HEALTH ACCESS

PRELIMINARY ANALYSIS *January 17, 2007*

Gov. Schwarzenegger's Health Care Proposal

Gov. Arnold Schwarzenegger on Monday unveiled a detailed and sweeping proposal to cover all uninsured in California, emphasizing "shared responsibility" – between individuals, employers, providers, insurers, and government.

The focus of the Governor's materials are threefold:

1) Prevention, health promotion, and wellness;
2) Coverage for all Californians; and
3) Affordability and cost containment.

In particular, the Governor's proposal focuses on removing the "hidden tax" of caring for the uninsured from the cost of private health coverage, by "creating an efficient, competitive market dynamic." The governor's team estimates that his proposal could cut the "hidden tax" that average families pay ($1,186) by half.

This plan includes an individual mandate to purchase private coverage, with some public program expansions and subsidies for some low-income families, as well as rules on and contributions by employers, insurers, and providers.

According to the materials, the structure is meant to ask something of each stakeholder group, but to benefit each group as well, including insurers, providers, employers, government, and individuals. So the providers get increased Medi-Cal rates, and millions of more insured—and thus paying—patients. But the proposal then asks for a dividend back, placing a fee on providers of 2% or 4%. This financing is used to draw down federal matching funds, just one example of the proposal's interlocking parts.

CONSUMER PERSPECTIVE

Some of these provisions are proposals that consumer groups have long supported as stand-alone legislation, especially around setting rules on insurers and employers, and the expansion of public insurance programs for children and adults. But there lies significant concern about the placing of risk to the individual consumers and families, through the individual mandate as well as other components of the proposal.

This is the beginning of the legislative year, and the Governor's proposal will need to be negotiated with members of the legislature, many of whom have their own proposals. The attention to health reform, and the Governor's new consensus with legislative leaders about the need for expanded public programs, and standards for employers and insurers, suggests that there is reason for optimism.

Consumer advocates will need to be vigorous in opposing elements that are steps backward, pushing on provisions are steps forward but that don't go far enough, and keeping the urgency and visibility of this issue in the forefront, in the goal of winning reform that helps health care consumers.

STEPS FORWARD: NEW RULES ON THE HEALTH SYSTEM

Among the concepts and elements that have been supported by consumer and community advocates in the past:

- **Universality:** The plan sets the goal to ensure that all Californians have access to coverage and care, and the Governor has stated that this is his top priority this year.

- **Expansion of public programs:** The proposal does expand Medi-Cal and Healthy Families, for children and adults.
    - *POOR ADULTS:* Adults without children at home living at or below the poverty level ($9800 for an individual; $13,200 for a couple) would now qualify for Medi-Cal--an expansion of 630,000 adults.
    - *CHILDREN'S COVERAGE:* Both Medi-Cal and Healthy Families would be expanded to cover all children up to 300% of the federal poverty level ($49,800 for a family of three; $60,000 for a family of four), regardless of immigration status.
    - *SUBSIDIZED POOL:* To comply with the individual mandate, subsidies to a state purchasing pool will be provided to low-income families (101-250%) to help purchase health coverage. While such coverage would be a comprehensive benefit package (Knox/Keene plus prescription drugs with a $500 hospital deductible), there would not have the protections in public programs, including vision or dental coverage, or cost-sharing limits. The premiums charged to these low-income individuals and families will be:

% Gross income	% FPL	Income Range (Single)	Income Range (Family of 4)
3%	100-150%	$9,800-$14,700	$20,000-$30,000
4%	151-200%	$14,700-$19,600	$30,000-$40,000
6%	201-250%	$19,600-$24,500	$40,000-$50,000

      Many advocates for low-income consumers would prefer public program coverage, and at least much lower financial burdens. In addition, there is significant concern about the need for assistance for those over 250% of the FPL ($25,000 for an individual, $50,000 for a family of four.)
    - *MEDI-CAL RATE INCREASE:* The plan also proposes increasing Medi-Cal rates for providers, hospitals, and health plans, which is likely to have a positive impact for those on Medi-Cal to have access to care by these providers. Some of these increases would be tied to "pay-for-performance" measures.

- **Rules for Insurers:** The plan would make major changes to the individual insurance market, many long advocated for by consumer advocates, as a first step toward greater oversight over the insurance industry.
    - The plan would set the principle ("guaranteed issue") that nobody should be denied coverage because of their health status--so-called "pre-existing conditions."
    - A related provision ("community rating") would prevent insurers from setting different rates based on health status or anything other than age or geography.
    - Finally, the plan would require insurers to dedicate 85 cents of every premium dollar to health care. While HMOs are already required to meet that threshold (known as a "medical loss ratio"), PPOs now spend as little as 50 cents per premium dollar on actual health care.
    - There will be a mandated minimum in the open insurance market limiting deductibles to $5,000, and out-of-pocket costs to $7,500 for an individual and $10,000 for a family. While there is no out-of-pocket cost maximum now, such costs still would place a insured person in medical debt and risk for bankruptcy.

- **Employer Contribution:** The plan does require employers with 10 or more employees to contribute to the health care system, to either provide some coverage or pay 4% of the payroll. While this employer "in lieu" fee is projected to raise $1 billion as part of the plan, it does not set a standard for on-the-job health benefits. According to the March 2005 Current Population Survey, employers now spend an average of 7.2% of their total payroll on health care and slightly over 10% of the payroll of those for whom they provide coverage. (Wal-Mart, for example, which now spends 7% of payroll, would not have to increase coverage or spend any more.) Also, since the fee is assessed as a broad aggregate of health spending, and not on a per-worker basis, an employer that provided very good benefits to management or long-time workers but little or nothing to new or part-time workers could still meet this low threshold. Unless the requirement were signficantly more and differently structured, this would not provide greater security to the 19 million Californians who now get coverage through employers.

STEPS BACK: NEW RISKS FOR CONSUMERS

While the theme of the proposal is "shared responsibility," the focus of the responsibility is on individual consumers. Based on what was proposed on Monday, patients and workers bear a disproportionate amount of risk. Consumer advocates will be working to remove or mitigate these aspects of the proposal.

*** The individual mandate:** The core of the proposal--the individual mandate--is something that has been opposed by consumer groups as unwarranted, unworkable, and unwise. Unlike the many health plans supported by consumer and community groups in the last several years, which have people share--and in many cases required to share--the cost and burden of health care (at the worksite, through public programs, or through a universal system), an individual mandate places the financial and legal risk and burden of coverage on individual patients and families.

Some of the other provisions attempt to mitigate these problems, but they don't provide the protections regarding the ability to pay, or provide a defined benefit of value. Most importantly, there is concern that the individual mandate would actually undermine the group coverage that many have now, especially through employers. Health Access California has a paper regarding individual mandates at:
http://www.health-access.org/expanding/ind_mandates.htm

Under the plan, everyone must prove they have health care insurance, with some limited assistance to low-income families, but beyond that with no consideration for ability to pay. Some specific issues:

- *Unfairness:* Unlike the employer or provider contributions to this plan, which are capped and based on ability to pay, the individual burden to buy coverage is unlimited. Even the only other state to ever adopt an individual mandate, Massachusetts, included a broad exemption if coverage was unavailable or unaffordable.
- *Undermining existing coverage:* Such a dynamic--with a low and capped employer contribution, but an ongoing and unlimited individual requirement--could lead employers to continue to shift more costs into workers.
- *Enforcement:* The plan envisions using providers to help enroll and expect proof of insurance. For those that are inevitably left out, it may discourage them to get needed care. Other enforcement mechanisms include the payroll through the Employment Development Department, and then with submitting proof of coverage on tax returns. Individuals would have to prove that they have health coverage through their tax returns. If their tax records show they have not purchased coverage for the year, there would be mechanisms to either enroll qualified individuals in the subsidized pool, or auto-assign people with a private plan for which they would have to pay.
- *Impact for low-income:* Those low-income Californians that qualify for public programs would certainly be better off insured, and the mandate would simply serve as an enrollment function. But those in the state purchasing pool (adults from 100-250% of poverty), will find themselves having to pay a major amount (3-6%) of their incomes, which many consider to be unaffordable for those living on such tight budgets.

- *Biggest impact:* The most impacted are those with no subsidies, because of their income or other disqualifying criteria. They will have two choices: either they will attempt to get a good comprehensive benefit at an extremely high cost, relative to their income, or they will attempt to mere the bare minimum of the mandate by spending good money on a product of dubious value. For instance, individuals above 250% of poverty (more than $24,500 for an individual, $41,500 for a family of three, or $50,000 for a family of four) are concerned. Yet, they'd be forced to go into the market – on their own – and purchase healthcare that could amount to nearly one-fifth of their annual income. Or to just meet the requirement they have to buy a high-deductible plan that may well be a little cheaper, but still a lot of money and of little value.

* **Concern about the safety net:** The proposal takes half of the money ($2 billion) that currently goes to public hospitals to pay for their care of uninsured patients. Even with more insured people, this could provide huge problems for key public hospital that we all rely on, yet which have been chronically underfunded. For example: Kern and Monterey Counties , which have been teetering on closure; San Francisco, which relies on San Francisco General and network of clinics to administer its not-yet-implemented Health Access Program for universal access, and in Los Angeles King-Drew hospital, which has had its own set of issues, and LA County/USC Medical Center. The closure of any public hospital would be hugely damaging for all Californians, who rely on trauma centers and emergency rooms in their community to provide care when they need it.

* **A review of of health plan benefits**, provider, and procedural mandates could be a threat to key consumer protections, such as the HMO Patients' Bill of Rights. The plan also considers "the elimination of unnecessary health plan reporting requirements," which may be a concern for consumer advocates.

* **Some low-income patients may lose some protections:** While the proposal does significantly expand Med-Cal coverage, it also shifts Medi-Cal recipients (excluding pregnant women) over the poverty level ($9800 for individual, $20,000 for a family of four) to other public programs, including Healthy Families and that have some fewer benefits and protections. This would impact 680,000 children and 215,000 adults.

* **The proposal also encourages underinsurance** and high-deductible plans, by offering a state tax break for Health Savings Accounts (which are only available for high-deductible plans). While employers aren't paying enough, individuals would pay too much. The governor's plan would establish a "minimum benefit package'' requiring people who must buy insurance on their own to have at least a $5,000 deductible plan. Health Savings Account holders would get a tax credit, taking money away from state coffers to provide access to health care.

OTHER PROVISIONS

Contrary to predictions that the plan would be small or vague, the proposal also is broad and detailed (although there are some questions that are not answerable, given that it is not in legislative language.) There are other major components, including:

On prevention and wellness:
* Structuring benefits and providing incentives to promote prevention and wellness, including a "Healthy Actions" requirement on public programs and to be offered in the private market to provide rewards and incentives.
* Major efforts and campaigns to focus on diabetes, obesity, and tobacco use.
* An effort to prevent medical errors, including requiring electronic prescribing of medication by 2010 and require new reporting of health safety measures at health facilities.

On affordability and cost-containment:
* Requiring employers to provide (but not fund) a Section 125 plan so their workers can use pre-tax dollars to pay for premiums of insurance in the individual market.
* An effort to reduce "regulatory barriers," including allowing the growth of retail-based medical clinics by making scope-of-practice changes for nurse practitioners and physician assistants.
* A new "'worst first' system of hospital conformity to seismic safety requirements.
* A new "24-Hour Coverage" pilot program for CalPERS (with opt-in for private sector) to coordinate worker's compensation with traditional group health coverage.
* A major Health Information Technology effort, which includes the adoption of standardized Personal Health Records, and a major focus on tele-health and tele-medicine.

THE BEGINNING OF A RENEWED DEBATE

What the governor proposed Monday is clearly only the beginning. In his announcement, he invited several people from a range of sources, to comment and critique his proposal. The range of views was as disparate as the panelists. To view the panel and the announcement, visit the Governor's web site at: http://gov.ca.gov/index.php?/press-release/5057/

In the last few years, the California Legislature has passed major bills to expand coverage to California workers, children, and all Californians, but have seen Governor Schwarzenegger oppose them. But now that he has come forward with his own, serious proposal—whatever its merits, this provides the framework for a real debate over these issues, and the real potential for action this year.

For more information, contact Health Access: http://www.health-access.org

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RECOMMENDATIONS ON ACCESS TO HEALTH CARE

INTRODUCTION

For California patients and families, health care and coverage is a deeply personal and important issue with direct impacts on life and livelihood. Although most Californians rely on employer-based coverage or public insurance programs, these two key pillars of our health system are eroding, threatening access to care for all Californians.

Additional Burdens on Working Families

The majority of employers are shifting costs to their employees as health costs rise; others are reducing benefits. Some employers are dropping benefits altogether, which places an additional burden on public programs. In spite of the higher need for public insurance, some politicians have proposed cuts or caps on Medicaid and Medicare coverage.

Californians More Likely to be Uninsured

Californians are more likely to be uninsured than residents in 45 other states.[1] Over six million Californians are uninsured—80% are workers or their family members—and many more are underinsured.[2] They are not uninsured by choice—over 85% of the uninsured are not eligible for coverage from an employer,[3] and purchasing insurance as an individual is prohibitively expensive for many low- and middle-income families.[4] For many, coverage is not available, because of "pre-existing conditions." Many who currently *have* insurance fear that it won't available when they need it most.

The Consequences of Uninsurance and Underinsurance

Those who are uninsured and underinsured live sicker, die younger, and are one emergency away from financial ruin. They often don't get needed care, including preventive screenings, ongoing treatment for chronic conditions, and emergency care, resulting in severe health impacts.[5] They are more likely to die prematurely than insured patients with similar problems.[6] Financially, nearly half of the uninsured reported having unpaid bills or being in debt to a health provider.[7] Medical problems and bills are a leading cause of personal bankruptcy.[8]

The Risks of Inaction

Without positive action, the health care system will continue to deteriorate, and individual patients and families will be forced to take on increased risks, and costs of health care.

A Mandate for Change

Our health system is at a crossroads, and action is needed just to preserve the level of health security we have today. Past legislative efforts to expand coverage to all children, provide consumer protections, set a standard for on-the-job benefits, and enact a universal system have failed or been vetoed, but they have created momentum for our current political moment. Now, both Governor Schwarzenegger and legislative leaders are making health care affordability and coverage expansion the major priority for this year.

These past legislative proposals provide a framework for debate—and provide the hope that there will be positive action for California families this year.

POLICY OBJECTIVE #1

Expand coverage by securing and building on what works in the employer-provided and public health insurance systems.

Background

Building on What Works

Of 36 million Californians, more than half (19 million) get health coverage through employers. Another 10 million get coverage through public insurance programs like Medicaid (Medi-Cal in California, covering low-income seniors, people with disabilities, children, and in some cases their parents) and Medicare (people over 65, and many people with disabilities). The common theme is that we come together to share the risk and cost of health care, either at the worksite or through a public program.

What Doesn't Work

In contrast, relatively few Californians – one to two million – buy coverage in the private marketplace. This path is often unaffordable or unavailable, with insurance companies denying coverage because of so-called "pre-existing conditions." Without the power of group purchasing, individuals don't have a chance against those insurers that actively work to avoid covering those who actually need care.

What's worse, some public policy proposals seek to encourage this trend toward what economist Jared Bernstein calls YOYO, or "you're on your own." YOYO proposals include using the tax system (through Health Savings Accounts) to encourage underinsurance and high-deductible plans, where consumers bear the risk for most medical expenses. Another YOYO proposal is the "individual mandate,'' which forces consumers to purchase private coverage as individuals, facing the burden of rising health care costs alone.

Coming Together

Together, we know it is more affordable and efficient to purchase insurance in a large group—and the larger the group, the more effectively we can spread risk, and the better we can bargain for lower rates.

New proposals should advance the goal of bringing people together, rather than further segmenting the insurance market, or further making health coverage an individual burden rather than a shared social responsibility. Proposals should build on the public insurance programs and employer-based systems that work, and continue to group people together to share risk.

Recommended Actions

The Legislature and Governor should:

A. **Set a standard for employer contributions to health care that provides security for workers and their families.** Set a standard for employer-based health coverage, like a minimum wage for pay, to level the playing field between the majority of employers that provide good health benefits, and those that do not provide coverage to all their workers. Support "pay-or-play" proposals that provide security for workers' coverage, and preserve employers' financial role and a mechanism of pooling people together.

B. **Expand and improve public coverage programs, for children and adults**, including:
   1. Expand eligibility in Medi-Cal and Healthy Families to cover all children, regardless of income or immigration status. Current proposals seek to expand Healthy Families to 300% of the poverty level.
   2. Work for the federal reauthorization (up in 2007) and increased funding of the State Child Health Insurance Program (SCHIP), which provides two-thirds of the funding for California's Healthy Families program. Funding levels should account for growth in the program, to meet to the goal of covering all children, and even cover the parents of the children in Healthy Families.
   3. Expand Medi-Cal to cover low-income adults, including those without children at home. These Californians are simply not eligible now, even those under the poverty level.

4. Increase Medi-Cal rate reimbursements to improve access to providers for those on Medi-Cal.
5. Simplify and streamline the Medi-Cal and Healthy Families programs so that families can more easily apply for, enroll in, stay on, and best use health coverage.

C. **Ensure that reforms take steps forward to a comprehensive, universal health system, like Medicare for all**. If we are stronger and healthier the more people are pooled together and covered, then we are strongest and healthiest under a universal "single-payer" system (as envisioned in last year's SB 840(Kuehl), to be reintroduced). By removing the confusing and dizzying amounts of paperwork and the middlemen of insurance companies, a Medicare-for-all system, compared to our current system, would yield substantial savings, cover more people, and allow us to make better, more democratic choices about our health care system.

D. **Oppose steps backward like "individual mandate" proposals that shift the burden and cost of health coverage to individual patients and families.** While consumer groups support many reform proposals (like those above) that require mandatory individual contributions, they oppose such proposals that don't take into consideration the individuals' ability to pay, that don't provide the benefits of group purchasing, and don't include strong standards for the products people are being required to purchase.

POLICY OBJECTIVE #2
<u>Ensure affordability and provide consumer protections</u> for uninsured, underinsured, and insured families to protect them against overcharging and oppose the growing cost burden on individuals and their families.

Background
While we work toward the goal of quality, affordable health care for all, we need to provide consumer protections, particularly for those who are most vulnerable because they are left alone to fend for themselves.

Consumer and affordability protections are needed in the individual insurance market so that individuals and families cannot be denied care due to "pre-existing conditions," age, gender, or geography. Additional oversight is needed over out-of-pocket costs. Finally, the Department of Managed Health Care (DMHC) and Department of Insurance (DOI) could adopt additional regulations to protect individuals and families that receive care through both public and private health plans.

Recommended Actions
The Legislature and Governor should pass legislation to:

A. **Place rules and oversight over insurers to protect consumers so they can get the health coverage they need**, including the following reforms:
1. *Guaranteed issue* to ensure that all Californians have access to coverage, including those with "pre-existing conditions." This would stop the insurance company practice of cherry-picking potential policy holders based on whether or not they are a low health risk, and denying those that would cost money.
2. *Community rating* to prevent price discrimination based on age, gender, geography, or illness.
3. *Minimum medical loss ratio* to ensure that our premium dollars go to patient care, rather than administration and profit.
4. *Standardization of benefits* so that consumers can better shop between comparable plans with similar benefit designs.

B. **Support additional oversight and consumer protections** to ensure quality of care. This includes:

1. Providing oversight of the implementation of strong consumer protection regulations at the Department of Managed Health Care (DMHC) regarding timely access to care, balance billing, and other key issues.
2. Ensuring that these consumer protections should also be applied to all health plans, including new Medicare Part D prescription drug health plans.
3. New reforms would include regulatory oversight over costs to allow regulators to review, in a public process, the procedures for setting rates, out-of-pocket costs, and benefit designs.

C. **Oppose the shifting of risks and financial burdens to individual consumers and families**. Policymakers need to place caps on deductibles and other out-of-pocket costs to ensure that insurance products actually help a patient get needed care, and prevent medical debt and bankruptcy. Policymakers should also reject attempts to promote Health Savings Accounts, which use tax dollars to encourage underinsurance and high-deductible plans.

D. **Preserve the safety-net of emergency rooms, clinics, and public hospitals on which we all rely, especially those left out of the system and without coverage.** Public hospitals already work on very thin margins, and have the challenge of being both a safety-net for all of us for trauma and other emergencies, and the primary provider of care for society's most vulnerable. Voters in some counties, including Alameda and Los Angeles, have supported tax increases to keep these institutions afloat, but more needs to be done to provide true financial stability for these institutions. Community clinics are also a critical "medical home" that provides access for many Californians.

E. **Support cost containment efforts focused on prevention, efficiency, transparency, and group purchasing so that consumers pay less and get more.** While consumer groups do not support efforts to reduce costs by reducing care, there is a full agenda of consumer-friendly cost-containment policies.
1. *Public health initiatives* around obesity, diabetes, heart disease, smoking, and other major ailments, and systemic changes to promote a healthy environment, will provide long-term savings to the health system.
2. *Efficiencies*, including information technology initiatives, can help streamline bureaucracy and identify best practices, as well as provide the transparency of where our premium dollars go to allow policymakers to weed out high-cost, low quality care.
3. *Group purchasing efforts* include the implementation of the California Prescription Drug Discount Program—last year's AB 2911 (Nunez/Perata), which uses the bargaining power of Medi-Cal to leverage better rates for the uninsured.

F. **Meet the specific needs of the full diversity of California, toward equity and access for all**.

While major health reform will generally help all Californians, different Californians have different needs. Specific policies are needed to reduce health disparities. Just three examples:
1. Oversight is needed over the pending regulations at the DMHC and DOI to set standards for cultural and linguistic access to care as set forth in SB 853 (Escutia). Doctor-patient communication is critical, including for those not fluent in English.
2. Standards should be set for health plans and providers to ensure that people with disabilities can get needed information and can access providers.
3. Federal and state reforms are needed to fix the "Medicare Part D" prescription drug coverage, to remove the burden of the "donut hole" in the drug coverage for those with Medicare, and the newly-imposed co-payments for low-income "dual-eligible" seniors and people with disabilities.

ENDNOTES

[1] U.S. Census, 2006
[2] California Health Interview Survey (CHIS), UCLA Center for Health Policy Research.
[3] California Health Interview Survey (CHIS), UCLA Center for Health Policy Research.
[4] "One in Three: Non Elderly Americans Without Health Insurance." Families USA, 2004.
[5] "No Health Insurance? It's Enough to Make You Sick." American College of Physicians-American Society of Internal Medicine, November 1999.
[6] "Care Without Coverage," Institute of Medicine, May 2002.
[7] "Paying for Health Care When You Are Uninsured," Access Project, 2000.
[8] "Medical Problems and Bankruptcy Filings," Norton's Bankruptcy Advisor, 2000.

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Controlling Health Care Costs
Phony Solutions and Real Answers

Health insurance can be much cheaper if it does not pay for health care -- taking the health out of health insurance! Real solutions are about cost-effective care, not about shifting costs and risks to the consumer.

Phony Solutions: Taking the Health out of Health Insurance

The first question to ask in debating cost containment in health care is: affordability for whom? Will it provide better access to more affordable care?
Phony solutions bring down the sticker price of health insurance by shifting more costs or more risk to consumers, including high-deductible plans and Health Savings Accounts, bare-bones and skeleton health plans, restrictions on the ability to get care, and the removal or pre-emption of consumer protections and mandates on insurers.

Examples of phony solutions

	The Illusion	**The *Real* Cost**
High Deductible Plans and Health Savings Accounts	Lower Premiums (Premiums are lowered by shifting costs to consumers who need care – precisely those people who need coverage the most)	Substantial out of pocket costs on individual consumers. (IE: HSAs are required to have at least $1,000 deductibles) * Recent surveys show many consumers who have high deductible accounts want out because of unexpected costs.
Bare Bones and Skeleton Plans	Provides “catastropic’’ insurance that will “cover’’ consumers in an “emergency" at lower premiums	Consumers are completely exposed, sometimes to literally hundreds of thousands of dollars in out of pocket costs. These plans fail even as “catastrophic” insurance since there are no caps on out of pocket costs and the costs paid by the so-called insurance is far less than the cost of care.
Benefit Mandate Repeal	Telling consumers they don’t have to pay for “others’’ ailments, which they “don’t need’’	Would leave consumers forced to pay out of their own pockets for a long list of benefits that most of us consider basic, from pap smears and mammograms to childhood immunizations and mental health services, from diabetes supplies to contraceptives.
Repeal of the HMO Patient Bill of Rights	Health care would be cheaper without state mandates and bureaucracy.	Less health care would be paid for. Would reduce overall health care costs by allowing HMOs to deny health care at the whim of the HMO with no standards and no right of appeal.
Repeal of Hospital Ratios and Hospital Seismic Requirements	“Mandates’’ make health care more expensive.	Unsafe care is often cheaper. Would reduce hospital costs because staffing would be lower and hospitals would not be forced to be safe during an earthquake
Three and Four Tier Drug Plans	Who needs brand name or non-formulary drugs? Use the generic or pay more if you want fancy drugs.	This means paying more and getting less in terms of life-saving medications and medications to manage long-term, chronic conditions such as diabetes and high blood pressure.

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Real Answers For Consumers

Instead of decreasing the value and integrity of health insurance, consumer groups support a range of other proposals to help control the cost of health care. While the support of any proposal by Health Access California or other groups depends on an analysis of the details, here are some broad categories of interest:

Proposal	How it works	Why it works
Focusing on Prevention	Provide coverage for preventive services with few or no financial barriers. Provide a medical home. Provide early detection tests.	Patients who have regular access to a doctor can catch problems early, and are less likely to need more expensive treatments later on.
Improving Public Health	Change the "toxic environment'' to promote wellness, from anti-smoking efforts, to constructing healthier communities.	A healthier population will ultimately lead not just to better health outcomes, but prevent worse and more expensive treatment.
Provide Disease management	Manage chronic conditions, such as asthma or diabetes, which are major drivers of health costs. They may be effectively managed for better health and cost-effectiveness.	Better disease management can help prevent a condition from becoming a full blown emergency. If not, it could send a patient to an expensive emergency room visit.
Installing Information Technology (IT)	Use information technology with medical records, prescriptions, and other data to avoid costly duplication, provide some simplification, and increase efficiencies.	IT can better allow doctors to access medical records for better diagnosis and prevent duplicative tests. IT can also produce better data about health results.
Advancing Transparency/ Disclosure of Cost & Quality	Disclose actual cost of care, following the premium dollar throughout the system. Ensure information about cost and quality can be easily compared across providers.	While consumers are usually not in a position to comparison shop, additional disclosure could help employers, businesses and advocates make comparisons. Institutions, themselves, may also use the information to self-regulate.
Reducing High Cost/Low Quality care	Spotlight health providers with "best practices,'' using disclosure and information technology systems.	Allows some plans to steer patients away from those institutions that offer the worst health outcomes while charging the most.
Ensuring everyone pays a Fair Share	Set a minimum standard for on-the-job benefits, -- or fund the health system through a fairer and more equitable tax system.	Prevents "free riders" -- companies who do not provide coverage to all of their workers – thus forcing them onto public programs. "Free riders" are costly to both other businesses, which are doing the right thing, and taxpayers.
Simplifying admin. of benefits	Standardize plans to make things easier for employers, providers and patients. Single payer, "pay or play,'' or statewide plans also allow smaller employers to outsource these tasks to a single administrator.	The complex tangle of rules and benefits for each plan and each company causes unnecessary strain. At the very least, a standardized system could help alleviate some of the administrative burden.
Planning	Assess what hospital services, providers and health infrastructure needs the community has, global budgeting for health or a universal health system. Provide a better review of hospital services and community's health infrastructure.	An overabundance of medical infrastructure drives the use and cost of particular treatments, rather than need – while capacity shortage undermines the health of the community and distorts service provision in adjacent areas.
Regulating HMO/Insurer administration, profits, rates	Tighten regulation to ensure that rates are justified. Also impose limits to how much of our premiums go to administration and profit.	Higher profits mean higher costs for consumers. Regulating profits could provide better value to consumers in the end.
Bargaining and Bulk purchasing	Pool people to purchase medical services with economies of scale. The VA and Medicaid get the best deals on prescription drugs. Segmented Medicare Part D cannot.	While it is not a magic bullet, larger purchasers of health care tend to get better deals from health care providers, drug companies, and other services.