HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

# Virtual Commission Meeting

May 21, 2021

# Welcome and Introductions

Mark Ghaly, MD, Commission Chair and Secretary of California Health and Human Services Agency

# Virtual Meeting Protocols

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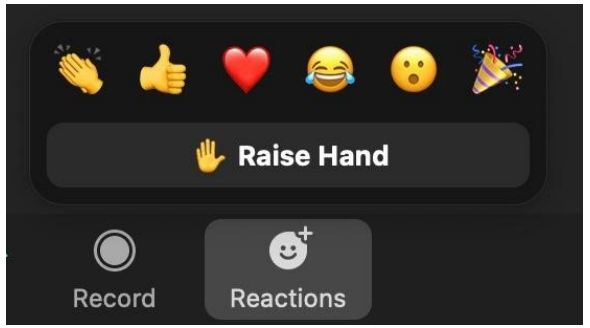
- This meeting is being recorded.
- Commissioners:
  - You have the ability to mute and unmute and the option to be on video.
  - Please mute yourselves when you are not speaking.
  - To indicate that you would like to speak, please use the “raise hand” feature:




- Members of the public:
  - You can listen to and view the meeting.
  - During the public comment period, you will have access to the “chat” feature for written comment, and you can use the “raise hand” feature to request to speak. You can also email comments to HealthyCAforAll@chhs.ca.gov.
  - Public comment provided during the meeting will be a part of the public record.

# Roll Call

# Introductory Comments

# Commission's Work to Date

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- Focus: How can unified financing support a California health care system that is accessible, affordable, equitable, high quality and universal?
- Previous meetings in January 2020 (in-person) and June, July and August, 2020 (via Zoom)
  - Discussion topics included equity, quality and financing
  - Environmental Analysis report completed in August, 2020
- In August, the Commission discussed considerations that should guide financing approaches:
  - Broad consensus that equity was of paramount concern
  - Acknowledgment that revenue strategies should also consider resilience and political realities

# Agenda Overview

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- Welcome and Introduction
- Unified Financing: Potential Effects and Design Options
  - Commissioner opening comments
  - Overview and discussion of analytic findings
  - Breakout group discussions of design options
  - Reports to full group and discussion
  - Public comment

# Community Engagement

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- CHHS is committed to a community listening process to hear views on unified financing from a diverse group of California residents with low incomes
- Independent process to inform the Healthy California for All Commission
- Findings will be presented and discussed at future Commission meetings
- Commissioners will also be invited to a webinar for an in-depth review of findings; webinar will be open to the public
- Sponsored by The California Endowment, the California Community Foundation and the California Health Care Foundation

# Draft Timeline

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| Date | Meeting/ Deliverable |
|---|---|
| June 25, 2021 | Commission meeting<br>• Discuss design options<br>• Community engagement update |
| August 25, 2021 | Commission meeting<br>• Discuss design options<br>• Community engagement update |
| October 11, 2021 | Commission meeting<br>• Synthesize work to date<br>• Review findings and draft report |

# Unified Financing: Potential Effects and Design Options

# Commissioner Opening Comments

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- Given the events of the last year, how, if at all, have your views changed regarding the potential value of a dramatic reordering of health care financing and delivery, as contemplated under unified public financing?

# Feedback From Commissioner Conversations (Part 1)

Marian Mulkey, MPP, MPH

Mulkey Consulting

# Commissioner Conversations

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- Between March 29 and April 16, two or more members of the consulting team interviewed each Commissioner
- Commissioners offered:
  - Feedback on consulting team's proposed analytic plan
  - Priorities regarding design features of unified financing
  - Additional input related to the Commission's work

# Commissioner Input: Analytic Plan

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- Most Commissioners supported looking at two options, one focusing on direct payments to providers and one involving health plans or other intermediaries
  - Questions arose about role that intermediaries (health plans or health systems) might play; views on the value of intermediaries diverged
  - Some raised questions about provider payment structure and the emphasis on fee-for-service payment arrangements within one option
- Several Commissioners noted that total spending and people covered were not the only important outcomes, urging greater attention to equity, quality of care and health outcomes
- Many Commissioners questioned realism of premises and assumptions (e.g., that federal government would provide needed funds and permissions)

# Additional Commissioner Input

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- In addition to the two versions of Unified Financing previously mentioned, several Commissioners encouraged consideration of what they judged to be more attainable approaches such as:
  - Building blocks toward unified financing (e.g., greater price regulation of pharmaceutical sector or health care providers, uniform clinical records, better cost tracking)
  - Incremental steps more likely to align with federal permissions (e.g., start with a sub-population; expand or modify existing public programs)
- Today's meeting focuses on comprehensive unified financing, its implications and the design features that would affect how, and how well, such an approach would work

# Overview of Analytic Findings

Rick Kronick, PhD
Herbert Wertheim School of Public Health
University of California San Diego

# Analytic Consulting Team

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- UC Berkeley: Ken Jacobs, Laurel Lucia, Miranda Dietz, Tynan Challenor
- UCLA: Gerald F. Kominski, Srikanth Kadiyala

# Description of Unified Financing

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- All California residents are covered for a comprehensive package of benefits
- Distinctions among Medicare, Medi-Cal, employer sponsored insurance (ESI), and the individual market are eliminated
- Statutory change at the federal level would allow people who otherwise would have been Medicare or Medi-Cal beneficiaries to instead receive benefits through the UF system, and to write checks to California in lieu of making direct payments through Medicare and Medi-Cal

# Estimated Effects of Unified Financing in California

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- Under Unified Financing (UF), all Californians would be covered for a comprehensive package of services
- Under UF,  care would be more equitably delivered because access to health care providers and systems would be more equal and benefits would be standardized at levels that assure cost rarely deters care-seeking
- Under many scenarios for UF, aggregate health spending in California would be slightly lower in the first few years than in the status quo
- Under all scenarios modelled for UF, aggregate spending would be substantially lower over a 10 year period than in the status quo if, as expected, health spending grows more slowly under UF than in the status quo

# Overview

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- Assumptions about how Unified Financing might be implemented
- Approach to estimating the effects of UF
- Results
- Areas in which decisions would be needed about how to implement UF

# Overview - Assumptions

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- **Assumptions about how Unified Financing might be implemented**
- Approach to estimating the effects of UF
- Results
- Areas in which decisions would be needed about how to implement UF in order to understand how it would work

# Areas in which assumptions are needed to model the effects of UF on aggregate health spending

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- Covered benefits
- Cost sharing
- Level of provider payment
- Role, if any, for intermediaries
- Level of reserves and method of funding
- Funding a just transition for displaced workers
- Rate of growth of health spending over time

# Covered Benefits

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- We provide estimates for a comprehensive package of benefits, including
  - Essential Health Benefits as defined in the Affordable Care Act (ACA)
  - Adult Dental
- We also provide estimates for the addition of
  - Long Term Services and Supports (LTSS), including both institutional and non-institutional long term care

# Patient Cost Sharing

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We provide estimates for two scenarios:

1) No cost sharing
2) Income related cost sharing
   - No cost sharing for households earning < 138% of the Federal Poverty Limit (FPL)
   - 94% Actuarial Value for households at 138-399% of FPL
   - 85% Actuarial Value > 400% of FPL

# Level of Provider Payment

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- We provide estimates for a scenario in which aggregate payments to hospitals, physicians, and other health care providers would be at levels equal to the weighted average of current Medi-Cal, Medicare, and ESI payments, minus estimated reductions in costs due to reduced billing and insurance related costs
- We assume that drug payment policies such as international reference pricing would be implemented as part of UF

# Role, if any, for Intermediaries

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- We provide estimates for two scenarios:
  - A scenario, similar to Canada, in which Californians could choose to receive services from any licensed physician or hospital. In this scenario, payments to physicians and other non-institutional providers would largely be made on a fee-for-service basis. Hospitals would be paid based on global budgets.
  - A scenario, somewhat similar to Medicare Advantage, Covered California, and models in Germany and the Netherlands, in which all Californians enroll in a health plan or health system. Each plan or system would offer the same set of benefits and the same cost sharing (if cost sharing is used). Plans and systems would be paid a risk-adjusted capitation.

# Rate of Growth of Health Spending Over Time

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- We provide estimates for two scenarios
  - Health spending would grow at projected rate of growth of National Health Expenditures (NHE), minus 0.5% per year
  - Health spending would grow at the projected rate of growth of the Gross Domestic Product (approximately NHE minus 1.3%)
- A reduction in rate of spending growth could be accomplished by curbing rates of increase in prices, and reducing low-valued care, fraud, and abuse

# Overview - Approach

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- Assumptions about how Unified Financing might be implemented
- **Approach to estimating the effects of UF**
- Results
- Areas in which decisions would be needed about how to implement UF

# General Approach

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- Used evidence generated by health service research to estimate the effects of UF on health care utilization, spending, and select other outcomes
- Relied heavily on estimates made by the Congressional Budget Office, adapted to the unique health care environment in California
- Unable to directly model the effects of UF on many important outcomes, including:
  - Safety of care
  - Timeliness of Care
  - *Efficiency of Care (can partially model)*
  - *Equity of Care  (can partially model)*
  - Patient-centeredness of Care
- All estimates are subject to substantial uncertainty

# Effects that are Estimated

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- Increase in health care spending from insuring the uninsured
- Increase in health care spending from improving coverage for the under-insured, under two scenarios:
  - No cost sharing
  - Cost sharing
- Reductions in hospital, physician, and other providers billing and insurance related costs under two scenarios:
  - Direct payment
  - Use of health plans and health systems as intermediaries
- Reductions in insurer administrative costs under two scenarios
  - Direct payment
  - Use of health plans and health systems as intermediaries

# Effects that are Estimated (cont.)

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- Reductions in health care spending as a result of lower prices for pharmaceuticals
- Increase in health care spending from benefit enhancements:
  - Adult Dental
  - LTSS
- Changes in health care spending due to less use of capitation in the scenario based on direct payment
- Costs for reserves
- Costs to facilitate a just transition for workers in billing and insurance related functions who experience job loss

# Overview - Results

HEALTHY CALIFORNIA FOR ALL

- Assumptions about how Unified Financing might be implemented
- Approach to estimating the effects of UF
- **Results**
- Areas in which decisions would be needed about how to implement UF

# CA Health Expenditures in 2022 – Varying Role of Intermediaries

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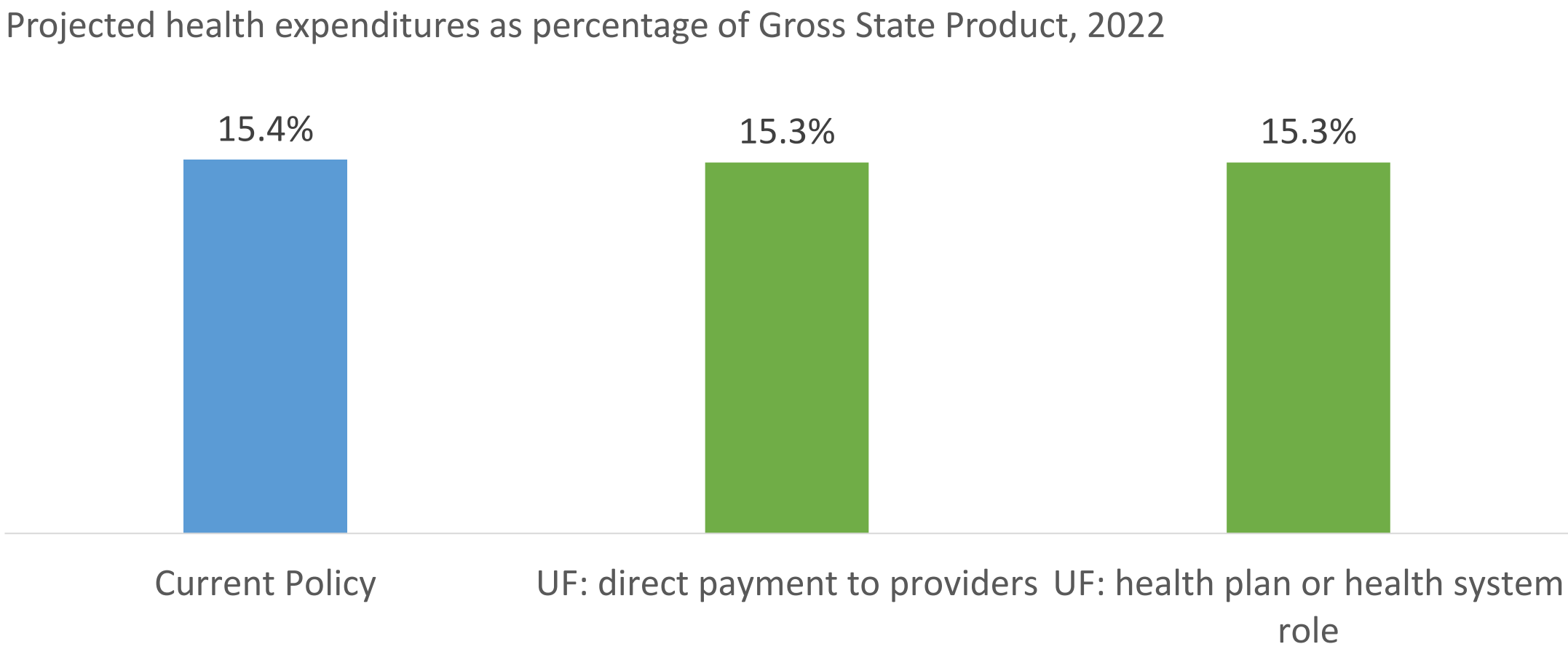
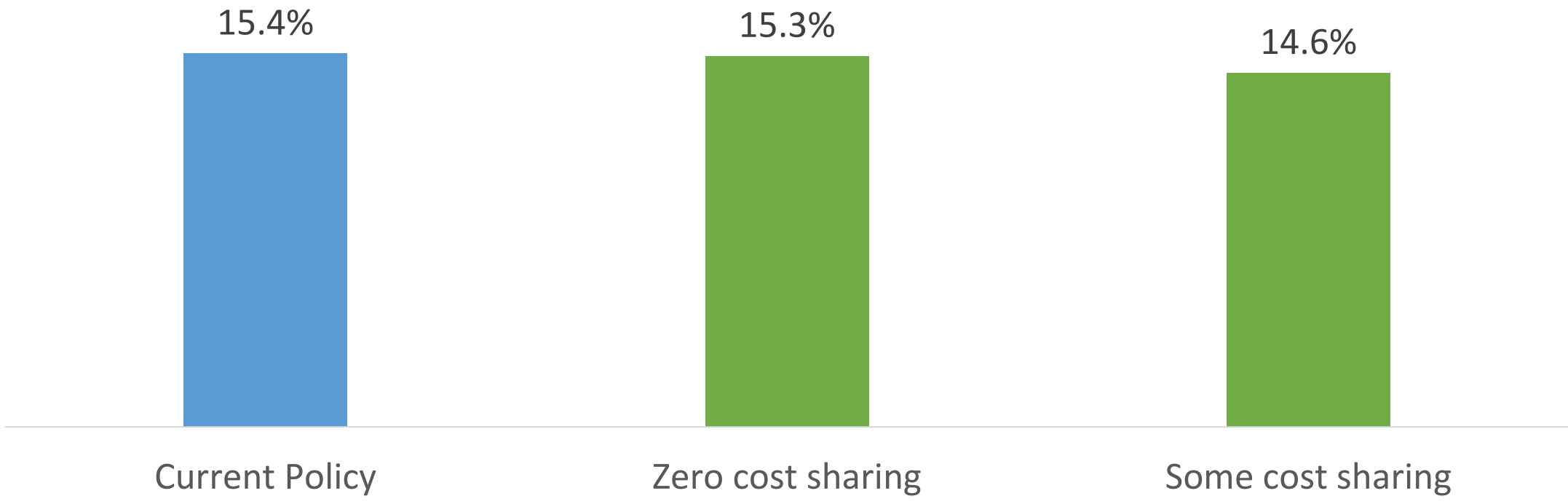



UF scenarios: zero cost sharing and LTSS not expanded

# CA Health Expenditures in 2022 – Varying Cost Sharing

HEALTHY CALIFORNIA FOR ALL

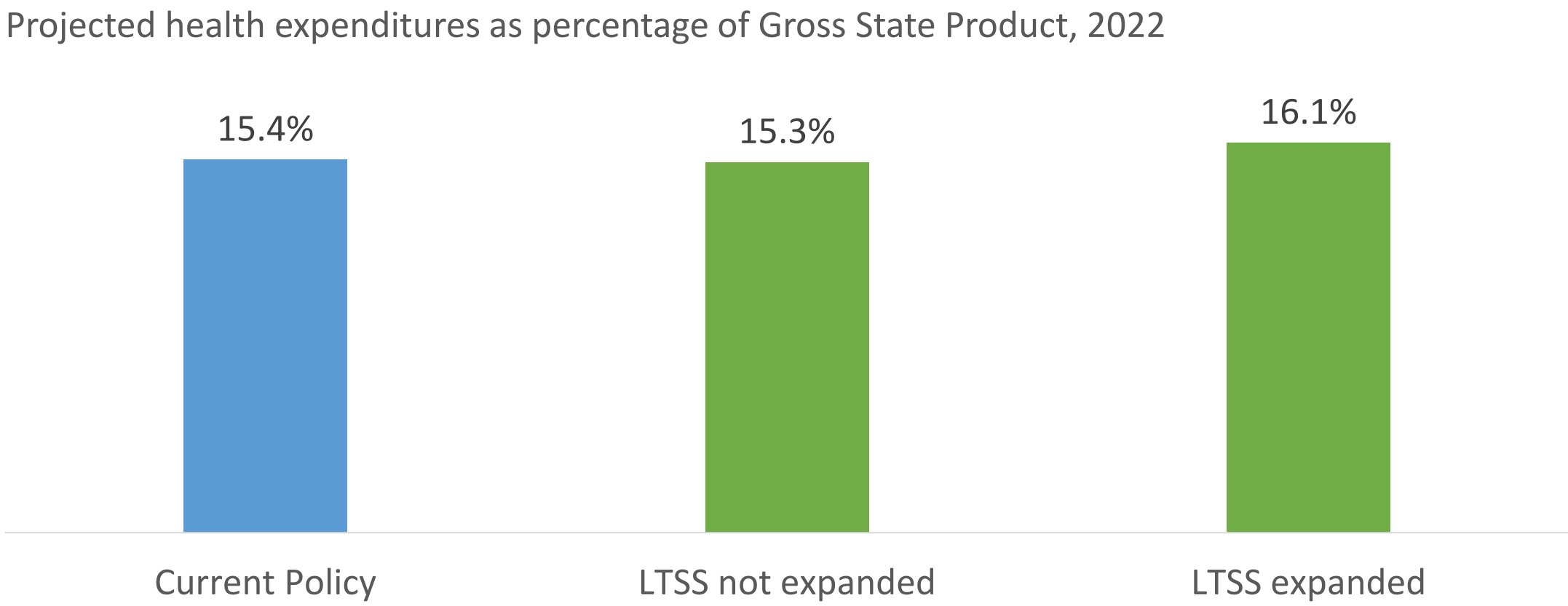
Projected health expenditures as percentage of Gross State Product, 2022




UF scenarios: direct payment to providers, LTSS not expanded

# CA Health Expenditures in 2022 – Varying LTSS

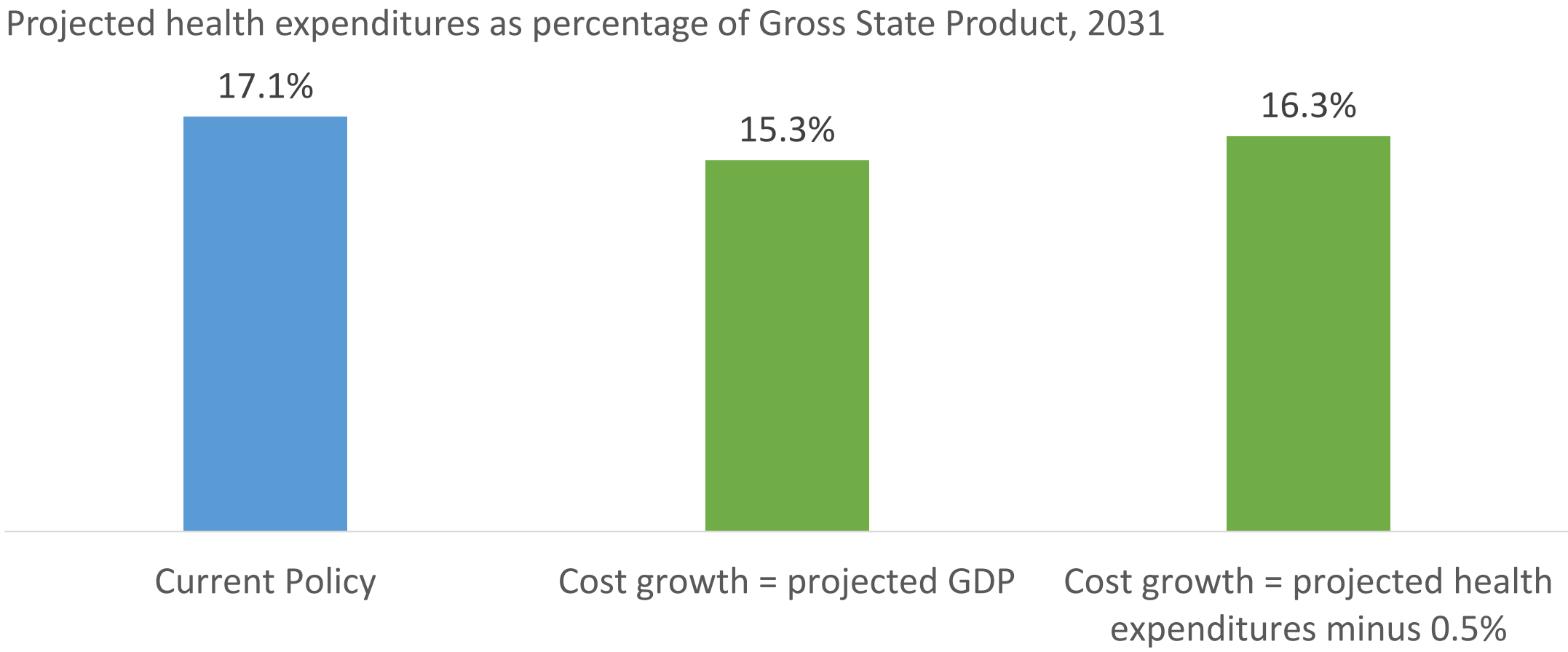
HEALTHY CALIFORNIA FOR ALL




UF scenarios: direct payment to providers, zero cost sharing

# CA Health Expenditures in 2031 – Varying Cost Growth Target, LTSS Not Expanded

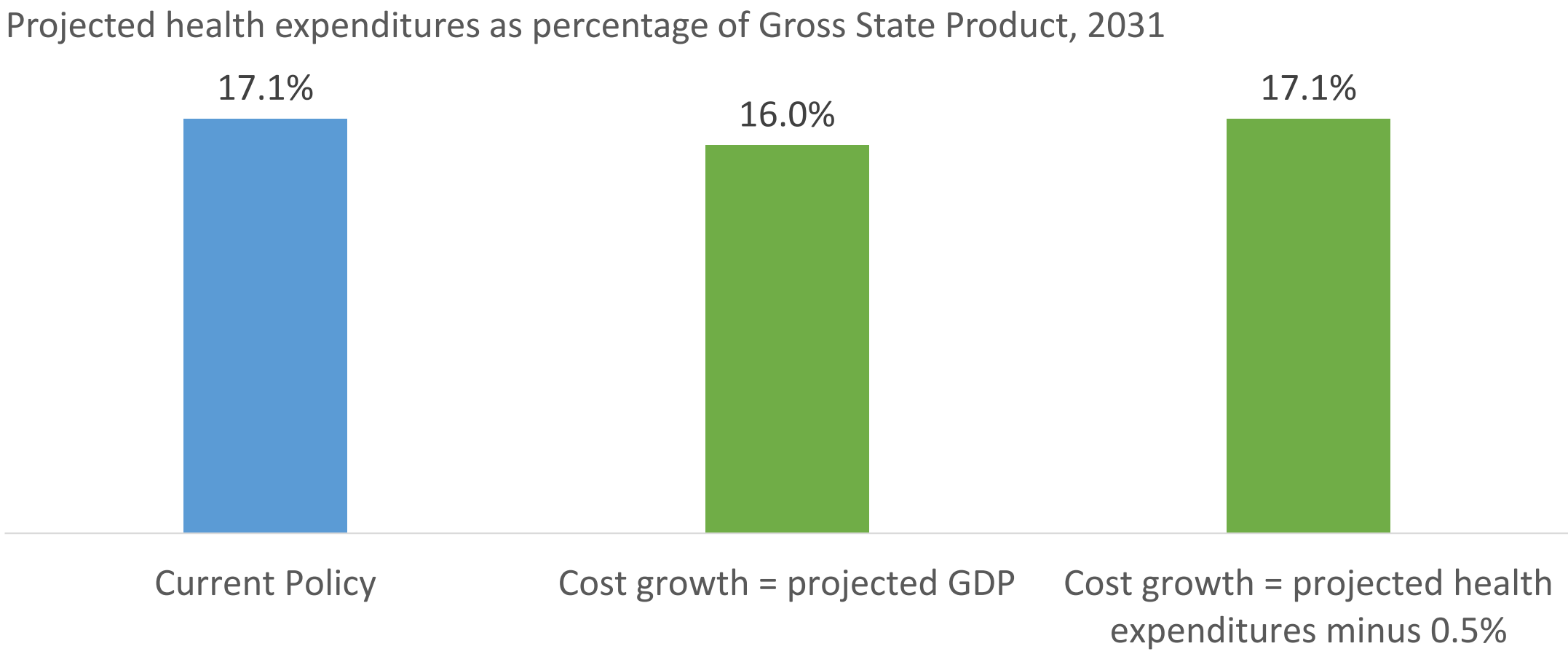
HEALTHY CALIFORNIA FOR ALL




UF scenarios: direct payment to providers, zero cost sharing

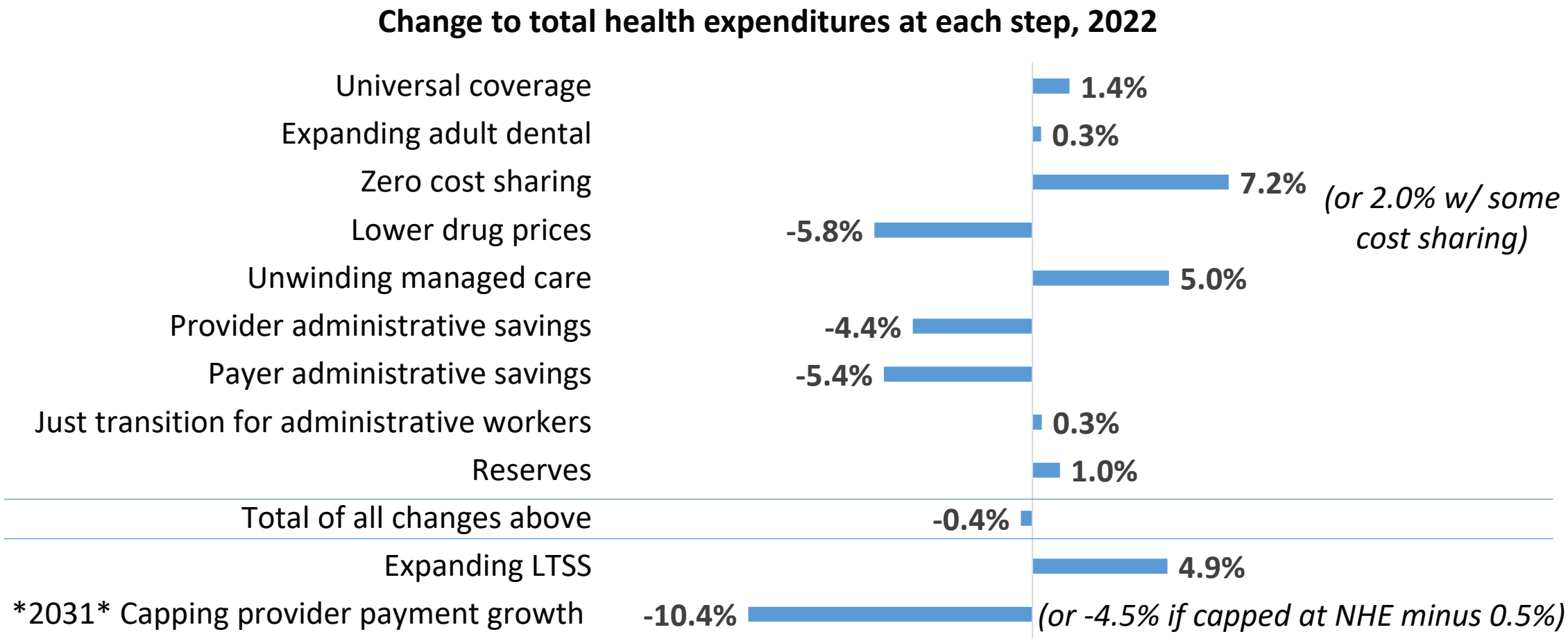
# CA Health Expenditures in 2031 – Varying Cost Growth Target, LTSS Expanded

HEALTHY CALIFORNIA FOR ALL




UF scenarios: direct payment to providers, zero cost sharing

# Estimated Changes in Health Expenditures under UF with Direct Payment to Providers



# Estimated Changes in Health Expenditures under UF – Varying Role of Intermediaries

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| Change to total health expenditures at each step, 2022 | UF: direct payment to providers | UF: health plan or health system role | Difference |
|---|---|---|---|
| Universal coverage, expanding adult dental, zero cost sharing, lower drug prices* | *Changes shown on prior slide, do not vary between options* | | |
| Unwinding managed care | 5.0% | 0.0% | -5.0% |
| Provider administrative savings | -4.4% | -2.1% | 2.3% |
| Payer administrative savings | -5.4% | -2.5% | 2.9% |
| Just transition for administrative workers | 0.3% | 0.2% | -0.2% |
| Reserves | 1.0% | 0.7% | -0.3% |
| **Net change** | **-0.4%** | **-0.7%** | 0.3% |

* LTSS not expanded

Note: Due to rounding, difference may not appear to correspond with the sum of the figures.

# Estimated Gains from Universal Coverage

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Projected uninsured rates ages 0-64 in 2022:

- All: 10%
- Undocumented immigrants: 65%
- Latino: 16%
- Household income at or below 200% FPL: 15%

→ *100% of California residents covered*

Percentage without usual source of care in 2019:

- Insured: 11%
- Uninsured: 52%

→ *Vast majority of Californians will have a usual source of care*

An estimated 4,000 + excess deaths each year due to lacking insurance

→ *4,000 or more lives saved annually*

Sources: UCB-UCLA CalSIM 3.0, California Health Interview Survey 2019, Sommers, American Journal of Health Economics, Vol 3. No. 3.

# Estimated Gains from Universal Coverage and Eliminating Underinsurance

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Percentage with no doctor visit in prior 12 months:

- Insured: 13%
- Uninsured: 44%

→ *Approximately 1 million more Californians will have at least one doctor visit annually*

20% of Californians reported problems paying medical bills, including 32% of those with income under 200% FPL, 26% of Latinx adults and 30% of Black adults in late 2020/ early 2021

→ *Few Californians will have problems paying medical bills*

Sources: California Health Interview Survey 2019, The 2021 CHCF California Health Policy Survey

# Estimated Gains from Eliminating Underinsurance

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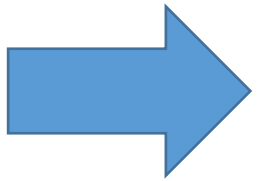
Percentage of population that experienced an access barrier because of cost in past year (2016):

- England (7%)
- Netherlands (8%)
- Sweden (8%)
- Australia (14%)
- Canada (16%)
- France (17%)
- New Zealand (18%)
- Switzerland (22%)
- U.S. (33%)



*Under UF with no cost sharing:*

*Few situations in which Californians would avoid or delay care due to cost*

*Under UF with some cost sharing tied to income:*

*Access barriers would decrease due to a reduction in average cost sharing, making the U.S. more closely resemble other high-income countries on this metric*

Source: Commonwealth Fund Biennial Health Insurance Survey 2020, Commonwealth Fund International Health Survey 2016

# Estimated Gains from Eliminating Distinctions among Medi-Cal, Medicare & Private Insurance

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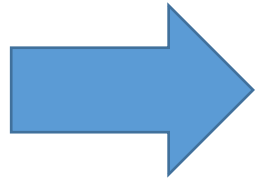
27% of those with household income <200% FPL reported it was somewhat or very difficult to find a medical care provider who took their insurance, compared to 10% of all others in late 2020/ early 2021

Physicians accepting new patients in 2015:

| | Primary Care Physician | Specialist |
|---|---|---|
| Medi-Cal | 55% | 62% |
| Medicare | 62% | 83% |
| Private Insurance | 79% | 87% |
| Uninsured | 32% | 41% |



*More equitable access to care*

Sources: The 2021 CHCF California Health Policy Survey, California Physicians A Portrait of Practice (CHCF 2021)

# Estimated Gains from Administrative Simplification

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Estimated $85 billion in spending on insurance administration and billing and insurance related costs incurred by California hospitals, physicians and other health care entities in 2022

→ *$42 billion less under UF with direct payment to providers, $18 billion less under UF with health plans/ health systems*

U.S. workers spend billions of dollars worth of work time on the phone with health insurers to resolve their own billing/ insurance related issues

→ *Patients will spend less work and personal time dealing with health insurance companies*

Time spent on interactions with health plans averaged nearly 3 weeks physician time per year plus 23 weeks of nursing time per physician per year in U.S. in 2006

→ *Physicians and nurses can spend more time on patient care*

Sources: Pfeffer et al., Magnitude and Effects of "Sludge" in Benefits Administration: How Health Insurance Hassles Burden Workers and Cost Employers, *Academy of Management Discoveries*, October 2020. Casalino et al., What Does It Cost to Interact With Health Insurance Plans? *Health Affairs* May 2009.

# Estimated Gains from Expanding Adult Dental Coverage

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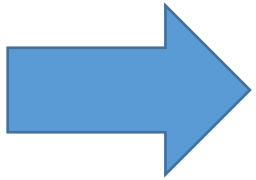
Latino, Black, and Asian Californians report worse oral health (34%, 30%, 27%) than whites (21%)

Immigrants and low-income Californians report poorer oral health (37%, 45%) than their native born and higher-income counterparts (22%, 17%)

Californians ages 65+ are less likely to have dental coverage (54%) than other adults (75%)



*100% of California residents will have dental coverage, which will support better and more equitable oral health*

Sources: Pourat and Ditter, Income Disparities Widen the Gap in Oral Health of California Adults, UCLA Center for Health Policy Research, November 2020; California Health Interview Survey 2018-2019.

# Overview - Results

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- Assumptions about how Unified Financing might be implemented
- Approach to estimating the effects of UF
- Results
- **Areas in which decisions would be needed about how to implement UF**

# Areas in which decisions are needed to know how and how well UF would work

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- Covered benefits and cost sharing
- Role, if any, for intermediaries
- Mechanisms of accountability for improvements in quality and reductions in disparities
- Provider payment levels and methods, separately by provider type
  - How much redistribution, if any, would there be among institutional providers, and over what time frame?
  - If global budgets are used for hospitals, would they adjust for volume changes, and, if so, how?
  - How much rebalancing would there be, if any, between primary and specialty care, or across geographies?
  - How would safety net providers and behavioral health providers be paid?
- Transition issues
- Financing – how would money be raised to pay for the non-federal share of financing?

# Summary

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- As has been shown in many other analyses, IF the federal government, the California legislature, and the California electorate agree to create Unified Financing…
- THEN it would be possible to cover all Californians, greatly increase health equity, not spend more money, and reduce the rate of health spending growth over time
- Many design decisions need to be made to understand how, and how well, Unified Financing would work in improving the safety, timeliness, equity, efficiency, and patient-centeredness of care, as well in creating a sustainable financing system over time

# Questions

# Feedback From Commissioner Conversations (Part 2)

Marian Mulkey, MPP, MPH

Mulkey Consulting

# Commissioner Input: Design Features

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- The design topics most frequently noted included:
  - How would accountability for equitable, high-quality outcomes be assured?
  - What role, if any, should health plans or intermediaries play?
  - How would provider payments be set and managed?
- Also mentioned: covered benefits and cost-sharing, transition issues, data integration, administrative streamlining, workforce
- Today's breakout conversations will delve more deeply into Commissioners' design priorities, allowing an exchange of ideas and informing next steps

# Breakout Discussion Topic

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- What are the 2 or 3 design features that the Commission should focus on? Why?
- What design issues are truly worthy of this group's attention and time, given that we are talking about a dramatic reordering of financing and care?
- Input from today's conversations will guide topics for future commission meetings

# Breakout Discussion Protocols

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- Commissioners
  - Will be divided into four breakout groups and automatically “moved” to a breakout room
- Members of the Public
  - Will be randomly assigned and automatically “moved” to one of the five breakout rooms
  - Will be able to observe the breakout group in “listen-only” mode
- Facilitation and Report Out
  - All four breakout rooms will address the same discussion topic
  - Consultant team members will facilitate and capture input
  - Each group will select a commissioner as spokesperson during report-out
  - Video recordings of breakout rooms will be posted to web page following this meeting

# Commission Discussion

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- Hear reports from each breakout group
- Reflect and discuss

# Public Comment

# Adjourn