Healthy California for All
Commission Meeting
September 23, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: video recording of September 23, 2021 Healthy CA for All Commission meeting.

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Sandra Hernandez, Rupa Marya, Andy Schneider, Carmen Comsti, Antonia Hernandez, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Michelle Baass, Don Moulds, Richard Pan, Cara Dessert, Bob Ross, Peter Lee (commissioner biographies can be found here: Healthy California for All Commissioner Biographies)

1. **Welcome and Introduction**
   - Virtual meeting protocols and roll call
     - Karin Bloomer, a member of the consulting team, reviews the virtual meeting protocols and conducts roll call for the commissioners.

   - Introductory remarks and agenda overview
     - California Health and Human Services Agency (CHHS) Secretary, Dr. Mark Ghaly, welcomes the group and frames the work of the commission as follows:
       - Today's focus will be on 1) community engagement and how to build community voice into the development of a unified financing system, even beyond the commission, and 2) the state-federal relationship and what it will take to secure dollars and authority to implement a unified financing single payer approach to health care.
     - Commissioner Ross issues an apology for the use of the word "zealot" in an interview and clarified it was in the context of speed and that zeal is needed.
       - Commissioner Marya relays her testimony from the front lines as a doctor, conveying the urgency to move to a single-payer model. Dr. Marya notes a difference between zeal and bold incremental change.
   - Update on community engagement
       - Secretary Ghaly reviews the findings of the community engagement surveys and interviews to gain input from 2,000 Californians with low incomes and 60 leaders of advocacy and community-based organizations. A few key points: 65% indicated support for a single statewide government

-run health care program with higher support from communities of color; affordability is a top priority; wide agreement that coverage does not guarantee access; comprehensive and integrated services (behavioral, long term care, dental, vision) were key priorities; 90% want a system that treats everyone with dignity and respect; and 88% want to be involved in their health care decisions and want to be part of designing a new system.

- Secretary Ghaly poses two questions for commissioners: 1) What should we remember from this community engagement work? 2) How can we have authentic community involvement and consumer engagement in designing, building and governing a system of unified financing?
- Commissioner Sandra Hernandez gives a breakdown of the community engagement meeting. The big takeaway, as she frames it, is that we need a system that treats everybody with dignity and respect and includes people's voices as central and not just an add-on at the table. She notes tradeoffs will need to be made and that they should not be between living and dying or having a good quality of life or not, but about what gets included, how much choice, and those third or fourth level tradeoffs. She brings up the importance of a big push towards a culturally competent workforce. Regarding models we could learn from, Commissioner Hernandez brings up the Alaska Native Medical Center that created the Nuka system of care to address the needs of Native Alaskan communities.
- Secretary Ghaly notes two points to frame the conversation on tradeoffs, one being that we cannot trade away a system that covers all Californians with high-quality health care, and the other, that this transition is an opportunity to address decades' old workforce gaps and issues with cultural competency.
- Commissioner Wright gives his comments on the community engagement meeting, noting there are parts of our health care delivery system that are needlessly complex for consumers, and we need to make sure the process is there to integrate the public (broad consensus and specific experiences) into decision-making and to incorporate some ongoing element after the report to include the public in decision-making.
- Commissioner Flocks notes the striking level of cultural disrespect and discrimination and that a focus needs to be placed on how we measure and correct that and hold providers accountable. She notes the labor commission's statewide effort, driving directly to farm workers and their employers to talk about their rights and new laws under COVID.
- Commissioner Wood highlights the importance of workforce to make a universal health care system work, and how that is a bold step that can be taken right now. He requests to know more about the Commissioner Goals and Values survey results, asking who was against each point and why.

2. State/Federal Relationship and Financing Mechanisms

- Secretary Ghaly presents background information on current federal and state financing of health care: In 2019, $441 billion of total California health care expenditures (roughly 35%) came from federal sources; the other 65% came from state funding (7-10%), out of pocket spending (11%), other state and local programs (11%), and private insurance premiums (33%). He asks a few framing questions: What are the strategies to secure funding – waiver, legislation, other? What are hurdles to securing federal support? How does California clear these hurdles? How do we ensure sustainable federal funding?
- Presentation by Carmen Comsti (View the Presentation on State/Federal Relationship and Financing Mechanisms):
  - Slide 12: Commissioner Comsti notes a few key takeaways: 1) Yes, we can integrate federal programs within a state unified financing system, and 2) No, we do not need to change federal statute to secure federal financial participation. The federal government and California have in the past implemented new or better ways to get Medicare and Medicaid beneficiaries their care. The only new part is we want everyone included, not just some. Federal waivers are when specific laws are being waived by the Secretary of Health and Human Services (HHS). Congress sets how and when laws can be waived. HHS waives those laws within the rulebook set by Congress. States apply to the Centers for Medicare and Medicaid Services (CMS) for waivers. Some waiver authorities are defined with guardrails, while others are open ended giving discretionary latitude to the HHS Secretary to grant approvals. Although statutes may not explicitly list single payer as a program, the Secretary is not prohibited from approving such a program. Why would California want a waiver? We want everyone in one system and want to benefit from the federal funding.
  - Slide 13: “Will the federal government approve this?” This question puts the cart before the horse. We cannot answer this until we design a system. Instead: What are the rules? What's out there? What's available? And how can we construct a system to fit within those rules? We do not need to get stuck, because we do not need federal financing to look like a block grant program. What exists right now where we can get federal dollars to reimburse benefits under the state program? What's the level of administrative oversight CMS might want over federal dollars? We should look for ways the state can manage Medicare and Medicaid reimbursement, working with CMS to have monthly accounting or annual budgeting, or a system where the state program functions as a broker. No program has been approved before because no state has yet to present such a program to HHS. We need our leadership in California to take the lead and be the first state to put a single payer proposal or unified financing proposal together and make the ask. We'll never know until we ask. The basic roadmap: Program Design/Enactment → Apply to CMS → Negotiate with CMS → Approval → Implement.

- Slide 14: There are several major waiver authorities that Congress has created on federal health care programs. California has had an 1115 demonstration waiver to test new health care delivery models for decades. For the Medicaid innovation waivers, although it lists 27 models that could be tested, the HHS Secretary has discretion to approve new models. There are some major requirements: the state program has to be consistent with federal objectives, and federal spending to the government cannot increase under this type of waiver.
- Slide 15: Section 1332 of the Affordable Care Act gives HHS authority to waive ACA requirements and importantly, an ACA waiver has a coordinated and consolidated waiver process allowing the state to apply for all necessary federal health care waivers needed in a single application. HHS also has statutory authority to contract out administrative functions, like payment determination and reimbursement, so HHS potentially could enter into a contract with the state to administer Medicare. Another route is the Medicare Shared Savings Program authority, generally known as freedom of choice waivers, these together could be used to get a unified financing program approved as a statewide Shared Savings Program.
- Slide 16: How do these waivers work together? In the consolidated waiver process in section 1332 of the ACA, a state must show it has met the requirements of different waiver authorities and procedural and substantive requirements of 1332. The important part is that it has a state law and academic requirement, meaning the state needs to go in with state legislation already passed. AB 1400 gives the state enough flexibility to apply for different waivers and make adjustments if the Feds ask for it. We don't want informal discussions, so we need a bill to enter formal negotiations.
- Slide 17: The budget neutrality calculation is important because it sets the dollar amount for the federal share of funding that a state could get under a waiver. The key points here are that the budget neutrality formula is not set in statute or regulation. CMS has some guidance for a couple of different formulas, a per capita formula and an aggregate cap formula, but these formulas aren't necessarily set in stone, and we would not need federal statutory changes to change these formulas.
- Slide 18: DHCS is in charge of the waiver application and administration process. We have had comprehensive 1115 Medicaid waivers since 2005 and some before, and other waivers on mental health, community-based health services, etc. California has already applied the budget neutrality calculations creatively to maximize the federal share. Medicare Innovation Waivers have been tested with Vermont and Maryland and show CMS is willing to approve waivers that include a mix of all patient populations within a state.
- Slide 19: Under unified financing we're asking the Feds to provide Medicare and Medicaid beneficiaries their benefits through a state program. On sustainable financing, part of this requires non-federal revenue sources. We

should create a tool with multiple financing options and multiple tax rates for the legislature and governor, and put this in our final report, so they can start tinkering with some of these financing plans and start a serious debate. On sustainable financing, we can use global budgeting, price negotiations (drugs or rates) looking for ways to maximize federal share through budgeting formulas. Other federal health care proposals on the table could greatly increase the federal share such as Long-Term Care funding or Medicaid expansion. Becerra vs Grisham has the potential to change discretionary authority of 1115 waiver approvals. On budget neutrality, in the consulting team's modeling on aggregate savings under unified financing, California would save money relative to the status quo in year one, and that's with no cost savings. If we add long-term care, we reach savings by year three.

  - Slide 20: Takeaways: 1) Can California integrate programs into a state unified financing program? Yes. How? Pass legislation, ensure the program meets or exceeds the benefits under federal programs, apply for a combination of waivers, meeting the needs and guardrails set by the feds, ask the HHS Secretary to exercise his discretion, and lastly, make sure we get CMS the appropriate budgeting receipts. Do we need to change federal statute? No. We need a program that meets the parameters of the waivers that do exist and then administratively integrate the federal programs into the state program.

- Presentation by Andy Schneider (View the Presentation on State/Federal Relationship and Financing Mechanisms):
  - Slide 22: Can the Secretary of HHS transfer federal Medicare and Medicaid funds to a unified financing system in California? The short answer: no.
  - Slide 23: The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicare funds to a state for a unified financing system. The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicaid funds to a state for a unified financing system. If California wants to use federal Medicare and Medicaid funds as part of a unified financing system, including single payer, it will need to persuade the Congress and the President to change federal law.
  - Slide 24: Medicare accounted for 20% of California health spending in 2019 ($89 billion)—6.3 million Californians were enrolled in Medicare in 2019; they each have an individual entitlement to a defined set of health benefits. Medicare makes payments on behalf of its beneficiaries for covered services to providers and plans, not to states. The Secretary of HHS has authority to waive compliance with some Medicare rules, but that authority does not allow him/her to transfer federal Medicare funds to a state or its unified financing system.
  - Slide 25: One of the authorities that Carmen mentioned is Section 402(a) of the 1967 Social Security Amendments. Medicare was enacted in 1965. Right after that, Congress said, let's think about giving the Secretary the authority to start doing some demonstrations to see if we can improve Medicare. There's a

general purpose for the authority, then a specification as to what rules the Secretary can change. Section 402 is all about changes in payments, and methods of or amounts of reimbursement. Nothing else.

- Slide 26: Section 1115A of the Social Security Act authorizes the Secretary of HHS to “test innovative payment and service delivery models..." The statute lists 27 different models for testing; none of these is a unified financing system. The Secretary may waive “such requirements of [Medicare law] … as may be necessary solely for purposes of … testing models.” There are some all payer models a state can use, if it wants to set rates for hospitals for example, like Maryland. But in that circumstance, Maryland is telling Medicare what to pay and Medicare is agreeing to pay that rate. Medicare is still doing the payment. Medicare is not sending any money to the state of Maryland. The Secretary may waive under this authority solely the process of testing models, nothing else. You can't mess with Medicare eligibility. You can't mess with a Medicare entitlement. You can't change Medicare financing.
- Slide 27: Medicaid accounted for 14% of health spending in California in 2019 ($62 billion)—12.6 million Californians were enrolled in Medicaid in 2019; they each have an individual entitlement to a defined set of benefits. Unlike Medicare, Medicaid is a federal-state matching program; the federal government will match on an open-ended basis what the state spends on covered services for eligible individuals. The Secretary of HHS has the authority to waive compliance with certain Medicaid rules, but those authorities do not allow him/her to transfer federal Medicaid funds to a state unified financing system.
- Slide 28: Section 1115 of the Social Security Act authorizes the Secretary of HHS to enable states to conduct experimental, pilot, or demonstration projects which are “likely to assist in promoting the objectives of” Medicaid. For such projects, the Secretary may waive compliance with “any of the requirements of section…1902…to the extent and for the period he finds necessary to enable such state or states to carry out such project.” California is in the midst of discussions around CalAIM on what we can waive in Section 1902. The problem on the financing front is the open-ended matching arrangement, which is the entitlement to states for the federal government to match all its expenditures is in Section 1903, not section 1902. Section 1905 is the match for the expansion population. Can the Secretary waive them under Section 1115 as it's now written? No. He only has the authority to waive Section 1902 requirements, and only if they promote the objectives of Medicaid.
- Slide 29: In Section 402 of the 1967 Social Security Amendments, the Secretary may waive Medicaid requirements “insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge…” not relevant to the question of unified financing. Section 1115A of the Social Security Act specifies four requirements that the Secretary may waive in order to test

"innovative payment and service delivery models: 1902(a)(1) – requires that the Medicaid program be in effect statewide. 1902(a)(13) – relates to payment for hospital and hospice services. 1903(m)(2)(A)(iii) – relates to "actuarially sound" rates for managed care plans. 1934 – relates to PACE programs. That's it.
  - Slide 30: Commissioner Schneider presents three sources for this presentation, available here: (View the Presentation on State/Federal Relationship and Financing Mechanisms)
- Commissioner discussion
  - Secretary Ghaly invites commissioners to speak on these two perspectives.
  - Commissioner Wood notes, consistent with what was heard in a previous legislative select committee, there is opportunity to pursue waivers, but who has statutory authority to do what we're asking to do is in question. The conclusion he heard is that it would take federal statute to change that. There may be disagreement around that. Waivers are also time limited and have specific parameters around improvements on existing systems. Not aware if waivers have been granted for an entirely new system, only those meant to improve delivery within the Medicaid system. Veterans' health system is entirely different, which is another consideration. Also important to consider even if the HHS Secretary had the authority, the HHS serves at the pleasure of the President so if the President is not interested, the HHS would not be able to grant that.
  - Commissioner Lee agrees with both presentations on different things: any administration looks at a non-exclusive list as non-exclusive, and the Obama Administration pushed the envelope on what's allowed in a number of areas, but still bounded by the rules. Question for both presenters: Since waivers are at the discretion of the Secretary, that discretion changes with a new Secretary. How long would a waiver last? At most five years? It can't live at the whim of the next President. Where does a waiver provide long term certainty, or protect against a new HHS Secretary coming in and shutting it down sooner? Or how far out could it be extended since a waiver is not a law?
  - Commissioner Comsti notes if we worry about discretion of a political figure, we would never get anything done. No one says that about CalAIM. On duration, the Secretary can renew, whether or not that is limited to 3 or 5 or 10 years, it's just duration and the Secretary decides that. It is a disservice to our state to say the Congress and HHS hold all the strings so we're not going to try. We owe it to the people of California to put something together and ask. We can build a program and a state bill where we can give the state governing authority and the flexibility to adjust to any changes that may happen on the federal level, but we shouldn't throw the baby out with the bath water. We would leave the VA alone, but veterans would be able to be in the program.
  - Commissioner Schneider notes that 5 days before Trump left office, the Secretary approved a 10-year section 1115 Medicaid waiver, $3 billion in

uncompensated care money. Ten years is almost unprecedented but served at discretion of the Secretary. A new Secretary came in, and it was rescinded in April, and now they're in federal court. We don't know how it'll play out, but the takeaway is waivers are limited in time, whether it's 3, 5 or 10 and at the discretion of the Secretary and are subject to challenge by the federal courts. It is not a path to sustainable long-term funding for a universal financing system.

- Commissioner Hsiao highlights a study he did for Vermont to look into this question. Talking to an attorney in this field, as well as people in Washington, the conclusion came back that this is very fuzzy and unclear. There may be a way to move forward, but it would be much clearer if new legislation could be introduced to permit Vermont to do it, then get the funds transferred to Vermont. That's why former Governor Shumlin called President Obama asking officially to introduce legislation. Obama did not think that would be on his priority list. The good news is Vermont still decided to go ahead because it was unclear and thought there may be some legal way, using the Secretary to take some action.
- Commissioner Moulds follows up on a point that Commissioner Schneider made, that we need to think about the courts, not just what the President wants to do, when looking at expansiveness or lack of expansiveness of 1115 waivers. There were lots of examples of that in the Trump Administration. Lots of tests to Secretary's authority and other guardrails in CMS's ability to approve state requests to make changes to their Medicaid programs. It's an important consideration. Questions for Schneider: 1) We didn't hear about 1332 authority, which may be a real opportunity. Part of the impetus for 1332 was for progressive states to do exactly what this group is talking about; and, 2) this is something of a longshot, but when the ACA passed, there was authority granted to the Secretary through CMMI that allowed broad discretion for demonstration projects and to the Secretary broad discretion to adopt policies that were proven effective by those demonstrations. He wonders if there is a potential path through a demonstration to get at least part of the way there.
- Commissioner Schneider notes the reason he didn't speak to 1332 authority is he does not know as much about it, but his understanding is it does not implicate Medicare and Medicaid financing and that the Secretary can't change financing rules for trust funds or matching rules for Medicaid. The model testing notion was for models. The Secretary can essentially mandate that new approach in both in Medicare and Medicaid if that delivery system and reimbursement model work, that is, it's shown not to cost more, improve quality, etc., which is not about financing.
- Commissioner Comsti notes 1332 is new and no one has tried to use it to expand on the waiver authorities. Also, we have not talked about the 1915 freedom of choice waivers. No one has tried to engage beyond the ACA waiver authorities under 1332, but we should try. Can we renew other waivers

within the coordinated waiver process, can we build a program around this? Senator Sanders introduced 1332 as a way to get to single payer. We can challenge ourselves with transfer of funds. How do we administer Medicare and Medicaid? Can the state administer on behalf of CMS or is it a matter of the state fronting reimbursements then trying to seek payment from Medicaid later? Which is why the Shared Savings Program is interesting.

- Commissioner Pan notes that, as a Medicaid provider and legislator who oversees the Medicaid program, he sees an increasing reluctance to directly administer, with more movement to managed care plans. With CalAIM moving more into managed care plans, the state is not wanting to directly administer. The state contracts out or decides what it wants to directly administer. Regarding CalAIM, it had to shrink considerably. That's why CalAIM waivers are under 1915(b), as the 1115 waiver was limited, and we ran into walls there. From a legislative standpoint, while the desire to experiment is appreciated, when it comes to appropriations, many do not want to make promises to patients that they can't deliver. It doesn't have to be definitive—but is seen as inappropriate to assume we will get federal funds or new state revenue. Trying to build this on the unstable discretion of a Secretary, we have to be careful. With a new President and Secretary, we could lose it. This has guided the implementation of ACA and Covered California. It's not that everything has to be certain, but we want to be careful that we don't promise things we can't deliver or are at the whim of someone we can't control. That's going to be important as otherwise we'll lose the trust of the public. The other question is with the ACA, people get refundable tax credits. Biden expanded on that. Veterans can stay on VA, choose which one they want. For Covered California plans, what authority are we looking at? Are we writing off those refundable tax credits? Are we also looking to tap into that stream of funds? Not sure under what authority we could.
- Commissioner Comsti notes 1332 is very clear: the state can get past refunds on federal tax credits and subsidies, we can get it and put it into the state program. On the question of not promising something that we can't deliver and not appropriating on something we can't deliver on, in AB 1400 one of the ways we dealt with that is the program isn't implemented until it's fully funded. We can pass the bill, then go to Feds, then appropriate. We are not going to appropriate money until we have that agreement. We are building alternatives within the system because there a lot of different ways to approach getting the federal share.
- Commissioner Pan asks: So the tax credits, they estimate how much we get and the state claims it?
- Commission Comsti affirms yes, Alaska and Hawaii and a couple of other states have done this. Hawaii had a small business program, which had a totally different small business subsidy program, and they got all their small

business tax credits put into that program. 1332 has a section that says funds can be passed through to the state.

- Commissioner Lee also affirms 1332 allows that to be approved, if it passes financial tests of budget neutrality. APTCs are in the neighborhood of $8-9 billion, which while it is not the biggest piece, it all adds up.
- Commissioner Wright agrees with Commissioner Comsti, noting 1332 is new and that we did explore a 1332 waiver to allow undocumented immigrants to buy into the exchange, without subsidy, just to allow access. Regarding identifying obstacles: they are not an excuse for inaction, but to address how we can get around them. The issue of whether or not undocumented immigrants can buy into the exchange was not waivable, but with the 1332 waiver, the parts that were waivable, one thing we could do was create mirror plans that people would buy identical to qualified health programs in exchanges. This goes to another point: we did pass legislation, submitted a waiver, but then it was withdrawn because of a change in Administration. We do need to be mindful of that as well. To Commissioner Schneider: you mentioned there is not authority to transfer dollars directly, but Commissioner Comsti mentioned the idea of the state being the administrator, is that not a viable workaround? For Commissioner Comsti, what's the backup plan? If denied, do we forego moving forward with the whole system, or is there some complexity we are willing to work with? For example, allow Medicare to exist on its own. Regarding waiver constraints, yesterday the Biden Administration put out the new 1332 guidance. We were pushing for looser guardrails, but the new guidance didn't go as far as we'd like. Budget neutrality comes into play and works against us if we're expanding coverage. This prohibits bad players from doing things, but also limits more innovation. This is something we could push for right now.
- Commissioner Schneider replies he does not think section 1402 or 1115 authorizes the Secretary to let the state administer the Medicare program, but he is not aware of any other waiver authority that would allow that. The Secretary does use private insurers to administer and he is not aware that the Secretary uses state government to do that. In the case of Medicaid, the state runs the program within federal rules, but just the Medicaid program, not Medicare.
- Commissioner Comsti answers Commissioner Wright's question, noting the Shared Savings Program is an intriguing proposition in terms of administering Medicare. If there were some rejection from the feds, that's a question of how we make it as administratively simple as possible for people eligible for Medicare and Medicaid. The ACA question is much easier, other than the budgeting question, in terms of integrating those programs into a state program. With regard to Medicare and Medicaid, can we add everyone else who isn’t eligible, with the same name and with similar enrollment as Medicaid, or do we need dual programs? Does the state program participate in Medicare

as a plan might participate? But we should try the first option first before exploring a Plan B.

- Commissioner Baass urges to ensure that people entitled to traditional Medicaid benefits such as transportation can continue to receive them, to maintain special protections for the disabled, to provide alternative services for institutional care, persons with developmental disability, assisted living, etc. She highlights the need to keep and maintain what we are seeking to do with CalAIM to add services like housing navigation and support that are cost effective alternatives to Medi-Cal.
- Secretary Ghaly notes the blend of using the 1115 and 1915 class, not just (b) but (c), the addition of home and community-based service options here. Some roadblocks on 1115 popped up around budget neutrality and how that is calculated. Then there is the 1915(b) route through managed care and thinking about actuarial soundness. One of the other big things is that these waivers are five years but then we build on them. In the history of California's waivers, they come together nicely and build upon one another. CalAIM takes what was done in recent waiver under whole person care pilots and memorializes it, makes standard the benefits and grows in other areas. It is not one and done; they build on each other, we renew every five years, but continue to do the important things Commissioner Baass mentioned.
- Commissioner Marya notes potential obstacles but urges that if is not specifically prohibited for HHS to move funds through a waiver, we should do it, because of the historic moment we are in with the pandemic. Health care and equitable access to it are on the minds of most people, and more people are encountering the health care system. Someone recently said, "I'm glad I got COVID now because my deductible got covered as opposed to earlier in the year," indicating how broken our system is. She urges the commission to push on limits of what these waivers mean, noting California is a leader in cultural social movements. If we did apply, it would give an opportunity for the Feds to respond and push the whole issue nationwide and might change the dynamic of what we're seeing. The bolder we are in the framing, the more we can push the agenda nationally. Outside of federal waivers, non-federal streams, California's GDP is around $2.9 trillion, between Germany and UK if we were a separate nation. What can we do with non-federal streams, and how can we use our propositions and financial plan to curry political favor, to push the agenda on waivers? She also notes the UN meeting around food systems and asks the commission to think about how we can incorporate food access and farming, so every Californian has access to organic healthy food. As seen with hospitalizations, 67% of people hospitalized have some sort of nutritional derangement.
- Commissioner Comsti replies to the non-federal stream question, highlighting it is important when thinking about sustainable financing to look at what we can do in terms of savings. Instead of worrying about what happens if we don't

get that federal share, in our program savings we are building a cushion, and in terms of non-federal financing it is important to think about corporate taxes, gross receipt taxes, maybe payroll taxes and wealth taxes, and start to have these conversations. If we just wait for Congress or the next Administration for a clear vision, we'll be waiting forever. Thus, she urges the commission to move the ball as far forward as we can on our turf, trying to create that combination of savings, reduced prices, and direct negotiations with payers to build a program where we outcompete everyone, so everyone comes into the program. That should be the goal to strive for. Given the statistics from the community engagement research, she notes, we have to try.

- Commissioner Ross asks if an administrator but not a state, like a private insurance has more ability to administer than the state?
- Commission Schneider affirms yes, as this was a 1960s era program. At the time providers thought the best way to protect themselves from the federal government was to interpose private intermediaries, private insurers. There's been a long history, but the structure is still in place. There's no authority for the Secretary to change that.
- Commissioner Wood comments that experts have said both what Commissioner's Comsti and Schneider said, and the concern is this is complicated, and there are two very different opinions and federal courts to deal with as well. He hopes the commission can agree we don't know exactly, and may have to go in a different direction, and doesn't want to tell people yes, we can do this and go in that direction when we can't. He urges the commission to be realistic with people about what we know and don't know and cautions getting people's hopes so high that we can't deliver and so high that we can't sustain it. If we don't get federal waivers and resources, we need to understand how to get there. We also need to discuss affordability, health care spending rising at twice the rate of inflation. Addressing that must be a critical part of the conversation.
- Commissioner Scheffler presents another problem, which are self-insured plans covered under ERISA that pose a different set of legislative problems. This accounts for 40% of health care spending. Without their participation, which may require changes in federal law about what ERISA can do, we will still fall short of having financing.
- Commissioner Schneider warns he does not know much about employer-based financing and the tax code but does feel that a federal statutory change in this domain, as with Medicare and Medicaid, would be a more stable path toward a unified financing system, not at the mercy of the Secretary at any given time.
- Commissioner Comsti notes that if you don't implicate ERISA with respect to pay or play, that's how you address that. The other point is what Governor Shumlin said: you don't directly regulate in the bill, you regulate insurance, potentially a non-duplication of services provision, and then as a failsafe, you

outcompete the other plans so employers don't want to provide a plan that isn't the state program.
  - Commissioner Flocks highlights there are a lot of creative ways to get around ERISA without changing statute at the federal level. The key issue is that the tax break for health coverage is huge - if California is no longer availing that, that's a savings for federal and state which frees up money and can be leveraged as an opportunity. She encourages a session on tax implications and structure on ERISA.
  - Commissioner Sandra Hernandez brings up Healthy San Francisco and the ERISA issue. She mentions her experiences as chair of that effort, and notes it be worth a mini-case study. Although it was a narrow question regarding ERISA and Healthy San Francisco, they did prevail.
  - Secretary Ghaly sums up, thanking commissioners for a tremendous discussion, noting that Commissioners Comsti and Schneider came with very different perspectives, and that we talked about the gray in a successful way. He notes we are not going to vote in this session, but saw some hands go up and a general sentiment for "let's go for it," let's ask questions about what it means to push the envelope. How this session will fit into the final report is a good example of where, as we learn more about what permissions and authorities exist, we present multiple options. If we discover this or that, we might do it this or that way and take different pathways. In reality, what we end up doing might be a blend, and this provides a terrific substrate to push these different options. He acknowledges again the sentiment among several commissioners to push the envelope, a desire to see something that's different and move forward. At the next meeting, on September 28, we will look at structural racism and equity in the health care system, and talk about the goals and values survey, then on October 11th, we will have a deeper conversation around payments which will build on what we talked about today.
- Public comment
  - Karin Bloomer invites verbal and written public comment.
  - Note: For a transcript of all public comment provided during the meeting, please go to Transcript of Public Comment from September 23 2021 meeting.

3. Adjournment

- Secretary Ghaly thanks the public and commissioners for another rich conversation and adjourns the meeting.