Measure K349

INSTRUCTIONS:
Please carefully read the following description of a ballot measure that was written by a disinterested expert. Feel free to take notes or outline passages as you read.

This should take approximately 10 minutes.

BALLOT MEASURE K349

BACKGROUND

Health Care Spending
Annual spending on health care in California totals more than $100 billion. About two-thirds of this cost is covered by various forms of health insurance, with the remainder paid by other sources.

Roughly 80 percent of all Californians are covered by health insurance. Specifically:

- About half receive health insurance through their employer or the employer of a family member.
- Roughly 20 percent are covered by two major government-funded health insurance programs: the federal Medicare Program, primarily serving persons age 65 or older, and the Medi-Cal Program, jointly funded by the federal and state governments, serving eligible low-income persons.
- About 10 percent of Californians directly purchase health insurance.

Until recently, spending on health care had been growing much faster than inflation and population changes. During the 1980s, for example, average health care spending in the United States grew by almost 11 percent annually after adjusting for inflation and population. Since 1990, however, this rate of growth has slowed to about 4 percent annually.

Health Maintenance Organizations
In part, this slower growth has been due to efforts by employers and government to control their health insurance costs. One way they have attempted to hold down costs is to contract with health maintenance organizations (HMOs), which provide health services through their own doctors and hospitals or through contracts with physicians and hospitals. About one-third of Californians belong to HMOs. Most of these HMO members are covered under employee health plans, but many persons covered by Medicare or Medi-Cal also receive their health care through HMOs.

Generally, health coverage provided by an HMO is less expensive than comparable health insurance coverage provided on a ''fee-for-service" basis. Health maintenance organizations use

several methods to control costs, such as ''capitation" payments, other financial incentives, and utilization review.

Capitation and Other Financial Incentives. Under the traditional fee-for-service approach, doctors and hospitals charge fees based on the specific service provided to a patient. By contrast, HMOs generally use capitation to pay doctors. Under this approach, doctors receive a fixed payment for each HMO member regardless of the amount of service provided to the member. Capitation gives doctors a financial incentive to use cost-effective types of care.
In addition to capitation, HMOs use other financial incentives to control health care costs. The federal government, however, limits the types of financial incentives that may be used by HMOs when serving Medicare or Medi-Cal recipients. Specifically, federal law prohibits any financial incentives to doctors that could act to reduce medically necessary care to individual patients, such as a bonus payment for each patient that is not hospitalized during the year. However, federal law does allow ''risk pools" and other types of profit-sharing arrangements that enable doctors to benefit from controlling costs for groups of patients.

Utilization Review. Health maintenance organizations--as well as the state's Medi-Cal program and insurers using the fee-for-service approach--also attempt to contain costs by using ''utilization review" procedures. Under these procedures, health plans will not pay for certain types of expensive or unusual treatments unless they have approved the treatment in advance.

Controlling Hospital Costs
Health maintenance organizations also control their costs by reducing their use of hospitals and encouraging more treatment in doctors' offices and clinics. This trend has contributed to an excess of hospital beds.

On average, about half of the hospital beds in California were unused in 1994. As a result, some hospitals have downsized, merged, or closed; and many hospitals are seeking ways to reduce costs in order to compete for business more effectively. Since staffing is a major cost, hospital cost control efforts often focus on reducing staff and using less expensive personnel in place of more expensive personnel where possible (using nurses' aides rather than nurses, for example).

Regulation of Health Care Facilities
Licensing of Facilities. The Department of Health Services (DHS) licenses many types of health facilities in California, such as hospitals and nursing homes, and has general authority to set staffing standards for those facilities. Clinics that are owned and operated directly by doctors, however, are not licensed.

Staffing Standards. State regulations generally require hospitals to keep staffing records and to base their staffing levels for nurses on an assessment of patient needs. Hospitals are not required to have a specified number of nurses per patient, except in intensive care units. State law requires nursing homes to have at least one registered nurse per shift and sets minimum staffing standards for nurses and nursing assistants per patient.
The DHS is revising its current hospital staffing regulations to cover all departments within each facility. Additionally, the pending regulations require hospitals to establish their staffing needs

using a system that more specifically takes into account the condition of each patient. The DHS also enforces federal requirements that health facilities serving Medicare or Medi-Cal patients must have enough staff to provide adequate care.

Regulation of Health Plans and Health Insurance
The state Department of Corporations regulates the financial and business operations of health plans, including HMOs, in California. The Department of Insurance regulates companies that sell health insurance but do not provide health care themselves, including workers' compensation insurers.

PROPOSAL
This measure imposes new taxes on some health care businesses and individuals, with the revenue dedicated to financing a variety of health care services. It also establishes additional requirements for the operation of health care businesses.

The measure:

- Imposes new taxes on health care businesses for bed reductions, mergers, acquisitions, and restructurings; and on certain individuals who receive stock distributions from health care businesses. Provides that revenues from these taxes be spent to administer the measure and to fund specified health care services.
- Prohibits health care businesses from denying recommended care without a physical examination.
- Requires the state to set more comprehensive staffing standards for all health care facilities within six months.
- Prohibits health care businesses from using financial incentives to withhold safe, adequate, and appropriate care.
- Increases protections for certain health care employees and contractors.
- Requires health care businesses to make various types of information available to the public.
- Creates a new public corporation--the Health Care Consumer Association. The association, supported by voluntary contributions deposited in a new Health Care Consumer Protection Fund, would advocate for the interests of health care consumers.

The measure's provisions would affect both public and private health facilities. However, it is not clear whether the state's Medi-Cal Program would be considered a ''health care business" subject to the requirements of this measure.

STOP!

Please go to the online survey, enter the 4-character code for this ballot measure (printed at the top and bottom of this page) and answer the survey questions.