

Summary of SB 840 (Kuehl) - California Health Insurance Reliability Act

Governance: A **Health Insurance Commissioner**, elected every eight years with a two-term limit, will supervise the **California Health Insurance Agency**, which administers the **California Health Insurance System**. The Commissioner appoints the **Deputy Health Insurance Commissioner**, the **Health Insurance Fund Director**, the **Consumer Advocate**, the **Chief Medical Officer**, the **Director of Health Planning**, the **Director of the Partnerships for Health**, the **Director of the Payments Board**, and the **Regional Health Planning Directors**.

Health Insurance Policy Board: Chaired by the commissioner, includes the seven appointed state officers, the state public health officer and two representatives from Regional Planning Boards. A **Public Advisory Committee** to advise the board, representing doctors, nurses, hospitals, dentists, health practitioners, pharmacists, mental health providers, consumers, businesses, and labor will be appointed by the Assembly, the Senate, and the Governor. The Health Insurance Policy Board:

- Establishes scope of services.
- Sets priorities and guidelines for evaluations, research, capital investment, and public input.
- Determines need for change or increase in health insurance premiums.

Office of Consumer Advocate: Responds to and facilitates consumer complaints and suggestions. Establishes **Independent Medical Review System** to provide examinations of disputed health care services. Collaborates in forming Partnerships for Health.

Office of Health Planning: Plans for the health needs of the population, establishes system performance criteria, identifies health outcome disparities and service shortages and recommends corrective steps, establishes statewide health care databases to support planning and performance review, plans for system capital investments, and links state and private research to health system goals.

Office of Health Care Quality: Headed by the chief medical officer, sets standards of best medical practice, recommends an evidence-based formulary for pharmaceuticals and durable equipment, identifies treatments and medications that are safe and effective, recommends means to achieve an appropriate ratio of general practitioners to specialists. Collaborates in forming Partnerships for Health.

Health Insurance Fund: Receives and disburses all monies to be expended on health care.

Payments Board: Composed of finance and insurance experts and representatives of commissioner and regional directors. Plans compensation for upper level private health care managers, and health care providers. Three-year compensation plans made after negotiations with health care facilities and representatives of provider groups. Providers may choose fee-for-service compensation or salaries within health care systems. Facilities, integrated health care systems and group medical practices can choose capitated or non-capitated operating budgets. Payments may include bonuses for meeting the goals of the system. Employee unions will negotiate with the regional director.

Inspector General of the California Health Care System: Establishes an inspector general, in the office of the Attorney General, and appointed by the Governor, with authority to investigate fraud or misconduct by employees of the Health Care Agency, or by providers or consumers.

Health Care Regions: Up to 10 regions are established by the commissioner, headed by Regional Health Planning Directors, with funding established by the commissioner, to support local decision making in the health planning process. Patients may receive care in more than one region. Each region has a Partnership for Health.

Partnerships for Health: Establishes in the California Health Insurance Agency and in each region by collaboration between the consumer advocate, the chief medical officer, and the regional advocates and directors. Each Partnership for Health supports health maintenance, disease prevention, good communication between patients and providers, health education and better quality of care.

Transition: A transition Commissioner of Health Insurance, appointed by the Governor with Senate confirmation, will serve until the first election. With help from a transition advisory group, the transition commissioner will initiate the system, attempt to recover certain moneys to help fund the system, oversee the transition from contracted private insurers to the public system, and assist persons displaced from employment by the new system with retraining and job placement.

Eligibility: All state residents are covered, including undocumented residents, Californians traveling out of state for up to 90 days, and California retirees living out of state if they pay required taxes to the Health Care Fund. No waiting period for at least two years. Visitors will be charged prevailing rates.

Benefits: Inpatient and outpatient services by health facilities, physicians, or licensed health care professionals, diagnostic imaging, laboratory services, durable medical equipment including prosthetics, eyeglasses, and hearing aids, rehabilitative care, emergency or necessary transportation, language interpretation, immunizations, preventive care, health education, hospice care, home health care, prescription drugs, mental health care, dentistry, podiatry, chiropractics, acupuncture, religious healing that is protected under federal or state statutes, blood products, emergency care, vision care, adult day care, case management, substance abuse treatment, dialysis, and up to 100 days in a skilled nursing facility. If the budget permits, the Commissioner may add benefits above these required by the bill.

Excluded: Cosmetic procedures and private hospital rooms with no medical indication, care by unlicensed providers, and procedures or medications with no proven medical value. Chief Medical Officer may authorize treatment not included in the benefit package.

Budget: Prepared annually by the Commissioner. Includes facility and provider budgets for both fee-for-service and integrated systems (capitated or non-capitated budgets), capital investment, purchasing, research and innovation, and workforce development.

Capital expenditures: Capital improvements to health care facilities will be in accordance with plans made by the commissioner and regional directors. All capital investments including facility improvements, land and office space purchases and large medical equipment purchases are subject to the capital planning guidelines. The commissioner will establish standards for small capital expenditures funded through operating budgets. Capital improvements shall minimize unneeded expansion of facilities and services, and correct health care disparities. The system will not pay for mandatory earthquake retrofits.

Research: Includes studies to improve quality of health care, administration of the system, communication among health care providers, and education of patients.

Cost containment: The commissioner and regional directors are responsible for keeping the overall costs within the budget. The bill mandates that spending will grow no faster than the average growth in state GDP and population growth. Statewide or regional cost containment methods will or may include:

- Streamlining administration, with costs limited to a specified, low percentage of system budget.
- Developing electronic billing and reporting systems.
- Postponing new benefits or new capital investment, or a temporary decrease in benefits.
- Adjusting provider reimbursements to correct for inappropriate utilization.
- Limiting provider reimbursements above a specified amount of aggregate billing.
- Deferred funding of the Reserve Account.
- Negotiating bulk purchasing of pharmaceuticals and medical equipment.
- Limiting aggregate reimbursements to pharmaceutical manufacturers.
- Avoiding regional duplication of expensive services.
- Imposing a waiting period for new residents, if a large number of people are entering the state for the purpose of obtaining health care.
- Establishing consumer co-payments and/or deductibles, if necessary, only after the first two years, and limited to \$250 per person or \$500 per family. The commissioner shall establish standards for waiver of co-payments for those with low income.

When cost control measures are insufficient: Commissioner may ask the Legislature for an increase in health care taxes.

Funding: All federal, state and county monies currently spent on health care will be reallocated to the state Health Care Fund. This will supply about one-third of the needed funding. Federal waivers are required for allocation of federal dollars to the state Health Care Fund. The remaining funding will come from state health taxes that will replace health insurance premiums now paid to insurance companies and co-pays and deductibles now paid to providers. Premiums will be affordable for every Californian and every business because what families pay is in proportion to their income and what employers pay is in proportion to wages. Single-payer efficiencies control costs. Most businesses and families will save money.

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