RE: Single Payer
DATE: September 14th, 2018

I. Overview of the Issue

Single Payer can mean many different things, but at its most basic "single payer" refers to a single, centralized, publicly controlled means to collect, pool, and, distribute funds to pay for medical care for the entire population. No two healthcare systems are identical, and even single payer systems like England and Canada differ greatly when analyzed.

A single payer system, if designed and funded correctly, can meet a number of healthcare goals including: universal access and coverage, greater equity, greater access, improved affordability, lower administrative costs, and slower growth in healthcare costs. Implementing a single payer system in California without federal buy-in raises a number of issues that need to be addressed before the system can be successfully implemented.

Attached as Exhibit A to this document is a a policy proposal to implement a single payor type system for commercial insurance products in the state of California. This proposal does not need approval from the federal government.

Attached as Exhibit B is a brief memo outlining the power and the authority the Governor's Office has regarding implementation of single payer.

II. Summary of State Legal & Regulatory Structure

A. Regulatory Structure

California's healthcare system is extremely fragmented. 54% of Californians have private health insurance, 37% have public health insurance, and 8% are uninsured. Of the approximately 3 million uninsured, 1.8 million of those are undocumented immigrants. (minor change –used new KF numbers). (didn't know if you want to add this but here are UHW estimates: Of the 3 million uninsured roughly 1 million need state support to afford healthcare insurance)

1. Medi-Cal

Since the ACA Medi-Cal expansion, California has nearly doubled its Medi-Cal population from 8.6 in 2012 to almost 14 million currently. Eligibility in Medi-Cal is primarily determined by income (138% of FPL or less) although certain disabled populations are covered as well. There is limited cost sharing, but in practice, Medi-Cal enrollees almost never have to pay additionally for their care. Average per enrollee costs are low compared to other Medi-Cal programs (approx. 5200/enrollee) and this can be largely attributed to California's low provider payments rate which ranks about 49th when compared to other states.

- Over 1/3 of Californians are on Medi-Cal.
- Program nearly doubled after implementation of ACA.
- Low per enrollee costs but also low provider payments.

2. Medicare

In California, Medicare covers 4.3 million people. There are three parts of Medicare: Part A (Hospital Insurance); Part B (Medical Insurance); and Part D (Prescription Drug Insurance.) Medicare primarily covers seniors and has a 20% co-insurance provision built in for some services, as well as a deductible and premium. This means for any medical service not including hospitalization, the patient is responsible for 20% of the overall cost and must pay a monthly premium. The deductible for inpatient hospitalization is $1,316 for the 2018 benefit period.

- 20% cost sharing, deductibles, and premiums still makes this insurance unaffordable for some.
- Not a true single payer anymore because of Medicare Advantage which allows for-profit health insurance companies to contract with the federal government to manage benefits and services for enrollees. However, some single payer countries use private companies to administer their federal entitlement.

3. Private Insurance.

In California, 54% of the population is covered through private insurance. The vast majority received employer sponsored coverage while 8% purchase individual coverage.

4. Covered California.

About 1.4 million people receive coverage through Covered California, the state based insurance exchange created through the ACA. Individuals up to 400% of the FPL receive premium subsidies while those up to 250% of FPL receive cost sharing subsidies. While the exchange has been a success, double digit premium increases are making plans less affordable for people who don't receive subsidies, and federal attempts to dismantle funding remain a threat.

B. Challenges for a State Run Single Payer System

1. Most enrollees currently like their healthcare coverage, and so the transition to a separate, state government plan could be met with opposition.
2. What is done with insurance carriers? If private insurance is phased out altogether, it would be both a political issue (as they would campaign tirelessly to avoid the single payer program), and a potential economic one (as they employ many people).
3. Approval from the federal government: Most single-payer proposals would require passage of a Section 1332 Waiver, during an unfriendly

administration, in order to wrap together Medicaid, Medicare, CHIP, and ACA subsidies.

4. California currently contains a constitutional amendment (Proposition 98) that requires all tax increases to send a proportion of funds towards education, potentially complicating a tax to fund the law. Any redirection of these funds will require a public vote and passage of a ballot initiative and a likely expensive and contentious campaign.
5. New state employees will likely be needed to design healthcare benefit packages and financing systems, enroll customers, establish provider reimbursement rates and reimburse providers, and perform a myriad of other tasks.
6. Usurping the authority of the Insurance Commissioner (a constitutional officer) to regulate health insurers will be necessary (See Exhibit B) and may be difficult.
7. Realigning the authority of and funding for counties that administer local healthcare coverage programs will be needed and may be difficult.
8. Coordination with the State's Controller, Treasurer and Attorney General (constitutional officers, See Exhibit B) will likely be necessary.

More details on the need for constitutional amendments:

The Gann Limit

The Gann Limit became law when voters passed Proposition 4 in 1979. Among other provisions, it limits the growth in appropriations by the State Legislature. While implementing a single payer system might save overall costs on healthcare spending, government spending is certain to increase on a single payer system as all financing will shift to public funds. A constitutional amendment to allow an exception to the Gann Limit will be required in order to implement a bill like SB 562.

Proposition 98 and Single Payer Funding.

Proposition 98 requires the Legislature to utilize a complex formula for setting a minimum annual funding level for K-12 schools and community colleges. The result is that a percentage of all new and existing revenues is required to be devoted to educational funding unless the revenue stream has a specific exemption from the Proposition 98 formula. The only way to get an exemption is to amend the constitution. (See Proposition 56, Tobacco Tax.)

If California implemented a single payer system, a constitutional amendment would likely be required in order to protect the funding. Billions of dollars of new public revenue would be required to implement a single payer system, and these funds need to be exempted from the Prop 98 formula in order to give the system a sound and reliable funding stream. Any effort to exempt large portions of the state budget from the Prop 98 formula will likely be opposed by the California Teachers Association and other educational advocacy groups.

Section 1332 Waivers

Section 1332 of the Affordable Care Act permits state to apply for a state innovation waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. The waivers must create a health care system that is at least as comprehensive and affordable absent the waiver, with coverage to a comparable number of residents. The 1332 waivers are similar to the Medicaid 1115 waivers, but they are broader (encompassing any aspect of the health system that is federal in origin). The waiver period is for 5 years at a time, and is approved by the Centers for Medicare and Medicaid Services (CMS). This will represent a significant barrier to single payer, because to pursue changes to the ACA structure (i.e. combining Medicare, Medicaid, and private insurance subsidies into a single entity) would require approval from the Trump Administration.

Funding

While overall healthcare costs may go down under a single payer system, public funds spend on healthcare will increase. An economic analysis of SB562 (below) predicted that overall system costs would rise by 10%, but that the single payer system could provide savings of 18%. Therefore, new funding sources need to be identified in order to fully implement a single payer system. These could include:

- Gross receipts tax on businesses
- Sales tax
- Payroll Taxes (including employer paid)
- Employer Mandate
- Healthy SF like tax on Employers
- Tax on Sugary Drinks
- Reorganization of State Budget
- Marijuana Taxes
- Reorganization of insurance markets

A gross receipts tax of 2.3% on business transactions and sales tax of 2.3%, along with exemptions and tax credits for small business owners and low-income families to promote tax-burden equity, would pay for a single payer system.

III. Hot Topics Overview

A. SB 562: CNA sponsored legislation to set up a single payer system in California.

B. Federal Repeal and Replace Efforts: Republicans at the federal level are trying to dismantle the ACA.

C. Learning from previous attempts at Single Payer

1. Vermont

2. **Canada**
3. **Healthy San Francisco**

D. Implementation plan: Ideas for an orderly transition to Single Payer

1. **Combining Medicaid, CHIP, and Medicare into a single-payer system**
2. **A Public Option Single Payer Phase-in**
3. **Expansion of Single Payer Starting with Older Adults**
4. **Expanding Healthy SF Statewide**
5. **All-payer rate setting**
6. **Medicare Advantage For All**
7. **ERISA-sound single payer plan**

IV. Hot Topics In-Depth

A. SB 562:

1. Relevant Legislation/Regulation/Policy Proposals

CNA sponsored legislation authored by Pro-Tem Elect Toni Aktins and Senate Appropriations Chair Ricardo Lara that would set up a single payer system in California. Would pool all existing healthcare spending and create a single insurance product for all Californians. The Health Plans, Chamber of Commerce, Agricultural Industry, and the California Medical Association are opposed to the measure claiming it lacks funding details and would completely upend the current healthcare system.

An economic analysis accompanying this bill found that costs would increase by 10% but that a single payer system would decrease net overall costs (as it reduces administrative costs and uses its purchasing leverage to reign in other forms of cost) by 18%, a net savings of 8%. The authors proposed a gross receipts tax of 2.3% on all business transactions and a sales tax of 2.3%. Net health spending for middle-income families would be predicted to fall by 2.6-9.1 percent of income, small firms would experience a 22 percent decline in health care costs as a share of payroll, medium firms would see their health care costs fall between 6.8 and 13.4 share of payroll, larger firms with less than 500 employees would experience a 5.7 percent fall, and the largest firms would experience a 0.6 percent fall as a share of payroll.

2. Importance to CA

The bill attempts to address the shortcomings in our healthcare market. People are still struggling today with affording health coverage and even those that do have coverage, still face out-of-pocket costs that makes healthcare unaffordable. The economic analysis behind the bill adds academic rigor to a plan forward for single payer, ensuring it doesn't bankrupt the state. SB 562 would eliminate the private health insurance industry and the health plans are obviously opposed to the measure.

B. Federal Repeal and Replace:

Given that the individual mandate of the ACA has been repealed in the GOP tax bill, we expect to see premium increases based on young healthy individuals leaving the market and thereby negatively affecting the risk pool. Given rhetoric in Washington D.C., it is likely we will see further attempts to undermine the ACA and in turn, the amount of federal funding California receives for healthcare.

C. Learning from previous attempts at Single Payer

Opponents and proponents of single payer are likely to tie attempts at single payer in California to previous attempts, both successful and unsuccessful, so it is worth knowing the facts.

1. **Vermont attempts at single-payer: Green Mountain Care**

- Passed in 2011, it was spearheaded by Dr. Peter Schumlin, the newly elected Governor
- Initial passage in 2011 contained no details on financing, because the Governor thought this would leave it open to attacks that would fatally wound it in the legislature.
- Governed by a public-private partnership, and a third party (BCBS) would administer the program.
- Medicare not integrated with the plan, and plans from outside the state would still need to be processed, so not a true "single-payer" proposal.
- Initially based on study by Hsiao, called for 14.2% payroll tax (employers paying 10.6 % and employees paying 3.6%).
- Implementation: after initial passage of the legislation, there was a 5 person board appointed, who made ultimate decision regarding budgets and insurance rates. Centralized under the control of governor.

Why it failed

- State received $1.17 in matching funds for every $1.00 put into Medicaid based on FMAP percentage, and planned on a series of 3% increases to draw down additional funding.
- However, Vermont economy was not growing as fast as analysts thought, meaning state could no longer afford these increases.
- Simultaneously, the state increased AV to 94% from 87%, eliminated state taxes on medical providers, and allowed nonresidents working in Vermont to join, making the program more expensive.
- A 2014 analysis by Shumlin administration showed that single payer would increase payroll taxes by 11.5%, and state income tax by 9%, and program would only save 1.6% in costs, lower savings than predicted (even though this more expensive version would still lower costs for 90% of families).
- Trust in state to manage health care fell apart after disastrous launch of Vermont Health Connect, state exchange.
- Subsequent analyses seem to think that Vermont failed for political reasons rather than simply economic ones. The unresolved issue of paying for reform was a much tougher political sell, even if it would still benefit families, because the payroll tax would be immediately obvious on everyone's tax bill.

Considerations for California

- Include financing of the proposal upfront in any legislation to back a single-payer bill.

- Trust in CA to manage health care is likely higher than VT, given the widely successful rollout of Covered CA, so this may be less of an issue.
- A gross- receipts tax, as suggested by the Pollin study, may be more politically feasible, because such a tax would be "invisible," similar to the current tax credits for employer sponsored insurance. The sales tax component would certainly be more visible.
- Adopt policies promoting public buy-in and strengthening state infrastructure to make it easier to create single payer in the future. Since 1979, Vermont's Certificate Of Need program gives it broad authority to control hospital costs and the number of inpatient beds and since 2007 its All Payer Claims Database has collected, analyzed and released comparative information about healthcare costs and become a catalyst for data-driven innovation, transparency and accountability. California has adopted neither of these policies, just as examples.
- Third party administrator?
    - Leaning on third party administrators may be an effective way to wrap in private insurance carriers.
    - However, California has multiple payers, with no one insurance carrier dominating the market, like VT had. This would make it more difficult to have a single third-party insurance administrator.
    - If one insurance carrier is selected to be a solitary third-party administrator, Kaiser may make the most sense given its efficiency and long track record of success.
- Board to direct reform?
    - VT had a board to direct reform, which centralized the effort in the governor's office (rather than distributed across the agencies), and the goal was to expedite reform.
    - Pollin study (directed by the California Legislature) calls for similar proposal.

2. Canadian approach to single payer

- Born out of an initial implementation of single-payer, called Medicare, in Saskatchewan in the early 1960s.
- Saskatchewan overcame a "doctor's strike," which took place for 23 days.
- Medicare rapidly spread from Saskatchewan to the rest of the provinces, after a Commission (dubbed the "Hall Commission") recommended single-payer instead of a more stepwise approach. The Commission recommended it because it would produce more administrative savings and because it would cover Canadians regardless of ability to pay.
- The starting date was July 1, 1968, and the Act provided that the federal government would pay about half of Medicare costs in any province with insurance plans that met the criteria of being universal, publicly administered, portable and comprehensive. By 1971 all provinces had established plans which met the criteria
- In 1966, passed the National Medical Care Insurance Act, and private insurers were pushed out of the physician care markets where they were operating.
- Canada pays 11% of GDP on health care compared to 18% in US, with Canada having better life expectancy.
- Wait times in Canada are typically longer for specialty procedures, but not for other forms of care. A direct comparison of wait times across countries is difficult.

- For hospitals and doctors, Canadians don't pay a single dollar out of pocket. However, Canada does not cover vision, dental, prescription medications, psychotherapists, and physical therapy.
- About 2/3 of Canadians get private insurance to supplement Canadian Medicare.

Considerations for California

- Difficult to directly compare given that implementation of Canadian Medicare was fifty years ago.
- Private insurance continues to exist in Canada. It acts supplement to Medicare (not entirely dissimilar from Medicare Advantage), which could be a model for allowing private coverage to continue to exist in California.
- Large gap in administrative costs and administrative personnel required between US and Canada. Savings attributed to this reduction in administrative costs help fund Healthy CA in the Pollin study.

3. Healthy San Francisco

- Health care access program for uninsured adults ages 18 to 64. Is not a health insurance product, and is not single payer. Cannot get care outside of San Francisco.
- Healthy SF enrollees are required to choose one of participating clinics as point of first contact for all of their basic medical care.
- In between 2007 and 2011, had 95,580 unique enrollees, and in 2011 had 54,500 enrollees. Many exited because they were enrolled in public or private coverage, or moved out of the county. Had a high of 65,000 enrolled in 2014, which subsequently declined to 14,000 after the coverage provisions of the ACA began.
- 3 of 4 enrollees had a physician visit. Improved access to primary care and reduced uncertainty in meeting their health care needs.
- Thought to have played a role in declining non-urgent ED visits at SFGH

Considerations for California

- Difficult to make a direct comparison because this was not single payer, but rather a backstop program for the uninsured.
- The model of a backstop coverage option could be an alternative in case the push for single-payer fails, allowing us to achieve universal coverage in CA.
- It would certainly be cheaper and wouldn't require a section 1332 waiver (so could be an option if the Trump Administration rejects a 1332 waiver from California).
- If a 1332 waiver is approved, coverage of all of the uninsured, leading to universal coverage, could also be part of a plan of steady expansion to single payer (see below).
- The pairing of enrollees with primary clinic sites was lauded in the program as improving chronic disease management and primary care. Participants in Healthy CA could be required to choose a primary clinic site as well, creating a foundation in primary care in the state.

D. <u>Implementation plan: Ideas for an orderly transition to Single Payer</u>

1. **Combining Medicaid, CHIP, and Medicare into a single-payer system, and then expanding it to cover everyone else as it accrues savings and we build revenue from tax increases.**

- Combining Medicaid, CHIP, and Medicare would require a Section 1332 waiver. If this is carried through, it would allow for a reduction in health care costs through greater purchasing power.
- If the Pollin study is accurate, some savings will be accrued by savings in pharmaceutical costs and the provision of health services. Other administrative cost savings will only accrue once Healthy CA takes over from some of the private insurers (given the comparative efficiency of government-run care versus private care).
- We could start financing this with only the gross-receipt tax, which covers most of the price tag of the single-payer plan. We can delay the sales tax, which would potentially be more acutely felt by consumers, to be phased-in over time.
- These savings could then fund a gradual switch to single-payer, outlined in 2) or 3).

Pros:

- Would be potentially an easier political sell, as the gross-receipts tax will be less felt by consumers.
- Would ensure solvency of the program, as the expansion would happen only after revenues were first generated.

Cons:

- Requires 1332 Waiver, and an amendment to prevent tax increases from going all to education.
- Savings from reducing administrative burdens are not immediately generated

2. A Public Option Single-Payer Phase-in: create a public option with the intent of allowing it to slowly take over all private enrollees.

- Those not previously on Medicaid, CHIP, and Medicare could be allowed to buy in to Healthy CA, regardless of whether or not they are on the individual marketplace, uninsured, or an enrollee in an employer-sponsored plan.
- Individuals on the exchange and businesses would begin switching to the public option Healthy CA, as premiums became cheaper than private insurance plans.
- ACA subsidies could either be folded into Healthy CA at the outset, or gradually over time.
- Redirecting ACA subsidies away from private plans toward the public option would give it a comparative advantage, with the intent goal of eventually switching everyone into a single payer system.

Pros:

- Enrollees could gradually move to Healthy CA from their own private plans at their own pace, if it out-competes individual and employer sponsored plans.
- Eventually, savings would accrue from reducing administrative burden from private plans as they are pushed out of the market.
- Well-understood policy by the general public given the recent federal debates.

Cons:

- No potential role for private insurance plans in the long-term future, unless they are allowed to continue to exist as "Medicare Advantage" equivalents.
- May take longer to realize administrative savings, as private insurance would not disappear overnight.

3. A steady expansion of single-payer, starting with older adults:

- As revenues are generated and savings are accrued from the taxes and procedures outlined in 1), Healthy CA could also be expanded for free starting at the highest age groups (starting with 55+), gradually folding the individual and employer market in.
- Every 1-2 years, Healthy CA would enroll younger enrollees. The individual exchanges would be eliminated for enrollees above the age cutoff, and they would be enrolled automatically into Healthy CA.
- The sales tax and gross receipt tax would be phased in over time, allowing this expansion to take place over several years
- Higher proportions of these taxes will have to be phased in at first, as older adults tend to be more expensive to cover.
- Over 5-10 years (or, however long as stipulated), this expansion would cover every Californian.
- If for some reason the state collects less in revenues than expected, the expansion could be delayed at any time point, allowing the legislature to reconsider revenue-generating proposals.
- We could also allow others to buy-into the coverage pool to make the pool more diverse and reduce costs
- We could allow consumers to upgrade their benefit package by paying higher premiums, co-pays and/or deductibles.

Pros:

- Automatic enrollment means that enrollees no longer have to go through the often arduous process of choosing a plan, with many people not understanding how to shop and compare.
- This implementation plan takes the numbers generated by the Pollin study and can be hastened or slowed depending on the desired expansion time horizon.
- Insurance plans may be more willing to agree to this arrangement at first, given that the oldest adults are the most expensive ones, and insurers would be left to cover the remaining healthier adults.
- For those remaining in the individual market, their premiums would drop or stabilize, as the most expensive enrollees are shifted to the single payer system.

Cons:

- Enrollees may see less benefit of switching to Healthy CA if their premiums substantially drop or stabilize.
- If the expansion does have to stop because of lack of revenue, intense lobbying from those being taxed could thwart an expansion that covers every Californian. Even so, many more millions would already be covered.

4. Expanding Healthy SF Statewide

- The stopgap coverage provided in Healthy SF would be expanded to cover the remaining uninsured in California.
- Would instantly provide universal coverage to all Californians, regardless of immigration status (as about ⅓ of the uninsured are undocumented).
- New enrollees could be required to select a primary care site for their initial medical care, like Healthy SF, which has been successful
- Could be paired with any of the above expansions, either with a public option, or an expansion starting with older adults.
- This policy is well known to Lt. Governor Gavin Newsom, as he was the Mayor of SF when it was implemented there.

Pros:

- Would be a quicker way to achieve universal coverage in California, and could be part of the transition to single payer.
- Wouldn't require a 1332, unless it was to be folded in with Medicare, Medicaid, CHIP.
- The governor could tout that he has the experience in achieving universal coverage in SF, and he is now expanding that universal coverage scheme to the state.
- The previously uninsured have the most to gain from single-payer, because coverage in and of itself has been associated with a reduction in mortality.

Cons:

- As many of the uninsured tend to be poorer or undocumented, Healthy CA may become known as a "program for the poor," even though this wouldn't eventually be the case. As a result, others may not want to join the system because of misperceptions in lack of quality.
- This population may be some of the most expensive to cover, as previously uninsured adults seek care for the first time.

5. All-payer hospital rate setting:

- This would create a commission that would set rates for all hospital services within California. This could be done in conjunction with some of the other options offered.
- Maryland, the only state to have such authority, has done this since 1971. According to a 2009 study, the cost of a Maryland admission went from 26% above the national average in 1976 to 2 percent below the national average in 2007. Also resulted in greater access to equitable care, because even those on Medicaid can visit the state's top facilities. It makes no difference to the government because they charge the same amount.
- Also currently exists "de-facto" in Medicare. Regulation sharply limits the incentive that private insurers in Medicare Advantage have to pay providers more than traditional Medicare, so public and private Medicare often pay the same.
- The Pollin study also supports a rate-setting system, stating this approach "should be seen as potentially one important component of the newly created Healthy California Board, in its efforts to capture, through care integration, at least a significant fraction of the 18.8 percent in wasted spending on service delivery identified by the IOM. This task clearly falls within the framework outlined by the draft legislation."

Pros:

- Proven way to reduce costs and generate savings for the state.

- Maryland previously had set up a waiver to allow Medicare and Medicaid to pay hospitals on the basis of what it approved, so there is a long historical precedent of waiver approval.

Cons:

- Hospitals and providers will likely oppose attempts at cost control.
- Maryland authority, in part, comes from a federal Social Security Act waiver exempting it from the Inpatient Prospective Payment System and Outpatient Prospective Payment System. It is unlikely that the federal government will authorize this for California.

6. Allowing private insurers to continue to operate as "Medicare Advantage" equivalents to Healthy CA.

- About one third of Medicare enrollees choose Medicare Advantage over traditional Medicare plans.
- We could allow those enrolled in Medicare Advantage to stay enrolled in those plans even after implementation of Healthy CA.
- Simultaneously, the equivalent of Medicare Advantage could be created for Healthy CA enrollees not previously covered by Medicare, allowing for some insurers to maintain their enrollees.
- Similar to Medicare Advantage, the cost-sharing structures could be very regulated, with reimbursement rates set by Healthy CA.
- However, if Healthy CA benefit design doesn't have cost-sharing associated with most services, such as outpatient visits, pharmaceuticals, ER visits, or inpatient stays, and broad networks with sufficient drugs on its formulary, there would be little incentive for anyone to stay in a Medicare Advantage equivalent plan.

Pros:

- It would generate less opposition from insurance companies
- Would allow consumers to have some choice in their insurance plan.
- Wouldn't cause health insurers to shut down altogether, causing massive layoffs.
- Those already enrolled in Medicare Advantage plans wouldn't be kicked off

Cons:

1. Would need to have cost-sharing, narrow networks, or medications not on formulary as part of Healthy CA to make
2. anyone incentivized to purchase the equivalent of a Medicare Advantage Plan.
3. Wouldn't accrue the same amount of administrative savings that simply doing away with private insurance altogether would generate.

7. ERISA-sound Single Payer (See Exhibit A for full details)

- A large number of CA employers would form a new private organization (let's call it the ACE) – an association health plan – to purchase health insurance as a single risk pool / negotiating entity.
- Legally, ACE would be formed under the Trump Administration's finalized regulation to allow association health plans (AHPs) to operate as single employer ERISA plans, so long as they establish commonality of interest based on shared location in a single geography (or engagement in a common trade, industry, or business), and are "controlled by [their] employer members, either directly or indirectly."

- The State of California would create a new premium-support grant program to subsidize insurance premiums purchased by a qualifying program. The new State funding would be conditioned on an eligible program adhering to certain criteria, including limits on administrative overhead, provider payment rate-setting, quality improvement, and others.
- The subsidy criteria would be drafted with the ACE in mind, although Medi-Cal and other programs would be eligible to apply for the State subsidy. Public sector as well as private sector employers would be able to affiliate to the ACE.
- The ACE would contract with existing insurers and employees would choose among a selection of negotiated options.
- Though incentivized to participate by the promise of subsidized premiums, participation would be voluntary for employers. Employees of non-participating companies would not have recourse. The self-employed would potentially be eligible to participate, but their removal from the individual market would leave that market less stable.

Pros:

- Maintains a familiar construct for both employers and employees; bringing benefits without huge upheaval in the experience of offering or selecting health insurance
- Offers an appealing middle-path for political moderates because it doesn't require the creation of a large new government program
- The regulatory construct is supported by the Trump administration
- Wouldn't require a section 1332 Waiver

Cons:

- Would require significant funding for state subsidies in the form of a new tax
- New concept, which brings inherent unpredictability in legal footing; AHP regs. on which it hinges could be revoked
- ERISA preemption calls into question how many strings the state could attach to its money
- Not a true single payer solution
- Billions of state dollars flow to a single (or several) private organizations, with little ability to regulate without total revocation of funds
- Destabilizes the individual/small group market for any non ACE-participants
- Self-employed folks moving from Covered CA to the AHP would lose their ACA subsidies; leaving federal dollars on the table

V. Best Sources of Reporting/Research/Policy Papers on this Issue

Vermont:

All Payer Claims Database Council, https://www.apcdcouncil.org/state/vermont

Green Mountain Care Board http://gmcboard.vermont.gov/con

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Healthy San Francisco

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Meyer, Harris. "Clinton's Medicare Buy-In Concept Revives Debate on Public Option." Modern Healthcare, http://www.modernhealthcare.com/article/20160512/NEWS/160519951

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Exhibit A

VIRTUAL SINGLE PAYER OPTION #1: Association of CA Employers (ACE)

CORE CONCEPT

A large number of CA employers would form a new private organization (let's call it the ACE) – an association health plan – to purchase health insurance as a single risk pool / negotiating entity. The State of California would create a new premium-support grant program to subsidize insurance premiums purchased by a qualifying program. The new State funding would be conditioned on an eligible program adhering to certain criteria, including limits on administrative overhead, provider payment rate-setting, quality improvement, and others. The subsidy criteria would be drafted with the ACE in mind, although Medi-Cal and other programs would be eligible to apply for the State subsidy. Public sector as well as private sector employers would be able to affiliate to the ACE.

The ACE would contract with existing insurers and employees would choose among a selection of negotiated options. The ACE's sheer size would drive down prices and its adherence to the State's funding criteria would improve plan quality. The State could apply similar rules to Medi-Cal and CoveredCA plans, aligning nearly all health insurance and provider contracting.

Though incentivized to participate by the promise of subsidized premiums, participation would be voluntary for employers. Employees of non-participating companies would not have recourse. The self-employed would potentially be eligible to participate, but their removal from the individual market would leave that market less stable.

Legal Analysis & Potential Risks

1. **Legal Issues with Creating the ACE.** The first issue is how to create the ACE so that funding can be channeled to it. This implicates three ERISA issues: (1) the definition of an "employer" eligible to sponsor an ERISA plan; (2) how public sector organizations can join private sector ERISA plans; and (3) an ERISA preemption rule that a law cannot impermissibly make "reference to" an ERISA plan.

    - **Definition of Employer.** We imagine forming the ACE under the Trump Administration's proposed regulation to allow association health plans (AHPs) to operate as single employer ERISA plans, so long as they establish commonality of interest based on shared location in a single geography (or engagement in a common trade, industry, or business), and are "controlled by [their] employer members, either directly or indirectly." The regulation is still just proposed; thus subject to change before it is finalized, and will likely be challenged in court. The bulk of the rule seems likely to be upheld, although the provisions allowing self-employed individuals to affiliate to an AHP may not survive based on court precedent that an owner without another employee is

not an "employer." Note, however, that even without the ACE, an organization could be set up to receive funds—a Multiple Employer Welfare Association (MEWA)—that would not be an ERISA plan. With a MEWA, the ERISA plans would exist at each individual employer level, and the MEWA would serve as the plan administrator and broker.

- **Public Sector Affiliations.** Public sector employers can be part of an ERISA plan so long as the private sector participation is more than *de minimis*. To be even safer, the private sector employers should form the plan first and then affiliate public sector employers, so that private sector employers are "establishing" the plan.

- **Preemption of Laws that "Reference" ERISA Plans.** Courts have interpreted ERISA's preemption of laws that reference ERISA plans to mean that a state law cannot directly "refer to" an ERISA plan, cannot act "immediately and exclusively upon ERISA plans"; nor can "the existence of ERISA plans [be] essential to the law's operation." Therefore, enabling legislation cannot directly propose to fund the ACE. Instead, the law must be structured to fund (or at least potentially fund) non-ERISA programs that deliver healthcare in addition to the ACE, such as Medi-Cal, public sector plans that don't affiliate to the ACE, church plans, or other health care funding programs.

2. **Legal Issues with Funding the ACE and Other Programs.** The next legal issue is whether the size of the subsidies to the ACE and other programs that meet the criteria would be an impermissible **"connection with**" ERISA plans, and would thus be preempted. So long as the subsidies have only an "indirect economic effect on choices made by . . . ERISA plans," the subsidy should be upheld. If, however, the subsidies are so large or structured so as to create a "Hobson's choice" for ERISA plans, then a court is more likely to find the funding structure preempted, as discussed further in the memo on Covered California.

3. **Legal Issues with the Criteria Used to Fund the ACE and Other Programs.** There is also a risk of preemption with setting funding criteria that impinge upon matters "central to plan administration," which includes reporting, disclosure, fiduciary duties, and benefit design. There is a strong argument under Ninth Circuit precedent, however, that ERISA would not preempt such criteria if used to award the subsidy to the ACE, because case law is more favorable to a state law that offers "carrots" than to a law that attempt to impose "sticks" on ERISA plans. However, the carrot cannot be so large (or as Dan says, there cannot be so much chocolate offered) so as to effectively amount to forcing an ERISA plan to take those incentives. This is the same issue discussed above with regard to avoiding a subsidy that is so large as to be irresistible.

4. **Legal Issues with Insurance vs. Self-Insured Plans**. ERISA does not preempt "any law of any state which regulates insurance," which gives us some flexibility to set rules that govern claims administration and benefit design by regulating insurance. This is one reason to favor having the ACE be insured (i.e., offer its benefits through insurance companies), rather than self-insured. The extent to which the insurance savings clause would provide a defense to a plan to subsidize insurance premiums for insurance that meets certain criteria is untested, but it should factor into our plan design as a possible argument.

Summary of Pros / Cons

PROS	CONS
• Aggregates employers in a single entity to create "facts on the ground" for moving towards a unified health care system of payors that can lay the groundwork for centralized cost and quality controls. • The aggregate employer entity could be linked to future organizing by creating an employer association that acts in a unified manner with regard to employee benefits, and by laying groundwork for a member association. In turn, the member association would help insulate the AHP from legal challenges, particularly if the AHP were maintained by a collective bargaining agreement. • Maintains a familiar construct for both employers and employees; bringing benefits without huge upheaval in the experience of offering or selecting health insurance • Offers an appealing middle-path for political moderates because it doesn't require the creation of a large new government program • The regulatory construct is supported by the Trump administration • Offers a private sector solution that is more insulated from political interference than the Covered CA model	• New concept, which brings inherent unpredictability in legal footing; AHP regs. on which it hinges could be revoked • ERISA preemption calls into question how many strings the state could attach to its money • Billions of state dollars flow to a single (or several) private organizations, with little ability to regulate without total revocation of funds • Destabilizes the individual/small group market for any non ACE-participants • Self-employed folks moving from Covered CA to the AHP would lose their ACA subsidies; leaving federal dollars on the table • The benefits of the state subsidies would be hidden to consumers, as they would pass from the state to the AHP to the plans, potentially threatening the popularity of the payroll tax over time.

Exhibit B

MEMORANDUM

RE: Healthcare Reform: Governor Authority and Limitations

DATE: ********, 20**

This memorandum provides an overview of issues related to expansion of health care coverage through either a single- or a multi-payer approach. It can stand alone or serve as an addendum to the Single Payer and Multi-Payer Health Care Coverage and/or Health Care Costs memoranda. It includes information about:

- The authority of the Governor and some of its limitations related to such healthcare reforms
- California's complex managed healthcare and health insurance regulatory framework
- State programs likely impacted by either approach to coverage expansion, and
- Some policy issues to consider addressing that could support either approach to coverage expansion.

Authority of the Governor and Some Limitations

Although the Governor has significant health care-related regulatory and purchasing authority, this has significant limitations. As a result, leadership to successfully champion health care reform will likely include building and maintaining relationships with key Constitutional Officers and local public officials in order to address important interdependencies and coordinate policy and financing strategy development and implementation.

The Governor's authority includes oversight of licensing of physicians, hospitals, clinics, managed care plans and other health care professionals or health care facilities but not all health insurers[1] or all hospital, clinic and other facility licensing, health care coverage purchasing[2] [3]or healthcare transparency[4] [5], workforce development[6] or financing[7] programs.

Specifically, the Governor does not have authority over:

- The Insurance Commissioner who licenses and regulates health insurers and some managed care plans through the California Department of Insurance (CDI)
- The State Attorney General who has authority over corporate mergers and acquisitions and hospital and health plan conversion to or from for- or non-profit incorporation and antitrust laws that prohibit hospitals and other businesses from geographic price-setting[8]

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[1] http://dmhc.ca.gov
[2] http://board.coveredca.com
[3] http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx
[4] https://oshpd.ca.gov/HID/
[5] https://data.chhs.ca.gov
[6] https://oshpd.ca.gov/HWDD/
[7] https://oshpd.ca.gov/CalMort/
[8] https://khn.org/news/california-hospital-giant-sutter-health-faces-heavy-backlash-on-prices/

- County Governments who have authority to operate and finance clinics, hospitals and health centers largely serving uninsured persons and County Operated Health Systems (managed care plans)[9] [10] [11]
- Local Healthcare Districts who have authority to operate and finance hospitals and other facilities[12] or
- The State Controller and State Treasurer who have authority that impacts healthcare coverage purchasing and financing[13] and CalPERS which purchases coverage for state employees and retires and 1,200 local school districts[14].

Diverse Healthcare Delivery and Financing Models, Geography and People

In addition a fragmented regulatory framework, California policymakers face challenges crafting effective policy solutions in a state with significant geographic and economic variation, a large, culturally and linguistically diverse population and a wide array of healthcare delivery and financing models.[15]

California's Healthcare Delivery and Managed Care Landscape

California has one of the highest managed care penetration rates (percent of persons enrolled in managed care) of any state[16], providing the majority of private sector (employer-based) and public sector (including Medi-Cal) through managed care. Seven CDI-licensed health insurers and 71 Department of Managed Health Care (DMHC)-licensed health plans cover medical services[17] and 47 DMHC-licensed specialized health plans cover mental health, dental or vision or other services.[18]

Thousands of individual providers (i.e., physicians or medical groups) and facilities (i.e., clinics or hospitals) contract with health plans and insurers to be reimbursed at contracted or non-contracted rates. Around 450 hospitals are licensed by California and eight hospital systems, among them the University of California, provide 40% of the beds, 65% of which are at non-profit hospitals.[19] Around 800 freestanding ambulatory surgery centers, none licensed by California, operate under the authority of a physician's license.[20] These are just some examples of the marketplace complexity and size.

Managed Health Care and Health Insurance Regulation in California

Health insurance in California is subject to a complex patchwork of state and federal regulations with different rules depending on whether coverage is purchased directly by an individual or on behalf of a group (such as an employer). The rules also depend on the size of the group purchasing coverage. Consumer

[9] https://www.lhpc.org/local-member-plans
[10] https://www.chcf.org/wp-content/uploads/2017/12/PDF-GovernanceModelsCAPublicHospitals.pdf
[11] http://files.kff.org/attachment/fact-sheet-the-california-health-care-landscape
[12] http://www.lao.ca.gov/handouts/Health/2012/Overview_Health_Care_Districts_4_11_12.pdf
[13] https://cbig.ca.gov/Government-Partners/California-Health-Facilities-Financing-Authority
[14] https://www.calpers.ca.gov/page/active-members/health-benefits
[15] http://files.kff.org/attachment/fact-sheet-the-california-health-care-landscape
[16] http://www.chhs.ca.gov/InnovationPlan/CalSim_Market_Assessment_Final.pdf
[17] https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaHealthInsurers2017.pdf
[18] http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx
[19] https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaHospitals2015.pdf
[20] https://www.chcf.org/publication/californias-ambulatory-surgery-centers-a-black-box-of-care/

protections vary based on how an employer chooses to cover their employees' costs, whether they pay service claims directly or whether they purchase coverage through a state-regulated company.[21]

California health insurers and managed care plans are regulated based on their services offered and business models. The DMHC regulates 26 million consumers' medical coverage and 40 million specialty health plan policies.[22] The CDI regulates health coverage for 1.4 million consumers. The 2.5 million consumers' health coverage is regulated by local or federal government.[23] Some counties have established Local Health Plans – six County Operated Health Systems operate in 22 counties and nine Local Initiatives operate in nine counties collectively serve around 7 million Medi-Cal enrollees.[24] The federal government regulates coverage provided through large employers (self-insured), Medicare, ERISA and the Veterans Administration. Depending on the federal, state or local regulator, financial solvency standards, mandated health benefits and consumer protections vary.[25]

Industry Trends

Enrollment and Revenue Growth. From 2013 to 2015, California health insurer revenues were up 32% to $162.5 billion from $122.9 billion and LA Care, the largest county-operated insurer, more than doubled revenue due to Medi-Cal growth, making it the sixth largest insurer in the state. Enrollment in individual coverage and publicly managed health plans surged in 2014 and 2015, the former growing 58% (858,000) to 2.3 million and the later growing 52% (3.5 million) to 10.3 million.[26]

Market Consolidation. Health plan, hospital and medical group consolidation has led to price increases through a lack of competition in several California counties[27], prompting the Legislature to consider laws to address these issues[28] [29]. A CVS-Aetna merger is pending DMHC and CDI approval and since 2015[30]: Centene acquired HealthNet for $6.8 billion (CDI and DHMC approved), St Joseph and Providence hospitals merged (OAG approved), BlueMoon Capital Management acquired Daughters of Charity hospital (OAG approved), non-profit Blue Shield acquired for-profit Care 1st (DMHC and OAG approved)[31], Anthem acquired Cigna for $48.3 billion (CDI and DMHC approved) and Aetna acquired Humana (CDI and DMHC approved).

Non-Profit Hospitals and Health Plans. California provides significant tax breaks to non-profit hospitals and health plans and, in return, requires they provide "community benefits". Thirty-one of 71 DMHC-

[21] https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIMURegulatoryOversight.pdf
[22] https://wpso.dmhc.ca.gov/dashboard/MarketPlace.aspx
[23] http://www.chbrp.org/other_publications/docs/Estimates%20of%20Sources%202017%20Final%20082916.pdf
[24] http://www.itup.org/wp-content/uploads/2018/03/Public-option-issue-brief-3.20.18.output-1.pdf
[25] https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIMURegulatoryOversight.pdf
[26] https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaHealthInsurers2017.pdf
[27] http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf
[28] https://californiahealthline.org/news/california-lawmakers-consider-giving-state-regulators-more-grounds-to-reject-health-insurance-mergers/
[29] https://khn.org/news/california-hospital-giant-sutter-health-faces-heavy-backlash-on-prices/
[30] http://health-access.org/consumer-protection/merger-watch/
[31] http://static1.squarespace.com/static/54f9fdb2e4b0bec7776174f4/t/5611587ae4b00e2783b8c447/1443977338088/June+2+E-1.pdf

licensed health plans[32] and 191 of 450 California-licensed hospitals[33] are non-profit corporations. Policymakers have attempted to address these issues, including mergers and for-/non-profit hospital or health plan conversions. The DMHC, CDI and OAG may approve or delay such actions with stipulations, such as a requirement to establish a multi-million dollar community foundation, but the DMHC and CDI lack authority to reject them.[34] [35]

The Uninsured

The number of uninsured California residents dropped from 7 million[36] in 2012 to 2.9 million in 2017 due to Medi-Cal expansion and implementation of the ACA[37] [38] but many uninsured are not eligible for Medi-Cal due to immigration status.[39]

Coverage Expansion and Payment Reforms Impact on State Programs

State coverage purchasing programs are administered by Department of Health Care Services Medi-Cal ($1 billion for 13.3 million enrollees), CalPERS ($9.1 billion for 1.4 million enrollees)[40] and Covered California ($340 million for 1.4 million enrollees)[41]. Without more details about the approach to expand coverage, the extent of the impact and potential longterm efficiencies or cost savings cannot be determined. However, likely impacts to state programs, regardless of the approach, include:

- Adoption and implementation of a governance structure to establish, monitor and adjust financing strategies, benefit design and other policies;
- Financing mechanisms, including establishment of premium, copay and deductible amounts and ability to collect and manage funds;
- Expansion and management of provider networks, reimbursement rates and claims payment systems;
- Establishment of outreach programs to attract and contract with providers and enroll consumers, and;
- Cost-shifting away from county government and/or the private sector to the State.

Related Policy Topics

Some policy topics that may be incorporated into any approach to expand healthcare coverage include:

- Transparency & Public Reporting[42] [43] [44] and Confidential Data Sharing
- Cost Controls (Value-Based Purchasing, Rate Regulation and Performance Measures)

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[32] https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaHealthInsurers2017.pdf
[33] https://oshpd.ca.gov/HID/Hospital-Financial.html
[34] https://californiahealthline.org/news/california-hospitals-must-cough-up-millions-to-meet-charity-care-rules/
[35] https://californiahealthline.org/news/hospitals-want-to-cut-back-on-free-care-critics-say-no-way/
[36] https://www.kff.org/report-section/ca-uninsured-introduction/
[37] http://www.itup.org/wp-content/uploads/2017/08/ITUP-Remaining-Uninsured.pdf
[38] https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaUninsuredDec2016.pdf
[39] https://www.chcf.org/publication/californias-uninsured-as-coverage-grows-millions-go-without/
[40] https://www.calpers.ca.gov/docs/forms-publications/health-benefits-program-annual-report-2017.pdf
[41] http://board.coveredca.com/meetings/2018/05-17/CoveredCA_2018-19_Proposed_Budget-5-17-18.pdf
[42] https://www.hfma.org/transparency/
[43] https://www.rwjf.org/en/library/research/2016/03/how-price-transparency-controls-health-care-cost.html
[44] https://aspe.hhs.gov/basic-report/framework-evaluating-price-transparency-initiatives-health-care

- Healthcare Workforce (Education/Training, Supply, Distribution and Scope of Practice[45])[46]
- Tax Exempt Hospitals' Charity Care and Community Benefit Mandates[47] and
- Medication Costs, Transparency and Pharmaceutical Benefit Management Companies[48].

Additional Resources:

California HealthCare Foundation
California Health Reform Before the ACA: A timeline of policy proposals for California[49]
Key Questions When Considering a State Based Single Payer System in California[50]

California Research Bureau, Ninety Years of Health Insurance Reform Efforts in California[51]

Healthcare Now, links to national and states' single payer studies[52]

Legislative Analysts Office, The Uncertain Affordable Care Act Landscape: What it means for California[53]
University of California San Francisco, A Path to Universal Coverage and Unified Health Care Financing in California[54]

[45] https://www.library.ca.gov/Content/pdf/crb/reports/CRB_CPM_Final.pdf
[46] https://healthforce.ucsf.edu/publications/california-s-health-care-workforce-readiness-aca-era
[47] https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031914-122357
[48] http://www.pharmacy.ca.gov/publications/pbm_chcf_jan_03.pdf
[49] https://www.chcf.org/wp-content/uploads/2017/12/PDF-TimelineReformProposals.pdf
[50] https://www.chcf.org/wp-content/uploads/2017/12/PDF-KeyQuestionsSinglePayer.pdf
https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/
[51] https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1307&context=caldocs_agencies
[52] https://www.healthcare-now.org/single-payer-studies/listing-of-single-payer-studies/
[53] http://www.lao.ca.gov/reports/2017/3569/ACA-Landscape-021717.pdf
[54] http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Report%20Final%203_13_18.pdf