Comparison of California Health Coverage Expansion Proposals

	Governor's Plan	AB 8 (Núñez)	SB 48 (Perata)	SB 236 (Runner)	SB 840 (Kuehl) (and companion funding legislation SB 1014)
Californians to Be Covered	Estimated 6.6 million: all uninsured.	Estimated 3.4 million (or two thirds of Californians uninsured at a given point in time).	Estimated 3.4 million (or two-thirds of Californians uninsured at a given point in time).	Not yet estimated. (Emphasis on access to affordable care through expansion of community clinics and urgent care, not coverage.)	All Californians covered through newly created single-payer California Health Insurance System (CHIS).
Requirements Imposed on Consumers/ Individuals	All Californians are required to have coverage. To meet the requirement, a minimum benefit level of $5,000 deductible, with out-of-pocket maximums of $7,500 per person ($10,000 per family), must be maintained.	• An employee offered workplace coverage must participate unless they show proof of other group coverage, • An employee working for a firm that pays a fee (instead of paying for employee health expenditures) must enroll in the newly created state purchasing cooperative called California Cooperative Health Insurance Purchasing Program (Cal-CHIPP).	• All working/taxpaying Californians in households earning above 400% FPL[1] and their dependents are required to have a minimum coverage policy (defined as benefits required of Knox Keene[2] plans plus prescription drug coverage). • For employees of firms that opt to pay fees, the employee pays premiums and receives coverage through the newly created Connector. The maximum premium contribution would be 5% of income.	None.	Companion legislation, SB 1014, would require individuals to contribute a portion of income via taxes, in lieu of paying for health care premiums, co-pays, and deductibles. First $7,000 of income would be exempt.
Treatment of Self-Employed	Same individual mandate applies.	Enhanced access to coverage through state purchasing cooperative and reformed private insurance market.	Working group will evaluate access to the Connector for the self-employed.	Same tax treatment for self-employed who purchase health insurance as is available to larger employers.	All Californians have same access to same standard benefits, regardless of type of employment.

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Requirements Imposed on Employers	Pay or play approach -- employers with 10 or more employees that choose not to offer coverage contribute 4% of payroll toward cost of employees' coverage through purchasing cooperative. Employers of all sizes must establish Section 125 plans[3] to tax-shelter employer and employee health insurance contributions.	• Pay or play approach — employers required to pay 7.5% of Social Security wages for employee health care expenditures or pay equivalent amount into a trust fund to allow employees to access coverage through Cal-CHIPP. • All employers are required to establish Section 125 plans to tax-shelter employer and employee health insurance contributions.	• Pay or play approach -- employers required to pay 7.5% of Social Security wages for employee health care expenditures or pay into trust fund to finance employer share of coverage through Connector. • All employers participating in the Connector are required to establish Section 125 plans to tax-shelter employer and employee health insurance contributions.	Incentives to establish Section 125 plans and to make Health Savings Account (HSA)[4] contributions.	SB 1014 would require employers to contribute via a new payroll tax, in lieu of paying premiums. (First $7,000 of payroll for each full time employee would be exempt.)
Treatment of Small Employers	Employers with fewer than 10 employees exempt from pay-or-play requirement. Employees still subject to individual mandate.	Excludes firms with fewer than 2 workers, payroll of less than $100,000, or "newly established" businesses.	No exemption from pay-or-play mandate based on employer size.	Incentives to establish Section 125 plans and to make HSA contributions.	Not applicable.
Requirements Imposed on Providers	Providers required to pay fees on revenues: 2% on physicians and 4% on hospitals. Hospitals required to spend 85% of revenues on patient care.	None stated.	None stated.	None stated.	None stated.
Changes in Provider Payments/ Funding	Medi-Cal payments to providers.	None stated.	None stated.	• Medi-Cal rates would move closer to Medicare rates, over the next eight years. • Significant portion of $2 billion in disproportionate share hospital (DSH)[5] funding is reallocated to spur clinic creation and expansion.	• New CHIS commissioner would negotiate and set all rates. • Provides new right to providers to collectively negotiate rates and fees.

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Public Program Expansions and Support for Low-Income Individuals	• Healthy Families[6] expansion for children up to 300% FPL, regardless of immigration status. • Medi-Cal expansion for all legal residents up to 100% FPL. • Individual/ family contribution toward premium for coverage obtained through purchasing pool is linked to gross income: - 100 – 150% FPL (a family of four earning $20,650 – $30,975) pays 3% of income; - 151 – 200% FPL (a family of four earning $30,975 – $41,300) pays 4% of income; - 201 – 250% FPL (family of four earning $41,300 – $51,625) pays 5% of income.	• Healthy Families expansion for children up to 300% FPL, regardless of immigration status. • Establishes uniform eligibility standards for children regardless of age and simplifies the Med-Cal and Healthy Families enrollment process. • Expands Medi-Cal to parents at or below 133% FPL. • Expands Healthy Families coverage to parents up to 300% FPL, pending federal approval and financing. • Employees and dependents eligible for both employer coverage and public programs would receive primary coverage through employer and supplemental coverage via public "wrap-around" (employees not required to pay premiums higher than those under Medi-Cal or Healthy Families). • Combination of state subsidies and expansion of Medi-Cal and Healthy Families for those at or below 300% FPL with contributions on sliding scale relative to income.	• Healthy Families expansion for children up to 300% FPL, regardless of immigration status. • Expands Healthy Families coverage to parents up to 300% FPL, pending federal approval and financing. • Establishes uniform eligibility standards for children regardless of age and simplifies the Med-Cal and Healthy Families enrollment process.	• Directs additional First Five[7] funds to children's health care and insurance initiatives.	• Aims to consolidate funding for existing public programs into newly created Universal Healthcare Fund, under CHIS. • All Californians receive coverage under CHIS, regardless of income.

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Role of Counties	Counties maintain responsibility for care of the adult undocumented indigent population. To reflect reduced demands on county from public program expansion, half of funds used by counties for indigent care would be redirected to the state.	Counties' obligation to serve the indigent unchanged.	Counties' obligation to serve the indigent unchanged.	• Counties' obligation to serve the indigent unchanged. • Reallocates some First Five funds that flow to counties from early childhood programs to children's health initiatives and insurance.	Indigent receive care under CHIS; counties are largely removed of their obligation to care for indigent.
Role of Federal Government	Majority of federal financing associated with increased provider payments and eligibility expansions (expected under existing Medicaid policy). State would seek Medicaid 1115 waiver[8] to support innovations in financing and care delivery (e.g., incentives and rewards for healthy behavior) and to extend coverage to childless adults.	Expansion of Healthy Families and Medi-Cal would generate federal matching funds under existing policy (i.e., would not require Medicaid waiver application). Proposals to extend coverage for children and low-income families would not require federal waiver application. Expansion of coverage for low-income childless adults would require federal waiver or other funding strategy.	Expansion of Healthy Families and Medi-Cal intended to generate federal matching funds under existing policy. State share would come from employer and employee contributions through Connector, not state general fund.	• Requests that the federal government cover the $2.2 billion cost of care for mandated health services to undocumented immigrants. • First Five funds used to expand children's insurance could generate federal matching funds (through SCHIP[9]). • Governmental expenditures for clinic expansion could generate federal matching funds.	• Legislation intends for CHIS to consolidate funding from all existing public programs into the Universal Healthcare Fund, potentially including Medicare. • People eligible for federal programs (Medicare and Medi-Cal) would remain enrolled in them and CHIS would pay their premiums and deductibles.

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Changes in State Tax Code and State Tax Revenue	Modifies state tax code to conform to federal health savings account rules. Establishment by employers of Section 125 plans to tax-shelter employer and employee health insurance contributions would reduce state tax revenue.	No tax code changes stated. Establishment by employers of Section 125 plans to tax-shelter employer and employee health insurance contributions would reduce state tax revenue.	No tax code changes stated. Establishment by employers of Section 125 plans to tax-shelter employer and employee health insurance contributions would reduce state tax revenue.	• Modifies state tax code to conform to federal health savings account rules. • Encourages employers to establish Section 125 plans. • Provides tax credits to employers who contribute to employees' HSAs. • Provides hospitals and physicians with a tax credit to purchase health IT. • Establishes a provider tax credit for cost of care for the uninsured.	SB 1014 would modify state tax code to increase individual income tax and employers' payroll tax.

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Insurance Market Requirements/ Reforms: Guaranteed Issue, Rating Reforms, and Other Requirements Imposed on Health Plans	Health plans must guarantee coverage to all Californians. Premiums may vary based only on age and geography (not health status/conditions). Health plans must spend 85% on patient care.	• Simplified medical underwriting, including standardized form and uniformity with respect to medical conditions that may be basis for denial or pre-existing condition exclusion as determined by MRMIB. • To facilitate comparison shopping, all insurers must offer uniform benefit designs. • Applies rules currently regulating the small group market (such as guaranteed issue) to the mid-sized (51 - 250 employees) employer market. • Health plans must spend 85% of revenue on patient care.	• All health plans required to guarantee issue and use community rating in the individual market (e.g. premiums may vary based on age and geography, not health condition). • Products would be grouped in five classes to facilitate comparison and regulatory review. • Creates reinsurance fund to allow plans to cede and share risk (details TBD). • Applies rules currently regulating the small group market (such as guaranteed renewal) to the mid-sized employer market. • Health plans must spend 85% of revenue on patient care.	• Encourage greater availability of benefit designs that conform to federal requirements for HSAs and high-deductible health plans (HDHPs). • Requires the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to allow plans to put more products on the market. • Require CA Public Employees Retirement System (CalPERS) to offer HDHPs and HSAs to state employees. • Permit greater flexibility for premiums in the small group market.	CHIS becomes the primary policy for all Californians. Insurers may sell supplemental policies.
Insurance Market Requirements/ Reforms: Connector/ Purchasing Pool	A purchasing pool administered by MRMIB would establish a subsidized benefit package, administer premium subsidies, incorporate a "Healthy Actions Incentive/Rewards Program," and offer non-subsidized products, such as dental and vision.	Establishes CA Cooperative Health Insurance Purchasing Program (Cal-CHIPP) to be administered by MRMIB to negotiate and purchase health insurance for employees whose employers choose "pay" option and for individuals. Cal-CHIPP will offer at least three uniform benefit packages that will also be offered by insurers in the private market.	Establishes "Connector" administered by MRMIB that: • Provides choice of plans at three tiers (by network, contribution) with contributions linked to plan tier. • May buy in on negotiated basis to Medi-Cal managed care plans.	Not applicable.	All Californians receive coverage under CHIS.

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Insurance Market Requirements/ Reforms: Participant Contribution to Obtain Coverage Through Purchasing Pool	Sliding scale contributions of 3% – 6% of gross income required to obtain coverage through purchasing pool.	Employees whose firms pay a fee rather than pay for employee health expenditures would pay defined percentage of income to participate in Cal-CHIPP.	No additional cost (beyond employer and employee contributions) for plans in first tier (e.g., HMO-type plans).	Not applicable.	New administrative bodies are created to administer CHIS and develop a premium structure for Californians.
Financing Sources and Cost Estimates	Total $12 billion cost estimate, to be financed through: • Employer contributions • Employee and individual contributions • Federal funds • Redirection of safety net funds • Physician and hospital fees	Total $8.3 billion cost estimate to be financed through: • Employer contributions • Employee contributions • Federal funds (Medicaid, SCHIP)	Total $10.9 billion cost estimate, to be financed through: • Employer contributions • Employee contributions • Federal funds (Medicaid, SCHIP)	• Reallocate much of $2 billion provided to disproportionate share hospitals (DSH) to create and expand primary care clinics. • Align Medi-Cal benefits with private benefits for cost savings. • Use Prop 99 funds for the MRMIP wait list. • Reallocate $500 million from First Five to children's health care initiatives. • Reallocate much of $300 million spent on state only Medi-Cal and health programs to community clinics. • Federal government pays for $2.2 billion cost of providing health care services to undocumented immigrants.	• Creates the California Health Insurance Premium Commission to develop a premium structure to fund CHIS. • Legislation relies on an estimated $29 billion in administrative and other savings that are used to fund expanded coverage under CHIS. • SB 1014 would increase payroll and state income tax for financing. Legislation envisions: - Individuals would pay 3-4% of income (between $7,000 and $200,000). - Individuals would pay an additional 1% on income over $200,000. - Employers would pay 8% of payroll tax (on payroll above $7,000 for full time employees).

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Cost Containment: Prevention and Wellness	Subsidized products incorporate "Healthy Action Incentive/Rewards Program," which all health plans are required to offer; state-sponsored public health efforts to reverse obesity trends and continue smoking cessation efforts.	Uniform benefit packages include coverage for primary and preventive care with minimal patient cost sharing. California will "adopt and encourage" healthy lifestyles through workplace and individual efforts to improve health.	Participating health plans required to implement evidence-based preventive services.		Preventive care covered by CHIS.
Cost Containment: Additional Provisions	• Reduce regulatory requirements on health plans. • Reduce regulatory requirements in order to promote certain delivery models, such as retail health clinics. • Pilot to combine workers' compensation health benefits with traditional health coverage.	• Pay-for-performance for state-funded health coverage programs. • Require plans and providers to participate in implementation of a personal health records system. • Centralized assessment of new technology.	Cap on health plan administrative costs and profits (must spend 85% of revenue on patient care).	• Make hospital and provider pricing information more available to consumers. • Prioritize seismic upgrades for hospitals at greatest risk. • Encourage greater availability of benefit designs that conform to federal requirements for HSAs and high-deductible health plans. • Require DMHC and DOI to allow plans to put more products on the market. • Require CalPERS to offer HDHPs and HSAs to state employees. • Permit greater flexibility for premiums in the small group market.	Caps administrative spending to 5% of total system-wide spending and authorizes newly created CHIS Commissioner to create other forms of cost control.

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Enforcement	Payroll withholding and state tax system will play roles in monitoring and enforcing individual mandate. Providers will be involved through on-site enrollment. Penalty for non-compliance not specified.	None stated,.	Enforced through tax code: taxpayers must show proof of health coverage on tax returns or forfeit California personal exemption credit(s).	Not applicable.	None specified.
Implementation Timeline	Not specified.	• Jan/July 2008 – Insurance market reforms; • July 2008 - Healthy Families expansion; • January 2009 – Pay-or-play employer mandate; Cal-CHIPP created; • July 2009 – Health plans must spend at least 85% of revenue on patient services; • January 2012 – Coverage for remaining uninsured, low-income, unemployed, and childless adults.	January 2008 – Health plans must spend 85% of revenue on patient care; mid-sized employer market reforms take effect; July 2008 – Healthy Families expansion; January 2011 – Health plans required to offer plans on a guarantee issue basis; pay or play employer mandate; individual mandate for those in households earning above 400% FPL.	January 1, 2008.	• January 2008 – Premium Commission established. • On or before January 2010, Commission makes recommendations to the Governor and Legislature. • CHIS becomes fully implemented once the Secretary of Health and Human Services determines the Universal Healthcare Fund has sufficient revenue for the program to be operational.

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[1] **Federal Poverty Level (FPL**) is the minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. For 2007, Health and Human Services defines FPL for a family of four as $20,650.

[2] **The Knox Keene Health Care Services Plan Act of 1975** establishes basic benefits that must be offered by all health plans licensed in California. These include: physician services, hospital inpatient and outpatient, diagnostic lab and radiology services, preventive health services, home health services and emergency health care including ambulance, out of area coverage and hospice care.

[3] **Section 125** of the Internal Revenue Code allows companies to give their employees the opportunity to pay for benefits on a pretax basis.

[4] **Health Savings Accounts (HSAs)** help individuals save for future qualified medical and retiree health expenses on a tax-free basis. Any adult who is covered by a high-deductible health plan (and has no other first-dollar coverage) may establish an HSA.

[5] **Disproportionate Share Hospital (DSH)** payments are special Medicare payments made to hospitals that treat a disproportionately high share of low-income patients.

[6] The **Healthy Families Program** is California's version of the State Children's Health Insurance Program (or SCHIP), funded jointly by the federal government. Healthy Families provides low-cost health, dental, and vision coverage to California children in families with income up to 250% of FPL.

[7] **First Five** California is the California Children and Families Commission that works with county commissions to improve the well-being of young children by focusing on health, education, and social services.

[8] A **Section 1115 Waiver**, named for that section of the Social Security Act, allows a state to deviate from a many standard Medicaid requirements to test new ideas. In return for greater flexibility, states must commit to a policy experiment that can be evaluated formally.

[9] **SCHIP** is the State Children's Health Insurance Program (see Healthy Families above).