

The Affordable Care Act and California's San Joaquin Valley: A CAUSE Perspective

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**Central Valley Health Policy Institute
California State University Fresno**

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About the Central Valley Health Policy Institute

The Central Valley Health Policy Institute (CVHPI) was established as an ancillary unit of California State University, Fresno in April 2002 and funded by The California Endowment in 2003. Our mission is to improve equity in health and healthcare by developing the region's capacity for policy analysis and program development, implementation and evaluation through integrating and leveraging the resources of California State University, Fresno and the institutions and communities of the San Joaquin Valley.

Additional information about the Central Valley Health Policy Institute, its programs and activities (including this report), can be found at: www.cvhpi.org

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Executive Summary

The US health care system has many resources: our hospitals boast sophisticated equipment, most practitioners are well-trained, and impressive dedication to patient care is the norm. We fund health care more generously than any other nation in the world. Yet, in the midst of this abundance there are at least 52 million people uninsured and many more are underinsured. Lack of basic health care for everyone affects the health of individuals, families, communities, businesses, and our nation. The pressing need for our health care system to become more effective in improving population health is perhaps most evident in high poverty, rapidly urbanizing regions such as California's San Joaquin Valley. In 2010, the US began implementation of historically significant and sweeping legislative reform of the health care insurance and delivery systems. There will likely be important improvements to the system over the next decade. Even with the major changes in policy now being implemented, health care will grow to more than one-quarter of the economy within the decade. We believe the new national policy will not by itself produce excellent, equal opportunity health care for all, both in the United States as a whole and in our region in particular. This report explores the implications of national health reforms for the San Joaquin Valley and highlights policy and program challenges now facing the region.

The remarkably contentious national debate during 2009-2010 resulted in the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152). We will reference the new laws as the "Affordable Care Act (ACA)". Together these bills initiate a series of phased-in changes in health care insurance regulation, new requirements on US taxpayers and businesses, new government subsidies

for the purchase of private insurance, and a broad range of investments in enhancing health workforce, improving care and constraining costs. Yet there is no great sense of national unity or shared relief with its passage. This is not surprising. Although the President, House and Senate, health leaders, and various consumer and industry groups advocated certain goals for health care reform at various points in the debate, the process never came to an agreement on a set of principles that applied consistently as a mission statement in the formulation of health care policy.

ACA begins the most far-reaching effort to improve health care financing and delivery in the US since the passage of Medicare in 1965. ACA includes changes in the existing public health care programs (Medicaid, Medicare, S-CHIP) and the regulation of private insurance, new efforts to increase access to preventive services and improve management of chronic conditions, new funding for practitioner education and demonstrations of new health care roles and other changes. While important elements of the plan are being implemented this year, the most important changes begin in 2014. Over several years, ACA expands Medicaid (Medi-Cal in California) to low-income non-disabled adults, requires all households to acquire insurance, requires most employers to provide insurance, launches new private insurance products for low and moderate income people that are regulated and subsidized through state-administered exchanges, places new restrictions on private insurance, and invests in primary and secondary prevention, health professional education, safety net providers, chronic care coordination, and reimbursement reforms. Figure 1 summarizes some of the key components of ACA.

FIGURE 1
AFFORDABLE CARE ACT
Key Components and Timeline

When?	What will ACA change?
This Year 2010	<ul style="list-style-type: none"> ▪Persons 23-26 remain on parents' plan ▪New federally funded high risk pools for persons denied insurance because of pre-existing conditions ▪Tax credit for small employers to purchase coverage ▪Private insurance reforms (lifetime cap, cancellations, pre-existing conditions for children, preventive services with no co-pay, reporting on loss ratio and cost increase) ▪New requirements on non-profit hospitals ▪States receive federal support to establish exchange, adjust Medicaid programs, and implement new insurance regulations ▪New investments in safety net infrastructure, health care and public health workforce, primary prevention and public health
By 2014 and beyond	<p>Uninsured/Low Income</p> <ul style="list-style-type: none"> ▪Medicaid expanded to 133% of FPL with 100% match (match reduced to 90% by 2020) ▪State exchange for legal residents, 133-400%, other uninsured, small business employees, and insured employees with unaffordable coverage ▪Subsidized coverage with total exposure less than 10% of pre-tax for 133-200% FPL, but less affordable for higher incomes ▪Safety net improvements (increased Medicaid rates, FQHC funding, community long-term options, medical home/integrated care options, innovations center) <p>Medicare</p> <ul style="list-style-type: none"> ▪Reduced subsidy for Medicare Advantage plans ▪Phased in elimination of the Part D “donut hole” eliminated by 2020 ▪Benefit improvements (annual physical, no co-pay for preventive services, transitional care benefits) ▪Bundled payments, value-based pricing, primary care team, and other reimbursement reform demonstrations, ▪Comparative effectiveness, payment , and quality initiatives <p>Privately Insured</p> <ul style="list-style-type: none"> ▪States implement individual mandate to hold qualifying insurance. ▪Most employers devote at least 68% of payroll to purchasing qualifying insurance, cover most employee premiums or pay a similar amount in tax ▪Individual and group market insurance and qualifying plan requirements implemented by states (guaranteed issue, community rating, maximum out-of-pocket at several established levels, minimum benefits, payment increases)

The ACA will take time to implement and, without national and local agreement on health policy goals, the health care industry retains seemingly free rein to pressure for even more favorable treatment during implementation. Because ACA places new responsibilities on states for regulating the health care marketplace and on local providers to increase efficiency and cost-effectiveness of care, much of the debate and maneuvering will occur at the state and local level. In the San Joaquin Valley, important policy and program choices over the next few years will be most effective if made in the context of a local public conversation on health system goals and expectations.

US Health System Goals

Philosophers and political scientists have long debated the roles and goals of health care policies in democratic societies. Today there is consensus that health care has multiple, varied linkages and impacts across our society. As a result, health care policies have multiple goals. And these goals are intertwined with broader ideological perspectives and political movements. Through much of our recent national debate, these complexities are reduced to contrasting views of health care as an earned privilege, a right and a responsibility. Yet framing US health system goals in terms of choice between private markets and equitable access misses the fact that the US health system already exists with known patterns of financing and access, known achievements and inequalities. It exists as the product of how policies have compromised between privilege and rights perspectives and have interacted over time with technological, social and economic influences on health care systems. The real US health system already represents a heady mix of public and private financing, for-profit and altruistic service delivery, and effective and ineffective care. Not surprisingly this mix produces highly variable local contexts and individual experiences of access, quality and cost. This is particularly evident in the San Joaquin Valley, where differences in health care access and quality as well as broad differences in community access to environments and opportunities that support healthy living result in dramatic variations in life expectancy and disease burdens among zip code-defined communities.

The problems and opportunities for reforming the real US health system were explored in a four-year project

of the prestigious Institute of Medicine, National Academy of Sciences. They convened a diverse and distinguished panel of public health and health care scholars, practitioners, purchasers, and other stakeholders to review and synthesize available research on the causes and consequences of uninsurance in the US.¹ This four-year project estimated the financial and human toll for the nation of having a system of health care and health care financing that leaves so many out. Based on their analyses, the IOM panel achieved consensus on broad principles to shape a national response to the causes and consequence of having so many of our residents without adequate health insurance. In updating these principles to current health care system performance and the current political context, we believe that US policy should seek a health care system that is: 1) Continuous, 2) Affordable, 3) Universal, 4) Sustainable, and 5) Effective.

The CAUSE goals articulate an excellent, equal opportunity health system, where all patients have access to needed health services and can anticipate that necessary preventive and curative services are available in a coordinated way across the life course, and that tax-payers and community members feel secure in knowing that the health system provides the services needed to promote our nation's health while living within our collective means.

ACA and the CAUSE Principles

Figure 2 offers an overall assessment of ACA using the CAUSE principles.

Continuous: The current health system provides neither continuous insurance coverage nor consistent access to health services. In 2009 an estimated 25.7 million in the United States, 3.8 million Californians, and 456,000 San Joaquin Valley residents experienced a lapse in insurance coverage during the prior year. An additional 4.9 million Californians and 582,000 Valley residents did not have health insurance for all of 2009. Persons without insurance or with intermittent insurance are less likely to have any medical care in general, and are less likely to have a usual source of care. While most in the US report having a physician's office or family care clinic that they go to on a regular basis and where they have an established relationship, approximately 44.5 million

¹ Source: Institute of Medicine, (2004). Insuring America's Health: Principles and Recommendations. Washington D.C. The National Academies Press.

in the US, 6.3 million in California, and 700,000 in the San Joaquin Valley report no usual source of care. There is mounting evidence that even those with insurance often experience in gaps in coverage and lack of primary care coordination of services.

ACA has the potential to make marked improvements in continuity of care. Those newly enrolled in state Medicaid programs and private insurance plans through the exchange will have improved access to care and greater potential for ongoing relationships with a primary care provider. Through state implementation of new federal requirements, the potential for privately insured persons to be denied payment for specific services or denied coverage based on pre-existing conditions or other abusive policies will be greatly reduced. Individual who have

changes in work, family, and health needs may still experience gaps in coverage. New Medicare programs will ease elders' level and setting for care transitions and many more will have access to patient-centered medical homes. But those in private health plans may not see these dramatic changes in primary care and there are no proposed changes to private insurance reimbursement for prevention, diagnosis, counseling and coordination services. Significant new investments in medical education and loan repayment programs as well as increased funding for other health professional education may reduce the challenges for low-income persons in accessing primary and specialty care, but there is uncertainty about how well these programs will direct new professionals to underserved communities and regions.

Figure 2
Assessing ACA Using the CAUSE Principles

Principle	GRADE	Rational
Continuous	B	1) Reduces risk of private insurance denials of coverage or service, 2) Reduces risk of lost coverage during transitions, 3) More states/delivery systems may offer medical home, 4) Prevention benefit improvements, 5) Only demonstration of payment reform, 6) Workforce investments
Affordable	C	1) Makes health care affordable for under 200% FPL, 2) Does not ensure affordability for 200-400% FPL, 3) Does not limit growth of private premiums for 400+ FPL
Universal	C	1) Reduces demographic and need barriers to coverage 2) Unaffordable coverage may reduce enrollment below 95% estimate, 3) Rural initiatives/safety net expansions/disparity initiatives may not improve access
Sustainable	D	1) Extends Medicare solvency by 6 years, 2) Helps states expand Medicaid, 3) Some effort to “bend cost curve” but not enough, 4) No budget discipline for health care, 5) No FTT
Effective	C	1) Initiative commissions and demonstrations to improve effectiveness, 2) Better consumer information, 4) Health disparity initiatives 3) public health/healthy community initiatives

Affordable: Using the current US health system is costly for individuals and families. For many, these costs are increasingly beyond their reach. Before the recession took hold, nearly 20% reported difficulty meeting health care expenditures and more than 60% of bankruptcies were attributed to health care. Mounting evidence suggests that low income and middle class families begin to postpone or avoid needed health services as health as total health care spending (premiums and out-of-pocket) exceed 10% of pre-tax income. For most people, both the ability and willingness to pay for health care seems to be reduced dramatically as their health care costs exceed this threshold.^{2,3}

ACA dramatically improves health care affordability for many consumers but the legislation leaves out significant population groups and may still force others to choose between health care and other necessities. An estimated 32 million people nearly 1/10th of the US population are expected to receive care subsidized through ACA. In addition, there are an additional \$40 million in tax breaks for small business. For those citizens and documented residents with incomes up to 200% of poverty, Medicaid expansions and the subsidized coverage available through the state exchanges will keep health costs below 10% of pre-tax income. Persons with income 200-400% of FPL (about 88,000/year for a family of 4) will receive subsidies through the exchanges, but they will not keep total health costs below 10% of income. For otherwise uninsured, small-business employees, and the self-insured, selecting a qualifying plan from the exchange will offer clearer shopping, defined levels of financial exposure, and comparable benefit packages, and state oversight of the amount of premium increases. Those offered unaffordable health coverage through their employers also can seek less expensive plans on the exchange. Yet none of these ACA components specifically require that plans be available at 10% or less of pre-tax income or that limits the overall growth in premiums. More than 50,000 San Joaquin Valley residents who qualify for assistance through the insurance exchange and/or subsidies for purchasing care may not be able to find affordable plans in 2014. An additional projected 300,000 persons will be both uninsured and undocumented at that time and not eligible for MediCal or subsidies for purchasing private insurance.

Universal: The current US health care system does not provide health care for all. There are an estimated 56 million in the US, 6.4 million Californians, and 1 million San Joaquin Valley residents who were uninsured in 2009. While younger adults are more likely to lack health insurance, 61% of the uninsured adults are over age 30 and nearly one fourth of those in fair or poor health are uninsured. Although rates of uninsurance are higher among noncitizens, about 80% of the uninsured are US citizens.

Although the Congressional Budget Office projects that 95% of the US population will have health insurance when ACA is fully implemented, so-called undocumented immigrants are excluded from the exchanges or subsidies. In addition, groups defined by specific health service needs (mental health, long-term care, abortion) may still experience significant gaps in coverage, access, and care coordination. Further, the projected number of newly insured persons may be lower than anticipated. Massachusetts' experience with mandatory enrollment and subsidies has found that many people, particularly younger adults, find the cost of qualifying insurance much higher than the tax penalty for not enrolling. Depending on how states design and operate exchanges and insurance reforms, healthier young adults in California may make similar choices as ACA is implemented and reduce the proportion of the whole population that is insured. While more than two thirds of the persons in the San Joaquin Valley projected to be uninsured in 2014 without ACA will be eligible for subsidies or assistance through the insurance exchange, at least some of these persons may remain uninsured because insurance will still be unaffordable. Further, those who are undocumented immigrants---about 1/3 of the region's uninsured---will be excluded from coverage under the new law.

Sustainable: The current US health care system is not sustainable. Total health expenditures reached \$2.3 trillion in 2008, which translates to \$7,681 per person and 16.2 percent of the nation's Gross Domestic Product (GDP). The spending on healthcare has grown faster than the overall economy since the 1960s and is projected to reach 19.5% of the GDP by 2017. Without policy changes, total (public and private) national spending on health care could reach 49 percent of the GDP by 2082. Private insurance

²Source: Blumberg LJ, Holahan J, Hadley J, Nordahl K, "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs*, Web Exclusives [Epub, June 4, 2007], Vol. 26, No. 4, July/August 2007, pp. w463-w473.

³Source: Banthin JS, Cunningham P, Bernard DM, "Financial Burden of Health Care, 2001-2004," *Health Affairs*, Vol. 27, No. 1, January/February 2008, pp. 188-195.

cannot afford to take care of the oldest and sickest patients because the premiums they would need to charge are too high. Policy makers cannot shift excess cost burden to the states which face rising costs with limited resources. California is an example of a state ill equipped to financially support health care services. The 2009-2010 California budget included a 13% (about \$4 billion) reduction in Health and Human Services despite almost 5% growth in Medicaid enrollment. For the budget year 2010/11 the governor has proposed a 6.3% cut to health and human services, on top of continuing cuts from previous years.

A central hope for ACA is that it will increase the sustainability of the US health system. The ACA invests in a needed array of national panels, new comparative effectiveness studies, and reimbursement reform demonstrations. These initiatives may offer important improvements in both care quality and cost-effectiveness, but it is unclear how quickly these innovations will be more broadly adopted or if states will innovate regulatory and reimbursement frameworks that hasten a drive toward efficiency in health care. Primary prevention and preventive service enhancements are believed to increase population health and thus reduce long-term cost escalation, but it is unknown whether or not the scale and design of the ACA investments in public health and health equity are sufficient to create important impacts on the cost curve in the near term. But the legislation does not establish a pathway to budget discipline at national or other levels for health systems or populations. Without some kind of consensus limits on health care costs, we just do not know if the evolution of administration and practice approach in ACA will bring sufficient incremental reductions in the growth of health care costs compared to other economic sectors so that health care remains part of the social safety net of our society.

It is also important to find the most fair and painless way to distribute the burden of paying for health care. In order to finance new costs in ACA, the program obtains revenues from increased Medicare premiums for the very wealthy, new taxes on so-called “Cadillac health plans,” fees on the health care industry, a tanning tax, savings from Medicare Advantage program changes and additional Medicare savings from unspecified reimbursement reforms.

This financing strategy may limit long-term stability of the program: health care industry fees may contribute to increasing prices and premiums and employers may pull away from the most costly plans more quickly than expected. More importantly, because of several political compromises ACA avoided finding financing sources outside of the health care industry and it also needed to set subsidy levels at the less affordable levels noted above. In a political compromise, ACA does not establish a single national insurance exchange with nearly monopsony purchasing power and more capacity to inspire insurance price reductions. Putting this together, ACA may end up making US health care affordable for fewer people than anticipated and curbing the growth of health care less than needed.

Effective: Despite devoting a larger share of its resources to health care than other industrialized countries, the US does not lead the world in the delivery of safe, efficient, and effective care. Surprisingly, when the US health care system's performance is compared to those of other industrialized nations, it lags behind in a number of important benchmarks, including safety, effectiveness, efficiency, access, and equity. For example, on the measure of the number of deaths that could have been prevented with timely and effective care the US now ranks last among the industrialized countries. Ineffective health care in the US has devastating consequences throughout the life course: we have higher rates of infant mortality than our peer nations and only one-half of adults receive all age-appropriate preventative care. Concerns with the effectiveness of US health care arise in all sectors.

In order to promote improvements in effectiveness, ACA calls for establishing a national strategy for health care quality, a national comparative effectiveness research effort, bundled payment and value-based pricing demonstrations, demonstrations program around new health care roles and technologies to improve effectiveness, and new investments in health care and public health workforce. ACA also includes an annual physical exam benefit and elimination of preventive service co-pays in Medicare and coverage for preventive services in qualifying private insurance plans. Several ACA elements also address racial/ethnic disparities in care quality, including new data collection, new community health teams, and targeted workforce development programs. Over time these initiatives

may establish new policies and professional consensus on clinical and administrative practices that promote health care effectiveness. Yet it remains to be seen whether these initiatives will produce improvements in care for persons in private insurance or whether providers in underserved areas will have the resources to adopt recommended practice changes. Because many believe that greater health care effectiveness and population health are as much shaped by living conditions and health education efforts launched by public health and community equity advocates, ACA contains significant new investment in public health to support primary prevention and community transformation grants aimed at inequitable living conditions and primary prevention.

ACA Implementation: San Joaquin Valley Concerns

California is on track to become one of the first states to develop the insurance exchange and insurance regulation changes required by ACA. By October 2010 a bill authorizing the exchange had been signed. Government and provider groups are diligently exploring their roles in implementing the new law. Despite early efforts to implement ACA by 2014, California's short-term is harder to gauge. Still mired in the recession, the state seems poised for another round of draconian cuts in Medi-Cal and other safety net programs. The recession has had even more dire consequences for the Valley, where unemployment and lack of health care access have grown even more than statewide, while county and city budgets for health and human services have been slashed. Valley safety net hospitals face huge losses linked to uncompensated care and inadequate Medi-Cal rates, while other safety net providers are reeling with massive increases in demand. Meanwhile, several Valley counties are in the thick of planning or implementing Medi-Cal and indigent care changes, and a new multi-county Medi-Cal managed care program is just getting started. In this context, Valley health care stakeholders focus on maintaining and enhancing our under-funded and over-stretched health system, even while preparing to implement the new law. Using the CAUSE principles, we describe at least six issues that need to be addressed through Valley advocacy for state policy choices and local efforts to participate in federally-administered components of ACA.

- **Finance Care for the Undocumented:** At least 232,000 people or 8% Valley residents are both

undocumented immigrants and uninsured. Although these persons make up 42% of the uninsured in Valley, they are excluded from ACA's Medi-Cal expansions and private insurance subsidies. Inadequate access to continuous and effective care for this population has a significant negative impact on the overall health of our region. Because so many Valley children nearly 1/3 ---live in a home with at least one undocumented adult, it is in the best interest of all residents to ensure access to basic health care for this population.

- **Consider Valley Context in Medi-Cal Expansion** Given our relatively higher dependence on Medi-Cal than other portions of California and a relatively higher proportion of residents living near Federal poverty limits, the ACA expansion of Medi-Cal will be particularly important for our region. State eligibility determination and enrollment policies can dramatically shape the degree to which new patients are brought into the health care system. The Central Valley will need these systems to be culturally and linguistically responsive and geared to the needs of rural and urban fringe residents. Ongoing and enhanced attention to member participation in decision-making in existing and new managed care plans and administrative and clinical enhancements to support high volume service access sites will be crucial during ACA implementation. Finally, California has the opportunity to develop policies that direct a higher proportion of ACA increases in Federal support for Medi-Cal to the most under-served communities.
- **Medical Homes/Care Coordination:** The strong network of Federally Qualified Health Centers and related community clinics in the region have been noteworthy leaders in demonstrating components of the patient centered medical home approach. But most Valley safety net primary care providers are under-funded and have faced few past fiscal or regulatory incentives to fully develop these approaches. Given our vast geography, poverty and historic shortages and mal-distribution of health care resources, rapid progress toward patient-centered medical home programs is more important here than in other regions and coordinated multi-institutional and regional efforts to support these programs should be pursued. California will have the option to develop a Medi-Cal medical home program and Valley stakeholders can encourage adoption of this approach.

- **Health Care Workforce:** ACA devotes new funding to physician and other health professional education and provides new incentives for emerging practitioners to begin their careers in under-served communities. Establishing a medical school (at University of California, Merced) in the region, and supporting enhancements to post graduate training are importance elements of a comprehensive strategy. New funding for community health workers, public health, telemedicine and electronic health records also suggest the need for increased local education and professional development options.
- **Insurance Exchange and Insurance Regulation:** While California has made important first steps in establishing the insurance exchange and regulating private plans, there are many more decisions to make. New California legislation establishes the basic structure of the exchange, but does not include a specific plan for its financing after initial federal funding, nor does it lay out expectations for the exchange in terms of public engagement in decision-making and communications. Communication strategies used by the exchange need to be responsive to the cultural and language needs of Valley residents, and the governance process for the exchange needs to include representation of Valley communities and populations. The new legislation does not establish any clear guidance on the criteria to be used in selecting and regulating plans within the exchange. Valley patients and others could advocate for restrictions on plans that raise rates excessively or fail to adapt benefit and coverage decisions to special needs in rural and under-served areas. California has yet to seriously debate other changes in health insurance regulation as required by the ACA. As these debates develop, there will be opportunities to strengthen or water down other key insurance reforms in the national law, such as the use of community rating, limitations on loss ratios, consumer disclosure, and denials of coverage.
- **Behavioral Health:** All Valley counties are facing a growing gap between demands for mental health and substance abuse services and the availability of such care. Despite the Mental Health Services Act, behavioral health services have been more developed as a specialty service sharply separated from traditional primary care. Targeted initiatives to expand behavioral health in the Federally Qualified Health Centers and other settings can offer more appropriate service options for this

population and relieve pressure on over-burdened hospital emergency rooms and public safety settings.

Can We Do Better? Towards an Excellent Equal Opportunity US Health Policy

The important advances in health policy represented by ACA will expand health care access for many and make important steps towards improving the quality and efficiency of health care in the United States. We have also described a range of implementation strategies and incremental changes that can further improve the health care system. However we believe it is a worthwhile endeavor to achieve better than a “C” grade in fulfilling the goals of continuous, affordable, universal, sustainable and effective (CAUSE) health care in this country. This will require additional changes in US health policies and practices that go further than ACA does in satisfying the principles of CAUSE. Recognizing that our national conversation about health care will become more focused as elements of the ACA are implemented, we describe six areas of change most consistent with the CAUSE goals.

1) Break the Link between Employment and Health Care:

The ACA builds upon the present system of employment-based, primarily private coverage. ACA does not include a publically financed alternative such as Medicare-for-All that would allow employers a choice for purchasing something other than private insurance. Offering Medicare-for-All plans would provide competition to keep premiums in line. Having a national back-up plan available for all would free employees to seek a change in employment without worrying about the consequences of losing their health insurance.

2) Eliminate the Concept of Shopping for Insurance:

Even as ACA improves the continuity of coverage, some gaping holes in the medical safety net will remain. The concept that one must shop for insurance and wait 90 days for it to be in effect is different than having a publically supported plan that offers a core of benefits that are always available should one lose coverage due to a change or loss of employment. Development and incremental implementation of a Medicare-for-All plan would insure that all persons

always have access set of core benefits.

3) Bend the Curve: Reduce the Rate of Health Care Cost Increases:

Although ACA includes some initiatives to slow health care spending increase, several additional actions could be taken to reining in health care costs: a) Create new incentives to strengthen primary care so it provides all components of the patient centered medical home; b) Let go of the tenet that the government or private insurance must pay for all care simply because it is technologically feasible and available; c) Implement health care budgets. National, state, and sub-state democratically elected health boards can monitor utilization and re-shape coverage based on local experiences and values.

4) Provide Economic Incentives to Promote Health:

While the ACA provides some important new investments in public health and primary prevention and new initiatives around the nation seek to create policies and environments that support healthy lives, individuals still have responsibility for doing what they can to improve their own health. We can use existing employer/employee connections to offer tax credits to employers that engage employees in

managing these risk factors. Employers can also offer wage or benefit enticements for meeting personalized goals.

5) Consolidate Overlapping Health Coverage:

While ACA includes aggressive initiatives to reduce fraud and abuse in health care, it does not address the unnecessary expenditures associated with workers' compensation and automobile insurance. Both systems could be reformed to separate the financial compensation from the health care component of these plans.

6) Medical Malpractice Reform:

ACA includes funding for state demonstrations of medical malpractice reform, yet the new law does not feature a consensus on the shape of this reform and the national patchwork of inconsistent policies is likely to remain in place for years. We can enact a national malpractice approach based on alternative dispute resolution principles. An effective national policy would empower professional panels, chosen in consultation with state health boards, to review malpractice claims that cannot be resolved through mediation.

Introduction

The US health care system has many resources: our hospitals boast sophisticated equipment, most practitioners are well-trained, and impressive dedication to patient care is the norm. We fund health care more generously than any other nation in the world. Yet, in the midst of this abundance there are at least 52 million people uninsured and many more are underinsured with lapses in coverage, or with policies which fail to cover all essential medical needs. Though more is spent on health care in the United States than elsewhere, we trail the industrialized world in life expectancy and infant mortality, two clear indicators of the effectiveness of a nation's health policies. Lack of basic health care for everyone affects the health of individuals, families, communities, businesses, and our nation. The pressing need for our health care system to become more effective in improving population health is perhaps most evident in high poverty, rapidly urbanizing regions such as California's San Joaquin Valley. In 2010, the US began implementation of historically significant and sweeping legislative reform of the health care insurance and delivery systems. There will likely be important improvements to the system over the next decade. Even with the major changes in policy now being implemented, health care will grow to more than one-quarter of the economy within the decade. We believe the anticipated reforms will not produce excellent, equal opportunity health care for all, both in the United States as a whole and in our region in particular. This report explores the implications of national health reforms for the San Joaquin Valley and highlights policy and program challenges now facing the region.

As the 2010 health reform begins to unfold, the US approach to health care financing and delivery is failing from many perspectives. For physicians and other health professionals, the gratification in helping people stay well or cheat death often gives way to frustration and anger towards a system that treats sick people as commodities and practitioners as investors' tools. Private practitioners waste hours on billing and bureaucracy, trying to satisfy the inconsistent, myriad tangle of regulations that insurers and bureaucrats use

to avoid cost and to place barriers between doctors and their allegiance to patients. Meanwhile, practitioners in under-funded community health centers and other publicly oriented programs face growing demands for care that exceeds their skills and resources. The 2009 stimulus dollars helped to shore up struggling state programs, yet many states and California, in particular reeling from the recession, have been forced to make major reductions in health care for their swelling poor populations and face further reductions until new Federal financing or overall economic growth filters into state coffers.

Despite spending more than twice as much on health care as other developed nations, the US treats health as a commodity to be distributed according to the ability to pay within highly variable, regional markets rather than as personal well-being supported by services offered according to medical need and scientifically based consensus. In this market-driven system, insurers and providers compete, not so much to increase access and quality, but to avoid unprofitable patients and shift costs either to patients or other payers. This creates a paradox of a health-care system that is based on avoiding the sick. Despite the economic expansion in the US during the last decade, the emphasis by health care businesses on profit has led to a system characterized by growing numbers of uninsured. Even as the US debated health reform in 2009-2010, the crippling recession has created accelerated growth in the numbers who are uninsured, underinsured, or denied care, and in another paradox, dramatic growth in health care industry (insurance and pharmaceutical) profits.

These concerns with US health care are not new. Despite numerous reform efforts and massive changes in health care markets, technologies, and individual expectations, the basic structure of private and public financing has remained in place since the 1960s. With the election of Barack Obama as President and historic majorities for Democrats who promised health reform, many hoped that 2009 would bring meaningful progress. Instead, the extended and circuitous debate focused on symbolic proxies (death

panels, public option) rather than debating real policy differences. This remarkably contentious national conversation has underscored the power of the multitude of health care interests with their unseemly political donations, special interest lobbyists and embedded policy wonks. All the same, regular people's concern with making progress on this issue remains high. This heightened interest has been evident in the San Joaquin Valley, where health care providers, advocates, and consumers were deeply engaged in the national debate before the legislation passed and now find themselves in multiple public forums struggling to address how they can possibly take advantage of national reform to reduce local health care challenges.

The 2009-2010 national debate resulted in the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152). We will reference the new laws as the "Affordable Care Act (ACA)". Together these bills initiate a series of phased-in changes in health care insurance regulation, new requirements on US taxpayers and businesses, new government subsidies for the purchase of private insurance, and a broad range of investments in enhancing health workforce, improving care and constraining costs. Yet there is no great sense of national unity or shared relief with its passage. Some Republicans have initiated lawsuits and other efforts to stop implementation or rescind the new law, while many San Joaquin Valley candidates for national, state and local office continue to decry what they perceive as intrusive and wasteful policy.

Clearly, the passage of ACA does not reflect building a consensus about the major goals for health care public policy. This is not surprising. Although the President, House and Senate, health leaders, and various consumer and industry groups advocated certain goals for health care reform at various points in the debate, the process never came to an agreement on a set of principles that 1) were articulated to the US people, and 2) were applied consistently as a mission statement in the formulation of health care policy. Instead, the actual policy shaping for ACA occurred as a process of inside discussions with powerful health care interests about finding the clearest path to political victory. Because the path to legislative victory became muddled and frequently shifted over

time, so did the goals of health care reform as proponents and opponents sought to calm troubled waters of national opinion. By abandoning the search for meaningful public consensus on clear goals for health reform, our national politics also created an environment where health care industry interests shaped health policy around their goals even at the expense of impacts on the public's health. The ACA will take time to implement and, without national and local agreement on health policy goals, the health care industry retains seemingly free rein to pressure for even more favorable treatment during implementation. Because ACA places new responsibilities on states for regulating the health care marketplace and on local providers to increase efficiency and cost-effectiveness of care, much of the debate and maneuvering will occur at the state and local level. In the San Joaquin Valley, important policy and program choices over the next few years will be most effective if made in the context of a local public conversation on health system goals and expectations.

Even as the ink is drying on the new legislation, it is clear to many that ACA cannot solve the US health care system's problems. In the short run, ACA will improve health care access to persons with complex health conditions who have been unable to find coverage, extend coverage for students under their parents' insurance to age 26, and make important changes to Medicare that extend its fiscal health for another 7 years. Beginning in 2014, all individuals will be required to have insurance and the ranks of the uninsured will be reduced by up to two-thirds. At the same time, new regulations on insurance companies will curb some of the worst abuses, though locally significant population sub-groups will be excluded from subsidies or improved plans. Nonetheless, the new laws may not significantly interrupt the increasing costs of health care nor improve its quality and effectiveness. Despite the weariness that many feel with the national debate, passage of ACA will not eliminate the need for additional reform. As the newest battle fronts open, a different approach that starts from a consensus on goals is needed. Only through an approach based on unequivocal value-based principles can we have a debate about how to fix ACA, centered on how to affordably make our nation's people healthier rather than on forwarding agendas driven by special interests.

Health Care CAUSE

As practitioners and public health scholars, we share with the late Ted Kennedy, the life cause of creating excellent health care that is accessible to all so that everyone has the services that they need to be as productive and fully engaged in our democracy as they can.⁴ As a practicing physician in Central California, the first author found himself being asked for advice on national health reform by his patients. One such discussion with a concerned patient led to an opportunity to collaborate with public health scholars and health care economists at the Central California Health Policy Institute at California State University Fresno to help design a practical national health care policy that can work for everyone.

As a team, our perspective is partially shaped by the unique health challenges of the Central California region eight in-land counties characterized by enormous agricultural production, crushing poverty, and an overwhelmed, under-funded health safety net. In this context, we recognize that 1) health care is but one of the determinants of population health and well-

being, 2) health care needs are shaped by local conditions, and 3) health care access and quality are shaped not only at the national and state levels but also by unique local interactions between individual practitioners and systems of care. Drawing from 20 plus years of experience in practicing medicine as well as the Institute's insights into the health inequalities in the Central Valley yields a policy perspective applicable to many places in the US.

Over the last 2 years, we have closely tracked the national debate, met with policy makers and their helpers, and have brought the discussion home through multiple conferences and meetings. Throughout these encounters, we have repeatedly found ourselves asking others to not judge the merits of a health reform proposal based on individual or organizational gain and loss but rather, to evaluate reform on how well it meets the goal of making our nation healthier. Despite an almost dizzying variety in framing and emphasis, almost all have agreed that creating fair health care is a core component in achieving the national dream of a prosperous equal opportunity society.

San Joaquin Valley Demographics, 2007

Figure 1

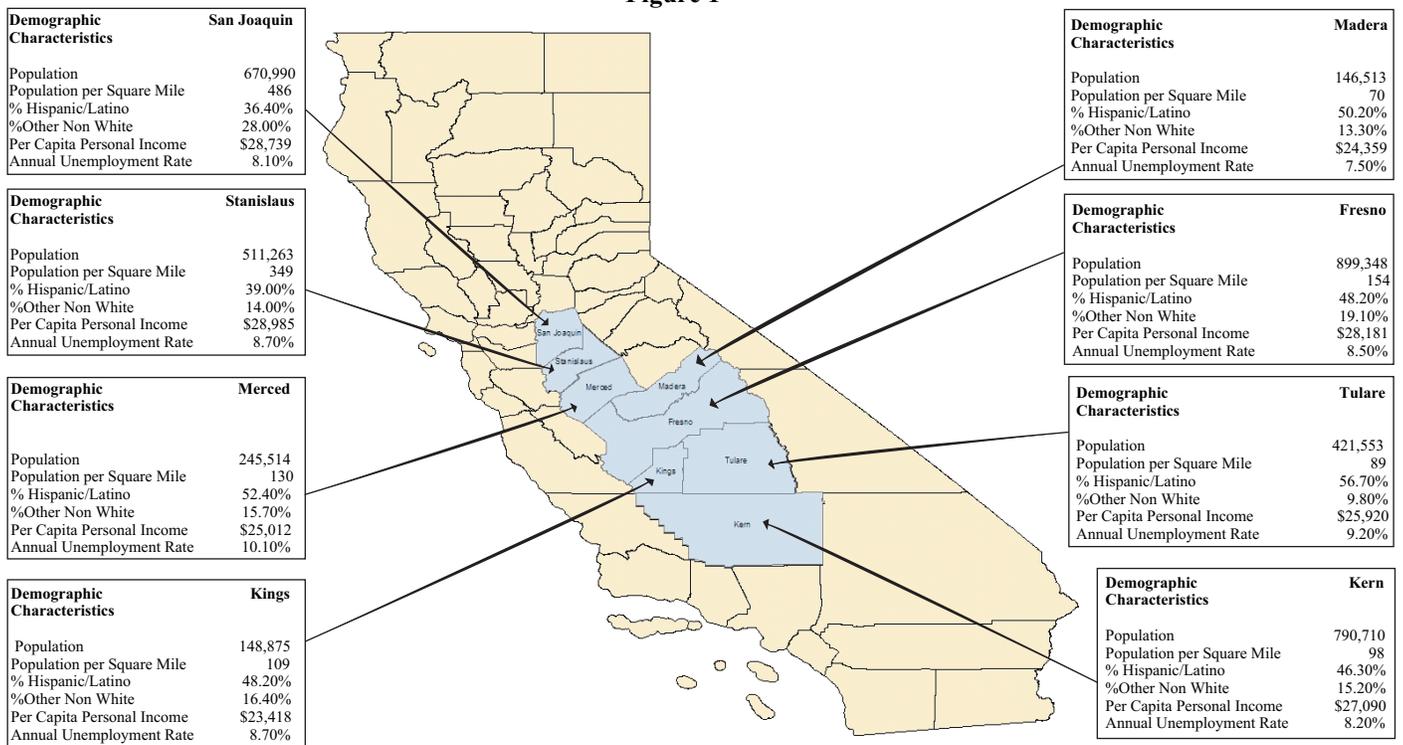


Figure 1 shows a map of California, highlighting the eight San Joaquin Counties; Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare. These data show that all San Joaquin Valley counties are less dense, less affluent, and more racially/ethnically diverse than the state as a whole. Source: Healthy People 2010, Central Valley Health Policy Institute.

⁴ Source: Ted Kennedy, "The Cause of My life," Newsweek, July 21, 2009. Retrieved from: <http://www.newsweek.com/2009/07/17/the-cause-of-my-life.html>

Health Care Reform Goals

Philosophers and political scientists have long debated the roles and goals of health care policies in democratic societies. Today there is consensus that health care has multiple, varied linkages and impacts across our society. As a result, health care policies have multiple goals, which are intertwined with broader ideological perspectives and political movements. Through much of our recent national debate, these complexities are reduced to contrasting views of health care as an earned privilege, a right and a responsibility. Individuals, who see themselves as working hard at least in part so that they are able to purchase health insurance and health care, focus on health care as a privilege. They value health care

policy that permits a private market with little interference and minimal consumer protections. This view is often extended to include a focus on responsibility with each of us responsible for striving to remain healthy and obtain needed health care. Individuals, especially those who perceive the horror of being denied needed services because of cost or coverage and those who have been harmed through bad care or faulty products and unsafe conditions, focus on health care as a right. They value health care policy that ensures access for all and strong consumer protections. This view is also often extended to include a focus on responsibility with each of us responsible for striving to remain healthy, avoid unnecessary health care use, and help pay the costs of the health care for all.

San Joaquin Valley Report Card: Healthy People 2010 Leading Health Indicators 2007

Table 1

Health Indicator	San Joaquin Valley Compared with California	San Joaquin Valley Compared with Health People 2010 Target
Physical Activity		
Adults	Similar	Met Target
Adolescents	Worse	Did not meet Target
Overweight and Obesity		
Adults	Worse	Did not meet Target
Adolescents	Worse	Did not meet Target
Tobacco Use		
Adults	Worse	Did not meet Target
Adolescents	Worse	Met Target
Substance Abuse		
Adults - Binge Drinking	Similar	Did not meet Target
Sexual Behavior		
Adolescent Abstain	Similar	Did not meet Target
Mental Health		
Adults - Treatment for Depression	Worse	Did not meet Target
Injury and Violence		
Motor Vehicle	Worse	Did not meet Target
Homicide	Worse	Did not meet Target
Environmental Quality		
Air Quality	Worse	Did not meet Target
Immunization		
Childhood	Worse	Did not meet Target
Flu Shots	Similar	Did not meet Target
Access to Health Care		
Health Insurance	Worse	Did not meet Target

Source: Healthy People 2010, Central Valley Health Policy Institute

In a series of reports, CVHPI has tracked San Joaquin Valley performance on the the 10 leading health indicators. The Valley consistently falls below California, the nation, and national goals on most indicators. Further, for all indicators where comparisons by race/ethnicity and rural/urban residence were available, Latinos and other people of color and rural residents had worse outcomes. Well-insured, suburban and white men in the region had comparable health to white men in other parts of California.

These perspectives assert powerful influence on how we assess current health care policies and systems and what we are seeking in reform. They appear to provide clear criteria for evaluating alternative policies. Yet this clarity is somewhat illusory. Framing health care reform debates as a choice between a value on private markets versus a value on equitable access misses the fact that the US health system already exists with known patterns of financing and access, known achievements and inequalities. It exists as the product of how policies have compromised between privilege and rights perspectives and have interacted over time with technological, social and economic influences on health care systems.⁵ Yet, because of the influence exerted by these simplified value choices and the constraints imposed by existing technology and resources, we believe that any politically and

practically feasible reform initiative will incrementally change the real health system in the US within the context of such ideological compromise.

The real US health system already represents a heady mix of public and private financing, for-profit and altruistic service delivery, and effective and ineffective care. Not surprisingly, this mix produces highly variable local contexts and individual experiences of access, quality and cost. This is particularly evident in the San Joaquin Valley, where differences in health care access and quality as well as broad differences in community access to environments and opportunities that support healthy living result in dramatic variations in life expectancy and disease burdens among zip code-defined communities.

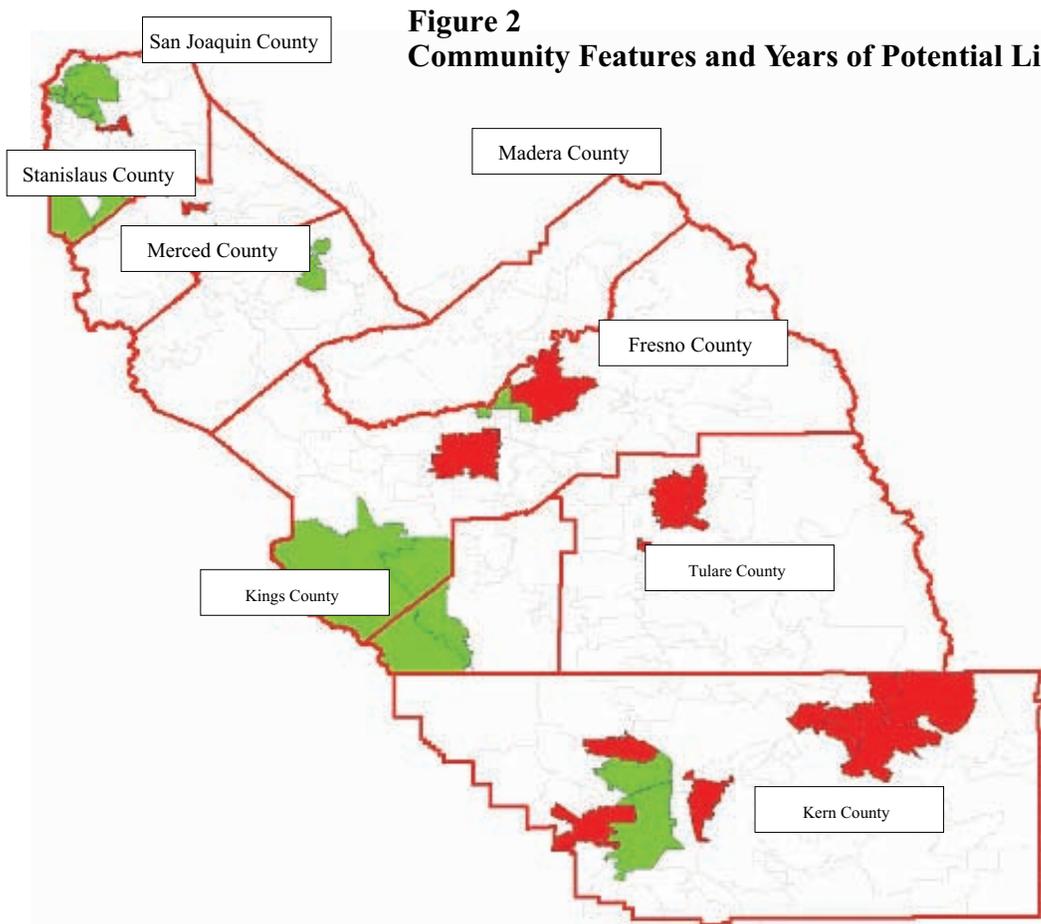


Figure 2 highlights the 15 ZIP Codes with the most loss of productive years (highest rate of YPLL) in red and those with the least loss of productive years (lowest YPLL) for 1998-2007 in green. YPLL provides a measure of the burden of illness on communities and it ranges from 17 to 75 with a mean of 42 in the Valley, a surprisingly large spread. Analyses examining the impacts of other ZIP Code characteristics on YPLL showed that poor communities in general and low-income, segregated urban communities lose more years of potential life. Source: Central Valley Policy Institute: Place Matters. Retrieved from: www.cvhpi.org

⁵ Source: Starr, P. (1982). *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry*. New York: Basic Books Inc

Despite the achievements of modern health care, a consensus has emerged that the policies which created our health system are failing even when viewed through the lenses of competing broad value choices. The private market for health care is failing to ensure choice: even individuals who have worked hard for their health care privileges are experiencing gaps in coverage and care amplified by broad variations in care quality as costs and profits continue to soar. Most agree that these problems will arise with increasing frequency as employers reduce coverage and more and more of us are priced out of the individual market. Public health care programs are also failing to ensure access, with more and more communities unable to meet the care needs of those left out of the private system. Under current law, Medicare and Medicaid will eat up a growing share of public resources. Even with the passage of ACA, Medicare is expected to go broke within 15-17 years. Demographic change, the aging of the boomer generation, and new technology will only bring growing demand and hasten this demise. All of these concerns are amplified by continuing dissatisfaction with well-documented biases in health care, including better funding for technology-infused treatment procedures than health promotion and chronic disease management, racial/ethnic and other inequalities in care access and quality, and lack of integration between primary health care and long-term behavioral health and eldercare services. Reforms that address the real health system in the US need to grapple with all of these problems. Coming to a national consensus on health reform goals is more about exploring our values with respect to these problems than engaging an abstract discussion about privileges, rights, and responsibilities.

The problems and opportunities for reforming the real US health system were explored in a four-year project of the prestigious Institute of Medicine, National Academy of Sciences. They convened a diverse and distinguished panel of public health and health care scholars, practitioners, purchasers, and other stakeholders to review and synthesize available research on the causes and consequences of uninsurance in the US.⁶ This four-year project estimated the financial and human toll for the nation of having a system of health care and health care financing that leaves so many out. Based on their

analyses, the IOM panel achieved consensus on broad principles to shape a national response to the causes and consequence of having so many of our residents without adequate health insurance. They also used these principles to evaluate health care reform proposals under consideration in 2007, when there was not a broadly inclusive national debate or opportunity for advancing new health policy in the US. In updating these principles to current health care system performance and the current political context, we believe that US policy should seek a health care system that is:

- 1) **Continuous**
- 2) **Affordable**
- 3) **Universal**
- 4) **Sustainable**
- 5) **Effective**

During the national health reform debate, we articulated a practical and politically feasible approach to transitioning US health care towards a system that meets the **IOM** objectives. Detailed on our website,⁷ the **CAUSE** proposal outlined a 15-year transition from our current system to one with both a national, universal, and comprehensive core delivery system, financed federally and delivered through diverse public and private organizations, and a private insurance system to help individuals obtain services beyond the national core. A regional forum sponsored by Central Valley Health Policy Institute (CVHPI), the Great Valley Center, AARP and others in September 2009 explored the **CAUSE** proposal and yielded broad consensus on the **CAUSE** goals if not on the details of national reform. Proposals such as ours, that included some adaptation of “single payer/national health plan” models, were consistently recognized as desirable but deemed politically impossible during the 2009-2010 federal debate because they were unacceptable to many in the health care industry and did not appear sufficiently embedded in the complex ideological compromises that have guided US health policy in the past. Nonetheless, the goals explored by the **CAUSE** approach and its specific implications for incremental approaches to changing US health policy remain relevant for an assessment of ACA and analysis of next steps for policy making and systems change. In the following sections, we will show how

⁶Source: Institute of Medicine, (2004). Insuring America's Health: Principles and Recommendations. Washington D.C. The National Academies Press.

⁷Source: Retrieved from: http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/cause/index.html

the IOM principles outline a **CAUSE** that can guide health care reform. We will show in some detail which concerns with the current health system are addressed by adopting each of the goals, how far ACA is likely to take us in achieving each goal, and the kinds of additional policy changes needed to come closer. We will also propose some fundamental reforms that are not presently a part of ACA, which we feel are necessary to better meet the principles of CAUSE, as well as a practical plan that effectively implements these reforms.

The CAUSE Goals:

Continuous

The current health system provides neither continuous insurance coverage nor consistent access to health services.⁸ As of 2009, 25.7 million in the United States had experienced a lapse in insurance coverage during the prior year, while an additional 32.8 million had been uninsured throughout the year. Persons without insurance or with intermittent insurance are less likely to have any medical care in general, and are less likely to have a usual source of care. While most in the US report having a physician's office or family care clinic that they go to on a regular basis and where they have an established relationship, nearly 41 million reported having no usual source of care in 2007. This has increased to approximately 45 million with the current recession.

There is also distressing evidence for lack of continuous care in California and the San Joaquin Valley.⁹ In California, 2.7 million persons under the age of 65 had a lapse in health insurance coverage during 2006, while an additional 3.7 million under the age of 65 were uninsured throughout same year. New

2009 data from the California Health Interview Survey (CHIS) reports that 24.3% or 8.4 million Californians under the age of 65 did not have health insurance either all or part of the year in 2009. Assuming that the ratio of the uninsured part-year (44%) to the uninsured year-round (56%) has remained steady for persons under the age of 65 since 2006, we estimate that approximately 3.8 million Californians had a lapse in coverage while an additional 4.9 million did not have health insurance for all of 2009. Furthermore, 5.0 million California residents of all ages reported having no usual source of care in 2005. This figure has since increased to 6.3 million with population growth and the current recession. Using the new CHIS data, we estimate that 28.5% of San Joaquin Valley residents lacked health insurance for all or part of 2009. This varied among counties, with Madera having an estimated 32.0% uninsured in 2009. Approximately 456,000 San Joaquin Valley residents did not have health insurance part of the year and 582,000 for the entire year in 2009. Furthermore, approximately 516,000 San Joaquin Valley residents reported having no usual source of care in 2005. Population growth and the current recession has brought this figure up to about 700,000 valley residents lacking a usual place to go for their health care needs.

Discontinuities in coverage and care access occur even for many of those with employer-sponsored or individual market private coverage. Changes in plans and benefits as well as changes in physician's business arrangements frequently interrupt care access. And those whose care needs change can have trouble accessing benefits while others lack assistance in coordinating services. Lack of continuity can affect management of an acute illness as well.

⁸Source: The Central Valley Health Policy calculations are based on data from (1) the National Health Interview Survey (NHIS), Early Release of Health Insurance Estimates by Cohen RA, Martinez ME, Ward BW. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2009. National Center for Health Statistics. June 2010. Retrieved from: <http://www.cdc.gov/nchs/nhis.htm>. (2) California Health Interview Survey (CHIS) Access and Utilization data updated up to 2005, and CHIS Health Insurance data updated up to 2007. Retrieved from: <http://www.chis.ucla.edu/> (3) U.S Census Bureau, National Population projections Released 2008. Projected population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: July 12000 to July 1, 2050 Retrieved from: <http://www.census.gov/population/www/projections/downloadablefiles.html> (4) California Department of Finance, State and County level population data. Retrieved from: <http://www.dof.ca.gov/research/demographic/data/race-ethnic/2000-50/> (5) Source: University Of California, Los Angeles Center for Health Policy Research, California's Uninsured by County, Shana Alex Lavarreda, Y. Jenny Chia, Livier Cabezas, and Dylan Roby. August 2010. Retrieved from: <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=422>

⁹Source: Retrieved from: http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/cause/index.html

What Happens When Care is Not Continuous? A Case Example

Eric, a 20 year old student, had gotten little sleep preparing for exams. He was taken to the medical facility by a teaching assistant after he was having trouble taking a final math exam because numbers were moving on the page. He also noted his foot was hurting. He was given an appointment for a later time that he missed after going home to get sleep. The following day his foot worsened and became red and swollen. He went back to the medical center, received an injection and prescription antibiotics. Because of his disheveled appearance, and altered mental status, the provider insisted that he go to a psychiatric hospital for an evaluation. He then took a cab to a different hospital where he spent the next several hours being evaluated for possible admission. Much later in the day, someone noted that his foot did indeed look badly infected and recommended that he be transferred to the emergency room. There he stayed until the wee hours of the morning where he received before being discharged, another, different antibiotic injection and another prescription.

His father drove up 180 miles to get Eric and they spent the rest of the early morning hours in a hotel room. His mother, a dermatologist, called her primary care physician for advice. He recommended that Eric be driven home to see the family physician as soon as possible. By 6pm when they got to the physician's office, Eric needed intravenous antibiotics and fluids. Within 24 hours of entering the hospital, his mental status had normalized and a few days later his foot was much better and he was discharged home.

Eric lacked a medical home. And until his father drove him home to see their physician, his care was sorely lacking in continuity. He saw several providers, none of whom knew him well resulting in emergency room visits in two different hospitals with the possibility of an unnecessary admission to a psychiatric hospital, avoided by his father driving 180 miles to retrieve him.

Because of current private financing, few primary care practices attempt to provide a medical home. Persons insured through Medicaid and the State Children's Health Insurance Programs also face discontinuous access because of eligibility practices and provider participation issues. Although the Federally qualified health centers are noteworthy because they often provide a medical home to Medicaid, uninsured and indigent groups, the health centers are not available in many communities and their patients often cannot access specialty health care when needed.

The American College of Physicians (ACP) has characterized our system of private health insurance and governmental programs as a structure that emphasizes acute care over management of chronic illness. Because acute infectious and cardiac diseases are better treated than in the past, people are living longer and more are having chronic illness. By 2015 approximately 150 million people in the US will have at least one chronic ailment. Health care delivery and reimbursement policies must change to accommodate the shift from acute to chronic care. The ACP proposes a model that links patients to a personal physician who is trained to provide continuous comprehensive care using evidence based medicine. This model, called *The Advanced Medical Home or Patient-Centered Medical Home*, is a patient centered physician guided model of health care in which the primary care physician, along with his staff and other members of the health care team, create an integrated and coherent plan for ongoing medical care in partnership with patients and their families. The primary care physician coordinates

many facets of the care including referrals to specialist, physical and occupational therapists, case managers, dieticians, social workers and other allied health professionals. The primary care physician helps the patient navigate through the complexities of our health care system. This model could be viewed as a fancy way of characterizing what has long been known, that maintaining a long-term relationship with a health professional who knows his patients, manages their chronic illnesses, keeps good medical records, and who coordinates their care is necessary for effective management of acute and chronic illness. Traditionally, this role was best filled by primary care physicians who were internists, general practitioners, and pediatricians. Because fewer medical school graduates are choosing primary care, there is a shortage of primary care doctors. Other health care professionals such as nurse practitioners try to fulfill this role and bridge the gap, but the need is too great, leaving many patients without someone to rely upon when they have a medical need. Therefore, many patients lack a medical home and their continuity of care for both acute and chronic illness suffers.

Continuous coverage and coordinated access to health care are more important goal for the US health system than in the past because of the health care and public health achievements of the 20th century. Infectious and other acute diseases are better prevented and treated than in the past and the number of years we can remain productive and engaged has increased. Nonetheless, chronic diseases affect at least 45% of the US population, far more than in the past. Because chronic conditions require services over time, 78% of all US health spending is for people

with chronic conditions.¹⁰ Elders see an average of seven different physicians and fill twenty or more prescriptions a year. Over the last few years, outpatient costs for managing chronic conditions have emerged as one of the major drivers for health care costs inflations overall and this trend will grow with the aging of the boomer generation.¹⁰ A growing body of research and demonstration programs supports increased use of the medical home amplified by community support opportunities as the best way to manage persons with a chronic condition, although this is not currently covered in the Medicare program or mandated and reimbursed by other insurance. Having an insured population with access to a medical home (primary care physician, other personnel, care management resource) who can coordinate care, focus on preventing disease, identify disease processes early, practice evidence based medicine to slow disease progression, and delay the onset of activity limitations from the chronic disease is what is needed to prevent unnecessary hospitalizations and other expensive and traumatic outcomes.

Medical progress in other realms has increased the importance of continuous coverage and consistent access. Stunning achievements in reducing cancer mortality come from expanded access to screening and early detection services since the 1990s, but people of color, rural residents and others with less continuity of coverage and access have not experienced these gains. Individuals with discontinuous coverage access and coverage are likely to participate in screening and thus less likely to be diagnosed with earlier, more treatable cancers. Among younger populations, those with even short interruptions in health insurance don't have consistent access to a health provider and are more likely to defer care. Such individuals are much less likely to receive counseling about cancer and heart disease risk factors.

In the current US health system, the lack of continuous health care coverage not only costs more in unnecessary hospitalizations from lack of timely intervention and poor coordination of care, but it also causes worse health outcomes, including untimely death. Progress towards continuous coverage and consistent access can improve population health in the US, restrain cost growth and ensure greater effectiveness of health care.

While a single national health plan with universal cradle-to-grave comprehensive coverage would insure continuous coverage and promote needed delivery system changes, at least five elements need to be included in incremental national reform to ensure continuity of care:

- ▶ **No breaks in coverage/primary care access:** Near universal coverage is a pre-requisite for continuity of care. At the very least, health insurance reforms must ensure that individuals do not experience lapses in coverage and access to primary care or other services as they undergo transitions in family, employment and health status.
- ▶ **Patient centered medical home:** Continuity also requires changes in how health care is delivered. Financing and regulation need to transform primary care needs so all patients have access to a medical home that takes ongoing responsibility for tracking health status, self-care behaviors, use of preventive care, and adherence to chronic care recommendations.
- ▶ **Reimburse “cognitive services”:** Since chronic conditions account for a growing share of all health care needs and expenditures, and potentially avoidable costs for high-technology services could be avoided with increased patient understanding of risks and benefits, shifting reimbursement to offer more incentive and opportunities for primary care diagnosis, patient education and counseling, and care management services are needed to improve care continuity.
- ▶ **Improve transition management:** Transitions between levels and settings for care continues to be a key continuity challenge for elders and others with complex health conditions. Continuity of care can be improved by new benefits and protocols for managing hospital discharge, institutional and community long-term care placement, and other transitions.
- ▶ **Increase supply of primary and specialty care:** Nationally, but particularly in rapidly urbanizing, under-resourced communities such as those of the San Joaquin Valley, there is both an absolute shortage and significant

¹⁰ Source: Kenneth E. Thorpe and David H. Howard The Rise In Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence And Changes In Treatment Intensity *Health Affairs*, 25, no. 5 (2010)

What happens when care is not affordable: A Case Example

Connie, a 56 year old with diabetes, found herself in a quandary. She was having pain in the center of her chest. When it had happened before, the pain was not severe, but this time, it would not go away. A myriad of thoughts passed through Connie's mind. Could the chest pain be my heart? Am I having a Heart Attack? If I ignore this, am I going to die? Connie was afraid and needed reassurance. She went to the emergency room. After some initial screening with blood tests and an EKG, the ER physician recommended admission to the hospital for further evaluation as a precaution, because the chest pain might be from coronary artery disease and that she would be at risk of getting a heart attack if it was. Astonishingly, Connie left the ER against medical advice.

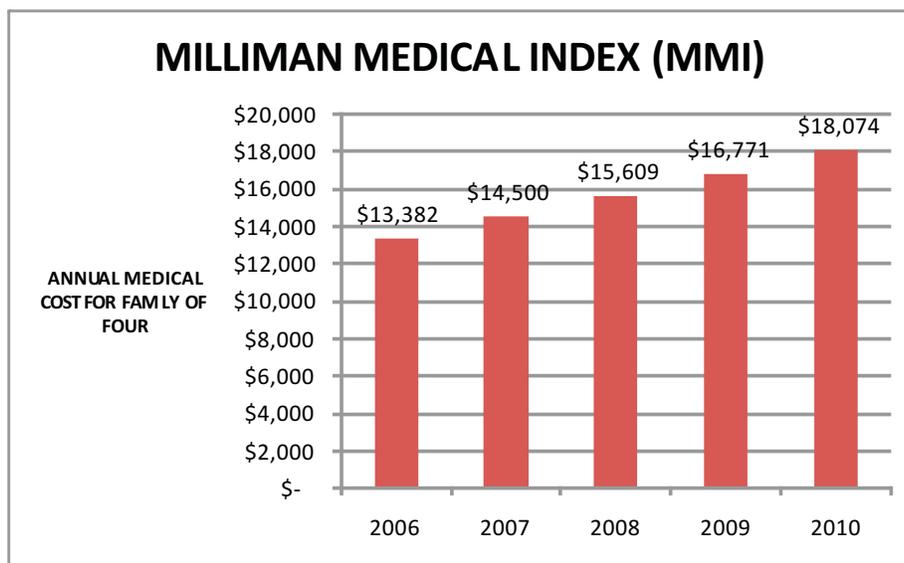
What would cause Connie to make this decision after an emergency room physician confirmed that her worst fear of heart disease might be true? Why would she take such a chance with her life? For Connie the reason was lack of affordable health insurance. She told her primary care physician later, "I lost my job, and could not get coverage because of my diabetes. The premiums for COBRA were \$500-\$600 per month, and I knew that I could not afford this. And I knew if I went into the hospital without health insurance, it would bankrupt me."

mal-distribution of primary and specialty physicians and other health professionals. Investments in health care and public health workforce development and new financing or regulatory changes to increase the attractiveness of practicing in under-resourced communities are required to ensure access to needed services on a continuous basis. There need to be economic incentives that encourage medical students to enter primary care specialties. Family practitioners and internists are particularly well suited at coordinating care, though nurse practitioners and other health care professionals also play an important role.

Affordable for Individuals and Families

Using the current US health system is costly for individuals and families. For many, these costs are increasingly beyond their reach (Figure 3). Before the recession took hold, nearly 20% reported difficulty meeting health care expenditures and more than 60% of bankruptcies were attributed to health care. A recently published study in the American Journal of Medicine found that in 2007 about 62 percent of all bankruptcies in the U.S. were medical expense related. This figure was almost 20 percentage points higher than the figures from 2001.¹¹ This is despite the fact that of those who filed for bankruptcy in 2007 nearly 80 percent had health insurance.

Figure 3



Source: Milliman Medical Index 2010 *Milliman Research Report, May 2010 Seattle Milliman Medical Index*. Retrieved from: <http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf>

¹¹ Source: Himmelstein, D, Thorne, D, Warren, E, & Woolhandler, S. (2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *American Journal of Medicine*, 1-6. Retrieved from: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

Across all US households, annual health care expenditures (excluding employer and government payments) were around \$3000 or 6% of all household expense. But this varied enormously: older people, those with chronic conditions, individual (rather than group) market enrollees as well as the uninsured and underinsured pay much larger shares of their household incomes. While estimates vary, about one quarter of US households spend more than 10% of their income on health care. When health care becomes unaffordable, individuals often forego health services for more immediate survival and the continuity and effectiveness of health services are diminished. When health care is affordable for families and individuals, they have the opportunity for continuous, effective care and they have the opportunity to fulfill their responsibility to contribute to their own and the nation's health. Some individuals and families go without health insurance because they have lost their job and cannot afford to buy individual private health insurance and cannot afford to extend their employment based coverage through COBRA.

In our system, care becomes unaffordable for families and individuals in multiple ways. For those forced onto the individual market, insurance premiums, co-payments and deductibles can increase or coverage can be denied, thus forcing unexpected expenses. Those who have employer-sponsored plans are more protected, but as employers face new costs, they may drop coverage or increase employee share of cost. There is little in the current system to restrain utilization and price increases. As consumers of health care we are poorly equipped to assess costs and outcomes, and insurance companies are able to pass cost increases to the insured. Care becomes unaffordable because provider organizations and pharmaceutical giants charge more while insurance companies seek to retain or expand profits.

Making health care affordable to individuals and families is a far more prominent policy goal than in the past, because health care has become more expensive. Family private insurance premiums rose 131% from 1990-2008, five times the general rate of inflation, according to a Kaiser Family Foundation poll. The proportion of employed persons who

received health benefits and the comprehensiveness of these benefits eroded during this same period. Out-of-pocket and supplemental insurance costs for elders as a percentage of income have also increased dramatically, even with the introduction of Medicare pharmaceutical coverage.

Individuals and families need affordable health care. The Institute of Health defines affordable as a system in which “no one should be expected to make contributions to their health care coverage that are so costly, that they cannot pay for basic necessities of life, or face a level of cost sharing so high that it would interfere with obtaining timely, necessary health services.”

According to the Milliman Index,¹² the care of medical cost increased to \$ \$18,074 in 2010 for a family of four. Of the \$18,074 total medical costs for a family of four, the employer paid approximately \$10,744 in employee subsidy (59%) while the employee paid \$4,325 (24%) in employee contributions and \$3,005 (17%) in employee out-of-pocket costs. Therefore, in 2010, a family of four whose income was \$44,050 (200% of the FPL) had average out-of-pocket costs of \$7,330 or 16.6% of pretax income.

While a national unified health care system with income-adjusted premiums and co-payments might be most efficient in ensuring health care affordability for individuals and families, incremental policy changes to increase affordability include:

- ▶ **Keep total health care expense to 10% or less of pre-tax income for those within 400% of poverty:** Although there is considerable ongoing debate about what constitutes affordable health care, mounting evidence suggests that low income and middle class families begin to postpone or avoid needed health services as total health care spending (premiums and out-of-pocket) exceed 10% of pre-tax income. For most people, both the ability and willingness to pay for health care seems to be reduced dramatically as their health care costs exceed this threshold.^{13,14} This affordability level is

¹² Milliman Medical Index 2010 *Milliman Research Report, May 2010* Seattle Milliman Medical Index. Retrieved from: <http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf>

¹³ Source: Blumberg LJ, Holahan J, Hadley J, Nordahl K, "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs*, Web Exclusives [Epub, June 4, 2007], Vol. 26, No. 4, July/August 2007, pp. W463-w473.

even lower for the very poor and those with complex health needs. Although lower income families and those with complex health challenges would still struggle in many cases to meet health care costs, constraining family health expenditures, including premiums and all out of pocket expenditures to 10% of pre-tax income would mean that covering health care costs would not come at the expense of other basic needs.

- ▶ **Limit growth in total health care insurance and out-of-pocket exposure:** Even for those with incomes above 400% of poverty and those with employment based coverage, large unexpected out-of-pocket costs (because of insurance denials of coverage, life-time limits on coverage etc.) and increases in premiums can be financially devastating or lead to trade-offs between care and other necessities. Limiting growth in total health insurance exposure begins with new regulation on insurance, but must eventually reduce the growth in total health care costs to remain sustainable.
- ▶ **Address the “donut hole” in Medicare Part D pharmaceutical plans:** While the Medicare Part D drug plans have increased access to pharmaceuticals and reduced out-of-pocket costs for many elders and particularly those with very high drug use, those whose costs in 2010 range from \$2700-\$6100 receive no Medicare assistance. Changes in the Medicare Part D program should at the very least reduce the burden of costs on elders with complex medication regimens. More broadly, the US continues to pay significantly more on a per unit basis for pharmaceuticals than other

advanced economies, and reducing effective prices for US consumers remains a priority.

Universal

The current US health care system does not provide health care for all. At present the projected number of uninsured U.S. residents is approximately 56 million.¹⁵ There are an additional 50 million people who are underinsured. Most of the uninsured are employed. Those without adequate health coverage come from all age and social groups and live in every state. While younger adults are more likely to lack health insurance, 61% of the uninsured adults are over age 30 and nearly one fourth of those in fair or poor health are uninsured. Although rates of uninsurance are higher among noncitizens, about 80% of the uninsured are US citizens. There were 6.6 million^{16,17} undocumented immigrants without health insurance in 2007. In 2006, of the 46.5 million uninsured 9.4 million are children. By 2010, as the recession continues, there are approximately 51 million uninsured adults, 4.6 million uninsured children.

While one in five Californians were uninsured before the recession and dramatic increases in unemployment, the rate of uninsured in the San Joaquin Valley was even higher. According to California Health Interview Survey, about 1 million residents of the SJV under age 65 were uninsured in 2007, much higher than other California regions. In the Valley, Latinos and those with incomes below 400% of poverty are at far greater risk for being uninsured and these trends are more pronounced than in other regions. Immigrants and especially the undocumented experience the greatest difficulties gaining coverage. About one quarter (2.7 million) out of the estimated 11.6 million undocumented immigrants in the U.S. live in California. Approximately

¹⁴ Source: Banthin JS, Cunningham P, Bernard DM, "Financial Burden of Health Care, 2001-2004," *Health Affairs*, Vol. 27, No. 1, January/February 2008, pp. 188-195.

¹⁵ Using percent increases of uninsured from 2007 to 2009 provided by the North Carolina Institute of Medicine and the Center for American Progress, the Central Valley Health Policy Institute estimated there was national average of 19.5% increase in the number of people who lacked health insurance between 2007 and 2010. The percent increase between 2007 and 2010 ranged from 12% to 26% in states such as Iowa and New Mexico respectively.

¹⁶ Source: Steve A. Camarota, "Illegal Immigrants and HR 3200 Estimate of Potential Costs to Taxpayers," 2009 (Estimates are for undocumented immigrants below 400% of the Federal Poverty Level in the entire U.S.).

280,745 of these immigrants live in the San Joaquin Valley, which is the center of California's fertile agricultural heartland.¹⁸

Several factors explain the growing ranks of the uninsured and underinsured. While most in the US, over 150 million, receive health coverage through their employers, these persons face increasing health insecurity. Faced with health costs that have grown more rapidly than wages, employers have increasingly dropped coverage altogether or increased the share of health care costs borne by workers. People lose coverage for a myriad of other reasons, from changes in their work and living arrangements, changes in health care needs for family members, to employer benefits management decisions. Other barriers to coverage include the decisions of some private insurers to deny enrollment or coverage for specific services to individuals based on their past or current health status. Because most insurance companies are for-profit and all function in a competition oriented environment, and because there is no law which mandates that everyone have insurance or that insurance companies must cover all patients who apply for insurance, health insurance companies strive to insure the most profitable among us and avoid dealing with the least profitable. Public safety net programs also erect barriers to health care participation. . For example, Medicaid and the State Children Health Insurance Program (SCHIP) are meant to provide coverage for those excluded from employment based health insurance. However, eligibility requirements often involve means testing as well as being in a specific group (pregnant women, disabled, children etc.) and meeting residency requirements that vary from state to state. These enrollment policies also change depending on the economic condition of the states which administers these programs. Some states have historically restricted access and some states have been forced by the recent recession to make draconian cuts in these programs.

Universal health care coverage is an even more important goal for the US than in the past. Lack of universal coverage has negative impacts on individuals and families without coverage and on the broader national economy. Lack of health coverage results in less access to a continuous source of health care. Without continuous access, there is much less potential to prevent catastrophic disease, such as cancer, or manage of chronic conditions, such as hypertension and diabetes. The uninsured are less likely to receive the standard of care for chronic conditions and appropriate preventative services. As a result they are at greater risk for poor clinical outcomes and premature mortality. There are also financial consequences for the uninsured and underinsured. The Commonwealth Fund reports that 77 million Americans age 19 or older (2 in 5) have accrued medical debt or have difficulty paying medical bills. Two-thirds of families with medical bill problems have sufficient medical debt to affect their ability to pay for other basic necessities such as rent, mortgage, transportation, food, and heating costs, which again affects the economy. Health insurance costs can also have a psychological and behavioral effect on decisions pertaining to life's choices such as when to start a family, seeking other employment, work force entry, and retirement. For employees accustomed to employment-based health insurance, the arrangement can have perverse incentives; people may get locked into jobs, especially if a dependent has a pre-existing health condition. Opportunities to enhance careers go by the wayside for fears of losing health insurance. This dampens the entrepreneurial spirit.

Beyond these impacts on individuals and families without adequate coverage, there are health and economic costs of having so many uninsured and underinsured. In addition to the financial vulnerability which goes with lacking insurance in the event of a severe illness, the rising cost of employment-based health insurance is forcing companies to delay wage increases, thereby reducing take home pay. This lowers purchasing power and

¹⁷Source: Data from the Centers for Disease Control and Prevention/ National Health Interview Survey states that in 2009, 8.2% of the total uninsured persons in the U.S. were children. Retrieved from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201006.pdf>

¹⁸Source: John A. Capitman, Diana Traje, and Tania L. Pacheco. "Undocumented Latinos in the San Joaquin Valley: Health Care Access and Impact on Safety Net Providers" (2009). Retrieved from: http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/publications/CPACPolicyBrief.pdf

increases our national difficulty in emerging from the current recession. Other external costs associated with lack of insurance include expenditures for uncompensated care. According to a Families USA report, in 2008 the uninsured received \$116 billion in care from doctors, hospitals and other providers of which 42.7 billion was never paid for. In order to recoup their lost income, the providers raised the prices to insurers who then passed it onto the consumers in the form of higher premiums. This “hidden health tax” amounted to \$1017 per family and \$368 for individuals in 2008. The Urban Institute estimates that without health care reform, uncompensated care will grow from \$62.1 billion to \$107 billion or more within the decade!⁹ Uncompensated care not only increased the costs of private insurance, but placed new burdens on communities and taxpayers. The swelling ranks of the uninsured and underinsured reduces access to care for all who live in a community as provider organizations quit or move in response to financial short-falls. In the San Joaquin Valley for example, less than one third of the population has adequate private insurance and as a result, the region faces shortages of primary and specialty practitioners and other health care resources. The region, like other US areas with a large uninsured population, faces elevated rates of vaccine-preventable and communicable diseases and increased costs for emergency and acute care for health problems that could have been addressed less expensively through primary care.

Policy approaches to achieving universal health care coverage and access are based on enrolling all in a health plan, regardless of individual preferences and use the tax system for all financing. More incremental approaches incentivize insurance purchase (individual and employer mandates, subsidies and penalties). In adopting an incremental approach to achieving universal coverage, policies must at least:

- ▶ **Remove demographic and health need barriers to coverage:** Under current policies, some groups of individuals are excluded from publicly subsidized coverage based on factors other than income and need for care, such as the exclusion of those without documented immigration status and non-disabled adults from Medicaid programs. Others are

excluded from coverage based on their health and social needs, such as the bias towards institutional care in Medicare and private coverage for long-term care or inadequate behavioral health coverage and coordinated access in public and private plans. An important first step in achieving universal health care is adjustment to Medicaid and other public programs to reduce these demographic and need barriers to health care.

- ▶ **Directly deal with the health needs of undocumented individuals:** The elephant in the room that no one has the political appetite to address candidly is our problem with immigration and how we deal with the health care of people who are undocumented but who have lived and worked in our country for many years. This will require comprehensive immigration reform which is beyond the scope of this paper. But there will need to be a program which levies requirements on those undocumented individuals that wish to stay in the United States so that they can get health care coverage. Not only is it the humane, compassionate, and consistent with the Hippocratic Oath, but it saves hospitals and communities the cost of non compensated care, avoidable hospitalizations and all the other costs associated with regions that have large numbers of uninsured.
- ▶ **Address the lack of adequate behavioral health coverage:** In California, the state average for the number of psychiatrists per 100,000 residents is 16.9. In the Central Valley that number is 6.9 per hundred thousand, the lowest in the state. One reason is because the county's mental health system has been severely affected by budget problems. The county has closed or scaled back outpatient clinics in recent years and has limited psychiatric care to only the seriously ill. In July of 2009 it closed its crisis-intervention center which provided short term assistance to the mentally ill who were experiencing a mental-health crisis. They could stay there an average of 8 hours. Now, that critical role is being shifted to emergency rooms, often with revolving door stays, which is a far more expensive and less effective way of treating mental illness in Fresno County.

⁹ Source: John Holahan and Bowen Garrett, “The Cost of Uncompensated Care with and without Health Reform” Urban Institute, March 2010. Retrieved from: http://www.urban.org/uploadedpdf/412045_cost_of_uncompensated.pdf

The problem will likely get worse. The only public 16 Bed Psychiatric Health Facility in Fresno County is in danger of closing. This also affects the insured because people with mental health disease will frequent the communities' emergency rooms increasing wait times, wasting public resources on an ineffective and inefficient way of dealing with mental health illness, and making it difficult to recruit psychiatrists for the County. Five years ago Fresno County had 21 psychiatrists responsible for adult care. Now there are only three. Because the Medicaid and State Child Health Insurance.

- ▶ **Move toward a set of covered benefits that promote population health and that are automatically available to those who lose their insurance due to loss or change of employment.** These benefits can be phased in over time and be publicly supported through a financial transaction tax. They may initially cover outpatient services so that people with conditions such as diabetes or hypertension can continue to get their prescriptions filled and their condition monitored while waiting for implementation of private coverage that they selected from the insurance exchange. This will avoid lapses in care and further diminish the numbers of the uninsured, and the underinsured.

Sustainable

The current US health care system is not sustainable. The US spends twice per capita what other major industrialized countries spend for health care (see Figure 4). Even as we debated health care reform, US health care continued to rise faster than inflation. Total health expenditures reached \$2.3 trillion in 2008, which translates to \$7,681 per person and 16.2 percent of the nation's Gross Domestic Product (GDP). Despite slower growth in overall health expenditures, the share of GDP devoted to health care increased from 15.9 percent in 2007, according to the CMS Office of the Actuary.²⁰ The spending on healthcare

has grown faster than the overall economy since the 1960s and is projected to reach 19.5% of the GDP by 2017. Unless trends change the Center of Medicare and Medicaid services (CMS) projects that by 2016 health care spending will be over 4.1 trillion or \$12,782 dollars per resident accounting for 19.6% of the GDP. With the passage of Medicaid and Medicare in 1960s, the public sector assumed a major share in health care financing (almost half of all costs by 2006) ---so increased costs for health care mean increased federal costs. In 2010 the federal spending on these two programs was 22% of the federal budget.²¹ Using the assumption that health care spending continues unchecked, the Congressional Budget Office projects that federal spending on Medicare and Medicaid would be 8% of the GDP by 2030, 12 percent of the GDP by 2050, and 19% of the GDP by 2082. Total (public and private) national spending on health care would reach 49% of the GDP by 2082. Private insurance cannot afford to take care of the oldest and sickest patients because the premiums they would need to charge are too high. In 2004, the health care spending per capital was \$14,797 for patients over 65 years of age. Policy makers cannot shift excess cost burden to the states which face rising costs with limited resources. California is an example of a state ill equipped to financially support health care services.

Challenges to health care system sustainability are particularly evident in California as state revenues tumult due to the recession and political stand-offs. After a protracted debate, the 2009-2010 California budget included a 13% (about \$4 billion) reduction in Health and Human Services despite almost 5% growth in Medicaid enrollment²² during the first year of the recent recession. These cuts eliminated state support for community based services for elders, reductions in mental and public health programs, elimination of dental care and other optional Medicaid services for adults, reduced payments to public, small, and rural hospitals, and closing the SCHIP ("Healthy Families") to new admissions. For the budget year 2010/11 the governor has proposed a 6.3% cut to health and human services, on top of

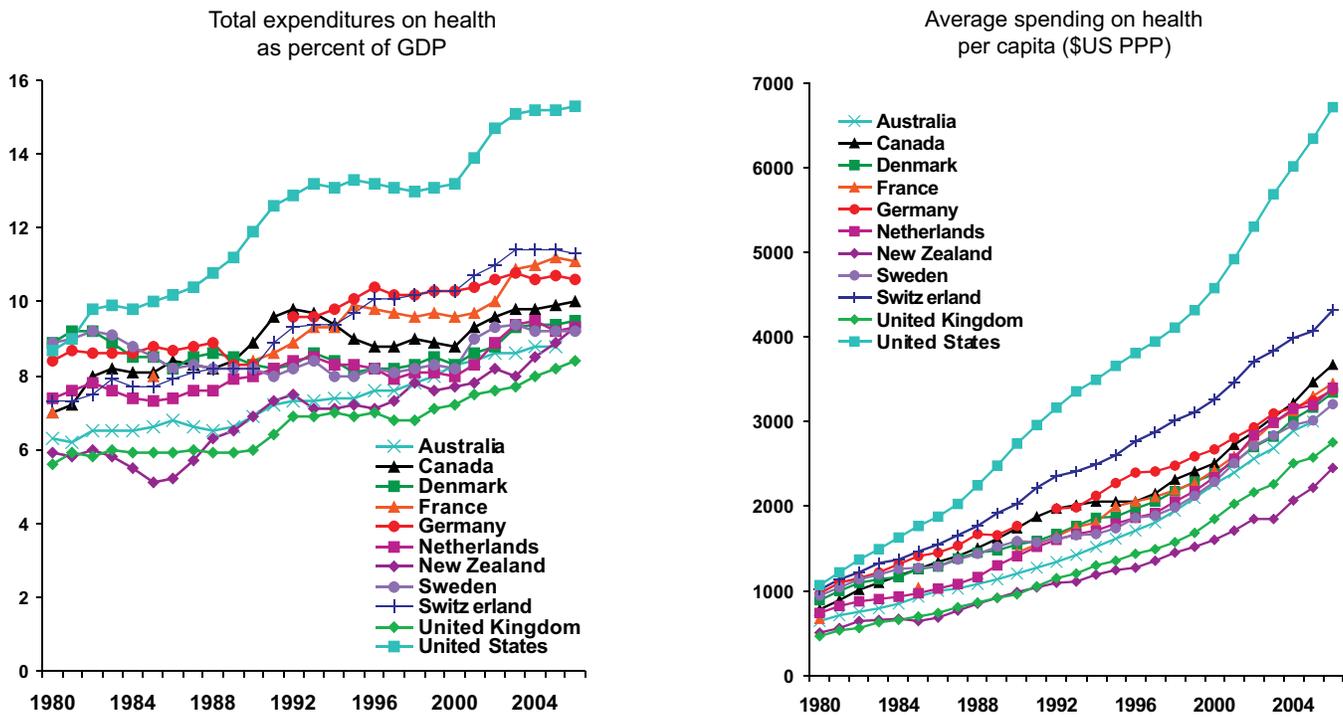
²⁰ Source: National Health Care Expenditure, Centers for Medicare and Medicaid Services. Retrieved from: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp

²¹ Source: Chantrill, C. (2010). Total Budgeted Government Spending Expenditure GDP CHARTS Deficit Debt: Retrieved from: <http://www.usgovernmentspending.com>

²² Source: Unemployment data from the U.S. Bureau of Labor Statistics, state budget shortfall amounts from the Center on Budget and Policy Priorities; and Medicaid enrollment data from Health Management Associates analysis of state Medicaid enrollment reports, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010. Retrieved from: www.kaiserstatehealthfacts.org.

Figure 4

International Comparison of Spending on Health, 1980–2006



Data: OECD Health Data 2008 (June 2008).

Retrieved from: <http://www.commonwealthfund.org/Content/Charts/Chartbook/Multinational-Comparisons-of-Health-Systems-Data--2008/1/International-Comparison-of-Spending-on-Health--1980-2006.aspx>

continuing cuts from previous years.²³ The cuts include drastic reductions in programs such as in-home support services. Cutting \$900 million in general fund dollars from Medi-Cal (Medicaid) and \$16.5 million to Healthy Families (S-CHIP) has been proposed. Because the federal government matches state spending on these programs, the actual lost revenues for California's health system will be well over \$1 billion.

Concerns with the high costs of health care are not new, but continued excess growth in health care spending makes sustainability a more central goal for US health care than in the past. Medicare is going broke right now. According to the most recent report of the Medicare Board of Trustees, the Part A program is now paying out more for hospital and other use than it takes in through dedicated taxes and will soon require general revenues to cover as much 45% of its costs. This suggests that if nothing is changed soon, projected increases in health care cannot be accommodated by slashing other spending because

there will not enough spending to cut and the task will become more difficult the longer we wait. The mathematics of Medicare reveals a system that is headed for insolvency. Medicare Part A \$326 billion trust fund will be wiped out by 2019. According to the most recent report of the Medicare Board of Trustees, the Part A program is now paying out more for hospital and other use than it takes in through dedicated taxes and will soon require general revenues to cover as much 45% of its costs. The 2008 Medicare Trustees report states that Congress could bring Medicare Part A into balance by either reducing spending by 51% or by increasing payroll taxes from 2.9% to 6.4%. Medicare Part B faces rapid growth from 187 billion in 2008 to 325 billion in 2017. This estimate assumes that physician fees will be cut 40% over the next 9 years. This suggests that if nothing is changed soon, projected increases in health care cannot be accommodated by slashing other spending because there will not be enough spending to cut and the task will become more difficult the longer we wait.

²³ Source: California Health and Human Services Agency, Budget Facts for 2009-2010, Sacramento CA. August, 2009.

While broad ideological debate about the role of Federal policy in determining the share of national economic activity devoted to health have added to the conflict over health reform, the current mix of public and private policies and actions in the real US health system is resulting in unacceptable continued growth in health care costs. Under current policy, the US faces equally unattractive choices between major further reductions in publicly financed care and/or major reductions in spending on other national priorities. Even those who loathe to restrict the share of US spending devoted to health care argue that current rates of cost increases are not sustainable since they are not producing comparable improvements in population health. Why spend more if we are more inefficient than other nations? From another perspective, escalating public costs are worrisome because of the distribution of burdens for health care. Even when taxes are considered, low income persons pay a larger share of their incomes for health care. Unlike other countries that use a variety of methods to finance health care, our use of payroll taxes as the primary dedicated revenue source creates these unequal burdens. Achieving sustainability for the US health system is in part about addressing the drivers of cost increases but also about finding stable and fair funding sources.

Five primary explanations for escalating health care costs have been noted during the 2009-2010 health reform debate: aging, technology, physician behavior, pharmaceuticals and administrative costs.

The US population is aging. But more years are accompanied by more chronic disease and health care use and so the CBO projects that 25% of the projected growth in health spending over the next 3 decades are associated with population aging. In addition to population aging, increased prevalence of chronic conditions in younger populations has also been cited as a cause for increasing health costs.

The increasing use and increasing sophistication of health care technologies are drivers health care costs increases. Economists tend to attribute about 50% of the increase in health care costs over the last half-century to technological advances and see no reason for this to change.²⁴ Some of this increase reflects new hope, new treatments for

persons with previously unmanageable conditions, but it also reflects often unnecessary increases in the frequency and intensity of services. Pricing for many new technologies has also remained high even after they have been widely adopted and developers have recouped their investments.

Physician behavior in response to reimbursement and regulatory pressures also fuels health care cost increases. Physicians are reimbursed much more by public and private insurance for procedural services (tests and high-technology treatment) than for cognitive services (diagnoses, self-management advice, patient problem solving). Patients have to come, expect, even demand, procedural interventions. The tendency to deliver unnecessary or overly costly procedures is exacerbated because there are not enough counterpressures to provide care based on scientific consensus on the most effective approach. Physicians may also practice so-called “defensive medicine” over-testing and over-treating to avoid possible tort claims. Although state experiments with mal-practice reform suggest that this is not as powerful a driver of cost increases as the practice behaviors associated with the procedural bias in reimbursement, it does impact the cost of medicine more than some of the policy wonks would have you believe.

Increasing use of prescription drugs and increasingly higher drug prices are one element of health care technology that fuels cost increases. Other countries pay 35-50% less for these same medications. Pharmaceutical manufacturers seek to maintain their high US profits by fighting similar price controls in the US. For example, the 2003 Medicare Part D voluntary drug plan specifically bars the government from negotiating drug prices. In addition, although the program has produced modest reductions in out-of-pocket expenditures for participating elders, the program is much more costly than projected (nearly \$50 billion in 2009). Further, Part D benefits will continue to erode and out-of-pocket costs increase as pharmaceutical costs continue climbing.

Our system of mixed private and public financing for health care creates an administrative cost burden for the health care system that is estimated at

²⁴ Source: Congress of the United States: Congressional Budget Office, Congressional Budget Office. (2008). Technological change and the growth of health care spending. A CBO Paper, Retrieved from: <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>

25%-35%. Most persons under age 65 are covered through private and typically for profit insurance companies. Their expenses for marketing, underwriting, management and profits are a major source of growing administrative costs. The Medicare and Medicaid programs have far lower loss ratios because they spend so much less on administration. Private sector health insurance companies face few incentives to lower costs or improve care for chronically ill and other costly to treat patients. More effective and efficient protocols can attract high cost patients and thus increase overall company expenditures. Even not-for-profit insurers face these same constraints as they function in the competitive market. Companies compete by choosing the healthy over the unhealthy and by limiting through denials of coverage once patients become unprofitable. Because of these invidious incentives, all insurers seek to withhold or delay payments as much as they are allowed to by state regulators. As a result, hospitals and other health care providers also face crushing administrative costs as they seek payment through a maze of multiple insurance companies with varying and complex rules.

Developing a sustainable approach to health care financing and specifically a method to pay for near term costs of expanded access to private insurance has been a key element of the national debate. The ACA financing mechanisms are focused mainly on generating revenues from within the healthcare domain. Other approaches that emphasize finding new revenues outside of current health care financing have been largely rejected.

There are at least a couple of arguments that can be made justifying the provision of funds from sources outside of the healthcare such as the Financial Transaction Tax (FTT) proposed in CAUSE. Perhaps most importantly, an external funding source such as the FTT could allow the nation to address the deficit in the Medicare Trust Fund and ensure its solvency moving forward. Addressing Medicare solvency is necessary to prevent a meltdown in the healthcare financing system which may adversely affect the whole economy. Since the efficiency gains in Medicare through various components of national health reform will take some time to materialize, it appears prudent to find needed resources in the short run from another sector of the economy to prevent any bankruptcy of the Medicare system. Financing health reform through the FTT or similar mechanism, as

opposed to seeking revenues in other sectors, is recommended. First, a financial transaction tax which has an impact of having Wall Street help pay for health care is more likely to be accepted by the general public because of their perception that zealous speculation contributed to our current recession, and the FTT can lower this speculation. Second, because transactions of financial instruments result in losers and gainers in the real broader economy, there are repercussions of such activities that directly or indirectly affect people's health or their access to health insurance. In other words, the negative externalities or adverse spillover effects exerted by financial activities/transactions on the population (and their health) which are not directly involved are not accounted for and thus need to be addressed. The literature in economics on externalities does suggest taxation in order to internalize the negative externalities which not only serves to discourage such activities but also allows for those who are affected to be compensated.

Recognizing this complex set of factors that fuel the escalation of health care costs underscores the importance of sustainability as a goal for the US. Some of this growth is not linked to changes in our population's needs or improvements in prevention and care, but to the perverse incentives created by current financing and regulatory approaches. While there are a range of potential incremental approaches to increasing the sustainability of the US health system, several broad approaches have received the most consistent support.

- ▶ **Establish budget discipline for health care at national, state, and local levels:** The US health system, unlike systems in other advanced economies, does not establish comprehensive health expenditures budgets. Health care costs increase more rapidly than inflation, at least in part, because there are no policy limits on total public and private expenditures. Health care budgets would need to be imposed incrementally as providers and regulators learn to restrain costs and plan for demographic and other drivers of increasing demand and prices without sacrificing care quality.
- ▶ **Change reimbursement and regulatory systems to promote prevention and efficiency:** Neither the procedure-based reimbursement approaches used in fee-for-service reimbursement nor the

reimbursement/regulatory structures for managed health plans included sufficient incentives and requirements for emphasizing prevention or maximizing efficiency in health care. By basing reimbursement on the delivery of evidence-based services and health care outcomes and by holding fee-for-service providers responsible for prevention focused and evidence-based care, the rise in costs for health care may be reduced to sustainable levels.

- ▶ **Alter reimbursement to reward cognitive services that promote health and lessen remuneration for procedures that do not promote health:** Physicians and other health care professionals need to be rewarded for spending time with patients, such as doing a systems assessment along with a physical examination, coordinating care with specialists, explaining options of treatment for a particular illness, dealing with end of issues life, and empowering patients with the knowledge necessary to live healthier when they have chronic illnesses. For example, physicians get paid much less for time spent managing medications and counseling on diet for diabetes, hypertension and hypercholesterolemia in a patient with coronary artery disease than the time spent by a physician who is putting in the sixth stent into a patient's coronary arteries.
- ▶ **Use FTT (financial transaction tax) to finance health care:** A central debate in health reform revolved around the distribution of financial burdens for subsidizing insurance and care for the currently excluded and under-served. It may be difficult to keep providers and insurers from passing on any new costs to consumers in the form of higher premiums or to avoid regressive payroll taxes. In the long run, basing care expansions solely on these sources may create policy incentives to reduce coverage and access, as currently seen by state's efforts to rein in healthcare liabilities. A very small FTT tax on large-scale financial transactions would produce needed revenue while making the most speculative transactions less attractive. The financial transaction tax is not a tax on specific financial institutions but rather on a specific financial transaction, whether it is for

a stock, bond, or other financial instrument. If there is no trade, there is no tax. What is interesting about the tax is that the volumes of trading are quite large and a very small tax per transaction can generate an astonishingly large amount of revenue. In 2000, Dean Baker, an economist and the co-Director at the Center for Economic and Policy Research in Washington DC, proposed taxing financial transactions on stocks at 0.25% for the buyer and the seller and lesser percentages for bonds, futures, currencies, and swaps. The money generated in 2000 even with factoring in a 30% reduction in trading, would generate 120 billion dollars. At the time the trading volume for stocks from all the exchanges was estimated to be \$11 trillion dollars. In 2010, the total dollar volume for the New York Stock Exchange alone exceeded 12 trillion dollars indicating that the FTT could generate higher revenue than the \$120 billion estimated in 2000. It is also less regressive than a national sales tax or a value added tax would be and would not be felt much by long term investors as compared to those who speculate. Investors of stocks or bonds are already used to paying fees or loads when buying or selling a stock. It may even be politically palatable for citizens in the US to accept this tax if they knew that speculators on Wall Street, whom they view as having profited from a government bailout, were being asked to funnel a portion of their profits toward financing healthcare. Having a tax that can generate revenue that the public is willing to support is important in today's political climate. The framework for the tax is already in place because it is used as a means of paying the costs for the Security and Exchange Commission. Financial transaction taxes are often linked to Nobel laureate economist James Tobin. In the 1970's he proposed taxing currency as a way of lessening wild swings in exchange rates. John Maynard Keynes advocated a FTT during the depression as a means of raising revenue and discouraging speculation. Between 1914 and the mid 1960s, the government applied a tax of 2 cents for every 100 dollars on all stock trade and transfers. The idea and its implementation are not new and there is growing international support among economists and leaders around the globe for it. For the US, its relevance for

financing an expansion of the insured is a unique application.

Effective

The US health system is not as effective as it should be. Despite devoting a larger share of its resources to health care than other industrialized countries, the US does not lead the world in the delivery of safe, efficient, and effective care. Surprisingly, when the US health care system's performance is compared to those of other industrialized nations, it lags behind in a number of important benchmarks, including safety, effectiveness, efficiency, access, and equity. For example, on the measure of the number of deaths that could have been prevented with timely and effective care the US now ranks last among the industrialized countries. Ineffective health care in the US has devastating consequences throughout the life course: we have higher rates of infant mortality than our peer nations and only one-half of adults receive all age-appropriate preventative care such as immunizations, pap smears, mammography, colonoscopy, blood pressure monitoring, cholesterol testing, and flu shots. Failure to meet these preventive and chronic disease management objectives often leads to unnecessary hospitalization and emergency room use, thus contributing to escalating health costs.

Disappointment with the effectiveness of US health care arises in multiple settings. Primary care physicians are in short supply in many communities, creating difficulties in access. Over-burdened practices and financial pressures also reduce effectiveness as providers compress visit times, and as a consequence, provide less timely and patient-centered care than desirable. And while there is an upward trend for hospital delivered, evidence-based treatment for common conditions such as heart attack, heart failure, and pneumonia, huge variations have been documented between the best and worst performing hospitals. If the bottom 25% improved to the top quartile, more than 2,000 deaths could be avoided. Primary care shortages and reimbursement rules also reduce the coordination of care. Patients receive unnecessary repeat tests and leave the hospital without adequate follow-up plans.

Effectiveness of US health care is a more important

goal than in the past. The US population is not getting healthier. Many believe that deteriorating health behaviors (obesity, physical inactivity, smoking etc.) are producing the first generations in the US that will not outlive their parents. There has been a 15% increase in the proportion of working age adults who are unable to work or perform everyday activities due to a health problem. Managing chronic conditions represents a growing share of health care and yet 44% of adults with diabetes and 41% of those with high blood pressure are not controlling their conditions. Hundreds of thousands of lives and billions of dollars are lost as a result. To some extent, these problems reflect increasing difficulty accessing care, even for the insured. Since 2005, the number reporting difficulty accessing care has increased from 61% to 73%. During this same period, the ranks of the uninsured have continued to grow. For persons without adequate insurance, effectiveness is further compromised since preventive care and chronic disease management are even less consistent. As a result, those without adequate coverage have more avoidable acute care use and premature mortality. And when the uninsured do get care, they are more likely to experience medical errors, poor coordination of care and other negative outcomes.²⁵

As with sustainability, there are a number of incremental policy and systems changes that could improve effectiveness of health care.

► **Change reimbursement and tort laws to promote evidence-based and safe practice:** Under current laws nationally and in most states, there are no specific incentives to offer the health services that are shown to be the most safe and efficacious. Further, reimbursement is not tied to the cost or clinical effectiveness of treatments. In most states, medical malpractice complaints and associated legal and insurance costs are viewed as driving health care costs with little real impact on care quality. Basing eligibility for any reimbursement on proven effectiveness of interventions and reducing payments for care not based on established guidelines or with demonstrably poor outcomes would provide clearer incentives. Adapting tort laws to require alternative

²⁵ Source: Institute of Medicine, (2004). Insuring America's Health: Principles and Recommendations. Washington D.C. The National Academies Press.

dispute resolution when the care delivered meets guidelines would reduce the costs of related litigations and reduce the cost burdens of defensive medicine and malpractice insurance.

- ▶ **Change reimbursement and regulation to promote prevention and “cognitive” services:** As noted above, one of the strongest strategies for improving sustainability of health care is to adjust reimbursement and regulation to provide strong incentives for providers to engage patients in prevention and provide sufficient education and counseling to avoid unnecessary care. Shifting reimbursement and regulation to more actively promote prevention activities and other cognitive services could improve the cost-effectiveness of health services. Creating new incentives and requirements to transform primary care to a patient-centered medical home model, promoting increased effectiveness in intervention around self-care and health-risk behaviors, and facilitating more informed choices around high-technology and end-of-life care have all been shown to increase effectiveness.
- ▶ **Address health inequities through financing and regulatory changes:** Race/ethnicity, class, and residential location variation in both the quality/appropriateness of health services and overall life outcomes have been well-established nationally and in places like the San Joaquin Valley. These disparities and particularly poor outcomes for the least well-served reduce the overall performance of the Valley and similar regions in population health measures. Along with disparities in accessing care, culturally inappropriate and language incompetent service settings and strategies have been identified as causes for seemingly unfair outcome differences. By strengthening enforcement of federal Culture and Language

Appropriate health Services (CLAS) standards, improving reporting of group differences in health outcomes, creating new roles in health care for community members, broadening the pathways to health care careers for persons in traditionally underserved communities, and enacting new significant public health investments tied to the most impacted communities, health care inequalities can be reduced and the overall effectiveness of US health care improved.

ACA and the CAUSE Principles

ACA along with the Health and Education Reconciliation represent perhaps the most far-reaching effort to reform health care financing and delivery in the US since the passage of Medicare in 1965. ACA includes changes in the existing public health care programs (Medicaid, Medicare, S-CHIP) and the regulation of private insurance, new efforts to increase access to preventive services and improve management of chronic conditions, new funding for practitioner education and demonstrations of new health care roles and other changes. While there are important initiatives in the short run, the most important changes begin in 2014. Over several years, ACA expands Medicaid to low-income, non-disabled adults, requires all households to acquire insurance, requires most employers to provide insurance, launches new private insurance products for low and moderate income people who do not receive qualifying coverage through an employer which are regulated and subsidized through state-administered exchanges, places new restrictions on private insurance practices and profit margins, and invests in medical education and strengthening safety net providers, chronic care coordination, and reimbursement reforms. Figure 5 summarizes some of the key components of ACA. The Congressional Budget Office estimates that the law will reduce the federal deficit by some \$138 billion by 2020 and lead to even larger savings in the following 10 years.

FIGURE 5
AFFORDABLE CARE ACT
Key Components and Timeline

When?	What will ACA change?
This Year 2010	<ul style="list-style-type: none"> ▪Persons 23-26 remain on parents' plan ▪New federally funded high risk pools for persons denied insurance because of pre-existing conditions ▪Tax credit for small employers to purchase coverage ▪Private insurance reforms (lifetime cap, cancellations, pre-existing conditions for children, preventive services with no co-pay, reporting on loss ratio and cost increase) ▪New requirements on non-profit hospitals ▪States receive federal support to establish exchange, adjust Medicaid programs, and implement new insurance regulations ▪New investments in safety net infrastructure, health care and public health workforce, primary prevention and public health
By 2014 and beyond	<p>Uninsured/Low Income</p> <ul style="list-style-type: none"> ▪Medicaid expanded to 133% of FPL with 100% match (match reduced to 90% by 2020) ▪State exchange for legal residents, 133-400%, other uninsured, small business employees, and insured employees with unaffordable coverage ▪Subsidized coverage with total exposure less than 10% of pre-tax for 133-200% FPL, but less affordable for higher incomes ▪Safety net improvements (increased Medicaid rates, FQHC funding, community long-term options, medical home/integrated care options, innovations center) <p>Medicare</p> <ul style="list-style-type: none"> ▪Reduced subsidy for Medicare Advantage plans ▪Phased in elimination of the Part D “donut hole” eliminated by 2020 ▪Benefit improvements (annual physical, no co-pay for preventive services, transitional care benefits) ▪Bundled payments, value-based pricing, primary care team, and other reimbursement reform demonstrations, ▪Comparative effectiveness, payment , and quality initiatives <p>Privately Insured</p> <ul style="list-style-type: none"> ▪States implement individual mandate to hold qualifying insurance. ▪Most employers devote at least 68% of payroll to purchasing qualifying insurance, cover most employee premiums or pay a similar amount in tax ▪Individual and group market insurance and qualifying plan requirements implemented by states (guaranteed issue, community rating, maximum out-of-pocket at several established levels, minimum benefits, payment increases,)

A key feature of ACA, unlike the House health reform legislation passed in November 2009, is vesting the states with the most responsibility for implementing key components of health reform, including major changes in health insurance regulation and expansions of Medicaid programs to all persons at <133% FPL in addition to establishing

and operating the health insurance exchanges. All applicable state laws remain in effect. By 2014, states are required to adopt policies consistent with most aspects of the new Federal law (Jost, 2010). California has made admirable progress in developing enabling legislation for the insurance exchange, but has not taken on changes in health

insurance regulation. States also have the option to develop alternatives to Medicaid expansion and subsidized insurance through the exchange, and after 2017 they can opt out of many other components of the national program. The possibilities for delays in implementation and the re-emergence of a national patchwork of inconsistent policies and programs are noteworthy.

In the following assessment of ACA using CAUSE principles, we assume that this implementation process occurs without major modifications and that California does not select opting out of major components. The assessment is summarized as a score card in Figure 6.

Figure 6
Assessing ACA Using the CAUSE Principles

Principle	GRADE	Rational
Continuous	B	1) Reduces risk of private insurance denials of coverage or service, 2) Reduces risk of lost coverage during transitions, 3) More states/delivery systems may offer medical home, 4) Prevention benefit improvements, 5) Only demonstration of payment reform, 6) Workforce investments
Affordable	C	1) Makes health care affordable for under 200% FPL, 2) Does not ensure affordability for 200-400% FPL, 3) Does not limit growth of private premiums for 400+ FPL
Universal	C	1) Reduces demographic and need barriers to coverage 2) Unaffordable coverage may reduce enrollment below 95% estimate, 3) Rural initiatives/safety net expansions/disparity initiatives may not improve access
Sustainable	D	1) Extends Medicare solvency by 6 years, 2) Helps states expand Medicaid, 3) Some effort to “bend cost curve” but not enough, 4) No budget discipline for health care, 5) No FTT
Effective	C	1) Initiative commissions and demonstrations to improve effectiveness, 2) Better consumer information, 4) Health disparity initiatives 3) public health/healthy community initiatives

▪ **Continuous:** ACA has the potential to make marked improvements in continuity of care. Those newly enrolled in state Medicaid programs and private insurance plans through the exchange will have improved access to care and greater potential for ongoing relationships with primary care providers. Through state implementation of new federal requirements, the potential for privately insured persons to be denied payment for specific services or denied coverage based on pre-existing conditions or other abusive policies will be greatly reduced. In the short run, successful implementation of an expanded high-risk pool, should make an important contribution to this. Although the exchange and private insurance changes will facilitate maintaining or changing health care arrangements as an individual experiences changes in work, family, and health needs, such persons may still experience gaps in coverage and may still need to change provider systems. In general, ACA will change but not eliminate the challenges faced by consumers when their life circumstances require new health care arrangements. New Medicare transitional care benefits and optional new state community care programs will ease elders' level and setting for care transitions. Through demonstration projects, safety net investments, Medicare payment enhancement, and Medicaid optional programs, many more will have access to patient-centered medical homes. However, those in private health plans may not see these dramatic changes in primary care and there are no proposed changes to private insurance reimbursement for prevention, diagnosis, counseling and coordination services, even though benefit and co-payment requirements on preventive services will encourage greater adherence to guidelines. Most of the major initiatives around payment reform in ACA are in the context of Medicare and Medicaid demonstrations. Significant new investments in medical education and loan repayment programs as well as increased funding for other health professional education may reduce the challenges for low-income persons in accessing primary and specialty care, but there is uncertainty about how well these programs will direct new professionals to underserved communities and regions.

▪ **Affordable:** ACA dramatically improves health care affordability for many consumers but the legislation leaves out significant population groups in some states and may still force others to choose between health care and other necessities. An

estimated 32 million people nearly 1/10th of the US population are expected to receive care subsidized through ACA and there are an additional \$40 million in tax breaks for small business. For those citizens and documented residents with incomes up to 200% of poverty, Medicaid expansions and the subsidized coverage available through the state exchanges will keep health costs below 10% of pre-tax income. Persons with income 200-400% of FPL (about \$88,000/year for a family of 4) will receive subsidies through the exchanges, but that will not keep total health costs below 10% of income. For otherwise uninsured, small-business employees, and the self-insured, selecting a qualifying plan from the exchange will offer clearer shopping, defined levels of financial exposure, comparable benefit packages, and state oversight of the amount of premium increases. Those offered unaffordable health coverage through their employers also can seek less expensive plans on the exchange. Yet none of these ACA components specifically requires that plans be available at 10% or less of pre-tax income or limits the overall growth in premiums. As shown in Table 2, more than 50,000 San Joaquin Valley residents who qualify for assistance through the insurance exchange and/or subsidies for purchasing care may not be able to find affordable plans in 2014. An additional projected 300,000 persons will be both uninsured and undocumented at that time and not eligible for MediCal or subsidies for purchasing private insurance.

▪ **Universal** Although the Congressional Budget Office projects that 95% of the US population will have health insurance when ACA is fully implemented, so-called undocumented immigrants are excluded from the exchanges or subsidies. In addition, groups defined by specific health service needs (mental health, long-term care, abortion) may still experience significant gaps in coverage, access, and care coordination. Further, the projected number of newly insured persons may be lower than anticipated. Massachusetts' experience with mandatory enrollment and subsidies has found that many people particularly younger adults---find the cost of qualifying insurance much higher than the tax penalty for not enrolling. Depending on how states design and operate exchanges and insurance reforms, healthier young adults in other states may make similar choices as ACA is implemented and reduce the proportion of the whole population that is insured. As shown in Table 2, while more than two thirds of the

Table 2
Affordable Care Act and the San Joaquin Valley
Projected Program Eligibility in 2014²⁶

	FPL %	SJV Included	SJV Excluded	Insured Last 12 Months (Age 0-64)	Total
Medi-Cal Eligible	0 - 133	194,247	210,888	761,743	1, 166, 878
Exchange Subsidized	133 - 200	139,326	38,227	319,690	497, 243
Exchange Less Subsidized	200 - 400	204,310	37,415	828,988	1, 070, 713
Exchange Unsubsidized	Above 400	140,801	16,957	1,038,440	1, 196, 198
Total		678,684	303,487	2,948,861	3, 931, 032

As shown in Table 2, 25% of the Valley population or 982,171 persons would be otherwise uninsured or insured but with unaffordable coverage and thus eligible for the ACA expansions in coverage in 2014. We assumed that the income distribution, proportion uninsured, and proportion who are undocumented remain comparable to 2007 in 2014. Because of the exclusion of undocumented persons from ACA, at least 8% of the Valley population would remain uninsured. Among those eligible for ACA, 29% would be eligible for Medi-Cal, 50% would be eligible for use of the exchange and subsidies for insurance purchase, and the remainder could use the exchange but would receive no subsidies.

We used the 2007 income distributions and rates of uninsured in 2014 on the belief that the current recession will have moderated by then. But there is considerable doubt about the speed of recovery. Using California Health Interview data, Lavarreda et al estimate considerable growth in the uninsured statewide and most notably in the San Joaquin Valley. If the Valley's economy recovers less quickly from this recession than other areas, the number of otherwise uninsured and eligible for ACA MediCal expansion or the exchange and subsidies could be much higher. Using the same approach, but assuming that 2014 looks more like 2009, the total uninsured or insured but with unaffordable coverage could be as high as 34% of the population or 1,348,344.

These projections are likely to overstate the proportion of the Valley population that would be insured as ACA is implemented because insurance may remain unaffordable for many. Those with incomes between 200%-400% of poverty, in particular, may not find affordable insurance even with the subsidies. For example, a family of four at 200% of FPL would receive premium subsidies so that the maximum cost to the family would be 6.3% of income or \$2,735. The out-of-pocket limits would be one-third of the HSA limits or \$3,967 per family. The total cost could be \$6,702, about 16% of pretax income. For families of four at 400% FPL, premiums would be capped at 9.8% or \$8,624 and two-thirds of the HSA limits or \$7,983 per family as limit for out-of-pocket cost. These families might face health care costs up to \$16,597 or 19% pretax income. With the prospect of health care costs above 10% of pretax income, those at 200%-400% of poverty might feel forced to pay the tax penalty rather than purchasing unaffordable insurance.

²⁶ The Central Valley Health Policy calculations are based on data from (1) the National Health Interview Survey (NHIS), Early Release of Health Insurance Estimates by Cohen RA, Martinez ME, Ward BW. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2009. National Center for Health Statistics. June 2010. Retrieved from: <http://www.cdc.gov/nchs/nhis.htm>. (2) California Health Interview Survey (CHIS) Access and Utilization data updated up to 2005, and CHIS Health Insurance data updated up to 2007. Retrieved from: <http://www.chis.ucla.edu/> (3) U.S Census Bureau, National Population projections Released 2008. Projected population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: July 1 2000 to July 1, 2050 Retrieved from: <http://www.census.gov/population/www/projections/downloadablefiles.html> (4) California Department of Finance, State and County level population data. Retrieved from: <http://www.dof.ca.gov/research/demographic/data/race-ethnic/2000-50/> (5) University Of California, Los Angeles Center for Health Policy Research, California's Uninsured by County, Shana Alex Lavarreda, Y. Jenny Chia, Livier Cabezas, and Dylan Roby. August 2010.

persons in the San Joaquin Valley projected to be uninsured in 2014 without ACA will be eligible for subsidies or assistance through the insurance exchange, but at least some of these persons may remain uninsured because insurance will still be unaffordable. Further, those who are undocumented immigrants---about 1/3 of the region's uninsured---will be excluded from coverage under the new law.

▪ **Sustainable:** Given the mounting public debt in the US and the fiscal challenges facing the states, perhaps a central hope for ACA is that it will increase the sustainability of the US health system. In the current system, reducing or changing directions on the rapid growth in total health care spending compared to other economic sectors remains the major strategy for achieving sustainability. The ACA invests in a needed array of national panels, new comparative effectiveness studies, and reimbursement reform demonstrations. These initiatives may offer important improvements in both care quality and cost-effectiveness, but it is unclear how quickly these innovations will be broadly adopted or if states will innovate regulatory and reimbursement frameworks that hasten a drive toward efficiency in health care. Primary prevention and preventive service enhancements are believed to increase population health and thus reduce long-term cost escalation, but it is unknown whether or not the scale and design of the ACA investments in public health and health equity are sufficient to create important impacts on the cost curve in the near term. For Medicare, there is also a new national Medicare payment advisory council charged with recommending ways to change reimbursement rules and pricing structures in order to keep Medicare expenditures within targets. These may bring incremental reductions in the growth of health care costs compared to other economic sectors. But the legislation does not establish a pathway to enforce budget discipline at national or other levels for health systems or populations. Without some kind of consensus limits on health care costs, the evolution of administration and practice approach in ACA may not bring sufficient incremental reductions in the growth of health care costs compared to other economic sectors so that health care remains part of the social safety net of our society.

It is also important to find the most fair and painless way to distribute the burden of paying for health care. In order to finance new costs in ACA (including

Medicaid expansion, Medicare benefit enhancement, individual subsidies to purchase private insurance and small business tax breaks), the program obtains revenues from increased Medicare premiums for the very wealthy, new taxes on so-called “Cadillac health plans,” fees on the health care industry, a tanning tax, savings from Medicare Advantage program changes and additional Medicare savings from unspecified reimbursement reforms. This financing strategy may limit long-term stability of the program: health care industry fees may contribute to increasing prices and premiums and employers may pull away from the most costly plans more quickly than expected. More importantly, because of several political compromises ACA avoided finding financing sources outside of the health care industry and also needed to set subsidy levels at the less affordable levels noted above. In one political compromise, ACA does not establish a single national insurance exchange with nearly monopsony purchasing power and more capacity to inspire insurance price reductions. Putting this together, ACA may end up making US health care affordable for fewer people than anticipated and curbing the growth of health care less than needed.

The sustainability of Medicare is still a concern. Because the sole pool of patients that can participate in Medicare remains those over 65, those classified as disabled under the Social Security Administration and those with end stage renal failure, it will continue to be comprised of a high risk pool of patients. This group of patients utilize the greatest amount of health care resources, particularly during the last 6 months of life. This is verified when one looks at personal health care spending per capita according to age. In 2004, the per capita spending for individuals aged 0-18 was \$2650. Per capita spending for patients aged 19-64 was \$4511, for persons aged 65-84 it was \$14,797, and for those age 85 or older spending climbed to \$25,691 per person. Expansion of the private insurance market into the Medicare population will not fix this because at \$25,691 per individual, insurers could not charge an affordable premium without a steep governmental subsidy. What would help would be a means of increasing the pool of people to include younger and healthier individuals who use the system less and pay into it. Offering a Medicare-for-All option for the employer or the individual to purchase over the insurance exchange would broaden the pool of patients and help with the sustainability of Medicare. Because the pool of patients comprising Medicare is unchanged and budgetary discipline in deciding what

is covered is lacking, Medicare's long term economic viability continues to erode, and with that, fosters an increasing uncertainty in its ability to provide quality care to the retiring baby boomers. Under ACA as it is currently configured, costs of all health care for the federal government may continue to rise and longer term sustainability remains problematic unless there is a draconian cut in the benefits that government pays for or a commitment to an outside stable revenue source is made.

- **Effective:** In order to promote improvements in effectiveness, ACA calls for establishing a national strategy for health care quality, a national comparative effectiveness research effort, bundled payment and value-based pricing demonstrations, demonstrations program around new health care roles and technologies to improve effectiveness, and new investments in health care and public health work force. ACA also includes an annual physical exam benefit and elimination of preventive service co-pays in Medicare and coverage for preventive services in qualifying private insurance plans. Some states may explore medical home and other community and prevention oriented models for better care coordination. Several ACA elements also address racial/ethnic disparities in care quality, including new data collection, new community health teams, and targeted workforce development programs. Over time these initiatives may establish new policies and professional consensus on clinical and administrative practices that promote health care effectiveness and there is the potential for the national quality strategy and other initiatives to accelerate adoption of more effective practices. Yet it remains to be seen whether these initiatives will produce improvements in care for persons in private insurance or whether providers in underserved areas will have the resources to adopt recommended practice changes. From a different perspective, the establishment of the state insurance exchanges as competitive marketplaces for informed health insurance purchase, new insurance reporting and disclosure requirements, investments in health information technology and related components of ACA all have the potential to significantly improve the health of patients and promote the health care information so vital to patient engagement in effective care. States may vary significantly in how they create their health exchanges and these variations may limit how much new and helpful information patients receive. Because many believe that greater health care effectiveness and population health are as much shaped by living conditions and health education

efforts launched by public health and community equity advocates, ACA contains significant new investment in public health to support primary prevention and community transformation grants aimed at inequitable living conditions and primary prevention.

ACA Implementation: San Joaquin Valley Concerns

California is on track to become one of the first states to develop the insurance exchange and insurance regulation changes required by ACA. By October 2010, a law establishing the exchange had been signed. Government and provider groups are diligently exploring their roles in implementing the new law. Despite early efforts to implement ACA by 2014, California's short-term is harder to gauge. Still mired in the recession, the state seems poised for another round of draconian cuts in Medi-Cal and other safety net programs. The recession has had even more dire consequences for the Valley, where unemployment and lack of health care access have grown even more than statewide, while county and city budgets for health and human services have been slashed. Valley safety net hospitals face huge losses linked to uncompensated care and inadequate Medi-Cal rates, while other safety net providers are reeling with massive increases in demand. Meanwhile, several Valley counties are in the thick of planning or implementing Medi-Cal and indigent care changes, and a new multi-county Medi-Cal managed care program is just getting started. In this context, Valley health care stakeholders focus on maintaining and enhancing our under-funded and over-stretched health system, even while preparing to implement the new law. Using the CAUSE principles, we describe at least six issues that need to be addressed through Valley advocacy for state policy choices and local efforts to participate fully in federally-administered components of ACA.

- **Undocumented:** Although estimates vary, there are around 281,000 undocumented person in the 8 San Joaquin Valley Counties, 11% of all documented persons in California. About 232,000 people or 8% of Valley residents are both undocumented immigrants and uninsured. Although these persons make up 42% of the uninsured in Valley, they are excluded from ACA's Medicaid expansions and private insurance subsidies. Inadequate access to continuous and effective care for this population has a significant negative impact on the overall health of our region. Because so many

Valley children, nearly 1/3, live in a home with at least one undocumented adult, it is in the best interest of all residents to ensure access to basic health care for this population. Health care in California's heartland can not make serious progress towards continuity and effectiveness while allowing such a significant number of residents to remain outside a coordinated health program. Even as ACA is implemented Valley policy-makers will find it necessary to work at the state and county levels to develop a strategy to finance and deliver health services for this population. It is unlikely that either participation in the Medicaid coverage initiative or easily crafted changes to the realignment funding program will address this challenge. Valley counties may need to explore both new revenue sources and new collaborative delivery systems to meet this need.

- **Medi-Cal Expansion:** Given our relatively higher dependence on Medi-Cal than other portions of California and a relatively higher proportion of residents living near Federal poverty limits, the ACA expansion of Medi-Cal will be particularly important for our region. State eligibility determination and enrollment policies can dramatically shape the degree to which new patients are brought into the health care system. The Central Valley will need these systems to be culturally and linguistically responsive and geared to the needs of rural and urban fringe residents. The existence of paperwork and other barriers to enrollment needs to be monitored. Given current fiscal challenges, already implemented and proposed cuts in Medi-Cal coverage, California may lose access to some federal matching funds and may face more difficult challenges in meeting ACA Medicaid requirements. The recent emergence of multi-county County Operated Health Systems and multi-county two-plan models in several Valley counties and the continued successes of alternative Medicaid plans in other counties of the region allow greater local participation in decision-making around the details of Medi-Cal expansion. Ongoing and enhanced attention to member participation in decision-making in these plans will be crucial during ACA implementation. Finally, while ACA increases federal medical assistance program (FMAP) support to Medicaid programs and calls for federally financed improvements in Medicaid reimbursements, California has the opportunity to develop policies that direct more of these increases to the most under-served communities. Because of its size and diversity, California should continue to explore joining with other large states with significant under-served

regions (over 3 million people, provider shortages, lower overall health status) to allow FMAPS based on poverty rates in sub-state regions.

- **Medical Homes/Care Coordination:** The strong network of Federally Qualified Health Centers and related community clinics in the region have been noteworthy leaders in demonstrating components of the patient centered medical home approach. But most Valley safety net primary care providers are under-funded and have faced few past fiscal or regulatory incentives to fully develop these approaches. Other primary care settings have typically made even less progress in adopting these innovations. Given our vast geography, poverty and historic shortages and mal-distribution of health care resources, it is not surprising that many Valley communities experience higher rates of ambulatory care sensitive condition admissions than other regions. Patient-centered medical home programs are perhaps more important here than in other regions and coordinated multi-institutional and regional efforts to support these programs should be pursued. California will have the option to develop a Medi-Cal medical home program and Valley stakeholders can encourage adoption of this approach. Other care coordination and quality improvement initiatives available through ACA, such as expanded training and support for community health workers and community chronic care teams for patients seen in private practices, are other examples of effectiveness initiatives in which the region's providers should seek to participate.

- **Health Care Workforce:** ACA devotes new funding to physician and other health professional education and provides new incentives for emerging practitioners to begin their careers in under-served communities. Many in our region have concluded that these incentives are unlikely to fully eliminate shortage of doctors unless there are also medical education, training, and research opportunities in the region. Establishing a medical school (at University of California Merced) in the region, and supporting enhancements to post graduate training through internships, residencies and fellowship through UCSF-Fresno. Fellowship training and other postgraduate training is essential because many physicians stay to practice in the community in which they train.

Professional education and training initiatives aimed at other health care and public health roles should be

encouraged as well. The region needs to build on current initiatives and seek participation in ACA program enhancements. New funding for public health and new attention to telemedicine and electronic health records also suggest the need for increased local education and professional development options. Increasing the capacity of local providers to utilize these technologies and creating appropriate reimbursement strategies to promote telemedicine will also be an ongoing part of the response to health care workforce shortages.

▪ **Insurance Exchange and Insurance Regulation:** States have many options in designing the health insurance exchanges, and these programs will vary on governance, eligibility for use of the exchange, how qualifying plans are selected and regulated, and other factors. While California has made an important first step in developing these systems, with passage of SB 900 and AB1602 in August. Although this legislation establishes the basic structure of the exchange, it does not include a specific plan for its financing after initial federal funding, nor does it lay out expectations for the exchange in terms of public engagement in decision-making and communications. Communication strategies used by the exchange need to be responsive to the cultural and language needs of Valley residents, and the governance process for the exchange needs to include representation of Valley communities and populations. The new legislation does not establish any clear guidance on the criteria to be used in selecting and regulating plans within the exchange. Valley patients and others could advocate for restrictions on plans that raise rates excessively or fail to adapt benefit and coverage decisions to special needs in rural and under-served areas.

California has yet to seriously debate other changes in health insurance regulation as required by the ACA. As these debates develop, there will be opportunities to strengthen or water down other key insurance reforms in the national law, such as the use of community rating, limitations on loss ratios, consumer disclosure, and denials of coverage. As specific debates unfold, Valley stakeholders can use the CAUSE goals to shape resolutions that promote population health.

▪ **Behavioral Health:** All Valley counties are facing a growing gap between demands for mental health and substance abuse services and the

availability of such care. Though the California Mental Health Services Act has brought new attention to prevention and the needs of underserved communities, reductions in funding from other sources have left public mental health systems in disarray while even those with private insurance find some needed services unavailable. A number of efforts are ongoing to improve the behavioral health workforce and delivery systems in the region, but lack of public consensus on the relative priority of behavioral health services and inconsistent private sector leadership has hampered real progress to date. In this context, public sector-oriented behavioral health services have been more developed as a specialty service sharply separated from traditional primary care settings through the use mental health “carve outs” and related policies. Few Valley safety net or private practice primary care services have the capacity to offer integrated physical and behavioral health. ACA includes behavioral health benefits among the core services to be covered by qualifying plans, adding more force to the recent national mental health parity legislation. Federally qualified health centers are now able to bill for behavioral health services beyond these carve-outs, but only a few Valley providers have needed capacity. In the short run, targeted initiatives to expand behavioral health in the FQHCs can relieve pressure on over-burdened hospital emergency rooms.

Can We Do Better? Towards an Excellent Equal Opportunity US Health Policy

The important advances in health policy represented by ACA will expand health care access for many and make important steps towards improving the quality and efficiency of health care in the United States. We have also described a range of implementation strategies and incremental changes that can further improve the health care system. However, we believe it is a worthwhile endeavor to achieve better than a C grade in fulfilling the goals of continuous, affordable, universal, sustainable and effective (CAUSE) health care in this country. This will require additional changes in US health policies and practices that go further than ACA does in satisfying the principles of CAUSE. Recognizing that our national conversation about health care will become more focused as elements of the ACA are implemented, we describe six areas of change most consistent with the CAUSE goals.

1) Break the Link between Employment and Health Care: The ACA builds upon the present system of employment-based, primarily private coverage. This model relies on employers with greater than 50 employees to continue to contribute a substantial portion of needed revenues, because they are now mandated to provide coverage for their workers. During difficult economic times and facing rising premiums, employers may shift more of the costs to employees. Employees, also mandated to buy insurance, may need to rely on government subsidies to help pay for the health insurance. Accordingly, federal and state governments will take on the costs of subsidies to make private insurance affordable. Without firm budgets in place for health expenditures, costs to the federal and state governments will rise. Even with regulation of health insurance premiums, intense lobbying for rate increases would remain. ACA does not include a publically financed alternative such as Medicare-for-All that would allow employers a choice for purchasing something other than private insurance. Offering Medicare-for-All plans as an option for employers and for those seeking coverage through the insurance exchanges established by ACA would provide competition to keep premiums in line. Over a fifteen year period, the Medicare-for-All program could be incrementally adjusted using data emerging from comparative effectiveness and quality research to cover only those services that have been found to benefit health. As this program develops it can offer a lower cost alternative to current private insurance and could be made into an automatic benefit for everyone. Those who wish for additional services not covered in the public plan or who wished to remain in private plans would retain the option of purchasing comprehensive or supplemental private coverage. Having a national back-up plan available for all would free employees to seek a change in employment without worrying about the consequences of losing their health insurance. It would initially reduce the costs and eventually free employers from the mandated expense of employee health care coverage. US employers would be better positioned to compete globally with countries that do not require that employers insure their workers.

2) Eliminate the Concept of Shopping for Insurance: Even as ACA improves the continuity of coverage, some gaping holes in the medical safety net

will remain. For example, by 2014 state insurance regulation will limit private health insurance waiting periods for new coverage to 90 days. This means that if a family breadwinner loses health insurance because of an employment change and acts instantly to purchase insurance through an exchange, the family could be subject to a waiting period of 3 months, with the prospect of significant economic and health consequences if someone becomes ill while waiting for the new insurance to become active. The concept that one must shop for insurance and wait 90 days for it to be in effect is different than having a publically supported plan that offers a core of benefits that are always available should one lose coverage due to a change or loss of employment. This is just one example of the potential challenges around shopping for insurance. Others include complexities around enrollment and premium payments and the effectiveness of communication by health plans on benefits, limitations of coverage and participating practitioners. Development and incremental implementation of a Medicare-for-All plan would insure that all persons always have access to a set of core benefits. The US health system would shed significant costs around marketing and administration of private insurance and the public would experience a greater sense of health security.

3) Bend the Curve: Reduce the Rate of Health Care Cost Increases: Although ACA includes some initiatives to slow health care spending increase, several additional actions could be taken to rein in health care costs: a) Create new incentives to strengthen primary care so it provides all components of the patient centered medical home. Revise reimbursement structures to truly reward time spent in diagnosis and management of diseases and to reduce payment for procedures that do not show significant health benefit. b) Let go of the tenet that the government or private insurance must pay for all care simply because it is technologically feasible and available. Further developing and using evidence-based guidelines could allow public expenditures only for those services that have shown to be efficacious and cost-effective. c) Implement health care budgets. National, state, and sub-state democratically elected health boards can monitor utilization and re-shape coverage based on local experiences and values. Over time it will become evident what the costs to promote and sustain population health are, and budgets could be set based

on fact.

4) Provide Economic Incentives to Promote Health. While the ACA provides some important new investments in public health and primary prevention and new initiatives around the nation seek to create policies and environments that support healthy lives, individuals still have responsibility for doing what they can to improve their own health. Today's most common chronic illnesses can be prevented if patients controlled five easily measured benchmarks: blood pressure, cholesterol, weight, avoidance of smoking, and control of diabetes. We can use existing employer/employee connections to offer tax credits to employers that engage employees in managing these risk factors. Employers can also offer wage or benefit enticements for meeting personalized goals. The tax code can be amended to allow employees to use flexible spending accounts for specified programs that reward good health care.

5) Consolidate Overlapping Health Coverage: While ACA includes aggressive initiatives to reduce fraud and abuse in health care, it does not address the unnecessary expenditures associated with workers' compensation and automobile insurance. Worker's compensation systems cover financial supports and medical care costs for employees injured at work, while automobile insurance addresses medical care costs and financial losses for persons injured in an automobile. Both systems could be reformed to separate the financial compensation from the health care component of these plans. A legal process through which qualified physicians are hired by the state to determine the extent of the claimed disability for purposes of financial compensation, while individuals could receive needed medical care services through the Medicare-for-All plan. This would generate savings from eliminating duplicate services like separate health care providers, lowered premium costs, increased administrative efficiency, and allowing patients to see their own physicians for these injuries. Employers would see lowered workers' compensation premiums. Injured persons would receive needed care on a more timely basis because legal haggling about financial responsibility would not inhibit access to needed care.

6) Medical Malpractice Reform. ACA includes funding for state demonstrations of medical malpractice reform, yet the new law does not feature a consensus on the shape of this reform and the national

patchwork of inconsistent policies is likely to remain in place for years. There is ongoing debate on the extent to which medical malpractice and defensive medicine add to the cost of health care. It is not easy to quantify the cost of defensive medicine. There are also arguments that suggest that doctors practice defensive medicine to order more procedures and thus improve their incomes, yet there is an extraordinary amount of defensive medicine practiced in emergency rooms where ER physicians do not stand to make a profit from the evaluations that they order. An alternative to curb this would be to enact a national malpractice approach based on alternative dispute resolution principles. An effective national policy would empower professional panels, chosen in consultation with state health boards, to review malpractice claims that cannot be resolved through mediation. The panels would act on the presumption of reasonableness if the health care provider adhered to the accepted evidence-based and clinical practice guidelines established by the national and state board. Across health care settings, practitioners would feel free to use their clinical judgments knowing that following established guidelines would indemnify them from malpractice liability.

The national debate on how to achieve an excellent equal opportunity health care system in the United States did not end with passage of ACA. Even as relatively poor and inadequately served states and sub-state regions, such as the San Joaquin Valley, struggle to use the new policy to improve access to needed care and reduce inequities in health outcomes, the absence of consensus on the goals for health system improvement limits progress and underscores the unfinished work of reform. This lack of consensus on health care goals coupled with the political compromises needed to achieve passage of ACA leaves the San Joaquin Valley and California with noteworthy risks for failure. We have shown how the goals of continuous, affordable, universal, sustainable and effective health care, the health care CAUSE, are even more important than when they were first articulated by the Institute of Medicine. We have also shown how the ACA partially meets many of these goals and highlighted a series of implementation strategies and incremental changes to new national policy that could bring us closer to a CAUSE health system. In addition, we outlined six major changes that if enacted, would take us further than ACA does in attaining excellence in health care.

In the attached appendix, we show one example of how the CAUSE principles can be applied to fashion a practical solution for our health care system. The CAUSE approach breaks the link between employment and health care, replaces the concept of shopping for insurance with a true safety net for those unexpectedly left without coverage, aggressively addresses rising health care costs, provides incentives to promote health, reduces duplicative insurance systems, and offers malpractice reform. The CAUSE approach would fundamentally change the delivery of

health care in ways that ACA begins but not achieve. Details of the CAUSE plan are summarized in the following appendix. As health care costs continue to rise and disparities in access and quality remain in many parts of the nation, the US public and our leaders will find it necessary to continue to seek ways to achieve an excellent, equal opportunity health care policy. Perhaps CAUSE can offer some answers for what remains a formidable challenge for our nation.

Download Appendix 1: CAUSE Plan

http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/cause/documents/CAUSE_Plan.pdf

Download Appendix 2: CAUSE Implementation

http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/cause/documents/CAUSEImplementation.pdf