Comparison of Major Health Care Reform Proposals
Using League of Women Voters of California Evaluation Criteria
September 9, 2007

Section I: Elements Supported by the LWVC

Elements	SB 840 (Kuehl) (Amended 6/27/07) and **SB 1014, the** funding bill for SB 840 (amended 4/23/07)	AB 8 (Nunez/Perata) (Amended 9/05/07)	Governor's Proposal (Governor has not introduced a bill)
Universal access	Covers 36 million California residents. Establishes the California Healthcare System, a publicly financed system that includes a state fund to reimburse all care provided to residents.	Does not provide universal coverage. Will cover 3.4 million uninsured (of 6.5 million). Forbids exclusions for pre-existing conditions. Does not include unemployed. Coverage for self-employed individuals is unclear. Projected number of newly insured may be reduced by exemption from employee mandate for those above 300 percent of poverty whose costs would be more than 5 percent of income.	Does not provide universal coverage. Covers estimated 4.8 million (of 6.5 million uninsured). Forbids exclusions for pre-existing conditions. Individual mandate: all adult residents required to purchase insurance for self and dependents.
Comprehensive coverage	Full comprehensive benefits—all medically necessary care.	Private insurers and new state program, California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), required to offer uniform benefit plans similar to Medi-Cal and Healthy Families coverage. All benefit designs must be equivalent to Knox-Keene (state-required minimum coverage) plus drug coverage.	Coverage varies per plan. Everyone is required to purchase at least a high deductible policy. Deductible must be met before any care is covered.
Expanded risk pools (insurance pools)	All Californians will be covered in one risk pool.	Multiple risk pools; establishes purchasing pool (Cal-CHIPP) as option for employers mandated to provide coverage .	Multiple risk pools. Establishes a purchasing pool as option for employers mandated to provide coverage (only those with 10 or more employees). Contribution is 4 percent of Social Security wages. Participation and size unknown.

Elements	SB 840 (Kuehl)	AB 8 (Nunez/Perata)	Governor's Proposal
Expanded public programs	Eliminates current public programs and folds all residents into one publicly financed health fund.	Expands eligibility for Medi-Cal and Healthy Families to families up to 300 percent of Federal Poverty Level (FPL) if funded. Enrollment is expected to decline by 1 million due to shift to employer coverage and Cal-CHIPP.	Expands Healthy Families coverage for children up to 300 percent of Federal Poverty Level (FPL). Medi-Cal for legal adult residents expanded to 100 percent of FPL. Eliminates MRMIP (Managed Risk Medi-Cal Insurance Program) because of Guaranteed Issue. Eliminates Access for Infants and Mothers program (AIM). Moves recipients to Healthy Families or pool.
Purchasing pools offering affordable, comprehensive benefits to all residents who choose to participate	All Californians will be covered in one risk pool that provides a single standard of affordable comprehensive coverage.	Cal-CHIPP available only to employees whose employers choose to participate. Affordability unknown except for those below 300 percent of FPL. Premium costs not controlled above that level. There are no limits on co-pays, deductibles or other out-of-pocket costs. Those above 300 percent of poverty with costs above 5 percent of income are exempted from mandate to participate.	Only available to employees of participating employers and those below 250 percent of FPL with premium cost controls for this group. Affordability unknown above 250 percent of poverty. No controls on premiums or out-of-pocket costs above that level.
Ensure affordable comprehensive coverage for the working poor	Comprehensive coverage for all Californians. Individuals taxed according to means: 3.78 percent on income over $7000 to a ceiling of $200,000 and an additional 1 percent on income from $200,000 to $1 million.	Limits premium costs for those below 300 percent of poverty to not exceed 5 percent of income. Those above 300 percent of poverty are exempted from accepting coverage if the costs are above 5 percent of income, leaving them uninsured or seeking insurance in the individual market.	Premium contributions in purchasing pool are linked to income for those below 250 percent of poverty level. Premiums of 3-6 percent of income on sliding scale for those between 100 percent and 250 percent of poverty.
Limits on insurers' administrative costs/ a required minimum Medical Loss Ratio, the percent of revenues spent on health care services	Limits administrative costs to 10 percent within five years and 5 percent within ten years.	Medical Loss Ratio required to be at least 85 percent of premiums, etc., collected. Regulations to define administrative costs due by 7/1/08.	Medical Loss Ratio required to be at least 85 percent of premiums collected. Hospitals also required to spend 85 percent on patient care.

Elements	SB 840 (Kuehl)	AB 8 (Nunez/Perata)	Governor's Proposal
Community rating (group premiums do not vary on basis of age, sex, health status, occupation, etc.)	Health coverage funded by taxes based on income and payroll size instead of premiums. Other issues do not apply.	Modified community rating – may vary by age, geographic area, family size, and health improvement discounts.	Modified community rating—may vary by age, geographic area, and family size, but with overall limits on the amount of rate variation.
Guaranteed issue (coverage cannot be denied on the basis of health status)	All residents are guaranteed health coverage under the single payer system.	Guaranteed issue in the individual market. High-risk individuals referred to MRMIP (Managed Risk Medical Insurance Program). Requires extension of small employer regulations to employers of up to 100 employees. Five levels of benefit plans required.	Provides guaranteed issue in the individual and small and medium-sized group markets.
Improve access to preventive and primary care, disease management, and evidence-based practice	Encourages these strategies. Access available to all, including for preventive and primary care. Everyone chooses a primary care provider. Standards based on clinical efficacy. Establishes program to promote coordinated care, patient education re: health maintenance, etc.	Encourages these strategies. Will improve access to prevention and primary care for newly insured whose coverage includes these services. Includes programs to promote prevention and health maintenance, disease management.	Will improve access for newly insured. Establishes technology assessment process to promote evidence-based care. Encourages adoption of incentives/rewards for healthy behaviors. Funding for Obesity, Diabetes, and Tobacco Control programs.
Support Information Technology (IT) development and implementation	Calls for investment in health IT, electronic medical records, development and electronic dissemination of best practices. Establishes electronic claims and reimbursement system. Includes requirement for patient education systems.	Requires electronic medical records in 5 years. Intends that all providers participate in Internet-based records accessible to patients. No provisions to support development.	Proposes 100 percent health data exchange in 10 yrs; electronic prescribing by 2010. Expand broadband coverage to improve telemedicine in underserved areas. Develop public/private partnerships to meet capital needs. Electronic submission of documents between insurers and enrollees.

Section II: Elements Not Supported by the LWVC

Elements	SB 840 (Kuehl) (Amended 6/27/07) and **SB 1014, the** funding bill for SB 840 (amended 4/23/07)	AB 8 (Nunez) (Amended 9/05/07)	Governor's Proposal (Governor has not introduced a bill)
Individual or employee mandates to purchase insurance	No residents are required to purchase insurance. Everyone pays a share of taxes based on their income to fund public system.	Limited individual mandate. Employees of employers participating in Cal-CHIPP must enroll or demonstrate other coverage. Does not limit premium cost for anyone earning more than 300 percent of the poverty level or control costs on co-pays or deductibles. Exempts those above 300 percent of poverty from accepting coverage if costs exceed 5 percent of income, leaving them uninsured or seeking coverage in the individual market.	Individual mandate on all to purchase employer offered or individual plan with at least high deductible coverage. Individuals would pay all out-of-pocket costs until deductible is met.
Proposals that promote limited coverage to provide affordability (such as Health Savings Accounts (HSAs) and high deductible plans)	Does not provide different levels of coverage. Everyone has the same single level of comprehensive care.	Does not do so directly. Does not establish standard for employer/ employee cost sharing. Employers must spend a minimum of 7.5 percent of Social Security wages on health care expenditures, including activities beside insurance coverage. Current average for insurance is 10.7 percent in 2005 (source: California Health Care Foundation, 2007). May encourage employers to offer lower quality coverage. Individuals above 300 percent of poverty who are exempted from employer coverage due to high costs may be forced to accept high deductible plan in the individual market.	Minimum requirement under individual mandate is a $5000 deductible plan with maximum out-of-pocket expenses of $7,500 per individual or $10,000 per family. (Primary care and preventive services would be exempt from the deductible.) Provides for tax code changes to encourage HSAs.

Elements	SB 840 (Kuehl)	AB 8 (Nunez)	Governor's Proposal
Proposals that encourage individual coverage rather than expanded risk pools	No individual insurance coverage. Creates one large risk pool administered by the state that provides everyone with the same standard of comprehensive coverage.	Does not encourage individual coverage directly, but this may be the only option for those exempted from the employee mandate (see above).	Individuals who do not have employer provided coverage, including unemployed and all individuals in firms with fewer than 10 employees, or who are not public program eligible, must purchase individual plan under mandate.
Proposals that lack effective, assured cost controls	Controls costs thru global budgeting, bulk purchasing, prevention and primary care, resource planning, and capital management. Limits spending increases to changes in state gross domestic product and actuarial demographic changes.	Supports preventive care, disease management, and best practices guidelines for high-cost chronic diseases. Encourages wellness and fitness programs. Encourages information technology. Includes requirements regarding risk adjustment. Permits (does not require) bulk purchasing of drugs. Includes transparency requirements for reporting cost and quality data.	Expects cost decreases due to participation in wellness programs, healthy lifestyle incentives/rewards. Also plans obesity, diabetes, and tobacco control programs, and programs to reduce medical errors and hospital acquired infections.
Proposals that do not ensure the same basic level of care for all	One standard of care (same benefit package) for all—full comprehensive benefits.	Benefits vary by insurance plan. Plans similar to Medi-Cal and Healthy Families must be offered.	Benefits vary by plan. No standard benefit packages.
Employer mandated contribution less than current average	All employers contribute through taxes on payroll (Social Security wages) at 8.17 percent.	Required employer contribution is 7.5 percent of Social Security wages. Average in 2005 was 10.7 percent (CHCF, 2007). Employer contribution may include programs other than insurance coverage such as wellness programs, health fairs, screenings, HSA contributions, etc.	Required employer contribution is 4 percent for employers with 10 or more employees. Other employers not required to provide coverage. Average employer contribution in 2005 was 10.7 percent (CHCF, 2007).
Employer mandate not applicable to most employers	All employers pay taxes based on payroll (Social Security wages).	Mandates all employers to spend 7.5 percent of Social Security wages on health expenditures or pay similar amount to Cal-CHIPP.	Does not include employers with 10 or fewer employees. Most employers in state are in this category.

Elements	SB 840 (Kuehl)	AB 8 (Nunez)	Governor's Proposal
Decreased funding to safety net hospitals in advance of decrease in number of uninsured	Funding for hospitals currently designated "safety net" would improve. Would no longer be limited to low public program reimbursement. All patients would have same coverage.	Reimbursement varies by funding source, i.e. private plan or public program, etc. Safety net hospitals remain dependent on public program funding and required to care for uninsured.	Proposes redirection of 50 percent of safety net funding from counties as part of the financing plan for the proposal. Decreased funding could occur before numbers of uninsured were reduced (uninsured are responsibility of counties by law).
Insurance reform that does not include: • Community rating—group premiums do not vary on basis of age, sex, health status, occupation, etc. • Guaranteed issue—coverage cannot be denied on the basis of health status • Minimum Medical Loss Ratio—percent of revenues spent on health care services • Standard comprehensive benefits • Rate regulation	SB 840 is a total reform of the health insurance industry. Provides nonprofit insurance that is administered by the state. These issues are fully addressed by the revised system.	Includes minimum Medical Loss Ratio and guaranteed issue. Requires standard application form to identify 3-5 percent of people most expensive to treat; refers them to reinsurance fund. Includes modified community rating and some benefit requirements (does not cover all individuals). Some requirements regarding risk adjustment and regulation of rate changes from one period to the next.	Includes guaranteed issue and minimum Medical Loss Ratio. Includes modified community rating (variation by age and geographic area allowed). No standard benefits or rate regulation.