San Diegans for Healthcare Coverage
A Coalition for Health

Consensus Principles and Required Elements for Health Reform

Consensus General Positions

- Reforms should consider whether and where a complete overhaul is required and where building on existing elements of the healthcare system will best meet reform objectives; however, it is felt that the existing system of providing healthcare coverage and care in the United States is broken and getting worse.
- Healthcare reform should ensure that basic, meaningful health coverage and access to care are not market-based commodities but are accessible and affordable to all.
- Achieving comprehensive health reform is imperative to individuals and families, business, government and the economy.
- Developing solutions, oversight and funding for health coverage is everyone's responsibility – government, business, and individuals.

Specific Principles and Required Elements

Models: Health reform and coverage expansion should be pursued through parallel models incorporating both public and private (employer and individual) options to achieve universal coverage. For the public option, a model similar in design to existing public-private partnership programs is preferred; however, that option must incorporate safeguards to ensure that the plan is not overpromised and underfunded. Coverage expansion cannot rely solely on expansion of existing public programs.

Meaningful, Accessible Coverage: All citizens and legal residents should have access to affordable *meaningful basic/minimum* benefit package (***Table 1***) that provides access to medically necessary care and services and encourages early intervention, preventive care, and disease management, and incorporates healthy behavior incentives.

Affordability: Both coverage and premium share should take family income into consideration:

- Premium share and out of pocket (Co-payments) should be limited by family size and income and should not be a barrier to needed care (for example, 2% of premium and 5% limit on out of pocket expense for those under 300% FPL)
- Deductible levels by income category, with no deductibles for low to modest income individuals (for example, under *300% FPL); deductibles apply after specified level of expense (e.g., $1,500); and, exemptions from deductibles* (e.g., well-child care, screening exams, recommended periodic exams)

Employer Participation: Incorporate incentives for employers to voluntarily provide coverage (premium assistance program through the workplace, state tax credits, etc.). Incentive program (premium assistance) should have defined minimum benefits and options to purchase more extensive coverage. This is especially important for those employers with fewer than 10 employees (50% of uninsured).

Reimbursement: There must be adequate reimbursement to healthcare providers, including elimination and avoidance of cost-shifting from public payors. Quality and efficiency incentives should be transitioned into health reform.

Reinsurance: Offer government funded reinsurance program for both premium assistance program and for individual guaranteed issue programs; do not carve-out individuals by disease from risk pools. Any program should ensure continuity of coverage and care (e.g., portability), especially when an individual is diagnosed with a chronic disease.

Cost Containment: Ensure transparency, care guidelines and reporting that allow for consumer options, encourage appropriate utilization and utilize comparative effectiveness and evidence-based protocols.

Administrative Simplicity: Simplify and minimize administration, consolidate and eliminate fragmented programs. Incorporate requirements for easy enrollment in coverage through electronic, web-based systems and other means; minimize administrative burden on employers and employees; maximize opportunities for eligibility simplification rather than complicated and costly documentation requirements.

Local Outreach and Enrollment: Incorporate requirements and structure for local outreach, education and enrollment; healthcare delivery and networking relationships are local.

Program Evaluation and Adjustment: Establish clear objectives for both process and outcomes, including measures and methods. Integrate the ability to make program adjustments as necessary to meet program objectives.

Table 1

Minimum Basic Benefits Package	
Service Category	Benefit Description
Primary Care: Services provided by primary care provider (PCP), including office visits, supplies and administered drugs; preventive, wellness exams and education.	Must select a PCP from a specific group/clinic in plan network. No coverage outside of designated group. May switch PCP through plan (HMO).
Specialty Care: Services provided by a specialist, including office visits, supplies and administered drugs and outpatient and inpatient consultations, maternity, surgery and other procedures.	On referral by PCP for initial consultation to group panel; prior approval for ongoing care; No coverage outside designated panel. (HMO)
Diagnostic: Laboratory, Radiology, Cardiac and other diagnostic tests and procedures ordered by a physician. Includes routine screening exams (mammograms, pap smears, colon exams)	Routine tests and screening ordered by PCP. Some expensive tests prior approved by plan. (HMO)
Hospital: In-patient hospital medical, surgical and maternity services or maternity delivery services and newborn care. All hospitalizations are approved and reviewed by plan.	Medically necessary hospitalization in hospital designated by primary physician and plan. (HMO)
Pharmacy: Prescription drugs ordered by your physician necessary to treat a medical condition.	Covers drugs through tiered system of generic, preferred and non-preferred only.
Rehabilitation Services: Outpatient Therapy, Home Health Care or Skilled Nursing Facility (SNF) services and equipment necessary to improve functioning following an illness or injury.	Medically necessary outpatient therapy and home health care; short term rental/ purchase of most required medical equipment at 80%; up to 30 days in a Skilled Nursing Facility for rehabilitation. All with plan approval.
Transplantation – Investigational: Organ transplant services and treatments still under investigation (e.g., drugs, devices, treatments)	Organ transplants covered at designated facilities for cases approved by health plan according to transplant criteria. Investigational services, drugs and devices not covered.
Mental Health: Outpatient and inpatient mental health and chemical dependency services.	Up to 20 visits per year for therapy; up to 20 days per year in hospital for mental health or chemical dependency treatment with prior plan approval.
Quality of Life: Services are not to treat a current medical condition but which may improve quality of life (e.g., Fertility treatments, Weight reduction, etc.)	Covers such things as weight-reduction program/procedures at 50%, infertility treatments at 50%
Dental: Services provided by a dental health professional to care for teeth.	X-rays, Cleanings each six months at no cost. $50 deductible ($150 per family), then 80% for basic dental services (filling cavities, removal of teeth, oral surgery). 50% for major dental services (crowns/bridges , repairs) Annual max $2,000.
Vision: Eye examinations (including acuity, pressures, etc.), glasses and contact lenses.	Routine eye examination every two years; $100 for glasses or lenses every two years.
Not Covered: Complementary Services (Acupuncture, Chiropractic), Experimental Services, non-emergency out of network or unauthorized services.	

Notes: Minimum, basic benefit package developed through focus groups and Business and Labor Roundtable forums
HMO Model of Coverage for basic benefit plan

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SDHCC Positions -- The Federal Landscape

Individual Mandates (not a position for a mandate – only if a mandate is imposed)

Any individual mandate must ensure that individuals have access to:

- A meaningful basic benefits coverage program providing access to medically necessary services
- Affordable based on family size and income;
- Administratively simple, for enrollment, retention and administration
- Provides adequate provider reimbursement and, therefore, access and choice
- Cost containment strategies, care and comparative effectiveness guidelines
- Healthy behavior incentives
- Program evaluation and adjustment to meet program health objectives
- Automatic enrollment of individuals not selecting a specific coverage option

Public Plan (Parallel Models)

- Health reform and coverage expansion should be pursued through parallel models incorporating both public (new) and private (employer and individual) options to achieve universal coverage.
- Healthcare reform should ensure that basic, meaningful health coverage and access to care are not market-based commodities, but are accessible and affordable to all.
- For the public option, a model similar in design to existing public-private partnership programs is preferred.
- The public option must incorporate safeguards to ensure that the plan is not overpromised and underfunded. The plan must be actuarially sound relative to private market rates.
- Administrative simplicity (and feasibility) for enrollment and management of premium assistance programs requires that there be a coordinating entity to collect and distribute funds, including government funds (e.g., premium assistance, comparative effectiveness evaluation, connector).
- The public plan governance structure must be designed to isolate the plan from unfair advantage and perverse incentives.

Employer Role

- Employers should have the option of providing employer sponsored coverage directly, offering employer-sponsored coverage through some form of public plan (or connector) or, in lieu of providing employer sponsored coverage, paying through payroll taxes.
- The program should incorporate incentives for employers to voluntarily provide coverage; there should be defined minimum benefits and options to purchase more extensive coverage. This is especially important for those employers with fewer than 10 employees (50% of uninsured).
- Adjustments to employer contributions should be based on size and average wages, but no employers, sole proprietors or self-employed should be excluded.

Health Insurance Reform

- Establish a maximum percentage of premium that may be spent on insurer administration, marketing, broker/agent fees and overhead with transparency of these costs to consumers for both the private and public plans in the marketplace.
- Guaranteed issue, modified community rating, rate regulation and portability of coverage are essential to successful health reform that incorporates mandates and/or premium assistance programs.
- Set and enforce the rules of the insurance marketplace (and connector) in such a way that they apply to all participants, public and private alike. Holding public and private plans accountable to the same marketplace rules will level the playing field, while providing market efficiencies.