

# Health Care for All?

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**C**hange is coming to our health care system, whether we like it or not. We spend over 14% of our GDP on medical care, compared to 8-10% for modern European countries and Canada, and yet we have poorer health care indices, including infant mortality, access, and preventative care. Many of us utilize the newest in medical technology and the most expensive drugs ever developed. But, despite our record expenditures, nearly one in six of our citizens have no health care insurance, and this lack of insurance has been shown to lead to delays in care, poorer health outcomes, and huge societal costs. Something has to change, but where will we go, and who will decide?

## Proposals for Change

In 2001, The California Health and Human Services (CHHS) Agency sponsored a study for proposals to expand health insurance coverage in California, as required by a 1999 law (SB 480-Solis). Nine proposals were developed and studied for their coverage, benefits, costs, and limitations ([www.healthcareoptions.ca.gov](http://www.healthcareoptions.ca.gov)). Now, in the California State Legislature, several proposals have been submitted in an attempt to begin to address this overwhelming issue. These span the range from a single payer system to incremental approaches expanding existing employer coverage and safety-net programs, mirroring many of the suggested solutions from the CHHS study.

It is unclear if a definitive solution will be passed by the California Legislature this session, but these proposals presage a period of study and trial legislation which will most likely lead to significant legislative action. It should be apparent to providers and users of the health care system that participation by all involved parties is important if “universal” health care for California is brought into existence over the next few years.

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### **CMA Principles for Health Care Reform**

The California Medical Association (CMA) has produced a set of principles it will promote in the debate. These principles include that:

1. There be no physician mandate to participate;
2. Premiums must be actuarially sound;
3. Patients must be permitted a choice of physician;
4. Reimbursements should not be set by the government;
5. All eligible employees must participate;
6. Coverage should be portable;
7. Any program not be an extension of Medi-Cal.

While these CMA principles may be acceptable to the CMA and to many physicians, other stakeholders may not support them.

### **Single Payer—Just Let the Government Do It**

There is a large consumer constituency supporting a single payer health care system, most commonly modeled after the Canadian system. Proponents argue that a single payer system could replace all employer based and private health insurance, workers' compensation, Medi-Cal, Healthy Families and Medicare, for less than is currently spent for each of these separate systems in California. Analyses of single-payer proposals predict savings of \$3.7-\$7.6 billion in total health care spending in California (currently at \$151 billion/year), primarily because of reduced administrative costs and bulk purchasing of drugs and medical durable equipment. Nearly 8,000 physicians have endorsed a national single payer system detailed in *JAMA* (Aug. 13, 2003, Vol. 290, No. 6, pg. 798-805).

Senate Bill 921 (SB 921, Kuehl) proposes such a system for California. It creates a California Health Care System (CHCS), administered by a Health Care Agency. An elected Health Care Commissioner would determine eligibility, benefits, payment, budgets, standardize claims and reporting, enroll all residents, determine geographical regions, bid for drugs and durable medical equipment. A Health Policy Board (composed of three physicians and 19 non-physicians) would be charged with establishing policy on medical issues, scope-of-service, access, evaluation, and standards. A Medical Practice Board would determine medical practice standards, and a Health

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Care Inspector General would have broad powers to investigate financial and business records of all providers of care and prosecute fraud and abuse. Regional Health Agencies would be created to deal with geographic issues.

SB 921 would cover all California residents. Non-residents receiving care would be billed for services. Covered services would include formulary drugs, and co-payments and deductibles would be severely limited. All current expenditures for health care, including employer and employee contributions, governmental program contributions at the federal, state and local levels, and many out-of-pocket costs would be eliminated and replaced by the CHCS system. Funding would include a new personal income tax, cigarette, tobacco and alcohol taxes, employee and employer contributions, and waivers allowing the application of Medi-Cal and Medicare funds. All insurance companies, insurance agents and other intermediaries would be replaced by the CHCS, saving additional expenses. Physicians and other providers would not be government employees, but would provide services at negotiated rates and arrangements, which are undefined but which could include fee schedules, capitation or salary.

The potential problems with a single payer system include the obvious issues related to governmental control of all policy, quality, access, and reimbursement issues. While Medicare boasts an extremely low administrative cost (4% vs. 15-30% for HMOs), it is easy to imagine the effect of limiting budgets, new versions of RBRVS, certificates of need for technology, and rationing to limit costs. With little to limit the public's consumption of health care, control could come through reduced reimbursement, delays, and less accessible care. The image of Canadians crossing the border for MRIs and bypass surgery dims the appeal of single payer for many.

### **Incrementalism—Will A Little At A Time Be Enough?**

In 2001, 6 million Californians lacked health insurance at some time during the year, and another 3 million had no health insurance at any time. Of those Californians without insurance, up to 80% are employed or family members of a wage earner. Unfortunately, because of cost, many small businesses do not provide medical insurance to their employees. The incremental approach to health care reform involves attempts to expand existing programs and fill gaps in coverage by increasing participation in employer based and government programs. Healthy Families has expanded to include more children and

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their families in low income households, and play-or-pay will attempt to force more businesses to insure their employees.

The most prominent health care reform attempt in the current legislative session is SB 2 (Burton, Speier), which is a “play-or-pay” bill. All employers would be required to provide health care insurance for their full-time employees and uninsured dependents, comparable to a standard health care service plan and including basic prescription drug coverage. Employers could not require employees to pay more than 20% of the premium. Employers could select and purchase health plan coverage, self insure, or pay a fee to the State Health Purchasing Program (SHPP), which would then insure their employees. Employees choosing coverage beyond a basic package could be required to pay the balance. Co-payments and deductibles would be limited for basic coverage packages. Coverage would be coordinated for those eligible with Medi-Cal and Healthy Families programs.

If not “playing” by insuring employees, an employer would be required to pay a comparable amount into the SHPP, which would then insure employees through a purchasing pool, contracting with participating health plans.

Several variants on SB 2 have been introduced, and will probably be folded into SB 2. AB 1527 (Frommer) would require only employers with 500 or more employees to provide health care coverage to their employees and dependents. This would be done by providing employer-sponsored insurance, paying into a California Health Care Coverage Pool, or enrolling eligible employees and their dependents into available public programs and contributing any share of cost required. AB 30 (Richman) would expand the Healthy Families program to provide coverage to employed childless adults who are uninsured for health care and who meet certain income requirements. AB 1528 (Cohn) would enact a standard uniform benefit package, require universal employer participation, and provide public support when necessary. These variations on the theme, and SB 2 itself, are in very preliminary form currently and may represent the tip of the eventual iceberg of health care reform legislation ([www.californiaconnected.org/your/vote/2003/0417.html](http://www.californiaconnected.org/your/vote/2003/0417.html)). They demonstrate the various ways political forces will try to modify an employer mandate to soften the blow to business.

Business groups and employers, fearful of increased overhead costs and competitive pressures in an already weak business climate, generally oppose such mandates on employers. Incremental steps will obviously not address issues

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of redundant layers of administrative costs, overlapping programs, care for the unemployed and underinsured, and the drain of funds by the for-profit institutions.

### **Should Physicians Have A Voice?**

The final solution to our complex system of medical care, and its admitted gross inadequacies, is far from definition. Powerful forces are nonetheless working towards constructing a new system, whether in simple steps or in a broad, sweeping stroke.

Physicians are the center of any system of health care, currently receiving only 20% of the revenue but responsible for most of the expenditures in hospital costs, drugs, and office care. It may seem easy to avoid involvement in the current discussion with the daily crises of inadequate reimbursement, over-regulation and for-profit control of large segments of the population. But, these attempts to create a new system of health care may continue and lead to legislative solutions. We can sit back and be pawns in the manipulations of others, forced into a system where government salaries are the only choice if we want to see patients. Or, we can participate in the process and strongly register our opinions about quality care, appropriate rationing mechanisms, and the need for educated patients to choose their own physician and participate in the cost of their care.

CMA has obviously chosen to be at the table, and will continue to represent physicians, patients, and quality medical care standards to legislators working on these very difficult challenges. If you care about your future as a physician and as a patient, you should participate in the process as well. You can learn about the bills through [www.cmanet.org](http://www.cmanet.org), participate in your county medical association's political activities [*Editor's Note: and your CSA's political action activities*], and follow the media as these proposals work their way through the Legislature. As you learn more, you may wish to share your concerns on troublesome directions of legislative solutions with your friends, patients and elected representatives.

The future of our health care system is now being decided. Hopefully, the voice of physicians will be heard beyond the surgery lounge or hospital lunchroom, before we find ourselves thrust into a system that makes for-profit managed care look good!