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POLITICO Pro California Q&A: Assembly Health Committee Chairman Jim Wood

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POLITICO Pro California Q&A: Assembly Health Committee Chairman Jim Wood

By Angela Hart

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SACRAMENTO — Assemblyman Jim Wood (D-Santa Rosa) has become one of California's most active lawmakers on health care and has risen quickly enough to become chairman of the Assembly Health Committee.

This year, he's pushing health care legislation that puts him at odds with some of the most powerful forces in California politics, including the California Medical Association, pharmaceutical interests and the two leading dialysis providers, DaVita and Fresenius.

Among bills he's authored are proposals that would: give nurse practitioners in California the authority to practice independently of physicians; curb a longstanding practice by drug makers of paying generic companies to delay the release of lower-cost pharmaceuticals; and limit dialysis payments on the commercial side to Medicare rates.

Wood was instrumental in creating the new state Council on Health Care Delivery Systems after California's 2017 single-payer bill died in the Legislature. That panel's future is in question now that Gov. Gavin Newsom is pushing to remake the council into a commission focused specifically on single-payer rather than the council's broader examination of universal coverage and various delivery approaches, which include but are not limited to single-payer.

This transcript has been edited for length and clarity.

Where do you stand on the governor's proposal?

When Dr. [Joaquin] Arambula and I proposed [the council], it was to look at the short-term possibility of getting to universal coverage and the long-term of how we get to a uniform publicly financed system of health care. So if I understand the governor's change of position, he wants to focus on the unified publicly financed system and move to set up a process to transition in that direction.

I'm not against the governor looking at single-payer, but I'm surprised the focus has been narrowed from where we started. And how does the short-term game go forward? How do we get to that universal coverage? We envisioned that being part of that panel.

For me, the longer I study this and the more time I spend looking at this, there are two critical issues that rise to the surface that are a huge impediment for us in California that are not in the documents and the background that we really worked on. No. 1 is cost containment: How do we contain the cost of health care?

Health care is rising at twice the rate of inflation every year. How do we contain that? If we can't contain that, then whatever financing mechanism we put together is going to count on additional resources year after year after year — and at a much higher level than inflation. That's going to be problematic.

And what about our workforce? We are struggling to have primary care providers in this state. We don't have enough mental health providers to keep up with the need now and as we expand coverage and coverage options to more and more people, that demand on the workforce continues to grow. So if we are, as the governor indicates, looking at focusing this commission on how we transition to single-payer, we have to talk about workforce. We have to invest in our workforce, and we have to talk about cost containment.

Is the existing council the right format for those deliberations?

We kind of left it broad deliberately, to keep the discussion broad. But in addition, on single-payer, there are constitutional amendments that would need to be made. Whatever changes are required would have to go to the voters, we believe,

and I suspect this commission will probably find the same thing. There are issues with the Gann spending limit and Prop. 98, and changes to those will require going to voters. And if you're raising taxes, that's going to go to voters as well.

Is unified public financing and single-payer the same thing?

It could be.

For me, it's what do you look at as single-payer, because there's like 60 different versions of single-payer. The goal, in my mind, is we create something that's uniquely California that reflects the diversity, the geographic differences and the size of our state. So is it one group's version of single-payer or is it something that is uniquely California? Maybe it's a hybrid of all 60.

If the goal is something that's envisioned in Senate Bill 562, CA SB562 (17R), that has never been done in any country. That would be the broadest, most sweeping plan ever implemented. In other countries, what we found is there still is a role for private insurance in most of the single-payer plans out there, but it's a very limited role and it's a very highly regulated role. Even with Medicare, you have supplemental insurance.

Medicare only covers 80 percent and then you have supplemental insurance. So then is the vision to eliminate that supplemental insurance as well?

Then we have the issue of Kaiser, which represents 20 percent of California's population in their system. We've been told consistently by Kaiser that certainly what was envisioned in Senate Bill 562 would eliminate Kaiser because they are a health insurance plan, they are a provider network and they are a hospital. So I guess what I'm getting at is this commission will find many of the same things that we found over the last year and a half — that this is an incredibly complex system and changing it will take time.

Could you see supporting the change sought by Newsom?

I support looking at single-payer. I want to understand his vision for continuing to look at universal coverage because that I don't understand — why he's eliminated that from what we put forward.

I'm not in opposition, I support the commission looking at single-payer, absolutely. But I do wonder what does this mean for us, because we envisioned this commission continuing to look at some of the challenges we face getting to universal coverage as well. Because there is no one definition of either universal health care or single-payer, the ultimate solution should be crafted specifically for the needs of California and the people in California. What would work in Massachusetts, for instance, might not be what's needed here.

A pair of bills this year would restore a state-based individual mandate and tax penalty for those without insurance. What's your position?

It's an important piece of the puzzle. We have to get everybody covered.

There are obviously penalties associated with that, but the more people that are covered, the less penalties there are, so it's not a financing mechanism, although short-term it will produce revenue. The reality is if the mandate goes into effect, we're not going to see any of those revenues — if there are revenues — for another year and a half because of the way the Legislature is structured. So imagine the bill passes this year, it goes into effect in 2020, you wouldn't see that until 2021.

So it's not a revenue solution but it's an idea to try to get more people into the system, and the more people in the system, the healthier the system is.

What level of health insurance subsidy should the state offer low- and middle-income residents?

Ideally, all of it. Seriously, if we had the money, we'd do it all.

That subsidy from 400 to 600 percent [of federal poverty], that will have a huge impact on their lives — especially if they're older and not quite 65, and not eligible for Medicare yet. These are not wealthy people. And then the lower-income levels potentially help more people, more poorer people. So it's a tough one because they all need help.

We have limited resources, so we're still looking at that — what is the right level. We're trying to see how we maximize the benefit for as many people as possible. This may be in stages. This year we'll do that, next year we'll tackle the next group. But I think what's important is we need additional revenue to offset the costs.

I think the [managed care organization] tax is important. We've asked about that and I understand it's still a consideration, but I am concerned that if you don't renew the MCO tax, that's a $1.5 billion dollar hole and you leave federal money on the table.

What in your mind is the difference between universal and single-payer health care?

Universal health care in my mind is that everybody has coverage. It's pretty simple.

Single-payer means that you have a single entity that pays providers and hospitals. Presumably, if you had single-payer, you'd also have universal coverage.

But you could have universal coverage without single-payer.

Both of my members of Congress believe the best solution is a federal system and they're not sure that California could do it on its own, even with the federal waivers, because of the complexity of it.

I don't know. Maybe this commission comes to that conclusion, I don't know. But I do think that even if we do ultimately get "Medicare For All," it's likely to have to be sequential. I don't think you can flip the switch and suddenly have that. I think we could get there, but it's going to take years.

And I still go back to two fundamental things, which are workforce and cost containment. If you don't tackle those, it's an empty promise.

Some believe the choice is to protect Obamacare or move toward single-payer, but not both.

I disagree.

I absolutely believe that we have to, No. 1, preserve the gains that we've made through the Affordable Care Act and expand on that. I believe that's the short-term game.

And then the second part is looking at the long-term game. Can we get to single payer?

We've done more in California with the Affordable Care Act than any other state, and I believe we've done really good things for people. We've given people something they've never had before, and I think we owe it to them to preserve that and enhance that. Then if we can get to single-payer then you transition to that, but I think you absolutely owe it to Californians and Covered California and everyone who is invested in this to do everything we can to protect the Affordable Care Act.

California is often talked about as a leader on health care. Is that the case?

I think we are in some things and we aren't in others.

There are some things that we haven't progressed on, and I think workforce is one of them. I have a bill this year to expand the scope of practice for nurse practitioners. Twenty-two other states have already done this.

Typically you'd see California leading the way on things like this, but there's strong opposition from the CMA. I think that's just one issue that has been somewhat vexing and is one big example where we're not leading.

We are leading on drug transparency and we are pushing back against the drug companies. I'm working on that this year with Attorney General [Xavier] Becerra. And I have a bill looking at dialysis. For me, all these things are focused on the critical issue of cost containment — they are areas where spending is high.

Sometimes, people say, "Well, you're just kind of nibbling around the edges." You may look at it that way, but I'm happy to make gradual, incremental progress toward the big goal, rather than swinging at every pitch and striking out.

We are trying to make changes with very powerful organizations and it's difficult. It's really difficult, and there's a lot of pushback.

We have also been incredibly creative and pushed the limits on how we could get more and more people covered, and that has frustrated the federal government, I think. Other states look at us with envy because we have been more successful than any other state in waivers and implementing the Affordable Care Act. That's where we are the leader.

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