



Accessible, Affordable, Equitable, High Quality, Universal

An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California

Delivered to

Gavin Newsom, Governor of California

Senator Richard Pan, Chair, Senate Health Committee

Assemblymember Jim Wood, Chair, Assembly Health Committee

Final: August, 2020

Authorship and Review Process

This report was drafted and revised by a research team led by Andrew Bindman, M.D., of the University of California, San Francisco. Marian Mulkey was the lead author with major sections contributed by Richard Kronick, Laurel Lucia and Dr. Bindman. Additional contributors were Ken Jacobs, Jerry Kominski, and Srikanth Kadiyala. Early versions benefited from review by Alice Chen, M.D., and Vishaal Pegany of the California Health and Human Services Agency. Juliana Fung and Joslyn Maula provided design and formatting assistance.

In early June, 2020, a draft for review (“Version 2”) was provided to members of the Healthy California for All Commission. In connection with the June 12 Commission meeting, a version was posted for public review and comment. Extensive comments, including in-depth written comments from seven Commissioners, over 70 pages of written comments from consumer advocacy organizations and stakeholders, and additional verbal feedback from members of the Commission and members of the public, were received and carefully reviewed by the consulting team.

In late July, Commission members received a revised version (“Version 3”) which reflected extensive adjustments in response to prior feedback. Changes included:

- Clarified definition of Unified Financing
- Added a section on “Equity and Community Health” and elaborated throughout on racial and ethnic disparities and issues affecting other marginalized populations
- Clarified definitions of “quality” and population-based metrics as compared to individual health outcomes
- Expanded and clarified discussions of risk, payment and population management, including greater attention to uncertain and potentially adverse outcomes related to integrated care and capitated payments
- Added more information about financial incentives and financial performance of health plans, hospitals and other sectors of the health care economy
- Updated references to COVID-19 and adjusted descriptions of pandemic implications, based on reviewer feedback as well as new realities
- Substantially revised the discussion of self-insured employers and ERISA based on reviewer feedback

- Restructured Section 2 with a different categorization of the types of steps California could take
- Expanded the types of steps California might take to prepare to transition to a unified financing system

Feedback from Commission members on Version 3 was addressed as follows:

- When Commissioners proposed specific line edits that clarified the intended meaning, changes were made.
- When Commissioners offered additional context that could be readily incorporated in the draft as structured, changes were made.
- When requests involved extensive additional elaboration, or identification and incorporation of new data, changes were not made. Such suggestions will inform content for future Commission meetings and the Commission's second report.
- When members of the Commission offered formal comments in the form of a one-page comment letter, they are incorporated within an appendix to this version.

On August 13, 2020 the Healthy California for All Commission took an advisory vote to forward this report to Governor Newsom and to the Legislature. The final report will be posted to the Healthy California for All [web page](#) where public comments that meet basic guidelines regarding accessibility and length will be posted as part of the public record.

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Introduction and Overview

Established by Senate Bill (SB) 104 (Chapter 67, Statutes of 2019), the Healthy California for All Commission is charged with developing a plan that includes options for advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians.

As used in this report, the concept of “unified financing” describes a state-wide system to arrange and assure health care in which:

- All Californians would be entitled to receive a standard package of health care services
- Entitlement would not vary by age, employment status, disability status, income, or other characteristics
- Distinctions among Medicare, Medi-Cal, employment sponsored insurance, and individual market coverage would be eliminated within the system of unified financing

As international examples make clear, there are many methods to achieve unified financing. For example, Canada and Taiwan use a single payer approach, the United Kingdom has publicly provided care, and Germany and the Netherlands require mandatory purchase of standardized, non-profit, insurance.

As the first deliverable required of the Commission under SB 104, this report takes stock of the strengths and limitations of California’s existing health care system across multiple dimensions and identifies options for improvement. In recent years, California has made strides in expanding coverage and improving access to care for many of its residents, yet the state still falls short of an accessible, affordable, equitable, high-quality, and universal system.

The COVID-19 pandemic has laid bare many shortcomings within the California health care system. For example, millions of newly unemployed Californians will need to enroll in Medi-Cal or purchase coverage through Covered California as a result of losing their employer-sponsored coverage, and many more will likely become uninsured. Hospitals, physicians, and other health care entities dependent on fee-for-service revenue suffered revenue declines when stay-at-home orders caused visit volume to fall and elective procedures to be canceled. Many frontline health care workers, particularly those in settings that disproportionately serve low-income

people, are facing serious health risks without adequate personal protection at the same time that lay-offs and job furloughs loom. People of color are disproportionately affected by COVID-19 due to structural racism and other social determinants of health. As of this writing, Latino Californians, who represent 39 percent of the population, accounted for 57 percent of COVID-19 cases, and 41 percent of deaths and Black Californians (6 percent of the population) represented 9 percent of deaths.¹ The full implications of the pandemic remain to be seen, but changes in coverage, access, and quality of care are inevitable. Acknowledging the rapidly changing circumstances related to COVID-19, this report offers some initial observations.

Section 1 describes the current state of health care delivery and finance in California and summarizes implications for access, affordability, equity, quality, and universality. Section 2 discusses steps California might take to prepare to transition to a unified financing system. Section 3 recaps coverage expansion proposals and efforts underway that address some of the goals of the Healthy California for All Commission.

California falls short of a universal and equitable approach that treats all residents according to their needs rather than imposing distinctions based on coverage sources. Fragmented financing and a patchwork delivery system compromise access to services and quality of care for many Californians. Status quo health care delivery and financing arrangements, including profit motives for many players, add layers of complexity and drive up spending without commensurate improvements in clinical quality or health outcomes, reduced disparities or better consumer experience. The COVID-19 pandemic has revealed weaknesses in care delivery systems and underinvestment in public health. Under our present system, inequities by income level, region, race and ethnicity persist.

A subsequent Commission report will analyze key design considerations for a unified financing system, including a single-payer financing system, and will offer options by which the state can move toward a Healthy California for All.

Section 1: The Current State

This section is divided into six parts: Equity and Community Health; Demographics and Coverage; The Health Care Delivery System; How the Money Flows; How Will a Pandemic Affect California Health Care?; and Implications.

Equity and Community Health

California is a state of rich diversity across racial, ethnic, language and socioeconomic domains. Despite important consumer protections in state law related to language access, timely access and network adequacy, inequities in access to care persist. Structural barriers, including those stemming from structural racism, affect both health care access and health outcomes for historically marginalized populations including Black, Indigenous and Persons of Color (BIPOC), immigrants, Limited-English Proficient (LEP) individuals, LGBTQ+ and persons with disabilities. The members of these communities continue to report stigmatizing and disrespectful treatment when they seek care and encounter heightened barriers related to affordability and accessibility.²

Social risk factors, which vary across California's diverse neighborhoods and communities, also influence health outcomes. Community-level factors, including education, public sector infrastructure, community engagement and many others, substantially affect life expectancy and quality of life.³ Long-standing structural racism adversely affects health outcomes.⁴

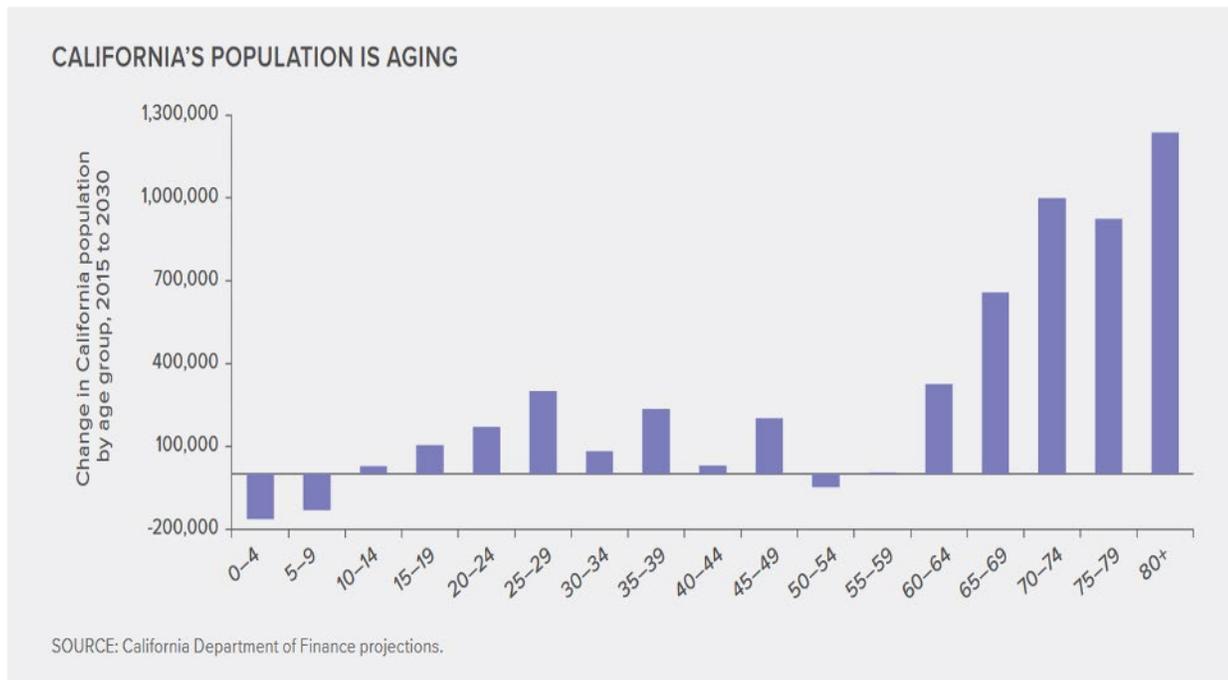
Most of the remainder of this section offers a broad survey of experiences across the state and for California's population in the aggregate. However, it is important to note that health is a personal matter – people's individual circumstances affect their health needs, preferences and outcomes. When the Commission considers ways to improve health care in California, it will be important to consider the barriers to health equity that exist today and ensure that proposed solutions lessen those barriers.

Demographics and Coverage

Demographics

California's population currently is approximately 40 million. Growth rates have slowed in recent years.⁵ The Department of Finance forecasts increases of about 200,000 people per year in the coming decade.⁶ As shown in Figure 1, the state's population is aging and growth among school-age children is stagnant.⁷

Figure 1: Projected Growth Rates Highest Among Elderly (PPIC, [California's Future: Population](#))



About 600,000 Californians are American Indians and Alaska Natives, and another 135,000 are Asian Pacific or Hawaiian Island native people.⁸ About one in four Californians is foreign-born. While most foreign-born Californians are legally present, about two million undocumented immigrants live in the state.⁹ Latinos are the state’s largest ethnic group, but Asia has surpassed Latin America as the largest source of immigrants to the state.¹⁰ More than 200 languages and dialects are spoken in California, and nearly 7 million Californians report speaking English “less than very well.”¹¹

California’s population is concentrated in major urban areas near the coast including the greater Los Angeles area, the San Francisco bay area, San Jose and San Diego.¹² The population of inland counties such as Riverside, San Bernardino, Fresno and other parts of the Central Valley has grown in recent decades.

Prior to the economic downturn associated with the COVID-19 pandemic, California’s median annual household income of about \$72,000 was higher than the U.S. median income of \$60,000.¹³ Thirteen percent of the state’s population earned at or below the federally defined

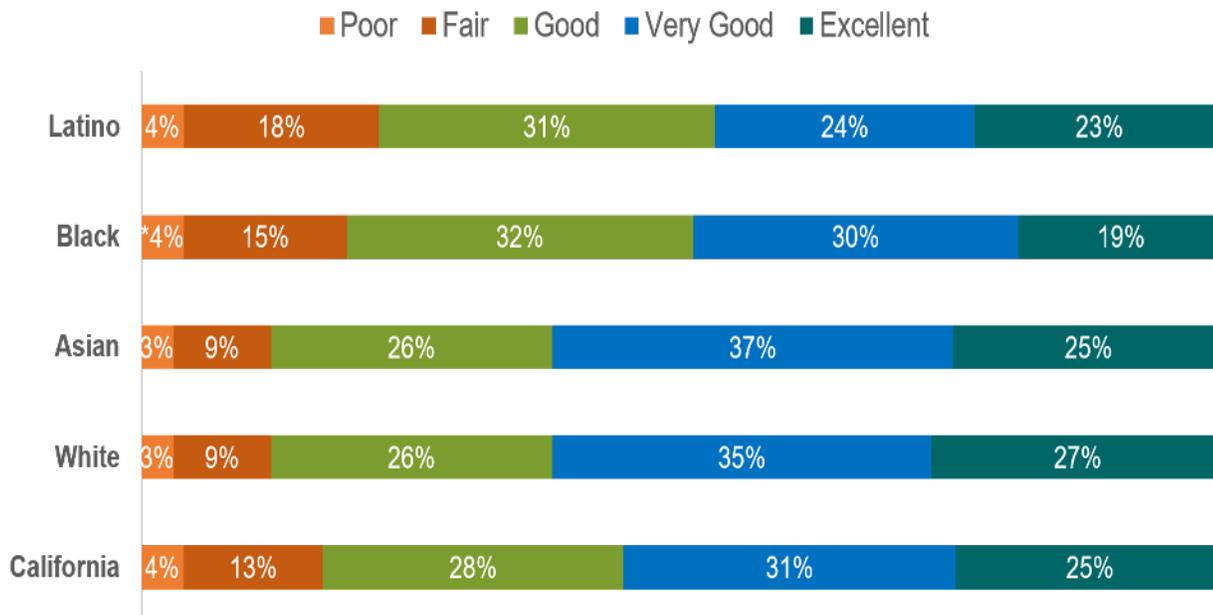
poverty level, similar to levels across the U.S. However, California had the second highest poverty level of any state when using the Supplemental Poverty Measure, which takes into account regional variation in expenses, as well as the value of government assistance programs for low-income households.¹⁴ Income levels and poverty rates varied across the state. Counties with high concentrations of households living in poverty (defined in one analysis as over 18.8 percent) were found in more rural parts of the state (Humboldt, Mendocino, Lake Tulare and Yolo counties), in coastal areas with intermediate population density (Santa Cruz, Santa Barbara), and in densely populated urban areas (Los Angeles, Orange, San Diego).¹⁵ Income inequality was substantial in the state, with families in the top income decile earning on average 12.3 times as much as families in the bottom decile.¹⁶ While income levels will certainly be negatively affected by unemployment and other economic dislocations associated with the pandemic, the scope and duration of that impact remain to be seen.

Key Health Indicators

About half of all Californians report their health status to be very good or excellent, but reported health status varies dramatically by race/ethnicity, education, and income level.¹⁷ People with private insurance report better health status than the uninsured or those who have Medi-Cal, Medicare, or other public coverage,¹⁸ although health status may be a factor that influences the source of coverage rather than a consequence of that coverage. Blacks and Latinos are disproportionately more likely to report poor or fair health status as shown in Figure 2.¹⁹

In California, Latinos are less likely to report having a usual source of care and more likely to have difficulty accessing specialty care than are members of other racial and ethnic groups.²⁰ The African-American or Black population is particularly likely to experience poor outcomes in the health care system, including a range of outcomes related to maternity and childbirth and very high rates of hospitalizations that could be prevented with better access to outpatient care.²¹ Black and Native American people have higher age-adjusted death rates than members of other racial and ethnic groups.²²

Figure 2: Health Status by Race/ Ethnicity, California, 2017 (CHCF, [Health Disparities by Race and Ethnicity](#))



In California and throughout the United States, behavioral health needs have been stigmatized and are often under-diagnosed and inadequately treated.²³ The prevalence of serious mental illness is much greater among people with lower incomes.²⁴ In addition, behavioral health services are often provided in settings separate from those focused on physical health care. The prevalence of serious mental illness is much greater among people with lower incomes.²⁵ In both 2019 and 2020, Californians ranked “making sure people with mental health problems can get the treatment they need” as their top health care priority.²⁶

By law, the Commission’s work focuses on California’s health care delivery system, the coverage programs and financial arrangements that support health care in California today and the ways these might be reorganized to improve access, affordability, equity, quality and universality in the future. However, medical services are estimated to affect only 10 to 20 percent of modifiable health outcomes. The remainder results from social determinants of health, the “conditions in which people are born, grow, live, work and age...; circumstances [that] are shaped by the distribution of money, power and resources at global, national and local levels.”²⁷ Social determinants of health include health-related behaviors (e.g., diet and exercise), socioeconomic factors (e.g., education or income level), and environmental factors

(e.g., air and water quality, transportation or housing). The impact of the Commission's focus on health care would be enhanced by additional steps the state can take to address social determinants of health.

Health Insurance Overview

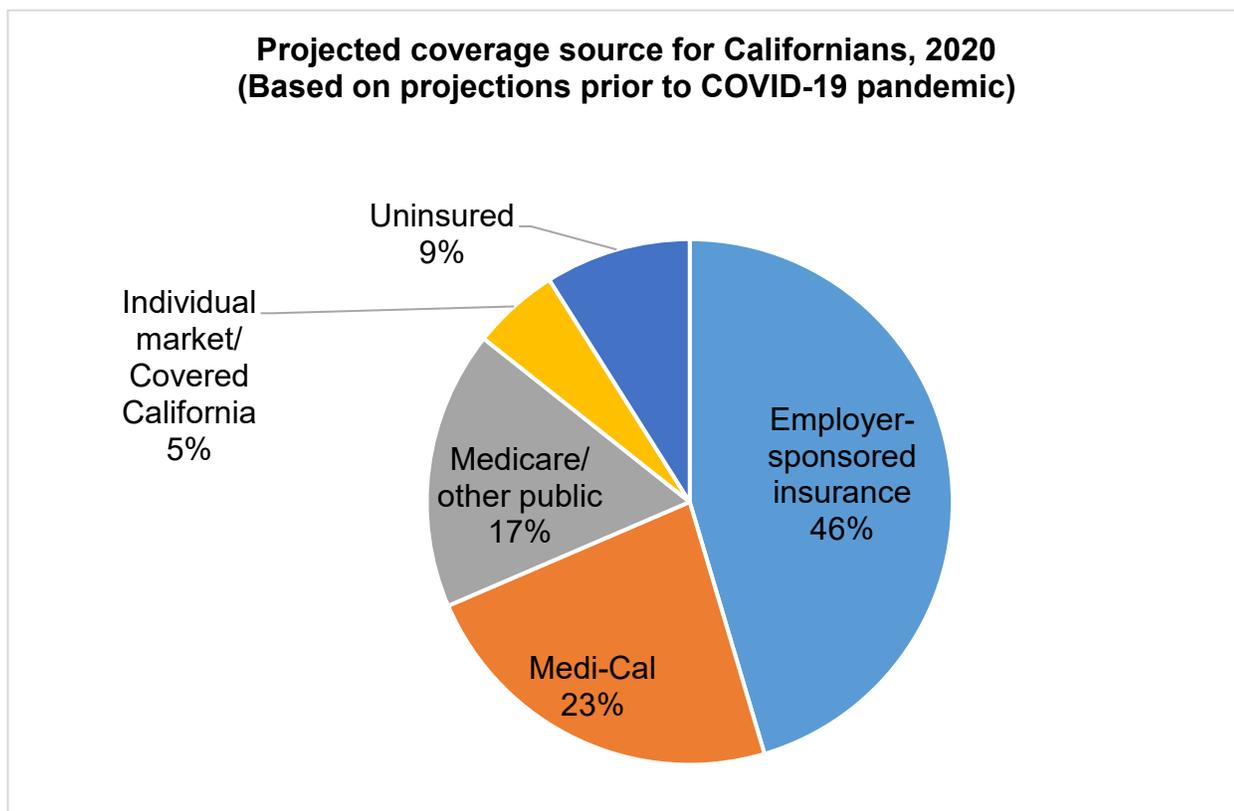
The research is clear that having insurance is associated with improved access to health care, better health outcomes, and improved financial security, compared to being uninsured.²⁸ Those with health insurance are more likely to use preventive services,²⁹ use and adhere to prescribed drugs,³⁰ and receive earlier diagnoses.³¹ Health insurance coverage expansions are associated with improvements in self-reported physical and mental health, and reductions in mortality rates.³² Health insurance also protects individuals from financial distress and excessive out-of-pocket spending.³³

Californians get their insurance from a range of sources, and individuals may receive coverage from various sources over the course of their life. Figure 3 shows the anticipated insurance status for 2020 based on projections prior to the COVID-19 pandemic. At that time, half (46 percent) of Californians were projected to have job-based coverage in 2020, either through their own or a family member's employer, according to estimates from the UCLA-UC Berkeley California Simulation of Insurance Markets (CalSIM) model. Approximately 5 percent of Californians purchase insurance through the individual market, either through Covered California or directly from insurers. Medicare covers the vast majority of those age 65 and over, plus certain individuals with disabilities under the age of 65. Approximately 17 percent of Californians are covered by Medicare or a handful of other public programs such as the VA, military healthcare, and the Indian health services. Medi-Cal, California's Medicaid program, covers approximately 23 percent of Californians who qualify based on income or disability status. (This estimate excludes Californians who are only eligible for emergency and pregnancy related services.¹ It also excludes those who have both Medicare and Medi-Cal coverage, or are "dual eligible," who are counted within the Medicare/other public category.) Approximately 9 percent of Californians were projected to be uninsured, a figure that includes the portion of undocumented Californians who have restricted-scope Medi-Cal and are not eligible for comprehensive medical services.³⁴ A spike in unemployment associated with the COVID-19

¹ In recent years, pregnant women enrolled in restricted-scope Medi-Cal receive comprehensive benefits, but due to data limitations CalSIM is not able to distinguish between undocumented adults receiving pregnancy services and those receiving emergency services covered by Medi-Cal.

pandemic will certainly reduce job-based coverage; one national estimate finds that across the U.S., 25 million people might lose employer-sponsored health insurance.³⁵ With falls in job-based coverage, the share of Californians who rely on Medi-Cal and the individual market for insurance will rise. Absent policy solutions and public sector investments, uninsurance rates may climb.

Figure 3: Projected Coverage Source for Californians, 2020 (UCLA-UC Berkeley CalSIM version 2.7 and California Health Interview Survey)

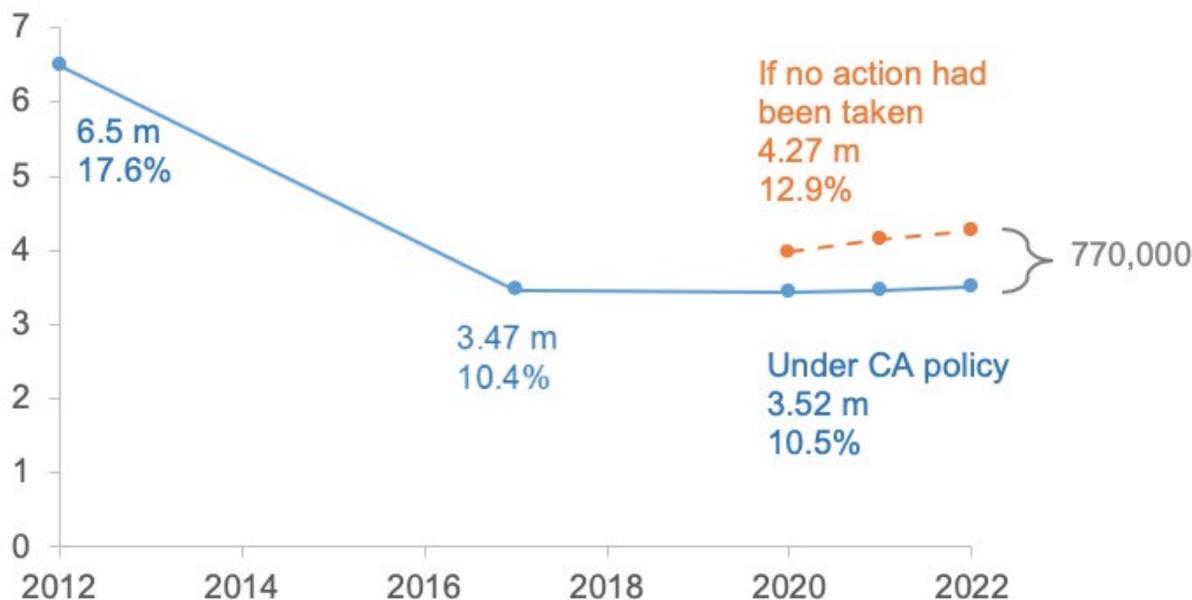


California’s robust implementation of the federal ACA reduced the number of uninsured significantly (see Figure 4). California experienced the largest drop in uninsurance of any state³⁶ through its adoption of the ACA Medicaid expansion; the creation of a successful state-based health insurance marketplace, Covered California; and many other steps taken by state and local policymakers, stakeholders, and others to ensure high levels of enrollment under the ACA.

Since 2014, California has also taken steps to build on the ACA. California expanded Medi-Cal eligibility to all low-income children regardless of immigration status in 2016 and added eligibility for undocumented young adults under age 26 in 2020. These expansions added to the eligibility groups already offered full benefits using state funds, such as Lawful Permanent Resident adults who received a green card within the last five years and immigrants with Deferred Action for Childhood Arrivals (DACA) status.

After the ACA’s individual mandate tax penalty was zeroed out, California adopted its own requirement (a state individual mandate) that residents have minimum essential coverage for each month or pay a penalty effective in 2020. It also provided state-funded premium subsidies for income-eligible households. These policies are projected to help ensure that enrollment in Medi-Cal and the individual market remains strong.³⁷

Figure 4: Number of Uninsured (in millions) and Uninsured Rate among Californians Age 0-64, 2022 (UCLA-UC Berkeley CalSIM version 2.7; based on projections prior to COVID-19 pandemic)



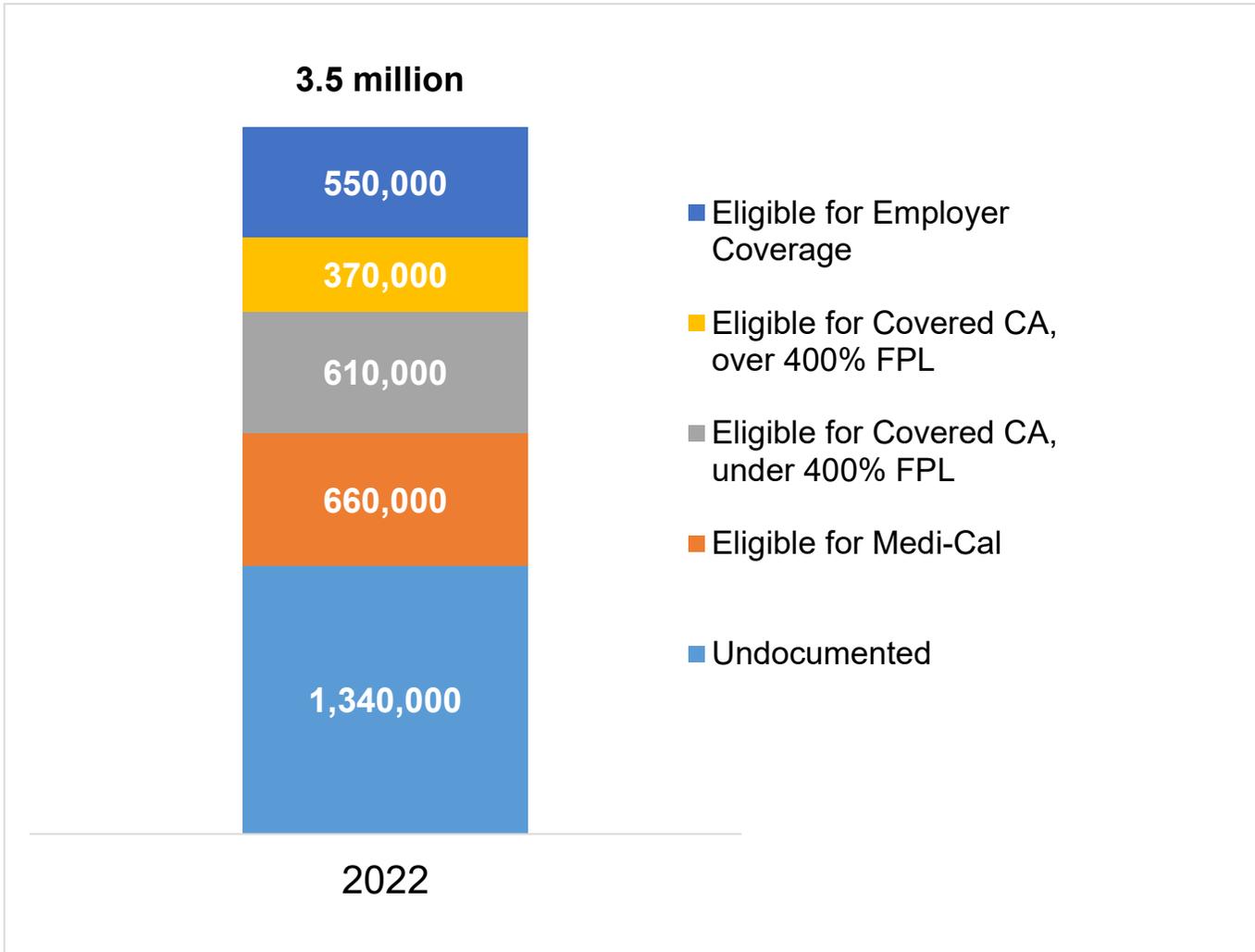
California has taken additional steps toward ensuring a stable individual market. For example, California has maintained a three-month open enrollment period, longer than in the Federal Marketplace. Covered California spends over \$100 million on marketing and outreach each year to promote stable enrollment, whereas the Federal Marketplace has virtually eliminated spending on marketing and has reduced support for navigators.³⁸

California enacted laws in 2018 that banned the sale of short-term limited duration health plans³⁹ and limited association health plans,⁴⁰ in response to federal rules that expanded options for such plans. Beginning in 2020, California provides state-funded premium subsidies to improve affordability for certain Covered California enrollees, including some who qualify for federal ACA subsidies but still struggle to afford coverage and others who earn too much for federal ACA subsidies.

As a result of these actions, prior to the COVID-19 pandemic, California was on track to protect the gains made under the ACA. The major new state coverage policies effective in 2020 – expanding Medi-Cal to undocumented young adults, providing state subsidies to improve affordability of insurance through Covered California, and implementing a state mandate -- were projected to keep the number of uninsured steady at approximately 3.5 million over the next few years, barring further policy change, as shown in Figure 4. Absent further policy change, the number of uninsured Californians will almost certainly grow due to the COVID-19 pandemic and economic fallout, particularly as millions of California workers and their dependents lose employer-sponsored insurance due to job loss or reduction in work hours.

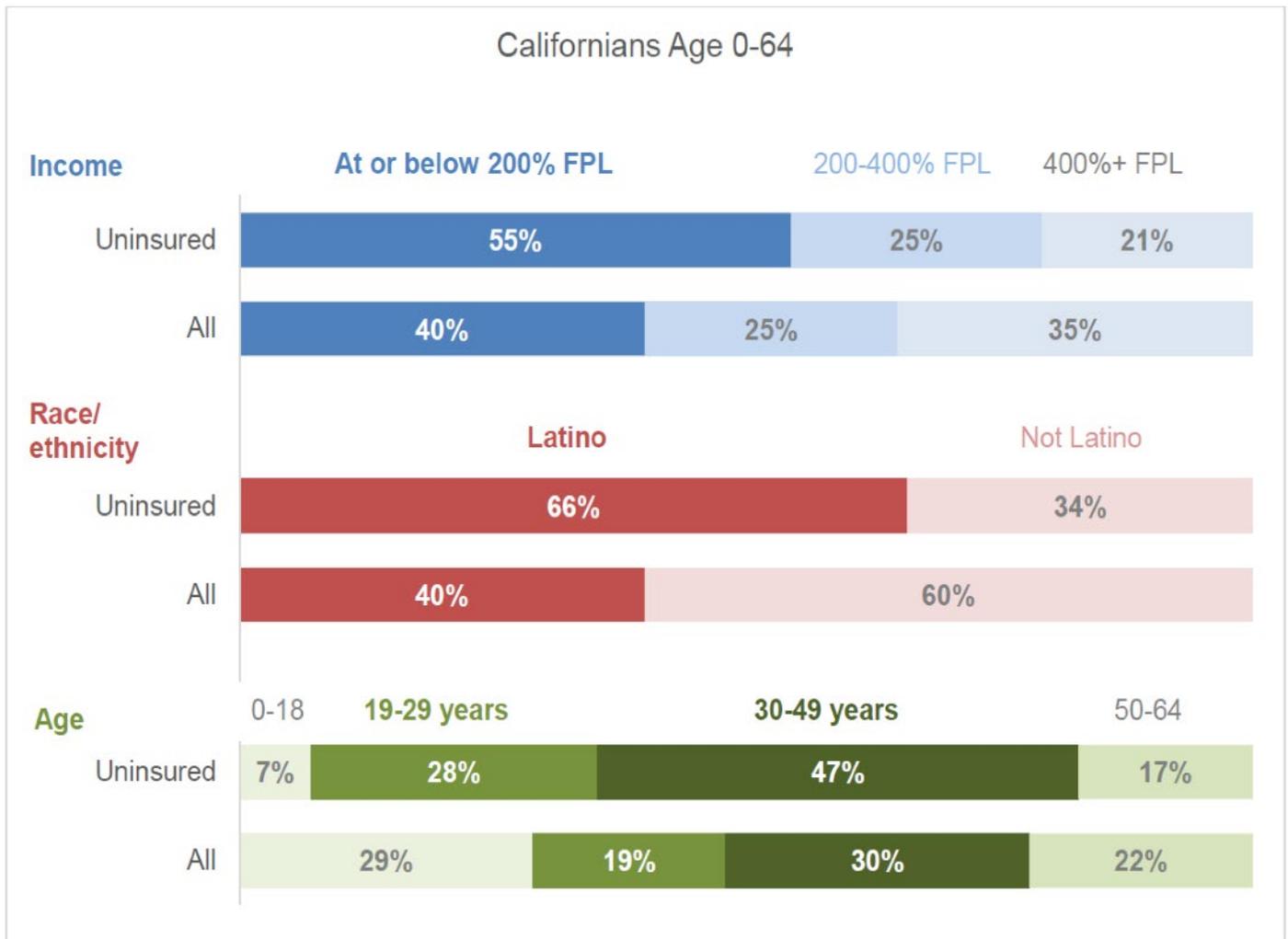
Under pre-pandemic projections, even with these new state policies, approximately 3.5 million Californians were projected to be uninsured in 2022, as shown in Figure 5. The largest group among those projected to be uninsured were undocumented Californians, who are excluded from full-scope Medi-Cal coverage if they are over the age of 25 and are not eligible for subsidized coverage on the individual market. Nearly 1 million citizens or lawfully present immigrants are eligible for Covered California but remain uninsured, most of whom (610,000) have family incomes that are under 400 percent of Federal Poverty Level (FPL). For this group of uninsured, affordability is the biggest barrier to enrollment. Approximately 660,000 Californians are projected to be eligible for Medi-Cal but not enrolled because they do not realize they are eligible or for other reasons. Another 550,000 Californians are eligible for coverage through an employer, but cannot afford it or do not enroll for other reasons.

Figure 5: Projected Number of Uninsured Californians Age 0-64, 2022 (UCLA-UC Berkeley CalSIM version 2.7)



Californians who are low-income, Latino, or adults age 19 to 49 are more likely to be uninsured, as shown in Figure 6 below.

Figure 6: Demographics of Uninsured and All Californians Age 0-64, 2022 ([UCLA-UC Berkeley CalSIM version 2.7](#))



Most counties offer at least some care for undocumented immigrants and others who remain uninsured, but available services are generally limited to within the county and do not cover out-of-county services.⁴¹ Local services have been organized in a variety of ways. For example, Healthy San Francisco (HSF) is available to all San Francisco residents with income at or below 500 percent of the federal regardless of immigration status and provides health coverage to approximately 14,000 uninsured San Francisco residents.⁴² HSF provides access to affordable health care services through an ongoing primary care relationship and focuses on prevention and management of chronic conditions. MyHealth LA is a no-cost health care program for people who live in Los Angeles County and do not have and cannot get health insurance. The program is intended to preserve access to care for uninsured patients and encourage coordinated, whole-person care. At the end of fiscal year 2018-19, over 140,000 people were enrolled in MyHealth LA.⁴³ Many other counties, including some large ones such as Orange and San Diego, do not have well-organized systems for managing the care of the medically indigent although they do provide some limited services. The County Medical Services Program (CMSP) offers services to low-income residents in 35 mostly rural counties. CMSP services were once limited to emergency conditions, but CSMP programs now link some low-income people to primary and preventive care through community health centers.⁴⁴

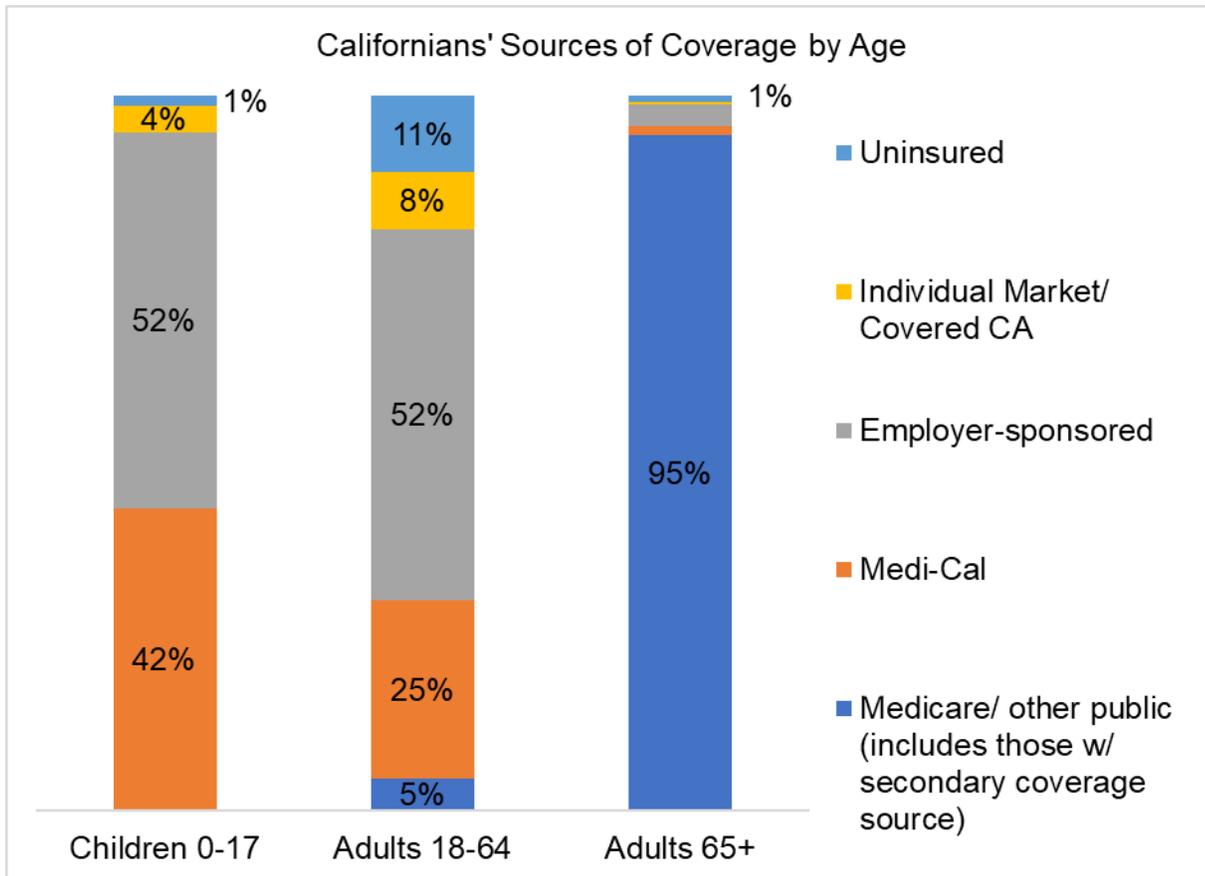
Coverage Programs by Age

Largely as a result of public insurance programs, California has achieved close to universal coverage for the elderly (age 65 and older) and for children (18 years of age and younger). As shown in Figure 7, the sources of coverage are starkly different for the two groups.

With California's expansion in 2016 of Medi-Cal to undocumented children who meet income requirements, the vast majority of California children are now covered with some form of insurance (see Figure 7). More than half of the state's births are paid for through the Medi-Cal program and 42 percent of children are covered through Medi-Cal.⁴⁵ Children's hospitals are an important source of specialty care for children. The California Children's Services program provides county-based case management for children with special health care needs.

At the other end of the age spectrum, since 1965 the federally financed Medicare program has been the primary payer for acute care for almost all Americans over age 65.

Figure 7: Californians' Sources of Coverage by Age (California Health Care Foundation, [Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians](#), February 2019.)



Covered Benefits

Across the U.S., health insurance emerged in the mid-20th century as a financial vehicle to spread risk and manage expensive payments for hospital and physician services. With the passage of time, our understanding of health needs has evolved as have available treatments and interventions. Because financing of health care is fragmented across different payers, there is not a systematic approach for updating covered benefits and revisiting how services are organized. For this reason, many health care services that contribute to positive health outcomes are not covered under health insurance or are poorly integrated within mainstream health care delivery arrangements.

For example, dental benefits are not typically provided by the same plans through which employer-sponsored health benefits are provided but many employers offer stand-alone dental plans. According to the National Association of Dental Health Plans, an estimated 85 percent of the state's total population (33.6 million people) have dental coverage. This includes 20.6 million enrollees in private coverage, the majority of whom are in dental preferred provider organization (PPO) arrangements; 11.8 million enrollees in dental coverage through Medi-Cal; and nearly 1.2 million Californians with dental coverage through their Medicare Advantage plans.⁴⁶

Until fairly recently, most health insurance in the individual market either excluded behavioral health care services or subjected behavioral health care to greater restrictions than physical health care. Many factors, including stigma, contribute to the marginalization and underuse of behavioral health care services. The ACA expanded access to behavioral health care services by making treatment for mental health conditions and substance use disorders part of the "essential health benefits" that health plans must cover under individual or small group coverage, and required these plans to comply with the federal Mental Health Parity and Addiction Equity Act.

Historically, individuals in California with behavioral health needs are disproportionately more likely to be covered by Medi-Cal than by other payers. When California took advantage of the ACA option to expand Medi-Cal to include low-income childless adults, the number of individuals with behavioral health care needs covered by Medi-Cal increased further. Medi-Cal enrollees with mild to moderate mental health needs receive these services through the managed care plan that provides their physical health services, while those with severe mental health needs or substance use disorders are required to rely on county-run programs for treatment of these conditions. Integration of services is a substantial challenge for Medi-Cal enrollees with behavioral health needs, particularly for those who also have physical health

needs, and involves managed care plans coordinating with specialty carve-out programs administered by county behavioral health departments.⁴⁷

Long term services and supports (LTSS) are also important for the well-being of many Californians, yet are not included in the typical package of health insurance benefits. According to an Urban Institute analysis, 11 percent of Americans 65 and over purchased supplemental long-term care insurance in 2014.⁴⁸ Costs for private policies can be unpredictable and unaffordable.⁴⁹ Medi-Cal covers long-term care, but only for individuals with low incomes and limited assets. As California's population ages, the need to organize and pay for care that helps aging or disabled people maintain quality of life will increase. Governor Newsom's administration is exploring these issues via the California Master Plan on Aging, which includes a subcommittee on LTSS.⁵⁰

Many persons with disabilities have particular needs for services and supports including durable medical equipment; assistive technologies; protracted physical, occupational and or speech therapy; and other social supports. Medi-Cal covers such benefits and funds home and community based services for many Californians with disabilities.⁵¹ For those who meet long-term disability criteria, Medicare plays a role in covering such services.⁵²

The ACA brought greater uniformity to covered benefits for subsets of the market. Under the ACA, **individual market and small group plans** (100 or fewer employees) are required to offer ten categories of essential health benefits: outpatient, inpatient, emergency, laboratory, mental health and substance use disorder services, including behavioral health treatment; maternity, newborn, and pediatric care; prescription drugs; and rehabilitative and habilitative services and devices. Individual market plans include dental and vision coverage for children only, and adults can purchase separate dental and vision plans. Coverage offered by large employers (more than 100 employees) is not subject to the federal requirement for essential health benefits, but California law requires that DMHC-regulated health plans cover medically necessary "basic health care services."⁵³

Medi-Cal covers ACA-mandated essential health benefits, some dental, vision, and hearing benefits, and long-term services and supports that are not typically covered in private medical insurance plans. The long-term services and supports include in-home supportive services (IHSS), other home and community-based services, and care provided in nursing facilities. Pediatric oral and vision services are covered as essential health benefits, mandated through federal Medicaid requirements. Adult dental services, optional under federal Medicaid requirements, are covered under California's Medi-Cal program but have been subject to past

cuts in response to state budget shortfalls. Other Medi-Cal optional benefits may also be subject to reduction or elimination in tight budgetary times.

Traditional **Medicare** benefits include inpatient and outpatient care, physician care, prescription drugs, and limited skilled nursing facility and home health care services. Medicare does not cover dental, vision, hearing aids, and long-term services and supports, though some Medicare Advantage plans offer some of these services.

California employers are required to purchase a **Workers' Compensation** insurance policy from a private insurance company or the State Compensation Insurance Fund.⁵⁴ Health care expenses associated with workplace injuries, as well as disability payments for injured workers, are financed through such stand-alone policies. Workers' compensation arrangements contribute to fragmentation of health care delivery, since occupational care is often delivered separately from non-occupational health care.

Who Pays?

Employer-sponsored insurance is paid for through employer and worker premium contributions using pre-tax dollars, which means that federal and state governments essentially subsidize employer-sponsored insurance via foregone tax revenue. In addition, most plans require that workers or their family members make payments when they access care, typically via co-payments or deductibles.

Since 2008, premiums for job-based family health coverage in California have grown by 49 percent while real median wages in California have stagnated.⁵⁵ The high and rising cost of health insurance matters for workers with job-based coverage both because workers bear increasing costs directly through rising premiums and deductibles, and because even the share employers pay is ultimately borne by workers in foregone wages or other benefits. Economic theory indicates that any increase in health care costs not passed through to workers via higher worker premium contributions or out-of-pocket costs will come out of workers' wages or other compensation over the long run. Research has found that rising health care costs can impede wage growth, though the relationship is not one-to-one.⁵⁶

In California, single coverage premiums averaged \$8,712 per year in 2018,⁵⁷ equivalent to \$4 per hour for someone working 40 hours per week. For family coverage, the average premium was \$20,843, equivalent to \$10 per hour worked for a full-time worker—just three dollars less per hour than California's current \$13 minimum wage for employers with more than 25 workers.

For those working fewer than 40 hours per week, the hourly equivalent cost of health benefits was even greater.⁵⁸

On average, California workers paid approximately 14 percent of single coverage premiums and 27 percent of family coverage premiums in 2018, with employers contributing the remainder.⁵⁹ Low-wage workers spend a higher percentage of their income on premium contributions than higher-wage workers because most California employers require the same premium contributions regardless of wages.⁶⁰

Although workers' share of premium contributions are more visible to them, employer premium contributions make up a significant portion of total compensation and are of consequence to workers. For example, for a family earning \$70,000—the median family income for California workers—the \$15,730 average California employer contribution to family health coverage comprises 15 percent of total compensation.

Out-of-pocket costs, including deductibles, co-payments, and other forms of cost sharing, are another significant type of household spending on health care, with median out-of-pocket spending of \$500 per year in 2016-2017 for California households with employer-sponsored insurance.⁶¹ Under the ACA, enrollees' out-of-pocket spending on covered services is capped at \$8,150 for an individual and \$15,800 for a family in 2020.

Deductibles are one major contributor to the difficulty some Californians face in affording out-of-pocket costs, though other forms of cost sharing cause affordability concerns as well. Nearly half (46 percent) of Californians with employer-sponsored insurance had a deductible in 2018,⁶² up from 36 percent in 2008.⁶³ (This is still lower than the national share of 82 percent,⁶⁴ likely because California has more workers enrolled in HMOs that tend not to have deductibles.) Among California workers with a deductible, the average deductible amount was \$1,402 for those with single plans and \$2,706 for those with family plans in 2018.⁶⁵ Average deductibles in California have increased 84 percent for single enrollees and 77 percent for those with family coverage since 2008, after accounting for inflation.⁶⁶

Deductibles and copayments cause Californians to use less health care than they would use if care were free at the point of service. The RAND Health Insurance Experiment found that a 10 percent increase in patient cost-sharing reduced health care spending by 2%.⁶⁷ Cost sharing appears to reduce both appropriate and inappropriate care. That is, some of the care that is foregone as a result of copayments and deductibles is care that physicians judge might have produced benefit. Subsequent research has highlighted that cost sharing is associated with a reduction in the receipt of preventive care services, such as screening mammograms, and the

use of necessary medications for chronic conditions including diabetes, hypertension, and hyperlipidemia.⁶⁸

In the **individual market**, the cost to purchase insurance depends on age, region, and eligibility for federal (ACA) or state affordability assistance based on income. Generally, individual market enrollees who are not eligible for federal or state subsidies pay much more for premiums than those with employer-sponsored insurance because they pay the entire premium, instead of sharing the cost with their employer.

Among those who are eligible for subsidies, premium contributions vary based on income and plan selection. The average annual Covered California premium per subsidy-eligible member was \$7,200 as of June 2019. Enrollees paid approximately 21 percent on average, and the remainder was paid by federal advance premium tax credits.⁶⁹ Beginning in 2020, the state is providing additional subsidies averaging approximately \$192 per member per year for those with income between 200 to 400 percent of the Federal Poverty Level (FPL).⁷⁰ Enrollees with income 400 to 600 percent FPL, who earn too much for federal ACA subsidies but often still struggle to afford premiums, are now eligible for state subsidies averaging \$3,492 per member per year if their premiums exceed 9.68 to 18 percent of income, depending on their exact income level.⁷¹

The ACA legislated that individual market plans must cover at least 60 percent of covered medical expenses across an average population. Prior to the ACA, half of Americans with individual market coverage were in plans that paid less than 60 percent of costs.⁷² The ACA uses “metal tiers” to categorize plans based on actuarial value, or the average share of costs covered. Bronze plans cover 60 percent of costs on average, silver plans cover 70 percent, gold plans 80 percent, and platinum plans 90 percent.

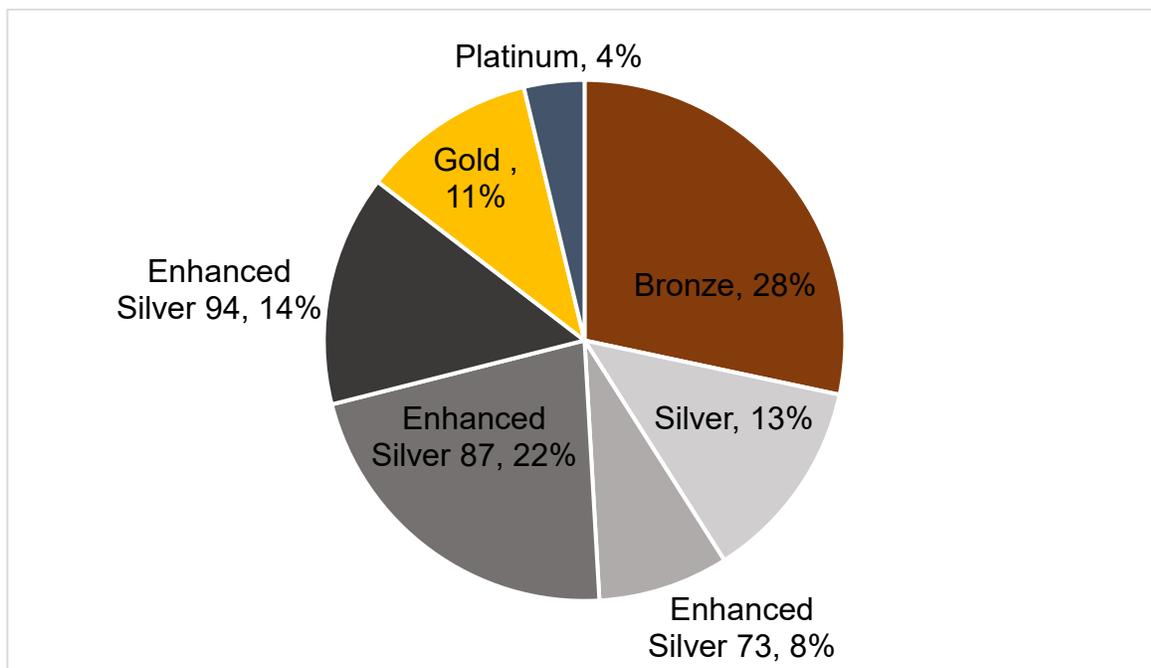
Covered California has done substantial work to standardize benefit designs in the individual market so that within the same metal tier consumers can make an apples-to-apples comparison and focus on more important factors, such as price, networks, and quality. Standard benefit designs mean that all plans offered through Covered California within the same “metal tier” have the same cost sharing levels (e.g. the same co-pay for a lab test or visit to the emergency room), as well as the same dollar levels for deductibles and out-of-pocket limits. Further, for silver metal tiers and above, plans do not apply the deductible to most outpatient services (doctor’s visits, ER visits, lab tests, x-rays and imaging) and more often use flat dollar co-pays versus co-insurance.

To help ensure affordability for enrollees with the lowest incomes, the ACA provided cost sharing reductions (CSRs) that reduce out-of-pocket costs even further for those with incomes

below 250% FPL. CSRs are available through “Enhanced Silver” plans in which actuarial values are 73, 87 or 94 percent depending on the degree of CSR support, which is in turn linked to income level.

More than one-quarter (28 percent) of Covered California enrollees have a bronze plan with a combined medical and drug deductible of \$6,800 for an individual plan and \$13,600 for a family plan, with the first three doctor’s visits subject only to a co-payment (Figure 8). All other Covered California plan designs have lower deductibles or no deductibles, with common services not subject to the deductible.⁷³ The ACA’s overall limit on out-of-pocket spending also applies to the individual market.

Figure 8: Covered California Enrollment by Metal Tier, June 2019 (Covered California Active Member Profile)



In contrast to employer-sponsored insurance and the individual market, most individuals enrolled in **Medi-Cal** pay no premiums or cost sharing. The costs of Medi-Cal are shared between the state and federal government.

Medicare is paid for via a 2.9 percent payroll tax split by workers and employers (with a 0.9 percent additional tax paid by high-income earners), funds from general revenues, plus premiums and out-of-pocket costs paid directly by Medicare beneficiaries. In 2016, traditional Medicare beneficiaries in the U.S. paid an average of \$2,640 in premiums for Medicare and supplemental insurance and \$3,166 in out-of-pocket costs on covered and non-covered services,⁷⁴ but premium and out-of-pocket costs vary significantly based on a number of individual factors.

Most Medicare beneficiaries have a second type of coverage that helps them pay for premiums and/ or out-of-pocket costs to varying degrees. Among traditional Medicare beneficiaries nationally, 30 percent of Medicare beneficiaries also had employer coverage, 29 percent had Medigap coverage, 22 percent had Medicaid, and 19 percent had no supplemental coverage in 2016.⁷⁵

Approximately 99 percent of Medicare enrollees pay no premium for Part A benefits. For those without another type of coverage that reduces premiums, in 2020 annual Medicare Part B premiums range from \$1,880 to \$5,900 depending on income⁷⁶ and Annual Part D premiums range from \$156 to \$996 depending on the plan chosen.⁷⁷

Medicare enrollees' out-of-pocket spending can be high given that traditional Medicare has a \$1,408 deductible for inpatient care in 2020, no out-of-pocket spending cap, and does not cover certain services like dental, vision, hearing aids, and long-term services and supports.⁷⁸ Medigap plans and employer-sponsored insurance plans reduce out-of-pocket costs for the Medicare enrollees who have these types of supplemental coverage. Medi-Cal provides assistance with Medicare cost sharing for "dual eligible" enrollees. Out-of-pocket spending amounts not only depend on supplemental sources of coverage, but also vary based on income, age, gender, and health status.⁷⁹

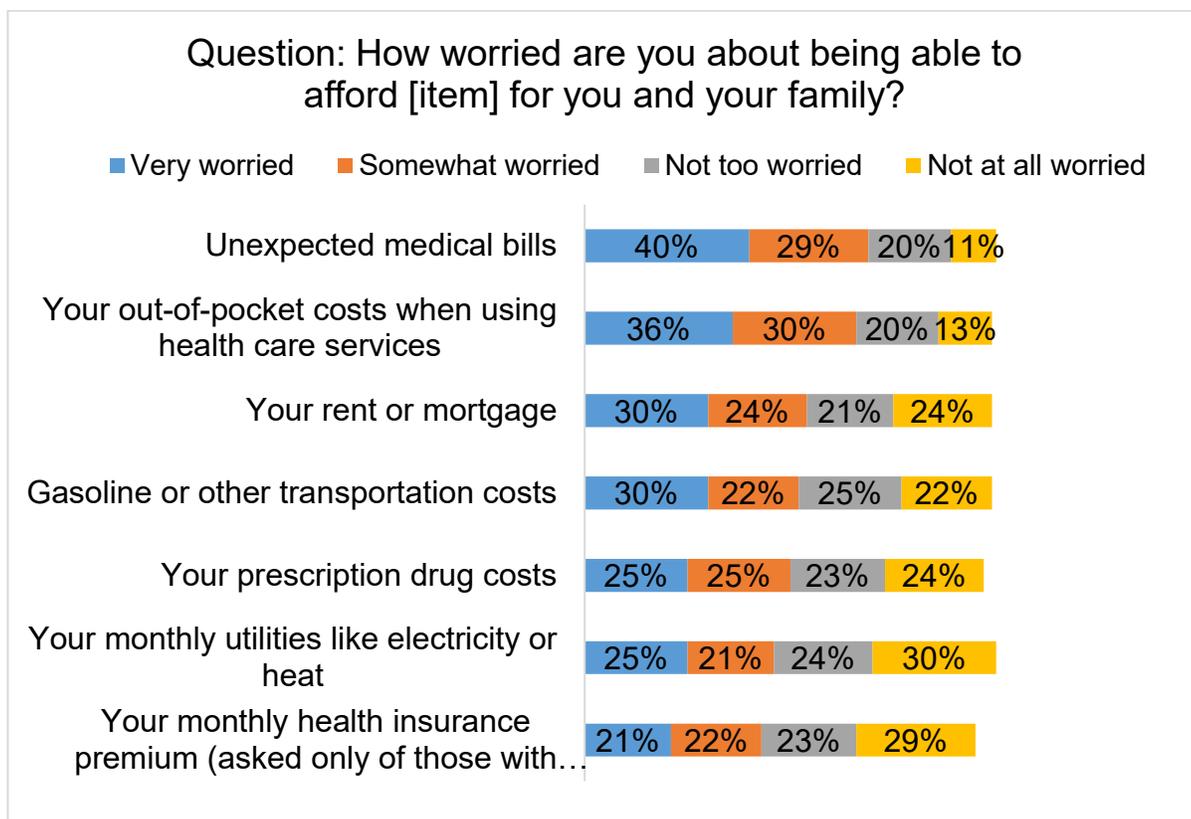
Medicare enrollees can voluntarily choose to enroll in a private health plan through the Medicare Advantage program. Medicare Advantage plans, which require enrollees to obtain services within a defined provider network, enrolled 40 percent of Californians with Medicare in 2018. Medicare Advantage plans often require premium contributions and out-of-pocket costs that are lower than in traditional Medicare.⁸⁰ Currently, Medicare Advantage plans must cap out-of-pocket spending at \$6,700, though many plans set a lower cap.

Remaining Affordability Challenges

Despite gains in coverage and even when the state’s economy was expected to remain strong, many Californians still struggled to afford health care. Because financing is fragmented, costs of coverage and care are uneven and can be difficult to predict.

As shown in Figure 9, 40 percent of Californians report being very worried about unexpected medical bills and another 29 percent were somewhat worried.⁸¹ Approximately two-thirds were very or somewhat worried about out-of-pocket costs when they access health care. These health care affordability worries ranked higher than concerns about rent and mortgage payments (54 percent somewhat or very worried) and affording gasoline and other transportation costs (52 percent somewhat or very worried).

Figure 9: Californians’ Ability to Afford Health Care Costs, 2019 (California Health Care Foundation, Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey)



The high degree of worry about unexpected medical bills reflects how common it is to receive these bills. As of late 2018, approximately three out of ten (31 percent) Californians received an unexpected medical bill in the prior year,⁸² despite California policies that protect many consumers from surprise medical bills from out-of-network providers at in-network health facilities and balance billing for emergency services. Millions of Californians do not benefit from state protections because their employers have arranged to assume full financial risk for employees' medical claims (known as self-funding) or because their plans are regulated by the California Department of Insurance.⁸³

Another way to measure affordability challenges is by assessing levels of underinsurance. The Commonwealth Fund defines underinsurance as out-of-pocket spending—excluding premiums—equaling more than 10 percent of income or at least 5 percent of income among those who are below 200 percent of the federal poverty level, or having a deductible that constitutes at least 5 percent of income.

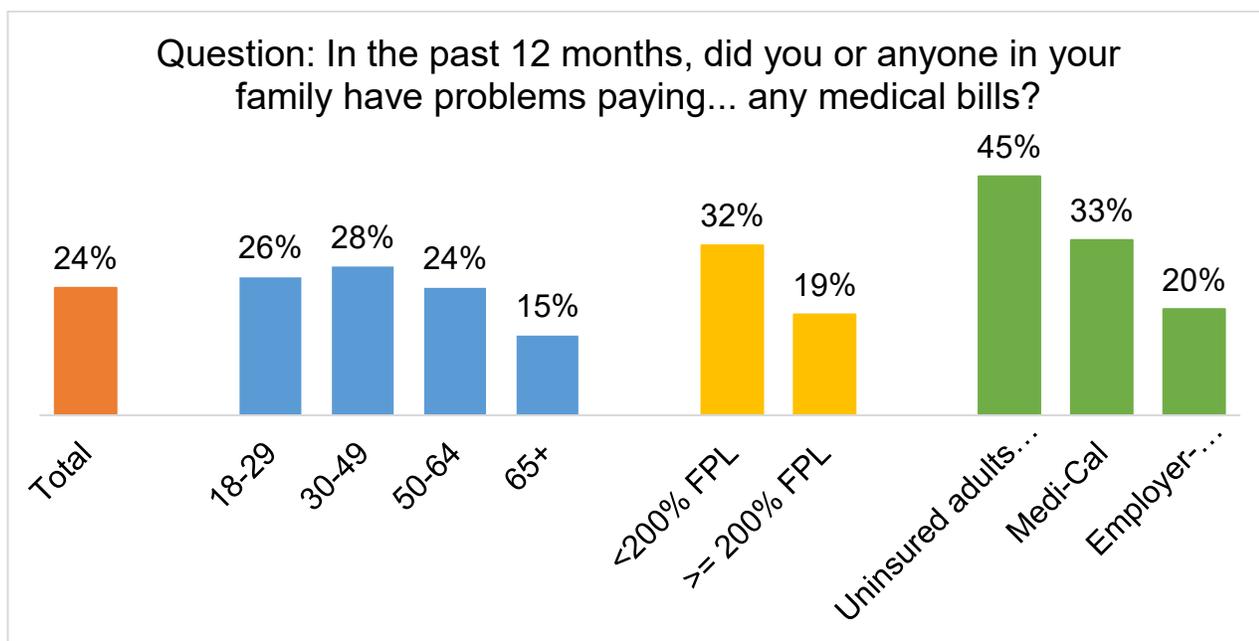
In 2018, among people in the U.S. under the age of 65, underinsurance was more common among adults who are enrolled in individual market insurance (42 percent) than among those with employer-sponsored coverage (28 percent), but since 2014 underinsurance across the U.S. has been growing most quickly among adults with employer-sponsored coverage.⁸⁴ Underinsurance among adults with both types of private insurance has grown since 2003, but since 2014 underinsurance has been growing most quickly among adults with employer-sponsored coverage. Underinsurance is also a problem for Medicare beneficiaries, particularly those below 200 percent of FPL, because Medicare imposes substantial consumer cost-sharing, does not limit out-of-pocket costs for covered benefits, and excludes a number of potentially costly benefits such as dental, hearing, and most long-term care services.⁸⁵

Struggles with health care affordability impose a range of financial hardships. As shown in Figure 10, nearly one-quarter (24 percent) of California adults age 18 to 64 report difficulties with paying medical bills in the past 12 months, according to the 2019 California Health Care Foundation/ SRSS survey.⁸⁶ Difficulty paying medical bills was most common among adults with income below 200 percent of the Federal Poverty Level, uninsured adults, and adults with Medi-Cal.

Among California adults, nearly 10 percent reported being unable to pay for basic necessities due to medical bills, according to the 2018 California Health Interview Survey. Adults with Medicare only and uninsured adults reported this problem at a higher rate: 15 percent and 14 percent respectively.⁸⁷

With the increasing cost of health care, individuals and families are forced to forego medically-necessary services. Half of Californians (51 percent) report that they have postponed or skipped care due to cost. Among those, 42 percent say that postponing or skipping care made their condition worse. This was particularly a problem for uninsured adults under age 65, of which 69 percent postponed or skipped care due to cost.⁸⁸

Figure 10: Difficulty Paying Medical Bills Among Californians, 2019 (California Health Care Foundation, Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey)



As a consequence of the COVID-19 pandemic, reduced earnings along with an increase in uninsurance and greater reliance on the individual market will almost certainly increase the number of Californians who struggle to afford out-of-pocket expenses and forego care due to cost concerns. Affordability will vary depending on the household's eligibility for premium tax credits and cost-sharing reduction plans.

In sum, health care affordability concerns are pervasive, even among those who have insurance, and cause many Californians to compromise care and to experience financial hardship. Fragmented financing, and the many ways in which benefits and consumer protections vary based on source of coverage, exacerbate affordability problems for many

subgroups including the remaining uninsured, low-income consumers, consumers with high deductibles and those with serious health conditions.

The data reported here were collected during a strong state and national economy. Even in that economy, many Californians expressed concerns about being able to afford needed care. During the severe economic downturn associated with the COVID-19 pandemic, concerns about affordability of coverage and care will increase substantially.

Coverage Transitions and Churn

Because health insurance availability and affordability are linked to an individual's employment and income, changes in people's circumstances can cause them to gain or lose coverage. Over a two-year period, a 2018 analysis estimated that 11 million Californians will change coverage status: 4.2 million will lose employer-sponsored insurance, 4.1 million will leave Medi-Cal, 800,000 will leave Covered California, and 1.8 million will move from being uninsured into coverage through another source.⁸⁹ The factors that drive these coverage shifts include losing or gaining a job through which employer-sponsored coverage is available, experiencing a change in income or marital status, or moving. A spike in coverage transitions is likely during the economic downturn associated with the COVID-19 pandemic as people experience dislocations in employment, income and living situation.

Protections under state law allow people to maintain provider relationships in some circumstances, and Affordable Care Act (ACA) provisions allow special enrollment when people's circumstances change. Covered California has offered a special open enrollment period to respond to COVID-19.⁹⁰ In contrast, the federal government continues to require documentation of coverage loss or other qualifying circumstances in the states that rely on the federally-facilitated exchange, [healthcare.gov](https://www.healthcare.gov).^{91,92} However, lack of awareness of such protections and the need to take action within limited windows of time can lead to disruption in care or gaps in coverage. As described further below, the health plans available through each coverage source offer different hospitals, physician and provider networks. Coverage transitions sometimes contribute to disruptions in care and may add to consumer confusion about in-network providers, covered services, procedures that need prior approval, and processes to fill prescriptions.⁹³ With no uniform method for identifying patients or providers, information sharing between care delivery settings can suffer.

Frequent transitions in coverage reduce the rewards to health systems to invest in prevention, and blunt health system incentives to increase affordability of care. High turnover within an enrolled population makes it more difficult for health systems to accumulate the data needed to

learn what works and what does not work. Coverage transitions also limit systems' ability to apply population management strategies to increase quality at a lower cost.⁹⁴

Synthesis: Demographics and Coverage

California has made impressive progress in reducing the number of uninsured, but 3.5 million Californians remain uninsured and many struggle with affordability. Public and private coverage arrangements serving California's diverse population are complex and variable. Distinct provider networks and payment systems may result in discontinuities in care. A recession or an economic shock (such as that associated with the COVID-19 pandemic) disrupts coverage and care arrangements, exacerbating anxiety and reducing access to care for low-income Californians and those marginalized by systemic economic and racial inequality.

Since 2014, when the coverage expansion provisions of the Affordable Care Act were implemented, California has greatly reduced the number of residents without health insurance. Even so, spending on health care continues to climb and many Californians continue to struggle with affordability. In addition, 3.5 million Californians remain uninsured, nearly 4 in 10 of those because they do not qualify for public coverage programs due to immigration status.

California consumers are diverse and the public and private coverage arrangements that serve them are complex and vary along many dimensions. In some instances, coverage arrangements have evolved to serve a sub-population's needs. For example, dedicated public funding streams support care for children with disabilities through California Children's Services, and the Medi-Cal In Home Supportive Services (IHSS) program funds services for people with functional disabilities. However, the design of these arrangements can become a consumer liability when distinct provider networks and payment systems result in discontinuities in care, as occurs with Medi-Cal's behavioral health services carved out from physical health services.

Working within the current fragmented financing system, California has made a number of policy choices that build connections among coverage programs, address affordability challenges for various population segments, and provide assistance to consumers as they choose among options and navigate complex systems. As long as Californians continue to obtain coverage from multiple sources subject to different rules, however, complexity, discontinuity and affordability challenges will persist.

California's Health Care Delivery System

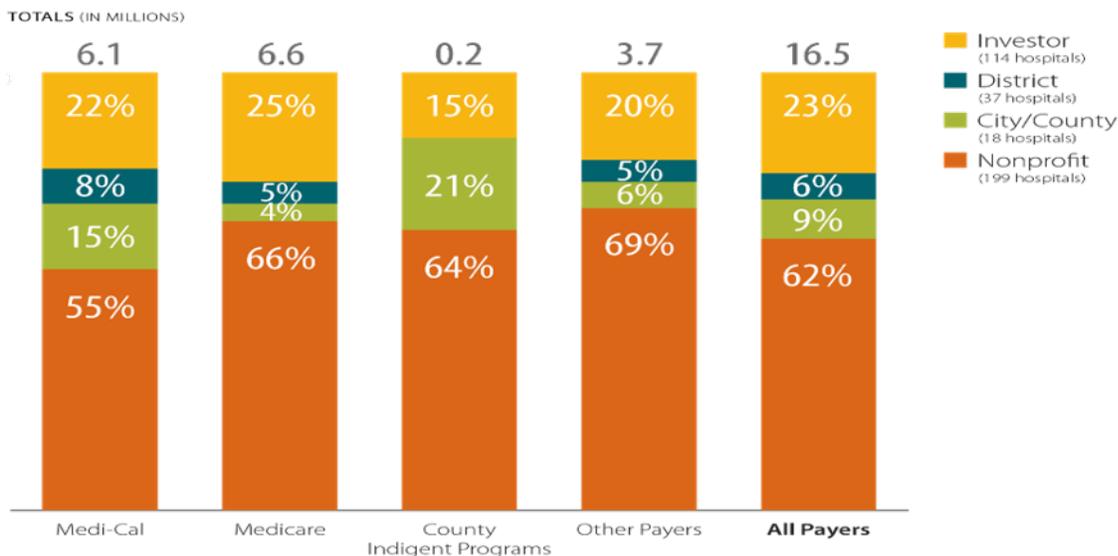
Hospitals, Physicians and Clinics

Californians obtain health care in settings and under arrangements that vary by location and coverage source. The state's 367 general acute care hospitals and nearly 72,000 beds are spread widely across the state but are concentrated in population centers.⁹⁵ Rural hospitals provide essential services in more remote areas but can struggle to maintain a solid financial footing.⁹⁶ Californians enrolled in Medi-Cal and county indigent care arrangements receive care more often from county hospitals than do Medicare enrollees or those with private insurance (Figure 11).⁹⁷

Figure 11: Hospital Ownership Type Varies by Payer (CHCF, California's Safety Net, 2019)

Inpatient Hospital Days

by Hospital Ownership Type and Payer, California, 2017



Notes: Total number of inpatient days noted at top of bar. Data are only for hospitals classified as comparable and thus do not include state and Kaiser hospitals or facilities classified as psychiatric or long-term care. *Other payers* includes private insurance, hospital-provided charity care, self-pay, and all other payers not included elsewhere. *Investor* hospitals are operated by an investor-individual, investor-partnership, or investor-corporation.

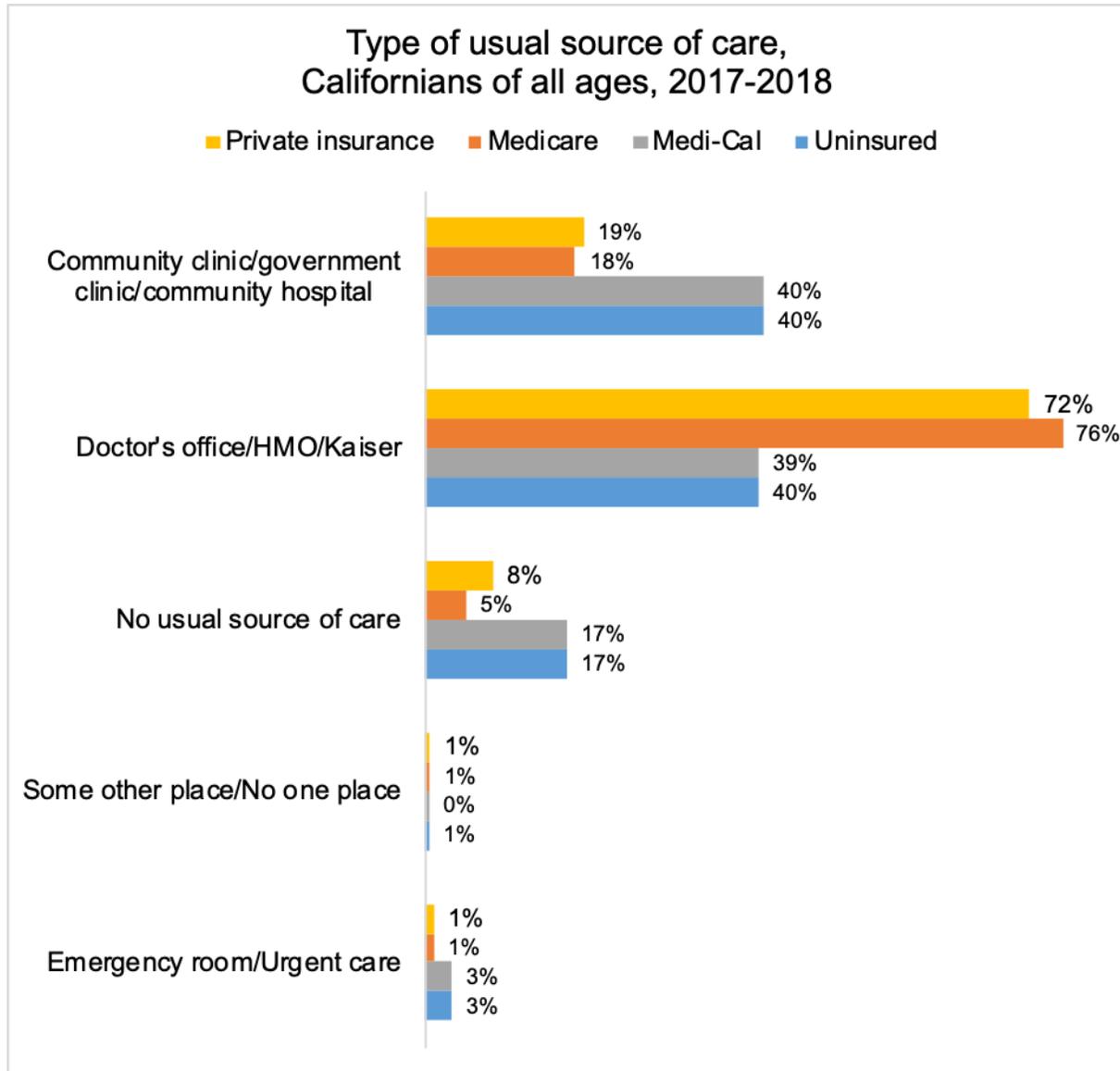
Source: Blue Sky Consulting Group analysis of 2017 Pivot Table — Hospital Annual Selected File (September 2018 extract), Office of Statewide Health Planning and Development, November 5, 2018, data.chhs.ca.gov.

Whether Californians have a usual source of care, and what those sources of care are, also varies depending on payer and program, as shown in Figure 12. Californians covered by private insurance and Medicare typically receive care in doctor's office, through an HMO or Kaiser. Medi-Cal managed care plans are required to assign each beneficiary a primary care provider. Nevertheless, Medi-Cal enrollees -- like the uninsured population -- are more likely to report that they have no usual source of care. Approximately 50% of the Medi-Cal enrollees who have a usual source of care identify community or government clinics or community hospitals as their usual source.⁹⁸ This suggests that Medi-Cal plan assignments to specific practitioners do not align with enrollees' experiences in seeking care.

Many low-income Californians receive much of their health care at hospitals and clinics that disproportionately serve the poor. These sites are sometimes referred to as the 'safety net'. However, because the availability of such providers and programs varies across geographic regions, they are not a reliable safety net with a consistently defined set of services. As such the term 'safety net' is used sparingly in this report, and information is instead provided on a variety of health care providers and programs that serve low-income Californians.²

² The broad expansion of Medi-Cal coverage to low-income Californians under the ACA has shifted the payer mix in such care sites and strengthened their finances. For example, the median payer mix distribution for California federally qualified health centers (FQHCs) shifted from 43 percent Medi-Cal and 36 percent uninsured in 2013, to 65 percent Medi-Cal and 17 percent uninsured in 2017. (Capital Link, [California Federally Qualified Health Centers Financial & Operational Performance Analysis, 2013-2017](#), 2019.)

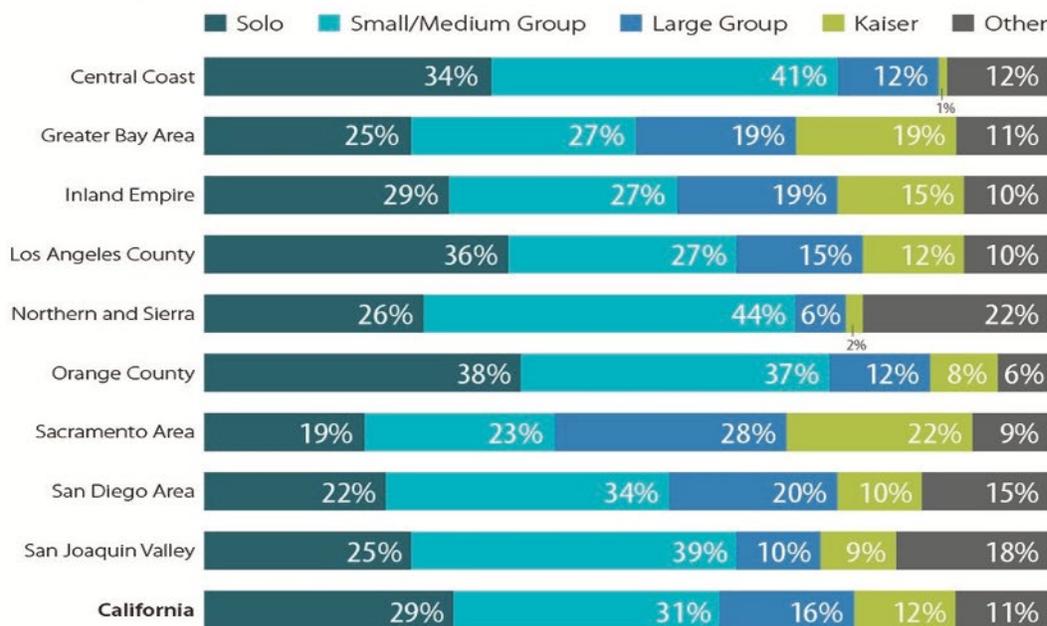
Figure 12: Usual Source of Care by Coverage Type, Californians of All Ages, California Health Interview Survey 2017-2018



California’s physician supply varies by region. In 2015, only the Bay Area met the recommended supply of primary care physicians (PCPs). The Inland Empire, San Joaquin Valley, and Northern and Sierra counties all fell short of the recommended supply of specialists.⁹⁹ Most California physicians work in a group setting, but the size and structure of group arrangements vary by region, as shown in Figure 13.

Figure 13: Physicians by Practice Setting and Region (CHCF: California's Physicians, 2017)

Physicians, by Practice Setting and Region California, 2015

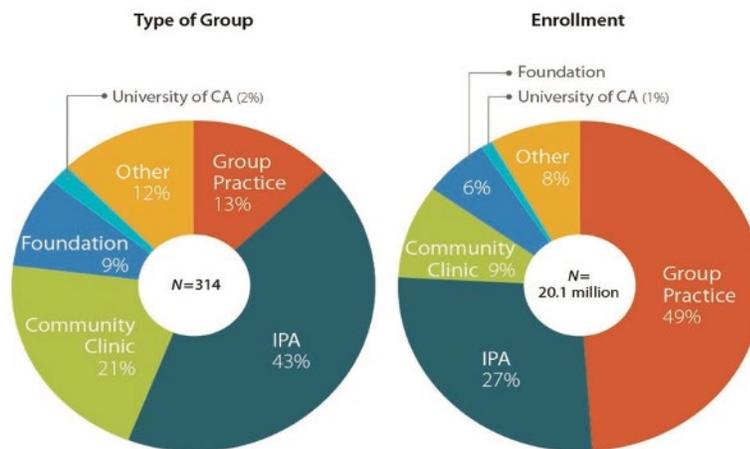


Notes: Data include active MDs providing at least 20 hours of patient care per week, and are based on a supplemental survey that elicited responses from 8% (approximately 5,200) of the active patient care physicians whose licenses were due for renewal between March 2015 and December 2015. Percentages are percentages of physicians who reported a practice type. *Small/Medium Group* consists of practices with no more than 49 physicians, excluding Kaiser Permanente. *Other* includes community clinics, public clinics, rural clinics, military facilities, VA medical centers, and other settings. One percent of respondents to the supplemental survey did not provide a practice setting. Percentages may not sum to 100% due to rounding.
Source: Voluntary Supplemental Survey (private tabulation), Medical Board of California, 2015.

In addition to varying by size, medical groups vary by type and enrollment. In 2016, 314 medical groups served California’s 20 million HMO enrollees. As shown in Figure 14, while 43 percent of these groups were independent practice associations (IPAs), they accounted for only 27 percent of enrollment. Group practices, including Permanente Medical Groups, are fewer in number but serve nearly half of HMO enrollees.¹⁰⁰ (Physicians in independent practice associations share some management and contracting infrastructure but their practices remain legally independent with separate tax identification numbers. Physicians in group practices, in contrast, are legally bound and engage in contractual relationships as a single entity with one tax identification number). An alternative to group practices such as Kaiser, for both health care practitioners and consumers, IPAs in the California market coordinate contracting functions between providers and health plans. In some cases, they also oversee utilization management, quality assessment, and provider credentialing.¹⁰¹ IPAs are heterogeneous and plan contracting relationships with IPAs vary, so it is difficult to generalize about consumer experience through IPAs as compared to other practice settings.

Figure 14: Medical Groups, by Type and Enrollment (CHCF, California Physicians, 2017)

Medical Groups, by Type and Enrollment California, 2016



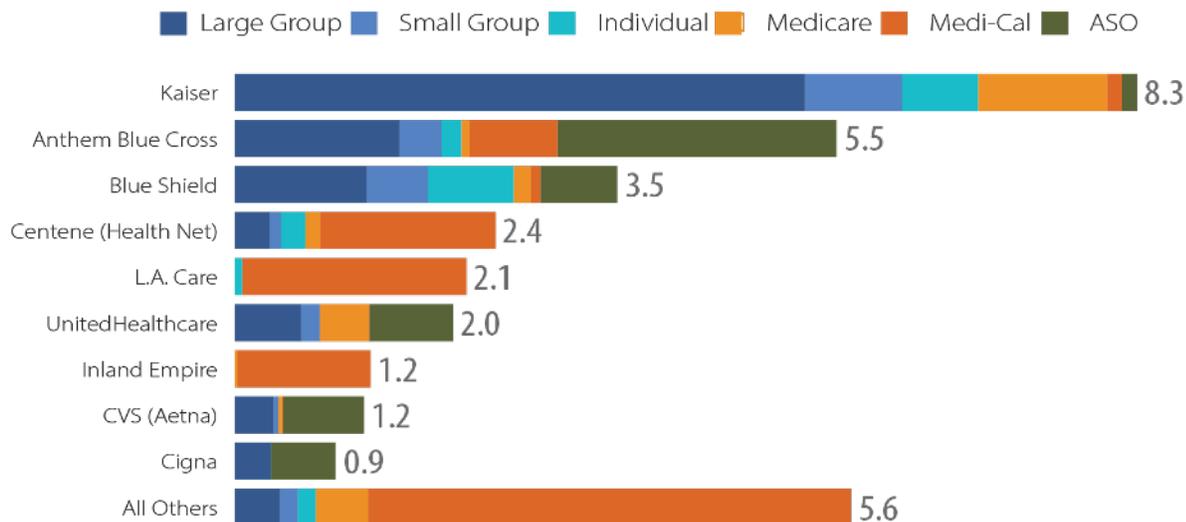
Notes: Data include medical groups with at least six primary care physicians (PCPs) and that accept contracts directly from HMOs. Physicians frequently participate in more than one independent practice association (IPA). Other includes state and county groups and groups organized under California Health and Safety code. See Appendix B for definitions of medical groups. Segments may not total 100% due to rounding.
Source: Report #18: Active California Medical Groups by Common and Legal Names Sorted by Organizational Type (private data request), Cattaneo & Stroud, 2016.

Community health centers and rural health centers are an important part of California’s health care delivery environment and play a central role in serving Medi-Cal enrollees and uninsured Californians. In 2017, the state’s 177 federally qualified health clinics served 4.7 million Californians. Fifty-seven percent of FQHC patients were Latino and 73 percent earned at or below the federal poverty limit.¹⁰² Latinos, Pacific Islanders and American Indians are more likely to report community clinics, government clinics and community hospitals as their usual source of care than are members of other racial and ethnic groups.¹⁰³

Health Plans and Insurance Carriers

The health insurers that offer coverage in California vary across a wide range of dimensions including the market segments and regions they serve, the types of products and benefits they offer and the breadth of their provider networks. As shown in Figure 15, Kaiser enrollees primarily obtain coverage through large and small groups, the individual market or

Figure 15: Enrollment by Insurer and Market Segment, California 2018 (in millions) (Wilson, Katherine, B., California Health Insurers and Enrollment, CHCF, December 23, 2019)



Medicare. Anthem Blue Cross offers both commercial and Medi-Cal coverage and offers Administrative Services Only (ASO) to self-insured employer plans. Blue Shield of California also serves all market segments with a higher proportion of individual market enrollees than other insurers. Enrollment in local Medi-Cal managed care plans, including LA Care, Inland Empire Health Plan and many others, accounts for a large portion of Medi-Cal enrollment statewide.¹⁰⁴ Many local Medi-Cal managed care plans subcontract portions of their enrollment to private plans such as Kaiser, Anthem Blue Cross, Health Net and Care 1st.¹⁰⁵

Health insurance carriers in California vary in the extent of their geographic reach. A few national carriers, such as United and Cigna, have a California market presence, particularly among self-insured large group purchasers. Blue Shield of California, Anthem Blue Cross and Health Net have enrollment throughout the state. Kaiser Permanente serves all major metropolitan areas and has high market penetration within its service areas but is unavailable in sparsely populated regions. Many Medi-Cal managed care plans serve residents within the boundaries of a single county. Some plans offering privately purchased insurance, such as Sharp, Chinese Community Health Plan and Western Health Advantage also have limited geographic reach.

Market competition among insurance carriers varies substantially from region to region. As an illustration, an analysis by zip code showed that in 2019, 71 percent of Covered California enrollees had four or more health plan choices; 9 percent had three choices; 15 percent had two choices; and 4 percent had only one plan choice.¹⁰⁶

Managed care arrangements are pervasive in California. Over 60% of Californians covered by health insurance are enrolled in an HMO. In the commercial market, 10.5 million Californians are enrolled in HMO products, including about 6.8 million in Kaiser. HMO enrollees account for 74% of the 14 million Californians covered by commercially insured products.¹⁰⁷ Managed care is also prevalent in public programs. An additional 10.8 million Californians are enrolled in Medi-Cal managed care, representing a managed care penetration rate of 83 percent.¹⁰⁸ In Medicare, 41 percent of California's 6.1 million enrollees are in Medicare Advantage, Medicare's managed care option, compared to 33 percent Medicare Advantage penetration across the U.S.¹⁰⁹ Over many years, California's enrollment within managed care arrangements in both Medi-Cal and Medicare has expanded.¹¹⁰

The Integrated Healthcare Association (IHA) reports that in almost all regions in California HMO products tend to have higher quality and lower costs than PPO products. IHA attributes the better measured performance to integrated care delivery networks and more sophisticated care management infrastructure, such as information technology and data systems, as well as to

payment incentives such as capitation that hold physician groups accountable for the health of a defined HMO member population.¹¹¹ Better *average* measured performance on cost and quality for HMOs compared to PPOs does not necessarily translate into better performance for each *individual* enrollee. Further, granular data on HMO performance for members of marginalized communities is not available – as far as we are aware, there are no data that compare HMOs and PPOs on the quality of care delivered to patients from disadvantaged communities.

Each carrier offers a diversity of products, some targeting a particular market segment (e.g., Medi-Cal, individual purchasers or small groups). Products have different cost-sharing arrangements and, within boundaries imposed by the ACA, may have some variation in benefits. Except for closed network products such as those offered by Kaiser Permanente, the networks available from product to product may also vary. In recent years, products with narrower provider networks have become more common. As a result, the provider network available to consumers may change when their coverage source (employer-sponsored, individual market, or public program) shifts, even if they continue to select coverage through the same carrier.

Consumers struggle with health insurance literacy.¹¹² Complex and highly variable health insurance products add to the burden consumers face in choosing coverage that meets their particular needs. As a result of Covered California's position as an active purchaser and its imposition of standardized benefit designs, individual market consumers in California face fewer challenges navigating the purchase of health insurance compared to consumers in most other states.¹¹³ Nevertheless, California consumers have trouble evaluating health coverage options and making well-informed choices when their coverage source shifts or they move from one plan to another. Less-educated Californians, those with limited English proficiency, and those with low levels of health literacy face particular obstacles related to the complexity of health insurance information.

The Influence of Coverage on Sources of Care

Sources of coverage influence where Californians obtain health care, as do plan contracting requirements and provider payment arrangements. When individuals from low-income groups receive care, it is disproportionately from safety-net providers, such as county-operated public hospitals and community-based clinics. In contrast, those with private health care coverage or Medicare are more likely to obtain care in private physician offices or from integrated medical groups, such as Kaiser Permanente. The availability and capacity of the health care safety net varies throughout California. The state's 18 county public hospitals supplied 9 percent of total inpatient days for California's total population, but provided 15 percent of Medi-Cal and 21

percent of uninsured inpatient days in 2017.¹¹⁴ In the same year, California's county public hospitals supplied 12 percent of hospital-based outpatient visits but 23 percent of those for Medi-Cal beneficiaries and 77 percent of those for the uninsured.

The concentration of low-income patients among a small proportion of providers is partially related to federal requirements and funds that provide enhanced payments to FQHCs, other community clinics called "FQHC look-alikes," rural health centers and hospitals including county public hospitals that provide a disproportionate share of their services to Medi-Cal and uninsured patients. These federal mechanisms are intended to support access to care for individuals from low-income groups. Providers in these settings may have expertise and access to resources to deliver more culturally-sensitive care than practitioners in other settings. However, when combined with Medi-Cal payment policies that pay private providers less than other payers, they also contribute to the segregation of care by income and payer.¹¹⁵

With the expansion of coverage that accompanied California's implementation of the ACA, the overall participation of physicians in the care of Medi-Cal beneficiaries has not kept pace with the growth of enrollment in the program.¹¹⁶ There has also been a substantial reduction in the provision of charity care to low-income patients by non-profit hospitals in the years following the implementation of the ACA in California.¹¹⁷ Meanwhile, care of Medi-Cal beneficiaries among safety-net providers has grown substantially since the adoption of Medi-Cal expansion in California. This is true for primary care clinics as well as for county-based hospitals.¹¹⁸ County-based hospitals have experienced greater growth in Medi-Cal inpatient days and a somewhat smaller decline in uninsured bed days than nonprofit hospitals since the implementation of the ACA in California.

Californians who receive coverage from an employer, who purchase coverage individually, or who elect a Medicare Advantage plan as the way to receive their Medicare benefits are also likely to face some restrictions on the providers they can choose for their care. Health plans use selective contracting and narrow networks as a means to control health care costs. The degree to which this limits an individual's choice of providers varies by plan and region throughout the state.

Sources of coverage intersect with income, race and ethnicity to influence access to care. Medi-Cal enrollees are more likely to face obstacles in obtaining specialty care than are those with private insurance. In 2015, 39 percent of physicians serving Medi-Cal enrollees reported difficulty obtaining referrals for specialist services compared to just 6 percent of physicians serving the privately insured. Barriers for referrals to diagnostic imaging and behavioral health services were also much higher in Medi-Cal.¹¹⁹ Independent of coverage source, 4 in 10 Latino

and Black Californians report that their communities lack adequate primary care and specialty providers, compared to 3 in 10 white Californians.¹²⁰ That the racial and ethnic make-up of California communities influences physician availability and access has been long established.¹²¹

Quality of Health Care

Separate from the differences in the comprehensiveness of health insurance coverage and availability of health care providers, there are also important differences in the clinical quality of care furnished by providers who care for different segments of the California population. Having said that, it is challenging to offer a concise, comprehensive description of the quality of health care in California. The fragmentation in the state's health care system is reflected in a fragmented collection and reporting of quality indicators. To the extent there are indicators of quality, they are often not available over time or across payers. Even for Medi-Cal, the collection and reporting of measures are inconsistent between beneficiaries in managed care versus those in the fee-for-service program. Quality reporting requirements imposed by different authorities contribute to administrative burden for providers who are most often the source of quality data.

Multiple state agencies in California gather information relevant for the assessment of health care quality, but in many cases, they capture information on just a subset of the population defined by type of payer, market, or delivery model. For example, the California Department of Managed Health Care (DMHC) captures complaint information but only for those individuals enrolled in the plans DMHC regulates and generally focuses on issues related to coverage and access, not experience with providers or direct delivery of services. The Office of Statewide Health Planning and Development (OSHPD) and the California Department of Public Health gather some information on health care quality for the entire state population but tend to focus on a narrow set of activities within health care such as coronary artery bypass surgery or maternity outcomes. In some cases, these agencies have applied rigorous data collection methods and utilized public reporting to promote accountability, but their findings are not routinely integrated with payers nor used as the basis for a broadly applied quality improvement program.

Beginning in 2012, California established the "Let's Get Healthy California" task force. Articulating the goal of making California the healthiest state in the nation, the initiative, co-chaired by California's Secretary of Health and Human Services, identified health care quality as an important determinant of health. The task force's 2012 report identified six measures of health care quality to be monitored over time: (1) percentage of patients receiving timely primary care; (2) percentage of patients receiving timely specialty care; (3) percentage of patients whose

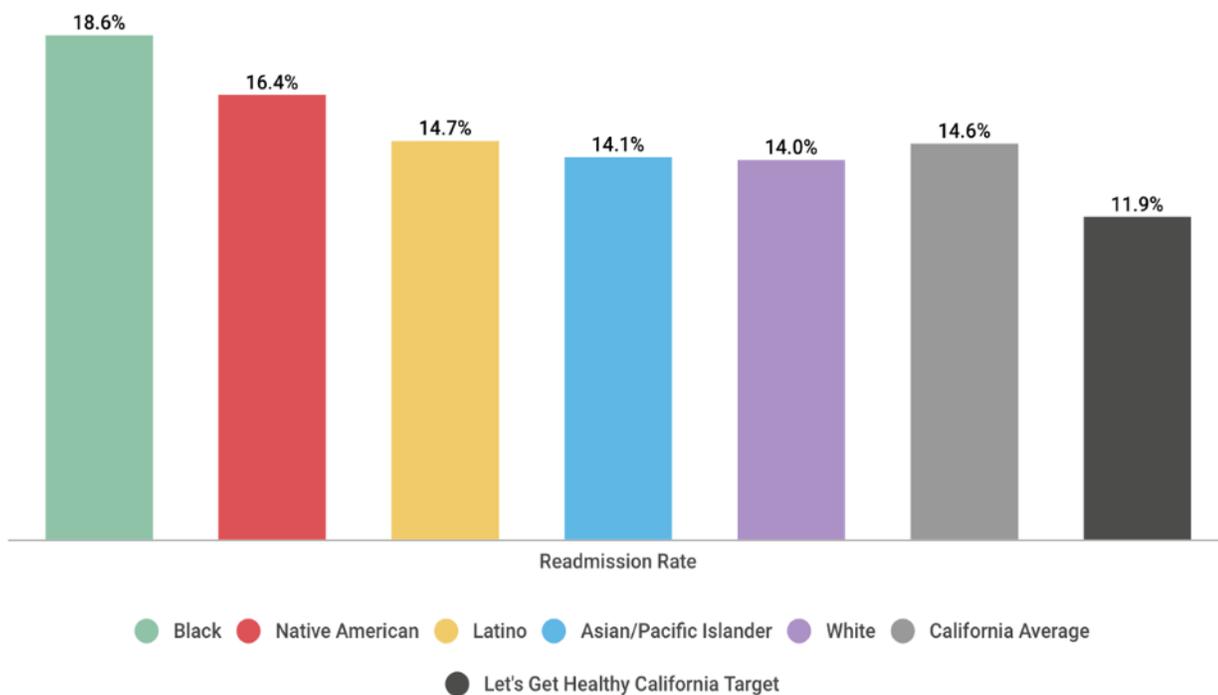
doctor’s office assists with care coordination; (4) preventable hospitalization rates; (5) 30 day hospital re-admission rates; and (6) rates of hospital acquired conditions. The most up-to-date information suggests that progress toward the pre-specified targets has been small and inconsistent except for an improvement in preventable hospitalization rates (Table 1).¹²²

Table 1: Let's Get Healthy California Quality Measures (“How Is California Doing?”)

Measure	Year 2011/12	Year 2017	Target
% Timely Primary Care	54.1%	58.2%	78.0%
% Timely Specialty Care	58.1%	62.1%	78.0%
% Care Coordination	67.0%	63.0%	94.0%
30-Day Hospital Readmission Rate	14.0%	14.6%	11.9%
Rate of Hospital Acquired Condition/1,000 discharges	0.76	0.53	0.50
Preventable Hospitalization Rate/100,000	1291	990	727

For some measures (hospital re-admission rates and preventable hospitalization rates) where there are data by race and ethnicity, as well as a number of other measures where comparisons can be done by racial and ethnic sub-groups, the quality of health care for people of color in California is worse than average.¹²³ For example, in 2017 hospital death rates and hospital readmission rates (Figure 16) were higher for Black, Latino, and Native American groups than for the white population in the state.¹²⁴

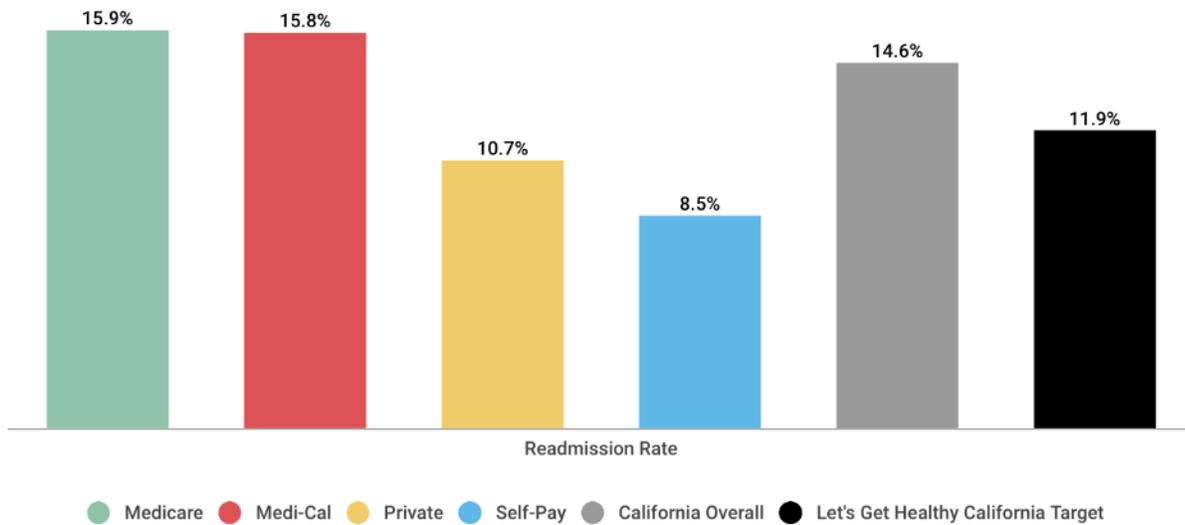
Figure 16: Hospital Readmission Rates, 2017, by Race/ Ethnicity (CHCF, 2020 Edition Quality of Care: Providers)



Information on quality of care across payers in California is currently limited due to the lack of a data collection tool, such as an all payer claims database, that could be used for these assessments. OSHPD does collect abstracted patient discharge-level administrative data related to all discharges from non-federal hospitals, ambulatory care surgery centers and emergency departments, which can be used to make some limited comparisons of health care quality by payers in these settings. For example, 30-day hospital re-admission rates are higher in California for those in public insurance programs (Medicare and Medicaid) than for those with

private coverage; however, these rates are not adjusted for differences in case-mix across payers (Figure 17).¹²⁵

Figure 17: Hospital Readmission Rates, 2017, by Payer (CHCF, 2020 Edition Quality of Care: Providers)



The biggest gap in data collection is in the ambulatory care setting, which includes doctor offices as well as hospital-based and community-based clinics. One of the main ways of assessing health care quality in this setting is by measuring preventable hospitalization rates. Hospitalizations for asthma attacks or complications of diabetes are preventable with access to high quality ambulatory care. These rates are lower when individuals have better access to ambulatory services.¹²⁶ Rates of preventable hospitalizations vary markedly across California counties (Figure 18).¹²⁷

Figure 18: Preventable Chronic Care Hospitalizations By County, 2017 (CHCF, 2019 Quality of Care: Chronic Conditions)

Preventable chronic care hospitalizations vary by county.



The gap is partially filled by the voluntary multi-payer claims data base assembled by the Integrated Healthcare Association. The IHA aggregates member level data for both ambulatory and inpatient care for 20 million Californians insured through commercial plans, Medicare Advantage plans, and traditional Medicare. The data are used to calculate performance on clinical quality, hospital utilization, and cost of care measures, and these results are reported publicly in IHA's Cost & Quality Atlas (atlas.iha.org).

Although not available across payers, some of the state's most robust data on health care quality is collected within the Medi-Cal program. The California Department of Health Care Services produces an annual report describing the performance of all health plans at a county or multi-county local regional level participating in Medi-Cal managed care. These plans are required to report results of assessments of health care quality based on standardized measures from the Healthcare Effectiveness Data and Information Set (HEDIS), established by the National Committee for Quality Assurance, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey designed to capture patients' experience with their health care. Similar information is reported for commercial plans at a statewide level on the Office of the Patient Advocate website.¹²⁸

An analysis of these data over the decade from 2009 to 2018 indicates that Medi-Cal beneficiaries rate their experiences with health care below the national average of Medicaid beneficiaries and that quality has been stagnant for many of the monitored measures.¹²⁹ Of particular concern is the finding that 6 of the 9 measures of children's health care quality declined or were stagnant over the decade. On average, the performance of for-profit health plans providing Medi-Cal managed care services over the past decade was worse than that provided by non-profit and public plans throughout the state.

Though DHCS engages an External Quality Review Organization (EQRO) to annually prepare a statewide health disparities report, the data are not collected or reported in a way to support assessments of health care quality by race, ethnicity, primary language, or other important demographic characteristics at the plan or regional level.¹³⁰ DHCS operates a quality improvement program to oversee the delivery of health care services for Medi-Cal managed care members and implements various quality improvement projects for specific programs and populations, each with different approaches and targets.¹³¹ For plans underperforming on quality measures, the Department of Health Care Services utilizes various levers intended to improve plan performance, including written performance plans and sanctions and penalties for plans that do not demonstrate improvement. However, an independent analysis found that these strategies have not resulted in improvements in plan performance over time.¹³²

Generalizing from the Medi-Cal program, California has proven capable of creating and sustaining a system to capture robust information on the quality of a large state operated health care program. Other examples of state-level efforts at assembling data on quality and outcomes include the work done by Covered California¹³³, as well as the data collected by the Integrated Healthcare Association (IHA), which is a voluntary effort to collect information on health care quality from health insurers, Medicare, and California medical groups and independent practice associations. IHA has data on 90% of commercially insured HMO and PPO members.

However, the state has been challenged to ensure that the results of health care quality assessments are incorporated into systems of accountability to produce improvements over time. Medicare, Medi-Cal, Covered California, and private insurers and employers each have their own systems of measuring and rewarding quality. A variety of efforts to coordinate quality measurement and reward systems across payers have made some progress, but physicians, hospitals, and other health care providers still are faced with a dizzying array of quality measures, are forced to spend considerable resources on producing information to populate these measures, and are not consistently rewarded for improving quality and outcomes. IHA has filled an important gap in data collection, but the reliance upon a private voluntary effort for collecting and reporting data among commercial providers may not be as dependable as a public entity charged with this responsibility. Consolidating the fragmented funding streams of multiple payers under a unified financing system would make it more possible to extend and build out the capacity to improve quality for California's entire population.

California's Health Care Workforce

Appropriate, high-quality health care depends on a health care workforce that is accessible to and trusted by Californians throughout the state. California's health care workforce is characterized by existing gaps and looming challenges. Similar to the rest of the nation, the availability and distribution of the health care workforce is affected by incentives and payment levels that vary by payer and program. For example, lower reimbursement rates for primary care relative to specialty care services influence fewer medical school graduates to choose primary care.¹³⁴ The resulting workforce imbalance – in the U.S., about one-third of physicians practice primary care and two-thirds provide specialty services, a ratio that is reversed in other high-income countries – is associated with higher spending and poorer health outcomes.¹³⁵

Figure 19 shows the distribution of primary care providers and specialists across California. The Bay Area is the only region in which primary care provider supply meets recommended levels. The racial and ethnic composition of active California physicians does not reflect the diversity of California’s population. In 2015, for example, 6 percent of the California population was African American but only 3 percent of physicians providing patient care were African American. Meanwhile, Latinos represented 38 percent of the California population but only 5 percent of physicians were Latino.¹³⁶

Figure 19: Primary Care and Specialists by California Region, 2015 (CHCF, California Physicians: Who They Are, How They Practice, November 2017)

Primary Care Physicians and Specialists by California Region, 2015



*The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include doctors of osteopathic medicine (DOs) and are shown as ranges in the chart above.
Notes: Data include active MDs working 20 or more hours in patient care per week, excluding residents and fellows. There is a slight difference in regional per population estimates of physicians since not all respondents provided geographic information. See Appendix A for a list of counties within each region.
Sources: Survey of Licensees (private tabulation), Medical Board of California, 2015; Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010 to July 1, 2015, US Census Bureau, June 2015.

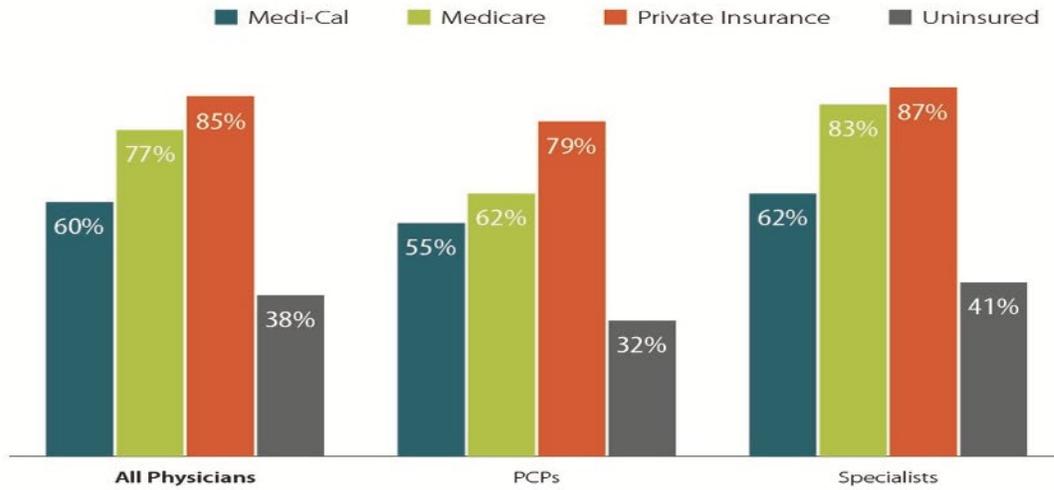
According to the California Future Health Workforce Commission (CFHWC), seven million Californians, the majority of them Latino, African American, and Native American, live in federally designated Health Professional Shortage Areas. Shortages are most severe in some of California's largest and fastest-growing regions, including the Inland Empire, Los Angeles, and San Joaquin Valley, and in most rural areas. Shortages will be exacerbated in coming years by the retirement of baby boomers who currently comprise a large part of the health care workforce. The CFHWC identified a looming crisis of health care professionals, particularly in the areas of primary care, behavioral health and workers to care for older adults, to address the State's future population needs.¹³⁷ The CFHWC recommended total investments of \$3 billion over a 10-year period to increase opportunities for all Californians to advance in the health professions; align and expand education and training to prepare health workers to meet California's health needs; and strengthen the capacity, retention, well-being and effectiveness of health workers.¹³⁸

Financing structures – from reimbursement rates under various coverage programs to investments in higher education – influence the size, composition and distribution of California's physician workforce. For example, although federal and state mental health parity laws expanded insurance coverage for behavioral health services, many California psychiatrists focus their practices on self-pay patients. A 2015 study found that 77 percent of psychiatrists who provided patient care in California had any patients with private health insurance, and that 55 percent of psychiatrists had any Medicare patients and 46% had any Medi-Cal patients.¹³⁹ As shown in Figure 20, primary care physicians and specialists are less likely to accept new patients who are uninsured or enrolled in Medi-Cal than to accept those covered by Medicare or private insurance. Although dedicated federal and state funding streams support graduate medical education for training of physicians, funding levels are not well aligned with population needs nor accountable for improved access or distribution of physicians.^{140,141}

Payment rates and other financial considerations are an important factor in the career decisions of physicians and other members of the health care workforce. But other factors, including prestige, location of training programs, work-life balance, and workplace culture, also influence workers' choices about where and for what type of organization to work. Although physicians play an essential and visible role in health care delivery, they make up a small share of California's total health care workforce. Registered nurses, nurse practitioners and other advanced practice nurses, licensed vocational and practical nurses, nurse's aides – and many others – play crucial roles in delivering health care services.

Figure 20: Physicians Accepting New Patients, By Payer, California 2015 (CHCF, California Physicians: Who They Are, How They Practice, November 2017)

Physicians Accepting New Patients, by Payer California, 2015



Notes: Data based on a supplemental survey that elicited responses from 8% of active MDs providing at least 20 hours of patient care per week whose licenses were due for renewal between March 2015 and December 2015. If a physician reported they accepted new patients in a payer category, they were included in the reported percentage. All differences across insurance types are statistically significant at $p < 0.05$.

Source: Voluntary Supplemental Survey (private tabulation), Medical Board of California, 2015.

CALIFORNIA HEALTH CARE FOUNDATION

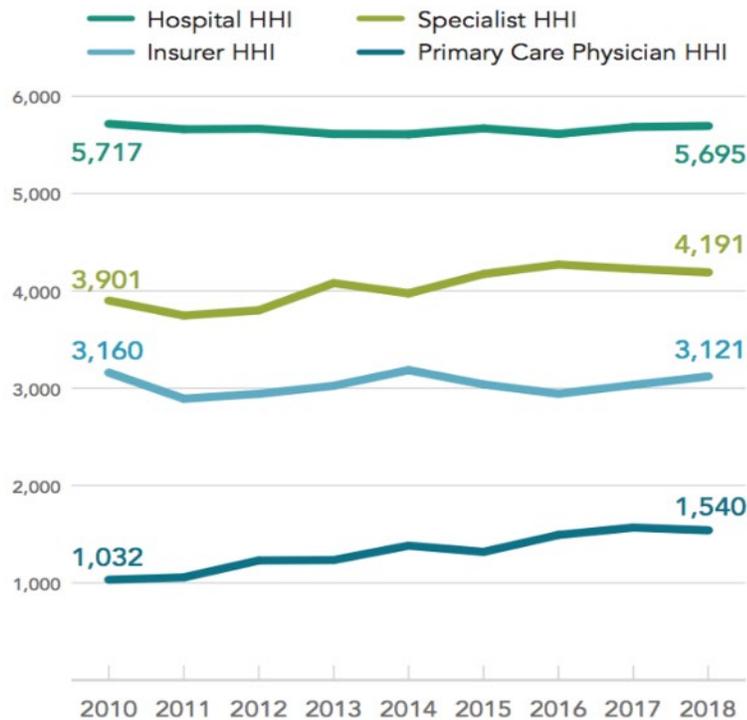
Policies and payment arrangements under status quo financing leave room for improvement in the distribution of non-physician workers as well. For example, workforce growth among physician assistants, who are more likely than physicians to provide care in rural areas and to care for low-income and underserved populations is limited by California supervision regulations that impose a 4:1 ratio of physician assistants to physicians.¹⁴² Community health workers and *promotores* can play an important and cost-effective role in supporting Californians to engage in healthier behaviors. But because most payers focus on reimbursing licensed providers who deliver specific health care services, the involvement of community health workers and *promotores* in providing care in California is uneven and relies on a patchwork of funding sources.¹⁴³

Provider Consolidation

Lack of competition gives health care providers substantial leverage when negotiating with insurers and employers. Most health care markets in California are highly concentrated, and most hospital markets have been highly concentrated since at least the mid-1990s.^{144,145} Richard Scheffler and colleagues at U.C. Berkeley report on concentration using a measure called the Herfindahl-Hirschman Index (HHI), which ranges from 0 to 10,000.¹⁴⁶ The Horizontal Merger Guidelines used by the Department of Justice (DoJ) and the Federal Trade Commission (FTC) define markets with HHI between 1,500 and 2,500 as moderately concentrated, and markets with HHI above 2,500 as highly concentrated.

As shown in Figure 21 below, the average HHI in hospital markets in California was 5,700 in 2019, indicative of highly concentrated markets. Average HHI levels were somewhat lower for specialist physicians and insurers, but still, on average, well above the DoJ/FTC threshold for being highly concentrated. Markets for primary care services were somewhat more competitive, although still, on average, in the 'moderately concentrated' range. Over the 2010-2018 period, average HHI increased by about 50% for primary care providers, increased slightly for specialist physicians, and did not change appreciably for hospitals or health insurers.

Figure 21: California Health Care Horizontal Concentration Trends, by County-Level HHI 2010-2018 (Scheffler, Richard M., Daniel R. Arnold, and Brent D. Fulton, [The Sky's the Limit Health Care Prices and Market Consolidation in California](#). CHCF, October 2019)

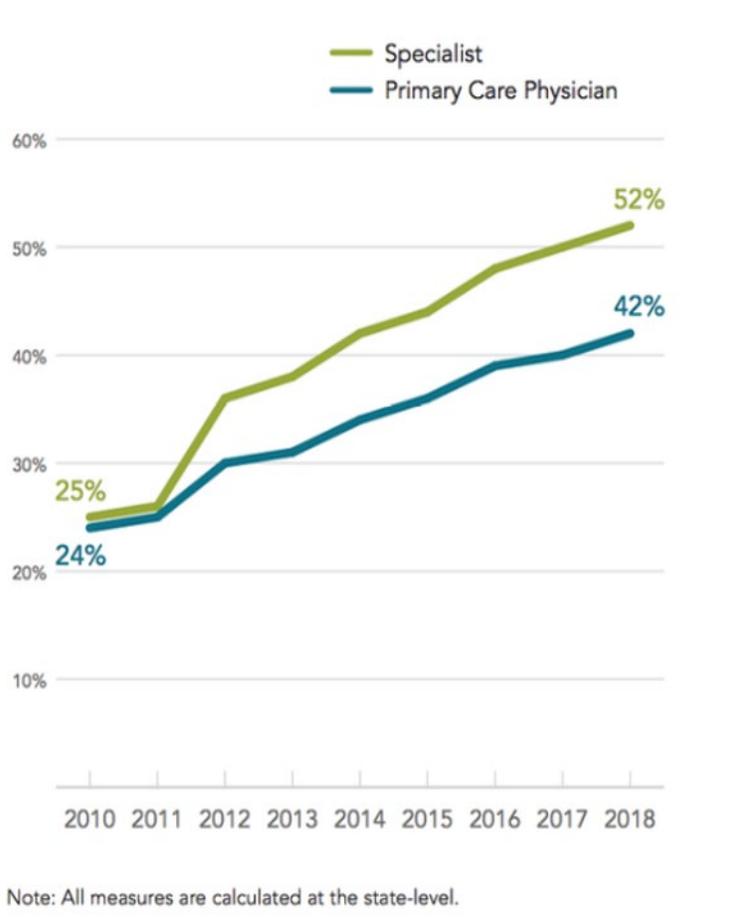


One way in which providers become concentrated is through horizontal integration in which separate providers of a similar type align under a common ownership. For example, Melnick and colleagues report that from 1996 to 2016, the proportion of California hospitals, and hospital beds, that were part of health systems increased from 39% to 60%.¹⁴⁷

Another way in which concentration occurs is through vertical integration, where doctors' financial interests are aligned with those of hospitals. These arrangements increased substantially from 2010 to 2018. The fraction of primary care physicians working in practices that were considered to be owned by a hospital or a health system in California increased from 24% in 2010 to 42% in 2018 (Figure 22). The corresponding increase among specialists was

even steeper – from 25% in 2010 to 52% in 2018.¹⁴⁸ These increases parallel changes nationwide.

Figure 22: Percentage of Physicians in Practices Owned By A Hospital/Health System in California By Type of Physician, 2010-2018 (Scheffler, Richard M., Daniel R. Arnold, and Brent D. Fulton, [The Sky's the Limit Health Care Prices and Market Consolidation in California](#). CHCF, October 2019)



Data from the AHRQ Comparative Health System Performance (CHSP) project suggest that the increase in vertical integration between 2016 and 2018 may be even greater than was previously estimated. Data from CHSP show that the fraction of California physicians in health

systems increased from 39% in 2016 to 57% in 2018, and that the fraction of primary care physicians in health systems is similar to the fraction of specialists.

Health care in California is increasingly being delivered by a relatively small number of very large health systems. In 2018 the ten largest health systems in California accounted for 46 percent of all the physicians in the state. This is a sharp increase from 2016 when 31 percent of physicians in the state were associated with these ten health systems (Table 2).

Table 2: Number of Physicians and Hospital Beds in the Ten Largest Health Systems in California, 2016 and 2018

	Number of Physicians		Number of Hospital Beds	
	2016	2018	2016	2018
Kaiser Permanente	15586	18241	7312	7470
University of California Health	5198	10145	3363	3580
Dignity Health	1730	7821	6324	6310
Sutter Health	3250	6215	4030	4025
Providence Saint Joseph Health	956	4435	1800	3878
Stanford Health Care	2452	3081	955	921
Los Angeles County Health Services Department	1652	1983	1251	1113
Cedars-Sinai Health System	968	1841	1030	1474
Sharp HealthCare	596	1623	1717	1695
Adventist Health	724	1420	2374	2389
Total, 10 largest systems	33112	56805	30156	32855
Total, all systems	42290	69852	56862	59277
10 largest systems percent of statewide total	30.7%	46.0%	43.1%	47.0%
All systems as percent of statewide total	39.3%	56.5%	81.3%	84.8%
Note: Approximately 5% of physicians are counted as members of more than one system.				
Source: AHRQ/Mathematica analysis of data from the AHRQ Comparative Health System Performance data base.				

A number of large systems, including the University of California, Sutter, Cedars-Sinai, and Adventist approximately doubled their physician count from 2016 to 2018, and Sharp Healthcare grew even more rapidly. In 2018, Providence Saint Joseph Health had more than four times as many physicians as it had in 2016, and Dignity also grew by more than a factor of four.

Both forms of integration, horizontal and vertical, contribute to greater concentration and less competition. Not surprisingly, less competition is associated with higher prices and higher cost of delivering care. Melnick and colleagues show that average cost per case-mix adjusted admission increased more rapidly at hospitals that were part of multi-hospital systems than at independent hospitals over the 1996-2016 period. Scheffler and colleagues show that the price of caesarean sections is higher at hospitals in less competitive markets (as measured by the hospital HHI). Further, Scheffler and colleagues found that the price of a head CT scan without contrast increases both as the HHI of radiologists increases and as the percentage of radiologists working in practices owned by hospitals or health systems increases. As shown in the section on 'How the Money Flows' below, commercial insurer payments for evaluation and management services are approximately at the level of Medicare payments, while payments for many procedures are at 150%-200% of Medicare. The much greater concentration of specialists compared to primary care physician likely accounts for at least some of this difference.

Although greater concentration contributes to higher prices, it is only one part of the story. Provider market power can manifest in other ways, such as demand by consumers and employers for a hospital because of its brand name or reputation. These hospitals are considered 'must have' institutions by employers and their employees in their communities, and even in an area with a substantial number of competitors, 'must have' status provides hospitals substantial negotiating leverage.

In addition to the level of concentration, type of ownership almost certainly affects the incentives and performance of physicians, hospitals, and other health care providers. None of the 10 largest health systems in California shown in Table 2 are for-profit organizations, but an increasing number of physician practices nationwide are being purchased by private equity firms.¹⁴⁹ Private equity incentives to maximize shareholder profits are unlikely to align with California's population health and health equity goals.

The preceding discussion focused on the negative effects of vertical and horizontal integration on prices paid by private insurance, but integration also has the potential to facilitate improvements in quality and outcomes. A substantial fraction of health care in California is

delivered by physicians who are part of large integrated medical groups, and these groups are more likely to be engaged in a variety of quality improvement efforts than medical groups in other areas of the country. As shown in Table 3, analysis of data from the National Survey of Health Care Organizations and Systems found that medical groups in California are more likely than medical groups in the rest of the country to have implemented a variety of care management processes. This includes use of programs to care for complex and high needs patients, shared decision-making, use of electronic health records (EHRs) for decision support, evidence-based guidelines, and registries.¹⁵⁰ Large integrated medical groups have more capacity to conduct quality improvement and cost containment activities, which likely contributes to these differences.

Table 3: Care Management Innovations: California Compared to Rest of U.S.

Implementing Innovations in Care Management Processes (0 to 100 scale)

	California Practices (N=219)	Rest of the Country (N=1,971)	P-value
Care of complex/high need patients	46%	39%	0.0001
Shared decision-making with patients	49%	42%	0.0001
Use of EHRs for decision support	63%	55%	0.0001
Use of evidence-based guidelines	73%	60%	0.0001
Use of registries	63%	49%	0.0001

Source: Analysis of National Survey of Healthcare Organizations and Systems (NSHOS) – Dartmouth, Berkeley, High Value Health Care Collaborative Center of Excellence, April, 2019



The structure of financial incentives also influences outcomes. Large integrated health care systems are better able to accept financial risk via prepaid capitation payments than are smaller groups of physicians. Capitation payment arrangements, as compared to fee-for-service

reimbursement, encourage investments in prevention, discourage the use of duplicative services, and reward groups for success in health planning – that is, in figuring out how many and what types of health care resources are needed to provide high quality care to a defined population. Analysis conducted by the Integrated Healthcare Association shows that risk-adjusted cost of care is substantially lower and measured performance on a variety of quality metrics is substantially higher for patients in medical groups paid by capitation than in groups paid using fee-for-service¹⁵¹ – one indication that integration of the sort offered through California HMOs increases efficiency and quality on a population level.

However, capitation arrangements also encourage stinting, in which medical groups and health systems have incentives to provide less than optimal care to high needs patients, in the hopes of saving money and discouraging such patients from enrolling or encouraging them to disenroll. The incentives to stint can, in theory, be attenuated by careful management of competition among medical groups and health systems – e.g., providing patients reliable information about medical group performance, assuring that all medical groups offer the same set of benefits and are required to take all comers, carefully monitoring patterns of enrollment and disenrollment, and risk-adjusting the capitation payments.¹⁵² Whether the incentive to stint can be attenuated sufficiently in practice to assure that medical groups and health systems paid by capitation will provide high quality care to those most in need – and work to increase health equity and improve care for marginalized and vulnerable communities -- remains an open question.

Although comprehensive nationwide data on payment methods are not available, it appears that capitation payment is much more prevalent in California than in the rest of the country. Data from the Integrated Healthcare Association's Cost & Quality Atlas shows that virtually all payments for professional services for privately insured patients enrolled in HMOs and for Medicare patients enrolled in Medicare Advantage plans are made through capitation.¹⁵³ As a result, capitation accounts for approximately 60% of all commercial insurance and Medicare payments for professional services in California.

HMO patients account for approximately 60% of privately insured and Medicare patients in California, and thus capitation accounts for approximately 60% of payments to medical groups in California. Capitation also accounts for virtually all payments for inpatient and outpatient facility services for Medicare Advantage patients, but for privately insured HMO patients, inpatient and outpatient facility services are mostly paid on a fee-for-service basis. In total, capitation accounts for approximately 14% of payments for inpatient and outpatient facility care

for privately insured and Medicare patients.³ The IHA data do not include information on payment for Medi-Cal enrollees, most of whom, as noted above, are enrolled in managed care.

Synthesis: California's Health Care Delivery System

Market forces and incremental policy decisions have combined over time to produce a complex landscape of health plans, hospitals, clinics, physicians and other practitioners across California. Various delivery system actors focus on their own financial viability or profitability. Disjoint incentives and an absence of government intervention to address inequities make it difficult to address persistent health disparities and unsatisfactory public health outcomes.

Health care in California is provided in a variety of settings and the extent to which services are integrated across sectors also varies. The geographic distribution of the health workforce is uneven, does not reflect the diversity of California's population and is not optimized to meet emerging population needs. The balance between public and private sector responsibility to pay for, arrange and deliver care varies by population, service sector, and region. Across most aspects of the health care delivery system, accountability for high-quality clinical outcomes, positive consumer experience, and improved efficiency is limited and diffuse.

In addition to these shortcomings, it is important to note, particularly within the context of the COVID-19 pandemic, that California's public health infrastructure – like that in most jurisdictions across the U.S. – is almost entirely separated from health care financing and delivery arrangements. Information- and resource-sharing between those responsible for delivering health care services and those responsible for protecting public health is extremely limited.

Fragmented financing makes it challenging for policymakers and operational leaders to focus on achieving a health care system that is accessible, affordable, equitable, high quality, and universal for all Californians. Inequities in access, quality and affordability are virtually inevitable

³ In the Integrated Healthcare Association data, payments from Kaiser Health Plan to Kaiser Foundation Hospitals for privately insured patients are reported as fee-for-service payments. However, Kaiser Health Plan and Kaiser Foundation Hospitals largely operate as if they were being paid based on capitation – an increase in inpatient admissions generates additional costs but does not generate additional system revenues . If payments for privately insured patients at Kaiser Hospitals were considered to be capitated, the 14% estimate cited in the text would increase to over 30%.

when providers and organizations throughout the delivery system make resource allocation and business decisions in response to their distinct incentives and constraints.

How the Money Flows

Comparison of California and U.S. Spending

As shown in Table 4, in 2018, California's total health expenditures were an estimated \$399.2 billion, while U.S. national health expenditures (excluding investments in research, structures, and equipment) were \$3.475 trillion.⁴ California's economy, measured by the state's Gross Domestic Product (GDP), was \$3.018 trillion, so health care spending accounted for 13.2 percent of the state's economic output. For the U.S., health spending was a greater share of total economic output at 16.7 percent. California's per capita health spending is also slightly lower than national spending on a per capita basis -- \$10,086 compared to \$10,621 nationally. The health care industry in California employed an estimated 1.670 million individuals in 2018, accounting for 9.8 percent of the state's total workforce, compared to 11.7 percent of the total workforce nationwide.

In 2018, the major payers for health care in California were Medicare (19.6 percent), Medi-Cal (18.5 percent), private insurance (32.2 percent), and other (29.7 percent) based on CMS state level data (Table 4). However, both the private insurance and other categories include a mix of public and private payments. For example, the private insurance total includes approximately \$7 billion in federally-funded premium tax credits for people purchasing plans through Covered California, as well as premiums paid by federal, state, and local governments.

⁴ Lassman, D, et al., "[Health Spending By State 1991–2014: Measuring Per Capita Spending By Payers And Programs](#)," *Health Affairs* 36(7): July 2017. In this paper, 2018 California health care spending is extrapolated from 2014 California state health expenditure account data using health expenditure growth rates calculated from the National Health Expenditure Account data, which are available yearly.

Table 4: Key Facts about Health Care Expenditures and the Economy, California and U.S., 2018

	California	U.S.
Health care expenditures (excluding investments) (in billions) ^{154, 155}	\$399	\$3,475
Gross domestic product (GDP) (in billions) ¹⁵⁶	\$3,018	\$20,865
Health care as a percent of GDP	13.2%	16.7%
Total population (in millions) ¹⁵⁷	39.6	327.2
Per capita health care spending	\$10,086	\$10,621
Health care employees (in millions) ¹⁵⁸	1.670	16.866
Total employees, excluding self-employed (in millions) ¹⁵⁹	17.008	144.733
Health care employees as a percent of total workforce	9.8%	11.7%
Percentage of total health expenditures by major payer: ^{160, 161}		
Medicare	19.6%	21.6%
Medicaid	18.5%	17.2%
Private Insurance	32.2%	35.8%
Other	29.7%	25.5%

Hospitals account for 33 percent of health care spending in California (Table 5) while spending on physician and clinical services accounted for 24 percent of total health care spending. Prescription drug spending accounted for approximately 11 percent of total health care spending, with the remaining 33 percent of health care spending divided across many other spending categories, including home health care, nursing home care, dental care, and others. The health spending distribution in California by provider type is similar to the health spending distribution nationally.

COVID-19 has shifted health utilization and spending patterns, but its full impact on the economy and on health spending remains to be seen. While COVID-19 testing and treatment will increase spending, in the pandemic’s early months, health spending is declining precipitously, with a sharp decline in ambulatory visits, cancellation of elective procedures, and an apparent decline in admissions even for non-elective causes such as heart attacks and

strokes.¹⁶² The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act has provided funds to hospitals and other health care providers to support the spending on COVID-related care and attenuate the decline in other health spending.

Table 5: California Health Care Spending, by Service Type, 2018 (extrapolation based on Lassman, D, et al., “Health Spending By State 1991–2014: Measuring Per Capita Spending By Payers And Programs”)

	California, 2018 (billions)	Percent of Total Expenditures	U.S. 2018 (billions)	Percent of Total Expenditures
Hospital Care	\$130	33%	\$1191	34%
Physician and Clinical Services	\$94	24%	\$726	21%
Prescription Drugs and Other Non-Durable Medical Products	\$43	11%	\$401	12%
All Other Categories	\$133	33%	\$1156	33%

Non-profit hospitals are required to report community benefits in order to maintain their tax-exempt status. Since the passage of the ACA, the amount of charity or discounted care provided reported to have been provided to the uninsured or low-income has declined. In addition to charity or discounted care, community benefits can include spending on community public health programs, writing off bad debt, or claiming losses associated with Medi-Cal reimbursement rates that are below their cost to provide care. From 2013 to 2017, as the ACA was implemented and Medi-Cal enrollment expanded, the charity care spending of California non-profit hospitals, excluding Kaiser hospitals, dropped from 2.02% to 0.91% of operating expenses.¹⁶³ This is consistent with a national study which reported that the amount of charity care provided by non-profit hospitals is a small fraction of the foregone tax revenue that results from hospital non-profit status. The same study found that charity care has declined since the passage of the ACA, particularly in states that expanded Medicaid and that non-profit hospitals with the best financial performance tend to provide the least charity care on a percentage basis.¹⁶⁴

Public Sector Spending on Health Care in California

The federal and state governments are responsible for a large share of health care spending in California. Much of that spending – for example, spending for Medicare, Medi-Cal, premium tax credits for people purchasing through Covered California, and spending for TRICARE beneficiaries – pays for services that California might wish to consolidate within a system of unified financing. Some government spending – for example, spending for health care in federal prisons – is made for special populations or providers and would likely not be consolidated, even under unified financing. In this section we provide statistics on the major federal and state funding streams that might be consolidated under unified financing.

In 2018, the federal government spent an estimated \$146 billion on programs for Californians that could potentially be consolidated in a system of unified financing (Table 6). The lion's share of this funding is for Medicare (\$78.2B) and Medi-Cal (\$56.4B), with smaller portions accounted for by premium tax credits for people purchasing through Covered California (\$6.9B), and payments for TRICARE beneficiaries (\$4.5B).^{5,6}

⁵ Not shown in Table 6 are federal payments for a variety of other programs that are so small as to be almost rounding error or that, even under unified financing, might arguably continue as under the status quo. Among the smaller programs that are not shown are: block grant funds for behavioral health services from the Substance Abuse and Mental Health Services Administration (SAMSHA); grants provided to Community Health Centers by the Health Resources and Services Administration (HRSA); Title X funds for family planning services, also from HRSA; and Ryan-White funds used to pay for health care services for people with HIV/AIDS, also from HRSA. Also not shown are payments for the Veterans Health Administration, which are on the order of \$10B, because it seems more likely that the VHA would continue as under the status quo, or payments for Military Treatment Facilities, which would almost certainly continue as in the status quo, or payments for the Indian Health Service or for health services in federal prisons. Also not included are payments for federal employee health benefits. The tax expenditure made by the federal government that results from excluding the value of employer provided health insurance from taxable income is also not shown, because Table 5 provides data on direct expenditures only.

⁶ The estimate of CHAMPUS spending in California is from [Evaluation of the TRICARE Program, Fiscal 2019 Report to Congress](#). That report states that total CHAMPUS spending was \$53.7 billion in 2018 (page 19), and that there were 793,000 California CHAMPUS beneficiaries, or 8.3% of the total 9.5 million beneficiaries. We have assumed that California beneficiaries account for 8.3% of total CHAMPUS spending. Estimated spending for premium tax credits for Covered California enrollees as reported by [Kaiser State Health Facts](#).

Table 6: Federal Spending on Health Care in California for Selected Sources, by Source

Estimated Federal Sources of Funds, 2018 for Selected Programs	Federal Spending, 2018 (or 19) (Billions of Dollars)
Medicare	78.2
Medi-Cal	56.4
Premium Tax Credits for Covered California	6.9
TRICARE	4.5
Total	146.0
Medicare estimates are from the CMS 2014 State Health Accounts data trended forward. Medi-Cal estimates are for Fiscal Year 2017-2018 based on data from California Department of Finance. Premium Tax Credits for Covered California as estimated by Kaiser Family Foundation State Health Facts. TRICARE estimates are Richard Kronick’s analysis from Evaluation of the TRICARE Program, Fiscal 2019 Report to Congress, pages 19 and 29.	

The State of California already spends billions of dollars each year on health care services and much of that spending could be redirected under unified financing, depending on how the system is designed and which benefits are included. State Medi-Cal funding (\$26 billion) is the largest source of health care spending from the State General Fund in the Governor’s Budget for Fiscal Year 2020-2021 that could be redirected to a unified financing approach. State general fund spending on Medi-Cal accounts for 16% of total general fund spending in FY 19-20, a statistic that has changed little over the past decade, but that is somewhat higher than the 12% of general fund spending that Medi-Cal accounted for in FY 1984-85.¹⁶⁵ Other potential state funding sources include \$5 billion in state general fund spending on In-Home Supportive Services, 2011 State-Local Realignment spending (\$1.1 billion mental health; \$2.5 billion behavioral health); and health care affordability subsidies through Covered California (\$439 million), among others.¹⁶⁶

Other funds that are currently part of the Department of Health Care Services budget, but which are neither Federal funds nor state General Funds, may also potentially contribute to a unified financing approach, depending on how the unified financing approach is designed and on further analysis of the ability of the state to repurpose various types of funds. Examples of these funds include Medi-Cal Drug Rebate and funds generated by the Mental Health Services Act.

Why is Health Care So Expensive in the United States?

Health care spending is much higher in the United States than in other developed countries primarily because the prices we pay for services in the U.S. are much higher than the prices paid in the rest of the world.¹⁶⁷ In two notable studies, Anderson and co-authors compared health spending statistics from Organization for Economic Co-operation and Development (OECD) countries over the 2000-2015 and 1990-2000 time periods. In both studies, the authors find that the U.S. is significantly lower on aggregate quantities such as per-capita bed-days, nurses per capita, and physicians per capita. The authors conclude that because health care spending in the U.S. is significantly higher than in other developed countries, but measured quantities are significantly lower, higher prices must explain cross-country differences in health care spending. The authors highlight additional evidence consistent with their conclusion regarding the importance of prices, including higher physician and nurse salaries in the U.S. compared to other OECD countries, and higher prescription drug prices in the U.S. Key findings with respect to utilization and prices have been replicated in a sample of high-income countries.¹⁶⁸

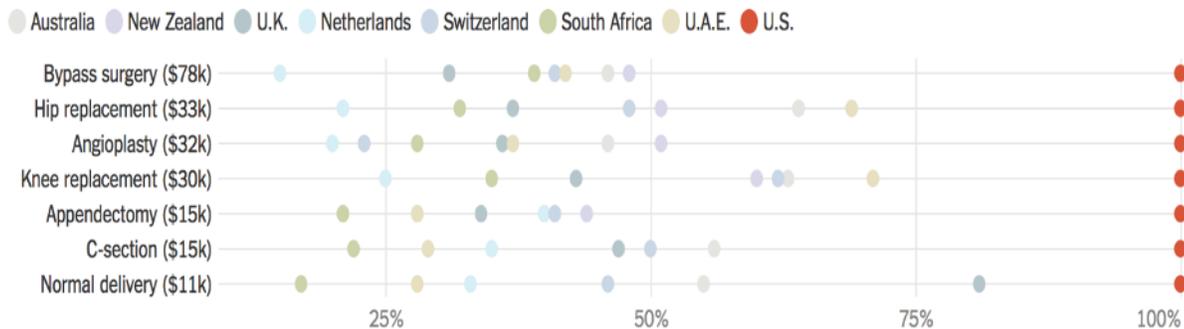
As shown in Figure 23, prices paid for many common procedures are much higher in the U.S. than elsewhere.¹⁶⁹ The data in Figure 23 are collected by the International Federation of Health Plans, and are not nationally representative in any of the countries studied, but provide reasonable estimates of the differences in prices for common procedures between the U.S. and selected other countries. Prices for some branded prescription drugs are three to five times higher in the U.S. than in many European countries.

Part of the reason that prices are higher in the U.S. than elsewhere is that hospitals and physicians devote more resources in the U.S. to billing and insurance related functions.¹⁷⁰ A review published in 2014 comparing billing and insurance related costs in the United States and Canada concludes that higher billing and insurance related costs for hospitals, physicians, and other providers in the U.S. compared to Canada accounted for approximately 10 percent of provider costs.¹⁷¹ If excess billing and insurance related costs were eliminated, the price differences between the U.S. and other countries shown in Figure 23 above would be reduced somewhat, but most of the price differences would remain. The same review found that, including both provider and insurer costs, excess billing and insurance related costs in the U.S. accounted for approximately 15 percent of U.S. health spending.¹⁷² This suggests that excess billing and insurance related costs account for approximately 30 percent of the difference in per capita health care costs between the in per capita health care costs between the United States and Canada.

Figure 23: Medical Care Prices are Higher in US (NYT December 27, 2019)

Medical Care Prices Are Higher in US

Percent of U.S. price in 2017.



Source: International Federation of Health Plans • By The New York Times

United States and Canada. Thus, excess billing and insurance related costs, which are a result of the fragmented system of financing and coverage, contribute to high health care spending in the U.S., but higher prices paid for care account for a larger part of the differential between our spending and that of Canada and countries in Western Europe.⁷

For some services, such as knee replacements and MRIs, we use more services per capita than elsewhere, although the effects of greater quantity on spending are much smaller than the effects of higher prices.^{173, 174}

⁷ In 2017, per capita health spending was \$10,224 in the U.S., and \$4,826 in Canada (adjusted for Purchasing Power Parity), for a difference of \$5,398 per person. If, by decreasing billing and insurance related costs to Canadian levels, health care costs were reduced by 15% in the US, per capita spending would be reduced to \$8,690, leaving a difference of \$3,864 with Canada. Thus, the difference between U.S. and Canadian health spending would be reduced to 71% of the status quo – that is, (3864/5398), supporting the statement that higher billing and insurance related costs account for approximately 30% of the per capita spending difference between the US and Canada.

As described in greater detail below, private insurers in California pay hospitals more than double the amount that is paid by Medicare or Medi-Cal for similar services. Thus, the prices paid for services by Medicare and Medi-Cal are much more similar to prices paid in other developed countries than the prices paid by private insurers in the U.S.

Health insurer profits and surpluses retained by hospitals each account for relatively small parts of the difference in per capita spending between the U.S. and other developed countries. Financial results for large California hospitals and health plans are shown in Tables 7 and 8, below.

In California, total net income for all hospitals except Kaiser from 2015-2017 (the most recent three years with available data) averaged \$5.3 billion per year.¹⁷⁵ This represents approximately 5% of total hospital revenue, and a little more than 1% of annual health spending in California. As shown in Table 7, from 2015 to 2017 some large hospitals consistently enjoyed substantially larger margins than the 5% statewide average.

Table 7: Selected Annual Statistics for the 10 California Hospitals with the Largest Total Margin in 2017

Hospital Name	Ownership Type	2017			2016			2015		
		Total Margin \$ millions	Total Expenses (incl. non-op.) \$ millions	Margin/Expenses %	Total Margin \$ millions	Total Expenses (incl. non-op.) \$ millions	Margin/Expenses %	Total Margin \$ millions	Total Expenses (incl. non-op.) \$ millions	Margin/Expenses %
Stanford Health Care	not for profit	483	3,499	14	72	3,344	2	389	2,901	13
UC Davis Medical Center	UC	361	1,952	18	219	1,854	12	193	1,660	12
Cedars-Sinai Medical Center	not for profit	276	2,548	11	341	2,510	14	391	2,276	17
Donald N. Sharp Memorial Community Hospital	not for profit	233	881	26	282	847	33	240	835	29
Hoag Memorial Hospital Presbyterian	not for profit	226	865	26	101	802	13	106	770	14
Sutter West Bay Hospitals	not for profit	188	\$1,060	18	119	1,075	11	151	1,055	14
El Camino Hospital	not for profit	170	739	23	44	739	6	95	687	14
Santa Barbara Cottage Hospital	not for profit	169	597	28	28	597	5	-18	587	-03
Good Samaritan Hospital LP	investor	156	479	33	128	477	27	104	467	22
Scripps Health - La Jolla	not for profit	136	547	25	112	502	22	89	457	19

Source: Analysis of OSHPD Annual Financial Disclosure Reports conducted by Richard Kronick

Total Margin is the sum of operating and non-operating revenue minus the sum of operating and non-operating expenses.

In 2019, full-service health plans regulated by DMHC showed total net income of approximately \$11.5 billion, or 5.6% of total revenue. In 2018, this set of plans showed total net income of approximately \$5.6 billion, or 2.7% of total revenue. Depending on the time period, these sums represent 1 to 3% of health spending.¹⁷⁶ Additional detail for six large California health plans is shown in Table 8.

Table 8: Revenue and Income for Large California Health Plans, 2018 and 2019

Health Plan	Ownership Type	2018 Total Revenue (Millions)	2018 Net Income (Millions)	2018 Net Margin	2019 Total Revenue (Millions)	2019 Net Income (Millions)	2019 Net Margin
Kaiser Foundation Health Plan, Inc.	Not for profit	\$80,365	\$2,503	3.1%	\$89,008	\$7,436	8.4%
California Physicians' Service (Blue Shield of California)	Not for profit	\$18,189	\$413	2.3%	\$18,919	\$573	3.0%
Blue Cross of California (Anthem Blue Cross)	For profit	\$15,895	\$773	4.9%	\$16,764	\$854	5.1%
Health Net of California, Inc.	For profit	\$8,851	\$94	1.1%	\$9,667	\$203	2.1%
Health Net Community Solutions, Inc.	For profit	\$6,982	\$494	7.1%	\$7,719	\$454	5.9%
Local Initiative Health Authority for Los Angeles County (LA Care)	Public agency	\$8,039	\$141	1.7%	\$8,081	\$237	2.9%
UHC of California (United Healthcare)	For profit	\$6,753	\$211	3.1%	\$6,826	\$278	4.1%

Source: Analysis of California Department of Managed Health Care, [Health Plan Dashboard](#) conducted by Marian Mulkey

California-specific financial results for Kaiser Foundation Health Plan are not available; these results reflect the aggregated performance of all Kaiser regions. Health Net of California is Health Net's commercial business. Health Net Community Solutions covers Health Net's public business. Blue Shield of California is recognized by the federal IRS as not for profit but lost its state tax-exempt status in 2014.

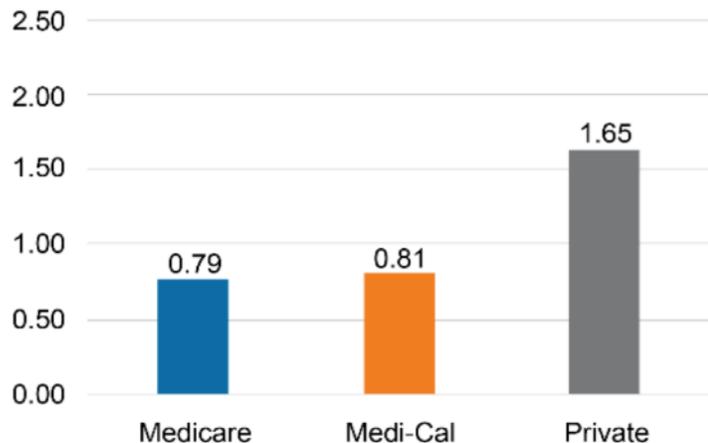
Net income can be used for a variety of purposes, including contributions to reserves. Plans, especially those that own medical office buildings or hospitals, may use net income to fund capital investments. For-profit plans may use net income to pay dividends to shareholders.

Price Variation Across Payers and Providers

Prices for **hospital services** paid by insurers on behalf of people covered by employer sponsored insurance in California are much higher than prices paid by Medicare or Medi-Cal for similar services. On average, in 2015-2016, private insurers paid hospitals more than twice as much as the amount paid by Medicare for similar services (Figure 24).¹⁷⁷ Medi-Cal payments to hospitals averaged 81 percent of cost in 2015-2016, approximately the same payment-to-cost ratio as Medicare.

Figure 24: California Hospital Reports of Proportion of Costs Reimbursed by Payer (Kronick et al, West Health Policy Center May 2019)

California Hospital Reports of Proportion of Costs Reimbursed By Payer: 2015/2016



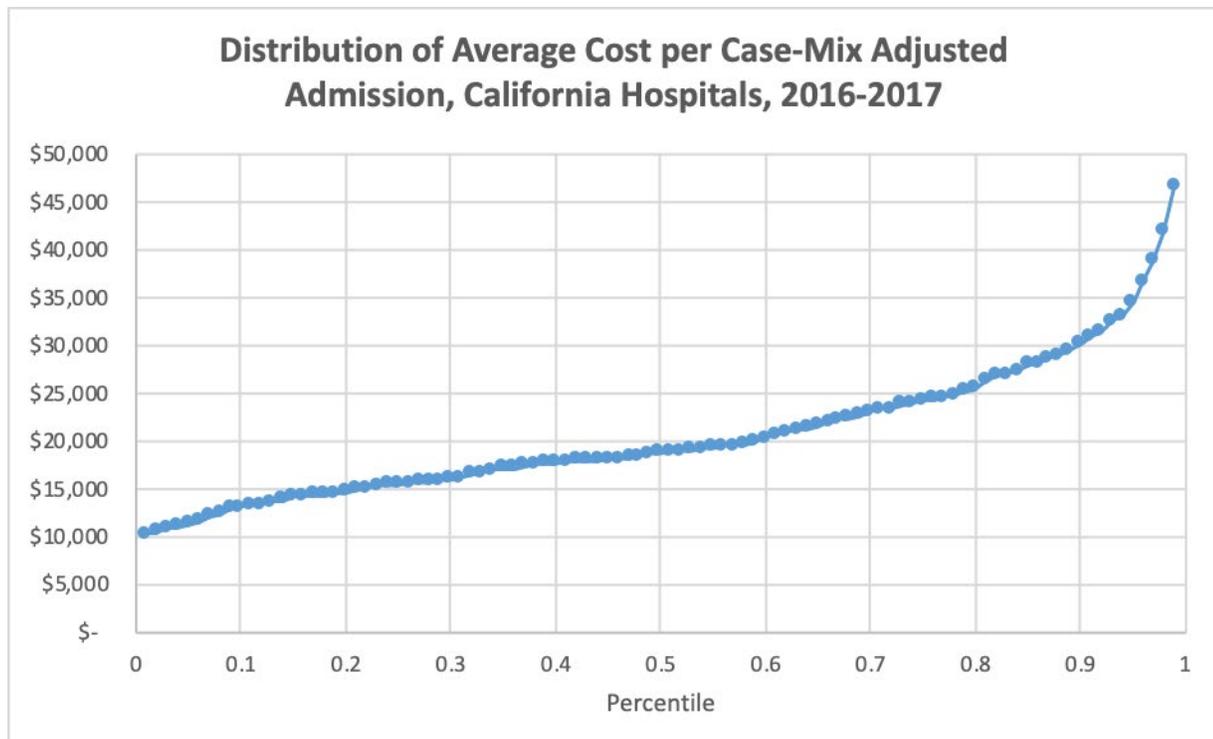
Kronick and Neyaz: <https://s8637.pcdn.co/wp-content/uploads/2019/05/West-Health-Policy-Center-Hospital-Pricing-Analysis-May-2019.pdf>

The private-to-Medicare price ratio in California – 209% -- appears to be similar to the average ratio in the rest of the nation.¹⁷⁸ However, the relationship between prices for people covered by private insurance and people covered by Medicare varies widely across hospitals. Among the 10 percent of hospitals with the largest differences between private and Medicare prices, private prices average 364 percent of Medicare; among the 10 percent of hospitals with the smallest

difference between private and Medicare prices, private prices average 89 percent of Medicare. Among hospitals with more than 300 beds, hospitals with the largest differences between private and Medicare prices include Stanford University Hospital (276 percent of Medicare), Sharp Memorial Hospital (271 percent), UC Davis (231 percent), and Cedars-Sinai (231 percent). Among large hospitals with the smallest differences between private and Medicare prices, public hospitals predominate, with private prices at some public hospitals either at or just above Medicare payment levels.

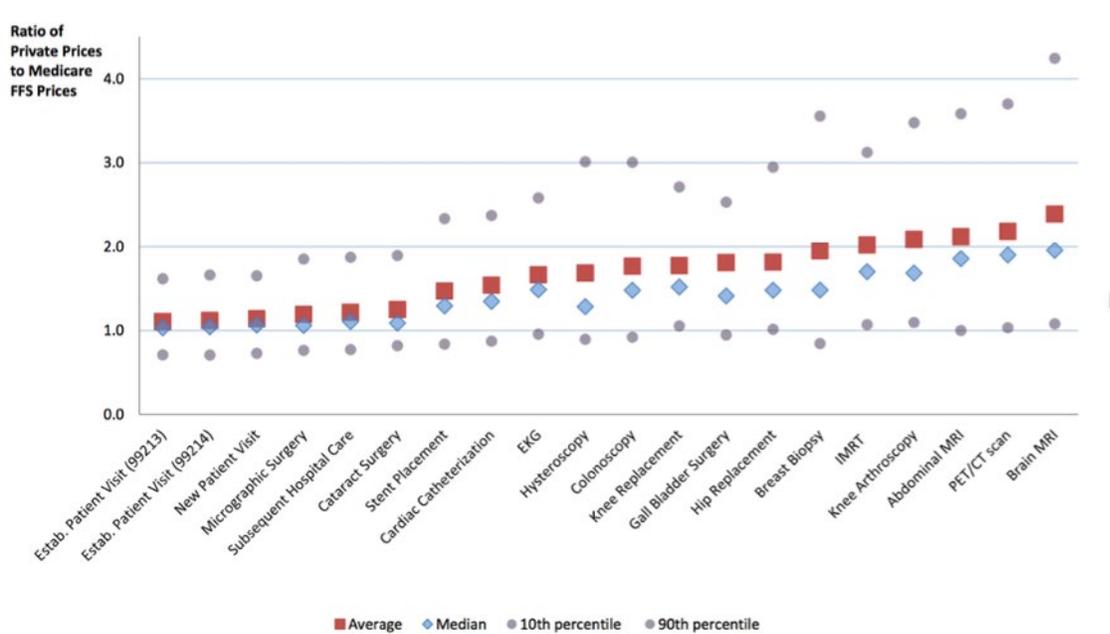
Hospitals vary widely in cost per case-mix adjusted admission as shown in Figure 25. The California average cost per case-mix adjusted admission in 2017 was \$18,981. Among hospitals with more than 300 beds, at the costliest 10 hospitals, cost per admission averaged \$34,100; at the 10 least costly large hospitals, the cost per admission averaged, \$15,100, or 55 percent lower.¹⁷⁹

Figure 25: Distribution of Average Cost per Case-Mix Adjusted Admission, 2016-2017 (Personal communication; Richard Kronick analysis of 2016-2017 Hospital Financial Disclosure Reports filed with OSHPD)



National data shows that prices for **physician services** paid by insurers on behalf of people covered by employer sponsored insurance are closer, on average, to Medicare and Medi-Cal prices than is the case for hospital services. MedPAC reports that, on average, physician prices paid by private insurance are approximately 135 percent of Medicare prices.¹⁸⁰ An analysis by the Congressional Budget Office using private insurance and Medicare claims data found that commercial prices for patient office visits (also known as evaluation and management services) average just slightly more than Medicare prices, while the prices for many surgical procedures averaged in the 150 to 220 percent of Medicare range (Figure 26).¹⁸¹ Similar results are found by Erin Trish and colleagues.¹⁸² Zach Cooper and colleagues report that in-network anesthesiologists are paid, on average, 367% of Medicare, and pathologists, 343% of Medicare.¹⁸³ Each of the studies cited above report statistics for the nation as a whole. The only California-specific data on physician prices that we are aware of is reported by Michael Chernew and colleagues, who find that prices paid by private insurers in California average 173 percent of Medicare, slightly higher than their estimate of 163 percent for the national average.¹⁸⁴ It is not clear why Chernew and colleagues' national estimate of 163 percent of Medicare is higher than MedPAC's estimate of 135 percent, nor is it clear which estimate is closer to the truth.

Figure 26: Commercial Prices For Selected Physicians' Services, 2014 (Pelech, Daria. Congressional Budget Office, Washington, DC. January, 2018)

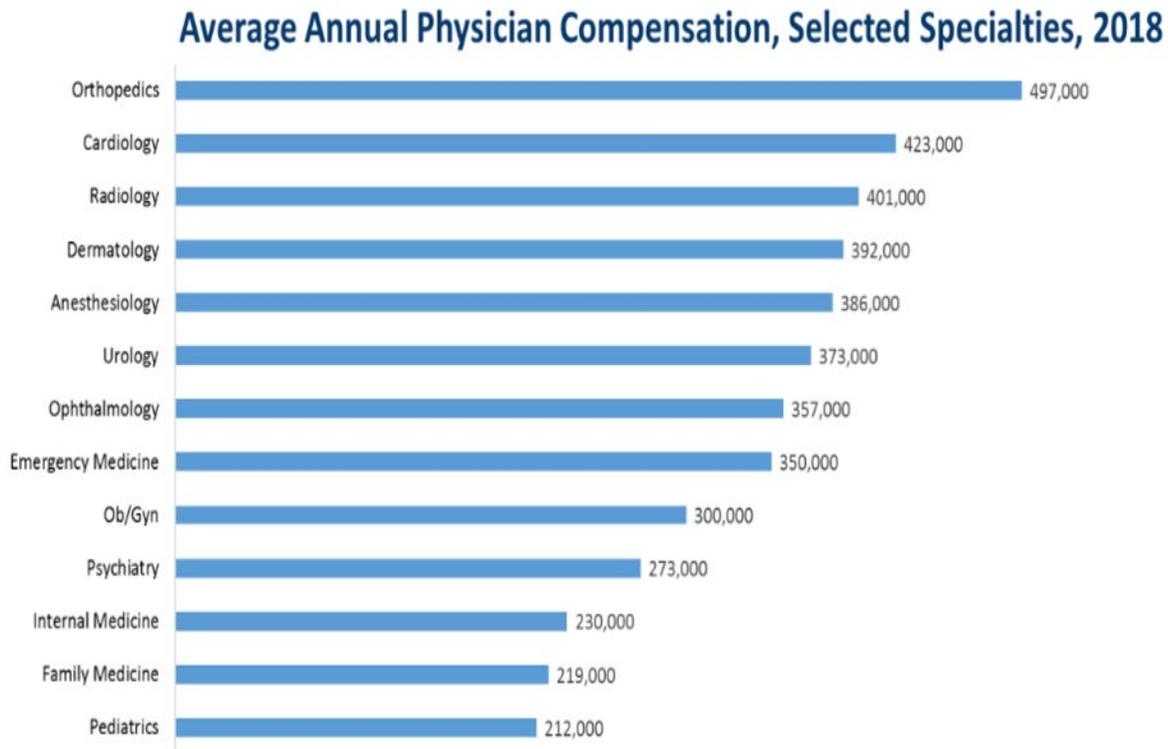


Prior to the Proposition 56 supplements to Medi-Cal payment rates for evaluation and management services, Medi-Cal fee-for-service physician payment rates were among the lowest in the country. Analysis by Zuckerman and colleagues at the Urban Institute found that fee-for-service Medi-Cal physician payment rates in California in 2016 averaged 52 percent of Medicare rates, substantially below the national average of 72 percent, and lower than all states other than New Jersey and Rhode Island. Because many Medi-Cal beneficiaries are enrolled in a Medi-Cal managed care plan, fee-for-service payments are a relatively small part of total ambulatory care payments. Proposition 56 funds have been used to increase Medi-Cal payments for evaluation and management services and for selected preventive services. The California DHCS reports that their target was to increase reimbursement for evaluation and management services to 85 percent of Medicare, and for selected preventive services to 100 percent of Medicare.¹⁸⁵ DHCS also required Medi-Cal managed care plans to pass these increases on to contracted physicians. Under the budget enacted for FY 20-21 those payments are scheduled to be eliminated in July 2021.¹⁸⁶

There are wide differences across physician specialties in average income per physician.¹⁸⁷ For example, as shown in Figure 27, a family medicine primary care physician earns approximately 50 percent of the earnings of a cardiologist. There are also wide differences in income within specialties, with physicians who serve a higher proportion of Medi-Cal patients receiving much less revenue than physicians serving a higher proportion of privately insured patients. Given the similarity of Medi-Cal, Medicare, and private insurance payments for evaluation and management, and the wide divergence in payments among the three payers for many procedures, it seems likely that payer mix influences income to a much greater extent for specialists performing procedures than for primary care physicians.

Although Medi-Cal payments for physician services have historically been lower than Medicare payments, and even further below the payments made by private insurance, Medi-Cal is required by federal statute to make cost-based reimbursement payments to federally qualified community health centers (FQHC) and to FQHC 'look-alikes.' As a result, these payments are substantially higher than what physicians in other settings receive from Medi-Cal for the same service. Approximately 40 percent of Medi-Cal beneficiaries and the uninsured report that their usual source of care is a community clinic, government clinic, or community hospital (Figure 12).

Figure 27: Average Annual Physician Compensation, Selected Specialties, 2018 (USC-Brookings Schaeffer Initiative for Health Policy Report. December, 2018)



Adapted from: Medscape Physician Compensation Report 2018

Large differences in payment rates among Medicare, Medi-Cal, and private insurance make it more difficult to achieve a health care system that is accessible, affordable, equitable, universal, and high quality. The ability of hospitals to negotiate prices with private insurers that are more than double Medicare and Medi-Cal rates makes it challenging to exert discipline on costs. Although Medi-Cal payments are a critically important source of revenue for many providers, it is also the case that lean Medi-Cal physician payments contribute to access problems, particularly for specialist services, and may perpetuate largely separate, and sometimes unequal, systems of care in the safety net. The ability of many specialists to negotiate much higher reimbursement rates from private insurers than the rates paid by Medicare contributes to the wide income differentials between primary care physicians and many specialists, and discourages medical students from entering a career in primary care.

Much of the preceding analysis was based on data from outside of California. California has taken a significant step towards increased transparency regarding health care costs, utilization, quality and equity with its enabling legislation for a statewide Healthcare Payments Database (HPD). In the recently enacted state budget for FY 2020-21, OSHPD will have the authority to collect data from health care service plans, health insurers, and other payers regarding utilization, payments and pricing for health care services. Data and analytics from the HPD, which is expected to be substantially complete by June 2023, will allow researchers, policymakers, and consumer advocates to identify the elements of California's health care system that are driving up costs and support the design of targeted interventions that improve public health, reduce disparities, advance health coverage, reduce health care costs, and increase oversight of the health care system.

Synthesis: How the Money Flows

In California and throughout the U.S., health care is financed through a mix of public programs and private payers. Fragmented financing creates disparities in access to care and health outcomes. Payments from different public programs are not well-coordinated and may not assure that quality and access goals are achieved. On the private side, differences in price are influenced by market leverage. The fragmented payer landscape also adds billing and administrative burden and raises costs for consumers and purchasers.

How Will a Pandemic Affect California Health Care?

The emergence of the COVID-19 pandemic has upended many expectations about health care and the economy in California and in the U.S. The full implications of the pandemic, including potential lasting changes to care delivery and payment policies, will emerge over time. This section offers some early observations about how pandemic response intersects with California's financing arrangements and delivery system.

Some shortcomings of status quo health care financing are exacerbated within the context of the pandemic. For example, multiple coverage programs with diverse benefits and provider networks mean that as unemployment surges, many people will lose job-based coverage. Most Californians who lose job-based coverage have an option to maintain that coverage for a defined period at their own expense under federal COBRA or state Cal-COBRA laws.¹⁸⁸ Continuing coverage under COBRA requires that individuals pay the full cost of coverage -- both employer and employee contributions, as well as a small administrative fee -- which many individuals find prohibitively expensive. Instead, they may scramble to enroll in Medi-Cal or

purchase insurance through Covered California at a time when they are already dealing with multiple hardships. Many are likely to end up uninsured, and others may lose access to their physicians when they switch plans.

The care delivery system has also been strained by the demands imposed by the pandemic. As Californians defer non-urgent care, providers that rely extensively on fee-for-service payments find themselves on shaky financial footing. A system that is fragmented and organized to respond to status quo financial incentives is ill-equipped to reorient itself for crisis response. A fragmented, multi-payer system with weak links to public health has no mechanism for efficiently distributing supplies and workforce according to need. However, delivery and payment approaches have adapted quickly along some dimensions. Telemedicine quickly became more widely available across a wide range of health care settings with new reimbursement flexibility from Medicare and other payers. Health insurers were quickly required by state regulators to reimburse COVID-19 screening tests. Questions about where to draw the line between individual and collective responsibility for the costs of treatment and rehabilitation have been raised without clear resolution; implications will continue to unfold as experience with COVID-19 grows.

Unified financing would certainly solve the coverage problem that the pandemic creates. However, in other respects, it is not clear that California would fare dramatically better in its pandemic response under unified financing. Under unified financing, a pandemic or other economic shock could undermine sources of funding. For example, a system that relied on payroll financing would face a shortfall if employment dropped dramatically via pandemic stay-at-home requirements. A system that relied in part on federal funding would suffer if federal payments were not adjusted to account for unanticipated expenses. Unless California found a way, perhaps in partnership with the federal government, to establish substantial reserves, the state's inability to run a budget deficit means that increases in state health spending not offset by program revenue increases would have to be offset by cuts in other programs or services.

Maintaining preparedness to respond to a rare but sudden surge of need under a pandemic would be challenging under most governance and financing arrangements. The priority placed on public health infrastructure, social solidarity, and public education may affect a country's response as much as, or more than, its health care financing arrangements.

California's Health Care Environment: Implications for Unified Financing

Health care in California relies on fragmented financing. Universal coverage and access are not assured. Shifts in coverage impose burdens on consumers and providers. A

unified financing approach would allow the state to move toward a more accountable and equitable system.

Fragmented financing, along with varied coverage and care delivery arrangements, is not designed to assure uniform outcomes. Because no overarching public policy rationale guides the distribution of resources nor sets clear standards for access, affordability, quality, equity and universality, the distribution of inputs and outcomes is idiosyncratic and often inequitable.

Whether Californians have coverage; where they get care; how affordable care and coverage is; and what levels of quality are assured are subject to forces beyond the control of individuals. Where one resides; whether one has access to job-based health insurance (and if so, what kind of benefits, protections and cost-sharing come with that insurance); one's income and family status; and one's race, ethnicity, gender identity, and immigration status are some of the many factors that affect coverage, access to health care, and health outcomes. Fragmented financing leads to frequent changes in sources of coverage, with negative consequences for continuity of care, as well as extra costs for patients and providers in adapting to new insurance arrangements. Fragmented financing and coverage make it more difficult to ensure that all Californians have continuous health insurance coverage, and that the coverage is adequate to provide individuals with not only financial protection but also access to high quality care.

Fragmented financing and coverage also impose substantial costs. Approximately 30% of the difference between the United States and Canada in per capita health care spending can be accounted for by excess billing and insurance related costs in the United States. Fragmented financing allows health care providers – particularly hospitals and drug companies, but also, in some places, physicians – to successfully negotiate high prices from payers, with the threat that if a payer refuses, the provider will simply refuse to do business with that payer, and will have the option of getting business elsewhere. Under fragmented financing, no entity has been responsible or accountable for managing resources to address the health care needs of the population as a whole.

A unified financing approach would allow the state to move toward a more accountable and equitable system. However, because Californians are situated so differently today, moving to unified financing will involve change and disruption, particularly in the short run. To achieve a universal health care system that assures access, affordability, high quality, and equity will require purposeful design decisions and transition planning.

Section 2: Steps to Prepare to Transition to Unified Financing

The first part of this section discusses factors that affect California's ability to take independent action to reorganize health care delivery and finance. The remainder identifies options for steps California can take to prepare to transition to a unified financing system.

Considerations Influencing California's Path to Unified Financing

Many factors affect California's ability to take independent action to reorganize health care finance and delivery.¹⁸⁹ To implement unified financing, California would need to grapple with federal law and regulation related to Medicare and Medicaid; address limitations under the Employee Retirement Income Security Act of 1974 (ERISA) on the state's ability to impose requirements on employer benefit programs; and navigate existing constraints on how California raises and spends revenue. These issues were discussed before the California Assembly's 2017-18 Select Committee on Health Care Delivery Systems and Universal Coverage,¹⁹⁰ are described in greater detail in the Committee's final report,¹⁹¹ and are summarized below.

Redirecting Medicare, Medicaid and Other Federal Funds

Existing federal law does not grant the federal Secretary of Health and Human Services authority to redirect Medicare's funding streams or trust fund dollars to states.¹⁹² Therefore, bringing the approximately 20 percent of funding for Californians' health care that is currently paid by Medicare into a unified state-based financing pool may require federal statutory changes. A variety of waiver authorities allow CMS some flexibility in spending Medicare funds. Further analysis is needed, but it does not appear that CMS' waiver authority is broad enough to allow even a cooperative federal administration to flexibly fund the Medicare portion of a California system of unified financing without statutory change.

Federal Medicaid requirements tie federal matching funds to the services provided to Medicaid-enrolled individuals. A Section 1115 waiver could allow California more flexibility in how it uses Medicaid funds, but those waivers are time-limited and are intended to be for demonstration purposes. For California to claim federal Medicaid funds for use through a unified financing pool as a part of a waiver, California would have to continue to track eligibility and expenditures related to individuals who meet complex Medicaid eligibility criteria. Requiring Californians to provide documentation related to household income and citizenship status, as required for continued compliance with existing federal Medicaid rules, would be burdensome for consumers. A simpler program in which all Californians could participate without such

documentation would likely require a change in federal law allowing greater state flexibility in the use of Medicaid funds.

Similarly, it might be possible to redirect subsidies provided through Covered California to a unified financing pool under existing Section 1332 waiver authority. However, under Section 1332 waiver authority states are still required to perform eligibility determinations for Premium Tax Credits. These eligibility determinations include an assessment of whether an individual was offered employer-sponsored coverage. But this would create a nonsensical administrative burden if California were functioning under unified financing, because in that case no California workers would be expected be offered employer-sponsored insurance and all employees under 400% of FPL would be eligible for federal premium tax credits. Thus as with Medicare and Medi-Cal funding, to secure premium tax credit funding on a secure and flexible basis, federal statutory change would likely be needed.

To redirect federal funds that currently support special populations such as TRICARE enrollees would involve revisiting long-standing expectations regarding benefits, and would also require federal statutory change.

Revisiting Employer Contributions and Obligations

As discussed in Section 1, the majority of Californians aged 64 and under obtain health insurance through employer-sponsored coverage. On average, employers contribute 86 percent of single coverage premiums and 73 percent of family coverage premiums.¹⁹³ However, levels and structure of employer contributions vary, as do covered benefits and cost-sharing requirements at the point of care. In aggregate, employer and employee payments for employer-sponsored coverage account for almost 30 percent of total health spending.¹⁹⁴ Unified financing implies that some or all of those funds would no longer be directed by the decisions of individual employers and instead some mechanism – perhaps linked to employment, but perhaps not -- would provide funding for a statewide pool through which people who are today enrolled in employer plans could access health care.

In developing a unified financing policy, the state will need to address potential conflicts with the federal Employee Retirement Income Security Act (ERISA) in relationship to self-funded plans. Self-funded plans are those in which the employer assumes the financial risk of employees' health care costs and pays for their health care expenses directly rather by purchasing insurance and having the risk shifted to a third party. Very large employers are most likely to self-fund because their size better positions them to forecast and spread risk, and because it allows them to offer uniform benefits to their employees nationwide, avoiding both state benefit

mandates and state-imposed insurance taxes.¹⁹⁵ At least 5.5 million Californians are covered through self-funded employer arrangements.¹⁹⁶

ERISA sets federal standards that apply to private sector employers that establish employee benefit plans. Intended to assure that multi-state employers can provide consistent benefit programs across multiple states, ERISA preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” covered by ERISA.¹⁹⁷ ERISA does not prevent states from directly regulating health insurance carriers and the products they sell to employee benefit plans but does exempt self-funded ERISA plans from state health insurance regulation.¹⁹⁸ ERISA would preempt a prohibition on self-funded employer sponsored plans in the state.

How ERISA’s complex provisions may apply within the context of a specific state policy construct would be subject to court interpretation.¹⁹⁹ State single payer proposals offer a range of strategies to reach their goals without ERISA preemption.²⁰⁰ For example, proposals may rely on funding plans that include employer contributions, such as broad-based payroll taxes. Another approach could be to place restrictions on providers, for example prohibiting providers from accepting payment from any source other than the unified system or at any different rates. These strategies would allow employers to continue to offer a self-funded plan if they chose to do so. Employers’ decisions would depend on the perceived value to employees of the self-funded plan when compared to services available under unified financing at little or no additional cost. While strong legal arguments can be made for these approaches, given the high financial stakes, litigation is likely.

State Capacity to Raise and Use Revenues for Health Care

An overarching issue in establishing a financial structure for unified financing at the state level is that California, unlike the federal government, cannot operate with a budget deficit. For many years, health care spending has risen more rapidly than overall economic growth. Specific health care needs can be unpredictable and revenue streams -- especially those linked to employment, income or capital gains -- can vacillate based on economic factors. The COVID-19 pandemic vividly illustrates how quickly and unpredictably health care use and revenue streams can be affected by forces outside of California’s control. For all these reasons, a unified financing approach would require careful financial planning and appropriate financial reserves.

At a more granular level, aspects of existing state law and budgetary policy may limit California's ability to raise and dedicate the funds needed to support unified financing. In 2018, the Legislative Analyst's Office (LAO) estimated that a state-run publicly financed healthcare program would cost \$400 billion in total. (An array of specific design and implementation decisions, to be further explored in Commission deliberations subsequent to the completion of this report, would affect both costs and savings under any future unified financing approach.) The LAO estimated that \$200 billion was potentially available for redirection from existing public programs and that the state would need to raise an additional \$200 billion in new revenues.²⁰¹ As a point of reference, California's 2019-20 enacted budget assumes total spending of \$208.9 billion, of which General Fund spending accounts for \$147.8 billion.²⁰²

Provisions of California's State Constitution constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to universal health coverage. Proposition 98 of 1988, as amended by Prop. 111 of 1990, guarantees a minimum funding level for K-12 schools and community colleges. Prop. 4 of 1979 (the "Gann limit"), as amended by both Prop. 98 and Prop. 111, sets limits on certain state appropriations. The scope and cost of a program to finance all health care throughout the state would trigger both provisions, rendering it prudent to seek explicit ballot initiative approval to dedicate new funds to health care.²⁰³

Additional Considerations

To move from status quo fragmented financing to a unified financing approach would bring substantial disruption to existing financial relationships and coverage arrangements. Financing for each existing public coverage program is tied to specific requirements; to revisit these would demand sensitive negotiations and might open the door for unintended consequences or potential litigation along a variety of dimensions. (To name one such limitation, the Hyde Amendment bars federal funds from being used to pay for abortions except in very limited circumstances.) Such changes may be needed to advance California toward health care that is affordable, accessible, equitable, high-quality and universal, but they are likely to evoke resistance from the institutional and business interests that are succeeding under the status quo. Despite the many flaws of existing health coverage and health care arrangements described in Section 1, people and organizations may fear losing what they have more than they value the benefits anticipated from a new and unknown system.²⁰⁴ These considerations are not absolute barriers but will influence change strategies.

Synthesis: Considerations Influencing California's Path

Depending on an array of choices related to the design and sequencing of steps toward unified financing, California's path will encounter challenges related to the redirection of federal Medicare and Medicaid funds, ERISA law, and state spending limits. California will need to develop legal, political and communication strategies that take these challenges into consideration.

Steps California Can Take to Prepare to Transition to Unified Financing

The Commission is charged with identifying options for steps California can take to prepare to transition to a unified financing system.²⁰⁵

Below we describe three types of preparatory steps:

- **Design steps** would define how a California unified financing system for health care would work and describe its implications for the outcomes associated with a Healthy California for All (Accessible, Affordable, Equitable, High Quality, Universal).
- **Legal steps** would assert California's intention to move toward unified financing and would set the stage for further policy debate and negotiation.
- **Steps to improve care and reduce fragmentation** that advance the outcomes associated with a Healthy California for All (Accessible, Affordable, Equitable, High Quality, Universal) and reduce the negative consequences of fragmented financing.

Design Steps

The rationale for focusing on design steps is that the effects of unified financing depend critically on an array of design questions such as how the state would raise and manage revenue, how providers would be paid, what services would be covered for whom, how services would be organized and delivered, and many others. An analysis of options and implications along each of these dimensions would identify tradeoffs and inform decision-making about the best path forward. Grappling with design steps would further clarify how unified financing aligns with desired outcomes and allow the public to better understand how unified financing might work in practice.

The Commission is specifically charged with describing options for key design considerations for a unified financing system in a second report due to the Legislature and the Governor on or before February 1, 2021. Exploring and analyzing design steps will illuminate tradeoffs and implications associated with different aspects of unified financing. Topics to be discussed⁸ include:

- Increasing health equity and improving quality
- Financing: federal assumptions/ requirements and state options/ expectations
- Provider payment
- Role, if any, for intermediaries such as medical groups and health plans
- Eligibility, covered benefits, patient cost-sharing
- Governance

Monthly Commission meetings from July through December, 2020 will be centered around discussions of central design issues. Take-aways from those conversations will inform the Commission's second report.

Legal Steps

The rationale for focusing on *legal steps* is that a defined legal and policy framework would focus the state's efforts and open channels through which California could pursue funds and flexibility for unified financing. Many factors beyond the control of state actors will influence the prospects of such proposals.

California could take steps through which changes in financing and delivery could be negotiated and clarified within the state and between the state and the federal government. This could include the development of policy options and draft legislative language that assert California's intent to develop requests for a Section 1332 waiver under the ACA, a Section 1115 Medicaid waiver, and/or an application for a Center for Medicare and Medicaid Services Innovation Grant. These steps would give California standing to engage with

⁸ The list of topics differs somewhat from the list of topics the enabling legislation directs the Commission to consider. The reorganization is intended to facilitate decision making. All of the topics enumerated in legislation will be included, in some fashion, in Commission deliberations and in the final report.

federal authorities to pursue more flexible financing in support of the Commission's values and goals.

In addition, the state could take steps to identify strategies to position any funding mechanism for unified financing to avoid or withstand potential ERISA legal challenges. Another potential avenue involves steps to address existing restrictions under the Gann Act and Prop. 98, in order to ease obstacles to collection and distribution of state funds that would be combined with captured federal resources in order to support a unified health care system.

California could also develop legislative proposals for Congressional consideration that would redirect federal Medicare, Medicaid, ACA premium tax credits and cost sharing reductions, and TRICARE funds to a California unified financing trust fund.

Steps to Improve Care and Reduce Fragmentation

Another set of options involves taking preparatory steps that advance the goals of accessibility, affordability, equity, high-quality and universality. The extent to which these steps are clear stepping stones toward unified financing varies and depends in part on future design decisions related to unified financing.

The rationale for focusing on this set of steps is that there is a substantial gap between existing health care delivery, financing, and legal realities and the conditions required for the sustainable implementation of unified financing. Preparatory steps within California's immediate control could improve health care outcomes and pave the way toward unified financing by *introducing greater consistency* among health care delivery and financing arrangements, which would ease the future transition to unified financing; and by *expanding tools, resources and policy infrastructure* that will be required for the effective implementation of unified financing.

California could take steps to *introduce greater consistency* within health care delivery and financing arrangements. As discussed in Section 1, access, affordability and quality are uneven across California's patchwork coverage and care delivery landscape. Efforts to bring greater consistency along important dimensions could improve outcomes of concern and could lessen the disruption associated with a future transition to unified financing. The state of California sponsors three major public programs – Medi-Cal, CalPERS, and Covered California – which collectively provide insurance to about one-third of all California

residents.⁹ These three programs, each of which provides benefits primarily by contracting with private insurers, differ markedly in benefits covered, provider networks, provider payment levels, quality measurement, and quality improvement activities.

As a preparatory step to achieving unified financing, California might unify, or, at least, align, existing public programs. Greater consistency and more uniform reporting about the health outcomes achieved through existing public programs could give Californians not covered by these programs – primarily those covered by employer sponsored insurance and by Medicare -- confidence that unified financing would serve their needs well. In addition, alignment across these programs holds potential to reduce the number of eligible but unenrolled Californians; reduce the adverse effects of “churn” in coverage status; reduce differentials in primary care physician payments; and improve transparency in health plan quality metrics.

Steps toward greater consistency and stronger demonstration that publicly run programs deliver appropriate, equitable and efficient care could include:

- Alignment and tighter coordination among the state’s major coverage programs (Medi-Cal, Covered CA, CalPERS). For example, state programs could impose more consistent health plan contracting requirements to improve quality outcomes, bring into greater alignment provider networks and payment arrangements, or streamline purchasing for pharmaceuticals or specialty services. State-regulated employer-sponsored coverage could also be encouraged or required to participate in aligned efforts.
- Alignment of regional units of accountability across markets and payers. Different public payers currently divide the state into sub-regions in different ways for determining prices and measuring quality of care. For example, Medi-Cal organizes services by county while Covered California divides the state into 19 regions for purposes of establishing prices and health insurance options. Some of those 19 regions conform to county lines,

⁹ As shown in Figure 3 above, pre-pandemic projections indicate 23 percent of Californians receive coverage through Medi-Cal only coverage. (Additional Californians are “dual-eligibles” for whom most care is paid by Medicare but some services, most notably long term care, are financed by Medi-Cal.) An additional 1.4 million Californians (about 4 percent) obtained coverage through Covered California in 2019 as indicated in organization’s most recent [annual report](#). Both Medi-Cal and Covered California enrollment numbers will grow as a result of the COVID-19 economic downturn. CalPERS provides health benefits to 1.5 million Californians, an additional 4 percent of the state’s population, per [CalPERS Fast Facts](#).

but many include multiple counties and Los Angeles is split into two regions. The development of a common approach for creating sub-regions in the state for price-setting and quality assessment could support a transition to a system that financially incentivizes population-based outcomes rather than volume of service delivery.

- A comprehensive strategy for integrating behavioral health and medical care. This could include continued progress toward integrating publicly and privately-delivered services for Medi-Cal enrollees,²⁰⁶ as well as alignment of performance reporting and incentives across multiple public programs.

California could also take steps to *expand tools, resources and policy infrastructure*. As discussed in Section 1, under the status quo California's health care workforce is stretched thin and not distributed equitably; coordinated action to address health care cost drivers is lacking; public and private investments in social determinants of health are not commensurate with potential benefits; different programs are held to disparate standards for access and quality; and tools to share health information and track population health outcomes are inadequate. Steps to address these issues would improve conditions under fragmented financing. In addition, depending on the design of a future unified financing approach, these steps could help set the stage for effective and sustainable implementation of unified financing.

Steps to expand tools, resources and policy infrastructure could include:

- Investments to expand health care workforce capacity, particularly in underserved regions and with special attention to developing a workforce that fully reflects the diversity of California's population. California's workforce could better incorporate a diversity of non-physician practitioners including advanced practice and general nurses, physician assistants, therapists and other others in well-coordinated teams. Steps could be informed by the report of the California Future Health Workforce Commission and the activities that have begun to emerge from it.
- Deeper scrutiny of cost drivers, accompanied by public and private efforts to curtail spending increases while maintaining or improving health outcomes. Steps could be coordinated with activities emerging from the OSHPD Healthcare Payments Database and other state efforts to improve cost transparency. Special attention might be devoted to inflationary effects of provider consolidation, rising pharmaceutical spending, and/or the connection between profit motives and health care spending.

- Reviewing and revising public and private sector budget priorities and policy decisions in recognition that modifiable health outcomes are influenced to a greater extent by environmental factors, socioeconomic factors, and health-related behaviors than by medical care. An initial set of steps might include the expansion of benefit structures to cover health-related services including housing, food, transportation and community health improvement plans. Oregon covers such benefits through its Medicaid State Plan.²⁰⁷ In California, local Medi-Cal managed care plans have begun to provide such benefits and indicate they would do so to a greater extent if incentives, such as including related costs in the medial portion of Medical Loss Ratio calculations, were offered.²⁰⁸
- Building policy infrastructure by which outcomes consistent with the goals of affordability, accessibility, equity, high-quality or universality are established and expanded. California raised standards in defining “essential health benefits” under the ACA and through legal requirements related to language accessibility and timely access to care. In a similar vein, California could establish standards that demonstrate the state’s commitment to reducing disparities and promoting equitable care regardless of the source of one’s health coverage. For example, it could set rules to improve access by reducing the divergence in payments between public programs and commercial plans or improve affordability by setting prices that apply across multiple payers. Such steps would reduce disparities under fragmented financing and establish a floor on which progress under unified financing could be built.
- Establishing an entity and infrastructure by which health care payment rates could be reviewed, regulated and/or established. As discussed in Section 2 above, relatively high prices paid for hospital, pharmaceutical, and other health care services account for much of the difference between the U.S. and other countries in the fraction of the economy that is devoted to health care. As was proposed in AB 3087 in 2018, California could create an agency with the authority to regulate the prices received by health care providers.
- Development of information technology and tools (e.g. master patient index, master provider index, as required in the 2020-21 budget agreement) to support patient care management and smooth handoffs among practitioners and across care settings. Whether financing remains fragmented or is unified, ready access among health care practitioners to clinical data would enhance care coordination, help avoid service duplication, and improve consumer experience. It would also support greater capacity to learn from the analysis of the population-based data on how to improve care over time.

Synthesis: Steps California Can Take to Prepare

The Healthy California for All Commission’s future activities and second report will explore key design features, options and tradeoffs. Other preparatory steps could include development and execution of legal steps; steps that introduce greater consistency across existing public programs; and steps that expand tools, resources and policy infrastructure in order to lessen the ill effects of fragmented health care financing. How much these last steps pave the way toward unified financing depends in part on future design decisions.

Section 3: Coverage Expansion Options

The primary purpose of the Healthy California for All Commission, as articulated in SB 104, is to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians. In addition, SB 104 charges the Commission to identify coverage expansion options with potential funding sources, including but not limited to the expansion of full-scope Medi-Cal to individuals over age 64 regardless of immigration status.

Coverage expansion under status quo financing arrangements can take several forms. California could expand eligibility for Medi-Cal to additional California sub-populations; make administrative simplifications to make it easier for eligible Californians to enroll and stay enrolled in coverage; or provide additional subsidies to help Californians afford premiums or out-of-pocket cost-sharing.

State action along any of these dimensions would come at a cost. At all times identifying new revenue sources and committing to provide expanded coverage and benefits occurs in the context of competing statewide budget priorities. In light of new expenditures and reduced revenues related to the COVID-19 pandemic, budgetary priorities have realigned and become more stark. The Governor’s May Revise budget projected a deficit of approximately \$54 billion.²⁰⁹ The budget deal approved by the Legislature on June 26, 2020 relies on sources such as rainy day funds, borrowing, and the expectation of new federal funding in order to balance the budget. While the budget deal largely avoids many of the cuts to health and human services programs that had been proposed in the May Revise budget, certain proposals for new or expanded programs that were included in the Governor’s January budget, such as the expansion of Medi-Cal to undocumented seniors, were not included in the final budget deal.²¹⁰ Further budget negotiations are expected to

lead to an “August revision” of the budget that will incorporate the latest information about 2019 tax revenues²¹¹ and the possibility of federal relief.

Whether or not funding is available to expand coverage to new populations, the state may wish to institute changes within its existing public coverage programs in order to strengthen the foundation for future coverage expansions or program alignment efforts.

Expand Eligibility for Medi-Cal

Governor Newsom’s January 2020 budget proposed to expand eligibility for full scope Medi-Cal benefits to undocumented Californians over age 64. The budget included \$80.5 million (\$64.2 million General Fund) for this expansion, including In-Home Supportive Services costs. The expansion would provide preventive care to an estimated 27,000 undocumented persons in the first year. (It is likely that most of the expansion population already receives federally required coverage for emergency care.) Full implementation costs were projected at \$350 million (\$320 million General Fund) for 2022-23 and beyond.

A Medi-Cal expansion to adults of all ages, regardless of immigration status, is another possibility although the cost would be substantial. In 2019, the Newsom Administration estimated that an expansion of full-scope Medi-Cal to undocumented individuals age 26 to 64 would cover over 1 million people and cost \$2 billion (\$1.5 billion general funds and \$507.6 million federal funds).²¹²

Administrative Simplification to Ease Enrollment

The process of enrolling and staying enrolled in Medi-Cal is cumbersome and particularly difficult for those with low levels of health literacy and limited English proficiency and for those with unstable housing. While federal rules require states to meet some process and documentation requirements, states have some leeway to make enrollment more streamlined and consumer-friendly. California delegates responsibility for Medi-Cal eligibility determination to counties which may add complexity in the administration of the program. As shown in Figure 5 (Projected Number of Uninsured Californians Age 0-64, 2022), under pre-pandemic assumptions more than 600,000 California residents are eligible but not enrolled in Medi-Cal. In response to the COVID-19 pandemic, attempts are being made to further streamline the enrollment process. Identifying barriers to enrollment and creating a process to support enrollment continuity could help the state move toward universal coverage over the longer term as well as help address more immediate needs precipitated by the pandemic.

Expand Covered California Affordability Assistance

As described in Section 1 (The Current State), nearly 1 million citizens or lawfully present immigrants are eligible for Covered California but remain uninsured. About 610,000 have family incomes that are under 400 percent of FPL. Additional investments to improve affordability for this group could expand coverage and prevent future erosion in coverage. In 2019, Covered California analyzed different approaches.²¹³ The amount of state funds required would depend on the structure and level of subsidies funded. It is worth noting that even with additional funding, some Californians may find coverage unaffordable.²¹⁴

Proposed 2020 legislation, AB 2347 (Wood) and SB 65 (Pan), would use state general funds to provide premium subsidies for Californians between 138% to 200%; expand premium subsidies for Californians between 200 and 600% FPL; and reduce cost-sharing for Californians earning 200% to 400% FPL.²¹⁵ Cost estimates are not yet available for these proposals.

Improvements in Coverage within the Current System

Even if constrained resources prevent California from expanding coverage to new populations in the near-term, the state might pursue opportunities to make improvements within existing public coverage programs. In particular, the COVID-19 outbreak has exposed vulnerabilities within the current system that largely reimburses providers on a Fee-For-Service (FFS) basis for the volume of services delivered, rather than on quality and cost-efficiency. As Californians stayed home, providers experienced significant declines in revenue for routine office-based visits and for elective procedures at hospitals. The loss of FFS payment revenue in the midst of a pandemic has downstream impacts on access to care and for health care workers' economic security as doctor's offices, clinics and hospitals are at risk for closures and staff layoffs.^{216,217}

Beyond exposing providers to considerable financial instability, FFS payments may not be the most effective way to incentivize providers to deliver high quality and cost-efficient care. Shifting from FFS towards prospectively paid per-member-per-month payments may offer providers a more predictable funding stream as well as flexibility to make practice changes that enable improved access, care coordination, patient engagement and quality.²¹⁸ Such practice changes include greater care management for high-risk patients, increased use of non-visit based services such as telehealth for lower-risk patients, and greater use of non-clinical providers in team-based care models that focus on more effective engagement of patients and families and culturally competent care.

As both a purchaser and convener of payers and providers, the state could play a greater leadership role in testing and evaluating alternative payment models. In any payment model, payers need to be alert for potential unintended and undesirable consequences such as avoiding vulnerable populations and people with complex health care needs, or providing care that meets the needs of “average” enrollees but fails to respect the preferences and needs of individual enrollees.

One model that can be built upon is Covered California’s contractual requirements that align eleven individual market health plans around a common set of goals for improving care quality and achieving delivery system reform. Covered California requires plans to report progress on alternative payments made to primary care physicians. Experience to date shows that some capitated medical groups and independent practice associations receive a prospective payment at the organizational level but may continue to pay individual physicians on a FFS basis.²¹⁹ Moving forward, the state could develop model standards for use between payers and providers during contracting across multiple programs. It might also specify the granular data required to track alternative payment model adoption and outcomes that could inform the appropriateness of broader adoption.

Synthesis: Coverage Expansion Options

First by taking advantage of broad coverage expansion opportunities under the ACA and subsequently through state investments to expand Medi-Cal eligibility to undocumented children and young adults, California has greatly reduced its uninsured rate. The state could expand coverage to additional subgroups, streamline access for those already eligible for public programs yet uninsured, and/or address affordability for those already covered. As an alternative or complementary strategy to coverage expansion, California may also wish to make improvements to existing coverage programs.

Conclusion

Section 1 (The Current State) summarized key characteristics of health care delivery, financing and coverage in California. The state has made great progress in expanding coverage, although 3.5 million Californians remain uninsured. Patchwork coverage programs and care delivery arrangements impose administrative burden for consumers and providers. Transitions in eligibility and coverage that come with changes in employment, income or other life circumstances compromise access and coordination of care. Quality of care is not always well-defined or well-documented and efforts to improve population health outcomes are fragmented. Provider payments are uneven and do not always reflect the cost

or importance of services rendered. Under fragmented financing, health care providers respond to distinct incentives and constraints that make it difficult to address inequities in access, quality and affordability. Unified financing has the potential to address these shortcomings.

Section 2 (Steps to Prepare to Transition to Unified Financing) described three types of steps that California could take to prepare to transition to unified financing. Design steps will be the subject of future Commission deliberations. Legal steps would assert California's intention to move toward unified financing and would set the stage for further policy debate and negotiation. Steps to improve care and reduce fragmentation may, depending on future design decisions, help pave the way toward unified financing.

Section 3 (Coverage Expansion Options) briefly described some of California's coverage expansion options.

The future work of the Healthy California for All Commission will draw on the data and analytic framework presented here. As it continues its work into early 2021, the Commission will explore the design elements, tradeoffs and implications of unified financing and its potential to assure Californians health care that is accessible, affordable, equitable, high quality and universal.

Appendix: Commissioner Comment Letters

Healthy California for All Commission Environmental Analysis: Comments by Commissioner Carmen Comsti

While I appreciate the effort that the consulting team has taken to incorporate my feedback on the Environmental Analysis, I have several outstanding concerns. Foremost, the lack of transparency in the process by which this report was drafted and the continued lack of transparency in the Commission's work remain troubling. The California Health and Human Services agency has delegated much of the Commission's legislative charge to a consulting team under contract with the agency, and, as such, the report drafting process did not allow the Commissioners to discuss our views and did not utilize our considerable expertise. Neither the detailed Commissioner feedback provided in interviews with the consulting team nor the Commissioners' written comments on the draft report were shared with the public or among the Commissioners. Thus, there is no means to validate that the contents and recommendations of this report accurately reflect the analysis and opinions of the Commission. As a *post facto* attempt at transparency, the Commissioners have been allowed to submit a single page of comments for inclusion in the final report. In the interest of greater transparency, I have made my extensive written comments on the draft report available online at <https://www.nationalnursesunited.org/hcfacomments>. I urge Commission Chair Ghaly to post all Commissioner comments on the Commission website as part of the public record.

The report fundamentally misstates the Commission's legislative charge. The Commission was not charged to provide "options for improvement" (p. 7) to California's existing health care system as stated in the draft report. Rather, our enabling legislation states that this report, among other things, provide "[o]ptions...to prepare for transition to a unified financing system, including, but not limited to a single-payer financing system[.]" Also, by our charter, the Commission is meant to develop a plan with options not only for coverage but also access to health care through a single-payer system. Access to care, however, is not adequately addressed in this report. For example, the discussion of provider consolidation (p. 52-59) fails to examine how financial integration of health care providers through corporate consolidation or provider risk-sharing arrangements can reduce access to care. Another example, the "Equity and Community Health" section on health disparities for BIPOC communities, immigrants, people with limited English proficiency, LGBTQ+ people, and people with disabilities (p. 9) deserves a more extensive examination. This section on health equity should examine how insurer and provider profit-seeking and systemic racism and bigotry result in hospital closures, health care redlining, and other structural and financial barriers to care for marginalized communities. Rather than rationalizing current racial and socioeconomic health inequalities, adopting a single-payer health care system that is accessible to all regardless of ability to pay, funds care based on need, and has a single network of care is the most effective step in improving health care equality.

While I agree with the report's overall documentation of our fragmented multi-payer system's failures, there are several areas where I disagree. First, the report briefly mentions that drafting state legislation that creates a single-payer system and that entering into discussions with the federal government on federal health program waivers are steps to unified financing, but I would also emphasize that these two steps—passing state legislation and applying for federal waivers—are the most critical steps in transitioning to a state single-payer health care system and in resolving the many failures of our current system. Indeed, passing state legislation is one of the statutory requirements for a state to secure certain pass-through federal health dollars. Second, the report, in large part, makes recommendations that mischaracterize continued piecemeal reforms of private insurance as preparatory steps to unified health care financing. Creating "consistency" in outcome measures, health plan contracting, or health information technology would not bring us closer to unified financing system (unless one makes assumptions about the design of said system). Third, I disagree with the recommendation to expand the use of per-member-per-month payments and other alternative payment models. Risk-based payments, such as these, are not preparatory steps to single-payer financing, would not improve health coverage, access, or equity, and would require doctors to spend more time on data entry instead of patient care. As the report documents, none of the quality and performance standards discussed therein have led to significant improvements in care. Fourth, I disagree with the report's nonspecific and unsupported statement that federal statutory changes are necessary to obtain federal health program waivers to implement a state single-payer program. There is a more complete discussion of available federal waivers in my comments linked above. Also, I disagree with the recommendation that California expand reimbursements to health care providers and managed care plans for addressing social determinants of health. Social determinants of health are best addressed through investment in robust public programs that comprehensively target their structural causes rather than by payments to health plans, hospitals, or physicians for superficial efforts. Finally, as an option for expanded coverage under Section 3, I would include a recommendation that, under Medi-Cal, the state directly contract with providers, eliminate private insurers and plans within the program, adopt a single provider network, and redirect savings to the provision of additional care.



July 31, 2020

Andrew B. Bindman, MD
Professor of Medicine and Epidemiology & Biostatistics
Philip R. Lee Institute for Health Policy Studies
University of California San Francisco

Transmittal via e-mail

Dear Dr. Bindman:

I appreciate the opportunity to review your team's revised report, *An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California* that will soon be submitted to the California Legislature on behalf of the Healthy California for All Commission. The report is excellent, and I appreciate the inclusion of the majority of my suggested comments based on the first draft report. In particular, the enhanced prominence of equity issues upfront and throughout the report and the inclusion of suggestions to strengthen both benefit offerings and financial incentives for health-related services provided by health plans (pgs. 86-87) are important additions.

The report, however, does not go far enough in emphasizing the overarching need to shift our health *care* system from one that focuses on acute care to a *health* system focused on prevention through individual and community health and well-being. Ideally, this notion would be a sixth principle of the Commission, underscoring the fact that if we are to create an equitable system a key pathway is through optimizing prevention and linking to and supporting the social determinants of health. As my initial comments noted, there are national and state innovations to bridge health care, public health, and social services, such as coordinated care organizations and accountable communities for health. These are promising intermediary organizations that also focus on equity and root causes of poor health.

Building on our nearly 25-year history in advancing health coverage and the social determinants of health, the California Endowment supports five essential elements for a transformed system that: 1) provides 100% coverage for all, regardless of immigration status; 2) embodies a unified financing mechanism that ensures affordability; 3) advances health equity by addressing racial equity; 4) optimizes prevention by linking to and supporting the social determinants of health; and 5) possesses a health workforce that is culturally representative and proficient in serving California's diverse landscape. My sincere hope is that the Commission's ultimate plan *fully* aligns with these core elements. I believe that could be achieved by embracing and addressing #4.

Best,

Robert K. Ross
President and CEO
The California Endowment
Commissioner, Healthy California for All

Commissioner Comment: Richard M. Scheffler, PhD.

As the commission examines the options of a single payer system and a unifying financing approach, it should look at whether the current system is sustainable, affordable, and equitable. It is widely recognized that 30 percent of healthcare spending is wasteful.¹ Commercial prices for hospital care are among the highest in the country and health insurance is becoming less affordable each year.² At the same time, the disparities in health and health access are persistent.

These are daunting challenges but they must be addressed. This means carefully examining the organization and financing of our healthcare delivery system, finding the parts that work and designing strategies to improve those that do not. The building blocks of our system are integrated plans with over 60 percent of the population enrolled in them.³ The largest part of that integrated system is Kaiser but other health insurers, including Blue Shield, are also expanding their integrated plans. About 40 percent of Medicare enrollees are in Medicare Advantage and about 80 percent of Medi-Cal enrollees are in Managed Care plans. In addition, there are now over 80 accountable care organizations in California.⁴

What all these plans have in common is that they are financed using some form of risk-based capitation. This method of payment incentivizes efficiency, value, and keeping people well. To move the health system towards giving consumers value we need to improve competition among providers, health systems, and health insurers in a way that lowers cost and increases quality.⁵ Public policy that increases the use of telehealth, the expanded role of nurses, and the development of frontline health care workers are important components of a cost containment strategy that the Commission needs to explore.³

All these changes must be viewed under the lens of reducing health disparities. We must focus on our most vulnerable populations. If our health system works for them, it will work for all Californians. That is our challenge.⁶

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HEALTHY CALIFORNIA FOR ALL COMMISSION: FIRST REPORT ADDENDUM

Anthony Wright, Executive Director, Health Access California

This “environmental analysis of health care delivery, coverage, and financing” is an impressive overview of the complex and confusing health care system in California. The system’s major inequities, misplaced incentives, and multiple issues of access and affordability--now more exposed in the COVID-19 crisis--are why Health Access California has strongly supported a single-payer solution for over 30 years. While we have also advanced other reforms toward our goal of quality, affordable health care for all, some issues will not be fully resolved without major structural reforms like the unified financing this Commission seeks.

HIGHLIGHTING THE CONSUMER EXPERIENCE IN OUR HEALTH SYSTEM: As a patient advocate who heads the statewide health care consumer advocacy coalition, I seek to spotlight the experience of the consumer, as not just the object, but as the point of the health system. I detail more on our website page about this Commission’s work at www.health-access.org/hcfa. The consumer experience navigating this uneven patchwork of providers, payers, and private and public plans, is often one of Kafkaesque confusion, frustration, and disempowerment. The environmental scan implicitly refers to this by detailing the complexity and fragmentation, but does not explicitly reflect the lived experience of consumers trying to get care or coverage, or how this fear and insecurity impacts life choices, careers, family finances, and more for the uninsured, the underinsured and all who may become so.

While many consumers struggle to afford care and to navigate this non-system, many more are at even greater disadvantage, due to income, education, language, disability, immigration status, race, ethnicity and culture, gender identity and sexual orientation, age, medical conditions, and more. The experience of powerlessness is more severe when patients are disempowered due to economic inequality, structural racism, social determinants, or the physical or mental health issues that lead patients to need care.

When issues arise, consumers find it hard to know where to complain, and how to get justice. Depending on your type of coverage or complaint, you may need to call the Department of Managed Health Care, Department of Insurance, Covered California, Department of Health Care Services, or another county, state, or federal agency, or your health plan, or your employer. We are proud of the patient protections we have won, but we recognize they are uneven in our fragmented system, leaving consumers without the full security of a universal guarantee of care that is affordable and available when needed.

MORE WORK NEEDED TO DETAIL THE URGENT PATH FORWARD: As a longtime supporter of single payer, I look forward to the work fleshing out important details of what a state universal, unified financing health system may look like, and the path to get there. In section 2, we welcome the discussion of obstacles to such a system—not as an excuse for inaction, but to figure out how to overcome those barriers. We needed more focus on surmounting these challenges. In section 3, we welcome the detailing of the transitory steps California can take now, steps that are not just complementary but in many cases necessary to get to single-payer. California should not be waiting around for federal approvals, whether of administrative waivers or Acts of Congress; the urgency of reform requires that California be ready to move ahead with preparatory steps that do not require federal or other actions, to provide real relief to Californians ASAP, and to make the transition smoother and quicker if approved. Section 3 would have been improved with the inclusion of more of the ideas discussed by the Governor and Legislature in recent years, and new proposals, to expand coverage, reduce fragmentation, or adopt elements of a unified system anticipating a transition.

While these sections are a good start, they lack specificity to provide needed guidance for policymakers, and should be revisited in our second report. With a developed plan of a health system with unified financing, we can more easily work backwards from that vision to determine the best pathway and steps to get to our shared goals, for an accessible, affordable, equitable, high quality, and universal health system for all Californians.

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