
SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 562
AUTHOR: Lara and Atkins
VERSION: April 17, 2017
HEARING DATE: April 26, 2017
CONSULTANT: Scott Bain

SUBJECT: The Healthy California Act

SUMMARY: Enacts the Healthy California program, which is required to provide comprehensive universal single-payer health care coverage system for all California residents.

Existing law:

- 1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low income individuals are eligible for medical coverage. Medi-Cal provides coverage to adults and parents with incomes up to 138% of the federal poverty level (FPL) who are under age 65, and to children with incomes up to 266% of the FPL. Undocumented children receive full scope Medi-Cal coverage, while undocumented adults receive limited scope services under Medi-Cal (primarily emergency only).
- 2) Provides federal funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children through the Children's Health Insurance Program (CHIP). The program is funded jointly by states and the federal government. CHIP is a capped program and each state is provided an annual CHIP allotment. CHIP is authorized under federal law until September 30, 2017.
- 3) Requires, under the Patient Protection and Affordable Care Act (ACA, Public Law 111-148), as amended by the Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), each state, by January 1, 2014, to establish an American Health Benefit Exchange that makes qualified health plans (QHPs) available to qualified individuals and qualified employers. Requires, if a state does not establish an Exchange, the federal government to administer the Exchange. Establishes requirements for the Exchange and for QHPs participating in the Exchange, and defines who is eligible to purchase coverage in the Exchange. Limits enrollment in the Exchanges to citizens or nationals of the United States, or aliens lawfully present in the United States.
- 4) Allows, under the ACA and effective January 1, 2014, eligible individual taxpayers, whose household income is between 100% and 400% of the FPL, an advanceable and refundable premium tax credit (APTC) to use for coverage under a QHP offered in the Exchange. Requires a reduction in cost-sharing for individuals with incomes below 250% of the FPL. Legal immigrants with household incomes less than 100% of the FPL who are ineligible for Medicaid because of their immigration status are also eligible for the APTC and the cost-sharing reductions. Undocumented individuals and incarcerated individuals are ineligible to purchase coverage in Exchanges.
- 5) Authorizes, under Section 1332 of the ACA, waivers for state innovation under which states can seek federal approval to waive major provisions of the ACA, including the requirement for Exchanges, QHPs, premium tax credits and cost-sharing reductions, the individual mandate and the employer responsibility requirement, provided federal requirements for comprehensive benefits, affordability, and comparable coverage are met and the state proposal does not increase the federal deficit.

- 6) Establishes, pursuant to federal law, the Medicare program, which provides coverage for seniors and certain persons with disabilities. Medicare is funded by payroll taxes, premiums paid by individuals who enroll in various “parts” of Medicare (Part A is hospital services, Part B is medical services, Part C is Medicare Advantage plans, and Part D is prescription drug coverage) and general revenue. Authorizes the federal Secretary of the Department of Health and Human Services, to develop and engage in experiments and demonstration projects for specified purposes, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations.
- 7) Creates within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (CMI), the purpose of which is to test innovative payment and service delivery models to reduce program expenditures under the Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under those programs.

This bill:1) Healthy California purpose and governance

Establishes the Health California program in state government as an independent public entity not affiliated with an agency or department. Requires the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Requires Healthy California to be governed by an unpaid (except for per diem) executive board consisting of nine members appointed by Legislature (4) and Governor (5). Four members have to be from the following: a labor organization representing nurses, the general public, a labor organization, and the medical provider community. Requires each person appointed to the board to have demonstrated and acknowledged expertise in health care.

Requires each board member to have the responsibility and duty to meet the requirements of this bill, the ACA, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program. Requires appointing authorities to take into consideration the cultural, ethnic, and geographical diversity of the state so that the board’s composition reflects the communities of California.

Requires a California Health and Human Services Agency-appointed 22 member public advisory committee. Requires the board to have all powers and duties necessary to establish and implement Healthy California. Requires the board to provide grants to health planning agencies, and requires the board to provide funds for retraining and assisting job transition for individuals in health and insurance-related fields whose jobs may be or have been ended as a result of Healthy California implementation. Requires the board to provide for the collection and availability of specific hospital-related and health information technology-related data to promote transparency, assess patient adherence, compare patient outcomes, and review utilization.

2) Eligibility for Healthy California

Makes every resident of the state eligible and entitled to enroll. “Resident” is defined as an individual whose primary place of abode is in the state, without regard to the individual’s immigration status.

3) Enrollee premiums in Healthy California

Prohibits members from Healthy California from being required to pay any premium.

4) Enrollee cost-sharing in Healthy California

Prohibits members from being required to pay any co-payment, co-insurance, deductible and any other form of cost-sharing for all covered benefits.

5) Enrollee benefits in Healthy California

Requires all medical care determined to be medically appropriate by the members' health care provider. Includes a broad benefit package, including all services covered by Medi-Cal, Medicare, the essential health benefits, and all health plan/insurance mandated benefits. Benefits required include chiropractic, vision, dental, ancillary health or social services previously covered by a regional center, skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective. Permits Healthy California to offer retiree benefits on a voluntary basis.

6) Choice of health care providers in Healthy California

Permits a member to choose to receive health care services from any participating provider, subject to the willingness and availability of the provider, and the appropriate clinically relevant circumstances. Per 7) below, providers generally have to be in California and be California-licensed.

7) Providers eligible to participate in health care providers under Healthy California

Permits any health care provider licensed to practice in California who is otherwise in good standing to be qualified to participate in Healthy California, so long as the provider's services are performed within the state of California. The Healthy California board is required to establish and maintain procedures and standards for recognizing health care providers located out-of-state for purpose of providing health care coverage for members who require out-of-state health care services while the member is temporarily located out-of-state.

8) Health care providers reimbursement in Healthy California

Requires the Healthy California board to adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under Healthy California by participating providers, care coordinators, and health care organizations. Permits a variety of different payment methodologies, including those established on a demonstration basis. Requires all payment rates under the program to be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services. Requires health care services provided to members under the program, except for care coordination, to be paid for on a fee-for-service basis unless and until another payment methodology is established by the Healthy California board.

9) Funding for Healthy California

Intent language on broad-based revenue, and intent for the state to work to obtain approval and other approvals so that Medicaid, Medicare, ACA and other federal funds and subsidies paid by the federal government that would otherwise be paid to the State of California,

Californians and health care providers would be deposited in the Healthy California Trust Fund.

The bill requires the Healthy California board to apply to the federal Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the ACA, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all Healthy California members to receive all benefits under the Healthy California program through the program, to enable the state to implement this bill, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the Healthy California Trust Fund, and to use those funds for the Healthy California program.

Requires all moneys in the Fund to be continuously appropriated without regard to fiscal year for the purposes of this bill, and any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year is authorized to be carried forward to the next succeeding fiscal year.

10) Care Coordination in Healthy California

Requires care coordination to be provided to members, defined to include administrative tracking and medical recordkeeping services, specifies the individual and entities that can be care coordinators, and allows reimbursement to a health care provider only if the member is enrolled with a care coordinator. Requires the Healthy California board to develop and implement procedures and standards by regulation for an individual or entity to be approved as a care coordinator.

11) Role of private health insurance under Healthy California

Prohibits health plans and insurers from offering benefits or services for which coverage is offered under the Healthy California program. Continues to allow plan/insurers to offer benefits to cover health care services that are not offered to individuals under the program, including to non-residents and during the implementation period.

12) Program standards in Healthy California

Requires Healthy California to establish a single standard of safe, therapeutic care for all residents of the state.

Requires the board to establish requirements and standards, by regulation, for the program and for health care organizations, care coordinators, and health care providers, consistent with this bill and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including specified requirements and standards established by this bill.

Requires the board to establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with the Healthy California program health care services and ancillary services currently provided by other programs, including, but not limited to, Medicare, the ACA, and federally matched public health programs.

13) Healthy California and Medicare

Permits the Healthy California to take actions consistent to enable the program to administer Medicare in California, and requires the program to be a provider of supplemental insurance coverage (Medicare Part B) and to provide premium assistance drug coverage under Medicare Part D (drug coverage) for eligible members of the program. Requires a member who is eligible for benefits under Healthy California, as a condition of continued eligibility for health care services under the program, to enroll in Medicare, including Parts A, B, and D.

Requires the program to provide premium assistance for all members enrolling in Medicare Part D drug coverage, limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

14) Healthy California and Medi-Cal

Permits the Healthy California board to apply for coverage for, and enroll, any eligible member under any federally matched public health program (such as Medi-Cal) or Medicare. Prohibits enrollment in a federally matched public health program or Medicare from causing any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

Requires the Healthy California board, by regulation, to increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the ACA. This provision does not apply for long-term care services. Permits the board, to enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, to require that every member or applicant provide the information necessary to enable the Healthy California board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

15) Collective Negotiation with Healthy California

Allows health care providers to meet and communicate for the purpose of collectively negotiating with Healthy California on any matter, including rates of payment and payment methodologies. Prohibits this provision from being construed to allow a strike of Healthy California by health care providers related to the collective negotiations. Establishes requirements for collective negotiations.

16) Healthy California and existing law

Requires this bill to apply and prevail to the extent any provision of California law is inconsistent with this bill or its legislative intent extent, except when explicitly provided under this bill.

17) Requirement that Healthy California develop proposals on workers compensation and long-term care coverage

Requires the board to develop a proposal for Healthy California coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

Requires the board to develop a proposal, consistent with the principles of this bill, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the bill, for its funding. Requires the board, in developing the proposal, to consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties.

18) Local authority to provide additional coverage

Prohibits this bill from preempting any city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than contained in this bill.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) *Author's statement.* According to the author, despite the incredible gains made under the ACA, almost three million California residents still do not have access to health care because cost or legal status. With the federal governments' promises to abandon the ACA and undo the progress we have made, leaving even more people without access to care, California has a chance to lead the rest of the nation toward a health care model that is less expensive and provides better coverage.

SB 562 will move health care services to one publicly run plan that covers everyone who lives in the state. Every Californian will have access to the same comprehensive health benefits under a single plan. Patients will have the ability to choose their providers without worrying about what their insurance will cover or if they are out of network. SB 562 will consolidate and streamline access to care for patients and simplify the billing for hospitals and providers.

SB 562 will fundamentally change California's health care system and improve health access and care for our residents. SB 562 will change health care in California from commodity to a right.

- 2) *The Affordable Care Act (ACA).* The federal ACA, approved on March 23, 2010, was the most transformative legislative action the U.S. health care system had seen in 40 years. The passage of the ACA meant sweeping changes to health care coverage in this country, including establishing more generous eligibility rules and federal funding for California's Medicaid (Medi-Cal) program, providing federally funded premium and cost-sharing subsidies offered through California's Health Benefit Exchange (known as Covered California), and imposing new requirements on health insurers that made it easier for individuals with pre-existing conditions to obtain coverage. The coverage expansions alone led to 20 million newly insured individuals in this country, including over 5 million Californians.

California has seen a remarkable decline in the number of people without health insurance coverage as a result of the ACA. Most notably, the percentage of Californians under age 65 without insurance declined from 22% in 2011 to 8.6% in 2015 (from 7.3 million in 2011 to 2.9 million in 2015). California experienced the largest percentage point decline in the uninsured rate of any state, according to the United States Census Bureau. The federal Centers for Disease Control and Prevention has indicated a further fall to 7.1% in the first nine months of 2016. The decline in uninsured as a result of the ACA crosses the major race/ethnic and income groups in California.

- 3) *How do Californians receive health coverage now?* Unlike other industrialized nations, the American health care system is primarily an employer-based system. Like the rest of the country, most of California’s 39 million residents receive employer-based coverage, which is subsidized by the state and federal tax code. Public programs are the other major health coverage source, followed by the individual insurance market. The chart below with data from the California Health Benefit Review Program shows the sources of coverage (or lack thereof) for Californians:

<u>Source of Coverage</u>	<u>Percentage</u>	<u>Population</u>
Employer-based coverage	56%	17,595,000
Individual coverage	7%	2,616,000
Medi-Cal (includes dual eligibles*)	29%	11,169,000
Medicare	10%	4,054,000
Uninsured	8%	3,079,000

*Individuals eligible for both Medicare and Medi-Cal

- 4) *How much is spent on health care expenditures in California?* According to an August 2016 Health Policy Brief by the UCLA Center for Health Policy Research, personal health care expenditures in California are estimated to total more than \$367 billion in 2016.

Approximately 71% of these expenditures will be paid with public funds, broadly defined to include government spending for public employee health benefits, Medicare and Medicaid, tax subsidies for employer-sponsored insurance and ACA insurance exchange and county health care expenditures. The chart below shows the expenditures by category, dollar amount and percentage:

California Health Care Expenditures (Billions of Dollars), 2016

Health Care Expenditure Category	Expenditures, in Billions (% of total Expenditures)
Public health care expenditures	
Direct government expenditures	
Medicare	\$74.7 (20.3%)
Medi-Cal	
Federal share	\$62.8 (17.1%)
State share	\$37.4 (10.2%)
Other government programs	\$10.0 (2.7%)
County health expenditures	\$10.0 (2.7%)
Government employer premium contributions	
FEHB*	\$1.9 (0.5%)
CalPERS	\$7.1 (1.9%)
TRICARE	\$4.1 (1.1%)
Tax subsidies	
Tax subsidies for ESI**	
Federal	\$33.1 (9.0%)
State and local	\$10.9 (3.0%)
ACA subsidies	\$8.9 (2.4%)
Total public health expenditures	\$260.9 (71.0%)
Private health care expenditures	
Employer share of premiums	\$58.3 (15.9%)
Employee share of premiums	
FEHB* premiums	\$0.7 (0.2%)
CalPERS premiums	\$1.0 (0.3%)
Private employee premiums	\$18.7 (5.1%)
Premium contributions for individually purchased insurance	
Covered California	\$3.8 (1.0%)
Outside Exchange	\$8.6 (2.3%)
OOP*** expenses for covered benefits	\$15.5 (4.2%)
Total private health care expenditures	\$106.5 (29.0%)
Total California health care expenditures	\$367.5 (100.0%)

*Federal Employees Health Benefits Program

**Employer-sponsored insurance

***OOP is out-of-pocket

5) *The remaining uninsured.* While estimates vary, somewhere around 2.9 million to 3.1 million Californians are uninsured. A December 2016 report by the California HealthCare Foundation entitled “California’s Uninsured: As Coverage Grows, Millions Go Without“ found that one in three of California’s uninsured had annual incomes of less than \$25,000, meaning they were potentially eligible for Medi-Cal, one in four were aged 25 to 34, one in three were noncitizens, and more than half were Latino. Sixty-two percent of the uninsured were employed. Of the 1.8 million uninsured workers, 44% worked in firms with less than 50 employees. Workers who were self-employed (16.4%) and who worked for private sector businesses with fewer than ten employees (19.2%) were the most likely to be uninsured. Twenty percent of the uninsured in California and nationally had annual family incomes over \$75,000. The uninsured are more likely to report fair/poor health status compared to the overall population (25.5% vs. 16.2%), to have no usual source of care (42.4% vs. 15.3%) and to delay care (16.5% v. 12.3%) according to 2015 data. The reasons cited for lack of insurance are as follows:

Can’t afford/too expensive	29%
Some other reason	37%
No need/don’t believe in insurance	12%
Not eligible due to citizenship/health condition	22%

While the uninsured rate dropped dramatically for families with incomes under \$25,000 as a result of the ACA, the uninsured are more likely to be from low-income families, as shown in the data below:

Under \$25,000	15%
\$25,000 to \$49,999	11.8%
\$50,000 to \$74,999	9.8%
\$75,000 or more	3.8%

The data below shows the age groups of Californians as a percentage of the population and as a percentage of the uninsured:

<u>Age Group</u>	<u>Percentage of Population</u>	<u>Percentage of Uninsured</u>
Under 18	27%	12%
18 to 20	5%	3%
21 to 24	7%	10%
25 to 34	16%	24%
35 to 44	15%	22%
45 to 54	16%	15%
55 to 64	14%	14%

6) *Federal waiver authority.* Medicaid (known as Medi-Cal in California) is a joint federal-state program to provide health coverage to low-income individuals. Section 1115 of the federal Social Security Act (Act) gives the Secretary of the Department of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act. This includes certain federal Medicaid requirements in any experimental pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of Medicaid. In addition, Section 1115 also allows states to use federal Medicaid funds to reimburse for costs in ways that are not otherwise allowed under federal Medicaid law. This is referred to as expenditure authority for “costs not otherwise matchable.” Section 1115 waivers are approved at the discretion of the Secretary

of HHS through negotiations between a state and CMS for projects that the Secretary determines promote Medicaid program objectives. Section 1115 waivers are generally approved for a five-year period and then must be renewed. Although not required by statute or regulation, longstanding federal administrative policy has required waivers to be “budget neutral” for the federal government, meaning that federal spending under a waiver must not be more than projected federal spending in the state without the waiver.

The ACA also contained waiver provisions related to Medicare and Medicaid through a newly established Center for Medicare and Medicaid Innovation (Innovation Center) and through a waiver of the tax credits for small employers and the premium and cost-sharing subsidies in the individual market under Section 1332. Specifically, Section 1332, the ACA permits states to apply to the federal government for a waiver of major provisions of the ACA beginning in 2017. The provisions of the ACA that can be waived under Section 1332 include any or all parts of the provisions relating to QHPs (including the essential health benefits package requirement), the Exchanges, premium tax credits and cost-sharing reductions, the minimum coverage requirement (commonly referred as the “individual mandate”), and the employer responsibility requirements. If a state is granted a Section 1332 waiver, the state can fund its reforms through the aggregate amount of federal funding that otherwise would have been paid out within the state for premium tax credits, cost-sharing reduction payments, and small business tax credits. However, to qualify for an innovation waiver, the state must establish that its reform plan would provide coverage that:

- a) Will provide coverage that is at least as comprehensive as ACA coverage;
- b) Will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the as ACA coverage;
- c) Will provide coverage to at least a comparable number of its residents as the ACA would provide; and,
- d) Will not increase the federal deficit.

The Innovation Center allows the Medicare and Medicaid programs to test models that improve care, lower costs, and better align payment systems to support patient-centered practices. The Innovation Center evaluates innovative reform efforts widely used in the private sector, and is unique in its ability to develop provider-proposed approaches and quickly adjust models in response to feedback from clinicians and patients.

Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ...while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or CHIP benefits. Congress provided the Secretary of HHS with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis. In order for the Secretary to exercise this authority, a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits.

7) *Prior legislation.* Since 2004, there have been four single payer bills and one bill to fund single payer, as follows:

- a) SB 810 (Leno of 2011) *failed passage on the Senate Floor in 2012;*
- b) SB 810 (Leno of 2009) *was not taken up on the Assembly Floor;*
- c) SB 840 (Kuehl of 2007) *was vetoed by Governor Schwarzenegger. In his veto message, the Governor cited a Legislative Analyst's Office analysis that estimated*

the bill to cost \$210 billion in its first full year of implementation and cause annual shortfalls of \$42 billion, and he could not support a bill that placed an annual shortfall of over \$40 billion on California's economy;

- d) SB 1014 (Kuehl of 2007) would have imposed a payroll tax to fund the single payer system. *SB 1014 was heard in the Senate Revenue and Taxation Committee but no vote was taken; and,*
- e) SB 921 (Kuehl of 2003) *was never heard in the Assembly Appropriations Committee.*

- 8) *Support.* This bill is sponsored by the California Nurses Association/National Nurses United and supported by numerous labor organizations, faith-based and consumer groups, certain businesses, and Democratic Party groups, who argue this bill would provide publicly funded and progressively financed health care coverage for all California residents regardless of age, income, or immigration status, with no network restrictions, deductibles, co-pays, or other limitations on necessary care. Supporters argue health care is a human right, and the United States continually outspends other wealthy nations on per capita health care costs—some by more than double—while the quality of care and national health outcomes continue to fall behind. Californians as individuals, workers, families, businesses, and taxpayers are driven past their breaking point because of soaring health costs and lack of access. Supporters argue the experience of Medicare and of nearly every other industrialized country shows a single payer system is the most cost-effective and equitable way to provide quality health care as all residents are covered, and the system can eliminate wasteful spending and rein in skyrocketing prices. Supporters argue the Healthy California Act would provide the comprehensive and quality health care coverage that all Californians deserve and would ensure that insurance companies and the corporate ledger no longer determines the health and well-being of our state.
- 9) *Support in concept.* The California Pan-Ethnic Health Network, Western Center on Law and Poverty, and Health Access California write that they support this bill in concept in that they support single payer and universal coverage, and suggest additional changes to this measure. Health Access California writes that further work needs to be done on financing, and raises questions about the lack of specifics or provisions that run counter to goals for a universal coverage system related to provisions in this bill regarding transition to a single payer system, system governance, whether existing consumer protections apply to the single payer system, quality improvements/delivery system reform and integrated care, purchasing for cost and quality, cost control and information technology.
- 10) *Opposition.* This bill is opposed by business and health insurance groups who argue this bill would create a single-payer government bureaucracy which would control and finance the state's health care system and ultimately result in significant job loss to the state. Opponents argue California employers cannot sustain an added tax burden after the most recently enacted transportation tax package, that significant job loss will result from this bill, that California voters in 1996 previously rejected a single payer health measure, that single payer costs are unsustainable, and government-run health care is less efficient and effective. Other opponents argue the state has made important progress in implementation of the ACA, but this progress is in a precarious position due to Congressional "repeal and replace" proposals, and this is not an appropriate time to divide the health care and policy community against itself with a symbolic measure that could not be implemented even if it were passed.

11) *Policy issues.*

- a) *Can single payer be implemented on a state level?* The US employer-based health care system is a tax-subsidized employer-based system, augmented by state and federal programs for low-income individuals (Medi-Cal) or seniors (Medicare), and federal premium and cost-sharing subsidies for low-to-moderate income individuals buying individual coverage through Exchanges. This system has grown incrementally over decades as health coverage programs have been created or expanded and mandates and tax subsidies have been enacted to increase insurance coverage. If state and federal legislators and the state and federal executive branch were starting with a blank state and designing a health care delivery system from scratch, the US health care delivery system would unlikely look like the one that exists today.

The extension of coverage to additional Americans through the ACA has largely been built upon that existing system, with significant amounts of new federal funding to provide health insurance coverage to additional people who were previously uninsured, either because the uninsured are low or moderate income and are unable to afford the high cost of insurance, or have a pre-existing medical condition that made coverage unavailable. For example, California received over \$19.2 billion in federal funds for ACA Medicaid expansion in 2016-17, and nearly \$5 billion in federal funds for premium subsidies (\$4.2 billion) and cost-sharing subsidies (over \$700 million) for Covered California enrollees in 2016.

For single payer to be implemented on a state level, existing spending by government (Medicare and Medi-Cal) would have to be allowed to be “pooled” into the single payer financing system. In addition, to finance single payer, existing spending by employers and individuals with employer-based insurance and individually purchased insurance would have to be replaced with tax revenue to finance the costs of the approximately 20 million Californians who receive employer-based coverage or purchase individual coverage. The UCLA study estimated just these costs at \$106.5 billion, and to implement single payer, this existing individual and employer-based spending would need to be shifted to the state. Many states, including California have a balanced budget requirement, and their state revenue is dependent upon the state and national economy. In California, tax increases require a 2/3 legislative vote, which makes raising tax revenue to fund an expansion of coverage more difficult. States, including California, have traditionally only been able to significantly expand coverage to the uninsured through the use of increased federal funds.

- b) *Financing single payer and risks to the state.* This bill contains intent language on broad-based revenue, and intent for the state to work to obtain approval and other approvals so that Medicaid, Medicare, ACA and other federal funds and subsidies paid by the federal government that would otherwise be paid to the State of California, Californians and health care providers would be deposited in the Healthy California Trust Fund.

Any tax increase to fund Healthy California costs would need to take into account the requirements of Proposition 98, the 1988 school funding initiative, which generally requires 40% of revenues from taxes go to K-14 public education. Because Proposition 98 is in the State Constitution, any tax increases would either have to receive voter approval to exempt the resulting revenue from the calculation of Proposition 98, raise enough new revenue to offset the amount of revenue allocated to Proposition 98, or have a “poison pill” that would invalidate the new taxes if a Proposition 98 claim reduced the resulting revenue to fund Healthy California.

In addition, if the state were able to receive federal approval to combine Medicaid, Medicare, Covered California premium and cost-sharing subsidies and other federal funds for health care, the state would still be potentially at risk if the formula for allocating those funds does not take into account actual state health care expenditures for expenditures the federal government would otherwise have made. While this bill does not request a block grant or per capita amount of federal funding, and the state would argue that it has a legal basis for funds that the federal government would have otherwise spent in the absence of the single payer system, if federal funds come to the state in a fixed amount based on projected expenditures, the state would need to ensure that those amounts would be adequate to fund the actual coverage costs of Healthy California for people who would have been enrolled in those programs.

The recent DHCS preliminary fiscal estimate of the impact on Medi-Cal of the proposed American Health Care Act illustrates the state fiscal risk of a per capita cap on funding, even when growth in the per capita amounts were tied to medical inflation. The DHCS fiscal analysis projected a financing shortfall of \$679 million in the first year of the proposed Medicaid per capita cap, increasing to over \$5.3 billion in 2027.

This bill's sponsor has funded a research project that will estimate the overall cost of the proposed Healthy California program in SB 562 which will examine different ways of financing the program. Specifically, the project will calculate the additional costs associated with covering California residents who are currently uninsured and the expansion of health care utilization of residents who are underinsured (for example, those that currently limit their use of health services due to high deductibles or co-payments). The project will identify areas of savings associated with the Healthy California program, including lower administrative costs and cost-control mechanisms for pharmaceuticals and rates for physician, clinical, and hospital services. The sponsor indicates estimates for additional costs and areas of cost savings will determine the financing needs, and based on these estimates, the project will explore different modalities for financing Healthy California. In addition, the project will assess the ability of the cost-control mechanisms to limit the rate of increase of health care costs over time, to ensure the fiscal sustainability of the program.

- c) *Health care costs and Healthy California.* Health care spending is driven by four principle components: who is eligible for coverage, the rates health plans, health care providers, and health facilities are paid, what benefits enrollees receive, and administration. One of the main arguments for single payer is the significantly higher amount spent on health care in the US as compared to other industrialized countries, despite a lack of evidence that the additional spending produces uniformly better health care outcomes. The principle reason for higher spending are the higher prices charged for health care goods and services in the United States. The United States spends far more per person and as a percentage of Gross Domestic Product as compared to other industrialized countries.

Single payer health care systems are more likely to achieve cost savings over the current multi-payer system by significantly reducing administrative costs through eliminating the multiple payers and associated billing-related costs in the current system, and by using the government's bulk purchasing power to negotiate and/or set rates with health care providers, health facilities, and prescription drug and device manufacturers.

While this bill requires the Healthy California program to provide a single-payer health care coverage and a health care cost control system, there are multiple provisions in this bill that would make cost control unlikely to occur. For example this bill:

- i) Requires reimbursement to health care providers to be reasonable and reasonably-related to costs (which could be inflationary, based on past Medicare hospital-payment experience, and could be used by providers as the basis for rate lawsuits over rates, based on the states' experience in the Medicaid program);
- ii) Requires health care benefits to include all care determined to be medically appropriate (as opposed to a narrower coverage standard of medical necessity);
- iii) Prohibits cost-sharing (a prohibition on co-payments and deductibles would increase utilization);
- iv) Allows Healthy California members to choose any health care provider (managed care plans use network providers to obtain price discounts based on cost and quality, and can require prior authorization for specialist referral);
- v) Requires a broad benefit package that exceeds the benefits in most employer-based plans, Covered California plans, and Medicare (benefits in Healthy California include dental, vision, chiropractic, acupuncture and Medi-Cal-covered services);
- vi) Allows health care providers to negotiate collectively (health plans negotiate and selectively contract with individual providers and anti-trust law limits collective negotiation); and,
- vii) Allows health care providers to override health information technology and clinical practice guidelines based on their professional judgment and prohibits health care organizations from using health information technology or clinical practice guidelines that limit the exercise of the professional judgment of physicians and nurses (payers use clinical practice guidelines and health information technology for quality and cost-related reasons).

In addition, this bill is silent on provisions commonly used by managed care plans and other payers to control costs, such as the use of a prescription drug formulary to obtain price concessions, the use of selective contracting to obtain price discounts from health care providers based on volume, and criteria to be used by Healthy California for coverage of new drugs, devices and procedures.

- d) *Should this bill have an implementation trigger?* As drafted, the provisions of this bill would take effect on January 1, 2018. The bill also requires the Healthy California board to determine when individuals may begin enrolling in the program, and requires there be an implementation periods that begins on the date that individuals begin enrolling and ends on a date determined by the board.

In order to have a successful implementation, the author may want to consider implementation triggers based on federal approval for the movement of Medicare and Medicaid beneficiaries into Healthy California, adequate financing, federal assurances on adequacy of existing funding being transferrable on an on-going basis, and system readiness before implementation can take effect. Prior single payer bills have contained a provision that only implemented the bill when sufficient financing has been identified to implement the system.

- e) *Healthy California governance, the state budget and the role of the Legislature.* Healthy California is housed in state government as an independent public entity not affiliated with an agency or department. The governing board would be 9 members (4 of whom would be appointed by the Legislature) who would be unpaid. Funds appropriated for Healthy California would be continuously appropriated. The existing state budget General Fund spending is projected to be \$123 billion in 2017-18. Given that existing spending on health care in California is estimated to be over \$367 billion from all sources, the significant role in state spending in Medi-Cal today (over \$19 billion General Fund for 2017-18), and the Legislature's role in the budget process, is a continuously appropriated fund and the unpaid governance structure appropriate for a program of this magnitude?
- f) *Other policy and bill language issues.* There are several provisions of the bill that require language tightening and/or policy clarification. For example, the bill makes all California residents eligible for Healthy California, but contains permissive language on the program administering Medicare, which could result in the program having Medicare enrollment but not Medicare funds. In addition, language is needed clarify the condition of Healthy California enrollment on Medicare-eligible individuals' enrollment in Medicare Parts A, B and D with the prohibition on paying a premium and providing coverage that provides the same benefits as Healthy California, to clarify the author's intent with regard to the scope of long-term care coverage for non-Medicaid enrollees of Healthy California, to address the scope of benefits that would be provided out-of-state to Healthy California enrollees, to specify the types of documentation the program will use to determine residency in California, to clarify the ability to opt out of an integrated delivery system in the event a member moves, and to clarify which payments would include a component of reimbursement for graduate medical education.

SUPPORT AND OPPOSITION:

Support: California Nurses Association/National Nurses United (sponsor)
 13 Pages Progressive Alliance for Government Ethics and Sanity
 28ers
 American Federation of State, County and Municipal Employees (AFSCME)
 Council 57
 AFSCME Retirees Ch. 36
 Alameda Progressives
 Alliance of Californians for Community Empowerment Institute
 AM Green Construction
 American Federation of Musicians Local 47
 Americans for Democratic Action, Southern California
 Arbeter Ring/Workmen's Circle
 Arlington Community Church
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 Asian Pacific American Labor Alliance
 Asian Pacific Environmental Network
 Bagg Lady Handbags
 Bay Area Chapter of Resource Generation
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 Berniecrats Labor Alliance Chartered Democratic Club of Yolo County
 Breast Cancer Action
 Business Alliance for a Healthy California
 Butte County Health Care Coalition
 California Alliance for Retired Americans

California Association of Marriage and Family Therapists East Bay Chapter
California Capital Chapter of Physicians for a National Health Program
California Council of Churches IMPACT
California Democratic Party State Central Committee San Gabriel Valley
California Domestic Workers Coalition
California Faculty Association - San Francisco State University Chapter
California Federation of Teachers, AFT, AFL-CIO
California Health Professionals Student Alliance
California Insurance Commissioner Dave Jones
California Labor Federation, AFL-CIO
California National Organization for Women
California One Care
California Partnership
California Physicians Alliance
California School Employees Association
California Teachers Association
Campaign for a Healthy California
Caring Across Generations
Central Valley Indivisible
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CEO to CEO
Chinese Progressive Association
City Designworks
City of Berkeley
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City of Richmond- Laurel Park Neighborhood Council
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Clinica Romero
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Communications Workers of American District 9
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Consumer Federation of California
Contra Costa AFL-CIO Labor Council
Courage Campaign
Courageous Resistance of Humboldt
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Democratic Action Club of Chico
Democratic Party of Orange County
Democratic Socialists of America – Los Angeles
Democratic Socialists of America, Orange County Chapter
Democratic Socialists of America, San Francisco
Democratic Socialists of America, Ventura County Chapter
Democratic Women's Coalition of Tuolumne County
Disability Action Center
Divine Feminine Yoga
Douglas L. Applegate Law Office
East Bay Democratic Socialists of America
Easter Hill United Methodist Church
Ecological Farming Association

El Cerrito Progressives
Elder Care Providers' Coalition
Elsdon Organizational Renewal
Empowered Investments
Encore
Far Leaves Tea
First They Came for the Homeless
For Grace
Forward Together
Fresno Economic Opportunities Commission
Friends Committee on Legislation
Giraud Photography, Inc.
Give Something Back Office Supplies
Glenview Area Groups for Action
Gray Panthers of San Francisco
Green Party of San Bernardino County
Green Party of Santa Clara County
Hand in Hand
Harvey Milk LGBT Democratic Club
Health Care for All - Alameda County
Health Care for All - California 15 Chapters
Health Care for All - Contra Costa County
Health Care for All-Marin
Health Care for All - Nevada County Chapter
Health Care for All - San Gabriel Valley County
Health Care for All – San Fernando Valley Chapter
Healthy California
Hunger Action Los Angeles
Indivisible Claremont
Indivisible Ladera
Indivisible Mader
Indivisible Orange County
Inland Coalition for Immigrant Justice
Inland Empire Immigrant Youth Collective
Inland Greens
J. Glynn & Company
Jane Thomas Press
Jobs with Justice San Francisco
Justice for All Ventura County
Justice for Palestinians
Kate Harris Consulting
Kramer Translations
Labor United for Universal Healthcare
Lake County Democratic Central Committee
Lamorinda Peace and Justice Group
Lawyers for Good Government
Lonely Liberals Indivisible of San Luis Obispo County
Long Beach Gray Panthers
Loving Way Midwifery
Low-Income Self Help Center
Lucille Design

Maddala Music
March and Rally Los Angeles
McGee-Spaulding Neighbors in Action
Media Alliance
Mini-Vacation Massage
Mobilize the Immigrant Vote
Monkey Wrench Brigade
Mt. Diablo Peace and Justice Center
Musicians Union Local 6
National Association of Social Workers-Fresno County
National Economic and Social Rights Initiative
National Union of Health Care Workers
Nevada County Democratic Women's Club
North Bay Jobs with Justice
Oakland Livable Wage Assembly
Oakley, California Mayor Sue Higgins
Occupy Torrance
One Page Plan
Organizacion en California de Lideres Campesinas, Inc.
Otis Chiropractic Neurology, Inc.
Our Developing World
Our Revolution, West San Fernando Valley
Peace and Freedom Party of California
Peralta Retirees Organization
Pilipino Workers Center of Southern California
Poverty Matters
Progressive Action for Glendale
Progressive Asset Management
Progressive Democrats of America-California
Progressive Democrats of America- Greater Palm Springs Area
Progressive Democrats of America- Lake County Chapter
Progressive Democrats of America- Orange County Chapter
Progressive Democrats of America- San Francisco Chapter
Progressive Democrats of America- Santa Monica Chapter
Progressive Democrats of America- Ventura County Chapter
Project Inform
Resource Generation
Richmond Progressive Alliance
Riverside Temple Beth El
San Francisco Green Party
San Francisco Berniecrats
San Francisco Latino Democratic Club
San Joaquin Valley Democratic Club
San Jose Peace and Justice Center
San Mateo Central Labor Council
Santa Barbara Women's Political Committee
Santa Clara County Board of Supervisors
Santa Clara County Green Party San Francisco Berniecrats
Santa Cruz for Bernie
Senior and Disability Action
Sierra Foothills Democratic Club

Silicon Valley Independent Living Center
Social and Economic Justice Coalition
Social Justice Alliance of the Interfaith Council of Contra Costa
Sol2Economics
South Bay Labor Council
Steve Giraud Photography
Strike Debt
Sue's Hair Salon
Sunflower Alliance
Therapists for Single Payer
Tenants Together
The Democracy Project
The Latina/Latino Roundtable
The Refill Shop
Trout in Hand Productions
Tuolumne County Democratic Club
UFCW, Local 5
Unitarian Universalist Justice Ministry of California
United Democrats of El Dorado County
United Steelworkers, Local 2801
United Steelworkers, Local 675
UNITE-HERE, AFL-CIO
University Professional and Technical Employees, Local 9119
Veterans for Peace, South Bay Chapter
Voices for Mothers and Others
Wellstone Democratic Renewal Club
Word Spark Writing & Editing
Yes We Can Democratic Club
Yolo MoveOn
Numerous individuals

Oppose: America's Health Insurance Plans
Anthem Blue Cross
Association of California Insurance Companies
Association of California Life & Health Insurance Companies
Bay Area Council
Blue Shield of California
California Association of Health Plans
California Association of Health Underwriters
California Chamber of Commerce
California Farm Bureau Federation
California Framing Contractors Association
California League of Food Processors
California Manufacturers & Technology Association
California Professional Association of Specialty Contractors
California Retailers Association
California Taxpayers Association
California Trucking Association
Camarillo Chamber of Commerce
El Centro Chamber of Commerce and Tourist Bureau
Fresno Chamber of Commerce

Greater Riverside Chambers of Commerce
Greater San Fernando Valley Chamber of Commerce
Health Net
Howard Jarvis Taxpayers Association
Independent Insurance Agents and Brokers of California
Kaiser Permanente
Long Beach Chamber of Commerce
Murrieta Chamber of Commerce
Molina Healthcare
National Association of Insurance and Financial Advisors of California
National Federation of Independent Business
North Orange County Chamber of Commerce
Oceanside Chamber of Commerce
Orange County Business Council
Oxnard Chamber of Commerce
Redondo Beach Chamber of Commerce and Tourist Bureau
Santa Maria Valley Chamber of Commerce
South Bay Association of Chambers of Commerce
Southwest California Legislative Council
Torrance Chamber of Commerce
Valley Industry and Commerce Association
Western Growers Association
Yuba-Sutter Chamber of Commerce

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