

Healthy California for All Commission Releases Report on Strategies to Implement Unified Financing Single-Payer System

The Healthy California for All Commission, established in 2019 through Senate Bill 104, was created to advance efforts towards a health care system that delivers affordable, equitable, accessible, high quality health care for all Californians through a unified financing system. Two of the Commission recommendations have already been implemented this year. First, with the expansion of [Medi-Cal eligibility](#) to all adults between the ages of 26-49 regardless of immigration status, all California residents are now eligible for the full scope of Medi-Cal benefits. Second, the state passed legislation that established the [Office of Health Care Affordability](#), providing the framework to control rising healthcare prices through cost growth benchmarks for health care entities. Next up on the Commission's agenda is the proposal to implement single-payer unified financing (UF), which the report asserted would lower health care expenditures in the aggregate as soon as the first year of implementation, creating a more efficient, affordable, and equitable health care delivery system.

In April 2022, the Commission issued its report, ["Key Design Considerations for a Unified Health Care Financing System."](#) Recognizing that transitioning to UF would require a "complete overhaul of existing health financing and coverage arrangements," the Commission identified various elements for which design decisions would be required: (1) eligibility and enrollment; (2) covered benefits and services; (3) patient cost-sharing (if any); (4) provider payment; (5) purchasing arrangements and role, if any, for intermediaries; (6) care coordination; and (7) greater efficiency and cost containment. The Commission recommended coverage for all Californians and presumed in its analyses that all Californians would be eligible for comprehensive services, including vision and dental.

Cost and Savings of Single-Payer System

The report projected that, under the current health care system, health care spending would increase by approximately “\$58 billion (in 2022 dollars) over nine years, representing an increase of approximately 30% over baseline spending,” while leaving many Californians with no or inadequate benefits. To assess the potential savings through UF, the Commission considered three elements of a single payer system in various combinations and the projected cost savings under each approach: 1) payment delivery options, 2) cost-sharing options, and 3) long-term service and supports options.

- *Payment delivery options*

The payment models evaluated were either direct payments to providers or payments to health plans or health systems. In the direct payment system, payment would be made from UF authority to hospitals, physicians, and other care providers directly and anyone could seek care from any provider, similar to Canada’s health care system. The other option considered was payment through an intermediary. In this scenario, patients would be required to enroll in a health plan or health system and receive services from providers in that plan/system, and UF authority would issue payments to the health plan or health system, similar to the systems in Germany and the Netherlands. Though the advantages and disadvantages of each were discussed, no consensus was reached as to which method would be the preferred payment option.

- *Cost-sharing options:*

The Commission also assessed the impact of implementing cost-sharing. One option was to eliminate cost-sharing altogether, while the other was to maintain a sliding scale of cost sharing requirements, ranging from no contribution to medical expenses for families with incomes below 138% of the federal poverty line (FPL) to 15% contribution for families with incomes above 400% of FPL. The Commissioners did not reach consensus as to which option would be better suited to achieve UF goals.

- LTSS options

Also considered was the inclusion of long-term services and supports (LTSS) and whether coverage should be expanded for these services or continue as currently provided through Medi-Cal. The Commissioners strongly supported the inclusion of expanded coverage for LTSS services in UF to achieve equity, access, and quality of care.

Through a comprehensive analysis, using the assumption of 2022 implementation to illustrate the calculations, different combinations of the above element options were assessed to compare impacts on cost in year 1. According to the analysis, the most savings would be realized through the combination of direct payment, sliding scale cost-sharing, and no LTSS expansion, which would yield a 7% or \$35 billion reduction in baseline spending. A close second in savings was through the combination of intermediary payments, cost sharing, and no LTSS expansion, which is projected to save 6% or \$31 billion in spending. The next highest savings was 3% reduction with direct payment, no cost sharing, and no LTSS expansion. The combination of direct payment with cost sharing and LTSS expansion reduced baseline costs by 2%, as did intermediary payment with no cost sharing and no LTSS expansion. On the other end of the spectrum, while the Commissioners strongly supported the expansion of LTSS, adopting that option along with no cost sharing under either payment options would increase baseline expenditures by 10-15%.

The Commission also assessed the potential impacts of each combination on utilization and efficiencies. The Commission predicted an increase in health care utilizations that would result from coverage for all Californians, the broad range of services provided, and the reduction or elimination of copayments. In addition, the report projected an increase in costs associated with the transition to the new system and the creation of a reserve fund to provide financial stability for the system. However, the Commission determined those increased costs would be offset by the savings realized from reduced administrative costs of health plans and insurers, reduced billing and insurance-related costs.

Financing the Single-Payer System

The Commission recognized that the adoption of the UF would not reduce health care costs in the absence of ensuring stable and sufficient revenue sources and controlling costs. California took a major step towards controlling health care costs with the establishment of the Office of Health Care Affordability in June 2022. But with \$222 billion (in 2022 dollars) currently spent on health care through premiums paid by employers and households, workers' compensation, out-of-pocket payments, and other sources, this shortfall must be replaced with other revenue sources. Further, the amount required will be dictated by which of the above models is implemented.

1. Non-federal Funding

The Commission examined the pros and cons of various options for replacing this revenue, including a payroll tax (as substitution for the current job-based coverage), gross receipts tax, extending sales tax, or increasing personal income tax, including the possibility of combining tax sources, with a cautionary note to avoid combining options that tax the same base. However, because the California State Constitution and other state laws limit the legislature's ability to raise taxes and channel the funds raised exclusively to health coverage or health spending, voter approval would be required to amend the relevant provisions to finance UF in this way.

2. Federal Funding

- *Waiver Authority*

The long-term financial viability of UF will also be dependent upon the continuation of federal funding as well as the rate of growth of federal payments. The Commission's cost savings assessment is contingent upon maintaining the current federal funding level. It is unclear if the existing Medicare, Medicaid, and Affordable Care Act (ACA) waiver authority could be used to access federal funding to support UF, or if changes need to be made in federal law to make federal funding available.

Section 1332 of the ACA allows states to apply to the Department of Health and Human Services (HHS) for waivers to implement innovative strategies to provide high quality, affordable health insurance, provided it retains basic ACA protections. Section 1115 of the Social Security Act (SSA) authorizes HHS to approve

experimental, pilot or demonstration projects that promote Medicaid objectives and waive certain provisions of the Medicaid law to provide states with the flexibility to implement innovative programs. Section 1115A of SSA gives HHS authority to allow states to test and evaluate innovative payment and service delivery models, provided the proposed models are likely to improve quality of care, reduce spending, and maintain guaranteed benefits.

The Commission engaged a law firm to examine these issues. The legal analysis determined that there is no single waiver authority that would allow the redirection of Medicare, Medicaid (Medi-Cal) and Affordable Care Act (ACA) funding to UF, as each funding stream is subject to different authorities. Although it may be possible to redirect funding from these sources through the separate controlling authorities, it is likely to be a complicated endeavor with regard to logistics, reporting, and politics. The enactment of a new federal waiver authority, which would allow states to access federal funds from existing programs to provide comprehensive health care coverage, would alleviate the need for multiple waivers from different authorities. However, there would likely be substantial opposition to changing Medicare, making a proposal for new federal waiver authority unlikely to succeed. Additionally, UF would require more than ensuring federal permission to redirect existing funds from Medicare, Medicaid, and ACA advance premium tax credits. The federal government would need to commit to a sufficient level of growth of federal funding. Because of the complexity and uncertainty of all these factors, the Commissioners agreed that the best path forward would be to pursue a “partially-unified” system that does not include Medicare in its initial iteration.

The Commission suggested engaging the Secretary of HHS to clarify funding opportunities through existing waivers and work with federal partners to explore new legislation for federal waiver authority. Further, the Commission anticipated that the federal government would require assurances that the health care coverage and protections afforded to Californians through UF would be at least as comprehensive as, if not better than, those afforded by Medi-Cal, Medicare, and ACA subsidies. In the report, the Commission recommended that the California Department of Health and Human Services establish a task force to engage federal partners in assessing options with the federal government and develop a detailed proposal for UF that addresses eligibility and enrollment, scope of benefits, cost

sharing and payments to providers, and accountability.

- ERISA Preemption

Another consideration that arises with UF is its interplay with the Employment Retirement Income Security Act (ERISA), which establishes minimum standards for employer-provided pension and health benefits included in employee compensation packages. Employers offering health benefits can either outsource their group health plan to a third-party health insurer or self-fund their employee health care costs. Because ERISA preempts “any and all” state laws that “relate to” any benefit plan covered by ERISA, and UF eliminates employer-based health care coverage, UF would be incompatible with ERISA. Unlike Medicaid, Medicare, and ACA, ERISA does not contain any waiver provisions as workarounds.

To create a pathway around ERISA preemption, the report suggested several congressional amendments to “clear the way for state-level unified financing,” namely 1) replace the “any and all” ERISA preemption with floor preemption used in other health statutes; 2) eliminate the ERISA “deemer clause”, which prohibits states from regulating self-funded employee-based plans; or 3) add a statutory waiver provision to ERISA, similar to Medicare and ACA, allowing the federal government to permit states to explore innovative health policy approaches. Lastly, the report considered the possibility of new judicial interpretation of ERISA that would limit its preemptive reach, although it is deemed to be unlikely.

If neither congressional action nor new judicial interpretation is feasible, the report discussed three models based on the proposals and experiences of other states that have considered a single payer program. The first model uses revenue from payroll taxes and/or income taxes, which would incentivize employers and employees to drop employment-based coverage and transition to single-payer programs or use it as supplemental coverage only. The second model uses provider regulations that bar providers from billing any third parties other than UF. A third option is to allow single-payer program to pay for services and be reimbursed from employer-based health plans. However, as no UF plan has been passed, the ERISA avoidance strategies have not been tested in court and it is unclear if they would survive legal challenges. Nonetheless, the report concluded that overlapping, hybrid models that combine the three approaches could maximize the possibility of sidestepping the

ERISA conflict.

Overall, the Commissioners agreed that moving to a single-payer UF would be a transformational step towards a health care system that prioritizes access, quality, equity, and affordability. They considered many, but not all, of the major components of a single-payer system, though not all factors were assessed in depth. They didn't reach consensus on the precise design of the UF system, which was beyond their mandate; however, they did present viable design options for some essential components of a UF system, discussed advantages and disadvantages of the options, and established next steps to pursue UF for California.