



California Health Care Foundation



## Key Questions When Considering a State-Based, Single-Payer System in California

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## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).

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## ASKING THE IMPORTANT QUESTIONS

California's health care system has made great strides under the Affordable Care Act. Among many signs of progress, the state's uninsured rate has been cut in half to 8.5%. Universal coverage in California is finally within reach, a goal that seemed like a long shot just five years ago.

Even with this progress, much work remains. Every Californian should be covered with a comprehensive set of benefits. We can and should do this while also ensuring that care is both affordable to California consumers and that the state's health care budget does not crowd out other key state investments. Care must be easy to access, evidence based, and patient centered – regardless of a person's place of residence, race or ethnicity, or type of health insurance.

Achieving universal coverage alone will not get us there, but the reforms needed to tackle costs, access, and quality are more likely to be successful when everyone is already included in the system.

There are many policy approaches to achieve universal coverage. Over the past year, mirroring growing national interest around a single payer system, there has been increasing momentum in California to create a state-based single-payer system. Our health care system affects tens of millions of lives, provides hundreds of thousands of jobs, and costs hundreds of billions of dollars each year. Any time major reforms to that system are proposed, a rigorous analysis is warranted.

The California Health Care Foundation (CHCF) commissioned this paper to provide a basic understanding of the core features of a state-based single-payer system as well as the major issues and values at play in the creation of such a system. The report does not take a stance, nor does it analyze specific single-payer legislation or proposals. Instead, it provides a baseline understanding of what a "single-payer" system is, what it isn't, and what it might mean for California.

Like any policy, the feasibility and effectiveness of a state-based single-payer system in California ultimately depends on the problem it is attempting to solve. Different goals trigger different tradeoffs, as well as a variety of nuanced implementation choices. The paper surfaces what some of these tradeoffs might be. In doing so, it raises key questions that need to be answered about any single-payer proposal for California. Some of these questions are the same questions that should be asked about any major health care reform policy; others are more specific to implementation of a single-payer system.

It is our intention that this publication be a valuable resource across the political spectrum, as California's Select Committee on Health Care Delivery Systems and Universal Coverage, and other key stakeholders, grapple with how to best move our health care system forward.

Regardless of your views on single payer, we encourage you to ask the important questions and consider the opportunities and challenges they present. By taking that approach together, we can start to gain clarity about what we are ultimately trying to achieve with further health care reforms – and what it will take to get there. This will only strengthen California's chances of success, no matter what path we ultimately take to achieve universal coverage.



A handwritten signature in white ink, appearing to read 'Sandra Hernández'.

Sandra Hernández, MD  
President and CEO  
California Health Care Foundation

## Executive Summary

**B**y embracing implementation of the Affordable Care Act (ACA), California has decreased its uninsured rate to an all-time low of 8.5%. Nevertheless, a substantial number of residents remain uninsured, whether ineligible for public coverage due to immigration status or unable to afford coverage; quality of care and access remain uneven; and systemwide health care costs continue to rise. Recent actions by the current federal administration and Congress have called into question the stability of the federal ACA framework. The desire for a simpler, less costly, and more efficient alternative has drawn renewed attention to a potential state-based, single-payer health care system in California.

However, “single payer” can mean different things to different people. At its most basic, “single payer” refers to a single centralized, publicly organized means to collect, pool, and distribute money to pay for the delivery of health care services for all members of a defined population. The potential of a state-based, single-payer system to deliver improved outcomes depends on policy decisions and design issues that have not yet been fully defined and vetted in California.

This paper identifies questions and issues that bring into better focus what single payer could mean for California. Some of these key questions, discussed in more detail in the paper, include the following:

### What Problems Is a Single-Payer System Being Designed to Solve?

A single-payer health care system in California could help the state meet a number of goals — universality of health care coverage, comprehensiveness of coverage, greater equity, greater access and quality, improved affordability, lower administrative costs, and slower growth in health care costs. Finite resources and inherent tensions among several of these goals mean that design choices, either explicit or implicit, will accompany a single-payer program. A robust debate around any single-payer proposal demands clarity regarding what problems the proposal aims to address, what goals it intends to achieve, and how policy decisions and design choices link to those goals.

### What Money Is Available to Support a Single-Payer System in California?

More than half of health care spending in California today is controlled by the federal government, and an additional substantial portion flows through self-funded employer plans that are explicitly exempt from state control. The ability to marshal financial resources to support a state-based, single-payer system raises a number of questions and has implications for the system’s goals and design.

Redirecting federal funds to a state-based, single-payer system is by no means assured. Identifying funds under state control to substitute for current federal spending would require substantial new revenue. For example, approximately 27% of California health care expenditures are for the Medi-Cal and Healthy Families programs, which are both jointly funded via state (about 10%) and federal (about 17%) contributions. A substitute source of funds for the federal share for Medi-Cal and Healthy Families populations is unlikely to be readily available. Thus, a key policy decision is whether a single-payer system would include the Medi-Cal population and, if so, whether or how the state could ensure that federal funding will not be jeopardized under a state-based, single-payer system.

In addition to federal constraints, there are potential barriers to allocating or raising the necessary funds for health care under California law. For example, increases to the general fund (i.e., through taxation) can trigger other budgetary rules that would limit the ability of the state to raise funds solely for health care spending. Another fundamental constraint is that, unlike the federal government, states cannot operate with a budget deficit and must abide under annual budgetary constraints. Could California adequately ensure that revenues would keep pace with health care costs under a state-based, single-payer system? Any external factor that reduces expected revenues in a given year, or increases unpredictability of revenues or costs, could jeopardize sustainability. Budgetary constraints would in turn affect payments to providers. For example, would fee levels paid to health care providers be reduced or constrained over time to reduce public revenues needed to support the single-payer system? While this happens to some degree with Medi-Cal and other public programs today, budgetary pressures under a single-payer system would apply to a broader population with more widespread implications for providers.

## How Would a Single-Payer System Work?

Many program design questions need to be considered.

- ▶ **How would a single-payer entity arrange to purchase health care services?** What role, if any, would insurers or other intermediaries (such as county-operated health systems or mental health departments) play in delivering or managing care?
- ▶ **How will payments to providers of health care services be set and structured?** Would payments be tied to existing schedules or rates, such as Medi-Cal rates or Medicare fee schedules? Adequate payments to providers are necessary to ensure provider participation and, ultimately, to achieve adequate access to care. Establishing a clear payment methodology with appropriate controls and oversight is necessary to minimize fraud and abuse and to align incentives. For example, payment methods can be used as a lever to encourage efficiency and value in the system.
- ▶ **What are the conditions of provider participation, and how would the system ensure adequate provider supply and access?** Would all health care providers that are board certified and state licensed be eligible to participate? Would the system impose quality of care, performance, or other accountability standards on providers?
- ▶ **Who would be eligible to use the system?** Would all Californians be eligible? How is residency defined, and what parameters are required to establish residency? Would temporary residents and visitors be covered? How would a state-based, single-payer system enforce participation, and how would such enforcement mechanisms interact with existing tax penalties under the ACA? Would anyone be allowed to opt out and, if so, under what circumstances? If the goal is to make sure that all Californians have coverage under a single payer, then major disruption in the system is inevitable.
- ▶ **What are the covered benefits and services?** Would an existing set of benefits (e.g., essential health benefits under the ACA or Medicare benefits) be adopted? Among a variety of questions that flow from the set of benefits, perhaps one of the most important is whether consumers would be required to pay for a portion of their coverage and care.

Coverage with high or unaffordable patient cost-sharing may cause enrollees to forego necessary care and compromise quality, while low cost-sharing requirements increase the state's cost due to a combination of its paying a higher share of the costs and higher utilization of services by those covered. For drugs, medical supplies, and devices, would formularies — different levels of cost-sharing depending on the efficacy and/or cost of the treatment — be adopted? Would cost-sharing levels be standard for everyone or vary based upon household income? What services would be explicitly excluded (e.g., adult vision benefits, such as glasses; long-term care services; transportation)? For services that are not covered, would Californians be able to access supplemental insurance policies to augment coverage?

- ▶ **How would the system's governance and administrative structure be designed?** A sound governance model promotes accountability, effective oversight and management, and an evidence-based, data-driven approach, all the while encouraging consumer and stakeholder participation. A variety of questions around governance and administration emerge, including: What is the governance structure? Would the program be governed by a board with appointed members representing various interests (including consumers or patients)? Or would it be administered by a state agency under the governor or another elected or appointed official? What is the relationship of the governing body to the legislature, the governor, and other state agencies?

## What Next?

With the health and well-being of all Californians — along with more than one-eighth of the state's economy<sup>1</sup> — at stake, careful consideration of the goals, features, and implications of any large-scale reform to the state's health care system is needed. A rigorous, thorough debate around a state-based, single-payer system in California starts with asking the right questions, which this paper attempts to outline.

# Introduction: What Does “Single Payer” Mean?

In the US, health care is provided and paid for through a variety of means. The diversity of financing and delivery arrangements lead to variable levels of access and affordability, as well as uneven quality of care. States that embraced the Affordable Care Act (ACA), including its Medicaid expansion, such as California, attained significant gains in coverage. Indeed, California (where Medicaid is called Medi-Cal) cut its uninsured rate by more than half under the ACA, falling to 8.5% in 2016, largely by expanding Medi-Cal. The portion of Californians citing cost as a reason for remaining uninsured has dropped, as has the percentage of Californians spending more than 10% of their income on health care.<sup>2</sup>

Nonetheless, over two million Californians remain uninsured, the majority ineligible for ACA programs due to immigration status. Many Californians struggle to find affordable coverage. Quality of care and access remain uneven, and already high systemwide health care costs continue to rise. Recent actions by the current federal administration and Congress have called into question the stability of the federal ACA framework.

In California, the desire for a simpler, less costly, more equitable, and more efficient alternative that can improve health care quality has renewed interest in a state-based, single-payer health care system.

**Fundamentally, “single payer” refers to a single, centralized, publicly organized means to collect, pool, and distribute money to pay for the delivery of consistent health care services for all members of a community.**

Fundamentally, “single payer” refers to a single, centralized, publicly organized means to collect, pool, and distribute money to pay for the delivery of consistent health care services for all members of a community. A single-payer system aims to address the complexity, disparities, and inefficiencies of our present approach. However, its potential to deliver those benefits depends on a range of policy choices and design details. With the health and well-being of all Californians — along with more than one-eighth of the state’s economy<sup>3</sup> — at stake, a systematic and nuanced exploration of the goals and features of a proposed California single-payer system is needed to determine whether and how such a proposed system could meet California’s goals.

The aim of this paper is to assist California policymakers and stakeholders as they evaluate state options for securing and extending access to quality health care for all Californians. It lays out key questions, presents assumptions, and identifies policy and implementation trade-offs associated with a California-based, single-payer system. Some of these questions and implementation considerations are unique to a state-based, single-payer approach, but many arise with any broad overhaul of health care finance.

This paper does not analyze or endorse particular state or federal policy proposals — single-payer or others — nor does it catalog prior proposals or other countries’ systems. Instead, it identifies the questions and issues that need to be addressed to bring into better focus what a single-payer system would mean for California.

As with any broad effort to reform or expand coverage, to move from a broad concept to a more concrete proposal requires that a range of critical definitional questions be addressed:

## ► What problem is it trying to address?

Fundamentally, establishment of a single-payer system may be attempting to address all or some shortcomings of our health care system, but may prioritize some problems over others, particularly in the short term. For example, is the main concern that all residents of California gain coverage? Is the primary goal to address pressing issues of consumer affordability and underinsurance? Is the priority to integrate funds and services in such a way that all Californians have equal access to one system of care?



Or is the primary focus to stem increases in or even reduce total health care expenditures? Many of our health care system's shortcomings are interrelated, so how the problem is defined does not mean that efforts must be limited to addressing a single issue. However, defining goals and elevating a particular set of intended outcomes will drive the parameters and key features of a single-payer system.

- **How will the system be financed, and under what budgetary constraints will it operate?** There are fundamental questions regarding how a single-payer system will be financed to be sustainable while meeting budgetary constraints. Consider feasibility questions, such as: (1) What ability does the state have to redirect federal and private dollars into a single state-administered pool?, (2) What are the

### Putting "Single Payer" in California in Context

California's current exploration of a single-payer system is part of a bigger picture. Many countries use variations of single-payer programs to finance their health care systems.<sup>4</sup> Single-payer systems have been proposed for the US as a whole and within several states.<sup>5</sup> In California, single-payer policy proposals, and many other efforts to broadly expand coverage within the state, have been advanced over many decades.<sup>6</sup> Recent policy concepts — some federal, some state-based — intended to make coverage more widely available or more efficient include:

- **Medicaid/Medi-Cal expansion.** Medicaid covers a wide range of benefits with minimal or no cost sharing, but eligibility is currently limited by income. Those concerned with consumer affordability and improved access (particularly access to comprehensive services) see advantages in extending Medi-Cal on either a mandatory or an optional "buy in" basis. Such expansion, though, could introduce provider participation and funding challenges.
- **Medicare expansion.**<sup>7</sup> Medicare, available to most individuals age 65 or over and certain people with disabilities, has a long track record and a robust administrative structure. Beneficiaries have substantial cost-sharing responsibilities, and benefits are less comprehensive than those offered through Medicaid. Medicare offers two payment approaches: fee-for-service (FFS) arrangements based on structured fee schedules, and Medicare Advantage, a prepaid arrangement with access to a defined provider network. Those seeking to achieve greater efficiency through established structures and processes see Medicare as offering a solid infrastructure for further coverage expansion. Notably, however, current premiums and beneficiary cost sharing cover only a portion of total program costs; for example, beneficiary premium contributions made up only 13% of the total Medicare expenditures in 2016.<sup>8</sup>

- **State-based public option.** Developing a public health plan option (through Covered California, Medi-Cal, CalPERS, or another state-based entity) that allows buy in for some or all of the population could expand access to coverage. Those concerned about consumer choice see this option as providing an alternative to private health plans, particularly in locations where competition among private plans is limited. The capacity of a public option plan and private health plans to coexist and compete effectively and fairly hinges upon how the public plan secures contracted provider reimbursement levels and whether selection effects are adequately managed via risk pooling, reinsurance, and risk adjustment mechanisms.
- **State-based universal coverage.** A state guarantee of access to certain health care services, with a mechanism to pay for services for people not otherwise insured, has been considered in Colorado<sup>9</sup> and Vermont.<sup>10</sup> While both are considered "single-payer" approaches, both states allowed for exemptions of populations covered by existing federal programs. Vermont's proposal would have allowed those with existing employer-sponsored insurance to maintain their coverage and obtain "wraparound" coverage. Those concerned with universality and comprehensiveness of coverage seek to build on existing coverage arrangements while addressing remaining coverage gaps.

To fully understand these broad concepts and to appreciate their potential opportunities and pitfalls requires additional detail and analysis beyond the scope of this paper. They are mentioned as a reminder that any state-based, single-payer proposal emerges not in a vacuum, but within a field of potential alternatives.

state constitutional and legal requirements related to the budgeting and appropriations process?, and (3) Can sufficient tax-based revenue or other funds be collected to cover existing or new costs?

- **Who will be covered?** The concept of single payer is sometimes conflated with universal coverage, but the ideas are distinct. Universality can be achieved through a variety of policy options that range from extending current coverage programs and rules, to establishing a single-payer system. A universal system need not establish a single centralized means of collecting, pooling, and distributing funds; rather, universality could be achieved through penalties for nonenrollment or enforcement of mandatory enrollment in either public or private health plans. A single-payer approach can be universal — applying to everyone within state boundaries irrespective of age, gender, income, health status, employment, and citizenship. Alternatively, a single-payer system could apply to a subset of the population, as with Medicare for people age 65 and over and the disabled, or the Veterans Health Administration (VHA) program for veterans. In sum, a single-payer system must clearly define the population that it includes.

The concept of single payer is sometimes conflated with universal coverage, but the ideas are distinct. Universality can be achieved through a variety of policy options that range from extending current coverage programs and rules, to establishing a single-payer system.

- **What benefits and providers will be included?**

Physician office visits, hospitalization, prescription drugs, mental health and substance use disorder services, therapy, preventive care — just to name a few — are benefits delivered by a wide range of health care providers in a variety of settings. A single-payer system must define what benefits are covered, who will be paid for providing them, and how the covered population will be permitted or assured access to those services. This includes determination of the portion of costs for which the covered population will be responsible, if any, and how to structure that contribution; for example, through premiums or cost sharing. It must also determine if varying benefit plans would be made available within the system at the consumer's choice and if health care may be obtained outside of the single-payer system — for example, through privately purchased supplemental policies that provide wraparound coverage. Allowing such buy-up options would allow a private pay market to coexist with a single-payer system.

These fundamental questions define the boundaries and key features of a single-payer system. Understanding what problem it is trying to address, who will use the system, what and how much it will pay for, and who it will pay, will drive system design.

## What Problems Is the Single-Payer System Expected to Solve?

Before leaping to the “how” of a single-payer system, a first-order question is “why?” Which problems is a new approach intended to solve, and how would a single-payer system address or possibly exacerbate those problems? Table 1 tees up this set of questions. (See page 9.)



**Table 1. Potential Goals of a Single-Payer System**

CALIFORNIA'S STATUS	HOW COULD SINGLE PAYER HELP OR HINDER?	UNANSWERED QUESTIONS
<b>Universal Access to Health Insurance Coverage</b>		
Under the ACA, California has seen broad expansions in coverage, particularly via enrollment in Medi-Cal. In 2016, 8.7% of nonelderly Californians were uninsured, a dramatic drop from much higher levels prior to ACA implementation (near 20%). Noncitizens continue to be much more likely to be uninsured than citizens. <sup>11</sup> California's enrollment gains under the ACA could slip if federal policy to overturn or substantially modify the ACA is enacted.	<p>Collective financing implies taxation across a broad base. Financing across a broad base brings a responsibility to provide health care coverage broadly and consistently.</p> <p>Enacting a broad-based single-payer system could establish health coverage or health access as a fundamental right for Californians.</p>	<p><i>Is universality defined as extending coverage only to the remaining uninsured, or does universality mean moving everyone with insurance into a single system?</i></p> <p><i>How will constraints around use of federal funds (Medicaid, Medicare, subsidies available to eligible enrollees in Covered California, etc.) influence universality?</i></p>
<b>Comprehensive Coverage</b>		
The ACA established a floor for health care coverage through its essential health benefits provisions. However, certain health care services, such as long-term care, adult dental, and vision are not typically covered under most types of health insurance. Lack of coverage of certain benefits can constrain access to care and lead to financial hardship.	<p>Collective financing implies taxation across a broad base and brings a responsibility to provide health care coverage broadly and consistently. Enacting a single-payer system could explicitly establish a single standard for coverage comprehensiveness.</p> <p>If allowed, private insurance plans could be offered to supplement services not covered or to reduce patient cost-sharing amounts.</p>	<p><i>Is comprehensive coverage an explicit goal? If so, how comprehensive (across types of services and care settings) is comprehensive enough?</i></p> <p><i>Will supplemental or competing plans offered by the private market be allowed? Under what circumstances (for example, to offer wraparound coverage)?</i></p>
<b>Equity</b>		
<p>Disparities in access and quality of care are significant and arise from a variety of factors: source of health insurance, geographic variation, race/ethnicity, sexual orientation, and other socioeconomic factors.</p> <p>Premiums for individuals and families vary considerably based on household income and geographic area.</p>	A single-payer system is intended to increase equity among its covered population by leveling benefits, cost sharing, and provider reimbursement rates. However, some factors that lead to inequitable outcomes today, such as uneven distribution of health care providers throughout regions of the state, could persist within a single-payer system.	<p><i>Will resources be sufficient to ensure everyone has access to high-quality health care? If not, how will equity gains be experienced by "winners" and "losers"? In addition, those relatively advantaged under the status quo may experience diminished access, higher costs, or lower quality of care as those who are less advantaged see gains along those dimensions.</i></p>
<b>Better Access to Care</b>		
<p>Enrollees in commercial plans with health maintenance organizations or plans with narrow networks are limited in the providers they may access.<sup>12</sup></p> <p>Enrollees have reported difficulties finding providers who accept Medi-Cal as well as accessing certain specialists (e.g., pediatric psychiatrists).<sup>13,14</sup></p>	<p>If coverage is universal, those who were previously uninsured would have increased access. If the system is well financed, it may increase access for those who were previously underinsured. Assuming supply and financing constraints of some kind, however, those who previously had access may face new constraints.</p> <p>Access to specialty services already in short supply may be exacerbated by a single-payer system, especially in the short term.</p>	<p><i>Will resources be sufficient to address existing access gaps, even as the covered population grows? With a reduction in the numbers of uninsured and underinsured, will there be newly introduced congestion in the system as measured by the difference between provider availability and consumer demand?</i></p> <p><i>Will mechanisms (such as pharmacy formularies or preferred provider arrangements) be put in place to encourage people to use care that is appropriate and cost-effective? If so, how will such mechanisms affect enrollees' perceived and actual access to care? If not, will the supply and distribution of providers and services meet consumer demand and patient needs?</i></p>

**Table 1. Potential Goals of a Single-Payer System, *continued***

CALIFORNIA'S STATUS	HOW COULD SINGLE PAYER HELP OR HINDER?	UNANSWERED QUESTIONS
<b>More Affordable Care (lower / less rapidly rising consumer costs)</b>		
<p>The average annual premium for single employer coverage in California is about \$7,200. Although the ACA led to fewer Californians bearing a high health care cost burden, about one in six families remains in this situation.<sup>15</sup> Affordability is a longstanding concern as more people are enrolled in high-deductible health plans and the share of costs borne by consumers continues to rise.<sup>16</sup></p>	<p>Depending on how administration and governance is designed, a centrally administered system may be better positioned to limit consumer cost-sharing requirements (if any) than are fragmented private payers that compete based on premiums.</p> <p>If a single-payer system can be administered for less than a multipayer system and/or the size of the single payer allows greater leverage for negotiating (or dictating) lower provider reimbursement, then it can lead to lower underlying costs and allow for lower-cost sharing and/or premiums.</p>	<p><i>Cost-sharing requirements can affect health care use and health care cost trends. How acceptable and desirable is it to have zero cost sharing for all services? Is there a need for incentives to seek more cost-effective care or constrain coverage based on effectiveness and cost-effectiveness (e.g., drug formularies)?</i></p> <p><i>Will an adequate number of health care providers be willing to accept potentially lower reimbursement rates for consumers to have more affordable care?</i></p>
<b>Better Quality of Care</b>		
<p>Quality of care — as measured by patient safety, process, and outcome measures — is uneven and improvements are not always rewarded under the status quo. Public and private efforts to improve care quality are currently underway, with mixed results.<sup>17</sup></p>	<p>Depending on the stated goals and design, a centrally administered system can set quality standards, demand reporting as a condition for participation or payment, and collect data for evaluation, monitoring, and technical assistance.</p>	<p><i>Who would invest in, support, and monitor quality data? Is there the will to hold providers accountable for performance? Under a single-payer system, will providers' incentives to address quality become more or less fragmented, compared to today's mix of integrated delivery systems?</i></p>
<b>Lower Administrative Costs</b>		
<p>Increased administrative costs and inefficiencies may result from multiple entities managing and operating redundant functions throughout a multipayer system.<sup>18</sup></p>	<p>Administrative cost reductions are dependent on how a single-payer system's governance and administrative system are designed and implemented. A centralized administrative entity may reduce redundancy by centralizing and streamlining key functions, such as enrollment, provider claims processing, and payments.</p>	<p><i>How will governance and administrative systems be designed to maximize efficiency in functions?</i></p> <p><i>Will visibility and political considerations influence what is targeted for efficiency gains?</i></p> <p><i>Administrative costs for insurance are estimated to make up about 12% to 17% of total health care expenditures, with lower administrative costs for public insurers.<sup>19</sup> A reduction in administrative costs alone may not be sufficient to cover the cost of a new single-payer system.</i></p>
<b>Transparency and Accountability</b>		
<p>In today's highly fragmented system, it is hard to know where the money is going and how it contributes (or doesn't) to access and quality outcomes.</p>	<p>Depending on the system's design, a centrally administered pool of funds can support accountability. However, transparency and accountability (to the public or to contracting entities) enabled through data collection and reporting may be hindered or helped depending on the capabilities of the single-payer administrator.</p>	<p><i>Will transparency and accountability be imposed downstream from the single-payer pool?</i></p> <p><i>Will consumers have access to price and quality information to make informed decisions?</i></p> <p><i>Will access and quality outcomes be monitored? Who will monitor? Can feedback loops ensure that outcomes inform program design, payment, and other decisions?</i></p>

**Table 1. Potential Goals of a Single-Payer System, *continued***

CALIFORNIA'S STATUS	HOW COULD SINGLE PAYER HELP OR HINDER?	UNANSWERED QUESTIONS
<b>Lower Rate of Cost Increases</b>		
Health care costs continue to rise at rates that exceed the growth rate of the general economy. According to the Centers for Medicare and Medicaid Services (CMS), total health care expenditures are projected to grow 1.2 percentage points faster than the gross domestic product (GDP) per year over the 2016-2025 period. As a share of GDP, health care expenditures are expected to rise from 17.8% in 2015 to 19.9% by 2025. <sup>20</sup>	<p>Depending on how the system is designed, a central pool of funds can impose discipline because the budget is dependent on the revenue collection rate. Depending on the governance structure, system administrators may be motivated to manage spending and find cost savings somewhere.</p> <p>If a single-payer system can be administered for less than a multipayer system and/or the size of the single-payer system allows for greater leverage for negotiating (or dictating) lower provider reimbursement rates, then it can lead to lower unit costs and to lower health care cost increases.</p> <p>The effects of a centralized system setting prices for goods and services are difficult to fully anticipate. Prices may not quickly factor in new technologies and care innovations, and may be insensitive to variations in efficiency or quality. On the other hand, a centralized system may allow for more rapid adoption of new technologies once they are approved for payment.</p>	<p><i>Will governance structures and administrative structures impose greater discipline on overall health care spending?</i></p> <p><i>Will they increase or impede system efficiencies? Will political considerations influence what is targeted for efficiency gains?</i></p> <p><i>How will provider supply and consumer demand for services be influenced by payments for services and price at the point of service?</i></p> <p><i>To what extent can a state program address system cost drivers that play out across a broad national context; for example, the price of specialty drugs?</i></p> <p><i>How will the single-payer system set or negotiate health care provider reimbursement rates?</i></p> <p><i>If the system is not universal to all markets, will lower health care costs in the single-payer market result in cost shifting to other markets?</i></p>
<b>Other Broader Societal Benefits</b>		
Health care costs represent 18% of GDP, and this fraction is increasing each year. In California in 2015, medical and health services managers, health care practitioners and technical occupations, health care support occupations, and community health workers composed 7.3% of total employment. <sup>21</sup> In addition to many medical professionals who are employed in the direct delivery of health care services, many jobs are associated with administering and supporting health care delivery.	<p>Medical workforce and health industry labor market: If a single-payer system is successful at lowering costs and increasing system efficiency, some health sector jobs may be eliminated, wages in some roles may be reduced, and jobs may be redistributed among the public and private sectors. There could be an increase in public sector jobs and a decrease in private sector jobs, with a net decrease in redundant jobs.</p> <p>Redistribution of spending on health care to other sectors: If total public health care dollars are decreased, there may be an increase in public spending on other sectors, including for social services. Recent research shows that when a state spends a greater proportion of its funds on social services versus health care services, there are a range of associated positive and significant health care outcomes.<sup>22</sup></p>	<p><i>What are the greater socioeconomic repercussions that may result from the introduction of an efficient and lower-cost single-payer system?</i></p> <p><i>What effects will there be on the California health care workforce and the workforce pipeline? Will young people bypass medical professions to pursue other, more lucrative professions instead?</i></p> <p><i>Will lower provider reimbursement rates result in physician and other health care professionals fleeing California for better-paying states?</i></p> <p><i>What effects will there be on budget spending on other sectors, and what are the potential downstream effects of that spending?</i></p>

**TO SUM IT UP:** A single-payer program could be designed to address a number of goals. Consensus among policymakers, stakeholders, and administrators about program goals and priorities is needed to guide design choices and to evaluate progress.

# What Funds Can Be Used for a Single-Payer System?

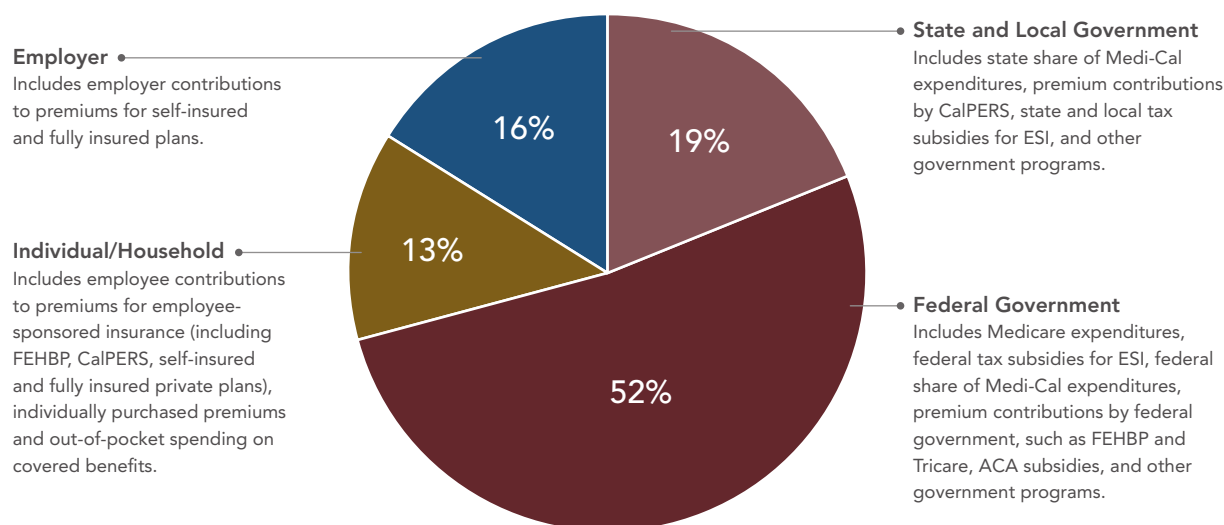
**F**undamentally, a single-payer system seeks to combine, centrally administer, and more wisely use funds that currently come from many sources. Today the federal government is the source of a substantial portion of dollars spent on health care across the US and in California. Redirecting those funds to a state-based, single-payer system is by no means assured. If federally controlled funds are not available, identifying funds under state control to substitute for current federal spending would require substantial new revenue.

Figure 1 provides a summarized view of four main funding sources for health care in California: the federal government, state and local governments, employers, and individuals. These dollars are not currently captured in a single revenue pool. Table 2 provides further details about funding sources and raises questions regarding the feasibility and implications of redirecting these dollars into a single state-administered pool. (See page 13.)

Today the federal government is the source of a substantial portion of dollars spent on health care across the US and in California. Redirecting those funds to a state-based, single-payer system is by no means assured.

States, unlike the federal government, cannot operate with a budget deficit. Therefore, the ability to ensure that revenue trends keep pace with health care cost trends is a fundamental concern for a state-based, single-payer program. Any external factor that reduces expected revenues in a given year, or increases unpredictability of revenues or costs, could jeopardize program sustainability. In addition to the funding sources and sufficiency questions

**Figure 1. Main Health Care Funding Sources, California, 2016**



Notes: Categories do not include other sources of funding for health care such as philanthropy, investments, or individual/household spending for non-covered health care services. Payroll taxes are not explicitly categorized by this chart.

Source: Adapted from *Public Funds Accounts for Over 70 Percent of Health Care Spending in California*, August 2016, UCLA Center for Health Policy Research.

**Table 2. Health Care Financing Sources and Feasibility Questions**

CURRENT MECHANISMS FOR COLLECTING MONEY ALLOCATED TO HEALTH CARE	KEY ISSUES REGARDING FEASIBILITY
<b>Individuals and Households</b>	
<p><b>Premiums.</b> Estimates indicate that about 9% of total private and public health care expenditures in California are premium contributions by individuals in the privately insured employer-based, individual, or small group markets.</p> <p><b>Cost sharing at point of service.</b> In addition, about 4% are out-of-pocket costs for covered benefits.<sup>23</sup></p>	<p>Funds currently spent by individuals and households could be used instead to contribute to a single-payer system. However, an additional funding mechanism may be required to offset cost-sharing reductions or elimination and the increased use that would result from cost-sharing reduction or elimination.</p> <p>Some of these newly required funds may be offset if administration costs are lowered.</p>
<b>Employers</b>	
<p><b>Premiums.</b> Estimates indicate that about 16% of total California health care expenditures come from fully insured and self-insured employers' share of premiums.<sup>24</sup></p> <p><b>Employer-sponsored insurance (ESI) exclusion.</b> Premiums paid by employers are exempt from state, local, federal, and payroll taxes. Approximately 12% of total California health care expenditures come from this tax subsidy.</p> <p><b>Self-insured or self-funded ERISA plans.</b> There are approximately 3.3 million individuals in California who get their health insurance through self-funded/self-insured plans.<sup>25</sup> These plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA), which is administered by the US Department of Labor. They are exempt from state-specific health insurance regulations.</p>	<p>Coverage provided through employers is administered and negotiated between firms and their employees, and part of overall compensation arrangements. Changing those arrangements would require shifts in employee expectations. In some cases, such shifts could upend long-term, hard-won agreements between labor and management and might be subject to legal challenge.</p> <p>There is no current mechanism to divert federal tax subsidies to a state-based fund. Allowing employers to contribute to a state-based fund, instead of to their employees' premiums, would require Congressional action, including altering the tax code. Would this be feasible?</p> <p>As such, what amount, if any, would be expected to be contributed by employers to the cost of the single-payer system? Upon what equitable methodology would their assessments be based?</p> <p>The Department of Labor and the state of California must secure authority to redirect funds for ERISA plans. This includes a substantial amount of work, including federal statutory, regulatory, and administrative steps. Absent federal statutory changes, state efforts to alter elements of ERISA employer plans could be subject to court challenge.</p> <p>There may be legal ways for the state to assess all employers to fund the single-payer system, regardless of whether the employer also provides ESI. In this scenario, employers may have less incentive to offer health insurance because it would be at least partially duplicative of coverage through the single-payer system.</p>
<b>Federal, State, and Local Government</b>	
<p><b>MEDICARE</b> An estimated 20% of California health care expenditures are from the Medicare program.<sup>26</sup></p> <p><b>Payroll tax.</b> Employers and employees contribute to Medicare through payroll taxes. Nationwide, the federal government collected approximately \$253.5 billion in revenue from payroll taxes in 2015.<sup>27</sup></p> <p><b>Medicare premiums.</b> Medicare beneficiaries contribute monthly premiums. For example, in 2017 the standard Part B monthly premium is \$134. Premiums may vary depending on enrollment in Medicare Advantage plans, income levels, and eligibility.</p> <p><b>Medicare out-of-pocket expenditures.</b> Medicare charges deductibles and co-insurance. Actual out-of-pocket costs vary depending on enrollment in Medicare Advantage plans, income levels, and eligibility.</p>	<p>A single-payer system that includes the Medicare-eligible population would require redirection of Medicare Trust Fund dollars to a newly established California state fund, which would require Congressional action. There would be substantial hurdles that include federal statutory, regulatory, and administrative steps necessary for CMS and states to obtain the authority to redirect funds.</p> <p>Where CMS has current authority, states can work with CMS to request required permissions. Section 3201 of the ACA established the Innovation Center and allows the agency to test and scale "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care." This may allow California and partnering providers and/or payers to redirect a portion of current Medicare payments to encourage system improvements for a subset of population and services.</p> <p>Medicare expansion proposals would need to be directed at the federal level, since states do not have the authority to alter eligibility for Medicare.</p>



**Table 2. Health Care Financing Sources and Feasibility Questions, *continued***

CURRENT MECHANISMS FOR COLLECTING MONEY ALLOCATED TO HEALTH CARE	KEY ISSUES REGARDING FEASIBILITY
Federal, State, and Local Government, <i>continued</i>	
<p><b>MEDI-CAL AND HEALTHY FAMILIES</b></p> <p>Approximately 27% of California health care expenditures are spent on Medi-Cal and Healthy Families programs, which are both jointly funded via state and federal contributions.<sup>28</sup></p> <p>The 2017-18 governor’s budget proposed \$19.1 billion for Medi-Cal under the general funds. According to the Legislative Analyst’s Office, total Medi-Cal spending (for all funds, including federal) is estimated to reach \$102.6 billion in 2017-18. For families, children, seniors and persons with disabilities, and pregnant women, the federal share is 50%. The federal share for the expansion population (childless, low-income adults made eligible under the ACA) is 94.5% in 2017-18 and under current law will decrease to 90% by 2020-21.<sup>29</sup></p>	<p>California would continue to need federal financial participation to cover those presently eligible for Medi-Cal and Healthy Families.</p> <p>A single-payer system that includes the Medi-Cal population would likely need to isolate or separately account for Medi-Cal dollars to meet federal and state spending requirements (e.g., budget neutrality rules, federal medical assistance percentage [FMAP] requirements).</p> <p>A number of current federal proposals would affect the FMAP for the Medicaid expansion and/or the State Children’s Health Insurance Program (SCHIP) population, or affect federal spending (e.g., through block grants or other financing schemes). Reduced federal funding — or increased uncertainty about future federal commitments — would make it harder to ensure sufficient and sustainable funding at the state level.</p> <p>On an ongoing basis, funding for Medi-Cal would be at the discretion of the federal administration and Congress. Any state authorizations would be dependent on federal guarantees that may not be reliable into perpetuity. Thus California authorization would likely require protections (such as “poison pill” provisions that would de-effectuate state requirements) if federal funds do not materialize.</p> <p>Another related concern is whether California is left more isolated or vulnerable to federal action if it adopts a unique system — currently, California shares the same systems as other states, so it is difficult to harm this state’s system through policy measures without harming other states.</p>
<p><b>OTHER PROGRAMS</b></p> <p>Many other programs contribute to health care spending for California residents including:<sup>30</sup></p> <ul style="list-style-type: none"> <li>▶ Veterans Health Administration (VHA)</li> <li>▶ Indian Health Services</li> <li>▶ TriCare</li> <li>▶ Federal Employees Health Benefits program</li> <li>▶ Indirect medical education (IME) and disproportionate share hospital (DSH) adjustments<sup>31</sup></li> <li>▶ Subsidies for premium and cost sharing for eligible Covered California members</li> <li>▶ California Public Employees’ Retirement System, which covers about 1.4 million public employees, retirees, and their dependents<sup>32</sup></li> </ul>	<p>Each federally administered program imposes rules and constraints unique to its statutory and regulatory authority, funding sources, delivery system, and population. Whether and how readily funds could be redirected to state coffers is a key consideration.</p> <p>What mechanisms to divert state and local tax subsidies for premium payments (about 3% of the total) are needed?</p> <p>Coverage of all or almost all of the currently uninsured will reduce the amount of uncompensated care currently paid by or to health care providers. What are the effects of such reductions?</p>



raised above, there are potential barriers to allocating necessary funds for health care under the Gann Limits and Proposition 98 requirements. The Gann Limits were passed as Proposition 13 (1978) and Proposition 4 (1979). The limits amended the California Constitution to impose spending limits on the state and most local governments. The limits are intended to keep inflation- and population-adjusted appropriations to certain levels and revenues in excess of the limit are required to be rebated to taxpayers.<sup>33</sup> Proposition 98 (1988) amended the California Constitution to establish rules for calculating minimum annual funding levels for K-14 education (which includes community college). The rules and related formulas are complex, but essentially, they require approximately 40% of state general fund revenue to be allocated to schools and community colleges.<sup>34</sup> Thus, increases to the general fund (e.g., through taxation) or appropriations can trigger the Gann Limits or Proposition 98 requirements and limit the ability of the state to raise funds solely for health care spending.<sup>35</sup>

This review of health care financing sources and questions of feasibility yield the following takeaways:

- **State financing decisions cannot be made in a vacuum.** However, they must consider overall impacts to the state budget, distribution of dollars spent on health care versus other appropriated funds, and overall budget constraints.
- **The ability to integrate all or many financing sources and populations is one key to reaping some of the intended benefits of a single-payer system.** It may be difficult to achieve systemwide access and quality goals if a substantial portion of the population is excluded from the single-payer program. For example, the Medicare population accounts for 14% of the California population and is responsible for about 20% of total state health care spending — it may be difficult to see systemwide improvements if this population is excluded and program goals are not well aligned.<sup>36</sup>

- **Single-payer design notions that eliminate or reduce premiums and cost sharing would need to secure offsets.** This could be accomplished via increased tax revenue, lower payments to providers, or some other funding mechanism. Premiums and cost sharing account for a substantial portion of health care expenditures today. Eliminating cost sharing may improve access to care and consumer affordability, but could increase costs due to greater use of services and ultimately compromise long-term sustainability.
- **The ability to manage costs is predicated on a single risk pool that has the potential to centrally impose cost controls.** But if that pool is less than universal, market forces will limit its reach, potentially undermining the ability to address consumer affordability, at least for some consumer segments. For example, the employer-based market composes 45% of the California population. If those people and funds were excluded, the ability to advance goals of equity and affordability would be limited.

**TO SUM IT UP:** There is substantial uncertainty about California's ability to *collect sufficient dollars* to fund a single-payer system and its ability to *aggregate and direct funds currently devoted to health care* within the state.

States, unlike the federal government, cannot operate with a budget deficit. Therefore, the ability to ensure that revenue trends keep pace with health care cost trends is a fundamental concern for a state-based, single-payer program. Any external factor that reduces expected revenues in a given year, or increases unpredictability of revenues or costs, could jeopardize program sustainability.

# How Should a Single-Payer System Be Designed?

Establishing a single-payer system would require redesign of the state's current health care system along many lines. What follows is a discussion of several major design questions associated with a single-payer system:

- ▶ What role, if any, would insurers or other intermediaries play in managing care?
- ▶ How would health care services payments to providers be set and structured?
- ▶ Under what conditions would health care providers participate?
- ▶ Under what conditions would consumers participate?
- ▶ What benefits and services would be covered?
- ▶ How would the program's governance and administrative structure be designed?

Design choices too are best considered within the context of the intended goals of the single-payer effort.

## Purchasing Arrangement: Use of Intermediaries Versus Direct Purchase of Health Care

A single payer could arrange to purchase health care by paying providers directly, using intermediaries to pay providers, or a combination of the two design options. The two approaches differ in their potential to advance different goals.

Direct purchase of health care — allowing consumers to choose where they get care — is well aligned with goals of equity (defined as equal access, if not equal outcomes). It moves the state toward a level playing field in terms of access to care. A single payer directly arranging health care through a uniform method would reduce the variation in the source of coverage and provider payment methods. Direct purchase of care might also decrease administrative costs and inefficiencies associated with a multipayer system.

Using intermediaries to purchase health care, such as health insurance carriers or county-operated health systems, could help advance goals of systemwide efficiency, better quality, and long-term program sustainability. Presuming intermediaries possess the capabilities to pay providers based on performance, manage health care use and costs, and conduct population health management, they could impose quality standards and prioritize care whose effectiveness has been documented over care that does little to improve health outcomes.

Studies show that increased application of health care management techniques — such as utilization reviews, use of case managers, analytics to identify populations at risk for high health care costs — brings greater potential for improved performance of the health care system. For example, HMOs typically employ such health care management techniques to a greater extent than PPOs. In California, commercial HMOs frequently outperform commercial PPOs on clinical quality and cost measures across California's 19 geographic regions.<sup>37</sup> However, the key trade-off for having increased health care management is that patients typically have less choice at the point of service.

If health insurers and managed care plans were eliminated under a single-payer system, one set of questions follows. Would any of the current capabilities and functions of insurers and health plans be developed elsewhere — for example, in state government or through state contractors? If so, how would that affect the goals of efficiency and administrative simplification?

If intermediaries were permitted, a different set of issues and questions arises and must be considered in the context of policy goals:

- ▶ **What intermediaries would be permitted?** Would there be limits on the structure and organization of the intermediary? For example, would participation be limited to Knox-Keene licensed health plans or to nonprofit health plans? Could accountable care organizations or provider-led, risk-bearing entities participate? How about county-operated health systems that currently administer Medi-Cal programs? Allowing more and varied entities may further the goal of affordability through competition and choice, but it would run contrary to the goal of administrative efficiency by perpetuating a version of a multipayer system.

## Examples of Direct Purchasing and Use of Intermediaries

In California, the Medi-Cal program operates both fee-for-service (FFS) Medi-Cal and Medi-Cal Managed Care. Under the FFS program, health care providers are paid through Medi-Cal fiscal intermediaries.

Under Medi-Cal Managed Care, the California Department of Health Care Services (DHCS) contracts with managed care organizations to provide health care benefits to eligible enrollees. One unique aspect of California's Medi-Cal Managed Care program is that each county operates under one of six managed care models:

- ▶ A **County Organized Health System (COHS)** is a local agency created by a county board of supervisors to contract with DHCS to provide health care benefits to enrollees in the county. There are six COHSs operating in 22 counties.<sup>38</sup>
- ▶ Under the **Two-Plan Model**, DHCS contracts with two managed care plans to provide health care benefits to enrollees in the county. The managed care organizations may be either local initiative plans or "commercial" health plans. Local initiative plans are governed or initiated by county boards of supervisors and operated by a local managed care organization, whereas (in this context) a commercial health plan is a nongovernmental entity. This model is available in 14 counties.
- ▶ The **Geographic Managed Care model** is for eligible enrollees and is available in two counties. The managed care organizations are nongovernmental commercial entities.<sup>39</sup>
- ▶ Under the **Regional Model** and the **Imperial Model**, DHCS contracts with two health plans to cover enrollees in 18 (mostly rural) counties and Imperial County. Under the **San Benito model**, DHCS contracts with one plan, but also allows members to choose Medi-Cal FFS.<sup>40</sup>

In addition, it should be noted, nursing facility services are paid for on a per diem basis by DHCS, and substance use disorder services and most mental health services are administered by the counties.

The Medi-Cal program's intricate and complex infrastructure is centralized at the state level, but uses intermediaries including private, commercial entities as well as local agencies to administer services to about 13 million enrollees throughout the state.<sup>41</sup>

The Medicare program also employs both design options to pay eligible providers:

- ▶ **Medicare Part A** pays hospitals, skilled nursing facilities, and other facility providers on a fee-for-service basis. Part B is the medical insurance that pays physicians, durable medical equipment suppliers, mental health providers, ambulance services, and other eligible providers. To administer Parts A and B, the Centers for Medicare and Medicaid Services (CMS) contracts with Medicare administrative contractors (generally, private insurers) in 12 jurisdictions. These contractors conduct a host of functions such as fraud, waste, and abuse controls; provider enrollment; claims adjudication and processing; and local coverage determinations based on medical necessity. Even a design that envisions directly paying providers requires infrastructure to make correct payments to the right providers for covered services.
- ▶ **Medicare Advantage (or Part C)** more obviously uses intermediaries. CMS contracts with private health insurance companies to provide Parts A and B (and in most cases, the Part D drug benefit) to Medicare beneficiaries in a defined service area. Under Medicare Advantage, health insurers develop provider networks and pay those providers based on contractually agreed-upon arrangements. Health insurers also conduct a host of other functions such as rate setting, provider claims adjudicating and processing, marketing, member enrollment, member service functions, data analytics, network development, provider credentialing and contracting, and quality reporting, monitoring, and improvement.

Other nations with a single-payer system use two main arrangements. Some pay providers directly for covered health care services through an organized health care delivery system — which includes public and private providers. Examples include the United Kingdom, which pays providers through the National Health Service; Denmark, which has a centralized organization but regional administration; and Canada, which also regionally administers an insurance fund that pays providers directly. Other single-payer systems are best described as a public exchange in which private insurers participate in the exchange and contract with the central or regional government to arrange for and deliver covered benefits. Currently, France, Germany, and Israel illustrate variants on this approach — Germany has 118 competing insurers, while Israel has four.<sup>42</sup>

► **What would the role of the intermediaries be?**

Would they be passive third-party administrators that strictly process claims, or would they actively employ strategies for cost containment and population health management? The passive design option may further the goal of improving access, but greater use of both necessary and less-essential services could follow. A more passive role for intermediaries would likely accelerate health care cost trends rather than slowing them.

## Payment Adequacy and Methodology

Depending on payment design and structure, a centrally managed system can impose cost discipline. Adequacy of payments to providers is necessary to ensure provider participation and, ultimately, to achieve the goal of access to care. For example, payments could be tied to existing schedules such as Medi-Cal rates or Medicare fee schedules, or set through another mechanism. It is often pointed out that Medi-Cal provider reimbursement rates, as a percentage of the Medicare rates, are one of the lowest in the country.<sup>43</sup> The adequacy of payment rates in covering costs to deliver services and attracting an appropriate workforce should be considered.

Establishing a clear payment methodology with appropriate controls and oversight is necessary to minimize fraud and abuse. Payment methods can also be used to encourage efficiency and value in the system. For example, pure fee-for-service payment methods are known to reward volume, and there has been a movement in recent years to move to value-based payments.<sup>44</sup> Tying payments to value, rather than just volume, can help encourage providers to behave more efficiently.

Broadly speaking, payment design options, and the questions that should be asked of them, include:

- **Retrospective payments under FFS.** On what basis will payments be made? For example, will Medicare fee schedules be adopted? What will be the base payment rate, and what adjustment will be made based on regional input cost variation, morbidity, and other factors? How will payments be adjusted to reflect changes in technology, to encourage innovation, or to reward outcomes?

► **Prospective payments to intermediaries that can manage risk.** If prospective payments will be made

on a capitated basis, what services will be included in the capitated per member per month payment from the single payer to the intermediary? What services may be excluded from the capitated rate and made as a pass-through payment to providers (if any)? Will intermediaries have flexibility to engage in a variety of payment arrangements to meet the goals of provider participation (and access to care) and efficiency? For example, can payments from managed care organizations be made to contracting providers on a subcapitated basis, or can they use value-based payments? Will payment levels vary depending on whether a single administrator is used or if multiple (third-party) administrators are used?

Systems to update payments based on clear, sound methods that are driven by the need to maintain payment adequacy (rather than political pressures) are important to meet goals of transparency and efficiency. For example, Medicare has mechanisms available to redistribute payments *within* a prospective payment system. These are necessary to correct adverse risk selection, address disproportionate profits associated with particular procedures, and limit inequity among providers.<sup>45</sup>

California has strong integrated delivery systems in certain regions. The structure of payments, as well as other design decisions, could result in the unraveling of integrated systems (and the health information technology systems that support them), with undesirable implications for quality and efficiency.

There are also second-order effects related to payment policy. For example, coverage of all or almost all of the currently uninsured will reduce the amount of uncompensated care. This may reduce disproportionate share hospital (DSH) payments or alter payment rates to Federally Qualified Health Centers related to services for the indigent or uninsured.

Both the level and structure of provider payments have far-reaching implications for consumer access as well as for total health care costs and rates of increase. They may also affect comprehensiveness of coverage, quality of care, and administrative spending. Ultimately, they will play a central role in the long-term fiscal sustainability of any single-payer plan.

## Provider Participation

In a true single-payer model with no other payers, all or nearly all health care providers who are board certified and state licensed would have to participate out of financial necessity. Nonparticipation or exclusion would severely limit a provider's business model. Assuming direct pay continued to be permitted, providers excluded from the single-payer system would only be able to generate revenue from those individuals or entities willing and able to pay out of pocket.

If there is more than one payer (e.g., if the Medicare program remains separate), then a key design issue relates to provider participation. Would any board-certified and licensed provider be permitted to participate, or would there be additional conditions of participation, provider enrollment, or certification? If so, would the single-payer administering entity develop its own set of standards and requirements or adopt Medi-Cal's or Medicare's? What regular quality assurance and monitoring programs, including data collection and reporting, would be implemented to ensure accountability and adherence to quality of care standards? Would high-performing health systems be rewarded and would other health systems be offered incentives to improve performance? Each of these questions links to single-payer system goals. Provider participation can hamper or improve access, and it can hamper or improve transparency, accountability, and quality of care.

Reimbursement levels will be a key factor in provider participation. Lower provider reimbursement rates may result in physicians and other health care professionals leaving California for states with better rates. Lower earning potential may also affect the workforce pipeline, as young people may choose to pursue more lucrative professions. On the other hand, a single-payer system may present opportunities to redesign the workflow, allowing health care professionals to spend less time on administrative functions and more time with patients. Reports of physician burnout resulting from "increased clerical burden," is a public health concern.<sup>46</sup> If a single-payer system can reduce the administrative burden for providers, increased physician satisfaction and retention may be a potential benefit.

## Consumer Participation: Eligibility and Enrollment

Approximately 91% of Californians have health insurance coverage; the remaining uninsured population includes adult unauthorized immigrants and individuals who opt not to purchase insurance, including those who find cost or enrollment processes a barrier. If the state's goal is to ensure that all Californians are covered under a *single* payer, then major disruption in the system is inevitable. Transitioning individuals who have health insurance to another coverage is inherently disruptive and politically challenging. Recall the federal government's decision to allow individuals to keep their non-ACA-compliant health plans during the transition years of ACA implementation to honor the promise "if you like your plan, you can keep your plan."<sup>47</sup>

First, the population that is included in the single-payer program must be defined. Next, consider what it means to be included in the system: What rights and obligations does the inclusion impose on consumers? If all residents are included, how is residency defined and what parameters are required to establish residency? Will temporary residents and visitors be covered? Can a state impose durational residency requirements to be eligible for state benefits under "right to travel" laws and legal precedents?<sup>48</sup> If not, then eligibility standards requiring a minimum length of stay could not be enforced, potentially leading to gaming of the system by out-of-state individuals who move into California for expensive health care procedures and then leave. Are additional premiums or penalties assessed on individuals (or their employers) who live in the state but work out of state? Is access to the program permitted for people who live out of state, but work in California?

A universal, single-payer system presumes mandatory participation, with revenues assessed across the entire population and coverage similarly widely available. Such an approach would establish a large risk pool and help minimize adverse selection. However, it introduces a level of compulsion that is not aligned with the Affordable Care Act's tax penalties intended to encourage (but not absolutely mandate) enrollment. How would a state single-payer system enforce participation, and how would such enforcement mechanisms interact with existing tax penalties? Would anyone be allowed to opt out of the state program, and if so, under what circumstances?



Design choices regarding the covered population link to goals regarding universality, access, and consumer affordability. They may also affect program sustainability and the rate of total health spending.

## Covered Benefits and Services

The benefits and services covered under a single-payer system affect access to care, comprehensiveness of coverage, and consumer affordability. The more benefits covered, the greater the financial risk for the payer. Covered benefits will affect use of services, which in turn impacts health care cost trends, ultimately affecting health care costs and affordability. On the other hand, not covering specific benefits may hinder certain populations' access to specific treatments or services.

For years, even prior to the ACA, core health benefits were well established: inpatient services, outpatient care, doctor office visits, and emergency services. However, there was still variation in covered benefits across programs and market segments. For example, Medicare coverage of prescription drugs was not authorized until 2003 under the Medicare Prescription Drug, Improvement, and Modernization Act. In California, prior to the passage of the ACA, health insurance policies sold

to individuals did not necessarily cover maternity benefits. Despite enactment of mental health parity laws, mental health coverage for conditions other than "serious mental illness" and substance abuse services were not explicitly mandated to be covered until passage of the ACA.

Currently, certain benefits are covered under Medi-Cal but not by other payers: adult dental, eyeglasses for children, and long-term services and supports (LTSS). If a "Medi-Cal-for-all" version of a single-payer system is considered, then would these benefits — traditionally excluded by other payers — be covered? Lifetime LTSS costs are estimated to be on average \$138,000 for someone turning 65 (in 2016), with 15% of 65-year-olds incurring \$250,000 or more in future LTSS.<sup>49</sup> However, a costly health care event requiring long-term care can deplete retirement assets for middle-income households.<sup>50</sup> LTSS is an extreme example of the trade-offs that must be made in determining an *affordable* set of benefits while ensuring access to a minimum set of benefits and protecting consumers.

To illustrate variations in covered benefits by market, Table 3 provides an overview of covered benefits under the ACA, Medi-Cal, and Medicare.

**Table 3. Overview of Covered Benefits Under the ACA, Medi-Cal, and Medicare**

ESSENTIAL HEALTH BENEFITS (EHBs) UNDER THE ACA	MEDI-CAL	MEDICARE
<ul style="list-style-type: none"> <li>▶ Ambulatory patient services</li> <li>▶ Emergency services</li> <li>▶ Hospitalization</li> <li>▶ Maternity and newborn care</li> <li>▶ Mental health and substance use disorder services, including behavioral health treatment</li> <li>▶ Prescription drugs</li> <li>▶ Rehabilitative and habilitative services and devices</li> <li>▶ Laboratory services</li> <li>▶ Preventive and wellness services and chronic disease management</li> <li>▶ Pediatric services, including oral and vision care</li> </ul>	<ul style="list-style-type: none"> <li>▶ Includes all EHBs</li> <li>▶ Adult dental</li> <li>▶ Vision <ul style="list-style-type: none"> <li>▶ Routine eye exam</li> <li>▶ Eyeglasses for eligible individuals under 21 and pregnant women through postpartum</li> </ul> </li> <li>▶ Long-term services and supports <ul style="list-style-type: none"> <li>▶ Skilled nursing facility services (91+ days)</li> <li>▶ Personal care services</li> <li>▶ Self-directed personal assistance services</li> <li>▶ Community first choice option</li> <li>▶ Home- and community-based services</li> </ul> </li> </ul>	<p><b>Part A.</b> Inpatient hospital care, skilled nursing facility (up to 100 days), hospice, lab tests, surgery, home and hospice health care.</p> <p><b>Part B.</b> Doctor's office visits, preventive services, outpatient care, durable medical equipment, home health care.</p> <p><b>Part C (Medicare Advantage).</b> All of the above Parts A and B benefits. Other benefits may be offered by Medicare Advantage and Part D plans.</p> <p><b>Part D.</b> Prescription drugs.</p>
Additional benefits mandated under California law for Knox-Keene licensed plans and under the Insurance Code <sup>51</sup>	For Medi-Cal Managed Care plans, additional benefits mandated for Knox-Keene licensed plans	



The first question that must be answered: Which services are covered? The next set of questions involves design of the benefit package and its structure, including the cost-sharing requirements, benefit limitations, and exclusions. Cost sharing is an important design question that directly affects the affordability at the point of service. Coverage with high or unaffordable patient cost-sharing levels may cause enrollees to forego necessary care. For drugs, medical supplies, and devices, would formularies —different levels of cost sharing depending on the efficacy and/or cost of the treatment — be adopted? Would cost-sharing levels be standard for everyone or vary based upon household income? Once benefits are defined, processes to determine coverage would need to be established. For example, would certain low-value services — for which the efficacy has not been widely demonstrated, such as surgery for low back pain — require medical review or precertification? Would certain specialized or high-cost services be limited to people with demonstrated need? If so, what would be the process for authorizing that coverage? What recourse would be in place for consumers to appeal denials?

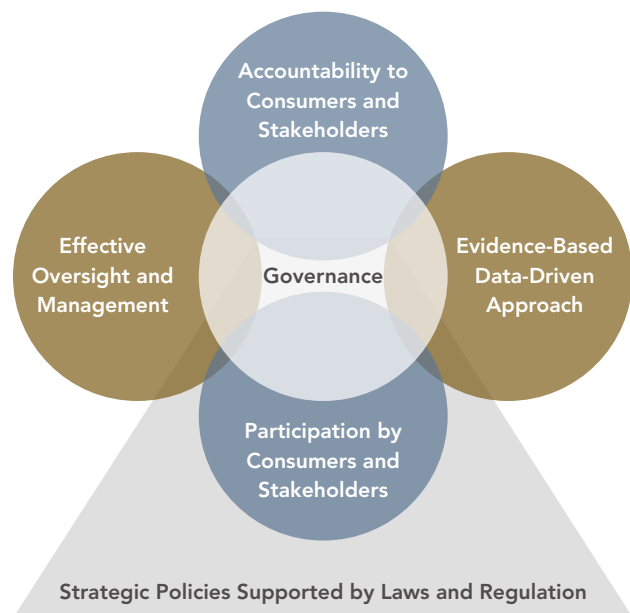
If a set of minimum benefits is established, how would noncovered services be accessed? If only some consumers can afford to pay directly for services beyond the minimum, equity goals will be undermined. Would supplemental insurance policies be permitted in the market, similar to Medigap policies for beneficiaries with Medicare Parts A and B?

Covered benefits and cost-sharing arrangements have far-ranging implications for access, consumer affordability, overall health care spending, and equity. A single-payer system would bring these design decisions into sharper focus, but does not offer easy answers to them.

## Governance and Administration

The success of health care programs is dependent on sound governance. A sound governance model promotes accountability, effective oversight and management, and an evidence-based and data-driven approach, all the while encouraging consumer and stakeholder participation. Governance activity is grounded upon a strategic policy direction supported by laws and regulations. Figure 2 provides a visual representation of this sound governance framework.

**Figure 2. Governance Framework**



Source: Milliman, Inc.

Several questions pertaining to governance influence the potential impact and effectiveness of a single-payer approach:

### ► What is the governance structure?

- Will the program be governed by a board with appointed members representing various interests (including consumers or patients)? Or will it be administered by a state agency under the governor or another elected or appointed official? Or will it be a quasi-public entity? A hybrid model using a board with advisory rather than governance functions is another approach.
- What is the relationship of the governing body to the legislature, the governor, and other applicable state agencies?
- In the case of a board, what are criteria for board member participation, what is the selection or election process, and what are the term limits? What overall charge, scope, and bylaws define the board's work?

► **How will key policy and program implementation decisions be made?**

- What processes and systems will be put into place to promote transparency? For example, what opportunities will consumers and stakeholders have to provide input on benefit design? What data and expert input will be used to balance stakeholder interests with the need for fiscal responsibility and program sustainability?
- What mechanisms will be used to revisit and update decisions affecting payment, benefit coverage, provider participation, and program integrity? Following initial implementation, program performance and shifts in the environment are certain to require adjustments and updates along one or all of these dimensions. Actions may be required by the state legislature (if the single-payer fund were tied to the state budget), the administering agencies, as well as other bodies involved in administering or overseeing aspects of the single-payer system. For example:
  - Payment *policy* changes (e.g., changing the basis or adjustment factors on which payment is made) that can affect provider supply and access to care would require careful and independent analysis. Would such work be conducted by the administering agency or through a separate independent body (e.g., a commission)?
  - Determining whether new technologies ought to be covered should be based on independent analysis of their medical effectiveness, cost-effectiveness, public health and societal benefits, and impact to the fund. Who would conduct these analyses and how would their recommendations be considered by the governing/decisionmaking entity? How would tensions between expanded access, cost-effectiveness, and fiscal sustainability be reconciled?

A centralized administrative entity must have the requisite capabilities to pay providers, manage health care use and costs, and conduct population health management if it is to advance the goals of greater efficiency, better quality, and greater long-term program sustainability. Table 4 (see page 23) provides a high-level summary of capabilities and functional requirements of a single-payer administrator or its contractor(s). Functional requirements would be dependent on actual design elements. For

example, there may be less of a need for marketing if enrollment were entirely compulsory.

Ultimately, a centralized health care system, financed by public dollars, must be accountable to taxpayers and consumers. Unless safeguards and oversight are incorporated into design, the governing and administrative body(ies) can be threatened by special interest capture, especially by provider groups, hospitals, drug companies, or other players with a vested interest in increasing health care payments.

Governance and administration can promote or hamper efforts to create efficiencies, encourage innovation, and ensure accountability and program sustainability. Each related design decision — from the big picture (e.g., decisions regarding centralizing or decentralizing functions) to the granular (e.g., decisions regarding term limits of a governing board) — involves trade-offs.

**TO SUM IT UP:** Myriad design choices have far-reaching consequences for a single-payer system's viability and for its impact on consumers, health care providers, intermediaries, and other stakeholders. Design decisions are best considered within the context of the single-payer program's overarching goals and priorities.

## What Tensions and Trade-Offs Would Arise?

If California reaches a consensus about *why* a single-payer approach addresses its policy goals, decides to proceed, and determines *how* the new single-payer program should function, it will then face the task of managing a transition from the status quo to a substantially different system for financing, delivering, and obtaining health care. Above and beyond the trade-offs that derive from competing policy goals, implementing a single-payer system in California would surface additional questions regarding timing and priorities. Some likely tensions associated with navigating the transition are presented below.

**Disruption and potential losses.** A universal single-payer system envisions a future state in which all Californians have access to a full array of services and benefits. Today, there is considerable variation among groups depending on the programs through which they obtain coverage

**Table 4. Summary of Capabilities and Functional Requirements of a Single-Payer Administrator**

<b>Payments</b>	<ul style="list-style-type: none"> <li>▶ Retrospective claims processing or prospective per member per month payment</li> <li>▶ Risk adjustment to account for variation in health status</li> </ul>	<ul style="list-style-type: none"> <li>▶ Adjudication or reconciliation</li> <li>▶ Controls for fraud and abuse</li> <li>▶ Technical assistance, auditing, and training</li> </ul>
<b>Actuarial, Accounting, Finance, and Budget Support</b>	<ul style="list-style-type: none"> <li>▶ Actuarial analysis</li> <li>▶ Accounting, finance, and single-payer fund management</li> <li>▶ Legal/compliance</li> </ul>	<ul style="list-style-type: none"> <li>▶ Investments</li> <li>▶ Annual budgeting support to appropriate state agencies</li> </ul>
<b>Marketing and Enrollment</b>	<ul style="list-style-type: none"> <li>▶ Market research</li> <li>▶ Benefit and plan design (if variation is permitted)</li> <li>▶ Risk assessments</li> <li>▶ Eligibility verification</li> </ul>	<ul style="list-style-type: none"> <li>▶ Marketing (including advertising)</li> <li>▶ Relations/agreements with brokers, navigators, and local and community-based organizations</li> <li>▶ Enrollment</li> <li>▶ Cultural and language competencies</li> </ul>
<b>Member Services</b>	<ul style="list-style-type: none"> <li>▶ Customer service and satisfaction</li> <li>▶ Call centers</li> <li>▶ Self-service digital health tools</li> <li>▶ Member communications</li> </ul>	<ul style="list-style-type: none"> <li>▶ Cultural and language competencies</li> <li>▶ Member appeals and grievances</li> <li>▶ Patient services such as eligibility and benefit verification, appointment scheduling, billing and collections</li> </ul>
<b>Contractor Relations</b>	<ul style="list-style-type: none"> <li>▶ Procurement (e.g., bid process, including rate review and approvals for managed care organizations, if any)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Contract enforcement, oversight, and monitoring</li> </ul>
<b>Provider and Medical Management</b>	<ul style="list-style-type: none"> <li>▶ Provider credentialing/contracting</li> <li>▶ Provider relations</li> <li>▶ Pharmacy benefit management</li> <li>▶ Provider access and quality reporting, monitoring, and improvement</li> </ul>	<ul style="list-style-type: none"> <li>▶ Utilization management / medical management / care coordination</li> <li>▶ Telemedicine management</li> <li>▶ Benefit, coverage, and medical necessity determinations</li> </ul>
<b>Population Health Analytics and IT</b>	<ul style="list-style-type: none"> <li>▶ Encounter data collection and analysis</li> <li>▶ Evaluations of interventions</li> <li>▶ Health information exchange</li> </ul>	<ul style="list-style-type: none"> <li>▶ Information technology support and capacity development (e.g., digital health tools for providers and members)</li> </ul>
<b>Government and Public Relations</b>	<ul style="list-style-type: none"> <li>▶ Legislature and governing body(ies) reporting and support</li> </ul>	<ul style="list-style-type: none"> <li>▶ Public reporting and feedback (e.g., town halls, public sessions of board meetings, etc.)</li> </ul>

and those programs' funding streams. Compared to the status quo, the majority of Californians would experience disruption and real or perceived losses. Should some groups, markets, or programs be exempt from the new system? If so, who should be exempt and for how long? Should changes in coverage arrangements be phased in over time?

**Special population needs.** Improving access to coverage is a step toward better outcomes but does not ensure more equitable health outcomes. Today many targeted programs aim to address special needs of sub-populations.<sup>52</sup> How can a single-payer system preserve and expand efforts to address special needs and disparities while simplifying payments and leveling access to care? What population-specific competencies and activities should be preserved, and how?

**Provider and program diversity.** California's health care system is diverse, with strengths and weaknesses that vary among providers and programs. How can a single-payer system in California preserve the positive aspects of today's system (for example, unique features of the safety net, strengths of integrated health care, payment and delivery system innovation) while increasing efficiency and addressing equity concerns?

**Regional variation.** How would a single-payer system balance centralized, statewide oversight versus an approach that allows regional variation and customization to address local conditions or preferences? "Smaller organizations, properly structured and steered, are inherently more agile and accountable than are larger organizations," according to the World Health Organization.<sup>53</sup> However, it can be easier to address equity concerns, systematically introduce new technologies, and reduce administrative redundancies in a centrally administered system.

**Governance and oversight.** Today's diverse coverage arrangements are subject to different types of governance and oversight, with accompanying strengths and weaknesses. For example, Covered California conducts business in open meetings and invites extensive public input; privately held health plans do not. Private, publicly traded, for-profit plans are accountable to

shareholders for meeting financial targets; the Medi-Cal program is subject to multiple levels of federal and state oversight and control, making it sometimes difficult to assign accountability for performance. How would the single-payer program monitor outcomes and assign responsibility to decide when and how to adjust course?

**Technical expertise and nimbleness.** Implementation of large-scale health care system changes requires technical expertise and careful monitoring. Recent experience with the ACA implementation demonstrates that key decisions must often be made with limited data, carefully balanced with the need for political and stakeholder support. How well-positioned would a single-payer system be to adjust and recalibrate expectations based on rapid cycle evaluations, available data, and input from stakeholders on the front lines?

**Spending priorities.** Status quo health care spending priorities emphasize medical care and acute needs over preventive care, population health, and social supports that play a critical role in improving health. Pooling funds under a single payer offers new flexibility to revisit spending priorities, but the extent and way in which investments might shift is highly dependent on the program's goals, governance, and reward structure. How would the single-payer system ensure robust financing for today's medical needs, yet invest appropriately in social determinants of health and preventive care to improve outcomes and reduce health service utilization in the future? How would it use data and evidence to ensure resources are allocated where they are most effective?

**TO SUM IT UP:** Moving from the status quo to a single-payer system will take time. Striking a balance between statewide uniformity and local or population-specific variation will require careful consideration at the onset. It will be important to monitor progress and adjust implementation actions accordingly.

## Next Steps

California's health care system is complex, with a variety of features and shortcomings that affect various populations and stakeholders differently. Meaningful improvement will require significant shifts in health care finance and delivery. Such changes are more likely to be embraced if broad consensus regarding goals has been achieved. Furthermore, implementation of any significant change is more likely to be successful if stakeholders acknowledge and plan for the inherent challenges and trade-offs they will encounter.

Efforts to improve California's health care system should begin by establishing principles to guide the development of solutions. A threshold question, given today's reliance on federal funding and federal permissions, involves the extent to which California could gain access to resources currently controlled by the federal government. If that central feasibility challenge can be met, a serious review of potential system goals — universality; equity; affordability; improved access, quality, and efficiency; and greater transparency and accountability — can follow. It may be possible to endorse all these outcomes to a degree, but resource constraints and tensions among goals make it likely that some will become “must have” and others “nice to have.” Clarity on core values and priorities will help solidify support and keep implementation on track, if and when a major policy change is adopted.

If multiple goals and outcomes are pursued, as seems likely given the reach and complexity of the health care system, it will be important to establish priorities and actions in the immediate term, short term, and longer term. It may be desirable to develop a road map that articulates the final destination while distinguishing between steps within immediate reach and those that will require a longer planning or implementation horizon. Doing so would help to prioritize policy actions, without capitulating on important actions that might prove more disruptive or for which there is less short-term political appetite.

When a single-payer proposal — or any broad health reform policy proposal — is under consideration, a systematic evaluation of feasibility and impact can help guide design and implementation. See box on page 26 for an initial set of questions.

California has led the way in expanding coverage and implementing other reforms under the Affordable Care Act. Progress has been substantial, yet the health care needs of many Californians still are not well served by our current system. What next steps are most likely to achieve the promise of excellent health care for all Californians? A clear, shared set of goals and a structured process for evaluating options will help clarify the potential of the proposal for a single-payer system, or any sweeping health reform proposal, to fulfill the state's needs and aspirations.

## Evaluation Questions

### Feasibility

- ▶ What is the likelihood of feasibility from a federal perspective? What is the likelihood of federal approvals?
- ▶ What is feasible from a state perspective? How likely is it that ballot initiatives and legislative action will be required, and on what timeline? What new state administration roles and functions are required, and how much time will it take to establish those?

### Financing

- ▶ What is the projected\* tax revenue needed to fund the program annually? What revenues are needed in total, for benefit categories, and on a per enrollee basis? What is the impact on the federal contribution to health spending in California?
- ▶ What is the projected impact on health expenditures in total, for benefit categories (e.g., inpatient care), and on a per enrollee basis?
- ▶ What are the projected impacts on administrative costs?
- ▶ Is the structure furthering the goals of equity in finance? Is the financing adequate? Is the financing sustainable?
- ▶ What are the incentives implicit in the financing mechanism? Will it promote value in the health care system?

### Coverage, Access, Equity, and Affordability

- ▶ What is the projected impact on health insurance coverage? For example, who would gain access to health insurance?
- ▶ Is there a potential for reduction in health insurance coverage in certain markets; for example, if coverage becomes unaffordable?
- ▶ What is the projected “disruption” in the market? For example, who would lose their current coverage and be required to switch plans?
- ▶ What is the projected impact on access to primary care, specialty care, or specific benefits (e.g., behavioral health)? What is the impact on “congestion,” measured by the difference in provider availability and consumer demand?
- ▶ What is the projected impact on affordability measured by out-of-pocket costs as a proportion of income? This would include premiums and cost sharing for covered benefits if those features are part of the single-payer design.

### Quality, Cost, and Efficiency of Care

- ▶ What is the potential impact on safety and quality of care?
- ▶ Does the policy option promote value in health care?
- ▶ Does the policy option have effective cost and utilization controls?
- ▶ Does the policy option encourage the development and adoption of systems, processes, and enabling technology to promote care coordination, integration, and patient-centered care?

### Administrative Costs

- ▶ What are the start-up or transitional costs associated with establishing the administrative and governance infrastructure of a publicly organized system? For example, the costs associated with ensuring the system has the needed capabilities, people, processes, and systems.
- ▶ What are the ongoing administrative and governance costs for operationalizing a publicly organized system?

### Transparency and Accountability

- ▶ Does the policy option promote transparency and accountability to taxpayers and consumers?
- ▶ Does the policy option promote appropriate engagement by stakeholders?
- ▶ Does the governance and administrative structure allow for data-driven, evidence-based policy development and implementation decisions?
- ▶ Does the governance and administrative structure have appropriate checks and balances to minimize the risk of regulatory capture?

### Socioeconomic Downstream Effects

- ▶ What are the socioeconomic repercussions that may result from an efficient and lower-cost single-payer system?
- ▶ What are the potential effects on the medical professional workforce and the health care industry labor market in the short term? What are the potential effects on the workforce pipeline?
- ▶ If dollars that were previously spent on health care services are reallocated to other sectors, such as social services, what are the potential downstream effects of that spending, including on overall population health?

\*Projections should account for variability based on optimistic and pessimistic assumptions, to allow the state to plan for mitigation strategies.



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