HEALTH ACCESS

Testimony to the Institute of Medicine
Essential Health Benefits

Anthony Wright
Executive Director
Health Access California
Costa Mesa, CA
March 2, 2011

Financial Security and the Fine Print

The Affordable Care Act is a landmark piece of legislation that seeks to resolve a series of major issues. While it has been called health reform, the Act is actually as much about economic security as health coverage. It has the potential to solve the problem of medical bankruptcy—achieving the goal that was repeated virally during the health reform debate: "No one should die because they don't have healthcare. No one should go broke because they get sick."

Having served for a decade as the executive director of Health Access California, the statewide health care consumer advocacy coalition, I know that patients and consumers share a fundamental fear about whether their coverage will be there for them when they need it.

Consumers are worried about "the fine print"—the exclusions, loopholes, and caveats that mean that the care they need will not be covered when they eventually need it, leaving them in financial ruin when they are really sick.

In many ways, the Affordable Care Act provides major consumer protections against consumers getting trapped in the fine print of insurance contracts. Among the protections that are provided by ACA:

- Strict regulation of rescissions, losing coverage when you try to use it.
- No denials of coverage for pre-existing conditions or being denied coverage when you need it.
- An end to lifetime and annual limits that means insurance cuts off just when you need it the most.
- A standard on medical loss ratios, so most of your premium dollar goes to patient care, rather than administration and profit.
- An actuarial value standard, so a plan covers a certain percentage of a patient population's care.
- Subsidies on a sliding scale, out-of-pocket maximums, and other minimum benefit protections.

The debate in which the Institute of Medicine is engaged about the nature of the essential health benefit is perhaps the most important remaining debate about the fine print and its impact on financial security.

The essential benefit standard can uphold or undermine the spirit of the law expressed through these numerous consumer protection provisions—to make real the promise that coverage will be there for us when we need it.

The Layperson's Definition on What Constitutes Health Coverage

Opinion Research: 2006: Our work is informed by many years of state health reform efforts in California, from an effort to expand employer-based coverage in 2003 and 2004, to a state proposal by Governor Schwarzenegger in 2007 and 2008 similar to what was passed federally. Health Access participated in privately funded opinion research in the year 2006 in preparation for the health reform efforts in 2007. During that research, we participated in 14 focus groups in which we asked consumers and small businesses what constituted basic health care benefits. The list was remarkably consistent from group to group:

- Doctors
- Hospitals
- X-ray, lab
- Prescription drugs
- Mental health parity

Consumers and small businesses regarded basic benefits as those benefits covered by most employer-based coverage in California.

There is a layperson's definition of coverage, which includes an expectation of coverage for basic services. In these focus groups, consumers were horrified to discover that lifetime limits or annual caps could leave other consumers exposed to tens of thousands or even hundreds of thousands of dollars in costs.

People buy coverage and make life decisions about their coverage based on this layperson's definition—and so when they find holes in the benefits, it leaves people in financial trap. We know what that looks like in California because a small share of health insurance is regulated by the Department of Insurance where there is no standard for an essential benefit or basic health services. Here are some real examples:

- Susan Braig, Altadena, a self-employed graphic designer, bought what she thought was catastrophic coverage when she turned 50. She got breast cancer---and virtually none of her care was covered because what she had purchased was a hospital-only plan and almost all breast cancer treatment was outpatient. She ended up tens of thousands of dollars in debt and uninsurable.
- Laura Burwell, retired to Chico to open a wine shop and bought what she was told was coverage just as comprehensive as what she had previously from her very large employer. . She was clearing out her backyard, got bit by a

> rattlesnake, was taken to a local hospital, only to discover that her coverage did not cover the first and most expensive day in the hospital. Her bill for that first day of care was over $73,000 and her insurance covered only $3,000, leaving her on the hook for $70,000 in hospital care.

These two California consumers did the right thing and voluntarily purchased health insurance but saw their financial security destroyed by the fine print.

There is no benefit to consumers to having insurance products with these types of holes in coverage experienced by these consumers. One cannot, and should not be expected to, anticipate needing care for one ailment or not another; or inpatient rather than outpatient care; or a certain number of hospital days or prescription drugs. Even when these plans prominently disclose the holes in their benefits (which many do not), they rely on consumers lacking actuarial and medical information to provide context and evaluate risk appropriately.

Simplicity matters: insurance is a complex and confusing world, and it is in the consumers' interest to standardize as much as possible, to minimize the number of variables they need to consider when choosing a plan. In fact, we want a health care system where insurers compete based on key elements of cost and quality, rather than on the confusing nature of their benefit design.

While many may seek ways to make a premium more affordable, the benefit package is the last place to seek such savings. To undermine a basic benefit package is to violate the point of coverage to begin with, which is to provide economic security and piece of mind.

A cheap premium is always attractive, but even cheap junk is still junk.

California Law: Medically Necessary Basic Health Services

In stark contrast, most health coverage sold in California has a much better standard for a basic benefit package.

Since 1975, California law has required health plans to cover medically necessary "basic health services". Since 1999, California law has used independent medical review to determine what constitutes medically necessary care.

California law does not provide for a definition of medical necessity. Instead medically necessary care is determined through the process of independent medical review. The law provides a single independent medical review process with two sets of different standards, one for determinations of medical necessity and another for experimental and investigational treatments.

Medical Necessity as Determined by Independent Medical Review

California law provides that any care recommended by a provider, including an out-of-network provider as well as emergency or urgent care, is subject to a determination of medical necessity through independent medical review.

Specific medical needs of the consumer: Under California law, independent medical review requires that the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the *specific medical needs of the enrollee:* this requirement means for instance, that if a diabetic with a broken leg needs additional physical therapy visits because healing is delayed by complications of diabetes, the reviewers must take that into account. Specific medications, length of hospital stays, the specific type of surgical procedure may all vary depending on the specific medical needs of the enrollee.

Scientific evidence, professional opinion, and treatments likely to provide benefit: The reviewer or reviewers are required to base their determination of medically necessary care on:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(2) Nationally recognized professional standards.
(3) Expert opinion.
(4) Generally accepted standards of medical practice.
(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

The combination of the specific medical needs of the enrollee and the standards of scientific evidence, professional opinion and treatments likely to provide a benefit allows the definition of medically necessary care to evolve as the science evolves while assuring that the clinical needs of the individual enrollee are taken into account.

During the debates of the mid-1990s, Health Access staff reviewed numerous definitions of medical necessity and made a deliberate decision to oppose inclusion of such a definition in California law. Why did we come to that conclusion? Specific definitions of medical necessity often short-change persons with disabilities or persons with degenerative conditions such as multiple sclerosis or ALS that are not likely to improve, at least under the current science. Congress plainly meant that the process for determining essential benefits should take into account the needs of persons with disabilities as well as those with degenerative conditions. In addition, many definitions of medical necessity focus on illness, literally ruling out coverage of prenatal care, since pregnancy is a healthy condition, not an illness. Again, Congress intended to take into account the needs of women and children who are well served by adequate prenatal care.

Comprehensive Benefits Versus Swiss Cheese Coverage:
Over 80% of Coverage in California is Comprehensive

California has two different regulators of health insurance with two very different underlying structures of law: the California Department of Managed Health Care regulates about 80% of coverage regulated by the State of California, an estimated 17-18 million covered lives, while the California Department of Insurance has jurisdiction over about 20% of coverage, an estimated 2-2.5 million covered lives. Most employer-based coverage regulated by the Department of Managed Health Care; individual coverage has been divided about 60/40 back and forth between the two departments with the majority now at the Department of Insurance.

DMHC: Available and accessible care: The California Department of Managed Health Care regulates about 80% of coverage: its enabling statute states that it is the intent and purpose of the Legislature to promote the quality and delivery of health care services by health plans by

> "Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care" (Section 1342 (d))

DMHC: Basic health services: California law governing health plans defines "basic health services", providing a list of services remarkably similar to that included in Section 1302 of the Affordable Care Act, except that California law includes hospice care but not prescription drug coverage. It is estimated that 96%-98% of employer-based coverage in California includes prescription drug coverage. Basic health services include:

> (1) Physician services, including consultation and referral.
> (2) Hospital inpatient services and ambulatory care services.
> (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.
> (4) Home health services.
> (5) Preventive health services.
> (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.
> (7) Hospice care pursuant to Section 1368.2

California Department of Insurance: Limited Benefit Coverage: 10% of the market
Under existing California law, insurers are not required to cover medically necessary care or to provide a specific list of benefits. Insurers can and do sell coverage that covers

- Hospitalization with no or only a few doctor visits
- The second day of hospitalization but not the first
- A limited formulary of generic drugs, even when there is no generic substitute for a brand name drug

Little of this coverage is sold in the group market, especially the large group market. Most of the policies regulated by the California Department of Insurance that provides severely limited benefits are sold in the individual market. We estimate that only about 10% of all coverage sold in California has such significant limits.

Experimental and Investigational Therapies

California law uses the same process for independent medical review for both determinations of medical necessity and determinations of whether to cover experimental and investigational therapy.

Recognizing that experimental and investigational therapies by definition involve medications, devices, procedures, and other care that has not been subject to the full scrutiny of more established treatments, the standard for review is that:

> The requested therapy is or is not likely to be more beneficial for the enrollee than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the plan, citing the enrollee's specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence (Section 1370.4 (c)(3))

Benefit Mandates

In our role as the lead statewide consumer advocacy coalition, Health Access has supported some key benefit mandates in the state legislature, such as mental health parity or coverage of prenatal care in the individual market—items to be mandated by the ACA.

But even as consumer advocates, we do not endorse benefit mandates automatically or even frequently. We value the work of the California Health Benefits Review Program in assessing the appropriateness of benefit mandates, including the clinical science to justify these mandates. We were involved in its creation as a way to assess both costs and benefits of these proposed requirements.

We are well aware that some benefit mandate proposals are put forward by pharmaceutical manufacturers, device manufacturers and other segments of the industry that stand to benefit from requiring coverage of a specific drug, device, test or procedure. For this reason, we rarely support benefit mandates that appear to relate to a specific drug, device, test or procedure.

However, some benefit mandates reflect the lack of a process that can evolve as the science evolves: for example, the standard of care for diabetes management requires intensive, daily intervention but insurance coverage did not keep up in terms of providing coverage for diabetes test strips and glucose monitoring devices.

Other benefit mandates reflect longstanding social views, such as the failure to provide mental health parity or to cover contraceptive devices.

The CHBRP process has provided a useful tools in evaluating benefits, including not just the calculated impact on premium costs, but also the market impacts, the social benefits, the cost shift to public programs, and other factors.

Limits on Benefits

California law for both health plans and health insurers permits limits on benefits.

Generally health plans regulated by the Department of Managed Health Care are not permitted to put limits on basic health services except for lack of medical necessity as determined through independent medical review. Other covered benefits which are not basic health services may be subject to limits.

Health insurance under the jurisdiction of the California Department of Insurance is not required to cover comprehensive health services: in the individual market, limits on coverage for hospital stays, doctor visits, prescription drugs and other services are common. This does not apply in the large group market.

DMHC: Physical therapy, occupational therapy, durable medical equipment: For health plans regulated by the Department of Managed Health care, limits are permitted for services that are not basic health services but if a benefit is a covered benefit, then it is subject to the medical necessity determination under independent medical review. For example, physical therapy and occupational therapy, if covered, are generally provided for a limited number of visits but the specific medical needs of an enrollee require more visits, then under independent medical review an enrollee can obtain more visits. Similarly, durable medical equipment is not a basic health service but if it is a covered benefit, then it must meet the specific medical needs of the enrollee.

DMHC: Prescription drugs: There are specific statute and regulations about prescription drugs that allow the use of formularies and tiered cost-sharing. The regulations on formularies require coverage of brand name drugs if there is no generic substitute. Cost sharing for brand name drugs may be higher than that for generics.

CDI: Prescription Drugs: Products sold in the individual market under the jurisdiction of the California Department of Insurance are permitted to offer limited formularies that cover only select generic drugs and do not cover any brand name drugs, even if there is no generic substitute.

CDI: Maternity: Maternity is not a covered benefit under most CDI products in the individual market. While this reduces the premium for consumers in their 20s and 30s, it increases their financial exposure—and the financial exposure of public programs that cover pregnant women.

Impact on Public Programs

Limits on essential benefits often end up raising imposing costs on public programs and taxpayers. When some essential services are not covered, but are a commonly used therapy or device, that means that public programs are being asked to pick up the slack. Some examples include:

- Durable medical equipment: covered by Medicaid/Medi-Cal if not covered by health insurance or health plan
- Long-term physical therapy or occupational therapy: covered by Medicaid/Medi-Cal, California Children's Service or K-12 education for special needs children
- Maternity coverage: covered by Medicaid/Medi-Cal or by other public programs designed to maximize prenatal care
- Mental health care: Lack of mental health parity results in costs to Medicaid/Medi-Cal as well as greater use of emergency rooms and public mental health services

Affordability

In our research during state health reform debates, we struggled with the issue of affordability, which is core to the question of an essential health benefit. Consideration of affordability must include not just premiums, but the full costs to the patient, including cost-sharing due to co-payments, deductibles, and benefits not covered. From a policy point of view, a shift of cost from premium to cost sharing places a greater burden on the sickest, and a greater barrier to care for those who need it most.

A research scan found financial data suggesting that a significant percentage of those at or below median income have few assets, if they are not in debt. Medical expenses of $5K or $10K—whether from uncovered benefits or high deductibles—may be enough to send the family into bankruptcy. So for these families, more comprehensive, first-dollar coverage is key.

While perhaps not at the subsidy levels we would have wanted, the ACA acknowledges this tension, not just by creating Exchanges with subsidies on a sliding scale tied to income, but the benefit levels also scaled to actuarial value, and additional protections against out-of-pocket costs at the lower incomes. The spirit of the law would be to ensure a comprehensive essential benefits package to make sure coverage was meaningful at these lower incomes.

This would also ensure the trust and confidence of coverage at higher incomes, even those with higher cost-sharing. Efforts to reduce premiums should focus on how care is delivered. Other ways to reduce costs, including narrow networks, and even cost-sharing, are preferable to undermining the basic definition of coverage for consumers.

The goal should be the simplicity and security of consumers knowing that coverage will be there when they need it.

Appendix A: Relevant Code Sections: California Law

Health and Safety Code: Governing Health Plans: 80% of covered lives

Section 1342 of the Health and Safety Code:

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

Section 1345 of the Health and Safety Code:

(b) "Basic health care services" means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(7) Hospice care pursuant to Section 1368.2.

Section 1367

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

Section 1374.33 of the Health and Safety Code of California (b)

Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the *specific medical needs of the enrollee* and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

Section 1374.30 (j) of the Health and Safety Code of California

(1) (A) The enrollee's provider has recommended a health care service as medically necessary, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

1370.4. (a) Every health care service plan shall provide an external, independent review process to examine the plan's coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of the following criteria:

(1) (A) The enrollee has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, "life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(2) The enrollee's physician certifies that the enrollee has a condition, as defined in paragraph (1), for which standard therapie have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the enrollee, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the enrollee's physician, who is under contract with or employed by the plan, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or (B) the enrollee, or the enrollee's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat

the enrollee's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the enrollee than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the plan to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to the plan contact.

(4) The enrollee has been denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3).

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service, except for the plan's determination that the therapy is experimental or investigational.

(b) The plan's decision to delay, deny, or modify experimental or investigational therapies shall be subject to the independent medical review process under Article 5.55 (commencing with Section 1374.30) except that, in lieu of the information specified in subdivision (b) of Section 1374.33, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The plan shall notify eligible enrollees in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the enrollee's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 1374.33.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the enrollee than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the plan, citing the enrollee's specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence, including, but not limited

to, the medical and scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the plan contract.

(d) For the purposes of subdivision (b), "medical and scientific evidence" means the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) Either of the following reference compendia:

(A) The American Hospital Formulary Service's Drug Information.

(B) The American Dental Association Accepted Dental Therapeutics.

(5) Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(A) The Elsevier Gold Standard's Clinical Pharmacology.

(B) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(C) The Thomson Micromedex DrugDex.

(6) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

Insurance Code: Governing Health Insurance: 20% of covered lives

106. (a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, ***or*** surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

(c) In a statute that becomes effective on or after January 1, 2008, the term "specialized health insurance policy" as used in this code shall mean a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies.

APPENDIX:
Health Access California: Mission and History

HEALTH ACCESS CALIFORNIA is the statewide health care consumer advocacy coalition, advocating for **the goal of quality, affordable health care for all Californians.** Health Access works with a broad coalition of over 80 member organizations representing communities of color, immigrants, people with disabilities, children, seniors, people of faith, labor, and working families.

As the leading coalition voice advocating for patients in California, **we represent health care consumers in the legislature, at administrative and regulatory agencies, in the media, and at public forums**. In Sacramento, the health industry—from insurers to drug companies, from doctors to hospitals—is well represented. Health Access ensures that the interests of Californians are heard.

Health Access is leading the movement for health care reform in California, simultaneously **promoting comprehensive health reform proposals and advocating for specific strategic budget fixes, consumer protections, and policy improvements** to provide immediate help to California families. We have spearheaded reform initiatives at the state level, and led the California activity of national campaigns like Health Care for America Now! to pass the Affordable Care Act in Congress—with all California Democrats voting for the new law (and all who voted for it getting re-elected).

Health Access is a resource to the Legislature, as well as for the Executive Branch, independent regulatory agencies, the California congressional delegation, the media, and our member and allied organizations. Health Access provides timely updates, alerts and analysis on health policy issues, develops policy solutions, and organizes events and full campaigns. . With **offices in Sacramento, Oakland, and Los Angeles**, Health Access bridges advocacy work between different constituencies and between the grassroots and senior policy levels.

Our Core Mission Includes:

- **Preserving access to care —** Health Access has led coalition advocacy around the state budget crisis to protect our health infrastructure of public health coverage programs like Medicaid (Medi-Cal), SCHIP (Healthy Families), and Medicare, and our safety-net of public hospitals and community clinics. Health Access works to improve and strengthen these services, to save them from cuts, to support the revenues they need to survive and thrive, and to win the budget reforms needed to allow for continued investment.

- **Advancing consumer protections —** Health Access serves broadly as the voice of California health care consumers, as a counterpoint to insurers as well as the health care industry. We develop and advocate for policies so consumers are able to get the care they need when they need it. This includes stopping insurers and providers from denying care, or overcharging for it. Focusing on cost, quality, access, and wellness, this work includes legislative advocacy, administrative advocacy overseeing various state agencies, and public education.

- **Expanding coverage and fulfilling the promise of health reform—**Health Access has, for nearly 25 years, pushed forward a broad range of reforms, including expansions of coverage through public programs, employer-based benefits, or a universal, single-payer system. After leading California efforts for comprehensive health reform, we are committed to implementing and improving upon new federal health law, and continuing toward the vision of quality, affordable health care for all Californians.

Accomplishments:

Over the years, our work has established an impressive track record of working to preserve access to care, protect consumers, and reform our health care system. Among our victories, Health Access California has:

- Led California efforts to **win comprehensive health reform**, ensuring all Democratic members of Congress voted for the new federal health law; and working with the California State Legislature to **pass the first-in-the-nation bills to implement and improve the law**;
- Ensured **access to coverage for children, including those with pre-existing conditions**;
- Worked to **expand coverage to tens of thousands of Californians through county-based initiatives** such as **Healthy San Francisco** – efforts that will be expanded under the new federal law and, at our urging, under the **new Medicaid waiver**;
- Helped **prevent health care budget cuts** proposed by various Governors that would have denied more than one million people health care coverage, and caused millions more to suffer increased costs;
- Worked to **expand and streamline Medi-Cal and Healthy Families** for children and parents;
- Passed over **two dozen managed care consumer protections, creating the Department of Managed Health Care**, and allowing patients to get an independent review of any HMO denial of care or coverage;
- Secured **additional reforms** that include protections regarding access to **prescription drugs**, **timely access to care** and **language access to care**;
- **Exposed rate hikes**, by requiring notice to policyholders, and by requiring public rate filings and rate review at the regulators;
- **Prevented hospitals from overcharging the uninsured**, by passing a first-in-the-nation (with New York) law so the uninsured are not price-gouged by hospitals, having to pay 3-4 times what insurers pay for the same treatment; and **limiting what ER doctors charge the uninsured** as well;
- Won **passage of a prescription drug discount program**, one that would use the negotiating power of the government;
- **Advanced the vision and movement for universal health care** by leading and supporting several campaigns and coalitions to win comprehensive health reform – each effort bringing the state and national conversation closer to the goal. This includes our work for single-payer proposals, universal children's coverage, expansions of employer-based coverage, Healthy San Francisco, and the federal health law.

Contacts:
For more information, contact

Health Access California

1127 11th Street, Suite 234,

Sacramento, CA 95814,

916-497-0923.

www.health-access.org
blog.health-access.org
www.facebook.com/healthaccess
www.twitter.com/healthaccess