SENATE COMMITTEE ON APPROPRIATIONS
Senator Ricardo Lara, Chair
2017 - 2018 Regular Session

SB 562 (Lara) - The Healthy California Act

Version: April 17, 2017
Urgency: No
Hearing Date: May 22, 2017

Policy Vote: HEALTH 5 - 2
Mandate: No
Consultant: Brendan McCarthy

This bill meets the criteria for referral to the Suspense File.

Bill Summary: SB 562 would create a universal, single-payer health care system in California.

Fiscal Impact: The fiscal estimates below are subject to enormous uncertainty. Completely rebuilding the California health care system from a multi-payer system into a single payer, fee-for-service system would be an unprecedented change in a large health care market. There are numerous uncertainties about how enrollees, providers, employers, and the state would adapt to such a system.

The projected costs and revenue needs for the proposed Program are as follows. For a discussion of the underlying assumptions, see Staff Comments below.

- Total annual costs of about $400 billion per year, including all covered health care services and administrative costs, at full enrollment.

- Existing federal, state, and local funding of about $200 billion could be available to offset a portion of the total program cost.

- About $200 billion in additional tax revenues would be needed to pay for the remainder of the total program cost. Assuming that this cost was raised through a new payroll tax (with no cap on wages subject to the tax), the additional payroll tax rate would be about 15% of earned income.

  It is important to note that the overall cost of those new tax revenues would be offset to a large degree by reduced spending on health care coverage by employers and employees. Although precise estimates of total spending for employer sponsored health insurance are not available, the best available information indicates that existing spending is between $100 and $150 billion per year. Therefore, total new spending required under the bill would be between $50 and $100 billion per year.

Background: The health care system in the state is primarily based upon an employer-sponsored health insurance model (about 45% of the population), with a significant number of people covered by Medi-Cal (26%), Medicare (10%), the individual market (9%), and other federal coverage (2%). Currently, about 8% of the state's population is uninsured.

Of the 3 million Californians under age 65 who are uninsured, about 1.8 million are undocumented adults (who are not eligible for Medi-Cal or subsidized coverage through Covered California),about 550,000 are individuals who are eligible for Medi-Cal, but not

enrolled, about 400,000 are individuals who are eligible for subsidized coverage through Covered California, but not enrolled, and about 550,000 are individuals who are not income-eligible for subsidies through Covered California.

The delivery of health care services in the state varies widely. Some payers, such as Kaiser Permanente, operate fully integrated health maintenance organizations that accept financial risk from payers (typically private employers) and pay for all necessary health care services. On the other hand, most Medicare beneficiaries receive their health care services through a fee-for-service system in which enrolled providers bill Medicare for services provided with no financial risk to the provider and varying levels of care coordination between different providers. About 80% of individuals enrolled in Medi-Cal receive their health care from Medi-Cal managed care plans who bear most of the risk for enrollee health care costs, although the level of clinical integration varies between plans. Bonds vs Equities

In the United States, health care spending represents about 19% of gross domestic product. This is roughly twice the average level of spending in other developed countries. Of the total spending on health care, 32% is for hospital care, 27% is for physician and other professional services, 13% is for prescription drugs, 7% is for health insurance administration, and 5% is for capital investment. It is important to note however, that a significant portion of the nation's spending on prescription drugs (particularly high cost drugs) takes place in hospitals or physicians' offices, and is therefore not counted in the estimated 13% of spending that goes for prescription drugs.

With regard to administrative costs, there are two important issues to note. First, the estimated cost of health insurance-related administration does not reflect the significant costs to providers to interact with health insurers. The costs to negotiate contracts with multiple payers and comply with differing administrative requirements are substantial. On the other hand, any health care system will have significant administrative costs, simply to manage enrollment and pay claims made by providers. For example, the administrative cost to operate the Medicare and Medi-Cal fee-for-service systems are about 6% per year. This is lower than the overall cost of health insurer administration, but still a substantial cost.

Proposed Law: SB 562 would create a universal, single-payer health care system in California.

Key provisions of the bill would:

- Establish the Healthy California Program, to be overseen by an appointed Board;
- Authorize the Board to establish a single-payer health care system;
- Prohibit health insurers or health care service plans from providing coverage for any service covered by the Program; Cash Practices?
- Require the Board to develop plans for providing coverage for long-term care services, coverage for retirees who move out of California, providing coverage for existing retirees, and including the existing workers compensation system within the Program;
- Authorize unspecified funding for retraining of workers in the health insurance industry who would no longer be employed under the bill;
- Require collection of certain information from hospitals (but not other providers);
- Make every resident of the state eligible for the Program;

- Prohibit any cost sharing for enrollees such as premiums, copayments, or deductibles;
- Require coverage for "all medical care determined to be medically appropriate by the member's health care provider";
- Also require coverage for all health care services covered by Medi-Cal, Medicare, health plans regulated under the Knox-Keene Act, and the essential health benefits mandated in the Affordable Care Act;
- Authorize any licensed health care provider to provide services to a member;
- Authorize members to receive health care services from any willing provider, without needing a referral from a primary care provider or a care coordinator;
- Require care coordination services to be provided to members;
- Prohibit care coordination administrative tracking and recordkeeping from requiring the utilization of electronic health records by providers;
- Require payments to providers to be made on a fee-for-service basis unless other payment methodologies are developed by the Board;
- Require all payments to be reasonable and reasonably related to the cost of providing health care services and to ensure an adequate supply of services;
- Authorize integrated health care delivery systems to choose to be compensated on a capitated or non-capitated system budget; <<
- Require the Program to negotiate payment rates with providers' representatives;
- Prohibit payments to for-profit providers or care coordinators to compensate for profits, return on investments, or tax payments made by the provider or care coordinator; ??
- Require the Board to apply to the federal government for permission to include the participants and funding streams for Medicare, Medi-Cal, and Covered California in the Program;
- State legislative intent to develop a financing plan;
- Authorize providers to collectively negotiate payment rates with the Board.

Related Legislation: There have been several bills introduced in recent years attempting to create a single-payer system in the state, including SB 810 (Leno, 2011), SB 180 (Leno, 2009), and SB 840 (Kuehl, 2007). None of those bills were enacted.

Staff Comments: As noted above, this bill would require unprecedented changes to a mature health care system. Therefore, there is tremendous uncertainty in how such a system would be developed, how the transition to the new system would occur, and how participants in the new system would behave.

The following are some of the key underlying assumptions for the fiscal estimates above.

The system is a fee-for-service health care market. The bill would require all payment rates under the program to be "reasonable and reasonably related to the cost…" and require all payments to be made on a fee-for-service basis unless and until another payment methodology is adopted by the Board. While the bill would allow for other forms of payment, the basic requirement in the bill that payments be cost-based and requirements in the bill that patients are able to see any willing provider of services would make it difficult for the Board to create capitated payment systems that would work under those constraints. Administrative Cost Reimbursed

Health care utilization levels and administrative costs are based on the existing Medi-Cal fee-for-service system. The state currently operates the Medi-Cal fee-for-service system which provides services to about 2.7 million people in the state, with a variety of beneficiary types served through fee-for-service. This analysis builds upon the costs and utilization for the Medi-Cal fee-for-service system (with adjustments). There are factors that make fee-for-service Medi-Cal an imperfect model for a state-wide single payer system. For example Medi-Cal beneficiaries, on average, tend to have lower health status than the general population. This would indicate that utilization of services may be lower for a state-wide program. On the other hand, low reimbursement rates in Medi-Cal are likely to constrain the ability for beneficiaries to access service, to some extent. On balance, using the Medi-Cal fee-for-service system as the base for modelling a single-payer system seems to be a reasonable assumption.

There is likely to be increased utilization of health care services over fee-for-service Medi-Cal. Under the bill, enrollee access to services would be largely unconstrained by utilization management tools commonly used by health care payers, including Medi-Cal. The ability for enrollees to see any willing provider, to receive any service deemed medically appropriate by a licensed provider, and the lack of cost sharing, in combination, would make it difficult for the Program to make use of utilization management tools such as drug formularies, prior authorization requirements, or other utilization management tools. Therefore, it is very likely that there would be increased utilization of health care services under this bill, compared to fee-for-service Medi-Cal, Medi-Cal managed care, or the current employer sponsored health insurance system. Therefore, this analysis assumes a 10% increase in health care service utilization over fee-for-service Medi-Cal. Given all the factors that would make utilization management difficult, a 10% utilization increase is likely a conservative assumption.

Provider rates are based upon the rates paid by Medicare. Medi-Cal fee-for-service rates are very low, compared to Medicare or commercial insurance reimbursement rates. Under current practice, providers such as physicians and hospitals rely on Medicare and commercial insurance to subsidize the cost to care for Medi-Cal patients. There seems to be consensus that Medicare rates are close to the cost of providing care. This analysis assumes that the Program would need to pay reimbursement rates close to Medicare rates to ensure continued access to services.

Most state residents are included in the program. The analysis assumes that the state is able to enroll most residents, including those currently covered under Medicare, Medi-Cal, coverage purchased through Covered California, employer sponsored insurance, and the uninsured population. This assumes that the state is successful in obtaining federal approval to enroll participants in federally authorized programs and employer-sponsored insurance regulated at the federal level. The analysis excludes certain federal health care programs for federal employees, military personnel, and veterans.

Most existing state and local funding sources for health care program are made available for the program. This reflects the assumption that the federal government would allow the state to combine federal funding sources with state resources to finance the program. In addition, it assumes that the necessary state law and constitutional changes are made to make most existing state and local funding for health care programs available to finance the program.

Costs are presented in 2017 dollars although full implementation would likely take many years.

The following are some of the key implementation issues the state would face in creating a single-payer system.

How long would it take for the state to implement the system? In order to effectively manage the single-payer system envisioned in the bill, the state would need to develop systems to track member enrollment, track provider enrollment, and pay claims to providers. Development of the information technology systems to perform those functions at the scale envisioned in this bill would be a substantial undertaking. For example, the state is in the process of preparing to replace the existing system for paying Medi-Cal fee-for-service claims (for about one tenth the enrollees that would be covered under the bill). That project was started in 2007. In 2016, the Department of Health Care Services severed its agreement with its contractor and is about to begin the process of procuring a new contractor to restart the project.

Because the bill would include coverage for Medicare and Medi-Cal enrollees, any claims processing system developed by the state would probably need to be able to track whether a member is eligible for either of those programs, in order to ensure that the state can access federal matching funds. (This would only be necessary if federal funding continued to be provided as matching funds for state funding.)

The costs to design, develop, and implement the information technology systems to facilitate the operation of the program alone are likely to be in the billions.

How would the state manage the transition? It would likely take many years to fully implement the system envisioned in the bill. It is difficult to foresee how health care markets would react as the operational date approaches. For example, would health insurers and health plans be able to retain enough employees or make necessary investments in their systems to remain viable up to the transition time? Also, as the prospect of comprehensive health care coverage with no cost sharing by members approaches, would young and health consumers drop their existing coverage, knowing that they would soon be able to receive services at no cost?

In the transition to a single-payer system, essentially all workers in the health insurance industry and many individuals who provide administrative support to providers would lose their jobs. The ability for a very large number of workers to successfully find new employment over the short-term is hard to predict. (Even with job retraining programs authorized in the bill.) Predicting the labor market effects the sudden elimination of a significant industry in the state is beyond the scope of this analysis. decreased insurance cost estimates

Would the federal government cooperate? Under current law, the federal Centers for Medicare and Medicaid Services is authorized to waive certain requirements of the Social Security Act, which governs both Medicare and Medicaid. The federal governments grants "waivers" to a state so that the state can make innovative changes to is Medicaid program. Generally, a waiver must improve health care access or delivery and not increase the federal deficit over the waiver's lifetime. Currently, the state has a number of waivers in place, governing many aspects of the Medi-Cal program. In theory, the federal government could give the state a waiver to allow the state to incorporate Medicare, Medi-Cal, and Covered California subsidies into a single

state program, provided that it met the above requirements. However, there is nothing in federal law that requires a waiver to be granted to a state; it is completely discretionary for the federal government.

Many large employers in the state are self-insured, in that the employer retains the risk for the costs of providing health care to employees. Self-insured employers are regulated under the federal Employment Retirement Income Security Act (ERISA). About 3.7 million Californians receive health care coverage under ERISA plans that are not subject to state regulation. In order for the state to include those individuals in the Program, a change would likely be needed to federal law.

Implementation of the bill would require approval by the voters. There are several provisions of the state constitution that would prevent the Legislature from creating the single-payer system envisioned in the bill without voter approval.

Article XIII B (often referred to as the "Gann Limit") constrains overall state spending growth based on population growth and inflation. Due to subsequent changes made by the voters, the Gann Limit has not fundamentally constrained state spending since the 1980s. However, the very large tax revenues that this bill would require (almost twice current General Fund revenue) would clearly exceed the Gann Limit. Therefore, to successfully implement the bill, the voters would need to amend the state constitution to either repeal the Gann Limit or exempt the taxes to fund the Program from the Gann Limit.

Article XVI, Section 8 (Proposition 98 of 1988) generally requires the state to make payments for K-14 education equal to about 50% of annual General Fund revenues. (The actual funding formulas for Proposition 98 are complex and vary from year to year based on economic conditions and state budgeting.) In the context of Proposition 98, the term "General Fund" revenue refers to state tax revenues, not simply revenues that are deposited in the state's General Fund. Any taxes raised to support this bill would be considered the proceeds of taxes and would be subject to the requirements of Proposition 98. Since it would be infeasible to dedicate one-half of the new revenues for this program to education (or to raise twice the amount needed for the bill), the voters would need to exempt the tax revenues generated to fund this bill from the requirements of Proposition 98.

Article XIII, Section 36 (Proposition 30 of 2012) guarantees that certain tax revenues will be provided to counties to pay for services relating to public safety that were realigned to the counties in 2011. Included in the 2011 realignment is funding for certain mental health services and substance abuse services. In order for those funds to be available to contribute to the financing of the Program, the Constitution would need to be amended.

There would be limited ability for the state to control costs under the bill. In general, there are two ways to control health care spending – controlling utilization of services or controlling costs. In theory, having a single, statewide payer for health care services could create significant bargaining power for that payer to manage utilization and/or control costs. A single payer could be in a very strong negotiating position with health care providers such as doctors, hospitals, and drug manufacturers. However, the single-payer system envisioned in this bill strongly limits the state's ability to control costs.

With respect to utilization of health care services – First, the bill would provide coverage for all medical care "determined to be medically appropriate by the member's health care provider". This broad language would allow health care providers to determine what services they are going to provide, without any ability for the Program to set standards or guidelines for providing services. This would seem to prohibit tools such as prior authorization requirements, drug formularies, or other utilization management tools. Second, the bill would make any licensed health care provider eligible to perform services, which means that the state could not use potential exclusion from the system as a means of negotiating favorable prices, as health insurers often do. Third, the bill would prohibit members from needing a referral before seeing a provider (such as a specialist). This would prevent the Program from ensuring that utilization of expensive specialty care is appropriate.

With respect to health care prices – The bill would constrain the Program's ability to negotiate prices with providers, since it would require all payments to be reasonably related to the cost of providing care. Requiring providers to be paid based on their cost of providing care is likely to lead to increased inflation in costs, since providers would have little incentive to control costs through increased efficiency.

In addition, the ability to negotiate favorable prices for health care services does not necessarily mean that such authority would be used effectively. In practice, any attempt by the state to negotiate favorable prices would be strenuously resisted by health care providers and drug companies. The federal Medicare program is a case in point. Medicare is essentially a single-payer system with about 55 million enrollees. In theory, this should provide Medicare with significant power to bargain favorable prices for services. In practice, the rates that Medicare pays to providers are similar to those paid in the commercial market and are generally thought to correspond to the cost of providing care. Medicare has not been able to successfully use its bargaining power to "bend the cost curve" on health care prices. Further, federal law actually prohibits Medicare from using its bargaining power to secure favorable drug prices. A state-based single payer system would be subject to the same political constraints as Medicare. In addition, it is possible that the federal government would restrict the state's ability to negotiate favorable drug prices, either as a condition of a waiver or through a federal law change.

Administrative cost savings would be real, but limited. Under a single payer system, the overall administrative cost of the system would likely be lower than it is in the current multi-payer system. In the United States, the cost of the health insurance industry is about 7% of total costs. In addition, providers, such as hospitals and physicians, incur significant administrative costs to negotiate contracts and comply with health insurer billing requirements. If we assume that the costs on the provider side are equal to the costs of the insurance industry, then current administrative costs are likely to be about 15% of total spending. Administrative costs in the Medi-Cal fee-for-service system and Medicare are about 6% of spending. Assuming that dealing with a single payer system reduced provider administrative costs by half, total administrative costs of the system in the bill would likely be about 9-10% of total spending. This does represent a significant savings in a $400 billion health care system. However, administrative savings are not likely to substantially lower the overall cost of providing health care in the state, compared to costs associated with expanding coverage to the uninsured and increased utilization of services under the bill. ??

How would Medicare and Medi-Cal funding be provided to the Program? If the federal government were to approve a state waiver request to include funding for Medicare and Medi-Cal into the Program, there are two primary ways that could be done, with myriad variations. The federal government could simply allow the state to provide coverage for those populations and draw down federal matching funds for services provided to those populations. This would represent the entire cost for Medicare beneficiaries and varying levels of federal matching funds for Medi-Cal beneficiaries based on their eligibility. This would represent a status quo in terms of payment systems, from the federal government's perspective. It would have the advantage that the state would not need to accept any new risk for providing coverage for those populations, but it would require the state to develop an information technology system that could accurately track spending on those populations to receive federal matching funds.

Alternatively, the federal government could impose some sort of a "per capita funding" system or a "block grant" system, in which the state either received a fixed amount of funding for each enrolled individual or an overall amount of funding for the program. This would somewhat simplify the state's administrative obligations. On the other hand, the state would likely face risk for increased in utilization levels or costs. Since no state has ever implemented a single-payer system, it is difficult to know what requirements the federal government would place on the state to allow Medicare and Medi-Cal to be included.

The economic impact from the necessary tax increases is unknown. This analysis assumes that the state would impose a roughly 15% payroll tax to finance the unfunded cost of the Program. Such a payroll tax would raise about $200 billion per year. Because the bill would relieve employers of the responsibility for providing employer sponsored insurance, employers would see a reduction in their costs. In the long-run, it is likely that employers would increase wages to employees, so that total compensation would be roughly equivalent to what it was when employers were paying for employee health benefits. How this would play out in reality would depend on the labor market dynamics in place at the time. For example, in a recession when unemployment is high, employers may be under less labor market pressure to pass cost savings along to employers. The opposite effect could be seen in a very competitive labor market.

Effective Employer rebate 50% (tax deductable)

Even after accounting for the fact that employers would see a reduction in their costs for providing employer-sponsored insurance, the bill would result in a significant overall increase in the cost of health care for employees. Under the staff estimates above, the gap between current employer spending on health insurance and the additional revenue needs under the bill would be between $50 and $100 billion per year. The cost of that funding gap would fall on employees under a payroll tax. That means that between 25% and 50% of the payroll tax revenues would represent a new tax on employees, not likely to be offset by higher wages. The state-wide economic impacts of such an overall tax increase on employment is beyond the scope of this analysis.

-- END --