



**Healthy California for All  
Commission Meeting  
February 23, 2022  
Meeting Synopsis**

Note: a video recording of this meeting can be found at: [video recording of February 23, 2022 Healthy CA for All Commission meeting](#).

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Sandra Hernandez, Andy Schneider, Carmen Comsti, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Don Moulds, Richard Pan, Cara Dessert, Michelle Baass, Peter Lee (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 (CalHHS) Secretary, Dr. Mark Ghaly, welcomes the group and notes commissioners will receive a draft report by March 15<sup>th</sup>. Commissioners will be invited to provide comment on the draft report by early April. Comments will be made available to the public. The final report will be released towards the end of April, and a week after will be the final meeting. Because of the important conversation on federal opportunities and authorities and the legislature versus waivers, Secretary Ghaly asked for a legal memo of what's possible. This legal memo will be attached and included in the draft report. Today the discussion will focus on cost sharing under financing, the challenges, opportunities, and should be included in the report. The second topic will be the role of coordinating entities under unified financing.

**2. Cost Sharing Under Unified Financing**

- Secretary Ghaly tees up the conversation on cost sharing: When, if at all, should patients/consumers be asked to share part of the cost of care? He provides

background information on cost sharing literature and comparison points, available on Slides 7-9 of the [PPT presentation of the Feb 23rd meeting](#).

- Secretary Ghaly invites Commissioner Hsiao to provide opening remarks for the topic of cost sharing.
- Commissioner Hsiao states that an ideal system would include no cost sharing and outlines the situations where it might be considered. Cost sharing can open another source for revenue generation aside from taxation, reduce unnecessary use of medical services, and is an option to limit services when supplies are limited. However, cost sharing produces undesirable effects: it can deter people from seeking care, compromise the principle of equal financial access to health care, and increase administrative cost for providers. Decisions about introducing cost sharing involve tradeoffs and require careful planning. To ration when supplies are limited, Taiwan and Vermont chose cost sharing, and Canada and the UK chose waiting times.
- Commissioner Pan notes that, in some cases, such as with chronic disease drugs, cost sharing can deter use and increase overall costs. He asks what types of cost sharing (deductibles, co-pays) work best and where do you impose cost sharing?
- Commissioner Hsiao notes from an economist's point of view you want to impose cost sharing where patients are most sensitive to the prices, and that empirical studies show people have the highest price sensitivity to drugs. There should be no cost sharing on vaccines, for example, but considered for other drugs that are overused like antibiotics or opiates. Regarding type of cost sharing, he recommends co-pays instead of deductibles.
- Commissioner Scheffler brings up the point that cost sharing is about more than controlling cost, as it can help to limit overuse, but that there is an easier way to solve this problem and produce the same savings. Medicare is a case study for this, which is a capitated system and costs 10-15% less than a fee for service system. On \$400 billion, that is at minimum \$40 billion in savings even without cost sharing. In capitation payments we can also address inequities. It would be better to have no cost sharing, and capitated systems are better to address these issues.
- Secretary Ghaly summarizes that co-payments have their challenges, but capitated systems produce savings that are important to consider as we think through costs.
- Commissioner Comsti strongly opposes cost sharing and asserts that it serves to create income-based tiers of care – a tradeoff people are not willing to make. It is not a long-term solution to issues related to supplies, services, or cost. She notes using behavioral economics or psychology to limit use or cost means we don't have a well-functioning system. Cost sharing increases administrative costs and places burden on the system to hunt down those copayments. It's a regressive tax, and we need a more progressive financing structure. People should not have to choose between health care and rent, etc. Savings can be gained by

eliminating middlemen and administrative costs. If we are limited in supplies, there are other solutions such as creating programs to retain doctors and nurses and recruit more professionals. In the short term, we can help doctors manage scheduling and provide tools. In Taiwan one solution was allowing clinics to stay open longer. Fundamentally, reducing demand by an economic stick is inappropriate and inequitable.

- Commissioner Dessert reiterates the goal is to build an efficient and accessible system that improves health overall. She asks about the tradeoff between efficiency and health overall. If people were to overuse some services, what are we losing in health outcomes?
- Commissioner Hsiao notes many researchers are attempting to do this evaluation, but conditions differ and may not apply to the US. It also varies by income/age. We know in the US antibiotics are overused. The tradeoff is we may be able to reduce overuse, but some people may forgo the necessary drugs, which is why it is important to exempt low-income patients from co-payments. South Korea adopted universal coverage but did not cover MRIs or control MRI prices, so doctors could charge patients and it resulted in the highest use of discretionary MRI tests. He notes this is why system design is important. Do providers have the incentive to do it? Demand is not purely on the patient side. Patients are mostly influenced by doctors in these cases.
- Commissioner Sandra Hernandez notes in the Canadian system wait lists are how things are slowed through the system and asks how the quality of care is or is not compromised by a waiting list system.
- Commissioner Hsiao replies that in Canada specific services are allowed on the wait list. Patients may experience some inconvenience and pain, but it will not kill them. Canada and the UK also have a triage system where serious conditions are treated immediately and rationing by waiting lists is done in a sophisticated and not a general way. Rationing by waiting time is on selected conditions.
- Commissioner Wood relates his experience in his dentistry practice for 30 years, noting that even a minor co-pay of \$5 was an effective tool in getting patients to show up for the appointment. He states that when it is completely free the value to the patient is different. When people don't show up, they cannot be cared for, so it influences both equity and health. From the research, what is the impact of zero co-pay in the practices of physicians and overall health of the system?
- Commissioner Hsiao confirms there are studies done for small populations that do show absenteeism in a zero-co-pay system. Economists explain this as when you offer something for free, people put a zero value on it. This can be changed by placing some value or using public education to educate people.
- Commissioner Chin Hansen shares an example of how some health plans guide patients towards higher performing providers by saying if you go to them, there is no co-pay but for providers in the lower tier of performance there is a co-pay. She asks if any countries have tried this approach? This is another way to look at access and to steer people towards higher quality performers.

- Commissioner Hsiao acknowledges that the new thinking is to change cost sharing or payment rate for providers with different performance. This has mostly been done through the payment system rather than the patient side. Polls taken decades ago found that patients associated higher price with higher quality, which is not always true in the medical field. The common practice is even if you pay capitation, 30% is fixed and 30% is based on performance, but it is hard to measure.
- Commissioner Pan shares his experience as a physician confirming the no show rate for Medi-Cal is very high. The UC Davis clinic struggled to get a show rate above 50% and other places were doing worse—that was with doing things to incentivize people to show up. However, it is important to consider patients bore a non-financial cost to make the appointment, including travel and other conflicts. He notes they had to do dysfunctional things like overbooking to keep up. The Medi-Cal program without cost sharing imposed other ways to control utilization like treatment authorization request (TAR) forms, which added administrative burden to prescriptions and treatments. If one piece of paper was missing it would be rejected, and not right away but months later. It was an added administrative hassle to keep doctors from ordering too many. Another example is contracts where you have to take in a certain number of patients, which forces doctors to discharge patients prematurely. Cost sharing may not be the answer, but it is a tool, and in the absence of it, the government imposes other types of controls to force doctors to behave in ways that do not improve quality of care.
- Commissioner Hsiao notes that a primary reason these types of controls are imposed is when the government is running it—the paperwork and burden for patients and providers in these scenarios is tremendous.
- Commissioner Wright states that cost sharing is a tax on the poor and the sick. Even a nominal co-pay of \$25, for a senior with six prescriptions, adds up to \$150 a month, a lot for seniors on a limited income. The current system is deeply regressive with regard to income. He recommends this is not the place to start to reduce costs. He notes some commonality in earlier remarks: for example, cost-sharing is a blunt instrument, and the type of cost-sharing matters. For example, he notes that co-insurance – such as asking for 5-10% of the cost – is almost fraudulent as people do not have a grasp of what that means in practice. Deductibles are in the same category. The RAND study showed cost sharing does reduce use but that people are not good at distinguishing between what care is necessary or not. It is not fair for people who have been injured to have to make a decision about going to the ER or not based on cost. Cost sharing is a last resort, not a first. If it is done, it should be small and exclude low-income people.
- Commissioner Hsiao explains that high deductibles were pushed by Bush to give workers a choice to get a health savings account with an up to \$3,000 deductible, and some workers did select that. He was opposed to that. Singapore is an example of the adverse effects of this.

- Commissioner Moulds recommends looking at the Commonwealth Fund research in delayed care because of cost. These negative effects are also seen from the cost sharing within the Medicare program. He recommends staggering cost-sharing based on income. He offers a political observation: when people are deciding how they feel about a proposal, they will look at what they're paying now and compare to what they will be paying. People in employer coverage are at 89% of average costs covered, with a CalPERS HMO at 97%, if you're looking at 15% cost sharing or even 6% cost sharing, people will end up paying more and politically that's going to be a real problem. At that point it would be necessary to look at supplemental products or changing cost sharing based on those concerns.
- Secretary Ghaly summarizes that there is a lot of caution, but that there are legitimate outcomes we want to control, such as thoughtful utilization of services whether appointments, drugs, or procedures. Sometimes cost sharing may be a lever to use to address these outcomes; however, it is not the best or first strategy to use as it has other negative effects.

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

- Secretary Ghaly tees up the conversation on the role of coordinating entities under unified financing: "How is care organized and coordinated under UF?" Some commissioners are in favor of including plans, and others say no plans, arguing that they just serve as a middleman and anyone who imposters as a plan also isn't needed. What are the options for taking care of the issues presented in Slide 14 of the presentation (see [PPT presentation of the Feb 23rd meeting](#)), namely: quality improvement, care coordination across the full continuum of providers and services, population health improvement, and disparities reduction. He describes what the Statewide UF Authority would do and what physicians, institutions, and other health care providers would do. He covers the Roles for State UF Authority (Slide 15) and Key Questions for Care Coordination and Delivery (Slide 15-16).
- Commissioner Sandra Hernandez agrees care coordinating entities are necessary, as it is difficult for individuals to do these things. It is difficult for providers to do the right thing in a fragmented system with multiple payers and expectations. In a fee-for-service system, the financial incentive is to do more, not better. She recommends a data system that allows all providers in the state to share useful information about health care needs in real time. She notes this cannot be left entirely on the delivery system to sort out. Better tools, training, data, and data exchange are necessary. The financial incentives should incentivize population-based health, actively reducing disparities, and collecting and sharing needed racial and ethnic data. Referring to the earlier conversation regarding cost sharing, she acknowledges the system may have to involve some sort of triage. In that case, she says, primary care providers need to be the place where the health care decisions are made, with incentives that encourage providers to look across the entirety of each patient's needs.

- Commissioner Pan recommends paying primary care providers as opposed to health plans for care coordination, as these efforts are more successful. He cautions against one entity setting rates with another trying to structure financial incentives. He recommends adjusting wording from “establishing payment rates” to “negotiating payment rates.” He notes health care needs to be an entitlement, as cuts are made not in response to health outcomes but in response to budget needs. The IT infrastructure needs to be financed, as it’s not just about paying the doctor, it’s about the health care team having the resources needed and who has oversight. It’s a balance between resources for building infrastructure and making sure the frontline providers have the resources to manage and coordinate care properly.
- Commissioner Lee remarks on cost sharing and benefit design, noting it must look at income levels to make sure people have as few burdens as possible. Most do not have that: there are not standard benefit designs in Medicare Advantage or employer-based coverage. In Medi-Cal benefits are standard with no copays. In Covered California there is standard benefit design, and premiums and out of pocket are tied directly to income. It is a question or not whether it should be zero, but no doubt that individuals with lower incomes should be paying less. It is important to guard against coverage only in name: in employer coverage, 30% are under covered, 35% in Medicare are spending 20% of their income on health care coverage. That is why it is important to have standard benefit designs and income adjusted plans. He notes the point of unified financing isn’t coverage, but to get people the right care at the right time. Right now getting the right care is a coin toss and it has not improved in the last 20 years. There is strong evidence that says you are more apt to get higher quality care in an effectively coordinated setting, and that in a non-integrated setting (fee-for-service, PPOs) you get worse care. Primary care can be the anchor for care coordination but needs help to coordinate across the full spectrum. Whether that’s an integrated delivery plan or accountable care organization is up for debate. But non-integrated health plans have not proven they can be the engines of quality improvement.
- Commissioner Chin Hansen concurs with Commissioner Lee’s points. She notes that the PACE program is a model to encompass health plans and providers, incorporating each of the three categories in Slide 14. She recommends this is a system to look at and that sometimes we don’t have to reinvent, but rediscover.
- Commissioner Baass encourages reimagining what coordinating entities could do, focusing also on social drivers of health, as for many vulnerable Californians health is about more than health care; it includes housing, food, and so on.
- Commissioner Comsti clarifies that care coordination means people on the care team are working together to provide the best care, sharing information, and being compensated. She notes this coordination is best done by the primary care team directly and questions the value of an entity doing this. When a corporation or risk bearing entity does this it means unlicensed professionals are dictating how care should be implemented, and their goal as a corporation is to have returns for their

structure, shareholders, or the corporation as a whole if a non-profit. Instead, care coordination can be done by directly paying for care coordinating time by doctors and nurses. Tools can be provided and paid for to help doctors, medical groups, and hospitals get what they need to access health information and give proper referrals. We should not fall into a false dichotomy between fee-for-service or risk bearing entities, as there are global budgeting options and salaries that can be worked out instead. Fraud and abuse by administrators are more concerning than from providers, with the example of Kaiser upcoding to game the system. She notes the burden of the paperwork of health plans and of government, and that by enrolling people into risk bearing entities with narrow networks it allows corporations to divvy people up and compete over the healthiest and push out the sickest, which is a fundamental problem. She discourages a competitive economic model for care coordination and instead recommends giving tools and resources to providers to spend more time on care coordination and simply allow providers to talk to one another.

- Secretary Ghaly relates his experience as a physician that when plans begin to do a coordinating function, while the provider feels the same responsibility to coordinate care, it may not get done well in either place. This is an opportunity to be thoughtful in how these structures are set up.
- Commissioner Scheffler affirms Commissioner Lee's points, except for one quibble, that the fee-for-service versus capitation argument is 45 years old and to go back to that now would be lunacy. The evidence is overwhelming, and the field has moved on. In the UK and Canada primary care doctors are paid on a capitation system, per patient, and compete for patients to get a capitation rate. Hospitals are paid on block grants and buy services for them. He notes serious issues with making profits from health care and is less concerned with nonprofits like Kaiser or Blue Shield. Most doctors are in some kind of group, and 99% are set up for profit, and profit is not a bad word, but there are concerns with big corporations and health care plans. We can't talk about care coordination unless we talk about how we're going to pay for it. Care coordination means everyone working together, not on a fee, and capitation is the way to pay it. This also gives a powerful tool for dealing with disparities in the health care system. Medi-Cal is working on paying for things like transportation, housing, and coordinating across sectors, and this is all done in a capitated system. It doesn't work in a fee-for-service system. He does not think the state can coordinate care unless they say every doctor works for the state, which they are not likely to do. The state can set guidelines and incentivize things by the way they pay, but care coordination has to be done by providers on the ground. Someone has to run the hospitals so there has to be some higher level that coordinates hospitals and other providers. The model we have developed in California is an integrated delivery system.
- Commissioner Hsiao clarifies two dimensions of coordinating care, 1) care between behavioral health care and physical care, and 2) coordinating between primary care, specialty care, secondary care, tertiary care, rehab, and maybe

even social services. He recommends considering two major forks, one is organizing this internally within an organization like Kaiser. The other is externally coordinating, like the UK, where you have to rely on contracts. Internally, you organize differently using employment, promotion, corporate culture and so forth and he recommends this option. He echoes and supports that this cannot be done through directives, it requires incentives. With capitation the organization is responsible, and you can hold them accountable to results.

- Commissioner Lee highlights Commissioner Comsti's point that clinicians should be guiding clinical care, not guided by non-clinicians or allowing any entity that would avoid sick people or try to get healthy people in. A fundamental issue is 99.9% of doctors are in entities, so how do we incentivize getting better quality care and not just enrollment. A unified financing system needs to look at setting up financial structures for entities that incent and demand global responsibility for populations.
- Commissioner Flocks notes that all of this is dependent on granular and robust data collection and an IT system to support this. In holding people accountable, payments are inseparable in terms of care coordination and ensuring quality improvement and equity. Whether that is rate setting or negotiation, there must be an awareness that payments do more than just pay providers, they help us achieve our goals and hold people accountable. Part of the challenge with primary care providers coordinating care is a workforce issue, as we need more providers. There needs to be a regional entity or model like Kaiser that is beyond individual patient care coordination that looks at equity, disparities, and variations in quality.
- Commissioner Moulds agrees with Commissioner Lee on the importance of care coordination. This is seen within CalPERS where PPO plans have a higher total cost to members yet struggle to meet quality standards, all because they have less coordination.
- Commissioner Wright suggests going one more level down in detail. He is skeptical of plans or intermediaries due to their for-profit motives and track record of not moving the needle on giving the right care at the right time. He notes it is not ideal for everyone to have access to everything but with no coordination. There is bottom-up navigation and system coordination, and he recommends incentivizing systems to compete to become world class providers on diabetes, heart disease, obesity, and other specific focuses. This requires thinking about how to organize the system at the top level, and at regional levels to recognize the specific needs of each area. On the question of transition, he notes there may be an aversion to changing too much of the system initially as people may have fidelity to their providers, so there must be a balance between providing that sense of security and sequencing, incentivizing and changing that system.
- Commissioner Schneider notes that there needs to be accountability for results, and while transparency is not sufficient, it is necessary. There are not enough monitors in either a state financing authority or care coordinating entity to stay on top of what is going on. Once information about use of services in specific



populations is public, and all can see who is performing and who is not, then regulators, care coordination entities, and providers will up their game.

- Commissioner Scheffler notes the commission needs to weigh in on profits and nonprofits in the health care system. Where is it appropriate to make a profit or not? What is an ethical way to make a profit by improving care and efficiency, rather than making profits from market power? The structure of the system and the power various groups have within the system is important for the state to be able to go on. There are ethical judgments about when it is and isn't appropriate to make a profit.
- Secretary Ghaly summarizes that the commission agrees care coordination is necessary. It's good for care coordination to be done closer to providers, and if it falls in the hands of providers, they need to be equipped with tools, data, and people to do it. Accountability and transparency are important. In reimagining the health care delivery system, we fundamentally want a system that does better by patients, and understanding those goals get supported through payments and incentives is what we're working to sort out.
- Secretary Ghaly notes that the December survey results are available and takes questions on the draft report process.
- Commissioner Comsti asks if comments will be able to be attached to the final report, and if the commission will be discussing the draft report or finalizing with no additional changes. She asks if the draft will be made available to the public, or only the final. She asks if the legal memo was developed by outside counsel or within CHHS.
- Secretary Ghaly responds that the draft report will be made public at the same time that commissioners receive it. The public will have the opportunity to comment. He will be seeking commissioners' input on the report using a survey format that provides an opportunity to weigh in broadly, as well as seeking targeted feedback. The legal memo is by outside counsel and that will be made available. Around March 15, commissioners will receive the draft report and they will be asked for feedback via a survey. That feedback will inform revisions to the final report, which will be distributed a week before the last meeting. Then commissioners will come together to talk about it. Feedback might cause him to consider calling another meeting.
- Commissioner Wright asks if the outside counsel has expertise in ERISA or Medicare waivers. The deep dive expertise on various aspects of this may exist in different places.
- Secretary Ghaly notes that we will do as much as we can before the final report. The final report will have a section on next steps where we aim to get concrete about what else is needed to move toward unified financing. This may involve commissioning more work, among other things.
- 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 Public Comment from February 23 2022 meeting](#).

#### **4. Adjournment**

- Secretary Ghaly thanks the public and commissioners for the thoughtful comments and that the draft report will be sent out and feedback solicited before the next meeting.
- Secretary Ghaly adjourns the meeting.