
Initial Thoughts on Next Steps for California Health Reform

We had an opportunity for far reaching health reforms last year, but we failed to take advantage of it. My suggestion is that we stop blaming others (which for a time admittedly has been vital to relieving my bitter disappointment) and start by asking, “what did I do to make it happen; what did I do to make it fail”.

What should we do next time to secure passage?

The next time we need to start with the understanding that the financing has to be on the ballot. There is no chance that there will be a two-thirds vote for financing in both houses of the state legislature.

The legislation needs from the start to be tailored to voters and their deeply held preferences and to the expectation of a ballot fight. Since 95% of voters are insured, their initial question asks what’s in it for them, rather than what does the bill do for the uninsured.

There will be opposition, and the choices are to have one or two strong opponents or multiple opponents. Some opponents are worth having (they help make the case for reform); for example imagine a windfall profits tax to fund alternative energy that would not be opposed by “Big Oil”. Others are simply unavoidable.

Who supports the bill and how much will they be able to bring to the table?

Ideally, business and labor would be on the same side; however last year’s effort ended up with business and labor each split within their own ranks. It is difficult for business and labor to agree on anything, yet health reform is one issue on which they have a great deal in common since each is paying for ever-escalating costs without much improvement and some troubling deterioration in the population’s health.

Last year’s reform effort showed us our painful cleavages. There is a significant split in the consumer movement between those whose primary interest is coverage for the uninsured and those whose chief goal is to eliminate managed care and private insurance. There is an equally wide divide among insurers between those who are willing to eliminate medical underwriting and cover everyone with mandates and those who believe medical underwriting is a bulwark against *inevitable* adverse selection and a voluntary system is a mainstay of insurer profitability. Providers are divided as well between those who expect to benefit from reform and those who fear losses, between those who see large numbers of uninsured and Medi-Cal patients and those who do not, between those involved in primary care and the specialty care practitioners, and finally between low and high cost and high and low quality providers.

Payors (business, labor and consumers) will favor stronger cost containment while providers (hospitals, doctors and the drug industry) are more likely to be opposed to it. In

the final analysis we will need almost everyone in order to win in the legislature and at the ballot,¹ so there is a difficult balancing act and much healing to be achieved.

We need to have a more honest discussion of the alternatives to the status quo. There have been many false choices in the past – Canadian single payor vs. status quo is but one example. Single payor has many virtues (including equity and simplicity), but it also has flaws (poor approaches to cost containment and financing). In the past, it has been given a pass because there was no realistic chance that its financing could secure a two thirds vote in the legislature or a majority of voters on the ballot. It should now be examined honestly and afresh in the debate.

The status quo has many virtues as well with its familiar systems of access to care and reimbursement for the insured and its excellent care for the insured with serious injuries or acute illnesses, and its has three growing faults -- the numbers of uninsured, the prices of care and coverage, and the impacts on population health. The status quo is, I believe, unsustainable in a global marketplace where the health, education, opportunity, and productivity of a nation's citizens, its workers, its children are paramount to its continuing success.

Single payor (Canadian style) is not the only road to universal coverage, nor is it necessarily best suited for California. France, Germany, The Netherlands, Switzerland, Japan, Israel, England, and doubtlessly many other countries have systems that should be studied and considered for what they have to offer towards our own evolution. Germany, The Netherlands and Switzerland cover all their citizens. They rely on private insurance to pay the bills and they use a combination of market approaches with regulation to control rising costs. Canada covers all its citizens; the government pays the bills, and it relies on regulation of prices to control rising health costs. It is like Medicare, but it offers a fuller range of services for all citizens without all the copays, deductibles, and doughnut holes that bedevil Medicare beneficiaries. Britain covers all its citizens and relies heavily on public employees to deliver health services. For those who think that universal coverage equates to socialized medicine, only Britain, the federal Veterans Administration and county hospitals and clinics (where the government owns the hospitals and employs the doctors and nurses) aptly fit that description. Other countries are learning from our systems and excelling; we need to learn from them.

We should combine the better features of our own systems and lessons from the different compatible systems to develop a universal, cost and clinically effective approach uniquely suited to California.

Shared responsibility as proposed and negotiated by the Governor and legislative leaders encompassed both coverage expansion and cost containment reforms. The final product offered major reforms in financing (everyone paid), coverage expansion (everyone but

¹ Past, go-it-alone health ballot measures from the CMA, Health Access, nurses, labor, hospitals and emergency physicians have for the most part failed.

undocumented adults was covered) and elimination of medical underwriting exclusions in the individual market. The cost containment solutions were not as developed as they could/should have been.

The Governor has affirmed his intent to secure passage of major health reform during the remainder of his term. He believes that reform cannot be passed piecemeal as there are important trade-offs to be negotiated and the final pieces need to fit together. To a large degree, he is right. Others however will argue with equal fervor and wisdom that you cannot hold back the tide, and health reform needs incremental victories while we are seeking to negotiate the shape of a final reform package, which of course will be adjusted forever after it is passed and implemented.

On some issues, it makes no sense to wait for the final reform package. For example, the reform package had important provisions to improve health outcomes and reduce spending in public programs, such as pay for performance reimbursement, e-prescribing, or improved care coordination for patients with diabetes. These could be beneficially addressed as part of the resolution to the state's budget crisis. The reform package also had provisions to put an end to the front-page scandals of rescissions of individual coverage through post-treatment medical underwriting; it is past time to foreclose that option. The reform package included measures designed to improve care and control costs with increased transparency of price and quality information about providers and health plans. These reforms could prove essential to retention of employer-sponsored coverage during the economic downturn.

Other issues that could be resolved incrementally need both policy agreement and funding. Coverage for all California's children was widely viewed as the lowest common denominator of public policy maker agreement last year; yet its fortunes sank along with the over-all reform effort when the looming state budget crisis overwhelmed all hopes for progress on health reform. Coverage for all children had a General Fund cost of less than \$400 million and could be funded with a 50¢ increase in the cigarette tax – albeit a declining revenue stream over time. This could be a stand-alone measure as a 2010 ballot initiative. There are as yet unresolved policy issues on how this stand-alone reform would deal with issues such as a parental mandate to cover their children, individual market underwriting and exclusion of ill children, and interface with private employer and individual coverage.

Providers want an increase in their Medi-Cal rates to Medicare levels. If hospitals are indeed willing (which they may not be) to self-fund their own rate increase with an across the board hospital tax, should this move forward independently, could it be a part of this year's budget crisis solution or must it be inextricably linked to the over-all reform package?

Some (probably most) counties would like the opportunity to match their spending on care to the medically indigent adults with federal matching funds using an 1115 waiver as many other states have already done, and they would be willing to expand coverage and

delivery systems through contracts with community clinics and others with the new funds. Some would be willing to use local Medi-Cal managed care systems if the price is right. County health programs of care to the uninsured are the most under-funded aspect of care in California. Should we wait for agreement on an over-all reform package or prepare a request for the incoming federal administration and seek to secure this federal matching opportunity for California?

In this series of ITUP articles, we plan on looking at other countries, at our own system, at cost containment, delivery system redesign, financing, affordability, incentives, taxes and mandates and at the opportunities and challenges of change.

We want to encourage discussion, thought and dialogue, not the numbing repetition of talking points and long held, well-known positions. So what are your thoughts, please let us know at www.itup.org

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