ITUP
INSURE THE UNINSURED PROJECT

Your Thoughts on Health Reform
Insure the Uninsured Project
May 13, 2008

Thank you for all your excellent suggestions on how to proceed with health reform.[1] We summarized them as follows:

Substance

1. Minimum agreement on principles: There appears to be a level of minimum agreement on the following principles.
    a. Kids 1st, 50¢: Kids should be covered first and financed with a fifty-cent increase in the state cigarette tax.
    b. Universal: Every California citizen and legal resident should be covered; it makes no sense to leave some Californians uninsured.
    c. Cost containment: The measure has to include meaningful and effective cost containment or the reform will unravel relatively quickly.
        i. IT: IT and EMR are the essential building blocks of cost containment; they simplify administration, improve efficiency and the quality of patients' treatment for their conditions and save money for everyone.
        ii. Transparency: Comparative price and quality measurements should be readily available to patients and the public.
        iii. Malpractice reforms: Defensive medicine and its attendant costs should be reduced/eliminated; it is not clear how.[2]
        iv. Reduce administration: Administrative costs should be reduced for plans, hospitals and doctor's offices.
        v. Appropriate use of the ER: ERs should be reserved for genuine emergencies, not for primary care or after hours care and treatment which should be provided and paid for in less costly settings.[3]
2. Benefits of coverage: The benefits of coverage vs. non-coverage (uninsured status) should be clearly delineated. It should not be assumed that all health benefits require a coverage solution.[4]
3. Capacity to care for the uninsured: Research is needed to assess whether there is adequate primary care and specialty care capacity to provide care for the uninsured as they become insured. Research and analysis are needed to determine how to ensure adequate, accessible primary and specialty care for those who may

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[1] We have tried to summarize and explain 50 or so responses and comments we received in e-mails, in person or over the phone. We are not here stating ITUP's views, except to a limited degree in the footnotes, but rather reflecting the commentators' views.

[2] While federal proposals often propose tort reform, they are less common in California reform proposals due to the positive impacts of MICRA one assumes.

[3] In some communities, urgent care clinics, nurse advice lines and longer clinic hours offer an alternative to the ER for after hours care; more accessible alternatives to the ER are needed.

[4] This commentator points out that there are many low cost or low benefit medical procedures and services that do not require insurance coverage and indeed the cost of the procedure is increased due to coverage. However it also should be noted that many providers charge a much higher price for procedures not covered by insurance than for those covered by insurers.

remain uninsured. What if anything does California need to do to increase primary care capacity and access by region?

4. Labor/business -- no direct benefit from uncompensated care reduction: Labor and business were not convinced that reducing/eliminating "uncompensated care" by covering the uninsured and paying providers at Medicare rates for their Medi-Cal patients would result in a decrease in their premiums. The next round of reform may require a mandated "pass through" of the "cost shift" savings.
5. Skin in the game: Consumers should be able to choose different levels of coverage and need to have some financial consequences of their choices in coverage and in types of care and treatment; at the same time co-pays and deductibles should not be designed to deny/deter access to patients' needed care; these require a careful balance.
6. Align incentives: Incentives should be consistent among public and private health programs; otherwise they cancel each other out and have no discernible impact.[5]
7. Role of profit: Some contended that for profit providers and health plans are inconsistent with medicine's healing role and maintained that profit incentives were at the root of rises in the cost of health care.[6]
8. Use of premium care: One reason that the US health system is more expensive than other countries is the use of "premium" care – i.e. higher use of more costly specialty care, greater use of MRIs, and more elective surgeries. Should copays be used to encourage patients to use the less costly of two appropriate treatment modalities?[7]
9. Medicare rates of reimbursement: All public and private programs should pay for care at roughly the same rate – e.g. the Medicare physician fee schedule and DRGs.[8]
10. Consolidate/coordinate/simplify public programs: To reduce administrative costs and structures, the state's multiple public programs should be consolidated or coordinated around a common model – the Healthy Families program was suggested.
11. Federal government's role: The last reform skirted the role of the federal government by relying on federal financing where there was little room for denial. Should the next set of reform proposals ask for greater flexibility and financing

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[5] For example, assume a hospital has 1/3rd Medicare patients paid on the basis of DRGs, 1/3rd patients for whom it is capitated and 1/3rd fee for service patients with per diem reimbursement. What is the over-all direction of the financial incentives for the hospital and its doctors? Will physicians make very different treatment decisions for each type of patient depending on their source of payment or will they treat them all the same?

[6] Others maintain that the profit incentive is just what is needed to reduce costs and improve quality. We would like to see some studies, citations or other evidence that non-profit providers in California provide better care at a lower cost.

[7] If the choice is back surgery or daily exercise and physical rehabilitation, should the surgeries be allocated based on wait lists with medical criteria or based on higher co-pays and deductibles? Does your answer change if the co-pays and deductibles are income adjusted?

[8] The assumption of this commentator is that Medicare rates are mid=way between Medi-Cal and commercial insurance. Should uninsured consumers still be billed at two, three, five times hospital costs after reform?

from the federal government concerning such issues as federal match, state match, mix and match public-private financing, ERISA and/or the state costs of care for the undocumented?

12. The undocumented. Undocumented adults live and work here and they pay federal, state and local taxes on their consumption, their shelter and often their wages as well. Yet there is strong voter disapproval of the use of public funds to pay for their use of health care services, which is about half the rate of American citizens and long time residents. What is the right solution and how do we get there or is this an issue that must be resolved at some later date?

Process

1. Voter literacy on health reform issues: Most voters are completely unaware of the myriad differences between public and private coverage, between Medicare, Medi-Cal and/or Healthy Families and between the different approaches to controlling rising costs. A broad unbiased educational campaign is needed so that voters know and understand the options facing state and federal policy makers. One suggestion was for a continuing series of educational town hall events in communities across the state.
2. Call to arms: The final health reform product needs to be simple, compelling and easy to understand and explain to your neighbors and potential voters.[9]
3. Government as a problem vs. government as a solution: There is a perspective among many that ineffective and inefficient government is the "problem"; yet many of the reform proposals rely heavily on "government" to finance, regulate and make vitally important decisions.[10]
4. Leadership: Where is the legislative leadership for the next round of reform? Which legislative leaders are going to emerge as the champions of a thoroughgoing reform? Will they be pragmatic incrementalists or will they embrace major reforms in collaboration with the Governor?
5. Transparency: Negotiations were closed door, and many legislators were unengaged and uninformed. The next effort must engage legislators but without succumbing to the piece-meal parceling of disconnected and contradictory concessions that plagues the committee-by-committee process.
6. Intertwined: The product of last year's negotiations reflected bargaining on system transformation. While it may have gone further than some wished or was less thoroughgoing than some preferred, it had a measure of coherence as if it was bargained in round-table fashion (though it was not). How do we maintain that breadth of vision and connect the dots of reform in a cohesive fashion?
7. Coverage expansion compatibility with cost controls: Labor, business and consumers want effective cost controls, while providers and consumers want the

[9] There should be no Trojan horses.
[10] What is the right balance of public vs. private solutions and where are public-private partnerships appropriate?

coverage expansion component of reform. Some question whether these disparate coalitions can co-exist under one roof in support of one measure, and if they cannot, which comes first, the chicken or the egg?

8. Attitude shift from skeptics to collaborators: Many entered last year's reform debate as hardened skeptics, and it was very difficult to make the transformation to health reform collaborators. How can this be better managed, given the disappointing conclusion of last year's reform efforts, which reinforced the "I told you so" from the skeptics?[11]
9. Over-reaching and its perils: Some question whether last year's reform package included so many significant concessions to important supporters that the package toppled from its own weight and still had only tepid support from supporters at the end.
10. Double-dealing, bad blood and suspicion: There is an enormous residue of bad feeling after last year's reform effort that must be resolved so that the next effort is not doomed by low expectations and hard feelings.
11. Employer engagement: California employers should decide what health reforms they prefer/oppose and engage more proactively in the state's debate on health reform.
13. Labor/business cost containment: Labor, business and consumers need to jointly develop a cost containment agenda for the next round of the reform efforts.
14. Labor splits: The failure of labor to agree on the reform effort was particularly deadly to the reform effort and must not be repeated.

We should note in closing that we found very encouraging the continued broad commitment from most commentators to the reform efforts.

[11] Converting skeptics and persuading opponents will be critical in the next round of reform discussions and argues against the narrow clashing coalitions of the like-minded that too often dominate and define the reform debate.