Date: November 11, 2021
To: Carmen Comsti, Commissioner, Healthy California for All Commission
From: Rick Kronick on behalf of the Healthy California for All Consulting Team
Re: Comments on Methods and Assumptions

We appreciate Commissioner Comsti's helpful and constructive comments, dated July 31, 2021, on the estimates of the effects of Unified Financing on health spending, access, and equity presented to the Commission on May 25, as updated on July 8, and on the Methods and Assumptions document and accompanying Excel spreadsheet that describe the methods used to generate those estimates. In this document, we respond to questions and concerns raised in Commissioner Comsti's comments.

Before responding to the Commissioner's technical questions and concerns, it is important to clarify how the estimates presented on May 25th and subsequent revisions relate to the main body of work that the Commission is doing. As Secretary Ghaly stated in the Commission meeting on June 25, the final report of the Commission will focus on Commission deliberations, capturing themes and comments articulated by Commissioners. Building on meeting themes and comments, Commissioners will, through an iterative process, weigh in on the goals, values and propositions that should guide California's steps toward Unified Financing. To the extent that the estimates presented on May 25th are useful to Commissioners as they form opinions about how Unified Financing might best be implemented in California, then those estimates will influence the contents of the Commission's Final Report.

Specific responses:

In 1a, Commissioner Comsti writes: 'it is clear that under a single-payer health care system California would spend less and get more care when compared to both to our current fragmented health system and to the intermediary scenario.'

As the Commissioner notes, we did estimate that in a direct payment scenario, health spending in 2023 might be approximately $3-$4 billion lower than in a scenario in which intermediaries are used. However, given the level of uncertainty in estimating spending, it would be more accurate to state that the estimates show that spending in the direct payment and intermediary scenario would be approximately equal, not that California would spend less in the direct payment scenario.

1b) Many of the estimates that Commissioner Comsti requests are presented on slide 23 of the presentation and in the 'Output 3' tab of the Excel spreadsheet. To the extent possible, we present estimates of the beneficial effects of Unified Financing on access and health outcomes on slides 25-30, although we acknowledge that the evidence base about the effects of Unified Financing on many important outcomes other than health spending is sparse.

1c) The Commissioner requests that the estimates assume that:

a) *Payments to primary care physicians be made at the weighted average of current payment rates*
b) *Payments to specialist physicians be made at Medicare levels*
c) *Global budgets to hospitals and outpatient clinics be based on the institutions' operating expenses.*

To a large extent, the assumptions we make about physician and hospital payment levels are consistent with the assumptions Commissioner Comsti suggests. The main exception is a difference in assumption about payment to physician specialists, where we assume payment would be made at the weighted average of current payment rates minus the estimated savings from reductions in billing and insurance related costs, rather than at Medicare rates. Further, as described in the Methods and Assumptions document, we assume that payment rates to both physicians and hospitals would decrease to reflect the expected decrease in administrative costs under Unified Financing.

For hospitals and outpatient clinics, the assumption we make about average payment rates is quite similar to the assumption that Commissioner Comsti suggests. Our assumption is different from Commissioner Comsti's suggestion in two ways: first, as noted above, we assume that payment rates would be reduced by estimated reductions in administrative costs. Second, our estimates start with hospital (and other providers) current level of operating revenue, while Commissioner Comsti suggests starting with operating costs. For hospitals, operating margin – that is, the difference between operating revenue and operating costs – has averaged approximately 4% over the 2014-2018 period (although almost certainly declined substantially during COVID as operating costs increased and revenue decreased). The average total operating hospital margin statewide averaged approximately $4 billion per year from 2014-2018, or a little less than 1% of state health spending.[1]

We agree with Commissioner Comsti that in determining the global budget for a given hospital, or, alternatively, determining the DRG rate for that hospital, it would make more sense to determine the budget (or the DRG rate) based on operating costs, and not operating revenue. That is, it makes sense to us that a hospital with a 12% surplus of revenue over cost should receive a budget (or a DRG rate) based on its costs, not its revenue, and, similarly, a hospital operating at a deficit should not have that deficit baked into its payment stream under Unified Financing.

However, for the purposes of modelling aggregate spending under Unified Financing, the effect of starting with operating costs rather than operating revenue to estimate aggregate spending will be minimal. As noted above, the difference between operating costs and operating revenue averages a little less than 1% of state health spending. Further, if hospital budgets were based on operating costs, some allowance would be needed to fund capital investments.

[1] Data from OSHPD: https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/ec126df1-4eea-4289-b8d7-8e6739a40183.

Although we don't have an evidence-based estimate of how much money would be needed to fund capital investments, an allowance of about 4% of costs seems in the right neighborhood.

For physicians, Commissioner Comsti suggests that primary care rates should be at the weighted average of current payment rates for all payers, and rates for specialists should be at Medicare rates. The suggested assumption about primary care rates is similar to the assumption we make, although, as with institutional providers, we assume that rates would be reduced to reflect estimated reductions in administrative costs.

The suggested assumption about payment rates for specialists – that they be paid at Medicare levels – would result in substantially lower payments to specialists than under the status quo, and substantially lower than we have assumed in our modelling. An extremely rough estimate is that payments to specialists from private insurers average approximately 150% of Medicare payment levels, and that Medi-Cal payment to specialists averages approximately 70% of Medicare, with lots of variation around these extremely rough estimates by specialty and by medical group.[2] (Although we are unaware of solid data on private to Medicare ratios by specialty, private insurer payments to radiologists and anesthesiologists are substantially greater than 150% of Medicare.) Assuming that the average payer mix for specialists is 60% private, 18% Medicare, and 12% Medi-Cal[3] (again with lots of variation around these averages by specialty and by physician), then the weighted average status quo payment level is 130% of Medicare. Thus, an extremely rough estimate is that a reduction to Medicare payment levels would be a 23% reduction in reimbursement for the average specialist, with substantially larger reductions for physicians in some specialties, and for physicians who currently have relatively few Medicare and Medi-Cal patients. (We assume that the reduction for assumed savings in lower administrative costs would be on top of the reduction to Medicare levels.)

Payments to physicians account for approximately 20% of aggregate health expenditures, and payments to specialists likely account for approximately 75% of payments to physicians, or 15% of aggregate expenditures. Thus, the direct effect of a 23% reduction in payments to specialists might be on the order of magnitude of a 3% reduction in aggregate expenditures.

---

[2] In Lopez, et. al,. How Much More Than Medicare to Private Insurers Pay? A review of the literature, https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/, the authors report an average private to Medicare ratio of 143%. Trish and colleagues and Pelech and colleagues each show that private to Medicare ratios for services delivered by specialists are substantially higher than for evaluation and management services. Trish, Erin et. al. 2017. "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance". JAMA Internal Medicine. 177(9): 1287-1295. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349, and Pelech, Daria. 2018. "An Analysis of Private Sector Prices for Physicians' Services". Washington, D.C.: Congressional Budget Office, Working Paper 2018-01. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf. Zuckerman and colleagues estimate that Medicaid physician fees in California for services other than primary care were approximately 70% of Medicare levels in 2019 (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611).

[3] See Table 4 of the CMS Nationlal Health Accounts. We are not aware of California specific data for this statistic.

An immediate 23% reduction in payments to specialists (in addition to the reduction due to assumed reduction in administrative costs) would almost certainly make it more difficult to attract and retain a high quality workforce of specialists in California. If Unified Financing were being implemented nationwide, there would not be much concern about specialists moving to Canada, Europe, or other countries. With nationwide implementation, a reduction in reimbursement to specialists would likely cause, over time, an increase in interest in primary care, which we and many others would view as a positive effect. However, if Unified Financing were implemented in California while the rest of the nation continued with fragmented financing, newly minted physicians finishing their fellowships would be less likely than in the status quo to begin practice in California, and existing physicians would be more likely than under the status quo to move to other states. The opportunities for out-migration might be especially large for physicians perceived to be higher quality. Fewer specialists in California would create indirect effects on aggregate health spending in California. The indirect effects on spending from an outflow of specialists would potentially be much larger than the direct effect from lower payment to the existing stock of specialists. Lower spending would be a result of lower utilization, and many patients would certainly complain about inadequate access to care. The effects on quality of care and patient outcomes are unclear.

1d. Our estimates are based on the assumption that in a scenario with intermediaries, each intermediary would offer an identical package of health benefits (including identical cost-sharing, if cost-sharing is used). Further, maximum payment rates to physicians, hospitals, and other providers would be determined by the Unified Financing authority (just as they would be in the direct payment scenario), although intermediaries could negotiate capitated, salaried, or other payments with providers. Intermediaries would be paid a risk-adjusted capitated amount.

1e. The summary of the methods and assumptions document has been made public. We are happy to distribute the excel spreadsheet to any member of the public who requests it. The difficulty in posting it to the website is that modifications required for ADA compliance are at odds with the user's ability to manipulate data and follow the formulae that link cells together.

1f. If Federal legislation is enacted that is likely to have a material effect on the estimates, we would revisit the estimates, subject to time and resource constraints.

1g. At the August, 2020 Commission meeting, we provided estimates of the revenues that would be generated by a number of potential revenue sources.

IIIc. As discussed above, we expect the final report will reflect the content of Commissioner discussion and deliberations. We expect that the estimates provided in May will be an adjunct to the final report. We note that in the scenario that contemplates some cost sharing, we assumed no cost sharing for Californians with income below 138% of the Federal Poverty Level, and quite limited cost sharing for Californians with incomes between 138% and 400% of FPL. Although there is always concern that cost sharing might cause some people to avoid or delay receiving care that would improve their health, eliminating cost sharing for low income

Californians and sharply limited cost sharing for moderate income Californians would substantially mitigate those concerns.

IIId. There are many unknowns in estimating the savings from reduced prices for prescription drugs under Unified Financing, starting with uncertainty about what the policy might be, which has not been discussed by Commissioners. It is important to remember that Medi-Cal, which accounts for 10% of prescription drug sales, already pays much lower prices than other payers, and that prices paid by large integrated health plans are likely much lower than prices paid by other payers. An estimate of 40% average savings will be viewed as overly aggressive by many, and is consistent with the estimates in the Pollin analysis.

IIIe. We appreciate Commissioner Comsti's review of the literature on some of the problems created by managed care plans. As discussed above, we expect the final report will focus on themes emerging from Commissioner deliberation. Propositions emerging from the process may reflect wide agreement or capture differences of opinion among Commissioners but will not be determined based on the consulting team's review of the literature.

Commissioner Comsti writes:

'While it is not entirely clear from the summary and the detailed worksheets what precisely is being adjusted under this category of assumptions, it appears that the consulting team is assuming that under the direct payment scenario utilization and, thus, health care expenditures would increase as a result of managed care plans being replaced by fee-for-service. It bears repeating, however, that this assumption—that the direct payment model will use only fee-for-service—is a false one.

Adjust provider rates under the direct payment scenario to account for institutional global budgeting, valuation of physician services, and options for salaries.'

To clarify, we are assuming that health care utilization for the estimated 59% of California expenditures currently covered by managed care will increase by 10% if managed care is replaced by a physician payment system that is primarily fee-for-service.[4] As described in the Methods and Assumptions document, this estimate is consistent with the estimate made by the Congressional Budget Office, and with results published by the Integrated Healthcare Association in California.

If, as Commissioner Comsti suggests, implementation of Unified Financing were accompanied by a substantial reduction in payment rates to specialist physicians, then the assumption of a 10% increase in utilization from the unwinding of managed care would be an overestimate of the expected effect. As discussed above, a substantial cut in payments to specialists would likely result in a reduction in the number of specialists practicing in California. Service volume

[4] The 10% increase is not applied to long term care services, which we are assume would be unaffected by a shift away from managed care.

for remaining specialists would likely increase somewhat, but capacity constraints would prevent that increase from fully compensating for the reduction in the number of specialists.

We do not understand how an option for physicians to accept a salary from the Unified Financing authority would work. What would physicians be required to do to receive the salary? How would the salary be determined? If physicians could choose to either be salaried or be paid fee-for-service, what would prevent low volume physicians from choosing salary and high volume physicians from choosing fee-for-service?

Our estimate does assume that hospital global budgets would be adjusted, at the margin, for changes in utilization. If hospital budgets were fixed, and did not adjust for utilization changes, then our assumption of a 10% increase in hospital utilization, and a 5% increase in hospital spending from an unwinding of managed care would be too high. Even with fixed global budgets, hospital utilization would likely increase somewhat as physicians would be more willing to admit patients to the hospital and/or more willing to extend lengths of stay if they are paid using fee-for-service rather than by capitation. However, if hospital revenue did not adjust at all as volume changed, hospitals would push back strongly and attempt to limit any increase in volume. Further, if hospital budgets did not adjust at all for changes in volume, then, by definition, any increase in volume would not result in an increase in reimbursement.

The question of whether, if hospitals are paid using a global budget, the budget should adjust with changes in volume is not a question that has yet been considered by Commissioners. We have assumed that global budgets would adjust for volume changes, as described above, because that is the approach taken in Maryland, which has the only hospital global budgeting system in the US, and because it is similar to the approaches taken in Massachusetts, New York, and New Jersey when those states operated all payer rate setting systems in the 1980s.

Commissioner Comsti writes:

'Account for provider time-savings under the direct payment scenario.'

We agree with Commissioner Comsti that physicians and other providers will spend less time on administrative activities and have more time for clinical work under Unified Financing than under the status quo. It is not clear to us what adjustment, if any, Commissioner Comsti would like us to make in our estimates of aggregate spending as a result.

Commissioner Comsti writes:

'Account for differences in California's private and public managed care models.'

It is not clear to us if or how these differences would change the estimates of the effect of Unified Financing on aggregate spending.

IIIf.

Commissioner Comsti asks:

'In other words, hospital global budgeting could reduce excess profit/net revenue that is not reinvested into providing care. Are the projected savings from hospital pricing adjustments solely based on reductions in marginal costs? Or does the modeling account for overall reductions in hospital expenditures?'

The major source of estimated savings in payment to hospitals comes from the assumption that hospital budgets (or DRG rates, if they are used) would be reduced by the estimated reduction in billing and insurance related costs under Unified Financing – 5% on the non-Kaiser share of the market in the direct payment scenario, 2.5% in the scenario with intermediaries. As discussed above, the operating margin in California hospitals averaged 4%, or approximately $4 billion from 2014-2018. Our estimates assumed that hospital revenue would continue to generate that margin. If, instead, hospital revenue were equal to hospital costs, hospital revenue would decline by an additional 4%, or a little less than 1% of state health spending. However, as discussed above, funds would certainly be needed for investments in hospitals to allow the adoption of new technology, for seismic concerns, and for the replacement of aging infrastructure.

Commissioner Comsti asks:

'Thus, to aid analysis of the assumptions presented on hospital global budgeting, it would be helpful for the consulting team to explain what they assume is the baseline costs for hospitals under the status quo, where those baseline estimates come from, and whether or how those baseline hospital costs are being applied to hospital global budgeting projects.'

We start with CMS estimates of hospital revenue in California. As noted above, data from OSHPD indicate that hospital operating revenue is approximately 4% higher than operating costs. The most recent CMS State Health Account data is from 2014. We trend the 2014 estimates forward using CMS National Health Account trends. As discussed in the Methods and Assumptions document, we assume that hospital revenue under Unified Financing would be reduced by estimated reductions in billing and insurance related costs.

Commissioner Comsti asks:

Is it accurate to say that, in the "UF_Assumptions_1" worksheet, marginal cost reductions in hospital pricing are captured in cell B4, which takes the "assumed growth rate for relevant types of expenditures" listed in B3 and divides that growth rate in half?

Yes, the Commissioner understands the calculations correctly.

Commissioner Comsti requests:

In addition to clarifying the baseline costs for hospitals being used for the consulting team's model, it would be helpful if the consulting team explains why they chose to estimate marginal costs at 50% of average costs.

We are not aware of a strong evidence on the relationship of hospital marginal to average costs. The relationship clearly varies on the time frame – in the long run, all costs are marginal. The 50% estimate is based on our understanding of how Maryland is implementing global budgeting in urban areas, and our understanding of the all payer rate setting practices in New York, New Jersey, and Massachusetts in the 1980s.

Commissioner Comsti requests:

Finally, as I explain elsewhere in these comments, pricing reduction based on global budgeting should also apply to outpatient clinics and it would be helpful if such savings in lower outpatient clinic rates are accounted for in this modeling.

As described above, other than the savings from estimated reductions in billing and insurance related costs, and the reduced spending from the assumption that volume increases are paid at 50% of average cost, there are not additional savings assumed from global budgeting.

3g. Commissioner Comsti asks for clarification of what is included in provider administrative savings, and specifically asks

- *Given that the need for marketing will be greatly reduced for providers under a direct payment system, is marketing and potential reductions costs related to reduced need for marketing under a direct payment scenario included in BIR administrative cost baselines and projections?*
- *Given that billing need would be reduced if hospitals and other institutional providers are reimbursed through negotiated institutional global budgets, is administrative savings for institutional providers using global budgeting accounted for in BIR administrative savings?*

The estimates rely heavily on Jim Kahn's 2005 Health Affairs article, which provided California specific data, and the definitions of billing and insurance related activities in that article. We do not think that marketing activities were included as a billing and insurance related function. To the extent that marketing activities for hospitals were reduced, estimated spending reductions would be slightly larger than estimated in our analysis. Estimated administrative savings from institutional global budgeting are a key part of our estimates.

Commissioner Comsti requests:

'the impact of administrative time savings for providers should be discussed in our final report and reflected in modeling as appropriate.'

It is not clear to us how Commissioner Comsti would like us to reflect reductions in provider time spent on administration in our modelling.

Commissioner Comsti asks:

Why was 50% of the direct payment scenario savings chosen as the projected administrative savings under the intermediary scenario?

Under the scenario with intermediaries, we are assuming that covered benefits and cost sharing would be identical for each intermediary. That scenario is starkly different from the status quo, in which benefits differ by payer (e.g., Medicare, Medi-Cal, ESI), and by plan. Under the status quo, the proliferation of benefit packages and cost-sharing create significant billing and insurance related burdens. We are unaware of evidence-based estimates of the extent to which those burdens would be reduced under a system of Unified Financing. Because of changes such as the standardization of benefit packages and cost-sharing, and the implementation of universal and more stable coverage, we estimate that there would be a 25% reduction in billing and insurance related costs from the status quo under the intermediary scenario, or 50% of the savings under the direct payment scenario.

Commissioner Comsti requests:

Clarify why and how assumptions about the Kaiser adjustment was reached.

To estimate Kaiser's share of statewide health spending, we used an estimate of Kaiser revenues in California divided by estimated statewide spending.

We agree with Commissioner Comsti that the administrative costs of operating Kaiser would be lower under Unified Financing than in the status quo, and our estimates of insurer administrative savings reflect this assumption. Our estimates assume that billing and insurance related costs for Kaiser Permanente physicians and Kaiser Foundation Hospitals would not change under Unified Financing, because those organizations incur very low billing and insurance related costs in the status quo. They receive most of their revenue from Kaiser Foundation Health Plan in the status quo, and billing and insurance related costs on the provider side are, as far as we are aware, quite low.

IIIh.

Commissioner Comsti asks a number of related questions:

what is the rationale for assuming payer administrative expenses would be 6% for the intermediary scenario?

why would payer administrative savings go down when there are still multiple plans and payers under the intermediary scenario?

what is the rationale for assuming that health plans or systems under the intermediary scenario would have administrative costs similar to large self-insured employers at 5% and how was this estimate calculated?

given that the unified financing system would have significantly more regulatory responsibilities over multiple health plans and systems under an intermediary scenario, the assumption that the system under the intermediary scenario would only have 1% administrative expenses seems to be a gross underestimate. At best, the administrative costs to the system under the intermediary scenario should be the same as the direct payment scenario at 3% not 1%.

As described in the Methods and Assumptions document, there are strong reasons to expect that insurer administrative costs will be substantially lower under Unified Financing than in the status quo. In a Unified Financing scenario using intermediaries. savings relative to the status quo would be expected because health plans or health systems would be administering a single benefit package (rather than separate packages for Medicare, Medi-Cal, and other payers), have a single contract with each provider (rather than contracts that vary by payer), have a single set of claims payment rules, not need to market to multiple employers, and, presumably, be more tightly limited in the surplus they would be allowed to generate. The expected immense scale of intermediaries under Unified Financing will facilitate lower administrative costs. A reasonable expectation is no more than a handful of large statewide health plans, with perhaps a somewhat larger number of local health systems. Each of these very large organizations, administering a single benefit package with a single set of provider payment rules, can certainly function with lower administrative costs than in the status quo.

In the status quo, payer administrative costs are an estimated 8.5% of total health spending. We are not aware of an evidence base that would support a precise estimate of how much payer administrative costs will decline under Unified Financing using intermediaries, but a decline of 29%, to 6% of total costs, was used as a reasonable approximation.

The estimate that administrative costs for large self-insured health plans are 5% is based on off-the-record discussions with the administrators of a few of these plans. We are not aware of publicly available data that allows an estimate of this statistic. Commissioner Comsti is correct that marketing costs to individuals will create more administrative cost for health plans than is incurred by self-insured employers, although these additional costs will be partially offset by reduced costs in marketing to employers. We acknowledge that there is substantial uncertainty in the 5% estimate, as there is in many of the estimates we have provided.

In the direct payment scenario, the Unified Financing authority will be responsible for claims payment to physicians and other non-institutional providers, for credentialing providers, for making decisions on medical necessity, for adjudicating appeals, and for quality improvement and disparity reduction initiatives. In a scenario using intermediaries, these activities will largely be the responsibility of intermediaries, although the Unified Financing authority will be involved with some of these activities. The assumption that under a scenario using intermediaries the Unified Financing authority would operate with a $5 billion administrative

budget seems reasonable. Under a direct payment scenario, the UF authority would need substantially more resources to pay claims and to perform other functions assumed by intermediaries in the status quo.

IIII.

Commissioner Comsti writes:

As I suggested in my comments on the Draft Analytic Plan, it would be helpful to project more generous estimates on reductions in health expenditure growth at 2% per year more slowly than NHE starting the second year of implementation.

The Commissioner, or any member of the public who requests the workbook, can easily change the assumptions in the spreadsheet 'UF Assumptions 2'.

Commissioners have not yet discussed what rate of growth in health spending would be reasonable, sustainable, and desirable. We note that a rate of growth that is 2% lower than NHE growth would result in health spending growing, on average, 0.7% less per year than the rate of growth of the rest of the economy.

Commissioner Comsti asks:

Can the consulting team explain their assumptions on growth rate reductions in the intermediary scenario? It does not seem reasonable to assume that the same growth rate reductions for both the direct payment scenario and the intermediary scenario.

We are assuming that in the intermediary scenario, as in the direct payment scenario, the Unified Financing authority would be determining maximum provider payment rates. To the extent that spending growth rates in the two scenarios would be different, it is arguably the case that in the intermediary scenario, spending growth rates might be slightly lower, because the rate of increase in utilization might be somewhat lower.

Vb.

Commissioner Comsti writes:

The model should assume that reductions in fraud and abuse would be higher in the direct payment model than in the intermediary scenario given that the retention of multiple payers, plans, and risk-bearing health systems presents a greater opportunity for fraud and abuse.

Although we are not aware of data estimating the magnitude of fraud and abuse in California, we strongly suspect that the prevalence of capitated payments to medical groups results in substantially less fraud and abuse in California than in most of the country where fee-for-service is the dominant payment model. As discussed in the Commission's Environmental

report, over 60% of payments to professional groups for Medicare and commercially insured patients are made through capitation, and that proportion is likely even higher for patients insured through Medi-Cal. To the extent that physicians in these groups are engaged in fraudulent and abusive practices, these practices will result in reduced revenue available to other physicians in the group, but will not have any direct effect on health care spending. Capitation creates strong incentives for medical groups to monitor and sanction abusive behavior by their members. As a result of this dynamic, the effect of fraud and abuse on aggregate health care spending in California is likely smaller than for the nation as a whole.

Long and painful history with Medicare and Medicaid efforts to reduce fraud and abuse have demonstrated that it is difficult for the government to root out fraud and abuse, in part because of due process requirements, and in part because public opinion often favors the motivation and credibility of providers over those of government regulators. It is likely that a Unified Financing authority would have somewhat more success than the Medicare and Medicaid programs have had in reducing fraud and abuse, but it is also likely take progress will take time and be incremental. The assumption that we have made that health spending will grow more slowly under Unified Financing than in the status quo at least implicitly anticipates a reduction in fraud and abuse over time.

Vc.

Commissioner Comsti writes:

Comparing the May and July versions of the slides on the analytic findings, there appears to be an error in the slide on estimated changes in health expenditures under the direct payment scenario (Slide 23 in the July version). The May version of the slide states that, in 2031, capping provider payment growth would result in -10.4% change and the July version of the slides this figure is -10.1%. However, one or both of these projections must be in error. Given that the year 2022 savings projected in the May version is -0.4% and in the July version -3.0%, it would be reasonable to expect that savings in year 2031 would be greater for the July number given its greater year 2022 savings compared the May version.

We have reviewed this and note that this was not an error. As the Commissioner notes, estimated 2022 spending under Unified Financing is lower in the July version of the analysis than in the May version. As a result of the lower 2022 base, the effect of reducing health expenditure growth is slightly smaller in the July version than in the May version.

Summary

We appreciate the Commissioner's thorough review of the analysis and acknowledge that estimating the impact of a sweeping, unprecedented shift to UF for California is an inexact undertaking. Nevertheless, we believe that – with the possible exception of suggestions regarding payment levels for specialist physicians – the suggestions for refinement that the

Commissioner offers would have very modest effects on the overall findings. We'd be happy to make ourselves available if you would like to further discuss your questions or our responses.