**Memo**

To: **Healthy California For All (HCFA) Commission Team**

From: Anthony Wright, Executive Director, Health Access

**Re: Comments on Draft Report**

Date: June 16, 2020

I greatly appreciate the ability to review the draft of the first report of the Healthy California for All Commission.

The first 66 pages are an impressive review summarizing many key aspects of our health system and some of the problems California consumers deal with. While this compiles together much of our understanding—and our critique—of the system we are trying to change, the review does have some significant gaps, that need to be included and highlighted, even in the summary form that the scan suggests. If this is the “problem” statement that we are trying to address with our solutions, the scan needs to be centered on how consumers actually experience the health system, with that, that different communities have very different experiences in it. As such, there also needs to be a specific focus on health equity, even if those issues had not been highlighted recently by COVID-19 and the protests. Other areas that were touched on but require additional attention are how the health system does and doesn’t interact with public health, on consumer protection, and on the market failures—how the current incentives are unaligned with any public goals of access, quality, cost, or equity.

The last fifteen pages include sections to provide options on ways to transition to unified financing, as well as for coverage expansions. This is a start, but incomplete both in describing the barriers it takes to get to unified financing, how to address them, and the many steps we could take to get closer. Also, we would note that contrary to the characterization in the presentation to the Commission, the enabling statute clearly requires the Commission to look at \*both\* moving to a unified system of financing and preparatory steps, not either one or the other. It is both, and we want to flesh out both. My consumer advocacy organization has long supported a single-payer system—and if this Commission is successful is detailing an effort that is passed in short order, we still would want to implement those preparatory steps as part of any transition. Because of its importance of these steps, I urge the consultants to take the time and focus to get the input from the Commissioners and the public to really flesh out these options.

On the environmental analysis:

* Overall Comment: As stated above, the scan should be centered on the individual consumer’s experience. A section, if not the frame, should not be from the financing or coverage perspective—but from the consumers’ perspective. The complexity and confusion deserves its own section, beyond what is on P.25 about churn. Over the course of their life, consumers will be forced to switch plans, switch providers, switch programs and many will fall through the cracks, and others will just be lost. People without health coverage live sicker, die younger, and are one emergency from financial ruin. People without health conditions still make life choices based on health care—job type, career, location, etc. Insecurity, anxiety, worry, fear—and that’s before we get to actually needing care. In earlier opinion research, the most prevalent emotion people expressed about health care was fear—fear of loss, fear of death, fear of pain, fear of not having coverage when needed. This consumer perspective is very different than that of those responsible for running the health care system.
* Consumer protections: As part of this there needs to be a section about consumer protection—who regulates, what, and who is actually accountable if something goes wrong. If you have a complaint, you could have five places to complain to or none. It’s unclear who is accountable to who. Surprise medical bills, timely access to care, continuity of care, all these issues are more complicated to solve in our fragmented system, but also should be values in any new system we build.
* Finally, inextricable from the consumer experience is that different communities have different experiences. People with specific conditions or situations face particular challenges and hurdles. And has been highlighted by COVID-19 and the protests in the street, African Americans specifically and communities of color in general have very specific issues and challenges.
* Overall Comment: Health equity issues and the needs of specific populations are sprinkled in in some places in the report, but they deserve a section of their own. In 80 pages, there is little or no mention of LGBTQ populations, or Asian Pacific Islander populations, or other communities. Even an overview should at least provide a sense of the issues specific to specific populations such as seniors, people with disabilities African Americans face worse outcomes in morbidity and mortality (not just maternity and childbirth) even when accounting for income and insurance type. A fragmented system of financing makes it harder to hold institutions accountable for reducing disparities and racial bias. In contrast, a Medicare-like system was a major tool to desegregate the South. Language access issues are significant, especially for those who need behavioral health. Rural issues are mentioned but worthy of attention as well.
* P.9. 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.
* Generally, the paper is more sure of the impacts of COVID-19 than I would be. Few predicted the revenue loss would be as much as it was, nor the lack of enrollment in Medi-Cal to date. 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.
* P11. The individual mandate should be in the paragraph with the other Covered California reforms.

* P12. 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.
* P17. Dental benefits are not the only benefits on the chopping block in Medi-Cal. Dental services can be listed as one of several cuts pending. Several benefits and long-term care services are also in budget negotiations.
* P17. Another policy issue with the integration of worker’s compensation is the question of how to maintain employer incentives and accountability for worker safety. Some universal coverage countries retain worker’s compensation-type systems precisely to encourage workplace safety. Also, worker’s compensation includes income replacement as well as health benefits.
* Overall Comment: \*\*This includes an appropriate critique of employer-based coverage. As we seek to transition from an employer-based system, we should acknowledge what people like about it, so we can incorporate that in our thinking about a change. In the absence of other coverage, many millions of Americans depend on it, many who have solid coverage with good benefits (at least better than Medicare fee-for-service). Many employers do provide HR-type services to help people navigate our fragmented system. Group coverage may still preferably to individual coverage when the individual is all alone at the mercy of the insurer and the industry. Even with the existence of Covered California and both state and federal subsidies, for many worker’s employer coverage offers greater affordability, more expansive benefits and the assistance of the employer’s human resources department in dealing with the mysteries of health insurance.
* None of this excuses the failing of an employer-based system, that have been exposed even more during this pandemic, with millions losing jobs, incomes, and employer-based coverage. Employer-based coverage also creates inequities among employers and between industries in part because of the differential impacts based on wage structures in an industry: for a high wage employer, health benefits may seem a modest cost while for a low wage employer, health benefits may loom large. This raises important policy (and political) questions in terms of a transition to a unified financing system.
* The discussion of the delivery system would be strengthened by including a bigger discussion of the safety-net of community clinics and county hospitals which are of special importance to low-income Californians and diverse communities.
* P29. In the paragraph that begins, “Across the state, *among physicians that participate in HMOs,”* it is unclear what percent of physicians participate in HMOs, to know the import of the rest of the numbers. Also, the citation says that this refers to Medicare Advantage enrollees, not commercial or Medi-Cal enrollees. Given the differences, it is also not necessarily that what applies in Medicare Advantage applies to other coverage sources. Put another way, it may just be that 60% of Medicare Advantage enrollees in California are in Kaiser and that this is the only information this paragraph actually conveys.
* P.30. As written, the paragraph on medical groups varying by type and enrollment is not clear on the differences between “group practices” and “IPAs” and the significance of the difference for consumers. Is this a continuum or a significant difference in terms of care delivery?

* P.33: In describing the California market, I think it’s easier to think of the “Big 3” or Big 4, with the recognition that the configurations are different by market segment, as well as by region. In every part of the state where 80%-90% of Californians live, there are three or four major carriers: Kaiser, Anthem, Blue Shield and in most, Centene/HealthNet.

* P.35. This talks about the reduction of the uninsured and the increase in Medi-Cal usage. Is this a time change in use by these patients, or is it that these safety-net providers just seeing the same patients, but they are classified differently? Or both? As the previously uninsured became covered through Medi-Cal as a result of the ACA, access to care improved.
* P. 35: There is no such thing any longer as a “city operated hospital”. San Francisco General is operated by the county. The phrase “city and county operated hospital” should be replaced with “county hospital.”
* P.36. The section on quality can be improved, partially because it uses “quality” to mean so many different things. 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. As written, this sections jumbles a lot together, and it would benefit from being teased out. All these points are worth discussing, but not bundled together.
* P.36. The reference to the Let’s Get Healthy California seems out of place in this part of the report, because many of those metrics are yet 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.
* \*\*Overall Comment: 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.
* P.41. We strongly support the inclusion and highlighting of the good academic work done on Medi-Cal quality and access, and the accountability of the Medi-Cal managed care plans.
* P.48. We agree with the sense that these mergers yield bigger entities and higher costs, with no improvement in quality or equity. I would make the case in that bigger is not just bigger and more market power, but the nature of the provider ownership changes, especially if ownership becomes non-local. The growth of private equity, and its incentives, is especially pernicious.

\*\*Overall Comment: In this environmental scan, a part should note that the profit motives and market forces in general are not aligned with lower cost, improved quality, better outcomes, reduced disparities, public health, or consumer experience. Lots of good providers do good work, but the current profit incentives tend to be, with exceptions, for consolidation and market power, avoiding sicker and poorer people, and more care, not better care. The profit motive—over public health, prevention, equity, or other factors—is a prominent reason that those of us who advocate for single-payer lack trust in the health system. Unified public financing doesn’t automatically solve these issues, but provides the levers to change the incentives in the system toward public goals.

* P. 54. Community benefits: No law, state or federal, *requires* non-profit hospitals to provide any community benefits at all.

Both state and federal law require non-profit hospitals to report on community benefits—but if it is zero, then nothing happens to their tax status. (This is not true in other states: it is true in California.) Changing the law requires a two-thirds vote, a high hurdle.

* P.58. It’s unclear if “excess billing” as stated is the cost of the function of billing, or inflated prices. This may need to be teased out in different paragraphs. The phrasing is confusing. Professor Jim Kahn’s pieces actually refers to is “excess costs due to expenses related to billing and insurance,” not inflated prices. They deal with inflated prices in the second part of the same paragraph: the two ideas should be separated out and drafted more clearly.
* P.59. A small paragraph makes a big point that we can’t just go after insurer profits or hospital reserves. Obviously the resulting question is where does the money go? Is it really that baked into the system? I would frame this differently—that so many people make so much money off the health system that the money not all in one place.
* P. 63: The report asserts, inaccurately, the Medi-Cal FFS rate is the basis for capitation rates paid to MCMC plans. Our understanding is that this has not been the case since at least 2006. It was in the distant past, but it is no longer how Medi-Cal managed care capitation rate is built. Here is a [CHCF explainer](https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedPaymentManagedCarePlansCurrentProcessChallenges.pdf) that can be used to summarize the capitation rate development process in one sentence. Also, because Medi-Cal fee for service rates have been frozen for so long, Medi-Cal managed care plans may or may not use those fee-for-service rates as the basis for provider payments.

On the options:

* On obstacles, the paper goes into obstacles including sustainable financing, federal law, state constitution, and employer transition. There are three other major obstacles to unified financing that deserve mention:
	+ Industry opposition, from both insurers that would no longer exist for this purpose, and most importantly providers that would have their rates set or more heavily negotiated.
	+ Ideological and partisan opposition from those that are opposed for this role of government, those who are concerned about taxes and mandates (even if the overall cost would be the same or less than what the private insurers costs), and the polarized environment we are in.
	+ Public concern about loss of existing coverage, including the loss aversion of being told that what we value will be replaced, even with something with a promise or a hope of being better.
* Discussions about policy solutions and preparatory steps should explore how to address these concerns. I cite these obstacles with no intention to say we can’t undertake this reform, but we should at least acknowledge the problems in order to address them. Even political issues may have policy responses.
* Of the issues addressed, the main one was the federal laws. It should be explicit that the options are to 1) change federal law, or 2) accept that a state system of “unified financing” might have to be a hybrid to work around. For example, CA could have a single-payer system for those under 65, avoiding the need to mess with Medicare. Some changes do need federal law, others have more potential to create a hybrid plan—which might be our vision.

* P. 68 talks about California’s vision of Healthy California for All, but unless I am mistaken, we have not defined that yet.
* Do we have some assessment of which federal law and rules are easier to get around than others? Which is more feasible? Changing the rules for a 1332 waiver? Getting a block grant in Medicare? Or getting a change in ERISA? The assessment of what is feasible at the federal level is important as are the implications for other states that might use such flexibility to accomplish other goals, such as shrinking the size of government or eliminating entitlements.
* The issue of getting flexibility of Medicare money raises other issues—including the concern about the precedent for the other 49 other states that might use the money in a very different way, undermining the only single-payer system we have in the country.
* On raising the money, the discussion of raising $200B a year is explicitly to replace employer/employee spending appropriately reflects the magnitude of the shift. How much would we also need to raise for reserves on top of that? What is a reasonable reserve-raised either one time or ongoing--given the volatility of state revenues? There needs to be a robust discussion of the implications of a tax structure sufficient to generate that kind of revenue—and one that is both progressive and stable in raising revenue to sustain the health care system.
* Another option that merits a short paragraph is some sort of hybrid—if the federal government created a framework, much like the ACA created the funding and framework for Covered California and the Medicaid expansion/reform, then California could implement and improve on it as we did with the ACA.
* Overall, on the list of steps, I appreciate the categories of legal pathways, greater consistency, and expanding tools and resources.
* Perhaps this is within these categories, but I think of “build policy infrastructure.” The ACA created Covered California and recreated Medicaid. It established a common definition of benefits, and rebalanced financing toward public programs. All these things and many more brought us closer to single-payer and unified public financing. It’s stuff we probably would need to do in a broader reform.
* I would think of the categories differently. The way I see it, we have certain goals—and can we get closer—or even reach--those goals without doing everything at once?
	+ If a key benefit of unified financing is being able to set prices, why not just set prices, across the board? It’s strange not to include rate setting as such an example, especially since it has been a topic of legislative discussion.
	+ If we want everyone to pay on a sliding scale as a percent of the income (perhaps eventually as a tax), why not improve on those in Covered California and other programs—creating a benchmark for a financing system. In p. 78, it’s not just about the existing proposal for Covered California subsidy—it’s about a vision of guaranteed affordability, that no one of any income has to spent more than 8% for coverage--and less as you go down the income scale. That would also mirror what some progressive tax structures might look like to finance single-payer.
	+ In getting to a universal system, we would need to open the doors of Covered California to all Californians, not just citizens and those lawfully present, and ultimately provide affordability help to those regardless of immigration status. For those of us pursuing legislative efforts right now, we recognize that’s farther down the road than the Medi-Cal expansion effort—and we may not want to have it explicit in this report. But it’s a good example of policy infrastructure: If we can resolve the question of whether our health system treats people regardless of immigration status, so we don’t have to deal with it anew in the debate over this reform.
* On page 75, and elsewhere, we presumably want the concept of the Office of Health Care Affordability listed, or that of other oversight bodies.
	+ Maybe we don’t want to include this, but since the Governor already proposed it—the idea of setting cost-growth benchmarks, with accountability and teeth—is how a single-payer system might initially do its coordination of a health system. It could also provide planning infrastructure.
	+ There’s a lot of creativity we could explore here, about an agency looking at not just consolidation, but with regard to global budgets, to the public health goals of our health system, and the myriad issues that have come up in the COVID-19 pandemic.
* Ultimately, this section repeats some of what has been proposed already in the Legislature and by advocates—but not even all that has been proposed. We would want to include other proposals that have been in the discussion here in California, and to provide new ideas in the mix. If we want this Commission to be useful, or at least this report, it should put forward a lot more ideas of how we get to a saner health system—even if they are implausible or unfeasible in the moment, or even if they are explored to be rejected. Rate setting, global budgets, standardization of not just quality metrics but all contracts. Employer pay-or-play to at least set standard for an employer contribution. Standardized formulas and negotiation with the drug companies across payers. Public option ideas, including raising the Medicaid levels even farther. Automatic enrollment for all residents into a form of California coverage with a standard card, even if the backend payer changes for now. Greater direct regulation and oversight of providers directly in terms of cost, quality and disparities rather than indirectly through insurers or other payers.
* There’s so much that could be done here—the question is what would be useful to propose and to flesh out, to figure out the basic concepts and financing.

Thank you so much for putting together a draft of this important report. I hope these comments show the interest and enthusiasm for this project and your good work as we try to address and solve for these major issues.