



HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

Virtual Commission Meeting

June 25, 2021

Welcome and Introductions

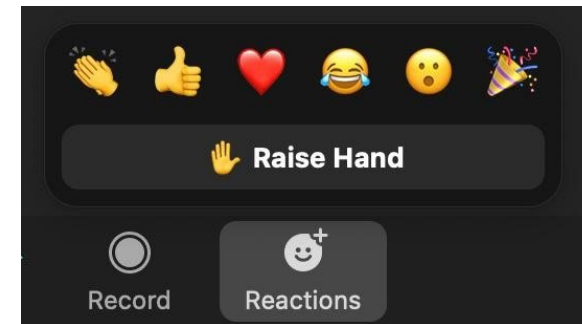
Mark Ghaly, MD, Commission Chair and Secretary
of California Health and Human Services Agency

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.





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Roll Call



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Introductory Comments



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Roadmap for Future Meetings

Roadmap for Future Meetings



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Date	Meeting/ Deliverable
July 8, 2021	Commission meeting <ul style="list-style-type: none">• Use of Intermediaries
August 25, 2021	Commission meeting <ul style="list-style-type: none">• Systems of Accountability
September 23, 2021	Commission meeting <ul style="list-style-type: none">• Provider Payments
October 11, 2021	Commission meeting <ul style="list-style-type: none">• Financing and Federal Engagement
November TBD	Commission meeting <ul style="list-style-type: none">• Ensuring a Smooth Transition
Dec/Jan TBD	Commission meeting <ul style="list-style-type: none">• Draft report; other topics TBD
Jan/Feb 2022	Final Commission meeting and final deliverable

Process Adjustments



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- Facilitation by Chair
- Active engagement among Commissioners
- Implications for final report



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Commissioner Discussion



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Public Comment



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Experience and Lessons in Designing Realistic Classic Single Payer Healthcare Systems

Commissioner William C. Hsiao

Professor, Harvard T.H. Chan School of Public Health

Presentation Outline



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- Background information on Taiwan and Vermont and their principles and major questions in designing a classic single payer healthcare system.
- The importance of a payment system to providers that incentivizes providers to deliver equitable, effective, high quality and efficient healthcare.
- Advantages and disadvantages of the classic single payer healthcare system
- A simple distinction between the classic single payer system and its hybrids.

Sharing Experience from Taiwan and Vermont



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- Their goals: Same as California's Unified Financing with the addition of the following:

“Universal access to affordable and high quality health care equitably and on a sustainable basis.”

The Question: How to design the key components of a healthcare system to achieve these goals?

Clarification: Why should sustainability be added?



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Principles of Universal Social Health Insurance

- It's a social compact between the government and the eligible people who pay a contribution for a “contractual” set of benefits. i.e., an exchange, NOT a welfare program
- It's a long-term social insurance program. Examples: Medicare and Social Security Retirement Plan
- The government can NOT arbitrarily change the key provisions of the compact, such as the benefit package or the premium rate.

Background of Taiwan and Vermont



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Taiwan

Population: 21 million in 1995
Health insurance coverage: 57%
Cost & Financing for SP system:
Big increase in spending for
healthcare have to be financed by
employers and workers, resulting
in them paying **MORE** in
premiums and **greater**
government budget spending.

Vermont

Population: 620,000
Health insurance Coverage: 93%
Cost & Financing for SP system:
Significant reduction in the cost for
healthcare by removing waste, fraud
and billing abuses. Most employers
and workers would pay **LESS**.

Six Major Design Decisions for Taiwan and Vermont



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1. What healthcare benefits to cover?—e.g. LTC and any copayment?
2. What kind of healthcare delivery system would be desirable?—Gatekeeper? Moving toward integrated delivery?
3. What method to use to pay the providers? How much to pay the providers?—payment methods: FFS, bundled, DRG, capitation, global budget, rate set by funder, negotiation between funder and providers, medical professionals self set & regulate under medical global budget?
4. How much would Unified Financing cost over time?
5. Who will pay? How to finance it on an equitable and sustainable basis?—targeted income tax, payroll tax with government budget for subsidies, wealth or capital gain tax, gross revenue tax, VAT?
6. How to govern the UF and who will manage/administer?—How to be accountability for performance? Institutional form: government, quasi-government, delegate to corporatist entities?

Importance of Payment Method and Rates to Providers



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Payment system is the most critical instrument that policymakers have to influence:

- Access—supply of services available, their quality and location.
- Efficiency—the cost of healthcare, affordability and sustainability of the Unified Financing over time.
- Quality of healthcare—whether or not healthcare is fragmented or integrated.
- Can healthcare cost inflation be contained over time?

Payment Methods Create Incentives and Financial Risks to Providers



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Hospital services

Retrospective

- Fee-for-service (FFS)
- Per day
- Per admission

Prospective

- DRG
- Hospital global budget with volume targets (e.g. days, admission, DRGs)

Physician Services

Retrospective--FFS

Prospective

- Bundled
- Capitation

Integrated Delivery System

Prospective Risk adjusted Capitation.

Advantages and Disadvantages of Payment Methods



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Method	Advantages and Disadvantages
Fee-for-service	Historical method & providers like it; inflationary; induce over-treatment and upcoding
Per day	Keep patients longer in the hospital
Per admission or DRG	Shorter hospital stay, promote outpatient surgery; admit more patients, upcoding DRG
Risk adjusted capitation based on some quality outcome	Use most efficient diagnostics & treatments; under treat patients, cherry picking healthy patients or enrollees.

Payment Rates



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- Who sets the payment rates?
 - Single-payer agency sets the rates
 - Negotiation between funding agency and providers
 - Medical professionals self-regulate and set physician service rates—Germany
 - Multiple health insurance plan each set or negotiate with providers—USA now
- What basis to set the level of rates?
 - Rates set under overall global healthcare budget—most nations with single-payer system do this.
 - Historical rates or budget
 - Factual basis— transparent actual prevailing cost, relative values for physician services

How to Contain Health Expenditure and its Inflation?



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The Brutal Facts:

Health Insurance Expenditure =
Price x Volume of services =
Revenue of Providers

Providers can affect both price and
volume of services

Advantages of Classic Single Payer Healthcare System



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1. Universal coverage—need to mandate enrollment and pool health risks
2. Universal “Equal” access to covered health services, drugs and equipment.
3. People have choice of providers
4. Financing on an equitable basis
5. Lower cost—removes multiple health insurance plans, utilizes efficient production of health services, bulk purchase of pharmaceuticals and medical supplies, and set prospective total state health budget → Affordability and Sustainability
6. Simplify and reduce paper work for patients, employers and providers
7. Improve health status of the population and remove financial hardship due to healthcare costs, and high public satisfaction.

Disadvantages of Classic Single Payer Systems Managed/Operated by a *Government Agency*



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- Tax or premium payers, and receivers of payments (healthcare providers and suppliers) all focus their attention on the government agency
- Political interference and influence
- Provisions favoring certain actors or stakeholders
- System stagnate over time from lack of innovation

How Hybrid Single Payer Models Differ from the Classic Model?



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- Ideology: Belief in choices in health insurance, and market competition can improve efficiency. Leave market space for complementary and/or supplementary insurance.



Creates tiers of healthcare leads to “unequal” access to healthcare

- Governance institutions and structure— hybrid uses multiple corporatist entities + multiple complementary/supplementary insurance



Higher costs



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Commissioner Discussion



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Chair's Summary of Key Points



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Public Comment



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Adjourn