Capitol Journal Healthcare Topic Webinar

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Capitol Journal Healthcare Topic Webinar

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Guest Panelists:
Diana Dooley—Secretary, California Health and Human Services Agency

Dr. Micah Weinberg— President, Bay Area Council Economic Institute and CEO, Healthy Systems Project

Rich Ehisen: All right. Well good morning everybody and welcome to the LexisNexis StateNet Legislative issues series for 2019. I'm State in the Capital Journal Managing Editor, Rich Ehisen. And today we're going to be talking about health care, one of the most challenging topics facing lawmakers at all levels of government, every state or county, the feds, all of them.

We're very fortunate today to be joined by two of the most respected voices on this topic, anywhere in the country. Sitting to my immediate right is Diana Dooley, former secretary of California Department of Health and Human Services, and also former chief of staff to Governor Jerry Brown. And joining us remotely is Dr. Micah Weinberg, President of the Bay Area Council Economic Institute. Welcome to both of you. Thank you very much for joining us here today. Their bios are in front of you right now. So I'll let our online attendees review that for themselves.

Suffice it to say we really appreciate both of you joining us here today to share your insights and expertise. One note for everybody, we're going to try to save some time at the end for questions. So if you want to ask something of our panel, send in a question we're going to be collecting them and trying to choose one or two to answer toward the end as we have time.

So anyways, healthcare is a huge topic, that a lot of moving parts far more than we can cover in any one setting. So today, we're going to zero in on just a few broad aspects of the issues we think are having a big impact this year on state house, and you see them in front of you right now, the health and the stability of the Affordable Care Act. A lot of issues surrounding Medicaid. A lot of issues surrounding single payer proposals. And then of course, drug prices, which have been a long-standing issue in healthcare forever. And as you can see, there already been significant number of bills introduced them to state houses in each of these areas this year. And we certainly anticipate even more as the year goes on. So that's a lot of ground to cover within just these four areas. So let's get started.

And we're going to begin with the Affordable Care Act. As we all know, control the US House of Representatives changed hands in January. And it seemed that the time that that meant congressional efforts to overturn the ACA, were finally over for the foreseeable future. Of course, that is not the case. But setting aside the ongoing legal challenges in the courts, there's still a lot of efforts to undercut the law, both predominantly from the Trump Administration, a lot of changes that have made the law come under fire. So if possible, let's quickly assess the state of the

law right now. And take a look at some of the biggest challenges facing state lawmakers and regard. For example, California and Washington are two states that are pondering, implementing their own individual health care coverage mandate to replace the one discarded by Congress. We've seen a few others that are all have already done this, including New Jersey, Massachusetts, Vermont, Washington DC, many other issues running, rising health costs, declining enrollment, preexisting conditions, coverage for preexisting conditions, etc.

So all that is part and parcel to the Affordable Care Act. So, Diana, we're going to start with you given all of this and probably a lot of other things I couldn't talk about, how would you assess the current date of the Affordable Care Act as the states are dealing with it?

Diana Dooley: But I think, generally I thinks that it's in pretty good shape. It's in better shape than California than it is in many places of the country. But even in places that resisted it, at the outset, are coming around. And I think we can talk about that a little bit more. When we talked about Medicaid people think about the Affordable Care Act primarily as a coverage expansion and the health benefit exchanges. That act was 2000 pages and covered many aspects of the healthcare delivery system, the prevention system, the ways healthcare are paid for it—but certainly we focus very often on coverage expansion and the health benefit exchanges in California—that's Covered in California.

I often said when I was as Secretary of Health and Human Services, I was also on the Covered California Board. I was the chair of the California Board for all of the time of my service. And so we stood that up from nothing but what's got labeled Obamacare was really Romney care in Massachusetts and Schwarzenegger care in California.

It had been proposed the essence of the Affordable Care Act was what had been enacted and tried to be enacted by other Republican Governors. And with the market-based approach again, we can talk a little bit more about that when we talk about single payer, most democrats wanted a single payer system but what they got was a market based incremental approach to that.

And in California, it had been not only attempted on a statewide level by Arnold Schwarzenegger, he embraced it in the last year of his governorship, both by committing to the expansion of Medicaid program and working with The democratic legislature in fall of 2010 to establish the authorizing law that created what became Covered California.

So when we took over after Jerry Brown was elected in January in 2011. We took this baton from the Republican Administration that had been very committed to its success. And I mentioned that because I think that the key contributor to California is the ability to move as quickly as we had to move to get this up and running in that three-year window.

It took effect in 2014. And we use that time regrettably, we also took a different baton from that administration, which was $27 billion deficit. So we were preparing to have a major expansion at the same time, we were making very painful and consequential cuts to health and human services programs until the voter approved tax measure in the fall of 2012. Part of what makes us successful today is that the test by fire in those early years we were very transparent with very nimble. And we were very inclusive across all the sectors, not just the partisan differences, but with the plans and the providers, and with the consumers who are going to benefit from this. And so I think we built a strong foundation.

We have been battling for the last two years to maintain the gains that we've made in the face of administrative actions that the Trump Administration has taken. The legislative action to eliminate the individual mandate was serious. The premise of any insurance IT program, whether it's fire, auto or home, is the pooling. And so you have to have healthy lives as well as those that need to use health care to have a good risk mix and to have it be successful.

So if you let people opt out by not requiring them to have insurance if they think they can skate, they're very healthy, they are younger for whatever reason they think they don't need health insurance. And they're not in the pool. It adversely affects everyone who lives in the pool and system costs more. So it—but there are costs associated with making people buy something they don't want to buy. And that's

what the legislatures will deal with in enacting an individual mandate. From a policy standpoint, it's critically important to the health of the program, and the viability of—and really holding costs down from a premium standpoint. But there is political risk anytime you're going to have a mandate. So I'll pause there if you want to give Micah a shot at this question.

Rich Ehisen: Yes. And Mike, thank you also for joining us here today. I—you know, we're talking about the individual mandate and I meant also pre-existing conditions, enrollment. One of the other major issues was a big cut in the federal funding that the exchange of their states were able to use to advertise open enrollments for their exchanges. You're a noted authority on health benefits exchanges. You know, what's your assessment of the Affordable Care Act now and some of the efforts that are—the states are undertaking to try to counter some of these negative impacts that have come down the pike in the last year or two?

Micah Weinberg: Sure. Thank you so much Rich. So I'm actually enormously impressed with the exchanges and the work of people like Secretary Dooley, especially but not exclusively in Covered California and here in California. I mean, this is a, you know, a set of exchanges that have really taken a licking and he kept on ticking.

It's amazing that they continue to exists with all the headwinds over the course of now almost a decade, both in terms of setting them up and then keeping them operating. In some ways, the concern around the exchanges distracts from one of the bigger issues which has always been those people that fall outside of the subsidy range. So people above 400% of poverty and recent statistics from the Kaiser Family Foundation have shown a 40% decrease in enrollment in unsubsidized ACA compliant plans since 2015. And there are lots of different reasons for that. But it is something that places like California and other states have been looking to address through the individual mandate legislation that New Jersey and others have moved forward. And other types of proposals such as topping up the subsidies here in California. So as we think about all the things that the ACA is, we need to make sure that we continue to think about, you know, that particular population.

I'll just say one more thing, you know, the Secretary mentioned, the 2000 pages of the of the Affordable Care Act, two thirds of which were really about health care costs control and delivery system reform. And the health care system, it turns out is enormously complicated and complex. So it's difficult to attribute any particular policy intervention, even one is sweeping as the Affordable Care Act as being responsible for something as large as health care costs. But when you look at the health care costs trend since the passage of the Affordable Care Act, it's still what many of us would consider too high, you know, in the sort of 7% 6% range. That's substantially lower than the ranges of health care costs growth that we saw at other periods in US history, and even the period immediately before the passage of the Affordable Care Act.

So one of the things that didn't really come to happen that people were worried about is, oh, we're going to pass this bill and health care costs are going to explode, when in fact, the opposite is true. In part, I believe due to some of the elements in the Affordable Care Act, our health care costs, growth, and especially the sort of value that we get for that spending, with substantially more people covered, getting more care has really been a positive and perhaps overlooked story.

Rich Ehisen: Right, thank you. Well, of course, we talked about Medicaid and I mentioned Medicaid. So because a big part of the ACA from the beginning has been the expansion of Medicaid eligibility to those that 138% of the federal poverty line gives me poverty line.

There have been at least three significant areas of movement in this regard in the last few months last several months anyway, voter approved expansion in a handful of states, predominantly red states and last November's midterms, growing call in states like California to expand Medicaid coverage on authorized immigrants, and an even bigger call that's growing across numerous states to expand Medicaid and Medicare coverage to the broader population. I do want to tackle those in order.

So let's start with the expansion of Medicaid in Idaho, Nebraska and Maine, excuse me, Idaho, Nebraska, Utah and Maine. I mean, of course, both 2017 didn't

get implemented until this year, the governor at the time block that implementation. But one of the more interesting things we're seeing right now is happening in Utah, where voters with a 53% approved endorsed Medicaid expansion last November. Utah lawmakers in the meantime have significantly amended that measure to limit eligibility to just 100% of the federal poverty line has also imposed work requirements, neither of which has allowed under the ACA. So both of these are going to require approval by the Trump Administration. Now granted, in theory, Utah would be the only state that has so far receive that kind of permission, but in theory would lead more states maybe to follow suit. So the question is, to my panel of experts here is, you know, with so many states so deep into their expansion, how big of a deal is this really? I mean, what impact will this have perhaps on stage, that haven't expanded already, or maybe even those that have is this something where somebody maybe would consider going back and rewriting their rules of expansion and well, but saying I'll start with you.

Diana Dooley: Sure. Well, I think it's interesting to note that Medicare and Medicaid were enacted in 1965 and took effect in 1966. And it was 1984, before every state in the Union had a Medicaid program. So we have actually had an uptake of this much faster in part because I—the original law required the states to expand their Medicaid program. And that's the case that went to the Supreme Court that upheld the constitutionality of the Act but held that Medicaid programs had to be optional for the state. Medicaid is significantly different in many ways to Medicare, but the most significant way is that they are state run programs and in partnership with the face.

So whereas we have one national Medicare program, we have 50 plus the territories 50 plus Medicaid programs with every state having a variety of budgets—have different funding formula California is a 5050 share 50% state funds 50% federal funds, and then you've got Mississippi at 73% federal funds and many in between. So the state programs have always been different. And Utah isn't the only state to ask for work requirements. Kentucky and Arkansas have already and compact techies' waiver was approved to allow work requirements.

I think you will see variation in the program. The 100% level, the lower threshold is probably allowed. The federal government has extraordinary flexibility in its management of the Medicaid programs to negotiate. They're called waivers. They waive the standard law to allow states to have what are called demonstration projects and in the business. We all get into this language but essentially every state has a contract with the federal government to administer the Medicaid program consistent with that state values. It's a state's rights issue. And so I think we will see differences.

The fact that we've seen so many red states add is because all the blue states came in at the beginning. So the ones that are left outside now are the remaining red states. And I think, over time, more and more of them—will come because their citizens will demand the coverage as they did in Maine, but also the provider community is looking to eliminate the uncompensated care that walked into emergency rooms and the homelessness than the mental health and the variety of needs that communities have that can be addressed by the Federal participation and the funding that comes from the federal Medicaid program.

Rich Ehisen: Micah, what do you think about all this?

Micah Weinberg: Yes, I guess maybe I'm just feeling upbeat this morning. I mean, I'm—I think work requirements are the worst, they cost more to administer than you save. They make no sense because in order to have upward mobility, you need to make sure to have a safety net. And if you don't have health care coverage, it's not likely to make you a long-term productive citizen. However, that's me. And in a broader context, I see this as states figuring out how to get to yes, rather than the Hell No, we won't go of, you know, five and 10 years ago. So I guess I'm seeing that in more of a positive light.

And then one technical note is there's a very fortuitous drafting error in the Affordable Care Act. I mean, if folks can remember back to that time, of course, there was the Quick reconciliation of the senate go with the House Bill using the senate bill as the chassis. And the people were only supposed to get eligibility to ACA subsidy starting in 138 of poverty. And because of this sort of quick drafting error, they had eligibility to substitute at 100% of poverty. So

those states that get a waiver to extend Medicaid to 100% of poverty, everybody above that are going to get extraordinarily generous, Affordable Care Act subsidies that make their health care coverage almost free. So I don't necessarily see that as a bad idea. And I can certainly see how that appealing to a lot of states since they then won't have a match for that—those ACA subsidy. Again, it's not how I would do it. It's not how we've done it in California, but I see a lot of this as States for growing out how to get to yes and figuring out how to continue to have Medicaid programs that as Secretary Dooley points out, have always been very unique from state to state based on the waivers.

Diana Dooley: Let me just add a footnote Micah, add to what you said about the work requirements, I agree. But they also make almost no difference. Very high percent of the Medicaid eligible population is already working. And all of the work requirement rules that the federal government has put out, has to be able body. So you have to be able to work and they're very small numbers. So that adds to the administrative burden is a very much bigger political issue than it is a fiscal or at impact, it costs more as you said, than it isn't.

I will also say to your point about the process of the enactment. Almost any even far less significant legislation than then I anticipate that they'll be clean up legislation over time. And the way this was established—this was enacted didn't and the political fallout immediately following it. Prevented any of the kind of modification legislatively that many experts have pointed out are needed. And upside of that however, it's been it's probably been the most stable federal law ever in terms of implementing it.

So we've all known what the rules are, we've understood them and we've made it work. It will be very interesting to me to see in the next decade or so as we get to making the kind of legislative reforms that are needed. They're going to be very different now than they would have been if we started tinkering with it right after its passage.

Rich Ehisen: Well you mentioned the political element of this. And of course, we're in an age where everything is political. But let's tackle one of the really big issues that has a huge political element to it, of course, which is Governor Newsome's proposal to extend Medicaid coverage to unauthorized immigrants here in California. And this may be only a really a predominantly a California issue. But you know, there is some truth to be said that, you know, as goes California, so goes country. That's not nearly as true as some of us here in California, maybe would like to think it is but you know, there is some validity to it. So, Micah, let me just time start with you. What do you think about this proposal that the governor has made? What—what are his chances? What's the good and bad here?

Micah Weinberg: Well, I mean, I'm hearing very positive things about the extension of Medicaid coverage to low income undocumented adults under 26. I think that's what we're looking right now. Last year, there was a proposal to expand Medicaid to all low-income undocumented folks in California and not had a price tag that even though groups such as my own supported, it ended up being a bridge too far for the legislature. So that's certainly something that people need to look at.

I mean, what I emphasize is, look, we all have different attitudes about immigration policy. We may believe that there should or shouldn't be undocumented immigrants in our country and that's a whole different conversation than what should we have as a health care policy for people that are here. And the health care policy that is not universal is a health care policy, that doesn't work. And so my bias is definitely towards getting everybody into the system. Otherwise, it's very difficult to get consistent quality outcomes and everything from controlling healthcare costs to achieving public health goals.

Diana Dooley: I would add to that to say that I in the Brown Administration, we've felt very strongly that this is an immigration issue and it needs to be addressed as an immigration issue. But having said that, we expanded coverage to children under 18 and under and the expansion to 26 of them is a next step. Many counties already provide indigent care. And so many of these people are getting some levels of care. It varies from county to county. And as often happens when counties do the right thing with the people that live there, they come in and they ask for a state program to take care of the rest of the program.

I'd also point out that California has long had date only program and where according to the values of California, we have met people's needs in the health care system for 100%. And that's what we're really talking about Medicaid, as I said, as a shared program between the state and federal government. And the state only programs, other programs that we pay for 100%. So we've been paying 100% for the children, if this is an act that will pay 100% for young adults to up to 26. Fundamentally, they should come into a whole program that is handled from an immigration standpoint.

Rich Ehisen: Well, this leads very nicely right into really the conversation we've met, we've been, as I said, you know, we kind of laid this out earlier, and we've been talking about it and little bits and pieces here, but lots of talk now about Medicare for all, and we're seeing it from the Democratic caucus in the US House of Representatives. But we've been saying this at the state level for a while, where I think was Nevada few years ago, passed legislation for Medicaid buy in. That was vetoed by Governor Sandoval at the time. But there's numerous proposals out there for whether it's a Medicaid buy in, or whether it's a Medicare for all type of proposal. Assess maybe the differences in those and know what, how feasible are either of these options, whether we're talking about Medicaid buy in or a somehow a single payer Medicare for all.

Diana Dooley: Do you want me to start.

Rich Ehisen: Oh, yeah, I'm sorry. I'm sorry, yes.

Diana Dooley: That's right, I just popped in because I heard Micah is very good on this subject. And I agree with him that I would just say, first is there is no common definition of what we mean when we're talking about Medicare for All. Single payer is a little better understood. But and I understand the natural appeal because it seems simple. But Medicare—the medical delivery system and the payment system is not simple. I often say (Rube Goldberg) would not have built a machine that looks like this.

We've got so many variations on coverage and services and some government pays directly for services some we buy insurance some we have plans. Even Medicare, which is a federal run program has Medicare Advantage, which is using private insurance plans for their managed care products. So to unwind all this we often hear people say well, the other developed countries have universal coverage.

Even universal coverage means something different than Medicare for all or single payer. But they started, everything started at a World War Two, and each country did something different in that expansion period of the 50s and the 60s. To unwind what we have and start over with a single payer is just not feasible. And I'll say it in in three ways. One is we have these government funded programs Medicare and Medicaid that we've already talked about the difference between Medicare, being federal and the Medicaid being states, the state—the federal government, spends in the neighborhood of $65 billion a year for California's program. So to have a state-run program, the federal government have to give us $55 billion a year and they okay do with it whatever you want with no strings attached.

They'd also have to turn over their Medicare programs to California and let California run Medicaid. So the message to the government funded programs would have to be run. You would have to take all of the employer sponsored care and say, okay, employers, you're not going to pay your insurance premiums and people, you aren't going to pay your premiums, but you're going to pay a tax to cover that care and everyone who has private care would get a government run program.

And then you would have to actually run it as the government. So you have like a PVC type or you know, you'd have some organization that would do what the insurance companies do now, which is contract with health doctors and hospitals, and they tell you whether you've got your care, second MRI, so you pick any one of those three buckets and say, which one do you think is the easiest to make happen? I understand and I appreciate the appeal. I would have liked to have had single payer to 50 years or 60 years ago if we started then. But I've never spent too much time on it because I'm so committed to making our incremental system better and working through the system that we have. I haven't spent much time or attention on what they call single payer.

Rich Ehisen: Micah, before you answer let me ask you to address this to some extent, in a little bit of context, because we know Governor Newsome here, and Governor Inslee in Washington, a newly minted presidential candidate has—they both already been talking about not just individual mandate in their states, but also laying that groundwork for a statewide single payer system.

So Diana just played out a lot of the problems with that. I know you're very familiar with places like Vermont that have tried, you know, these kinds of programs in the past and, you know, a fraction the size of a state the size of California or even Washington, and they still couldn't make it work.

So if you would, when you address this, maybe address these kind of current proposals we're seeing as well in this historical context.

Micah Weinberg: Yeah, I mean, so there's a lot of talk about single payer and actually just this week, you know, Governor Newsome is wanting to refashion a state task force to really focus specifically on this. But at the same time, the hard work of building towards universal affordable coverage continues. And that's where Governor Newsome is putting his actual policy efforts. And that's where most of the actual policy efforts are around the state. So his proposal to create an individual mandate to top up subsidies and to expand Medicaid to undocumented kids up to 26. Those are the actual proposals.

Beyond that there are task forces which can, you know, get the same presentation. Of all the points that Secretary duly laid out. And I don't see those as being especially realistic. And you know, the Medicare for all if you think of like Helen of Troy's the face that launched 1000 ships Medicare for All is sort of the catchphrase that launched 1000 proposals. And it is sort of amazing to me how little the Democratic presidential candidates appear to know about the Medicare program. So, you know, somebody like, you know, our State Senator Kamala Harris can say, "I support Medicare for all and the elimination of all private insurance companies." Well, that would be a real surprised to the 40% of California Medicare enrollees that are enrolled through Medicare Advantage plans, and that Oh, by the way, are the happiest Medicare enrollees in the state in terms of their satisfaction.

So what I would really love to see and what I'm very glad to receive from the Newseum Administration is sure we can keep talking about, you know, these sort of geometrical proposals as much as folks want. But on a parallel track, we can't forget the real actual hard, but impactful policy work of moving towards universal coverage that is affordable based on our existing system.

Rich Ehisen: Before we move on, I want to remind everybody if you have a question for either of our panelists, or if you're in for some inexplicable reason for me, feel free to send us an email question and we'll and we'll address it at the end. So we've been talking about so many aspects of healthcare and as I noted earlier, we're going to talk about one of the ones that has been a bugaboo in the system since the beginning of the system, which is the cost of prescription drugs.

And this is one of those rare cases of late where it seems like California in the Trump Administration are actually on the same page and that everybody agrees that the paraphrase the cost of prescription drugs are too damn high, right. There's no agreement, though on the best way to rein in these costs. And of course, if you're coming from the Pharma side, you might say that we don't need rain in these costs. That may be a whole nother discussion as well. But let's talk about the things that are on the table.

We've seen a lot of proposals over the years some of the more current ones. We know Governor Newsom here has ordered I centralization of government drug purchasing. Florida's governor Rhonda Santa seeking permission to import prescription drugs from Canadian pharmacies and everything in between. We've seen proposals in fact, we saw the Supreme Court overturned a law not many not speak for I'm sorry, but a district court overturned a Maryland law that requires justification of drugs increases to our price increases. What are some of the ideas you think here that will really have the most traction that we should be looking at? Is there really an effective way that is out there to control the rising cost of prescription drugs? Or is this one of those things where we're going to be constantly tilting at windmills until the end of time? And Micah will start with you?

Micah Weinberg: Well, I mean, I think as a point of contexts, it's really important not to, when I call sort of chase chickens around the yard. One of the things

that I worry about in terms of the you know, focus on prescription drugs is that the first thing you learn about health care costs in the United States is that they will keep rising inexorably. But the second thing that you've learned about health care costs, is it there, everything. You know, it's prescription drugs, but it's also hospitals. It's also the devices. It's also doctors, it's also nurses, it's every part of the American healthcare system is more expensive than every part of the healthcare system everywhere else.

So it's understandable because a lot of the cost increases have occurred within pharma recently that we're putting a lot of effort there. But I do worry about our inability to sort of see an act on the broader picture. And therefore I do worry about some of the proposals that essentially say, well, let's take the pharmacy benefit out of the broader health care bond and benefit and let's just try to hammer down the prices through bulk purchasing. And I certainly see on some level the appeal of that, but it really does, you know, move away from the integrated the whole person care that is offered through ideally, these integrated delivery systems that can help manage both the amount of drugs and biologics that are prescribed as well as their total price.

So, I'm much more on the, you know, trying to put things together, just speaking quickly from the employer world. I don't know that employers, you know, after decades of experience with pharmacy benefit managers where they sort of broke out the pharmacy benefit and, you know, tried to get a better deal. You know, through looking at that and having that managed differently. I don't know that you'll get that went especially well. Now, this isn't perfectly analogous there. But I do sort of worry about these kinds of proposals.

Rich Ehisen: Diana before, weigh in. One of the other things we've seen a lot of lay across many states are our bills to address some so-called gag clauses with pharmacy benefit managers that address their ability, or maybe sometimes their lack of ability to offer generic information about generic drugs to their clients. Do you see that as being something that's really impactful in this discussion of a rising drug crisis?

Diana Dooley: Well, let me pick up on where Micah was, and I'll and I'll include that. We tried—I think drug prices, it's sort of like the weather everybody talks about it but doesn't know quite what to do to do about it. And we formed—it when I was secretary. I thought four or five years ago, we had a series of meetings with everyone around the table all of the users this collaborative Department of General Services that the Governor Newsome is included in his executive order, which does bulk purchasing for the jail for anybody who wants to they have bulk purchasing we have, you know, what, almost 14 million members in Medi-Cal that we bulk purchase. I mean, we don't vote purchase for, but we purchase for what they want to pull out of the plans. Purse has 150 any 1.5 million lives Covered California has 1.5 million lives, you would think that there would be some leverage, but there never is. It's sort of like bargaining with OPEC. You—they have a product that you have to have.

And that's one of the fallacies in this book purchasing idea is that you've got formulary issues where you can't drop a drug Medi-Cal, for example, under federal law has to offer everything that is FDA approved. So in private sector, you could say, I want this drug but not that drugs. Or you can set up systems to make it easier. But that's about all you can do because patients need the drugs and wants the drugs that are available.

The reason there's so much secrecy is the competitive advantage or disadvantage of having your drug prices. We did adopt—the Governor,

Governor Brown signed a bill two years ago, Senator Fernandez that would require that disclosure of increases over 16% over two years now 16% to 8% a year. Is that what most drugs are we were trying to get at the outlier drugs that have gained so much attention. But even that is being challenged in the court and one of the side or unintended consequences of transparency is when—and we've seen this in some of the work we've done a Covered California, where you have standard benefits and standard pricing, those that are below see that there's room in the market to come up.

So in some ways when you become transparent, you telegraph to people what the market will bear and it a high tide raises all ships. It adds to the increase in the inflation. So it's very complicated. I very much appreciate Micah's pointing out the conflicts between pulling all the drugs out to do a boat purchase. At the same time we're trying to integrate care in whole person care and medication management with a management plan. You've got to be able to have all of the tools in the box medication of which is an important one as you're trying to control costs.

So like the rest of the healthcare delivery system it's very, very complex, and you have a high risk of unintended consequences when you start pulling things apart, like this idea that you can pull all the drugs out and buy all the drugs for California in one place.

Rich Ehisen: And then the PBM I mentioned.

Diana Dooley: The Pharmacy Benefit Managers are finding that they provide a service, not only for the employers, as Micah said, but for the plans. Because they do at some scale have an advantage where they're purchasing for more than what it is sort of a bulk purchasing measure. The issue of transparency is as I said, they have trade secrets and they again, they don't always want to say what they're getting and then they've got it—I'm sorry, I'm rambling a little bit but then they've got all the rebates which are very hard to understand. They have advantages for certain drugs and certain manufacturers in certain circumstances where they get rebates. And I think that idea of a rebate is offensive to most people. They want to know what it is and who's getting it and how it comes through. At Purse for example, they have self-funded plans where they manage the benefits and all of those rebates goes to the premium price for the members and for the employers. Most are not that transparent.

Rich Ehisen: Right. We have one question I want to ask is, what have we missed? I narrow this down when we started all this to this a very small number of categories. But as I don't have to tell you, there's a very broad subject healthcare with many, many tendrils. So is there something that you're seeing now that we haven't talked about? Maybe today or maybe talked about in a different way, that would be really critical for people to be paying attention to, either in a positive way or maybe a negative way. But I mean, what did we miss here in this conversation that we really should be paying some attention to? And, Micah, I'll start with you.

Micah Weinberg: Well, I mean, you know, we haven't talked that much about employer sponsored insurance. And one of the trends that has continued over the course of the past, you know, 10 or 15 years is the increasing cost sharing both in terms of deductibles, primarily in terms of deductibles in employer sponsored insurance plans.

So, but the interesting thing is that they are, really that means that people are beginning to have comparable insurance plans, because employer sponsored insurance where, you know, for many years, basically first dollar

comprehensive coverage, and then although the Affordable Care Act is, you know, kind of it was sort of called socialism. You know, at one point, it's nothing to do certain. In fact, there's a tremendous amount of consumer cost sharing in the Affordable Care Act, especially once you get above 250% with federal poverty level and certainly above 400%. But that is still an area where, you know, about half of people in the United States get their coverage. So it's certainly an area that we need to be keeping an eye on along with Medicare and Medicaid and the rest of these programs.

Rich Ehisen: Okay and you Diana.

Diana Dooley: Well, I think clearly, in the decade since the Affordable Care Act, more people talk about health care more often and there is much greater understanding there is as employer sponsored care. more active participation by members' employees, with their health, their human resources department. about what they're getting and how they're getting it. And I think all of that leads to the personal responsibility that comes with care. We don't ask the question, you know, how much is enough? often enough? We—did this escalation is because the demand exceeds the supply.

And that's what's driving like in any economic model. That's what's driving the cost. It's gas and the jars expanding to the space available. And so somewhere in this, there has to be if we really want to control costs it then we have to address the question on an individual level. How much do I need; how much do I want? How much can I get and how much am I willing

to pay for and that's what some of the cross-sharing programs are about to put some of the prevention programs have been about. Micah mentioned the trend that has been mitigated.

The health care costs have are still increasing, but they're not increasing at the same rate. And there was an interesting journal article just a couple of weeks ago. That one of the key factors in that is the treatment of hypertension. And some of that comes from medication. So we complain about the drug costs, but the statins and other drugs that are controlling hypertension are limiting, expensive hospital stays and adding to people's quality of life and links of life by controlling cardiac incidents.

So there's a lot of evidence of improvement that exists. If there were ever any way to disassociate the partisan healthcare has never before been such a partisan issue. As it became in the Obama Administration and the sense that they were just a resistance to it because it was his program without getting to the substance. I think we're moving toward periods where we can actually talk about the complexity people understand, in some ways that one of the important things is you have to know what you don't know. And this is a very difficult area, we're still naturally inclined to simple answers. But we're taking—we have more engagement and I think that's an overall positive effect for how this will continue to evolve over time.

Micah Weinberg: And If could add one more thing on the on the subject of cost and sort of give the people on the call and assignment because I see we have lots of them. If your state is considering sensible scope of practice expansion legislation as California is we're looking at practice authority for nurse practitioners, I know that a couple of other states have moved in that direction recently, we're up to about 20 or low 20s now in terms of states with for practice authority. But not just nurse practitioners, you know, all the way down to the better use of community health workers.

And then really, you know, having a health care system that focuses on health rather than, you know, just shuttling everybody to a increasingly small number of extraordinarily highly trained individuals who really should be, you know, quarterbacking, the healthcare system. I would ask everybody on this call to get involved in and if it's sensible support, the you know, expansion of scope so that we can make sure that we have the workforce that we need to serve the people who need health care.

Rich Ehisen: Well thank you, you know, this isn't a bad thing discussion, and we could probably go on for hours and hours, but of course we can't. So we're going to wrap it up here.

And I want to say a really big thank you to Diana Dooley. And of course, Micah Weinberg. You're not only a tremendous expert in this field, you're two of my favorite people. So thank you for being here today. Thank you for sharing all of your insight into this very complex, very challenging issue.

And of course, a big thank you to everybody who joined us on the call today. We greatly appreciate your presence here as well. Join us next time, likely in May for our next webinar for our 2019 hot issues, seminars series. Topic to be determined will let you know soon as we have that dial down.

So thank you very much again, have a great day. And thanks again to our panelists. See you next time.

Micah Weinberg: Thanks, Rich.

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