HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

# Virtual Commission Meeting

February 23, 2022

# Virtual Meeting Protocols

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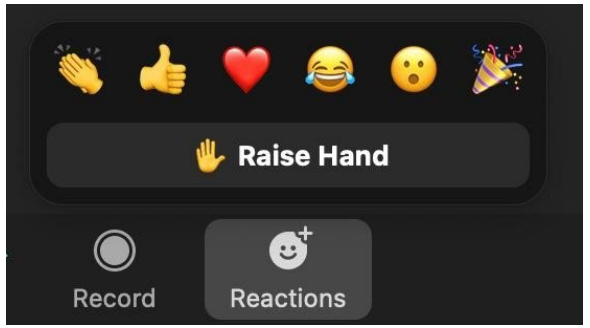
- This meeting is being recorded.
- Commissioners:
  - You have the ability to mute and unmute and the option to be on video.
  - Please mute yourselves when you are not speaking.
  - To indicate that you would like to speak, please use the “raise hand” feature:




- 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

# Next Steps

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| Timing | Activity |
| --- | --- |
| By March 15 | Commissioners receive draft report |
| By early April | Commissioners provide comments, via survey, on draft report. Comments will be consolidated and made available to the public. |
| Late April | Final Commission meeting |

# Today's Agenda

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- Introductory Comments
- Commissioner Discussion
  - Cost Sharing Under Unified Financing
  - The Role of Coordinating Entity(ies) Under Unified Financing
- Public Comment

# Cost Sharing Under Unified Financing

***When, if at all, should patients/ consumers be asked to share part of the cost of care?***

# Cost Sharing Literature

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- The RAND Health Insurance Experiment (HIE) found that patients use more health care when it is free at the point of service than when they are required to pay out-of-pocket for some of the cost of that care.
- The RAND HIE also found that with the partial exception of low-income patients, health outcomes for patients subject to cost sharing were no different than heath outcomes for patients receiving free care.
- However, multiple research teams have shown that patients are not good at differentiating potentially beneficial care from care that is not likely to produce benefit, and care of both types is less likely to be received by patients subject to cost sharing.
- Recent research on Medicare Part D shows that patients entering the ‘donut hole’ are less likely to fill prescriptions and suffer worse outcomes as a result.  It is clear that cost sharing, if used, needs to be designed thoughtfully.

# Cost Sharing Comparison Points

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- Actuarial value (AV) is the portion of covered medical expenses, for an average population, paid by insurance. AV captures the aggregate impact of copayments, coinsurance, deductibles and other enrollee out-of-pocket cost-sharing.
- In California today, AV varies by payer. The consulting team estimated AV for existing coverage arrangements as follows:
  - Medicare: **83% AV** (without supplemental coverage, Medicare Advantage or dual Medi-Cal eligibility)
  - Medi-Cal: Close to **100% AV**
  - Covered California: **77% AV** (across all coverage types, with different products varying from 60% AV (Bronze) to 90% AV (Platinum) to 94% for those eligible for cost-sharing reductions)
  - Employer sponsored coverage: **89%** on average, with great diversity among different employer plans. For example, CalPERS HMOs average 96% AV, CalPERS PPOs range from 85 to 92% AV, and California small business plans often have an AV of 80% or less.

# Cost Sharing Context: Assumptions and Implications

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- Consulting team modeled two scenarios:
  1) No cost sharing
  2) Income-related cost-sharing in which:
     - Families below 138% FPL face no cost sharing
     - Families 138-400% FPL pay, on average, 6% of medical expenses
     - Families >400% FPL would pay, on average, 15% of medical expenses
- In the scenario with income-related cost sharing, an estimated $168 billion in new tax revenue would be needed. The $168 billion is less than is currently spent by employers and households. The $168 billion is not new spending; rather it replaces some (although not all) existing employer and household spending. In this scenario, Californians would pay an estimated $20 billion in out-of-pocket spending.
- In the scenario with no cost sharing, an additional $39 billion in new tax revenue would be needed, for a total of $207 billion.

# Opening Remarks

**William C. Hsiao, Ph.D.**

Research Professor of Economics

Department of Health Policy and Management and Department of Global Health and Population

Harvard T.H. Chan School of Public Health

# Cost Sharing Considerations in a Single-payer or Unified Financing health system

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- Ideal single-payer systems would not have cost sharing. Under what circumstances would cost sharing be considered?
  - Make the funding of a single-payer program feasible—open another source of revenue besides taxation.
  - Reduce unnecessary uses of medical services —e.g. drugs, diagnostic tests, office visits, plastic surgery, etc.
  - Choose better alternative ways (i.e. cost sharing, waiting list and lower quality of health care) to ration selective health services when their supplies are limited.
- Cost sharing produces some undesirable effects:
  - Could deter some people seeking necessary health care
  - Compromise principle of equal financial access to health care even when poor are exempted from cost sharing
  - Increase administrative cost for providers
- Decision about introducing cost sharing involves *trade-offs* between its undesirable and desirable effects, and requires careful planning.

# Commissioner Discussion

# The Role of Coordinating Entity(ies) Under Unified Financing

***How is care organized and coordinated under Unified Financing?***

# Care Coordination and Care Delivery: Summary

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**Statewide UF Authority**

- Benefits
- Eligibility
- Establish payment rates
- Data monitoring and transparency
- Grievances and appeals

**Care Coordinating Entity(ies)**

- Quality improvement
- Care coordination across the full continuum of providers and services
- Population health improvement
- Disparities reduction

**Physicians, Institutions, Other Health Care Providers**

- Clinical care for individual patients
- Data reporting

# Roles for State UF Authority

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- Determine benefits, initially and over time as treatments and technology change
- Confirm eligibility based on residency
- Establish payments rates, and make equity-related payments or adjustments when needed
- Collect and make public data on quality, access, equity to assist consumer decision-making and for program oversight
- Manage grievances and appeals
- Monitor and address health disparities

# Care Coordination and Care Delivery: Key Questions

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- Under the status quo, multiple, fragmented payers often support:
  - Quality improvement programs
  - Care management initiatives
  - New approaches to delivering care (e.g., remote monitoring or home-based care)
- Under UF, how and by what entity(ies) should improvements in quality of care and care coordination be advanced?
  - If health plans or health systems were used as care coordinating entities, how could they be reimagined to improve quality and better coordinate care?
  - If health plans/ health system intermediaries were not used as care coordinating entities, how could the UF authority encourage better coordinated, better quality care for all Californians?
  - Is there a role for regional sub-authorities?

# Commissioner Discussion

# Public Comment

# Adjourn