CALIFORNIA PROGRESS REPORT

Health Care Reform in California

By Diane Lefer

"The way the health care delivery system developed in this country has been a global scandal," said Michael Hiltzik, author and *Los Angeles Times* columnist, as he concluded the community program he moderated August 22 on the effects of the Affordable Care Act.

Speaking at the National Council of Jewish Women Los Angeles, expert panelists acknowledged the obvious limitations of the act, which was found constitutional (for the most part) by the Supreme Court at the end of June. They also cited new benefits flowing from the legislation. But what became very clear was that there are steps we in California can take to make reform more meaningful even without action on the federal level.

If you want to skip the context and the bad news and go straight to what we can do now, please jump down the page to **Recommendations for Action**.

What's Wrong

The whole insurance-based health care system in the U.S. "violates the Hippocratic Oath," said Paul Song of the board of directors of Physicians for a National Health Program, California. Thirty-five thousand people die each year because they don't have insurance while 75 percent of people forced into bankruptcy due to health care costs actually carried health insurance. And if the ACA looks like it was written by private insurance companies, he said, there's a reason for it: 3300 lobbyists descended on the Hill when Congress was tasked with drafting the legislation.

Recently, the news media reported that America's beleaguered middle class has shrunk to barely more than 50 percent of the population. The poor aren't even in the picture and 21 percent of all U.S. children live in poverty. While all this was happening in the

last ten years, according to Song, profits in the private insurance industry went up by 450 percent.

Questions of Access

Susan Fogel directs the reproductive health and justice program at the National Health Law Program. Instead of jumping into the current controversy over whether our female bodies have magical powers, she pointed out that 24 percent of women in California are uninsured, with women of color disproportionately going without insurance, with Latinas more likely to have diabetes, African American women more likely to die of complications of pregnancy and childbirth. She celebrated the fact that the expansion of Medicaid (called Medi-Cal here) will bring coverage to more low-income women. For example, until now, women who were childless or whose children were grown, were ineligible for coverage no matter how dire their poverty.

"But never confuse coverage with access," she warned. Though all women, including those in low-income communities, are now covered for preventive care, screenings, contraception and maternity care at no cost, there may not be physicians available and willing to treat them. As for pregnancy terminations, half of California's counties lack even a single abortion provider, she said. And the single largest health care system in the state–the network of Catholic hospitals and providers–functions with severe restrictions on reproductive health services.

Undocumented immigrants and green card holders who haven't been here long get no coverage, but a huge number of Americans–more than 30 million people–will be newly insured. Where will all the doctors we need–especially general practitioners–come from?

The average debt from going to medical school comes to about $200,000, said Song, and that's on top of student debt from college, training, and the cost of malpractice insurance. This makes the more lucrative specialties more attractive than ever. Of course it may also mean that "people have to love it and go into it for the right reasons," said Song. "If they want a 13 percent tax rate, they have to go into finance."

While Obama's policies take nothing away from Medicare beneficiaries, they do cut some reimbursement rates to providers. Romney-Ryan aren't all wrong here: Some doctors may begin to refuse Medicare patients–another factor in the expected shortage.

(An interesting aside from Michael Hiltzik: Romney-Ryan now assure seniors that their Medicare benefits won't change at all while telling younger voters that Medicare must be changed to a voucher system if – because of those greedy seniors! – it's to exist at all by the time they reach retirement. This is exactly the strategy recommended in an article published in 1983 in the journal of the right-wing Cato Institute by authors disappointed in Ronald Reagan's failure to privatize – i.e., destroy – Medicare. Take a page from Lenin's playbook, they urged, and weaken the opposition by isolating its constituent parts.)

Questions of Cost

Given the benefits the act guarantees to the insurance and pharmaceutical industries, how will it meet the goal of containing health care costs?

Get ready for overall costs to rise–in the short term. "The population is expanding and aging so increased costs will naturally occur," said Jim Lott, executive vice president of the Hospital Association of Southern California. But the costs of treating individuals–the per capita costs–can come down with greater efficiency, holistic care, more risk-reduction and more primary care (from those primary care physicians we sorely lack).

With the expansion of coverage, said Susan Fogel, "we have to have a long view and not be sidetracked by the fact that costs will go up in the short term as we are going to be bringing into the system the uninsured people who are sicker and have put off care."

Mark Patterson, professor of Public Policy, Political Science, and Law at UCLA's School of Public Affairs, agrees that more clinical prevention–screenings–for more people will increase costs. But "the Affordable Care Act is about more than insurance. Title IV is all about preventive care" – not only for individuals. The public health model in the Act is aimed at "transforming population health–helping communities design programs to combat diabetes, obesity, tobacco-related illness," all of which can save both money and lives. "Ten percent of mortality is a function of health care," he said. "The rest is environment, genetics and behavior. If you deal with problems *in utero* and the early years of life, you reduce the need for health care later. You can trace heart disease back to what was happening in the neighborhood when a kid was three years old."

The public health model that has been so successful in controlling and preventing infectious disease is now a part of federal law and policy when it comes to chronic disease.

Recommendations for Action

1. Create a braking mechanism for rate hikes.

With Assembly Bill 52 (introduced by Mike Feuer), Insurance Commissioner Dave Jones sought the power to reject excessive increases to health insurance premiums, co-pays, and deductibles.

While AB 52 passed in the Assembly last year, it stalled out in the Senate.

We need to try again, support this bill, and get it through.

As Paul Song explains, the ACA does mandate that insurance companies spend 80-85 percent of revenues on actual patient care. Sounds good, but there's a loophole: Nothing in the act stops them from "charging more to make up the difference" and maintain existing levels of compensation, administrative overhead and profit. AB 52 would close the loophole.

2. Pass legislation to empower "physician extenders"

With the general practitioner or family practice doctor now a vanishing breed, yes we could and should put in place incentives to encourage more medical students to go into the field. But we also need to address the problem without delay.

"Utilize physician extenders," said Jim Lott.

When I worked for Maine Medical Center in Portland in the 1970s, the Department of Community Medicine spearheaded the use of nurse practitioners and physicians' assistants in rural areas that had no doctor or only part-time medical personnel. The patients I interviewed were satisfied and grateful for the care they received from these new-fangled (at the time) health care providers.

Under-served communities in California–both rural and urban–deserve as much.

Especially as health care delivery becomes more "holistic" under the requirements of the ACA, Lott said. Patients will have a universal health record. "Nothing short of a sea change," he said. Hospitals won't be paid based on the number of 'heads in beds', but

instead, hospitals, doctors, and insurance companies will have to cooperate and be paid on how well they contribute to the overall health of individuals and communities. Without primary care providers, it seems unlikely to me that this cooperative paradigm will work. “We are going to be forced to do something we haven’t done before,” said Lott. “Talk to each other.”

Here in California, one immediate step is to support AB 2348 to allow RNs and nurse practitioners to write prescriptions for birth control. As I reported earlier this month, thousands of women seeking contraception are currently being turned away from clinics because there aren’t enough doctors to see them.

Then we should move forward with ways to empower and employ more nontraditional providers of primary care.

3. Continue to work toward a single payer system

There is nothing to stop California from creating our own Medicare-for-all or other single-payer system.

Instead of blaming Obama for falling short, let’s see what we can do here at home.

And keep in mind the context provided by Mark Patterson. Theodore Roosevelt, inspired by social programs in Europe, first tried to reform U.S. health care in 1912. Truman wanted a single-payer system. Nixon, Carter and Clinton all put plans forward. And? “There was never a single vote in Congress, in the House or Senate.” Bills never got out of committee. Obama’s plan was the first time there was ever actually a vote on health care reform, and with its compromises, it passed. “You have to figure out how to do the politics first,” Patterson said. (And here I’ve been wishing for years that Obama would handle Congress like LBJ. In this case, I guess he did.)

Paul Song, a champion in California’s fight for a single-payer system, pointed out we already came close to achieving it, having lost out in the Senate by only two votes. He thinks more people will begin to see the advantages: eliminate administrative waste, negotiate bulk drug pricing, save doctors $70,000 year and valuable time by reducing paperwork. Last time around, according to Song, Jerry Brown said if the single-payer bill passed, he would sign it.

We have “a platform to build on, but for that to happen, the Affordable Care Act has to stay in place,” said Jim Lott, adding, “I don’t have to tell you what outcome is required in November.”

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