A PATH TO UNIVERSAL COVERAGE AND UNIFIED HEALTH CARE FINANCING IN CALIFORNIA

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This report reflects the authors' attempts to explain information that emerged from the six Select Committee hearings and to assemble the findings from the hearings into a coherent set of possible recommendations for the California Assembly. This report reflects the views and opinions of the authors and should not be interpreted as the official policy of the University of California or members of the Select Committee.

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Copies of this report may be found at http://healthcare.assembly.ca.gov/reports

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Executive Summary

In March 2017, California Assembly Speaker Anthony Rendon appointed a Select Committee on Health Care Delivery Systems and Universal Coverage to identify the best and quickest path to universal coverage for California and to explore strategies for improving our health care system. This summary and the accompanying report document and synthesize Select Committee hearings held between October 2017 and February 2018.

Health coverage and care in California today

Under the Affordable Care Act (ACA), the number of Californians without health insurance fell dramatically from nearly 7 million in 2013 to about 3 million today. The majority of the remaining uninsured population, about 1.8 million, is not eligible for public coverage programs due to immigration status. Various factors including affordability and awareness contribute to others remaining uninsured.

Health care spending across California from all sources totals about $400 billion. Of this total, more than half comes from public sources of which the largest are Medi-Cal (more than $100 billion) and Medicare ($75 billion). Employer-sponsored coverage remains the dominant source of coverage in the state and accounts for the largest share of private health care spending (between $100 and $150 billion). In addition to the portion of the $100 billion to $150 billion in employer-sponsored insurance premiums that is paid by employees, consumers pay $10 billion for premiums for individual insurance and $25 billion to $35 billion in out-of-pocket spending.

The health insurance market in California is relatively competitive and includes multiple national, state-based and local health plans. Health plans are responsible for health care provider contracting and payment and, to varying extents, plan contracts establish rules and incentives for providers to meet quality standards and achieve positive health outcomes. California has a long history of managed care arrangements within both private and public health plans. The settings in which Californians receive health care vary depending on their source of coverage (employer-sponsored, Covered California or remaining individual market, Medi-Cal or Medicare).

Challenges under the status quo

Despite California's substantial progress in increasing coverage, a number of challenges remain. Even among people with coverage, some are underinsured, facing substantial financial barriers to access. Access to care also varies with coverage sponsor, geographic location and health plan. People with coverage through the individual market and Medi-Cal report better access to care than the uninsured, but more difficulty than those with employer-sponsored coverage. Access to care in rural areas is a particular challenge, regardless of coverage source. When individuals' health insurance status changes, they often must switch plans and physicians which can disrupt care and increase consumer confusion.

Even as health care financing arrangements create access barriers and inefficiency, a substantial share of health care services is low-value, potentially unnecessary and possibly harmful. Many factors contribute to sub-par outcomes, including payment systems that reward volume rather than good health outcomes and a heavy dependence on specialists rather than primary care health care providers.

In California and across the U.S., prices for health care services are higher than in other developed nations and vary by type of coverage. Medi-Cal payments are substantially lower than those paid via employer-sponsored insurance (ESI) and contribute to barriers to care for Medi-Cal enrollees. High hospital prices paid by ESI reflect a lack of competition among hospitals in most parts of the state and the ability of some hospitals to command "must-have" status within health plan networks. Billing and insurance-related costs borne by providers as they collect money from private insurers contribute to high prices.

Improving health care and coverage under today's financing structure

As a part of the Select Committee hearings, presenters described a variety of policy approaches to achieve universal coverage, make health care more affordable and improve access and make our multi-payer system less fragmented and more transparent.

Address remaining coverage gaps and reduce affordability barriers, for example:

- Expand Medi-Cal eligibility and Covered California financial assistance to people currently ineligible due to immigration status
- Provide enhanced affordability assistance for Covered California beyond that available under the ACA
- Address underlying premium trends by limiting out-of-network hospital prices
- Impose penalties for those who don't maintain coverage (to replace the federal ACA individual mandate penalties that will be eliminated in 2019)

Improve access and continuity of care, for example:

- Stabilize or expand health plan competition via a "public option"
- Develop a comprehensive strategy to address health care workforce needs that better develops and sustains the primary care workforce and addresses gaps in rural areas
- Address regulatory and reimbursement issues related to the use of telehealth

Reduce fragmentation and increase transparency, for example*:*

- Make health insurance products more uniform between Covered California and ESI
- Require that health care providers make information available on average negotiated prices for ESI as a percentage of prices paid by Medicare
- Establish an all-payer claims database

Improving California's health care system via a unified, publicly financed approach

An alternative to our current patchwork financing approach would be to establish a unified, publicly financed approach that assures coverage for all state residents; pools funds for health coverage across Medicare, Medi-Cal and other major financing sources and dramatically reduces or eliminates variations in eligibility, benefits and payments. A unified, publicly financed system would increase equity, be simpler for patients and

providers and reduce administrative costs. It would likely increase efficiency and produce better health outcomes, although these results would depend on how well the system was managed and on mechanisms of accountability. To accomplish such a sweeping transition would require substantial and unprecedented changes in federal and state law as well as decisions regarding many design parameters.

Considerations related to integrating multiple payers: The public and private funding streams that support health care and coverage today are accompanied by many requirements not readily eliminated or easily reconciled. The federal government is the largest source of funds for health care in California today. Redirecting those funds would require federal permissions and actions such as statutory changes to redirect Medicare funds to a state-based pool. Similarly, either statutory changes in federal Medicaid law or an agreement on a means to track eligibility and expenditures for Medicaid-eligible populations that enables California to claim federal matching yet preserves simplicity and equity goals, would be needed. Further, Congressional action would be required if revenues linked to federal ESI tax exclusion were to be redirected to state control.

Because direct state intervention in plans that must comply with the Employee Retirement Income Security Act of 1974 (ERISA) is impermissible, either federal ERISA statute would need to be amended or California would need to devise financing approaches that do not run afoul of ERISA legal challenges and associated delays. This might involve a broad state-based payroll tax to finance health care on all employers, whether or not they currently have or maintain an ERISA plan.

Considerations related to state financial oversight: Provisions of the State Constitution require California to enact a balanced budget each year and strictly limit the state's ability to engage in deficit spending. Many forces and factors could introduce volatility into revenue streams and expenses associated with state-managed universal coverage. It will be important to establish and finance reserves upon which the health fund can draw in periods when costs are unexpectedly high or revenues fall short of projections. Provisions of the State Constitution also constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to universal health coverage. These provisions render it prudent to seek explicit ballot initiative approval to dedicate new funds to health care.

Design and implementation considerations: In moving from diverse benefit, payment and delivery arrangements under today's fragmented financing and coverage programs to a more uniform set of expectations, tradeoffs would arise. In the course of establishing and implementing a statewide universal coverage program, it would be important to consider matters such as:

- The extent to which integrated managed care arrangements would be encouraged and the role, if any, for health plans;
- How provider payment levels would be set and adjusted;
- Whether and how payments and delivery system arrangements might be allowed to vary based on regional differences, local preferences and needs;

- How quality and access to care would be assured;
- The extent to which the needs of special populations would be prioritized;
- What governance structures and management tools would be put in place to assure accountability and effective oversight

A host of transition issues, including job dislocation for people currently involved in billing and insurance-related activities would also need to be addressed.

Potential paths forward

California has made great progress in reducing the number of uninsured but has not yet achieved universal coverage. In high-performing health care systems around the globe, universal coverage is essential for ensuring access to care, improving outcomes and controlling costs. A strong primary care system, a comprehensive basic benefit package, provider payments that reward better health outcomes, a strong social safety net and administrative simplicity are other important ingredients for high performance. California could take short-term steps and establish a longer term roadmap for system transformation.

Short-term steps

Working within California's current fragmented financing system, various approaches are available. California could:

- *Improve coverage* by using state funds to:
  - Expand Medi-Cal coverage to income-eligible undocumented adults
  - Extend Covered California premium tax credit assistance to undocumented individuals
- *Improve affordability*:
  - Address affordability and participation for those already eligible for Medi-Cal and Covered California
  - Limit out-of-network prices for hospitals benchmarked to a specified ratio of the price paid by Medicare for similar services
- *Improve access*:
  - Increase the amount of Medi-Cal payment rates
  - Explore a Medicaid Public Option
- *Simplify the consumer choice process* by requiring each fully insured product in the large group market to be either a bronze, silver, gold or platinum plan as defined by Covered California
- *Increase transparency*:
  - Require hospitals and larger medical groups to post information on the average prices received from people covered by ESI, Covered California, Medicare and Medi-Cal
  - Establish an all-payer claims database

Short-term approaches can be evaluated against several criteria: their potential benefits for consumers and the delivery system, state fiscal cost, potential to preserve gains under the ACA, and the extent to which they either lay a foundation for, or undermine, potential future heath reforms.

A roadmap for a broader transformation of California's health care system

California could embrace a goal of guaranteed access to health care for all through unified public financing that improves health outcomes and keeps costs for the state and its residents in check. To achieve that goal, several preconditions would need to be satisfied:

- Diverse stakeholders must develop a sense of shared purpose and mutual responsibility to advance a health system that works well for all Californians
- Data must be collected and analyzed to better understand the status quo and to explore how a new system could be monitored and managed
- State budgetary implications must be modeled; financial risks must be assessed and mitigated
- A detailed proposal would need to be developed and the Legislature would need to enact enabling legislation
- State constitutional amendments would need to be approved by the voters
- Federal statutory changes and waivers would need to be obtained

The California Legislature could demonstrate leadership by establishing a planning commission responsible for advancing progress toward universal coverage and unified health care financing. The Legislature would establish the governance structure of the planning commission, provide its charge and appropriate funding. The commission would:

- Convene a stakeholder engagement and analytic process by which key design features are refined and vetted
- Establish data collection and reporting efforts to support management, evaluation, transparency and public accountability
- Model state budgetary implications and assess options for raising and managing funds
- Make recommendations to the Legislature on the design of a system of unified public financing and work with the Legislature to draft necessary state enabling legislation and any necessary ballot propositions.
- Ready the state to seek federal waivers and statutory changes by which funds managed by the federal government but used on behalf of Californians can be consolidated with other funds
- Explore operational requirements related to information technology and financial management
- Establish partnerships to coordinate activities with nongovernment entities

Conclusion

California has established itself as a leader in using the opportunities created by the ACA to increase insurance coverage. Testimony at hearings identified many ways to build on that foundation, both short-term and over coming years. Short-term efforts to expand coverage, improve access, reduce fragmentation and improve transparency, coupled with development of a longer term path toward unified public financing, would help secure a future in which all Californians have access to the health care they need and deserve.

BACKGROUND

In March 2017, California Assembly Speaker Anthony Rendon appointed a Select Committee on Health Care Delivery Systems and Universal Coverage (Committee) to identify the best and quickest path to universal health coverage for California and explore strategies for improving our health care delivery system. Co-chaired by Dr. Joaquin Arambula (D-Fresno) and Dr. Jim Wood (D-Santa Rosa) with members Autumn Burke (D-Inglewood), David Chiu (D-San Francisco), Laura Friedman (D-Glendale), Tom Lackey (R-Palmdale) and Marie Waldron (R-Escondido), the Committee held a series of public hearings in late 2017 and early 2018. The Committee engaged a University of California team to capture themes from the hearings (but not recapitulate details available elsewhere), describe policy options that could work well within the California context and identify issues likely to arise within that context.

This report describes health coverage and care in California and identifies remaining challenges related to access, coordination, and cost. It presents a range of options to expand coverage, address issues of fragmentation and cost under our current mixed public-private financing system, followed by options and considerations should the state move toward a state-based publicly financed approach. It concludes with a discussion of potential paths forward in the near future and over the longer term.

1. Health coverage and care in California today

Insurance status and sources of coverage

California experienced dramatic expansions of coverage under the Affordable Care Act (ACA). Prior to the ACA, the number of uninsured residents approached 7 million, or about 17% of the non-elderly population; post-ACA, it has fallen to around to 3 million (about 7%).[1] California embraced the Medicaid expansion available under the ACA. In addition, in 2016, California expanded Medi-Cal to all children, regardless of immigration status, using state funds. As a result of these and other policy and administrative actions, Medi-Cal enrollment is now approaching 14 million.[2]

Coverage through employment continues to be the dominant source of coverage for Californians, accounting for about 17.5 million people. About 6 million Californians with employer-sponsored coverage are in self-insured arrangements subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) and over which the state has

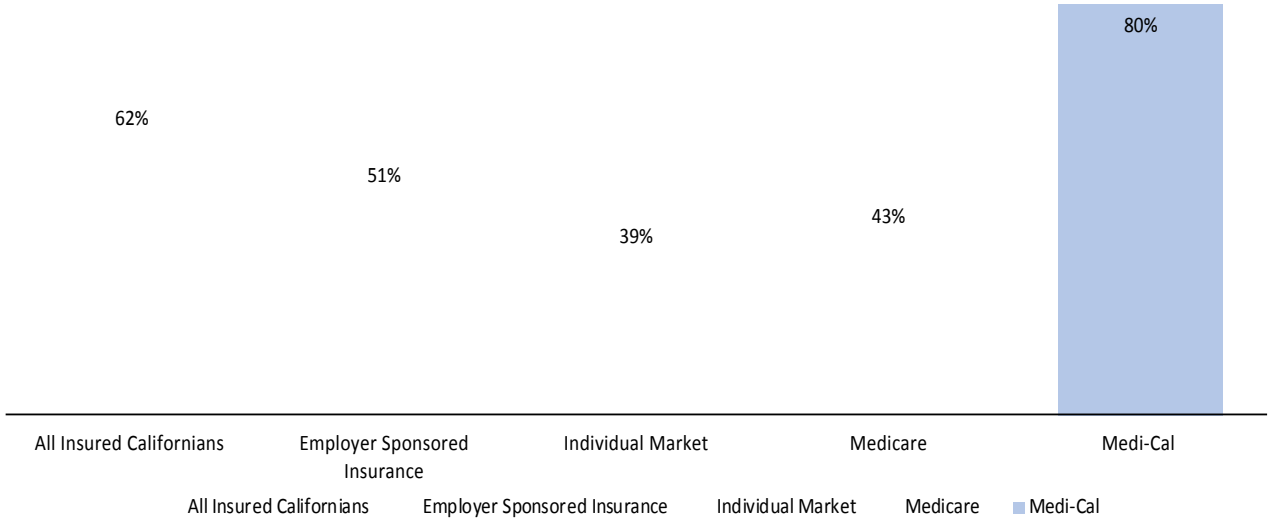
[1] Kelch, Deborah, "Overview of Coverage and Care in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

[2] Ibid.

limited regulatory oversight.[3] ERISA prevents states from directly regulating private employer health insurance arrangements. In particular, ERISA prevents states from imposing a mandate that private employers offer or pay for health insurance. ERISA also prevents states from imposing taxes on private employer-sponsored plans.[4]

California has a long history of heavy reliance on managed care arrangements -- including incentives or restrictions related to provider network -- in both public and private health plans. More than 60 % of insured Californians are enrolled in Health Maintenance Organization (HMO) plans, a higher share than most other states. Among California Medicare enrollees, 41% are in Medicare Advantage managed care plans, and approximately 80% of Medi-Cal enrollees are in managed care plans.[5]

Percentage of Insured Californians Enrolled in HMOs, by Source of Insurance, 2016



Source: CHCF statewide CA Health Insurers Enrollment Database, combines figures from DMHC Enrollment Summary Reports and CDI Covered Lives Reports.

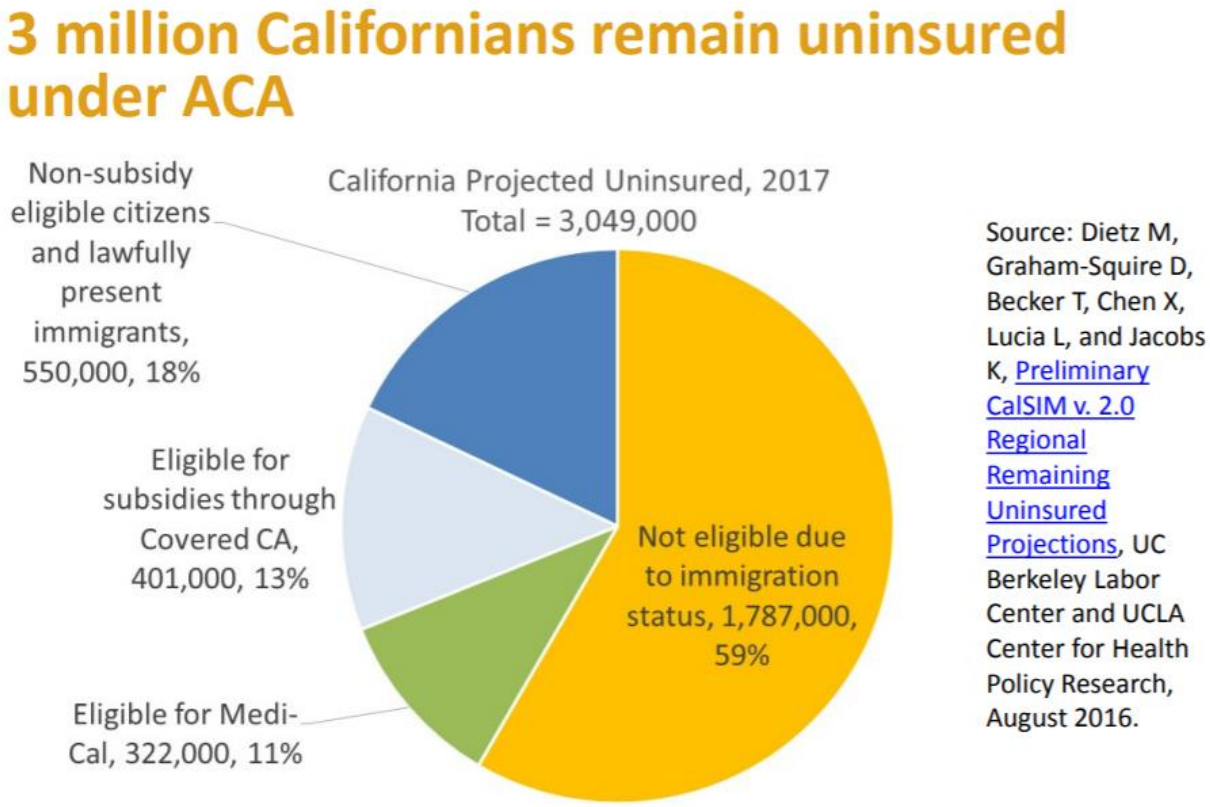
Note: Employer-sponsored insurance includes 5.7 million people in Administrative Services Only (ASO) coverage. The underlying CDI reports do not separate ASO coverage into HMO and non-HMO coverage. The statistic here assumes that ASO coverage is not HMO. The count of Medicare enrollees in HMOs may include some Medicare beneficiaries in Medicare Advantage PPOs.

[3] Wilson, Katherine B., California Health Insurance Enrollment, 2016, (California Health Care Foundation: February 12, 2018) available at https://www.chcf.org/publication/california-health-insurance-enrollment-2016/

[4] Marciarille, Ann Marie, "Implementation Considerations for Universal Coverage: ERISA," Testimony before California Select Committee on Health Delivery System and Universal Coverage, February 5, 2018.

[5] Based on Department of Health Care Services data, in October 2017 10.7 million people were enrolled in Medi-Cal managed care. This represents about 80% of Medi-Cal total enrollment of 13.3 million.

Despite gains in coverage under the ACA, 3 million Californians remain uninsured.[6] The majority of California's remaining uninsured, about 1.8 million, are not eligible for coverage programs due to immigration status; characteristics of other subsets are shown in the chart below.



Even among the 93% of Californians who have health coverage, many continue to face challenges in affording health care and may curtail health service use as a result. Underinsurance, defined as having high cost burden or exposure to high health cost sharing, affects 21% of insured Californians using Commonwealth Fund criteria.[7] Although state-specific data are unavailable, the subpopulations most affected by underinsurance across the U.S. are those enrolled in Medicare (47%) and the individual market (44%).[8]

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[6] Lucia, Laurel, "Health Coverage Gaps in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

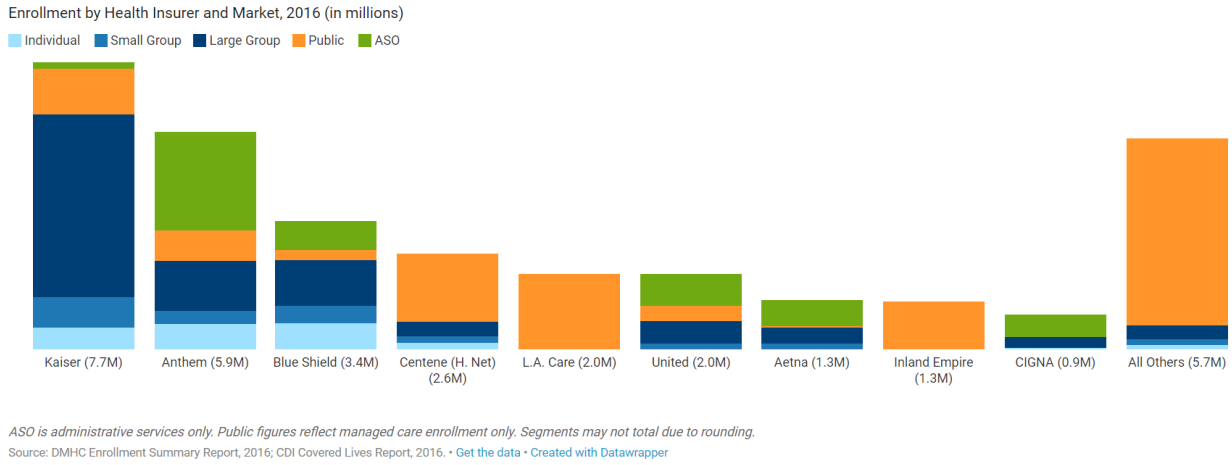
[7] The Commonwealth Fund defines underinsurance as either 1) incurring out-of-pocket health expenses (excluding premiums) of ≥5% of income in households at or below 200% of the Federal Poverty Level (FPL) or ≥10% of income in households over 200% FPL or 2) having coverage with a deductible of 5% or more of household income, regardless how much is actually spent.

[8] Lucia, Ibid.

Spending and sources of payment
Total health care spending across the state of California, from all sources, totals about $400 billion. Of this total, more than half comes from public sources of which the largest shares are Medicare ($75 billion); Medi-Cal (more than $100 billion); and federal ACA subsidies through Covered California ($6 billion). Private spending is primarily through employer-sponsored insurance premiums (ESI) ($100 billion to $150 billion). In addition to the portion of the $100 billion to $150 billion in employer-sponsored insurance premiums that is paid by employees, consumers pay $10 billion for premiums for individual insurance and $25 billion to $35 billion in out-of-pocket spending.[9]

Federal and state tax law allows payments toward employer-sponsored insurance to be excluded from employees' taxable income. In California, this exclusion accounts for foregone revenues between $40 billion and $50 billion. About 75% of this indirect tax benefit comes from the federal government. [10]

Health plans and provider networks
Compared to many states in the country, California's health insurance market is relatively competitive. The state's three largest insurance carriers by total enrollment are Kaiser, Anthem and Blue Shield of California. Other plans, including Medi-Cal managed care plans in many California counties, also provide coverage for millions of Californians. The share of enrollment by market segment (individual, small group, large group, Medi-Cal and Medicare and Administrative Services Only (ASO) for self-insured arrangements) varies considerably across insurers.



[9] Legislative Analyst's Office, "Financing Considerations for Potential State Healthy Policy Changes," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, February 5, 2018.

[10] Legislative Analyst's Office, Ibid.

Source: Wilson, Katherine B., "California Health Insurance Enrollment 2016, California Health Care Foundation: February 12, 2018

Health insurers collect premiums from purchasers and establish contracts with providers to deliver care to enrollees. Plans differ in the composition of provider networks: Kaiser contracts exclusively with Permanente physicians and offers the same providers to all enrollees. Other plans develop networks that vary by product and market segment. People purchasing in the individual market, including Covered California, appear to be more price-sensitive with respect to health plan premiums than people covered by employer-sponsored insurance. To keep premiums lower and attract enrollment, plans in the individual market tend to have narrower networks than typical plans in the ESI market.

Health insurers perform a variety of functions, and the functions vary significantly across channels of coverage – that is, health plan functions in the individual and small group market are different from their functions in the large group market, and different again from their functions in the Medicare and Medi-Cal markets. For individuals and small groups, a key function is the aggregation of risk. For large groups, the main functions of health plans are provider contracting and payment, member services, and working with (and sometimes against) providers to reduce the provision of low value care and increase quality and efficiency.

Some California health insurance carriers reimburse providers via full or partial capitation arrangements that reduce or eliminate provider incentives to increase the volume of services. Although fee-for-service remains the most common method of paying providers, California health plans are increasingly tying providers' financial risk more explicitly to accountability for quality and outcomes.

Unlike small- and medium-sized employers, there is no reason that publicly financed programs would necessarily need to contract with risk-bearing health insurers. Medicare and Medi-Cal can perform all of the functions listed above without using health insurers -– these programs can either hire government personnel to perform these functions, or contract with independent entities (third party administrators) to perform them. It is notable, then, that Medicare and Medi-Cal, which once functioned as 'single payers,' have turned to health insurers as risk-bearing intermediaries. One rationale for involving health insurers is that they can work more flexibly with providers than can the government in reducing the delivery of low value care, potentially yielding more appropriate use of health care services.[11]

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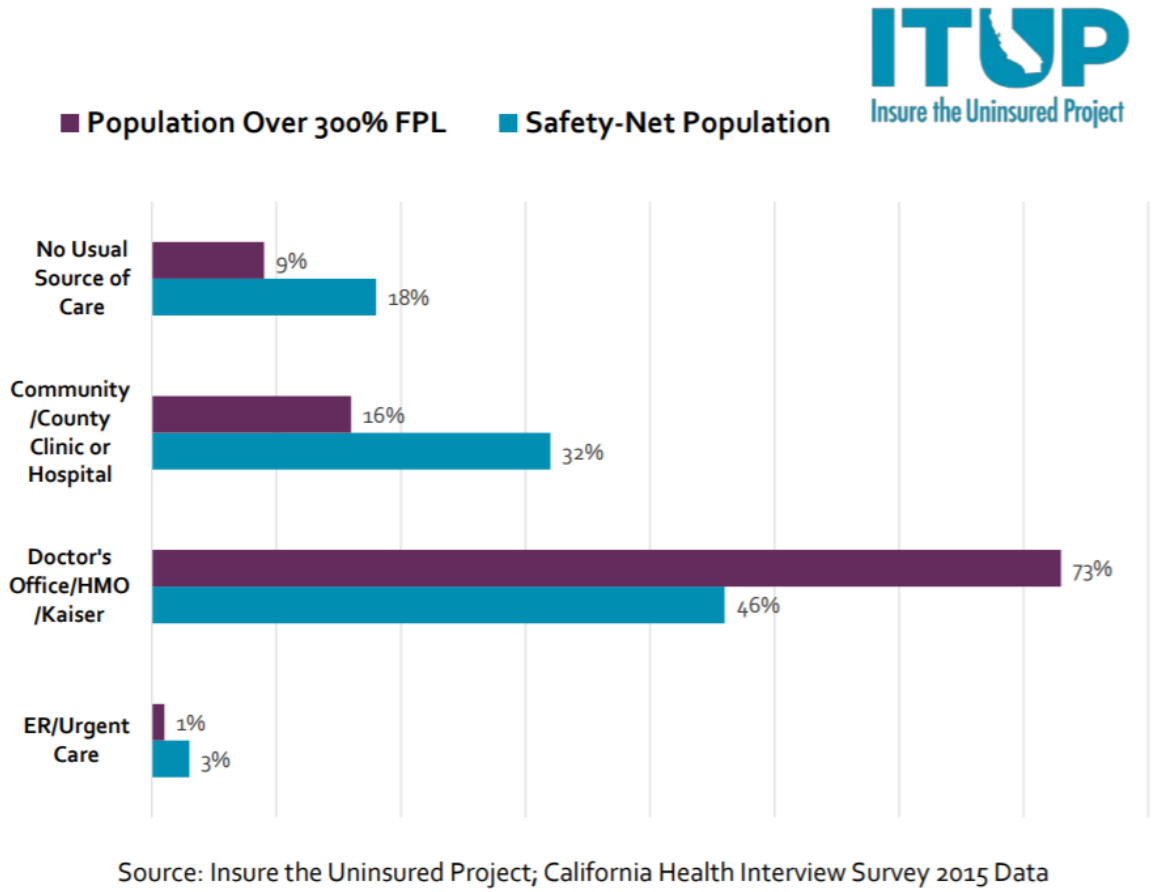
[11] Landon, Bruce, et al. Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09. Health Affairs 31, NO. 12 (2012): 2609–2617.

Sources of care
Californians receive their health care in an array of settings. Sources of coverage influence where Californians obtain health care, as do plan contracting requirements and provider payment arrangements. In particular California's safety net population – those who are uninsured, enrolled in a public coverage program, and with incomes under 300% of Federal Poverty Level -- is more likely to rely on a community or county health clinic, or to lack a usual source of care than are people with household incomes above 300% FPL.[12]



Source: Kelch, Deborah, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

2. CHALLENGES UNDER THE STATUS QUO

Despite California's substantial coverage expansions under the ACA, a number of problems related to health care delivery and finance remain. These include problems with access to care; fragmentation and inefficiency in care delivery; and issues related to high prices and administrative costs.

[12] Gallardo, Elia, "Safety Net Programs, Populations, and Providers," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017.

Remaining uninsured and coverage gaps
People who are uninsured are more likely to forego care and experience worse health outcomes than those with health insurance. In addition, being without health insurance increases the likelihood that households will experience health care-related financial burden. Because the remaining insured are more likely to be low-income and people of color, coverage gaps contribute to disparities in health outcomes and household financial stability across California.[13]

Subgroups of the remaining uninsured face different obstacles to getting and keeping coverage:

- Those ineligible for coverage programs due to immigration status (about 1.8 million Californians) cannot access low-cost options such as Medi-Cal or subsidized coverage through Covered California. Most do not have access to ESI and would find individual coverage outside Covered California unaffordable.
- Those whose family earnings exceed criteria for subsidy eligibility through Covered California (about 550,000 Californians) may nevertheless struggle with affordability when annual premiums cost many thousands of dollars and annual deductibles are as high as $6,300.[14]
- Those eligible for Covered California subsidies but unenrolled (401,000) and may be unaware of their eligibility or may have decided that even subsidized premiums do not fit within their household budgets. Those eligible for Medi-Cal but unenrolled (322,000) may be unaware of their eligibility or may have encountered administrative obstacles. Enrollment requires multiple steps; some people, particularly those who view their lack of coverage as temporary, may not complete the process.

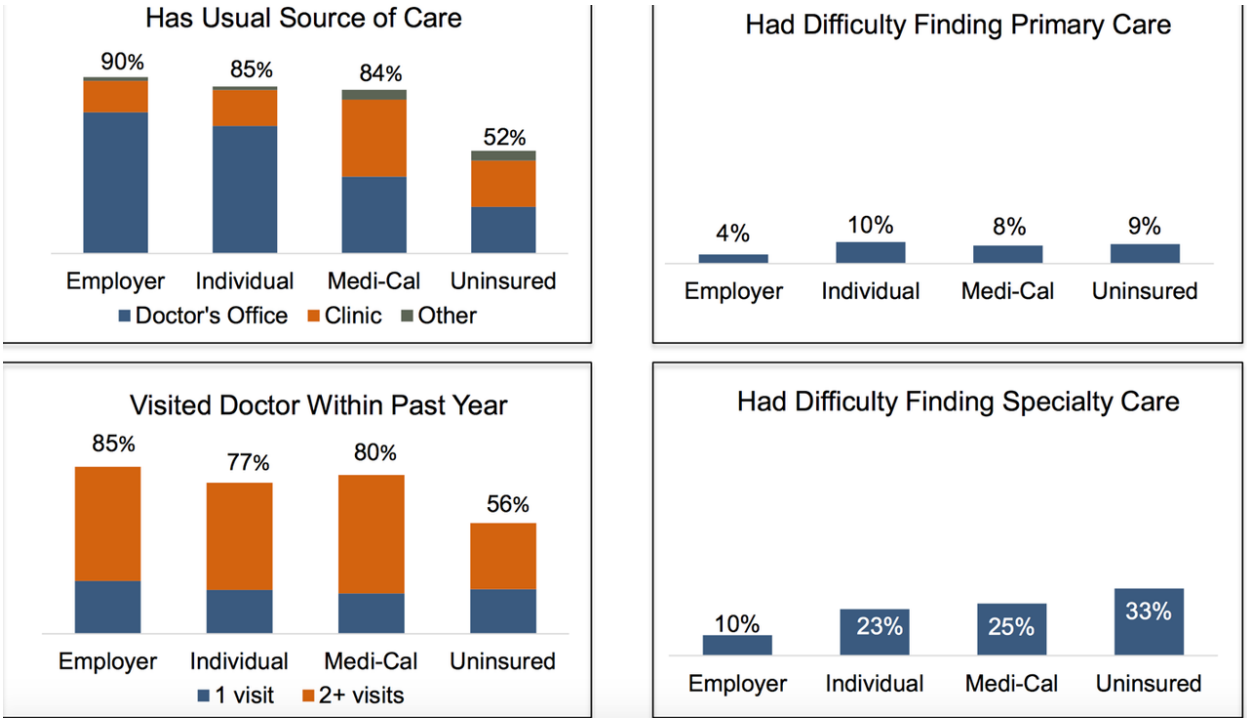
Access challenges
Fragmented health care financing results in variability in individuals' access to health care services. The lack of health insurance coverage is the single largest barrier to care, but even among those with coverage, access varies by an individual's sponsor of coverage, geographic location and health plan.

In general, Californians with employer-sponsored coverage report the fewest barriers to care. Physicians in California are not required to participate in the Medi-Cal program and many do not for the main reason that the payment rate is lower than the payment from Medicare and commercial insurers. Growth of physicians participating in the Medi-Cal program has not kept pace with the growth in the number of beneficiaries following the implementation of the ACA. Nonetheless, those covered by Medi-Cal report similar rates of having a regular source of care as those with coverage in the individual market. In each

[13] Lucia, Laurel, "Health Coverage Gaps in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

[14] 2018 Covered California Patient-Centered Benefit Designs and Medical Cost Shares available at https://www.coveredca.com/PDFs/2018-Health-Benefits-table.pdf

case, this is substantially better than for those who are uninsured, but somewhat lower than for those in employer-sponsored coverage. Medi-Cal beneficiaries and those covered in the individual market are more likely than those with employer-sponsored coverage to report difficulties finding primary care and specialist physicians.



Source: Perrone, Chris, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Even among Californians with the same source of coverage, individuals may experience marked differences in their ability to access medical care. Some of the disparity is related to the availability of physicians who are not distributed equally throughout the state. Rural areas, particularly those in the Central Valley and in the northern part of the state are particularly challenged, with physician-to-population ratios below established federal benchmarks.

The parsing of physicians into health plan networks can also amplify workforce shortages as beneficiaries of plans will typically only have financial coverage for physicians who are within the plan's network.

Statewide, Covered California offers more health plan choice than is available in most states through the federal exchange. Yet within some parts of the state, particularly in more rural areas, Californians may have a choice of only one or two plans through Covered California. In 2018, 66,000 Californians had only one plan option and another 216,000 lived in areas with two plan options. As compared to 2017, the number of Californians with limited (one or two) health plan choices grew over time. This reflects a decision by insurers to leave markets where they are concerned about their ability to be profitable.

	Number of Choices							
	1	2	3	4	5	6	7	Total
Thousands of Enrollees								
2017	0	120	158	189	332	470	203	1,473
2018	66	216	135	382	302	371	0	1473
Distribution of Enrollment								
2017	0%	8%	11%	13%	23%	32%	14%	100%
2018	5%	15%	9%	26%	21%	25%	0%	100%

Monterey, Santa Barbara, San Luis Obispo counties account for ¾'s of all single choice enrollment. San Benito, Mono, Inyo counties are also universally single choice .

Los Angeles county (Regions 15 & 16)

Source: Corlette, Sabrina, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Health insurance is also not uniform. Rules -- regarding covered benefits and services, the procedures that need to be followed to access particular services, and the out-of-pocket costs for beneficiaries -- vary widely across payers and plans. Navigating this variation can be timely and frustrating for patients and physicians.

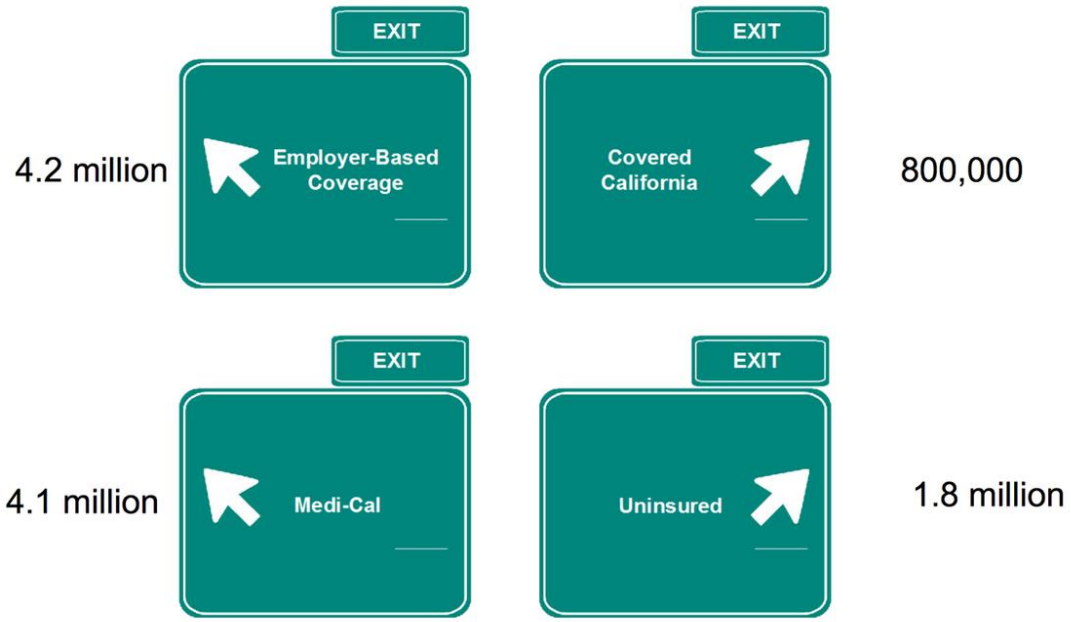
Many health plans restrict access or create financial incentives for patients to use "in network" providers. However, accurate information on which providers are "in network" can be difficult for individuals to determine, when enrolling in a plan or when seeking services. And although California law now limits patients' risk from many surprise bills from out-of-network providers for services delivered at in-network facilities, services delivered in emergency departments are not covered, and employees in self-insured plans regulated by ERISA are not protected.

Physicians and hospitals typically contract with many different insurers, and typically serve patients from multiple channels of coverage (that is, Medicare, Medicare Advantage, employer sponsored insurance, Covered California, and Medi-Cal). As a result, physicians and hospitals must invest substantial resources in personnel to provide the necessary documentation for billing, gaining prior approval, and reporting on quality all of which vary substantially across payers and plans. This administrative burden has not decreased with the growing availability of electronic health records and can be a source of frustration for patients as well as providers.

Further complicating the situation is the upheaval referred to as churn which occurs when individuals have a change in their health insurance status. For example, this may occur due to a change in job status or financial eligibility for public programs. A change in health

insurance coverage can result in a change in health plan, which due to physician network and service differences across plans can disrupt care and relationships between patients and providers. The ACA has not changed the rate of churn but it has shortened the duration of time individuals who lose coverage go without health insurance.

It is estimated that 11 million Californians will change their insurance status in the next two years. The figure below reflects the source of coverage these individuals are expected to exit during that time.



Source: Graves, John, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Churn is associated with a subsequent increase in the use and cost of health care services including a greater number of emergency department visits. Transitions may contribute to a heightened degree of consumer confusion about how to identify in-network providers, the services that are covered, the procedures which need prior approval, and how to fill prescriptions.

Problems associated with care delivery

At the same time that the U.S. health care financing system creates access barriers and administrative inefficiency, there is also ample evidence to suggest that a substantial fraction of the health care we receive is low value, potentially unnecessary and possibly harmful. The National Academy of Medicine estimates that 30% to 40% of care delivered

nationwide may be unnecessary.[15] Unnecessary care not only contributes to increased health care costs for payers and patients but can place patients at risk for complications, which can result in significant morbidity and mortality.

Many factors contribute to quality and safety problems in the delivery system, and unfortunately there are no magic wands that can simply be waved to make these problems disappear. Some analysts point to the influence of for-profit institutions and the entrepreneurial ethos that characterizes much of health care. These are certainly contributing factors, but the hospital industry in the U.S. is dominated by non-profit organizations yet quality and safety problems are nevertheless widespread.

Another contributing factor is a system primarily based on fee-for-service payment. Even when care is delivered by a managed care plan, the plan often pays physicians using fee-for-service. Fee-for-service payment rewards volume of care rather than good health outcomes. The fee schedules used in fee-for-service payment systems also undervalue cognitive services relative to procedural services. In the U.S., approximately two-thirds of physicians are specialists and approximately one-third in primary care, a ratio that is reversed in many Western European countries. The difference between the U.S. and other countries mirrors differences across countries in relative incomes of primary care and specialist physicians. Further, in the U.S. as in other countries, the payment system was designed at a time when caring for acute episodes of illness was the dominant need, and is ill-adapted to an emphasis either on prevention or on the coordinated care needed by people with chronic illnesses.

High prices and administrative costs

In California, as in the rest of the U.S., average prices for most health care services are much higher than in other developed nations. Further, prices vary substantially by type of coverage. Nationally, the prices paid for hospital services for people covered by ESI are approximately 75% higher than the prices paid by Medicare, and Medicaid pays hospitals substantially less than Medicare. The same is true in California, where Medi-Cal's hospital payment rates are similar to the national average.[16]

We note three implications of the wide price differentials. First, if hospitals were paid Medicare rates for all their patients, as has been suggested in some reform proposals, total hospital revenue would decline substantially, causing significant disruption in the hospital industry, with substantial and detrimental effects on access to care. Second, if the prices paid to hospitals for patients covered by employer sponsored insurance were brought somewhat closer to the prices paid by Medicare, there would be substantial opportunities for savings. Hospitals would no doubt be concerned about how they would maintain high

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[15] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, September 2012.

[16] Trish, Erin, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 19, 2018.

quality in the face of a reduction in the rate of growth of revenue, but the limited evidence that exists suggests that hospitals that are heavily dependent on Medicare provide high quality care. Third the substantially lower prices paid by Medi-Cal have contributed to beneficiaries experiencing barriers to care and have inhibited the achievement of one of the original goals of the Medicaid program – namely, the mainstreaming of care for low income people into the same care settings as patients with other forms of coverage.

Price differentials between Medicare and private payers for physician services are smaller than for hospital services. Nationwide, private insurers pay approximately 18% more than Medicare for physician services[17], and there is some evidence to suggest that the differential is smaller in California.[18] Thus, while a proposal to pay Medicare rates for all hospital services would lead to substantial revenue declines and disruption for hospitals, a similar proposal for physician services would not be as disruptive because the differential between private payers and Medicare rates is much smaller for physicians than it is for hospitals.

In sharp contrast, while the Medicare to private payer differential for physician services is substantially smaller than it is for hospital services, the Medicare to Medi-Cal differential for physician services is much larger than it is for hospital services. The Medi-Cal fee schedule pays physicians approximately 40% less for the same services paid by Medicare. Medi-Cal's physician payment rates are among the very lowest among all Medicaid programs nationwide. The relatively low Medi-Cal payment rates contribute to California having one of the lowest rates of participation by physicians in Medicaid programs nationwide.[19] In California, approximately 60% of physicians participate in the program.[20] As a result in many California communities Federally Qualified Health Centers and 'look alike clinics' [21] furnish a high proportion of primary care services to Medi-Cal beneficiaries.

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[17] Biener, Adam and Selden, Thomas. "Public and Private Payments for Physician Office Visits." Health Affairs, December, 2017 available at (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0749).

[18] Ginsburg, Paul. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Health Systems Change Research Brief, #16, November, 2010 available at (http://www.hschange.org/CONTENT/1162/).

[19] Decker, Sandra, "Acceptance of New Medicaid Patients by Primary Care Physicians and Experiences with Physician Availability among Children on Medicaid or the Children's Health Insurance Program," Health Serv Res. 2015 Oct; 50(5): 1508–1527.

[20] Coffman, Janet, "Physician Participation in Medi-Cal: Is Supply Meeting Demand?" California Health Care Foundation, June 28, 2017 available at https://www.chcf.org/publication/physician-participation-in-medi-cal-is-supply-meeting-demand/

[21] Federally Qualified Health Centers (FQHCs) and some other county operated ambulatory care sites designated by Medi-Cal as "look alike clinics" receive a higher rate of Med-Cal reimbursement than what is paid to office-based physicians. When these FQHCs and look alike clinics furnish services as a part of a Medi-Cal managed care contract, they receive additional payments ("wrap around") from the state Medi-Cal program that maintain a substantially higher payment rate than what is provided for similar services when

High prices paid to hospitals for patients covered by ESI reflect the lack of a competitive market for hospital services in most areas of the state. Consolidation in the hospital industry has contributed to a lack of competition – in some areas of the state one or two large hospital systems account for a large fraction of the available hospital beds, and these hospital systems are in a very strong bargaining position when negotiating with private insurers. Using the Herfindal-Hirschman Index (HHI), an index measuring market concentration that is used by the Federal Trade Commission and the Department of Justice in evaluating market competition, virtually all hospital market areas in California are highly concentrated, and most markets have become more concentrated over time.

But concentration in the hospital industry is not the only factor leading to relatively high prices. Unlike many other industries, where the goods being traded are commodities with little differentiation in competing products across firms, many hospitals and some medical groups have been able to establish themselves as 'must have' providers. An insurer that did not include a well-regarded teaching hospital in its network might have a very hard time selling its product, and this knowledge gives the hospital substantial negotiating leverage, even in a market with multiple competing hospitals.

Relatively high prices reflect, in part, relatively high costs of producing care, and part of those high costs reflect the high costs borne by providers in collecting money from private insurers, Medicare, and Medi-Cal.[22] Billing and insurance related costs in California have been estimated at 13.9% of the total costs of physician practices and at 6.6%-10.8% of the cost of hospital services.[23] In a simplified system in which hospitals and physicians could employ fewer people whose job it was to collect money from third party payers, prices could be lower without any reduction in the bottom line for hospitals, or in the net income of physicians. In addition, the cost of health insurance includes the administrative costs and profits of health insurers, estimated to average approximately 7.9% of premium costs.[24]

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furnished through physicians' offices. See Wunsch, Bobbie and Reilly, Tim, "Medi-Cal Managed Care Plans and Safety Net Clinics Under the ACA," December 2015 available at https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalMgdCarePlansSafetyNet.pdf

[22] Larry Levitt, "The Cost of Administering Health Care" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

[23] Kahn James et al. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Aff (Millwood). 2005 Nov-Dec;24(6):1629-39.

[24] Kamal Rabah and Cox Cynthia. "How Has U.S. Spending on Healthcare Changed Over Time." Peterson-Kaiser Health System Tracker available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/?post_types=chart_collection#item-per-capita-basis-health-spending-grown-substantially_2017

In sum, health care in California relies on a diverse patchwork of funding sources and delivery arrangements. Consumers face challenges regarding access to care, navigation of coverage, and affordability. Accountability is diffuse. Health outcomes and system costs are neither well-understood nor well-managed.

3. IMPROVING HEALTH CARE AND COVERAGE UNDER TODAY'S FINANCING STRUCTURE

As a part of the Select Committee hearings, presenters described a variety of policy approaches that have been tried or considered in other countries, in other states, and in California to address challenges in achieving universal coverage, making health care more affordable and improving access to care, while also making our multi-payer system less fragmented and more transparent. This section describes these approaches and the rationale for them as a part of an incremental process of improvement. Section 4 will address ways to achieve these goals via a more fundamental change to today's fragmented financing and patchwork methods which could result in a more equitable and less complex health care system.

Address remaining coverage gaps

California embraced and effectively implemented new coverage opportunities under the Affordable Care Act, reducing the state's uninsured population to about 3 million. People are uninsured for a variety of reasons: ineligibility for public financial assistance due to immigration status; inability to afford coverage; uncertainty about the value of obtaining health insurance, particularly if insurance products have high deductibles or other cost-sharing requirements; and the complexity of getting and keeping coverage, particularly across changes in life circumstances. These causes are not mutually exclusive. Policy solutions to expand coverage to California's remaining uninsured aim to address one or more of these challenges.

Nearly 60% of California's remaining uninsured population is undocumented, so expanding eligibility for Medi-Cal and premium subsidies to this population would likely make substantial inroads toward universal coverage. Undocumented residents are specifically excluded from eligibility for Medicaid and for federal premium subsidies and cost-sharing assistance under the ACA. Therefore, a state proposal to extend Medi-Cal eligibility to undocumented residents, or to provide subsidies to assist this population in affording coverage, would need to be financed solely with state funds.[25] Implementing this proposal would be relatively straightforward because it would build on California's recent experience expanding coverage to undocumented children through the "Health4AllKids" campaign.

[25] Legislative Analyst's Office, "Financing Considerations for Potential State Healthy Policy Changes," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, February 5, 2018.

Reduce affordability barriers
Difficulty affording premiums and concerns about coverage comprehensiveness are factors for many Californians who remain uninsured. Some population segments face particular affordability challenges. For example, people affected by the ACA's so-called "family glitch" are eligible for employer-sponsored health insurance that falls under the ACA affordability threshold for them, yet their employers contribute little or nothing toward family premiums. Under the ACA, no premium subsidies are available for anyone in the family, thus dependents face high premiums and may remain uninsured. For others, health status, age, or residence within a region with especially high health care costs may leave consumers responsible for costs that make up a substantial portion of their income. Under the ACA, people over 400% of the federal poverty level (FPL) receive no affordability assistance; one proposal would be to provide state-funded subsidies to assure that people in such households need spend no more than 10% of their income on premiums. People between 138% and 400% FPL are eligible for ACA subsidies but some still find premiums and out-of-pocket costs a burden and may forego coverage as a result. The state could fund additional subsidies to reduce the share of income people are expected to pay toward subsidies across the entire sliding scale range.

Affordability could also be tackled by moderating underlying premiums. For example, the state could seek to moderate the cost of health care inputs or the prices charged for health care services. One approach to this would be to limit out-of-network hospital prices. As discussed above, many hospitals have negotiated much higher prices for people covered by employer-sponsored insurance than the prices paid by Medicare for similar services. The nationwide average mark-up over Medicare prices in 2012 was 72%, and it seems likely that the differential in some markets in California is considerably larger. For a variety of reasons, insurers have not had enough leverage in their negotiations with many hospitals to limit the prices they pay to anything close to the prices that Medicare pays.

One option that was raised at the hearings to improve the bargaining leverage of insurers is to limit the prices that hospitals could receive for out-of-network services to some percentage (e.g., 150%) of the amount that would be paid by Medicare for similar services. [26] If the California Legislature enacted such a proposal, it is unlikely that hospitals would be able to negotiate in-network rates that were higher than the out-of-network cap.

If the upper limit were set quite high the proposal would only affect hospitals that have been able to negotiate extremely high prices. A much lower cap would result in steep declines in hospital revenues, and be quite disruptive to the industry. Regardless of where the cap was set, regulations would be needed to specify how the comparison of private prices to Medicare prices was to be calculated, and phase-in periods should be considered.

[26] Laurence Baker "Price Variations and Consolidation" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

A somewhat similar proposal was enacted for physician services by the California Legislature in 2016.[27] However, the legislation on physician services was primarily intended to limit 'surprise billing' from out-of-network providers at in-network hospitals. Legislation on hospital services would be intended to indirectly limit the prices that hospitals could negotiate for in-network services.

Another policy option that could help to make health insurance coverage affordable is the use of a mandate for coverage. The federal health insurance mandate as a part of the ACA was intended to encourage healthy, not just sick individuals, to pursue coverage. Having healthy individuals in the insurance pool lowers premiums relative to what they would be if just sick individuals were enrolled. With the 2019 elimination of federal penalties for not maintaining creditable coverage, the state may want to consider imposing its own penalties on people who go without health insurance. The state could consider a variant of a proposal being discussed in Maryland, in which penalty payments made by uninsured individuals are essentially put in escrow for them, to be made available for the purchase of insurance in the coming year.[28]

Improve access and continuity of care

One way insurers control costs is by limiting the network of providers, hospitals and physicians, available to the members of their health plan. By limiting the providers who can be a part of their plans, the insurers have leverage to negotiate lower rates of payment to these providers. Health plans then compete for consumers within different segments of the market – employer based coverage, Medicare, Medicaid and the individual market- in part related to differences in their networks. An insurer may or may not use the same physician network across all payers.

Insurers may avoid competing in certain communities if they perceive that the number or the way the physicians or hospitals are organized will limit their ability to negotiate payment rates which will allow them to be profitable. This issue has garnered significant attention in the individual market where certain parts of the country, particularly rural areas which typically have fewer physicians per population and fewer competing hospitals, have struggled to create competition among health plans. Most Californians enjoy choice of

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[27] AB 72, effective 7/1/17, requires that if a patient receives non-emergency services at an in-network hospital, the payment received by any out-of-network physicians providing services to that patient is limited to 125% of the Medicare rate. The rationale for that legislation is to avoid surprise billing, in which a patient chooses an in-network hospital, but is confronted by high priced out-of-network bills. The effect, however, is likely to be similar to the effect of the hospital pricing proposal discussed above. It seems unlikely that physicians would be able to negotiate prices much higher than 125% of Medicare for services delivered to hospital inpatients if they are limited to 125% of Medicare if they are out-of-network.

[28] McDaniels, Andrea, "General Assembly weighs bill to require Marylanders to buy health insurance," Baltimore Sun, February 20, 2018 available at http://www.baltimoresun.com/health/bs-hs-individual-mandate-20180216-story.html.

two or more plans, but in some parts of the central coast and in some rural areas in northern California and the southern central valley there is only one choice.[29]

One proposed solution to the problem of limited health plan competition in the individual market is the establishment of a "public option" as an alternative to existing private health plans. A public option could be a plan or a set of plans across the state. Many details regarding its structure, financing and governance remain to be resolved.[30] Offering a public option through Covered California would enable eligible consumers to use federal subsidies to support its purchase, but to do so, a public option would have to meet ACA Qualified Health Plan (QHP) requirements.

A public option offers several potential benefits to consumers. First, it guarantees that consumers will have a choice of at least one plan in an area even if private insurers choose not to enter the market. Second, a public plan may be less expensive to consumers than private insurance offerings since a public plan does not need to generate a profit and may be able to contract providers at lower reimbursement rates. Third, to the extent a public option includes providers who are not available through other insurers, it can broaden the physicians and hospitals available to consumers.

In Medi-Cal, health plan public options were created at the county level beginning in the 1990s using "local initiatives" which relied to a greater extent than private plans do on safety-net providers. Creating a public option in the individual market might similarly be able to expand the availability of providers by making access to safety net providers a choice for consumers via Covered California. If the public option utilized the same or a similar network of physicians for Medi-Cal beneficiaries as it did through a Covered California product, people who churn between Covered California and Medi-Cal would be less likely to experience a disruption in patient-provider relationships.

Medicaid as a public option is distinct from a Medicaid expansion. A Medicaid expansion or what is sometimes referred to as a "buy in" enables individuals to gain access to coverage through the Medicaid program but it does not expand the choice of plans for those in the individual market. No state has used its Medicaid program to create a public option but a few, including Nevada and Minnesota, are exploring this policy approach.
The regulatory and financial requirements imposed on QHPs in Covered California differ from those required for Medi-Cal participation. This creates a barrier to entry for public Medi-Cal plans interested and able to expand into the individual market. Medi-Cal contracts with a public plan in 36 of California's 58 counties, but currently only one, LA Care, is available as a choice through Covered California and it is only available in Los Angeles.

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[29] Semanskee, Ashley, et al., "Insurer Participation on ACA Marketplaces, 2014-2018," Kaiser Family Foundation: November 10, 2017; Corlette, Sabrina, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

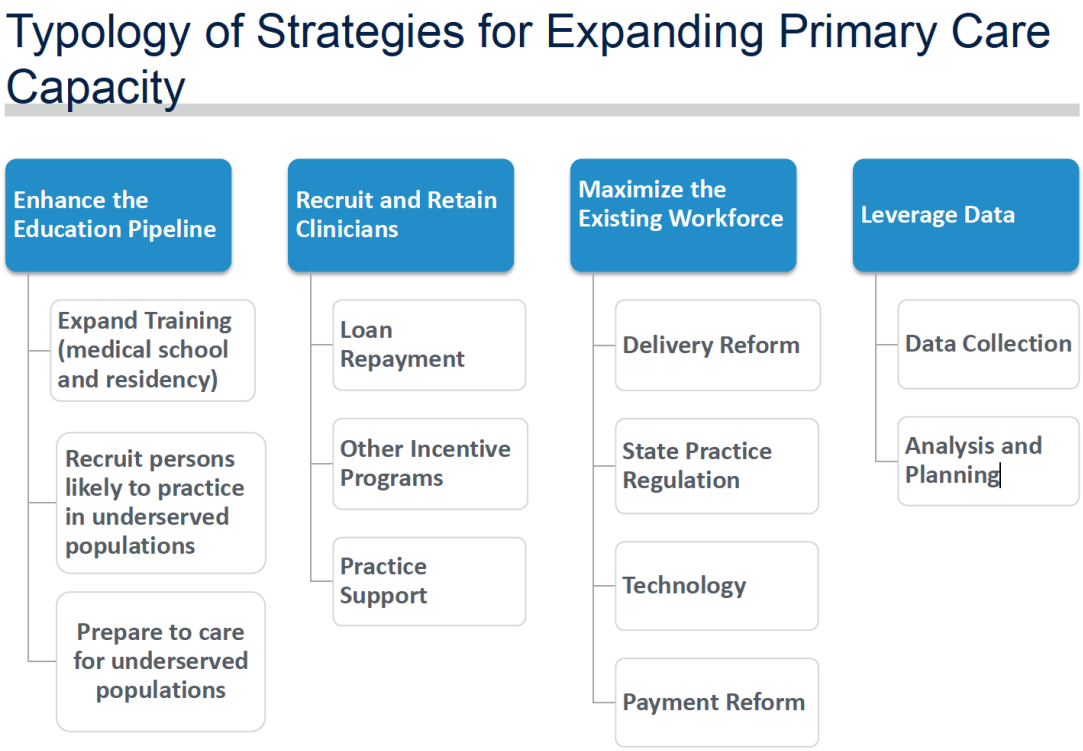
[30] Insure the Uninsured Project, "Exploring Public Options in California: Key Issues and Considerations," February 2018.

Helping Medi-Cal's public plans to expand their mission to serve as a public option in the individual market could potentially expand competition and access to care in some parts of California. But there are risks to this strategy as well. Policymakers would need to carefully consider how best to assist Medi-Cal plans to compete in Covered California in a way that does not undermine healthy competition among other insurers in the exchange. Furthermore, policymakers would want to ensure that if Medi-Cal plans were used in this expanded role, their ability to serve the ongoing needs of Medi-Cal beneficiaries would not be undermined.

Even if California were to expand health plan competition through a public option in the individual market, additional steps would be needed to overcome physician workforce shortages in underserved areas. Some of this might be addressed by producing more physicians, but this is a lengthy and expensive process. There is also no guarantee at the end of that training that these newly minted clinicians would enter primary care or work in a rural area. Nurse practitioners and other mid-level clinicians may be a part of the solution but the same issues arise in terms of a long training period and a disincentive to enter into primary care or to work in rural areas.

To overcome workforce shortages California needs a comprehensive strategy, utilizing incentives to overcome the market forces that discourage physicians and other clinicians from specializing in primary care and practicing in underserved areas. Such an approach could include incentives (1) to ensure that the physician training pipeline includes individuals who are interested and prepared for these roles, (2) to reduce the financial and practice barriers for individuals to enter in these roles, and (3) through physician payment policies which can sustain them in these roles over time.[31]

[31] Coffman, Janet, "Access to Physicians in California" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.



Source: Coffman, Janet, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

California should consider additional investments in each of these areas to address access barriers in underserved areas, but the most glaring shortcoming is in its Medi-Cal physician payment policy. Medi-Cal is the most significant payer in underserved communities, especially in rural areas where Medi-Cal is an even more prevalent payer than in urban areas.[32]

The state sets physician payment rates in Medi-Cal using a fee schedule. California is among the very lowest payers in the nation. Medi-Cal managed care plans are not bound by the fee schedule. Data are lacking on physician payment rates in Medi-Cal managed care. They are assumed to reflect what is paid in Medi-Cal fee-for-service but greater transparency of what is paid would inform future policy decision-making.

As with other Medi-Cal expenditures, increases in physician payments are paid in part by the federal government. With approval through a state plan amendment, the federal government provides 50% of the cost of any physician payment increase for services provided to beneficiary groups who were eligible for Medi-Cal prior to the passage of the

[32] Foutz, Julia et al. The Role of Medicaid in Rural America available at https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

ACA and a minimum of 90% for physician services for those who became eligible under the ACA (e.g., childless adults).

In January of this year, California received approval from the federal government for a state plan to implement a one-year supplemental payment increase for a limited number of physician services including office visits and psychiatric visits. The supplemental payments range from $5 to $50 per claim and are being paid retrospectively dating back to July 1, 2017. The state plans to assess the impact of the supplemental payments on access to care to determine if additional payment changes are warranted.[33] As a part of the ACA, a provision of two years' duration (2013-2014) required states to increase primary care physician payment rates in Medicaid to at least those of Medicare. A study in ten states (not including California) found that this policy was associated with increases in Medicaid beneficiaries' access to care but that delays in its implementation blunted its impact.[34]

Given the size and scale of California's health care workforce challenges, the state should also utilize technology to leverage available personnel. Telehealth is a rapidly developing area which holds much promise as a means to quickly and efficiently address workforce shortages. It includes a wide range of digital communication strategies such as text messaging, email, audio-video interactions from home or a health care setting between patients and practitioners, and consultative services between primary care and specialty practitioners on behalf of a patient. There are structural resources needed to make this type of non-face-to-face communication possible, but the growing presence of computers and mobile devices with all of these communication capabilities makes this a diminishing component of what limits the use of telehealth as a strategy to improve access to care in underserved areas. Regulatory and payment policies are what are needed to accelerate this service approach.

Regulatory policies are also needed to ensure that the communication is secure to protect the privacy of the patient in a way which does not also make it overly cumbersome for either the patient or the practitioner to use telehealth. There are also more nuanced issues having to do with how care delivered via telehealth is counted toward network adequacy standards. Plans might be more likely to accelerate the use of telehealth if they were able to receive credit for its use in how the state regulatory agencies judge the adequacy of their network. California can encourage greater use of telehealth by reimbursing for virtual visits and including them in assessments made of network adequacy, but it should do this in a way which does not undermine the ability of patients to see practitioners when that is appropriate.

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[33] California Hospital Association. Medi-Cal Supplemental Payments for Selected Physician Services Approved available at https://www.calhospital.org/cha-news-article/medi-cal-supplemental-payments-selected-physician-services-approved

[34] Polsky Daniel et al. Appointment Availability after Increases in Payments for Primary Care N Engl J Med 2015; 372:537-545

Many clinicians have been slow to embrace telehealth in part because most services delivered through these methods are not directly reimbursed. Payers have been cautious in establishing payment codes for non-face-to-face delivery of services through telehealth due to concern that it could substantially increase total spending. In settings where clinicians are paid either a salary or based on capitation there has been more rapid adoption of telehealth. This suggests that policies which encourage the use of alternative payment methods could encourage widespread adoption of telehealth into clinical care.

Reduce fragmentation and increase transparency
In a scenario in which Medicare, Medi-Cal, employer sponsored insurance, and Covered California continue as the primary channels through which Californians obtain health insurance, testimony presented at the hearings provided suggestions about how California could streamline consumer experience and improve market performance. A brief synopsis of some of these suggestions follows.

Reduce fragmentation: The multiplicity of coverage channels adds costs and confusion for consumers, providers, and insurers. One proposal to attempt to reduce costs and confusion would be to require all insured products sold in California in the employer sponsored insurance market to offer the cost sharing parameters and covered benefits of one of the plans offered in Covered California.[35] Under this proposal, all fully insured products sold in the ESI market in California would be required to be either a bronze, silver, gold, or platinum plan, and the cost-sharing parameters at each metal level would be required to be the cost-sharing parameters for the applicable metal level as determined by Covered California. For example, silver plans have a deductible of $2,500, and a primary care visit office copayment of $35, with the first three visits not subject to the deductible. This approach is similar to the approaches taken in the Netherlands, Germany, and most other countries that rely on private health insurers to deliver benefits, and was mentioned as a possibility for California in testimony to the committee.[36]

One advantage of this proposal is that it would simplify the choice process for consumers – when comparing among insured products, consumers would not need to pay attention to teasing out differences in copayment and deductible structures offered by competing insurers. As a result, competition on price and quality would be strengthened – insurers would be prevented from competing by trying to design a benefit package that would be unattractive to high risk members. Administrative costs for insurers should decrease at

[35] Although it might in principle be useful to standardize products in all market segments, a change in federal law would be required to apply this principle to Medicare offerings. Further, the low-income people who are covered by Medi-Cal would find even the relatively low copayments required under platinum plans a substantial financial barrier to accessing care.

[36] Robin Osborn "Where the US Health Care System Stands Compared to Other Industrialized Countries" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 24, 2017.

least marginally, since the number of benefit packages they would need to administer would be greatly reduced.

This proposal also has disadvantages. Some employers may think that there are benefits to the particular configuration of copayments and deductibles they are purchasing, and that being forced into one (or more) of the standard bronze, silver, gold, platinum offerings will reduce the value of their offerings to employees. Other employers may have implemented, or be planning to implement, innovative benefit structures such as reference pricing, and be concerned that there will be less beneficial innovation in copayment structures under the proposed standardization than there would be under the status quo. However, there is little evidence that the variation among employers in copayment and deductible structures has resulted in gains to consumers, and similarly, limited evidence that innovations in benefit packages in ESI have led to meaningful improvements in cost or quality. Further, Covered California has created a robust process for updating its benefit package, gathering input from a wide variety of stakeholders, and, ultimately, requiring approval from the publicly appointed Covered California board.

A significant limitation of this proposal is its limited scope. The standard Covered California benefit packages are already required in the individual and small group (< 100 employees) market. The proposal would extend the standardization requirement to the fully insured segment of the large group market, but federal ERISA statute would prevent California from imposing a similar requirement on self-insured plans. However, many large employers offer both fully insured and self-insured plans, and some attempt to offer the same cost sharing in both types of plans. If forced to offer standardized bronze, silver, gold, or platinum cost sharing in their fully insured plans, some of these employers might move to standardization in their self-insured plans as well, potentially extending the effect of the requirement beyond fully insured plans.

Increase transparency: Lack of price transparency differentiates health care from most other goods and services in our economy. As noted by one of the Committee co-chairs, when he takes his dog to a veterinarian, he is presented with a price list, but similar price lists in health care generally do not exist. As discussed at the January 17, 2018 hearing, the Legislature could potentially require providers to post price lists of some sort.[37] A provision requiring price lists to be posted was included in the ACA, although the Department of Health and Human Services did not issue regulations to implement the requirement.

However, it is not clear how meaningful or helpful price lists would be. If the posted prices simply reflected list prices that are charged, as opposed to the contracted prices negotiated by insurers that are actually paid, they would not be of much use to patients because they would not reflect the prices that insured patients would be required to pay. If the prices reflected average contracted prices, they would be somewhat more helpful, but still would

[37] Laurence Baker "Price Variations and Consolidation" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

not reflect the amount that any individual patient could expect to pay, since contracted rates typically vary across insurers.

More importantly, it is not clear that price information, in the absence of useful quality information, would either encourage patients to choose lower price providers or result in downward pressure on prices. Some patients will assume that higher prices are associated with better quality, and may gravitate towards higher priced providers. Further, if prices are publicly available, providers who have negotiated prices on the lower end of the spectrum may, after observing the higher prices that their competitors have negotiated, attempt to hold out for higher prices in the next round of negotiations.

One proposal that might put some downward pressure on negotiated prices would be a requirement that hospitals and medium to large-sized physician groups (e.g., groups with at least 25 physicians) make information available on their average negotiated prices for patients covered by employer sponsored insurance, expressed as a percentage of the prices paid by Medicare. As discussed above, it appears that the mark-up above Medicare prices for inpatient hospital services is quite large for some hospitals in the state. Public scrutiny of very high prices might lead to community-wide pressure on outlier hospitals and medical groups to extract less of a premium above Medicare prices in subsequent negotiations (although might also, as discussed above, encourage relatively low-priced providers to hold out for higher prices). If this proposal were adopted, regulations would be needed to specify how the price comparisons were to be calculated.

An additional means to increase transparency would be to establish an All-Payer Claims Data Base (APCD). The Massachusetts Health Policy Commission (HPC) makes extensive use of the information collected by the Massachusetts All-Payer Claims Database (APCD) to monitor changes in utilization and price at the health system level. The HPC uses the data from the APCD to determine whether each health system in the state is adhering to spending targets. Similarly, an APCD in California would provide useful information to support a variety of efforts at improving the quality and efficiency of care, and would be a useful building block in improving the ability to successfully implement a system based on unified public financing. An APCD in California would expand on the hospital discharge data that is currently collected by OSHPD. However, the OSHPD data are limited to inpatient hospital discharges, and do not contain information on allowed or paid amounts.[38]

Additional approaches

<u>More closely scrutinize proposed mergers and acquisitions:</u> Consolidation has increased hospitals' negotiating leverage, and contributed to high prices. Increased oversight of

[38] In 2016 the Supreme Court ruled that a Vermont requirement on self-insured plans to submit data to the Vermont APCD was preempted by the ERISA statute. Any proposal to establish an APCD in California would need to work within the restrictions created by that decision.

proposed hospital mergers would likely have at least a small effect in restraining future price growth. As described in the December 11 hearing, the Massachusetts Health Policy Commission analyzes proposed mergers and acquisitions in Massachusetts, and the Massachusetts Attorney General seriously considers the HPC's evaluation of the likely effects of proposed consolidation when deciding whether to challenge a proposed action. California could consider a similar model.

Greater scrutiny of proposed mergers and acquisitions would likely be helpful, but would likely also be of limited utility. The market for hospital care in most regions of California is already highly concentrated – the horse is already out of the barn. Further, as discussed above, concentration is only one factor that gives hospitals the leverage to negotiate high prices.

All-Payer Rate Setting: An alternative approach to limiting prices would be to implement some version of all-payer rate setting. Testimony at the December 11 hearing described the all-payer hospital rate setting system used in Maryland in detail, and a number of other people who testified at the hearings suggested that an option like this could be considered for California. Under the Maryland model, Medicare, Medicaid, and ESI all pay the same rate for hospital services. An important component of generating support for this system within the state is that Medicare payments to hospitals are higher, on a per-admission basis, than would be paid under the Diagnosis Related Group (DRG) system which Medicare uses to determine hospital payments in the rest of the country.

It seems unlikely that the Maryland all-payer model would be feasible in California. First, the federal government is unlikely to increase the amount that Medicare pays for hospital services, and, as discussed above, if ESI rates were to be reduced to Medicare rates, the revenue loss to hospitals would be catastrophic. Further, Medi-Cal rates are substantially lower than Medicare rates, and the state is not likely to be interested in increasing Medi-Cal hospital rates to Medicare levels. A variant of the Maryland model, in which all payers use the same unit of payment (e.g., DRGs) but payers pay different multiples of a base rate, could be considered for California. However, this model would work at cross purposes with the emphasis in California, both from Medi-Cal and private insurers, on selective contracting with hospitals, and it is not clear that it would bring benefits that outweigh the disruption it would entail. Proposals to extend Maryland-style all-payer rate setting to the California context need more development before they could be fully vetted.

California could also consider a global budgeting approach limited to hospitals in rural areas of the state, similar to the demonstration waiver obtained by the Commonwealth of Pennsylvania in an attempt to shore up the financing of rural hospitals and to provide incentives for them to invest in moving care out of the inpatient setting.[39]

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[39] Sule Calikoglu Gerovich "A New Hospital's Payment Model: Maryland's Global Budgeting System" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, December 11, 2017. Additional information on the Pennsylvania Rural Health Model, as described by CMS available at https://innovation.cms.gov/initiatives/pa-rural-health-model/.

Consolidated public program purchasing: Consolidated purchasing for pharmaceuticals or other services, particularly across Medi-Cal, CalPERS, and Covered California, was mentioned at one hearing as a potential approach to attempt to reduce prices and spending. Given the very large number of people covered by Medi-Cal, it seems unlikely that adding the relatively smaller number of CalPERS and Covered California members to the Medi-Cal purchasing pool would provide much by way of benefits to Medi-Cal. And while such an approach might, in theory, provide some benefit to CalPERS or Covered California, the legal, technical, and political difficulties in attempting to consolidate purchasing across these agencies seem likely to outweigh any potential benefits that such consolidation might create.[40]

Reduce health plan administrative costs and profits

A variety of proposals have been suggested to limit the amount of money that health insurers can spend on administrative costs, including further restricting the fraction of premium revenue that insurers can spend on activities other than medical care (that is, tightening the Medical Loss Ratio (MLR) requirements, regulation of health plan profits, and limiting the compensation that can be earned by health plan executives. Any such proposals would need further development before they could be meaningfully evaluated.

In sum, a wide array of approaches could be pursued to address various shortcoming and opportunities within California's existing health care system. These approaches are incremental by design and differ in terms of the policy goals they aim to advance. Each brings associated tradeoffs and uncertainties.

4. IMPROVING CALIFORNIA'S HEALTH CARE SYSTEM VIA A UNIFIED PUBLICLY FINANCED APPROACH

The current patchwork approach to financing health insurance and health care is accompanied by uneven access and, in many cases, inefficient delivery of services. Under the status quo, funds follow individuals and are constrained by disparate rules based on the payer or program from which they originate. Highly fragmented funding adds administrative burden and potential confusion for consumer and providers throughout the system.

An alternative would be to establish a unified, publicly financed approach that

- Assures coverage for all state residents;

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[40] Bailit M and Burns M. "All Together Now: Coordinating California's Public Sector Health Care Purchasing" available at https://www.chcf.org/publication/all-together-now-coordinating-californias-public-sector-health-care-purchasing/

- Pools funds for health coverage across Medicare, Medi-Cal, and other major sources of financing;
- Dramatically reduces or eliminates variations in eligibility, benefits and payments.

A unified publicly financed approach to health care coverage would eliminate the differences between Medicare, Medi-Cal, and employer sponsored insurance in consumer cost-sharing and benefits. A unified publicly financed approach would reduce the considerable administrative burden that today's financing arrangements impose on purchasers, consumers and providers. Taken together, these changes would create a more equitable health care system. It would likely increase efficiency and produce better health outcomes, although these results would depend on how well the system was managed and on mechanisms of accountability. To accomplish such a sweeping transition would require substantial and unprecedented changes in federal and state law as well as decisions regarding many design parameters.

One such proposal would create the Healthy California Program to "provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state." Necessary waivers and permissions would be sought; financing provisions are not spelled out in the bill but would be developed. The legislation would not take effect until the California Secretary of Health and Human Services notifies the Senate and the Assembly that the Healthy California Trust Fund has the revenues to fund implementation costs.[41]

Other states have sought to establish a single payer system. Vermont pursued a single payer approach that went further than most yet was never implemented. Vermont's exploratory effort began in 2010, followed by 2011 legislation to establish Green Mountain Care, a government-financed system to replace most health insurance in Vermont.[42] As planning efforts evolved, it became clear that Medicare, Medicaid, health plans for veterans and military personnel, and plans serving workers at out-of-state companies would continue to operate in Vermont even after the implementation of Green Mountain Care.[43] In 2014, after serious planning efforts, Governor Peter Shumlin withdrew the plan citing "the limitations of state-based financing, the limitations of federal law, the limitations of our tax capacity, and the sensitivity of our economy."[44]

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[41] SB 562, The Healthy California Act (2017-18), described at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB562

[42] VerValin, Joe, "The Rise and Fall of Vermont's Single Payer Plan," Cornell Policy Review, July 13, 2017.

[43] Ollove, Michael, "Vermont Is 'Single-Payer' Trailblazer," Pew Charitable Trusts: Stateline, August 7, 2014.

[44] McDonough, John, "The Demise of Vermont's Single Payer Plan," N Engl J Med 372: 1584-1585 (April 23, 2015).

The history of California health reform and single payer proposals is described elsewhere.[45] Questions and issues that would confront California in any comprehensive re-organization of health care financing have also been explored.[46] The purpose of this discussion is to review, within the current context, California's opportunities and challenges with respect to consolidated financing for health care.

Considerations related to integrating multiple payers
The public and private funding streams that support health care and coverage today are accompanied by many requirements not readily eliminated nor easily reconciled. Pooling funds to pay for health care for all residents depends on navigating those requirements and either renegotiating their terms or working around them.

Federal funding and permissions: The federal government is the largest source of funds for health care in California today.[47] Federal funds flow via:

- Medicare, the federal program that serves most people aged 65 and over and certain people with disabilities;
- Medi-Cal -- California's Medicaid program-- the jointly funded state-federal program available to people who meet income eligibility criteria;
- The provision of subsidies under the Affordable Care Act for income-eligible individuals and families who obtain insurance through Covered California;
- The exclusion from federal taxable income of employer and employee premiums for employer-sponsored health insurance; and
- A variety of additional federally funded coverage programs such as Tricare (for the dependents of active duty military and military retirees).

To redirect funds from these sources to a unified state-based pool would require federal action. For example:

- Because existing federal law does not grant the federal Secretary of Health and Human Services authority to redirect Medicare's funding streams or trust fund dollars to states, bringing Medicare funds into a unified state-based public financing pool would require federal statutory changes.[48]

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[45] Dimmitt, Michael, "Ninety Years of Health Insurance Reform Efforts in California," *California Agencies* Paper 316 (California State Library: 2007).

[46] Philip, Susan and Mulkey, Marian, "Key Questions When Considering a State-Based, Single-Payer System in California," available at https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/

[47] Sorensen, Andrea et al. "Public Funds Account for Over 70 Percent of Health Care Spending in California," (UCLA Center of Health Policy Research, August 2016) available at http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/PublicSharePB_FINAL_8-31-16.pdf

[48] Cubanski, Juliette, "Federal Law Considerations and Medicare," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

- Federal Medicaid requirements tie federal matching funds to the services provided to Medicaid-enrolled individuals. To claim federal Medicaid funds for use through a unified financing pool, California would either need a change in federal law, or would have to continue to track eligibility and expenditures related to individuals who meet complex eligibility criteria. Some steps required for continued compliance with federal Medicaid rules might well be in conflict with the simplicity and equity principles of unified public health care finance in California.[49]
- Subsidies through Covered California might be redirected to a unified financing pool under existing Section 1332 waiver authority, if ACA statutory guardrails including federal deficit neutrality are met.[50]
- If California moved away from employer-based financing of health insurance, and wages were increased in California to compensate for the elimination of employer contributions to health care, federal income tax revenues would increase. To capture the resources associated with the current federal tax subsidy for employer sponsored insurance, Congress would need to pass legislation providing for a direct payment to California in the amount of the estimated increase in federal tax revenues.
- To redirect federal funds that currently support special populations such as CHAMPUS enrollees and veterans would involve revisiting long-standing expectations regarding benefits.

Employer-sponsored coverage and ERISA: Employer-sponsored health insurance covers about 17.5 million Californians and is another major source of health care funding. Today, employers choose health plans with which to contract and decide what coverage to offer based on business needs and employee preferences and in some cases through collective bargaining. As a consequence, employer-sponsored health insurance products vary greatly, including variation in provider networks, benefits, and cost-sharing arrangements. As previously described, about 6 million Californians are in self-insured private employer plans subject to ERISA.

Although direct state intervention in ERISA plans is impermissible, either federal ERISA statute would need to be amended or California would need to devise financing approaches that do not run afoul of ERISA legal challenges and associated delays. California could impose a broad state-based payroll tax to finance health care on all employers, whether or not they currently have (or continue to maintain) an ERISA plan. Given the amount of money and number of people and firms involved, some degree of resistance in the political or legal sphere is likely. A "pay or play" financing approach might also be considered, but

[49] Manatt Health, "Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California," available at https://www.manatt.com/getattachment/6c6ebd95-d8da-40be-9529-04cbbb7b8142/attachment.aspx

[50] Brooks-LaSure, Chiquita, "Medicaid (1115) and Marketplace (1332) Waiver Authority," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

would have also have to be carefully constructed to withstand ERISA legal challenge and deviates from the spirit of fully integrated financing.[51]

In sum, self-insured plans represent a large share of covered lives and an important financing source for a unified state program. However, efforts to integrate them within a state coverage program would have to navigate potential legal challenges and could be subject to associated delays and uncertainty.

Considerations related to state financial oversight
Across all sources and programs, about $400 billion will be spent on health care in California in 2017-18.[52] A program based on unified public financing with a guarantee of access to care for all residents would likely need to raise, manage and spend approximately that sum on an annual basis. State fiscal realities and California constitutional provisions would influence California's ability to effectively execute those responsibilities.

For years, in both California and nationally, health care spending has risen more rapidly than spending throughout the economy as a whole.[53] A unified financing approach might alter these trends, but the magnitude of any savings as well as the timeline over which savings would be achieved is unclear. On one hand, unified financing would clarify how funds are being used and would introduce new spending discipline. Some administrative savings would be achieved by virtue of simplified administrative processes, but many of these would be one-time. On the other hand, bringing everyone into a system of guaranteed access with minimal cost-sharing will increase expectations and reduce cost-sharing considerations that today exert downward pressure on spending. One forecast asserts a net 5% per year reduction in health care spending under SB 562 due to reductions in low value care.[54] In the view of these authors, that estimate is highly speculative and depends to a great extent on program design and implementation decisions that are as yet unknown.

Provisions of the State Constitution require California to enact a balanced budget each year and strictly limit the state's ability to engage in deficit spending. Many forces and factors could introduce volatility into revenue streams and expenses associated with state-managed universal coverage. It will be important to establish and finance reserves upon

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[51] Manatt Health, "Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California," available at https://www.manatt.com/getattachment/6c6ebd95-d8da-40be-9529-04cbbb7b8142/attachment.aspx

[52] Legislative Analyst's Office, "Current Healthcare Coverage and Spending Landscape," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

[53] "California Personal Health Care Spending," California Health Care Foundation: September 2017 and Wilson, Katherine B., "Health Care Costs 101: Spending Growth Slowed," California Health Care Foundation: September 2017.

[54] Pollin, Robert, et al., "Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562)," University of Massachusetts Amherst Political Economy Research Institute: May 31, 2017.

which the health fund can draw in periods when costs are unexpectedly high or revenues fall short of projections.

Provisions of the State Constitution also constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to universal health coverage. Proposition 98 of 1988, as amended by Prop. 111 of 1990, guarantees a minimum funding level for K-12 schools and community colleges. Prop. 4 of 1979 (the "Gann limit"), as amended by both Prop. 98 and Prop. 111, sets limits on certain state appropriations. The scope and cost of a program to finance all health care throughout the state would trigger both provisions, rendering it prudent to seek explicit ballot initiative approval to dedicate new funds to health care.[55]

Design, Implementation and Transition Considerations

Consolidating financing for health care within a single statewide pool would bring new opportunities for financial oversight, more transparent and accountable decisions regarding covered services and providers, and greater consistency and equity in how health care providers and consumers were treated. In moving from diverse benefit, payment and delivery arrangements under today's fragmented financing and coverage program features to a more uniform set of expectations, a number of tradeoffs and tensions would likely arise.[56] For example, the following topics would invite serious deliberation and careful monitoring in the course of establishing and implementing a statewide universal coverage program:

- The extent to which integrated managed care arrangements would be encouraged, and the role, if any, for health plans;
- How provider payment levels would be set and adjusted;
- Whether and how payments and delivery system arrangements might be allowed to vary based on regional differences, local preferences and needs;
- How quality and access to care would be assured;
- The extent to which the needs of special populations would be prioritized; and
- What governance structures and management tools would be put in place to assure accountability and effective oversight.

In addition to these significant design choices, many thorny transition issues would arise. For example, it may be prudent to begin to accumulate funds in a reserve fund prior to program launch. Managing and explaining how new revenues would be collected in parallel with current financing arrangements would be challenging. Jobs in billing and insurance related functions in hospitals, physician offices, and health plans may disappear when

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[55] Graves, Scott, "Constitutional Constraints on Moving Toward Universal Coverage in California," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

[56] Philip, Susan and Mulkey, Marian, "Key Questions When Considering a State-Based, Single-Payer System in California," available at https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/

administrative costs are reduced; a program of transitional assistance or retraining for people in those roles would merit consideration.

In a broad reorganization of financing and delivery of health care in California, existing financial and care delivery relationships would need to be reimagined and restructured. Some degree of disruption is inevitable. Clear articulation of priorities and program goals, along with a systematic planning effort, would be helpful in navigating the transition to universal coverage and more effective care delivery systems.

5. POTENTIAL PATHS FORWARD

California has made great progress in reducing the number of uninsured, but has not yet achieved universal coverage. Studies of high performing health care systems around the globe suggest that universal coverage is essential for ensuring access to care, improving outcomes, and controlling costs. A strong primary care system, a comprehensive basic benefit package, provider payments that reward better health outcomes, a strong social safety net in addition to universal health care, and administrative simplicity are other important ingredients for high performance.[57] There are many pathways to achieving universal coverage and a more efficient health care system. Western European countries have taken a variety of paths to universal coverage, varying in their use of public and private sources of funds to provide universal coverage as well as in the degree to which they rely on the government to pay for services directly, versus relying on residents to make a choice among available health plans.

A unified publicly financed health care system offers a means to a less complex health care system, but the process of transitioning to it would be a substantially more disruptive path of expanding coverage in the state than building upon the foundation of the current system. Californians and their elected representatives will need to assess whether the financial risks and disruption of transitioning from the current multi-payer system to a publicly financed system is in the best interests of the state; make a judgment about the likelihood of obtaining necessary federal statutory changes and waiver approvals; and, if they believe that moving forward on this path makes sense, what timing and practical steps are needed to make it possible. Even if California were to decide today that it was prepared to transition to a publicly financed universal health care system for its residents, it would take years to accomplish the necessary steps at the state and federal level to make that possible. In the meantime, there are steps California can take in the near term to improve coverage, affordability and access to care while also building its capacity to pursue a broader change agenda.

[57] Schneider EC et al." Mirror, Mirror 2017: International Comparison Reflects flaws and Opportunitiies for Better U.S. Health Care" available at http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

To evaluate policy approaches that build on California's current multi-payer approach, policymakers may wish to consider the following criteria:

- Extent and immediacy of benefit for Californian consumers and the health care delivery system
- State fiscal cost
- Potential to preserve gains achieved under the ACA
- Extent to which incremental approaches either lay a foundation for, or undermine, potential future reforms

Below we consider short-term approaches within the context of these criteria.

SHORT-TERM STEPS TO IMPROVE COVERAGE, AFFORDABILITY, ACCESS, FRAGMENTATION AND TRANSPARENCY

IMPROVE COVERAGE

Expand Medi-Cal coverage to income-eligible undocumented adults: California could choose to build upon what it has already done to provide full scope Medi-Cal using state funds to low-income undocumented children by expanding the age range of eligibility.

- The proposal targets the largest group of individuals who remain uninsured in California. More than 1 million residents are estimated to be in an income group that would allow them to qualify for Medi-Cal but for their immigration status. California would be required to take some administrative actions to execute on this strategy but it would have a relatively immediate impact on expanding coverage in the state.
- The costs of this approach would depend on the eligible age range, and it could perhaps become more feasible by expanding the age range over time. The state could also anticipate substantial offsetting savings from spending currently associated with providing restricted scope Medi-Cal benefits (for care related to pregnancies and emergencies) to these same individuals. Much of the additional cost would allow these individuals to obtain primary care services which could contribute to reduced emergency care needs.
- Expanding coverage to undocumented adults in the near term would indicate that these individuals would also be included in coverage were California at a later time to transition to a universal coverage system supported by unified public financing.

Extend Covered California premium tax credit assistance to undocumented individuals using state funds

- The proposal targets the majority of the uninsured undocumented individuals whose income is too high to qualify for Medi-Cal. These individuals would be eligible for federal insurance subsidies in Covered California but for their immigration status. Similar to the approach using Medi-Cal, California could choose to use state funds to provide these subsidies, substantially lowering financial barriers for these individuals to purchase coverage.

- This strategy would have a relatively immediate impact on expanding coverage in the state.
- The costs of this approach would depend on whether California chose to target the full income range (e.g., 138% FPL to 400% FPL) reflected in the federal approach or to limit financial support to those at lower income levels (e.g., 138% to 200% FPL). California could also choose a smaller subsidy than what is provided by the federal government but this would reduce the impact of the policy as it would most likely not provide sufficient cost relief to consumers to encourage them to purchase coverage in Covered California.
- Similar to the proposal to use Medi-Cal to expand coverage to low-income undocumented adults, this approach would be an indication that this group of individuals would also be included in coverage were California at a later time to transition to a universal coverage system supported by unified public financing.

IMPROVE AFFORDABILITY

Address consumer affordability and participation for those already eligible for Medi-Cal and Covered California

- The LAO estimates that there are 1 million uninsured in California who are citizens or legal residents and that more than two-thirds of them are already eligible for Medi-Cal or subsidies to purchase insurance in Covered California. These numbers are likely to grow beginning in 2019 with the repeal of the federal tax penalty associated with the individual mandate.[58]

- California could undertake one or several steps with a relatively immediate impact on expanding coverage and preventing erosion of coverage gains achieved under the ACA:
    - Build upon the state's extensive outreach efforts to ensure individuals who are eligible for Medi-Cal and federal subsidy support to purchase coverage through Covered California are aware of their options.
    - Enhance coordination between Medi-Cal and Covered California so as to minimize disruptions in coverage for those who are required, due to changes in their income, to churn between these two programs.
    - Use state funds to reduce financial barriers to coverage by further subsidizing insurance premiums and/or cost-sharing for those who qualify for federal subsidies and/or to create subsidy support for those whose incomes are above the 400% federal poverty limits for federal subsidies.
    - Implement a state individual mandate with a tax penalty to replace the federal ACA individual mandate penalties that will be eliminated in 2019. Such a policy would be likely to generate state revenue and more importantly it would provide an incentive for young, healthy adults to obtain coverage. This not only

[58] Congressional Budget Office. Repealing the Individual Health Insurance Mandate: An Updated Estimate available at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

provides financial protection to them, but would have the impact of lowering health care costs for everyone purchasing insurance through Covered California.

- The costs of subsidy-oriented approaches would vary based on the size of the subsidy and the income ranges to which subsidies were provided. The impact and administrative burden associated with each approach also vary, depending on how policies are designed and implemented.

Limit out-of-network prices for hospitals to a specified ratio of the price that would be paid by Medicare for similar services

- Some hospitals have been able to negotiate much higher prices than the prices paid by Medicare. Hospitals heavily dependent on Medicare appear to be able to provide high quality care. If the prices that hospitals could receive for out-of-network services were limited, it seems likely that in-network prices would be reduced at those outlier hospitals that currently have negotiated prices above the specified ratio. This would result in lower premiums for employers and employees, and, potentially, for members in Covered California. The adjustment at hospitals whose prices were limited would be difficult, and phase-in options should be considered.

- Reducing price differentials across payers would, arguably, ease a potential transition to a system of unified public financing.

IMPROVE ACCESS

Increase Medi-Cal payment rates: The number of physicians available to care for Medi-Cal beneficiaries has not kept pace with the program's rapid expansion following the implementation of the ACA. Physicians cite low reimbursement rates as the main reason they do not participate in the program. As California looks to translate its gains in coverage into improved access and considers additional expansion of the Medi-Cal program to incorporate undocumented adults, it will need to take steps to improve the program's capacity to provide medical services. Medi-Cal has recently undertaken a step toward increasing physician payment rates but it is time-limited. Additional time and larger increases may be needed to more effectively address barriers to care in Medi-Cal. Medi-Cal might explore requiring its health plans to be more transparent regarding physician payment rates so that the state could use this information to guide evaluations of access to inform future payment policy.

- The proposal would improve access to care for California's many Medi-Cal enrollees.
- The state budgetary impact could be significant. However, state commitments to any physician payment increases can be scaled in amount and targeted to selected services. For example, primary care may be a priority. Evaluations of a primary care physician payment increase to make Medi-Cal payments equivalent to those in Medicare suggests the impact on access can occur within a 1- to 2-year period. State commitments will be

matched with federal support so long as Medi-Cal receives federal approval of a state plan amendment.

- Bringing Medi-Cal payment rates nearer to those of other payers would reduce disincentives to care for Medi-Cal enrollees and help pave the way to uniform payment rates under a future unified financing system.

Explore a Medicaid Public Option

- California has health plan competition in the individual market throughout most areas of the state and there are no areas where there is not at least one option. A Public Option in the individual market in parts or all of the state could protect the state against erosion in coverage if insurers choose to leave any of the regional markets.
- While a Public Option using Medi-Cal's public plans might provide consumers with a lower cost option, there are many questions which would need to be answered about the provider network, provider payment rates, and provider capacity. Before embarking on this effort, California should pursue a planning process with Medi-Cal, Medi-Cal's public plans, Covered California, and key stakeholder groups to assess the costs and benefits, as well as any barriers, legal or otherwise, which could impact the feasibility and timing of this policy approach.

SIMPLIFY THE CONSUMER CHOICE PROCESS

Require each fully-insured product in the large group market to be either a bronze, silver, gold, or platinum plan as defined by Covered California

- Bringing greater uniformity to the plans available to employees and their dependents would focus competition among insurers on price and quality, and eliminate the ability of insurers to fashion benefit packages in an attempt to avoid high cost enrollees. However, greater uniformity would also eliminate the ability of employers to experiment with innovative coverage options and copayment and deductible structures. The ERISA preemption would likely prevent this proposal from directly affecting the offerings of self-insured employers.
- Greater uniformity of benefit packages in the status quo would arguably ease a potential transition to a uniform benefit package under unified public financing.

INCREASE TRANSPARENCY

Require hospitals and larger medical groups (e.g., > 25 physicians) to post information on average prices received from people covered by ESI, as well as average prices received from people covered by Covered California, by Medicare, and by Medi-Cal

- Greater transparency on pricing might lead to community pressure on high-priced hospitals and medical groups to limit their prices (although also might encourage low-priced providers to negotiate harder). The information would be useful employers and purchasers in understanding differences across providers in pricing.
- Better information on status quo pricing would facilitate a potential transition to uniform pricing under unified public financing.
- Regulations would be needed to specify how average prices were to be computed in order to make them comparable across providers and across payers.

- If an APCD were successfully established, average prices could be calculated from the data in the APCD. However, we assume that it will take quite a few years before an APCD is fully operational, and the posting of average prices could be accomplished more expeditiously. Further, ERISA preemption might limit the ability of an APCD to obtain data from self-insured plans, but would not appear to apply to the ability to require hospitals and medical groups to provide data on average prices.

Establish an All-Payer Claims Database (APCD)

- As demonstrated by the work of the Health Policy Commission in Massachusetts, the data in an APCD is extremely valuable to monitoring the cost and quality of care produced by the state's health systems, and to working with those systems to improve cost and quality, as well as potentially sanctioning systems in which per capita costs increase more quickly than the state benchmark.
- A system of unified public financing could be more effectively managed if APCD data were available than if it were not.
- Establishing an APCD would require resources from the state, and resources from the health insurers required to contribute data, and would be a multi-year process. Privacy protections would need to be established. Legal analysis would be needed to determine the extent to which the 2016 Supreme Court ruling on the Vermont APCD would limit the ability to obtain data from self-insured plans.

A Roadmap for a Broader Transformation of California's Health Care System

As suggested by the former Governor of Vermont, Peter Shumlin, the California Legislature could declare that California embraces a goal of guaranteed access to health care for all its residents via a system of unified public financing that improves health outcomes and keeps costs for the state and its residents in check. Under a system of unified public financing, the differences in financing and coverage among Medicare, Medi-Cal, employer-sponsored insurance, and the individual market would be largely eliminated.

To achieve this goal, several preconditions would need to be satisfied:

- Diverse stakeholders must develop a sense of shared purpose and mutual responsibility to advance a health system that works well for all Californians
- Data must be collected and analyzed to better understand the status quo, and to explore how a new system could be monitored and managed
- State budgetary implications must be modeled; financial risks must be assessed and mitigated
- A detailed proposal would need to be developed, and the Legislature would need to enact enabling legislation.
- State constitutional amendments would need to be approved by the voters to assure that the new system did not run afoul of Propositions 4 and 98, and would be desirable to assure broad-based support for the sweeping state revenue changes that such a system would require.

- Federal statutory changes and waivers would need to be obtained.

A system based on unified public financing would have far-reaching effects on how Californians obtain insurance coverage and on health care delivery. The existing channels through which Californians obtain coverage – primarily, Medicare, Medi-Cal, employer sponsored insurance, and Covered California (and the individual market outside of Covered California) – would be replaced with a unified public financing mechanism.

To implement such a system, the federal government would need to agree to write checks to the California unified public financing authority to replace the money that would otherwise be spent to pay for Medicare, Medi-Cal, and subsidized Covered California enrollees. Such agreement would require federal statutory change, most notably in Medicare law, as well as cooperation in obtaining waivers from the federal executive branch. A sensible principle would be that the federal government would write a check to California to replace the money that would otherwise have been spent on Medicare, Medi-Cal, and Covered California subsidies (as well, presumably, for funds that would have been spent on CHAMPUS beneficiaries), in exchange for California's assurances that people who would have been beneficiaries of these federal programs would now be entitled to state benefits. Moving from a sensible principle to an operational and sustainable program would require extensive planning and negotiation. In addition to establishing an initial set of assurances about benefits and payments, agreements would be needed about how to determine the rate at which the federal payment to California would grow over time.

California can increase the chances of favorable federal action if it designs a system of unified public financing that generates broad-based support within the state. Demonstration of that broad-based support could be shown through a favorable vote on a statewide ballot proposition that established the basic building blocks for a system of unified public financing, and cleared away any legal obstacles to such a system created by Propositions 4 and 98. With a favorable vote on enabling legislation, the California congressional delegation would be in a strong position to argue for the required federal statutory changes and waiver approvals.

And even if, somehow, the federal statutory changes and waiver approvals could be obtained tomorrow, it would take at least two years, and more likely three to four, to develop the policies and operational systems needed to implement a system of unified public financing. The period 2018-2020 affords an opportunity to build a firm foundation for unified public financing that could then be implemented following potential federal action in 2021.

The Legislature could demonstrate leadership and advance progress via a Roadmap to Universal Coverage and Unified Financing by establishing a public entity responsible for advancing progress toward universal coverage and unified health care financing. The Legislature would establish the governance structure of the planning commission, provide its charge, and appropriate funding. The commission would engage in activities such as the following:

1. Convene a stakeholder engagement and analytic process by which key design features are refined and vetted.
    - Coverage and Benefit Packages: Develop proposals for covered services, and patient cost-sharing, if any. If cost sharing is lower for lower income people (or if covered benefits are broader (e.g., lower income people receive coverage for dental and vision, but upper income do not), develop proposals for what the income-cost sharing relationship should be, and how income would be determined.
    - Eligibility rules: Develop proposals for how to determine whether someone is a resident of California entitled to health care coverage. For example, rules will need to be developed about coverage for undocumented Californians as well as those who are either travelling temporarily outside of California, or who have temporarily relocated. Similarly, rules will be needed about out of state dependents (e.g., college students) of Californian residents.
    - Provider payment rules: Develop methodologies for paying hospitals, physicians, laboratories, pharmaceuticals, and other providers. If there is a role for health plans, develop methodology for paying health plans, including method for risk adjustment of payments. If hospitals are paid based on a budget, develop method for budgeting. If major capital investments will require approval by a public authority, develop rules/process to do so.
    - Quality assurance and improvement: Develop quality standards, a process for maintaining and updating them over time, and a system of incentives that promotes quality improvement over time.
    - Role, if any, for county government or other sub-state decision making or advisory bodies: Particularly if hospitals are paid based on a budget or if capital investments require approval, but also as other decisions are made that affect the configuration of the delivery system, consideration is needed for how local input into these decisions would be obtained, and whether any decision-making authority can or should be devolved to local governments or other organizations.

2. Establish data collection and reporting efforts to support management, evaluation, transparency, and public accountability.
    - Leverage existing and develop new data systems such as an All Payer Claims Data Base that can be used to establish an accurate baseline for California's health care system and be used to monitor and support informed decisions as California implements changes over time.
    - Develop reporting systems that minimize burden on providers but provide an accurate and comprehensive assessment of performance at the population level as well as among important subgroups of individuals throughout the state.

3. Model state budgetary implications and assess options for raising and managing funds
    - *Revenues:* Tax-based financing would be needed to replace most of the money currently paid by employers and employees for employer sponsored insurance. There are a variety of options to raise these funds, including an increase in

the state sales tax, an increase in the state income tax, a gross receipts tax, or a state payroll tax. Each of these options, as well as others, has advantages and disadvantages.

- We note here that while an increase in the income tax would be more progressive than a payroll tax, given current federal tax law, an increase in the state income tax would likely result in a significant increase (in the tens of billions of dollars) in Californian's federal income tax payments.[59] Further, one advantage of a payroll tax relative to an increase in the income tax (or other sources of financing) is that there will be fewer winners and losers among employers and employees relative to the status quo. Winners and losers could be even further minimized if the payroll tax were firm-specific -- that is, if each firm paid a percentage of payroll that was similar to (perhaps slightly less than) the percent it paid in recent years.[60]
- *Costs:* Benefit design and payment approaches have significant implications, both direct and via the incentives they establish, for total spending. The financial (and other) implications of different designs would need to be explored not only through actuarial modeling and stakeholder input but also by engaging representative members of the public in a structured deliberative process to understand and evaluate trade-offs. Further, it makes sense to be concerned that California could become a magnet for sick people -- if health care coverage is much better in California than in other states, it is possible that people in need of care will move to California. The design of the revenue and financing system (and perhaps eligibility rules) would need to be able to accommodate this possibility.

4. Make recommendations to the Legislature on the design of a system of unified public financing, and work with the Legislature to draft necessary state enabling legislation and any necessary ballot propositions.

5. Ready the state to seek federal waivers and statutory change by which funds currently managed by the federal government but used on behalf of Californians can be consolidated with other funding sources
   - Prepare waiver requests and draft changes in federal law as needed. Coordinate with Department of Health Care Services to explore and manage implications for existing

[59] The implication on federal taxes is based on the assumption that if employers are no longer contributing to health care then employees will receive compensating raises. However, increased income to employees will result in increased federal tax payments. In contrast, if employer paid a payroll tax, and if that tax were approximately equal to the amount that would have been paid for employer sponsored insurance, then there would be minimal effects on federal income tax liability.

[60] If a firm-specific payroll tax were contemplated, methods would be needed to calculate the rate for each firm, and rules would be needed for new firms as well as firms that previously did not make any payments for health care or made very small payments. Further, consideration would be needed about whether differences across firms in these percentages should be narrowed over time.

programs such as Medi-Cal. Support state efforts to negotiate with the Executive branch and Congress.

6. Operational requirements
   - Information technology: Develop an initial scope and recommendations to build (or contract for) an IT system capable of administering the system – determining residency, making provider and health plan payments, measuring utilization, spending, and quality
   - Financial management systems: develop an initial scope and budget to support a system capable of receiving checks from the Federal government for Medicare, Medicaid, and Premium Tax Credit funds, as well as from the state for tax revenue to replace current employer and employee payments for health insurance. Develop a financial control system capable of assuring that money is collected and spent as intended. The agency will be managing somewhere in the neighborhood of $300 billion to $400 billion of funds annually, and clearly many safeguards are needed. Develop estimates of reserves needed, and methods of funding and managing reserves.

7. Coordination

It is anticipated that non-government entities (foundations, nonprofits, consumer advocacy organizations and faculty at the University of California) would be enthusiastic partners in educating the public about cost, access and quality under the status quo as well as opportunities for improvement under a unified public financing approach. Coordinating such activities among public and private partners would be encouraged as the Roadmap is refined and implemented.

8. Roadmap

Many tasks will need to be successfully completed by the executive and legislative branches to achieve unified public financing in California. Given the complexity of tasks, this might best be done by enacting legislation to establish and fund a planning commission to work on behalf of the Legislature and Governor to pursue the necessary steps.

Among the early tasks, the planning commission could engage with stakeholders to resolve design features, including coverage and benefits, eligibility, provider payment rates, and quality metrics. The planning commission could oversee analysis of options to inform the financing of a unified public financing approach. A planning commission could also recommend a management plan with realistic estimates of the information technology needs as well as the operating costs for running the program overall.

After the planning commission had helped policymakers better define the parameters of a system of unified public financing, it could partner with stakeholders to educate the public regarding proposed changes. The planning commission could also assist in the drafting of state legislation and ballot propositions necessary to implement recommendations.

Assuming that policymakers and the public endorsed the unified public financing approach, the planning commission could assist state policymakers in drafting needed federal

statutory changes, developing federal waiver requests, and negotiating with the federal executive branch and Congress.

While it is difficult to estimate exactly how quickly these tasks can be accomplished, at a minimum it would require a multi-year process.

Conclusion

California has established itself as a leader in using the opportunities created by the Affordable Care Act to increase insurance coverage. Building on that foundation, as discussed during the hearings and summarized in this report, state leaders can take steps now to make coverage more widely available, increasing coverage from its current level of 93% to very close to 100%. Further, state leaders can take steps to reduce financial barriers to care for people who are insured. Something close to universal coverage can be achieved even with continuation of the current fragmented system in which Medicare, Medi-Cal, employer-sponsored insurance and the individual market continue to be the main channels through which Californians obtain coverage.

Testimony during the hearings also suggested a number of options for mitigating the deleterious effects of fragmentation and reducing the rate of growth of health spending within the context of a fragmented financing system. This report has summarized many of those suggestions and provided an assessment of the some of their major advantages and disadvantages.

Many people who testified during the hearings also voiced the opinion that the surest way to achieve universal coverage and the most likely way to substantially improve equity, quality and efficiency would be to implement a system of unified public financing. Under such a system, all Californians would have health insurance coverage by virtue of living in the state, and the separate coverage systems of Medicare, Medi-Cal, employer sponsored insurance and the individual market would be eliminated.

However, testimony also made clear that there are substantial legal, political and technical obstacles to implementing such a system. Substantial changes in federal law and federal waivers would be required to transform Medicare, Medi-Cal and the funds used for premium tax credits for Covered California enrollees into a system of unified public financing, and to allow the federal government to transfer funds to California in lieu of continuing to pay for Medicare, the federal portion of Medi-Cal and premium tax credits. In addition, the state would need to raise new revenue to replace most of the money currently spent by employers and employees for employer-sponsored insurance.

While there are obvious shortcomings in the design and implementation of the Medicare program, the Medi-Cal program, employer-sponsored insurance, and Covered California, 93% of Californians currently have insurance through one of these channels. Transitioning the vast majority of Californians into a new system of coverage, which does not have an established track record in the state, involves uncertainty and some risk. Policymakers

have a responsibility to educate the public about the benefits and risks of various options to provide health care coverage and to incorporate the public's values and priorities into their decision-making.

Short-term changes to increase coverage and improve equity, quality, and efficiency make sense given uncertain prospects and a multi-year timeline for achieving unified public financing. This is particularly true if short term changes are pursued in ways that facilitate rather than impede a potential future transition to unified public financing. Short-term efforts to expand coverage, improve access, reduce fragmentation, and improve transparency, coupled with development of a longer-term path toward unified public financing, would help secure a future in which all Californians have access to the health care they need and deserve.