

Analysis updated July 8, 2021

The analysis has been refined in several ways since the May 21, 2021 meeting. The only major substantive change is that we now assume that increases in hospital expenditures under UF due to universal coverage, reducing cost sharing, and unwinding managed care would be paid based on hospitals' marginal cost (approximately 50% of average cost). This assumption reduces expenditures under UF relative to our prior assumption that increased volume would be paid at average cost.

Overview of Analytic Findings

Rick Kronick, PhD

Herbert Wertheim School of Public Health
University of California San Diego

Analytic Consulting Team



HEALTHY CALIFORNIA FOR ALL

- 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



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

Overview - Assumptions



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 in order to understand how it would work



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

- 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

- 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



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



General Approach

- 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



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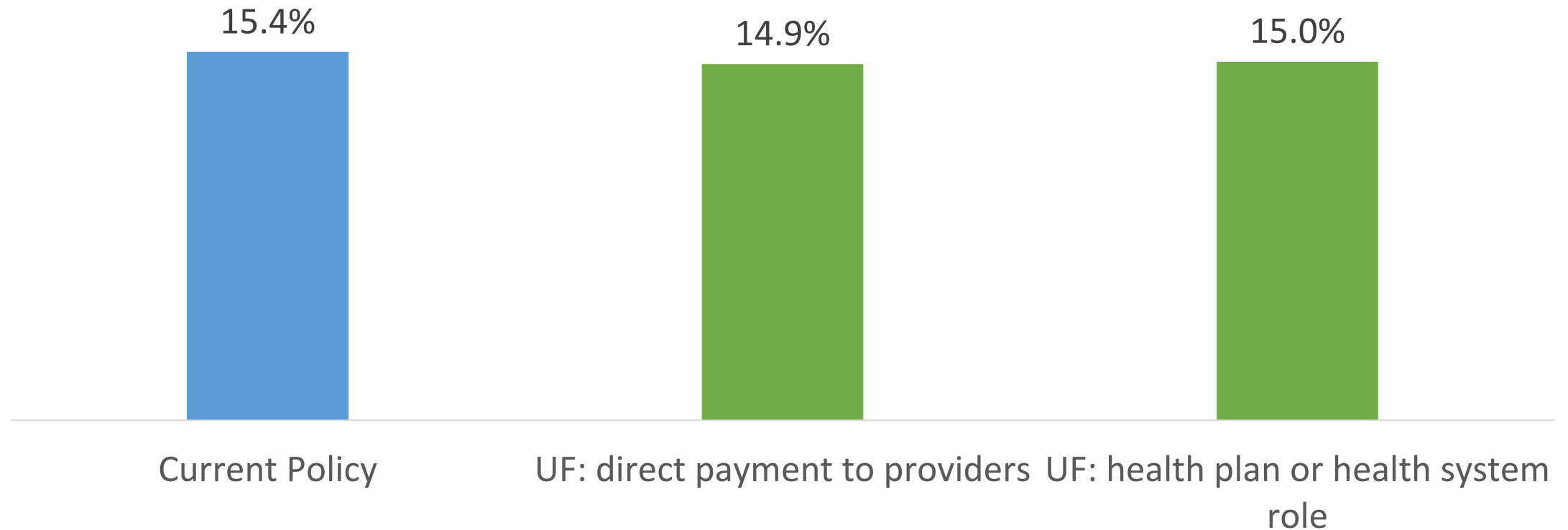
- Assumptions about how Unified Financing might be implemented
- Approach to estimating the effects of UF
- **Results**
- Areas in which decisions would be needed about how to implement UF

CA Health Expenditures in 2022 – Varying Role of Intermediaries



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Projected health expenditures as percentage of Gross State Product, 2022



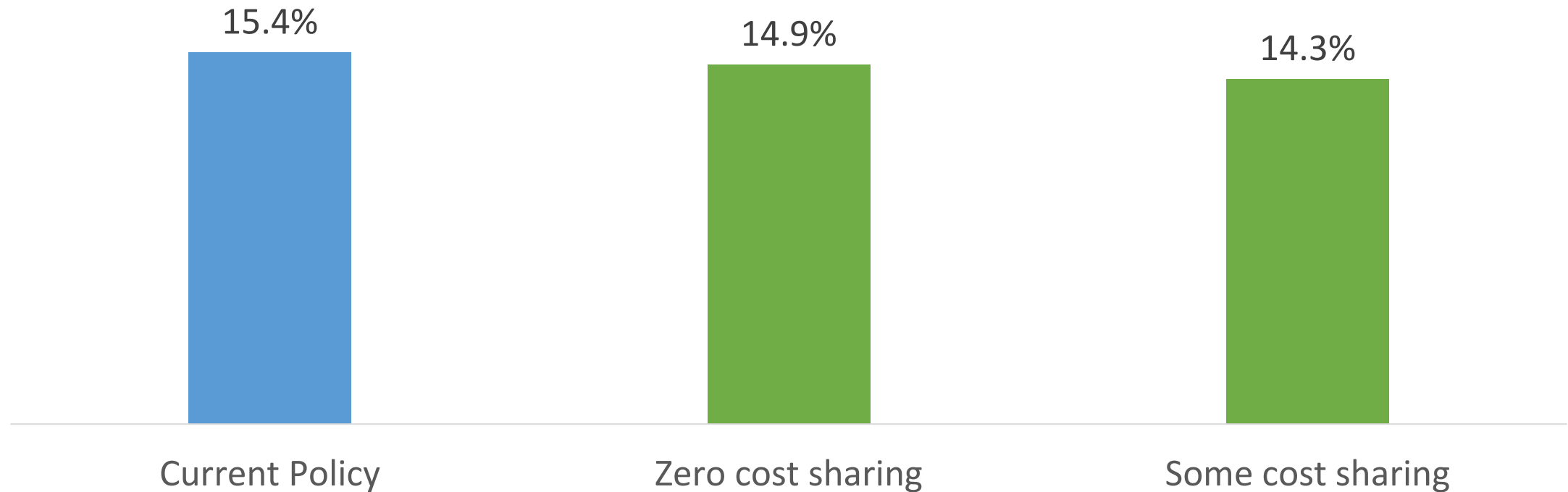
UF scenarios: zero cost sharing and LTSS not expanded

CA Health Expenditures in 2022 – Varying Cost Sharing



HEALTHY CALIFORNIA FOR ALL

Projected health expenditures as percentage of Gross State Product, 2022



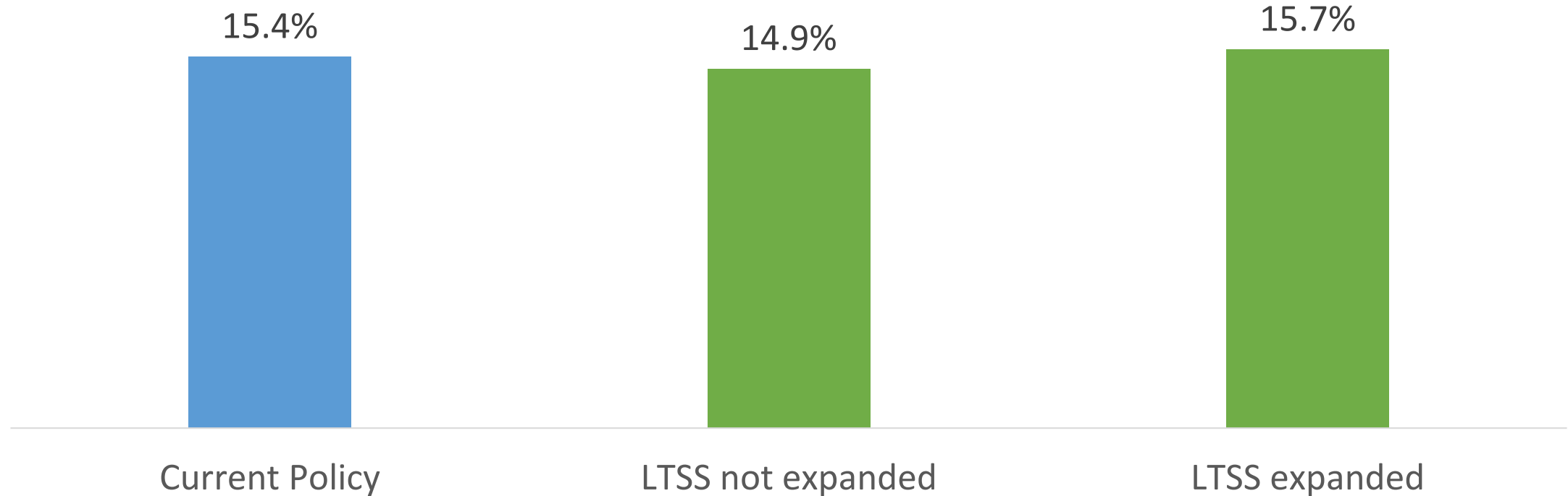
UF scenarios: direct payment to providers, LTSS not expanded

CA Health Expenditures in 2022 – Varying LTSS



HEALTHY CALIFORNIA FOR ALL

Projected health expenditures as percentage of Gross State Product, 2022



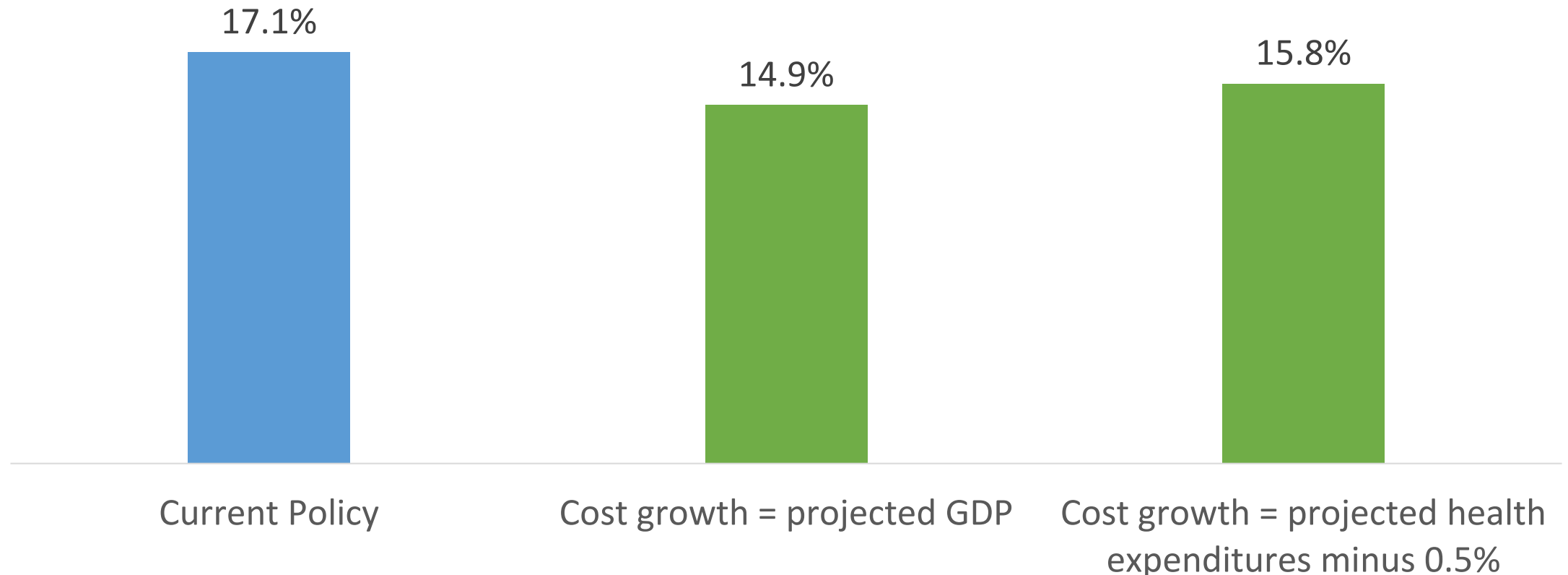
UF scenarios: direct payment to providers, zero cost sharing

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



HEALTHY CALIFORNIA FOR ALL

Projected health expenditures as percentage of Gross State Product, 2031



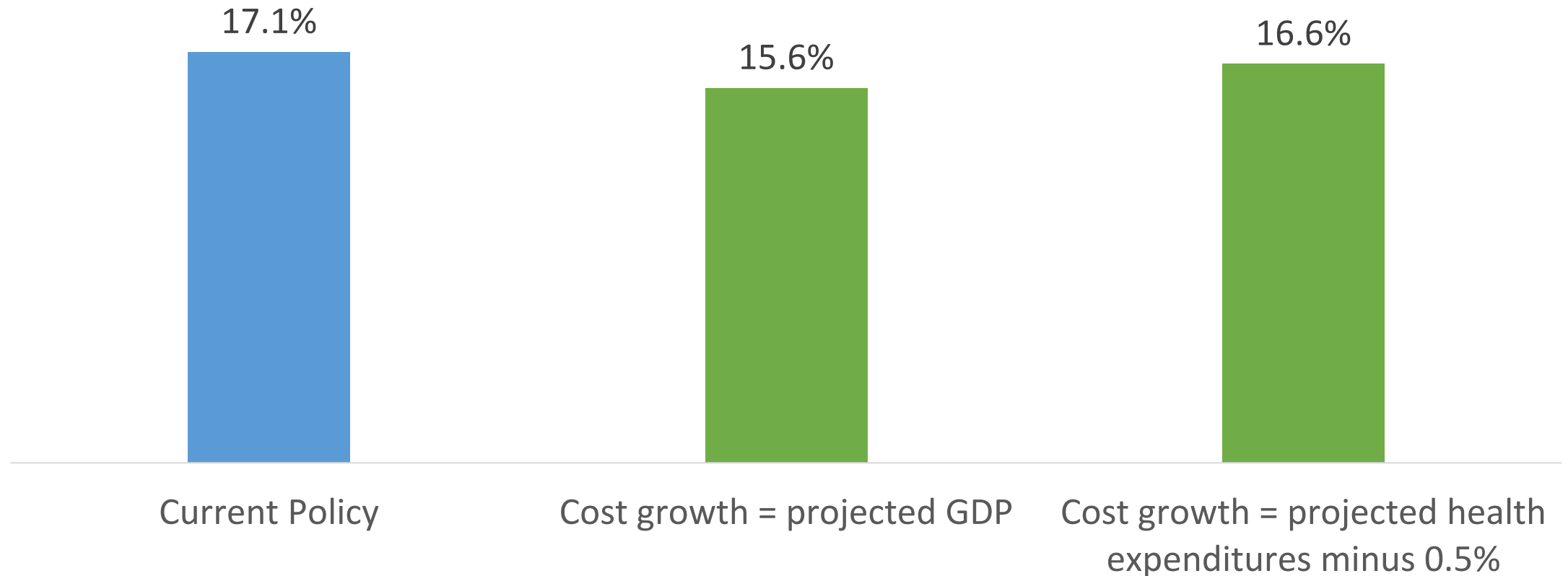
UF scenarios: direct payment to providers, zero cost sharing

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



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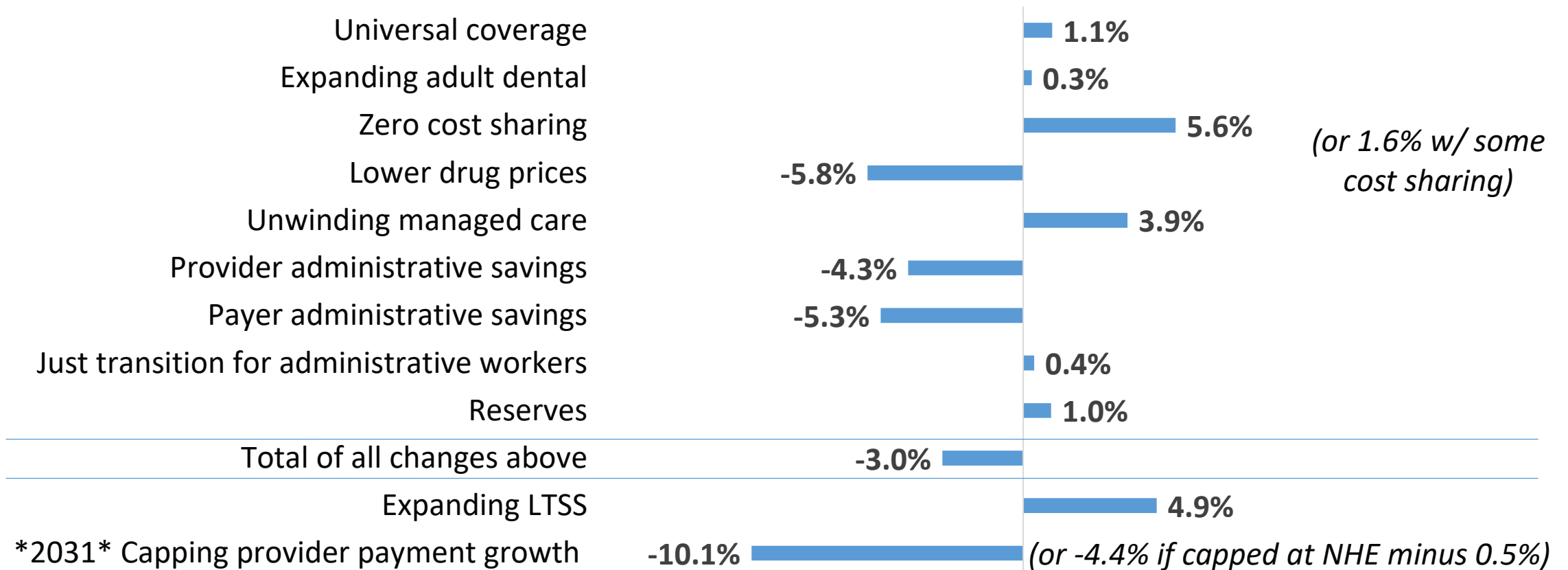
Projected health expenditures as percentage of Gross State Product, 2031



UF scenarios: direct payment to providers, zero cost sharing

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

Change to total health expenditures at each step, 2022



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*	<i>Changes shown on prior slide, do not vary between options</i>		
Unwinding managed care	3.9%	0.0%	-3.9%
Provider administrative savings	-4.3%	-2.0%	2.2%
Payer administrative savings	-5.3%	-2.4%	2.8%
Just transition for administrative workers	0.4%	0.2%	-0.2%
Reserves	1.0%	0.7%	-0.3%
Net change			0.6%

* LTSS not expanded

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

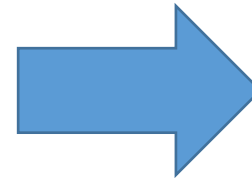
Estimated Gains from Universal Coverage



HEALTHY CALIFORNIA FOR ALL

Projected uninsured rates ages 0-64 in 2022:

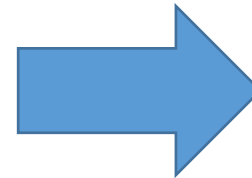
- All: 10%
- Undocumented immigrants: 65%
- Latino: 16%
- Household income at or below 200% FPL: 15%



100% of California residents covered

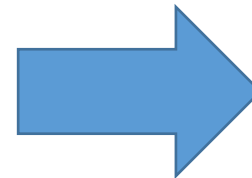
Percentage without usual source of care in 2019:

- 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.

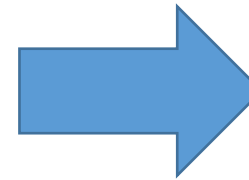
Estimated Gains from Universal Coverage and Eliminating Underinsurance



HEALTHY CALIFORNIA FOR ALL

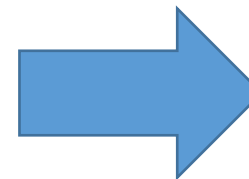
Percentage with no doctor visit in prior 12 months:

- 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

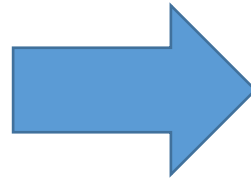
Estimated Gains from Eliminating Underinsurance



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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

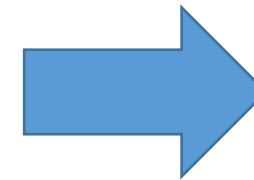


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27% of those with household income <200% FPL reported it was somewhat or very difficult to find a medical care provider who took their insurance, compared to 10% of all others in late 2020/early 2021

Physicians accepting new patients in 2015:

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



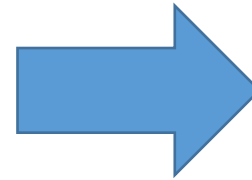
More equitable access to care

Estimated Gains from Administrative Simplification



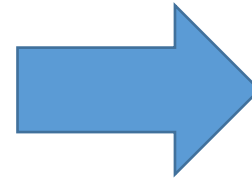
HEALTHY CALIFORNIA FOR ALL

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



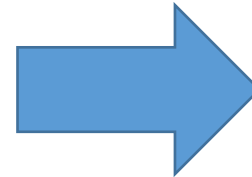
\$42 billion less under UF with direct payment to providers, \$18 billion less under UF with health plans/ health systems

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

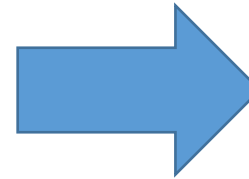


HEALTHY CALIFORNIA FOR ALL

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



HEALTHY CALIFORNIA FOR ALL

- Assumptions about how Unified Financing might be implemented
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- **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



HEALTHY CALIFORNIA FOR ALL

- 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

- 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