LEGISLATION COMMITTEE

Agenda

March 1, 2010
9:00 – 10:30 A.M.
651 Pine Street, Room 101, Martinez

Supervisor Susan A. Bonilla, District IV, Chair
Supervisor Gayle B. Uilkema, District II, Vice Chair

Agenda Items:	Items may be taken out of order based on the business of the day and preference of the Committee

1. **Introductions**
2. **Public comment on any item under the jurisdiction of the Committee and not on this agenda**. (*Speakers may be limited to three minutes*.)
3. **Record of Action:** February 1, 2010
4. **State Budget Update** – Presenters: Lara DeLaney, Cathy Christian
5. **State Legislation Update**– Presenters: Lara DeLaney, Cathy Christian
6. **LAO Analyses of June 8, 2010 Ballot Measures**
7. **Federal Legislative Issues Update**– Presenter: Lara DeLaney
8. **Adjourn to the next regular meeting scheduled for Monday, April 5, 2010 at 9:00 a.m.**

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Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:
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Glossary of Acronyms, Abbreviations, and other Terms (in alphabetical order):

Contra Costa County has a policy of making limited use of acronyms, abbreviations, and industry-specific language in its Board of Supervisors meetings and written materials. Following is a list of commonly used language that may appear in oral presentations and written materials associated with Board meetings:

AB	Assembly Bill
ABAG	Association of Bay Area Governments
ACA	Assembly Constitutional Amendment
ADA	Americans with Disabilities Act of 1990
AFSCME	American Federation of State County and Municipal Employees
AICP	American Institute of Certified Planners
AIDS	Acquired Immunodeficiency Syndrome
ALUC	Airport Land Use Commission
AOD	Alcohol and Other Drugs
ARRA	American Recovery and Reinvestment Act
BAAQMD	Bay Area Air Quality Management District
BART	Bay Area Rapid Transit District
BCDC	Bay Conservation & Development Commission
BGO	Better Government Ordinance
BOS	Board of Supervisors
CALTRANS	California Department of Transportation
CalWIN	California Works Information Network
CalWORKS	California Work Opportunity and Responsibility to Kids
CAER	Community Awareness Emergency Response
CAO	County Administrative Officer or Office
CCHP	Contra Costa Health Plan
CCTA	Contra Costa Transportation Authority
CDBG	Community Development Block Grant
CEQA	California Environmental Quality Act
CIO	Chief Information Officer
COLA	Cost of living adjustment
ConFire	Contra Costa Consolidated Fire District
CPA	Certified Public Accountant
CPI	Consumer Price Index
CSA	County Service Area
CSAC	California State Association of Counties
CTC	California Transportation Commission
dba	doing business as
EBMUD	East Bay Municipal Utility District
EIR	Environmental Impact Report
EIS	Environmental Impact Statement
EMCC	Emergency Medical Care Committee
EMS	Emergency Medical Services
EPSDT	State Early Periodic Screening, Diagnosis and treatment Program (Mental Health)
et al.	et ali (and others)
FAA	Federal Aviation Administration
FEMA	Federal Emergency Management Agency
F&HS	Family and Human Services Committee
First 5	First Five Children and Families Commission (Proposition 10)
FTE	Full Time Equivalent
FY	Fiscal Year
GHAD	Geologic Hazard Abatement District
GIS	Geographic Information System
HCD	(State Dept of) Housing & Community Development
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Syndrome
HOV	High Occupancy Vehicle
HR	Human Resources
HUD	United States Department of Housing and Urban Development
Inc.	Incorporated
IOC	Internal Operations Committee
ISO	Industrial Safety Ordinance
JPA	Joint (exercise of) Powers Authority or Agreement
Lamorinda	Lafayette-Moraga-Orinda Area
LAFCo	Local Agency Formation Commission
LLC	Limited Liability Company
LLP	Limited Liability Partnership
Local 1	Public Employees Union Local 1
LVN	Licensed Vocational Nurse
MAC	Municipal Advisory Council
MBE	Minority Business Enterprise
M.D.	Medical Doctor
M.F.T.	Marriage and Family Therapist
MIS	Management Information System
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MTC	Metropolitan Transportation Commission
NACo	National Association of Counties
OB-GYN	Obstetrics and Gynecology
O.D.	Doctor of Optometry
OES-EOC	Office of Emergency Services-Emergency Operations Center
OSHA	Occupational Safety and Health Administration
Psy.D.	Doctor of Psychology
RDA	Redevelopment Agency
RFI	Request For Information
RFP	Request For Proposal
RFQ	Request For Qualifications
RN	Registered Nurse
SB	Senate Bill
SBE	Small Business Enterprise
SWAT	Southwest Area Transportation Committee
TRANSPAC	Transportation Partnership & Cooperation (Central)
TRANSPLAN	Transportation Planning Committee (East County)
TRE or TTE	Trustee
TWIC	Transportation, Water and Infrastructure Committee
UCC	Urban Counties Caucus
VA	Department of Veterans Affairs
vs.	versus (against)
WAN	Wide Area Network
WBE	Women Business Enterprise
WCCTAC	West Contra Costa Transportation Advisory Committee

Schedule of Upcoming BOS Meetings

Mar. 02, 2010
Mar. 09, 2010

Legislation Committee

Supervisor Susan A. Bonilla, Chair
Supervisor Gayle B. Uilkema, Vice Chair

Record of Actions

Feb. 1, 2010
Room 101, 651 Pine Street, Martinez

1. **Introductions**

The meeting was called to order by Chair Bonilla. Vice Chair Uilkema was in attendance. Staff and the public introduced themselves.

2. **Public Comment:** None.

3. **State Budget Update** : No action.

4. **ARRA Stimulus Funds Status Report**: No action.

Legislation Committee recommended that the letter from the County to the congressional delegation regarding a second stimulus include the need for funding of social services. Supervisor Uilkema recommended that we seek more flexibility in funding streams and identify what flexibility is required. There was also a suggestion to utilize our unpaid mandates and unpaid reimbursements as our local match and seek support for that concept through CSAC and UCC.

5. **U.S. Board on Geographic Names Requested Name Change for Mt. Diablo (to Mt. Reagan)**

Legislation Committee recommended that the Board of Supervisors oppose the proposed name change and send a letter to the BGN to that effect.

6. **Request from CSAC to Send Our Congressional Delegation a Letter Re: S. 1703: Quick Carcieri Fix**

The Legislation Committee recommended that the Chair of the Board sign the letter.

7. **Request from CSAC to Support H.R. 3332 Creating a National Commission on Intergovernmental Affairs**

The Legislation Committee did not support the bill though the generally support the concept.

8. **2010 Federal Platform and Federal Legislative Issues Update**

The Legislation Committee supported the inclusion of the DCC proposal into the Platform as an appropriations request.

9. **Adjourned to the next regular meeting scheduled for Monday, March 1, 2010 at 9:00 a.m**.

OFFICE OF THE COUNTY ADMINISTRATOR
CONTRA COSTA COUNTY

TO: Legislation Committee
Supervisor Susan A. Bonilla, Chair
Supervisor Gayle B. Uilkema, Vice Chair

FROM: Lara DeLaney, Legislative Coordinator

DATE: February 24, 2010

SUBJECT: **Agenda Item #4: State Budget Update**

RECOMMENDATION

ACCEPT report on the State Budget and related matters and provide direction, as necessary.

REPORT

Monday, February 22, the Legislature attempted to finalize action on the emergency budget package amidst considerable confusion and irritation. Eventually, the Assembly sent five measures to the Governor, achieving about **$2.3** billion in savings. Outstanding issues remain, however, including concurrence on two measures that have already passed the Senate and failed in the Assembly, as well as the cash management proposal and gas tax swap. The chart below outlines the various bills in the Extraordinary Session, as well as their current status. Please keep in mind that identical measures were amended in the Senate and Assembly, but the Assembly measures are moving.

Bill	Description	Status
ABX8 1	Current Year Budget Changes	To the Governor
ABX8 2	Budget Year Budget Changes	To the Governor
ABX8 3	DOJ/Corrections Trailer Bill	To the Governor
ABX8 4	Health/Human Services Trailer Bill	Assembly failed to concur; reconsideration granted
ABX8 5	Cash Solutions (urgency)	Assembly Floor
ABX8 6	Transportation Part I	Senate Floor
ABX8 7	Resources Trailer Bill	Assembly failed to concur; reconsideration granted
ABX8 8	Tax Enforcement	Assembly Floor
ABX8 9	Emergency Response Initiative	Senate Floor
ABX8 10	General Government Trailer Bill	To the Governor
ABX8 11	Transportation Part II	To the Governor

While February 22 was the official deadline for action in the Extraordinary Session convened by the Governor, the Legislature has indicated that their actions serve to "address the state's fiscal emergency," even though the complete package is not finalized. The Eighth Extraordinary Session remains open to allow for additional negotiations on various components of the package. Under the provisions of Proposition 58, the Legislature can continue to work on budget matters in the Eighth Extraordinary Session beyond the 45-day deadline, but is prohibited from "acting on bills," a phrase that is certainly subject to interpretation. The items still to be acted by both houses are as follows: Gas Tax Swap, Social Services bill, tax enforcement bill, furlough bill, resources trailer bill and the Emergency Response Initiative.

Transportation. On February 17, the Senate Budget Committee adopted "in concept" the Senate Democrats' proposed alternative "transportation funding swap", and both houses had planned to take action on Monday, February 22. The alternative proposal would eliminate the sales tax on gasoline, including Proposition 42 but would provide additional revenues for highways, local streets and roads, and transit above the Governor's proposal.

In the first year, the proposal would impose a 12.9 cent gas tax that would be allocated consistent with the Governor's proposal, which provides $629 million for local streets and roads, equivalent to what Prop 42 would generate. However, beginning in 2011-12, the proposal would start to capture the potential growth of the sales tax revenue stream by adjusting the excise tax to fully replace what the sales tax on gas would otherwise have generated, and local streets and roads will continue to received 40% of these revenues (consistent with what Proposition 42 currently provides).

While the Governor's proposal completely eliminates transit funding, this alternative would partially restore transit funds by providing some one-time funding and approximately $313 million on an annual basis for transit operations and the ability for metropolitan planning organizations (MPOs) to levy a regional fee to support SB 375 implementation.

While the Senate alternative holds harmless local streets and roads funding into the future by adjusting the gas tax annually to the level that the sales tax on gas would generate, it does not address the loss of constitutional protection afforded Proposition 42 revenues. Further, this proposal eliminates significant revenue streams for transit, while providing new additional revenues for the state highway system for maintenance and also retaining a significant portion for the State Transportation Improvement Program (STIP).

ABX8 6 was amended on February 19 to contain trailer bill language related to the Legislature's draft proposed alternative to the Governor's transportation tax swap proposal. There is only one significant difference between the recently released language and what was proposed to the Senate Budget Committee last week. This most recent version makes additional changes to transit funding as follows:

- Increases the sales tax rate on diesel to 6.75% starting in 2011-12 to provide additional revenues for the Public Transportation Account (PTA). This revenue stream is projected to increase over time.

- Appropriates, in the period between now and June 30, 2011 (i.e. current year plus budget year), $400 million from the PTA balance to the State Transit Assistance (STA) program.

- Appropriates some non-Article XIX funds to the PTA.

The Governor has indicated concerns with the Legislature's developing alternative proposal (apparently related to the corporate tax breaks rather than the actual transportation components), so negotiations continue in order to reach a compromise. Schwarzenegger officials for weeks have raised concerns that the Democratic gas-tax swap would not reduce Proposition 98 spending and thereby foreclose a significant opportunity to save general fund dollars. But Democrats have said they do not want to consider adjusting Proposition 98 until after the Governor's May revised budget.

At this time, it is possible that further changes to the transportation component could be made during negotiations, yet we still expect resolution on this issue and a vote in the Legislature on a compromise package by the end of this week.

Cash Management/ Cash Deferrals. The Administration has been working with the State Controller's Office, State Treasurer's Office, the Legislative Analyst's Office, and legislative staff on a proposed cash management plan to address current year and budget year cash shortfalls. <u>While the state will experience a cash shortfall in the current year, there are no additional payment deferrals to counties in the current year</u>.

For the budget year, the proposal includes significant deferrals to counties in the areas of social services, transportation, and Proposition 63. For all of these deferrals, the proposal includes a $1 billion cap in outstanding payments to local governments (counties and cities) at any given time in 2010-11. The deferrals would be limited to the 2010-11 fiscal year and small counties (those with a 50,000 or less population) and cities within those counties would be exempted from the deferrals. The Department of Finance, the State Controller's Office, and the State Treasurer's Office will be in regular communications on the state's cash situation and will have some discretion to modify deferrals due to hardship.

- **Highway Users Tax Account (HUTA) deferrals:** HUTA payments will be deferred $50 million per month from July 2010-March 2011 and will be fully repaid in April 2011. These funds would be deferred half from cities and half from counties.

- **Social Services deferrals:** Social services payment deferrals would be limited to three times in the fiscal year: July 2010, October 2010, and March 2011. The July and March deferrals are limited to 60 days, while the October deferral is limited to 90 days. With a 30-day notice (that may be waived by the Joint Legislative Budget Committee), the deferrals may be moved 30 days (i.e. the

October deferral could be used in September or November and paid in 90 days). While the 30-day notice is required for legislative notification only, we are told by the Department of Finance that affected entities would also be notified.

- **Proposition 63 deferrals:** The Proposition 63 July 2010 payment of $300 million would be paid in May 2011.

The details of these deferrals are contained in ABX8 5.

Public safety/corrections. The Legislature adopted an $811 million cut to the federal prison healthcare receiver's budget, a $41 million reduction to the Division of Juvenile Justice, and a $45 million reduction to the Department of Justice related to forensic lab services. On the latter item, the reduction to DOJ forensic lab funding reflects concurrent action to increase by $2 the existing criminal penalty assessment (authorized in Government Code Section 76104.7), which is expected to produce revenue for operation of state criminal laboratories in an amount equivalent to the cut.

We anticipate additional negotiations will result in more action by the Senate and Assembly in the Eighth Extraordinary Session this week.

For additional information about the $5.5 billion in Legislative budget solutions, see Attachment A.

Source material: CSAC Executive Director's Watch

Special Session (8X) – Budget Proposal
UCC Summary of February Legislative Package
DRAFT 2-22-10

The Legislative package includes $5.5 billion in solutions to address the budget deficit of $20 billion in the current year. The majority of the items in this package have been passed by both houses of the Legislature as of February 22, 2010. The items still to be acted by both houses are as follows: Gas Tax Swap, Social Services bill, tax enforcement bill, furlough bill, resources trailer bill and the Emergency Response Initiative. These proposals are still discussed below and UCC will send out a final summary when the final bills are enacted sometime this week. The Governor has not yet acted on any of these proposals.

Corrections

- DNA Penalty Assessment. This is a Governor's proposal to increase the DNA penalty assessed on all convicted offenders from $1 to $3 and use the revenue to offset General Fund costs related to the state's crime labs.

- Department of Juvenile Justice. Reduction of $48 million in the package which is intended to include changes to time credits and transfer 18 year olds to state prison if allowed under the terms of their incarceration. However, the details of this reduction are to be worked out in the subcommittee process. (ABx8 2)

- Medical Receiver. This proposal would reduce the receiver's budget by $811 million (ABx8 2).

- Rehabilitation Programs. The package includes intent language that CDCR must consider prioritizing the reestablishment of credentialed teacher and vocational instructor positions in lieu of establishing teacher assistant position. (ABx8 3)

- Immigration and Customs Enforcement Commutations. The package includes savings of $182 million related to commutation and deportation of certain illegal immigrants housed in state prisons. (ABx8 2)

Health and Human Services

- Medi-Cal Anti-Fraud. Reduces funding by $28.3 million to recognize additional anti-fraud activities by DHCS to be focused on physician services and pharmacy. These activities will be funded with existing resources. (ABx8 2).

- Regional Centers. Continues the three percent reduction authorized last year to the Regional Centers, and exempts regional centers from some reporting requirements. (ABx8 4)

- Office of AIDS fund shift. Shifts $3.5 million of federal funds within the Office of AIDS to use the funding before the authorization expires. (ABx8 1)

- Foster Care. Package includes language that would allow the state to get additional federal funds for foster care. (ABx8 4)

Local Government

- Mandates. Package recognizes a savings of $228 million by suspension of certain mandates. The Crime Victims' Rights mandate and the Local Recreational Background Checks mandate were excluded from the suspension for further analysis to be done in the budget subcommittee. (ABx8 2)

- Cash Management (ABx8 5). The package requires the Department of Finance to develop a cash management plan. Included in this plan is the ability for various deferrals during 2010-11 and provides a $1 billion cap in outstanding payments to local governments at any time during 2010-11. Specifics are as follows:
    - Deferrals are kept to the fiscal year.
    - A maximum of three deferrals per specific programs may be made during the fiscal year (exceptions for HUTA, and mental health).
    - Payments to local governments may be deferred for social services programs, transportation programs and Proposition 63 (Mental Health Services Act).
    - Transportation deferrals (HUTA) will be capped at $50 million a month from July 2010-March 2011 to be fully repaid in April 2011.
    - Social services deferrals have three deferral months: July, October and March. The July and March deferrals are for 60 days, the October deferral is for 90 days. However, with 30-day notice the deferrals can be moved earlier or later.
    - Rural cities and counties (population less than 50,000) are exempt from these deferrals.

Resources

- Beverage Container Recycling Program. The package makes several changes to the program to deal with the fiscal stability of the funding. This includes accelerating by 30 days payments by beverage distributors of the CRV, and sets expenditure priorities by suspending various continuous appropriations which includes the community beverage container grants. (ABx8 7)

- Emergency Response Initiative. This proposal by the Governor would place a 4.8 percent surcharge on all residential and commercial property insurance statewide. The ERI would be used to fund the state's emergency response efforts, including CAL Fire and assistance to local first response agencies. (ABx8 9)

Transportation

<u>Gas Tax Swap</u>

The Governor's proposal is to eliminate the sales tax on gas, eliminate the sales tax on diesel and increase the excise tax to 18%. However, the Legislature had concerns over this proposal since it contained no funding for transit. Instead the Democrat alternative would do the following (ABx8 6 or SB x8 6):

- Sales Tax. This proposal would eliminate the sales tax on gas, but retain the sales tax on diesel. The sales tax on diesel would provide $313 million annually for transit with 75% for operating and 25% for intercity rail.

- Excise Tax. Increase the excise tax by 12.9 percent. This increase would provide funding to be used for bond debt service ($720 million) and the rest by formula to the following: Local Streets and Roads (40%), State Transportation Improvement Program (30%) and State Highway Operations or SHOP (30%).

- Transit. Besides the funding of the sales tax on diesel (see above) which will help to fund transit beginning in 2011-12, this bill provides $400 million in one-time funding for 2010-11.

- Light Duty Vehicle Mitigation Fee. In order to make up for the lack of transit funds, the bill also allows local Metropolitan Planning Organizations (MPOs) to impose a light-duty vehicle mitigation fee through a majority vote of their board and the electorate for implementing SB 375. The fee may be used for transit, bicycle, and pedestrian programs including operation and maintenance of transit services that have been identified in the regional transportation plan. Following the adoption by the MPO of the RTP that provides for a fee, the board of supervisors of each county where the fee is to be imposed must place the fee on the ballot for approval. The fee can be imposed within all or part of the region.

- General Fund Relief. Provides additional revenues by increasing the 2009-10 bond reimbursement by $162 million and increases 2010-11 GF by $655 million by delaying by one year the unitary group credit sharing and limits Net Operating Loss to 68 percent of income for one year.

While this would be considered revenue neutral, there are no protections for the local streets and roads funds like there is currently provided under Proposition 42.

Revenues

This package of revenues would help to generate approximately $174 million in 2009-10(ABx8 8):

- Financial Institution Record Match. This proposal would create a program similar to an existing program for child support collections. It would also require the Franchise Tax Board to reimburse a financial institution for its actual costs incurred to implement FIRM, up to $2,500 for startup costs and no more than $250 per calendar quarter thereafter. Projected revenue of $32 million in out years.

- Professional License Revocation. This proposal would allow the state to suspend state occupational and professional licenses because of unpaid income tax liabilities. Proposed revenue of $14 million in 2009-10.

- Abusive Tax Shelter. This proposal would eliminate inconsistencies in the definition of abuse tax shelters by providing a single definition. Proposed revenue of $500,000 in 09-10 with growth in the out years.

- Sales Tax Nexus. Requires out-of-state sellers, like Amazon, to collect use tax on their sales to California residents. This is proposed to collect $107 million in 2010-11.

Other

- Furloughs. This would exempt from the furloughs employees at the Franchise Tax Board, Board of Equalization and other offices. (ABx8 29).

- Employee Compensation. Includes Governor's proposal for reductions to employee compensation by five percent.

OFFICE OF THE COUNTY ADMINISTRATOR
CONTRA COSTA COUNTY

TO: Legislation Committee
Supervisor Susan A. Bonilla, Chair
Supervisor Gayle B. Uilkema, Vice Chair

FROM: Lara DeLaney, Legislative Coordinator

DATE: February 24, 2010

SUBJECT: **Agenda Item #5: Legislation Status Report**

RECOMMENDATION

REVIEW the attached listings of bills of interest to the County.

RECOMMEND positions on bills to the Board of Supervisors, as appropriate.

BACKGROUND

New Bills Introduced

February 19 was the bill introduction deadline for the Legislature, and over 1,000 new bills have been introduced. While CSAC, UCC, and County staff are still reviewing all of these bills, here are some highlights of some of the new bills:

- Election Reimbursement. SB 994 (Price), sponsored by Los Angeles County, would require the state to reimburse counties for vacancy elections called by the Governor for congressional and state legislative elections.

- Vote-by-Mail Elections. There are two bills on vote-by-mail elections including SB 1102 (Liu) which allows for vote-by-mail for specific offices, and AB 1682 (Yamada) which is specific to Yolo County.

Bankruptcy Bill

SB 88 (DeSaulnier) which was the vehicle for the bankruptcy bill late in session last year has been changed, and it is our understanding that this bill will not contain the bankruptcy bill provisions. However, AB 155 (Mendoza) will be resurrected and be heard in the Senate Local Government Committee sometime this spring.

Attached to this report is information about various bills in which the County may have an interest or on which the County has already taken a position.

- *Attachment A: Various Bills*
- *Attachment B: County Health Executives Association of California Hot Sheet*
- *Attachment C: CSAC Legislative Bulletin.*

Additional information may be provided to the Committee regarding any of these bills.

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State's main environmental law targeted on broad front in Capitol

By **John Howard** | 02/23/10 12:00 AM PST, Capitol Weekly

Years of exemptions from California's principal environmental protection law are being crafted in the Capitol by the Schwarzenegger administration and lawmakers in both parties, who believe speedy approval of dozens of projects, public and private, will create jobs and spur economic growth.

The projects are potentially worth billions of dollars and thousands of jobs -- although just how much money and how many jobs have not yet been identified. "If there is a list, if it exists, nobody has seen it," one Capitol staffer said.

"California is going through the worst economic downturn since the Great Depression," said Sen. Lou Correa, D-Santa, author of one of the exemption bills. "This continues to provide environmental protection and balances that with the opportunity to create jobs."

Environmentalists say the proposed end-run around the California Environmental Quality Act constitutes one of the most significant changes to CEQA since the law was written 40 years ago and inspired environmental legislation across the country. CEQA is a frequent target of lawsuits and legislation.

Four bills – two in each house – contain Schwarzenegger's proposal to exempt 25 projects, selected geographically by county, from court review and CEQA each year through 2014. Two of the bills are regular-session measures, the other two were introduced in the 8th Special Session. All are mirror images of each other. Privately, those familiar with the legislation say there is a scramble among lobbyists to get clients' projects on the exemption list.

The proposals are supported by manufacturers, builders, engineers, developers, business interests and others. They say the proposals will expedite construction of numerous, still-unknown projects and jumpstart the weak economy. They restrict the

power of the courts to review the projects and give final authority over the projects to the administration.
The projects could range from refineries to commercial development, housing tracts, highways and water works, among others.

A fifth bill, which would apply retroactively, would exempt critical infrastructure projects for flood control, highways, port security, disaster preparedness and air quality. The proposal is similar to a plan that was proposed last year and rejected. Funding for the projects was approved by voters in 2006 as Proposition 1B, the $19.9 billion transportation bond, and Proposition 1E, the $4.1 billion flood protection bond. Of the funding that was approved, about $16 billion worth of bond funding remains unissued.

The measures containing the administration's proposals have Democratic and Republican authors. The fifth bill, the infrastructure plan, is authored by Senate GOP Leader Dennis Hollingsworth.

CEQA has long been a target of developers, builders, manufacturers, timber and mining interests and others, but the latest series of bills seeking changes is unusual for their number and scope, observers say. They cite the Legislature's earlier approval of exemptions for air-emission credits for the South Coast Air Quality Management District and a proposed NFL stadium in Los Angeles County as the progenitors of the latest legislation. Those two proposals constituted the most significant environment-related legislation of 2009.

"We said at the time that they would encourage more of these proposals, and it's done exactly that," said Bill Magavern of Sierra Club California. "We're seeing a stepped-up attack on CEQA this year, and I think we're seeing development interests using the recession as an excuse for the CEQA rollbacks that they have been gunning for."

The administration's proposal, reported by Capitol Weekly in January, is being carried in the Assembly as AB1805 and AB37 8x by Assemblymen Charles Calderon, D-Montebello, and Brian Nestande, R-Riverside. In the Senate, Sens. Correa and Dave Cogdill, R-Fresno, are authoring virtually identical bills, SB 42 8x and SB 1010. The infrastructure exemptions are contained in SB 56 by Hollingsworth, R-Murietta.

The administration's proposal allows exemptions for at least 25 construction projects located across California. Ten would be chosen from Imperial, Los Angeles, Orange, Riverside, San Bernardino and San Diego counties; five from Alameda, Contra Costa, Marin, Napa, San Francisco, Santa Cruz, Solano and Sonoma counties; five from Fresno, Kern, Kings, Madera, Merced, Sacramento, San Joaquin, Stanislaus and Tulare; and five projects located in the rest of the state.

The proposal, which includes a provision for at least one public hearing and legislative input, gives final authority over the projects to the Business, Transportation and Housing Agency, or BTH, a cabinet-level superagency whose secretary, a gubernatorial appointee, reports directly to the governor.

The goal of the governor's proposal is to expedite projects that would generate jobs and stimulate the sluggish economy.

The proposal sets up a timetable for projects to be approved, and allows for approval if the entity seeking the project expects the project ultimately to receive environmental approval. If the project fails the environmental certification, the BTH can choose alternates. The plan calls for BTH to give lawmakers and the public a list of the projects that win final approval.

Environmentalists said the governor's plan would weaken environmental safeguards, and questioned whether the language barring court review would pass constitutional muster.

Last year, the governor signed AB 81 3X by Assemblyman Isadore Hall, D-Compton, that streamlined certain CEQA requirements to construct a new NFL stadium in the City of Industry. The stadium proposal, already exempted, would not be covered by the latest legislation.

The governor also signed SB 827 by Sen. Rod Wright, D-Los Angeles, with an estimated $4 billion economic impact affecting some 65,000 jobs in the L.A. basin. The bill allows air regulators to distribute valuable emissions credits in the way they did before the courts, responding to environmentalists, blocked them.

Years of exemptions from California's principal environmental protection law are being crafted in the Capitol by the Schwarzenegger administration and lawmakers in both parties, who believe speedy approval of dozens of projects, public and private, will create jobs and spur economic growth.

CONTRA COSTA COUNTY
LEGISLATION TRACKING REPORT

CA AB 12

AUTHOR: Beall [D]
TITLE: Fostering Connections to Success Act
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 12/01/2008
LAST AMEND: 01/25/2010
DISPOSITION: Pending
LOCATION: Senate Human Services Committee
SUMMARY:

Relates to the licensing of foster family homes and community care facilities in which non-minor dependents of the Juvenile Court are placed, independent living settings and placement for non-minor dependents, the procedures for a non-minor dependent to remain under the court's jurisdiction, the approval of relative or nonrelative homes for placement of non-minor dependents, related long-term foster care, revising the KinGAP Program, AFDC-FC benefits eligibility, and the Adoption Assistance Program.

STATUS:

02/11/2010 To SENATE Committee on HUMAN SERVICES and JUDICIARY.

NOTES: Board supported on 4/28/09

CA AB 155

AUTHOR: Mendoza [D]
TITLE: Local Government: Bankruptcy Proceedings
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 01/26/2009
LAST AMEND: 07/01/2009
DISPOSITION: Pending
LOCATION: Senate Local Government Committee
SUMMARY:

Provides that a local public entity may only file under federal bankruptcy law with the approval of the State Debt and Investment Advisory Commission.

STATUS:

07/08/2009 In SENATE Committee on LOCAL GOVERNMENT: Not heard.

NOTES: OPPOSE requested by CSAC. Recommendation from Leg?

CA AB 682

AUTHOR: Lowenthal B [D]
TITLE: In-Home Supportive Services Program: Fraud
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/26/2009
LAST AMEND: 09/03/2009
DISPOSITION: Pending
LOCATION: Senate Appropriations Committee
SUMMARY:

Existing law requires counties, public authorities, and nonprofit consortiums to

complete criminal background checks of specified persons who seek to become in-home supportive services providers. Requires that the criminal background checks be conducted at the provider's expense, unless the nonprofit consortium or public authority agrees to pay for the criminal background check in which case the department shall seek federal financial participation to cover the costs.

STATUS:

09/03/2009	From SENATE Committee on APPROPRIATIONS with author's amendments.
09/03/2009	In SENATE. Read second time and amended. Re-referred to Committee on APPROPRIATIONS.
NOTES:	Refer to IHSS for comment/analysis

CA AB 1409

AUTHOR:	Perez J [D]
TITLE:	Public Contracts: County Highways: Work Authorizations
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/27/2009
LAST AMEND:	06/02/2009
DISPOSITION:	Pending
LOCATION:	Senate Transportation and Housing Committee

SUMMARY:

Relates to public contract requirements. Revises the provision authorizing the work on certain county highway contracts to be done by purchasing the material and having the work done by day labor, only after advertising and requesting bids, and the board of supervisors passing a resolution making a specified finding, or purchasing the material and having the work done by specified employees.

STATUS:

07/16/2009	In SENATE Committee on TRANSPORTATION AND HOUSING: Not heard.
NOTES:	CSAC Recommends Oppose

CA AB 1445

AUTHOR:	Chesbro [D]
TITLE:	Medi-Cal: Health Centers and Rural Health Clinics
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/27/2009
LAST AMEND:	06/01/2009
DISPOSITION:	Pending
LOCATION:	Senate Appropriations Committee

SUMMARY:

Amends existing law that relates to Medi-Cal reimbursement per-visit rates for benefits for federally qualified health center and rural health clinic services. Provides a certain maximum numbers of visits taking place on the same day at a single location shall be reimbursed under certain conditions. Requires an FQHC or RHC that currently includes the cost of encounters with more than one health professional that take place on the same day at a single location as constituting a single visit.

STATUS:

07/08/2009	From SENATE Committee on HEALTH: Do pass to Committee on APPROPRIATIONS.
NOTES:	Dr. Walker recommends Support; to the BOS on 5/12

CA AB 1487

AUTHOR: Hill [D]
TITLE: Inmate Medical Expenses
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 02/27/2009
LAST AMEND: 06/22/2009
DISPOSITION: Pending
LOCATION: Senate Public Safety Committee
SUMMARY:

Provides for fees for inmate medical expenses. Require that any amount collected for an inmate-initiated medical visit in excess of a specified amount be placed into the county inmate welfare fund. Requires that money deposited in the inmate welfare fund pursuant to this legislation be expended by the sheriff only for the benefit and education of the inmates.

STATUS:

07/14/2009 In SENATE Committee on PUBLIC SAFETY: Not heard.

NOTES: To BOS for support on 6/16

CA AB 1681

AUTHOR: Yamada [D]
TITLE: Elections: All-Mailed Ballot Elections
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 01/25/2010
DISPOSITION: Pending
LOCATION: Assembly Elections and Redistricting Committee
SUMMARY:

Authorizes as a pilot program elections in Yolo County, other than statewide primary or general elections or special elections to fill a vacancy in a state office, the Legislature, or Congress, to be conducted as all-mailed ballot elections if specified conditions are satisfied.

STATUS:

02/04/2010 To ASSEMBLY Committee on ELECTIONS AND REDISTRICTING.

NOTES: Watch

CA AB 1801

AUTHOR: Yamada [D]
TITLE: In-Home Supportive Services: Quality Assurance
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/10/2010
DISPOSITION: Pending
LOCATION: ASSEMBLY
SUMMARY:

Requires the Department of Social Services to continue to provide the report evaluating the implementation of quality assurance and fraud prevention on an annual basis. Requires the department to identify stable ongoing funding sources for IHSS services.

STATUS:

02/10/2010 INTRODUCED.

NOTES: John Cottrell doesn't support it.

CA AB 1987

AUTHOR: Hernandez [D]
TITLE: Public Retirement: Final Compensation: Retirees

FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/17/2010
DISPOSITION: Pending
LOCATION: ASSEMBLY
SUMMARY:

Relates to the Public Employees' Retirement System, the Teachers' Retirement Law and the retirement laws for county employees and city employees. Provides that any change in salary, compensation or remuneration for enhancing a member's benefits would not be included in the calculation of a member's final compensation for purposes of determining that member's defined benefit.

STATUS:

02/17/2010	INTRODUCED.

CA SB 326

AUTHOR: Strickland T [R]
TITLE: Land Use: Housing Element
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 02/25/2009
LAST AMEND: 06/22/2009
DISPOSITION: Pending
LOCATION: Assembly Local Government Committee
SUMMARY:

Amends the Planning and Zone Law. Provides that if a city or county in the prior planning period failed to identify or make available adequate sites to accommodate that portion of the regional housing need allocated to it, the city or county, within the first year of the planning period of the new housing element, would be authorized to identify adequate sites to accommodate the unaccommodated portion of the regional housing need allocation from the prior planning period.

STATUS:

06/22/2009	From ASSEMBLY Committee on LOCAL GOVERNMENT with author's amendments.
06/22/2009	In ASSEMBLY. Read second time and amended. Re-referred to Committee on LOCAL GOVERNMENT.

NOTES: CSAC opposes

CA SB 346

AUTHOR: Kehoe [D]
TITLE: Hazardous Materials: Motor Vehicle Brake Materials
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/25/2009
LAST AMEND: 06/24/2009
DISPOSITION: Pending
LOCATION: Assembly Environmental Safety and Toxic Materials Committee
SUMMARY:

Requires a survey of the concentration levels of nickel, zinc, copper and antimony in motor vehicle brake friction materials. Establishes a maximum allowable concentration level of lead and other minerals. Require copper monitoring. Prohibits the sale of vehicle brake friction materials containing specified constituents including cadmium, lead and mercury in certain amounts

and concentrations. Requires a fee for each new axle brake sold. Requires the keeping of accurate books, records and accounts.

STATUS:

06/24/2009	From ASSEMBLY Committee on ENVIRONMENTAL SAFETY AND TOXIC MATERIALS with author's amendments.
06/24/2009	In ASSEMBLY. Read second time and amended. Re-referred to Committee on ENVIRONMENTAL SAFETY AND TOXIC MATERIALS.
NOTES:	CCCWP Supports; support letter requested
Position:	BOS Support *04/06/2009*

CA SB 686

AUTHOR:	DeSaulnier [D]
TITLE:	Environment: CEQA Exemption
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/27/2009
DISPOSITION:	Pending
LOCATION:	Assembly Natural Resources Committee

SUMMARY:

Makes a technical nonsubstantive changes to a provision of the Environmental Quality Act. Exempts from the provisions of the Acts regarding the addition or deletion of a class of projects.

STATUS:

05/12/2009	To ASSEMBLY Committee on NATURAL RESOURCES.
NOTES:	Our sponsored legislation for CEQA exemption for infill
Position:	Support

CA SB 694

AUTHOR:	Correa [D]
TITLE:	Public Works: Competitive Bidding: Procedures
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/27/2009
LAST AMEND:	01/12/2010
DISPOSITION:	Pending
LOCATION:	ASSEMBLY

SUMMARY:

Extends the time that the State Uniform Construction Cost Accounting Commission to review a public agency project that is to be performed after the rejection of all bids, and for review of work for which evidence was provided that the work has exceeded the force account limits or has been improperly classified as maintenance.

STATUS:

01/25/2010	In SENATE. Read third time. Passed SENATE. *****To ASSEMBLY.
NOTES:	On CSAC watch list to Oppose Unless Amended

CA SB 810

AUTHOR:	Leno [D]
TITLE:	Single-Payer Health Care Coverage
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/27/2009
LAST AMEND:	01/13/2010

DISPOSITION: Pending
LOCATION: ASSEMBLY
SUMMARY:

Establishes the State Healthcare System to be administered by the newly created State Healthcare Agency under the control of a Healthcare Commissioner appointed by the Governor. Makes all residents eligible for specified health care benefits under the system, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for them. Extends the application of insurance fraud laws to providers of services and products under the system.

STATUS:

01/28/2010 In SENATE. Read third time. Passed SENATE. *****To ASSEMBLY.

NOTES: BOS supported on 5/19

CA SB 958

AUTHOR: Lowenthal A [D]
TITLE: Health and Safety: Housing
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/05/2010
DISPOSITION: Pending
LOCATION: Senate Transportation and Housing Committee
SUMMARY:

Designates the Department of Housing and Community Development as the state agency responsible for administering the federal Housing Trust Fund. Requires the department to administer the federal funds pursuant to the multi-family housing program, except that up to a certain percentage of the funds may be appropriated to the CalHome Program.

STATUS:

02/18/2010 To SENATE Committee on TRANSPORTATION AND HOUSING.

NOTES: Should we seek an amendment to make local govt a co-equal partner?

CA SB 994

AUTHOR: Price [D]
TITLE: Elections: Payment of Expenses
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/09/2010
DISPOSITION: Pending
LOCATION: Senate Elections, Reapportionment and Constitutional Amendments Committee
SUMMARY:

Provides that expenses incurred for elections proclaimed by the Governor to fill a vacancy in the office of State Senator or Member of the Assembly, or to fill a vacancy in the office of United States Congressman, are to be paid by the state.

STATUS:

02/18/2010 To SENATE Committee on ELECTIONS, REAPPORTIONMENT AND CONSTITUTIONAL AMENDMENTS.

NOTES: Watch

CA SB 1102

AUTHOR: Liu [D]
TITLE: Elections: Vote by Mail

FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 02/17/2010
DISPOSITION: Pending
LOCATION: SENATE
SUMMARY:

Allows a special general or primary election called to fill a vacancy in an office of Representative in congress, State Senate or Member of the Assembly to be conducted wholly by mail within a county if certain conditions are satisfied. Revises procedures applicable to elections conducted wholly by mail, including procedure relating to notifying voters of information relating to the election.

STATUS:

02/17/2010 INTRODUCED.

NOTES: Recommend Support to Board

CA SCA 18

AUTHOR: Liu [D]
TITLE: Local Government: Property-Related Fees.
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 03/10/2009
DISPOSITION: Pending
FILE: 8
LOCATION: Senate Third Reading File
SUMMARY:

Proposes an amendment to the Constitution to exclude fees and charges for stormwater and urban runoff management from voter approval requirements for the imposition or increase of a property-related fee or charge by a local government.

STATUS:

06/17/2009 In SENATE. Read second time. To third reading.

NOTES: CSAC requests support.

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CHEAC Hot Sheet #5 – 2010
February 19, 2010

Bill Number **Author** **Subject** **Last Amendment**	**Bill Status**	**Description**	**CHEAC Position**
ASSEMBLY BILLS			
AB 223/Ma *Public Health* Amended 1/4/10	*Location*: In Senate.	Repeals existing state law on the practice of tattooing, body art and piercings. Would require all body art practioners to annually register with local enforcement agencies and require these practioners to comply with specific requirements including the completion of a blood borne pathogens exposure control training program (with annual updates). Facilities are also required to have valid health permits issued annually by local enforcement agencies and must have infection prevention and control plans in place. Allows local enforcement agencies to collect fees sufficient to pay for the administration of these programs. Local enforcement agency is defined as a county or city health agency. For those jurisdictions where EH is not within the health department, the jurisdiction must designate who is the local enforcement agency (health or EH).	S-2
AB 342/Bass *Medi-Cal Hospitals* Last amendment 5/18/09	*Location:* In Senate Health Committee.	Requires DHCS to submit a waiver to CMS to implement a demonstration project to strengthen the safety net, expand coverage and improve health outcomes.	Special Interest Bill
NEW BILL **AB 537/Arambula** ***Nutrition***	*Location*: In Senate.	**Allows the State Department of Social Services to designate or assign an interested Food and Nutrition Service-authorized organization to operate an EBT acceptance system in a farmer's market selling fresh produce beginning by 1/1/12. Does not require markets themselves to create, operate or maintain an EBT system.**	**S-2**
AB 1225/De La Torre *Public Health Emergency Preparedness* Amended 1/4/10	*Location:* In Senate.	Requires CDPH and LHDs to establish a process when conducting infectious disease outbreak exercises to identify any deficiencies in the preparedness plans and procedures and track implementation of corrective measures.	Watch w/ Concerns

Bill Number Author Subject Last Amendment	Bill Status	Description	CHEAC Position
AB 1445/Chesbro *Medi-Cal* Last amendment 6/1/09	*Location*: In Senate Appropriations Committee.	Allows reimbursement for a max of two visits to an FQHC or RHC on the same day and at the same location if the patient suddenly suffers and illness or injury subsequent to the first visit or if the patient has a medical visit and "another health visit" – meaning a face-to-face encounter with a clinical psychologist, licensed clinical social worker, dentist, dental hygienist or registered dental hygienist in alternative practice.	S-3
AB 1487/Hill *Jail Medical* Last amendment 6/22/09	*Location*: In Senate Public Safety Committee.	Increases the fee that can be charged to an inmate's account for medical visits from $3 to $6.	SIA
AB 1503/Lieu *EMS*	*Location*: In Senate Health Committee.	Creates a new physician and surgeon pricing policy for uninsured visits to the emergency room. Ties Maddy Fund reimbursements to these new provisions.	Watch w/ Concerns
NEW BILL **AB 1599/Beall** ***Medi-Cal*** ***Drug & Alcohol***	*Location:* In Assembly Health Committee.	**Establishes the Medi-Cal Alcohol and Drug Screening & Brief Intervention Services Program to allow local funds to draw down federal funds via CPE. Funding obtained to be used to provide alcohol and drug screening and brief intervention services to Medi-Cal beneficiaries who are pregnant women or women of childbearing age. Requires any public entity drawing down FFP to reimburse the state their costs for creating and administering the program.**	**S-3**
NEW BILL **AB 1653/Jones** ***Medi-Cal*** ***Hospitals***	*Location:* In Assembly Health Committee.	**Exempts public hospitals, specialty hospitals (as defined by OSHPD), long term care hospitals (satisfying Medicare criteria) and small, rural hospitals (as defined by OSHPD) from the Hospital Quality Assurance Fee passed last year.**	**S-3**
SENATE BILLS			
SB 4/Oropeza *Public Health* Last amendment 7/13/09	*Location:* On Senate Floor.	Bans smoking at state parks and beaches.	S-3
SB 152/Cox *Medi-Cal* *Mental Health* Last amendment 4/14/09	*Location:* In Assembly Health Committee.	Would require DMH to send a reimbursement claim to the Controller for fee-for-service county mental health managed care contractors within 90 days. Interest accrues on unpaid claims and would come out of DMH's budget.	S-3

Bill Number Author Subject Last Amendment	Bill Status	Description	CHEAC Position
SB 208/Steinberg *Medi-Cal Hospitals*	*Location:* In Assembly Health Committee.	Requires DHCS to submit a waiver to CMS to implement a demonstration project to strengthen the safety net, expand coverage and improve health outcomes.	Special Interest Bill
SB 769/Alquist *Public Health* Last amendment 9/9/09	*Location:* On Senate Floor.	Provides that for FY 09/10 federal funding received pursuant to the federal Supplemental Appropriations Act for state and local public health and emergency response infrastructure for pandemic flu be–subject to appropriation by the Legislature for allocation by DPH pursuant to the CDC grant agreement. Requires DPH to use funds to expand CAHAN capacity for hospitals and clinics. Urgency clause added to the bill.	Special Interest Bill
SB 771/Alquist *Medi-Cal* Last amendment 1/26/10	*Location:* In Assembly.	Extends the change from annual to semi-annual Medi-Cal eligibility determinations for children in the event that the enhanced FMAP in ARRA is extended.	S-1
SB 810/Leno *Health Care Reform* Last amendment 1/13/10	*Location*: In Assembly.	Establishes the California Healthcare System to be administered by the newly created CA Healthcare Agency under the control of an elected Healthcare Commissioner. Makes all CA residents eligible for specified health care benefits under the system, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. Requires the commissioner to seek all necessary waivers, exemptions, agreements or legislation to allow various existing federal, state and local health care payments to be paid to the system. Creates a health insurance policy board. Allows the Healthcare Commissioner to determine city and county contributions to the program. Other provisions.	SIA
SBX3 26/Alquist *HFP* Last amendment 4/16/09	*Location*: In Senate Rules Committee.	Would allow for the creation of a dental-only coverage option offered by the Healthy Families Program.	S-2

*****2-Year Bill – A bill that has not passed out of its house of origin policy or appropriations committee by designated deadlines in the first year of a two-year legislative session. Must be then passed out of its house of origin by January 31, 2010, or it becomes a dead bill. (Please note all deadlines may be waived by Legislative leadership.)

Definitions of Legislative Terms

Chaptered – A bill passed by the Legislature and signed into law by the Governor.

Concurrence – The approval by the house of origin of a bill that was amended in the opposite house.

Dead Bill – A bill that has not passed out of its house of origin by the end of January of the second-year of the two-year legislative session. (Please note all deadlines may be waived by Legislative leadership.)

Failed Passage – A bill that has been voted on in either a committee or assembly or senate floor and did not receive a majority vote. An urgency measure or tax increase must receive 2/3 vote on the floor.

Gut and Amend – An amended bill where the previous legislative language is removed and replaced with entirely new subject matter.

Held in Committee – Status of a bill that is heard in committee but no action is taken.

Inactive File – A bill ready for floor consideration but placed on a dormant list upon the author's request.

Interim Study – The assignment of a bill's subject matter to the appropriate committee for study during the period the Legislature is not in session.

Reconsideration Granted – A motion giving the opportunity to take another vote on a bill that has failed passage in a committee hearing or floor session.

Rules Committee – All bills are initially referred to this committee in each house for policy committee assignments.

Spot Bill (or intent bill) – A bill that proposes nonsubstantive changes to a code section in a particular subject area. Often used as a legislative vehicle later in the legislative session for ideas not fully fleshed out when the bill is introduced.

Suspense File – Bills meeting a certain appropriation threshold in fiscal committees are placed on the suspense file. Fiscal committees in each house hold a special hearing close to the fiscal committee deadlines (late May and August) to determine which bills will come off the suspense file and move forward. The decision on each bill is pre-determined by leadership and the committee vote is mostly a formality.

CHEAC Legislative Position Chart

S - 1 **Strong Support**	**S - 2** **Soft Support**	**S - 3** **Discretionary Support**	**SIA** **Support if Amended**
O - 1 **Strong Oppose**	**O - 2** **Soft Oppose**	**O - 3** **Discretionary Oppose**	**OUA** **Oppose Unless Amended**
WC **Watch with Concerns**	**W - SIB** **Watch - Special Interest Bill**	**W** **Watch**	**R/BB** **Refer/Bring Back**

CALIFORNIA Counties LEGISLATIVE BULLETIN

Friday, February 19, 2010 VOLUME 110 NUMBER 6

News & Advocacy

Special Session on Budget Ends on February 22
Administration of Justice
Agriculture and Natural Resources
Employee Relations
Government Finance and Operations
Health and Human Services
Housing, Land Use and Transportation
Calendar of Events
Ask Our Advocates
Legislative Tracking
PDF Version

February 19, 2010

Special Session on Budget Ends on February 22

Legislature Expected to Send Package to Governor Monday

By Paul McIntosh, Executive Director
pmcintosh@counties.org

The Senate approved yesterday components of a budget package to partially address the state's estimated $20 billion budget deficit. The deadline for action to address the state's fiscal emergency is Monday, February 22, and both the Senate and Assembly plan to reconvene that day to finalize the budget package.

The special session package includes $347.5 million in current year budget savings and $4.66 billion in budget year savings, for a total savings of about $5 billion to address the shortfall.

The budget package includes $2.1 billion in expenditure solutions, with over half coming from corrections medical savings ($811 million) and capping state agency employee costs ($450 million). Among other items, the expenditure solutions also include the Governor's proposal to suspend and defer certain mandates ($232 million).

In addition, the Legislature has not yet acted on two components of the plan that are of interest to counties: the transportation funding swap and cash management solutions. The two houses are expected to vote on the transportation and cash proposals on Monday; as of print deadline, language is unavailable on both proposals. The Senate Democrats have crafted an alternative to the Governor's January transportation swap proposal that generates $1.5 billion in savings. For additional details, please see the Housing, Land Use and Transportation section of this Bulletin.

The Administration has been working with the State Controller's Office, State Treasurer's Office, the Legislative Analyst's Office, and legislative staff on a proposed cash management plan to address current year and budget year cash shortfalls. While the state will experience a cash shortfall in the current year, there are no additional payment deferrals to counties in the current year.

For the budget year, the proposal includes significant deferrals to counties in the areas of social services, transportation, and Proposition 63. For details, please see the Government Finance and Operations section of this Bulletin.

The package also contains tax enforcement and administration savings. The tax compliance and revenue acceleration measures would raise General Fund collections by about $174 million in 2009-10 and 2010-11 combined, and by about $162 million in 2011-12. The measure includes more aggressive matching of assets to pay delinquent tax debts and strengthening laws related to abusive tax shelters. There is also a provision that requires out-of-state sellers, such as Amazon, to collect use tax (equivalent to sales tax) on their sales to California resident. This is estimated to produce $107 million. The package also contains $550 million in fund shifts and other revenues.

The Senate acted on the following measures yesterday:

- ABX8 1 Health
- ABX8 2 Public Safety
- ABX8 3 Fines & Forfeitures Related to ABX8 2
- ABX8 4 Human Services
- ABX8 7 Beverage Recycling Bill
- ABX8 8 Tax Enforcement and Administration
- ABX8 10 Tribal Gaming

The Assembly will need to approve these measures on Monday. Once actions between the two houses are complete and more detailed information becomes available, CSAC will report on the full package in a *Budget Action Bulletin*.

February 19, 2010

Administration of Justice

For more information, please contact Elizabeth Howard Espinosa at 916/650-8131 or ehoward@counties.org or Rosemary Lamb at 916/650-8116 or rlamb@counties.org.

Vehicle Code
SB 949 (Oropeza) – Request for Comment
As Introduced on February 4, 2010

SB 949, by Senator Jenny Oropeza, seeks to amend Sections 21 and 21100 of the Vehicle Code to require that local public safety officers issue moving violations under the California Vehicle Code and not under local municipal codes, as currently permitted under Section 21100.

It is our understanding that the author is attempting to address a practice employed by local governments that makes use of existing authority to regulate certain traffic violations through local ordinance. In these instances, when a ticket is issued under the local municipal codes, the fines inure solely to the benefit of the jurisdiction issuing the violation and are not subject to the fees and penalty assessments that attach to tickets given under the Vehicle Code. Further, a violation issued under a local ordinance is not reported to the Department of Motor Vehicles nor to the driver's insurance company, and the fine is much lower than a driver would pay under the Vehicle Code.

CSAC is concerned about the current drafting of the bill, which appears to usurp local control and eliminate an option local governments have in approaching traffic safety within its jurisdictions. We are interested in receiving feedback from counties regarding this measure and specifically would like to hear from jurisdictions that have elected to exercise the authority set forth in Section 21110. Please review SB 949 and provide feedback as soon as is practical to Rosemary Lamb at rlamb@counties.org.

Court Security
AB 1697 (Hall) – Request for Comment
As Introduced on February 1, 2010

AB 1697, by Assembly Member Isadore Hall, relates to the provision and funding of court security. As introduced, the measure seeks to streamline the funding and processes associated with court security, as well as extend an increase to the court security fee – enacted for a two-year limited term pursuant to SBX4 13 (Ducheny, 2009) — for an additional five years. AB 1697 is sponsored by the California State Sheriffs Association (CSSA).

Counties should recall that SBX4 13 made a number of changes to court security funding. In addition to increasing the court security fee by $10 (from $20 to $30, applied to all criminal convictions), the 2009 judiciary/public safety trailer bill put certain limitations on how court security costs could be charged (average personnel costs vs. actual costs) and eliminated retiree health benefits as an allowable cost in the context of court security agreements. Counties are certainly aware that shortfalls in court security funding have persisted for many years.

AB 1697 would do all of the following:

- Extend the authority to charge a $30 court security fee through July 1, 2016, and permit annual indexing of the fee annually based on the California Consumer Price Index;
- Require the Administrative Office of the Courts (AOC) to publish the current court security fee on its Web site.

- Direct court security fees into a separate fund for the express purposes of funding sheriffs' and marshals' court security endeavors.
- Suggests an as-yet unspecified allocation of court security funding on a county-by-county basis.

AB 1697 is awaiting committee assignment.

February 19, 2010

Agriculture and Natural Resources

For more information, contact Karen Keene at 916/327-7500, ext. 511, or e-mailkkeene@counties.org or Cara Martinson at 915/327-7500, ext. 504, or email cmartinson@counties.org.

Solid Waste
AB 2138 (Chesbro) – Request for Comment
As Introduced on February 18, 2010

AB 2138, by Assembly Member Wes Chesbro, would enact the Plastic Ocean Pollution Reduction, Recycling and Composting Act. Specifically, this bill would prohibit a food provider (i.e. restaurants, grocery stores, retail, etc.) from distributing disposable food service packaging or a single-use carryout bag to a consumer that does not meet a specific composting rate of 25 percent or more. Disposable food service packaging is defined in the bill as plates, cups, bowls, trays, and hinged or lidded containers.

AB 2139 (Chesbro) – Request for Comment
As Introduced on February 18, 2010

AB 2139, by Assembly Member Wes Chesbro, would create the California Product Stewardship Act. This bill would create a product stewardship program for medical sharps, pesticide containers for residential use, small personal use propane tanks, personal butane lighters, and single-use food packaging. Specifically, this bill would require a producer of the aforementioned products to develop and implement a product stewardship plan with the goal of sharing in the responsibility of reducing the lifecycle impact of its products.

This bill is similar to last year's AB 283, which would have established a more comprehensive Extended Producer Responsibility (EPR) Framework. EPR, a concept supported by CSAC, is a mechanism for environmental product and packaging streamlining that creates producer-lead reduction, reuse, and recycling programs to deal with a product's lifecycle impacts from design through end of life management.

Invasive Species
AB 1929 (Hall) -
As Introduced on February 17, 2010 -

AB 1929, by Assembly Member Isadore Hall, would provide that an operator of water delivery and storage facilities, who has prepared and implemented a plan to control and eradicate dreissenid mussels in accordance with the existing law, would not be subject to any civil or criminal liability for the introduction of dreissenid mussel species as a result of operations of those facilities. This bill is identical to last year's AB 804 by the same author.

February 19, 2010

Employee Relations

For more information, contact Eraina Ortega at 916/327-7500, ext. 521, oreortega@counties.org , or Faith L. Conley at 916/327-7500, ext. 522, fconley@counties.org

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Pension Bills Introduced

AB 1743 (Hernandez) – Pending
As Introduced on February 8, 2010

AB 1743, by Assembly Member Ed Hernandez, would require placement agents to register as lobbyists prior to influencing any investment decisions made by state retirement systems, including CalPERS and STRS, the State Teachers' Retirement System. For local retirement systems, placement agents would be required to register as lobbyists if the local jurisdiction has an ordinance in place requiring lobbyists to register before lobbying the governing body.

A placement agent is an individual who is hired by a company for the purpose of finding people who are interested in investing in the company. A company may hire a placement agent if it doesn't want to spend too much of its own time searching for investors. Placement agents have come under increasing scrutiny in recent months after investigations by the Security and Exchange Commission have turned up alleged pay-to-play corruption.

As registered lobbyists, placement agents would be subject to campaign contribution and disclosure limits, gift limitations and would be prohibited from receiving compensation contingent upon pension investment decisions.

AB 1743 is sponsored by CalPERS and is awaiting referral to a policy committee.

AB 1987 (Hernandez) – Request for Comment
As Introduced on February 17, 2010

AB 1987, by Assembly Member Ed Hernandez, would provide that final compensation for the calculation of retirement benefits cannot include changes in salary or compensation that were changed specifically for the purpose of enhancing the member's retirement benefits. AB 1987 would limit a member's final compensation calculation to an amount that cannot exceed the average salary or compensation increase received by employees in the same or similar group as the member within the final compensation period and the two preceding years.

Additionally, the bill requires state and local public retirement boards to adopt a requirement that a retired member cannot perform services for an employer covered by a state or local retirement system until that member has been separated from service for at least six months.

AB 1987 was introduced to address the practice of "pension spiking" where an individual attempts to maximize his or her final compensation in order to increase a retirement allowance beyond what it otherwise would have been. The bill is awaiting referral to a policy committee.

California's Attorney General Calls on CalPERS to Divest from Iran

Attorney General Jerry Brown, on February 8, sent a letter to CalPERS urging the board to abide by state law and divest from Iran.

In 2007, the California Public Divest from Iran Act (the Iran Act) was signed into law, requiring CalPERS to annually report holdings in, and divest from any company doing business in the gas, nuclear, defense and petroleum industries in Iran. However, the CalPERS Board of Administration has sole fiduciary responsibility for the management of assets, and as such may withhold action if it believes the action will have a negative impact on the pension fund's beneficiaries.

CalPERS filed a 2009 Iran Related Investments report with the Attorney General's office in accordance with the Iran Act. The Attorney General, in his February letter to CalPERS, claims the report failed to provide enough detail as to whether CalPERS is complying with the Iran Act. Additionally, the Attorney General asserts that the report failed to include several of the Iran Act's reporting requirements, including whether CalPERS has reduced its investments in companies doing business with Iran and when full divestment from Iran is planned.

For more information, contact Jean Kinney Hurst at 916/327-7500, ext. 515, orjhurst@counties.org or Geoffrey Neill at 916/327-7500, ext. 567, or gneill@counties.org.

Cash Management

The Administration has been working with the State Controller's Office, State Treasurer's Office, the Legislative Analyst's Office and legislative staff on a proposed cash management plan to address current year and budget year cash shortfalls. While the state will experience a cash shortfall in the current year, there are no additional payment deferrals to counties in the current year.

For the budget year, the proposal includes significant deferrals to counties in the areas of social services, transportation, and Proposition 63. For all of these deferrals, the proposal includes a $1 billion cap in outstanding payments to local governments (counties and cities) at any given time in 2010-11. The deferrals would be limited to the 2010-11 fiscal year and small counties (those with a 50,000 or less population) and cities within those counties would be exempted from the deferrals. The Department of Finance, the State Controller's Office, and the State Treasurer's Office will be in regular communication on the state's cash situation and will have some discretion to modify deferrals due to hardship.

CSAC has not seen language on cash management but the following description is our understanding of the proposal.

· **Highway Users Tax Account (HUTA) deferrals:** HUTA payments will be deferred $50 million per month from July 2010-March 2011 and will be fully repaid in April 2011. These funds would be deferred half from cities and half from counties.
· **Social Services deferrals:** Social services payment deferrals would be limited to three times in the fiscal year: July 2010, October 2010, and March 2011. The July and March deferrals are limited to 60 days, while the October deferral is limited to 90 days. With a 30-day notice (that may be waived by the Joint Legislative Budget Committee), the deferrals may be moved 30 days (i.e. the October deferral could be used in September or November and paid in 90 days). While the 30-day notice is required for legislative notification only, we are told by the Department of Finance that affected entities would also be notified.
· **Proposition 63 deferrals:** The Proposition 63 July 2010 payment of $300 million would be paid in May 2011.

Legislation
SB 85 (Cogdill) – Support
As Amended on October 26, 2009

SB 85, by Senator Dave Cogdill, would achieve two important changes to the allocation of property taxes in certain counties. First, it would cap the dollar amount of the "negative bailouts" for the six counties that pay them (Alpine, Lassen, Mariposa, Plumas, Stanislaus, and Trinity); these unfair and unintended negative bailouts resulted from local government bailout legislation passed in the wake of Proposition 13. Second, the bill would increase the property tax allocation for one county (Yolo) at the expense of the Educational Revenue Augmentation Fund (ERAF).

Both of these provisions would help to end unintended fiscal policy that has been slowly cutting into these counties' property tax allocations. The bill would not retroactively make these counties whole again, but would at least keep the problem from getting any worse.

The Senate Local Government Committee passed the bill unanimously on February 10. The Senate passed the bill without a dissenting vote on February 11. SB 85 now goes to the Governor for his consideration.

February 19, 2010

Health and Human Services

For more information, contact Kelly Brooks at 916/327-7500, ext. 531, or kbrooks@counties.org, or Farrah McDaid Ting at 916/327-7500, ext. 559, or fmcdaid@counties.org.

Assembly Budget Subcommittee Hears HHS Special Session Items

The Assembly Budget Subcommittee No.1 on Health and Human Services met on February 10 and 11 to hear special session budget issues. On February 10, the subcommittee heard human services proposals and First 5, and on February 11, the subcommittee focused on health and mental health issues, including Proposition 63.

The subcommittee expressed skepticism over a number of proposals heard over the two days and concern about how program reductions and eliminations would shift costs to counties. The Department of Finance and Legislative Analyst's Office provided testimony and the committee took public comment, including comments from CSAC and other county affiliates.

CSAC testified on the CalWORKs, In-Home Supportive Services, California Food Assistance Program, Cash Assistance to Legal Immigrants and Proposition 63 proposals. In addition, Supervisor Linda Seifert, Solano County, addressed the subcommittee on the First 5 fund ballot redirection.

The Assembly finished its subcommittee hearings on special session budget issues, and is expected to take up the special session proposals on the floor on Monday, February 22.

The Senate acted on a number of special session items on February 18. The human services proposals are in ABX8 4 and the health proposals are in ABX8 1. For descriptions of the proposals, please see the February 11 Budget Action Bulletin. Please recall that the Eighth Extraordinary Special Session will expire on February 22.

Feds Announce Enhanced Medicare Part D Funds for California

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced on February 18 that states will be able to claim enhanced funds for Medicare Part D drug payments. This will allow California to claim approximately $680 million and potentially an additional $160 million more if the American Recovery and Reinvestment Act is extended by Congress for an extra six months.

At the beginning of this month, Governor Schwarzenegger and California's legislative leaders sent a letter to HHS Secretary Sebelius requesting she revisit the calculations used to determine the state's Medicare Part D "clawback" that, under the current application, has imposed an added fiscal burden to the state.

February 19, 2010

Housing, Land Use and Transportation

For more information, contact DeAnn Baker at 916/327-7500, ext. 509, or dbaker@counties.org or Kiana Buss at 916/327-7500, ext. 566, or kbuss@counties.org.

Transportation Funding Swap

The Senate Budget Committee adopted "in concept" the Senate Democrats' proposed alternative "transportation funding swap" on February 17, and both houses plan to take action this coming Monday, February 22. The alternative proposal would eliminate the sales tax on gasoline, including Proposition 42, but would provide additional revenues for highways, local streets and roads, and transit above the Governor's proposal. CSAC has not seen language on the transportation swap but has a conceptual understanding of the Senate proposal.

In the first year, the proposal would impose a 12.9 cent gas tax that would be allocated consistent with the Governor's proposal, which provides $629 million for local streets and roads, equivalent to what Prop 42 would generate. However, beginning in 2011-12, the proposal would start to capture the potential growth of the sales tax revenue stream by adjusting the excise tax to fully replace what the sales tax on gas would otherwise have generated, and local streets and roads will continue to received 40% of these revenues (consistent with what Proposition 42 currently provides).

While the Governor’s proposal completely eliminates transit funding, this alternative would partially restore transit funds by providing some one-time funding and approximately $313 million on an annual basis for transit operations and the ability for metropolitan planning organizations (MPOs) to levy a regional fee to support SB 375 implementation.

While the Senate alternative holds harmless local streets and roads funding into the future by adjusting the gas tax annually to the level that the sales tax on gas would generate, it does not address the loss of constitutional protection afforded Proposition 42 revenues. Further, this proposal still eliminates significant revenue streams for transit, while providing new additional revenues for the state highway system for maintenance and also retaining a significant portion for the State Transportation Improvement Program (STIP).

February 19, 2010

Calendar of Events

Don't miss upcoming CSAC events.

February 19, 2010

Ask Our Advocates

Further questions about topics in this Bulletin? Contact our Legislative Staff.

February 19, 2010

Legislative Tracking

Keep track of important legislation online.

February 19, 2010

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OFFICE OF THE COUNTY ADMINISTRATOR
CONTRA COSTA COUNTY

TO: Legislation Committee
Supervisor Susan A. Bonilla, Chair
Supervisor Gayle B. Uilkema, Vice Chair

FROM: Lara DeLaney, Legislative Coordinator

DATE: February 24, 2010

SUBJECT: **Agenda Item #6: LAO Analyses of June 8, 2010 Ballot Measures**

RECOMMENDATION

ACCEPT report.

REPORT

The Legislative Analyst's Office has released its draft analyses of measures on the June 8, 2010 ballot, which are available for public inspection through March 15, 2010. Note that there may be court-ordered changes until that date.

Proposition 13

Property Tax: New Construction Exclusion: Seismic Retrofitting.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact

- **Fiscal Impact**: Minor reduction in local property tax revenues related to the assessment of earthquake upgrades.

Yes/No Statement

A **YES** vote on this measure means: Earthquake safety improvements made to unreinforced masonry (such as brick) buildings would not result in higher property taxes until the building is sold.

A **NO** vote on this measure means: Earthquake safety improvements made to unreinforced masonry buildings would continue to be excluded from property taxes but for only up to 15 years.

Background

Local property taxes are based on each property's assessed value. When a property is purchased, it is generally given an assessed value equal to its purchase price. As long as a property has the same owner and there is no new construction on the property, its assessed value generally remains the same, except for a small annual increase for inflation. New construction generally causes a reassessment if it adds a building, adds space, converts a building to a new use, or renovates the building to make it like new. The property's assessed value is increased to reflect the value added by the new construction. In contrast, the assessed value is not increased for normal maintenance and repair, such as replacing a leaky roof.

Currently, there are several specific exclusions in the State Constitution from the new construction rule. Among them are two separate provisions regarding earthquake safety modifications on existing buildings. The first one excludes earthquake safety upgrades on "unreinforced masonry buildings" (such as those made of brick or cement blocks) that are required by local ordinances. Such upgrades are excluded from reassessments for a period of 15 years. The second excludes from reassessment other earthquake safety modifications to any type of building and has no time limit. Both exclusions apply only until the property is sold.

Proposal

This constitutional amendment deletes both of the existing exclusions and replaces them with a single exclusion for all earthquake safety upgrades. The exclusion would not be time-limited and would last until the property is sold. This amendment has the practical effect of removing the 15-year limit to the exclusion for safety upgrades on unreinforced masonry buildings.

Fiscal Effects

This measure would allow properties with masonry buildings currently receiving an exclusion from reassessment of 15 years for earthquake upgrades to extend this exclusion. It would also allow any properties with future masonry upgrades to receive exclusions with no time limits. This would reduce local property tax revenues to the extent that properties are no longer reassessed at higher values after 15 years. Many county assessors, however, have indicated that they either: (1) do not track the number of years that unreinforced masonry upgrades have received an exclusion or (2) classify these upgrades as maintenance or repair. In addition, many properties sell before the 15-year period is up, which triggers a reassessment of the entire property. For these reasons, the loss to local property taxes as a result of this measure is probably minor.

Proposition 14

Elections: Open Primaries.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact

- **Fiscal Impact**: No significant net change in state and local government costs to administer elections.

Yes/No Statement

A **YES** vote on this measure means: All voters would receive the same primary election ballot for most state and federal offices. Only the two candidates with the most votes—regardless of political party identification—would advance to the general election ballot.

A **NO** vote on this measure means: Voters would continue to receive primary election ballots based on their political party. The candidate with the most votes from each political party would continue to advance to the general election ballot.

Background

Primary and General Elections. California generally holds two statewide elections in even-numbered years to elect candidates to state and federal offices—a primary election (in June) and a general election (in November). These elections (such as those for Governor and Members of Congress) are partisan, which means that most candidates are associated with a political party. For these partisan offices, the results of a primary election determine each party's nominee for the office. The candidate receiving the most votes in a party primary election is that party's nominee for the general election. In the general election, voters choose among all of the parties' nominees, as well as any independent candidates. (Independent candidates—those not associated with a party—do not participate in primary elections.) The winner of the general election then serves a term in that office.

Ballot Materials Under Current Primary System. For every primary election, each county prepares a ballot and related materials for each political party. Those voters affiliated with political parties receive their party's ballot. These party ballots include partisan offices, nonpartisan offices, and propositions. Voters with no party affiliation receive ballots related only to nonpartisan offices and propositions. Parties, however, may allow voters with no party affiliation to receive their party's ballot.

Partisan Statewide Elections in California. Partisan elections for state office include those for the Governor, Lieutenant Governor, Controller, Secretary of State, Treasurer, Insurance Commissioner, Attorney General, the 120 members of the Legislature, and four members of the State Board of Equalization. (The Superintendent of Public Instruction is a nonpartisan state office.) Partisan elections also are held for federal offices including President, Vice President, and Members of Congress.

Proposal

This measure, which amends the State Constitution, changes the election process for most state and federal offices. Its provisions and related legislation would take effect for elections after January 1, 2011.

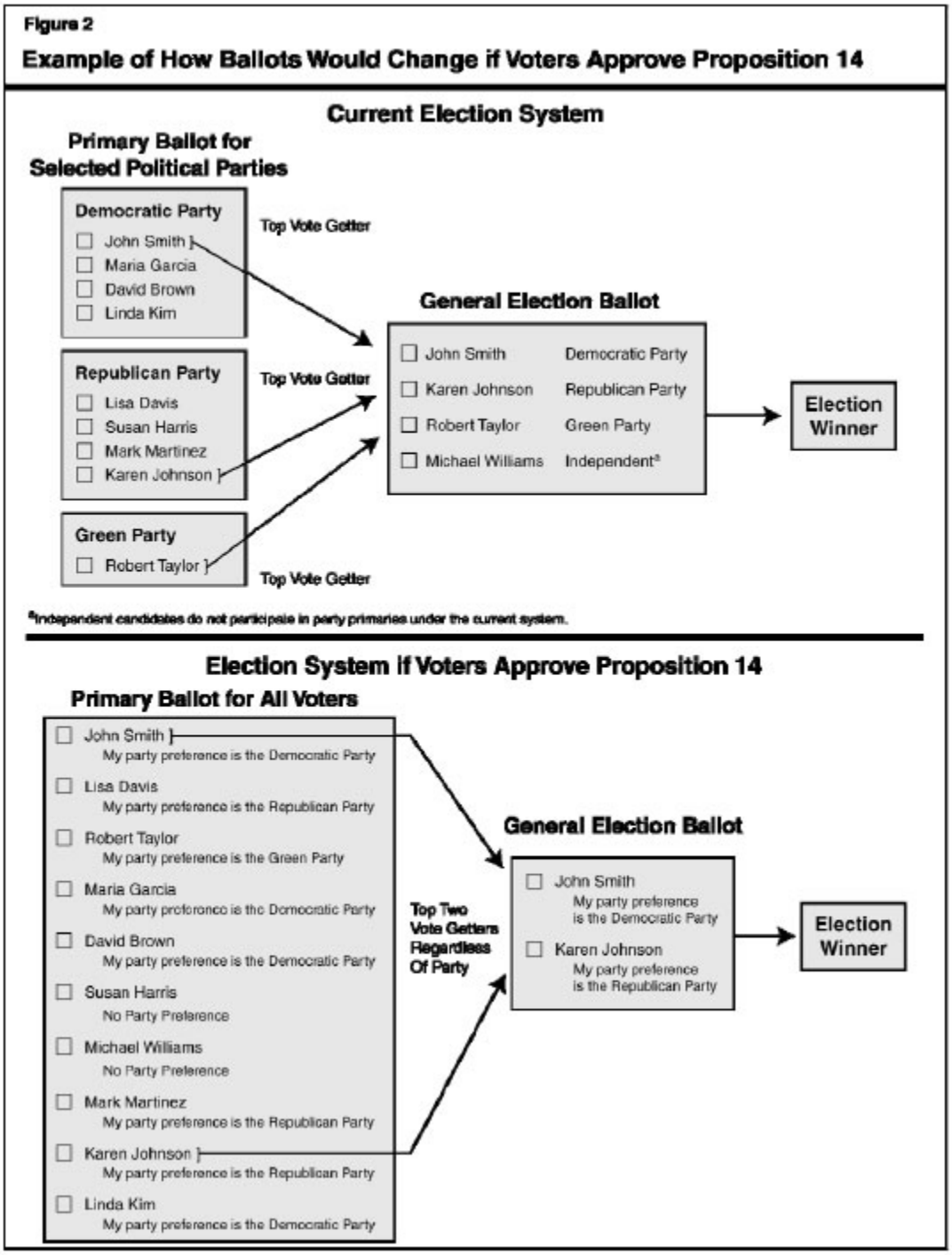
Creates a Top-Two Primary Election. This measure creates a single ballot for primary elections for those congressional and state elective offices shown in Figure 1. Candidates would indicate for the ballot either their political party (the party chosen on their voter registration) or no party preference. All candidates would be listed—including independent candidates, who now would appear on the primary ballot. Each voter would cast his or her vote using this single primary ballot. A voter registered with the Republican Party, for example, would be able to vote in the primary election for a candidate registered as a Democrat, a candidate registered as a Republican, or any other candidate. The two candidates with the highest number of votes in the primary election—regardless of their party preference—would advance to compete in the general election. In fact, the two candidates in the general election could have the same party preference.

Figure 1

Offices Affected by Proposition 14

Statewide Officials
Governor
Lieutenant Governor
Secretary of State
Treasurer
Controller
Insurance Commissioner
Attorney General
Other State Officials
State Senators
State Assembly Members
State Board of Equalization Members
Congressional Officials
United States Senators
Members of the U.S. House of Representatives

Figure 2 illustrates how a ballot for an office might appear if voters approve this measure and shows how this is different from the current system.



Does Not Affect Presidential Elections and Political Party Leadership Positions. Under this measure, there would still be partisan primary elections for presidential candidates and political party offices (including party central committees, party officials, and presidential delegates).

Fiscal Effect

Minor Costs and Savings. This measure would change how elections officials prepare, print, and mail ballot materials. In some cases, these changes could increase these state and county costs. For instance, under this measure, all candidates—regardless of their party preference—would be listed on each primary election ballot. This would make these ballots longer. In other cases, the measure would reduce election costs. For example, by eliminating in some instances the need to prepare different primary ballots for each political party, counties sometimes would realize savings. For general election ballots, the measure would reduce the number of candidates (by only having the two candidates who received the most votes from the primary election on the ballot). This would make these ballots shorter. The direct costs and savings resulting from this measure would be relatively minor and would tend to offset each other. Accordingly, we estimate that the measure's fiscal effects would not be significant for state and local governments.

Indirect Fiscal Effects Impossible to Estimate. In some cases, this measure would result in different individuals being elected to offices than under current law. Different officeholders would make different decisions about state and local government spending and revenues. These indirect fiscal effects of the measure are unknown and impossible to estimate.

Proposition 15

Political Reform Act of 1974: California Fair Elections Act of 2008.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact

- **Fiscal Impact**: Increased revenues (mostly from charges related to lobbyists) totaling over $6 million every four years. These funds would be spent on public financing for campaigns of Secretary of State candidates for the 2014 and 2018 elections.

Yes/No Statement

A **YES** vote on this measure means: The state ban on public funding for political campaigns for elected offices would be lifted. For the 2014 and 2018 elections, candidates for the office of Secretary of State could choose to receive public funds to pay for the costs of campaigns if they met certain requirements. Charges related to lobbyists would be increased to pay for these costs.

A **NO** vote on this measure means: The state ban on public funding for political campaigns for elected offices would continue. Candidates for the office of Secretary of State would continue to pay for their campaigns with private funds subject to current rules. Existing charges related to lobbyists would not change.

Background

Ban on Public Funds to Pay for Campaigns. State law bans the use of public funds for political candidates' campaigns. This ban extends to all elected offices at the state level and most elected offices at the local level. (Using powers that they already have under the State

Constitution, a small number of charter cities have created programs for the public financing of candidates for certain local offices.)

Entities That Oversee Campaign Finance Laws. The state's campaign finance laws are administered by the Fair Political Practices Commission (commission) and the Secretary of State. Under state law, individuals and groups must disclose how much money has been given, received, and spent on political campaigns. This information is available to the public on the Secretary of State's Web site. The commission monitors candidates and donors, and it can assess fines on candidates and donors who violate election laws.

Lobbyist Registration Administered by Secretary of State. The Secretary of State is elected statewide every four years and serves as the state's chief elections official. The Secretary of State also has other duties, such as monitoring activities of lobbyists. Lobbying is the act of communicating directly with public officials in order to influence governmental actions on behalf of the lobbyist's employer or client. Every two years, lobbyists, lobbying firms, and lobbyist employers must register with the Secretary of State. There is currently a $25 fee related to each lobbyist to cover the administrative expenses of registration.

Proposal

As shown in Figure 1, this measure:

- Lifts the ban on public funding for political campaigns.
- Establishes a public funding system for campaigns for the office of Secretary of State.
- Requires lobbyists to pay higher charges for this public campaign funding.

Figure 1

Main Provisions of Proposition 15

✓ **Lifts the Ban on Public Funding for Political Campaigns**

✓ **Establishes Public Funding for Secretary of State Campaigns**

- The Secretary of State—the state's chief elections officer—is elected on the statewide ballot every four years.
- A candidate for Secretary of State meeting certain requirements could receive state funds to pay for the costs of a political campaign.
- The amount of state funds that a candidate would receive would go up if an opponent spent more private funds.
- The measure expires on January 1, 2019—meaning it would apply to Secretary of State campaigns in 2014 and 2018. The Legislature could extend this expiration date by a majority vote.

✓ **Higher Charges Related to Lobbyists**

- Increases charges related to lobbyists to $700 every two years.
- Raises more than $6 million every four years from these increased charges and other sources to implement the measure.

Lifts the Ban on Public Funding for Political Campaigns

This measure eliminates the ban on using public funding for political campaigns for elected office. This would allow the Legislature—and, in some cases, city, county, and other local elected policy makers—to create public financing programs in the future. As described below, this measure creates a public financing program only for the office of Secretary of State.

Establishes Public Funding System for Secretary of State Campaigns

Public Funding Levels and Requirements for Primary Election Campaigns

$5 Qualifying Contributions. To receive public funds for a *primary election* campaign, a candidate for Secretary of State would have to collect a certain number of $5 contributions ("qualifying contributions") from registered voters. Candidates seeking a nomination from a major party (that is, a party that earned at least 10 percent of the votes in the last gubernatorial or Secretary of State election) must collect 7,500 qualifying contributions (a total of $37,500). Candidates in other parties must collect 3,750 qualifying contributions (a total of $18,750). (The

Democratic Party and the Republican Party currently count as major parties under this measure. Other parties now count as "minor parties," but could become major parties based on performance in future elections.) Candidates choosing not to participate would fund campaigns from private sources under existing rules.

Funding for Eligible Candidates in Primary Elections. Figure 2 summarizes funding amounts and other requirements under this measure for Secretary of State campaigns. Participating candidates competing for a major party's nomination would receive a base level of funding of $1 million for the primary election. These candidates would receive additional funds ("matching funds") to equal the money spent by nonparticipating candidates or outside groups trying to influence the election. Participating candidates could receive up to an additional $4 million of these matching funds for the primary. For example, if a nonparticipating candidate were to raise and spend $3 million and another interest group were to spend $2 million in favor of the nonparticipating candidate, the participating candidate would be eligible to receive $5 million—$1 million in base funding, and $4 million in matching funds. Eligible candidates from minor parties would receive $200,000 in base funding. These minor party candidates also could receive the matching funds described above—up to an additional $800,000—if they demonstrate broader support by collecting 15,000 qualifying contributions (a total of $75,000) instead of 3,750.

Figure 2

Proposed Qualifying Requirements and Public Funding Levels for Secretary of State Candidates

		Primary Election Funds		General Election Funds	
	Qualifying $5 Contributions Needed	Base Level	Maximum Level of Matching Funds	Base Level	Maximum Level of Matching Funds
Candidates from major political parties	7,500	$1,000,000	$4,000,000	$1,300,000	$5,200,000
Candidates from minor parties	3,750	200,000	Not eligible	325,000	Not eligible
Candidates from minor parties demonstrating broader support	15,000	200,000	800,000	1,300,000	5,200,000
Independent candidates	15,000	Not applicable[a]	Not applicable[a]	1,300,000	5,200,000

[a] Currently, independent candidates do not participate in primary elections.

Public Funding Levels and Requirements for General Election Campaigns

Winning a Party's Primary Election. In order to receive public financing for a *general election* campaign, a party candidate must have participated in the public financing program in the primary election campaign. Candidates who participate in the public financing program in the primary election must follow program rules if they proceed to the general election.

Independent Candidates. Independent candidates—that is, those not affiliated with any party—would not have participated in a primary election. These candidates must collect 15,000 qualifying contributions to receive the same level of public financing in the general election as major party candidates who participate.

Funding for Eligible Candidates in General Election. The base level of funding for major party candidates and independent or minor party candidates demonstrating broader support is $1.3 million for the general election campaign. Similar to the primary election campaign, eligible candidates would receive additional matching funds to equal the money spent by nonparticipating candidates or outside groups trying to influence the election. Eligible candidates could receive up to an additional $5.2 million of these matching funds. Other eligible candidates from minor parties would only receive $325,000 in base funding.

Other Requirements to Receive Public Funds for Campaigns

To receive public funds for the primary or general election campaign, candidates for Secretary of State would have to follow new rules and requirements described below.

Private Contributions Restricted. To receive public funding, a candidate could not accept private campaign funding, with four main exceptions:

- First, candidates must collect the $5 qualifying contributions. (These qualifying contributions would be deposited into the fund supporting the public financing program, as described below.)
- Second, beginning 18 months prior to a primary election, candidates could collect and spend start-up contributions, or "seed money." (These funds could be spent, for example, to pay costs for collecting the qualifying contributions.) The measure restricts seed money contributions to $100 for each registered voter, and total contributions would be limited to $75,000 per campaign.
- Third, candidates could accept a certain amount of contributions from political parties—5 percent of the base level of public funds in each of the primary election and the general election—that is, up to $50,000 for the primary election campaign, and $65,000 for the general election campaign.
- Fourth, in the event that the program did not have enough funds to give to eligible candidates, candidates could raise from private donors the difference between what they were entitled to receive from the state and what they actually received.

Use of Funds. The public funds could only be used for direct campaign expenses. The measure contains various restrictions to prevent funds from being used for other purposes.

Other Requirements. Publicly funded candidates also would be subject to other requirements. For example, they would have to participate in debates with other candidates before each election and submit campaign expenditure records to the commission. In addition, aside from initial seed money, candidates could not use their personal funds to pay for campaign costs or raise funds for other candidates in other campaigns or for political parties.

Other Provisions

Smaller Awards if There Are Insufficient Funds. If the commission determines that there is not enough money in the program to fund all eligible candidates, the commission would reduce the grants proportionately to all eligible candidates. If there are insufficient funds, participating candidates would be allowed to raise money up to the amount that they were entitled to receive from the public financing program.

Rules for Those Not in the Public Funding Program. Secretary of State candidates could choose not to participate in the public funding program. As soon as a nonparticipating candidate begins to spend more than the base amount of funding for participating candidates, the nonparticipating candidate must report his or her campaign spending to the commission

electronically within 24 hours. Other individuals or groups that spend more than $2,500 in a year to influence the outcome of the Secretary of State's race also must report such spending within 24 hours.

Amounts Adjusted by Inflation. Every four years, the commission would adjust seed money limitations and public funding amounts for the program by the rate of inflation.

Expires January 1, 2019. This measure would end public financing for Secretary of State campaigns on January 1, 2019. Public financing, therefore, would be in place for the 2014 and 2018 elections. The Legislature, however, could extend this expiration date by passing a bill signed by the Governor.

Interaction With Other Measure on the June 2010 Ballot. Proposition 14 on this ballot would change the primary and general election process for state offices, including for the Secretary of State. The nearby box discusses how this measure interacts with Proposition 14.

Proposition 14 and This Measure

If approved, Proposition 14—a constitutional amendment also on this ballot—would change the primary and general election system for state offices, including Secretary of State. Proposition 14 makes changes that could conflict with the proposed statutory provisions of the public campaign funding system under this measure. For example, a potential conflict is this measure's linking of certain funding decisions to participation in a *partisan* primary election, which would no longer exist if Proposition 14 were to pass.

If both measures pass, conflicting provisions of these two measures would have to be reconciled through additional legislation, judicial action, or a future ballot measure.

Requires Lobbyists to Pay Higher Charges

Fair Elections Fund Established. The public funds for Secretary of State campaigns would be paid out of a new Fair Elections Fund, which would be funded by increased charges on lobbyists, qualifying contributions, potential voluntary tax check-off donations (on state personal income tax forms), and other sources.

Increases Charges Related to Lobbyists. This measure requires charges for lobbyists, lobbyist firms, and lobbyist employers of $700 every two years. The measure requires that these charges be adjusted by the rate of inflation in the future. These charges likely would be the main source of money for the public funding program. As of January 2010, over 4,300 individuals and groups were registered as lobbyists, lobbying firms, or lobbyist employers. If similar numbers of registrations were to occur in the future, this source of revenue would raise about $6 million every four-year election cycle.

Administrative Costs. The measure allows up to 10 percent of all money deposited to the Fair Election Fund every four years to pay for administering the public funding program. Such funds would be paid to the Secretary of State's office, the commission, and other departments with new duties under this measure.

Fiscal Effect

New State Revenues. We estimate that this measure would raise more than $6 million every four years. This includes funds from the lobbyist charge, as well as qualifying contributions. This amount would grow with inflation in future years. It is possible that other revenues would be generated from voluntary tax check-off donations and other sources.

New State Costs. The new funds would pay for costs associated with the measure. The costs paid from the new Fair Elections Fund to administer this measure could not exceed 10 percent of moneys deposited into the fund—about $600,000 every four years. The remaining funds would be available for candidates for Secretary of State who choose to receive public funds for their political campaigns. The amount of spending on the public funding of Secretary of State election campaigns would depend on a number of factors and vary from election to election. Among the factors affecting this spending would be:

- The number of candidates accepting public funds.
- The amount of money spent by candidates not receiving public funds (which would be a factor in determining the level of any additional matching funds payments).

Based on the amount of campaign spending for Secretary of State candidates in recent elections, total costs would most likely be between $5 million and $8 million per campaign. If there are not sufficient funds available to provide all candidates with the amounts envisioned under the measure, public funding provided to the candidates would have to be reduced so that overall expenses do not exceed the funds available to the program.

Proposition 16

New Two-Thirds Vote Requirement for Local Public Electricity Providers. Initiative Constitutional Amendment.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact

- **Fiscal Impact**: Unknown net impact on state and local government costs and revenues—unlikely to be significant in the short run—due to the measure's uncertain effects on public electricity providers and on electricity rates.

Yes/No Statement

A **YES** vote on this measure means: Local governments would generally be required to receive two-thirds voter approval before they could start up electricity services or expand electricity service into a new territory.

A **NO** vote on this measure means: Local governments generally could continue to implement proposals involving the start-up or expansion of electricity service either through approval by a majority of voters or actions by governing boards.

Background

Provision of Electricity Service in California

CaliforniaElectricity Providers. Californians generally receive their electricity service from one of three types of providers: investor-owned utilities (IOUs), local publicly owned electric utilities, or electric service providers (ESPs). These provide 68 percent, 24 percent, and 8 percent, respectively, of retail electricity service in the state.

Investor-Owned Utilities. The IOUs are owned by private investors and provide electricity service for profit. The three largest electricity IOUs in the state are Pacific Gas and Electric (PG&E), Southern California Edison, and San Diego Gas and Electric. Each IOU has a unique, defined geographic service area and is required by law to serve customers in that area. The California Public Utilities Commission (CPUC) regulates the rates charged by IOUs and how they provide electricity service to their customers.

Publicly Owned Utilities. Publicly owned electric utilities are public entities that provide electricity service to residents and businesses in their local area. While not regulated by CPUC, publicly owned electric utilities are governed by locally elected boards which set their own terms of service, including the rates charged to their customers. Electricity service is currently provided by local governments through several different governmental structures authorized under state law, including:

- Utility departments of cities, such as the Los Angeles Department of Water and Power.
- Municipal utility districts, such as the Sacramento Municipal Utility District (SMUD).
- Public utility districts, such as the Truckee Donner Public Utility District.
- Irrigation districts, such as the Imperial Irrigation District.

Electric Service Providers. The ESPs provide electricity to customers who have chosen not to receive electricity from the IOU or publicly owned utility that would otherwise serve their geographic area. Under this approach, an electricity customer enters into what is termed a "direct access" contract with an ESP that delivers electricity to the customer through the local utility's transmission and distribution system.

The Creation and Expansion of Publicly Provided Electricity Services

Community Choice Aggregation. In addition to the ESP arrangements discussed above, state law allows a city or a county, or a combination of the two,to arrange to provide electricity within their jurisdiction through a contract with an electricity provider other than the IOU that would otherwise serve that local area.This is referred to as "community choice aggregation." Although only one community choice aggregator (CCA) currently exists to provide electricity in California, several communities are exploring this option. A CCA could get its electricity from an ESP, using the transmission and distribution system of the IOU serving that local area. Electricity customers within that area would automatically get their electricity from the CCA unless they elected to continue to receive service from the IOU.

Proposals to Create and Expand Public Electricity Providers. In recent years, a limited number of local governments in the state have explored the idea of creating new public providers of electricity or expanding publicly owned utilities into new territory currently served by an IOU. For example, the City and County of San Francisco has considered creating a CCA that would

include territory currently served by PG&E. As another example, Yolo County explored having SMUD provide electricity service to territory within the county currently served by PG&E. In some cases, these proposals have been put before the voters for their approval, under provisions of state law discussed below.

Voter Approval Requirements for Publicly Owned Electricity Providers. As noted above, publicly owned utilities can be organized under several different types of government structures. Each type of local government entity that is authorized to provide electricity service, and that is considering either the start-up of electricity service or the expansion of existing service beyond its current service area, is subject to certain state requirements.

Various statutes specify whether voter approval is required for the *start-up* of electricity service by authorized local government entities. Under state law, if a local government intends to *expand* its electricity service into a new territory, that new area must be annexed and, in certain cases, a majority of the voters in the area proposed for annexation must approve the expansion. In such cases, however, no vote of the public is generally required within the existing service territory of the local governmental entity that is proposing the expansion. (In some cases, a local commission requires such a vote as a condition of approving the annexation.) In contrast, local agency action to *create and begin implementation of a CCA* may be undertaken upon a vote of the local agency governing board and does not require local voter approval.

Proposal

The measure places new voter approval requirements on local governments before they can use "public funds"—defined broadly in the measure to include tax revenues, various forms of debt, and ratepayer funds—to start up electricity service, expand electricity service into a new territory, or implement a CCA.

- First, before an authorized local government entity can start up electricity service, it must receive approval by two-thirds of the voters in the area proposed to be served.
- Second, before an existing publicly owned utility can expand its electric delivery service into a new territory, it must receive approval by two-thirds of the voters in the area currently served by the utility and two-thirds of the voters in the new area proposed to be served.
- Third, the measure requires two-thirds voter approval for a local government to implement a CCA.

The measure provides three exemptions to local governments from these voter approval requirements:

- If the use of public funds has been previously approved by the voters both within the existing local jurisdiction and the territory proposed for expansion.
- If the public funds would be used solely to purchase, provide, or supply specified types of electricity from renewable sources, such as wind or solar power.
- If the public funds would be used only to provide electric delivery service for the local government's own use.

Fiscal Effects

Local Administrative Costs for Elections. Because this measure requires voter approval for specified local government actions that can currently be accomplished without such votes, it would result in additional elections costs. These costs would primarily be related to preparing and

mailing election-related materials. In most cases, the balloting could be consolidated with already scheduled elections. As a result, the increased election-related costs due to this measure would probably be minor.

Potential Impact on State and Local Government Costs and Revenues. This measure could affect local government costs and revenues due to its potential effects on the operation of publicly owned utilities and CCAs. It could also affect the finances of state and local government agencies in California because of its potential impact on electricity rates. These effects would largely depend upon future actions of voters and local governments. We discuss these potential effects in more detail below.

First, the new public voter approval requirements for the start-up or expansion of publicly owned utilities or the implementation of CCAs could result in public disapproval of such changes. Also, the existence of these new voter approval requirements could deter some local government agencies from proceeding with such plans. To the extent that this occurred, these local government agencies would be somewhat smaller in size and have fewer customers than would otherwise be the case. As a result, they would have lower total revenues and costs.

Second, the enactment of this measure could also affect the finances of state and local government agencies in California due to its potential impact on electricity rates. As noted above, some local government agencies might not start up or expand a publicly owned utility into a new territory or implement a CCA as a result of the measure's new voter approval requirements. In this event, the rates paid by electricity customers in that and neighboring jurisdictions could be higher or lower than would otherwise have been the case. For example, if this measure prevented the expansion of publicly provided electrical service that depended upon the construction of new energy infrastructure, rates might be held lower than might otherwise occur. On the other hand, if this measure lessened the competitive pressures on private electricity providers by reducing the opportunities for expansion of publicly provided electrical service, the rates charged to electricity customers might eventually be higher than otherwise. These impacts could affect state and local government costs, since many public agencies are themselves large consumers of electricity. To the extent that changes in electricity rates affect business profits, sales, and taxable income, these factors could also affect state and local tax revenues.

In the short run, the net fiscal effect of all of these factors on the finances of state and local government agencies is unlikely to be significant on a statewide basis. This is due to the relatively limited number of local government agencies considering the start-up or expansion of electricity services into new territory. In the long run, the net fiscal effect of the measure is unknown and would depend on future actions of local governments and voters.

Proposition 17

Allows Auto Insurance Companies to Base Their Prices in Part on a Driver's History of Insurance Coverage. Initiative Statute.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact

- **Fiscal Impact**: Probably no significant fiscal effect on state insurance premium tax revenues.

Yes/No Statement

A **YES** vote on this measure means: Insurance companies could offer new customers a discount on their automobile insurance premiums based on the length of time the customer had maintained bodily injury liability coverage with another insurer.

A **NO** vote on this measure means: Insurers could provide discounts to their long-term automobile insurance customers, but would continue to be prohibited from providing such discounts to new customers switching from other insurers.

Background

Automobile insurance is one of the major types of insurance purchased by Californian residents. It accounted for about $19.7 billion (36 percent) of all premiums collected by California insurers in 2008. Among the types of automobile insurance coverage available is bodily injury liability, which provides protection in the event a motorist physically injures someone else.

State Regulation of Automobile Insurance. In 1988, California voters passed Proposition 103, which requires the Insurance Commissioner to review and approve rate changes for certain types of insurance, including automobile insurance, before changes to the rates can take effect. Proposition 103 also requires that rates and premiums for automobile insurance policies be set by applying the following rating factors in decreasing order of importance: (1) the insured's driving safety record, (2) the number of miles they drive each year, and (3) the number of years they have been driving.

The Insurance Commissioner may adopt additional rating factors to determine automobile rates and premiums. Currently, 16 optional rating factors may be used for these purposes. For example, insurance companies may provide discounts to individuals for being long-term customers of theirs. Insurance companies are prohibited, however, from offering this kind of discount to new customers who switch to them from other insurers.

In addition, Proposition 103 contains a provision related to individuals who were previously uninsured. Specifically, Proposition 103 prohibits insurance companies from using the information that an individual did not previously have automobile insurance to: (1) determine whether the individual is eligible for coverage or (2) decide the premiums charged for coverage.

Insurance Premium Tax. Insurance companies doing business in California currently pay an insurance premium tax instead of the state corporate income tax. The tax is based on the amount of insurance premiums earned in the state each year for automobile insurance as well as for other types of insurance coverage. In 2008, insurance companies paid about $247 million in premium tax revenues on automobile policies in California. These revenues are deposited into the state General Fund.

Proposal

This measure amends Proposition 103 to allow an insurance company to offer a “continuous coverage” discount on automobile insurance policies to new customers who switch their coverage from another insurer. If an insurance company chooses to provide such a discount, it must be based on the length of time the customer continuously had bodily injury liability coverage. Customers would generally be eligible for this discount so long as their coverage had not lapsed for more than 90 days in the past five years, except if any lapse was the result of a failure to pay the premium. Also, customers would still be eligible for this kind of discount under the measure if a lapse in coverage was due to military service in another country. Children residing with a parent could qualify for the discount based on their parent’s eligibility.

Fiscal Effects

This measure could result in a change in the total amount of automobile insurance premiums earned by insurance companies in California and, therefore, the amount of premium tax revenues received by the state for the reasons discussed below.

On the one hand, the provision of continuous coverage discounts could reduce premium tax revenues received by the state. This would depend, however, on the extent to which insurers choose to offer such discounts to their customers, and the size of the discounts provided. On the other hand, insurers offering such discounts could make up for some or all of these discounts by charging higher premiums to some of its other customers.

The net impact on state premium tax revenues from this measure would probably not be significant. This is because overall premiums are predominately determined by other factors—such as driver safety, the number of miles driven, and years of driving experience—which are unaffected by the measure.

OFFICE OF THE COUNTY ADMINISTRATOR
CONTRA COSTA COUNTY

TO: Legislation Committee
Supervisor Susan A. Bonilla, Chair
Supervisor Gayle B. Uilkema, Vice Chair

FROM: Lara DeLaney, Legislative Coordinator

DATE: February 24, 2010

SUBJECT: **Agenda Item #7: Federal Issues Update**

RECOMMENDATION

ACCEPT the report on federal legislative matters.

WASHINGTON, D.C. REPORT

On February 1, less than a week after his State of the Union address, President Obama released his $3.8 trillion fiscal year 2011 budget request to Congress. Under increasing pressure to rein in soaring budget deficits, the President's funding proposal provides for a three-year freeze in spending that is not related to national security programs and activities.

The Obama Administration's blueprint provides for outlays of $3.2 trillion, with revenues estimated at nearly $1.9 trillion. Under the chief executive's plan, the deficit for next fiscal year would be $1.3 trillion. Once again, Obama's budget would assume billions of dollars in new revenue from the cap-and-trade climate legislation, which remains stalled in the Senate with growing concerns among key lawmakers.

The budget document clearly reflects President Obama's desire to tackle the sky-rocketing budget shortfalls. The proposed freeze would affect a number of discretionary domestic programs, including transportation and criminal justice. Activities under military, veterans' affairs and homeland security accounts would be exempt from the hold on spending. Additionally, the brakes would not be put on a new jobs bill that is emerging on Capitol Hill or spending from last year's $787 billion stimulus measure. The president's proposal is also unlikely to affect the stalled health care bill.

Under the President's plan, education and certain research programs would also escape the freeze. In fact, these programs would actually realize a significant boost in funding under the President's spending plan.

Cash-strapped states also would be winners under the administration's budget blueprint, with $25 billion targeted to fiscally ailing state governments in the upcoming year.

While the freeze proposal has attracted a lot of attention, it would only affect a small portion of the overall federal budget, the majority of which is devoted to entitlement programs such as Social Security, Medicare and Medicaid. Nevertheless, with the public anxious about the ballooning budget deficit, the White House is eager to demonstrate a commitment to reducing federal spending.

With regard to job creation efforts, the Obama Administration is proposing a business tax credit of up to $5,000 for companies that hire new employees or boost the wages or hours of current workers. New businesses would be eligible for 50 percent of the credit and the maximum benefit would be set at $500,000 per company.

With the unveiling of President Obama's budget package, the action now shifts to Capitol Hill, where lawmakers will put together the necessary tax and spending legislation. Although fiscal year 2011 begins October 1, seldom are all 12 appropriations bills approved before the start of the new fiscal year.

Listed below are just *some* of the major federal programs of interest to counties and President Obama's funding and policy requests for next year. It should be noted, however, that Congress is likely to modify a number of provisions included in President Obama's fiscal year 2011 budget proposal.

Criminal Justice/Law Enforcement

President Obama's budget requests $29.2 billion in discretionary spending authority for the Department of Justice, a 6% increase over this year's funding level.

Among other things, the president's budget asks for $40 million for a new grant program, the Byrne Criminal Justice Innovation Program. It would distribute demonstration grants in selected communities for what the Justice Department describes "innovative, evidence-based approaches to fighting crime and improving public safety."

In a somewhat surprise move, the administration has requested level funding for the State Criminal Alien Assistance Program (SCAAP), which received $330 million in the current fiscal year. The proposal marks a turnaround for the Obama Administration, which recommended the elimination of the SCAAP program in its last budget submission to Congress.

The spending plan also includes $600 million for the Community Oriented Policing Services (COPS) hiring program, doubling the amount appropriated in the current fiscal year. In the area of juvenile justice, the Juvenile Justice and Delinquency Prevention Act would be funded at $62 million.

Homeland Security

First responder aid programs under the Department of Homeland Security would receive a slight decrease in funding next year from the fiscal year 2010 spending levels.

However, several homeland security programs would realize a boost in funding. For example, the State Homeland Security Grant Program (SHSGP) would receive a spending increase, ramping up from $890 million in fiscal year 2010 to over $1 billion next year. It should be noted that $50 million of the $1 billion for SHSGP would be designated for southwest border grants.

The Urban Area Security Initiative Program would also be given a spending hike, increasing to $1.1 billion as opposed to this year's amount of just under $890 million.

Nevertheless, a number of programs would be targeted for spending reductions. FIRE grants would be sliced from $810 million in fiscal year 2010 to $610 million next year, a $200 million dip in funding. The State and Local Training, Measurement and Exercise Program is also slated for a spending cut, with a proposed fiscal year 2011 funding level of over $210 million, compared to this year's appropriation of over $262 million.

One notable program on the chopping block is the Interoperable Emergency Communications Grant Program. However, this program - along with a number of others – would be allowable expenses under the State Homeland Security Grant Program.

Health and Human Services

Under President Obama's budget blueprint, the Temporary Assistance for Needy Families (TANF) state family assistance grant would be funded at current levels. While TANF is due to be reauthorized in 2010, the administration is proposing to extend the current program for one more year.

In addition, the budget proposal would provide $1.7 billion for the Social Services Block Grant (SSBG), the same level as the current fiscal year.

The administration also has proposed:

· Extending the increased federal matching for Medicaid and IV-E foster care enacted under last year's stimulus measure for an additional six months, through June 30, 2011.

· Continuing the TANF-Emergency Funds program through fiscal year 2011 via a new, $2.5 billion program giving additional incentives for counties and states to invest in subsidized jobs.

· Extending the authority of states and counties to use as match child support performance incentive funds through fiscal year 2011.

Transportation

Under President Obama's budget plan for next year, the massive federal-aid highway program would be funded at nearly $41.4 billion, which represents less than a 1% hike in funding over the fiscal year 2010 level.

With regard to transit, the president's $10.8 billion budget request would provide for modest growth – again, just below 1% – for formula-driven and capital grants.

Aviation did not fare quite as well in the president's budget proposal as other modes of transportation. The $3.5 billion request for the Airport Improvement Program represents level funding for next year. Additionally, the program that provides federal subsidies to commercial airports serving rural communities, the Essential Air Service, would receive $182 million, compared to $200 million this year.

Rep. James L. Oberstar (Minn.), Chairman of the House Committee on Transportation and Infrastructure, has urged the Senate to pass an extension of current highway and transit law without making changes to existing funding formulas and distribution procedures.

In December 2009, the House passed H.R. 2847, the Jobs for Main Street Act, which extends the U.S. Department of Transportation's surface transportation programs through September 30, 2010. The Senate has included its surface transportation extension provision in the Hiring Incentives to Restore Employment Act, which is expected to be considered on Monday, February 22, 2010.

Unless Congress extends surface transportation programs by February 28, several DOT agencies and vital transportation and safety programs will shut down. The affected agencies include the Federal Highway Administration and the Federal Motor Carrier Safety Administration.

Oberstar's statement points out three significant differences between the House and Senate transportation extension bills. First, the House bill allows DOT to select projects under the Projects of National and Regional Significance and the National Corridor Infrastructure Improvement programs under a competitive basis, while the Senate version skews the highway formula to certain states. Second, the House bill distributes funds through all of the 13 current state highway formula programs, while the Senate version distributes funds through only six of the 13 programs. Finally, the Senate version cuts more than $3 million in funding from the Motor Carrier Safety Assistance Program.

Community Development and Housing

President Obama's spending plan requests full funding for the Community Development Block Grant (CDBG) program, or $4.4 billion in fiscal year 2011. In addition, the budget proposes a number of improvements to the CDBG program, including redesigning the state and local government consolidated plans and planning process, increasing program accountability and improving performance metrics in grantee reporting.

The administration's proposed funding level for the HOME Investment Partnerships Program is $1.65 billion for next year, or a $175 million reduction from current spending levels. The program provides flexible assistance to local governments and states to increase the supply of affordable housing and expand homeownership for low income persons.

Resources

The Obama Administration elected not to fund the Energy Efficiency and Conservation Block Grant (EECBG) in its fiscal year 2011 budget proposal. The EECBG, which provides dollars to help reduce greenhouse gases and energy consumption, was funded at $3.2 billion in the American Recovery and Reinvestment Act.

In addition, President Obama is requesting $2 billion for the Clean Water State Revolving Fund, down from $2.1 billion in the current year. The Drinking Water State Revolving Fund also would be reduced – from nearly $1.4 billion this year to almost $1.3 billion in fiscal year 2011.

Employment and Training

The Obama administration proposes to increase funds for Workforce Investment Act (WIA) adult employment and training from $861.5 million in fiscal year 2010 to $906.8 million next year.

The fiscal year 2011 budget request also would create a $107 million Workforce Innovation Fund (WIF). The Fund would be comprised of 5% contributions from the WIA Adult Program ($45 million) and the Dislocated Worker Program ($62 million). WIF grants would be awarded competitively to states or localities to demonstrate promising new ideas and to replicate proven practices.

The administration also is requesting $1.475 billion for the WIA Dislocated Worker program, of which $1.2 billion would support formula grants to states and localities, $230 million would fund emergency grants, and $62 million would be reserved for the Workforce Innovation Fund.

Youth Employment: The budget includes $1 billion for youth, which includes an increase of $101 million over fiscal year 2010. That increase is specifically targeted to create a Youth Innovation Fund (YIF).

The fund would allow the Department of Labor to support and evaluate innovative means of providing improved youth services to at-risk youth, particularly out-of-school youth. The YIF would have two components:

· **Summer and Year-Round Employment Opportunities**. These grants would create an estimated 20,000 summer and year-round employment opportunities for youth.

· **Work Experience Plus Program**. These competitive grants to local workforce investment boards, in partnership with youth service providers (including community-based organizations), governors and state workforce boards, would serve exclusively out-of-school youth ages 16 to 24.

Senate Jobs Bills

In a related development, the Senate Democratic leadership announced on February 4 its intention to move a jobs bill measure that focuses on small business tax incentives and extensions of unemployment and COBRA insurance.

For its part, the House passed last December a $154 billion jobs bill (H.R. 2847) that aims to create jobs in an economy with unemployment rate exceeding 10%.

Senate passes jobs bill, 70-28

By Alexander Bolton - 02/24/10 11:36 AM ET , The Hill

The Senate voted 70-28 on Wednesday morning to pass a $15 billion jobs package, giving Senate Democrats their first legislative victory of the year.

Thirteen Republicans joined 55 Democrats and two independents to vote for the bill. Sen. Ben Nelson (Neb.) was the only Democrat to vote against it.

Final passage of the bill was made possible by the support of Sen. Scott Brown (Mass.) and four other Republicans who voted Monday to cut off a GOP filibuster.

Democratic leaders must now negotiate the differences between the Senate bill and a much larger House jobs bill, which costs $154 billion.

The bill included four components: a $13 billion tax credit for employers who hire new workers; greater flexibility of businesses to write off capital expenditures; $2 billion in Build America Bonds to lower municipal borrowing costs; and a $20 billion transfer in highway funding, which did not require a spending offset and counts toward the overall cost of the legislation.

Reid said that he would soon move a travel and tourism promotion bill that would be particularly helpful to tourism-dependent Nevada.

Reid said the travel and tourism bill would create 40,000 new jobs in the service sector and 240,000 other jobs. Republicans blocked the legislation last year.

Reid said he would also advance a Federal Aviation Administration bill that would create “thousands” of jobs.

The jobs bill did not include an extension of expiring unemployment insurance and COBRA health insurance subsidies. A Democratic aide said that leaders plan to pass a short-term extension of unemployment insurance and COBRA but Reid said Wednesday his plan is to eventually pass a year-long extension.

Reid said he planned Senate votes on the travel and tourism bill, the FAA reauthorization, a package of short-term extension of expiring tax credits, increased federal Medicaid assistance to states and a small-business assistance bill.

Reid said the Senate Banking, Finance and Small Business committees are working on the small-business legislation.

Water: Feinstein Planned to Offer Emergency Water Amendment

Senator Dianne Feinstein announced plans to offer an amendment to increase the water available to Central Valley users in response to the drought devastating the region. The amendment would temporarily ease Endangered Species Act restrictions that limit pumping water to the Sacramento-San Joaquin Delta. It would boost water allocations to Central Valley farmers and water districts to between 38%-40% of their normal allocations from the Central Valley Project for the next two years. Last year’s water deliveries were only about 10 percent of allocations, and hundreds of thousands of acres of land have been left idle for lack of water.

The amendment’s language has not been reviewed, but it may include a section rewriting biological opinions that control California water allocations and protect delta smelt and salmon. Aid to salmon fishermen may also be included. Feinstein indicated that she would try and have the amendment added to the jobs bill that the Senate passed on February 24, 2010. However no amendments were accepted.

Feinstein’s plans have drawn criticism from some California representatives, including Rep. George Miller (Martinez), who argue that the amendment would further harm the already decimated salmon population, and cause job losses among salmon fishermen and local economies. In 2002, the Sacramento River's Chinook salmon population was 750,000. By last year, it had fallen to 40,000.

In other Delta water-related activity, the Delta Counties Coalition’s Technical Advisory Committee (TAC) is in the process of considering a list of legislative concepts that

Senator Feinstein's staff has requested. Specifically, her staff has requested a general list of ten or so items that—if implemented with federal assistance—would "raise the profile" of the Delta by promoting regional recreation, tourism, and related opportunities.

The final list will be used by her staff to research an appropriate legislative approach, such as a National Heritage Area designation or (more likely) another designation that is specifically crafted for the Delta, for moving these items forward. That is the limited purpose of the final version of the list that is compiled, which itself will not be directly incorporated into federal legislation.

In addition to these efforts, the DCC will be seeking the support of Senator Boxer and others in the Congressional delegation to become a substantive partner in preparing the various Delta implementation plan(s) to ensure forthcoming policy and management changes do not irreversibly (and negatively) affect water quality, in-Delta water use, agriculture, flood management, socio-economics, and the recreational resources unique to the Delta. The DCC is offering to work in partnership to develop an implementable legislative concept that addresses Delta issues in a comprehensive and sustainable manner.

Health Care Reform

The White House's unwillingness to discuss what steps will follow the February 25, 2010 bipartisan healthcare summit is intensifying GOP worries that the party is walking into a public-relations trap.

Congressional Republicans have been wary from the beginning about how the summit might be portrayed, and their criticism has only increased since the release of President Barack Obama's healthcare plan on February 22.

White House press secretary Robert Gibbs repeatedly refused to discuss any of Obama's post-summit plans if the meeting fails to bring Democrats and Republicans together, even though all evidence indicates there will be no melding of the minds at the Blair House.

Gibbs said the president is hopeful that healthcare reform will be more likely to pass when the summit ends, but declined to offer any specific reasons for optimism. He did say Republicans will be less inclined to attack Obama and his policies when they sit down face to face for six hours.

Obama has invited Republicans to a meeting and is expressing an openness to compromise even as he unveiled a proposal that hewed closely to Democratic legislative proposals on healthcare.

Many on Capitol Hill have said they view Thursday's summit as a last chance for Obama to portray himself as reaching out to Republicans before Democrats pursue

moving a healthcare bill through the Senate via special budget rules requiring only a bare majority vote.

White House officials indicated this week that if Republicans are unwilling to compromise on Thursday, that's exactly what they'll do.

In the run-up to the summit, the Democratic National Committee (DNC) upped the ante provided by the White House earlier in the week by laying the groundwork for a defense of reconciliation.

On Wednesday, the DNC began distributing what looked like talking points that can be used to portray anti-reconciliation Republicans as hypocrites because they voted for such measures in the past.

In turn, Republicans were only too happy to remind reporters that as a senator, Obama spoke out against bypassing filibusters.

"You know, the Founders designed this system, as frustrating as it is, to make sure that there's a broad consensus before the country moves forward," Obama said in 2005.

"And what I worry about would be you essentially have still two chambers — the House and the Senate — but you have simply majoritarian absolute power on either side, and that's just not what the Founders intended," Obama said.

Source:
http://thehill.com/homenews/administration/83499-coy-white-house-attitude-hints-at-health-summit-pr-trap-for-gop

Health Reform Comparison Tools Now Reflect New Administration Proposal

The Kaiser Family Foundation has updated its interactive side-by-side health reform comparison tool to reflect provisions included in President Obama's health reform proposal, unveiled February 22 in advance of the February 25 reform summit with congressional leaders. The online tool allows users to quickly compare the new proposal with the House and Senate bills approved separately in each chamber last year. The Foundation also has updated its interactive calculator to reflect the subsidies proposed in the President's reform proposal. (*See Attachment A*)

SIDE-BY-SIDE COMPARISON OF MAJOR EALT CARE REFORM PROPOSALS

Passing comprehensive health care reform has been a priority of the President and Congress. The U.S. House of Representatives passed the Affordable Health Care for America Act on November 7, 2009 and the U.S. Senate passed the Patient Protection and Affordable Care Act on December 24, 2009. On February 22, 2010, President Obama announced a proposal incorporating ideas from the both the Senate and House-passed bills. The following summaries of the President's proposal and the two bills focus on provisions to expand health care coverage, control health care costs, and improve the health care delivery system.

[Note: The proposal offered by President Obama builds on the Patient Protection and Affordable Care Act passed by the Senate. The summary below includes the Senate bill language and incorporates changes to particular provisions made by the President's proposal. The changes are identified by italicized text. If a provision was not addressed by the President's proposal, we have left the Senate bill language as is. An important caveat is that while the summary of the Senate bill was based on statutory language and is therefore quite precise, the language in the President's proposal is somewhat less specific.]

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
Date plan announced	February 22, 2010	November 18, 2009 (passed by the Senate on December 24, 2009)	October 29, 2009 (passed by the House on November 7, 2009)
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.	Require most individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 150% of the poverty level.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
INDIVIDUAL MANDATE			
Requirement to have coverage	• *Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, if the lowest cost plan option exceeds 8% of an individual's income, and for those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples).*	• Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $750 per year up to a maximum of three times that amount ($2,250) per family or 2% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $495 in 2015, and $750 in 2016 for the flat fee or .5% of taxable income in 2014, 1.0% of taxable income in 2015, and 2% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, if the lowest cost plan option exceeds 8% of an individual's income, and if the individual has income below 100% of the poverty level.	• Require individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), religious objections and financial hardship. (Effective January 1, 2013)
EMPLOYER REQUIREMENTS			
Requirement to offer coverage	• *Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $750 for each full-time employee. For employers that impose a waiting period before employees can enroll in coverage, require payment of $400 for any full-time employee in a 30-60 day waiting period and $600 for any employee in a 60-90 day waiting period. (Effective January 1, 2014)*	• Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $750 per full-time employee. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $750 for each full-time employee. For employers that impose a waiting period before employees can enroll in coverage, require payment of $400 for any full-time employee in a 30-60 day waiting period and $600 for any employee in a 60-90 day waiting period. (Effective January 1, 2014)	• Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. (Effective January 1, 2013) • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $750,000: – Annual payroll less than $500,000: exempt – Annual payroll between $500,000 and $585,000: 2% of payroll; – Annual payroll between $585,000 and $670,000: 4% of payroll;

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
EMPLOYER REQUIREMENTS (continued)			
Requirement to offer coverage (continued)	• Exempt employers with 50 or fewer employees from any of the above penalties. • Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)	• Exempt employers with 50 or fewer employees from any of the above penalties. • Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)	– Annual payroll between $670,000 and $750,000: 6% of payroll. (Effective January 1, 2013)
Other requirements	• Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	• Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	• Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage. (Effective January 1, 2013) • Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer hardship exemption is appropriate. (Report due January 1, 2012)
EXPANSION OF PUBLIC PROGRAMS			
Treatment of Medicaid	• *Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI). All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were*	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI). All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
EXPANSION OF PUBLIC PROGRAMS (continued)			
Treatment of Medicaid (continued)	*not enrolled), states will receive 100% federal funding for 2014 through 2017, 95% federal financing for 2018 and 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive an increase in the federal medical assistance percentage (FMAP) of 8 percentage points for certain health care services. (Effective January 1, 2014)*	not enrolled), states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes at or above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018, except Nebraska, which will continue receiving 100% federal funding for newly eligibles after 2017. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. The increased FMAP for all states, except Nebraska, will be capped at 95%. Certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or a .5 percentage point increase in the FMAP for 2014 through 2016. (Effective January 1, 2014)	Medicare rates by 2012. Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013)
Treatment of CHIP	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.	• Repeal the Children's Health Insurance Program (CHIP) and require enrollees in separate state CHIP programs with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. Children with incomes above 150% of poverty enrolled in Medicaid-expansion CHIP programs will keep Medicaid coverage and states will receive the enhanced CHIP match rate for these children starting in 2014. CHIP enrollees with incomes between 100% and 150% FPL will be transitioned to Medicaid and states will receive the CHIP enhanced match rate for children above current levels and up to

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
EXPANSION OF PUBLIC PROGRAMS (continued)			
Treatment of CHIP (continued)			150% FPL. Require a report to Congress with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011)
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS			
Eligibility	• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.	• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.	• Limit availability of premium and cost-sharing credits to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 12% of the individuals' income.
Premium credits	• *Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:* *$22,000-$29,000: 2 - 3% of income* *$29,000-$33,000: 3 – 4% of income* *$33,000-$44,000: 4 – 6.3% of income* *$44,000-$55,000: 6.3 – 8.1% of income* *$55,000-$66,000: 8.1 – 9.5% of income* *$66,000-$77,000: 9.5% of income* *$77,000-$88,000: 9.5% of income*	• Provide refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL, except that for those with incomes between 100 and 133% FPL, the premium contribution is limited to 2% of income. (These are the provisions as drafted; however, individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) • Increase the premium contributions for those receiving subsidies annually by the rate of premium growth from the preceding year.	• Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 – 5.5% of income 200-250% FPL: 5.5 - 8% of income 250-300% FPL: 8 - 10% of income 300-350% FPL: 10 - 11% of income 350-400% FPL: 11 - 12% of income (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS (continued)			
Premium credits (continued)	• Increase the premium contributions for those receiving subsidies annually by the rate of premium growth from the preceding year. • Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014	• Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.	• Index the affordability premium credits after 2013 to maintain the ratio of government to enrollee shares of the premiums over time.
Cost-sharing subsidies	• *Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:* *$29,000-$33,000: 94%* *$33,000-$44,000: 85%* *$44,000-$55,000: 73%* *$55,000-$66,000: 70%* *$66,000-$77,000: 70%* *$77,000-$88,000: 70%*	• Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. American Indians with income less than 300% FPL will not be subject to any cost-sharing requirements.	• Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% (Effective January 1, 2013) • Lower the out-of-pocket spending limits established in the essential benefits package ($5,000/individual and $10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: 133-150% FPL: $500/individual; $1,000/family 150-200% FPL: $1,000/individual; $2,000/family 200-250% FPL: $2,000/individual; $4,000/family 250-300% FPL: $4,000/individual; $8,000/family 300-350% FPL: $4,500/individual; $9,000/family 350-400% FPL: $5,000/individual; $10,000/family (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS (continued)			
Verification	• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.	• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.	• Require verification of both income and citizenship status in determining eligibility for the federal premium and cost-sharing credits.
Subsidies and abortion coverage	• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest. If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.	• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest. If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.	• Prohibit federal premium subsidies from being used to purchase a health plan in the Exchange that includes coverage for abortions except to save the life of the woman or in cases of rape or incest. Individuals receiving federal subsidies may purchase supplemental coverage for abortions but that coverage must be paid for entirely with private funds.
PREMIUM SUBSIDIES TO EMPLOYERS			
Small business tax credits	• Provide small employers with no more than 25 employees and average annual wages of less than $40,000 that purchase health insurance for employees with a tax credit. – *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. – *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's	• Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. – *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. – *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's	• Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than $80,000 per year. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREMIUM SUBSIDIES TO EMPLOYERS (continued)			
Small business tax credits (continued)	contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.	contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.	
Reinsurance program	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $10 billion over ten years for the reinsurance program. (Effective 90 days after enactment)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM			
Tax changes related to health insurance	• *Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.* • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer	• Impose a tax on individuals without qualifying coverage of the greater of $750 per year up to a maximum of three times that amount or 2% of household income to be phased-in beginning in 2014. • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer	• Impose a tax on individuals without acceptable health care coverage of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. (Effective January 1, 2013) • Permit only prescribed drugs to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account that are not used for qualified

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)			
Tax changes related to health insurance (continued)	MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2011) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • *Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 2.9% assessment on unearned income for higher-income taxpayers. Funds from the additional tax on earned income will be credited to the Part A Trust Fund and funds from the new tax on unearned income will be credited to the Part B (Supplementary Medical Insurance) Trust Fund. (Effective January 1, 2013)* • *Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,350 for individual coverage and $3,000 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise unexpectedly quickly prior to implementation*	MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2011) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly; funds deposited into the Medicare Part A Trust Fund. (Effective January 1, 2013) • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $8,500 for individual coverage and $23,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,350 for individual coverage and $3,000 for family coverage. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this increase is subsequently reduced by half each year until it is phased out in 2015. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the	medical expenses to 20% (from 10%) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending arrangement for medical expenses to $2,500 per year. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)			
Tax changes related to health insurance (continued)	*of the tax in 2018. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this increase is subsequently reduced by half each year until it is phased out in 2015. Adjustments will also be made for firms with higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018)*	employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. (Effective January 1, 2013)	
Tax changes related to financing health reform	• *Impose new fees and taxes on segments of the health care sector:* – *$2.3 billion annual fee on the pharmaceutical manufacturing sector, increasing by $10 billion over 10 years (effective 2011);* – *Fees on the health insurance sector totaling $67 billion over 10 years. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by employers (effective 2014);* – *Excise tax on the medical device manufacturing sector to raise $20 billion over 10 years (effective 2013).*	• Impose new fees on segments of the health care sector: – $2.3 billion annual fee on the pharmaceutical manufacturing sector (effective for sales after December 31, 2008); – $2 billion annual fee on the medical device manufacturing sector increasing to $3 billion after 2017 (effective for sales after December 31, 2009); and – Annual fees on the health insurance sector of $2 billion in 2011, $4 billion in 2012, $7 billion in 2013, $9 billion in 2014-2016, and $10 billion in 2017 and thereafter (effective for net premiums written after December 31, 2009).	• Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000. (Effective January 1, 2011) • Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)			
Tax changes related to financing health reform (continued)	• Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective January 1, 2010)	• Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective January 1, 2010)	
HEALTH INSURANCE EXCHANGES			
Creation and structure of health insurance exchanges	• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)	• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)	• Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.
Eligibility to purchase in the exchanges	• Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.	• Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.	• Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage.
Public plan option	• No similar provision to create a public plan option. • Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the	• No similar provision to create a public plan option. • Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the	• Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Prohibit the public plan from providing coverage for abortions beyond those

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
HEALTH INSURANCE EXCHANGES (continued)			
Public plan option (continued)	qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.	qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.	permitted by federal law (to save the life of the woman and in cases of rape and incest). Finance the costs of the public plan through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services.
Consumer Operated and Oriented Plan (CO-OP)	• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)	• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)	• Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. (Effective six months following enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
HEALTH INSURANCE EXCHANGES (continued)			
Benefit tiers	• Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Catastrophic plan* available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family); – 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.	• Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Catastrophic plan* available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family); – 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.	• Create four benefit categories of plans to be offered through the Exchange: – *Basic plan* includes essential benefits package and covers 70% of the benefit costs of the plan; – *Enhanced plan* includes essential benefits package, reduced cost-sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – *Premium plan* includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; – *Premium plus plan* is a premium plan that provides additional benefits, such as oral health and vision care.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
HEALTH INSURANCE EXCHANGES (continued)			
Insurance market and rating rules	• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)	• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)	• Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment. • Require risk adjustment of participating Exchange plans.
Qualifications of participating health plans	• Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.	• Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.	• Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers and Indian health care providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. Require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician's order for life-sustaining treatment.
Requirements of the exchanges	• Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.	• Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.	• Provide information to consumers and small employers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website, and provide information on open enrollment periods and how to enroll.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
HEALTH INSURANCE EXCHANGES (continued)			
Basic Health Plan	• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.	• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.	No similar provision.
Abortion coverage	• Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in	• Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the	• Require private insurers that opt to provide a plan in the Exchange that covers abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest) to also offer an identical plan that does not cover abortions for which federal funding is prohibited. Private plans participating in the Exchange may offer supplemental coverage for abortions. Federal premium subsidies may not be used to purchase a plan or supplemental coverage that covers abortions beyond those permitted by federal law. Prohibit plans participating in the Exchange from discriminating against any provider because of an unwillingness to provide abortions.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
HEALTH INSURANCE EXCHANGES (continued)			
Abortion coverage (continued)	the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.	Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.	
Effective dates	• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.	• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.	• Unless otherwise noted, provisions relating to the Health Insurance Exchange are effective January 1, 2013.
BENEFIT DESIGN			
Essential benefits package	• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) • Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)	• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) • Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)	• Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective January 1, 2013) • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective January 1, 2013) • Require a report on including oral health benefits in the essential benefits package. (Report due one year following enactment)
Abortion coverage	• Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)	• Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)	• Prohibit abortion coverage from being required as part of the essential benefits package. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE			
Temporary high-risk pool	• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)	• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)	• Establish a temporary national high-risk pool to provide health coverage to individuals (and spouses and dependents) with pre-existing medical conditions. Individuals who have been denied coverage, offered unaffordable coverage, have an eligible medical condition or who have been uninsured for at least six months will be eligible to enroll in the national high-risk pool. Premiums for the high-risk pool will be set at not higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age; annual deductibles will be limited to $1,500 for an individual; and maximum cost-sharing will be limited to $5,000 for individuals. (Effective January 1, 2010 and until the Health Insurance Exchange is established)
Medical loss ratio and premium rate reviews	• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) • *Establish a process for reviewing increases in health plan premiums and require that if a rate increase is deemed unreasonable or unjustifiable, health insurers must lower premiums, provide rebates, or take other actions to make premiums affordable. Establish a new Health Insurance Rate Authority to provide needed oversight at the federal level, help states determine how rate review will be enforced, and monitor insurance market behavior. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)*	• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) • Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)	• Limit health plans' medical loss ratio to not less than 85% to be enforced through a rebate back to consumers and prohibit plans from imposing aggregate dollar lifetime limits on coverage. (Effective January 1, 2010) Prohibit insurers from rescinding coverage except in cases of fraud. (Effective July 1, 2010) • Require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE (continued)			
Administrative simplification	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective upon enactment)
Dependent coverage	• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)	• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)	• Provide dependent coverage for children up to age 27 for all individual and group policies. (Effective January 1, 2010)
Insurance market rules	• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • *Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to age 26, prohibit rescissions of coverage, and strengthen appeals processes. Beginning in 2014, prohibit grandfathered plans from imposing annual or lifetime limits on coverage, including pre-existing condition exclusions, or discriminating in favor of highly compensated individuals. Beginning in 2018, require grandfathered plans to cover proven preventive services with no cost-sharing.* • Require all new policies (except stand-alone dental, vision, and long-term care insurance	• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above	• Prohibit individual and group health plans from placing aggregate dollar lifetime limits on coverage. Prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) • Limit pre-existing condition exclusions for group policies prior to implementation of the insurance market reforms by shortening the period plans can look back for pre-existing conditions from six months to 30 days and shortening the period plans can exclude coverage of certain benefits from 12 months to three months. (Effective January 1, 2010) • Prohibit reductions to retiree benefits unless reductions also apply to current employees. (Effective upon enactment) • Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. (Effective January 1, 2013) • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange. (See creation of insurance pooling mechanisms.) (Effective January 1, 2013) • Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE (continued)			
Insurance market rules (continued)	plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • *Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014)* • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)	these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • Penalize employers that require a waiting period for coverage of more than 60 days by requiring a payment of $600 for each full-time employee subject to the waiting period. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)	obtain acceptable coverage. (Effective upon enactment)
Consumer protections	• Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)	• Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)	• Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms and accurate and timely disclosure of plan information. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE (continued)			
Health care choice compacts and national plans	• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)	• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)	• Permit states to form Health Care Choice Compacts to facilitate the purchase of individual insurance across state lines. (Effective January 1, 2015)
Health insurance administration	• *Allocate $1 billion to implement the health insurance reform policies.*	No similar provision.	• Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.
Anti-trust exemption for health insurers	No similar provision.	No similar provision.	• Remove the anti-trust exemption for health insurers and medical malpractice insurers. (Effective upon enactment)
STATE ROLE			
State role	• Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand	• Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand	• Implement the Medicaid eligibility expansions and the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. Maintain Medicaid eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid matching payments and extend the maintenance of eligibility requirement for children in Medicaid-expansion CHIP programs with incomes

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
STATE ROLE (continued)			
State role	enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)	enrollment beginning in April 2010), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)	above 150% FPL. Require CHIP maintenance of eligibility to June 16, 2009 through December 31, 2013. • Establish a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • May determine eligibility for affordability credits through the Health Insurance Exchange.
COST CONTAINMENT			
Administrative simplification	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted	• Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. (Effective upon enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)			
Administrative simplification (continued)	July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)	July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)	
Medicare	• *Restructure payments to Medicare Advantage (MA) plans by creating a set of benchmark payments for MA plans at different percentages of Medicare fee-for-service (FFS) rates, by area, phased in over an unspecified period, taking into account relative payments to fee-for-service costs in an area. Provide bonuses for quality and enrollee satisfaction, and lower plan rebates for "low-quality" plans. Achieve additional savings by further adjusting payments to plans for coding practices related to the health status of enrollees.* • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary) • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate.	• Restructure payments to Medicare Advantage (MA) plans (except PACE plans) to base payments on the average of plan bids in each market, phased in over four years beginning in 2012, with bonus payments for quality, performance improvement, and care coordination beginning in 2014. Change plan service areas beginning in 2012. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (with requirement that these plans participate in a new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding, authorizing up to $5 billion for the period between 2012 and 2019 for rebates associated with extra benefits. • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary) • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011)	• Restructure payments to Medicare Advantage plans (except for PACE plans), phasing down to equal 100% of fee-for-services payments by 2013, with bonus payments for higher-quality and improved-quality plans in qualifying counties. (Effective FY 2011). • Reduce market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. (Effective dates vary) • Reduce Medicare Disproportionate Share Hospital (DSH) payments to account for reductions in the national rate of uninsurance as a result of the Act, based on recommendation by the Secretary. (Medicare DSH reductions effective 2017) • Conduct Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. (Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012) • Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)			
Medicare (continued)	Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2015) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of	• Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2015) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care	that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) • Reduce Medicare payments for potentially preventable hospital readmissions. (Effective October 1, 2011) • Require the Institute of Medicine to conduct studies on geographic variation in Medicare spending and in health care spending across all providers and recommend strategies for addressing these variations by promoting high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation. (Report due one year following enactment; final implementation plan due 240 days following receipt of report; regulations issued by May 31, 2012) • Require the Secretary to negotiate drug prices directly with pharmaceutical manufacturers for Medicare Part D plans. (Effective upon enactment; applies to drug prices beginning on January 1, 2011)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)			
Medicare (continued)	their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)	organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)	
Medicaid	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010)	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010)	• Increase the Medicaid drug rebate percentage to 23.1% and extend the prescription drug rebate to Medicaid managed care plans. (Effective January 1, 2010) • Reduce Medicaid DSH allotments by a total of $10 billion ($1.5 billion in 2017; $2.5 billion in 2018; and $6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)			
Medicaid (continued)	• Reduce a state's Medicaid DSH allotment by 50% or 25% for low DSH states (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)	• Reduce a state's Medicaid DSH allotment by 50% or 25% for low DSH states (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)	rates and those that do not target DSH payments. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective January 1, 2010) • Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment) • Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention (effective one year following enactment) and refuse Medicaid payments for certain health care-associated conditions. (Effective January 1, 2010)
Prescription drugs	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)	• Enhance competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs. (Effective upon enactment)
Waste, fraud, and abuse	• *Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. Establish a comprehensive Medicare and Medicaid sanctions database; require registration and background checks on Medicare billing agencies; expand access to the Healthcare Integrity and Protection data bank; limit debt discharges for fraudulent*	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. (Effective dates vary)	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. (Effective dates vary)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)			
Waste, fraud, and abuse (continued)	*health care providers and use tax data to identify fraudulent providers; strengthen standards for community mental health centers; and require states to monitor and remediate high-risk Medicaid prescription drug billing activity. (Effective dates vary)*		
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE			
Comparative effectiveness research	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010)
Medical malpractice	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)	• Provide incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance. (Effective upon enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Medicare	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)	• Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following submission of report)
Dual eligibles	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between	• Require the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. (Report of activities due within one year of enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Dual eligibles (continued)	benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)	the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)	
Medicaid	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)	• Expand the role of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all individuals and require MACPAC to report to Congress on nursing facility payment policies by January 1, 2012 and pediatric sub-specialist payment policies by January 1, 2011. Require reports on the implementation of health reform that relate to Medicaid and CHIP, including the effect of implementation on access. ($11.8 million in additional funds appropriated beginning January 1, 2010)
Primary care	No similar provision.	No similar provision.	• Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers to 100% of Medicare rates (phased-in beginning in 2010 through 2012) and providing Medicare bonus payments to

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Primary care (continued)			primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011.
National quality strategy	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)	• Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011)
Financial disclosure	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Effective March 2011)
Disparities	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)	• Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS			
National strategy	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)	• Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011)
Coverage of preventive services	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective July 1, 2010) Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS (continued)			
Coverage of preventive services (continued)	within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	
Wellness programs	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit	• Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (Effective July 1, 2010)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS (continued)			
Wellness programs (continued)	participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)	participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)	
Nutritional information	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
LONG-TERM CARE			
CLASS Act	• *Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. Make technical changes to the CLASS program. (Effective January 1, 2011)*	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010)
Medicaid	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to	No similar provision.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
LONG-TERM CARE (continued)			
Medicaid (continued)	300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2010) • Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)	300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2010) • Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)	No similar provision.
Demonstration programs	No similar provision.	No similar provision.	• Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. (Demonstration program established within 180 days of issuance of recommendations)
Skilled nursing facility requirements	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)	• Improve transparency of information about skilled nursing facilities and nursing facilities. (Disclosure reporting regulations issued within two years of enactment; reporting of information required 90 days after regulations are issued)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS			
Medicare	• Make improvements to the Medicare program: – *Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and eventually eliminate the Medicare Part D coverage gap by phasing down the coinsurance to the standard 25% by 2020 (Effective January 1, 2010);* – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couple (Effective July 1, 2010); – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)	• Make improvements to the Medicare program: – Increase the Part D initial coverage limit by $500 for 2010 to reduce the size of the coverage gap (Effective January 1, 2010); – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couple (Effective July 1, 2010); – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)	• Make improvements to the Medicare program: – Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 in 2010 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap. (Effective January 1, 2010). – Increase the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to $17,000 per individual and $34,000 per couple. (Effective 2012) – Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years. (Effective January 1, 2013)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS (continued)			
Workforce	• Improve workforce training and development: – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish	• Improve workforce training and development: – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish	• Improve workforce training and development: – Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. (Funds appropriated beginning FY 2011) – Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. (Effective July 1, 2011) – Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. (Funds appropriated beginning FY 2011) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. – Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. (Funds appropriated beginning FY 2011)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS (continued)			
Workforce (continued)	a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) • Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011) • Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)	a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) • Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011) • Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)	
Community health centers and school-based health centers	• *Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).*	• Improve access to care by increasing funding for community health centers and the National Health Service Corps (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2011) and nurse-managed health clinics (effective fiscal year 2010).	• Improve access to care by increasing funding by $12 billion over five years for community health centers; establish new programs to support school-based health centers (effective July 1, 2010) and nurse-managed health centers (effective 2011), and set criteria for the certification of federally qualified behavioral health centers.
Trauma care	No similar provision.	No similar provision.	• Establish a new trauma center program to strengthen emergency department and trauma center capacity and to establish new trauma centers in urban areas with substantial trauma related to violent crimes. Create an Emergency Care Coordination Center within HHS; develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated for five years beginning in FY 2011)

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS (continued)			
Public health and disaster preparedness	• Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)	• Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)	• Provide grants to each state health department to address core public health infrastructure needs. (Funds appropriated for five years beginning FY 2011) • Establish the Public Health Investment Fund for financing designated public health provisions. (Initial appropriation in FY 2011)
Requirements for non-profit hospitals	• Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)	• Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)	No similar provision.
American Indians	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)
FINANCING			
Financing	*CBO has not provided an estimate of the costs of the proposed changes to the Patient Protection and Affordable Care Act included in the President's proposal. According to the White House, the proposal would reduce the deficit by $100 billion over the next ten years.*	The Congressional Budget Office estimates the cost of the coverage components of the Patient Protection and Affordable Care Act to be $871 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $438 billion over ten years and the primary sources of these savings include reductions in updates in Medicare payment rates for hospitals, home health agencies and other providers (other than physicians), reductions in payments to issued by a new Independent Payment Advisory Board, and increases in Medicare Parts B and D premiums for higher	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $891 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $396 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments.

	President Obama	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
FINANCING (continued)			
Financing (continued)		income Medicare beneficiaries, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from an excise tax on high-cost insurance, which CBO estimates will raise $149 billion over ten years. Additional revenue provisions include fees on certain manufacturers and insurers, an increase in hospital insurance contributions for high high-income taxpayers, and other provisions that will generate $264 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $132 billion over ten years.	(See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above $1,000,000 and individuals with incomes above $500,000, which is projected to raise $460 billion in revenue. Additional revenue provisions will generate $110 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $138 billion over ten years.
Sources of information	http://www.whitehouse.gov/health-care-meeting/proposal/	http://www.democrats.senate.gov/	http://democraticleader.house.gov/members/health_care.cfm