Date: November 10, 2021
To: CAHP/CAHU
From: Rick Kronick on behalf of the Healthy California for All Consulting Team
Re: Comments on Methods and Assumptions

We thank the CAHP/CAHU for their careful review of the Methodology and Assumptions document, and agree with some of their comments. However, we respectfully disagree with many of their statements, which reflect in many cases a misreading of the work we have done.

1. *There is enormous uncertainty in the Commission's cost projections, which are dependent on many highly improbable yet very significant assumptions that could leave taxpayers on the hook for hundreds of billions of dollars.*

We agree that there is substantial uncertainty in our projections, as there inevitably is in any such exercise. We also agree that implementation of unified financing will require state and/or federal policy action, including the California legislature enacting changes to raise revenue that is sufficient to replace most of the funds currently spent by employers and employees for employer sponsored insurance. However, we are confident in our conclusion: If the federal and California legislatures were to enact legislation to implement Unified Financing, and if California voters approved the requisite constitutional amendments, then, under a reasonable set of assumptions about how Unified Financing might be implemented in California, all Californians could have health care coverage, health spending would be no greater, and likely somewhat lower than under the status quo, access to care and health equity would increase, disparities would be reduced, and the rate of growth of health spending would likely be slower than in the status quo.

2. *The analysis often uses flawed, out of date or non-California data to predict California costs. A number of the assumptions simply don't square with reality or come with severe but glossed-over trade- offs for access to health care, as noted by the CBO report.*

We are confident that we have conducted a high quality analysis. We relied on the best available data sources. We look forward to any concrete suggestions from the commenters about better data sources.

3. *Sequence/premature: why is the Commission conducting a cost analysis before it determines the actual design elements of universal financing, which would at least narrow the range and provide Californians and stakeholders a clearer view of what is being proposed? Many of the assumptions are dependent on variables that the Commission can make recommendations on.*

CHHS asked us to provide Commissioners with information about the potential effects of Unified Financing on outcomes such as health spending, access, and equity. There are certainly cart and horse problems here – the effects of Unified Financing on outcomes depends, in part, on design decisions that have not yet been made about how Unified Financing would be implemented. For this exercise, we made a number of reasonable assumptions about various design parameters, but Commissioners might well support other assumptions. A main purpose of the exercise is to demonstrate that there are a variety of reasonable design choices for Unified Financing that would result in universal coverage, increases in access and health equity, and lower levels of health care spending.

4. *A significant portion of the report's projected cost savings under Unified Financing (UF) appears to come from significant cuts to provider payments and from pharmaceutical savings. Putting aside the unrealistic nature of these assumptions, they would harm the access Californians would have to both providers and prescription drugs.*

The commenters misrepresent the assumptions we make. The only reductions we assume in provider payment rates are to reflect the estimated reductions in provider billing and insurance (BIR) related costs under Unified Financing. We assume, for example, that hospital BIR costs would decline by 5% (at non-Kaiser hospitals), and that hospital revenue would be 5% lower as a result. There is no reason to think that change will create access problems – hospital costs and revenues are expected to be reduced by equivalent amounts. Aside from the BIR savings, we do not assume any reduction in provider payment rates, and there is no reason to anticipate access problems. We do assume substantial reductions in pharmaceutical prices. It is possible that some pharmaceutical companies might refuse to sell their products at a price that California is willing to pay. However, the prices we assume in California are similar to the prices paid by many Western European countries and the VA, and there are few instances of drug companies not being willing to sell drugs in either of those settings.

5. *The analysis appears to omit a number of considerations which could drive up costs even further under UF, including a) lost revenue to the state from the loss of the hospital waiver and MCO tax, b) the lost revenue from the insurance tax, bank and corporations tax, local property taxes and income taxes no longer paid by health plans and their employees, and c) the potential for medical tourism to California.*

Some current funding flows would likely be interrupted or redirected under UF; however, those changes do not affect the outcomes we estimated. The analysis we provided focused on estimating the effects of Unified Financing on health spending. We did not provide estimates of how much revenue would need to be raised in California. If there is lost revenue from loss of the hospital waiver or the MCO tax (and there is no necessary reason to think that there would be lost revenue), then that would affect the revenue that needs to be raised, but not have any direct effect on spending. Similarly, if the tax revenues listed do decrease, that would also affect the state's revenue needs, which, to reiterate, were not addressed in our analysis. The commenters are correct that if people in need of care move to California, establish residency, and enroll in coverage, then health spending would be greater than the estimates we provided. We did not address how residency would be established, a topic that would need careful consideration in the implementation of Unified Financing.

1. Federal waivers

We agree with the commenters that it will be a significant challenge to convince Congress to enact legislation that would allow the federal government to write a check to California's Unified Financing authority in lieu of making direct payments for Medicare and Medi-Cal services. And we agree with the commenters that even if the federal government were to agree to support Unified Financing in California, that there is some danger that a future Congress or Administration might seek to renege on the agreement. However, it would be possible to include terms in enabling legislation that would make it more difficult for the federal government to renege on its commitments.

While it is always possible, as the commenters are concerned, that the federal government would not make timely payments to the state, the federal government has a long and extensive history of paying its obligations on time.

The commenters are concerned that Unified Financing might not be achievable if either the Federal government does not provide an ERISA waiver or California does not require ERISA plans and their employees to participate. We do not assume that the federal government would provide an ERISA waiver (although legal challenges could be minimized if federal enabling legislation clarified that the Congress did not think that any features of Unified Financing ran afoul of ERISA). We also do not assume that California would require ERISA plans and their employees to participate. However, we do assume, as seems overwhelmingly likely, that if California were to offer high quality coverage under Unified Financing to all California residents, that ERISA plans would not offer duplicate benefits to employees.

2. Additional prerequisite actions

We agree with the commenters that voter approval of constitutional amendments in California would be required to implement Unified Financing. If voters did not approve the requisite constitutional amendments, Unified Financing would not be implemented. While it is theoretically possible that future voters could vote to change the California constitution again to revoke approval for Unified Financing, if Unified Financing were implemented, it seems overwhelmingly likely that voters would not seek to revert to a fragmented financing system.

3. Deficit spending

Commenters correctly note that California does not have the ability to run deficits. In our estimates of health spending, we assume that a reserve fund would be created to cover unexpected, short term increases in spending or shortfalls in revenue. The commenters are correct that if projected health spending grows more quickly than projected revenue growth, then either health spending growth would need to be reduced, revenue growth would need to be increased, or other state spending would be crowded out. Under UF, this dynamic, along with more powerful levers, would, we think, lead to much greater pressure to control spending growth than exists in the status quo fragmented financing system.

The commenters ask:

- *Why isn't the Commission using the costs of getting to universal health coverage using the existing system as the baseline? Even if the Commission doesn't use this as a baseline, we encourage the Commission to compare the costs of obtaining universal coverage under the Affordable Care Act to those of creating an entirely new universal financing system.*

The commenters are correct that if the only goal of financing reform were to achieve universal coverage, it would be much less disruptive to existing coverage and financing arrangements to build on the progress made under the ACA than to move wholesale from fragmented to Unified

Financing. However, the charge to the Commission is to explore the ways in which Unified Financing could be implemented in California, not simply to explore how universal coverage could be achieved. Further, it is clear that achieving universal coverage through building on the ACA would lead to increases in health spending, would not provide additional levers to control health spending growth, and would not lead to increases in equity to the same extent as Unified Financing, or in access to care for currently underinsured Californians.

The commenters write:

- *Why doesn't the baseline reflect the impact of recent activities to improve cost?*

  The baseline projections appear based on a hodgepodge of different data sources – they start with 2014 California data and trend using national numbers. Why isn't the Commission using California data to model California trends?

To estimate the multiple effects of sweeping change required us to draw on data from a variety of sources. We did use recent data from the California Department of Finance on Medi-Cal spending, and, in a variety of places, incorporated data from the California Department of Managed Health Care, from the California Office of Statewide Health Planning and Development (OSHPD) and from the California Integrated Healthcare Association. However, the commenters are correct that estimates of baseline spending are largely based on estimates of 2014 state health spending published by CMS, trended forward. We started with the 2014 estimates because those are the most recent estimates available for state health spending. If the commenters have concrete suggestions of other data sources and concrete suggestions for how those data sources should be used, we would be happy to consider those suggestions.

The commenters write:

The end of the report acknowledges that all estimates are "subject to substantial uncertainty" and that additional study will be required to have a clearer picture of CA-specific costs – to what extent does this impact the suggested range of overall costs? It does not instill confidence in the Commission's final work product if the cost estimates that are the basis for developing universal financing are so uncertain. Does the Commission plan on rerunning the cost estimates prior to finalizing its report?

To correct the record, while we did write that all estimates are subject to substantial uncertainty, we did not write that additional study would be required to have a clearer picture of CA-specific costs. Notwithstanding uncertainty in the estimates, it does seem overwhelmingly likely that IF Unified Financing were implemented using the assumptions made in one of the scenarios for which we have provided analytic results, THEN: access and equity would be increased, and would likely increase more over time than in the status quo; health spending would be no greater, and likely lower than in the status quo; and levers to reduce the rate of growth of health spending would exist, as well as greater pressure to do so. If Commissioners coalesce around alternative scenarios for how Unified Financing might be implemented, and if time and resource constraints permit, additional analysis might be performed.

The commenters write:

This analysis assumes an almost immediate implementation in 2022. This is not just unrealistic – it is impossible given the timing of some of the required prerequisite actions, . . .

We agree with the commenters that a 2022 implementation is not possible. We used that date for illustrative purposes. The main results of the analysis would not be changed with an assumption of a later start date.

The commenters write:

The estimate of the cost of covering the uninsured in 2016 ends up being around $281.50 PMPM – a figure seemingly based on a number of assumptions including an Oregon study. On its face, this is too low.

If anything, the Commission should ask Covered CA for a more reliable estimate of the cost of covering the previously uninsured.

The commenters apparently overlook data showing that the remaining uninsured are disproportionately young, and also are likely to be a relatively low risk group. Our estimates of the cost of insuring the remaining uninsured are consistent with those made by the Congressional Budget Office and many other analysts.

The commenters write:

The analysis assumes an average level of dental benefits per year, which translates to $1,000-$1,500 max (annual caps) and significant cost-share or coinsurance.

This is usually what employers provide, so to use this seems to fly in the face of single payer. Recent single payer bills in the Legislature did not limit dental coverage in any way, so these costs could be low and not reflective of the envisioned single payer system.

We agree with the commenters, and we tried to make the same point in the Methods and Assumption document, where we wrote:

"Most private dental insurance includes annual maximum benefit amounts, as well as significant (often 50%) coinsurance on orthodontia, crowns, and other major procedures. Assuming that the limitations on dental coverage were reduced or eliminated under Unified Financing, dental utilization and expenditures for people currently covered by private insurance would be expected to increase. However, we are not aware of research that would provide guidance on how much change in expenditures to expect among those covered by private insurance. Further, because dental expenditures are a relatively small part of total health expenditures, we have chosen not to invest additional analytic resources in estimating the

increase in expenditures from eliminating or reducing benefit limitations in current dental policies. As a result, our estimates should be interpreted as estimates of the effects of providing the average level of benefits in status quo private dental insurance to all Californians, and not to the effects of providing unlimited dental coverage with no patient cost sharing. The latter would certainly result in higher dental spending than we estimate here."

Spending on dental services accounts for approximately 4% of California health expenditures. Even a fairly substantial increase in this 4% will be relatively small share of total health expenditures.

The commenters write:

The analysis predicts that getting rid of cost sharing will increase health care costs by only 5.6% due to a slight uptick in utilization. However, the analysis doesn't appear to account for the estimates elsewhere in the report that cost sharing is 8.7% of total health care expenditures. Those payments are taken in by hospitals and providers, so erasing them creates a significant overall reduction in payments to providers.

The commenters have misread our results. In the scenario in which cost sharing is eliminated, the fraction of total health expenditures that are currently made through out-of-pocket payments would be shifted into spending made by the Unified Financing authority in the direct payment scenario, or by health plans and health systems in the scenario in which intermediaries are used. But this shift would not, in and of itself, be an increase in health spending. The estimated 5.6% increase in health spending is an estimate of the increased demand that would result from the elimination of costs sharing.

The commenters ask:

- *Do the estimates for a 50% reduction in average hospital costs account for the reduction in cost sharing payments made to hospitals?*
- *Do the estimates for reduced provider payments account for this lost revenue?*
- *Are the predicted administrative savings to hospitals (5%) and providers (7%) erased by the elimination of cost sharing payments?*

In our estimates, we assume that, to the extent that cost sharing is reduced or eliminated, payments that are currently made out-of-pocket by patients will instead be made by the Unified Financing authority or by health plans and health systems. Providers will not lose revenue as a result of the reduction or elimination of cost sharing. Further, to the extent that it is costly for providers to collect cost sharing amounts, collection costs will be reduced or eliminated.

The commenters write:

Income-related cost sharing in a fee-for-service environment would be complex, especially if it was tied to current income.

We agree that income-related cost sharing is more complex than no cost sharing or income-invariant cost sharing. However, income-invariant cost sharing would almost certainly create undesirable access barriers for low-income Californians. If Unified Financing were implemented with income-related cost sharing, we would suggest that income be determined by prior year income, with some possibility for exceptions in the case of substantial decline in income.

The commenters write:

Actuarial Value may not be appropriate to use in determining premium cost shares. There are two cost share options on page 7. One would use actuarial value to determine payment tiers based on FPL. Actuarial Value does not equal cost – there are benefits not included in Actuarial Value that can also drive up costs. This could create misalignment between anticipated revenue and medical costs creating a liability for the state.

This strikes us as a minor point, unlikely to materially influence overall estimates.

The commenters write:

The report assumes the average employer sponsored Actuarial Value is 89% (platinum). This does not take into account large self-funded plans that typically have larger deductibles. A more realistic assumption would be that the average employer sponsored plan is closer to gold (80%).

We agree that the estimate that the average AV for employer sponsored insurance is 89% is surprisingly high. However, this estimate starts, as the commenters urge, with California-specific data from the Department of Managed Care, which is consistent with an estimate that the average AV for the 40% of the market covered by large group insured plans is a surprisingly high 92%. National data from the Dept. of Labor shows that the AV for self-insured plans is slightly lower than for fully insured plans, but the difference between self-insured and fully-insured in the national data is relatively small. If the 92% AV estimate for the 40% of the market that is self-insured is correct (and the commenters do not seem to dispute that estimate), then the AV for the other 60% of the market would need to be 72% if the commenters suggested 80% AV for the average ESI plan were correct. An estimate for a 72% average AV for self-insured plans is certainly way too low, and inconsistent with information from employer surveys on average deductible levels. If the commenters have any data to share that would improve the accuracy of the estimate of average ESI AV, we would be delighted to receive it.

The commenters write:

The induced utilization assumption used is way too low and is based on a Rand Health Insurance Experiment from the first term of the Clinton administration (1993). The report goes from average Actuarial Value of 92.8% to 100% and assumes total costs would increase 8.7% (7.2% cost sharing and 1.5% induced utilization). Based on the normal induced utilization factors used for pricing, it is more likely total costs will go up closer to 15%-20%.

This is a misreading of our results. As a minor point, we note that the Rand HIE was conducted between 1971 and 1982. More importantly, we assume that eliminating cost sharing would increase utilization and spending by 8.7%. As discussed above, that increase would be *in addition* to the shift of 7.2% of spending from out-of-pocket to the Unified Financing authority (or to health plans and health systems). Perhaps the comment about the 'normal induced utilization factors used for pricing' indicates that the premium is 15%-20% higher for a plan with no cost sharing than for a plan with an AV of 93%. If that interpretation of the comment is correct, then our results are quite consistent with the commenters expectations. We expect health spending for covered services would increase by 8.7% if AV goes from 92.8% to 100%. Adding the shift of 7.2% of spending from out-of-pocket to third party payment, the 'pricing' of an insurance product would increase by 16%, consistent with the 15%-20% range.

The commenters raise a number of concerns and questions about our estimates on drug spending. The commenters write:

The drug issue alone creates a swing of 5.8% in the estimates. If Congress doesn't pass legislation the estimates of savings are erased.

We make no assumptions about Congressional action on drug pricing. Although legal challenges from the pharmaceutical industry might be anticipated, we are aware of no legal impediments that would prevent California from taking a variety of aggressive actions to reduce pharmaceutical pricing.

The commenters ask:

If any of the drug savings come from those purchased by physicians and office-based injections this would result in a significant income loss to those physicians. Is this factored into other reductions in physician reimbursement?

For physicians who are administering office-based injections, we assume that the price that physicians would pay to purchase those drugs and the payment they would receive to administer them would be reduced. To the extent that some physicians are currently making a profit by buying drugs at a lower price than the price that Medicare or other payers assume when making payment, that source of profit would be eliminated.

The commenters ask:

It appears the cost increase from eliminating managed care is derived by estimating the number of Californians in managed care (59%) and multiplying it by 10% to derive a 5.9% increase. Why not instead calculate this based on total % of expenditures?

It would arguably be preferrable to use an estimate based on the share of total expenditures associated within managed care arrangements, although any such estimate will have more uncertainty than the enrollment-based estimate. Given that managed care penetration is higher than average in the relatively low cost Medi-Cal population, and lower than average in the relatively high cost Medicare population, we suspect that an estimate based on spending would be similar to the enrollment-based estimate.

The commenters ask:

The report appears to acknowledge that our health care system can't handle the increase in utilization caused by single payer under a FFS model – but also includes an assumption that California would need to expand the workforce. How much would the expanded workforce cost?

We provide estimates of increased utilization and the increased revenue to providers that would accompany the increase in utilization. The analysis does not directly address the question of to what extent additional health care providers will be needed versus to what extent existing providers will be able to provide additional services. The analysis assumes that revenue to hospitals and other health care entities will increase as utilization increases, and the increase in revenue will allow hospitals to hire additional nurses and other staff as needed.

The commenters ask:

Labor costs are at least 60% of health care costs: does this mean nurse staffing ratios will be reduced to take care of additional utilization, since most of a hospital's costs are driven by labor? Shouldn't this report estimate the impact of lower salaries for health care workers in its calculations?

In the estimate provided by the commenters that labor costs are at least 60% of hospital operating costs, labor costs include costs of clinical staff and other staff directly involved in patient care, as well as the cost of administrative personnel not directly involved in patient care. Although in the long run, all costs are marginal, in the short to medium run it is likely that some labor costs and many of the costs of operating the hospital physical plant will not change as volume expands marginally. It is our understanding that the global budgeting system in Maryland assumes that marginal costs are 50% of average costs, and all payer rate setting systems in New York, New Jersey, and Massachusetts used a similar figure when they were implemented in the 1980s. There is not strong evidence, as far as we are aware, about how much hospital costs change when volume changes. Even without strong evidence, it is clear that marginal costs are less than average costs, and the 50% estimate is consistent with the approach taken by other rate setting systems in the US. The results are consistent with a

scenario in which there is no change in nurse staffing ratios or in average salaries for health care workers.

The commenters ask:

- *How would items such as capital repairs, new hospitals, California seismic requirements be funded?*

There are two parts to this question: one relating to whether there would be enough money in the system to fund new capital expenses, and a second relating to how decisions about capital investment would be made. To the first part of the question, in year 1 of Unified Financing, in the analysis we have provided, hospitals and other institutions would receive as much revenue as they would have under the status quo, with the exception that revenues would decline to reflect estimated reductions in billing and insurance related costs, and increase to reflect additional utilization. In subsequent years, it is possible that the rate of growth in hospital revenues would be somewhat slower than in the status quo (see more on this below), and it is possible that the rate of growth of new capital investment will slow. To the second part of the question, regarding how decisions about capital investment would be made, we did not make any assumptions about that process, because such assumptions were not needed to estimate the effects of Unified Financing on aggregate spending. It is reasonable to think that there would be greater public involvement in capital investment decisions, perhaps akin to the Certificate of Need process, but different from that process in that the effects of capital investment decisions on health spending would almost certainly feature more prominently in decisions.

The commenters write:

The report makes no mention of Medicare's special payments (DSH, IME, GME, and others) and whether that money would be kept in the baseline (and distributed as Medicare would have done).

The Methods and Assumptions document states that the analysis assumes hospital budgets (or DRG rates if DRG rates are used) would be based on the revenue that hospitals receive in the status quo. Implicit in this statement is the assumption that hospitals that currently receive DSH, IME, and GME payments from Medicare would have a budget (or DRG rates) that would lead to an equivalent amount of revenue. (As discussed in response to Commissioner Comsti's comments, at a hospital-specific level it likely makes more sense to start with operating costs, not operating revenue, in determining hospital budgets (or DRG rates). Basing budgets on operating costs will continue to provide support to teaching hospitals.)

The commenters ask:

What impact would this have on many hospitals' ability to operate?

To reiterate, in Year 1 of Unified Financing, under the scenarios we've analyzed, the only change in hospital revenues would be the reduction in revenue associated with reduced billing and insurance related costs, and the increase in revenue from increased utilization. These changes should not have any material effect on hospitals' ability to operate. We address the longer term questions below.

The commenters write:

A large part of the savings projected by the analysis appear dependent on capping provider growth and reducing it by 10% over time.

- *How much would this actually save?*
- *What percentage of these putative savings would come in the form of reductions to provider salaries or reimbursement rates?*
- *If some reductions were required, which providers would see cuts? What impact would these cuts have on the ability of the state to recruit the additional workforce required?*
- *Equitable access to care is important. Efforts to cut provider rates will likely exacerbate poor access to care in underserved areas because providers may not continue to operate in those areas.*

To be clear, the analysis does not 'cap' provider growth. However, the commenters are correct that the analysis does assume that health expenditure growth will be somewhat slower under Unified Financing than under the status quo fragmented financing system. The estimated effects of slowing health expenditure growth are displayed clearly on slide 23 of the presentation: slowing expenditure growth to the rate of growth of the rest of the economy would reduce expenditures by approximately 10% relative to the status quo nine years after Unified Financing was implemented; reducing the rate of growth by 0.5% annually would save about 4.5%.

Health spending equals price times quantity.

It is quite possible that a slower rate of health spending growth, if accomplished in a thoughtful fashion, could be accomplished primarily by a slower rate of growth in quantity, and this slower rate of growth in quantity would be compatible with improvements over time in access to care, in quality of care, and in equity. These beneficial effects could occur if a slowdown in spending growth is accomplished by some or all of the following: a reduction in fraud and abuse; a reduction in the delivery of low-value care; a slowdown in the rate of growth of the diffusion of expensive new technology, more closely matching the rate of diffusion of new technology with the value that the new technology offers (a subset of the 'reduction in low-value care' approach); a reduction in the rate of growth of pharmaceutical prices as the result of more negotiating leverage; increased investment in primary care and prevention, leading to fewer acute care needs; decisions about end-of-life care that pay more attention to the preferences of patients and their families, likely leading to less aggressive care at the end of life; shifting

health care resources over time from areas with an abundance of resources to those where resources are scarcer.

There is nothing magical about Unified Financing that will provide ironclad assurances that any of these beneficial effects will occur. It is possible that fraud and abuse and low value care will not decrease; it is possible that more resources will not be devoted to primary care and prevention, or that these resources will not lead to improvements in health status and a decreased need for acute care; it is possible that the rate of growth of pharmaceutical prices will not change; it is possible that there will be no change in the use of resources at the end of life.

If Unified Financing does not result in a slowing in the rate of growth of utilization, then slowing the rate of growth of spending would require slowing the rate of growth of prices. At the extreme, if Unified Financing had no effect on utilization, and slowing the rate of growth of spending were accomplished entirely by a reduction in the rate of growth of prices, then nine years after the implementation of Unified Financing, prices would be approximately 10% lower than under a continuation of the status quo if spending growth were reduced to the rate of growth of the rest of the economy.

The effects of lower prices on access, quality, and equity of care are unclear. If physician prices were 10% lower under Unified Financing than under the status quo (in addition to the reduction in revenue to account for lower billing and insurance related costs), then, unless physicians were able to reduce office expense, physician net income might be 20% lower than under the status quo. That is a large enough difference that it might make it difficult to attract and retain a high quality physician workforce. However, physicians might well value practicing in an environment in which they are not required to perform 'wallet biopsies' (that is, not be required to be concerned with whether their patients could pay their bills), and in which they are able to provide the same quality of care to all of their patients. And since the changes in revenue would be gradual and occur over a decade and could largely be anticipated, many physicians might be able to adjust to those changes and happily remain in practice in California.

This dynamic would certainly have limits – if physician net income in California were much lower than in the rest of the nation, and if the divergence were expected to increase indefinitely, California would have difficulty attracting and retaining the desired physician workforce. A similar dynamic would apply to the mid-level workforce.

Similarly, if hospital budgets increased more slowly under Unified Financing without any change in the rate of change in the volume of services provided by hospitals, hospitals would either need to become more efficient at producing care, or would need to decrease quality. Increases in efficiency are certainly possible and could be expected. There are large differences across hospitals in cost per day and cost per admission, with little evidence that more expensive hospitals produce better outcomes. It is certainly possible to imagine that hospitals could, on average, reduce cost per admission by 10% over the next decade without a negative effect on quality or outcomes.

Related to equity, it is reasonable to expect that under Unified Financing, if the rate of growth of prices needed to be slowed, that a Unified Financing authority would work to protect price growth in underserved areas, and use the financial pressures as an opportunity to increase equity.

To summarize, if slowing the rate of growth of spending under Unified Financing were accomplished entirely by slowing the rate of growth of prices, then there would be reason for concern, although even under that scenario, it is quite possible that access, quality, and equity could continue to improve. More importantly, it seems likely that under Unified Financing, slowing the rate of growth of spending could be accomplished largely, and potentially entirely, by slowing the rate of growth of utilization, with largely beneficial effects for access, quality, and equity.

The commenters ask:

The report also appears to assume that California will be paying hospitals a global budget capitated amount. However, the state will very likely want to see claims and encounters to control costs – what impact will this have on the estimated administrative savings?

Yes, the analysis assumes that hospitals will be required to provide patient-level reports on utilization even in a global budget scenario. It will be important to have such information in order to measure and reduce disparities. Further, if global budgets are adjusted for changes in volume, utilization information will be required to implement volume adjustments.

The commenters write:

Currently, employer plans frequently administer benefits with programs that incentivize wellness and help control chronic conditions through incentivized participation. Can and will the state mandate engagement in these programs that currently result in lower costs? If not, what will be the impact?

There is very little evidence that employer wellness programs result in lower cost.[1]

Finally, the commenters write:

The Commission's failure to engage in this regard has resulted in a set of cost projections that are wildly unrealistic and if implemented would cause massive disruptions to health care.

We vigorously dispute the charge that the cost projections are wildly unrealistic. We agree, as stated earlier, that it will be extremely challenging to get the federal government to write a check to the California Unified Financing authority in lieu of making direct payments for

[1] See, for example: Abraham, JM. Employer wellness programs: A work in progress. *JAMA.* 2019;321(15):1462-1463. doi:10.1001/jama.2019.3376

Medicare and Medi-Cal beneficiaries. We acknowledge that it will be challenging for the California legislature to enact revenue increases to transfer voluntary employer and employee payments for health insurance into publicly funded coverage. And we agree that it will be challenging to persuade California voters to approve the necessary amendments to the California constitution to allow Unified Financing to be implemented. However, we remain confident in the results of our analysis, which are similar to results of many other analysts: IF the federal and state legislation necessary to implement Unified Financing were enacted, and IF the required constitutional amendments were approved by California voters, and IF Unified Financing were implemented with the high-level design parameters assumed in our analysis, THEN Unified Financing could be implemented without massive disruptions in the delivery of health care, with improvements in access, quality, and equity, without increases in health spending, and in a sustainable fashion over time.