

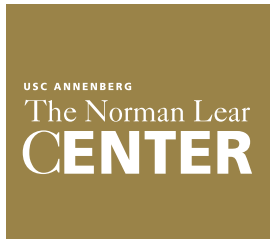
STAYIN

THE TRUTH ABOUT OBAMACARE

ALIVE



Transcript of a panel held by **Hollywood, Health & Society** | June 27, 2013 | Writers Guild Theater, Beverly Hills



The Norman Lear Center

The Norman Lear Center is a nonpartisan research and public policy center that studies the social, political, economic and cultural impact of entertainment on the world. The Lear Center translates its findings into action through testimony, journalism, strategic research and innovative public outreach campaigns. On campus, from its base in the USC Annenberg School for Communication & Journalism, the Lear Center builds bridges between schools and disciplines whose faculty study aspects of entertainment, media and culture. Beyond campus, it bridges the gap between the entertainment industry and academia, and between them and the public. Through scholarship and research; through its conferences, public events and publications; and in its attempts to illuminate and repair the world, the Lear Center works to be at the forefront of discussion and practice in the field.

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Hollywood, Health & Society

Hollywood, Health & Society (HH&S), a program of the Norman Lear Center, provides entertainment industry professionals with accurate and timely information for storylines on health and climate change. Funded by the Centers for Disease Control and Prevention, the Bill & Melinda Gates Foundation, The California Endowment, the Grantham Foundation, ClimateWorks, Skoll Global Threats Fund, among others, HH&S recognizes the profound impact that entertainment media have on individual knowledge and behavior. HH&S supplies writers and producers with accurate health information through individual consultations, tip sheets, group briefings, a technical assistance hotline, panel discussions at the Writers Guild of America, West, a quarterly newsletter and web links to health information and public service announcements. The program also conducts extensive evaluations on the content and impact of TV health storylines.

For more information, visit www.usc.edu/hhs

➡ To watch a video of the full panel discussion, part of the HH&S outreach to writers, [click here](#).



Participants



PETER LEE is the executive director of Covered California, the state’s health benefit exchange, whose goal is to improve the affordability and accessibility of quality health care for Californians. The exchange—the first created following the passage of federal health care reform under the Affordable Care Act of 2010—was established by the state to support the expansion of coverage by creating a new insurance marketplace, where individuals and small businesses can purchase competitively priced health plans using federal tax subsidies and credits beginning in January 2014. Prior to his current role at Covered California, Peter served as the deputy director for the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services (CMS) in Washington, D.C. There, he led initiatives to identify, test and support new models of care in Medicare and Medicaid, resulting in higher quality care at lower costs. Before that, he was a director in the Office of Health Reform at the U.S. Department of Health and Human Services, where he coordinated delivery reform efforts for Secretary Kathleen Sebelius and assisted in the preparation of the National Quality Strategy. Prior to his work in public service, Peter was an attorney in Los Angeles. He holds a juris doctorate from the University of Southern California and a B.A. from the University of California, Berkeley.



VICTORIA SORLIE-AGUILAR received her medical degree from the Keck School of Medicine of USC in 2003 and completed her residency in family and community medicine at UCSF Fresno. There, she developed a cultural competency curriculum while working as assistant clinical professor and co-authored a paper titled “Tremors vs. Seizures: When Language and Cultures Collide.” Last year she was a National Hispanic Medical Association Leadership fellow, where she learned health reform law, related legislation and policy skills culminating with a national presentation with recommendations for the surgeon general regarding childhood obesity. Dr. Sorlie-Aguilar is currently working as a lead physician at the Centers for Family Health clinic, the ambulatory branch of CMHS non-profit hospital in Ventura County, and serves on Covered California’s plan management advisory board. She has been in direct primary care for over 10 years, working in low income clinics with rural California’s most disadvantaged patients. She is thrilled to serve on the leading edge of health delivery reform with Covered California so that doctors who practice good medicine with exceptional outcomes will be recognized and emulated. Dr. Sorlie-Aguilar envisions quality and equitable care for all Californians and looks forward to the positive changes that come with the Affordable Care Act and Covered California. She is married, with two daughters, and lives in Ventura.



Participants



ZOANNE CLACK is a writer and co-executive producer on the award-winning hit ABC series *Grey's Anatomy*. She has been with the show since it began and also acts as a medical advisor, assisting in production of all medical aspects of the show. She attended Northwestern University, UT Southwestern Medical School, and Rollins School of Public Health at Emory University. Dr. Clack completed a residency in emergency medicine, a fellowship in injury prevention, and spent a year at the Centers for Disease Control and Prevention (CDC) in international emergency medicine. She is a staunch advocate of promoting public health issues through the media, serving on the board or as an advisor for several global health groups that educate through entertainment.



NEAL BAER is an executive producer and show runner for the CBS television series *Under the Dome*. He was executive producer of the CBS medical drama *A Gifted Man*, as well as the executive producer for the award-winning NBC-TV series *Law & Order: Special Victims Unit*. Prior to his work on *Law & Order*, Dr. Baer was a writer and executive producer for another hit NBC series, *ER*, where he was nominated for five Emmys. His other work includes “Warriors,” an episode of *China Beach* (nominated for a Writers Guild Award for best episodic drama), and the ABC Afterschool Special *Private Affairs*, which he wrote and directed. The Association of Women in Film and Television selected the program—which dealt with sexually transmitted diseases—as the best children’s drama of the year. His first novel, “Kill Switch,” co-written with Jonathan Greene, was published in January 2012. Dr. Baer graduated from Harvard Medical School and completed his internship in pediatrics at Children’s Hospital Los Angeles. His primary medical interests are in adolescent and global health, and he’s written extensively for teens on health issues, covering such topics as teen pregnancy, AIDS, drug and alcohol abuse, and nutrition. Dr. Baer recently established the Center for Storytelling, Activism and Health at USC, where he is working on projects using new media to promote global health. A clinical professor of preventive medicine at the Keck School of Medicine of USC, Dr. Baer is also a senior fellow at the USC Annenberg School for Communication and Journalism and a lecturer in the School of Arts and Sciences at USC. He lives in Los Angeles with his wife and son.



Participants



SANDRA DE CASTRO BUFFINGTON is director of Hollywood, Health & Society, a program of the USC Annenberg Norman Lear Center. For her work with the entertainment industry, Sandra was named one of the “100 Most Influential Hispanics” in America by Poder Magazine, and has received numerous other honors, including the USAID MAQ Outstanding Achievement Award. Her vasectomy campaign in Brazil won seven international advertising awards, including a Bronze Lion at Cannes and a Gold Medal at the London International Advertising Awards. She led Hollywood writers and producers on trips to South Africa and India in 2011, and helped create the Storybus Tour series and Climate Change Initiative. In 2013, Sandra designed and launched a global network of centers for entertainment education in India and Nigeria, with the hub in L.A., to mainstream socially provocative cinema and television. She is a former associate faculty member at the Johns Hopkins University Bloomberg School of Public Health, and currently serves on the boards of the Harvard Medical School Personal Genetics Education Project, Women@The Frontier and Primary Purpose Productions.



MARTIN KAPLAN holds the Norman Lear Chair in Entertainment, Media and Society at the USC Annenberg School, where he was associate dean for 10 years. He is the founding director of the school’s Norman Lear Center, whose mission is to study and shape the impact of media and entertainment on society. He was Vice President Walter Mondale’s chief speechwriter and deputy campaign manager of Mondale’s presidential bid. He worked at Walt Disney Studios for 12 years, where he was first a feature films vice president and then a screenwriter/producer. His movie credits include *The Distinguished Gentleman*, starring Eddie Murphy, and the film adaptation of Michael Frayn’s *Noises Off*. A summa cum laude in molecular biology from Harvard College, where he was president of The Harvard Lampoon, he won a First in English as a Marshall Scholar at Cambridge University, and he holds a Ph.D. from Stanford in modern thought and literature.



Marty Kaplan: Good evening. And thanks for coming. I just turned off my cell phone, and I hope you will, too. My name is Marty Kaplan. I'm on the faculty of the Annenberg School for Communication and Journalism, here at the University of Southern California. I'm also the founder and director of something called The Norman Lear Center. Our mission is to study and to shape the impact of media and entertainment on society. We believe that what happens in media and entertainment doesn't stay in media and entertainment.

And we do this research, and we do some stirring of the pot, in a wide range of areas, from the impact of local television news coverage of politics on democracy to the impact of intellectual property law on creativity. And I invite you to learn more about the Lear Center at our website, learcenter.org.

Tonight, we're going to be hearing about healthcare, the coverage of citizens to receive healthcare. It's a topic that has had lots of heat. I hope tonight will not only add light but also the human face, the stories, which is so central to what it's about and what it can be. That effort—public health and its relation to entertainment—is conducted at the Lear Center by our program, one of our oldest and largest programs, called Hollywood, Health & Society. And so it's under those auspices that we're here this evening to hear from an amazing panel. Truly, you could not get better people to be here on this topic than this panel.

And to be our sherpa for the evening, please welcome the director of

Hollywood, Health & Society, Sandra de Castro Buffington.

Sandra de Castro Buffington: Good evening, everyone, and welcome. It's so good to see you tonight. I'm thrilled to bring you this panel, "Stayin' Alive," on what is known as the Affordable Care Act, or Obamacare.

Before we begin, I'd like to thank the Writers Guild for making this beautiful theater available to us tonight. The room where we usually hold our panels is under construction, so we'll be back there soon.

As Marty said, I'm the director of Hollywood, Health & Society, a program of The Norman Lear Center that works to connect writers

"We're here tonight because television and film are powerful forces in raising awareness and debunking myths. . . . Watching stories crafted by writers and producers . . . can do what the title of our panel says—tell the truth about Obamacare."

– SANDRA DE CASTRO BUFFINGTON, HH&S DIRECTOR

and producers to help experts in information for their scripts. Like it or not, we know people are learning from television and movies. That's why Hollywood, Health & Society serves as a free resource to the industry. We work to inspire and inform storylines to help writers make their stories more compelling by making them realistic and accurate.

So how do we work? We'll connect you to health experts, we'll inspire you with real stories of real people. We'll take you on site visits to hospitals, clinics, the city morgue and other places. We'll review your scripts for accuracy. We'll provide transmedia content for your websites and social media. We'll evaluate the impact of your stories on viewers' knowledge and attitudes. And we also recognize exemplary TV



health storylines at our annual Sentinel for Health Awards.

We're here tonight because television and film are powerful forces in raising awareness and debunking myths, and by watching stories crafted by writers and producers, such as those on the panel and those of you in the audience. Your characters can do what the title of our panel says—tell the truth about Obamacare.

We're so pleased to bring this extraordinary panel together. And I'm going to introduce our panelists now, and I'd like you to hold your applause till the end, if you would.

Here on stage, we have four panelists—three medical doctors, one lawyer, two executive producer/writers. Now, can you guess kind of who's who? Okay.

So, I'm going to start with Peter Lee. He's the first executive director for California's health benefit exchange, Covered California. Mr. Lee oversees the Covered California program in its efforts to improve the affordability and accessibility of quality healthcare for Californians.

Prior to his current role at Covered California, Peter served as the Deputy Director for the Center for Medicare and Medicaid Innovation at CMS in Washington, DC. He also served in the Department of Health and Human Services, where he coordinated reform efforts for Secretary Kathleen Sebelius and assisted in the preparation of the National Quality Strategy. Prior to his work in public service, Mr. Lee was a practicing attorney in Los Angeles.

I'm also very pleased to introduce, seated next to him, Dr. Victoria Sorlie-Aguilar. Dr. Sorlie-Aguilar is currently working as a lead physician at the Centers for Family Health, a branch of Community Memorial Health's nonprofit hospital in Ventura County, a family medicine system that sees 222,000 patient visits a year.

She's been in direct primary care for over 10 years, working in low-income clinics with rural California's most disadvantaged patients. And last year, she was a National Hispanic Medical Association



Leadership Fellow, where she learned health reform law and presented to the Surgeon General recommendations on obesity. She serves on Covered California's Advisory Board. So, welcome.

Next, I'd like to introduce the amazing Dr. Zoanne Clack, seated here. Dr. Clack is a writer and co-executive producer of the ABC award-winning series *Grey's Anatomy*. She's been on the show since it began and serves as the medical advisor assisting in production of all medical aspects of the show.

Zoanne is a medical doctor. She graduated from the University of Texas Southwestern Medical School. And she also holds a master's degree in public health from Emory. I think you're the only one in Hollywood with those two degrees, actually.

Zoanne travels the world as a staunch advocate of promoting public health through the media, serving on the board or advisory committees of several global health groups that teach through

"Stayin' Alive" panel members, from left: Dr. Neal Baer of "Under the Dome"; Dr. Zoanne Clack of "Grey's Anatomy"; HH&S Director Sandra de Castro Buffington; Peter Lee, executive director of Covered California; and Dr. Victoria Sorlie-Aguilar of the Centers for Family Health. Martin Kaplan, director of the USC Annenberg Norman Lear Center, presented the evening's opening remarks.



entertainment. And Zoanne has traveled with Hollywood, Health & Society and with me to India, Puerto Rico, Croatia, Washington, DC. She's conducted congressional briefings with me. She's really done a lot of amazing work. So, thank you for being here tonight.

And last, but definitely not least, I'm pleased to introduce Dr. Neal Baer. Dr. Baer is the executive producer and show runner for the incredible new CBS series *Under the Dome*. He was also executive producer of the CBS medical drama *A Gifted Man*—and we'll see a clip of that tonight—NBC's *Law and Order: Special Victims Unit*, and the NBC series *ER*, for which he was nominated for five Emmy Awards.

Neal graduated from Harvard Medical School and completed his internship in pediatrics at Children's Hospital in Los Angeles. He also serves as the co-chair of Hollywood, Health & Society's advisory board and has been an incredible partner to me and to the organization over many years.

If you get a chance, ask Neal about the Story Tour series he helped us to launch. He has traveled all over the world—to Mozambique, to South Africa, to numerous countries, working to improve the lives of children, women and families.

I don't think he ever sleeps. He does more work than anybody I've ever met. And we're so pleased to have you. Thank you.

Now, please join me in welcoming them.

So we're going to start with Peter Lee. Peter, would you like to take the podium?

Peter Lee: Sandra, thanks so very much. And thanks for coming this evening. I am the suit here.

I really, though, went back to law school after being an AIDS advocate for five years in the HIV epidemic, and rented my soul for a couple years. But what I've done for all my life is been a health-care advocate, for people with AIDS, HIV; for consumers, for the elderly.



And I now have the honor of helping launch the Affordable Care Act here in California.

And so I'm going to frame this—sort of, I might call it, in the Dragnet mode—of just the facts, ma'am—about what the Affordable Care Act is and what it's not. Because for the last three years, there's been sort of a drumbeat of disinformation and misinformation, and very little real facts. And we're coming up on January 2014, where the biggest elements of the Affordable Care Act will take effect.

So, let's frame this. This is a very, very big deal. Our vice president called it a BFD, but I'll just keep it at a big deal. It's the biggest change in healthcare since Medicare was implemented 50 years ago.

And in some ways, it's both more and less than what happened 50 years ago. It's less, in that if you have healthcare coverage through your employer now, you keep it. If you have Medicare, you keep it. But it's more, in that for the first time, we as a nation are saying

The Affordable Care Act "is a very, very big deal," said Peter Lee, who pointed out that it's the biggest change in health care since Medicare was implemented 50 years ago.



everyone has a right to healthcare—that is a very, very big deal—and with policies behind that to help people afford healthcare, and to change the rules so insurance companies can't stop people from getting healthcare because they have a preexisting condition. This is a very, very big deal. What it means is that 45 million Americans that don't have insurance all of a sudden will have the opportunity to have insurance. That's a big deal.

For the working insured—people that have insurance through their job—it's a big deal, because they know that they don't have to stay at their job to have insurance. They can actually know that they'll get insurance if they leave their place of employment.

So, it's big. It's happening everywhere in the country. As you heard, I'm running what's called Covered California. But we're one of 17 states across the country that are implementing this in a state-based fashion. But it's happening in every single state in the country. Because even states that are saying—yeah, they aren't so sure about this Obamacare thing, there's going to be a federal implementation. So every American is going to have access to affordable healthcare. That's a big deal.

And let's go into some of the facts and some of the myths. First, many of the provisions of the Affordable Care Act have already taken effect, and you might've heard about them, such as kids—and as I get older, a kid means up to 26 years old—can get coverage through their parents' policies. Six million Americans have health insurance because of that unto itself. Another thing Affordable Care Act did—Medicare now covers preventive care. Medicare didn't used to cover preventive care? Didn't cover preventive care. And it expands coverage for drugs for seniors.

But starting January 1, 2014, whole new day. First, the rules change for insurers. Right now, insurers pick healthy people and try to avoid sick people. That's what insurance is about today. New day—insurers have to take everybody, regardless of their health status. They can't charge more if someone has diabetes, has asthma. They've got to take everybody. And there's going to be standard benefits. So insurers

can't play the gimmicks and gotchas games of saying—oh, that's not really quite covered, even though you sort of thought it was. Standard benefits. So everyone's going to know what they're getting. They can make informed decisions and get covered.

There's going to be competition. So we actually in Covered California have 33 health plans that wanted to participate; we ended up picking 13. And across the nation, on average, 90 percent of Americans will be able to pick between five and six health plans.

But the big deal for most Americans that have not been able to have

“Well, this isn't about death panels. This isn't about anyone coming in between patients and their doctors, this isn't government takeover of health care. This isn't raising costs for everybody. What it is, though, is more than about policy stuff. It's about people's lives.”

– PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA

insurance is insurers can't turn them away, number one; and number two, they're going to get a financial leg-up that we that have insurance there are job get through our employer. Premium assistance that's going to be adjusted by income. People with lower income are going to get a bigger check that they can spend with the private health plan they pick through groups like Covered California.

Large employers—new rules. Have to offer insurance—the vast majority do. If they don't, they'll pay a penalty. Individuals, which will now have the ability to buy affordable care—if they decide to go bare, which is a technical term, as in not have insurance, they'll pay a small penalty. Now, why? Well, if they don't buy insurance, we are all providing their insurance. Okay? And in this new day, they're going to get a leg-up to buy insurance, make it affordable. So we want to get



everyone in coverage.

So what's going to be happening between now and January 1? Well, you're going to start hearing a lot more about the Affordable Care Act. In California, 2.6 million Californians will get that financial leg-up to get health insurance coverage. Another 2.5 million will be able to get coverage and make enough money they won't need the leg-up, but can't be turned away by their insurance company.

Now, California is a very diverse state. About half of those eligible for subsidies are Latino; 350,000, Asian-Pacific Islanders. But this isn't just a California story. There is Cover Oregon. There's the Massachusetts Connector, there's Connect for Health in Colorado, there's the federal marketplace. It's a very big deal.

Come October of this year, everyone's going to be talking about this. We're going to be running ads, people are going to be talking around their dinner tables. And it's something that they should be talking—all of us have family members, friends, neighbors that need insurance.

So what isn't this? Well, this isn't about death panels. This isn't about anyone coming in between patients and their doctors, this isn't government takeover of health care. This isn't raising costs for everybody. What it is, though, is more than about policy stuff. It's about people's lives. And one of the things I think you'll be hearing from the other three panelists are some of the human dimensions of this. Because, you know, the public policy stuff's kind of interesting, but we all have friends or family members that have been touched by this, by the fact of not having access to healthcare.

And I'm going to give you one story that actually brings it home to many of your industry. I'll note that we actually are working with the Actors Fund here in Hollywood to reach out to the entertainment community, which has a lot of people that don't have health care. But there was a cameraman who'd worked for a long time with a global TV company. He left his job because he had a heart attack. Then he lost COBRA. He was uninsured. And what happened after that? Because of that, he couldn't get coverage.



His wife, then, got a rare form of cancer. He was uninsured. How did her chemo get covered? Literally through bake sales—through the families of friends, neighbors raising money to get chemo to get surgery. And she's recovered. She's doing good right now. She's recently come out of remission and having problems again. They're looking at potentially having to sell their house. This is the sort of thing that is touching our neighbors, our families, all the time. And it's something that we shouldn't have people in our state and our nation afraid to go to the doctor. We shouldn't have families living in fear, living in what is today a culture of coping. So we're actually moving to a new day for America, which is a big deal, about a culture of coverage, a culture of people not living in fear, and having every American having health care.

So yesterday, 50 years ago, we didn't have Medicare. Now we can't imagine a day in which seniors didn't have good health care coverage. We take it for granted—it's a new day. Today, we have emergency rooms that are flooded with people that don't have

The panel was held at the Writers Guild Theater.



health insurance, that aren't getting good preventive care, that go to the emergency room and get the most expensive care in the worst place to get care, and not being treated for preventive care; and family members keeping jobs that they'd rather not have, because they think that's the only way to keep insurance.

Well tomorrow, I look forward to 10 years from now looking back and us saying—how could America ever have been a country that didn't think healthcare was a right? And that's the change that we're part of today, making happen with the Affordable Care Act, which is no longer a thing for pundits, no longer a thing for political debate; it's the law that's being implemented come January 1, 2014 to make sure that all Americans get health care.

So I'm thrilled to be here with you today to answer your questions and engage in discussion with the rest of the panel. So thank you very much.

Sandra de Castro Buffington: So now I'd like to invite Dr. Victoria Sorlie-Aguilar to share some stories and interesting—real stories of real people and case studies with us, people who've been affected by health insurance or lack thereof.

Victoria Sorlie-Aguilar: Thank you, Sandra.

So I want to tell you a story. This story is about a woman named Adella. Somebody asked me earlier—what do you do? I said—I'm just a doctor. They said—but why are you here? I said—I'm just a doctor. But why'd they ask you? And I think they asked me because, at the end of the day, when you're vulnerable, in a little lab coat, in a little gown, half-naked and scared, that's me on the other side of the door. And a lot of these issues which are sort of political and economic come down to a human being, and a human being behind the exam room door, and what happens afterward.

So I'm going to tell you a story about Adella. And for a moment, I want you to hold in your mind that Adella is your mom or your sister, or your daughter or your cousin, Adella. So I want to tell you about

Adella before Obamacare and what could've happened after. This was before Obamacare.

Adella is a beautiful 53-year-old Latina woman who had no idea that she had high cholesterol, diabetes or high blood pressure until the day she landed in a small town emergency room. She went there because suddenly her right arm went limp, and she couldn't speak to her daughter anymore.

In the ER, she had a CAT scan done of her head, a head CT, and it was read as normal. And she was diagnosed with a TIA—a mini-stroke some people call it, or a transient ischemic attack—and sent home

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– DR. VICTORIA SORLIE-AGUILAR, CENTERS FOR FAMILY HEALTH

with a diagnosis of high blood pressure, diabetes, high cholesterol; and told to follow up with her primary care doctor. Well, being your average working mom, working a job, trying to make ends meet, Adella had no health insurance and, of course, no primary care doctor.

So at my clinic, before I walk into the room, I look at the chart to see what I'm going to do in there. And it says Pap, Pap smear. Because in California right now, there's a program that covers a Pap smear for poor women. Right? Every Woman Counts, it's called, which is nice—every woman does count. But it really just covers the Pap and the mammo. So Pap.

So I walk in, and she was tearful. And I said—what can I do for you? I



had no idea [about it to] illustrate it—what can I do for you? You here for your Pap? And she started crying. And she said that she'd been scheduled for a Pap, and—but what's wrong with my arm? And her arms still wasn't moving right. And I looked at her report from the ER, and it said transient ischemic attack. And I thought, that can't be right, her arms still not moving right. Whatever happened is still happening. And her blood pressure was like 180/100—super, super high.

And then I noticed that Adella was there with her daughter, her daughter was there in the seat. And Adella kind of sounded drunk, like—what's wrong with my arm? And I thought—is that normal for her? I don't know. And her daughter said—no, she doesn't sound like that, and no, my mom doesn't drink. And Adella was tearful. And I did a complete exam, and I noticed she had definite problems with her muscles, she had problems with her coordination and obviously her speech. And it was likely that she had actually had a stroke that was too small to be picked up on her CAT scan.

She was confused. I said— I think you've had a stroke. Said—I'm confused, I've been to the doctor every year all these years, and I've been healthy. And I looked back, and yeah, she'd been to the doctor, but she'd been for [Pap tests], under Every Woman Counts. And all that was counted for her was a Pap smear and a mammo. And it didn't cover the labs, or anything like that.

So because now she'd had a stroke, and because now she had a disability, she could qualify for Medicaid. And we were able to get her an MRI, which confirmed that she had a stroke in her brainstem.

So hypertension is the silent killer, and high cholesterol—you can't feel it till the damage is done, like your stroke or your heart attack. And diabetes doesn't really have symptoms until it's pretty severe. And all these were easily diagnosed with routine labs. And Adella is a tragic example of why we needed Obamacare, and why we need more people to be enrolled and have health insurance.

Because if Adella—so in 2010, the insurance reform began. And preventative care is covered under insurance. Adella would've had a



Pap smear like usual, she would've had her mammogram, and she would've had basic labs check that could've showed her cholesterol and diabetes at no extra cost. That's part of it. And with Covered California, she'd be getting regular physicals, she'd be getting her labs tests. She would've been having labs done since the time that she was 35 years old. And she would've been diagnosed with those diseases, and she would've been prescribed three pills to take once a day. And she never would've had a stroke.

With 2011, there was money that went to community health centers like the one where I worked. And Adella would've had access to care and not had to wait months and months in county clinics for help. In 2013, expanded Medi-Cal would've helped her—even if she would've lost her job, like she did after she had that stroke, she could have qualified for expanded Medi-Cal.

In 2014, the exchange will begin. And Adella would've been able to purchase insurance through subsidies through the exchange.

“Adella is a tragic example of why we need Obamacare,” said Dr. Victoria Sorlie-Aguilar, referring to a patient who had suffered a stroke after going without routine preventive care for a long time.



In 2014, there would've been no annual limits of coverage and guaranteed renewability, meaning that even once the insurance found that she'd had a stroke, which is a big deal to have on your medical record—and diabetes and hypertension and cholesterol—she would be guaranteed not to be refused insurance for pre-existing conditions.

So Adella's story, for me, paints a picture of how one woman—mother, sister, grandma's—life could've been changed if all this could've happened maybe just five years ago, and is an example to me about why we should convince all our mothers, sisters, aunts, daughters to get health insurance and get checked out before they feel the symptoms.

Sandra de Castro Buffington: Thank you. I think we'll move on now and hear from Dr. Zoanne Clack. And we're going to start with a clip from *Grey's Anatomy*. Do you want to set it up, Zoanne?

Zoanne Clack: I don't know—are there any *Grey's Anatomy* watchers in the audience? (Pause) Season 10, baby. (Pause) This is when Henry was—I'm not sure which clip—which you guys chose.

Sandra de Castro Buffington: It's Henry.

Zoanne Clack: So when they first met? Well, this is when Henry came in, and he had VHL, which is von Hippel-Lindau syndrome, which comprises of multiple tumors that you get continuously throughout your life. And he had to have multiple different surgeries. And he had been in multiple jobs, because he was trying to keep insurance up. And every time he had a surgery, he would have to stop the job. So he was basically at the end of his ropes and at his max for his insurance. And we'll see how much [it] shows.

Sandra de Castro Buffington: That's all you need.

Zoanne Clack: It'll show.

(Video plays and ends)

Zoanne Clack: I actually love that story, because Scott Foley is awesome. He's not bad to look at, either.

So, the start of that story was actually—well, I'll just start with the fact that I have always been very insurance-conscious myself, personally. It actually was a major concern for me, even when I was picking my specialty for—out of medical school. I became an emergency medicine physician. (Inaudible) provide fantastic care, but after the fact. No preventive medicine.

But I was trying to circumvent the insurance issue completely by doing emergency medicine. Because I figured I could go in there, I'd

“I was trying to circumvent the insurance issue completely by doing emergency medicine. Because I figured I could go in there, I'd have to treat everybody by law. No one could tell me I couldn't treat someone. I couldn't not accept anyone, which also became the bane of my existence later.”

– DR. ZOANNE CLACK, CO-EXEC. PRODUCER, “GREY'S ANATOMY”

have to treat everybody by law. No one could tell me I couldn't treat someone. I couldn't not accept anyone, which also became the bane of my existence later.

But it also—the insurance thing just infiltrated into everyday practice, even in emergency medicine. Because a patient would ask, you know—can I follow up with you? I was like—no. I don't have a practice. But, you know, it was very flattering. But I would have to ask them, what kind of insurance do you have, in order to refer them to onward care. And that was always—seemed very tacky to me. You know, it's like—oh, doctor, please help me. Where can I go to continue the care that you started? And I would always have—my first question to them would be—what kind of insurance do you have? It just sounds like



you've just stopped the caring process.

I couldn't refer them to people that I trusted. Sometimes I couldn't even refer them to the on-call doctor, because the on-call doctor wouldn't take certain people's insurance, or no insurance, or whatever. So it was always kind of very—very much got under my skin when I was practicing.

And then, there's the whole billing process, which really turned me off. You know, sometimes you can walk into the ER, see a patient, pretty much know in five minutes what they have. But then, you know, two hours later and hundreds of thousands of tests later, you have a semi-diagnosis of the flu, or whatever they came in for, earache. But on the billing, you can't just say, you know, pneumonia, or viral syndrome. You'd have to put, say, multi-lobar infiltrates consistent with bacterial pneumonia, so that then you get more billing.

And that was always—first of all, it slows you down. You're in the ER, you're trying to get things done. You're not trying to—you know, if you get family history, that's more billing that you can do. But family history for someone who comes in with a cold is really unnecessary. But if you do it, you get billed more. So that was always—I just was never into the whole insurance thing.

And this particular storyline came because when Shonda—when we were starting season seven, we figured we needed some reinvigoration. You know, we were in season seven, we thought that was so long; but now we're in season 10, and it's so long.

So she told the entire staff that we would have to come up with three special episode ideas and a list of things we'd like to see happen in season seven. Arcs big and small, surgeries big and small. And we just needed fresh ideas to push forward.

So we were all sitting in this room, all the staff. And Shonda was shooting down pitches, like one by one. And people had like big, huge storylines thought out, you know, long pitches about what people were going to do and how they were going to get there. And I was just



kind of sitting there because that was more towards the end. I will say, though, that that's also the meeting where the documentary episode came out—got started, that idea got pitched. So there were some really big ideas and good things that came out of that.

But I basically was trying to just keep it short and sweet and pitch that Teddy marries an underinsured or uninsured patient, so that he can have insurance. And that was pretty much my pitch, just done.

And then I just kind of let it sit there. And Shonda thought about it for about a second, she's like—*Love it. Love it. Let's do it.* And from that, Teddy and Henry were born.

There was actually no pushback. Because unfortunately for us, insurance gives us a huge storyline. It's very dramatic for patients not to have insurance and for our doctors to push for them. So Obamacare is going to be extremely bad for our drama.

An idea that Zoanne Clack pitched in a "Grey's Anatomy" staff meeting became the basis for a storyline about an uninsured patient.



I was just thinking, we had a lot of insurance issues. Even this past season, we had a patient that we colloquially called Santa Claus, because he was this constant frequent flyer to the ER, always with vomiting and high alcohol levels. And people were just blowing him off. It turned out he had cyclic vomiting syndrome. And we referred him to our free clinic and gave him free samples. And we also started a free clinic. And by the way, we gave him a free sample. And I don't know who was paying, but Sumatriptan got a huge product placement—I have no idea why. So don't blame us, we did not pay them. And I'm not sure what happened with that. But I should've caught that.

So it's been a big issue throughout our show. Back when Denny Duquette—our other long-term patient love affair—died, he left Izzy \$8.7 million, and she started off a clinic with it, a free clinic, which we don't really mention that much anymore, but it's still there. Sort of. So it's always been a big issue that we've tried to tackle on the show.

And I've been watching *Call the Midwife*. If anybody's watched that, it's a BBC show. And what's interesting about that is I think that's where we're going to be headed with Obamacare. Because they're always talking about —without the National Health Service, we wouldn't be able to do this.

And I think there's going to be a lot of that going on now in the medical shows. So it'll be interesting to see how it affects drama.

Sandra de Castro Buffington: Thank you. And now, Neal, we're going to see a clip from *A Gifted Man*. Do you want to set it up?

Neal Baer: Sure.

So this was a show I wrote and produced last year. And as the stories were being told by Peter and Victoria, this was based on a true story as well. And when you heard their stories, weren't you pissed off? It's like, you heard the story about Adella, who had a stroke, and it could've been prevented if she'd had access to care. But that story got you, probably, I hope, kind of invigorated and maybe thinking about other people you know, which is what stories can do. They can engage

you and then make you think about other stories you know, and then maybe get you going, we hope, to talk to other people or really engage you in some kind of action, to talk to your own provider or to various people that Peter works with. So that's the power of storytelling.

So this is a story about a guy who didn't have access to healthcare, in the sense that he didn't have insurance. So he went to a free clinic in Manhattan.

(Video plays and ends)

“How do we normalize the view that people have a right to [healthcare]? I think one way is through storytelling . . . and the way that we can tell those stories that can invigorate us and make us talk to our legislators and talk to each other, and talk to providers, and talk to insurance companies.”

– NEAL BAER, EXEC. PRODUCER, “UNDER THE DOME”

Neal Baer: If only he'd had insurance.

So, you know, it's so complicated, the twists and turns so many individuals take to get healthcare or even preventive care.

So I'm really interested in telling the stories of healthcare, and certainly the fundamental human right, as Peter said, to healthcare, and how that's such an issue in this country, which is kind of mindboggling but still is. So how can that be changed?

Well, with the Supreme Court ruling yesterday, we certainly saw that minds can be changed in terms of the right to marry whomever you love. And how did that change? How did that change over time? Well, it changed because of storytelling, certainly. And it was certainly



reflected in television shows, not just “Modern Family,” but many, many shows long, long before that. And it kind of normalized the view that people are people.

And so, how do we normalize the view that people have a right to be healthy? And I think one way is through storytelling, certainly, and the way that we can tell those stories that can invigorate us and make us, you know, talk to our legislators and talk to each other, and talk to providers, and talk to insurance companies. And that’s what happened with Affordable Care Act.

What’s interesting to me is that we keep talking a lot about healthcare access, and that Obamacare will do that, which is true if you live in the right state. You know, what’s not talked about often is that there are some states that have decided—like Texas, Mississippi, Alabama—not to participate in the sense of offering Medicaid, so that some of the poorest of the poor will still have trouble getting healthcare insurance and will have to still rely on emergency rooms, which are much more expensive.

So we have to really make the stories clear that it’s not just in a wonderful state like California or Massachusetts, or other states that really do provide for individuals. Because states do have certain choices, as we just saw yesterday, though the Supreme Court did affirm that if you were married, you know, you would get all the federal benefits. So we need to affirm, in some ways, or encourage states, to all participate. And we can do that through, I think, stories.

Because I don’t think people really understand what the Affordable Care Act is and what it means. I’m always kind of surprised that the right is against it, when it’s actually providing care and will be less expensive in many ways. Because we’re taking care of people not when they are so terribly sick through the emergency room system.

So, we talk a lot about giving people access to healthcare providers. But that’s really not the biggest problem, I don’t think personally, in providing healthcare. I think it really is what we call the social determinants of health. And it’s what—we talk about healthcare, but



really we’re talking about sick care. We’re talking about people getting in to see doctors, hopefully earlier.

And there’s a lot of really interesting elements of the Affordable Care Act, particularly with healthcare clinics. And I work with the Venice Family Clinic, which is the largest free family clinic in the country. And they’re encouraged to do a lot of experimenting now—how do we do outreach? How do we do education? How do we make sure that every diabetic is tested for their, what we call, hemoglobin A1c, so we can see how they’re doing over time, that their eyes are checked, et cetera?

So we’re trying to implement things and trying to work in figuring out new ways—do we just have to deliver care in our healthcare clinics? Can we do it in other places? You know, experimentation, I think, is good. But I think we have to really think hard about healthcare as the care before we go to the doctor, and how preventive care will really come to the forefront.

“I think we have to really think hard about healthcare as the care before we go to the doctor,” said Neal Baer.



So, I want to direct you to an organization that's thinking—so I'll tell a little story about an organization called Health Leads. And it's found in Boston and Baltimore and Providence and New York City. And what is Health Leads? If you go on healthleadsusa.org, you'll see. This is an organization made up of college students. And they go and work with healthcare providers—physicians, nurses, nurse practitioners, physician assistants, social workers—to do all the things that those healthcare providers don't have time to do.

So think about the social determinants of health—a kid who stays up really late because both their parents work, or because there's so much noise in the building, or because there are toxic fumes from the refinery nearby—or, or, or—all of these things. Or they have lead paint in their building, and it's peeling off, and they've been exposed to that toxicity. Or they have asthma because roaches are there, and the antigens are too prevalent to really take care of. And so those kids are constantly exposed.

So those social determinants cause people to not be well. Or people are obese because they don't have access to fresh fruits and vegetables, and they're eating very low-cost processed, or McDonalds, which are—you know, it's really cheap, but really bad for you—or drinking soda, the number one contributor to childhood obesity.

So how do we get those stories out? What Health Leads does is—all those things that doctors don't have time—you know, a doctor is really in a tight schedule in most places, and they don't have time, really, to get to all those social determinants. So what if their patient doesn't know English well? What if they're having trouble with their landlord, and they're getting kicked out, and they're living in a homeless shelter, or they soon will be? What if their landlord isn't cleaning up debris or preventing roaches from coming in? What do they do? Well, a doctor—who has—they don't have time. They treat symptoms.

So Health Leads—but the doctor then checks off all of these problems that they're getting the story from their patient. And it goes to these college students who've been trained to access the multiple resources

that fortunately do exist, particularly in states like California. So they then work with the patient to really attack the issues that are bringing that patient into the clinic when, if the prevention were there, they wouldn't have come in for that. Or they would come in healthier.

And so this is really an important project that I've seen, actually, at Bellevue in New York City, and it's changing people's lives. Because health is not just going to the doctor; health is a broad part of our life. It's so many choices we make, in what we choose to eat, or when we choose to exercise, or if we walk up the stairs, or if we smoke or don't smoke, or drink alcohol. And all these choices affect our health. And what physicians can do is so profoundly limited.

“Health is not just going to the doctor. ... It's so many choices we make, in what we choose to eat, or when we choose to exercise, or if we walk up the stairs, or if we smoke or don't smoke, or drink alcohol. And all these choices affect our health. And what physicians can do is so profoundly limited.”

– NEAL BAER, EXEC. PRODUCER, “UNDER THE DOME”

So I'm really excited about a program that can—and we're trying to bring it to California now—that can be a partner to physicians and healthcare providers, so that that part of healthcare that we don't talk about can be addressed. Because for instance, one in nine Angelinos has type 2 diabetes. So, you know, healthcare reform is not going to save us from the drastic costs that that's—what is it estimated to be—\$137 billion? I mean, you hear these like crazy numbers. Who knows what it will cost? But it will cost a profound amount, and we won't be able to afford it.

So how do we deal with these issues before the patient comes to the doctor? So one way is through an organization like Health Leads that can help people access exercise partners, places in their church



where they can go to exercise. Whatever it is, there are all of these things that are going on. So it's quite important and exciting. But we have to hear those stories, and then we have to share them. So that's my hope with healthcare reform—that the stories of success, the stories that you two told, will really convey the essence of what's going on and will change people's minds of those who don't think healthcare is a right.

Thanks.

Sandra de Castro Buffington: I'd like to ask one follow-up question to each of you. And I'll start with you, Neal. Do you think it is a writer's responsibility to tell these stories? And if so, what advice do you have for the writers in the room tonight?

Neal Baer: Well, of course—is that a setup? You know, I'm a pediatrician. So yes, I do think it's our responsibility as writers to tell all kinds of stories about social justice. So that's why I love the Story Tour bus. Because we took writers to see cities that they've never been to in L.A. that are here—like Vernon and the City of Industry, where people live on top of rendering factories and have higher cancer rates—and things that we don't typically see in our day but people are exposed to.

So I do think it's a responsibility. You know, I never talk about entertaining or education, because I'll fall into that rabbit hole. You know, I'm not there to be pedantic, and I'm not there to be mindless, I hope; but to tell an engaging story. And the healthcare story is the story of our lives.

And on our new show, *Under the Dome*, you know, if you're stuck under the dome, that clinic that we have is going to run out of medicine. And so, how do we start to divide resources? And things like that we're going to get into, certainly. And we're going to see the importance of, really, healthcare.

But I think it's our responsibility to tell stories of people's lives. And if you're not healthy, or you don't have access to healthcare, your life is



really shit. So it's like—I think that that's really, you know, primary.

And I think it's really important to tell the stories accurately. Because like it or not, people really believe what they see on TV. And I was castigated in the first year I did *ER* about cardiopulmonary resuscitation and showing it as working too well. So I had Noah Wyle, like, break this elderly gentleman's ribs and, you know, trying to get a guy's heart started again, to show that it's not so easy to do.

So I think we have a responsibility. But we also have a responsibility to be accurate.

Sandra de Castro Buffington: Thank you. Zoanne? Grey Sloan Memorial Hospital is a state-of-the-art hospital and has its own genome lab now. So is the topic of affordability for the patient something you see—I mean, you addressed it in this particular episode, the sequence—but do you see that going forward as something that will be featured on the show?

"I do think it's our responsibility as writers to tell all kinds of stories about social justice," said Neal Baer. "The healthcare story is the story of our lives."



Zoanne Clack: Affordability, in that—?

Sandra de Castro Buffington: Affordability of services. I mean, of any kind of service.

Zoanne Clack: Unfortunately, on our show, we just make it work. The doctors will often foot the bill or do it pro bono. And now that our doctors own the hospital—which was also a thing that Obamacare messed us up with—I pitched long ago, like maybe Season 2, that maybe the doctors can buy the hospital. And then, it just didn't—the story wasn't ready for that until this past season, and we decided to do it. And then we realized Obamacare was there, and that it was illegal to do such a thing, through Obamacare.

And I'd gotten the idea because when I was working at Centinela Hospital, all the doctors were pitching in because it was about to—I think it was Tenet at the time, I'm not sure—but they were going to—they were selling it. So all the doctors were getting together with monthly meetings, and trying to buy it. And I just remembered that experience and was bringing that into the story.

And then, when we decided to try to do it, we realized it was illegal. And then we tried—we talked to multiple different lawyers and health professionals and tried to find kind of a way around it. So it's a corporation that has bought it, but our doctors are part of the foundation within the corporation. So they're still running it, and they bought it. But it's not a physician-owned hospital, technically.

So now that—all that is to say that now that the physicians don't own the hospital, I think a lot of things we're going to try to change, as far as people's access to care, and insurance issues, and bringing in this Affordable Health Care Act, and trying to figure out how it fits in with the story that we're telling, with the doctors now having such control over the hospital itself.

And what's interesting is, what I just wrote down, is apparently, ABC is doing a thing where we're going to tell a bunch of stories, stop for a little while, and then tell a bunch of stories in the next half. And

so, the next half will be after January 1st. And I was just thinking about how we could change from one to the other, and what will look different on our show based on that starting to come into effect. So that'll be interesting, now that our doctors have more of a—they're at board meetings all the time, and they're always talking about finances. And it actually opens it up a little bit more on our show, that we can actually discuss it, but of course dramatizing it in some way.

Sandra de Castro Buffington: Great, thank you. We'll hold you to that.

Zoanne Clack: Yeah.

“I've been sitting in focus groups listening to hundreds of Californians, who are saying, 'God, I want health insurance. I just can't afford it.' And it really is a culture of coping ... operating on themselves, sewing up their own finger, using old drugs.”

– PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA

Sandra de Castro Buffington: So Victoria, I was wondering if you would share that wonderful story you told me about your patient, a man and his son who came in. I don't want to sort of blow the punch line here, so I'm trying to tell you which story this is without giving it away. But the man who kept putting off the screening? Okay.

Dr. Victoria Sorlie-Aguilar: Oh, oh. So this is actually a story about a man who actually did have insurance. But the story was about a man named Julian, who had diabetes, had visual problems, had lost his driver's license and was having to be brought to the clinic by his son every time he came. And this is a really big story, because I use it like five times a week, and Julian.

So I said—Julian, if you stick with me, I'll get your diabetes right, I'll get your blood pressure right. But you got to get a colonoscopy.



You're 55, you still haven't had a colonoscopy. He said, 'Doc, I'd rather die than get a colonoscopy.' So I looked at Julian Jr., his son, and I said—I'm going to write that in the chart, but we're going to work on this.

I saw Julian very often, because his blood sugar was out of control. And over time, adding insulin and all this work, we did so good; we got his diabetes perfect. And I said—Julian, your blood sugar's perfect now, things are looking good for you. You might live a long time now. You got to get that colonoscopy—'I'd rather die than get a colonoscopy.' No, I really mean it, Julian. It's not that big of a deal, they're going to put you to sleep—I'd rather die than get a colonoscopy.'

Well, since his diabetes was well-controlled—and I document that every time, every time—and his diabetes was under control, I saw him much less often. And the next I heard of him was a discharge summary report from the hospital—he'd gone in for abdominal pain and been diagnosed with metastatic colon cancer.

So I never got to see Julian again. Because from there, he went to a larger hospital and had a series of treatments, and then expired. Julian died. But I have patients every day who tell me the same thing. Or—I don't want to take that drink, that's disgusting. And I'm like—if the hardest part of your day is taking that drink, I mean, jeez, it's not that bad; let me tell you about Julian.

And sometimes I convince them, and sometimes I don't. But you guys have a Julian, and you women have a Julian, in your life—you got to tell him to get it done. Yeah.

Sandra de Castro Buffington: Thank you.

So Peter, according to CMS, Americans use preventative services about half the recommended rate. So how do you hope to encourage preventative practices in the general public?

Peter Lee: Well, as a couple people have noted, Affordable Care Act



now pays for all coverage, you get a free preventive care visit. No co-pay, no anything, right out of the gate. And this is like—again, we think—we take this sort of—isn't that the way it should be? And it is the way it should be, but it's not the way it is today.

Audience member asks the panel a question.

And so this is where, you know, the story you just heard is—this is a person that had coverage. But many people don't. And I love these stories. I mean, actually, the guy—the \$8 an hour guy—I've been sitting in focus groups listening to hundreds of Californians, who are saying, 'God, I want health insurance. I just can't afford it.' And it really is a culture of coping, of operating on themselves, sewing up their own finger, using old drugs—I mean, all those things. And so it's a huge change. So having the ability to engage with healthcare professionals, and think about preventive care, is great.

I also want to just second entirely what Neal is saying—that we do have a sick care system. Getting everyone insured is the right thing to do. It enables us to stop playing the blame game and saying—oh, it's



the uninsured, it's the ER, et cetera; and get about to being healthy, which is social determinants, which is about poverty, which is about education. It's about what you eat. But without getting a health care system that says everyone's in, and we're all in this together, you can't really get to the bigger [protection] [basis] of changing parts of society.

Couple things on that, and this is where I've got bad news, which is—or good news for the storywriters—there will still be a lot of people without insurance. So that's going to still—they're still going to be out there.

Zoanne Clack: Undocumented.

Peter Lee: And so—

Zoanne Clack: We can have it about the undocumented who won't be able to come in and get their surgery.

Peter Lee: First, there's (multiple speakers) in California, a million undocumented that don't get access to insurance coverage through the Affordable Care Act, which is why we still need community clinics like Venice and others.

The penalty—let me tell you how the penalty works. Next year, if you choose to not buy insurance, and you can afford it, and there's a test on affordability—how much money it's going to cost you—one percent of your income, or \$95, whichever is greater. So you can do the math. You make \$30,000, you'd have a \$300 penalty. Two years from now, it'd be 2.5 percent of your income, or \$695, is the penalty.

Now, \$695 is actually a pretty steep amount of money. And if you're that young person—and people talk about the young immortals—and I like to say they may be young immortals, but they aren't young and stupid—young folks are saying—if I could afford coverage and have a way to get it, and keep it, I actually want it.

And so our job is to make it affordable. And we've got health insurance

that is affordable and has a leg-up for those low-income youth. Because we're giving them federal assistance to buy the insurance they want to get. So we're very optimistic. We're going to have a good mix of people, which is what we need for all of us to have what's called a good-risk pool.

Now, this gets into wonkdom. But part of the story we need to tell is, if a lot of people say—I'm going to not get this insurance thing, insurance isn't buying a service tomorrow; it's insuring in case something bad happens. You don't know if it's going to be you, your

“The health care system in America, as a system, is a problematic system. The incentives are all wrong in all sorts of ways. There's pharmaceutical companies that make a boatload of money, there's insurance companies that make a boatload. And there's some doctors that make boatloads of money.”

– PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA

neighbor, your brother, your sister. If you don't get insurance—this is the other thing about—gets into the rules—let's say you're that young person, or old person, that says—you know, now I understand I'm guaranteed to get insurance. I'm not going to enroll right now. Okay, we'll have this open enrollment period for six months. So it actually goes after January 1 into March, for the first year.

In June, you have that ache in your side, you go to the hospital—I want to sign up for that insurance, which is guaranteed. You will be SOL—a statistical term. You will not be given guaranteed coverage, until next round of open enrollment.

So we're going to be needing to move into the next years of education of this new world that it's a right, but it's also an obligation that you have to be a part of the system.



Sandra de Castro Buffington: Okay.

Unidentified Audience Member: Yes, also for Mr. Lee, quickly—two things—on the stipend, if you qualify because of your income for a subsidy from the government, does the payment go directly to the provider? That's the way it's insured that it goes—is the payment directly to the provider?

And second question is—if you have a job that you lose, and lose your health coverage because of it, and then go on the public coverage, the Obamacare; then you pick up a job down the road several months later that offers coverage, you go off Obamacare to take that coverage. And then, should you lose that job, can you go back and forth off of Obamacare virtually indefinitely, as long as you qualify?

Peter Lee: Absolutely. And I'm going to flip back to the last question really quickly, about how will the penalty be enforced: the IRS will enforce the penalty. You're going to have to—one of the new things, on all of our tax forms, you'll say—do I have insurance, the IRS will say—if you do, it'll show you have it. If you don't, you pay the penalty. So the IRS, which is pretty good at penalties, will collect the penalty.

Back to this question. First, you can go back and forth, and back and forth, and back and forth. And we want everyone to have coverage. If you get coverage through your job, keep that coverage. Hallelujah, that's great. But if you don't, an insurance company can't turn you down.

And how this federal subsidy works is—right now, the federal government helps many of us buy a house, but through mortgages. And in all sorts of ways, this is federal support, it's our tax dollars, in the form of a subsidy that the individual says—I want to pick this private health plan. And the IRS writes one check to that private plan, and you write your share. So it's not going to the provider as in a doctor, but it's going to, in California, Kaiser, Blue Shield, Anthem, Health Net, L.A. Care. You pick which plan you want to be in. The IRS will write a check for a portion of the premium. The size of how much they write depends on your income, and you write a check for the other.



Unidentified Audience Member: Yes. We've been talking about educating the people. Well, part of the people are the doctors. So my question to you is—and this is because I live in a world with people that are doctors, and I hear a lot of complaints from them about this transition—now, I would like to know, just personally, what will be the impact onto the doctors? I guess the gripe is they're not going to be as rich as they were. And I would like that clarified, if possible.

Zoanne Clack responds to a question from the audience at panel on Obamacare.

Because madam, on the right, mentioned in the beginning that she, in the ER room, was trained to code the procedures in a certain way, so that the income could be the greatest. How do we stop that, too?

Peter Lee: Well, I think that's sort of to me again. But then we'll pass it over the ER doc who did up-coding—not really up-coding, but—couple things—one, the health care system in America, as a system, is a problematic system. The incentives are all wrong in all sorts of ways. There's pharmaceutical companies that make a boatload of money, there's insurance companies that make a boatload. And



there's some doctors that make boatloads of money. But I'll tell you, the doctors who it generally isn't is primary care docs, it's family docs, it's those that spend more time with their patients. And I think the good news is that there's a whole bunch of things in the Affordable Care Act, and there's things that we're doing at Covered California, to have the health plans we contract with pay more for primary care.

And so the issue that we need to get to a system that actually doesn't reward mostly and only folks that, you know, operate and do procedures—which are important things to do, and they make good drama, so don't get me wrong on that—but that rather pay and reward for people that keep people well. And that's something that the Affordable Care Act (inaudible) a whole bunch of things to do, including, in California—and I know it's been trouble playing out—but the Affordable Care Act actually says across the nation, Medicaid programs—which are generally the lowest paid for the poorest people, and in California particularly low-paid physicians —will have—all the primary care doctors will be paid at least what Medicare pays doctors. Okay? That's a big deal.

Now, I know it's had trouble playing out. But that's a statement that the Affordable Care Act says it's not just about expanding insurance coverage—which it is, and it's a big deal. But it has to be about how we actually deliver health care, which means we need to change how money moves. We need to be paying more for primary care, for prevention, for getting out ahead of disease.

Dr. Victoria Sorlie-Aguilar: The problem that I see, as far as like the health system, and especially the emergency department in particular, is that the way it runs now is that we're robbing Peter to pay Paul. We're trying to, you know, get the money where we can, so that the people who don't have insurance can still get some medical care. But again, they're coming in when, you know, their symptoms are the worst. And they're waiting, because they don't have the money, or they don't have, you know, coverage. And so the bills are exorbitant. And so, that's the whole medical system, it's the whole—not the whole reason, but a very large reason of why it was just distasteful to me.

I loved treating the patients, and I loved the practice of medicine. But the business of medicine was always very distasteful. And the robbing Peter to pay Paul situation is prevalent. And it's not going to change unless we get some preventive care and unless we change kind of the philosophy of American medicine in general, I feel.

Sandra de Castro Buffington: Do you want to say anything, Neal?

Neal Baer: You know, as Peter was saying, there are so many factors, beginning with the cost of medical education and loan debt,

“There are so many factors ... cost of medical education and loan debt [that] encourages doctors not to go into primary care, when pediatricians—family medicine docs particularly—are the least paid but the most important. Because they're the ones who are on the front lines.”

– NEAL BAER, EXEC. PRODUCER, “UNDER THE DOME”

which then encourages doctors not to go into primary care, when pediatricians—family medicine docs particularly—are the least paid but the most—in some ways you could, well, argue the most important. Because they're the ones who are on the front lines.

So, you know, there are forgiveness programs and things like that that are coming along, too, that are really important. But it's just this—as you said, this whole kind of systemic problem in the way that doctors are rewarded, and for seeing a certain number of patients over a certain number of time, and things like that.

So at least we're starting to address those things, so that doctors aren't feeling too beleaguered. Because most doctors I know who've been in practice for awhile wish they hadn't. And that's not a good thing.



So there's a lot of, I think, positive things that can be done to encourage people to go into primary care and pay them fairly, and help them with their loans.

Zoanne Clack: You could talk to me, I'm still happy.

Sandra de Castro Buffington: Okay. (to audience member) Yes?

Unidentified Audience Member: This is maybe for Mr. Lee, but also for some of the other doctors and storytellers on the panel. Now, I know that anybody in charge of implementing ACA is probably very scared of any implication of death panels, or anything like that. But I wonder what the act does to address some of the very real imbalances in which a lot of the resources are directed toward those final weeks of, you know, an ill person in the hospital, in intensive care? And I'm sure anybody who has a loved one who has passed away in such a situation probably felt that conflict of wanting the best care, but a lot of it is perhaps not the most well-used resource.

Peter Lee: Well, I'll tell a little story, of sorts. I spent two years in Washington. I was an appointee of the president. I didn't hang out with him very often. But two of the real tragedies that I came back with was—one, this whole thing around death panels. It created a fear of talking about: how do we help people die? And instead of being able to talk about good policies to help people say—what do I want to have happen at the end of my life—it scared the public health policy world about talking about real issues. And it's really—so that's one story.

Another story—and we were talking before we came out here about the gentleman who ran Medicare, a pediatrician named Don Berwick, who is the most decent, smart physician that you could ever be blessed to have as a public servant. And he would go and sit down with a senator behind closed doors, have this nice chat, think things were going well—the senator might be a Republican. And that senator would walk out and say—I've just met with this rationer-in-chief.

And the issues that we need to get to—and I really appreciate what



the center here does—is not be talking about the extremism, death panels or pundits, et cetera, et cetera—what are the facts? And the Affordable Care Act does very little specifically to deal with end of life because they got scared off from dealing with that. Quite honestly. And so I think it's something that we need to be doing in our communities.

Peter Lee of Covered California meets with member of the audience following the panel talk.

Covered California, which is contracting with health plans—and we are saying, what are you doing to make sure that patients and doctors are making decisions that are right for that patient? And so what we're doing—and this is the thing that I think needs to be played out around the country—is, if you let a patient and a doctor work together, in a lot of cases, it's not going to be the most expensive stuff. In some cases, it might be. Okay, we'll bear those costs. We're already spending twice what any other country in the world does. But that's not what most patients actually want.

So how do we actually encourage paying for time spent talking instead



of paying for that next MRI? And this comes back to—I'm sort of an incentivista. I think a lot of it is where the money goes.

Sandra de Castro Buffington: I'd like to add to that. There's a project—I think it's called The Conversation—that was started by Ellen Goodman—Conversation Project, I think. And it is starting to roll out across the country. And it's about sort of stimulating these conversations about, what do you want at the end of life—so that every person, when they reach a certain age—fairly early in adulthood—starts to have that conversation with their family, so that we do start making choices about what we want.

And so anyway, I wanted to mention—

Neal Baer: And with their physician. Because physicians aren't really trained in medical school—

Sandra de Castro Buffington: No.

Neal Baer: —to have these conversations. So Ellen is really—I think after her sister died, fairly recently, really sort of put this into play. And it's an important project. Because as the gentleman said—I forget the figure, maybe you know what the percentage of our health care dollars are spent in the last several months of life—it's astounding. And it doesn't have good outcomes.

So, you know, this is something that we just haven't talked about. The Institute of Medicine is beginning to talk about it. So people are—and then there's the wonderful film that was not made in the United States, called *Amour*, that won the Oscar last year, that was about this. And so, we're hoping and encouraging people to write about this, too. Because *Amour* was a very powerful film about this issue.

Unidentified Audience Member: Yes, thank you. And thank you for coming down with a well-prepared presentation. I appreciate this and enjoyed hearing what I've heard.

Now, we're all going to end up with for-profit insurance policies.

I haven't heard one word about the single-payer health care delivery system, which they have virtually all over the world, but not here. Why not? Why aren't we doing an outreach for single-payer?

Peter Lee: Well, we actually have an interesting country that—I may prefer other systems. I've lived in England, and lived there with the National Health Service. We actually have a huge step forward with the Affordable Care Act, that squeaked through. The Affordable Care Act has nonprofit and for-profit health plans. We contract with Kaiser, which is a nonprofit; Blue Shield, which is nonprofit; and for-profit

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health plans. And what we have as a nation, though—and I think this is—maybe I'm a glass-half-full guy—we have as a nation seen, everyone has a right to coverage. And I'd also note—and I've spent time in Europe—the single-payer systems out there don't necessarily mean there aren't multiple health plans. The German health care system is a universal coverage system that's delivered through 48 separate insurance companies.

So there's a lot of different ways to do it. And I think that right now, we have the law. There's some around the country, as Neal noted—Texas or others—that want to repeal this law. Let's get everybody covered. Now, we can re-litigate, so to speak, and push other things down the road. But we have an opportunity to have all Americans have healthcare coverage.

Unidentified Audience Member: This is step one. But if you take the



profit out of the system, those dollars will go farther, won't they? Of course.

Peter Lee: They might well, but I just want to remind us that there's profit in lots of places in the system—in pharmaceutical, in those that own hospitals, those that make things—and in some physicians not the primary care—that individually make OK. The reason that health care costs more in America than most of the rest of the world is we pay more at every step of the way. And so it's at every single step of the way.

So, I mean, again, there's a lot of other problems with the health care system. And I want to also pile on (inaudible) others about medical education. One of the reasons we do spend a lot more in health care is medical students graduating with \$200,000 debts are going—I can't do God's work like Victoria is. So I'm going to become a radiologist. And these are social issues that—there are a lot of other pieces. The Affordable Care Act is a piece of solutions for some of the major problems. But I think we really should be celebrating that we're saying that health care's a right.

Unidentified Audience Member: Thank you.

Peter Lee: Thank you.

Sandra de Castro Buffington: Thank you.

Neal Baer: The person who's writing—I think the best work right now is by Atul Gawande. And he's written in *The New Yorker* about experiments in Texas, and medical errors, and end-of-life issues. So I think—so I refer you to Atul's work. Because he really tells stories quite beautifully about medical ethics issues and their impact on reform.

Sandra de Castro Buffington: We brought Atul to L.A. to speak with some of the shows, to do some briefings.

Unidentified Audience Member: Well, I'm trying to make a question



out of this, out of everything that's been said so far. But I'm one of the citizens who did take five months off during 2009-2010 to work on the Affordable—with Obamacare at the time, to get it passed, and was very disappointed at what came out. But we'll work with it; it's a start. But what I'm finding very troubling now is that we're celebrating that—OK, everybody can get health insurance. Everybody who wants it can find something to buy. We're not addressing what it's going to cost. And we know for a fact that the biggest health providers now are hiking up, jacking up the prices 20 percent on some premiums. And all that, plus the deductibles and everything, are going up. And I have to tell you—Kaiser, the co-pay for colonoscopy for some of us, is \$3,000.

Zoanne Clack meets with students from the University of Southern California following the panel.

So I have to tell you—and I know a lot of you MDs don't know that. And that's considered one of the cheaper ones. And Kaiser is a nonprofit. So the terms are so misleading. And I'm finding as a storyteller, as a writer, I'm still going to be writing the stories about people going bankrupt on their deductibles, on their premiums.



And just—you know, I saw something in one of the financial—the pharmaceuticals that run insulin? They are predicting such a big payday because all the diabetics are in the system now.

So before we cheer, we celebrate and we do that, we have to have a plan now. Because we don't have single-payer, we don't have public option. We've sailed on that. But now we have more people who are still going to go broke. And they're going to pay for their insurance, but they're not going to dare to go. Because they can't afford the co-pays or the premiums.

So, I don't know. There's a question in there, folks. I'm not sure what it is.

Peter Lee: Well, I would encourage you to go to coveredca.com. That's our website for Covered California. And you look at—we have standard benefit designs. OK? And that's one of the things that California—and this is where, you know, California is different than a lot of the country. But across the country, there are standard benefit designs. But in California, it's even more standardized. Within each benefit design, you can pick a plan; they're all covered in the same way.

Now, health care in America is really expensive. OK? But even the cheapest plan, which is called a Bronze plan, which is the lowest premium, says the most you will have to spend in a year, your maximum out-of-pocket, is \$6,000. \$6,350. Now, \$6,350 is a lot of money. If you're that \$8 person, it's a shitload of money, OK? But it's not what's going to send you into bankruptcy.

And if you go to a hospital, and if something really bad happened, you could have what you saw up here—someone having hundreds of thousands of dollars of bills. And that's the kind of protection that right now people don't have. It is absolutely the case that right now, you could have insurance and go bankrupt. That's not the case as of 2014.

So we could argue about the glass-half-full and half-empty. But we

should understand that maximum out-of-pockets are meaningful. They make a difference. And so, every one of the plans in Covered California—and this is also outside of buying in our marketplace—will have new rules of saying—there's, number one, no lifetime maximums—another one of the storylines we saw up here. Number two, a maximum out-of-pocket.

So, is health care still expensive? Absolutely. Is it going to be a struggle for some people even with the subsidy, that are making \$18,000 and have a family, to pay the \$50 that it might cost them

“Medicine for profit—corporate medicine, which we have in the United States—is really at odds with health care as a human right. ... If it's a basic human right, then how do you provide it, if profit might not be there? It becomes quite complex.”

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every month, given what else they're balancing out? Absolutely. Health care's expensive. But are we changing the game in a big way? Absolutely.

Neal Baer: You know, medicine for profit—corporate medicine, which we have in the United States—is really at odds with health care as a human right. So how do we deal with that? Because if medicine is for profit, pharmaceutical companies for profit—now you can get drugs in the United States—if you have HIV in the United States, you can get treated, but you can't in Africa. Depends on the country. But still, not every child who has HIV is covered in Africa. Every child in the United States is covered.

So we do a pretty good job with certain things in the United States, and that cannot be denied. But we do a terrible job around the world. So when we compare ourselves to other places, then things are pretty



good. We're not so good compared to other industrialized countries.

But as long as profit is an underlying factor, it's going to be—you know, and that gets into this issue of single-payer—as long as profit is an underlying factor, it really kind of—it clashes with sort of health care as a basic human right. Because if it's a basic human right, then how do you provide it, if profit might not be there? And so, it's very—it becomes quite complex.

Sandra de Castro Buffington: (to audience member) Yes?

Unidentified Audience Member: Thanks. And thanks to my fellow audience member for bringing up that point. Because your response actually answered half my question. I buy health insurance because I'm a freelancer, so I pay for it entirely myself. I have a \$5,000 deductible. I pay a premium to a supposedly nonprofit HMO, and it creeps up and up and up.

People tell me I'm paying a very low premium compared to what they're paying. Now, if in 2014 this is found to be below-market, can this HMO then hike it up, you know, preventing me from staying with them? So that's part one of the question. Part two—if I go to your website, and I find another alternative that seems more affordable; but if my cost is based on my income, who's going to take into account that in this town two-thirds of my income is gobbled up by rent? So there isn't a whole lot left over for that premium.

So it's a slightly redundant question. But could you put a fine point on, you know, what kind of flexibility the HMOs are going to have to raise premiums precisely because they think we're paying too little now?

Peter Lee: Well, a couple things—one of the things the Affordable Care Act did is backed a change in the rules for insurers, as saying that now, insurance companies have to spend the vast majority of the money they collect, the premium, on health care. So it depends on what the plan is. But either 80 percent or 85 percent of all the money you send a health plan—for-profit or nonprofit—must go to health care, to what it's covering for other people.



So the premium we all spend is, I know, mostly not going to high-paid executives and profit; it's going to health care, which in America costs a lot for all the reasons about testing and all the things we've been hearing about. So that's one. And it's regulated and overseen, so they can't charge more than that 80 percent or 85 percent going for health care.

HH&S Director Sandra de Castro Buffington steers the conversation as panel moderator.

With the changes in 2014, we've negotiated rates with the plans to be the lowest possible, but not so low that there won't be enough to pay the doctors to have the services out there. You can pick any plan, stay with the plan you've got. And it'll be overseen by the regulators to make sure they aren't overcharging and collecting more money than they need to be spending.

So the specifics—I don't know about your age, what your—et cetera. But that's something you could actually check right now with coveredeca.com and see what the rates would be (inaudible) would compare.



Sandra de Castro Buffington: I'm being given the stop sign. But maybe we could take one last question. And then we're going to have to close for the evening.

Unidentified Audience Member: Hi. I guess, as a concerned college student, at my school they require us to enroll into the school student health insurance plan, or if our health insurance doesn't meet those certain requirements, I guess. My question is—will Obamacare provide the same quality of care as a PPO would, or, just in general, private health insurance coverage would?

Peter Lee: Maybe we should have each one maybe answer this—we all got to wrap up. Again, this is a start. And I think the point—it's a start of getting everyone covered in the same sorts of plans that people are covered with today. It also has some tools to help change how we actually deliver care and help people stay well better, by addressing some of the social determinants that we heard about—prevention.

So, you know, it's historic. It's a big-deal change to say that everyone has a right to coverage. But what people can pick—for some people, they see this as a great thing. For some, it's the awful thing—it's picking the same damn plans that are out there today. Now, you call the same damn plan the same plans you're in. In L.A., pick any of the six plans. You can pick, you know, Kaiser, Anthem, Blue Shield, Health Net, L.A. Care, Molina.

And so these are plans that are out there today. And it's the same doctors providing care out there that you're going to be finding. So it's not going to be a two-class system.

And it's something that's going to also—the president said this— not be perfect on day one. But I'd remind folks that when Medicare passed—I'm going to come back to history—50 years ago, the AMA opposed Medicare. The AMA said Medicare was putting America on the path to socialism. Today, no one would say we shouldn't have Medicare.

It's a historic time. We're about to move into a time when we say every

American should have a right to health care. And we're going to be implementing that. Not just in California; in every state in the country, even those laggard states that don't really want to do it. And so, as the story—it's not just a California story. I think we'll do a pretty good job in California. But I hope they do a good job in Oregon. The federal government, which sets up a marketplace in Texas, does a good job.

And I do think—this is my last sales pitch—that the stories you tell will help folks in Texas understand—boy, this is something that—I have a right to healthcare. This is something—this is the American way. That's a story I want to make sure is heard in every part of America.

Victoria Sorlie-Aguilar: I think that her question, to being a student and having to buy insurance—I was recently—it seems recently, was 10 years ago—was a student who had to buy insurance. And when I bought that insurance, the plan was at my school. So the people that saw me were my friends. And I definitely did not want that insurance, but—

So when I finally wound up in the hospital, I'm like—no, not you, not you, not you. But I think that the difference is you'll be able to see what your school's insurance—for example, you—has, next to what Health Net has and Anthem has. And you can provide—you can see the benefits across the board. And then you may not be so restricted as to the smaller school system that you have. And if you qualify, you'll be able to share the cost of that with the federal government, which—we never had that before.

Sandra de Castro Buffington: Anybody else? Zoanne or Neal?

Well, then, I would like to thank our amazing panelists for a very exciting evening, and also to remind you that for the writers and producers in the room, you can always call on Hollywood, Health & Society for help with your health storylines.

Thank you all for being here tonight.

(Applause)