



## ADVOCACY IN A TURBULENT WORLD SOLUTIONS FOR CHANGE

EXECUTIVE SUMMARY PROGRAM PROCEEDINGS | SHERATON GRAND HOTEL, SACRAMENTO, MARCH 12, 2018

### Introduction to Latino Physicians of California and Latino Health Disparity

**José Alberto Arévalo, MD, FAAFP, Chairman, Board of Directors, Latino Physicians of California**

Latinos are the largest ethnic group in the State representing 38% (over 15 million). They are much younger (median age 29), compared to the white population (median 45). By 2050, Latinos will be half of the state population. The greatest health disparities are in hypertension, diabetes, asthma, HIV. Latinos are nearly 40% of the state population, yet we represent only 4.3% of the physicians listed by the Medical Board of California. Latinos are graduating from medical school, unfortunately more Latinos are reaching retirement and we're not replacing ourselves at the same rate; especially in rural underserved communities. Significant representation disparity exists for Latinos in pharmacy, dental, nursing and other health professions. We have to address the socioeconomic issues that confront our population. LPOC supports Latino health in California through partnerships, creating networks of Latino physicians statewide and working with schools, at undergraduate, community colleges, universities, medical and other health professional schools. We created the first Latino Physician Health Assessment Survey published in 2016 and will reinitiate in 2019.

### Advocacy in a Turbulent World- Solutions for Change

**J. Mario Molina, MD, President, Golden Shore Medical Group and Former CEO of Molina Healthcare**

Affordable Care Act (ACA). There were threats to the ACA. Tax cuts were promised and, to pay for them, there had to be cuts in spending on healthcare. The ACA was saved, we are less worried about its repeal. A Kaiser health poll indicated that 74% of respondents had a favorable impression of Medicaid - 52% thought that Medicaid was working well and 7 of 10 Americans had some connection with the Medicaid program. It expanded coverage, and subsidized programs and the expansion of Medicaid. Before the ACA, the number one cause of personal bankruptcy was medical bills - that has dropped to almost zero.

Cost Sharing Reductions (CSR). Attempts failed to repeal the ACA, but there are moves to undermine the law that could not be repealed. The attempt was to remove CSR's. These were payments to help low income people make their copays to the doctors. A person on a Medicaid plan with an income of less than 200% FPL (about \$24,000 a year) qualified. A person on a Medicaid plan with an income of less than 200% of FPL (about \$24,000 a year) qualified. When making a copay, it was reduced; the health member would take part and physician would take part, and then the health plan would get reimbursed (dollar for dollar) by the federal government. There was no profit on the CSRs - it was to provide poor people with access to care by helping with health care copayments. The government reneged on their contractual obligation. As a result, the health plans, who still were obliged under law to provide these subsidies to the patients, raised their premiums 25 to 50%, depending on the state. Healthcare premiums went up - healthcare became less affordable for a small percentage of people in the marketplace. By removing the CSRs and increasing the premiums, the federal government actually had to pay about \$2 billion more than it would have had it funded the CSRs, because 70-75% of the people in the marketplace get subsidized coverage. As the premiums went up, the federal subsidies went up. The unfortunate thing is that those people who were getting subsidized - 20-25% of middle-income Americans were getting hurt because subsidies were not extended far enough.

Mandate to buy insurance. The mandate that required people to buy insurance was removed and if they did not have proof of insurance, they'd get a penalty - assessed by the IRS - like a tax. What this tax means is, people that are not getting subsidized insurance can't afford it. A recent Kaiser study showed that only 40% of people even knew the mandate had been repealed. If health insurance were affordable, people would buy it in spite of the mandate. Affordability is the biggest issue. We're spending just under 18% of GDP on healthcare. That's money we don't have for infrastructure improvements or education. That's where the cuts come in. The amount of money the state government, gives to the University of California system has declined by about 50%. Worldwide, the

rankings of the campuses of the UC's have declined. We are cannibalizing our future because we can't fund education, and we won't be as competitive on the national scale and the international scale.

Short-term insurance policies. If for some reason you had a gap in coverage, you could buy one short-term policies that would be relatively expensive and would cover you for a few months without all the essential benefits. Eventually insurance companies had to find ways to exclude people with pre-existing conditions. This was probably the single most unpopular aspect of health insurance before. Now, it might not be quite that overt. They may just raise your premiums to the point where you can't afford something because you have a pre-existing condition. But the effect will be the same. A policy that's a year long then renews every year is not a temporary stopgap measure...It becomes a permanent insurance plan - called illusory policy. It is a dangerous thing; it will undermine the marketplace.

Medicaid expansion. When the Affordable Care Act was passed. Then later, the Supreme Court said the states did not have to expand Medicaid if they did not want to. The two states with the highest number of uninsured, Florida and Texas – decided they didn't want to expand. Many people in those states do not have insurance. The first that you hear about is “work” plans. Most Medicaid beneficiaries who can work - do work - 75-80% of households have somebody who's working. If you're going to put a Medicaid work requirement in: You have to add money for job training, for transportation, and money for childcare. If you spend more money on transportation and childcare than you're making, what's the point of working?

Employment and redetermination. Years ago in California, the way we reviewed Medicaid was to acquire quarterly certification that you were eligible, and then go through a redetermination. If everybody's healthy and you didn't have the time or you had to work, you didn't go -- people were constantly losing their Medicaid. A University of Cincinnati study showed that it actually costs states more money to do quarterly redeterminations than they saved -it cost them more money to do semi-annual redeterminations than they saved. Most states stopped doing annual redeterminations. Now, we're doing quarterly redeterminations based on whether you're working. If you decrease or eliminate redeterminations there would be money for training and for support. The redetermination is about cutting the Medicaid rolls and saving states money. In Kentucky, for example, when they tried this, an estimated 95,000 people lost their coverage. The 95,000 people who don't have health insurance are going to have problem. They're going to delay care until everybody's sick -- the hospitals finally treating them aren't going to get paid. If you have a poor person who goes to the hospital and has no insurance coverage, they're basically judgment free. You can try to get money from them. You can sue them and you can throw them into bankruptcy, but you're never really going to get the money. So the hospitals get hurt, too.

Medicare. The Speaker of the House would “voucherize” Medicare. A person would get so much money to buy a policy. However, the money they're going to give is probably not enough to cover the policy. It will place a greater financial burden on seniors. Right now, about 30% of seniors are in Medicare advantage plans. They join HMOs because it saves them money. Fifty percent of seniors who are on Medicare have incomes below \$26,000 (almost 200% of poverty level). They can't afford to spend more money on Medicare. There are some things that we can do on Medicare. One would be to allow people to buy into it. The marketplace is expensive and, when you get to 65, you get Medicare. It has been proposed to let people buy into it early. Many people, given the opportunity, would buy into Medicare. Another option is a bill that would allow people to buy into Medicaid. That would be a better solution. Medicaid for all is better than Medicare for all. Medicaid is more comprehensive. It pays for 62% of long-term care in this country. Medicare does not cover it. Long-term coverage is very expensive. Medicaid could cover everyone who opted to buy in. For a low-income family, it covers pediatrics and obstetrics. So, a simple solution to extend coverage to everyone is to have Medicaid buy-in and Medicare.

Healthcare workforce. The number of Latino physicians in this country has not changed in the last 20 years and the situation has gotten worse because while the number of physicians has stayed relatively constant, the population has grown. Thus, there are fewer Latino physicians to serve the population. We know that black and Latino physicians are more likely to practice in underserved areas. We need more physicians, Latino especially, and high-end care physicians to serve them. We don't have the supply -- we don't have the education pipeline. This is a national issue - very big in California. Outside of California, 19% of the population is Latino, and that number is growing everywhere. How many Latinos apply to medical school? Around 4,600 out of about 50,000 applicants are Latino and 42% get in, the same as for Anglos. The problem isn't that Latinos can't get in to medical school; it is that so few apply. Why is this and what are we going to do?

An Academic Medicine study on the last 20 years on students going to medical school and their backgrounds, found that it's a pipeline problem. It's not that students don't want to go to medical school -They're not applying to medical school and that's the root cause. The determinants if one goes to, graduates from college and goes on to medical school starts in the primary grades. The first has to do with STEM (science, technology, engineering and math). Young Latinos get discouraged at an early age -they lose interest in science and math. To get into medical school, the biggest predictor is, how one did in organic chemistry, or took calculus. If you're discouraged in the third grade, you are not going to go on. The second is lack of financial support. Latinos are poorer than the rest of the population. It's expensive to go to college and to medical school. There is familial pressure to drop out and go work. The third is

expectations. A person in a family where children are expected to go to college is more likely to go to college. If the mother had gone to college, the children were much more likely to go to college. Finally, we have too few role models. We need more Latinos in the health professions - not just doctors, we don't have enough Latino nurses, dentists, optometrists; all health professions.

### **Reaction/Discussion Panel**

Sandra Hernández, MD, President and CEO, California Healthcare Foundation, Moderator - Xavier Becerra, Attorney General of California; Ricardo Lara, Senator, California 33rd District; Assemblyman Joaquin Arámbula, MD, Assembly District 31.

#### **Dr. Hernández**

One of the first groups I met with when I took over the California Health Care Foundation was the LPOC. We met and we looked at the data. It was astounding that the data look exactly like they looked like when I applied to medical school. We have to talk about that. Let's open it up with a few questions for our distinguished panel (select questions and answers). We are pleased to have Attorney General Becerra here tonight.

#### **Xavier Becerra**

I worked with President Obama and others, I told him: "You don't have to wait for Congress." I referenced the Temporary Protective Status program for Central America nations and other groups. Another program was called Deferred Enforced Departure – DED. Three years later, we had DACA. There won't be just Dreamers and their families and Latinos or Asians or African communities that are fighting for the opportunity to keep immigrants here. There will be American citizens as well.

#### **Dr. Hernández**

We have an upcoming national election in 2018 and we have an election in California. Do you have any thoughts about Latino voter engagement in this state and across the country?

#### **Xavier Becerra**

Shame on us if we don't have record Latino voter turnout in 2018. We need to be out there ...we could be the pivotal vote.

#### **Dr. Molina**

Should California pass an individual mandate?

#### **Dr. Arámbula**

We found in discussions in the Select Committee that subsidies are a better incentive than penalties. So if we can find ways to deal with affordability, that we're encouraging people to sign up for coverage - the subsidies will accomplish the same goal. We're trying to figure how we can increase the amount of money that we're spending on the 138% to 400% of federal poverty level population - to analyze if that has the same design.

#### **Senator Lara**

A combination works, but we need to fully fund and increase reimbursement rates before creating different mandates. We have data, doctors want to do the good thing, patients want access. We should first fully fund our current system adequately.

#### **Dr. Arámbula**

I'm a fan of the UC PRIME program. You're going to see an increase by the end of this year-- our attempt to double the number of PRIME students today. This program has shown demonstrable effects and metrics: Latino physicians return to underserved areas. We're also going to build on the UCLA pilot program that trains international medical graduates who have both cultural and linguistic skills to return to underserved areas. I'm going to codify that pilot program and see if it's scalable to other UCs. We can train international medical doctors who want to come into our communities. We have to look at programs like this to improve and increase the numbers of culturally and linguistically competent physicians.

#### **Dr. Arámbula**

How do we open more doors? How do we create more opportunities? We should support Latino physicians, especially those who are inclined to go into public service. My goal is to return a hundred doctors to replace me. I believe by opening those doors for students like you, that's what makes me successful, and that's why I will continue to strive to do more.

#### **Senator Lara**

We want to hear from you; give us recommendations on what we need to do now. We're working on legislation that ensures that admissions people are not turning Latino students away. We need to expand the representation of Latinos in nursing, and on Medical

School Admissions. We need to make sure we're investing in the CSU which is ground zero for our nurses. We need to invest in international programs to make sure we get nurses from other countries who can assist, as we move now towards expanding health care services and access.

### **Xavier Becerra**

You've got an Assembly member, a Senator, and an Attorney General sitting here - NOW. Make use of us. If someone is saying that the policies don't let us get more people through the door, then you have two people who are working on trying to do that. You have someone who's not going to let people through the door? You have the Attorney General here as well. Take advantage of us. Inform, advocate and make use.

### **Dr. Hernández**

If you were to give one recommendation to our panel of elected leaders that would open your path to medical school at UC, what would that be?

Comment: Have more voices on the Medical Admissions Board at each university who really understand how that process works. They need to know the experience of students of color going through and what gatekeepers are on the other side. It's a very behind the scenes, hidden process. Oftentimes we don't even have understanding representation. How can we get it across to them who cannot see?

### **Xavier Becerra**

We have to continue to lead in California...the political weather is a lot different outside our state. We should be happy that we are here and we get to have champions like this, who fight all the time. We're probably a generation ahead of most of the states in what we do. We must keep doing it, and sooner or later, the rest of the country will join us.

### **Senator Lara**

We are proud of the work that we've done in the Senate with access to education, access to healthcare - and access to justice. Looking at this in a much more holistic way, because, if a child is sick, they're not going to do well in school. If a child is more likely to be arrested, if they're brown or black in certain communities, then there goes an entire generation. We, in the Senate, are bringing work on an entire package of bills that attack all this in a much more holistic approach, where we're looking at a person as the entire experience. If a person has horrible air quality in their neighborhood, that also impacts their outcomes. Communities where we tend to live are disproportionately affected by poor air quality and pollution. It also impacts the outcome of this individual. The opportunity for this individual to become a doctor, or an attorney are far less. Now, we have a strong incentive to team up with other senators to work on this in a much more holistic approach. Taking what the World Health Organization has looked at, and getting out of our silos and making ourselves much more comfortable in working in areas that we wouldn't necessarily work on -- trying to figure out what is the child's overall experience? How do we develop a completely evolved Californian? That individual is going to have to have clean air and water, going to be able to live safe in their community, have access to education, and be able to determine what his or her future is going to be. ■

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