



July 30, 2021

Re: Cost Analysis and Methodology

Dear Healthy California for All Commissioners and Consultants,

Thank you for the opportunity to provide feedback to the Commission's initial cost analysis.

The below comments and questions represent the initial feedback from the California Association of Health Underwriters (CAHU) and California Association of Health Plans (CAHP). Our organizations and our members have worked for years toward achieving affordable universal coverage for Californians.

The below comments are not an exhaustive list, just the initial comments that we have been able to compile under the short time window offered for comments given the magnitude of the cost, complexity and consequences of overhauling California's health care system.

We and our other coalition partners will continue to examine the Commission's cost analysis and methodology and will very likely provide additional comments in the coming weeks.

Prior to offering comments on the specific sections, a few things stand out:

1. There is enormous uncertainty in the Commission's cost projections, which are dependent on many highly improbable yet very significant assumptions that could leave taxpayers on the hook for hundreds of billions of dollars.
2. The analysis often uses flawed, out of date or non-California data to predict California costs. A number of the assumptions simply don't square with reality or come with severe but glossed-over trade-offs for access to health care, as noted by the CBO report.
3. Sequence/premature: why is the Commission conducting a cost analysis before it determines the actual design elements of universal financing, which would at least narrow the range and provide Californians and stakeholders a clearer view of what is being proposed? Many of the assumptions are dependent on variables that the Commission can make recommendations on.
4. A significant portion of the report's projected cost savings under Unified Financing (UF) appears to come from significant cuts to provider payments and from pharmaceutical savings. Putting aside the unrealistic nature of these assumptions, they would harm the access Californians would have to both providers and prescription drugs.

5. The analysis appears to omit a number of considerations which could drive up costs even further under UF, including a) lost revenue to the state from the loss of the hospital waiver and MCO tax, b) the lost revenue from the insurance tax, bank and corporations tax, local property taxes and income taxes no longer paid by health plans and their employees, and c) the potential for medical tourism to California.

General Observations / Assumptions

1. Federal waivers

Your analysis – indeed, the entire premise of shifting California’s health care system to universal financing – rests on the assumption that California will be able to obtain federal waivers to shift nearly \$200 billion / year in funding from Medicare and Medicaid to California’s new government-run health program. As your analysis notes, this will require Congressional action and Presidential signature to amend federal law.

- One, no Administration to date has supported such a change to federal law, including the current Administration, who is not supportive of single payer. While the question has never been called in Congress, the polarized nature of the health care debate in Congress in recent years suggests such a waiver is highly unlikely.
- Two, in the unlikely event California obtains Presidential support, majority support in the House, and filibuster-proof support in the Senate for the needed changes to federal law, there are no guarantees that a future Administration and Congress won’t revoke the waivers. In this event, what would the consequences be to health care in California, including cost, quality and access to care?
- Three, in the unlikely event that federal law is changed and the even more unlikely event that no political change occurs in Washington which jeopardizes California’s waiver, what guarantees are there that the federal government pay California the full amount on a regular basis. What would the impact be of delayed federal funding?

The methodology document fails to mention ERISA even once. What is the impact on overall design and cost to the system if either a) the federal government refuses to provide a waiver for ERISA-plan enrollees, or b) California does not require ERISA-plan enrollees or employers to participate in the system?

2. Additional prerequisite actions

The politically fraught, likely costly and harmful transition to Unified Financing would require several key additional steps beyond creation and implementation legislation, including:

- Voters approving a Constitutional amendment to Prop 98 (school funding protections).

- Voters approving a Constitutional amendment to Prop 4 (the state spending limit).
- Voters approving \$30 billion in bonds (maybe two votes: one to retrain workers, one to create a reserve).
- Voters approving new and higher taxes in the tens of billions of dollars – or more – per year.

What happens if voters don't approve any one or more of these measures? As important, what happens if voters revoke their approval for any of these measures?

3. Deficit Spending

In the event that California is able to obtain the changes to federal law, the required federal waivers, approval from California voters for the Constitutional amendments, the required legislation and the higher taxes – in short, the necessary changes to divert hundreds of billions of dollars a year to the new state-run program – what guarantees are there that the program won't spend more than the existing sources of revenue? California does not have the ability to run deficits like the federal government, so in the event of cost-over-runs there would either need to be additional taxes beyond those already contemplated or cuts to other important programs.

Baseline Projections

California is closer than ever to achieving universal coverage and is leading the nation in developing and implementing efforts to improve affordability, including the very successful launch and continued operation of Covered California, expanding Medi-Cal to more undocumented adults, enhancing state premium and ARP subsidies and potentially creating the Office of Health Care Affordability.

- Why isn't the Commission using the costs of getting to universal health coverage using the existing system as the baseline? Even if the Commission doesn't use this as a baseline, we encourage the Commission to compare the costs of obtaining universal coverage under the Affordable Care Act to those of creating an entirely new universal financing system.
- Why doesn't the baseline reflect the impact of recent activities to improve cost?

The baseline projections appear based on a hodgepodge of different data sources – they start with 2014 California data and trend using national numbers. Why isn't the Commission using California data to model California trends?

The end of the report acknowledges that all estimates are “subject to substantial uncertainty” and that additional study will be required to have a clearer picture of CA-specific costs – to what extent does this impact the suggested range of overall costs? It does not instill confidence in the Commission's final work product if the cost estimates that are the basis for developing universal financing are so uncertain. Does the Commission plan on rerunning the cost estimates prior to finalizing its report?

Spending Under Unified Financing

This analysis assumes an almost immediate implementation in 2022. This is not just unrealistic – it is impossible given the timing of some of the required prerequisite actions, including Congressional action on federal waivers and California ballot measures to amend Prop 98 and Prop 4 (the Gann Limit) and to obtain voter approval for hundreds of billions of dollars in new taxes and bonds.

Additionally, transitioning a single payer financing system is much, much more complicated than other efforts that have been undertaken by the state and could take up to 10 years for full implementation.

The administrative costs of standing up and implementing a direct payment system (or even a global budget) would be enormous and take time to implement. A 3% overhead rate is low. Medicare reports that number because it outsources a huge chunk of its revenue collection costs to the IRS and Social Security Administration, who never report how much of their costs are attributable to Medicare.

Estimated Effects

Universal Coverage

The estimate of the cost of covering the uninsured in 2016 ends up being around \$281.50 PMPM – a figure seemingly based on a number of assumptions including an Oregon study. On its face, this is too low.

- It does not make sense to use the 2008 Oregon experiment as a benchmark.
- The analysis then compares this to estimates from other non-CA states and acknowledge a 2017 study specific to CA, which the report appears not to use for some reason.
- The selective use of non-California studies and failure to use California studies raises questions about the reason some studies are used and others are not.

If anything, the Commission should ask Covered CA for a more reliable estimate of the cost of covering the previously uninsured.

The projected impact of induced utilization is too low and fails to take into account pent-up demand – a very real dynamic for previously uninsured people.

Adult Dental

The analysis assumes an average level of dental benefits per year, which translates to \$1,000-\$1,500 max (annual caps) and significant cost-share or coinsurance.

- This is usually what employers provide, so to use this seems to fly in the face of single payer. Recent single payer bills in the Legislature did not limit dental coverage in any way, so these costs could be low and not reflective of the envisioned single payer system.

- Related, the Commission has discussed limiting or eliminating cost-sharing – what impacts will this have on overall cost to taxpayers?

Cost Sharing

The cost-sharing assumptions generally don't reflect reality.

1. The analysis predicts that getting rid of cost sharing will increase health care costs by only 5.6% due to a slight uptick in utilization. However, the analysis doesn't appear to account for the estimates elsewhere in the report that cost sharing is 8.7% of total health care expenditures. Those payments are taken in by hospitals and providers, so erasing them creates a significant overall reduction in payments to providers. This leads to more questions:

- Do the estimates for a 50% reduction in average hospital costs account for the reduction in cost sharing payments made to hospitals?
- Do the estimates for reduced provider payments account for this lost revenue?
- Are the predicted administrative savings to hospitals (5%) and providers (7%) erased by the elimination of cost sharing payments?

2. The analysis outlines two cost-sharing scenarios, one of which assumes none at all for anyone and another that assumes income-based cost-sharing. The latter second scenario also builds in assumptions related to employers chipping in “to assure that cost sharing for employees does not increase under Unified Financing.” None of the recent bills contemplate any patient cost-sharing.

Income-related cost sharing in a fee-for-service environment would be complex, especially if it was tied to current income.

3. Actuarial Value may not be appropriate to use in determining premium cost shares. There are two cost share options on page 7. One would use actuarial value to determine payment tiers based on FPL. Actuarial Value does not equal cost – there are benefits not included in Actuarial Value that can also drive up costs. This could create misalignment between anticipated revenue and medical costs creating a liability for the state.

4. The report assumes the average employer sponsored Actuarial Value is 89% (platinum). This does not take into account large self-funded plans that typically have larger deductibles. A more realistic assumption would be that the average employer sponsored plan is closer to gold (80%).

5. The induced utilization assumption used is way too low and is based on a Rand Health Insurance Experiment from the first term of the Clinton administration (1993). The report goes from average Actuarial Value of 92.8% to 100% and assumes total costs would increase 8.7% (7.2% cost sharing and 1.5% induced utilization). Based on the normal induced utilization factors used for pricing, it is more likely total costs will go up closer to 15%-20%.

Drug Costs

The analysis assumes a 40% decrease in drug pricing via direct negotiation, including savings from Congress passing HR 9 or similar legislation to enable Medicare to directly negotiate drug prices.

- If this assumption is off even a little, it could throw the entire report estimates off significantly.
- The drug issue alone creates a swing of 5.8% in the estimates. If Congress doesn't pass legislation the estimates of savings are erased.

The report also acknowledges the drug savings would also require the state to employ a "tight formulary" turning down certain drugs and taking away access to an unspecified number of prescription medications for Californians. Will exceptions to this "tight formulary" be made on an individual basis? If so, under what circumstances and with what administrative process? Have the costs associated with such a process been incorporated?

The report also assumes drug price reductions would apply to clinic and hospital administered medications. What ramifications would this have, if actually implemented?

If any of the drug savings come from those purchased by physicians and office-based injections this would result in a significant income loss to those physicians. Is this factored into other reductions in physician reimbursement?

Managed Care

It appears the cost increase from eliminating managed care is derived by estimating the number of Californians in managed care (59%) and multiplying it by 10% to derive a 5.9% increase. Why not instead calculate this based on total % of expenditures?

Hospital Costs

The estimated hospital costs are also likely low.

The report appears to acknowledge that our health care system can't handle the increase in utilization caused by single payer under a FFS model – but also includes an assumption that California would need to expand the workforce. How much would the expanded workforce cost?

The hospital pricing adjustment of 50% seems pulled out of thin air.

- Labor costs are at least 60% of health care costs: does this mean nurse staffing ratios will be reduced to take care of additional utilization, since most of a hospital's costs are driven by labor? Shouldn't this report estimate the impact of lower salaries for health care workers in its calculations?

- How would items such as capital repairs, new hospitals, California seismic requirements be funded?
- The report makes no mention of Medicare's special payments (DSH, IME, GME, and others) and whether that money would be kept in the baseline (and distributed as Medicare would have done).
- What impact would this have on many hospitals' ability to operate?

Provider Savings

A large part of the savings projected by the analysis appear dependent on capping provider growth and reducing it by 10% over time.

- How much would this actually save?
- What percentage of these putative savings would come in the form of reductions to provider salaries or reimbursement rates?
- If some reductions were required, which providers would see cuts? What impact would these cuts have on the ability of the state to recruit the additional workforce required?
- Equitable access to care is important. Efforts to cut provider rates will likely exacerbate poor access to care in underserved areas because providers may not continue to operate in those areas.

The report also appears to assume that California will be paying hospitals a global budget capitated amount. However, the state will very likely want to see claims and encounters to control costs – what impact will this have on the estimated administrative savings?

Reserves / Cash Flow

As noted above, the assumption that “federal funds would arrive in a timely manner and are not at risk, and thus are not estimating a reserve to cover claims fluctuations on the money that would have been used to pay for Medicare and Medicaid benefits” is an overly optimistic assumption about how funds will flow from the federal government. The state would likely have to front load billions in funds to get the program going.

Employer Issues

Currently, employer plans frequently administer benefits with programs that incentivize wellness and help control chronic conditions through incentivized participation. Can and will the state mandate engagement in these programs that currently result in lower costs? If not, what will be the impact?

Summary

As health coverage providers who have fought for affordable universal coverage for years, our members have deep experience with all facets of California's health care system, yet have not been contacted by the Commission to help inform your analysis of this or other issues. The Commission eliminated its plans for engagement with employers and for engagement with providers, and instead appears intent on listening only to a very small number of activist voices that do not represent the residents of California or the hundreds of thousands of health care professionals working in California.

The Commission's failure to engage in this regard has resulted in a set of cost projections that are wildly unrealistic and if implemented would cause massive disruptions to health care.

We encourage you to reach out to the organizations representing California's doctors, nurses, hospitals, plans, brokers and employers going forward.



Nick Louizos, California Association of Health Plans



Faith Borges on behalf of California Association of Health Underwriters