

## THOUGHTS FOR CALIFORNIA HEALTH REFORMS Where Are We Going? How Do We Get There? California's Way Forward!

There were three major roads that California explored to cover all Californians prior to the adoption of the Affordable Care Act.<sup>1</sup>

**One was single payer**, Canadian style, fee for service, low or no copays, rates and fees set by federal or state regulation, freedom of choice of providers, no private insurance plans -- the Lara bill, the Kuehl bill, the Petris bill.<sup>2</sup> This was much like Bernie Sanders' Medicare for All. It is not Medicare, as it exists;<sup>3</sup> it covers more services, eliminates most patient out of pocket and gets rid of private insurance entirely. And in fact it is more like the old MediCal (Medicaid) program before California moved nearly everyone into managed care. Although it is revenue neutral, it was and is very expensive to state taxpayers to replace virtually all private financing with state taxes – an amount equal to all taxes of any kind collected by the state of California – that's \$200 billion.<sup>4</sup> It would be a far-reaching change in California's reimbursement and delivery systems. It has very appealing concepts to the voting public until you get to the increase in your taxes and the elimination of your own insurance plan.<sup>5</sup> It is very difficult to explain that level of tax increase (albeit trading private premiums and out of pocket for public taxes) as being revenue neutral.

**Two was single payer with multiple competing plans**; consumers have freedom of choice among multiple competing plans; they pick their preferred plans and pay the incremental premium difference above the lowest cost plan(s).<sup>6</sup> This approach is about market competition and building the right financial incentives among plans and between providers and with consumers on a level playing field. It uses a very strong purchaser to set the table and assure price and quality. It's the antithesis of the Sanders and Lara approach in terms of reimbursement and delivery systems and far more consistent with what California has now since all of Medi-Cal, all employees and 40% of Medicare subscribers are enrolled in insurance plans. The Congressional equivalent was the bi-partisan Wyden Bennett bill.<sup>7</sup> Rick Kronick, Larry Levitt, and Walter Zelman developed these ideas for then Insurance Commissioner John Garamendi. While the Garamendi plan is less expensive than the Kuehl/Lara/Petris bill because it does not

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<sup>1</sup> Zelman and Wulsin, California's Efforts to Cover the Uninsured (Health Affairs, Sept. 2018) <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0475>

<sup>2</sup> Ibid.

<sup>3</sup> Wulsin, Understanding Medicare for All (Jan. 2019) at <http://www.luciensblog.com/blog/2019/1/31/understanding-medicare-for-all>

<sup>4</sup> Legislative Analyst's Office, Financing Considerations for Potential State Health Policy Changes (Feb. 2018) at <https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/FINAL%20LAO.pdf>

<sup>5</sup> Freid et al, Another Look at the Midterms: Public Not Ready for Medicare for All, (Health Affairs, Dec. 2018) at <https://www.healthaffairs.org/doi/10.1377/hblog20181217.603723/full/>; Politico and Harvard School of Public Health, American's Health Priorities for the 2019 Congress (January 2019) at <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2019/01/Politico-Harvard-Poll-Jan-2019-Health-and-Education-Priorities-for-New-Congress-in-2019.pdf>

<sup>6</sup> Zelman and Wulsin, California's Efforts to Cover the Uninsured

<sup>7</sup> Congressional Budget Office, Analysis of Wyden Bennett Proposal (May, 2008) at <https://www.cbo.gov/publication/24777>

cover long-term care or incorporate Medicare; it still costs a very large amount in new state taxes to replace the costs of private premiums for employment based and individual insurance. I'd guesstimate about \$150 billion (or more than the entire state of California General Fund) would be needed to finance this idea. While I love the concepts, I'm not sure that universal enrollment in private insurance plans is nearly as popular with the voting public as "Medicare for All, and I don't see politically how we finance it. We could use Covered California, as the purchasing pool to incrementally cover many more people and programs in a simpler and more consistent manner, and I'll come back to that interesting opportunity and discuss it later. The fundamental improvements of the Garamendi and Wyden/Bennett plans over the Sanders and Kuehl Medicare for All plans are the flexibility built into contracting, the coordination of care, the development of organized delivery systems and the ability to use many other levers other than rates of reimbursement to effectuate improvements in our state's health.

**Three was the hybrid plan**, which builds on our existing public and private financing and reimbursement and delivery systems.<sup>8</sup> It was conceptually developed by Governor Schwarzenegger and Speaker Nunez and earlier by Assemblyman Margolin (who I worked for) and is now implemented as California's version of the Affordable Care Act. The ACA expanded MediCal, provided premium assistance in the individual market and retained private, employment-based insurance with an employer mandate for those employers with 50 or more employees. These approaches primarily cover the uninsured and upgrade coverage for the underinsured; they protect all consumers from some predatory insurance practices, which go under the rubric of medical underwriting, but basically redline those with pre-existing conditions. Since they do not aim to uproot employment based and individual insurance, they cost state taxpayers far, far less – less than one tenth as much as single payer. But California still would have had to secure voter and legislative approval for such a large tax increase – projected \$10-15 billion in 2008.<sup>9</sup> This takes a 2/3<sup>rd</sup> vote in our state, and it was never achieved. None of the California hybrid measures ever passed the legislature, or were put on the ballot. The ACA solved most of our state's funding problem for the uninsured (increased federal funds of about \$25 billion)<sup>10</sup>, and it simplified Medicaid eligibility, and it reformed the private individual insurance market, and it introduced payment reforms in Medicare, and it slowed the rise in per capita spending. The premium assistance and cost sharing reductions in the ACA are a good start that California can and ought to build on. While the ACA had some payment reforms and spending caps, it did not do enough to simplify our exceedingly complicated and incoherent delivery and reimbursement systems<sup>11</sup> or to

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<sup>8</sup> California's Efforts to Cover the Uninsured

<sup>9</sup> See York, Post Mortem Analysis of the Health Care Bill (Jan, 2008) at <http://capitolweekly.net/postmortem-analysis-of-health-care-bill/> and Lauer, Report on Funding for Single Payer Health Care (July 2008) <https://californiahealthline.org/news/report-on-funding-for-singlepayer-health-care-welcomed/>; LAO, Analysis of SB 840 (Kuehl) at [https://lao.ca.gov/2008/hlth/sb840/SB840\\_analysis.pdf](https://lao.ca.gov/2008/hlth/sb840/SB840_analysis.pdf); LAO, Presentation of LAO on AB X1 (Nunez) <https://lao.ca.gov/Videos/Player?playlistId=32>

<sup>10</sup> LAO, Uncertain Landscape of the Affordable Care Act in California (Feb. 2017) <https://lao.ca.gov/reports/2017/3569/ACA-Landscape-021717.pdf>

<sup>11</sup> A friend who runs a large rural clinic once explained to me "I have 600 different payers and each one has their own different billing and reimbursement system; that adds to my costs and does nothing to improve our patient care."

markedly reduce its costs. For example, we should have assured that all electronic health record products for all providers, insurers and consumers are fully compatible, just as your bankcards are, so when you have an emergency condition, the doctor can easily access your medical information and health records. Under the ACA, California now has a purchasing pool for the individual market and the small employer market; it is a building block that could be expanded by California policy makers to the mid-sized and larger employers (if accompanied by insurance underwriting reforms to prevent it from becoming a bad risk dumping pool).

For those like me whose priority was covering the uninsured, the ACA was manna from heaven. And the state of California only had to pay for 10% of the Medicaid expansion. The ACA gave California a major opportunity to cover its uninsured, and we took full advantage to drive our uninsured numbers down from 7 million to 3 million, from 17% uninsured to 7% uninsured.<sup>12</sup> We have to understand that we are on our own right now, and Californians are going to get no help and likely ever increasing obstacles from the Trump Administration for the next two years. So Californians need to chart our own course, albeit within the constraints of federal financing.

We need to understand that single payer is a fervent wish and aspiration of many but not an imminent reality given the enormous price tag and political and legal hurdles involved in replacing all the private sector financing and the fact that the federal government controls nearly all our public financing.<sup>13</sup> Governor Newsom has done the right thing by requesting the funding and flexibility to construct a single payer bill from the President and Congress for California, but let's not kid ourselves about the ability to easily move to single payer; it would require Acts of Congress and Administration approval to block grant Medicare and Medicaid to California, to give us the necessary ERISA flexibility, and to block grant the federal tax expenditures on employment-based coverage.<sup>14</sup> It would still require massive increases in state taxes to replace private premiums and cost sharing for which there is realistically no governing appetite.<sup>15</sup> In California, we do not have a lot of state General Fund dollars in the game (\$23 billion out of \$100 billion spent on Medi-Cal)<sup>16</sup>, and little local funding remains in indigent care outside a handful of public hospital counties like San Francisco.<sup>17</sup> However

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<sup>12</sup>Lucia, Director, Health Care Program, UC Berkeley Labor Center, Health Coverage Gaps in California (Oct. 2017)

[https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/laurellucia\\_director\\_healthcare\\_reprogram\\_ucberkeley.pdf](https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/laurellucia_director_healthcare_reprogram_ucberkeley.pdf)

<sup>13</sup> See the presentations of Susan Philip, Juliette Cubanski, Scott Graves, Ben Johnson, Ann Marie Marciarille, and Chiquita Brooks La Sure before the Assembly Special Committee on Health Reform on Feb, 5, 2018 at <https://healthcare.assembly.ca.gov/content/2017-2018-hearings>

<sup>14</sup> Ibid.

<sup>15</sup> LAO, Financing Considerations for Potential State Health Policy Changes

<sup>16</sup> Wulsin, Governor Newsom's Proposed Budget for Health and Human Services (Jan. 2019)

<http://www.luciensblog.com/blog/2019/1/26/governor-newsoms-proposed-budget-for-health-and-human-services>

<sup>17</sup> AB 85 County Indigent Care Profiles at

[https://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County\\_Profiles\\_ADA.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County_Profiles_ADA.pdf) About \$750 million was redirected from county indigent health to county social services reflecting the assumption under state formulas of county savings due to the implementation of the ACA. If the state further expands

universal coverage is now within reach in California if we summon the will and secure the financing to build on the existing financial structures and proceed incrementally.

In my opinion, we Californians now need to solve a series of different challenges in our health systems, that are related but not necessarily interlocking.

### **The Remaining Uninsured**

The first is to complete the job of covering three million uninsured; that has two important parts -- better affordability and improved participation in Covered California (one million uninsured Californians) and access to coverage of basic health services for undocumented working families (1.8 million California residents).<sup>18</sup> Each costs between \$2.5 and \$3 billion.<sup>19</sup>

### **High Prices**

The second is to better use our purchasing powers and regulatory authority to slow the 5.5% projected annual rise in health expenditures from now through 2026<sup>20</sup> and to improve the effectiveness of our spending. Since 1982, California has embraced competition and contracting as the antidote to rising health costs, and they have worked reasonably well in the more competitive markets like Los Angeles and San Diego.<sup>21</sup> Part of our problem is that California's competition model does not work well in monopolistic and oligopolistic provider markets, and we don't have any ready alternative like rate setting or aggressive anti-trust or a Medicare buy in. Non-competitive markets include rural, some Bay Area and other communities dominated by one hospital and medical group.<sup>22</sup> One reason for rising prices is hospital consolidation to gain market dominance; another is the natural monopoly in "one dominant hospital" communities.<sup>23</sup> The natural provider monopolies and large dominant oligopolies have

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MediCal coverage for the undocumented, it may wish to partially finance it with the remaining county indigent funds and with hospitals' DSH funds.

<sup>18</sup> Lucia, Health Coverage Gaps in California

<sup>19</sup> Wulsin, The Individual Market and Covered California (Jan. 2019) at

<http://www.luciensblog.com/blog/2019/1/30/the-individual-market-and-covered-california-potential-improvements-in-affordability-for-consumers>; Wulsin, Financing Care for the Undocumented (April, 2016) at

<http://www.luciensblog.com/blog/2016/4/20/4z8e62e0c8wvovytgdt6k2ush4ht7y?rq=Coverage%20for%20the%20Undocumented>; Senate Appropriations, Fiscal Analysis of SB 974 (Lara) (May, 2018) at

[https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201720180SB974](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180SB974)

<sup>20</sup> CMS Office of the Actuary, Projected National Health Expenditures 2017-2026 at

<https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2017-2026-projections-national-health-expenditures>

<sup>21</sup> Covered California 2019 Premiums and Plans at

[https://www.coveredca.com/newsroom/PDFs/CoveredCA\\_2019\\_Plans\\_and\\_Rates.pdf](https://www.coveredca.com/newsroom/PDFs/CoveredCA_2019_Plans_and_Rates.pdf) I compared bronze monthly premiums for a 64 year old in Los Angeles, San Francisco and Eureka. In my part of LA, the monthly premium for an Oscar Bronze plan is \$658; the lowest cost Kaiser Bronze is \$710. If I move to San Francisco, the lowest cost Bronze is Chinese Community Health Plan for \$892; the Kaiser Plan is \$916, but with an HSA and a high deductible health plan combination I can reduce my monthly premium to \$891. If I move further north to Eureka, my lowest price bronze plan is an Anthem Bronze EPO at a monthly premium of \$962. That is 23% of the \$50,000 income of a 64 year old.

<sup>22</sup> Ibid.

<sup>23</sup> Scheffler et al, Consolidation Trends in California's Hospital Market (Health Affairs, Sept. 2018) at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0472>

the consequent ability to increase their prices and raise our health insurance premiums. Adding more insurance plans in provider monopoly counties will do nothing to reduce insurance premiums; transforming the provider network might. Another challenge is drug manufacturers' overpriced products and their ability to dictate price for single source drugs or medications in limited supply.<sup>24</sup> And another is providers' bad experience with inconsistent financial incentives from our multiplicity of payers; there are so many different incentive plans, the incentives and bonuses simply cancel themselves out; as a doctor you cannot treat your Aetna patients differently than your Molina patients. Consumers are not supportive of the move towards narrow networks, high deductibles, limited choice EPO's and the other plan designs that some insurers have turned to. These just dodge private insurers' fundamental responsibility to do a much better job of reining in excessive and high prices.

We don't have enough readily available, reasonably understandable, transparent information on provider prices and quality to make competition work as well as it should/could for consumers using elective care.<sup>25</sup> It's not altogether clear that having access to that information would by itself have much impact on costs.<sup>26</sup>

Although we in California have done a great job on improving maternal health outcomes,<sup>27</sup> we need to consistently and effectively harness our health system's extraordinary healing powers to take on issues like the opioid epidemic in rural California,<sup>28</sup> the increases in obesity,<sup>29</sup> urban and rural food deserts<sup>30</sup> and their related illnesses to try to get healthier outcomes in rural and inner city California. We are a healthy state, but we have geographic pockets and populations with avoidable poor health outcomes. Reducing homelessness, as one example, is going to take sustained coordination among housing, social services, medical care, behavioral health and criminal justice systems.<sup>31</sup> And due to all our program siloes, we are not well set up for the coordinated multi-disciplinary approaches necessary to help those patients in truly dire need of multiple interventions that are not the straightforward medical care in which our medical systems so excel.

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<sup>24</sup> Aspen Institute, Deep Dive: Drug Prices and Access to Medicine (2016)

<https://www.aspenideas.org/sites/default/files/transcripts/Deep-Dive-Drug-Prices-and-Access-to-Medicine.pdf>

<sup>25</sup> See discussions in Blumenthal, Creating Effective Health Care Markets (Commonwealth Fund) at <https://www.commonwealthfund.org/blog/2018/creating-effective-health-care-markets> and Baicker, Coordination vs. Competition in Health Care Reform (New England Journal of Medicine)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4083619/>

<sup>26</sup> Ibid.

<sup>27</sup> Main et al., Addressing Maternal Mortality and Morbidity in California (Health Affairs, Sept. 2018)

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0463>

<sup>28</sup> We have a low rate of opioid deaths nationally, but they are concentrated in rural Northern California counties and they are particularly prevalent in middle age. Davis, How California Ranks in the Nation's Opioid Epidemic (San Diego Tribune, Feb. 10, 2019)

<https://www.sandiegouniontribune.com/news/health/sd-me-opioid-conference-20171108-story.html>

<sup>29</sup> While California has the 4<sup>th</sup> lowest obesity rate in the nation, we have gone from 10% to 25% obesity rates for adults since 1990. The State of Obesity in California. <https://stateofobesity.org/states/ca/>

<sup>30</sup> Sabol, The Presence of Food Deserts in Southern California at <https://www.geospatial.institute/wp-content/uploads/2018/03/Mapping-Food-Desserts-in-Southern-California-Counties.pdf>

<sup>31</sup> League of California Cities, What Can Cities do to Reduce Homelessness (2017) at [https://www.ca-ilg.org/sites/main/files/file-attachments/homelessness\\_session.pdf](https://www.ca-ilg.org/sites/main/files/file-attachments/homelessness_session.pdf)

## Mal-distribution of Providers

The last is the shortage of providers, particularly those located, based in and serving rural California. According to the recent UCSF studies, the Central Valley, Central Coast and other farming regions are badly short changed in their access to primary care and specialty care (e.g. we have a rampant over-supply of doctors in San Francisco and Napa, a totally inadequate supply in counties like Glenn, San Benito, and Imperial).<sup>32</sup> The variability in local provider access runs as high as 10/1 for specialty care and 4/1 for primary care doctors.<sup>33</sup>

## California's Remaining Uninsured

Using CPS data, we have about 3 million remaining uninsured – mostly individuals eligible for Covered California who cannot afford the premiums or workers and their family members ineligible for Medi-Cal due to their immigration status.<sup>34</sup> Covered California has two problems of its ACA design – the sharp cliff in premium assistance at 400% of FPL and the very steep curve in declining financial assistance for premiums and cost sharing from 138% of FPL up to 400% of FPL and 250% of FPL respectively.<sup>35</sup> A couple of years ago, I looked at the cliff impacts for a 60 year old in San Francisco; the effective premiums doubled as they exceeded 400% of FPL; that cliff has only gotten worse as insurance premiums have increased a lot since then and far more than worker's wages.<sup>36</sup> I think the very recent Covered California paper on options to improve the program's affordability of premiums and cost sharing is very promising and points us in the right direction if they are accepted and then financed by the Governor and state legislature.<sup>37</sup> They reduce the premiums required of existing and abstaining subscribers to more affordable levels; they upgrade their coverage, and they extend premium assistance to those over 400% of FPL.<sup>38</sup> This is projected to cover 750,000 of the one million uninsured Californians eligible for but not enrolled in Covered California.<sup>39</sup> The projected \$2.5 billion in new costs, however, will need new state financing.<sup>40</sup> We should be cautious in making assumptions about the Trump Administration's anticipated responses to California requesting a §1332 waiver.<sup>41</sup>

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<sup>32</sup> Coffman, California Physician Supply (California HealthCare Foundation, 2018) <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf> and Gaines, How Many Primary Care and Specialty Physicians are in Your County? (CHCF, 2017) <https://www.chcf.org/publication/california-maps-how-many-primary-care-and-specialist-physicians-are-in-your-county/>

<sup>33</sup> Ibid.

<sup>34</sup> Lucia, Director, Health Coverage Gaps in California

<sup>35</sup> Covered California, Options to Improve Affordability in California's Individual Insurance Market. (Feb. 2019) at [https://hbex.coveredca.com/data-research/library/CoveredCA\\_Options\\_To\\_Improve\\_Affordability.pdf](https://hbex.coveredca.com/data-research/library/CoveredCA_Options_To_Improve_Affordability.pdf)

<sup>36</sup> See n. 21

<sup>37</sup> Options to Improve Affordability in California's Individual Insurance Market

<sup>38</sup> Ibid.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

<sup>41</sup> See Wulsin, Discussion of §1332 Waiver Opportunities for California (Feb. 2016) at <https://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/February%2023,%202016%201332%20State%20Innovation%20Waiver%20Public%20Meeting/ITUP%20PowerPoint.pdf>, and Wulsin, Opportunities for California under a Section 1332 Waiver (Oct. 2016) at <http://www.luciensblog.com/blog/2016/10/16/opportunities-for-california-through-a-1332-waiver> The

We need to develop a better and deeper understanding of the differences between employment based coverage and individual coverage to grasp the scope of the reforms that are needed to improve affordability in Covered California. In the employment based coverage market, the employer on average pays a bit under 75% of the premium, and the employee pays a bit over 25%.<sup>42</sup> In the employment-based coverage market, the federal and state governments subsidize about 1/3<sup>rd</sup> of the premium costs with pre-tax purchasing, albeit in a very regressive fashion.<sup>43</sup> By contrast in the individual market, the employer contributes nothing, and tax advantages are available only as tax deductions for the self-employed, and they are highly regressive since the level of tax subsidy increases as the individual's income moves into higher tax brackets.<sup>44</sup> The ACA helped individuals with incomes under 400% of FPL pay their premiums with refundable tax credits; these tax credits were steeply progressive helping those with the lowest incomes (about \$17,000 a year for an individual) the most and phasing out entirely at about 400% of FPL (roughly \$50,000 for an individual).<sup>45</sup> Health insurance premiums in the individual market are age rated – i.e. those who are older pay higher premiums because on average they use more services. The ratio or rate band is 3/1 for a 64 year old vs. a 21 year old.<sup>46</sup> So premium assistance, where available, helps an older individual more, assuming their incomes are the same as the young person. However, as a corollary, the tax credit cliff at 400% of FPL impacts older individuals the most when they lose their eligibility for premium assistance.

On average, employers buy health coverage for their employees, which pays between 85 and 95% of their average medical bills.<sup>47</sup> Most subscribers in Covered California are buying bronze or silver coverage that covers respectively only 60% and 70% of your average medical bill (definitely not platinum or even gold).<sup>48</sup> They are faced with much

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Trump Administration has approved §1332 waivers for reinsurance in some states but not in others. See Wulsin Opportunities for States under §1332 Waivers (Sept. 2017) at <http://www.luciensblog.com/blog/2017/9/28/opportunities-for-states-under-section-1332-of-the-affordable-care-act?rq=1332%20waiver>

<sup>42</sup> Kaiser Family Foundation, Employer Health Benefits Survey 2018 at <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/> and California Healthcare Foundation, California Health Benefits Survey 2017 at <https://www.chcf.org/publication/california-employer-health-benefits-workers-shoulder-more-costs/>

<sup>43</sup> National Bureau of Economic Research, Tax Breaks for Employer Sponsored Health Insurance (Feb. 2019) at <https://www.nber.org/aginghealth/2010n01/w15766.html>; Tax Policy Center, Briefing Book, What Tax Provisions Subsidize the Cost of Health Care 2018 at <https://www.taxpolicycenter.org/briefing-book/what-tax-provisions-subsidize-cost-health-care>; Congressional Research Service, Health Related Tax Expenditures: Overview and Analysis (2016) at <https://fas.org/sgp/crs/misc/R44333.pdf>

<sup>44</sup> Ibid.

<sup>45</sup> See. n. 35.

<sup>46</sup> California Healthline, Age Bands, 2019 at [https://californiahealthline.files.wordpress.com/2017/10/sbm\\_2018\\_age\\_sloping\\_170926.pdf](https://californiahealthline.files.wordpress.com/2017/10/sbm_2018_age_sloping_170926.pdf) The Trump Administration recently changed the rating for children under and over the ages of 14 to charge higher premiums for children's coverage and even higher premiums for coverage of teenage children.

<sup>47</sup> Bureau of Labor Statistics, Measuring the Generosity of Employer-Sponsored Plans (2015) at <https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.htm>

<sup>48</sup> See n. 35.

higher copays and deductibles when they seek medical care unless their incomes are low enough to qualify for “cost sharing reductions.”

Covered California published a set of four options in February, 2019 that help set a framework for discussions and consideration by the legislature and the Governor.

**Under Option 1:**<sup>49</sup> Premium Assistance is extended to individuals with incomes up to 600% of FPL (\$73,000 for an individual or \$150,000 for a family of four) and expanded to all with incomes between 138% and 400%). Right now premium assistance ends at 400% of FPL (\$50,000 for an individual).

This option would set premium caps for individuals making 138-200% of FPL at 0% of income gradually rising to 1.9% of income; the ACA formula was 3% of income rising to 6.5% of income. For individuals with incomes between 200 and 250% of FPL, the new premium caps would start at 1.9% of income slowly rising to 3.4% of income; this is a big improvement from the ACA formula of 6.5% of income rising to 8.3% of income. For individuals with incomes between 250 and 400% of FPL, the proposed premium caps would slowly rise from 3.4% of income to 8% of income; under the ACA formula the premium caps increased from 6.5% of income to 9.8% of income. For individuals with incomes between 400 and 600% of FPL, the premium caps would increase from 8 to 12% of income; under the ACA there was no premium assistance available above 400% of FPL. Above 600% of FPL, the premium caps would increase from 12 to 15%; under the ACA, there was no premium assistance at this income level.

**Monthly Premium Caps for an Individual Purchasing the Reference Plan**

Percent of income	Premium cap	Option 1: Premium Cap
0-138% of FPL	\$0-29	\$0
138-150%	\$43-63	\$0-6
150-200%	\$63-132	\$6-38
200-250%	\$132-211	\$38-68
250-400%	\$211-399	\$86-324
400-600%	No cap	\$324-728
600% of FPL and up	No cap	\$728-1821

**Under Option 2:**<sup>50</sup> assistance for cost sharing (copays and deductibles) is increased. Cost sharing reductions are only available to individuals who choose the silver plan (70% of actuarial value). In essence “cost sharing reduction” buys lower copays and deductibles for subscribers who qualify. For individuals with incomes between 138 and 150% of FPL, cost sharing stays the same – 94% of actuarial value. For individuals with incomes between 150% and 200% of FPL, cost sharing will be upgraded from 87% to 94% actuarial value. For individuals between 200 and 250% of FPL, cost sharing will be upgraded from 73% to 87% of actuarial value. For individuals between 250 and 400% of FPL, their cost sharing (currently they get no assistance) will be upgraded to 80% of

<sup>49</sup> Options to Improve Affordability in California’s Individual Insurance Market and Wulsin, The Individual Market and Covered California, Potential Improvements in Affordability (Jan. 2019) at <http://www.luciensblog.com/blog/2019/1/30/the-individual-market-and-covered-california-potential-improvements-in-affordability-for-consumers>

<sup>50</sup> Ibid.

actuarial value (a gold plan). Most employer based coverage and Medicare already offer coverage equivalent to or exceeding a gold plan – i.e. copays and deductibles of about 20% of the average costs of medical treatments.

***Cost Sharing Reductions for Individuals Choosing a Silver Plan***

Income Level	Actuarial Value	Option 2 Actuarial Value
0-150% of FPL	94%	94%
150-200%	87%	94%
200-250%	73%	87%
250-400%	70%	80%

**Option 3**<sup>51</sup> would reinstitute the tax penalty for not purchasing insurance at the same levels that they were before Congress repealed them last year. It is projected this would reduce overall individual market premiums by 5% due to a more favorable risk mix.

**Option 4**<sup>52</sup> would provide reinsurance to insurers for the most costly cases in the individual market. It is projected this would decrease individual market premiums by about 10%, as the costs of the most expensive individuals would be reinsured with state funds. The state would seek a §1332 waiver from the federal government to recoup some of the federal savings generated by reinsurance.<sup>53</sup> Federal reinsurance was initially a part of the ACA and helped keep individual market premiums low; it was discontinued in 2015-16, and premiums then increased as a result.<sup>54</sup> Several states, starting with Alaska reinstated reinsurance and saw their premiums drop dramatically; other states followed this lead.<sup>55</sup> Alaska and other states secured §1332 waivers from the federal government to recapture the federal premium assistance savings to help finance their reinsurance programs.<sup>56</sup>

The projected increases in total enrollment from these four changes are 745,000 uninsured individuals newly enrolled in the individual market. The participation rates in the individual market would increase from 50% to 70%. Premiums in the individual market would decrease by 15% due to the more favorable case mix and the reinsurance. Consumers would experience much lower premiums and much reduced cost sharing.<sup>57</sup>

I think these options can be simplified for the public. My suggested graduated formula is up to 2% at 200% of FPL, 4% at 300%, 6% at 400% of FPL and 8% above 400% of FPL. I would recommend tying the premium assistance to the second lowest cost gold, as opposed to silver. Most with employer insurance or Medicare already have “gold” level of coverage. That may add more costs to the proposal that will require financing. We also may need to preclude double dipping at higher incomes from those eligible for both

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<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

<sup>53</sup> Ibid.

<sup>54</sup> See n. 41

<sup>55</sup> Options to Improve Affordability in California’s Individual Insurance Market

<sup>56</sup> See n. 41

<sup>57</sup> See n. 35

the new refundable tax credits and tax deductibility for the self-employed – i.e. you can choose the tax credit or the tax deduction, whichever is most advantageous but not both.

Covered California has just published an important report on the results of the 2019 Open Enrollment.<sup>58</sup> Overall enrollment is the same – 1.5 million; however, new enrollment is down by nearly 25% while renewals are up by 7.5%. While the health status of California’s enrollees has remained far healthier (20% better risk mix and 20% lower premiums) than other states; this is a harbinger that the Trump Administration’s efforts to dismantle the ACA are having some of their desired results and an important message to states to take better control over their own destinies under the ACA as the Newsom Administration is now proposing to do for Covered California. States in the federal Exchanges have experienced an over-all enrollment decline of 12.5% since 2016 while California’s enrollment in Covered California has fallen by 3.9%. The decline could be a combination of a steadily improving economy, the repeal of the tax penalty and the efforts to deter enrollment of legal immigrants through “public charge”.

To get to true universal coverage I think we need to develop continuous auto-enrollment in public and private coverage and to explicitly link the “tax penalties” to your contribution to your coverage. In other words, “you pay your Health Insurance tax/premium and you get your public or private coverage”. That’s a somewhat different and potentially more palatable message than the “individual mandate” to purchase coverage.

The LAO estimates covering low income undocumented adults through MediCal costs about \$3 billion.<sup>59</sup> California already uses Medi-Cal to cover undocumented uninsured children.<sup>60</sup> Governor Newsom proposes to offer full scope Medi-Cal to the next age group aged 19-25 at a new GF cost of \$195 million.<sup>61</sup> Many already have limited scope, emergency Medi-Cal for emergencies and maternity care.

MediCal coverage for low wage, undocumented adult workers may be politically difficult even in deep blue California.<sup>62</sup> Some undocumented have coverage through their employers; I think a better approach may be to build their coverage through their employment, which is already happening to some degree in industries such as

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<sup>58</sup> Covered California 2019 Open Enrollment: Early Observations and Analysis (Jan. 30, 2019) at [https://hbex.coveredca.com/data-research/library/CoveredCA\\_2019\\_Open\\_Enrollment\\_Early\\_Analysis.pdf](https://hbex.coveredca.com/data-research/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf)

<sup>59</sup> Senate Appropriations, Fiscal Analysis of SB 974 (Lara) (May, 2018) at [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201720180SB974](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180SB974) I think that figure is high because the use rate for immigrants is typically a good bit lower than for US citizens.

<sup>60</sup> Ibid.

<sup>61</sup> Wulsin, Governor Newsom’s Proposed Budget for Health and Human Services (Jan. 2019) <http://www.luciensblog.com/blog/2019/1/26/governor-newsoms-proposed-budget-for-health-and-human-services>

<sup>62</sup> Field Poll Finds Support for MediCal Coverage to Undocumented Immigrants (San Francisco Chronicle Aug. 26, 2015) at <https://www.sfgate.com/bayarea/article/Poll-finds-support-to-extend-Medi-Cal-to-6465070.php>

agribusiness and some restaurants.<sup>63</sup> California could adopt a Healthy San Francisco style “pay or play” financing or move towards an ACA style employer mandate extended to smaller employers, as Hawaii currently does with its ERISA exemption.<sup>64</sup> An ERISA exemption would be nearly impossible to get through Congress, and a Presidential signature is highly unlikely. In California we also need to explore three-way financing from the employer, employee and public – not just for the undocumented but even more importantly for the substantial flex workforces of temporary, contract, provisional and part time workers for whom Covered California is their best option.<sup>65</sup> We need to look at the interfaces between MediCal and employment-based coverage as well because the program’s enrollment is now mostly comprised of working families.

If we do these two approaches, over time we can probably get CA’s uninsured numbers down from 3 million to less than a million (2.5% uninsured), or maybe even 500,000 of our state’s population of 40 million.

### **Slowing the Rise in Health Spending**

Health care per capita spending increases have been modest recently (except in Covered California); however they will be going up to about 5.5% annually between now and 2026 projects the HHS Office of Actuary.<sup>66</sup> The biggest increases will be in Medicare spending (7.8%) due to the growing numbers of baby boomer retirements and their shift from employment-based coverage to Medicare.<sup>67</sup> Price increases by providers will continue to be the leading cause of per capita spending increases, and high prices are already the primary reason we spend a far larger percent of GDP on health care than any other nation.<sup>68</sup> We are not getting great value in increased life expectancy and other health indicators from our nation’s high spending habits; in fact our nation’s life expectancy maybe going in reverse as middle aged white working men and women without a college degree lose faith in the national economy’s inequitable impacts on their families.<sup>69</sup>

Since 1982, California is a state that has favored competitive markets, contracts, price negotiating and the growth of HMOs as opposed to state rate regulatory solutions;

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<sup>63</sup> Wulsin, Thoughts on Financing Care for Undocumented Adults (April 2016) at <http://www.luciensblog.com/blog/2016/4/20/4z8e62e0c8wvovytgdt6k2ush4ht7y?rq=Coverage%20for%20the%20Undocumented>

<sup>64</sup> Ibid.

<sup>65</sup> Ibid; and Wulsin, Coverage for the Flex Workforce (ITUP, October 2000); Options to Increase Coverage for the Child Care Workforce (ITUP, 2002), and California Child Care Providers Assoc. Health Policy Recommendations (ITUP, 2004)

<sup>66</sup> CMS Office of the Actuary, Projected National Health Expenditures 2017-2026 at <https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2017-2026-projections-national-health-expenditures>. See also, Kamal et al, How Much is Health Spending Expected to Grow (Health System Tracker, Dec. 2018) at <https://www.healthsystemtracker.org/chart-collection/much-health-spending-expected-grow/#item-start>

<sup>67</sup> Ibid.

<sup>68</sup> Ibid. and Squires, Explaining High Health Care Spending in the US (Commonwealth Fund, 2012) at [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_issue\\_brief\\_2012\\_may\\_1595\\_squires\\_explaining\\_high\\_hlt\\_care\\_spending\\_intl\\_brief.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_may_1595_squires_explaining_high_hlt_care_spending_intl_brief.pdf)

<sup>69</sup> Case and Deaton, Mortality and Morbidity in the US in the 21<sup>st</sup> Century (2017) at <https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf>

regulatory approaches are far more popular in some eastern states and quite successful in Maryland. Competitive models in California are facing multiple challenges: the rise of hospital oligopolies and their price increases, the rise of and the unanticipated failures of IDNs (integrated delivery networks) to achieve expected price reductions and care improvements, and the drug industry's ability and increasing willingness to raise prices sky high and with impunity for single source drugs. In large swaths of rural California, natural monopolies preclude price competition, resulting in high priced coverage for those living in low wage regions that can least afford it.<sup>70</sup>

Governor Newsom has proposed Prudent Purchasing of Drugs by Medi-Cal and as many other health programs as California can get into and under the big tent; its market size could give an approach like this good traction, but it will face a huge lobbying campaign by the pharmaceutical industry and allies in the state legislature.<sup>71</sup> The Trump Administration apparently wants to take on the Prescription Benefit Managers (PBM's)<sup>72</sup> who take a big (too big) cut on the price negotiations they are able to achieve such that the savings they achieve are not passed onto the consumer. Congress could be in the mood to take on the monopoly pricing power of Big Pharma on single source and life saving drugs.<sup>73</sup>

First, I'd like to see the California Attorney General start to investigate and bring antitrust actions against the local and regional provider and insurer monopolies and oligopolies that are using their market positions to raise their prices.<sup>74</sup> Second, we should consider Medi-Cal managed care buy ins into those regional commercial markets where competition is now failing to do the job of offering better priced care and coverage.<sup>75</sup> Third, we need to see greater price transparency across the board so those interested and able consumers can do a better job of shopping for elective services.<sup>76</sup> Fourth and maybe most important is to bring as many lives into Covered California as possible – MediCal, public employees, small businesses, mid sized businesses, large businesses, early retirees.<sup>77</sup> We need to simplify what is unnecessarily complex and

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<sup>70</sup> See n. 21

<sup>71</sup> Wulsin, Governor Newsom's Proposed Health and Human Services Budget (Jan. 2019) at <http://www.luciensblog.com/blog/2019/1/26/governor-newsoms-proposed-budget-for-health-and-human-services>

<sup>72</sup> HHS, Trump Administration Proposes to Lower Drug Costs (January 2019) at <https://www.hhs.gov/about/news/2019/01/31/trump-administration-proposes-to-lower-drug-costs-by-targeting-backdoor-rebates-and-encouraging-direct-discounts-to-patients.html>

<sup>73</sup> Emmanuel, Both Parties Agree that Prescription Drug Costs are Out of Control at [https://www.postandcourier.com/opinion/commentary/commentary-both-parties-agree-prescription-drug-prices-are-out-of/article\\_2cadb2b6-ec31-11e8-a952-87f5759935f7.html](https://www.postandcourier.com/opinion/commentary/commentary-both-parties-agree-prescription-drug-prices-are-out-of/article_2cadb2b6-ec31-11e8-a952-87f5759935f7.html)

<sup>74</sup> Scheffler, Consolidation Trends in California at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0472>

<sup>75</sup> While many favor Medicare buy-ins, I think the fee for service model is not conducive to a healthy competition with existing plans built on contracting arrangements with local providers, whereas the local MediCal managed care plans have contracted networks at favorable prices, providing a fairer competition.

<sup>76</sup> See n. 25. It seems absurd to me to have a competitive market without price transparency.

<sup>77</sup> Covered California could be the negotiator for MediCal and state and county and local employees with no changes in federal law; likewise federal law permits a state to use its Exchange to negotiate for mid-sized and large employers. There are a series of obstacles that must be overcome to assure that it does not become the dumping ground for bad risk employers and to assure that the risk pools remain separate.

administratively costly -- common coverage, common payment reforms, common health plans and provider networks and ultimately common pricing (this last one is very difficult). We need to bring some of the better performing Medi-Cal managed care plans into commercial markets to enhance price competition. We need to assure seamless continuation of medical treatments<sup>78</sup> as individuals transition among the different coverage plans offered as their incomes and family compositions change. We need to promote more successful integrated delivery networks in addition to and in healthy competition with the well-regarded Kaiser model.<sup>79</sup>

I'm not a big fan of the narrow network, high deductible, bronze tier plans being developed as a solution by insurers as a way to assure premium affordability for moderate and middle income working families.<sup>80</sup> I'd prefer to see them piloted for Members of Congress and high-ranking executive branch officials and their family members with no tax preferred spending accounts attached, maybe top health plan executives should enroll their families as well.

I'm becoming more and more interested in very broadly applicable expenditure caps because I'm growing increasingly skeptical that anyone technique or combination of techniques is going to slow and reverse this rise of health spending. Unless there are per capita global spending caps on all programs, we're likely to see the pressure you put on one side of the balloon pop right up on the other side. I liked the expenditure caps featured but never triggered for Medicare and the Cadillac benefits tax in the ACA;<sup>81</sup> I'd like to see California and Congress reinstate, fine tune and expand them. I'd like to see California adopt those aspects of Expenditure Targets that appear to be working in Massachusetts and were recently adopted in Rhode Island and Delaware.<sup>82</sup>

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However this would permit common reimbursement and simplified reimbursement, making the system far simpler and easier to navigate for doctors, hospitals, patients, plans and employers.

<sup>78</sup> It makes no sense and is seriously dangerous to patient outcomes to change doctors, treatment plans and hospitals for seriously ill patients as their income and family status and employers shift.

<sup>79</sup> <https://www.beckershospitalreview.com/hospital-physician-relationships/4-key-characteristics-of-successful-integrated-managed-care-models.html>

<sup>80</sup> These types of plans can leave moderate and middle-income patients far too exposed to high out of pocket costs they cannot afford and dependent on networks of care that they are not well equipped to assess and financial decisions on foregoing essential care that they cannot afford. They may result in large and unaffordable surprise bills from doctors out of the network. Governor Newsom's proposal to improve affordability of more extensive coverage through premium assistance and cost sharing is the much preferable approach. If these plans make sense for anyone, it's for high-income consumers with ample disposable income and access to expertise in making the complex provider, plan and cost sharing trade-offs that these designs require.

<sup>81</sup> The ACA had an expenditure cap on the growth in per capita Medicare spending and an Independent Payment Advisory Board with authority to make needed reimbursement changes to keep the program's spending growth under control. There are a wealth of different available approaches, see for example, Committee for a Responsible Federal Budget, How to Reduce Medicare Spending Without Cutting Benefits (2017) at <http://www.crfb.org/blogs/how-reduce-medicare-spending-without-cutting-benefits> The ACA also had a Cadillac Benefits tax of 40% on high cost plans. This has been strongly criticized by employers and unions alike as poorly designed given the variation in employer plans based on the health of their employees as opposed to the richness of their benefits, see e.g. Lemieux et al, About that Cadillac Tax (Health Affairs, April 2016) at

<https://www.healthaffairs.org/doi/10.1377/hblog20160425.054627/full/>

<sup>82</sup> Massachusetts, the highest priced health care in the nation, set per capita health expenditure targets equal to the growth in the state's economy. So far, they appear to be working and Massachusetts' health

## **Workforce Distributional Challenges**

In rural California, we do not have enough doctors, particularly specialists to deliver the necessary medical care, while in urban and suburban LA and the Bay Area we may have too many (and they do not seem to be very interested in moving to the Central Valley).<sup>83</sup> We are going to need more FQHCs and more RHCs who can hire physicians, more physician contracting, more telemedicine, better performing district hospitals with their capacity to raise funds from engaged local taxpayers, greater use of NPs (nurse practitioners) and PAs (physician assistants) who can help meet the doctor deficit, and the development of integrated urban/rural networks to better meet the health care needs of rural California.

## **Behavioral Health**

In Medi-Cal in order to develop specialty treatments of behavioral health conditions, we have trifurcated local agency responsibility for drug addiction, mental illness and physical health -- one patient, three systems of care and patient privacy barriers to sharing information vital to patient care.<sup>84</sup> Care for those patients needs to become seamless, and California has authority under its §1115 waiver to create “Whole Person Care” pilots. San Mateo, Inland Empire, Los Angeles, San Diego and Santa Cruz are making progress. It’s way past time for all Californians with these severe behavioral and physical health challenges to have access to a unified system of care, and Governor Newsom proposes to add \$100 million to the “Whole Person Care” pilots in the coming fiscal year.<sup>85</sup> We may want to investigate the creation of SHMOs (Social Health Maintenance Organizations) to combine and integrate the many elements needed to reduce homelessness in our communities.<sup>86</sup>

We have an engaged and experienced new Governor. Let’s get on with fixing what we can while we can.

Prepared by: Lucien Wulsin

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spending growth has been lower than the nation over the past four years.  
<https://www.mass.gov/files/documents/2018/03/28/Cost%20Trends%20Report%202017.pdf> Rhode Island just adopted an expenditure growth target of 3.2% per capita over the next five years.  
<https://www.aha.org/news/headline/2019-02-08-rhode-island-governor-announces-health-care-spending-target> Delaware likewise set an expenditure target per capita that will over time equal the growth in the state’s economy, beginning at 3.8% and phasing down to 3.0%.

<https://news.delaware.gov/2018/12/19/health-care-spending-benchmark/>

<sup>83</sup> See n. 32 See Recommendations of California Future Health Care Workforce Commission at

<https://futurehealthworkforce.org/wp-content/uploads/2019/02/ExecutiveSummaryFinalReportCFHWC.pdf>

<sup>84</sup> Connolly and Washington, California’s Drug MediCal Waiver is a Big Deal and Here’s Why (ITUP, Aug, 2015); Wulsin, Summary of §1115 Waiver Renewal Terms and Conditions (ITUP, January 2016); Shah, Whole Person Care Pilots and Drug MediCal (ITUP, Feb. 2016), and Wulsin, Mental Health and Substance Abuse in California’s Public Health Programs (ITUP, Aug. 2012)

<sup>85</sup> Connolly and Washington, Behavioral and Physical Health Service Integration in California’s Safety Net: Six County Profiles (ITUP, Oct. 2015) and Wulsin, Governor Newsom’s Proposed Health and Human Services Budget; ITUP, Notes from the Field, Behavioral Health (ITUP, Feb. 2019) at

<http://www.itup.org/wp-content/uploads/2019/02/Notes-from-the-Field-Behavioral-Health-FINAL.pdf>

<sup>86</sup> SHMOs were initiated in the early 70’s to help the elderly stay out of institutional care in nursing homes and hospitals. On Lok in San Francisco and SCAN in Long Beach were early pioneering plans.

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