CALIFORNIA MEDICAL ASSOCIATION

THIS REPORT DOES NOT REFLECT OFFICIAL CMA POLICY

Report to the Board of Trustees from the Healthy California for All Technical Advisory Committee

Elizabeth Griffiths, MD, Chair

OCTOBER 23, 2020

Committee Update and Renewal

Summary of Recommendations

RECOMMENDATION 1: That the Board of Trustees approve the renewal and continuation of the Healthy California for All Technical Advisory Committee with the new, additional objective of providing input and expertise to the CMA on actions to take should the Affordable Care Act get struck down or altered.

FISCAL IMPACT: *No impact.*

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Committee Update and Renewal

SUMMARY

Per the action of the Board of Trustees in 2019, The Healthy California for all Technical Advisory Committee (TAC) has been meeting regularly to place CMA in the best position to provide input and information to the Healthy California for All Commission. This report is an informational update to the Board on the TAC's policy considerations and efforts. It is also a request to renew and continue the TAC with a different objective and undertaking given the changes in the political environment since the beginning of the year.

BACKGROUND

In October of 2019, the Board of Trustees approved the creation of a Technical Advisory Committee to help guide CMA's advocacy and efforts as they relate to the Healthy California for All Commission (Commission). Governor Gavin Newsom created the Commission to discuss and develop recommendations for how California could transition to a unified financing (including, but not limited to, single payor) system of health care in California. The TAC's work plan contained two steps: to review and make recommendations on CMA's existing policy consistent with the TAC's objective and recommend to the Board a model or models that could best be used to achieve a single payor or unified financing system within California.

The TAC has taken this objective seriously and engaged in significant discussion and debate to recommend changes to CMA's current policy. While the TAC is comfortable with the policy changes that it is suggesting, it is not yet ready for action by the Board at this time (though a draft of the proposed changes are included in this report to keep the Board informed and to offer a venue for input on the draft changes). The TAC intends to present a comprehensive report that will provide a thorough discussion of the TAC's work, the materials it used to reach the conclusions it did, and provide items

for action that contain both changes to current policy and the recommended model to use. Additionally, financing a unified financing system in California requires more consideration and health economist input, which the TAC is seeking from outside sources.

CMA POLICY

The below policies were the primary sources that the TAC reviewed and is considering recommendations to modify. Other existing policies were called upon during the course of the TAC's work but were not instrumental to its deliberations.

MI-1B-17 - Health Care Reform: Single Payor and Public Option

CMA will only consider a single-payer health care financing and delivery proposal, if the following elements, at a minimum, are in place:

1. Appropriations for the single-payer system shall not be subject to limitations, and an adequate level of funding (with appropriate inflation adjustments) should be guaranteed. There must be a clear path to ongoing financial support and viability;
2. Physicians must be provided a means to ensure payment through usual and customary charges as defined by the Gould criteria whether delivered downstream through fee-for-service, capitation, or other payment options;
3. Pluralistic payment options for all types of physician practices must be retained and physicians must maintain the choice of how to organize their practice;
4. Physicians must be permitted to collectively negotiate;
5. Benefit/coverage design decisions should be made by a scientific, apolitical body comprised primarily of physicians and updated in a timely fashion based on current information.
6. There should be a basic benefit/coverage package outlined in the law that is developed with significant input from practicing physicians. These benefits should include, at a minimum, reproductive health, maternity, mental health, substance use disorder prevention and treatment, and preventive health services. Pharmaceutical services should be included. Appeals of adverse coverage decisions should be adjudicated by an independent medical review processed by practicing physicians of like specialty;
7. Patients are allowed to purchase supplemental coverage in addition to the "single" plan;
8. Access to care must be protected by ensuring there are mechanisms in place to address physician training, workforce shortages, capital investment, and infrastructure building;
9. Co-payments that promote effective care and appropriate utilization should be considered. Co-payments should be on a sliding-scale and waived for low-income individuals. Cost-sharing should not be applied to primary and preventive care;
10. There must be a system to evaluate quality of care and cost containment mechanisms to ensure that there are no disincentives for physicians to provide the highest quality care and that patients have access to appropriate care not driven by cost considerations but best patient outcomes; and
11. There be a mechanism for addressing fraud.

HOD B-4-08 - CMA Guiding Principles for Health Reform
This policy lays out guiding principles that CMA has abided by when advocating on issues related to health care reform. The policy also provides specific recommendations related to managed care reform, health system funding and tax reform, and proposals to address the health care workforce shortage.

BOT 03-19-10:1 – Health Care Reform
This policy was critical for CMA's advocacy on the federal level and the passage of the Affordable Care Act (ACA). It allows CMA to support specific provisions within the ACA that would increase coverage for Californians including extending parent's coverage to children under 26, standing up a health insurance exchange in the state, investing in primary care, and investments in prevention and wellness.

MI-1A-17 - Health Care Reform: Federal
This policy reaffirms CMA's core principles that would, among other things, improve access to physicians, ensure Californians do not lose coverage, and protect state and federal Medicaid funding, for the federal health care reform debate.

DISCUSSION

A. Current work of the TAC

The TAC regularly met to review CMA's current policy on single payor, health care reform, and other related topics. Working off CMA's existing policy and drawing on the shortcomings of the current system and physicians' experiences during the COVID-19 pandemic, the TAC began by developing central principles that would guide the association's advocacy on the issue. These principles ensure that any health care system is designed and created with the priority to care for patients, further health equity, value and invest in public health and wellness efforts, and deliver high-quality, affordable, evidence-based care to all Californians.

A draft of these policy recommendations (See Attachment A - Draft Policy Recommendations - Guiding Principles for a Unified Financing Health Care System in California) are attached to this report for your consideration and discussion as we prepare for action in the future. The TAC encourages your feedback and input as you begin to have conversations with your constituencies on the subject.

B. The Future Efforts of the TAC

During the TAC's work on this issue, the Secretary of the California Health and Human Services Agency, Mark Ghaly, MD, has postponed any work and meetings of the Commission until after the

start of 2021. This announcement comes as California's economic forecast is deteriorating and implementing single payor within the State becomes more challening given the lack of potential federal assistance or approval. Secretary Ghaly also noted that during a pandemic in which millions of Californians are losing health insurance the priority must be on addressing more pressing and immediate issues within the system. This postponement allows CMA and the TAC more time to consider and work on the subject of unified financing in the future.

In addition, with the passing of a Supreme Court Justice Ruth Bader Ginsburg, and the Trump Administration's efforts to fill her seat with a Justice that will inevitably alter the Supreme Court's ideological tilt, a different issue faces California's Medi-Cal expansion and health care system. In November, after the presidential election, the high court will hear oral arguments in a case (California V. Texas) seeking to overturn the Affordable Care Act. Should the Supreme Court strike down the law, 21 million Americans could lose their health insurance, California could lose tens of billions of dollars in Medi-Cal funding, and enrollees could face higher premiums. Furthermore, California's Health Benefit Exchange (Covered California) could lose millions of dollars in subsidies for qualifying purchasers, making it more costly for individuals to purchase health care and weaken the self-sufficiency of the exchange.

Given these shifts in the national and state political landscapes, the uncertainty of a Presidential election, the importance of maintaining coverage and access for patients (especially during a pandemic), and the necessity for CMA to develop policy proposals and strategies to safeguard and improve California's health care infrastructure, the TAC should be tasked with assisting with CMA's advocacy efforts in addressing these issues and developing policy proposals that help CMA navigate the uncertain future should the ACA be struck down.

CONCLUSION

While there are no actions to be taken on policy by the Board at this time, the focus of the TAC's work, at this moment, must address the more immediate crisis that is before us. Amending the objectives and the scope of the TAC is crucial to CMA to navigate the uncertain future should the ACA be struck down by a changed Supreme Court or altered by an Administration determined to do away with the landmark health care law.

RECOMMENDATION 1: That the Board of Trustees approve the renewal and continuation of the Healthy California for All Technical Advisory Committee with the new, additional objective of providing input and expertise to the CMA on actions to take should the Affordable Care Act get struck down or altered.

FISCAL IMPACT: *No impact*

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ATTACHMENTS:

A. Draft Policy Recommendations - Guiding Principles for a Unified Financing Health Care System in California

CALIFORNIA MEDICAL ASSOCIATION

Guiding Principles for a Unified Financing Health Care System in California

Background Information:

1. Healthy California For All Commission Definition of Unified Financing (Environmental Analysis Report):
   A. "As used in this report, the concept of "unified financing" describes a state-wide system to arrange and assure health care in which:
      i. All Californians would be entitled to receive a standard package of health care services
      ii. Entitlement would not vary by age, employment status, disability status, income, or other characteristics
      iii. Distinctions among Medicare, Medi-Cal, employment sponsored insurance, and individual market coverage would be eliminated within the system of unified financing
   B. As international examples make clear, there are many methods to achieve unified financing. For example, Canada and Taiwan use a single payer approach, the United Kingdom has publicly provided care, and Germany and the Netherlands require mandatory purchase of standardized, non-profit, insurance."

RECOMMENDATION 1: That CMA adopt the following updated unified financing policy for health reform and sunset the original single-payor policy.

1. That CMA recommend that health reform proposals advancing a unified financing model in California include the following elements, and that CMA will consider supporting such proposals to the extent that the following elements are included:

   A. Values Statements
      1. The purpose of the health care system is to care for patients, not to serve as a business venture or generate profit for shareholders. As such, any profit generated should be reinvested in the health care system.
      2. The health care system should be designed to further health equity rather than perpetuate and exacerbate health disparities.
      3. The health care system should value investment in public health, wellness, preventive care, and primary care.
      4. The health care system should deliver high quality, affordable, evidence-based care to all.
      5. The health care system must be funded in a sustainable and stable way in order to allow ongoing access to care.

B. Covered Benefits

1. There should be a standard benefits/coverage package outlined in the law and available to all Californians that is regularly reviewed by a clinical, apolitical body, which includes currently practicing physicians.
2. These benefits should prioritize high-value care, including but not limited to primary and preventive care, necessary specialty care, reproductive health, maternity care, mental health, and substance use disorder prevention and treatment. Emergency care, inpatient stays, pharmaceutical services, and evidence-based medical devices should be included.
3. Coverage and delivery of physical health, mental health and substance use disorder treatment should be integrated and reimbursed at parity.
4. The benefit package should include meaningful coverage for services delivered via telehealth.
5. Given the reality of funding limitations, coverage decisions may need to include input from independently-performed cost effectiveness analysis to determine the benefits and services with the highest value to Californians.
6. These decisions should be made by a clinical, apolitical body, which includes currently practicing physicians. Coverage decisions should be regularly and rigorously evaluated and modified as a result of evaluation.
7. Covered benefits should not be subject to annual or lifetime limits.
8. Patients should be allowed to purchase supplemental coverage to cover services not covered by the state benefit package.
9. The public health infrastructure and social services must be maintained and funded at adequate levels in order to prevent illness and address social determinants of health.

C. Cost Sharing

1. Any cost sharing, including co-payments, co-insurance and deductibles, should be designed primarily to incentivize more effective care and appropriate utilization, with higher cost sharing for low-value services and no cost sharing for high-value services, including but not limited to preventive care.
2. The relative value of specific services and thus the degree of cost sharing should be determined by a clinical, apolitical body, which includes currently practicing physicians. Determinations should be regularly reviewed and modified when appropriate.
3. Cost sharing should be on a sliding scale based on income, and no cost sharing (even for covered services deemed to be of lower value) should be allowed for low-income individuals.
4. A maximum deductible and annual cost sharing limit should be determined, and higher deductibles and annual cost sharing should not be allowed.
5. Any cost sharing payments should be collected by the payer(s), and the physician or other provider should not be involved.

D. Provider Rates

1. Reimbursement should be designed to incentivize value rather than volume of services provided, moving away from fee-for-service reimbursement to value-based payment models or capitation with carve-outs for select high-cost specialty services.
2. Value-based payment models should consider the burden of reporting requirements on physician time and administrative costs and thus seek to streamline and minimize unnecessary reporting requirements.
3. Any reimbursement model based on capitation or value-based payment should include high quality risk adjustment to prevent disincentives to care for the sickest patients or patients with complex social needs.
4. Physicians should be provided with the support and resources needed to transition to value-based payment models, including cost, utilization and quality data from the payer(s) and high quality electronic health records (EHRs) that are easy to use, interoperable, and provide population health data.
5. Reimbursement rates should be set through collective negotiation between physicians and the appropriate payer(s) in a unified financing system.
6. Reimbursement rates should be adjusted to account for regional variation in the cost of delivering care.
7. Reimbursement rates should be sufficient to support varied models of physician practice, including the required investments in technology to deliver high quality care.
8. Reimbursement rates should adequately value primary care and cognitive services.
9. Reimbursement should be site neutral.

E. Prescription Drug & Medical Device Costs

1. Reaffirmation of Addressing Increasing Pharmaceutical Costs Policy (HOD 2018), including particularly:
    i. That CMA support efforts by the Department of General Services (DGS) to consolidate drug procurement or engage in other joint activities with other state agencies and the private sector that will result in cost savings in the procurement of prescription drugs.
    ii. That CMA support efforts to ensure state regulators have the rationale and the evidence for the inclusion or exclusion of drugs on the formulary, and information from pharmacy benefit managers (PBMs), to determine whether formularies are being developed to benefit patients and consumers.
    iii. That CMA recommend a ban on direct-to-consumer advertising of prescription drugs and FDA-regulated medical devices (101a-05)
2. The government should be allowed to negotiate prescription drug prices on behalf of all Californians regardless of payer(s), to use international reference pricing to limit the cost of prescription drugs, and to use reference pricing when a new prescription drug is not demonstrably superior to existing prescription drugs.
3. The state should manufacture its own prescription drugs when this has the potential to significantly lower costs.
4. The California Attorney General should be allowed and encouraged to investigate prescription drug company behavior that may indicate collusion or other monopolistic behavior.

5. Medical devices should only be covered when they demonstrate efficacy in addition to safety.

F. Financing
1. Any state-based path to unified financing within health care must obtain the appropriate federal waivers.
2. Financing should be stable and adequate, relying on a broad base of funding from diverse sources in order to minimize variability in levels of funding with the economic climate of the state.
3. A mechanism for creating funding reserves in order to minimize disruptions during economic downturns must be established.
4. Financing should be fair and equitable, relying on Californians with the most wealth and/or highest incomes to contribute the most to the financing of the system.
5. Employers should be expected to contribute to a unified financing system.
6. Funding for a state-based unified financing system should be designated separately and should not be subject to the annual budget process or the limits of Propositions 4 and 98.
   Any projections of the cost of a unified financing system should take into account not only the cost of new coverage but also the savings of reducing administrative waste, low value services, and excessive profit for shareholders.

G. Eligibility
1. All Californians should be automatically enrolled in care supported by a state-based unified financing system upon birth, establishment of the system, or establishment of residence in California, including undocumented California residents.
2. Individuals establishing primary residence outside of California may be unenrolled or subject to additional cost-sharing to maintain their care within California's unified system. The State may need to consider a waiting period for start of coverage to avoid residents of other states coming to California at the time of a medical diagnosis.
3. Eligibility for coverage should not be tied to employment.
4. Eligibility should be determined at a state level with culturally competent local assistance available as needed.

H. Governance
1. Any insurers that continue to serve as intermediaries in the unified financing system should be nonprofit, requiring them to reinvest any profits into the health care system or return them to the state or enrollees.
2. Any administrative or reporting requirements should be standardized and handled by one state entity if insurers continue to serve as intermediaries in the unified financing system.
3. In addition to the clinical, apolitical body charged with covered benefit decision making, the unified financing system should be reviewed at least annually by an independent, apolitical governance body comprised of patients and community members, physicians and other health care professionals, economists and health policy experts.

4. This governance body should review the system to evaluate its viability, trends in access to and quality of care, affordability of care, the ability to maintain the necessary health care workforce, whether money is being appropriately reinvested in system, and to share best practices among payers if a multi-payer system is selected.
5. A grievance process should be established for patients, consumer groups, and health care providers to bring concerns to the governance body.
6. Both the clinical and governance bodies overseeing the system should be subject to Bagley-Keene Open Meeting Act and Brown Act requirements as appropriate.
7. Health services data, including data utilized in the annual review of the system, should be made publicly available to all.

I. Transition Issues
1. A period of transition between the current health system and any future unified financing system should be planned, allowing for the transition to be as seamless as possible and providing adequate time and resources for Californians and physician practices to prepare for the transition.

J. Workforce
1. The system of unified financing should be designed to maximize the amount of time physicians and other health care professionals spend with patients, rather than on administrative tasks, in order to minimize burnout.
2. Robust programs with sustainable funding sources should exist to incentivize the health care workforce to choose to work in underserved and rural areas, including but not limited to scholarships, loan forgiveness programs, graduate medical education (GME) programs, and enhanced reimbursement.
3. The composition of the health care workforce and leadership should reflect the diverse population of California.
4. Health care workforce development programs should primarily seek to incentivize health professions education and training among individuals identifying with traditionally underrepresented groups in health care.
5. Annual review of the system should include recommendations for long-term workforce development planning including anticipated specialty-specific or profession-specific shortages by region.
6. The health care workforce should include community health workers, peer support specialists, and family members of patients who desire to help care for them.
7. The system should be designed to incentivize high quality physician-led team-based care, including integrated delivery of primary care, mental health and substance use disorder treatment.