

**Additional Comments to the HCFA First Report for Potential Incorporation**

*From: Anthony Wright and Beth Capell, Health Access California*

1. **Persons with disabilities:** Although the definition of unified financing mentions that states that entitlement would not vary by disability status, nowhere does the report reflect the benefits that persons with disabilities need, not just long term care services and supports but benefits such as durable medical equipment or protracted physical, occupational and speech therapy or other social supports. Both Medicare and particularly Medi-Cal provide substantial help to persons with disabilities, including developmentally disabled children, that are not provided in employer coverage or individual coverage.
2. **Eliminating distinctions among coverage:** As the report notes, different sources of coverage provide different benefits and different cost sharing. One of the policy questions to be determined is whether more comprehensive benefits and lower or zero cost sharing offered by Medi-Cal would be changed to be more like other coverage.
3. **Alignment of state’s major coverage programs:** Since, as the report highlights, different programs cover different populations with different benefits, different cost sharing and networks of different providers, alignment of existing programs must take these differences into account. For example, Medi-Cal serves a large number of children, adolescents and pregnant women with more expansive benefits and little or no cost sharing and different providers than Covered California or CalPERS. Since 95% of the Covered California enrollees are adults over age 18 focusing quality measures on children or adolescents does not make much sense but it is very important for Medi-Cal to do a better job of delivering care to those under age 18.
* Nowhere a recognition of the imbalance of health services and social services driven by overinvestment in health care (because of high health care prices): the silence on this is sufficiently deafening that I assume it is a deliberate choice
* Individual market: even with subsidies, less affordable than ESI for many people—and hence need to further improve subsidies for both premiums and cost sharing as intermediate step
* P.12. The note on health insurance being a relatively small impact of actual health status is true, but this neglects to point out that health insurance is a big factor in economic security, which itself is a social determinant of health.
* P 13. The Medi-Cal rolls have not grown yet. As stated in previous comments, the paper is more sure of the impacts of COVID-19 than I would be. I suggest adjusting those sections on the impacts of COVID-19 to be more circumspect or risk this report looking dated in the near future.

In particular, “un-insurance rates will almost certainly climb” suggests there is nothing to be done. The number of uninsured should be characterized as a policy choice, rather than a happenstance of nature. For example, with proposed cuts or without additional action, the uninsured rate could grow. However, it’s not ordained: a robust response to the pandemic could actually reduce the number of uninsured. Please add “without policy adjustments and investments” or something to that effect.

Page 18: The discussion of county programs may leave readers with a wrong impression. Counties are ultimately responsible for the medically indigent—and they determine eligibility in terms of income and immigration status. Many do provide limited services, but some very big ones: San Diego, Orange County, etc, do not.

Highlighting SF and LA, perhaps the two most evolved coverage-like programs, gives a skewed impression of what the safety-net is like in the rest of the state. It would be important to highlight a few counties without a public hospital system, or that don’t provide safety-net services to undocumented.

Page 19: Regarding CMSP, “For undocumented residents, services are limited to those that address an emergency condition” is false. CMSP has both newer Path to Health and Connect to Care programs to provide primary/preventive care through clinics, unrelated to emergency status.

Page 27: The “strong state economy” is in present tense, which is no longer the case, alas.

Page 42: This section has been made clearer on the definition of quality, but could use further distinctions. quality of care is different than the quality of coverage (the comprehensiveness of benefits), which is different from the quality of your actual access to care, which is different than the quality of your experience dealing with your provider or health plan.

This section is mostly about outcomes, but it mentions DMHC, which takes complaints but only really has jurisdiction over issues of coverage and access to care, not the quality of the care provided or the experience with the provider.

Let’s Get Healthy California is cited for its health system metrics, even though most of its other metrics are another type of quality—of public health, which is important but probably needs to be in its own section.

A useful part of the environmental scan is how the health system interacts with public health—a problem to solve in designing a new system that focused on prevention. It would be worth to have a reference to how the health system does—or does not—interact with broader public health programs, goals, and strategies.

Page 62: Not sure if health spending will decline in 2020.

Page 73: In a long paragraph on how low Medi-Cal rates are, it is acknowledged “fee for service payments are a relatively small part of total ambulatory care payments.” It’s a missed point if the average doctor (or hospital) in a Medi-Cal managed care plan is getting similarly low payments, or if the fee-for-service rates are an outlier.

Page 73: The Prop 56 supplements are scheduled for another year, but are scheduled to be eliminated in July 2021, in the budget adopted this summer.

Page 79: The 1332 section is oblique. The current requirement that changes don’t impact the federal deficit may make it hard to get approval for any reform that increases enrollment, even for populations that are already eligible for coverage and assistance.

Page 79: ERISA is a federal barrier, and not just for self-funded plans.

Page 86: While we would want a more expansive version of this whole section about “tools resources, and policy infrastructure, and we proposed many ideas in our previous comments, it seems worth it to pitch again the inclusion of the notion of rate setting. As a step to Medicare for All, a rate-setting commission to set Medicare Rates for All was something proposed a few years ago in the legislature. It’s the kind of thing one would need to set up in a unified financing system anyway.

Page 87: Minor point: The recent budget trailer that enacted a Health Payments Database also requires the creation of a master provider index and master patient index, for precisely the reasons cited in the report.