million.</p> <p>Health Savings Accounts (HSAs) -- An account owned by an individual that can be funded by the employer, employee or both. Federal rules require that an HSA be paired with a high deductible health plan meeting federal standards, generally with an annual deductible of \$1,050-\$5,250 for an individual and \$2,700-\$10,500 for a family (2006 tax year). Employer contributions are not counted as income and employee contributions are pre-tax. The HSA account is portable and unused dollars can be rolled over.</p>	<p>Requires MRMIB to administer the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) for employees whose employer chooses to pay a fee rather than provide coverage.</p> <p>Cal-CHIPP would also be open to self-employed individuals and employers, such as small employers.</p> <p>Limits the conditions that plans and insurers can use to deny any person health coverage and restructures MRMIP to cover all individuals with those serious conditions.</p>	<p>Requires MRMIB to function as the "connector" and purchase coverage for employees whose employer chooses to pay a fee rather than provide coverage.</p> <p>Individuals and employers who wish to purchase coverage for their employees through the connector would be able to do so.</p>	<p>Requires MRMIB to establish a purchasing pool for all individuals with incomes 100-250% of FPL and provides subsidies only through the pool.</p> <p>Individuals without employer coverage and with incomes above 250% would have to purchase individual coverage available in the private market and requires health plans and insurers to cover everyone regardless of health status or pre-existing condition.</p>	<p>Establishes CHIS as a statewide purchasing entity negotiating and paying for all CHIS covered benefits.</p> <p>Establishes the new California Health Insurance Agency and directs the new Health Insurance Commissioner to purchase all services at the lowest possible price.</p>	<p>Requires CalPERS to offer high deductible health plans and Health Savings Accounts (HSAs) to state employees.</p> <p>Continues the existing MRMIP program for persons denied health coverage and redirects Proposition 99 monies to fully fund the MRMIP waiting list.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

PROVIDER /PLAN ISSUES - CAPS ON ADMINISTRATIVE SPENDING

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Medical / loss ratio -- The ratio between the expenses/costs for health care services and the total amount of money received by a provider or health plan. Serves to cap administrative costs and profits.</p>	No specific provision	Caps administrative costs and profits for those health plans contracting through the connector. Specific limit TBD.	Requires health plans and hospitals to spend 85% of payments /premiums received on health care services.	Limits administrative spending under CHIS to 5%. Authorizes the Commissioner to implement other cost controls.	No specific provision

PROVIDER /PLAN ISSUES - PAYMENT RATES

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Fee-for-service (FFS) payments – A method of reimbursing providers where the provider bills and is paid for each encounter or service provided.</p> <p>Capitation payments – A method of payment in which a provider, group of providers (such as a medical group) or health plan is paid a fixed amount, generally a monthly fee, per person, regardless of the actual number or cost of services provided.</p>	No specific provision	No specific provision	Increases provider payments in Medi-Cal to 80% of Medicare rates for physician /outpatient services and 100% of Medicare for inpatient services, as well as the resulting increases in MC managed care rates. Cost: \$4 billion.	Allows providers to negotiate rates and to choose FFS, capitation, or salary. CHIS Commissioner negotiates and sets all rates, fees and prices and the Payments Board establishes a uniform payments system.	Increases Medi-Cal provider rates (over eight years) so they are closer to Medicare rates, using savings from reducing Medi-Cal benefits.

<p>Pay for performance (P4P) -- Broadly defined, includes any type of performance-based provider or health plan payment arrangements, including those that target performance on specific cost or quality measures.</p>	Requires pay for performance in every coverage program receiving state funds, including Medi-Cal, Healthy Families and Cal-PERS.	No specific provision.	Ties future Medi-Cal plan and provider rate increases to performance improvements. Proposes purchaser partnerships on data related to P4P.	Establishes bonus provider payments for high performance, providing services in rural or underserved areas and incentive payments to address provider shortages.	Establishes a partial tax credit for providers for the cost of providing care for the uninsured.
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PROVIDER /PLAN ISSUES - PROVIDER FEES

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Quality Assurance Fee - Federal Medicaid law permits states to impose a broad based fee of up to 6% of gross revenues on certain providers, for purposes of increasing Medicaid reimbursements. California currently assesses a quality assurance fee on nursing homes, intermediate care facilities, and Medi-Cal managed care providers.</p>	None.	None.	Requires physicians and hospitals to pay a coverage dividend, 2% of revenues for physicians and 4% for hospitals.	None.	None.

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

PROVIDER /PLAN ISSUES - HEALTH PLANS AND INSURERS

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Guaranteed Issue – Requirement that health plans and insurers accept all applicants for coverage regardless of health status or pre-existing conditions. California only imposes this requirement on insurers selling coverage to employer groups of 2-50 employees. Californians unable to obtain individual coverage because of pre-existing conditions are eligible to buy health coverage at higher than market rates through the Major Risk Medical Insurance Program (MRMIP).</p>	<p>Requires guaranteed issue for individuals, except those with serious health conditions, as determined by MRMIB. Retains the MRMIP for persons with the serious conditions on the list and restructures the funding to cover all who are eligible.</p>	<p>Guaranteed issue of coverage only through a state-established health insurance purchasing cooperative, the "connector."</p>	<p>Guaranteed issue for individual coverage with no ability to price coverage based on health status or expected health service use. Rates only vary by age, family size and geography.</p>	<p>All state residents are eligible for the state health insurance system regardless of health status or pre-existing conditions.</p>	<p>No Guaranteed issue. Fully funds MRMIP for those who cannot get health insurance due to pre-existing conditions.</p>

BENEFITS

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Deductible – The amount an insured must pay before coverage under the plan is available.</p> <p>Co-payments /Coinsurance – Cost sharing for health care services where the insured person pays a fixed dollar amount (copayment) or a % (coinsurance) for health services received.</p> <p>Knox-Keene benefits – The Knox-Keene Health Care Service Plan Act of 1975 establishes basic benefits that must be offered by all health plans licensed by the Department of Managed Health Care (DMHC), generally Health Maintenance Organizations (HMOs) and some Preferred Provider Organization (PPO) plans. Knox-Keene basic benefits are: physician services, hospital inpatient and outpatient, diagnostic lab and radiology services, home health services, preventive health services, emergency health care, including ambulance and out-of-area coverage, and hospice care. Knox-Keene does not require drug coverage. Knox-Keene plans are also subject to other statutory benefit mandates applicable to plans and insurers.</p> <p>Insurance Code benefits -- Health insurers (traditional indemnity / some PPOs) are regulated by the Department of Insurance, and are not subject to a basic benefit requirement, but are subject to many other statutory mandated benefits applicable to health plans and insurers.</p>	<p>Existing Healthy Families and Medi-Cal benefits for persons enrolled in those programs.</p> <p>In the private market, and Cal-CHIP, all insurers would be required to offer and sell three uniform benefit designs, developed by MRMIB, which can be easily compared across companies.</p> <p>All uniform plans would include coverage with minimal cost sharing for primary and preventive care, including maintenance medications.</p>	<p>Existing Healthy Families and Medi-Cal benefits for those eligible.</p> <p>The connector would establish benefit plans in three-tiers, based on out-of-pocket costs such as copayments, and offer a choice of plans for those getting coverage through the connector.</p>	<p>Existing Healthy Families and Medi-Cal benefits for those eligible.</p> <p><i>Individual mandate:</i> Mandate can be met with a \$5,000 deductible plan with maximum annual out-of-pocket costs of \$7,500 individual and \$10,000 family.</p> <p><i>Subsidized coverage in the purchasing pool:</i> Knox-Keene basic benefits plus drug coverage. No specificity on cost sharing except proposed deductibles and copayments would encourage prevention and discourage use of emergency rooms.</p>	<p>Covers a comprehensive set of benefits, including, basic services similar to those in Knox-Keene, plus, among other things, rehabilitative services, prescription drugs, mental health, substance abuse, dental, vision, acupuncture, case management, and language translation services. Prohibits deductibles or copayments for at least two years. Provides that covered benefits include all care determined to be medically appropriate by the consumer's health care provider.</p>	<p>Proposes to give health plans and insurers increased flexibility regarding product design, including, but not limited to co-payments, deductibles, networks, mandates, and benefits.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

COST AND QUALITY - PREVENTION AND WELLNESS

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Preventive medicine – Care that has the aim of preventing disease or its consequences. Includes programs aimed at warding off illnesses (immunizations), early detection, and inhibiting further deterioration (exercise, maintenance medications, monitoring key indicators, etc.).</p> <p>Evidence-based medicine – The conscious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.</p>	<p>Uniform benefit designs would include coverage for primary and preventive care with low cost sharing. Encourages adoption of healthy workplaces and individual efforts to improve health.</p>	<p>Health plans participating in the connector would be required to implement evidence-based preventive services</p>	<p>Requires health plans to offer Healthy Action/Incentive Rewards plans and incorporates rewards and incentives into public and subsidized coverage.</p>	<p>Preventive benefits are covered under CHIS.</p>	<p>Allows hospitals to offer "preventive services only" coverage where care is delivered through a hospital's primary care clinic or a community-based clinic.</p>

COST AND QUALITY - HEALTH CARE TECHNOLOGY / HEALTH CARE INFORMATION TECHNOLOGY (HEALTH IT)

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Electronic health record (EHR), Personal health record (PHR) -- A <i>personal</i> medical record in digital format. An EHR is typically accessed on a computer or over a network. An Internet-based PHR permits a patient, caregiver, or provider to review a record related to the patient's health condition, medications, medical problems, and medical appointments via an Internet connection.</p> <p>Electronic medical record (EMR) – A <i>patient</i> medical record in digital format. An EMR typically includes much of the same information in an EHR and also includes the records of care and treatment received, appointments and patient demographics.</p> <p>E-prescribing – The use of an automated data entry system to generate a prescription rather than writing it on paper.</p>	<p>Proposes Internet-based PHRs in the short-term and requires providers to participate.</p> <p>Requires adoption of EMRs compatible across all providers and systems by January 1, 2012.</p>	<p>Requires health plans participating in the connector to promote Health IT.</p>	<p>Proposes a series of Health IT action steps, including a Deputy Secretary of HIT in the Health and Human Services Agency. Proposes to leverage state purchasing to advance Health IT, including support for uniform standards to ensure that records are compatible across providers and systems. Requires e-prescribing by 2010.</p>	<p>Requires CHIS to establish: (1) a secure EMR system; (2) an electronic referral system accessible to patients and providers; and (3) an electronic claims and payment system, including standardized claims and reporting methods.</p>	<p>Provides hospitals and physicians a tax credit to purchase Health IT, such as electronic medical records and telemedicine. Establishes low-interest loan program for non-profit hospitals and medical groups to invest in Health IT.</p>

COST AND QUALITY - TECHNOLOGY ASSESSMENT

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Technology assessment – The process of reviewing and evaluating emerging medical treatments, drugs and equipment to determine costs, benefits and effectiveness.</p>	<p>Proposes centralizing technology assessment at the state level.</p>	<p>Requires the connector to ensure the rational use of medical technology.</p>	<p>Proposes a technology assessment process to promote evidence-based care.</p>	<p>Establishes a Technology Assessment Committee to evaluate the cost and effectiveness of new medical technology.</p>	<p>No specific provisions.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

COST AND QUALITY - OTHER ISSUES

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Evidence-based medicine – The conscious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.</p> <p>Disease management – A coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition, (i.e., asthma or diabetes).</p> <p>Hospital seismic retrofit – California law requires all acute care hospitals to meet specified building code requirements, including standards for earthquake safety, according to specified timelines. Current law provides that hospitals posing a significant risk of collapse or posing a danger to the public be removed from service if certain seismic standards are not met by January 1, 2008. These hospitals can be granted two extensions of the 2008 deadline to 2013 and 2015. However, by 2030 certain high risk hospitals must be able to withstand and continue to serve the public after a major earthquake. Last year, funding was approved by the Legislature to allow the Office of Statewide Planning and Development to use new technology to re-evaluate which hospitals are truly at risk.</p>	<p>Incorporates disease management, including anti-obesity, diabetes management, and tobacco cessation, in all state funded health care programs.</p>	<p>Imposes requirements on health plans in the connector, including disease management, standardized billing, reduction of medical errors, etc.</p> <p>Authorizes the Connector to "buy-in" to Medi-Cal managed care plans on a negotiated basis.</p>	<p>Proposes review of regulations and mandates on health plans and providers for opportunities to reduce costs.</p> <p>Pilot project in "24-hour care," combining health care and medical care in workers' compensation.</p> <p>Includes a provision to reclassify hospitals at most risk in an earthquake and to modify the seismic safety compliance deadlines for hospitals that are determined to be at less risk.</p> <p>Sets a cap on out-of-network hospital reimbursements.</p> <p>Calls for a review of scope-of-practice for physician extenders, such as nurse practitioners and physician assistants, with the goal of expanding access to retail-based medical clinics and other low cost models of care.</p>	<p>Implements evidence-based medicine and system-wide standards of care, based on clinical efficacy.</p> <p>Establishes a system-wide approach to addressing medical errors.</p> <p>Establishes an Office of Health Care Quality charged with measuring, monitoring and improving quality.</p> <p>Anticipates bulk purchasing savings for drugs and durable medical equipment.</p> <p>Broad authority for the Commissioner and the Health Insurance Policy Board to implement a wide range of cost control measures, including benefit reductions, in the event that statewide trends indicate the need for cost-cutting.</p>	<p>Increases transparency of pricing information by hospitals and other providers.</p> <p>Reprioritizes hospital seismic retrofit requirements, focusing first on hospitals most at risk.</p> <p>Adjusts physician oversight requirements of nurse practitioners and other physician extenders to allow extender professionals to establish and run primary care clinics.</p> <p>Reallocates a portion of funds used for state-only health care programs to expand services delivered through primary care clinics.</p> <p>Reallocates to the community clinic expansion a portion of the \$2 billion currently allocated to DSH hospitals (that continue to serve a disproportionate share of low-income and uninsured patients).</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

FINANCING

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Disproportionate Share Hospitals (DSH) -- Hospitals that serve high numbers of uninsured and Medi-Cal patients. Qualified DSH hospitals receive supplemental payments or adjustments under Medi-Cal and Medicare to help defray the costs of caring for uninsured patients, pursuant to state and federal funding formulas and requirements.</p> <p>Safety net – The network of public and private providers which provide free, discounted or uncompensated medical care to medically needy, low income or uninsured populations.</p> <p>Bad debt – Services for which payment was anticipated but not received.</p> <p>Charity care – Services for which no payment was received nor expected to be received because of a determination of the patient's inability to pay.</p> <p>Uncompensated care – Measure of care provided for which no payment was received from the patient or insurer. For hospitals, it is the sum of a hospital's bad debt and charity care and it excludes unfunded costs of care due to Medicaid or Medicare underpayment.</p>	<p>Employer and employee contributions.</p> <p>Increased federal Medicaid and SCHIP funds.</p> <p>Assessments on insurance premiums to pay for the MRMIP high risk pool.</p>	<p>Employer and employee fees.</p> <p>Increased federal Medicaid and SCHIP funds.</p>	<p>Increased federal Medicaid and SCHIP funds (\$5.4 billion).</p> <p>Redirection of \$2 billion in county health care safety net funding.</p> <p>Employer fees based on 4% of payroll (\$1 billion).</p> <p>Coverage dividend in the form of fees paid by hospitals and physicians (\$3.4 billion).</p> <p>Re-direction of other state funds from existing coverage programs that would be eliminated, including the Access for Infants and Mothers (AIM) program and MRMIP (\$203 million).</p>	<p>Creates the Health Insurance Fund and the Payments Board to administer the finances of CHIS and the California Health Insurance Premium Commission to determine the cost of CHIS and to develop a premium structure for the system.</p>	<p>Reallocates a substantial part of the \$2 billion provided annually to DSH hospitals to be used to create and expand primary care clinics.</p> <p>Reallocates \$500 million from First Five (Prop 10) tobacco tax revenues to children's health initiatives (CHIs).</p> <p>Reallocates a substantial part of the \$300 million spent on state-only Medi-Cal and other health programs to offset tax expenditures.</p> <p>Uses savings from reduced Medi-Cal benefits to fund Medi-Cal provider rate increase.</p> <p>Redirects Prop. 99 monies to fully fund the MRMIP waiting list.</p> <p>Calls on federal government to pay \$2.2 billion in mandated health care services for undocumented immigrants.</p>

HEALTH CARE REFORM 2007 - ISSUES OVERVIEW AND PROPOSAL COMPARISON

ENFORCEMENT

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Employee wage withholding -- Employers in California are required to report all employee wages to the Employment Development Department (EDD) each calendar quarter. With the exception of some employers of household workers, periodic deposits of State Disability Insurance (SDI) and Personal Income Tax (PIT) withholdings are required. In addition to withholding and depositing state and federal income tax, social security, and Medicare taxes from an employee's wages, employers are responsible for withholding and paying a matching amount for social security and Medicare taxes.</p> <p>Self-employment tax – Refers to the full payment of social security and Medicare taxes by people who are self-employed. This tax applies to those who are sole proprietors and limited liability partnerships with a net profit of \$400 or more during the year.</p>	<p>There is no requirement on individuals to obtain health insurance. However, employee premiums would be collected via Sec 125 plans.</p> <p>No specified enforcement on employees who must take up employer offered coverage.</p>	<p>Employer and employee contributions would be collected through the EDD wage and tax withholding system.</p> <p>In addition, all working income tax filers would be required to show proof of health coverage at the point of tax filing. Failure to show proof would result in loss of the personal exemption credit or dependent credit on state income tax returns.</p>	<p>For persons who do not obtain health insurance, premium payments will be withheld from their wages through the EDD wage withholding system.</p> <p>An unemployed individual with income would be assessed a premium amount by the State Franchise Tax Board.</p> <p>Uninsured individuals who are assessed premiums would be auto enrolled into a private insurance policy meeting the minimum individual mandate requirement.</p>	<p>Not applicable.</p>	<p>Not applicable.</p>

EVALUATION

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
<p>Program evaluation – Careful collection of data about a program or some aspect of a program in order to make necessary decisions about the program. Program evaluation can include any or a variety of at least 35 different types of evaluation, such as needs assessments, cost/benefit analysis, effectiveness, efficiency, goal-based, process, outcomes, etc.</p>	<p>Establishes ongoing and annual oversight of specific goals and targets (TBD) and a five-year evaluation to determine progress, including impacts on employment and health insurance markets.</p>	<p>No specific provision.</p>	<p>Proposes ongoing evaluation.</p>	<p>Requires ongoing evaluation of the CHIS program.</p>	<p>No specific provision.</p>

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TAX CONFORMITY

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
Tax Conformity –Makes specific state tax provisions conform to federal tax law.	No specific provision.	No specific provision.	Conforms California tax treatment of HSAs to federal tax law. According to Franchise Tax Board, this would cost \$20 million in FY 2008-09.	No specific provision.	Conforms California tax treatment of HSAs to federal tax law. According to Franchise Tax Board, this would cost \$20 million in FY 2008-09

TIMELINE

Definitions of Concepts and Terms	Nuñez	Perata	Governor	Kuehl	Sen. Republicans
Implementation schedule and key milestones	<p>July 2008 - Insurance market reforms, coverage for children.</p> <p>January 2009 – Pay or play employer responsibility.</p> <p>January 2012 – Coverage for low-income, childless adults.</p>	No specific provision.	No specific provision.	<p>January 2007 – Premium Commission established.</p> <p>January 2009 – Recommendations on a premium structure from the Premium Commission.</p> <p>Implementation within 2 years of key findings and recommendations by the Secretary of Health and Human Services.</p>	<p>January 2008--General implementation.</p> <p>Increased Medi-Cal provider rates over eight years.</p> <p>Redirection of First Five Funds tobacco tax revenues on voter approval.</p>

* Features included here on the single payer plan are based on provisions of SB 840 (Kuehl) from 2006.