Healthy California for All
Commission Meeting
November 17, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: video recording of November 17, 2021 Healthy CA for All Commission meeting.

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Andy Schneider, Carmen Comsti, Antonia Hernandez, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Michelle Baass, Rupa Marya, Richard Pan, Cara Dessert (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, reviews the agenda. The primary topic is financial sustainability under unified financing. He highlights a few key points from the second survey on goals and propositions: the commissioners provided thoughtful responses to clarify values and key considerations, with suggestions on how to elaborate and improve language. A summary of survey responses will be posted on the Healthy California for All webpage. One additional, shorter survey will be administered to focus on areas of remaining ambiguity and newly identified propositions. The commission is moving towards consensus on the need for a unified financing system and the values the system should uphold. There is growing consensus that payments are one of the most powerful tools, not just who receives them but how they receive them, to ensure access and to address inequities. There are healthy discussions around integrating care and the difference between integrating and coordinating care. Important questions include: Who's in charge of doing that? Is it an entity that lives above like a plan? Or is it done at the provider level or the practice level? What is the role of health plans? Should we have health plans? How do we imagine them

differently? The general consensus is that, in order to achieve an equitable, high-quality, affordable system, we need some transformation at a minimum, or to remove them altogether. Many but not all commissioners felt that the health care system can and should address social drivers of health.

- Secretary Ghaly runs through the upcoming milestones:
  - December 9: commission meeting, potential topic "ensuring a smooth transition"
  - December 10-20: potential follow-up survey
  - January 14-26: commissioners review draft report
  - Late January: rescheduled commission meeting to discuss final report
  - February: potential final commission meeting to wrap up
- Secretary Ghaly shares his reflections so far. What we want: A truly universal system that provides all Californians the health care they need and deserve. The implications: Universal coverage, low or no cost-sharing, equal access to health care providers for all Californians. What we need: Systems of care that put people first and use resources wisely. Implications: Range of potential provider reimbursement approaches, including hospital global budgeting. What we need: Less complexity and reduced administrative burden for all. Implications: A single set of rules for consumers and providers; elimination of most billing and administrative activities and expenses. What we need: More equitable financing. Implications: A number of broad-based ways to raise funds that would substitute for the current regressive burden on employers and households.

2. Financial Sustainability Under Unified Financing

- Secretary Ghaly tees up the conversation on financial sustainability under unified financing. How do the finances we rely on today carry forward in a new system? How do we deal with issues of stability, not just in getting started but to ensure sustainability over time? What mechanisms should be used to reduce health care costs and manage growth? This will lead into a discussion around governance and how we would set up governance for a unified system at a state level.
- Presentation by Ken Jacobs, UC Berkeley Labor Center, on the mechanisms and opportunities for more sustainable financing under unified financing (View the Presentation on Unified Financing Considerations):
  - Slide 9: This presentation will discuss revenue needs and sustainability under unified financing, starting with a brief review of health care costs, financing under the baseline and projected changes over the next decade, and then revenue needs and potential funding sources, followed by a discussion of cost and revenue growth over a 10-year window.
  - Slide 10: By 2031 total health spending in California is projected to grow by $158 billion. Of this amount, employer and household spending is projected to grow by $47 billion. State and local government 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.

- Slide 12: Under the baseline total health care expenditures will be $517 billion: employer and household spending make up $222 billion, federal $204 billion, other spending $45 billion, and state and local $45 billion.
- Slide 13: Our current system of financing job-based coverage is regressive. The cost of coverage is passed on to workers in the form of forgone wages, which acts effectively like a payroll tax with equal costs regardless of income. For the middle class, health insurance is the largest tax they pay.
- Slide 14: When thinking about what would need to be done to replace spending on job-based coverage within a system of unified financing, it's helpful to look at the share of payroll that employers and workers are currently spending on health insurance. Employer contributions are now about 10% of payroll in offering firms. And if we look at employer and employee contributions together, it's about 12.6%. This doesn't include out of pocket costs.
- Slide 15: But this masks great differences by income level. There's some debate among economists on who ultimately pays for job-based coverage and whether or not the entire cost is passed through to workers. Assuming the full cost is passed through to workers, including the employer contribution, it comes to 30 to 40% of income for individuals and families at 200% of the federal poverty level. For a single individual earning $25,000 a year that's 32% of their income. For a family of four at 200% it's about 40%. For those at 400% of the federal poverty level, it's 16% to 20% for single and family, and 8% to 10% for those at 800% of the federal poverty level. Even if looking at just the employee share of premium out of pocket costs, it's still highly regressive, and quite high for families at the lower end of the income spectrum.
- Slide 16: By 2031, health care spending is projected to grow to $675 billion in 2022 in California, with a $47 billion increase in employer and household spending and a $16 billion increase in state spending. This includes both increased health costs per person along with growth in population. The main point here is to establish that baseline in order to compare it to unified financing.
- Slide 18: 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.

- Slide 19: Private insurance premiums and out of pocket spending could be replaced by more progressive financing: $222 billion in employer/household spending could be replaced by $207 billion in more progressive financing.
- Slide 20: The exact amount of revenues needed would depend on design options. With progressively scaled cost sharing so insurance covers 95% of cost, $20 billion would come from out-of-pocket costs and $168 billion would be needed to be raised in new revenues, $40 billion less than in the scenario with no cost sharing. If long term services and supports (LTSS) are expanded under the no cost sharing option, then the needed revenue increases to $233 billion.
- Slide 21: There are multiple ways that the state could raise the necessary revenue for a unified financing system. The payroll tax can be straightforwardly substituted for our current system of job-based coverage. It would be more progressive since payments would be scaled to income; the drawback is it's a tax on labor, which can distort the demand for labor versus capital. If the state were to consider a payroll tax, the commission should encourage an equal tax for independent contractors. Each 1% increase in payroll tax would raise about $14 billion. Another option is a broad tax on labor and capital income (a tax on compensation, corporate profits, unincorporated business income and interest income) which is more progressive than our current financing, treats capital and labor equally so there's no difference in how income is earned, and there's no incentive to move income in one direction or another. Each 1% broad tax raises $19 billion. A gross receipts tax has the advantage of a large and stable tax base. The drawback is it taxes goods and services at every point along a supply chain, which gives an advantage to firms that are vertically integrated. Gross receipts taxes are also not sensitive to a firm's ability to pay as would be a tax on profits. Existing gross receipts taxes tend to be small, in the 1% or less range, and tax rates often vary by industry. If considered, the commission may want to recommend exempting the first $2 million of income. The cost is mostly passed to consumers, similar to a sales tax and could be considered more regressive. Each 1% of gross receipts tax raises $47 billion. Another option is extending the sales tax to selected services. As with any consumption tax it has the potential to be more regressive. Each 1% raises $9.5 billion. Finally, the state could also increase personal income tax, to raise $16 billion per 1%. These sources could be supplemented with a range of other complementary taxes. When putting together multiple sources, the

commission should consider options that don't tax the same base, for example a payroll tax or income tax could be combined with gross receipts or sales tax.

- Slide 22: What is the financial effect on lower income workers and families if private spending is replaced by public financing? 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 California could see their real wages or purchasing power erode over time if employers pass through the costs of new taxes to workers, or if producers raise prices on goods that 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.
- Slide 23: 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 and how often the fund is utilized.
- Slide 25: Under current policy, health expenditures in California would increase to $675 billion by 2031. Under unified financing with no cost sharing and no LTSS expansion, if the cost growth is kept to a half percent below national health expenditures, total cost would be $51 billion below the baseline for a total savings of $88 billion below the baseline for a cumulative savings of $500 billion over the decade.
- Slide 26: One major factor that affects how tax rates change over time is annual health care spending growth. Over the last two decades, health spending has grown an average of 1.5% over gross domestic product (GDP), slower in the last decade and expected to grow about 1.3% over GDP in the coming 10 years. The second factor is extent to which the federal government insists on capturing some or all of the savings created by unified financing.
- Slide 27: Regarding the extent to which the federal government captures savings created by unified financing: The projected new revenues required would be $242 billion in 2031, reached by growing year one (2022) revenue estimates $207 billion, at the rate of projected growth of national GDP. Looking at different scenarios: If the state captures all the savings and cost growth is kept at the same level as GDP growth, there would be a substantial surplus by 2031, about 8.5%, which the state could use to reduce tax rates, increase investments in addressing social determinants of health, and build a more robust reserve fund. In the worst-case scenario of keeping cost growth at National Health Expenditures growth minus 0.5% and is not able to keep any

of the federal government's savings, revenues are still projected to grow at a rate to meet expenses, although there is not much margin for error.
  - Slide 28: Conclusions: 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 on reaching agreement with the federal government about the rate of growth in federal payments. An important part of that is reaching agreement with the federal government about how savings will be shared. Unified financing will increase equity in how health care is paid for and how it is delivered.
- Commissioner Discussion
  - Commissioner Wood: With regard to reserve funds, during the 2009 recession the state cut a lot of programs and provider rates. Did you consider that? A lot of programs have not been fully re-funded even though that was 10 years ago.
  - Ken Jacobs: The research considered the size the reserve fund needed to avoid cuts and looked at previous recessions to see what happened with those broad-based revenue streams. The federal government has raised matching rates during recessions, and the research assumed that would continue.
  - Commissioner Wood: Regarding reducing drug costs, a lot of that is at the federal level which is still bogged down. How do drug prices get reduced in California? The state's ability to bargain, such as with Medi-Cal? The legislature tried hard to reduce the price of drugs but did not have great success.
  - Ken Jacobs: The state would be the sole purchaser of drugs so would have tremendous bargaining leverage which doesn't exist today. At the federal level much can be done but the political will has not been there.
  - Commissioner Wood: Regarding inflation, did the research consider what happens if we see rampant inflation in general: gas, groceries, utilities, and how this would affect our ability to finance health care?
  - Ken Jacobs: In general, the bases would also grow at around the same pace. Overall, the inflation the US is facing right now is primarily a supply chain problem, and if there were any kind of longer-term inflation that was not based on those specific considerations, the Federal Reserve is expected to act as it has consistently in the past, so long-term inflation is less of a concern. But the economy is expected to grow along with inflation.
  - Commissioner Marya: California had great success with the public smoking ban which took 20 years to enact but saved over a million lives and $134+ billion. The commission should consider the intersection between industries and their negative impact on health. If the state was tied to paying for health care, it would be more incentivized to focus on social determinants of health. Can the modeling look at how certain industries are driving up health care

costs, and how curbing some of those industries might give us some benefits, like with the smoking ban? Due to the mass exodus of health care workers the quality of health care over the next 5 to 10 years looks dismal. Is this accounted for in the modeling? What are the ways we can safeguard funding to stay inside the system and focus on improving safety for patients, health care outcomes, and the safety of providers?

- Ken Jacobs: That is an important reminder that social determinants of health are not things currently contained within the health care system and that if the state were paying for health care, it may be incentivized to address those broader issues. To get to health equity requires equity in the health care system with affordability and access, but also requires going beyond the health care system.
- Commissioner Marya: We have separated health care and social determinants of health, and what the public smoking ban shows us is that when we don't atomize it and realize industry is directly impacting health, and the state makes bold moves to curb those toxic exposures we get a win/win/win. How can we encourage economic modelers to start looking more holistically for the state? That is what the push for single payer allows us to start imagining.
- Ken Jacobs: On the question of workforce, that is not something we are able to model, but that will be an important question.
- Secretary Ghaly: One of the things revealed when digging into the commissioner goals and values survey is that an area of grappling is around social drivers of health. A real focus of the State of California is the intersection between climate, equity and health and bringing these areas together. There is a lot of increasing movement that is coming from within and outside the health care system to tie it together. Regarding the issue of the workforce, there is a looming health care workforce crisis, but also an opportunity as many areas that need workforce also need transformation: where and how work is being done and who is doing it. So, there is an opportunity to re-envision this.
- Commissioner Pan: In terms of projection of health care costs, many factors will increase costs such as the aging population. Regarding labor costs for services rising faster than manufacturing and other areas, how is making sure benefits and wages are increased and maintained factored into the economic modeling? Things such as cost, underpayment, budget cuts, and increasing technology and more education required for people in health care. How should we incorporate that to be sure workers are being paid justly?
- Ken Jacobs: The cost projections are based on the CMS projections on NHE (national health expenditures), so those factors are included to the degree CMS has incorporated those factors. In the last decade health care spending has been growing more slowly, in part because of the ACA. CMS projections for coming years increase those rates, but it is reasonable to ask if that has been accurately estimated. In thinking about a reimbursement system that

ensures a stable, well-trained workforce going forward, that would need to be factored into policies.

- Commissioner Pan: The rising costs of workforce may rise faster than inflation. The RAND insurance study showed there will be a 20% increase in utilization, and we could cut everyone's reimbursement to equalize, but this does not appear to be reflected in the model. Was that incorporated into projections?
- Ken Jacobs: In the no cost sharing model there are projected increases from more people having coverage and, if cost-sharing is eliminated, from increases in utilization. The reason that still comes out lower than the baseline is because there are other savings from administrative costs, insurance costs, and drug price costs. Comparing that scenario to the one with cost sharing at 95% actuarial value, the costs go down by $20 billion. It assumes no cost sharing for those under 200% of federal poverty and something closer to job-based coverage at the top. The whole system is $20 billion less, and that model still has increased utilization due to lower cost sharing, so that is factored in.
- Commissioner Pan: Models have assumptions that don't always hit the mark. Given the uncertainties, would you say health care should be a right or an entitlement like Medi-Cal, and therefore not subject to ordinary budget pressures? If the money runs out, we cannot close everything down and roll into the budget next year.
- Ken Jacobs: This is a question of governance. One assumes there will be a separate pot of money from the state with a separate governance body making those decisions. These issues illustrate the importance of a broad enough base on financing to avoid large fluctuations. If health costs are growing faster than revenues, measures can be taken to control health care costs, for example reduce low value services or impose a small tax increase. As the trajectory is growing, with a healthy reserve there will be time to make these decisions. The current reality is costs are going up faster than they would be with unified financing, and people are paying more or there is rationing to the degree people cannot afford health care. Under UF, there would be new mechanisms to control costs with greater equity and more attention to value.
- Commissioner Pan: In the great recession the legislature was asked to vote to limit Medi-Cal to 10 visits, which needs to be kept in mind. During COVID, GDP went down while health care needs went up, so tying the two together doesn't always make sense. Vaccine hesitancy has been estimated to incur $3 billion nationally in additional health care costs. Despite efforts by the legislature, people have actively resisted public health measures, so there is a limit on what the state government can do to curb or influence behaviors.
- Commissioner Chin Hansen: For illustrative purposes, the scenario without LTSS expanded was used, but LTSS expansion ought to be more baked in as a scenario as our aging population, with increasing rates of dementia, Alzheimer's disease and multiple conditions, is the big under-the-iceberg factor

of where health care spending will go, as well as workforce. How is this factored in? This is not a piece we can separate as it is part and parcel of population health and chronicity which have tremendous costs.

- Ken Jacobs: That is right in terms of the effect around having LTSS expansion. In the model including LTSS and no cost sharing, with cost savings at half a percent below the NHE or at the rate of GDP, the overall cost is still lower than the baseline in our current system. It starts a little higher, as including LTSS expansion is a big investment upfront, but depending on how well costs are controlled, by the fifth year, costs are going below the baseline.
- Commissioner Chin Hansen: If the baseline is as if nothing changes with costs due to our aging population, there may be some creative ways to think about the force multiplier of this issue.
- Commissioner Scheffler: The health care system in California is 60% integrated capitated plans and growing, which have little or no co-payments. Which health care system are you modeling? Regarding taxes, Prop 63 was a 1% tax on millionaires that passed in 2004 for mental health, and it was suggested that all these millionaires would move to Texas, which didn't happen. That would be another financing mechanism as there is precedent. Another tax that is frequently used is an excess profits tax from market power and consolidation, both hospitals and providers make huge profits.
- Ken Jacobs: The modeling took into account the current capitation level and current actuarial values. With job-based coverage, the average actuarial value is around 85%, so when looking at the no cost sharing model, it is bringing that 85% up to 100% paid for by the system. The partial cost sharing model is bringing that up to 95%. On the issue of the millionaires' tax, it is important to consider what bases that are broad enough to raise the amount of revenue needed as well as provide the needed levels of stability. A 1% income tax on millionaires is about 1/5 of the total from the income tax side (total raised for all income tax was $16 billion per 1%).
- Commissioner Scheffler: I suggest that breakdown be added to the report. The report should also take a careful look at revenues and who pays them. A progressive tax on higher income (could start at $250k, $500k, or $1 million) in concert with an excess profits tax would add up to a significant amount, so is something to model and consider.
- Commissioner Comsti: The commission can and should put together very detailed options for the legislature and Governor on different revenue generation plans, as we are always getting caught up in this quagmire of how we are going to pay for this. The amount of state revenue that is no longer going to be paid through employer-sponsored insurance through premiums and deductibles and co-pays is important to include. It is key to distill what the potential exemptions could be for each of these options, for example ending corporate tax exemptions or charity care tax breaks (to not double-subsidize nonprofit hospitals). There is also the option of redirecting funds into health

care, for example, potential fees or taxes on polluters or reducing policing and incarceration costs. It is critical to not get caught up in the levers to reduce cost by reducing care, as it is the prices that are driving up health care costs. When discussing financing we must always consider what we are saving in terms of controlling prices, eliminating administrative waste and other measures, as are included in AB 1400. Reimbursement for providers must go back towards care, holding providers accountable through conditions of participation with the state as the single procurer of care. There are many ways to include these things in the economic modeling. On the workforce question, when we invest in protecting nurses and doctors and safe staffing, we get better care which overall helps with the costs of care and makes sure we aren't grinding away our workforce. It can be hard to incorporate in financial modeling but need to keep this as a principle, it is not just a calculation of utilization and prices.

- Secretary Ghaly: What mechanisms should be used to reduce health care cost growth? This is important to sustain the models discussed. For example, we could: 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/abuse, set targets for health expenditures as has been done with Massachusetts Health Policy Commission. These ideas (presented on Slide 30) are not comprehensive or meant to be the only ones the Commission endorses or talks about. What other ideas come to mind?
- Commissioner Wood: It is important to set enforceable targets not to limit care but to make providers, in this case hospitals, more cognizant of waste and not just ordering tests and doing things that provide low value care because they can. Entities should have an opportunity to weigh in as some investments are good: if they blow past a target because they invested in primary care, that's a good reason to invest. This should be universal for all sectors of health care: doctors, hospitals, and medical groups that provide care. People need to be good stewards of public dollars. Care for the patients should be first and foremost, not ways to protect income. But a challenge is the lack of data and ability to analyze data. It is important to have an all payers claims database to note where our health dollars are spent and what outcomes we are getting for those health dollars. Why is it in San Diego County, costs of care are 20% less expensive with better outcomes than in Shasta County? Regarding controlling drug prices, which has been frustrating, one novel idea the Newsom Administration supported is producing certain drugs here in California, such as insulin. It has been 100 years since insulin was invented yet we are still struggling with the price. Diabetes accounts for a huge expenditure, $3 billion in Medi-Cal. It is important to reiterate the value of prevention: Diabetes and heart disease are major drivers of cost and if we spent more on prevention we could achieve savings. In Portugal, 95% are vaccinated as they recognize the

value of the vaccine in their publicly financed system, and it seems to cross personal and political ideologies, which can be a tremendous preventative measure. This is an example of measures we need to see more of in California.

- Secretary Ghaly reiterates what Commissioner Marya spoke to regarding the importance of keeping our eye on not just the health care but social drivers of health and how the health care infrastructure can support these goals. He notes a tremendous opportunity here to think creatively about how to use other levers to improve the health of Californians and not just reducing the demand for care, but reducing the care needed as health improves.
- Commissioner Wood reiterates the importance of a robust health information exchange system to provide the best quality, timely and efficient care possible.
- Commissioner Hsiao highlights the importance of setting total state expenditure targets. To create a sustainable unified financing system, the international experience as well as Massachusetts has shown there must be agreement on what are expenditures in total for next year. Then the details are worked out, level by level, including the payment method as well as the rates or global budgets for hospitals. In that regard, Taiwan, Japan, Germany, UK, Canada, and Massachusetts all do this. Twenty states are considering setting up an aggregate health expenditure budget. The question is how do you do it? Who is involved in setting those targets? The commission should discuss examples. On fraud and abuse, in empirical studies, up to 15% of health expenditures are spent on fraud and abuse. That is a conclusion coming from partial studies and what the FBI said. The FBI gave a wide range, 3-10% of Medicare spending went to fraud. That's based on the legal definition and also what the FBI was able to investigate. There is an article in the New Yorker about abuse in health care services. What has been included in the estimation of what a unified financing system can do to reduce fraud? How this can be done is a unified clinical records system from which you derive a unified claims system. Neither the US nor California has this currently. Once you have a unified claims system, you can identify which provider may be engaged in abuse and fraud. There may be justification, but it indicates potential fraud and abuse. The first country to do this was Canada. There was an article in 1975, when Ontario Canada implemented a unified financing claims system that showed some physicians were making claims that meant they must be working 24 hours a day, 7 days a week. In Taiwan and Germany, they found the same thing. Not all providers are committing fraud and abuse, usually it's less than 12%. To catch these bad actors builds up the trust and reputation of the other 88%. Currently in the US we do not have this system, so if unified financing could seriously address this issue of 8% or more of our expenditures, we can have more funds to address health care needs. How do we deal with the workforce? We need money to build up community centers first. Other countries show how a unified financing system could do it. With big data and

nowadays artificial intelligence, California can do it even better. The commission should take this issue seriously in the cost and financing of a unified financing proposal. When we do that, we do not have to reduce the price of hospital budgets. That should be a non-starter. If unified financing will reduce revenue, then providers, doctors, nurses, hospitals, and testing labs will be organized to oppose any legislation to unified financing. We have to think ingeniously, constructively, and realistically about how we remove the waste in the current system.

- Secretary Ghaly invites commissioners to speak: Commissioner Antonia Hernandez on the narrative of our current system versus a new storyline, Commissioner Dessert around reserves, and Commissioner Flocks on other levers we could use in California to think about cost as we grapple with workforce issues.
- Commissioner Antonia Hernandez: 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? On the issue of infrastructure, the current system is totally dysfunctional. Fraud is a substantial part. We don't have a unified medical claims system where you can capture the costs associated with things like social determinants that impact health, fraud and abuse, and the issue of insulin and diabetes and those associated costs. The first conversation must be what we can do to eliminate costs we're incurring now, then we can deal with the cost of providing care. A unified claims system is very important. Right now, we put our vaccination record in our phone and it's simple. If we can do that, why can't we do that for the full system?
- Commissioner Dessert: What reserve do we need to sustain and what's the initial amount we need? The $20 billion bond over 30 years is helpful. If the state is the sole purchaser of drugs and we have the opportunity to reduce waste and fraud, there will be incredible savings. It is important to shine a light on Commissioner Chin Hansen's focus on LTSS. Regarding the LGTBQ community, there is a generation (in their 50's and 60's) that doesn't have family support that our seniors need to access care. It is important to think about how to support that generation. LTSS needs to be included in how we reimagine the health care system, particularly in the cost analysis. It is expensive and needs to be at the center and not the side of our discussion and analysis. The statement that improving health care in California will lead to reducing the demand may be misleading. Health care is currently inaccessible to many low income, LGBTQ, and immigrant communities and it should be anticipated that more people will use the system as it becomes accessible. The commission could focus more on how the health care system would

change services, such as more in prevention, more in long term care, and then analyze to what degree people will use these health care options if they are able.

- Commissioner Flocks: It is important to tie financing and cost containment together, both to avoid capping services because we run out of budget and as an opportunity to talk about addressing the social determinants of health. If we can save money in health care, it opens up more of the budget to address these issues, like pollution and housing. In terms of reducing the growth of health care costs, it's an overall reduction but it's really a redistribution. Currently there are areas with higher cost and worse care because of lack of competition and consolidation, so we must look at where resources are distributed and what we are paying for services. As Commissioner Comsti noted, prices are primarily driving costs, not utilization. What is charged and is the care appropriate? How do we optimize for the best outcomes? Everything we are spending we need to be able to track; data is crucial for accountability. We need a separate conversation on workforce to make sure there are living wages and high-quality safe care. We also need protections on more than just wages, as for example hospitals could try to reduce cost by saying we need to get rid of seismic requirements or nurse staffing ratios, which aren't wages but just as important in the system.
- Commissioner Marya: To limit fraud and abuse it is important to look at the private health care industry. For example, in California if your spouse dies you carry that medical debt. She relates her experience of sitting bedside of someone dying with cancer, who's had a protracted hospitalization, and being with a family who is simultaneously grieving their loved one while wondering if they were going to become homeless through the seizure of their assets from paying a $750,000 medical bill. Medical debt is the leading cause of bankruptcy, and debt itself is an independent driver of inflammation, with chronic inflammatory diseases being one of the biggest burdens on the health care system. Abolishing the private health care industry provides the freedom to create new frameworks to liberate people from financial abuses that have become the accepted reality of US health care. Eliminating toxic debt has immediate health care benefits. Eliminating payday loans leads immediately to a lower rate of drug abuse and overdose. Regarding diabetes and heart disease, one of the leading causes of Type 2 diabetes is air pollution. We need to partner at every level of the state to ensure our systems are healthy. The other connection to diabetes and overall health is our food system. A study in Paris showed that of hospital admissions to the ICU with severe COVID, 67% of them suffered from malnutrition. In California communities there are food desserts with no access to healthy organic foods. Every admission does not cost the same. The ones that are costing the most are people whose lives are structured through these toxicities. The solution involves partnering with our agricultural system and our farmers. We need think system-wide and imagine

novel partnerships that have not yet existed in California to advance a network of health, a web of health, that can lift all boats.

- Commissioner Wright: Unified financing/ single payer will give us more tools to move forward. It is a real opportunity, not just to address waste and fraud, but to address misaligned incentives and market failures. Many people are acting rationally in an irrational system, reacting to incentives in a fragmented system. We want incentives to be for better, not bigger or more, market concentration as they sometimes are today. So that's while we're excited about unified financing, but there is a question about the best system of taxation and how to make clear to business community, workers, families that any apparent tax increase replaces what they are paying today. Did you look at the ways taxes are applied or structured, and how that affects people's awareness of what they're getting for that tax? Could you talk about the taxes could be structured to make the benefits clear or have the least impact on people's perceptions?
- Ken Jacobs: Employer and employee contributions together are currently 12.6% of payroll. One idea is to replace a large part of this with a tax that people would generally experience as similar to what they're currently paying. If no health care is being provided by their employer, that could result in some people paying more, which could be mitigated with a rebate to keep them whole. These taxes can be set up in a way that people experience minimal change, and then supplemented with a broad tax on profits or gross receipts or a tax on services. So the revenues would be a mix of something that is roughly equal to what people can see they are paying today, with clarity that it will support health care, along with broader taxes that -- because they are spread over a broad base -- are less noticeable. A mix that replaces current spending with a clear alternative and then supplementing with less visible revenues could help minimize disruption.
- Commissioner Wright: Important to the transition is how to package these revenues so they make sense to people and can inspire the economic decisions we want that makes California attractive, which this shift would do in the long run. The commission should also explore how, if certain employers benefit from the switch to unified financing, any benefits are passed on to workers.
- Secretary Ghaly: The question you asked is really important. How people understand why we are doing what we are doing, how it affects their bottom line but also their experience. This is an important part of the transition conversation. It isn't the same conversation about what is the ideal system and how do we get there. This is about how we include all Californians in supporting change and reaping the benefits. When looking at other examples where unified financing hasn't worked, they have not handled these questions.
- Secretary Ghaly tees up discussion question 2: 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?

- Commissioner Hsiao: What is governance? One definition is the role, power, responsibility, and accountability of key players in the system. One question in setting up a unified financing system is, what's the role of the state level, the county/regional level, and to what extent do you want to make sure people at the grassroots level are engaged actively in that governance structure? In Taiwan, the president of Taiwan said he unified financing for national health insurance should design a system that takes the government out of the middle. He had experienced that people who get the benefits from a health care system always want more. The people who have to pay usually don't want to pay more. If the government is in the middle, then everyone puts pressure on the government and legislature. He wanted to insulate that. In Germany that's eventually what they did as well. How did Taiwan do this? The executive branch in consultation with the legislature set a target, an upper limit for next year's budget spending, then there is the council with representatives from those who have to pay, including workers, businesses, and the government, and those who receive the money, including hospitals, doctors, nurses, and people who want to expand the services. And the last group is the academics. A group of people that represent the public are involved. That's how Taiwan does it. The question is, how do we govern to decide on the overall spending for next year? Then the question next is how do we allocate it downward? In Germany, it is to every state. In Taiwan, with 24 million people, they divide it into 5 regions. California, with 40 million people, will have to allocate to regions or counties. Going back to the governance structure, what role do you give to each level, what power do they have, and what responsibilities are they accountable for? That all has to be spelled out.
- Commissioner Comsti: What are the structural changes we need? The simple answer is a single payer system with a single standard of care for everybody. That's the biggest structural and governance change we can make. That's how we get all the savings laid out in the financial modeling. The most important is reducing administrative waste which can be spent on care. The health care intermediary option is more expensive than the single payer option. We can more precisely exercise regulatory oversight to ensure access, quality, and equity with a single payer system versus a fragmented system. It is important to emphasize that creating more complexity increases the costs of the program. A broader sustainability measure could be direct negotiations with providers, which is where hospital global budgeting and negotiating individual provider rates come in. How we get there is having a single bargaining entity on the other side of that—the government agency we identify as the

bargaining agent to negotiate those prices with hospitals and individual providers. In AB 1400 there are control measures to ensure that payments go towards care and not profit. It is stated, reimbursements have to go back to care and not net revenue. There are controls that say there can't be excessive health care executive compensation, so there is that redistribution effect. In terms of the entity that does the oversight, we must caution against having the providers self-regulate. In Taiwan, in the national health insurance program and administration, they brought up the issue there may be too much self-regulation. The board that is identified to be the overseer must have control over regulating fraud and abuse. It is important to be able to investigate these things to contain costs. This oversight entity can dig into the why (when care is not being provided) and answer that rather than simply penalize doctors without understanding what's happening. California can take advantage of the single payer direct system provider relationship by conditions of participation to incentivize care. Given the DOJ's litigation against Kaiser for their alleged coding parties, it is important to get rid of those incentives in payment structure, and we can do that with conditions of participation. Getting rid of billing and administrative waste frees up time for nurses and doctors to spend on care. The CBO has made estimations on how much more care we can provide. Administrative sludge costs time and energy that has a real effect on providers and patients and it is important to get rid of that. What we need to prioritize in investments is care and prevention. We don't want to focus on limiting services to keep a cap on costs overall.

- Commissioner Pan: Regarding the discussion about revenue and millionaires' tax and excess tax, we need to look at not just revenue but volatility. In California, we are so dependent on high income earners, and health care spending is not that volatile, but it is counter cyclical. In terms of governance, it is important to consider how national politics can affect the system. Whatever rules are set up, we can't make assumptions about who will make what decisions and need to design a system that is somewhat insulated from the political back and forth so there is stability. With some reference to a single board, often times if you have a single entity that has all the authority, as Commission Hsiao mentioned, it gives stakeholders a way in and incentive to try and dominate that body. Minority groups tend to lose when we concentrate power in a particular entity. The commission should think about how much we want to concentrate and diffuse power to makes sure the least advantaged have equal power and consideration. We often establish systems that are designed for the majority when we consolidate power. Do we want a single board or to diffuse it out into different communities so more grass roots and local bodies have the opportunity to guide resources where they need it? Bureaucracy does not go away even in a unified financing system. For example, in Medicare, rural communities are disadvantaged in payment by design. There are conversations about everyone under a single plan, but we

need an honest conversation about people who have the means to go outside the system. We currently have Medi-Gap and Medicare Advantage plans. We can't ban people from going to private institutions. Is it realistic to say you can't go outside the system? In terms of what Commissioner Hsiao said, how much detail we want the government entity to get into, and what the dynamics are if they make those kinds of decisions. Perhaps Taiwan made it too loose, but also a question of how detailed or how much power it has, as with higher stakes there is a greater probability there will be entities that try to make sure they have influence there. Another question is what to do about low value care, for example prescribing antibiotics to people with a cold, which is some people's expectations. What do we do when there are conflicts between what some judge as low-quality care when some communities say “no we want this?” Kaiser was demonized for not providing bone marrow transplants for breast cancer but gave in to public pressure. Regarding fraud and abuse, there are issues on both sides. At UC Davis, for ten years through the Medi-Cal program, it denied claims, and the billing department didn't follow up. When the department did an audit, all the claims were legitimate. The government cheated the department out of $60 million, and the state said you have to refile all the claims that they had refused to pay. We have to make sure things like the government and state manipulating its own claims system to save money does not happen as well.

- Commissioner Schneider: On government and oversight, one thing to consider is who is the federal government going to be willing to negotiate with? To claim those $12 billion dollars in 2031 in the .5% below NHE scenario, we have to go to Congress. If there is an independent government structure, would the federal government be more or less willing to negotiate? There will be an oversight problem with such a large system, one way to mitigate this is transparency. To give an example, at Georgetown University there was a contract with CHIP managed care plans to post results for each plan. If the health dashboard is not specific to a plan, it is not helpful or actionable. Poor performers are shielded, good performers don't get the benefit. There's are benefits to transparency even just with the information we're already collecting.
- Commissioner Baass: The academic questions that come to mind are: Will the decisions be made at state level? Will regional differences be considered? And how do we foster innovation at the local level? What are the policy rules versus the financing rules, and does the same body make these decisions? The fundamental topic of governance is the commitment to a vision for the ideal system, ensuring access, quality and equity. In other countries like Costa Rica their focus on the integration of public health, primary care, workforce and community health workers have resulted in better outcomes and spending less. They designed a model that isn't just reactive, but structured where both at the national and local level every committee has a primary care team to provide visits to all its residents. That is a kind of common commitment that is

critical in terms of governance structure, so everyone is united and knows where it's going.
    - Secretary Ghaly wraps up the conversation reinforcing the last point, the presentation highlights there is real potential under unified financing to enable us not only to have something more affordable but also to create a system built around the values and propositions that we have been committed to all along as a commission. There is a real opportunity to address the workforce crisis we are facing; to address equity and the power dynamics, to focus on prevention and care of the whole person, and an opportunity to talk about LTSS in a different context and build it in on the front end. Not just the dollars and cents part, but an opportunity to build the system in the wake of Covid, in the wake of persistent disparities and inequities. To see the commission move in this direction is an important declaration and will help us as we craft the final report and convene our final meetings together.
- 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 November 17 Public Comment.

3. Adjournment

- Secretary Ghaly thanks the public and commissioners and adjourns the meeting.