Key Design Considerations for a Unified Health Care Financing System in California

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Final Report: April 2022

Authorship and Review Process

This report was developed under the guidance of the California Health and Human Services Agency. Secretary Mark Ghaly reviewed and edited multiple drafts and provided overall direction on this report's structure and content. Vishaal Pegany of the California Health and Human Services Agency provided oversight and editorial review and drafted portions of the report. Support for the Healthy California for All Commission process and assistance in drafting and revising the final report was provided by a consulting team contracted through the University of California, San Francisco (Joanne Spetz, Ph.D., principal investigator from November, 2020 to the present; Andrew Bindman, M.D., principal investigator from project inception through October 2020). Members of the consulting team included Marian Mulkey, Richard Kronick, Laurel Lucia, Ken Jacobs, Bobbie Wunsch, Eric Douglas and Karin Bloomer. Jerry Kominski, Srikanth Kadiyala, and Tynan Challenor contributed to the analytic findings. Joslyn Maula provided design and formatting assistance.

Members of the Healthy California for All Commission received a draft version for feedback and consideration on March 17, 2022, and the draft was available for public review beginning on March 18, 2022. Commissioner feedback on the draft was provided via survey; Commissioners' responses and comments on the draft are summarized here. The final report, will be provided to commissioners a week before the Commission's last meeting on April 25, 2022. Following the Commission's consideration, the final report will be delivered to Governor Newsom and to the Legislature. Commissioner comment letters on the final report received by May 6, 2022 will be included in Appendix E. The final report will be posted to the Healthy California for All web page with guidance on how public comments may be offered. Public comments on the final report that meet basic guidelines regarding accessibility and length will be posted as part of the public record.

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Opening Letter from Secretary Ghaly

April 18, 2022

Members of the Healthy California for All Commission:

When Governor Newsom and I sat down during the early days of his first year as Governor to discuss my serving as his Secretary for Health and Human Services, our conversation focused on two questions: (1) how do we better address the growing behavioral health needs of Californians? and (2) how do we move toward implementing a single-payer health system?

Little did we know that we would soon be facing a global pandemic that would require an immense amount of our collective time and attention. Yet in the midst of the danger and pain of the pandemic, COVID-19 has also opened up a renewed and necessary focus on race- and poverty-based inequalities and the desperate need for lasting change in how we seek to address them. At California's Health and Human Services Agency (CalHHS), we call the pandemic the great unmasker of inequities and the great accelerant for change. The pandemic's disproportionate impact on communities that have historically experienced worse health outcomes has been tragic but not surprising. Throughout the pandemic, COVID-19 death rates have been nearly twice as high among racial and ethnic minorities and have been concentrated in low-income communities. Beyond COVID-19's direct impact, delays and disruptions in care related to the pandemic have led to excess morbidity and mortality from smoldering, under-addressed illnesses in these same communities. We face an urgent need to undo longstanding social and structural inequities – in health and beyond – that led communities across our state to experience disproportionate incidence and adverse health outcomes from a ruthless virus.

It is, therefore, not surprising that the following report seeks to lean in and push the envelope toward genuine health care system transformation. The Commission engaged in rich, frank and occasionally tense discussions that resulted in a set of widely agreed on position statements. Many initiatives to accelerate our travels down the road to health care system transformation are proposed or already underway. Nevertheless, there are key areas where additional work is required.

I am proud to be part of an administration that has committed to investments and radical changes that will improve the health of all Californians. These include advancing the "Health for All" Medi-Cal expansion in the Governor's proposed budget; raising the bar for both health plan performance and system innovation in the recently released Medi-Cal health plan procurement; the transformation to move upstream to address social determinants of health at the core of CalAIM; the proposed Office of Health Care

Affordability; and the work to establish a data sharing framework through which we can have timely access to data required to address both health and social needs.

Each of these efforts is an improvement in and of itself but also moves California closer to the ultimate goal of total health system transformation. Access, quality, equity and affordability are all part of what our Commission considered foundational within the unified financing health care system we envision. To be clear, transformed financing is not an end in itself; rather it is a tool to drive the change we want to see. As Governor Newsom says each budget presentation, "a budget is a statement of our values." In the same way, the approach to financing health care – both collecting the funds and paying them out – is a statement of not just what we value, but who we value. A system of unified financing is uniquely positioned to transform care delivery and to shift the power that lies in health and health care to benefit those who have too often been overlooked.

Health reform of the magnitude we seek is not for the faint of heart. Indeed, the Commission's strong heart was regularly on display over these past two and a half years. We can and will build a health system that serves those in need well. We can do this together. This is how we build a Healthy California for All.

As a Midwest-born, first generation American with parents who did not know how to engage in a land they did not know, I benefited from government-sponsored health care services. We looked to the nearby Indian Health Services clinic for all our health care – urgent care, primary care, and dental care. Lines were long but care was thoughtful and available. This steady dependence on high-quality free or low-cost care are among my earliest memories. Despite the years that have passed, I clearly remember not just where I received care, but what it cost and how I was treated.

So, with this context in mind and with a deep sense of humility and hope, we release this report of the Healthy California for All Commission. The report documents the particular benefits and unique potential that a unified financing system holds for California. The report details a specific action plan for California to pursue, which includes engaging with federal partners to clear the threshold issue of securing adequate and sustainable funding from federal programs, refining the ultimate design of a unified financing system, and preparing to act decisively as policy and political windows of opportunity open.

In closing, I want to thank my co-Commissioners for their grace throughout the process. We juggled a diversity of viewpoints. We engaged in meaningful conversation and gave space for comments that were wide-ranging. We learned and grew together in a way that makes us proud. California Proud!

Arms linked,

Mark Ghaly

Introduction and Overview

Established by Senate Bill (SB) 104 (Chapter 67, Statutes of 2019), the Healthy California for All Commission is charged with developing a plan that includes options for advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians. This report, the final deliverable required of the Commission under SB 104, Chapter 67, Statutes of 2019, offers options for key design considerations for a unified financing system, including, but not limited to, a single-payer financing system. The report elevates a shared vision of a Healthy California for All that will ensure health care that is accessible, affordable, equitable, high-quality and universal and outlines the decisions and actions that will move California toward a unified financing system for health care.

The report draws extensively on discussions held by the Commission from January 2020 through February 2022. The report incorporates commissioner input, obtained via three surveys administered in September, November and December, 2021. Survey questions and statements were informed by commissioner comments during Commission meetings on the goals, values and key propositions that should guide Commission work.[1] In addition to those topics, the December survey sought input on priorities for the transition to unified financing. The report also draws on insights from analytic work conducted in connection with the Healthy California for All Commission and offers insights from community engagement research conducted in parallel with the Commission process. An earlier version of this report was shared with Commissioners and posted for public review on March 17, 2022; this version has been revised and improved as a result of comments received by many commissioners at that time.

As used in this report, the concept of unified financing describes a statewide system to arrange, pay for, and assure health care in which:

- All Californians will be entitled to receive a standard package of health care services;
- Entitlement will not vary by age, employment status, disability status, income, immigration status, or other characteristics; and
- Distinctions among Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage will be eliminated within the system of unified financing.

As international examples make clear, there are many methods to achieve unified financing. For example, Canada uses a decentralized approach administered by the country's provinces to pay private hospitals and physicians for medically necessary services without

[1] Complete survey findings are available at the Healthy California for All webpage. See "Meeting Information" documents for September 28, 2021 survey synthesis; November 17, 2021 survey report, and February 23, 2022 for the December 2021 survey report. Commissioner feedback obtained via survey on the March 17 report draft are available in this Survey Report.

cost-sharing at the point of use. In the United Kingdom, all residents are entitled to health care through the government-administered National Health Service, which owns hospitals and other providers such as ambulance, mental health and district nursing services, and pays salaries to physician specialists and capitated rates to primary care physicians. Germany requires mandatory purchase of statutorily-defined health insurance administered by highly regulated nongovernmental sickness funds. The Netherlands provides a mandatory, universal social health insurance program that relies on non-profit health insurers paid via a risk-based capitation formula.[2] Although international systems of unified financing rely on a variety of payment arrangements and structures, they share two characteristics: they are universal, and they provide the same benefits and access to services regardless of employment status and income.

The Commission's charge – to explore "options for key design considerations for a unified financing system, including, but not limited to, a single-payer system" – left room for discussion and debate about how unified financing or a single-payer system would work in California. Those discussions are the subject of the remainder of this report.

[2] More detail on international systems is available at https://www.commonwealthfund.org/international-health-policy-center/countries

Executive Summary

On behalf of the Healthy California for All Commission, this report provides:

- An endorsement of and the rationale for a system of unified financing that is accessible, affordable, equitable, high-quality and universal;
- A description of key decision points required to craft such a system for California; and
- Observations about next steps underway and planned that would move California toward the envisioned unified financing system.

Rationale for and Benefits of Unified Financing

In California today, many different health insurance arrangements (employer-sponsored insurance, public coverage programs, and individually-purchased health insurance) impose different eligibility rules, cover different benefits, and establish different networks and payment arrangements with hospitals, doctors and other health care providers. Fragmented financing hampers accountability for quality, access, and equity and can encourage plans and providers to avoid patients with costly and complex health care needs. There is no central accountability for spending and ample opportunity for plans, providers and other health care interests to seek financial rewards without improving health outcomes or offering the services and supports that provide clinical benefits and/or that people value. Today's fragmented financing system is very complex for patients and providers. It leads to gaps in coverage and access when people's circumstances change. Complicated billing requirements impose administrative burden, allow opportunities for fraud, and add cost.

The ills associated with fragmented health care financing do not affect all Californians equally. People with low or variable income and people with complex and/or behavioral health care needs are more likely to experience gaps in coverage and access and are more likely to struggle to afford and obtain care even when they are covered. People in communities that have been marginalized or excluded as a result of systemic racism or other biases – people of color, immigrants, LGBTQ+ people, people who speak languages other than English, and people with disabilities – report stigmatizing and disrespectful treatment when they access care and often experience worse health outcomes. Fragmented financing with no central locus of accountability make it all too easy for long-standing inequities to persist.

A system of unified financing (UF), bringing all Californians into a single system without distinctions based on employment, income, or other personal characteristics, creates new opportunities and a greater imperative to moderate the rate of growth of health care spending, make health care more affordable for individuals, improve health care outcomes, and improve equity in access and outcomes. It would also yield the benefits of simplification and reduced administrative burden for employers and health care providers.

A system of unified financing would also create significant opportunities to deliver health care more effectively efficiently, and equitably. It could restructure incentives and payment structures to encourage equity and high quality and could require greater transparency and accountability than is possible under today's fragmented financing system. It would also eliminate the complexity and administrative burden that detract from a focus on high quality care that is safe, timely, effective, efficient, equitable and patient-centered.

A system of unified financing has the potential to fundamentally transform the lives of family caregivers in California. Including LTSS as covered services would allow millions of low- and middle-income Californians to choose care options that better meet their needs. Those serving as unpaid family caregivers, disproportionately women of color, would have greater opportunity to fulfill their own goals and dreams rather than sacrifice on behalf of their loved ones.

Community engagement conducted in parallel with the Commission process found broad support among Californians with low incomes for a single, statewide, government-run health care program that covers all people who live in California. Californians with low incomes would value three key attributes of a reimagined health care system: lower system cost and greater consumer affordability; improved access to care; and greater cultural humility and respect. Participants also expressed desire for engagement in system design and deeper involvement in clinical care decisions.

The analysis done in connection with the Commission's work found that:

- Absent a shift to UF, aggregate health care spending in California is estimated to increase by $158 billion in 2022 dollars over nine years, representing an increase of approximately 30% over baseline spending;
- Under almost all scenarios analyzed, in the first year of implementation unified financing is expected to result in lower total health care expenditures than under the status quo;
- If, as expected, UF reduces the rate of growth of health spending, savings over time would be achieved under all scenarios examined, even when long-term care services and supports (LTSS) are included as covered services;
- Assuming that the federal and state governments support UF at the level they would have supported under status quo fragmented financing, the savings from UF will accrue to California employers and households, who will on average pay less to support UF than they pay in the status quo;
- Financing can be stable over time, but will depend on controlling cost growth and securing agreements with the federal government about the rate of growth in federal payments.

Key Design Decisions Required for UF

A move to UF would involve a complete overhaul of existing health care financing and coverage arrangements. Design choices on an array of dimensions would be required to effect this sweeping change. The Commission discussed many but not all of the

consequential decisions that lie on the path to UF, and began to explore the tradeoffs and implications associated with different options. These decisions include:

- Eligibility and enrollment
- Covered benefits and services
- Patient cost-sharing, if any
- Provider payment
- Purchasing arrangements and role, if any, for intermediaries
- Care coordination
- Greater efficiency and cost containment

Each of these topics involves considerable nuance; not all were explored with equal depth by the Commission. In all cases, Commission conversations made progress toward identifying the values that should guide California's future path and surfaced important considerations that should guide future steps. The role of health plans or intermediaries attracted particularly robust debate among Commissioners. There was broad agreement that if health plans were retained, they should be reimagined with greater constraints on corporate financial motivations. On the related topic of risk-based capitation, Commissioners expressed divergent views. Some argued that capitation is essential in providing cost discipline and efficient resource use and others argued that capitation encouraged health care providers to stint on the delivery of potentially beneficial care, and to engage in socially unproductive efforts to avoid serving patients most in need.

As California moves toward UF, determining how the system will be financed will be a matter of great consequence. Obtaining federal government permissions and securing adequate and sustainable federal funding for use within the state is a related threshold issue. It will also be important to establish governance structures to support an accountable and transparent system and implement a data exchange framework to enable timely and secure access to electronic information in order to address health and social needs and enable the effective and equitable delivery of services to improve health and wellbeing. A uniform claims database under UF would also reduce fraud and abuse in claims billing.

Next Steps Underway and Planned

The Commission's charge was to "develop options for key design considerations for a unified financing system, including, but not limited to, a single-payer financing system." Going beyond that specific charge, this report's final section takes stock of several steps underway that are aligned with the direction of an improved (accessible, affordable, equitable, high-quality, universal) health care system and identifies additional steps that can increase momentum toward UF.

The report's final section identifies illustrative tasks to advance unified financing. These tasks are not necessarily prerequisites for UF and could be sequenced in a variety of ways. Also included is a non-exhaustive set of concrete next steps – all of which would improve

access, affordability, equity and quality under status quo financing but whose impact would be deepened under UF – including:

1. **Workforce:** Invest in and support a workforce that is diverse, that can meet the cultural, socioeconomic, and linguistic diversity of California's residents and that is responsive to consumer and patient needs.
2. **Enact Office of Health Care Affordability:** Establish health care cost targets and address cost drivers in order to slow growth in health care spending.
3. **Cost of Delivering Care:** Leverage existing data and identify data gaps that have to be overcome to understand the actual cost of delivering frequently performed medical services (such as inpatient care, imaging, etc.).
4. **Role of Health Plans:** Evaluate whether health plans under the status quo add value by furthering access, affordability, quality and equity while accounting for excessive administrative costs and profits and burden on providers. If health plans are retained and reimagined under UF, what functions would they perform?
5. **Uniform Clinical Data Record:** Once policies for data sharing are in place under the forthcoming Data Exchange Framework, explore the potential benefits and feasibility of developing a statewide uniform clinical record.
6. **Administrative Costs:** Further study of the administrative burden on providers under the status quo and potential administrative cost savings under UF.
7. **Fraud and Abuse:** Upon implementation of the Health Care Payments Data Program, identify and take action on claims fraud and overbilling.

In order to extend the impact of the Commission's work into the future and advance the cause of UF, CalHHS proposes to dedicate staff to further refine UF design options, engage with the federal government, and develop creative legal, policy and political solutions that can engage and inspire Californians to embrace change. If the state is able to get traction with the federal government on permissions and adequate and sustainable funding, CalHHS dedicated staff will work with key constituencies that include health care providers, health care systems, employers, labor unions, and consumers including Californians with low incomes, Medicare beneficiaries, and people with employer-sponsored insurance to inform the development of a fuller proposal on how UF will work. Developing and vetting a specific proposal for UF will help to reassure Californians that the uncertainty associated with a move to UF is outweighed by its benefits. While the state engages the federal government, several actions, such as those described above, can happen in parallel to build the foundation for a system of unified financing that is accessible, affordable, equitable, high-quality and universal.

Composition and Focus of Commission

The 18 members of the Healthy California for All Commission were appointed by the Governor and the Legislature, pursuant to Section 1001 of the Health and Safety Code, to advise and assist policy makers in making informed decisions about the future of California's health care system with particular attention to illuminating the path to a system of unified financing.

The Commission was charged with two deliverables: (1) an Environmental Analysis Report, describing the current state of health care in California; and (2) a report to the Governor and Legislature on how the state could move to a unified financing system, including but not limited to a single payer approach, for health care.

The Commission's charter defined the Commission's role as advisory to the state. It had the authority to take advisory votes and those votes were not binding on the state.

Thirteen members of the Commission were voting members; five members were non-voting, ex officio members. At the initial meeting in January 2020, the Commission's members were:

Name:	**Organization:**	**Appointed by:**
Mark Ghaly	California Health and Human Services, Secretary	Statute
Carmen Comsti	California Nurses Association/National Nurses United, Lead Regulatory Policy Specialist	Governor
Jennie Chin Hansen	AARP, past president; American Geriatrics Society, past CEO	Governor
Sandra Hernandez	California Health Care Foundation, CEO	Governor
Bill Hsiao	Harvard TH Chan School of Public Health, Professor	Governor
Rupa Marya	UCSF School of Medicine, Associate Professor	Governor
Bob Ross	The California Endowment, CEO	Governor
Richard Scheffler	UC Berkeley School of Public Health, Professor	Governor
Andy Schneider	Georgetown University Center for Children and Families, Research Professor of the Practice	Governor

Name:	Organization:	Appointed by:
Sara Flocks	California Labor Federation, Policy Coordinator (at Commission's inception) Union Made, LLC, Partner (at present)	Senate
Janice Rocco[3]	Department of Insurance, Deputy Commissioner Health Policy & Reform	Senate
Antonia Hernandez	California Community Foundation, CEO	Assembly
Anthony Wright	Health Access, Executive Director	Assembly
Richard Figueroa[4]	Department of Health Care Services (DHCS), Acting Director	ex officio
Peter Lee[5]	Covered California, Executive Director	ex officio
Don Moulds	CalPERS, Chief Health Director	ex officio
Richard Pan	Senate Health Committee, Chair	ex officio
Jim Wood	Assembly Health Committee, Chair	ex officio

Mark Ghaly, MD, MPH, Secretary of California's Health and Human Services Agency, served as the Commission's chair. Dr. Ghaly organized and convened the Commission's meetings, established its operating principles and ground rules, and acted as a spokesperson for the Commission. He also facilitated the majority of Commission meetings.

The work of the Commission was supported by staff from the California Health and Human Services agency and an outside consulting team. Under the direction of the Commission's Chair, the staff and consultants worked together to develop agendas, speakers, and materials for each meeting and gather input from Commissioners between meetings. Consultants and staff also worked together to draft the reports of the Commission. The consulting team also conducted independent analyses of different approaches to unified financing for health care.

[3] Served a partial term.
[4] Served a partial term.
[5] Served a partial term.

The Commission's meetings were open to the public and time was allotted at each meeting for public comment, in accordance with the Bagley-Keene Act.[6]

Over its two-year existence, there were four changes in the Commission's composition:

- Janice Rocco resigned and was replaced by Caroline Dessert, CEO of the San Diego LGBT Community Center.
- Richard Figueroa, Acting Director of DHCS, was replaced by Will Lightbourne, when he was named Director of DHCS.
- Will Lightbourne was replaced by his successor at DHCS, Michelle Baass.
- Peter Lee, Executive Director of Covered California, retired and was replaced by his successor at Covered California, Jessica Altman.[7]

The Healthy California for All Commission was established as a result of California policy discussions related to systems of unified financing for health care, including but not limited to single payer approaches. For that reason, the Commission's public discussion and this report focus primarily on how funds currently used to pay for health care in California could be combined and used to secure accessible, affordable, equitable and high-quality *health care* for all Californians. A different – and extremely consequential – conversation might address the steps California could take, financial and otherwise, to advance *health and health equity* for all of its residents. Many commissioners advocated for additional work to identify investments in social services and social drivers of health that are clearly linked to the Commission's ambitious agenda. Because many drivers of health and well-being are outside of the health care delivery system, additional investments and interventions to improve social drivers of health should be developed in coordination with changes to the health care delivery system. Due to the Commission's scope, this report does not do full justice to the many ways – other than those associated with health care financing – by which the health of Californians might be improved.

Timeline and Process

The Commission held its first meeting on January 27, 2020. With the outbreak of the novel coronavirus (COVID-19) pandemic, the Commission canceled its scheduled meeting in April 2020 and resumed meeting virtually, starting in June 2020.

The table below shows the dates of Commission meetings and key topics addressed at each meeting.

Meeting date:	**Topics addressed:**
January 27, 2020	▪ History of health reform in California ▪ Current state of health care in California
June 12, 2020	▪ Draft Environmental Analysis Report

[6] State of California Department of Justice, Open Meetings, accessed 12/21/21.
[7] Jessica Altman replaced Peter Lee as Executive Director of Covered California on March 7, 2022.

Meeting date:	Topics addressed:
	▪ Future meeting schedule
July 8, 2020	▪ Unified financing and coverage: Key design elements and options o Equity and quality under unified financing
August 13, 2020	▪ Final Environmental Analysis Report o In an advisory vote, the Commission voted 10-2 to accept the final Environmental Analysis Report and transmit it to the Governor and the Legislature.
May 21, 2021	▪ Unified financing: potential effects and design options o Overview and discussion of consulting team's analytic findings
June 25, 2021	▪ Unified financing: direct payment models o Presentation by Commissioner William Hsiao
July 8, 2021	▪ Unified financing direct payment models: Vermont case study o Presentation by former Vermont Governor Peter Shumlin ▪ Advancing accountability, integration, and care coordination under unified financing o Panel discussion by Commissioners Peter Lee, Sandra Hernandez, and Anthony Wright
August 25, 2021	▪ Behavioral health integration and accountability o Presentation by Commissioner Will Lightbourne, Director, Department of Health Care Services, and Jacey Cooper, State Medicaid Director. ▪ Systems of accountability to assure improved equity, quality and access o Presentations by Commissioners Richard Scheffler and Sara Flocks
September 23, 2021	▪ Summary of community engagement findings ▪ State/federal relationship and financing mechanisms o Presentations by Commissioners Carmen Comsti and Andy Schneider
September 28, 2021	▪ Racial equity and health system design o Presentations by Commissioners Antonia Hernandez and Robert Ross ▪ Commissioner survey on goals, values, propositions
October 11, 2021	▪ Provider payments under unified financing o Presentation by Commissioner Don Moulds o Presentation by Dana Gelb Safran, President and CEO of the National Quality Forum, on value-based payments and health equity o Presentation by Joshua Sharfstein, MD, Johns Hopkins University, on global budgets
November 17, 2021	▪ Financial sustainability under unified financing o Presentation by Ken Jacobs, UC Berkeley Labor Center, on projected spending and funding options

Meeting date:	Topics addressed:
	○ Mechanisms to reduce health care costs
December 9, 2021	▪ Ensuring a Smooth Transition ○ Follow-up conversation on Long Term Services and Supports by Commissioner Jennie Chin Hansen ○ Transition discussion with opening comments by Commissioners Carmen Comsti, Anthony Wright and William Hsiao
February 23, 2022	▪ Cost Sharing Under Unified Financing ▪ The Role of Coordinating Entity(ies) Under Unified Financing

At the June 12, 2020 meeting of the Commission, Commissioner Dr. Robert Ross suggested that gathering structured input from residents of California with low incomes – those who potentially will benefit most from a unified system of financing for health care – was extremely important to the Commission's deliberations. Several other commissioners supported this direction. The consulting team began working in 2020 with CalHHS to organize this process. In the following months, Bobbie Wunsch of the consulting team twice described to regular meetings of the Commission a set of proposed community engagement activities that took into consideration pandemic conditions, target population groups and draft discussion topics. After a long break due to the COVID-19 pandemic, CalHHS recommended that the three foundations whose CEOs serve as commissioners independently organize and fund a robust community engagement process in order to gather the perspectives of Californians with low incomes. The process culminated in a September 21, 2021 webinar to share results with commissioners and members of the public. For more, see this report's Community Engagement section.

Prior Work on the Shortcomings of the Current Fragmented Financing System

The Commission's first deliverable, An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California (August, 2020) provided context on how health care is arranged and paid for in California today, suggested steps California could take to prepare to transition to unified financing, and described coverage expansion options. This section offers a brief summary of the Environmental Analysis.

In recent years California has built on opportunities available under the federal Affordable Care Act (ACA) and has enacted state legislation to increase coverage and affordability for low and modest-income residents. As a result, California has made great progress in expanding coverage to many state residents and addressing some of the coverage, access and affordability gaps that were pervasive prior to passage of the ACA. For several reasons, however, California has not achieved universal coverage to date. Many undocumented Californians have been left out; some who are eligible for coverage find premiums unaffordable; and the process of understanding and enrolling in coverage is complicated and can lead many people to experience gaps in coverage.

Beyond questions of coverage, a range of pervasive and troubling features of California's fragmented health care financing system compromise access, affordability, quality and equity. These include:

- Rising health care spending that takes an increasing share of the state's economy and public sector budgets;
- Persistent worries among Californians about their ability to afford medical costs;
- Disparities in health status and health care access by race, ethnicity, and income;[8]
- Where quality indicators have been identified and goals set, shortcomings in the quality of care and disparities across racial and ethnic groups;
- For many care outcomes and communities, a lack of clarity about what constitutes health care quality, how and by whom it might be advanced;
- An unevenly distributed health care workforce that does not reflect the state's cultural, racial and language diversity;
- Looming workforce shortages, including among primary care providers, nurses and many other health care workers;
- A diversity of provider payment arrangements, each with potential shortcomings. Fee-for-service payments provide poor incentives for improved quality, care coordination, and efficient resource use. Capitation is prevalent among California medical groups and provides incentives to deliver care more efficiently, but raises concerns among critics about stinting on care.
- Increasing market concentration among hospitals, insurers and physicians, which contributes to higher prices, particularly in some California regions;[9]
- High administrative costs, both for payers and providers; and
- Conflicting and counter-productive provider incentives exerted by different payers, which impede transparency and accountability and make it more difficult to achieve a single high standard of quality.

As described in the Commission's Environmental Analysis and at length in the remainder of this report, a system of unified financing will address the shortcomings of our current fragmented financing system.

[8] For a discussion of recent California efforts to advance health equity, see Scheffler R, Shane O. Health Equity: California Style. Milbank Quarterly Opinion. December 2, 2021. https://doi.org/10.1599/mqop.2021.1202

[9] The issue of provider consolidation and its impact on competition and prices was covered in depth on pp. 52-56 of the Commission's previous report, An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California.

Report Structure

This remainder of the report is organized as follows:

- A summary of commissioners' feedback on the goals, values and key propositions that should guide the work of the Commission;
- Insights from community engagement research;
- Analytic findings describing the potential effects of UF on health spending and other outcomes;
- Discussion of decisions and actions needed to achieve unified financing;
- A description of steps underway and within state control that will advance desired health care outcomes and may influence the path for UF implementation; and
- Observations about priority actions and next steps that will continue momentum toward UF after the Commission process concludes.

Goals and Values

Commissioners endorsed the vision of a "Healthy California for All" in which a sustainable unified financing system for health care services provides safe, timely, efficient, equitable and person-centered health care that advances the mental and physical health and well-being of all Californians. The system would ensure that care is high-quality, affordable and accessible. All Californians would feel empowered through a simplified system that treats them with respect and promotes equity across social and demographic factors, including by race and ethnicity. To that end, Californians would be treated by caregivers who understand their cultures, beliefs and values so the care they receive is relevant for them and their families.

Commissioners expressed general agreement with the following seven principles:

1. The health care system should address not just the acute, short-term needs of individuals but should focus on prevention, early intervention and population health approaches to limiting disease and improving health.
2. California's health care system should optimize care for people with complex needs by facilitating close communication and coordination among health care providers, including those delivering primary care, specialty care, behavioral health services and long-term services and supports.
3. Access to care, quality of care and health outcomes for individuals and for populations should be monitored and transparently reported. Accountability for high-quality, equitable outcomes (with particular attention to outcomes for people with complex conditions and high needs, and with emphasis on historical racial and ethnic disparities) should be established.
4. Provider payments and funding, including methods of payment and levels of payment, should address inequities and improve access and quality.
5. The unified financing system for health care services should proactively monitor, mitigate, and work to eliminate disparities in health care access and quality, including those resulting from structural discrimination related to race and ethnicity, those

associated with income, immigration status, disability, sexual orientation and gender identity, and the intersectional effects among these and other characteristics.

6. The health care system should, in coordination with other sectors, address social drivers that compromise health status.[10]
7. A new universal, unified health care system requires long-term commitments from the federal government and the State of California and will require sustainable financing. (Many commissioners noted that substituting a broad and progressive funding approach for the current mechanisms through which Californians pay for their health coverage and care would improve equity and transparency and reduce complexity.)

Through surveys, commissioners also weighed in on a number of more detailed goals and propositions. Detailed responses are available through summarized survey responses.[11] The specific statements offered for commissioner input are presented at Appendix A.

Unified financing creates levers and opportunities to achieve these goals, as discussed in Commission meetings and throughout this report. These gains could be achieved with lower health expenditures than in our current system and could be financed in a way that is sustainable over time and more progressive than our current system, as described later in the Analytic Findings section.

As further described in the next section on Community Engagement, there was alignment between Commissioner values and input obtained from the public, particularly with respect to the broad goals of access, affordability and equity. Some commissioners noted that shared values for health system improvement – for example, treating all Californians with respect, promoting equity and reducing health disparities across social and demographic factors, focusing on prevention – could be advanced through means other than unified financing.

Community Engagement

The Commission decided early in its deliberations that it was important to gather input from community residents with low-incomes throughout the state as well as from underrepresented populations to better inform the deliberations of the Commission. Before the COVID-19 pandemic, a series of community conversations was proposed to the Commission and commissioners provided feedback and suggestions to refine the proposal.

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[10] Although a majority of responding Commissioners agreed with this statement, Commissioner Flocks and Commissioner Comsti disagreed – the only instance among these seven statements in which multiple commissioners directly disagreed (as opposed to indicating they "didn't know" or "agreed with slight modifications"). Their responses cited concerns that to address social drivers would be beyond the scope and capacity of the health care system, might come at expense of reduced health care funds, and/or could compromise system sustainability. Commissioner Flocks further clarified that she feels "our state must address social determinants but… requiring the health care system to take on that burden distracts from the core mission of providing high-quality, equitable, affordable care in a sustainable system."

[11] Complete survey findings are available at the Healthy California for All webpage. See "Meeting Information" documents for September 28, 2021 survey synthesis and the November 17, 2021 survey report.

After the commission's break during the early pandemic response, the mandate for deeper community engagement became even stronger. The health and health care access inequities and disparities seen through the lens of COVID-19 were staggering and the impact on communities historically disenfranchised and disconnected from our health care system was further unmasked. The cumulative impact on minority populations in California was seen across the board with health, social, education and economic implications. Upon return to regular Commission meetings, the primacy of the community engagement work led to a keen focus to engage the stakeholder networks already attending to COVID-19 in the Commission's work. Engaging the communities often outside the health care reform conversations can no longer be tolerated if we are to create a true Healthy California for All.

When the Commission began to meet again virtually, there was a renewed effort to gather input from people of color, LGBTQ+, indigenous and other Californians with low incomes whose voices are often missing from policy conversations. Commission Chair, Secretary Dr. Mark Ghaly, asked three commissioners representing the California Health Care Foundation, the California Community Foundation, and The California Endowment to organize these community engagement efforts, given their long history and commitment to working with community residents and stakeholders on closely related policy issues. The three foundations and their staff commissioned a multi-method stakeholder input process to gain input from diverse communities. Almost 2000 Californians with low incomes from across the state participated and contributed their time and perspectives to this process. The full set of findings are available at the Healthy California for All web page with highlights provided below.

Community Engagement Approach

To achieve comprehensive engagement, while navigating the limitations for in-person events due to the pandemic and the short time frame of this project, the process included the following three elements:

1. **Health Care Experiences and Priorities of Californians with Low Incomes:** A synthesis of existing research and literature related to the health care experiences and perspectives of Californians with low incomes and communities of color that draws from 15 reports, polling, enrollment and utilization data, and consumer listening sessions from 2012-2021.

2. **Views on Improving the Health Care System among Californians with Limited Incomes:** Qualitative and quantitative independent non-partisan public opinion research engaging Californians with incomes under 250% of the federal poverty level, including: a) two three-day online discussion boards in English and Spanish and b) a statistically representative multilingual poll of 1,982 Californians, including oversamples of African American, Asian Pacific Islander and Native American households conducted in English, Spanish, Chinese, Vietnamese, Hmong, Korean

and Tagalog from August 19-September 5, 2021. Californians with incomes under 250% of the federal poverty level represent about one third of California's population.

3. **Views and Perspectives from Community Based Organizations Serving Californians with Low Incomes:** Phone interviews, virtual listening sessions with and survey of over 60 leaders of community-based organizations (CBO), including health advocacy and direct service organizations across the state conducted in August and September 2021.

Findings Related to A Single Statewide Health Care Program

Both the public opinion poll and the community-based organization leader interviews and surveys conducted show strong support for a single, statewide, government-run health care program that covers all people who live in California. The poll suggests that 65 percent of Californians with low incomes support the concept, with people of color showing greater support: 76 percent of African Americans, 71 percent of Latinos, 73 percent of Asian/Pacific Islanders, 65 percent of Native Americans and 54 percent of whites. Support among LGBTQ+ Californians was extremely widespread at 82%. Support varied slightly with coverage status: those with Medi-Cal (74%) and the uninsured (70%) were more likely to support the concept than those with employer-sponsored insurance (62%), Medicare (57%), or “other” health insurance (51%). Similarly, a majority of community-based organization leaders indicated support for the concept of a single statewide government-run health care program.

The community engagement effort explored levels of satisfaction with existing insurance arrangements. Among currently insured Californians with low incomes, the majority (80%) was either somewhat (41%) or very satisfied (39%) with their coverage. The leading concerns among Californians who were somewhat (11%) or very (8%) dissatisfied with their current coverage included cost of services and not covering all services. Paying for care was a major concern not just for the uninsured, but for people with employer-sponsored insurance, Covered California and Medi-Cal; paying for care was less of a challenge for those on Medicare. Among concerns experienced even after seeing a health care professional, affording a prescription, receiving insurance approval for a treatment, and not having their concerns heard stood out most.

The community engagement work found that Californians with low incomes would value three key attributes of a reimagined health care system, described further below.

<u>Cost and Affordability</u>

The synthesis of existing research, the statewide poll and the CBO interview data all confirm that cost and affordability are the top barriers to receiving care for Californians with low incomes and that affordability is a top priority area to address in a future health system.

In the statewide poll, 63 percent of Californians with low incomes identify the cost of health care as a very serious problem in California, as the top barrier to accessing health care (58 percent labeling it a challenge that they face), and as the improvement to health care they most want (a 49 percent plurality making it a first or second choice compared to other priorities).

Similarly, in the statewide poll, when asked about envisioning a new system, 73 percent of Californians with low incomes said eliminating out-of-pocket costs like co-pays and deductibles would be “very important” in an improved health system and 67 percent felt similarly about eliminating monthly insurance premiums. Consistent with the synthesis of existing research, CBO leaders unanimously agreed that copayments and premiums routinely cause individuals to delay or forego necessary care and do not effectively reduce the provision of unnecessary care. Similarly, the leaders strongly believe that “cost controls must be put in place on insurance companies and other system players that many believe contribute to affordability issues due to their priority for increasing profits.”

Access to Care

Consistent with the synthesis of existing research, the statewide poll and CBO interviews confirm that having health coverage, though necessary, is insufficient for accessing care and providers. CBO leaders consistently cited the hardships experienced by Californians with low incomes in navigating, understanding, and utilizing an overly complex system and that these hardships shut people out of adequate access. A majority of Californians with low incomes particularly people of color identified long waits at doctors’ offices (58 percent) and a lack of available appointments (53 percent) as among the top challenges to accessing care. These results are consistent with the findings in the synthesis of existing research that found nearly 60 percent of Californians with low incomes reporting they had to wait longer than they thought was reasonable for a medical appointment. CBO leaders almost universally agreed that effective system navigation must be an essential component to improve access.

The synthesis of existing research shows that social determinants such as immigration status, transportation barriers and others impact access to health care and this is particularly true for people of color, and members of LGBTQ+ and rural communities.

Californians with low incomes want their health providers to understand these non-clinical factors that impact their health and when asked about priorities in a new statewide health system, 74 percent of poll respondents indicated that providing connections to services that help people stay healthy, like housing, transportation and healthy food is important. CBO leaders believe the health system should support preventive care and “upstream” interventions.

Having access to comprehensive and integrated services was also repeated by Californians surveyed as well as CBO leaders. A large majority of Californians feel a new statewide system should provide dental and vision care (84 percent), long term care (79 percent),

mental health (79 percent) connections to social services (74 percent) and treatment for alcohol or drug use problems (71 percent). Similarly, CBO leaders agree dental, vision, mental and behavioral health are important to consider in a new statewide health system and that ideally, people would like to address their health care needs in one place and for their providers to work together to address their holistic health needs.

Cultural Humility and Respect

In addition to affordability and access, Californians with low incomes continue to seek care and services in a health system that perpetuates inequities. A system that values cultural humility and respect is a top priority among Californians with low incomes and CBO leaders. The synthesis of existing research found high rates of stigmatizing and disrespectful treatment in clinical care experienced by persons of color, individuals with Limited English Proficiency (LEP), people with disabilities and LGBTQ+ people in California. The statewide poll found that nearly one-third of Californians of color with low incomes who indicated difficulty in accessing care said that they felt discriminated against by staff or a health care provider at their doctor's office or clinic. Interviews with CBO leaders found that over 60 percent cited language access as a major barrier in providing culturally competent care and systemic biases within the health system continue to be perpetuated against specific population groups. When asked for priorities in a new statewide health system, over 90 percent of poll respondents indicated that health care leaders should prioritize "safe and effective treatment" and a system that "treats everyone with dignity and respect."

Consumer Engagement in Care and System Design

Engagement of consumers in both clinical care and design of the health system continues to be expressed as a desire by Californians with lower incomes. The synthesis of existing research confirms that consumers experience poor clinical engagement such as short appointments or poor explanation of medical procedures or medications. The statewide poll corroborates these findings, as the lack of attention from doctors is reported as one of the most common barriers to receiving care. Similarly, 88 percent of poll respondents indicated that they would like to have a role in decision-making about their health care.

Beyond engagement in clinical care decisions, Californians with low incomes would also like to be engaged in the overall system design. Key issues specifically mentioned as barriers to engaging include system navigation difficulties and lack of transparency (i.e., unclear grievance processes). CBO leaders and the synthesis of existing research suggest that enhanced integration of community-based organizations into the health system may be one option for helping to strengthen agency among consumers, while simultaneously addressing cultural competency and workforce issues.

Analytic Approach and Findings

Analytic Approach

The purpose of the analytic effort was to understand the broad, directional effects of UF. To advance that goal, the consulting team made assumptions about how UF could be implemented under a range of scenarios. These assumptions and scenarios were determined in consultation with CalHHS. Informed by California's policy context and existing research regarding the health care system, the assumptions and scenarios emerged from an assessment of the salience of alternative approaches for the Commission's work. Because it was not the role of the consulting team to make design decisions – nor, given its scope and timeline, could the Commission fully specify exactly how UF should be designed – the assumptions made and scenarios modeled *do not* reflect value judgements nor are they intended to be determinative of how California proceeds toward UF.

A few commissioners have offered critiques of the analytic approach. In some cases, commissioners' divergent views about the likelihood or desirability of various scenarios caused them to question whether scenarios should be contemplated at all.[12] For example, Commissioner Scheffler noted that integrated delivery systems paid via capitation are prevalent in California[13] and that such arrangements exert cost discipline on providers while, according to many analyses, offering higher quality outcomes.[14] Since the direct payment approach would eliminate health plans and capitated payments, Commissioner Scheffler argued against any analysis of an approach in which a state UF authority makes direct payments to health care providers, because that would be a radical departure from California's long shift away from fee-from-service payment approaches. The direct payment

[12] For example, on comments on the draft report, Commissioner Hsiao and Commissioner Scheffler each disputed the desirability of presenting estimates of a direct payment scenario in which capitation payments are eliminated. Commissioner Comsti argued that the analysis mistakenly conflates direct payment with fee-for-service payment arrangements for physicians and suggested that a number of alternative payment arrangements, such as physician salaries or time-based payments, could be substitute for fee-for-service payments. However, these alternatives were not sufficiently specified to lend themselves to further analysis. Commissioner Hsiao also noted that he felt estimated reductions in provider administration expenses were too low and that savings beyond those estimated by the consulting team could be achieved through reduced claims fraud and abuse.

[13] From the Commission's environmental analysis, pp. 58-59: "HMO patients account for approximately 60% of privately insured and Medicare patients in California and thus capitation accounts for approximately 60% of payments to medical groups in California. Capitation also accounts for virtually all payments for inpatient and outpatient facility services for Medicare Advantage patients, but for privately insured HMO patients, inpatient and outpatient facility services are mostly paid on a fee-for-service basis. In total, capitation accounts for approximately 14% of payments for inpatient and outpatient facility care for privately insured and Medicare patients." Additionally, the Commission's environmental analysis, pg. 39, describes the prevalence of managed care delivery systems in the Medi-Cal program: "Managed care is also prevalent in public programs. An additional 10.8 million Californians are enrolled in Medi-Cal managed care, representing a managed care penetration rate of 83 percent."

[14] See, for example, James, Brent C. and Gregory P. Poulsen, The Case For Capitation, Harvard Business Review, July-August 2016 and The Berkeley Forum for Improving California's Health Care Delivery System report. The Berkeley Forum, an in-depth effort through which California public and private leaders considered options for improving access to health coverage and care while slowing the rate of health care expenditure growth, recommended reducing the share of health care expenditures paid for via fee-for-service and increasing the share of the state's population receiving care via fully- or highly- integrated care systems.

option was included, however, because Commissioner Comsti objected to any scenario in which providers or plans assumed financial risk, and thus opposed any scenario that envisioned continuation of capitated payments to medical groups. Commissioner Comsti and many single-payer advocates argued that including health plans or other risk-bearing intermediaries would introduce obstacles to care and encourage actions that served corporate financial motives rather than the needs of Californians.

Analytic Findings

As discussed at Commission meetings, and as shown in an analysis conducted by the consulting team, implementing a system of unified financing (UF) is expected to bring substantial and valuable benefits to Californians.[15] The analysis conducted by the consulting team early in the Commission's process identified the following high level findings pertaining to health spending and financing:

- Unified financing is expected in lower total health care expenditures in the aggregate than under the status quo in the first year of implementation under most scenarios analyzed, and savings over time under all scenarios analyzed, even when long-term care services and supports are included as covered services[16];
- Assuming that the federal and state governments support UF at the level they would have supported the status quo fragmented financing, the savings from UF will accrue to California employers and households, who will pay less to support UF than they pay in the status quo; and
- Financing can be stable over time, but will depend on controlling cost growth and securing agreements with the federal government about the rate of growth in federal payments.

Analytic findings on spending and financing are summarized below. In addition, a few results on access, equity, and health outcomes are summarized, although many of the expected benefits of UF discussed by Commissioners, including increases in equity, reductions in the administrative burden experienced by patients and providers, and improvements in population health outcomes do not lend themselves to precise quantitative forecasts.

To estimate the effects of UF on health spending and other outcomes, the consulting team assumed:

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[15] See Healthy California for All webpage for a summary of analytic findings ; a description of the methods and assumptions underlying the analysis; comments from multiple authors on methods and assumptions (see Reports tab/ Methods and Assumptions topic); an Excel spreadsheet supporting the description of Methods and Assumptions; the consulting team's response to comments on methods and assumptions by Commissioner Carmen Comsti as well as the team's response to comments from California Association of Health Plans and California Association of Health Underwriters; and a presentation to the Commission on financing considerations on November 17, 2021.

[16] Note: In a scenario with LTSS expansion and no cost-sharing, expenditures would be somewhat higher in year 1 than under the current system (2% higher than the status quo, or $10 billion), but over the ten-year period health expenditures would be $213 billion lower than in the current system if spending grows at the rate of GDP growth.

- All Californians would be covered by a comprehensive package of benefits;
- Provider payments would, on average, be made at current levels, minus estimated reduction in costs due to lower billing and insurance related costs; and
- A substantial reduction in prices paid for prescription drugs.

In three areas, the consulting team estimated the effects of UF under alternative scenarios about design decisions:

- **Cost sharing:** In one scenario, the team assumed that Californians would face no cost sharing; in a second scenario, the team assumed that Californians in families with income below 138% of the Federal Poverty Line (FPL) would face no cost sharing; that those with incomes between 138%-400% of FPL would pay, on average, 6% of medical expenses (i.e., receive coverage with a 94% Actuarial Value (AV)); and that those in families with incomes above 400% of the FPL would pay, on average, 15% of medical expenses (i.e., 85% AV).

- **Use of intermediaries:** In one scenario, similar to Canada and consistent with the views of many advocates on what constitutes a "pure" single payer approach, the team assumed that the UF authority would make direct payments to hospitals, physicians, and other health care providers, and that Californians would receive coverage for services from any licensed provider. In a second scenario, similar to Germany and the Netherlands, the team assumed that the UF authority would make payments to health plans or health systems, and that Californians would be required to enroll in a health plan or health system and would receive care from the providers that were part of that plan or system.

- **Long Term Services and Supports:** In one scenario, the team assumed that coverage for LTSS would be expanded, as specified in an option modelled by the Congressional Budget Office.[17] In a second scenario, the team assumed coverage for LTSS as in the status quo[18], with a continuation of Medi-Cal coverage for LTSS services including but not limited to IHSS and nursing home care. Commissioners expressed strong support for including expanded coverage for LTSS services in unified financing. Results are shown with and without LTSS expansion to illustrate the impact of that design decision.

The consulting team's analytic findings are predicated on California being able to achieve the necessary federal and state-level approvals which are discussed in later sections of this

[17] Congressional Budget Office, How CBO Analyzes Proposals for a Single-Payer Health Care System, December 10, 2020

[18] The primary payer for long-term services and supports (LTSS) care is Medicaid (Medi-Cal in California). Medicare covers some short-term skilled nursing care but does not cover LTSS. Relatively few people have private insurance coverage for long-term care (7-9 million people throughout the US in 2011, per the Kaiser Family Foundation).

report. Further consideration of key design considerations is presented below in the section titled Decisions and Actions Needed to Implement Unified Financing.

Supporting documents offer further information about analytic methods and assumptions.[19]

Estimated Changes in Health Spending in Year 1

The analysis estimated that if UF were implemented in California using direct payment to providers, no cost sharing for patients, and without expansion of LTSS coverage, aggregate health spending in the first year of UF would be 3% lower than under the status quo fragmented financing system (Table 1). If, for illustrative purposes, the first year of full implementation were 2022, the analysis estimated that in the scenario described above, health spending would be $501 billion, or $16 billion less than in the status quo.[20] With income-related cost sharing, spending would be reduced by $35 billion from the status quo in a scenario without an LTSS expansion, or 7% of baseline spending; while in a scenario with income-related cost sharing and expansion of LTSS, spending would be reduced by $9 billion from the status quo, or 2% of baseline spending. The only scenario the consulting team analyzed in which Year 1 spending would be greater than under baseline is the scenario with an LTSS expansion and no cost sharing, in which spending would be $10 billion, or 2% greater than in the status quo. As discussed later in this section, even in that scenario cumulative savings would be expected over the first nine years of UF.

If health plans or health systems were used as intermediaries, expected health expenditures under UF would be very similar to estimated spending in the direct payment scenario (Table 1).[21] As in the direct payment scenario, expenditures in the health plan or health systems scenario are expected to be less than in the status quo in the first year of UF under three of the four scenarios modelled. As in the direct payment scenario, expenditures are expected to be somewhat greater than in the status quo if LTSS is expanded and there is no cost sharing.

[19] See Healthy California for All webpage for description of the methods and assumptions underlying the analysis, as well as a spreadsheet and companion guide explaining in more detail the expenditures analysis.
[20] Full implementation of UF would not be possible in 2022 given both the time needed to secure state and federal approvals and the time needed to implement the new system. 2022 is used as Year 1 throughout the analysis to ground the figures in current dollars and to avoid speculation about how long it would take to implement UF, a topic which the Commission did not discuss in depth.
[21] The point estimate for savings in the direct payment scenario is slightly greater than the point estimate for savings in the health plans or health systems scenario – a difference of $4 billion, or a little less than 1% of health spending. As discussed in the Methods and Assumptions document, there is considerable uncertainty around all of these estimates. Given the inherent uncertainty in the estimates, as well as a difference between the estimates of less than 1% of health spending, the estimates can be broadly characterized as ‘similar’.

Table 1: Estimated Total California Health Expenditures under Baseline and Unified Financing, 2022

Scenario	California Health Care Expenditures, 2022 ($ billion)	Change in Expenditures under UF Compared to Baseline
Baseline	$517	
UF: Direct payment to providers		
No cost sharing, no LTSS expansion	$501	-$16 (-3%)
Income-related cost sharing, no LTSS expansion	$482	-$35 (-7%)
Income-related cost sharing, with LTSS expansion	$508	-$9 (-2%)
No cost sharing, with LTSS expansion	$527	+$10 (2%)
UF: Health plan or health system role		
No cost sharing, no LTSS expansion	$505	-$12 (-2%)
Income-related cost sharing, no LTSS expansion	$486	-$31 (-6%)
Income-related cost sharing, with LTSS expansion	$513	-$4 (-1%)
No cost sharing, with LTSS expansion	$532	+$15 (3%)

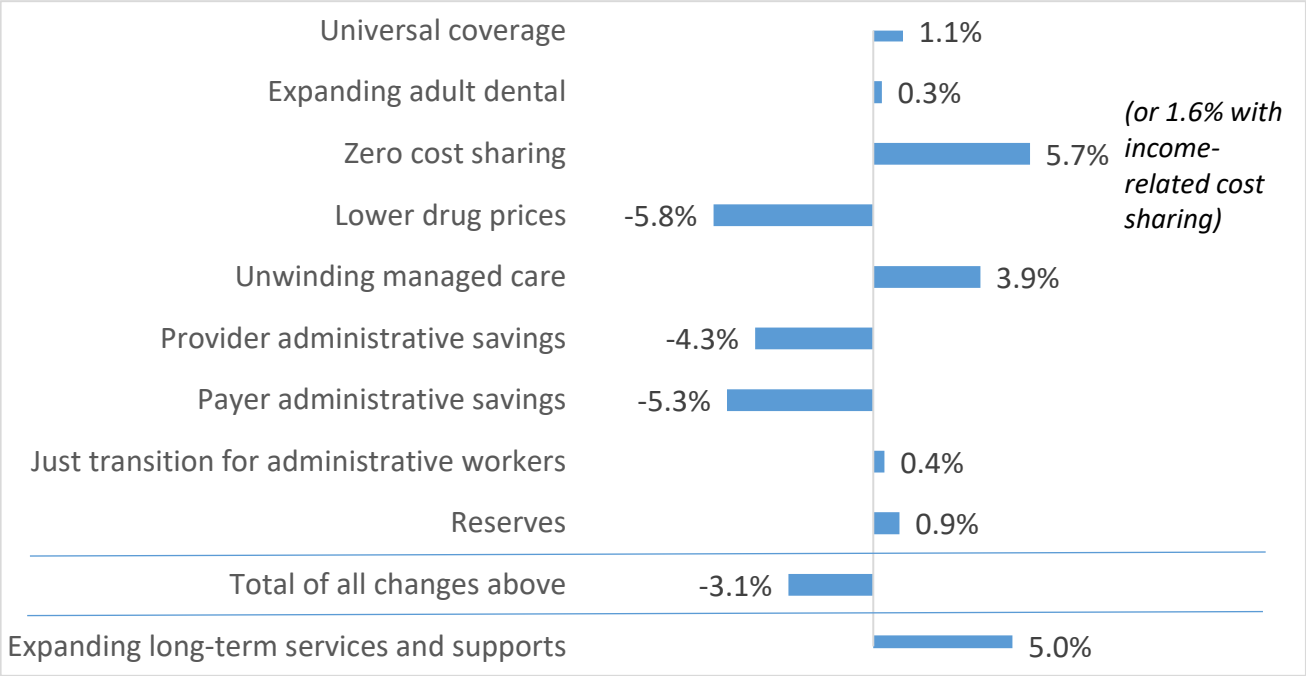
In the direct payment scenario, health care utilization is expected to increase substantially as a result of expanding coverage to all, covering adult dental services, the elimination (or reduction) of patient copayments, and the unwinding of managed care (Figure 1).[22] Further, spending is expected to increase in order to invest in a just transition for administrative workers and to create a reserve fund that would provide stability to UF in the face of fluctuations in health care spending and in recession-induced reductions in revenues.[23] The estimated increases in spending associated with these changes are expected to be more than compensated for by decreases in spending resulting from reductions in the administrative costs of health plans and insurers; reductions in the billing and insurance-related costs borne by physicians, hospitals, and other providers; reductions in the reimbursement received by these providers to assure that patients and tax payers receive

[22] In the scenario with income-related cost sharing, the analysis estimates that utilization will not increase by as much as in the scenario with no cost sharing. In the scenario with income-related cost sharing, the analysis assumes that some employers will offer supplemental benefits to assure that no employee faces higher out-of-pocket exposure under Unified Financing than they do in the status quo.

[23] The analysis assumes that reserves would be built up over the first 10 years such that the state has financial reserves equivalent to 10% state health funding to cover fluctuations in revenue resulting from economic downturns plus the equivalent of 5.2% to 11.7% of claims (depending on option) to cover fluctuations in claims. The analysis assumes that reserves would initially be funded with a $20 billion 30-year bond and then the remainder would be built up annually over a 10-year period.

the financial benefit of the reduced billing and insurance-related costs; and substantial reductions in the prices paid for pharmaceuticals.

Figure 1: Changes to 2022 Total Health Expenditures, Direct Payment Scenario



As shown in Table 2, estimated spending in the scenario in which health plans or health systems were used as intermediaries is very similar -- $3.8 billion higher, or 0.7% of total spending – than in the scenario in which direct payments were made to providers. Although total spending is expected to be similar in the two scenarios, the composition of spending differs somewhat in the two scenarios. In the scenario assuming health plans or health systems play an intermediary role, estimated administrative costs to pay the plans or systems are higher than in the direct payment scenario, and the savings from reduced billing and insurance related costs are lower (Table 2). These increases in spending are largely balanced by an estimated increase in utilization in the direct payment scenario due to the elimination of risk-based capitation and the elimination of health plan efforts at reducing low-value care,[24] which is accompanied by an increase in spending for services.

[24] Defining “low-value” vs “needed” health involves a degree of subjectivity and nuance. “Choosing Wisely” is a multi-year effort to encourage communication between providers and patients that supports patients’ choosing care that is supported by evidence; not duplicative; free from harm; and necessary. Such efforts are intended to reduce low-value services. More information is available at https://www.choosingwisely.org/.

Table 2: Change in Total Health Expenditures Compared to Baseline Spending in Scenarios With and Without a Role for Health Plans or Health Systems

Scenarios	**UF: Direct Payment to Providers**	**UF: Health Plan or Health System Role**	**Difference**
Universal coverage, expanding adult dental, zero cost sharing, lower drug prices*	*Changes shown in Figure 1, do not vary between options*	*Changes shown in Figure 1, do not vary between options*	*Changes shown in Figure 1, do not vary between options*
Unwinding managed care	3.9%	0.0%	-3.9%
Provider administrative savings	-4.3%	-2.0%	2.2%
Payer administrative savings	-5.3%	-2.4%	2.8%
Just transition for administrative workers	0.4%	0.2%	-0.2%
Reserves	0.9%	0.7%	-0.3%
Net change			0.7%

* Assumes long-term services and supports not expanded

Note: Due to rounding, difference may not appear to correspond with column sum.

Health Spending Over Time

By 2031, spending under the status quo is projected to grow by $158 billion in current dollars, using health expenditure growth projections by the Center for Medicare and Medicaid Services (CMS). Employer and household spending is projected to grow by $47 billion, federal spending by $92 billion, and state and local spending on Medi-Cal and IHSS by $16 billion.

Under UF, a reduction in the rate of spending growth could be accomplished by a number of mechanisms, including:

- Reducing fraud and abuse;[25]
- Reducing the provision of care that provides little or no patient benefit;
- Investments in primary care and prevention that result in improved health and less demand for care;
- Reducing the rate of diffusion of new technology;
- Reduced duplication of services resulting from improved health information exchange; and
- Reducing the rate of growth in prices.

[25] See comments from Commissioner William Hsiao on fraud and abuse in health care claims and the potential for related savings under unified financing.

Annual expenditure growth under UF after Year 1 is estimated under two scenarios:

1. Health spending grows at the National Health Expenditure (NHE) growth rates projected by Center for Medicare and Medicaid Services (CMS) minus 0.5% per year; and
2. Health spending grows at the rate of the Gross Domestic Product (GDP). The GDP growth rate option is approximately equivalent to the NHE growth rate minus 1.3%.

If health spending under UF grows more slowly than in the status quo, the reduction in spending will result in substantial savings for Californians. In the direct payment scenario in which spending grows 0.5% per year more slowly than in the status quo, estimated cumulative savings over the 2022-2031 period range from $32 to $535 billion in 2022 dollars (Table 3), depending on whether income-related cost sharing is applied and whether LTSS is expanded. With LTSS expansion and no cost sharing, expenditures would be somewhat higher in year 1 than under the current system (2% higher than the status quo, or $10 billion, as shown in Table 1), but over the ten-year period health expenditures would be $213 billion lower than in the current system if spending grows at the rate of GDP growth (Table 3). In a scenario with a health plan or health system role under UF, estimated cumulative savings are also significant, as shown in Table 3.

Table 3: Estimated Cumulative Savings ($ Billions) under UF Compared to the Status Quo under Two Growth Rate Scenarios, 2022-2031

UF Scenario	Growth rate: NHE less 0.5%	Growth rate: GDP
Direct payment to providers		
Income-related cost sharing, no LTSS expansion	$535	$698
No cost sharing, no LTSS expansion	$323	$496
Income-related cost sharing, with LTSS expansion	$245	$416
No cost sharing, with LTSS expansion	$32	$213
Health plan or health system role		
Income-related cost sharing, no LTSS expansion	$488	$655
No cost sharing, no LTSS expansion	$277	$451
Income-related cost sharing, with LTSS expansion	$183	$359
No cost sharing, with LTSS expansion	($29)	$155

Adopting a unified financing system will not automatically reduce the rate of growth of health expenditures. The rate of growth will depend on a number of design decisions within UF, as well as the behavior of the UF governing authority(ies), health care providers, patients, and the rate of development and deployment of new technologies. However, UF creates both additional tools to reduce spending growth and the imperative to do so.

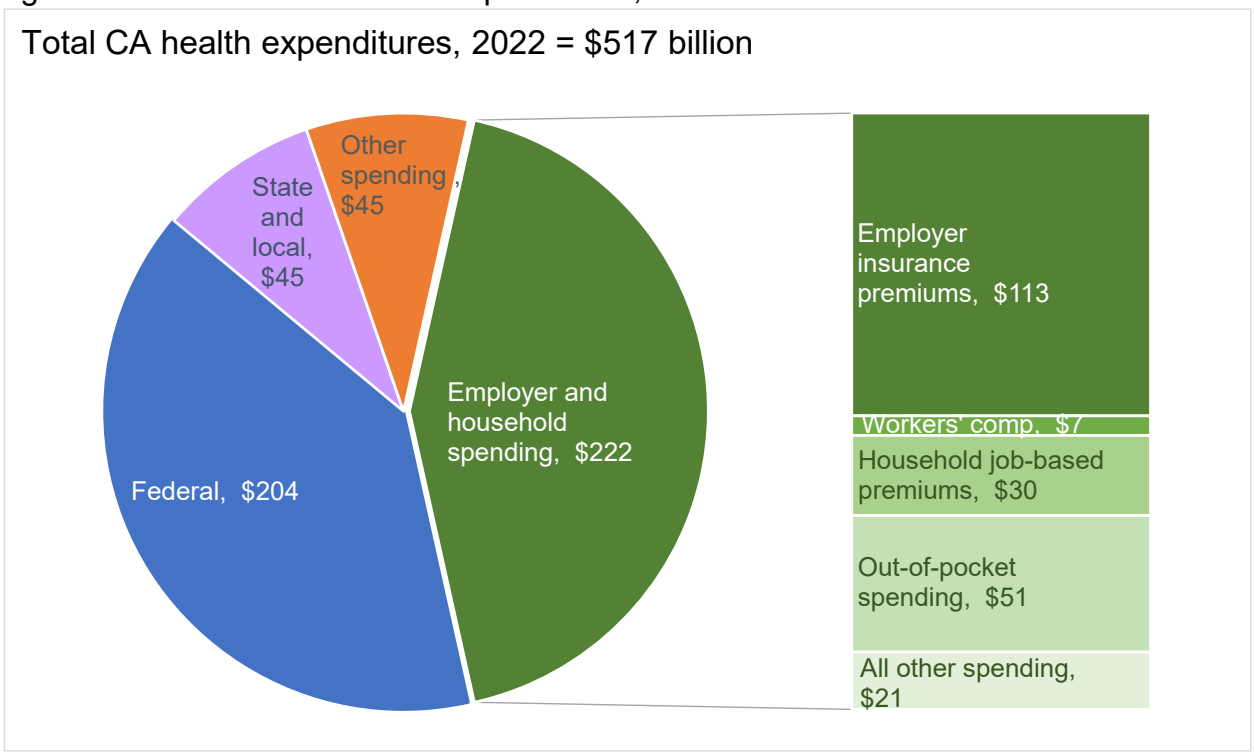
Revenue Sources for Year 1 of Unified Financing [26]

Under status quo fragmented financing, of the estimated $517 billion that will be spent on health care in California in 2022[27], estimated employer and household spending in 2022 will be $222 billion, federal payments for Medicare, Medi-Cal, IHSS, and ACA Premium Tax Credits an estimated $204 billion, with state and local Medi-Cal/ IHSS, and 'other' spending accounting for the remainder (Figure 2). The $222 billion statistic for employer and household spending represents current health care spending that can be repurposed to finance the non-federal share of funding needed for UF.[28] Further, under UF the financial burden for the non-federal share of funding can be distributed in ways that are more equitable than under the existing system, and, as discussed elsewhere in this report, with greater opportunities to slow health care cost growth. A large share ($143 billion) of the household and employer spending is accounted for by employer and employee paid

[26] This section provides analytic results on Year 1 financing. The 'Stability Over Time' section below provides results on financing over a longer time horizon.
[27] The $517 billion does not include spending on the Veterans Administration, military health services (including TRICARE), or the Indian Health Service.
[28] The estimated $222 billion in employer and household spending does not include an estimated $16 billion in premiums for Part B and Part D paid by Medicare beneficiaries. The Part B and Part D premium spending is included in the statistic for Medicare spending.

premiums. At firms that offer health insurance, employers will be paying an average of 9.9% of payroll for health insurance in 2022, with employees paying an additional 2.7% of payroll, on average.[29] In addition, employers are projected to spend over $7 billion on the medical portion of workers' compensation premiums in 2022, or an average of approximately 0.6% of payroll.[30]

Figure 2: Total California health expenditures, 2022



As noted above, in a UF scenario with direct payment to providers, no cost sharing, and without expansion of LTSS, estimated 2022 spending would decline by $16 billion to $501 billion.[31] If the federal, state and local, and 'other' funding sources remained at their status quo level in Year 1, then $207 billion would need to be repurposed from the non-federal amount currently spent on health care (Figure 3).[32] This $207 billion would replace much of

[29] UC Berkeley-UCLA California Simulation of Insurance Markets (CalSIM) 3.0

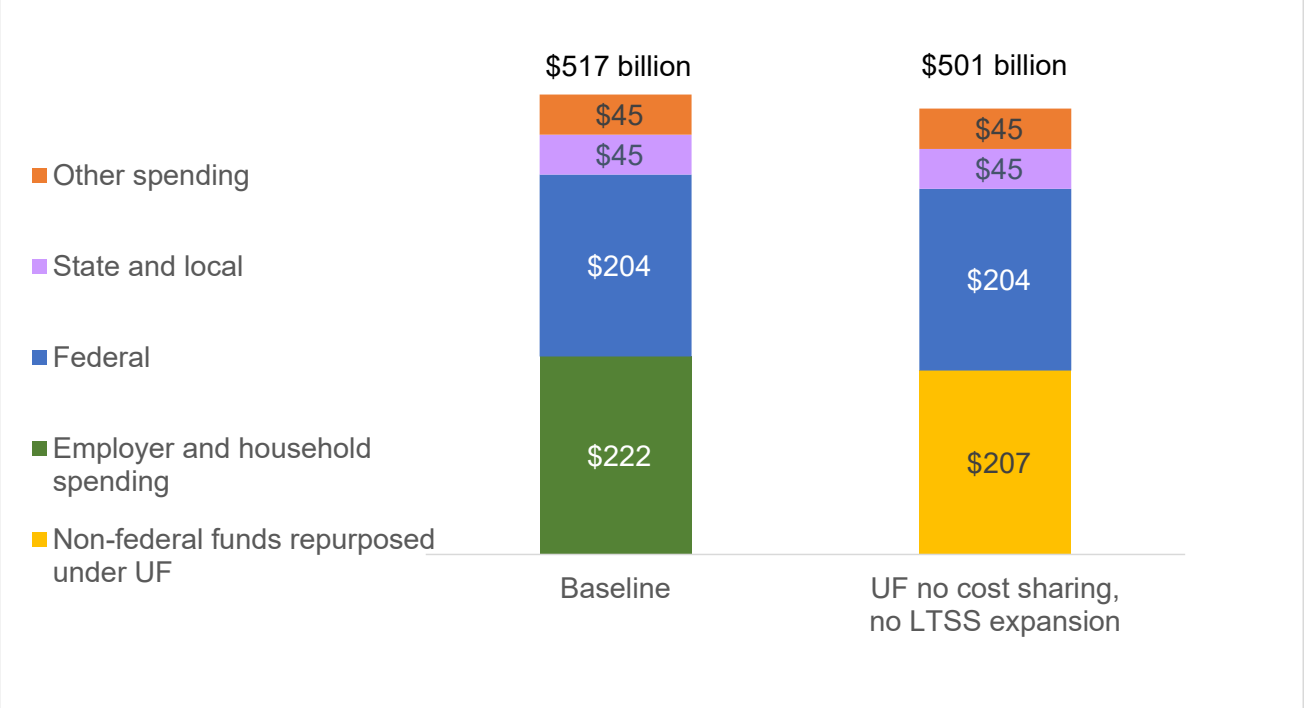
[30] As a percent of payroll, the medical portion of worker's compensation premiums are higher at many low wage firms that do not offer health insurance.

[31] In Figures 3, 4, and 5, results are shown in scenarios that assume direct payments to providers. As was shown in Table 1, estimated health spending in scenarios in which health plans or health systems are used as intermediaries is very similar to estimated spending in scenarios in which direct payments are made to providers. The results in Figures 3, 4, and 5 would change very little if they were presented for the health plans/health systems scenarios.

[32] If the federal government captured some of the Year 1 savings, that would increase the amount of state-based funds that would need to be raised every year. An additional uncertainty about federal funding and about how UF might be implemented concerns the treatment of Part B and Part D premiums paid by Medicare beneficiaries. Medicare beneficiaries can choose whether to enroll in Part B and in Part D, and, if they choose to enroll, pay a premium that covers approximately 25% of the cost. Under UF, Californians currently enrolled in Medicare would be covered by the state's UF system, and would presumably no longer pay Part B or Part D

the $222 billion currently spent on health care by employers and households for premiums for employer-sponsored insurance and workers' compensation, for out-of-pocket spending, and for 'other' employer and household spending such as individual market premiums and Medigap premiums. This $207 billion repurposed from non-federal funds currently spent on health care would be $16 billion less than employers and households are expected to pay for health care under the status quo. As was shown in Figure 1 above, lower spending is projected primarily as a result of decreases in administrative costs for providers and payers and reductions in the prices paid for pharmaceuticals, partially balanced by increased spending due to the elimination of uninsurance and underinsurance and new costs for establishing a reserve fund, for funding a just transition for employees in health care administration, and, in the direct payment scenario, from increased utilization resulting from the unwinding of managed care.

Figure 3: Total California health expenditures by payer, 2022

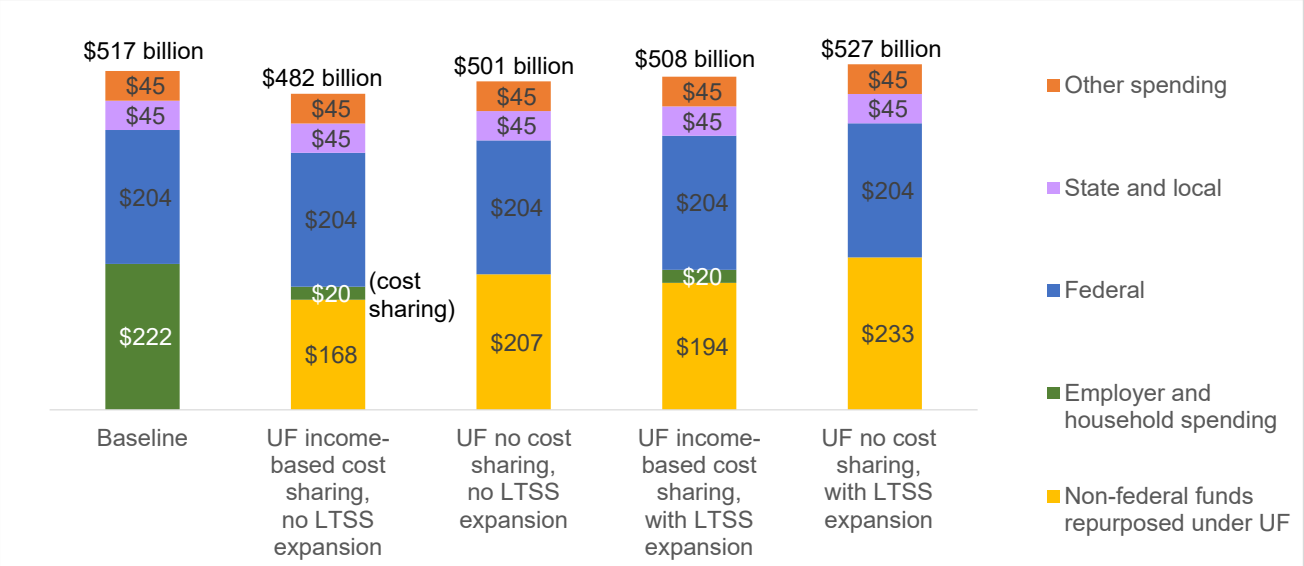


Note: UF scenario assumes direct payment to providers

As shown in Figure 4 below, the amount of non-federal money that is needed to support UF depends on a variety of design choices about how UF would be implemented. Under different scenarios, the amount needed ranges from $168 billion with income-based cost sharing and no LTSS expansion, to $233 billion with no cost sharing and expanded LTSS (Figure 4).

premiums. It is possible that rather than making a payment to the UF authority equal to gross Medicare spending made on behalf of California Medicare beneficiaries, the federal government would want that payment to reflect net Medicare spending – that is, gross spending minus Medicare Part B and Part D premium payments. In that circumstance, the amount needed to fund the non-federal portion of UF financing would be greater than the estimates shown in Figures 3, 4, and 5.

Figure 4: Total California health expenditures by payer, 2022



Note: UF scenarios assume direct payment to providers

What follow are hypothetical approaches that could provide core revenues for a unified financing system, including a variety of broad-based approaches (Table 4). These sources could be supplemented with a range of other complementary methods that could help meet additional objectives on equity and incentivizing positive health outcomes.

A payroll tax can be straightforwardly substituted for our current system of job-based coverage. It would be more progressive than our current system, since payments would be scaled to income, rather than being a flat 'head tax' in the current system. One drawback is that it is a tax on labor, which can distort the demand for labor versus capital. If the state were to consider a payroll tax, an equal tax for independent contractors should be considered to avoid creating incentives to circumvent the employment relationship. Each 1% increase in payroll tax would raise about $14 billion.

Because the total amount of money that needs to be raised from employers and households will be less under UF than in the status quo, it is plausible that the required payroll tax rate would be somewhat lower than the average percent of payroll paid now by employers and employees for employer-sponsored insurance, and that, on average, employers and employees will end up paying less money than in the status quo. (Of course, the actual rate needed for a payroll tax depends crucially on decisions about other potential revenue sources.) However, even if the payroll tax is lower, on average, than the average percent of payroll paid by employers and employees in the status quo, there will inevitably be winners and losers. Employers that currently do not offer health insurance will pay more under UF than in the status quo. Employers with high average wages and relatively young workforces will also pay more than in the status quo, while employers with relatively low wages and/or older workforces will pay less than in the status quo. The number and magnitude of winners and losers could be reduced if the payroll tax, at least for medium and large sized firms,

were made firm-specific, where the rate was adjusted based on the percent of payroll paid by the firm prior to the implementation of UF. If this approach were adopted, it would be important to use it for a phase-in period, and move towards a uniform payroll tax rate after some period of time. If differential payroll tax rates were made permanent, distortions to the market would be worrisome, as firms with high tax rates could outsource tasks to, or be acquired by, firms with low tax rates.

Another option is a broad tax on labor and capital income, which would tax compensation, corporate profits, unincorporated business income, and interest income. A broad tax is more progressive than our current financing. It treats capital and labor equally, with no differences in tax rates based on how income is earned, which minimizes economic distortions. Each 1% broad tax raises an estimated $19 billion.[33]

A gross receipts tax has the advantage of a large and stable tax base. The drawback is that 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 it would be a tax on profits. Existing gross receipts taxes tend to be small, in the 1 percent or less range, and tax rates often vary by industry.[34] If considered, the state may want to consider exempting firms with revenues below a specified threshold to exclude the smallest businesses. The cost of a gross receipts tax is primarily passed on to consumers, similar to a sales tax and could be considered more regressive.[35] Each 1 percent of gross receipts tax raises $47 billion.

Another option is extending the sales tax to selected services, such as professional, technical, and scientific services. As with any consumption tax it has the potential to be more regressive. Each 1 percent raises $9.5 billion.[36]

Finally, the state could also increase personal income tax, to raise $16 billion per 1 percent. The personal income tax is more volatile than the other sources discussed here, requiring a larger financial reserve fund.

If combining multiple tax sources, the State should consider options that do not tax the same base, for example a payroll tax or income tax could be combined with gross receipts or sales tax.[37]

Table 4: Estimated revenue from broad based financing options, 2022

[33] Estimate based on what could be achieved by building, relatively straightforwardly, on our current tax system. The base could be broadened with fuller accounting of business income.
[34] See for example, https://sftreasurer.org/business/taxes-fees/gross-receipts-tax-gr .
[35] Institute on Taxation and Economic Policy, “Broad-Based Gross Receipts Taxes: A Worthwhile Alternative? March 1, 2007, https://itep.org/broad-based-gross-receipts-taxes-a-worthwhile-alternative/
[36] This estimate assumes that construction, utilities, health, education, public administration and services provided by non-profit agencies would be exempt from the tax.
[37] For any tax proposal that does not retain the value of the federal tax exclusion on employer-sponsored insurance, the state could try to seek a change in federal law to recapture some of that revenue.

Tax Base	Estimated revenue per 1 percent* (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 Select Services (excludes construction, utilities, health, education, accommodation and food services)	$ 9
Taxable Personal Income	$18*

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

An important advantage of UF is the ability to finance health care in a more progressive manner than the regressive financing that underlies employer-sponsored coverage. One of the greatest inequities in the status quo is the financial burden on low- and middle-income workers with employer-sponsored insurance. Under the standard economic assumption that the employer contribution to health insurance is part of the employee's compensation, average annual premiums plus out-of-pocket costs ($8,115) make up 31.8 percent of income for a single employee earning $25,520 (200 percent of FPL), compared to just 7.9 percent of income for a worker earning $102,080 (800 percent of FPL).[38]

There are many options for more equitably distributing the financial burden of paying for health care. For example, if a payroll tax were used to replace employer and employee based financing, lower income employees would pay the same percentage of income as upper income employees, rather than a much higher percentage as in the status quo. However, attention is needed to assure that Californians receiving Medi-Cal or subsidized coverage through Covered California are not made worse off financially under UF. The expected effects on Californians with low income will depend on the extent to which equitable approaches are used. If a payroll tax were used, for example, to raise part of the revenue needed to support UF, employees who work for firms that do not now offer coverage could see a decline in wages to compensate for the new payroll tax. If a sales tax or gross receipts tax were used to raise part of the revenue, prices for goods and services purchased by low-income workers would be expected to increase. Tax rebates or other measures could be taken to mitigate any potential negative effects on Californians currently with Medi-Cal and Covered California coverage. The state might also consider requiring that employers pass through any savings from no longer providing job-based coverage to workers.

In considering the advantages and disadvantages of alternative revenue sources, the effects on Californians' federal income tax liability should be considered. As an illustration,

[38] See presentation to the Commission on financing considerations on November 17, 2021.

suppose that employers no longer paid for employees' health insurance, and the mechanism to repurpose the non-federal amount of current spending on health care to support Unified Financing were accomplished through a combination of a gross receipts tax and an increase in California income tax rates. In that scenario, we would expect, in the long run, employee wages to increase by the amount that employers previously contributed to health insurance. (If the state were to require that employers increase wages by the amount that employers were previously contributing to health insurance, this result would be achieved more quickly.) However, absent a change in federal tax policy, increased wages would lead to increased federal income tax revenues; the federal government would receive a windfall; and Californians would be, on average, worse off. For example, suppose that wages increased by $100 billion annually because California employers no longer paid directly for employees' health insurance, and that the combination of a gross receipts tax and income tax raised close to $100 billion. Federal income tax revenue would increase by more than $20 billion, and after Californians paid the increased income tax and increased prices as a result of the gross receipts tax, Californians would be approximately $20 billion per year worse off. California could attempt to persuade the federal government to return the $20 billion in increased income tax revenues to the state, which is likely to be difficult.

Similarly, if a payroll tax were used to replace much or all of the money that employers and employees currently pay for employees' health insurance, there would be significant tax advantages to fashioning this as an entirely employer-paid payroll tax, rather than dividing responsibility between the employer and employee. In the status quo, employer payments for health insurance at firms that offer coverage average approximately 10% of payroll, and employee payments average 2% of payroll. Federal corporate income tax law treats the employer payments for health insurance as a legitimate cost of doing business, and those payments reduce corporate profits. Federal individual income tax law excludes the employee payments for health insurance from the employee's taxable income. Under current federal law, if the employer were to pay a payroll tax and the employee were to pay a percentage of wages to support Unified Financing, the employee payment would be considered part of the employee's taxable income, and federal income tax revenues would increase. California could attempt to persuade Congress to change tax law to exclude from taxable income an employee-paid payroll tax of this nature. However, absent a change in federal income tax law, if a payroll tax were used to fund significant portions of Unified Financing, there are strong federal tax advantages for having the payroll tax be paid entirely by employers rather than paid in part by employees.

In considering the advantages and disadvantages of alternative funding sources, the effects on the competitiveness of California industry should also be considered. Some have raised concerns that the amount of non-federal funding needed to support Unified Financing will make California a less attractive place to do business, and hurt the California economy. These concerns need to be taken seriously. However, it seems likely that many methods of repurposing the non-federal amount currently spent on health care to support Unified Financing will make California a more attractive, not less attractive, place to do business. Suppose, for example, employer payments for health insurance were replaced with a payroll tax, and suppose, as expected, that the payroll tax rate remained constant over time in

California, while the fraction of payroll that employers pay for health insurance in other states continues to increase. In that scenario, California would become a more attractive place to do business.

Stability Over Time

A major concern often voiced about unified financing is that it will not provide stability over time. Two concerns are often mentioned, the first of which involves short term volatility. In a recession, revenues will drop, and the UF authority may be forced to impose painful and severe cuts. Alternatively, if health care needs increase rapidly (for example, as a result of a pandemic), revenues will not be available to support those needs. In the absence of being able to borrow money to cover short-term shortfalls, it is important for the UF authority to have a substantial reserve fund to cover short run revenue reductions or spending increases. In the estimates provided above, the consulting team assumed that a reserve fund approximately equal to 20 percent of state-based spending would be created, with some variation between options. The cost of creating that fund is built into the estimates.

The second, perhaps larger, concern is about longer-term stability. In the status quo, the cost of employer sponsored insurance and out-of-pocket costs for households have been increasing more quickly than workers' wages or productivity, and are expected to continue to do so in the future. In the status quo, the 'effective' payroll tax – that is, the percentage of wages that employers and employees pay for employer sponsored insurance – has been increasing over time, and is expected to continue to increase over the next decade. If health spending continues to increase more quickly than the rest of the economy, then tax rates would need to increase over time, which would be politically difficult to sustain.

Two major factors affect how much non-federal funding is needed over time: (1) the rate of growth of health care costs, and (2) the rate of growth of federal payments:

- Under the assumptions that health care costs grow at the status quo, and non-federal funding increases at the rate of growth of GDP, the $207 billion in non-federal funding in Year 1 would grow to $242 billion, in 2022 dollars, in 2031 (Figure 5).
- If health care costs grow under UF at the rate of growth of GDP (which would be substantially more slowly than projected under status quo fragmented financing), and federal government payments grow at the same rate as projected under fragmented financing, the amount of non-federal funding needed to support UF in 2031 would fall to $193 billion (in 2022 dollars), substantially less than the projected $242 billion if non-federal funding grows at the rate of growth of GDP. The surplus could be used in a variety of ways, including greater investments in the social drivers of health, building up a larger reserve fund, or reducing tax rates. If health spending grows at NHE minus 0.5%, the projected 2031 surplus would be smaller – $19 billion – but still substantial.

A likely scenario is that the federal government would insist on capturing some or all of the savings created by slowing the cost growth under UF. If the federal government captured all

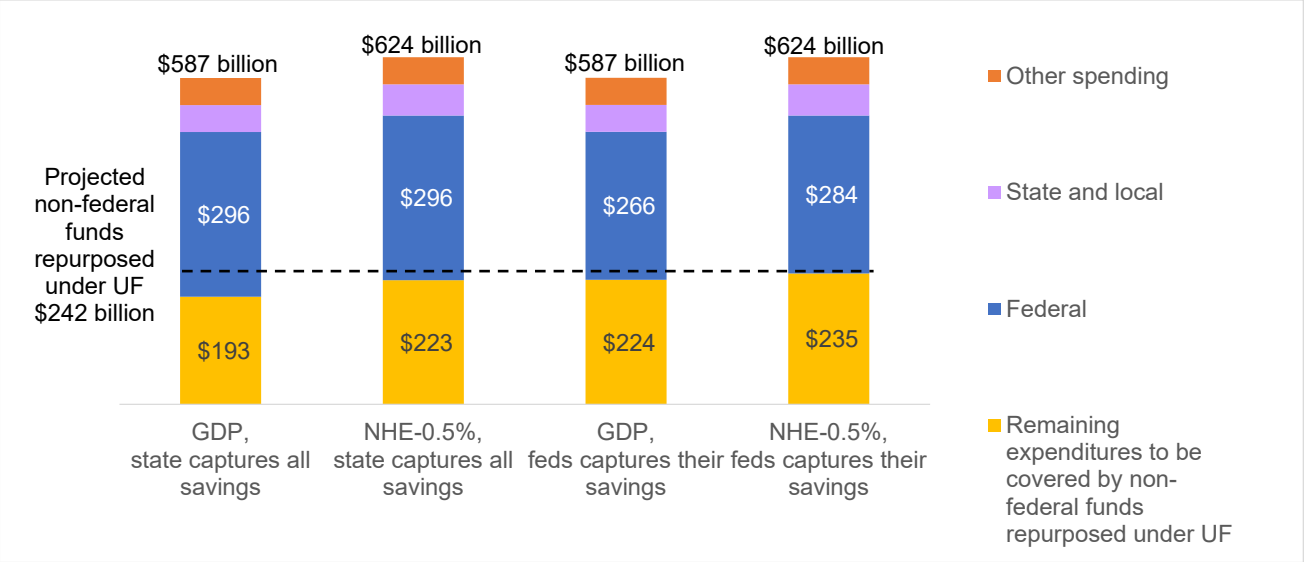
of the savings generated by a lower rate of growth of health spending, an $18 billion surplus would be expected in 2031 in the scenario in which health spending grows at GDP, and virtually breakeven if health spending grows at NHE minus 0.5%.[39] In this last scenario, in which the federal government captures all of its share of the savings, and health spending slows by 'only' 0.5% per year, there is little room for error. This result demonstrates that stability of funding needed to support UF depends on both reducing the rate of health spending growth and a strong and enforceable agreement with the federal government that assures an adequate rate of growth in federal payments.

Under the scenario in which expenditures grow by CMS-projected NHE growth rates minus 0.5%, and the federal government captures their portion of the savings generated by this lower growth rate, the estimated cumulative federal savings over the 2022 to 2031 period would be $55 billion.[40] The projected federal savings would be an important input in discussions with the federal government about the role of Medicare and Medicaid in unified financing in California.

[39] In all the scenarios modelled, the consulting team assumed that Year 1 federal payments would be at the status quo level, and that, even if UF created Year 1 savings, that the federal government would not receive a share of those savings. In part, this assumption is based on the practical reality that it is likely to be very difficult, if not impossible, to measure with any precision the extent to which aggregate spending in California in year 1 is different from what would have been expected under the status quo.

[40] The calculations supporting the $55 billion estimate are shown in the supporting spreadsheet, available at https://www.chhs.ca.gov/healthycaforall/#analytic-findings

Figure 5: UF expenditures by source compared to projected revenues, 2031 (2022$)
(Assumes non-federal funding increases at the rate of growth of GDP)



UF scenarios are with no cost sharing and no LTSS expansion[41]

Estimated Effects of Unified Financing on Equity, Health, and Other Outcomes

Unified financing would create universal coverage, filling the gap for the one in ten Californians under age 65 who lack insurance in our current system. Universal coverage is critical to improving equity in our health care system given that undocumented Californians, Latinos, and Californians with income at or below twice the federal poverty level are among the groups most likely to lack insurance in our current system. The consulting team estimated that universal coverage would save 4,000 or more lives annually.[42] The impact of universal coverage could be attained through UF or through other policy actions. For example, as described further under Priority Actions and Next Steps, Governor Newsom's 2022-23 budget proposes expanding Medi-Cal to all income eligible Californians and, when fully implemented, would bring California much closer to universal coverage.

Expansion of coverage and elimination of underinsurance would result in the vast majority of Californians having a usual source of care under UF, compared to our current system in which 11 percent of insured Californians and 52 percent of uninsured Californians lack a usual source of care. Furthermore, UF would result in approximately one million more Californians having at least one doctor visit annually and would greatly reduce the number

[41] In other scenarios the non-federal funds that would be needed to support UF in the first year of UF are shown in Figure 4, and the projected revenues in 2031 (increasing at the rate of growth of GDP) will change commensurately. However, the main result of the analysis – that the fraction of gross state product that would need to be used to support UF could remain stable (or potentially decline) if health spending grows by at least 0.5% less under UF than in baseline – remains unchanged.
[42] See presentation to the Commission on Unified Financing: Potential Effects and Design Options on May 21, 2021.

of Californians who avoid or delay care due to cost. The expansion of adult dental coverage would support better and more equitable oral health.

UF, by eliminating the distinctions among Medi-Cal, employer-sponsored insurance, Medicare, non-group coverage, and the uninsured, would also lead to a substantial increase in equity in how care is delivered. While access to care for residents of lower income areas would, in the first year of UF, still likely be inferior to access for higher income areas, no longer would physicians, hospitals, or other health care providers have a financial incentive to avoid providing care to low-income Californians, or racial and ethnic minority populations. Well-crafted payment systems and accountability mechanisms would, over time, substantially improve access to care for disadvantaged Californians.

UF, by creating a simpler and more uniform system of coverage and payment for patients and for health care providers, and by aligning incentives in a way that the status quo fragmented financing system cannot, has the potential to encourage health care providers and health systems to focus on improvements in population health, on investments in primary care and prevention, and on reductions in disparities. In the current fragmented financing system, even the largely non-profit hospitals in California focus on increasing their financial margins and growth strategies to generate surpluses and guard against uncertainty. Under UF, revenue streams could be made less uncertain through payment approaches such as global budgets, allowing health systems to shift focus from revenue maximizing strategies to strategies that maximize population health and reduce disparities. Under the current fragmented financing system, providers primarily serving more vulnerable populations, such as Medi-Cal beneficiaries and the uninsured, typically operate on lower revenue streams than those with large proportions of commercially insured patients. Under UF, these providers would significantly benefit through equitable payment arrangements.

As discussed extensively at Commission meetings, the extent to which UF realizes this potential is dependent on governance structures, payment systems, and accountability mechanisms. Similarly, UF has the potential to facilitate a pivot to invest in the social drivers of health. The extent to which this potential will be realized depends on many design decisions. However, virtually all commissioners agreed that addressing social drivers of health that compromise health status holds great potential yet noted that the health care system should do this not in isolation but in coordination with other sectors.

The benefits of UF would also extend beyond improved equity and health. For example, one in four Californians reported problems paying medical bills in late 2021, and the rate was even higher among Californians with income under twice the poverty level and Latino and Black adults.[43] Universal coverage and the elimination of underinsurance under UF would improve financial security as fewer Californians having problems paying medical bills. As another example, patients would spend less work and personal time navigating provider systems and dealing with health insurance companies as a result of administrative simplification.

[43] California HealthCare Foundation. 2022. The 2022 CHCF California Health Policy Survey. https://www.chcf.org/wp-content/uploads/2022/01/CHCF2022CAHealthPolicySurvey.pdf

Of particular consequence, the inclusion of LTSS as covered services under UF would improve the lives of millions of caregiving families.[44] Women – particularly Black, Indigenous, Latino, and Asian-American women – provide a disproportionately large share of this care, often while simultaneously caring for children and working outside of the home. Households of color are more likely than white households to be multi-generational, which may indicate these families are more likely to provide unpaid caregiving across the generations. As rewarding as this work may be, the time needed to care for a loved one can result in financial hardship and a decrease in lifelong Social Security earnings, which can continue the cycle of poverty and debt for low-income households. The emotional and physical stress of caregiving can also lead to poor health outcomes for the family caregiver. With their loved ones benefitting from LTSS as covered services, caregivers, particularly women of color, would have greater opportunity to fulfil their own goals and dreams rather than sacrifice on behalf of their loved ones.

Analytic Findings: Summary of Potential Benefits

Analytic work done in connection with the Commission process illuminated how California and Californians would be better off under UF. Across the entire state, as described above, a less fragmented system of financing and organizing health care would reduce duplication of effort and administrative burden and would provide greater accountability for equitable outcomes. The implications of UF for particular groups of potential beneficiaries are summarized in Table 5 below.

[44] Supporting caregiving for adults, like caregiving for children, is essential for family life, the economy, and a California for all ages. Across California, almost five million family caregivers help their parents, spouses, and friends who need assistance with everyday tasks to live well in their homes and communities. Of these, almost 1.7 million are caring for someone with Alzheimer's Disease or dementia, usually with little support or training. This constitutes about 4 billion hours of unpaid time, valued at $63 billion, each year. See California's Master Plan for Aging, January 2021.

Table 5: UF Benefits and Beneficiaries

Who Benefits?	Through What Mechanism?	How Do They Benefit?
Employers	• Elimination of employer health benefit procurement role	• Reduced administrative burden • Ability to focus on their areas of expertise and business goals rather than the health coverage needs of employees
Individual Californians	• Universal coverage (which can be achieved under UF or via other policy routes) • Delivery system changes that increase quality, accessibility and equity • More equitable financing	• Improved access to care and reduced cost-sharing • Expanded benefits (e.g. dental, LTSS) • Reduced uncertainty and worry • Better health outcomes • Fewer disparities and more equitable care • Financial burden on households is more predictable and better aligns with ability to pay
Health Care Providers	• Single set of rules for payment, quality, other outcomes	• Reduced administrative burden and greater opportunity to focus on patient care • More equitable and consistent payment

Decisions and Actions Needed to Achieve Unified Financing

As described in more detail in the Commission's Environmental Analysis,[45] key actions will demonstrate clear progress toward UF. The state will need clarity regarding federal commitments in order to include federal Medicare and Medicaid funds within the state UF system and to maintain a sustainable rate of growth for redirected federal funds. To successfully engage the federal government on the threshold issue of federal permissions and federal funding, the state will need to develop and refine a proposal for UF that finalizes design decisions and implementation steps that achieve goals of universality, improved equity, affordability, access and quality, while providing confidence that UF will meet federal legal requirements. The California Legislature will likely need to enact legislation specifying how UF will be implemented and funded. California voters may need to approve constitutional amendments to modify limits on state appropriations (for further discussion, see the section on Financing). Careful planning and political will, together with effective collaboration with the federal government, will be needed to achieve UF.

[45] Healthy California for All Commission, An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California, August 2020. See in particular pages 78-81.

A statewide UF system will require decisions and actions along many dimensions. Through Commission deliberations and via survey input, commissioners discussed many issues related to UF design and offered valuable perspectives on the implications of alternative approaches. Nevertheless, greater detail will need to be specified as California moves to implement UF. This section highlights many of the decisions and actions that will be required to establish UF. Where Commission discussions, input from commissioner surveys, and/or the consulting team's analysis pointed to preferred approaches or illuminated important trade-offs, those are also briefly described.

Design

Eligibility and Enrollment

A foundational premise for the work of the Commission has been that the UF system will be universal and will apply to all Californians. In their deliberations, many commissioners have expressed the intention that all Californians will be included under UF by virtue of state residence, with no distinctions based on their federal immigration status, and no commissioners have disagreed with that assertion. Residency criteria might include physical presence in the state of a defined duration, location of employer or employment within California, and/or family relationships (e.g., adoption by or marriage to a California resident). Qualification for certain benefits, such as comprehensive LTSS coverage, that are not available in other states might be subject to additional requirements. As with many of the design decisions that California will need to make on its way to UF, tradeoffs would need to be navigated, so that California's program is indeed welcoming and available to all residents yet not so easily accessed that people from outside California take advantage of the program, driving up its cost.

Agreements negotiated with the federal government to redirect federal Medicare and Medicaid funds and ACA premium subsidies to a state unified financing pool might require that information about Californians' eligibility for one or more of those programs be tracked after UF implementation. Data reporting, for example, on federally defined eligibility categories for public programs or federally required data reporting on quality measures could add administrative complexity that might influence California's ultimate design decisions.

Policies will be needed concerning California residents who require health care when they are not in the state, including determining when a California resident has permanently moved out of state and is no longer eligible for coverage; coverage for dependents who live out of state; and coverage for residents who live for an extended period of time in another state or country.

Covered Benefits and Services

Although the Commission did not devote much public meeting time to discussing covered benefits and services or cost-sharing, the tacit assumption was that benefits under UF will be comprehensive.

Benefits at levels comparable to those provided today under Medi-Cal were sometimes posited. Commissioners encouraged inclusion of comprehensive vision and dental services as well. At several points in the process commissioners acknowledged that medical necessity criteria should apply, as they are today in both private and public health insurance plans. While Commission process did not spend much public meeting time on the role of utilization management, such as prior authorization, all Commissioners agreed, as shown in the November 2021 survey summary, that individuals should be encouraged to select a primary care provider to coordinate their care. Commissioner Comsti, in particular, advocated for a system whereby consumers could access care without prior authorization or other utilization management techniques, such as step therapy. At the February, 23, 2022 meeting, Commissioner Sandra Hernandez stated that if some sort of triage is required to manage resources under UF, it is important for primary care providers to be in the position of making health care decisions that allow them to look across the entirety of each patient's needs. Both views are departures from some of the more stringent forms of utilization management used within the current health care system, where narrow networks and plan incentives to manage costs may limit access to needed care. Since the tradeoffs associated with utilization management were not fully examined, any future design of the UF system will need to consider mechanisms to ensure appropriate care and management of costs.

There was broad agreement among commissioners that the inclusion of comprehensive coverage for long-term services and supports (LTSS) was important to advance access, equity, and quality outcomes. In particular, several commissioners highlighted the hidden costs and consequences of the lack of access to LTSS today, including productivity implications and opportunity costs associated with family members leaving the workforce in order to take care of loved ones and the disproportionate stress and financial impact that family caregiving places on Californians with lower incomes. Given the absence of widespread, comprehensive LTSS coverage in the U.S. today, the Commission discussion acknowledged some uncertainty about LTSS benefit structure and cost implications. Nevertheless, commissioners concluded that under UF, LTSS benefits should be covered and coordinated with other health care and social services.

Via the December 2021 survey, all responding commissioners "agreed" or "agreed with slight modifications" to the following statements regarding benefits:

- Dental, vision and hearing services should be included among the benefits covered through a unified financing system
- Behavioral health services (that is, services to address mental health and substance use disorders) should be included among the benefits covered through a unified financing system

- Comprehensive long-term services and supports should be among the benefits covered through a unified financing system

Patient Cost-Sharing

Commissioner discussions on cost-sharing identified two potential goals for imposing even a modest level of cost-sharing: (1) to reduce the costs of financing the UF system and (2) to reduce the total cost of care by dissuading use of care that provides little or no patient benefit. In designing and implementing cost-sharing, the UF authority should be clear about what the goal is of a given cost sharing approach.

The consulting team modeled two different patient cost-sharing approaches, as described above in the Analytic Findings section. As discussions advance regarding UF design, the potential impact of different cost-sharing arrangements on the use of necessary and unnecessary services, the administrative burden that accompanies copayment collection, and the potential for generating revenue should all be considered. As shown in the November 2021 presentation to the Commission, the estimated revenue required in a scenario with income-related cost sharing is approximately $40 billion less than in a scenario with no cost sharing – $168 billion would need to be repurposed from the non-federal amount currently spent on health care in a scenario with income-related cost sharing, compared to $207 billion that would need to be repurposed from the non-federal amount currently spent on health care in a scenario with no cost sharing.[46] However, in a scenario with income-related cost sharing consumers will pay $20 billion more in out-of-pocket payments than in a scenario with no cost sharing.

Some commissioners expressed concern about the effects of out-of-pocket payments on access to beneficial care, as well as concerns about the administrative costs of implementing income-related cost sharing. Evidence from the RAND Health Insurance Experiment (HIE) showed that patients are not good at distinguishing care that is likely to be effective from care that is likely ineffective, and that cost sharing results in reductions in both types of care.[47] However, the RAND HIE also found that with the exception of low income patients, cost sharing did not result in measurable reductions in health status. As described above, in the assumptions made by the consulting team for one analytic scenario, patients in families with incomes below 138% of the Federal Poverty Level would not face any cost sharing, and those in families between 138% and 400% of the Federal Poverty Level would pay an average of 6% of total expenditures, with out-of-pocket liability likely capped at approximately $1,000 per year for an individual and $2,000 for a family.

Some commissioners believed that no patient cost-sharing was appropriate; others advised that any cost-sharing should be limited so that access to needed care is not impeded. Several commissioners commented that cost-sharing should exempt those with low

[46] Both estimates assume direct payment to providers and without expansion of LTSS services (slide 20 from November presentation to Commissioners.)
[47] RAND Corporation. “The Health Insurance experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate.” Research Brief, RAND Health (2006). https://www.rand.org/pubs/research_briefs/ RB9174.html

incomes but were open to limited cost-sharing if progressively structured with respect to individual or household income. In the December survey, all but one commissioner "agreed" or "agreed with slight modification" to the following statements regarding cost-sharing:

- The decision to impose patient cost-sharing should balance considerations of equity, appropriate use of health care services, administrative burden, and implications for revenue needs.
- Copayments or coinsurance, if any, should reflect individuals' and households' ability to pay.

The December survey elicited additional responses related to cost-sharing; interested readers are encouraged to review the summary for verbatim commissioner comments.[48] Cost-sharing was also discussed at the February 23, 2022 meeting. At that meeting Commissioner Hsiao expressed the view that an "ideal" single payer or unified financing health system would have no cost sharing. He described reasons to consider using cost sharing: in order to contribute to program financial feasibility; in order to reduce unnecessary use of medical services; or as a tool for managing use of health care services when supplies are limited. Throughout that discussion, most commissioners favored a system with no cost sharing; those who expressed guarded interest in modest cost-sharing acknowledged tradeoffs and the need for thoughtful design that spares, to the greatest extent possible, those with low incomes and high health care needs. For example, how any cost-sharing is structured makes a difference. Fixed dollar copayments are more readily understood by consumers than deductibles and coinsurance. Further, achieving the level of actuarial value contemplated under UF could be done in various ways, some of which would have a disproportionate impact on the sick.

Provider Payment

Decisions about how and how much health care providers will be paid are crucial for understanding how and how well UF will work. Commissioners were in strong support of the proposition that payment policy is one of the key levers that can be used in UF to achieve the goals of increasing access and improving equity, efficiency, quality of care, and health outcomes.

Institutional Providers

Maryland's experience with the country's only all-payer rate setting program for hospital services, in place since the 1970s, offers an important reference point for California. Over time, Maryland's rate setting model that limited the growth of inpatient hospital costs for each hospital stay became less effective, resulting in increases in the volume of hospital services provided and the state having one of the nation's highest per capita Medicare hospital costs. In 2014, Maryland significantly reformed its approach for paying hospitals for

[48] See December 2021 survey summary available through the February 23, 2022 meeting materials at the Healthy California for All web page.

each service to a Total Cost of Care (TCOC) model.[49] The TCOC model has the following components:1) prospective global budgets across all payers for hospitals; 2) incentives to reduce total costs of care, overall and for specific episodes of care; 3) waivers allowing hospitals to align incentives with other providers; and 4) the Maryland Primary Care Program to support practices in transforming care.

As described by Joshua Sharfstein in his October 11, 2021 presentation to the Commission on the Maryland global budgeting system, global budgets for hospitals and other institutions have a variety of advantages over fee-for-service payment. Most importantly, hospitals that are guaranteed revenue through a global budget can focus on reducing preventable admissions by implementing strategies to prioritize primary care, including supporting follow-up after discharge and care coordination, and by investments to improve community health. The status quo of fee-for-service hospital financing encourages hospitals to maximize revenue by investing in high margin/high technology areas, and in areas that will be attractive to privately insured patients.[50] In the TCOC model, the Maryland Primary Care Program is structured to incentivize primary care providers in Maryland to offer advanced primary care services to their patients and to encourage practices to reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements.

Sharfstein notes that hospital global budgets could, at least in Year 1 of UF, be based on the historical revenues for each hospital. Alternatively, the Year 1 budget could be based on historical costs at each hospital, which are on average about 4% less annually, or $4 billion, than hospital revenues.[51] If global budgets are based on historical costs, some allowance would be needed to accommodate capital investments to support new technology and replacement of facilities.

A variety of decisions will be needed about how global budgets would be implemented, with the most consequential ones described below:

- **Volume Changes:** How, if at all, will the budget adjust to changes in volume? As described above, one of the main advantages of global budgets is that they allow hospitals to focus on improving community health, and not on maximizing volume. However, if there are substantial volume decreases because a hospital closes a service, or substantial increases because a neighboring hospital closes, or shifts because a large medical group realigns its affiliation, then most would agree that a hospital's budget would need to be adjusted. A related question is whether fixed

[49] Maryland Total Cost of Care Model. https://innovation.cms.gov/innovation-models/md-tccm
[50] Sharfstein, J. M. (2016). Global budgets for rural hospitals. *The Milbank Quarterly*, *94*(2), 255; Rajkumar, R., Patel, A., Murphy, K., Colmers, J. M., Blum, J. D., Conway, P. H., & Sharfstein, J. M. (2014). Maryland's all-payer approach to delivery-system reform. *The New England Journal of Medicine*, *370*(6), 493-495; and Sharfstein, J. M., Gerovich, S., Moriarty, E., & Chin, D. (2017). An emerging approach to payment reform: all-payer global budgets for large safety-net hospital systems. *The Commonwealth Fund*.
[51] This average is based on the five-year period from 2014 to 2019, based on data from https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables. Note average operating margin declined to 0.7% in 2020 due to impacts from the pandemic.

global budgets that do not adjust for volume changes give hospitals incentives to reduce the availability of high cost services, and to stint on beneficial care.

- **Utilization Changes:** How much, if at all, should hospital budgets be adjusted to accommodate the expected increase in utilization as a result of eliminating uninsurance and underinsurance?
- **Capital Infrastructure:** What sort of approval process, if any, will be needed for major capital investment decisions, and how, if at all, should global budgets be adjusted for capital investments?
- **Equality Adjustments:** How, and how quickly, should resources be moved from the "haves" to the "have not" hospitals that currently vary in payer mix, negotiating leverage with payers and payment rates. For example, in the Los Angeles region alone, there are historically high priced hospitals that serve predominantly affluent populations in the west side of the county to financially weaker hospitals in other parts of the county that serve predominantly low-income people.[52]

Outpatient Providers

As discussed by commissioners, for physicians, mid-level practitioners, and other non-institutional providers, the UF authority would either set or negotiate fee-for-service based payment rates. Under the consulting team's scenario for direct payments under UF, aggregate payments to physicians would be equal to the weighted average of current Medi-Cal, Medicare, and ESI payments, minus estimated reductions in costs due to reduced billing and insurance related costs. One implication of UF is that physicians whose patients are currently primarily covered by private insurance will receive less revenue under UF than they do under the status quo, while physicians whose patients are primarily insured by Medicare or Medi-Cal will receive an increase in revenue. The analysis assumes that, because the UF system will be the only source of third party payment, all California physicians and other health care providers will participate in the UF system.

In addition to the inevitable redistribution of revenue, a variety of policy decisions are needed about physician payment, such as:

- Should payment for primary care be increased from status quo levels, and/or should payment for specialists be decreased? These decisions influence the ratio of primary care physicians to specialists, with implications for access, cost, quality and equity. Such policy decisions deserve a full evaluation.
- How could payment be used to increase the supply of physician services in underserved areas – both in low income areas of major metropolitan areas, as well as in the Central Valley and other areas of the state where physicians are in short supply?

Commissioner Comsti suggested that physicians and/or medical groups could choose to be paid a salary, rather than receive fee-for-service payment. Since this approach would be a

[52] California HealthCare Foundation. 2017. Los Angeles: Haves and Have Nots Lead to a Divided System. https://www.chcf.org/wp-content/uploads/2017/12/PDF-AlmanacRegMktBriefLA09.pdf

substantial departure from current practice, many design decisions would need to be made in order to implement such an approach, including[53]:

- How would the level of salary be determined? For example, Commissioner Comsti suggested existing salary structures could be a starting point for negotiations, with salaries adjusted based on factors such as years of practice, specialty, and serving a medically underserved area.
- For administrative simplification, would a medical group be limited to choosing only one approach (fee-for-service or salaries)? For physicians in independent practice, would they engage with the UF authority directly?
- Would the costs of operating the physician's office – including the cost of rent, equipment, utilities, and salaries for nurses and office staff – be paid by the physician or by the UF authority? If the former, how would the UF authority determine how big an allowance to provide each physician to cover those costs? If the latter, how could the UF authority efficiently review and make such payments in an efficient and responsible way?
- What would a medical group or physician need to agree to do to receive the salary? For example, would physicians commit to providing a certain number of hours of care (including for full time or part-time physicians) or seeing a certain number of patients?
- Given the size of California, how would the UF authority efficiently and effectively monitor whether the physician was fulfilling the agreement? Monitoring and compensation arrangements will need to handle a variety of scenarios, ranging from physicians serving more patients who may deserve higher pay, to situations in which physicians who receive upfront payments for care management or ancillary support underperform in their obligations.
- How would compensation arrangements affect California's ability to attract and retain physicians?

Purchasing Arrangements and Role, if any, for Intermediaries

One of the major decisions to be made in designing a UF system is whether payments will be made directly from the UF authority to hospitals, physicians, and other health care providers, or whether capitated payments will be made to health plans or health systems, which in turn make payments to providers. Commissioners engaged in several robust discussions on this question. Most commissioners supported capitated payments, with some remarking that the major advantage is that capitation provides health care providers and organizations the resources to coordinate care in order to provide high quality care and improve population health.

Commissioners supporting the direct payment approach argued that any system in which medical groups are paid by risk-based capitation would inevitably lead to administrative

[53] Many physicians working in large medical groups are currently paid by salary, but the process by which a medical group negotiates physician salaries, monitors physician performance, and provides the physical and staff infrastructure for the physician's office is entirely different from a scenario in which a Unified Financing authority would perform these functions.

waste and provide incentives to stint on needed care, engage in unproductive efforts to attract enrollees who are in relatively good health and avoid patients most in need of care. These divergent views were not resolved during the Commission process.

Each approach has advantages, but also raises significant concerns.

Direct Payment Approach

Direct payment would result in lower billing and insurance-related costs for physicians, hospitals, and other health care providers relative to a system that uses health plans or health systems as intermediaries. Similarly, the costs of administering a direct payment system would be less than the costs of administering a system that uses plans or systems as intermediaries. Under the direct payment approach, physicians (at least those paid by fee-for-service) would not have any financial incentive to stint on needed care. (Hospitals receiving revenues determined by a global budget would have an incentive to stint, although this incentive could be attenuated if budgets are adjusted for volume.) A direct payment approach is also more compatible with patients being able to receive care from any provider, a UF design feature that some commissioners and members of the public associate with a "pure" single-payer approach and that some but not all commissioners prioritize.

Notwithstanding these benefits of a direct payment system, many commissioners expressed significant concerns about moving to a direct payment approach. As described in the Environmental Report, 60 percent of the payments to medical groups for Californians covered by Medicare or private insurance are made through capitation, with the percentage likely higher for Medi-Cal beneficiaries. Analysis conducted by the Integrated Healthcare Association suggests that health care utilization is lower for patients cared for by medical groups paid through capitation, and performance on standard quality of care measures is higher.[54] Commissioners supporting the use of risk-based capitation emphasized that capitation can help to create integrated systems of care, particularly to serve the needs of patients with complex care needs, and noted the difficulty of arranging well-coordinated services in a direct payment approach. These commissioners also argued that, in an environment in which patients choose among groups to enroll, medical groups receiving risk-based capitation would work at reducing the provision of low-value care, better align the number and types of physicians and other resources with the needs of enrolled patients, improve the quality and timeliness of care, and encourage available resources to be used to maximize population health.

Some commissioners asserted that California's long-standing reliance on health plans as intermediaries, including within Medi-Cal, reflected an intentional choice to delegate some of the responsibility for maintaining access and assessing appropriateness of care to entities other than a central, statewide authority. These commissioners noted that, given the sheer

[54] Integrated Healthcare Association, California Regional Health Care Cost & Quality Atlas, In Search of Value: How Well Do Commercial HMOs and PPOs Deliver?

size and geographic diversity of California, health plans have been used because their existing infrastructure and relationships with providers allow them to more efficiently coordinate care. Some commissioners remarked that the direct payment approach would run counter to the trend of the Medi-Cal program increasingly delegating more responsibilities to managed care. This includes the mandatory enrollment of seniors and persons with disabilities into managed care, the transition of Healthy Families Program children into managed care, the Cal Medi-Connect (CMC) demonstration for dual eligible beneficiaries, and the upcoming transition of CMC beneficiaries into enrollment in aligned Dual Eligible Special Needs Plans (D-SNPs) and Medicaid managed care plans, also known as Managed Long-Term Services and Supports (MLTSS), under the California Advancing and Innovating Medi-Cal (CalAIM) waiver.[55]

Continued but Reimagined Role for Health Plans and Health Systems

At several points in commissioner deliberations, the view was expressed that if health plans or health systems were used as intermediaries under UF, the functions of those plans or systems should be quite different than the functions of health plans under the status quo fragmented financing. In the status quo, health plans administer a wide array of benefit packages and copayment structures, and have multiple contracts with providers (typically, separate contracts for Medicare, Medi-Cal, and ESI, and often multiple contracts for ESI). In the status quo, with the partial exception of Kaiser, membership turnover is common, caused by a myriad of factors such as gaining or losing employment, no longer qualifying for dependent coverage, changes in the plans offered by an employer, gaining or losing Medi-Cal coverage, or changes in availability or supplemental benefits offered by Medicare Advantage plans.

Under UF, all health plans or systems would be required to offer the same set of benefits and – if copayments are used at all – the same copayment structure. Each plan or system will have a single contract with contracted health care providers. As in Medicare Advantage, maximum payment rates for out-of-network services would be set by the UF authority as described above, although health plans or systems might negotiate other rates or forms of payment (such as capitation) with providers. With permanent consumer eligibility and a relatively stable landscape of plans and systems, each plan or system could anticipate a much more stable pool of members from year-to-year. Uniform benefit packages, a uniform data system, and the expectation of large and relatively stable membership would make much more transparent the performance of plans or systems in assuring access to care, reducing disparities, and improving population health outcomes.

Some commissioners also expressed interest in reimagining which organizations could play some or all of the intermediary roles currently held by health plans or health systems. For example, Commissioner Chin-Hansen raised the Program for All-Inclusive Care for the Elderly (PACE) providers as examples of entities that receive capitated payments and are

[55] The State will also require Medicaid managed care plans in all other counties in the state to establish D-SNPs and offer aligned enrollment as of 2025.

held accountable for the well-being and clinical outcomes for people who would otherwise require care in nursing homes. Commissioner Flocks suggested that community-based organizations, unions, clinics, or nonprofits may be able to play an expanded role in care coordination under UF. Commissioner Ross suggested a new type of intermediary called Recovery and Equity Councils or Accountable Communities for Health, which would be responsible for linking individuals with health-related social needs to community resources, facilitating partnerships and alignment among and across organizations and sectors, and addressing root causes of poor health, including structural racism at the community level.[56]

Commissioner Lee remarked on the importance of having "an organizer" in the health care system that takes a comprehensive view and noted that this does not have to be the health plan. Commissioner Lee indicated it is impractical to have 70,000 individual doctors and their teams coordinate care given the complexity of consumers' needs, with many requiring concurrent behavioral health treatment and inpatient and outpatient care for physical health needs. Commissioner Lee suggested the State of California, acting in the interest of consumers instead of corporate profits, could hold contracted intermediaries accountable for performance on access, quality of care, and equity but will need reliable data in order to send consistent signals to providers on payment and accountability.

In comments on an earlier draft, Commissioner Flocks observed that integrated health systems are core to California care delivery. She encouraged "seeing if there's a way to engineer payments that support [existing] models but do not involve the drawbacks of the current system of payments or reliance on health plans as intermediaries." In other comments she urged an end to "corporate profit-taking" under UF. Commissioner Wright imagined building on existing health systems and perhaps adjusting the role of local Medi-Cal initiatives to coordinate care. He too noted that care coordinators (discussed further below) "would not be the for-profit insurance companies of today."[57]

Systems of Accountability for Access, Equity, Efficiency, Quality, and Outcomes

Whether California were to use the direct payment approach or intermediaries via health plans or health systems, a consistent theme in commissioner discussions was that UF should implement systems of accountability to assure improved access, equity, efficiency, quality of care and health outcomes. Under systems of accountability, the UF authority will need to answer key questions in order to transparently measure performance and take action when necessary: (1) who is being held accountable? (2) who are they accountable for? (3) what are they accountable for? and (4) what are the levers to assure accountability? In discussing systems of accountability, Commissioner Scheffler noted that risk-based capitated payments made at the organizational level provide the resources to provide high quality care and improve population health via integrated delivery systems. Commissioner Scheffler recommended that the UF Authority ought to create "health equity scores" for

[56] Comments by Commissioner Robert Ross on Analytic Methods and Assumptions, August 2021.
[57] See summary of commissioner comments on March 17 draft, available at https://www.chhs.ca.gov/wp-content/uploads/2022/04/HCFA-Commission-March-Survey-Report-2022.pdf

plans and providers and that those with unacceptable scores on quality and equity should receive reduced resources and/or payments. Commissioner Flocks also emphasized the importance of the UF Authority having levers to distribute more health care resources to providers in medically underserved areas experiencing inequities and health disparities, often due to racism and biases. Commissioner Flocks noted that payment, including additional upfront payments to providers, can be used to support such equity goals, even in the absence of risk bearing intermediaries.

Invited speaker Dana Gelb Safran offered two policy approaches to acknowledge the differential resources that may be required to achieve desired outcomes in socioeconomically vulnerable populations.[58] Safran emphasized that adjustments should be made to payment, rather than lowering expectations for performance scores among more at-risk populations. Under the first approach, payment adjustment would be applied prospectively with increased upfront payments to providers who care for populations with greater social risk in recognition of the extra resources required to care for these populations. Under the second approach, the payment method would be applied through performance incentive payments—establishing a multiplier such that those serving a population with greater social risk would be rewarded more for achieving the same level of performance as their peers serving a more advantaged population. Commissioner Comsti raised concerns about limitations in risk adjustment methods and potential financial harm to providers serving vulnerable populations in any system in which payment to providers is contingent on measured performance.

Care Coordination

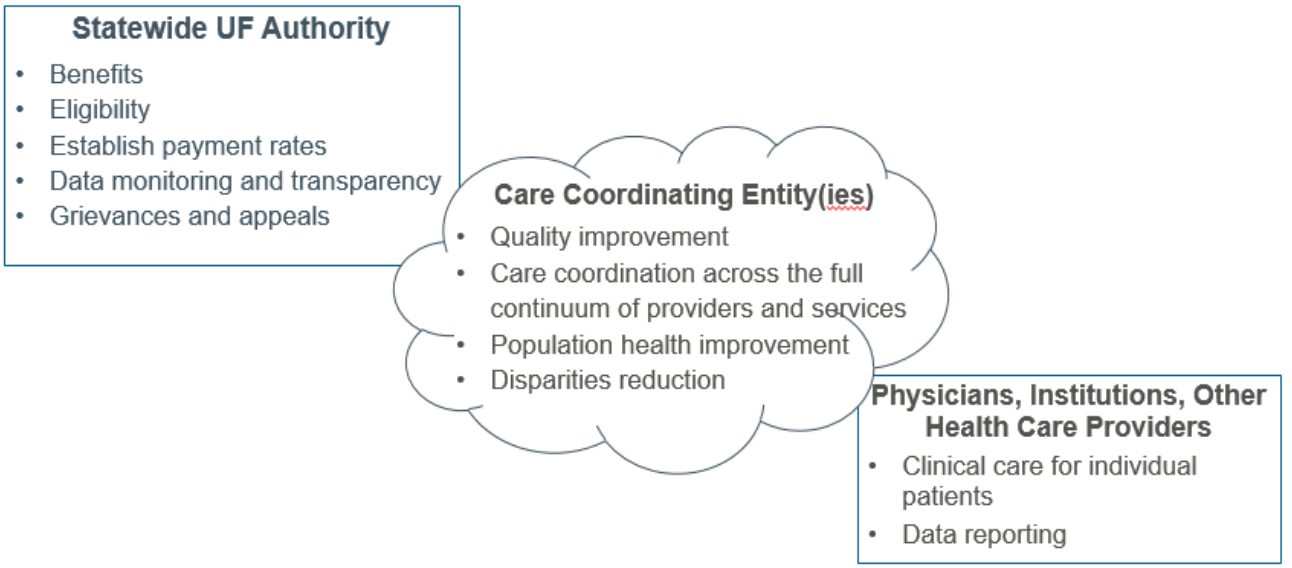
A conversation at the February 23, 2022 Commission meeting focused on the potential need for an entity or entities that could assist in care coordination across the full continuum of providers and services. As visualized in Figure 6, the premise of the conversation was that under UF, a statewide authority would be responsible for core functions related to establishing benefits, eligibility, and payments and ensuring transparency. Individual care providers, physicians and hospitals would be responsible for excellent clinical care for the individual patients they serve, and to report data on quality and access. In order to assure that all Californians receive care that is well-coordinated and high quality, the discussion explored how care coordination function in between those two levels could best be carried out.

Commissioner Sandra Hernandez underlined the importance of data systems to share information in real-time to support care coordination. Commissioner Pan noted that care coordination was best conducted close to the point of care, but indicated that payment levels and payment structures should allow health providers to direct resources in ways that advance care coordination. Commissioner Baass encouraged a vision of coordination that included both health care and social supports, particularly for vulnerable populations.

[58] "Addressing Social Risk Factors In Value-Based Payment: Adjusting Payment Not Performance To Optimize Outcomes and Fairness", Health Affairs Blog, April 19, 2021.

Commissioner Comsti questioned the appropriateness of any corporate structure playing a role in care delivery or coordination. Commissioner Wright encouraged commissioners to imagine a future system in which coordinating entities competed to deliver the highest quality care for people with complex conditions such as diabetes and heart disease. In summary, the commission discussion noted care coordination is important and must be done by some entity; that generally speaking, it was desirable to keep that role close to the patient with most decisions guided by primary care providers; that accountability and transparency are needed in order to assure that care is well-coordinated; and that it was important to attend to population outcomes as well as individual health indicators.

Figure 6: Care Coordination and Care Delivery



Greater Efficiency and Cost Containment

Many aspects of system design will influence total health care spending. For the system to be sustainable over time, aggregate spending targets will need to be established and achieved. Via the December survey, Commissioner Flocks offered the view that a key precursor to legislative and/or voter approval of UF was demonstration that the UF system would be sustainable. Through the same survey, 8 of 11 responding commissioners indicated that to "Establish and implement a prospective per capita health care spending target" would be a "very important" step on the path to UF and 4 commissioners said this was among the top three "most important" steps. As described above in the Analytic Findings section, UF provides both strong motivation and expanded levers to exert spending discipline. The levers include: global budgeting for hospitals; purchasing power over pharmaceuticals similar to that exerted by governments in other developed nations; the ability to control prices paid to physicians and other non-institutional providers; substantial reductions in administrative costs; enhanced ability to combat fraud and abuse; and, potentially, strengthened incentives for medical groups to figure out how to deliver high

quality care efficiently. The nature of financing agreements and governance arrangements, both discussed in more detail below, will play a crucial role in system sustainability.

In comments on an earlier draft, Commissioner Hsiao offered several cost containment strategies to advance progress toward UF. These included:

1. Conducting research to estimate administrative burden of providers due to a multi-payer health care system and potential administrative cost savings under UF;
2. Requiring hospitals and imaging laboratories to use standard cost accounting methods;
3. Setting an annual prospective health expenditure benchmark for California with a stated cap on the increase in health spending;
4. Establishing policies to control monopolistic pricing and high profits among health plans and providers;
5. Reducing drug prices through purchaser alliance bargaining with pharmaceutical companies;
6. Identifying and engaging firms with the expertise to identify claims fraud and overbilling; and
7. Timely development of a uniform clinical record and statewide claims record system.[59]

Care Delivery and Workforce

Many design decisions – including how provider payments are structured, how care coordination is provided, how costs are managed, and many others – will influence how care is delivered and the extent to which the ultimate goals of accessible, affordable, equitable, high quality and universal care are achieved. Although the Commission charge and its discussions did not go at length into the ways that care delivery would be enhanced under UF, throughout the process many commissioners offered suggestions. For example, Commissioner Antonia Hernandez urged that a new system rely on and fully support community health centers and health clinics, particularly in underserved regions, because they are well-equipped to meet Californians where they are with respectful, culturally sensitive care. Commissioner Ross encouraged California's future system to learn from experience under the California Accountable Health Care Initiative (CACHI) through which regional and local partnerships extending far beyond traditional health care providers work in concert to advance health equity. [60]

[59] The California Department of Health Care Access and Information is currently implementing a state all-payers claims database, which is known as the Health Care Payments Data Program (HPD). It will begin producing initial analytical reports after July 1, 2023.
[60] https://cachi.org/

Many commissioners reiterated the importance of investing in and supporting California's future health care workforce. Current workforce gaps and recommendations for targeted improvement strategies have been reviewed and discussed extensively by other bodies.[61] As California moves from the COVID-19 crisis to recovery, there are significant workforce proposals currently underway, with critical implications for the health of Californians.[62]

Under a UF system, design features must prioritize workforce development in order to achieve the Commission's vision of an improved health care system that is accessible, affordable, equitable, high-quality, and universal. The need to improve the representation of diversity within the workforce was elevated frequently throughout the Commission process. The Community Engagement process also highlighted that people in communities that have been marginalized or excluded as a result of systemic racism or other biases – people of color, immigrants, LGBTQ+ people, people who speak languages other than English, and people with disabilities – report stigmatizing and disrespectful treatment when they access care and often experience worse health outcomes. Through its design decisions, the UF system will need to grapple with these issues and create accessible opportunities to recruit, train, hire and advance an ethnically and culturally inclusive health and human services workforce. Strategies may include payments that adjust for equity, such that providers serving more socioeconomically vulnerable populations receive upfront payments or higher payment to achieve the desired outcomes.[63]

Adding LTSS as covered services will increase demand among Californians eligible for these services. Recruiting, training and organizing this workforce will take time and considerable effort. It also poses an important opportunity to improve the structure of these services and ensure we provide different models of LTSS based on cultural needs across California.

Financing

Obtaining Federal Government Permissions and Funding

UF cannot be accomplished in California without federal support. Commissioners disagreed about whether federal participation in UF could be accomplished through existing Medicare, Medicaid, and ACA waiver authority, or whether changes in federal law would be required. In a discussion on the state/federal relationship and financing mechanisms at the September 23, 2021 meeting, Commissioner Carmen Comsti offered the view that California could seamlessly integrate federal programs into a state single payer or unified financing system via existing federal waivers – and that no changes are needed in federal

[61] See, for example, the following reports: Future of Work Report; Quality Jobs Are Essential: California's Direct Care Workforce and the Master Plan for Aging; Master Plan on Early Learning and Care; Building an Inclusive Health Workforce in California: A Statewide Policy Agenda

[62] The workforce proposals are described in the section, Steps on the Path to Unified Financing under State Authority.

[63] For more discussion, see the section, Systems of Accountability for Access, Equity, Efficiency, Quality, and Outcomes.

law. At the same meeting, Commissioner Andy Schneider argued that the federal Secretary of Health and Human Services has no authority, by waiver or otherwise, to transfer federal Medicare or Medicaid funds to a state for a unified financing system. In Commissioner Schneider's view, if California wants to use federal Medicare and Medicaid funds as part of a unified financing system, including single payer, it will need to persuade the Congress and the President to change federal law.[64]

Some commissioners noted that even if a favorable agreement with the federal government is reached on Year 1 financing and on the rate of growth of federal payments over time, there is risk that the federal government could change the terms of that agreement in the future, (e.g., a different federal Administration or changes in federal law), and potentially leave California to shoulder an increasing financial burden. California policymakers and voters would need to assess the level of risk posed by potential future federal action, and whether that level of risk is acceptable. That risk would be higher if UF were implemented by an HHS waiver (if that were legally possible) than it would be if it were authorized and implemented under federal law. Although federal statutes could be altered by a future Congress, some protection is afforded by the size of California's Congressional delegation and the difficulty of enacting federal legislation. While there are also limits on the ability of a future Administration to change the terms of a waiver, it would be much easier to change waiver terms compared to enacting new legislation. This is particularly true if a waiver expires during the term of an administration that is not supportive of UF in California.

Given the uncertainty about whether federal support for a state-based UF system could be obtained through existing Medicare, Medicaid, and ACA waiver authorities, or whether changes in federal law would be required, CalHHS sought additional clarity from Brown & Peisch, a law firm that specializes in federally-funded health and benefit programs, including Medicaid, Medicare, and the Affordable Care Act.

In response, Brown & Peisch provided a legal memo included as Appendix C. Key points include:

- There is no single federal waiver authority that would allow the federal Department of Health and Human Services (HHS) to redirect federal funds for Medicare, Medicaid (Medi-Cal), and Affordable Care Act (ACA) advance premium tax credits. Instead, each funding stream is subject to different authorities that permit HHS to waive certain federal requirements and limitations.

- Pursuing a UF model would require stitching together various authorities, each of which has its own requirements for approval and most of which shift substantial financial risk to the State. There are relatively straightforward paths with respect to Medicaid and the ACA-covered population; however, these paths may be complicated by the size and diversity of California's population. California might be required to continue to track consumers who are Medicaid-eligible as CMS is unlikely

[64] See slides and meeting synopsis from September 23, 2021 Commission meeting.

to depart from the basic principle that it can only match state expenditures under the statutory formula. Although there are legal authorities that may allow for redirection of Medicare funding, the challenges are much greater than in obtaining waivers for Medicaid and the ACA-covered population and will depend in significant part on the current federal administration's interest in supporting a state-based unified financing system. Exercise of that authority would be unprecedented and politically challenging because the state would be seeking to assume responsibility over benefits to which Medicare beneficiaries are entitled by statute and might be seen as interfering with Medicare beneficiary freedom of choice of providers. In addition, there may be federal resistance to ceding authority to the state or compelling providers to participate in a new payment and service delivery model.

- An alternative that would allow California to better pursue full UF is enactment of new federal waiver authority to allow states to use federal funding from existing health care programs, including Medicare, Medicaid and the ACA exchanges, to deliver comprehensive health care coverage. As an example, proposed legislation such as H.R. 3775, the *State-Based Universal Health Care Act*, would provide the necessary authority for HHS to direct federal funds to California as a lump sum.

In feedback on an earlier draft, some commissioners expressed the view that persuading the federal government to relinquish funds and responsibility for Californians now eligible for Medicare to a state-based UF authority would pose substantial political challenges. Even if California Medicare beneficiaries support UF, these commissioners believe that Medicare beneficiaries and advocates in other states, wary about any changes to existing Medicare statutory health rights, would mount strenuous opposition. If this opposition materializes, Californian's future efforts may need to consider a "partially-unified" approach in which Medicare is not included, at least at the outset.

State Requirements Related to Raising and Using Funds for UF

Providing that federal permission and federal funding are secured, state-level decisions will be needed about how to repurpose the approximately $200 billion that is currently spent on employer and employee-paid premiums, out-of-pocket spending, and other sources. California cannot operate with a budget deficit; thus careful financial planning and appropriate financial reserves will be crucial in order for unified financing to succeed and remain sustainable over time.

Provisions of California's State Constitution and other laws enacted by voter initiatives constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to health coverage or health spending. Voter approval would be required to amend these provisions to allow for unified financing.

- Article XIII A (added by Proposition 13 of 1978) requires a two-thirds vote of the Legislature to increase state taxes and limits the ability to raise taxes on property

- Article XIII B (added by Proposition 4 of 1979, often referred to as the State Appropriations Limit or "Gann Limit") limits appropriations of proceeds of tax revenues for most operating expenditures to state fiscal year 1978-79 levels adjusted for inflation and population growth.

    - The scope and cost of unified health care financing system would exceed this limit. Voters could exempt funds raised to support the unified health care financing system from the State Appropriations Limit. Voters have approved such exemptions in past instances, for example, sections 12, 13, 14, and 15 of Article XIII B.

- Article XVI, Section 8 (added by Proposition 98 of 1988) requires about 40 percent of General Fund revenue to be allocated to K-12 schools and community colleges.
- Article XVI, sections 20-22 (amended by Proposition 2 of 2014) requires 1.5 percent of General Fund revenue and certain excess capital gains revenues to be deposited in budget reserves and be used to pay down state debts.

    - The Legislature could deposit revenues raised to support the unified health care financing system in a special fund to not impact Proposition 98 and Proposition 2. Given the amount of funding required to support a unified health care financing system, voters could amend the State Constitution to explicitly affirm the exemption of such funding from Proposition 98 and Proposition 2.

The State Constitution and initiative statutes also constrain the Legislature's ability to redirect funds from certain existing health care programs (to a unified health care financing system or for other purposes) as follows:

- Article XI, section 15 and article XIII, section 25.2 (amended by Proposition 1A of 2004) limits the ability of the Legislature to redirect certain local government revenues; some local government funds are currently used to support certain health care programs administered by local governments.
- Article XIII, section 36 (amended by Proposition 30 of 2012) guarantees that certain tax revenues will be provided to counties to pay for services realigned in 2011 including certain mental health services and substance abuse services in Medi-Cal.
- Article XVI, section 3.5 (added by Proposition 52 of 2016) requires voter approval to substantively amend the Medi-Cal Reimbursement Improvement Act of 2013 which imposes fees on private hospitals and uses fee revenue to draw down federal Medicaid funds to support Medi-Cal hospital payments
- Article XIII, section 36 (amended by Proposition 55 of 2016) increases personal income taxes through 2030 and requires up to $2 billion annually to be allocated to Medi-Cal if certain state budget conditions are met. As of 2022, this provision has not come into effect.
- Proposition 99 of 1988 and Proposition 56 of 2016 impose taxes on tobacco products and require a portion of those revenues to be allocated to specified state health care services programs and to increase funding for existing Medi-Cal programs and services. In state fiscal year 2021-22, tobacco revenues dedicated to health care are projected to total approximately $1 billion.

- The Mental Health Services Act (Proposition 63 of 2004) generates revenue from a one percent tax on personal income in excess of $1 million and requires the revenue to support various mental health programs, primarily at the county level. In state fiscal year 2021-22, revenue raised by the Mental Health Services Act is projected to total approximately $3.7 billion.
- The Control, Regulate and Tax Adult Use of Marijuana Act (Proposition 64 of 2016) levies excise taxes on the cultivation and retail sale of both adult-use and medicinal cannabis and requires the revenue to support various cannabis legalization related activities, including education, prevention, and treatment of youth substance use disorders and school retention. In state fiscal year 2021-22, revenue raised by the Control, Regulate and Tax Adult Use of Marijuana Act for education, prevention, and treatment of youth substance use disorders and school retention is projected to total approximately $401.8 million.

    - Voters could amend the State Constitution to allow these funds to be redirected to a unified health care financing system notwithstanding any other law.

Governance

In order to ensure goals are met and funds are well-managed to achieve desired ends, effective and trusted governance arrangements for the UF system will be required. Legislation to establish a UF governing body would articulate the goals and responsibilities of the body as well as its membership requirements and its relationship with elected and appointed state government officials.

The goals of the governing body would presumably have much in common with the goals and vision of the Healthy California for All Commission. The tasks of the governing body would include an array of program policy and management matters, such as establishing and updating provider payment arrangements, establishing performance reporting and conducting budgeting and financial oversight, among many others.

The size and membership of the governing body would be influenced by considerations such as knowledge and expertise across key domains including health care delivery, financing, law and public health coverage programs; reflection of California's diversity, including consideration of geographic, racial, ethnic and language, and socioeconomic differences; and avoidance of real or perceived conflicts of interest. Effective governance will require clear and robust prohibitions on conflicts of interest. Conflicts of interest could take many forms but would include, for example, the disqualification of any individual or employee of an organization with a direct financial interest in the decisions of the body.

The enabling legislation for a UF system will need to establish a governing body. At the outset, the state UF authority will need to establish and maintain trust and credibility with members of the Legislature and with federal authorities, as well as members of the public, health care providers, and others with a stake in the current or future health care delivery system. To serve the UF system's mission, it will be important to incorporate the perspectives of diverse and representative Californians, including those with low incomes, in

decisions and oversight. Although it can be challenging, to take time to invite and incorporate authentic community voices, it is essential in order to achieve more equity and inclusivity in the UF health system envisioned for our state.

California has experience in establishing health authorities that have balanced these goals, although not at the scale that will be required for a statewide UF system. For example, the Managed Risk Medical Insurance Board (MRMIB), which over its existence from 1991 through 2014 administered health programs including the Major Risk Medical Insurance Program (MRMIP), Access for Infants and Mothers (AIM), and Healthy Families also established norms of transparency and accountability in governance of health care programs.[65]

In 2010, following the passage of the ACA, California established the Health Benefit Exchange, now Covered California, as an independent public entity within state government. Its uncompensated five-member board, appointed by the Governor and the Legislature, must not be employed by or have a financial interest in health care providers, plans or trade associations.[66] Covered California imposes conflict of interest disclosure requirements for executive staff.[67] Bagley-Keene open meeting requirements impose transparency requirements. Although Covered California's ability to maintain some contract confidentiality drew some early criticism,[68] more recently observers have noted its effectiveness in negotiating with plans and providers to advance statewide policy priorities.[69]

Beginning in 1983, almost 40 years ago, local public health authorities were created in California to operate locally run Medi-Cal managed plans. Today California has 16 local, nonprofit health plans operating in 36 counties throughout the state serving the majority of Medi-Cal beneficiaries enrolled in Medi-Cal managed care.[70] These local public managed care plans are created by county ordinance and in some cases by state statute and/or federal legislation as well. All of their Boards of Directors or Commissions are appointed under county ordinance by the County Board of Supervisors. The health authorities who operate Medi-Cal managed care plans all operate under the Ralph M. Brown Act, an open meeting law governing county government meetings with requirements similar to the state's Bagley-Keene Act.

Prior California legislative proposals to establish a single payer health system envision governance structures that would balance independence, expertise and accountability. A 2017 bill, SB 562 (Lara), would have established the Healthy California Board as an

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[65] An example of detailed reporting from MRMIB can be found in its 2006 Fact Book for the California Major Risk Medical Insurance Program. For commentary on MRMIB's contributions and historical legacy see Gorn, David, State Agency Nearing Extinction: 'We Have Accomplished Our Mission,' California Healthline, January 23, 2014.
[66] California Government Code Title 22 Sec 100500
[67] Covered California, Conflict of Interest Code, Final Amended Text of Regulations, January 16, 2020.
[68] California Healthline, "Should Covered California Be Allowed To Keep Secrets?" July 11, 2013.
[69] Levy, Noam, So You Think Obamacare is a disaster? Here's how California is proving you wrong, Los Angeles Times, October 7, 2016.
[70] Local Health Plans of California, accessed 12/21/21.

independent public entity governed by a 9-member board.[71] Board members were to be uncompensated and free of financial conflicts of interest. An uncompensated public advisory committee including a range of health care providers, labor and employers to advise the board was to have met regularly. Advisory committee meetings, like those of the Board, would have been subject to Bagley-Keene open meeting requirements.

Systems and Infrastructure

Health Data Exchange

Policy decisions and financial considerations are of central importance in designing a system of unified financing and have obvious implications for how and how well the system works. Less visible, yet also crucial, is the underlying infrastructure needed to exchange health information and track financial and clinical activity. While parts of California's health care system rely on coordinated, interoperable electronic systems, other parts rely on decentralized, manual, and siloed systems of clinical and administrative data exchange that is voluntary in many situations. Consumers are too often left responsible for communicating their information and facilitating hand-offs from one provider or care setting to another; those who are most frail and sick are least able to play this role.

Safe and secure health information exchange across health and social services systems serving specific needs of individuals is fundamental to supporting individual and population health and wellbeing for several purposes, including but not limited to: addressing acute, chronic, or complex health needs; managing care across the continuum of services; supporting public health and emergency response efforts; and coordinating health and social services for individuals transitioning from incarceration and back into the community. Commissioner Wood and other commissioners noted the importance of health information exchange in supporting efficient, high-quality health care (under UF and otherwise).

Currently, key data exchange barriers faced by organizations include: technical infrastructure gaps for entities that often lack EHRs, such as small or rural providers, behavioral health providers, long-term care providers, and correctional health care facilities; data exchange barriers, such as fragmented data sources that limit the availability of a comprehensive health record or limited connections with payers, behavioral health and social service providers; and a lack of clear policies and requirements to share data between payers, providers, hospitals, and public health systems, resulting in hesitancy among organizations to share data.

To achieve the vision of a UF system, secure and seamless electronic health information exchange across the state will be required, including security provisions to assure consumers control the use and distribution of their information, as well as progress toward form and data standardization. Led by CalHHS, the Data Exchange Framework workgroup began meeting in August 2021 and seeks to establish a single data sharing agreement and

[71] SB 562, The Healthy California Act (2017-18), February 17, 2017.

a common set of policies and procedures to govern and require the exchange of health information among health care entities and government agencies in California. The Data Exchange Framework has articulated a vision that "every Californian, and the health and human service providers and organizations that serve them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing."

Potential follow up actions after the Data Exchange Framework enables routine data sharing include exploring the benefits and feasibility of implementing a uniform clinical data record, as advocated for by Commissioner Hsiao.

Unique Patient Identifier

The development and assignment of a unique patient identifier for every eligible resident will be required to facilitate eligibility and enrollment and payment of services, either through direct payment approaches or use of health plans or health systems. A unique patient identifier ensures accurate matching of an insured resident with a patient claim issued by a rendering provider[72] and is critical for matching the patient's identity with the correct treatment or service for patient safety reasons.[73] It would also advance a longitudinal health record for residents, and more readily allow for residents to control access to their information.

Data on Race, Ethnicity and Language and Sexual Orientation and Gender Identity

Data collection and reporting is important not just to simplify interactions between consumers and health care providers. Collecting and reporting standardized data is also essential for managing costs, reducing fraud and abuse, and assessing quality. Given California's diverse population and well-documented disparities in health outcomes, a transformed health care system would capture Race, Ethnicity, and Language and Sexual Orientation and Gender Identity (REaL/SOGI) demographic data and would stratify key outcome indicators accordingly.

Claims and Encounter Data

In order to track outcomes and manage resources, under UF it will be important to carefully monitor spending and service use at a granular level. The UF authority will need to capture

[72] Provinces in Canada's single payer system issue each resident with a card and unique ID to establish eligibility and issue payment to providers. Health plans in the U.S. also use their own unique identifiers for enrolled members to ensure proper payment, benefits administration, and to reduce potential for fraud.
[73] Today, regional and national health information exchange organizations (HIOs) implement expensive patient matching services that are driven by a set of incomplete demographic characteristics (name, date of birth, gender, address, and etc.). Patient matching results are uncertain and ambiguous as they rely on patient matching algorithms based on probabilistic or deterministic patient matching logic. Implementing a unique patient identifier would resolve this longstanding challenge and improve data exchange processes.

comprehensive and timely claims, encounter and/or payment data. Such data collection could build on existing state initiatives to develop an all payer claims database, the Health Care Payments Data (HPD) program administered by California's Department of Health Care Access and Information (HCAI). The need to carefully monitor spending and service use under UF will increase the value of the HPD as well as the CalHHS Data Exchange Framework.

Steps on the Path to Unified Financing under State Authority

Under the principle of a "Healthy California for All," the Administration has launched and implemented key initiatives to build the foundation of a unified financing system. In combination, these initiatives improve equity, transparency and accountability across the health care delivery system. Successful implementation of these initiatives will not only build the framework and infrastructure needed to move toward a successful UF system, they will increase confidence amongst the people of California in the ability of the state to transform the health care delivery system. The Administration has taken action to advance the overall well-being of California's 40 million residents and fundamentally reimagine the delivery system. While the Commission did not have an in-depth discussion of the Administration's key initiatives, the steps described below are informed by and supportive of the work of the Healthy California for All Commission.

Universal: The Administration's significant investments in recent years to expand coverage and increase affordability, along with the new proposal to cover the remaining uninsured in Medi-Cal, will bring California to near-universal eligibility for health care coverage.

- *Expansion of Medi-Cal to All Income-Eligible Californians* – Over the last decade, the Medi-Cal program has significantly expanded to cover children, young adults, and adults age 50 and over, regardless of immigration status. The Governor's 2022 Budget proposal expands full-scope eligibility to all income-eligible adults aged 26 through 49 regardless of immigration status, building on the prior year's expansion to older adults age 50 and over regardless of immigration status. If the Governor's proposal is approved by the Legislature, Medi-Cal will be available to all income-eligible Californians by 2024.

- *Individual Mandate and Marketplace Premium Subsidies* – The 2019 Budget Act instituted a state individual mandate to stabilize the health insurance market and authorized $1.5 billion over three years for state-supported premium subsidies at Covered California to provide additional financial assistance to low-income consumers and first-in-the-nation new subsidies for middle-income consumers who were not eligible for federal subsidies at the time. Because the federal American Rescue Plan Act (ARPA) provides significantly expanded federal subsidies through 2022, those have taken the place of the state subsidies, resulting in savings to the state. If federal ARPA premium subsidies are extended for calendar year 2023 and

beyond, the state may have the opportunity to invest these funds for affordability programs operated by Covered California starting in the plan year 2023.

Accessible: The Administration has undertaken multiple efforts to ensure Californians can better access care, such as ensuring that California's health and human services workforce reflects the state's ethnic and linguistic diversity, considerably expanding access to telehealth and behavioral health services, providing enhanced care management for enrollees with complex needs, and enabling care coordination through real-time exchange of health information.

- *Building a Workforce for a Healthy California for All* – The 2021 Budget Act includes increased funding for a number of programs that support workforce development, totaling over $140 million in one-time and ongoing funding, and the establishment of the California Health Workforce Education and Training Council at the Department of Health Care Access and Information to support and coordinate efforts for developing a health workforce that meets California's health care needs. The Governor's Budget for Fiscal Year 2022-23 proposes a substantial increase in state support for the health and human services workforce – a $1.7 billion investment over three years in care economy workforce development that will create more innovative and accessible opportunities to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, compensation, and health-equity outcomes.

- *Children and Youth Behavioral Health Initiative* – The 2021 Budget Act invested $2.9 billion over two years and $430 million ongoing, totaling over $4 billion over five years, to transform the behavioral health system for children in the state into a system that is prevention-focused, where all children and youth are routinely screened, supported, and served for existing and emerging needs.

- *Behavioral Health Continuum Infrastructure Programs* – The 2021 Budget Act invested $2.2 billion in funding for competitive grants for the construction, acquisition, and rehabilitation of facilities and mobile crisis infrastructure to expand the continuum of behavioral health treatment resources. The critical investment in capital infrastructure happening now will expand behavioral health capacity and support existing state efforts on behavioral health integration, CalAIM, the Children and Youth Behavioral Health Initiative, as well as homelessness.

- *Behavioral Health Services* – The Medi-Cal reprocurement requires managed care plans to implement "No Wrong Door" policies that include service coverage prior to determining a diagnosis, co-occurring treatment, the use of DHCS-approved standardized screening and transition tools for adults and children, and the concurrent provision of Non-Specialty Mental Health Services and Specialty Mental Health Services (SMHS). The reprocurement also includes contract requirements to

ensure prior authorization and other utilization review controls do not delay access to timely services.

- *Making Permanent Flexibilities for Telehealth* – Because social distancing was necessary to slow the spread of the coronavirus, many providers used telehealth, when clinically appropriate, to deliver services they would typically deliver to patients in-person. Under emergency authority pertaining to COVID-19, state regulators for health care service plans and health insurers issued directives beginning March 2020 that required: 1) reimbursing providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim; 2) for services provided via telehealth, not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person; 3) provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee. Learning from the experience of the COVID-19 pandemic, and the need to it, policymakers have codified many of these pandemic-related flexibilities through AB 457 (Santiago, Chapter 439, Statutes of 2021).[74] Given the importance of supporting greater access to scarcely available services in lower resourced communities, these efforts will help support timely access to care for millions of Californians.

- *Medi-Cal Enhanced Care Management Benefit* – Medi-Cal enrollees with complex needs must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder, and long-term services and supports. Under CalAIM, the ECM benefit will address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home. Additionally, enrollees will have connections to Community Supports to meet their social needs, including medically supportive foods or housing supports. Enrollees will have a single Enhanced Care Manager who will coordinate care and services, making it easier for them to get the right care at the right time.

- *Enabling Care Coordination through Health Information Exchange (HIE)* – The 2021 Budget Act puts California on a path to building a single data sharing agreement that will govern real-time HIE beginning in June 2024. The agreement will be designed to

[74] Prior to the passage of AB 457, AB 744 (Aguiar-Curry , Chapter 867, Statutes of 2019), barred health care service plans and health insurers from requiring in-person contact to occur prior to initiating telehealth services, prohibited limited the setting or providers that may use telehealth, required payment parity between health care services delivered in-person and through telehealth, and required obtaining patient consent prior to the utilization of telehealth, and allows all forms of telehealth (e.g., phone only, video, synchronous and/or asynchronous). Under AB 457, the effective date associated with AB 744 was removed, which extended the bill's requirements to all state-regulated health plans, except for Medi-Cal plans.

enable and require real-time access to, or exchange of, health information among providers and payers through any HIE network, health information organization, or technology that adheres to specified standards and policies. The vision is "every Californian, and the health and human service providers and organizations that serve them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing."

Affordable: The Administration will hold the health care industry accountable for increasing costs, to ensure that health care is affordable for all Californians while ensuring that the health care system is sustainable over the long term.

- *Office of Health Care Affordability* – Accomplishing cost containment will require a comprehensive understanding of cost trends and drivers of health care spending across the state. The Administration will move forward with its proposal to establish an Office of Health Care Affordability (OHCA) to address underlying cost drivers and improve the affordability of health coverage, benefiting millions of working Californians. The Office will be charged with increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and improving market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care.

- *Health Care Payments Data Program (HPD)* – Ongoing implementation of a state all-payer claims database or HPD, enables the use of claims, encounter, and payment information to produce analyses, research, and public reporting to support transparency, oversight, and accountability of California's health care delivery system. In addition to supporting OHCA, the HPD will provide valuable insights for statewide system costs and utilization, disease prevalence, longitudinal and population-based outcomes analyses, and measures of health care equity and disparities. The HPD is on track to begin producing initial analytical reports after July 1, 2023 and evolve to support linkages between various datasets that can enhance quality and outcomes analysis.

- *Medi-Cal Rx* – Under Executive Order N-01-19, all Medi-Cal pharmacy services were transitioned in January 2022 to a single standardized delivery system for over 14 million Medi-Cal beneficiaries, including the transition of the Medi-Cal pharmacy services from managed care to fee-for-service. Medi-Cal Rx results in a consolidated state negotiation and purchasing system for Medi-Cal pharmacy, strengthening the state's ability to negotiate state supplemental drug rebates with drug manufacturers, and creates a uniform Medi-Cal pharmacy provider network and pharmacy utilization policy.

- *Reducing The Cost of Insulin through CalRx* – The insulin market has long epitomized the kinds of market failures that plague the pharmaceutical industry. The Administration is working on plans to bring generic insulin to the market in California that is priced at a fraction of current market prices, which often exceed $300 per vial. Success in addressing the insulin affordability crisis will lay the foundation for state-led manufacturing of additional low-cost generic drugs.

Equitable: The health care system alone cannot address all the factors that influence health and will need to partner with public health and other sectors to address social drivers of health. In addition to fortifying the public health infrastructure that benefits all Californians, the Administration has reoriented the Medi-Cal program, covering 14 million Californians, to explicitly focus on health equity.

- *California Advancing and Innovating Medi-Cal (CalAIM)* – A better Medi-Cal program is a key building block of California's broad commitment to building a healthier and more equitable state. As such, CalAIM encompasses a broad-based delivery system program and payment reform across the Medi-Cal program to move California's whole-person care approach to a statewide level, with a clear focus on improving population health and reducing health disparities and inequities. In particular, Medi-Cal will provide new enhanced case management benefits that include non-clinical community supports to certain high-need, hard-to-reach populations, with the objective of improving health outcomes for beneficiaries and other low-income individuals in the state. By extending supports and services beyond hospitals and health care settings and directly into California communities, CalAIM will meet people where they are in life, address social drivers of health, and break down the walls of health care

- *Fortifying the Public Health System* – The COVID-19 pandemic has underscored the need for investment in our public health infrastructure, both to respond to public health emergencies and to improve the overall population health of California's population. As a result, the 2021 Budget Act included $300 million General Fund per year for investments in public health infrastructure that will improve the health of all Californians by increasing collaboration between state and local governments, the work force, data collection and integration, and community partnerships.

- *Directing Non-Profit Hospital Community Benefit Funding to Community-Based Organizations* – State and federal community benefit laws require non-profit hospitals, which are exempt from most federal, state, and local taxes, to provide community benefits. To promote additional investment in community-based organizations (CBO) that are focused on public health efforts, the Administration proposes to require non-profit hospitals to direct a specified percentage of community benefit dollars to investments that address the social drivers of health.

- *Hospital Equity Reporting* – Assembly Bill 1204 (Wicks, Chapter 751, Statutes of 2021)[75] requires general acute care hospitals, acute psychiatric hospitals, specialty hospitals, and hospital systems to prepare and file with the Department of Health Care Access and Information (HCAI) an equity report analyzing patient equity data and providing plans by which identified inequities will be addressed. HCAI is also required to convene a Health Care Equity Measures Advisory Committee to provide recommendations regarding the measures to be used by hospitals, hospital systems, and integrated delivery systems in their equity reports.

- *Additional equity efforts include the DMHC Health Plan Quality and Equity Standards, described immediately below.*

High Quality: The Administration will hold health plans accountable for delivering high quality care that is safe, effective, timely, patient-centered, efficient, and equitable, as well as align efforts across multiple payers to maximize impact on quality and equity.

- *Health Plan Quality and Equity Standards* – The 2021 Budget Act requires the Department of Managed Health Care (DMHC) to establish health equity and quality benchmark standards for health plans and to hold health plans accountable to those standards. DMHC has convened a Health Equity and Quality Committee to provide recommendations, including effective ways to measure health outcomes through demographic data or other data related to race, ethnicity, or socioeconomic variables and approaches to stratifying reporting of results by demographic factors to determine impacts on health equity and quality.

- *Medi-Cal Managed Care Plan Procurement* - In February 2022, the Department of Health Care Services released a Request for Proposal (RFP) for its commercial Medi-Cal managed care plan contracts to redefine how care is delivered, what leads to health equity and healthy communities, how to better hold the health care delivery system accountable for transparency, quality and results. New contract requirements for managed care plans include: accountability for the quality of care at all levels of delegation, including justification for the use of delegated entities and subcontractors; emphasis on coordination and integration of care through enhanced and expanded Basic Population Health Management, Complex Care Management, and Enhanced Care Management to ensure needs of entire population are met across the continuum of care; health disparity reduction targets for specific populations and measures, annual reporting of health equity activities and findings, and development of equity-focused interventions to address identified health disparities and social drivers of health; and sanctions and surrender of a portion of profits if quality improvement benchmarks are not achieved. By re-bidding commercial Medi-Cal managed care contracts, California will ensure that managed care plans are

[75] AB 1204 (Chapter 751, Statutes of 2021) and amended Chapter 2 Section 127345 and newly created 127376 of the Health and Safety Code.

committed to, capable of, and accountable for meeting the state's goal of achieving a Healthier California for All.

- *Multi-Payer Alignment Efforts to Maximize Impact on Quality and Equity* – The Covered California Quality Transformation Initiative (QTI) is a quality improvement payment program intended to set direct and substantial financial consequences for qualified health plans (QHP) to improve the quality of health care and to reduce health disparities. Specifically, the QTI focuses on improving care for a focused number of clinically important conditions for which there are major opportunities for improvement and good measures in current use. QHPs that fail to meet specified quality levels will be required to make payments that may be as high as 4% of premium. Covered California, CalPERS and Medi-Cal together are responsible for coverage for over 17 million Californians and are working together to align contractual requirements to drive higher quality and more equitable outcomes. The benefit of multi-payer alignment is that providers are given a consistent set of signals to focus their improvement efforts for quality and equity. Covered California is working to align both the selection of measures and the existence of substantial financial consequences with other major purchasers, including the California Department of Health Care Services (DHCS), CalPERS, and the Centers for Medicare & Medicaid Services' (CMS) Medicare payment programs. For the year 2023-25 contract, measures for high blood pressure control, diabetes management, colorectal cancer screening and childhood immunization status will be tied to payments for performance that should, in alignment with other purchasers, drive higher quality and more equitable outcomes.

Priority Actions and Next Steps

This section begins by summarizing how unified financing will advance California's goals; summarizes input offered by commissioners via the December survey regarding important next steps; and concludes by identifying additional steps by CalHHS that can increase momentum toward UF after the work of the Commission concludes.

The "North Star:" Unified Financing

Through commissioner discussions, analytic findings and input via community engagement, the Healthy California for All process clarified that unified financing offers unique benefits and creates significant opportunities, beyond those available under the current system, to achieve goals of universality, improved equity, affordability, access and quality:

- **Universal:** UF would create universal coverage, filling the gap for the one in ten Californians under age 65 who lack insurance in our current system.[76] All Californians would receive a comprehensive package of health care services and coverage arrangements that do not vary by age, employment, income, immigration status, disability status, or other characteristics.

- **Accessible:** Expansion of coverage and elimination of underinsurance would result in the vast majority of Californians having a usual source of care under UF, compared to our current system in which 11 percent of insured Californians and 52 percent of uninsured lack a usual source of care.

- **Affordable:** Under UF, households would no longer directly pay monthly premiums, resulting in a significant improvement in affordability even after accounting for revenues repurposed from the non-federal amount currently spent on health care. If cost-sharing is used, it would be progressively structured with respect to individual or household income. Services such as LTSS and dental that many struggle to afford under the status quo would be covered with no or low cost sharing.

- **Equitable:** UF, by eliminating distinctions in care and coverage among Medi-Cal, employer-sponsored insurance, Medicare, non-group coverage, and the uninsured, would lead to a substantial increase in equity in how care is delivered. Well-crafted payment systems and accountability mechanisms would, over time, substantially improve access to care and provide additional incentives to providers for the care of vulnerable populations.

- **High Quality:** UF, by creating a simpler and more uniform system of coverage and payment, and by aligning incentives in a way that the status quo fragmented financing system cannot, has the potential to encourage health care providers and health systems to focus on improvements in care quality, in population health, on investments in primary care and prevention, and on reductions in disparities.

Today's fragmented financing structures impedes or prevents improvements in all these dimensions, whereas a system of unified financing would enable California to implement and spread improvements across the state. California is pursuing and could continue to build on policies that improve upon the status quo, such as coverage expansions in Medi-Cal or increased state-financed subsidies in Covered California to defray premium costs. However, despite an ambitious agenda of actions under state authority, described in the previous section, incentives and requirements imposed by fragmented payers would continue to impose administrative burden, dilute efforts to improve outcomes, and provide opportunities to game the system. Thus, a system of unified financing must be the "North Star" toward which future policy and programmatic efforts are directed.

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[76] This and subsequent statistics cited in this section come from the Overview of Analytic Findings presented to the Healthy California for All Commission on May 21, 2021.

Clearing a Threshold Issue: Federal Permissions and Federal Funding

As previously described, over $200 billion in annual health care spending within California is currently governed by federal authority and requirements related to Medicaid, Medicare, the Affordable Care Act and other federal programs. Thus, a threshold issue for California involves securing federal permissions to redirect and consolidate existing federal funding for Medicaid, Medicare, and ACA advance premium tax credits within a state unified financing system. An agreement with the federal government to include federal Medicare and Medicaid funds within the state UF system must also secure a sustainable rate of growth for redirected federal funds. The level of federal funding approved has direct consequences for the amount the state would need to repurpose from the non-federal amount currently spent on health care.

To resolve this threshold issue, the state should engage the federal Secretary of Health and Human Services and leaders within the Center for Medicare and Medicaid Services (CMS) to gain a better understanding of what could be accomplished through existing waivers, and what changes would require federal legislation. If necessary, the state should work with federal partners to advance legislation to enact needed federal waiver authority. The Newsom Administration has begun initial engagement with the federal government on state flexibility for health coverage programs through two letters sent to President Trump and President Biden. [77]

1) Provided there is federal waiver authority to proceed, the state would work with federal partners to specify the amount of federal funding California would receive under UF in Year 1 as well as the method of determining the growth rate of that funding over time.

2) The state would likely need to provide assurances to its federal partners that under UF, Californians previously enrolled in Medi-Cal, Medicare and eligible for ACA premium subsidies would receive benefits and protections commensurate or superior to those programs. The state would also need to assure that the design and implementation of the state-based UF system would not run afoul of federal Employment Retirement Income Security Act (ERISA) provisions, although this issue might well be resolved through potential legal challenges rather than be elevated as a concern by federal partners in the context of health care financing negotiations. (See Appendix D for further explanation of ERISA related challenges.)

3) With greater certainty on sustainable federal funding, the state could more definitively consider what portion of the non-federal amount currently spent on health care could be repurposed to support UF.

[77] One letter was sent to the Trump Administration on January 7, 2019 and another letter to the Biden Administration on May 25, 2021.

To achieve a sustainable agreement with federal partners, further specification of an approach that achieves California's vision and fits within an existing or new federal legal framework would be required. More on how to achieve that outcome is described below under the section titled Moving Forward.

Commissioner Perspectives on Priority Actions

Via responses to the December 2021 survey,[78] commissioners expressed broad agreement that all of the following activities "represent important steps on the path" to a Healthy California for All unified financing system:

- Establish and implement a prospective per capita health care spending target;
- Address workforce shortages in underserved domains and geographic areas with a focus on increasing the cultural and language diversity of these workers;
- Expand training for doctors, nurses and other clinical staff with a focus on equity and the important cultural differences between diverse groups across the state;
- Expand and standardize cost reporting for hospitals, medical groups, and other health care settings;
- Aggregate purchasing power among payers within the status quo to demonstrate success in negotiating payment methods and rates with pharmaceutical companies and/or other providers of health care services;
- Establish a statewide system for patient identification and clinical data exchange;
- Decide on a set of quality indicators that should be captured in initial stages of UF;
- Establish a uniform claims/encounter data system to capture and report data across all payers who deliver services under the status quo;
- Building on California's large integrated delivery systems, refine and expand efforts to align payments with value (i.e., pay for high quality);
- Establish global budgets and all payer rate-setting and begin to address existing payment variation;
- Identify specific options for raising revenues that would substitute for non-federal health care spending;
- Obtain legislative and/or voter approval for the revenue plan; and
- Secure from the federal government guarantees regarding the payments California can count on with respect to federal share of Medicare and Medicaid payment.

Agreement was not as strong on the following items; nevertheless, most responding commissioners also indicated that the following were important steps on the path to UF:

- Identify "winners and losers" under UF among providers, consumers, employers and other participants in the health care sector and develop plans to mitigate negative impacts;

[78] Commissioners' responses about the importance of various steps does not speak to how various steps should be sequenced or whether some steps are prerequisites for others.

- Establish global budgets and all payer rate-setting and begin to address existing payment variation; and
- Standardize and align contracts among payers for how they pay for care, including for improvements in cost, quality, and equity.

The December 2021 survey also invited commissioners to specify up to three activities they judged to be most important steps on the path to UF. In prioritizing the 15 items suggested (with open-ended responses also invited), Commissioners expressed diverse priorities. Among steps that attracted at least one "most important" vote among the 11 responding commissioners, responses are shown in Table 6 below.

Table 6: Commission Ranking of Potential Transition Steps. Number of Commissioners saying step is most important or very important.

Transition Step	Among 3 "most important"	"Very important"
Address workforce shortages in underserved domains and geographic areas	4	10
Establish and implement a prospective per capita health care spending target	4	8
Aggregate purchasing power among payers within the status quo to demonstrate success in negotiating payment methods and rates with pharmaceutical companies and/or other providers of health care services	3	10
Obtain legislative and/or voter approval for the revenue plan	3	9
Secure from the federal government guarantees regarding the payments California can count on with respect to federal share of Medicare and Medicaid payment	3	8
Establish global budgets and all payer rate-setting and begin to address existing payment variation	3	7
Identify specific options for raising revenues that would substitute for non-federal health care spending	2	9
Establish a statewide system for patient identification and clinical data exchange	1	10
Expand culturally sensitive training for doctors, nurses and other clinical staff	1	9

Transition Step	Among 3 "most important"	"Very important"
Establish a uniform claims/encounter data system to capture and report data across all payers who deliver services under the status quo	1	9
Building on California's large integrated delivery systems, refine and expand efforts to align payments with value (i.e., pay for high quality)	1	8
Identify winners and losers among providers, consumers, employers and other participants in the health care sector and develop plans to mitigate negative impacts	1	6
Other: Start with children and families	1	N/A
Other: Pass legislation on policy and establish governance structure	1	N/A

Moving Forward

The Commission's work has demonstrated that UF offers unique benefits and creates significant opportunities, beyond those available under the current system, to achieve goals of universality, improved equity, affordability, access and quality. Moving forward, California should further clarify its desired approach, continue conversations with federal partners, and be ready to act decisively as windows of opportunity open.

In order to navigate issues related to federal funding and permissions, an iterative process is likely to be needed in which California seeks further clarity via federal engagement, then consults with state constituencies and stakeholders to refine and specify its preferred approach, and then bring a specific proposal to federal authorities. Figure 7 illustrates that process.

Figure 7: Iterative Process to Clear Threshold Issue of Federal Permissions and Federal Funding

Commission deliberations have touched on a wide range of decisions and actions that will pave California's way to a system of unified financing. Acknowledging that some activities are not neatly confined to one stage, activities can be grouped into the following stages:

- *Lay the Foundation:* These activities set up the structures, resources and capabilities essential to supporting UF, but are not necessarily prerequisites to UF. Many are already underway and most yield benefits under existing financing arrangements, though their relevance will be heightened and their impact deepened under UF.

- *Obtain Federal Permissions and Refine Design:* As described above, a crucial step will be to secure federal permissions to redirect and consolidate federal Medicaid, Medicare, and ACA advance premium tax credits funds within a state unified financing system in a way that is predictable and sustainable over time. Engagement with federal authorities will bring into focus considerations and tradeoffs that influence the ultimate design of UF in California. These activities will define exactly what UF will look like and how it will affect Californians, health care providers, and institutions. As described at several points in this report, broad and deep community and stakeholder engagement is important in understanding and choosing among available options. If there is a pathway to clear the threshold issue of federal permissions and federal funding, a community and stakeholder engagement process can be convened to describe implications of options and alternatives, hear concerns, and incorporate priorities. Ultimately, a solid design and federal funding will secure

the resources and commitments required for California's move to UF and set the stage for smooth implementation.

- *Implement and Sustain:* Robust data reporting, transparent governance, and efficient operations will support an effective launch and allow the UF system to make course corrections as needed over time.

Table 7 provides *illustrative* tasks within each category. The move to UF will be a complex undertaking in a fluid context; it is not possible to list all the steps nor to anticipate the exact sequence in which they will unfold.

Table 7: Stages on California's Path to Unified Financing

Lay the Foundation	Obtain Federal Permissions and Refine Design	Implement and Sustain
• Build expanded, culturally sensitive workforce • Expand behavioral health capacity • Collect and use health care payments data • Achieve health information exchange • Fortify the public health system • Establish equity and quality standards • Standardize and align payments for care, including payments associated with cost, quality and equity • Demonstrate pharmaceutical cost savings • Implement cost containment measures	• Gain a clear understanding of what is specified and allowable under existing law and waiver authority with respect to federal permissions and federal funding • If necessary, work with federal partners to advance legislation to enact new federal authority • If there is a pathway to clear the threshold issue of federal permissions and federal funding, convene a robust community and stakeholder engagement to refine the following design priorities: 1. Specify eligibility and enrollment rules 2. Confirm covered benefits (including LTSS) 3. Determine if and how cost sharing will be used 4. Determine how to best operationalize prospective global budgets for hospitals 5. Determine payment approaches for outpatient providers and methods for equality focused payments or adjustments 6. Specify purchasing arrangements and role, if any, for organizer and/or intermediaries 7. Develop systems of accountability to transparently measure performance and take action when necessary: (1) who is accountable? and (2) what are they accountable for? 8. If sustainable federal funding for UF can be secured, develop options for repurposing a portion of the non-federal amount currently spent on health care • Through a public communications campaign, describe how UF can improve access, quality, equity and affordability yet reduce total health care spending relative to status quo fragmented financing • Establish governance structures • Support regional preparedness of providers and facilities • Establish, vet and refine standards for quality, access and equity • Establish funding reserves and contingency plans to deal with potential uncertainty	• If there is a feasible path on federal permissions and adequate and sustainable funding, secure statutory changes through the enactment of enabling legislation and/or voter approval through a ballot initiative • Govern with transparency and accountability • Manage data and conduct oversight to support smooth operations • Monitor outcomes and implement improvement strategies as needed • Update policies, payment levels and approaches, and revenue strategies as needed to achieve goals

Within the Laying the Foundation category, high level illustrative tasks listed are informed by the discussion in earlier portions of the report (Steps on the Pathway to Unified Financing under State Authority and Commissioner Perspectives on Priority Actions); these tasks can significantly reform the current system and be initiated immediately as the state seeks more clarity on federal permissions and funding. A more concrete, but non-exhaustive, set of next

steps – all of which would improve access, affordability, equity and quality under status quo financing, although their impact would be deepened under UF – include the following:

1. **Workforce:** Invest in and support a workforce that is diverse, that can meet the cultural, socioeconomic, and linguistic diversity of California's residents and that is responsive to consumer and patient needs.
2. **Enact Office of Health Care Affordability:** Establish health care cost targets and address cost drivers in order to slow growth in health care spending.
3. **Cost of Delivering Care:** Leverage existing data and identify data gaps that have to be overcome to understand the actual cost of delivering frequently performed medical services (such as inpatient care, imaging, etc.).
4. **Role of Health Plans:** Evaluate whether health plans under the status quo add value by furthering access, affordability, quality and equity while accounting for excessive administrative costs and profits and burden on providers. If health plans are retained and reimagined under UF, what functions would they perform?
5. **Uniform Clinical Data Record:** Once policies for data sharing are in place under the forthcoming Data Exchange Framework, explore the potential benefits and feasibility of developing a statewide uniform clinical record.
6. **Administrative Costs:** Further study of the administrative burden on providers under the status quo and potential administrative cost savings under UF.
7. **Fraud and Abuse:** Upon implementation of the Health Care Payments Data Program, identify and take action on claims fraud and overbilling.

Commission deliberations and steps within state authority that are already underway form a solid foundation for next steps. To make additional progress on the path toward unified financing – and to move from laying the foundation to obtaining federal permissions and refining design – CalHHS should secure and task dedicated staff and resources to develop and implement a strategy for engagement with federal partners on the necessary federal approvals to proceed with UF and identify the next steps that will be needed at the federal level. This process could start with informal engagement by CalHHS staff of their counterparts at the Centers for Medicare and Medicaid Services to determine the broad contours of what approaches the federal government is prepared to consider. If conversations with federal partners confirm there is a feasible path forward, CalHHS would engage with stakeholders to develop a full proposal that will need to:

1. Specify eligibility and enrollment rules
2. Confirm covered benefits (including LTSS)
3. Determine if and how cost sharing will be used
4. Determine how best to operationalize prospective global budgets for hospitals and other institutional providers
5. Determine payment approaches for non-institutional providers and methods for equality focused payments or adjustments
6. Specify purchasing arrangements and role, if any, for organizer and/or intermediaries
7. Develop systems of accountability to transparently measure performance and take action when necessary: (1) who is accountable? and (2) what are they accountable for?

8. Develop options for repurposing a portion of the non-federal amount currently spent on health care

A dedicated team within CalHHS, informed by engagement with federal authorities and tasked with convening stakeholders and developing a proposal, might be held accountable for the following deliverables:

- Reporting on options and feasibility related to obtaining federal permissions
- Prepare a draft specific design proposal, including recommendations on Items 1-8 above
- Community and stakeholder engagement to inform final design before submission

As discussed previously, California's success in moving to UF will demand creative legal, policy, and political solutions that take into consideration a range of stakeholder perspectives. Some decisions and actions that lie on the critical path to UF require further investigation and development of consensus across key constituencies that include health care providers, health care systems, employers, labor unions, and consumers including Californians with low incomes, Medicare beneficiaries, and people with employer-sponsored insurance. Since federal approvals may be contingent on specific assurances pertaining to the Medicare program, it will be critical to obtain the buy-in of Medicare beneficiaries by ensuring they understand what is being proposed, how they could benefit, and how any remaining concerns will be mitigated.

As a necessary step to build political support for UF, state leaders will need to engage with these key constituencies to gather their input on design options and transition plans.

- For providers and systems, discussion topics would include payment methods and levels and structures; how quickly to standardize payments; and what financial and health care quality reporting to require.
- For employers and labor unions, discussion topics would include pros and cons from employer and worker perspectives of options to repurpose a portion of the non-federal amount currently spent on health care.
- For the broader community, discussion topics could include access to care, enrollment, benefits, cost-sharing, provider networks and quality, and transparency.
- With all interested parties, topics could include options for delivery system design; the role for a coordinating entity or entities and the potential use of intermediaries; accountability indicators; and governance structures. Many stakeholders would also provide useful input regarding infrastructure requirements.

Navigating the threshold issue of federal permissions and federal funding may involve tradeoffs or impose constraints that have important implications for health care providers and employers. Thus two-way engagement with stakeholders explaining state-federal dynamics and soliciting their input will be important both symbolically and substantively in moving California toward UF. Meanwhile, several actions, such as those described above, can happen in parallel to build the foundation for a system of unified financing that is accessible, affordable, equitable, high-quality and universal.

Conclusion

The Commission, through its discussions and deliberations, determined that California should move toward a unified financing system for health care services. UF will increase California's ability to make health care more affordable, comprehensive and consistent; make accessing health care simpler and more reliable; address inequities and disparities in care and access; build an expanded and more appropriate workforce; and confront the inherent power imbalance that people with low incomes and people of color often experience in the existing health care system.

Unified financing will be a marked improvement relative to the existing fragmented health care financing and delivery arrangements which compromise access to services and quality of care for many Californians; add administrative complexity that create confusion and frustration among consumers; encourage many entities to prioritize profit over care; drive up spending without commensurate improvements in quality, equity or consumer experience; and lead to persistent inequities by income level, region, race and ethnicity. A move toward UF provides California more leverage to reduce the overall growth of health care spending and address affordability challenges. Even more importantly, unified financing will allow California to fundamentally reimagine the delivery system to more effectively advance the overall well-being of California's 40 million residents.

As California lays the foundation for UF, there are immediate opportunities to expand on efforts to build a culturally, racially and ethnically diverse health workforce; establish performance standards for equity and quality; improve transparency; achieve health information exchange; and demonstrate effective cost containment strategies in ways that support UF. Engagement with federal partners to better understand federal funding constraints and opportunities will help to further refine California's options. Informed by a deeper understanding of the federal context, California will need to clarify what features and design details will fit best within the California context, a process that should be informed by robust community and stakeholder engagement. As the design comes into focus, plans and a detailed timeline can be finalized, agreements secured, and implementation preparations begun. It will be important to begin early in the process to define what accountability looks like in terms of access, quality and equity standards while acknowledging that those standards will benefit from refinement over time. Throughout the development process, continued community engagement; engagement with health care providers and others involved in advocating for, arranging and delivering care today to vet and determine how UF will work; and strong and effective communications to demonstrate the advantages and potential of UF relative to the status quo will help set the stage for success.

There is a stark contrast between the potential of UF and the flaws of status quo health care. The Commission has helped identify and elevate next steps on the path toward UF, some of which are already underway. The continued commitment and leadership of dedicated Californians, including those who offered their time and expertise to this Commission's work, will assure California's continued progress toward a health care system

focused on delivering health and allowing all Californians an opportunity to live up to their full potential and ultimately creating a Healthy California for All.

Appendix A: Commissioner Survey "Goals and Propositions"

Through surveys the statements shown below were presented to commissioners who were asked to respond with "Agree," "Agree with slight modifications," "Disagree," or "Don't Know." Some of the statements presented via the November survey had been refined in response to input from the September survey. Reactions from voting commissioners are summarized in reports from the two survey cycles available at the Healthy California for All webpage. (See "Meeting Information" documents for September 28, 2021 survey synthesis and the November 17, 2021 survey report.)

September Statements	November Statements
Healthy California for All: A "Healthy California for All" envisions a California health care system that delivers safe, timely, efficient, equitable and person-centered care for all Californians through a system of unified financing.	Healthy California for All: A "Healthy California for All" envisions a sustainable California unified financing system for health care through which safe, timely, efficient, equitable and person-centered health care advances the mental and physical health and well-being of all Californians. The system would assure that care is affordable, accessible and treats all people with respect.
Integration and Coordination: California's health care system should deliver care that is integrated and coordinated across all types of diagnoses and the continuum of care.	Integration and Coordination: California's health care system should deliver care that is integrated and coordinated across all types of diagnoses and the continuum of care.
Accountability: Care quality and health outcomes for individuals and for populations should be monitored and systems of accountability should be established.	Accountability: Care quality and health outcomes for individuals and for populations should be monitored. Robust systems of accountability to assure high-quality, equitable outcomes should be maintained, expanded or established.
Payment: Provider payments, including methods of payment and levels of payment, can exert leverage to address inequities and to improve access, cost efficiency, quality, and outcomes.	Payment and Funding: Provider payments and funding, including methods of payment and levels of payment, should be used to address inequities and to improve access and quality.
Equity: The health care system should proactively monitor, mitigate, and eliminate racial and ethnic disparities in health care access and quality.	Equity: The health care system should proactively monitor, mitigate, and work to eliminate disparities in health care access and quality, including those resulting from structural discrimination related to race and ethnicity, those associated with income, immigration status, disability, sexual orientation and gender identity, and the intersectional effects among these characteristics. The health care system should also contribute to addressing social determinants of health that compromise health status.

September Statements	November Statements
Public Health, Prevention and Population Health: The health care system should address not just the acute, short-term needs of individuals but should focus on prevention and the social and structural factors that affect long-term health outcomes for individuals and populations.	Public Health, Prevention and Population Health: The health care system should address not just the acute, short-term needs of individuals but should focus on prevention. In coordination with other sectors, the health care system should work to address the social and structural factors that affect well-being, functional status and long-term health outcomes for individuals and populations.
Sustainability: A new universal, unified health care system implies a long-term commitment by the State of California and will require sustainable financing.	Sustainability: A new universal, unified health care system requires policy alignment and action at the federal level and a long-term commitment by the State of California and will require sustainable financing.
To effectively advance a Healthy California for All, Unified Financing is required.	In order to advance a Healthy California for All, the state should move to a system of unified financing.
To effectively advance a Healthy California for All, health plans should be retained but reimagined, encouraging their role in care coordination and population health management but imposing greater regulation on their contributions to cost and administrative burden.	To effectively advance a Healthy California for All through a system of unified financing, integrated delivery systems should play a continued or increased role in care coordination and population health management.
To effectively advance a Healthy California for All, health plans and other risk bearing intermediaries should be eliminated.	To effectively advance a Healthy California for All, if health plans are retained they should be subject to greater regulation with respect to cost, profit and administrative burden.
	Added: To effectively advance a Healthy California for All through a system of unified financing, health plans and all risk bearing intermediaries should be eliminated.
Individuals selecting or being assigned a primary care provider that coordinates their care.	Individuals selecting a primary care provider that coordinates their care.
Integrating behavioral health and primary care services.	Delivering behavioral health care and primary care services within a single system of care so that providers in each domain – behavioral health and primary care – communicate and work together in models that integrate and/or coordinate care in the patient's interest.
Identifying and supporting dedicated entities that coordinate care for complex, high need populations.	Supporting dedicated entities (e.g., medical groups, behavioral health providers, clinics, hospitals, and/or community based organizations) that coordinate care for people with multiple chronic conditions and other complex, high need populations.

September Statements	November Statements
Expanding and building upon models, such as integrated delivery systems, with demonstrated success in integrating and coordinating care for a patient population.	Expanding and building upon models, such as Kaiser and PACE, with demonstrated success in integrating and coordinating care across the continuum for a defined patient population.
Standard measures of care quality, health outcomes and other outcomes of interest (e.g., timely access, consumer experience, social risk) for individuals and populations should be measured and publicly reported.	Standard measures of care quality, health outcomes and other outcomes of interest (e.g., timely access, quality of consumer experience, social risk) for individuals and populations should be measured and publicly reported. Detailed demographic data should be collected and used to analyze disparities and identify ways in which more equitable outcomes can be advanced.
Accountability for population health outcomes should be established so that when outcomes do not meet expectations, corrective action can be taken.	Accountability for population health outcomes should be established so that when outcomes do not meet expectations, the Unified Financing Authority can take corrective action, including imposition of penalties or other enforcement actions.
Unified data systems and health information technology that allow analysis of patient data (by characteristics such as race/ethnicity, gender, sexual orientation and gender identity, disability, age, and income), cost, quality, and health outcomes are necessary tools for accountability.	Unified data systems that assure patient privacy but allow analysis of patient data (by characteristics such as race/ethnicity, gender, sexual orientation and gender identity, disability, age, and income), cost, quality, and health outcomes are necessary tools for accountability.
The health care system should ensure that care delivery is centered on patient needs rather than excessive profit motives.	The health care system should ensure that care delivery is centered on patient needs rather than excessive profit motives.
Enrolling or assigning individuals into models with demonstrated success in integrating and coordinating care for a patient population would facilitate accountability for cost, quality and outcomes.	Encouraging individuals to enroll into models with demonstrated success in integrating and coordinating care for a patient population would facilitate accountability for cost, quality and outcomes. Patients should have a periodic opportunity (e.g., annually) to select a different care arrangement.
Continue the shift from fee-for-service (FFS) payments, which pay providers for the volume of services delivered, to value-based payments, which hold providers accountable for cost, quality, and outcomes.	Continue the shift from fee-for-service (FFS) payments, which pay providers for the volume of services delivered, to alternative payment models in which providers are held accountable for cost, quality, and outcomes across the populations they serve.
	Added: Ensure providers caring for populations with greater social risk factors succeed in alternative payment models by adjusting payment, including upfront supplemental payments or incentive payments that provide higher reimbursement.

September Statements	November Statements
Adequately support primary care and encourage greater use of primary care vs specialty services.	Provide increased support for primary care and improve access to primary care services.
Employ risk-based capitation payments to assign accountability for cost, quality and outcomes.	Provide hospitals, medical groups and health plans the flexibility to use resources to maximize the health of the populations they serve, rather than being tied to fee-for-service payment methods. One example of such flexibility would be to establish global budgets for hospitals, linked to community health and health equity measures. Another example might deploy risk-adjusted capitation payments to assign accountability for access, cost, quality and health outcomes while taking into consideration population size and provider financial solvency.
Assure care is well-coordinated, particularly for people with complex chronic conditions and/or behavioral health care needs.	Assure care is well-coordinated, particularly for people with complex chronic conditions and/or behavioral health care needs.
Encourage involvement of diverse levels and types of professionals and caregivers (e.g., nurses, other health care professionals, community health care workers).	Encourage the use of the non-physician health care workforce (e.g., nurses, other health care professionals, navigators, community health care workers) in situations where these roles have been demonstrated to improve access to care, address social determinants of health, reduce health disparities, and/or support effective patient engagement.
Encourage the use of community health centers with expertise in delivering care to diverse and underserved populations.	Encourage the use of community health centers with expertise in delivering care to diverse and underserved populations.
Encourage the equitable distribution of health care providers across California's regions and diverse populations.	Encourage the equitable distribution of health care providers and expertise across California's regions and diverse populations.
Racial equity should be centered throughout every aspect of health care financing arrangements and the health care delivery system.	Racial equity should be centered throughout every aspect of health care financing arrangements and the health care delivery system.
To achieve equitable care, differences in financial resources and social supports among individuals and between California communities should be addressed, including adjusting provider payment by a region's status as an underserved area or by providing targeted resources and supports that are not dependent on provider reimbursements.	To achieve equitable care, differences in financial resources and social supports among individuals and between California communities should be addressed, including adjusting provider payment by a region's status as an underserved area or by providing targeted resources and supports that are not dependent on provider reimbursements.

September Statements	November Statements
To achieve equitable care, the needs of other populations that have been marginalized – e.g., racial and ethnic minorities, the aged, people with disabilities, LGBTQ+, and people with limited English proficiency – should be elevated.	To achieve equitable care, the needs of populations that have been marginalized – e.g., racial and ethnic minorities, immigrants, the aged, people with disabilities, LGBTQ+, and people with limited English proficiency – should be addressed with the goal of eliminating disparities in access and outcomes.
The health care system should invest in a workforce that is diverse and responsive to consumer and patient needs, including addressing the current gaps in access to physicians and other allied health care workers and ensuring California's future workforce needs.	The health care system should invest in a workforce that is diverse, that can meet the cultural, socioeconomic, and linguistic diversity of California's residents and that is responsive to consumer and patient needs. The Unified Financing Authority should work in partnership with others in the public and private sector to address gaps in access to physicians and other allied health care workers and to ensure California's future workforce needs.
A system of governance that is responsive to the priorities of Californians and incorporates consumer voices, including voice of marginalized populations in priority-setting, should be established.	A system of governance and accountability that is responsive to the priorities of Californians and incorporates consumer voices, including voices of marginalized populations in priority-setting, should be established. This includes regularly soliciting meaningful, authentic community input regarding planned changes and establishing mechanisms to report back to communities.
	Added: Independent regional councils comprised of and governed by multiple sector and community stakeholders who work together to address the root causes of inequities should be established.
	Added: The governance of existing health organizations should be strengthened by including more members of the community in positions that have power.
A fundamental imbalance between high spending on medical treatment versus underinvestment in prevention should be addressed through increased investment targeting the social determinants of health.	A fundamental imbalance between high spending on medical treatment versus underinvestment in prevention should be addressed through increased investment in health screening, early diagnosis and disease prevention.
Because population health outcomes are influenced by forces outside the four walls of medical care settings, the health care system should tightly align with state and local public health departments to support community based prevention activities.	Because population health outcomes are influenced by forces outside the four walls of medical care settings, the health care system should tightly align with state and local public health departments to support community based prevention activities. The health care system should also connect to the social safety net to address issues such as food insecurity and housing instability.

September Statements	November Statements
	Added: Complementary investments (likely from outside the health care delivery system) in the social determinants of health, including but not limited to safe and affordable housing, equitable, high-quality education, and affordable and accessible early child care would improve health outcomes.
Obtaining federal approval to reinvest federal funding for public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and subsidies) in support of a state-based unified financing system.	Obtaining federal approval to integrate federal funding for public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and subsidies) with state-based funding sources is critical in supporting a state-based unified financing system.
Developing and managing sources of financing in ways that assure California upholds its long-term commitments.	Sources of financing, including federal contributions, should be developed and managed in ways that assure California upholds its long-term commitments.
Managing health care costs in line with a target annual rate of growth to ensure that California can continue to afford its health care system.	Health care costs should be managed in line with a target annual rate of growth benchmarked to measures such as state gross domestic product in order to ensure that California can continue to afford its health care system.
Establishing reserves to ensure sustainability when costs exceed revenue, such as during economic downturns.	Diverse sources of financing and reserves to ensure sustainability when costs exceed revenue, such as during economic downturns, should be established.

Appendix B: Why Do Estimates of California Health Expenditures Vary?

Over the years, many analysts have examined how health expenditures would change under national or state-specific unified financing policies, including single payer proposals. In addition to the analysis included in this report, other California specific-analyses in recent years have been conducted by the University of Massachusetts Amherst Political Economy Research Institute, or PERI (2017),[79] the California Legislative Analyst's Office, or LAO (2018),[80] and the California Health Benefits Review Program, or CHBRP (2021).[81] The depth of analysis conducted varied between estimates.

Analyses of how health expenditures would change under unified financing generally start with an analysis of total health expenditures under the current system. Even these **baseline estimates are subject to significant variation and uncertainty because there is no single recent data source for total health expenditures in California**. The Center for Medicare and Medicaid Services provides health expenditures data by state of residence but the most recent data available is for 2014 and state-level data is not available for administrative, public health, and investment expenditures.

When comparing estimates of total California health expenditures, **estimates must reflect the same time period to be accurately compared**. In inflating or deflating an estimate to a particular year for purposes of comparison it is important to use an inflation factor that is specific to health care, such as CMS projections of national health expenditures growth, rather than a general inflator like CPI because health care expenditures have generally grown faster than other economic indicators. For example, CMS projected that total health expenditures would be 29.2 percent higher in 2022 than in 2017, while CPI would be 12.8 percent higher.[82]

Another source of variation in estimates is the categories of health spending included in total health expenditures. The estimates in this report include all types of health expenditures included by CMS in their national health expenditures estimates including personal health care, government administration and net cost of health insurance, public health, and investment, while estimates from PERI and LAO exclude investment, which we estimate to equal approximately $28.8 billion in 2022. The CHBRP 2021 analysis only included personal health care expenditures.

The estimates of total baseline California health expenditures from the HCFA Consulting Team, PERI, and LAO are in a similar range when adjusted to 2022 using projected

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[79] Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562), University of Massachusetts Amherst Political Economy Research Institute, May 31, 2017

[80] California Legislative Analyst's Office, Financing Considerations for Potential State Healthcare Policy Challenges, Presented to Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, February 5, 2018

[81] California Health Benefits Review Program, California Assembly Bill 1400: Guaranteed Health Care for All, Summary to the 2021-2022 California State Legislature, April 22, 2021,

[82] Center for Medicare and Medicaid Services, National Health Expenditure Data

National Health Expenditures growth. The estimates from CHBRP are not shown below as they are significantly lower due to the exclusion of administrative, public health, and investment expenditures and the use of CPI to inflate expenditures in the lower bound scenario.

Estimated Total California Health Expenditures under Baseline from Select Recent Analyses

Source	As published reflecting various years	Estimate adjusted to 2022 using CMS National Health Expenditures growth projections
HCFA Consulting Team (2022)	$517 (2022)	$517 billion
LAO (2018)	$400 (2017-2018)	$497 billion[83]
PERI (2017)	$369 (2017)	$478 billion

Note: LAO and PERI estimates exclude investment which is approximately $28 billion in 2022.

Estimates of health expenditures under unified financing are affected by the specific policy design analyzed and how features of unified financing are assumed to impact health expenditures. Specific assumptions about the policy design of a unified financing system, such as how providers would be paid, whether individuals would pay any cost sharing, which benefits would be covered, etc. affect the estimates of how health expenditures would change. Analysts' assumptions about the impact that those policy design features and other features inherent to unified financing, such as universal coverage and administrative simplification, also vary.

Given the range of ways in which analyses vary, it is generally most accurate to compare estimates of current expenditures against projected expenditures under unified financing from the same source. The HCFA Consulting team estimated a range of changes in total health expenditures in year 1 from a decrease of 7 percent to an increase of 2 percent depending on the scenario (Table 1), with higher levels of savings achieved over time. PERI estimated that total health expenditures would decline by 10 percent in year 1 under the single payer proposal analyzed. The LAO estimated that the amount needed to run a publicly financed health care program would be similar to expenditures under our current system. These estimates are all within the range of the projected change in expenditures estimated in national analyses or analyses in other states.[84]

[83] The LAO estimate for 2017-2018 was inflated using the average of the projected growth rates from 2017 to 2022 and 2018 to 2022.

[84] According to one study that reviewed a range of analyses of single payer proposals in the U.S. or specific states, most past analyses of unified financing have concluded that some savings would be achieved relative to our current system, from slight savings to savings of approximately 15 percent in the first year. Christopher Cai et al, Projected costs of single-payer health care financing in the United States: A systematic review of economic analyses, PLOS Medicine, January 15, 2020

Appendix C: Legal Memo on Unified Financing of State Health Coverage

MEMORANDUM

To: **Ben McGowan**
Jared Goldman
John Puente

From: **Caroline Brown**
Phil Peisch
Julia Seidenberg

Date: **January 6, 2022**

Subject: **Unified Financing of State Health Coverage**

You have asked us whether there is existing federal authority that would allow California to consolidate federal funding from multiple sources to support the State's implementation of health care delivery through a unified financing system. As we understand it, the State's interest is in consolidating federal payments that currently flow through distinct health care programs overseen by the U.S. Department of Health and Human Services (HHS) in order to make available to Californians a comprehensive package of health care services and coverage arrangements that do not vary by age, employment, income, disability status, or other characteristics.

As we explain below, there is no single authority that would allow HHS to redirect federal funds for the three principal programs it oversees, i.e., Medicare, Medicaid (Medi-Cal), and advance premium tax credits under the Affordable Care Act (ACA). Instead, each funding stream is subject to different authorities that permit HHS to waive certain federal requirements and limitations, as summarized in the attached Appendix.

We address each program in turn, and the extent to which these existing waiver authorities could be used to facilitate a unified financing system by re-directing funds to the State, which would then be responsible for the provision of benefits to the covered populations. We conclude that there are relatively straightforward paths with respect to Medicaid and the ACA-covered population, complicated only by the size and diversity of California's population. Medicare is much more challenging. Although we have identified authorities that would potentially allow for redirection of funding, exercise of that authority would be unprecedented and politically charged. Even assuming that the consolidated funding is possible, the issue of different benefit packages for different populations might remain, as we question whether HHS would exercise its waiver authority to eliminate or reduce benefits to which beneficiaries are entitled by statute.

I. Redirecting Federal Funds

Existing federal waiver authority provides HHS with the ability to approve deviation from federally required standards and limitations in Medicare, Medicaid, and the individual and small group insurance markets (or "exchanges") created by the ACA. The extent to which these waiver authorities could be used to alter program financing structures varies, and the State's success in seeking federal approval of such waivers will depend on the current administration's interpretation of the authorities, as well as its willingness and interest in supporting state-based unified financing reform.

a. ACA Exchanges

Section 1332 of the ACA allows HHS to approve alternatives to some of the federal requirements governing ACA exchanges. *See* Appendix (listing statutory requirements waivable under Section 1332). If a Section 1332 waiver program reduces the amount of premium tax credit or small business health care tax credit that individuals and employers in the State would otherwise receive, HHS will pay the federal savings to the State as "pass-through funding." Thus, if the State operates a health care program that covers the population that would otherwise be eligible for advance premium tax credits (individuals with family income up to 400% of the federal poverty level, including nonqualified aliens not otherwise eligible for federal health programs), the State could receive a payment equal to the tax credits and cost-sharing subsidies that the federal government would otherwise spend on that population.

States seeking approval of a 1332 waiver must satisfy four "guardrails" or conditions specified in the statute: (1) coverage must be at least as comprehensive as the ACA exchanges, (2) coverage and cost sharing protecting against excessive out-of-pocket spending must be as affordable as the ACA exchanges, (3) coverage must be provided to a comparable number of residents as the ACA exchanges, and (4) the waiver cannot increase the federal deficit. § 1332(b).

b. Medicaid

Sections 1903 and 1905 of the Social Security Act (SSA) dictate the financing of Medicaid through a shared federal-state matching formula under which HHS matches the State's expenditures to providers serving Medi-Cal beneficiaries. Section 1115 of the SSA allows HHS to approve substantial modifications to the Medicaid program's delivery, coverage and payment of services. However, Section 1115 does not provide HHS with the authority to waive either Section 1903 or Section 1905, because Secretary's 1115 waiver authority extends only to "compliance with any of the requirements of section . . . 1902." (While Section 1115(a)(2) also gives the Secretary authority to provide federal financial participation in costs which are not otherwise included as program expenditures, CMS has not construed that authority as allowing it to depart from the basic principle that it can only match state expenditures under the statutory formula).

While Section 1115 does not allow HHS to alter the standard Medicaid funding structure, it can potentially be used to support a state-based comprehensive health care delivery system in which the State establishes itself as the single Medicaid managed care organization (MCO). Under this scenario, Medi-Cal would pay a capitated amount to the State-based MCO, which is then at-risk for paying providers for services furnished to Medi-Cal beneficiaries.

Vermont has used this approach for many years. Under its 1115 waiver, the Department of Vermont Health Access (DVHA), a department within the State Medicaid agency (SMA), operates a single, statewide Medicaid MCO and receives monthly capitation payments from the SMA. The waiver authorizes the State to use any savings from the capitation payments to DVHA to fund non-Medicaid health programs. In exchange for the significant flexibility to use federal Medicaid funds to

finance State health programs, Vermont agreed to operate under a global cap on the federal matching funds for all Medicaid services. Vermont's waiver, called the Global Commitment to Health Demonstration, has evolved since it was first implemented in 2005, but CMS has continued to approve the waiver's basic structure, wherein the State operates as the single Medicaid MCO, and is allowed to invest savings in non-Medicaid health programs.

c. Medicare

Conventionally, the State does not have a role in the financing or provision of Medicare benefits. Instead, the Secretary pays providers for services furnished to beneficiaries with funds drawn from the *Hospital* Insurance *Trust Fund (Part A),* the *Supplementary Medical* Insurance *Trust Fund* (for Part B), or both (for Medicare Advantage, Part C). Part D (prescription drugs) is funded through general revenues and beneficiary premiums.

Section 1115A of the SSA allows HHS to approve broad waivers of Medicare as necessary to test "innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care." This authority is exercised by the Center for Medicare & Medicaid Innovation (CMMI) and was created by the ACA.

Payment and service delivery models tested under 1115A are typically developed by CMMI, which then solicits applications. However, Maryland and Vermont have successfully sought approval for models that were not developed by CMMI, and we have not identified any authority or guidance that limits CMMI's ability to select models proposed from outside stakeholders, including States.

Section 1115A lists 27 different payment and service delivery models for CMMI to consider testing. § 1115A(b). While unified financing is not included in the described models, the statutory language ("…may include, but not limited to…") does not limit CMMI to the models listed. CMMI has confirmed this reading, stating that "although section 1115A(b) of the [SSA] describes a number of payment and service delivery models that the Secretary may choose to test, the Secretary is not limited to those models." 80 Fed. Reg. 73273, 73278 (Nov. 24, 2015). Models directed at state-based innovation is clearly contemplated by the statute, which includes in its list of models "allowing States to test and evaluate fully integrated care for dual eligible individuals in the State, including the management and oversight of all funds under applicable titles with respect to such individuals," and "allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals." § 1115A(b)(2)(B)(xi), (xii).

Section 1115A's authority with respect to Medicare is broad. The statute expands on existing and longstanding Medicare waiver authority at Section 402(b) of the 1967 SSA amendments, and Section 222(a) of the 1972 SSA amendments. These authorities are limited to waiving Title XVIII (Medicare statutory provisions) only "insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or … on the basis of reasonable charge, or to reimbursement or payment only for such services or item as may be specified in the experiment…" § 402(b), or "insofar as such requirements relate to methods of payment for services provided…" § 222(a). In comparison, Section 1115A broadly allows CMMI to waive any provision of Title XVIII "as may be necessary solely for purposes of carrying out this section with respect to testing models…" SSA § 1115A(d)(1). The statute further supports the breadth of CMMI's authority under 1115A by limiting administrative and judicial review of many decisions made by CMMI. *See* § 1115A(d)(2).

In selecting models for testing, CMMI must determine "that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures." § 1115A(b)(2). If CMMI determines that a model is not expected to improve the quality of care and/or reduce spending (without reducing quality), CMMI must terminate or modify the model. § 1115A(b)(3)(B). Finally, though 1115A itself does not limit

CMMI's waiver authority with respect to Medicare, Section 3601 of the ACA provides that "nothing in the provisions of, or amendments made by, [the ACA] shall result in a reduction of guaranteed benefits under title XVIII of the [SSA]." Accordingly, CMMI could not approve a model that requires a Medicare waiver that would reduce Medicare benefits. *See* 85 Fed. Reg. 61114, 61141 (Sept. 29, 2020) (requirement that model participants "continue to make medically necessary covered services available to beneficiaries to the extent required by law" adequately safeguards against reduction of guaranteed Medicare benefits).

Provided that the above requirements are met, we have identified three potential avenues in which the CMMI authorities could be exercised to test models in which some level of Medicare funding could flow through the State.

First, California could propose that CMMI use its authority to test payment and service delivery models and broadly waive Title XVIII requirements to approve a model under which the State would establish itself as the single Accountable Care Organization (ACO) providing coverage to traditional Medicare beneficiaries in the State. CMMI has developed and approved a range of Medicare ACO models already, and expanding Medicare enrollment in ACOs is among the goals described in CMMI's recently published *Strategy Refresh*.[85] For example, California can propose a model that integrates elements of CMMI's existing ACO demonstrations that, if adopted with some modification by the State acting as an ACO, could accomplish many of the flexibilities necessary to support a unified financing system. For example, CMMI's Next Generation ACO Model features almost complete financial risk sharing, shared savings based on prospectively set benchmarks, and the option to be paid using an all-inclusive population-based payment mechanism. Mandatory provider participation in the state-based ACO would further ensure comprehensive Medicare participation in California's unified financing system. While most ACO models tested have been voluntary, CMMI has repeatedly stated that it has the authority to require provider participation in 1115A models as a general matter. *See, e.g.*, 85 Fed. Reg. at 61141; 80 Fed. Reg. at 73278. Mandatory provider participation would also mean the State need not seek a waiver of Section 1802 of the SSA, which guarantees traditional Medicare beneficiaries' freedom of choice of providers.

Second, in conjunction with or as an alternative to operating a state-based Medicare ACO, California could propose that CMMI approve a model under which California would operate as the single Medicare Advantage plan providing coverage to Medicare beneficiaries in the State. Under that model, the State as the Medicare Advantage plan would receive capitated payments from HHS and would be responsible for the coverage and provision of Medicare benefits for the plan enrollees.

If enrollment were mandatory, CMMI would have to waive Section 1851, which provides that Medicare beneficiaries may choose to receive benefits through traditional Medicare or through enrollment in a Medicare Advantage plan, and may choose among available Medicare Advantage plans offered in the area where the beneficiary resides. While we have not identified any authority or guidance that limits CMMI's ability to waive Section 1851 and require beneficiaries to enroll in a particular Medicare Advantage plan, a proposal that limits Medicare beneficiary choice will likely face political challenges. Historically, health care reforms seen as interfering with Medicare freedom-of-choice have not succeeded in overcoming the political backlash that accompanies the perceived threat of losing access to Medicare entitlements. Accordingly, while Section 1115A provides the legal authority for CMMI to approve a model that limits Medicare beneficiary freedom of choice, it is unclear if such a proposal is politically feasible.

Third, we have considered whether CMMI would have authority under Section 1115A to test and approve a model under which Medicare funds are provided to the State outright in exchange for

[85] CMMI, *Innovation Center Strategy Refresh* at 16 (Oct. 20, 2021), https://innovation.cms.gov/strategic-direction-whitepaper.

the State's agreement to manage the program in California on HHS's behalf. We have not identified a discrete statutory or regulatory provision dictating how HHS must direct Medicare funds. Accordingly, even though the Secretary's waiver authority under Section 1115A is very broad, it is not clear what Title XVIII requirement could be waived by CMMI to implement a model where Medicare funds are redirected to the State.

That said, it is possible that CMMI would conclude that the authority for such a model is inherent in its mandate. The integration model for dual eligibles which is listed as a potential model in the statute specifically includes "the management and oversight of all funds under the applicable titles with respect to such individuals" by the State. § 1115A(b)(2)(B)(x). If CMMI can approve such a model with respect to dual eligibles, it may conclude that it also has the authority to approve such a model for all Medicare beneficiaries in a State. CMMI has previously taken a broad view of its authority. For example, in response to previous criticisms of 1115A models in which provider participation is mandatory, CMMI has noted that it does not rely on a specific provision in Section 1115A, but instead relies "on section 1115A of the [SSA] as a whole, as well as the Secretary's existing authority to carry out her duties and administer the Medicare program." 80 Fed. Reg. at 73278; *see also*, 85 Fed. Reg. at 61141 ("The statute does not require that models be voluntary, but rather gives the Secretary broad discretion to design and test models that meet certain requirements as to spending and quality."). "Specifically, the Secretary has authority under sections 1102 and 1871 of the [SSA] to implement regulations as necessary to administer Medicare, including testing this Medicare payment and service delivery model." *Id*.

Whether the State can successfully pursue any of the above proposed 1115A models will depend in significant part on CMMI and the current administration's interest in supporting a state-based unified financing system. For example, previous statements made by HHS political appointees and CMMI refusing to redirect Medicare funds to States or rejecting state-based single payer reforms suggested an unwillingness to approve such a model, rather than the belief that HHS lacks the authority to do so. CMMI, *State Innovation Models Funding Opportunity Announcement* at 13 (Aug. 13, 2012), https://innovation.cms.gov/files/x/stateinnovation_foa.pdf ("CMS will not compel providers in any Model testing state to participate in new payment and service delivery models, nor will CMS cede Medicare payment authority to the state."); Seema Verma, *Remarks at the Commonwealth Club of California* at 50:00 (July 25, 2018), https://www.commonwealthclub.org/events/archive/video/medicare-and-medicaid-administrator-seema-verma (suggesting that a waiver redirecting federal funds to a state-based single payer system would not be approved because it is not "fiscally sustainable").

II. Proposing New Federal Statutory Authority

As described above, pursuing a unified financing model would require stitching together various authorities, each of which have their own requirements for approval and most of which shift substantial risk to the State.

Amending existing statutory waiver authority could allow California to better pursue unified financing. Adding Sections 1903 and 1905 of the SSA to the Medicaid provisions that can be waived under either Section 1115 or 1115A would enable HHS to convert the conventional Medicaid financing stream into an alternative.

Amending the list of models described in Section 1115A to include unified financing would clarify that CMMI has the authority to redirect Medicare funds to the State as part of a payment and service delivery model.

Enacting a new waiver authority to allow States to use federal funding from existing health care programs, including Medicare, Medicaid and the ACA exchanges, to implement comprehensive

health care coverage would allow California to pursue full unified financing. As an example, proposed legislation such as H.R. 3775, the *State-Based Universal Health Care Act* , would provide the necessary authority for HHS to direct federal funds to California as a lump sum.

Please let us know if you have any questions regarding the above.

Legal Appendix

Waiver Authority	Statutory requirements waived	Notes
SSA § 1115: Medicaid Demonstration Waiver	SSA § 1902	This authority is frequently used to expand coverage, modify delivery systems, and restructure financing and other program elements. CMS has approved waivers across a number of different program areas to provide states with flexibility in administering their Medicaid programs.
SSA Amdts of 1967 § 402(b) (42 USC § 1395b-1)	Titles XVIII and XIX "insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or … on the basis of reasonable charge, or to reimbursement or payment only for such services or item as may be specified in the experiment…"	This authority was most commonly used for Medicare demonstrations prior to the ACA. HHS would develop its own demonstration proposal and then solicit participants. Many Medicare payment system changes and alternative delivery approaches adopted by Congress originated as Section 402 demonstrations. Projects involving waivers of both Medicare and Medicaid requirements have been approved, and State Medicaid agencies have implemented demonstrations created under this authority.
SSA Amdmts of 1972 § 222(a) (42 USC 1395b-1 note)	Titles XVIII and XIX "insofar as such requirements relate to methods of payment for services provided…"	This authority allows for Medicare demonstrations that test alternative prospective payment methodologies. This authority has commonly been used in conjunction with Section 402 waiver authority for demonstrations involving prospective payment.
SSA § 1115A: CMMI Waiver	Titles XI and XVIII SSA §§ 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), 1934 (other than subsections (b)(1)(A) and (c)(5))	CMMI usually implements Section 1115A by developing its own delivery system and payment reform models and then soliciting applications. Both Maryland and Vermont have successfully secured approval for a CMMI model that was not developed by CMMI. The suggested payment models listed in the statute expressly provides for duals

Waiver Authority	Statutory requirements waived	Notes
		Unified financing is not included in the suggested models, however the plain language of the statute ("… may include, but are not limited to…") clearly provide that the CMMI is not limited to those models listed. Thus far demonstrations focused on duals have been pretty narrow.
ACA § 1332 (42 USC § 18052): Innovation Waiver	42 USC §§ 18021-18024 (establishment of QHPs) 42 USC §§ 18031-18033 (consumer choices and insurance competition through health benefit exchanges) 42 USC § 18071 (reduced cost sharing for individuals enrolled in QHPs) 26 USC §§ 36B, 4980H, and 5000A (IRC)	This authority has most often been used to fund state-based reinsurance programs for the individual insurance market. The Trump administration approved the first broad waiver under this authority to restructure Georgia's individual market, however the Biden administration has taken actions to further evaluate Georgia's waiver and may reopen approval of the waiver.

Other Authorities	Notes
SSA § 1899: Medicare Shared Savings Program	Allows HHS to approve Medicare shared savings programs and accountable care organizations in Part A and Part B.
SSA § 1851 *et seq.*: Medicare Advantage	Optional alternative to the original Medicare fee-for-service program through Part A and Part B provides coverage through private managed care plans under contract with CMS.
SSA § 1874A: Medicare Administrative Contracting	Allows HHS to contract out Medicare administrative functions, including payment determinations and provider reimbursement.

Appendix D: Employment Retirement Income Security Act (ERISA) Considerations for Unified Financing[86]

Background on ERISA[87]

- The Employee Retirement Income Security Act (ERISA), passed in 1974, provides minimum standards that employers must meet when providing pension and certain health benefits as part of employee compensation packages.
- Importantly, ERISA does not require that employers provide a specific set of benefits, or any benefits at all. If employers do provide health and pension benefits, those benefits must comply with ERISA in a number of ways, including information disclosures, accessibility, portability, and more.
- ERISA has been amended several times. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996, for instance, are both examples of amendments to ERISA that expanded minimum standards for employer benefits.
- Several cases exempt group health plans from ERISA. These include:
    - Employer is a church/religious organization
    - Employer is a government or governmental agency
    - Group health plan is considered voluntary, and employer does not provide any contributions
- ERISA also covers other types of employer-covered plans (dental, vision, life insurance, disability, HRA, etc.)

The ERISA-Unified Financing Conflict[88]

- When employers offer health benefits, they may choose either to outsource their group health plan to a third-party health insurer, OR self-fund their employees' health care costs directly. This latter option is sometimes called an Administrative Services Only (ASO) contract.
    - Self-funding allows companies to control their expenditures and monitor employees' health care costs; however, it also requires companies to shoulder employees' health risks directly.
    - "Very large employers are most likely to self-fund because their size better positions them to forecast and spread risk, and because it allows them to offer uniform benefits to their employees nationwide, avoiding both state benefit mandates and state-imposed insurance taxes."[89]
    - "At least 5.5 million Californians are covered through self-funded employer arrangements."[90]
- **Unified financing proposals, depending on how they are designed, have the potential to conflict with ERISA's self-funded health plan option.** ERISA preempts "any and all

[86] This summary on ERISA Considerations for Unified Financing was drafted by David Toppelberg of the California Health and Human Services Agency.
[87] https://www.dol.gov/general/topic/health-plans/erisa
[88] This section is largely sourced from "An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California" report produced for the Healthy California for All Commission. In particular, this section is sourced from pages 79-82 (footnotes 193-205).
[89] Ibid.
[90] Ibid.

State laws insofar as they may now or hereafter relate to any employee benefit plan."[91] In other words, self-funded ERISA plans are exempt from state health insurance regulation, and thus cannot be prohibited by any State. Preemption doctrine generally displaces state law in favor of federal law. If, for example, a state enacted a law requiring all employer sponsored health plans to offer a specified set of benefits and use a specific copayment structure, the provisions of that law would almost certainly be preempted by ERISA, and the state would not be able to require employers that had established plans governed by ERISA to comply with the provisions of that law.

- While the ultimate decision on whether ERISA conflicts with a particular single-payer construct will likely have to be settled in the courts, these legal-regulatory hurdles complicate any unified financing proposal at the state level.

Reconciling ERISA and Single-Payer[92]

- Congress wrote ERISA's provisions such that the law preempts "any and all" state laws that "relate to" any benefit plan covered by the Act; this has been described as one of the most expansive preemption provisions in any federal statute, especially because of the "relate to" aspect of the preemption provision.[93]
- **A crucial aspect of making any unified financing or single-payer proposal economically and politically feasible is for employers to forego offering employer-sponsored coverage and instead, directly or indirectly, support a unified financing plan.**
- With over sixty single-payer bills introduced in 21 state legislatures during 2010-19, legislators have generally pursued **three distinct models intended to avoid having ERISA preemption** override state health reforms:
    1. Funding plans that use payroll taxes, income taxes, or both to raise revenue to pay for the single payer plan. Because employers/employees would be contributing to the single payer program *and* paying for employer coverage, this approach incentivizes employers/employees to switch *only* to the single payer program and drop employer coverage entirely, or, perhaps, retain it only for supplemental coverage.
    2. Provider regulations that restrict participating providers from billing any third party other than the unified financing program.
    3. Assignment/subrogation/secondary-payer provisions that allow the single payer program to pay for services and then seek reimbursement from patients' employer-based health plans.
- Because no unified financing plan has passed into law (other than Vermont's abandoned plan), these three models have not been tested in court. There is great judicial uncertainty in regard to the three aforementioned models in bypassing ERISA's preemption, especially because the courts have taken a rather "tortured" reading of the statutes that do not conform with the original Congressional intent.[94]
- Unlike most major federal health care statutes such as Medicare, Medicaid, and the ACA, **ERISA does not contain any waiver provisions** to allow state-level health reform experimentation.

[91] ERISA, Section 514(a), 29 U.S.C., Section 1144(a). Manatt Health, Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California, California Health Care Foundation, February 2018

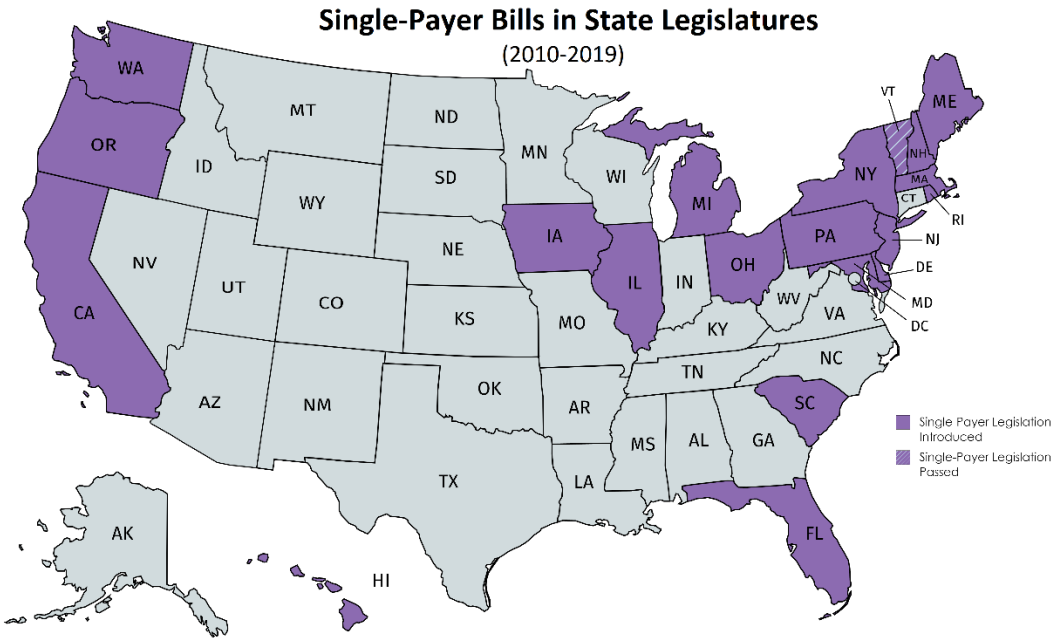
[92] This section's proposals are sourced from the following unless otherwise footnoted: Fuse Brown, E. C., & McCuskey, E. Y. (2019). Federalism, ERISA, and State Single-Payer Health Care. *U. Pa. L. Rev.*, *168*, 389.

[93] Ibid.

[94] Ibid.

- If the three models above do not bypass ERISA preemption, Brown and McCuskey suggest **four possible solutions** to clear the way for state-level unified financing (three legislative and one jurisprudential), as described below:
    1. Congressional amendment replacing the "any and all" preemption with floor preemption used in other comparable health statutes.
    2. Congressional amendment eliminating ERISA's "deemer clause", thereby clearing the barriers around interference with self-funded employer-based plans under ERISA.
    3. Congressional amendment adding a statutory waiver provision to ERISA. This would allow the federal government to manage degrees of uniformity and permit state experimentation to health policy.
    4. New jurisprudential interpretations that curtail the courts' vision of ERISA's preemption. The authors admit this pathway is most unlikely.
- If neither Congress nor the courts will act to reform ERISA's preemption provisions, the authors recommend that state legislators use overlapping, hybrid models for single-payer that combine the three approaches (economic incentives, provider regulations, assignment/subrogation/secondary-payer) to maximize the possibility of skirting around ERISA preemption.

Exhibit 1: Single Payer Bills in State Legislatures[95]



[95] "Could States Do Single-Payer Health Care?", Health Affairs Blog, July 22, 2019. Note: this article is a more accessible, less technical version of the previous article cited by the same authors.

Appendix E: Commissioner Comment Letters (forthcoming)