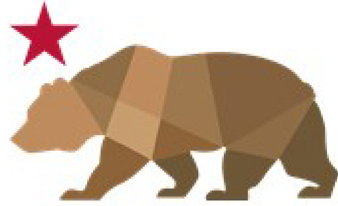


HEALTHY
CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

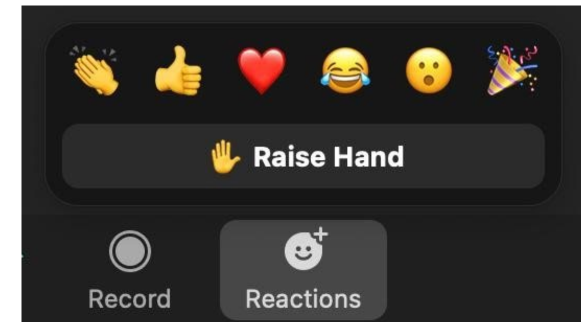
# Virtual Commission Meeting

November 17, 2021

# Virtual Meeting Protocols

HEALTHY CALIFORNIA FOR ALL

- This meeting is being recorded.
- Commissioners:
  - You have the ability to mute and unmute and the option to be on video.
  - Please mute yourselves when you are not speaking.
  - To indicate that you would like to speak, please use the "raise hand" feature:




- Members of the public:
  - You can listen to and view the meeting.
  - During the public comment period, you will have access to the "chat" feature for written comment, and you can use the "raise hand" feature to request to speak. You can also email comments to HealthyCAforAll@chhs.ca.gov.
  - Public comment provided during the meeting will be a part of the public record.

# Opening Remarks

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

# Today's Agenda

HEALTHY CALIFORNIA FOR ALL

- Next steps and reflections
- Presentation and discussion: "Financial Sustainability under Unified Financing"

# Goals/ Propositions Survey Round 2

Healthy California for All

- Commissioners' thoughtful responses continue to clarify values and key considerations
- We appreciated many excellent suggestions about where to elaborate or how to improve language
- Summary of survey responses will be posted at Healthy California for All webpage shortly
- In December we plan to administer a shorter survey focused on areas of remaining ambiguity or newly identified propositions

# Next Steps

| Timing | Activity |
|---|---|
| December 9 | Potential topic: "Ensuring a Smooth Transition" |
| December 10-20 (approx.) | Potential follow-up survey |
| January 14 -26 (approx.) | Commissioner review of draft report |
| Late January TBD | Rescheduled January Commission meeting to discuss report |

# Chair's Reflections

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| What We Want | Analytic Implications |
|---|---|
| A truly universal system that provides all Californians the health care they need and deserve | ✓ Universal coverage<br>✓ Low or no cost-sharing<br>✓ Equal access to health care providers for all Californians |
| Systems of care that put people first and use resources wisely | ✓ Range of potential provider reimbursement approaches, including hospital global budgeting |
| Less complexity and reduced administrative burden for all | ✓ A single set of rules for consumers and providers; elimination of most billing and administrative activities and expenses |
| More equitable financing | ✓ A number of broad-based ways to raise funds that would substitute for the current regressive burden on employers and households |

# Presentation and Discussion

# Financing Considerations

Ken Jacobs

UC Berkeley Labor Center

# Key Points

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By 2031, total health spending in California is projected to grow by $158 billion in current dollars. Of this amount:

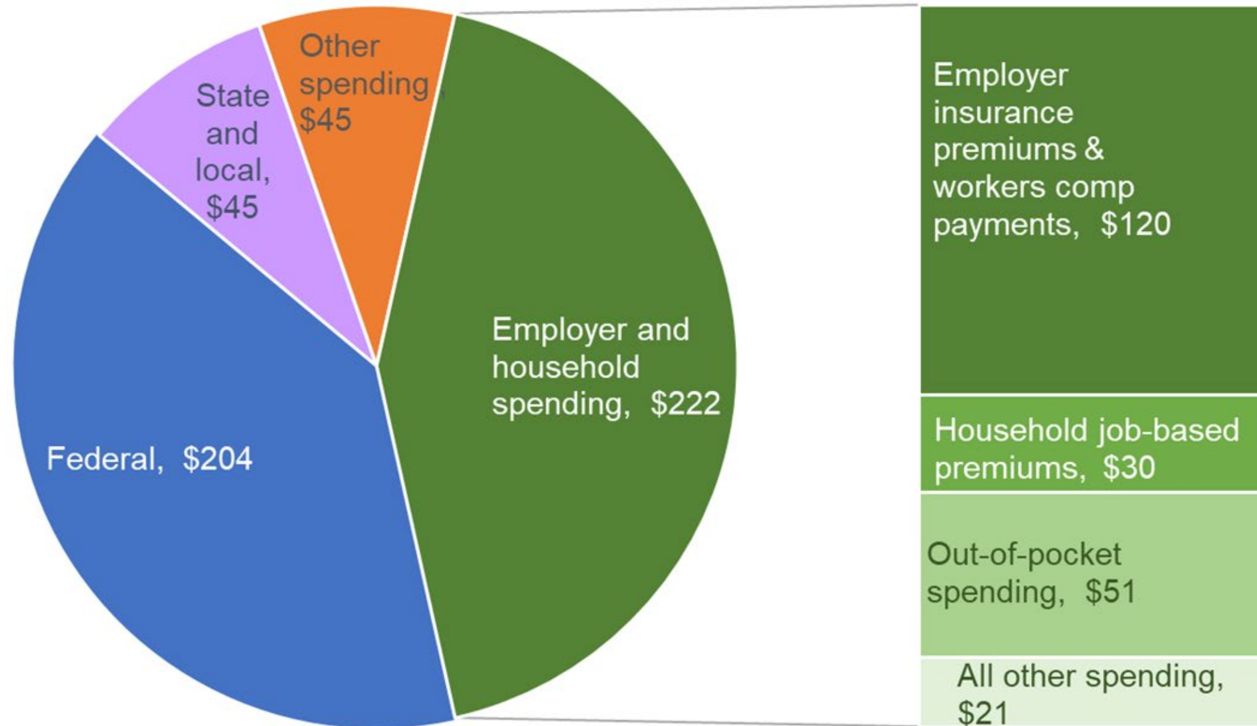
- Employer and household spending is projected to grow by $47 billion.
- State and local government spending on Medi-Cal and IHSS is projected to grow by $16 billion.

Under Unified Financing:

- Total health spending in California is expected to be $51 to $88 billion less than under current policy in 2031, for a cumulative savings of $323 to $496 billion over 10 years.
- The new revenues needed would be less than employers and households pay under the current system.
- The state has a variety of options for raising revenue, and could do so in a way that is more progressive than our current system.
- Financing can be done in a way that is stable over time, but will depend on controlling cost growth and agreements with the federal government about the rate of growth in federal payments.
- A reserve fund would enable California to address volatility in revenue sources.

# Baseline Financing

# California spending under baseline by source




Note: Federal includes Medicare, Medi-Cal, IHSS, and ACA. State and local includes Medi-Cal and IHSS. Other spending includes public health, research spending and a variety of other smaller programs. Employer spending includes private and public employer contributions.

Source: Total health expenditures are based on methods in Analytic Findings updated July 8, 2021. Estimates by source are based on estimates from CMS, CA Department of Finance, and other sources.

# Saez/Zucman: “for the middle class, health insurance is the biggest tax they pay”

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**Average U.S. tax rates in 2018, % of pre-tax income**

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

Health insurance poll tax

Estate tax

Individual income taxes

Payroll taxes

Corporate & property taxes

Sales taxes

P0-10
P10-20
P20-30
P30-40
P40-50
P50-60
P60-70
P70-80
P80-90
P90-95
P95-99
P99-99.9
P99.9-99.99
P99.99-top 400
Top 400

Source: Emmanuel Saez and Gabriel Zucman, The Triumph of Injustice

# What is the effective tax rate on workers and employers at California firms offering health coverage?

HEALTHY CALIFORNIA FOR ALL

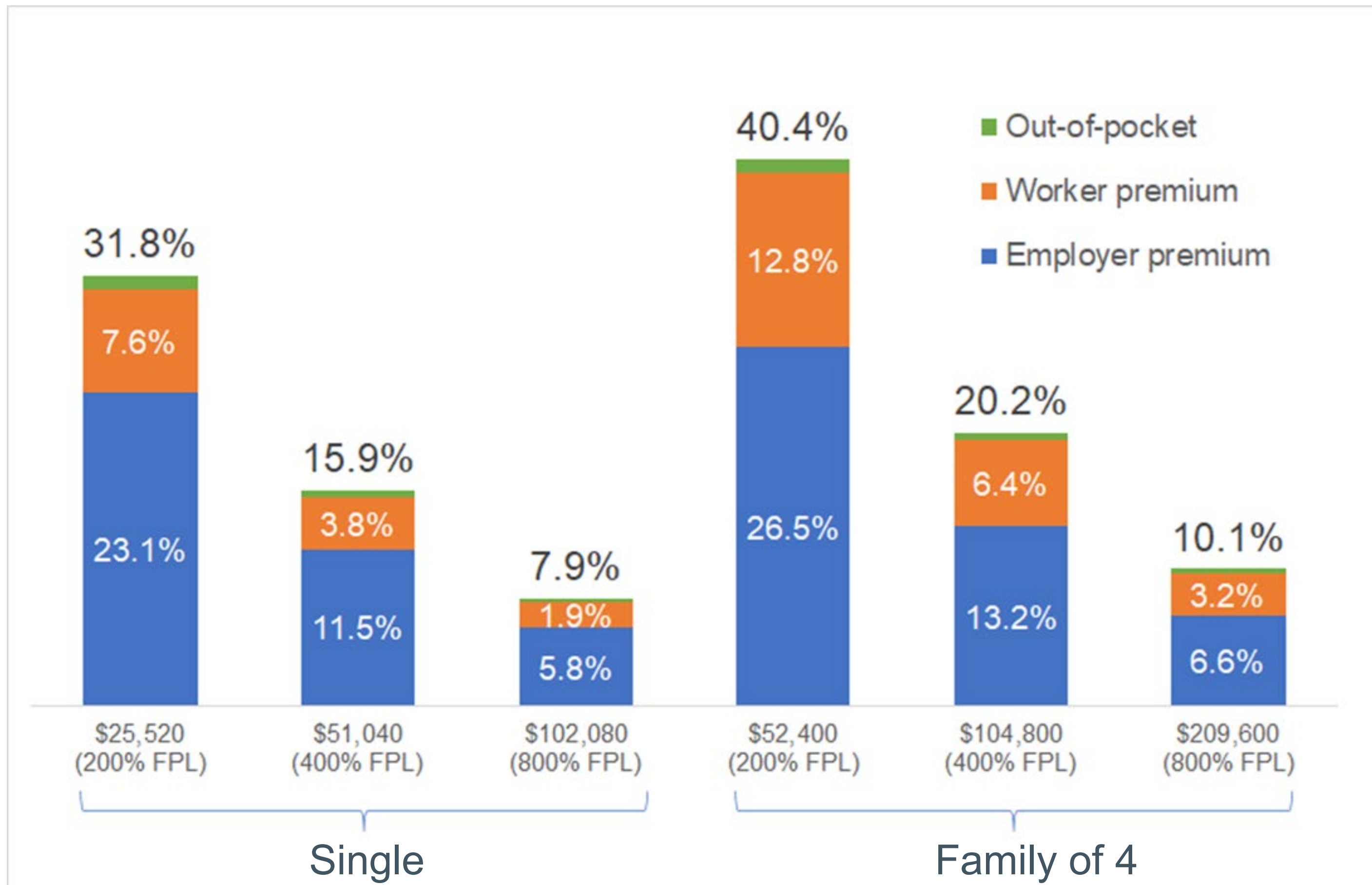
Projected premium contributions for California workers with job-based coverage in 2022:

| Contribution Type | As % of payroll for <u>all</u> workers at offering firm |
|---|---|
| Employer contribution | 9.9% |
| Employer + employee contribution | 12.6% |

Source: UC Berkeley-UCLA California Simulation of Insurance Markets (CalSIM) 3.0

# Californians with lower income pay higher share of income for job-based coverage

Examples of typical CA employer and worker spending on job-based coverage as a percentage of income, 2020

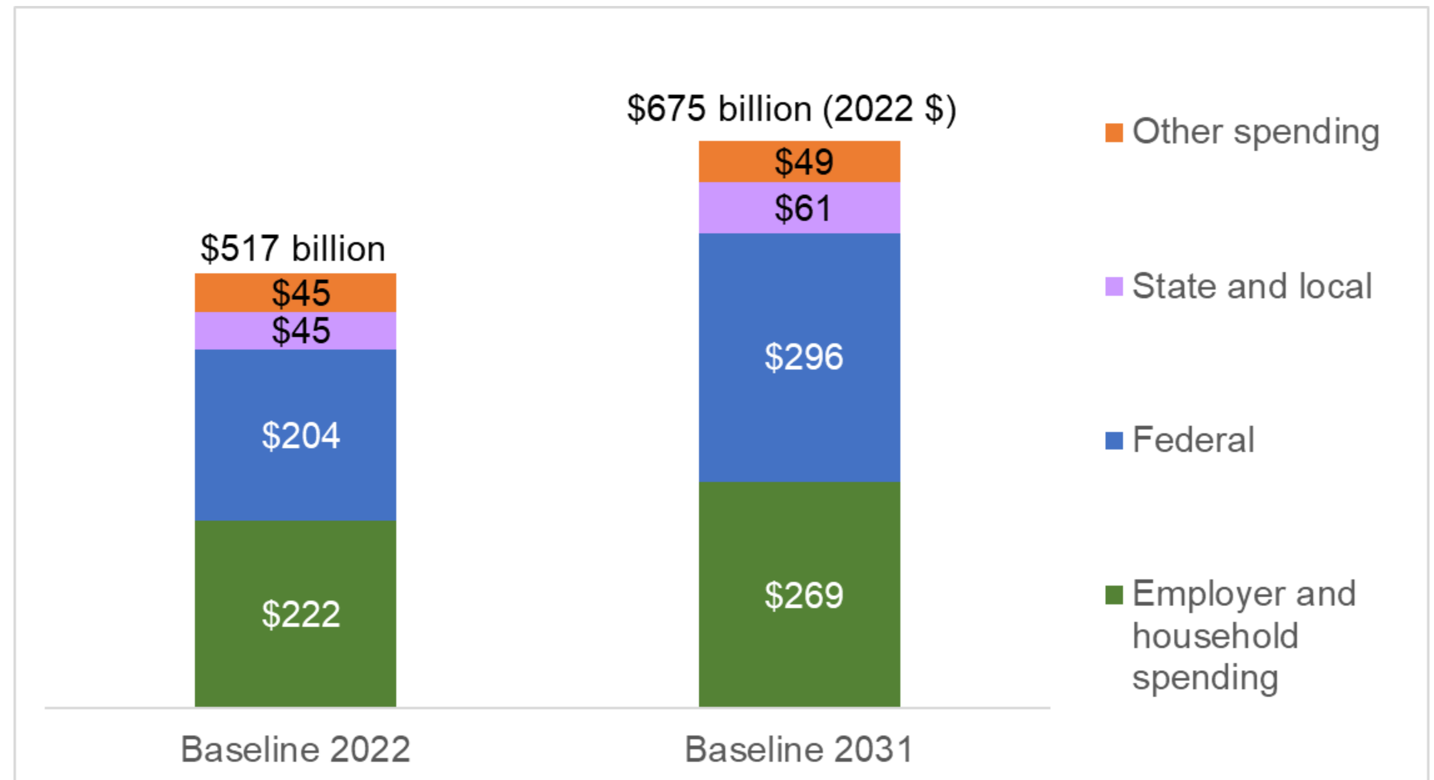



Source: Analysis of average California worker and employer premium contributions from CHCF California Employer Health Benefits Survey and median out-of-pocket spending for California households with job-based coverage in 2016-2017 from Commonwealth Fund analysis inflated based on CMS projections for out-of pocket spending.

# By 2031, spending in current system projected to grow by $158 billion in current dollars

Employer premium plus household premium + out-of-pocket spending would grow by $47 billion

State/other Medi-Cal spending would grow by $16 billion




Note: State and local government spending on employee health benefits is treated similarly to spending on private sector employee health benefits.
Source: Total health expenditures are based on methods in Analytic Findings updated July 8, 2021. Estimates by source are based on estimates from CMS, CA Department of Finance, and other sources.

# Potential Year 1 (2022) Financing under Unified Financing

# Context for Spending Estimates

Healthy California for All

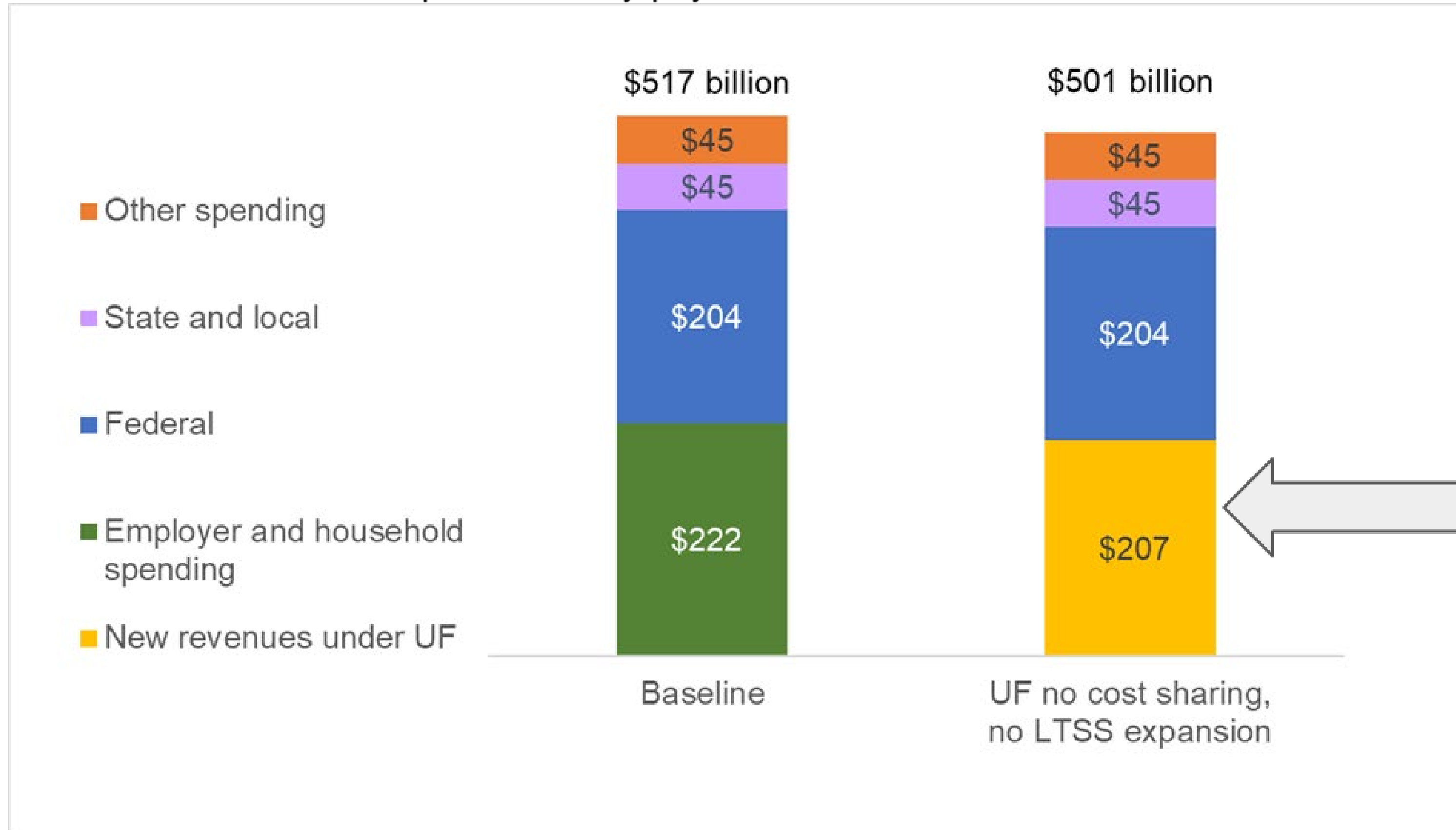
Estimates for spending under Unified Financing assume:

- Substantial savings related to administrative overhead
- Significant drug price reductions
- Provider payments, in the aggregate, in Year 1, are reduced by the estimated reduction in billing and insurance related costs, but are otherwise unchanged
- Increased use of services associated with the expansion of coverage and reduction in consumer cost-sharing
- Funding of reserves and a just transition for displaced workers
- Reduced health spending growth which could be achieved by various means including payment reforms, systems of accountability and care coordination

Estimates are consistent with improvements in access, quality and equity that the Commission has envisioned in its recent discussions.

# Private insurance premiums and out of pocket spending could be replaced by more progressive financing

Total California health expenditures by payer, 2022




Under one Unified Financing scenario:

$222 billion in employer and household spending could be replaced by $207 billion in more progressive financing

Source: Total health expenditures are based on methods in Analytic Findings updated July 8, 2021. Estimates by source are based on estimates from CMS, CA Department of Finance, and other sources.

# Amount of new revenues needed depends on Unified Financing design decisions

Total California health expenditures by payer, 2022

| | Baseline | UF no cost sharing, no LTSS expansion | UF income-based cost sharing, no LTSS expansion | UF no cost sharing, with LTSS expansion |
|---|---|---|---|---|
| Total | $517 billion | $501 billion | $482 billion | $523 billion |
| Other spending | $45 | | | |
| State and local | $45 | | | |
| Federal | $204 | | | |
| Employer and household spending | $222 | | $20 (cost sharing) | |
| New revenues under UF | | $207 | $168 | $233 |

Source: Total health expenditures are based on methods in Analytic Findings updated July 8, 2021. Estimates by source are based on estimates from CMS, CA Department of Finance, and other sources.

# Broad based financing options

| Tax Base | Estimated revenue per 1% (Billions 2022$) |
|---|---|
| Payroll | $14 |
| Broad tax on labor and capital income: compensation, corporate profits, unincorporated business income, interest | $19 |
| Gross Receipts | $47 |
| Sales Tax on Selected Services (excludes construction, utilitites, health and education) | $9.5 |
| Taxable Personal Income | $16* |

**Aggregate for 1% point increase in income tax rates. Distribution could vary by tax bracket.*

*See slides from August 2020 Commission meeting for further details*

# What is the financial effect on lower-income workers and families if private spending is replaced by public financing?

HEALTHY CALIFORNIA FOR ALL

- Effects will depend on the incidence of the tax(es) that replace individual and employer spending.
- Short-run wage impacts for workers with job-based coverage depends on whether state law mandates that employers pass through savings to workers.
- Workers in lower income families who are enrolled in Medi-Cal or receive large subsidies through Covered CA could see their real wages or purchasing power erode over time if employers pass through the costs of new taxes to workers or producers raise prices on goods low income workers consume.
- Depending on incidence of new tax(es) and projected effect on wages or prices, measures will be needed to mitigate any cost shift to lower-income families.

# Reserves Assumptions

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**Reserves needed:**

Financial reserves: 10% of state health funding to cover fluctuations in revenue resulting from economic downturns.

Risk reserves: 5.2%-11.7% of claims depending on option, to cover fluctuations in claims.

**Financing:**

- $20 billion, 30 year bond issued for initial reserve.
- Remainder, built up annually over 10 years. Could be built more quickly or more slowly depending on level of savings, how often fund is utilized.

# Potential Year 10 Financing under Unified Financing

# Health Expenditures in California under UF vs. Baseline 2022-2031 ($ Billions 2022)

Total health expenditures (2022 $ billions)

| Year | Baseline | UF, NHE-0.5% | UF, GDP |
|---|---|---|---|
| 2022 | $517 | $501 | $501 |
| 2031 | $675 | $624 | $587 |

Y-axis: $480, $530, $580, $630, $680, $730

X-axis: 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031

Cumulative reduction 2022-2031 compared to baseline

$323 billion (2022 $)

$496 billion (2022 $)

*UF scenarios are with no cost sharing and no LTSS expansion*

# Major factors that affect how tax rates change over time

- Annual health care spending growth
- Extent to which federal government insists on capturing some or all of the savings created by Unified Financing

# Unified Financing stability over time

UF expenditures by source compared to projected revenues, 2031 (2022$)
(Assumes tax rates remain constant after 2022 and new state-based revenues grow at GDP)

| Scenario | Remaining expenditures to be covered by new revenues | Federal | Total |
|---|---|---|---|
| GDP, state captures all savings | $193 | $296 | $587 billion |
| NHE-0.5%, state captures all savings | $223 | $296 | $624 billion |
| GDP, feds captures their savings | $224 | $266 | $587 billion |
| NHE-0.5%, feds captures their savings | $235 | $284 | $624 billion |

Projected new revenues $242 billion

Legend: Other spending; State and local; Federal; Remaining expenditures to be covered by new revenues

*UF scenarios are with no cost sharing and no LTSS expansion*

# Conclusions

HEALTHY CALIFORNIA FOR ALL

- By 2031, total health spending in California is projected to grow by $158 billion in current dollars.
- Unified financing could result in significant cost savings over time.
- There are various options to raise revenue, with different pros and cons, and which will require attention to the distributional effects.
- Stability in tax-rates over time can be achieved, but will depend on controlling cost growth and agreements with the federal government about the rate of growth in federal payments.
- Unified financing will increase equity in how health care is paid for and how it is delivered.

# Commissioner Discussion

# Discussion (Part 1)

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*What mechanisms should be used to reduce health care cost growth?*

For example, what could California do under Unified Financing to:

- Reduce the provision of low value care
- Improve the health of Californians, resulting in a reduction in the demand for care
- Reduce the rate of growth of unit prices and/or aggregate hospital budgets
- Reduce fraud and abuse
- Set targets for health expenditures as has been done with the Massachusetts Health Policy Commission

# Discussion (Part 2)

Healthy California for All

*Beyond cost containment efforts, what additional structural changes will be needed to assure the system we want?*

For example, under Unified Financing:

- What governance systems and level of oversight would be required to manage costs while assuring access, quality and equity?
- How would California prioritize investments (e.g. capital, workforce, information technology) needed to advance desired care outcomes?

# Public Comment

HEALTHY CALIFORNIA FOR ALL

# Adjourn