An Analysis of the Proposed California Universal Healthcare System

Steven C. Gabaeff, MD California Chapter of the American Academy of Emergency Medicine

The California Universal Healthcare System (CUHS) proposal advanced by State Senator Sheila Kuehl as SB 840 was passed twice by the Senate and Assembly but was vetoed by Governor Schwarzenegger when it arrived on his desk. The proposal has yet to garner any support among physician groups. CAL/ACEP and CalAAEM both have resisted supporting this measure in the past out of fear of government control and a sense that this would expand the poorly funded Medi-Cal system over which we have no control and will make the already awful situation we have even worse.

Yet this issue has taken up residence on the healthcare horizon and has been both a source of hope and derision within the medical community. Various approaches have been advanced since the rejection of SB-840, including the recent failed attempt by the governor, Senator Don Perata and Assembly Member Fabio Nuñez who also were unable to generate any real support for their respective proposals. A recent informed opinion predicted that no further action will occur during the 2008 legislative session.

The money needed to fund such a system projected by Kuehl was to be a combination of existing premium dollars from employers and individuals and a pooling of federal funds (Medicaid and Medicare) with the immediate exclusion and the anticipated demise of the private for-profit indemnity healthcare insurers (Blue Cross, United Health, etc with Kaiser specifically not included in this group). The why, from a strictly economic perspective in part, is that the administrative overhead and profit currently built into private health insurance accounts for about 25-30% of each premium dollar. Kaiser and MediCare currently spend 4% and 3% respectively on administrative costs. Shifting these funds to healthcare services would go a long way to cover the cost of the currently uninsured and covered anticipated system costs.

After reflecting on the dissonance of "for-profit" and the mission of the healthcare community, many have seen these insurance companies as a significant part of the healthcare coverage problem. Their use of exclusionary strategies for preexisting illnesses, underpayment, outright fraud, the use of bribes disguised as political contributions to impact policy, retroactive exclusion of insurees, denials of service and other activities are some of the unseemly and profit- dominated strategies and tactics that CAL/ACEP has struggled mightily to overcome. Virtually all physicians who study this crisis see these insurance entities as part of the problem and many see their influence as a significant obstruction to a comprehensive and effective solution to the healthcare services crisis. Corporate profits and a patent disregard for the welfare of their insurees seem to dominate their business plans.

The notion of a universal healthcare system run by a regulated agency of the state or the federal government has recently been advanced in another forum by former U.S. Senator Tom Dachel. The CUHS, generally referred to pejoratively as a "single payer system," so far has only achieved limited acknowledgement as "a recognized form of healthcare delivery" to CMA and a few other professional organizations. The California Nurses Association (CNA) is most likely the largest, most vocal, dynamic and unequivocal of the supporting professional organizations and has committed significant resources to this concept.

The CAL/ACEP Board, at the urging of a few board members, some months ago decided to re-seat a task force to look at the CUHS proposal again and come back with some language that the organization would consider supporting. On a parallel track, CAL/AAEM looked at the issue and decided, like CAL/ACEP, that if a set of guiding principles could be generated that met the needs of emergency physicians and would lead to a general benefit for all patients and providers, that they too would reexamine their position.

The task force independently generated some guiding principles that were regarded as essential. The language went through several iterations and ended up more or less congruent with CMA's position (see below). The CAL/ACEP resolution stated that if certain conditions were met, the organization would "consider" supporting the "single payer system." This version was brought before the CAL/ACEP board on March 4, 2008. Here the decision was made to offer the principles to the general membership for discussion and comment. The intent was to survey the membership to gauge support. The idea of presenting some of the constructs in more detail in a document like this, to determine if the concept is worthy of support and to get feedback from the general membership was subsequently implemented. CAL/AAEM had reached a similar decision in early February and is moving forward with the same strategy. This document in fact will be published in the next *Western Journal of Emergency Medicine*'s CAL/AAEM Chapter insert for a similar purpose.

The resolution offered to the Cal/ACEP board was as follows:

RESOLVED: That CAL/ACEP understands a single payer plan to be a viable form of healthcare delivery and;
RESOLVED: That CAL/ACEP supports the inclusion of the following principles in any single payer health reform proposal:

1) Every California resident is covered;
2) A neutral body, including physicians, determines the benefit package;
3) The benefit package is comprised of all medically necessary services, including emergency care services as defined by the prudent layperson standard;
4) Patients are allowed to purchase additional services outside the benefit package;
5) Emergency and on-call physicians are provided a means to ensure expeditious and fair payment for their services;
6) Funds are maintained to address costs accrued by those not enrolled in the plan, including undocumented individuals;
7) Physicians are allowed to collectively negotiate compensation.
8) It includes mechanisms for quality improvement, risk reduction, and outcome analysis to determine best practices;
9) It includes mechanisms to resolve patient complaints, review and compensate patients for true medical errors, and will develop a provider-paid risk pool as a source of compensation;
10) There is a means to address capital investment and infrastructure building.

The approved CMA version, recently reaffirmed, looked like this:

RESOLVED: That CMA considers a single payer plan to be a recognized form of healthcare delivery; and
RESOLVED: That CMA will continue to consider a single payer health reform proposal, if the following criteria, at a minimum, are in place:

1) Physicians must be provided a means to ensure payment of their usual and customary charges as defined by the Gould criteria;
2) A scientific, apolitical body must make benefit/coverage decisions;
3) Pluralistic delivery system options must be retained (e.g., pre-paid group practices, FFS);
4) There must be a mechanism for addressing fraud;
5) Patients must be allowed to "buy up" – to purchase additional coverage outside the "single" plan;
6) There must be a mechanism to address capital investment and infrastructure building;
7) Medically appropriate co-payments on a sliding scale must be incorporated to discourage excessive utilization;
8) Physicians must be permitted to collectively negotiate.

I wanted to discuss the concepts in more general terms and introduce some other variations to stimulate some response. The information gathered in response to this piece, it is hoped, will provide direction for the respective boards on how to move forward.

GENERAL CONSTRUCTS

Support vs. consideration of support

The primary issue that has emerged is that if these guiding principles were to be incorporated would the organization support or just "consider support" of the CUHS. While this may seem to be a subtle difference, experience demonstrates that support equates to inclusion in the process and "consideration" is not support. Several board members wondered aloud if the CUHS was even a good idea. As reference to the system as the "single payer system" gained traction over a concept of universal healthcare, the concept seemed to sidle up to other catchy phrases like "socialized medicine." Clearly the issue of how this is referred to evoked some visceral responses.

How should WE refer to the system?

The proposal was called the CUHS by Kuehl. "Single payer," as it is now referred to, was a term that evolved with the consequence, intended or not, of invoking some negative imagery. Canada, France, Germany and other first world countries with universal coverage and a government payment system characterized by some as "socialized" are technically single payer. Both terms evoke negative feelings and are frequently portrayed as inferior although frankly no evidence that I know of supports that. In fact, many measures of US healthcare indicate that we reside somewhere between Costa Rica and Slovenia in the grand scheme of things.

I feel this issue is better served by being referred to as Universal Healthcare and ask you to consider this approach. It helps define an intent that all citizens and legal residents will have health insurance. Who pays and how much should be separated from the intent to provide healthcare to all Americans.

Who pays and how much?

No one will accept inadequate payment. It isn't really an option. The determination of what is adequate is really

the issue. One approach is to start with current income levels and mandate cost-of- living growth. We can look at average income from patient visits, average RVUs per visit and develop schema to start with that are consistent with current revenues. Some version of an RVS-like system could be designed to allow for a fee-for-service approach, which is the bread and butter of EM. Looking at current revenue numbers, we would be able to work backwards to an RVU dollar amount that could be applied across a broad spectrum of standardized charges. The RVS-like system we would apply to ourselves for medical and surgical units could be applied to our colleagues in other specialties as well. The historical glow around the RVS system may make the entire idea more palatable to many physicians. The principle that everyone seemed to agree on is that funds flowing into the EMS system must be adequate by any standard that would be applied.

The issue of who pays theoretically is not that relevant. We would all be happy to have a payor who just pays when billed. However, for those who see the government as a negative, the single payer idea is joined at the hip with a belief in the inevitability of the initial negotiated rate decreasing over time, while we are left with no recourse and sink into a system that looks like a bad version of MediCal. This doomsday scenario is predicated on a lack of faith in government and a belief that the revenue will not match needs from day one, with the problems increasing over time. To insulate ourselves we will need contracts that set current revenue as a baseline from which the changes in cost of living would be added. Reductions in physician fees are not allowed and revenue streams must be flexible and designed to continually match needs.

So where will the money come from? It is clear that employers want out of this. Looking to patients to purchase health insurance at subsidized rates ignores the extreme pressure that the poor and middle class live under. We need only look around now to see how that does not work. Many struggling families and individual are unable to justify insurance with incomes that barely cover essential expenses. Until you have income north of $150,000 per year, life is a series of calculated monetary decisions generally based around the idea that you don't have enough and you have to prioritize. Under $50,000 there is very little discretion. Health insurance cannot supersede food, shelter and clothing.

The only people with money are the rich. Most of you readers will be somewhat relieved to know that I am not including the average EP in this category. I think of us as really upper middle class. Most of us have a nice salary but among the younger MDs especially, real wealth is not part of the equation, and a loss of income would soon lead to dire straits.

The super-rich, on the other hand, have systematically engineered the maldistribution of wealth from Reagan on and now have more than they know what to do with. In our efforts to raise supplemental revenue for universal healthcare we can focus on those making more than a million dollars. Their varied excesses are starkly in contrast to the vast majority of society (99%+) who live under duress on a daily basis and without basic needs fulfilled. It is my belief that the money is there to pay for universal healthcare, but the people that have it resist the notion of healthcare as a basic human right and see it as a privilege reserved for those who can pay for themselves. They are likewise disinclined to see emergency services as a public utility, like police and fire, and will not support even focused support of EMS. Regarding taxation, I think that we need to advocate a progressive tax structure that places more of the burden on those with greater income and wealth. Government must step in to redistribute capital until the needs of society are met under a moral mandate. It is clear that the "market" or the trickle of wealth passing through the hands of the super rich is grossly inadequate and fundamentally deaf to the problems we have that can only be solved by a mandated investment in the healthcare of Americans.

THE PRINCIPLES TO CONSIDER

Below are the principles that we would like input about. Feel free to comment and contribute to the discussion in any way you want. All comments will be reviewed and have appropriate representation in a follow-up document which our task force will put together.

The benefit package must include all necessary services

There has been a sense that the only system that will fly is a "basic" system in which all healthcare services that could be needed will NOT be included. The logical (or illogical) extension of this is that supplementary forms of insurance will be necessary. Many organizations acting on this premise have insisted that individuals be guaranteed the right to buy additional insurance. The point seems fundamentally moot to me but apparently not to others interested in a two-tiered system.

If there are insurance products out there for sale or facilities that want to cater to the rich and people want to sell insurance for that, fine. Anyone can buy anything. It really is not the issue. The real issue is whether the CUHS will provide all necessary medical services (including dentistry and optometry and other essential allied medical services) to all California residents. I think this is the most important aspect of the entire concept. If you are an enrollee, every medical service you will need must be provided. The intent of the program should be to provide all necessary medical services. Evaluation of alternative therapies – chiropractic, acupuncture, yoga, massage, herbs, medical marijuana, etc. – and their inclusion or exclusion

would be on an ongoing basis, and decisions evidenced-based.

Benefits will be defined by professionals, based on evidence based analysis

The scope of benefits should be defined by objective professionals working within the system and separated from revenue issues, using an evidence-based approach. There should be ongoing analysis of the system and adjustments made when new services need to be integrated into the standard of care.

There must be support for research and provisions to pay for experimental care at designated institutions. As these new modalities are proven worthwhile they should and would be included in the benefit package and payment for such services would be made to any qualified provider of these services. The system will need to consider the nurturing of the healthcare manpower and educational resources needed to operate the system and work to insure that there are adequate training programs in place to maintain the workforce

Mechanisms for quality improvement, risk reduction, outcome analysis and prevention will be included.

The system will incorporate mechanisms for quality improvement, risk reduction, and outcome analysis to determine best practices within each aspect of the program. Health promotion and disease prevention would be billable services. The nature of a single integrated system will provide data to measure, analyze, apply and adopt improvements.

Support of infrastructure development

California needs more hospitals. It needs the existing hospitals updated and more capacity. This important area has been underfunded for decades now. Some portion of the revenue stream into the system must be dedicated to identifying and funding such projects.

Maintain compatibility with the existing healthcaredelivery models

The system, at first, must support the different provider models that exist. PPOs, HMOs, IPAs, group practices and individual practitioners must all have reasonable means of interfacing with the CUHS and be paid for services from day one. Over time many contortions of healthcare delivery that we now have will presumably unwind into a system of payment for service. Those working harder will be paid more. Strategies to avoid delivering any healthcare to prepaid enrollees, the cornerstone of prepaid systems profitability (again except Kaiser), would be replaced with requirements, incentives and payments for preventive care.

Prompt payment will be guaranteed for all included medical services for all patients

All claims will be paid upon receipt. There will be an assumption that providers will be honest.

Intensive provider auditing on an annual basis will be mandated

The presumption of honesty would be buttressed by mandatory auditing. Auditing would be necessary to support prompt payment. Auditing will be compulsory and regular. Each year every provider or provider entity would be subject to an extensive audit. Computer analysis of claims would be used to identify patterns of fraud. If any fraud is discovered, the consequences would be expulsion from the system and mandatory fines. Providers should expect that any fraud will be discovered and the system will react with force and severity.

Back up physicians will be compensated

While this idea was assigned importance in our previous discussion, in the context of all physicians participating in the CUHS, this issue is moot. Everyone will be paid for all services. RVS-like codes for night care and on call work should be reinstituted to reward the hardy souls who take call and stay up at night. Paying back-up physicians will be part of the basic principle that all services will be provided and all providers will be paid for all medically necessary services, at all times, for all patients.

Services for the uninsured and undocumented will be paid for by the fund, promptly

Funds within the system will be carved out to address costs accrued by those not enrolled in the plan (out-of-state visitors, etc.), including undocumented individuals. All patients seen will be paid for by the system. The system will serve as collection agency for those nonmembers who are treated and can pay. Those that cannot pay will be an expense to the system, not the providers. The system and the state will continue any and all efforts to collect monies from the federal government for undocumented individuals receiving care.

Mechanisms to resolve patient complaints, review and compensate patients for true medical errors will be included.

The existing wording in SB 840 had provisions for dealing with patient complaints through both administrative

and medical review. The system provides for expanded opportunities for dispute resolution that would have a significant impact on the current "malpractice crisis." The key to responding to patient complaints and bad outcomes is objective review and a willingness to identify and acknowledge medical errors. Medical errors do occur and will continue to occur. The current legal defense strategy, denying all mistakes and fabricating a defense for the benefit of defense lawyers, could be replaced with a panel of analysts who objectively assess what happened. If a medical mistake is identified, the system's compensation fund will reasonably compensate the aggrieved patient or his family. It should be noted that medical costs for continued care, the bane of neurosurgery, obstetrics and orthopedic bad results, and often the most onerous and expensive part of a malpractice award, will not exist since all patients are covered for all necessary medical services for their entire lives. Compensatory damages will be fairly calculated. Litigation will be a last resort when reasonable offers to resolve are disputed or refused. Individual physician high-deductible polices are more feasible with such a system since, say, the first $250,000 of any compensation would come from the fund. Punitive damages would be reserved for issues that affect public welfare only and would benefit the system and the public interest, not the aggrieved patient.

Develop a provider paid risk pool as a source of funding for medical errors

A provider risk pool would be established to support the compensation fund. Such action is only a small step short of full self insurance. The costs of such a system can be paid for by a percentage of physician fees. Higher priced services and high volume providers would contribute proportionally larger amounts to the insurance fund based on the volume of services provided.

Physicians can bargain collectively.

This is a real plus. At the present time collective bargaining and strategic negotiations for a group of physician (by specialty) is forbidden under onerous anti-trust statutes that make little sense when applied to professional organizations working with government agencies and politicians to protect their specialties. By making it legislatively acceptable for a group of physicians to negotiate for fees for their specialty, a representative entity like CAL/ACEP, in concert with other organizations like CAL./AAEM, would be allowed to deal with the system collectively and on behalf of all EPs. In the context of an RVS-like system, or any other measure of average fees integrating cost-of-living increases, the negotiations should be relatively straight forward.

Summary of Principles to be considered

1. **The benefit package must include all medically necessary services.**
2. **Benefits will be defined by professionals, based on evidence-based analysis.**
3. **Mechanisms for quality improvement, risk reduction, outcome analysis and prevention will be included.**
4. **Support of infrastructure development is necessary.**
5. **Maintain compatibility with the existing healthcare delivery models.**
6. **Prompt payment will be guaranteed for all included medical services for all patients.**
7. **Intensive provider auditing on an annual basis will be mandated.**
8. **Services for the uninsured and undocumented will be paid for by the fund, promptly.**
9. **Mechanisms to resolve patient complaints, review and compensate patients for true medical errors will be included.**
10. **The plan must include development of a provider-paid risk pool as a source of funding for medical errors**
11. **Physicians can bargain collectively.**

Let us know you thoughts. Do you support a universal healthcare system? Can you support these principles? How can they be improved? What is missing? This is a starting point, but many of us on the task force envision a leadership role for EM on this important issue and an opportunity to raise the political profile of EPs. We stand on the front lines of healthcare on a day-to-day basis, and we believe we can move to the front lines of this issue and be effective.

Thanks for your consideration of this important issue.

Best regards to all colleagues,

Steven C. Gabaeff, M.D., F.A.A.E.M
Member, CAL/ACEP Task Force of Universal Health Care
Member, Board of Directors CAL/AAEM
Member, Past Presidents Council CAL/AAEM
CAL/AAEM Representative to the CAL/ACEP Board and ex-officio CAL/ACEP Board Member
CAL/ACEP member and strong supporter