Health Reform Proposals Comparison Chart
2007-08 Legislative Session

Issue	Assemblyman Nuñez (AB 8)	Senator Perata (SB 48)	Governor (No bill)	Senator Kuehl (SBs 840 / 1014)	Senate Republicans (Various bills)	Assembly Republicans (Various bills)
Individuals	No broad-based individual mandate. Take-up requirement: Requires individuals eligible for a statewide purchasing program, or purchasing pool, established for this purpose and administered by the Managed Risk Medical Insurance Board (MRMIB), to enroll in the pool unless they have other group coverage.	Individual mandate for families with incomes 400% of FPL or higher, including the self-employed, who must have minimum coverage, to be determined by MRMIB, for themselves and their dependents. Individuals are not subject to this requirement if the costs of the policy exceed 5% of family income.	Individual mandate for all Californians, including children, who are required to have at least minimum coverage, defined as a $5,000 deductible with maximum out-of-pocket limits of $7,500 per person and $10,000 per family. 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.	Single payer 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).	No individual or employee mandate. Gives those purchasing in the individual market the same tax benefit that is available for employment-based coverage.	Conforms state law to federal tax benefits for Health Savings Accounts (HSAs). Establishes a Health Insurance Exchange solely for the purpose of facilitating employee purchase of coverage using pre-tax dollars in a Section 125 plan offered by their employers.
Employers	Pay or Play Establishes an employer election to either: a) make health care expenditures equivalent to 7.5% of payroll, for both full and part-time employees, or b) pay an equivalent amount to the California Health Trust Fund. Exempts employers with less than two workers, or payrolls less than $100,000, and newly established firms.	Pay or Play Employers would be required to spend 7.5% of payroll on employee health care expenditures or pay an equivalent amount to a State Trust Fund.	Pay or Play Employers with 10 or more employees who choose not to offer health coverage to their workers will pay a fee, equal to 4% of payroll, toward the costs of health coverage.	Single payer 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. SB 1014 imposes a payroll tax on employers (8.17%) and employees (3.78%) to fund coverage under the single payer system.	No employer coverage or contribution proposed.	Allows insurers to apply to offer products for employer purchase that combine health and workers' compensation coverage.

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Low-income persons	All children in families up to 300% of FPL, regardless of immigration status, would be eligible for Healthy Families or Medi-Cal, with cost sharing adjusted for income. Parents 300% of FPL or below are eligible for Medi-Cal or Healthy Families. Parents not in Medi-Cal would receive a "benchmark" plan (similar to Healthy Families) and pay sliding scale premiums based on income, as determined by MRMIB. Clarifies eligibility for families, so that, generally speaking, families at or below 133% of FPL (except for infants and pregnant women), are in Medi-Cal, and families with incomes above that up to 300% are in Healthy Families type coverage. MRMIB would provide premium assistance for families under 300% of FPL in employer coverage.	All children up to 300% of FPL, regardless of immigration status, would be eligible for Healthy Families or Medi-Cal, with cost sharing adjusted for income. Parents 300% of FPL or below are eligible for Medi-Cal or Healthy Families. Parents not in Medi-Cal would receive a "benchmark" plan (similar to Healthy Families) and pay sliding scale premiums based on income, as determined by MRMIB. Clarifies eligibility for families, so that, generally speaking, families at or below 133% of FPL (except for infants and pregnant women), are in Medi-Cal, and families with incomes above that up to 300% of FPL are in Healthy Families type coverage.	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 at 100%. All children 100-300% of the FPL would be eligible for Healthy Families. 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. Undocumented adults without employer coverage and any persons temporarily uninsured would receive health care provided or paid for by counties.	All California residents, regardless of income, would be eligible for coverage under CHIS. Consolidates existing funding for public programs into one fund to provide coverage under CHIS.	No expansion of existing public programs. Reduces Medi-Cal benefits to mirror private health insurance. Proposes redirection of First Five tobacco tax revenues to fund children's health care initiatives, which requires voter approval. Proposes aggressive outreach program to enroll persons eligible for existing programs.	Allows Medi-Cal eligible persons to receive Medi-Cal benefits though a health savings account. Requires that 90% of the annual expenditure of charitable assets dedicated and transferred to a charitable, grant-making foundation as a result of a health care service plan conversion from nonprofit to for-profit, be spent for health care services for citizens who reside in California and who are not receiving health care services through a local, state or federal program.

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Purchasing Program or "Purchasing Pool"	Requires MRMIB to administer the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) for employees eligible for the statewide purchasing pool. MRMIB will establish premiums, contract with health plans, determine benefit levels and administer subsidies to eligible persons with incomes less than 300% FPL.	Requires MRMIB to function as the "connector" and purchase coverage for employees whose employer chooses to pay a fee rather than pay for employee health care.	Requires MRMIB to establish a purchasing pool for all individuals with incomes 100-250% of FPL and provides low-income subsidies for eligible persons only through the pool who will pay sliding scale premiums ranging from 3-6% of gross income.	Establishes CHIS as a statewide purchasing entity negotiating and paying for all CHIS covered benefits. Establishes the new California Health Insurance Agency and directs the new Health Insurance Commissioner to purchase all services at the lowest possible price.	Continues the existing MRMIP program for persons denied health coverage and redirects Proposition 99 monies to fully fund any MRMIP waiting list.	Allows small employers to join with other businesses to purchase health coverage through "guaranteed associations" and expands the existing exemption for such associations from rating and underwriting rules that apply generally in the small employer coverage market (often referred to as small group reforms)
Benefits	Existing Medi-Cal and Healthy Families benefits for children and parents under 300% of FPL, depending on income and program eligibility. In the private market, and Cal-CHIPP, all insurers would be required to offer three uniform benefit designs, developed by MRMIB, which would include coverage with minimal cost sharing for primary and preventive care, including physician office visits, lab services and maintenance medications for managing chronic diseases.	Existing Healthy Families and Medi-Cal benefits for persons eligible for those programs. Employee choice of health plans in the Connector to include coverage for benefits as required of health plans licensed by Department of Managed Health Care (DMHC) under Knox-Keene Health Care Service Plan Act (Knox-Keene), plus prescription drugs. The Connector would establish benefit plans in three-tiers, with varying out-of-pocket costs, copayments and deductibles.	Existing Healthy Families and Medi-Cal benefits for those eligible. *Individual mandate*: Mandate can be met with a $5,000 deductible plan with maximum annual out-of-pocket costs of $7,500 individual and $10,000 for a family. *Subsidized coverage in the purchasing pool*: 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.	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.	Requires CalPERS to offer high deductible health plans and HSAs to state employees. Proposes to give health plans and insurers increased flexibility regarding product design, including, but not limited to co-payments, deductibles, networks, mandates, and benefits.	Requires CalPERS to offer high deductible health plans and HSAs to state employees. Allows individual or employer purchasers of health coverage to waive coverage for benefits otherwise mandated in state law.

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2007-08 Legislative Session

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Private health insurance markets	Extends existing market reforms applicable to small employers (2-50 employees), including guaranteed coverage and rating restrictions, to employers with 51-250 employees. Allows health plans and insurers to develop and offer separate coverage products for groups of 51-250. Requires health insurers to use standardized applications for individual coverage and offer at least three uniform benefit designs. Insurers must issue individual coverage to all applicants, except for persons with specified serious health conditions, as determined by MRMIB. High risk individuals with serious conditions will receive coverage in a restructured Major Risk Medical Insurance Program (MRMIP).	Extends existing market reforms applicable to small employers to employers with 199 or fewer employees. Allows separate coverage products for groups of 51-199. Eliminates health status as a rating factor in small and mid-size group markets by 2011. On January 1, 2011, requires plans and insurers to guarantee issue coverage of one baseline plan, to be defined by MRMIB, to individuals on a guaranteed basis, subject to a transition period, with phased-in requirements. Sometime after 2011, and upon a finding by MRMIB that ___% of California residents have complied with the requirement to have minimum health care coverage, requires carriers to guarantee coverage to all individuals of products developed by the DMHC and Insurance (CDI).	Insurers must guarantee coverage to all individual applicants and premiums can only vary based on age, family size and geography. No changes to group markets proposed.	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.	Permits greater range of premium rates in the small group market than are currently allowed under small employer reforms enacted in 2002.	Allows out-of-state health insurers to offer coverage in California, without a state Knox-Keene license or certificate to sell insurance in this state to promote more competition and greater choice. Extends for six months, until July 1, 2008, the structure of existing coverage for medically uninsurable individuals through the MRMIP and the Guaranteed Issue pilot, tightens eligibility for MRMIP and states legislative intent that no waiting list shall exist for persons who are eligible to obtain health coverage in MRMIP. Requires termination of coverage for MRMIP subscribers who fail to participate in a disease management program of the participating health plan that provides their coverage, if participation is prescribed by the physician.

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2007-08 Legislative Session

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Private Health Insurance Markets (continued)		Requires DMHC and CDI to develop five classes of coverage that carriers must guarantee and provides for the ability of individuals to switch among classes of coverage annually or at significant life events, with restrictions. Establishes a reinsurance fund to allow insurers to share in the costs of covering high risk persons after full implementation of the guaranteed issue requirements.				
Private insurance - Administrative costs	Requires DMHC and CDI to adopt regulations by July 1, 2008 defining administrative costs and health care services, so that plans and insurers spend at least 85% of premium revenue on health care services.	Requires DMHC and CDI to adopt regulations by January 15, 2008 to require that no less than 85% of aggregate premium is spent on health care services for a plan or insurer's enrollees.	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 provision	No provision
Providers	No specific provision.	No specific provision.	Increases Medi-Cal provider payments 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.	Allows providers to choose payment methods, including fee-for-service, capitation, or salary. 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. Establishes a tax credit for providers for the cost of providing care for the uninsured.	Increases Medi-Cal reimbursement rates for physician services to 80% of the Medicare rate Creates a new tax credit for doctors who provide services to the uninsured and the underinsured.

Health Reform Proposals Comparison Chart
2007-08 Legislative Session

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Tax Incentives related to health coverage	Requires all employers to establish federally allowable Sec 125 plans so that employees can use pretax dollars to pay for health care.	Employers participating in the connector are required to establish Section 125 plans for employees.	Requires all employers to establish Sec 125 plans for their employees. Conforms state law to federal tax savings for HSAs.	Not applicable.	Offers incentives but does not require employers to offer health insurance and to establish Sec 125 plans. Proposes tax credits for employers who contribute to HSAs. Conforms state law to federal tax savings for HSAs.	Provides a tax credit equal to 15% of the costs of coverage to employers who newly offer health insurance to their employees in the form of a high deductible health plan. Provides a personal income tax deduction for the costs of medical care. Federal HSA conformity
Quality initiatives and incentives	Requires pay for performance in every coverage program receiving state funds, including Medi-Cal, Healthy Families, MRMIP 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 pay for performance strategies.	Establishes bonus provider payments for high performance, providing services in rural or underserved areas and incentive payments to address provider shortages.	No specific provision.	Requires nursing programs at community colleges to use merit-based admissions policies to reduce drop-outs and increase the number of trained nurses.
Prevention	Mandatory uniform benefit designs that must be offered by health plans and insurers to all purchasers, and in Cal-CHIPP, would include coverage for primary and preventive care with low cost sharing for prevention, including physician office visits, lab services and maintenance medications necessary to manage chronic diseases.	Health plans participating in the connector would be required to implement evidence-based preventive services and all benefit plans in the Connector would provide coverage for Knox-Keene benefits (plus prescription drugs) which include prevention services.	Requires health plans to offer Healthy Action/Incentive Rewards plans and incorporates rewards and incentives into public and subsidized coverage.	Preventive benefits are covered under CHIS.	Allows hospitals to offer "preventive services only" coverage where care is delivered through a hospital's primary care clinic or a community-based clinic.	No specific provision.

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2007-08 Legislative Session

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Health Information Technology (IT)	Proposes Internet-based personal health records in the short-term and requires providers to participate. Requires adoption of Electronic Medical Records (EMR) compatible across all providers and systems by January 1, 2012.	Requires health plans participating in the Connector to promote Health IT.	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.	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.	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.	No specific provision.
Medical Technology Assessment (MTA)	No provision.	Requires the Connector to ensure the rational use of medical technology.	Proposes a technology assessment process to promote evidence-based care.	Establishes a Technology Assessment Committee to evaluate the cost effectiveness of new medical technology.	No specific provisions.	No specific provision.
Cost Containment	Requires MRMIB to assume lead agency responsibility for identifying best practices in disease management and requires those practices and guidelines to be used in all state funded health care programs. Uniform benefit designs to ease administrative burdens for providers and simplify plan selection for all purchasers.	Imposes requirements on health plans in the Connector, including disease management, standardized billing, reduction of medical errors, etc. Authorizes the Connector to "buy-in" to Medi-Cal managed care plans on a negotiated basis.	Proposes review of regulations and mandates on health plans and providers for opportunities to reduce costs. Pilot project in "24-hour care," combining health care and medical care in workers' compensation. 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	Implements evidence-based medicine and system-wide standards of care, based on clinical efficacy. Establishes a system-wide approach to addressing medical errors. Establishes an Office of Health Care Quality charged with measuring, monitoring and improving quality. Anticipates bulk purchasing savings for	Increases transparency of pricing information by hospitals and other providers. Reprioritizes hospital seismic retrofit requirements, focusing first on hospitals most at risk.	Eliminates supervision requirements applicable to nurse practitioners for the purpose of allowing additional walk-in and neighborhood health clinics at convenient locations such as pharmacies, grocery stores and shopping malls.

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Cost containment (continued)	Expands disclosure of medical loss ratios to all group and individual purchasers. Requires Secretary of Health and Human Services to encourage fitness, wellness and health promotion programs that promote safe workplaces, healthy employer practices, and individual efforts to improve health.	Plans contracting with the Connector must implement evidence-based practices that control costs, including preventive care, management of chronic diseases, promotion of health IT, incentives for healthy lifestyles, patient cost-sharing to encourage appropriate use of medical care and rational use of technology.	at less risk. Sets a cap on out-of-network hospital reimbursements. 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. Proposed an array of various health promotion and wellness strategies.	drugs and durable medical equipment. 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.	Adjusts physician oversight of nurse practitioners and other physician extenders to allow extender professionals to establish and run primary care clinics. Reallocates a portion of funds used for state-only health care programs to expand services delivered through primary care clinics. Reallocates to 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).	Proposes science-based reforms to ensure seismic retrofitting of California hospitals is performed on a "worst-first" basis to ensure that health facilities will be available in an earthquake.
Enforcement	There is no requirement on individuals to obtain health insurance. However, employee premiums would be collected via Sec 125 plans. No specified enforcement on low-income employees who must take up employer offered coverage.	Employer and employee contributions would be collected through the EDD wage and tax withholding system. 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.	For persons who do not obtain health insurance, premium payments will be withheld from their wages through the EDD wage withholding system or for unemployed persons, assessed a premium amount by the State Franchise Tax Board. Individuals who are assessed premiums would be auto enrolled into a minimum coverage policy.	Not applicable.	Not applicable.	Not applicable.

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Financing	Employer and employee fees. Increased federal Medicaid and SCHIP funds. State General Fund.	Employer and employee fees. Increased federal Medicaid and SCHIP funds.	Increased federal Medicaid and SCHIP funds ($5.4 billion). Redirection of $2 billion in county health care safety net funding. Employer fees based on 4% of payroll ($1 billion). Coverage dividend in the form of fees paid by hospitals and physicians ($3.4 billion). 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).	Establishes the California Health Insurance System Funding Law and a health care coverage premium which consists of the following taxes: • 1% on taxable personal income in excess of $200,000 but under $1 million; • Unspecified percentage on self-employment income over $7,000 and under $200,000; • Unspecified percentage on the amount of non-wage income of individuals under $200,000; • 3.78% increase in the employee share of the payroll tax of income over $7,000 and under $200,000, and • 8.17% increase in the employer share of the payroll tax of an employee's income over $7,000 and under $200,000.	Reallocates a substantial part of the $2 billion provided annually to safety net hospitals to create and expand primary care clinics. Reallocates $500 million from First Five tobacco tax revenues (Prop 10) to children's health coverage initiatives at the county level. Uses savings from reduced Medi-Cal benefits to fund Medi-Cal provider rate increase. Reallocates a substantial part of the $300 million spent on state-only Medi-Cal and other health programs to offset tax expenditures. Redirects Prop. 99 monies to fully fund the MRMIP waiting list. Calls on federal government to pay $2.2 billion in mandated health care services for undocumented persons.	

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Evaluation and Monitoring	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.	Requires the Secretary of Health and Human Services to contract for, establish and administer a program to track and assess the effects of the Act, with assessment components detailed in the bill, guided by an advisory body with specified membership, and consistent with timelines for reporting to the legislature as determined by the advisory committee.	Proposes ongoing evaluation.	Requires ongoing evaluation of the CHIS program.	No specific provision.	No specific provision.
Timelines	July 2008 - Insurance market reforms, coverage for children. January 2009 – Employer spending requirement.	January 2008 – Mid-size group market reforms. July 2008 – Coverage for low income children and parents. January 2011 – Individual market reforms; employer spending requirement, individual mandate.	No specific provision.	January 2007 – Premium Commission established. January 2009 – Recommendations on a premium structure from the Premium Commission. Implementation within 2 years of key findings and recommendations by the Secretary of Health and Human Services.	January 2008--General implementation. Increased Medi-Cal provider rates over eight years. Redirection of First Five Funds tobacco tax revenues on voter approval.	Not applicable