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Abbreviated Analysis California Assembly Bill 1400:Guaranteed Health Care for All

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Abbreviated Analysis

California Assembly Bill 1400: Guaranteed Health Care for All

Summary to the 2021–2022 California State Legislature
April 22, 2021

Prepared by
California Health Benefits Review Program
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. AB 1400, introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. This limited analysis is intended to support the Legislature in assessing the potential impacts of AB 1400. It draws primarily from existing research, policy analyses, and simulations developed in recent years to assess related proposals at both the state and national levels. CHBRP found significant evidence that provides some broadly applicable cost estimates and policy implications/uncertainties resulting from AB 1400.

Bill Scope

Assembly Bill (AB) 1400 (Guaranteed Health Care for All Act), introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. CalCare would be charged with providing high-quality health care and long-term care to all California residents, including those who are presently either uninsured or underinsured. It is intended to create a state-run "single payer" health system in California.

Background

On March 3, 2021, the California Assembly Committee on Health requested that CHBRP complete a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. This limited analysis synthesizes various robust studies and research to support consideration of the fiscal and policy implications of AB 1400 for California.

Approach: Leveraging Existing Evidence

CHBRP relies on available studies and simulation modeling released by researchers, government entities, and policy analysts to synthesize the range of impacts that single-payer health care systems might have on the existing health care system in California, as well as long-term care implications. Common findings from these simulations of proposed redesigns of health care at the state and/or federal levels give policymakers much to consider. Where possible, CHBRP attempts to extrapolate the impacts on California.

CHBRP highlights some of the potential costs and benefits related to AB 1400 based on existing evidence[1], and provides a limited analysis related to how health care utilization might change as a result of AB 1400.

Finally, CHBRP was asked by the Legislature to provide an estimate of the initial fiscal reserves that would be needed to implement AB 1400 (in the short term). CHBRP attempts to provide an estimate based upon the existing literature, the California Legislative Analyst Office's work from 2008, and current health care spending in the state by government and private payers. CHBRP also provides an estimate of total California health expenditures for 2021.

Benefit Coverage

AB 1400 would provide for and cover a wide range of medical benefits and other services. These would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program.

Approximately 100,000 Californians received long-term care services through Certified Nursing Facilities in 2019 (Kaiser Family Foundation, 2019a). The majority of residents were Medi-Cal enrollees (62%), whereas 15% had Medicare coverage, and 23% had private or other coverage (including self-pay). Medicare limits reimbursement for long-term care for rehabilitation services after a hospital stay, such

[1] Studies include the LAO analysis, studies from RAND, Urban Institute, PERI, and the CBO.

that the burden of custodial long-term care falls upon Medi-Cal, private long-term care insurance, and out-of-pocket spending by families.

AB 1400 would greatly enhance the coverage for long-term care services throughout the state, but it would not only cover the costs from existing payers, it would likely subsidize families providing or financing caregiving on their own who do not benefit from one of the existing coverage programs.

Policy Context

The current U.S. health care system is a multipayer model with significant involvement and financial risk borne by employers, insurance companies, individuals obtaining health care and purchasing insurance, and taxpayers in the form of Medicare, Medicaid, Children's Health Insurance Program (CHIP), Tricare, Veteran's Health Administration, Indian Health Services, and local safety net programs.

Generally, single-payer systems are relatively less costly than multipayer privatized systems and are responsible for a slightly smaller share of the gross domestic product. In the United States, administrative and overhead costs for health care exceed other countries by at least 15%.

In the years between 2010 to 2019, twenty states proposed 59 different single-payer bills. Most, but not all, of the single-payer proposals come from states that expanded Medicaid under the Affordable Care Act (ACA), leaving only a small portion of the population uninsured. Many state single-payer bills share many common elements: they all make residents universally eligible for health insurance coverage, and include low or no cost sharing for patients, comprehensive benefits, limits on health insurers offering duplicate coverage, and set criteria for provide participation and reimbursement.

However, although single-payer models such as AB 1400 have been introduced at the state and federal level, none have ever been fully enacted and implemented in the United States.

The COVID-19 pandemic has exposed gaps in care delivery and in public health. In the present system, persistent disparities exist based on income, region, and race and ethnicity. Prior to the COVID-19 pandemic, the United States ranked last in life expectancy and highest in suicide rates among 11 over industrialized countries. The U.S. also reported high numbers of preventable hospitalizations and avoidable deaths. Some advocates believe that these deficiencies may be improved by legislation such as AB 1400.

Key Considerations and Unknowns

CHBRP's analysis is not intended to make recommendations. However, in reviewing the studies, analyses, and evidence from numerous studies, CHBRP offers these key considerations and the remaining unknown impacts or implementation pieces for consideration.

Fiscal Uncertainties

AB 1400 would rely on the state collecting revenues sufficient to fund a new single-payer health system and centrally control costs. Additionally, California would need to combine funds that currently fund health care within California via a variety of sources into a single budget managed by the state. Unlike the federal government, California must balance its budget each year. The state would need to ensure revenues collected for health care services would meet changing needs and health care cost trends. Any external or environmental issues that suppress revenue collection in a given year, or create unpredictability in revenues or spending would harm program sustainability.

Integration Considerations

Eliminating cost sharing in AB 1400 may improve access to care and consumer affordability, but could increase costs due to greater use of services and ultimately compromise long-term sustainability.

Provider Impact and Hospitals. Although a single-payer system allows for private providers to continue operating as private entities, the payment sources would be limited to the new CalCare single-payer program. Consolidating all Californians under one single-payer system would require price setting that takes the previous multipayer rates into consideration, adjusts them downward to address new administrative efficiencies, and pays hospitals

and providers a new, blended payment rate for services rendered or people cared for.

Administrative and Legal Questions

Federal revenues currently support Medicare, Medicaid, and Covered California's individual market tax credits and cost sharing reductions. In addition, the federal government allows for the deduction or exemption of employee benefit spending from payroll and income taxation. To obtain the necessary revenue to support AB 1400, CHBRP assumes that the state will negotiate separate waivers with the federal government to ensure federal funds from several sources flow into CalCare.

AB 1400 does not establish a revenue model for financing its provisions. CHBRP is also aware of two existing provisions in the State's Constitution (Proposition 4 of 1979 and Proposition 98 of 1988) that affect California's ability to raise and spend revenues necessary to successfully implement AB 1400.

Other Impacts

The scale and challenge of the implementation of AB 1400 may result in negative or unanticipated impacts to insurers, health care providers, hospitals, health care technology companies, and large segments of the health care workforce.

High Level Meta-Analysis

A high-level meta-analysis published in 2020 identified 22 modeled predictions (over the past 30 years) of the cost of single-payer health care in the United States. Financing or revenue plans were not considered, just cost estimates. It found that 19 of the 22 studies (86%) predicted net savings during the first year of operation, with a range of *7% higher net costs* to 15% lower net costs. The range of cost increases due to insurance coverage improvements resulting in higher use of services ranged between 2% and 19%. Simplification of payment administration, reduced prescription drug costs, and other components resulted in net savings of 3% to 27%. Overall, the authors estimated that net savings averaged 1.4% per year.

Consensus Cost and Reserve Estimates

CHBRP projects current California health care spending from all sources to total $330.7 billion in 2021. Adjusted for inflation, previous analyses of single-payer bills in California (SB 840, SB 562) suggest that California could result in between $314 billion and $391 billion in total health care spending in 2021. These estimates include approximately $33 billion in additional spending due to reduced cost sharing and deductibles.

CHBRP estimates that 50% of the current estimated health care spending plus the additional spending due to the implementation of AB 1400 should be placed in a reserve fund to ensure benefits can be offered to California residents. That amounts to $158.5 billion to $195.5 billion in reserves.

Conclusion

In the literature, there is a general consensus that single-payer health care would increase efficiency, initially decrease net costs, and result in long-term net savings over time. The uncertainty around immediate benefits, however, creates significant challenges for state implementation, in particular. The evidence illustrates that maximizing performance and savings will require a very complex and intensive undertaking.

AB 1400, if enacted successfully, would establish affordable coverage for the approximately 3.24 million who remain uninsured in California. AB 1400 would promote greater equity and reduce the financial burden that millions of Californians experience, even those with health insurance.

Considerable research and analysis has highlighted some of the requirements, potential benefits, pitfalls, and uncertainties for states considering single-payer proposals. Some of the key barriers and uncertainties facing policymakers if AB 1400 were enacted, include:

> The ability to integrate all or many financing sources and populations is one key to reap some of the intended benefits of a single-payer system. CalCare would need to consolidate federal funds from Medicare, Medicaid, and the ACA exchanges into the state single-payer plan using waiver provisions in those federal programs. Proposed state single-payer plans generally

lack "fallback" plans for capturing federal funds should the federal government deny the waivers.

Single-payer design notions that eliminate or reduce premiums and cost sharing would need to secure offsets.

Disruption to the state's health care workforce, health care providers, insurers, and residents may be high. Uncertainty in finance may impact innovation, technology adoption, and public health during an extended period of uncertainty.

Additionally, state constitutional prohibitions on deficit spending, constrain state plans when tax revenues fall during economic recession.

The scale of the uncertainties in fiscal projections and the risks managing hundreds of billions of dollars in health care spending provide a live experiment with opportunity but also unanticipated potential risks and costs.

Regarding long-term care, CHBRP found it difficult to project the fiscal impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide due to lack of measurable data, availability of long-term care supply, and how informal caregivers would respond to AB 1400.

BACKGROUND

On March 3, 2021 the California Assembly Committee on Health requested that CHBRP complete a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. This limited analysis is intended to support the Legislature in assessing the potential impacts of AB 1400. It draws primarily from existing research, policy analyses, and policy simulations developed in recent years to assess related proposals at both the state and national level. This limited analysis synthesizes several rigorous and high-quality studies and a substantial body of research to support consideration of the fiscal and policy implications of AB 1400 for California.

APPROACH

Leveraging Existing Evidence

In this limited analysis, CHBRP relies on available studies and simulation modeling released by researchers, government entities, and policy analysts to synthesize the range of impacts that a single-payer health care system might have on the existing health care system in California. Although important details vary among single-payer proposals that have been considered in recent years, common findings from these simulations of proposed redesigns of health care at the state and/or federal levels offer policymakers estimates of spending magnitude and suggest the policy implications to consider prior to enacting a comprehensive single-payer bill. These studies also help identify the challenges of potentially implementing AB 1400 at the state level. Where possible, CHBRP attempts to extrapolate the impacts on California by incorporating demographic adjustments and trending forward spending and utilization of some of these key examples. CHBRP also provides further information on the relative health status of the uninsured versus insured in California.

Finally, CHBRP was asked by the Legislature to provide an estimate of the initial fiscal reserves that would be needed to implement AB 1400 (in the short term). CHBRP attempts to provide an estimate based upon the existing literature, the California Legislative Analyst Office's (LAO's) work from 2008, and current health care spending in the state by government and private payers.

INTRODUCTION

This section provides information about the multipayer system of health care currently used in the United States and California, and contrasts it to single-payer options. CHBRP describes the traditional health care insurance and delivery model in the United States, which is used to deliver acute care and subacute care, and also delineates that system of providers and payers from the separate system used to provide long-term care to residents of the United States and California which relies on Medicaid, private long-term care insurance, and significant out-of-pocket spending by families and caregivers.

Overview of Multipayer System

The current U.S. health care system is a multipayer model with significant involvement and financial risk borne by employers, insurance companies, individuals obtaining health care and purchasing insurance, and taxpayers in the form of Medicare, Medicaid, Children's Health Insurance Program (CHIP), Tricare, Veteran's Health Administration, Indian Health Services, and local health programs (Donnelly et al., 2019). At a national level, our multipayer system leads to fragmentation and inequity, such that higher income individuals with tax-deductible or tax-exempt comprehensive employer-sponsored insurance coverage can access state-of-the-art care from highly regarded academic medical centers at little to no out-of-pocket cost, whereas low-income individuals with Medicaid face barriers to accessing care,

including limited provider networks. Today's health care system leads to approximately 8.5% of the California population going without insurance due to lack of affordable options, lack of information about benefits and programs available, perceived need, or explicit exclusions due to immigration status (Commonwealth Fund, 2020). The concept of single payer is sometimes conflated with universal coverage, but the ideas are distinct (Liu and Brook, 2017). Universal coverage can be achieved through a variety of policy options that range from expanding or adding to existing multipayer coverage programs and rules, to establishing a single-payer system. Alternatively, a single-payer system could apply to a subset of the population, as with Medicare for the disabled and people age 65 years and over, or the Veterans Health Administration (VHA) program.

Many proposals propose a universal single-payer approach that applies to everyone within state boundaries irrespective of age, gender, income, health status, employment, and citizenship. The label "single payer" can be misleading, as considerable differences exist among universal health care systems. There are essentially three types of universal health care (Glied et al., 2019). The first is single-payer coverage whereby all residents are covered. These systems are government financed through taxes, pays providers directly for all health care covered, and there are no out-of-pocket costs. The United Kingdom is a prominent example of this system (Glied et al., 2019). The second is based on a regulated compulsory private health care approach. Insurance is required for all residents unless exempted. The Government determines what's covered and there may be some deductible costs. Consumers pay premiums to insurers, and insurers pay providers. The Netherlands is a prominent example of this system (Glied et al., 2019). And third, there is government-financed mixed public-private coverage system, where all residents are covered, a wide variety of services are covered, there is some cost sharing, and there is a private insurance option for the rest. Government finances nonprofit insurers, but supplemental private insurance is also available. France is a prominent example of this model (Glied et al., 2019).

Generally, single-payer systems are relatively less costly than multipayer privatized systems and are responsible for a slightly smaller share of the gross domestic product (GDP) (Glied, 2009). Overall, the differences in system performance among the universal coverage of Organisation for Economic Co-operation and Development (OECD)[2] countries are very small, whereas the difference between the performance of any one of these countries and the United States is enormous and persistent (Glied, 2009). However, these differences in health outcomes could be driven by country or state spending on social programs that are likely to have more meaningful impacts on health outcomes than health spending (Papanicolas et al., 2019). There is even evidence that states with a higher ratio of social spending to health spending achieve better health outcomes within 1 to 2 years of switching (Bradley et al., 2016).

Despite higher levels of health spending in the United States when compared to other industrialized countries, the U.S. population uses fewer services in most categories. Higher spending is linked to higher overall prices paid due to the multipayer nature of the U.S. health care system and the lack of systematic price controls (Anderson et al., 2019). Whereas Medicare fee-for-service (FFS) sets rates for providers each year, private insurers who provide coverage to individuals through the individual market, employer-sponsored insurance, Medicaid Managed Care Plans, and Medicare Advantage plans all negotiate with providers separately to set payment rates. Providers and insurers with negotiating power due to market concentration, reputation, or other reasons are able to negotiate better prices than those without negotiating power (Anderson et al., 2019; Hussey and Anderson, 2003). The administrative burdens of negotiating prices and billing, plus the profit motive in the U.S. health system, results in administrative and overhead costs for health care exceeding other countries by at least 15% (Himmelstein et al., 2020; Woolhandler et al., 2003).

From 2010 through 2019, legislators in 20 states proposed 59 different single-payer bills (Keith, 2019). Most, but not all, of the single-payer proposals came from states that expanded Medicaid under the Affordable Care Act (ACA), leaving only a small fraction of the population uninsured. Thus, it appears that beyond achieving universal coverage, state single-payer bills also seek to control health spending

[2] The Organisation for Economic Co-operation and Development is an intergovernmental economic organization with 37 member countries, founded in 1961.

through expansive rate-setting authority and streamlined administration, as well as to relieve individuals of their growing out-of-pocket expenses. These state single-payer bills share many common elements: They all make residents universally eligible for health insurance coverage, and include low or no cost sharing for patients, comprehensive benefits, limits on health insurers offering duplicate coverage, and set criteria for provide participation and reimbursement. However, although single-payer models such as AB 1400 have been introduced at the state and federal level, none have ever been fully enacted and implemented in the United States (Parnell et al., 2020).

California does not yet offer universal access, despite significant coverage expansion over the past 10 years. In 2022, it is estimated that 3.2 million non-elderly Californians will be uninsured (9.5%), including 1.3 million undocumented Californians (Dietz et al., 2021a). Multipayer financing of health care and a diffuse delivery system, including a “patchwork” of safety net providers serving low-income and uninsured populations, result in inefficiencies and inequities in health care delivery, access to care, and quality for many Californians. Profits and financial incentives for providers and insurers often drive-up spending despite a lack of improvements in clinical quality, disparities, avoidable deaths, or patient experience. The COVID-19 pandemic has exposed gaps in care delivery and in public health. In the present system, persistent disparities exist based on income, region, and race and ethnicity (Healthy California Commission, 2020).

Communities of color experiences with racism, discrimination, socioeconomic deprivation, and environmental stressors were exacerbated during the COVID-19 pandemic (Fortuna et al., 2020). COVID-19 incidence and mortality have continued existing health disparities and created new inequities (Okonkwo et al., 2020). Persistent disparities due to higher rates of COVID-19 incidence and other health conditions exist by income, region, race, and ethnicity. Increasing access to health coverage and reducing out of pocket costs promotes equity, improves access to health care services, and will result in better outcomes (Bernstein et al., 2010). Prior to the COVID-19 pandemic, the United States ranked last in life expectancy and highest in suicide rates among 11 over industrialized countries. The U.S. also reported high numbers of preventable hospitalizations and avoidable deaths. (Choo and Carroll, 2020). Proponents of a universal single-payer system as proposed in AB 1400 believe it will reduce barriers to health care access and treatment, and make health care more affordable for the most vulnerable populations. Although these reforms would not address the racism and poverty that led to these disparities in health outcomes, it would attempt to address the poor health outcomes faced by underrepresented or vulnerable groups.

Long-Term Care

Although the U.S. focuses on primary and acute health care in policy discussions, long-term care is a very important component of the health care system that gets little attention. Long-term care affects people of all ages and is a major driver of spending in public programs, namely Medicare and Medicaid. People with long-term care needs often go without appropriate or preferred care, and this places burdens on families due to excessive caregiving and financial responsibilities. Twenty percent of adults with long-term care needs who reside in their community are unable to access the care they need (Feder et al., 2000). It is a global challenge, as the combination of disability increases, population aging, and need for LTSS is a concern throughout the world (Thach and Weiner, 2018; de la Maisonneuve and Martins, 2013; European Commission, 2015; World Bank, 2016).

In the United States, long-term services and supports (LTSS) is a blanket term that “encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities,” (Thach and Weiner 2018). LTSS services can provide assistance with activities of daily living (ADL), which include eating, dressing, and bathing. LTSS also provides supports for instrumental activities of daily living (IADLs), which include tasks like housekeeping and financial management. LTSS is designed to help people with disabilities function in their daily lives, and leverages LTSS providers that include informal, unpaid support and formal, paid caregivers. LTSS can be delivered in different settings, such as intermediate care facilities for those with developmental disabilities, nursing homes for custodial care and rehabilitation patients, and community-

based services (e.g., adult day services, assisted living). The financing and delivery systems have historically favored institutional settings, although government policies and advocacy efforts have facilitated a shift toward greater home and community-based services (HCBS) use (Thach and Weiner, 2018).

Medicaid, the federal-state health care and LTSS program for the low-income population, is a critical part of financing for LTSS. By 2040, the United States population is projected to increase from 318.7 million in 2014 to over 380 million people, with the elderly population increasing from 48 million to slightly more than 83 million people (Colby and Ortman, 2015).

The State of California currently administers LTSS, which provides long-term care services delivered through Skilled Nursing Facilities, In-Home Supportive Services, Home and Community-Based Services, Community-Based Adults Services, and a variety of other mechanisms. However, all of the programs listed above are not under the Medi-Cal umbrella; some are controlled and funded by the Department of Aging, Department of Developmental Services, and Department of Social Services. Although the Medi-Cal fee-for-service program spent approximately $16.2 billion on long-term care in 2018, there were other sources of services and spending for LTSS in the state (CHCF, 2020). In addition, it is estimated that another $8.4 billion was spent for long-term care in Medicare in 2017 (CHCF, 2017), and an unknown amount was spent by individuals or their private long-term care insurance policy.

Approximately 100,000 Californians received long-term care services through Certified Nursing Facilities in 2019 (KFF, 2019a). The majority of residents were Medi-Cal enrollees (62%), whereas 15% had Medicare coverage and 23% had private or other coverage (including self-pay). Medicare limits reimbursement for long-term care for rehabilitation services after a hospital stay, such that the burden of custodial long-term care falls upon Medi-Cal, private long-term care insurance, and out-of-pocket spending by families.

Given the unknown levels of spending occurring out-of-pocket for individuals and through private long-term care insurance policies, it is difficult to predict the monetary impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide.

Health Care Administrative Costs

Administrative and overhead costs in health insurance include activities related to billing, utilization review, marketing, compensation of administrators, and profit.

Medical Loss Ratio

A percentage of all health care expenditures relate to administration, overhead, and profit. The amount of money spent on medical care by a health insurance carrier or health plan as a percentage of their collected premium revenue is a term called Medical Loss Ratio (MLR). Per the ACA[3], Insurers in the large-group commercial insurance market are required to spend at least 85% of their premium revenues on medical care, whereas small-group and individual market insurers must spend at least 80% of the premiums collected on medical care. If the minimum MLR goal is not met in a given year, the insurer must issue refunds to their enrollees to meet the MLR target.[4]

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.

[4] However, traditional fee-for-service limits the administrative spending in the program by attempting to process claims through fiscal intermediaries (typically commercial insurers operating in the region) and allowing those fiscal intermediaries to charge a small portion (less than 2%) of the claims paid. That results in Medicare having an MLR of 98% or better, because they intentionally limit spending on administrative costs by contracting with fiscal intermediaries. In Medicaid, which is primarily delivered by commercial insurers, the MLR is 85% and is subject to rigorous requirements around reporting and calculation. However, insurers that use subcontractors who use their own employees to deliver services (rather than network providers) are able to capture the entire amount spent by the subcontractor in the medical cost numerator.

Evidence suggests that billing-and-insurance–related costs in our multipayer health system are substantial. Jiwani et al. (2014) estimate that approximately $375 billion in expenditures are added to the overall costs of our health system due to these multipayer billing-and-insurance–related activities. They estimate that moving to a simplified, single-payer system would result in 15% savings to the system. Woolhandler et al. (2003) published a landmark study on administrative spending in the United States in 2003, and updated it in 2020 using 2017 data (Himmelstein et al., 2020). They found that the United States spent 34.2% of every health care dollar on administration, in comparison to Canada, which spent 17% (Jiwani et al., 2014). Although we should not anticipate administrative costs to be removed entirely under a simplified, multipayer system, there is support for the notion that between 14% and 17% of current health care spending is due to inefficient administrative activities linked to the multipayer system. However, it is unreasonable to expect that a single-payer system could operate on a 2% administrative margin like Medicare.

Fraud and Abuse

Fraud and abuse are a problem throughout health care. In 2019, CMS estimated over $28.91 billion in improper payments (and $57.36 billion in Medicaid and CHIP Programs across the country) occurring in Medicare fee-for-service (CMS, 2019). It is difficult to assess the impact of fraud and abuse throughout the system, because information is limited to providers and individuals who were engaged in fraud and were caught. Although Medicare fee-for-service operates with a very low administrative overhead rate of less than 2% according to the most recent Medicare Boards of Trustees' report (2020). This level of administrative spending is comparable to a 98% or better medical loss ratio due to the automated review of Medicare claims and low overhead spending. However, the program is also a target for insurance fraud due to the lack of prior authorization, utilization review, and other strategies health insurance carriers often use to limit use of expensive or otherwise avoidable services. In shifting toward a single-payer model as proposed by AB 1400, planners and policymakers should consider that the savings from administrative spending reductions could be limited by the presence of health insurance fraud and abuse depending on the structures and barriers put in place to remove fraud and abuse. For example, Medicare's Center for Program Integrity (CMS, 2021) focuses on reviewing claims using algorithms to identify patterns, individual providers, and limit payments for fraudulent claims. In 2019, $2.2 billion from the overall administrative spending was allocated to Medicare's health care fraud and abuse control program (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020). Medicare Advantage and Part D plans, which are run by private insurers, must adhere to an 85% medical loss ratio (Society of Actuaries, 2019).

POLICY CONTEXT

Bill Provisions

Assembly Bill (AB) 1400 (the California Guaranteed Health Care for All Act), introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. CalCare would be charged with providing high-quality health care to all California residents, including those who are presently either uninsured, ineligible for public coverage, or underinsured (unaffordable high deductible plans, etc.). It is intended to create a state-run "single payer" health system in California.

AB 1400 would require coverage of "a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state programs, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program, (AB 1400, February 19, 2021 see Appendix A)." The bill seeks to enact a health care cost control mechanism to facilitate new health coverage and health care service delivery for all residents of California, including the undocumented. AB 1400 would prohibit participating providers from billing or

contracting with an individual eligible for CalCare benefits for a covered benefit, but would allow contracting for a health care service that is not a covered benefit if certain criteria were met. "The bill would authorize health care providers to collectively negotiate fee-for-service rates (with CalCare) of payment for health care items and services using a third-party representative, as provided. The bill would require the CalCare Board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget," (AB 1400, see Appendix A).

Existing state and federal programs in California would be affected if the legislation were fully implemented. AB 1400 would require the board of CalCare "to seek all necessary federal waivers, approvals, and agreements to allow various existing federal health care payments to be paid into CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds," (AB 1400, see Appendix A).

This bill states the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act.

Finally, AB 1400 would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act.

Evidence From California

Healthy California Commission

The Healthy California for All Commission[5] was established in 2019 to develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to a single-payer financing system. According to the Commission, the concept of "unified financing" describes a state-wide system to arrange and assure health care in which:

- There is a standard package of health care services;
- The standard package of health care services would not be limited by demographic, employment, disability status, or income;
- Benefit distinctions between public programs and private plans would be eliminated within a system of unified financing.

In its first deliverable required by SB 104, the report[6] explores strengths and limitations of California's existing health care system and identifies areas for improvement. A future Commission report will provide key considerations to inform the design of a unified financing system, as proposed by AB 1400. The Commission's Report (originally scheduled for February of 2021), was delayed due to the COVID-19 pandemic.

Existing Data on California's Health Insurance Coverage and Financing

Californians receive health insurance from a range of public and private sources, which can change over time. Roughly half of Californians receive job-based coverage in 2020 based on their own employment or

[5] Established by Senate Bill 104 (Chapter 67, Statutes of 2019).
[6] https://chhs-data-prod.s3.us-west-2.amazonaws.com/uploads/2020/08/24133724/Healthy-California-for-All-Environmental-Analysis-Final-August-24-2020.pdf.

a family members' employee benefits (CHCF 2017). Approximately 5% of Californians purchase insurance through the individual insurance market through Covered California or purchased directly from an insurance carrier. Medicare provides coverage for most elderly (age 65 years or over) residents and those with disabilities under 65. Approximately 17% of Californians are covered by Medicare, VHA, military health care, and Indian health services. Medi-Cal provides coverage to another 23% of Californians who are eligible due to income or disability (CHCF, 2017).[7] Approximately 3.2 million Californians are projected to be uninsured in 2022 (Dietz et al., 2021a), including the share of undocumented Californians who are covered through restricted-scope Medi-Cal and are not eligible for full-scope Medi-Cal coverage. Of the projected 3.2 million Californians who remain uninsured, 1.3 million are undocumented, and the majority of the remainder are eligible for Medi-Cal or Covered California with subsidies. According to the 2019 California Health Interview Survey, 50.4% of the uninsured report very good or excellent health status, whereas 61.2% of the insured report very good or excellent health status. The uninsured report higher levels of fair or poor health status (17.8%), whereas 12.1% of insured Californians report fair or poor health status.

California responded to the ACA by expanding Medi-Cal to low-income childless adults, parents earning 100%–138% federal poverty level (FPL), and by starting a state-based insurance marketplace, Covered California (Garrett and Gangopadhyaya, 2016). Federal policymakers expanded Medi-Cal eligibility to adults with incomes below 138% of the federal poverty level (about $16,700 for a single adult) and lawful permanent resident immigration status for over 5 years through the ACA, with the federal government covering 95% of total costs for this group in 2020 and beyond. California independently decided to expand its Medi-Cal program using state funds to other populations, including people earning up to 138% FPL who do not meet the 5-year bar for lawful permanent residents, and undocumented immigrants up to age 26 years. Californians earning incomes between 138%–600% of the FPL can purchase health plans through Covered California using premium tax credits. Between 1.2 and 1.4 million enrollees have insurance through Covered California, with about 85% of enrollees receiving federal tax credits or subsidies (McConville, 2018). The recently passed American Rescue Plan Act (2021) provides additional tax credits and subsidies to people earning up to 400% FPL and new tax credits for those earning more than 400% FPL (Dietz et al., 2021b).

California uses available federal, state, and local funds to provide health insurance to some immigrant population groups, such as young unauthorized immigrant children and pregnant women. Some counties, have provided access to outpatient and inpatient care for all low-income residents (Gelatt et al., 2014). Many of California's counties offer basic health care for uninsured residents and undocumented immigrants through public hospitals or private providers. However, the program is not portable and not equivalent to insurance coverage (Rojas and Dietz, 2016; Healthy California For All Commission, 2020).

The health care safety net for low-income residents of California represents a "patchwork of programs and providers." (Newman and Roh, 2019). Many Californians have gained insurance coverage due to the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014. Most lawful permanent residents earning less than 138% of the federal poverty level are now eligible for health care coverage through Medi-Cal, while those earning higher incomes have access to tax credits and subsidies designed to make health insurance more affordable through Covered California, California's health insurance exchange. While the federal government has provided the vast majority of funds for the Medi-Cal expansion, General Fund spending for Medi-Cal has increased by 5% annually, and currently constitutes about 17% of General Fund expenditures (McConville et al., 2017; Tatar and Chapman, 2019).

Overall Estimates of Health Spending in California

Based on National Health Expenditure (NHE) data, California spent $295 billion on health care (more than any other state) in 2014.[8] Unfortunately, NHE data is not updated at the state level on a yearly basis,

[7] This estimate excludes Californians who are only eligible for emergency and pregnancy related services. It also excludes those are "dually eligible" for Medi-Cal and Medicare. It counts them in Medicare and other public.
[8] National Health Expenditures, 2014: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

but applying the urban Consumer Price Index (CPI) to inflate the spending level of 2014 into 2021 dollars gives us a conservative sense of the possible magnitude of the state's current health care spending. From 2014 to 2021, CPI would add 11.9% to the $295 billion spent in 2014, for a predicted total of $330.7 billion from all sources in 2021. If we apply a historical growth rate from the NHE data (5.7% per year) to the 2014 total, the 2021 projected estimate increases to an upper bound of $435 billion. Per capita spending in 2021 (based on an estimated 39.51 million residing in California) would be $8,370 per year using CPI to calculate a lower-bound, or $11,010 using historical 1991-2014 NHE growth as an upper-bound. National evidence indicates health care spending grew at a lower rate than 5.7% from 2014 to 2018, which suggests that the actual per capita spending on health care in 2021 for California lies between those two numbers (California HealthCare Foundation, 2020).

Existing Data on Impact of Single-Payer Proposals in California

Several bills have been introduced in California to create a single-payer system, including SB 562 (Lara) in 2017, SB 810 (Leno) in 2011, and SB 840 (Kuehl) in 2007. None of those bills were enacted, but each proposal and cost estimate is helpful for assessing the likely impact of AB 1400. Although there are differences between AB 1400 and the three bills summarized below (Table 1), the cost estimates for each bill provide a useful range of values when estimating the potential costs of implementing AB 1400. The overall health care spending in California is estimated to be $330.7 billion or more in 2021 dollars (adjusted for inflation using CPI) so that the potential cost impact in 2021 for each bill can be compared to the current spending level and to assess the additional funds needed to implement each bill.

Table 1. Comparison of Previous California Single-Payer Bills

Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
Summary	• Establishes the California Healthcare System (CHS) that would be administered by a new agency under the control of a new Commissioner. • The CHS would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services.	• Establishes the California Healthcare System (CHS) that would be administered by a new agency under the control of a new Commissioner. • The CHS would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services.	• Establishes the Healthy California (HC) program and would provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. • An appointed HC Board would govern the program.
Populations Covered	All CA residents	All CA residents	All CA residents, regardless of immigration status
Benefits	• Designs benefit packages to provide a wider array of medical services than provided to many insured Californians under current law. • Includes all medical care determined to be medically appropriate for an individual by their health care provider. • Includes inpatient, outpatient, imaging, dental, vision, mental health, post-	• Includes all medical care determined to be medically appropriate for an individual by their health care provider. • Includes inpatient, outpatient, imaging, dental, vision, mental health, post-hospitalization nursing home care, prescription drugs, and more. • Residents at or below 200% of FPL would be eligible for no-cost Medi-Cal and would	• Would cover a wide range of medical benefits and other services and incorporate the health care benefits and standards of other existing federal and state provisions, including the state's Children's Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with

Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
	hospitalization nursing home care, prescription drugs, and more. • Residents at or below 200% of the Federal Poverty Level (FPL) would be eligible for the type of benefits offered under the Medi-Cal program.	be entitled to not less than the full scope of benefits available under the Medi-Cal program.	developmental disabilities, Knox-Keene, and Medicare. • Includes all medical care determined to be medically appropriate for an individual by their health care provider. • Includes inpatient, outpatient, imaging, emergency services, dental, vision, mental health, nursing home care, prescription drugs, and more.
Copays and Deductibles	Not specified but would allow deductibles and copayments beginning in year 3	Not specified but would allow deductibles and copayments beginning in year 3	Members shall not be required to pay any form of cost sharing for covered benefits
Financing Mechanism	Means-based premiums from sources including employers, individuals, and government[9]	Means-based premiums from sources including employers, individuals, and government[10]	Revenue plan to be determined
Organization and Planning	• The Commissioner would seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the CHS, which would then assume responsibility for all benefits and services previously paid for with those funds. • Prohibits health care service plan contracts or health insurance policies from being issued for services covered by the CHS. • A Payments Board would administer the finances of the CHS. • A Premium Commission would determine the cost of the CHS and develop a premium structure for the system that complies with specified standards.	• The Commissioner would seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the CHS, which would then assume responsibility for all benefits and services previously paid for with those funds. • Prohibits health care service plan contracts or health insurance policies from being issued for services covered by the CHS. • A Payments Board would administer the finances of the CHS. • A Premium Commission would determine the cost of the CHS and develop a premium structure for the system that complies with specified standards.	• The HC Board would administer the program, including seeking all necessary waivers, approvals, and agreements to allow existing federal health care payments to be paid to the HC program, which would then assume responsibility for all benefits and services previously paid for with those funds; engaging and paying health care providers; authorizing program expenditures; and determining when individuals may start enrolling in the program. • Prohibits health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the HC program.
Potential Cost Impact	$210 billion (LAO estimate)	Unknown	Approximately $400 billion (Senate Rules Committee

[9] SB 1014: *Taxation: single-payer health care coverage tax* was introduced in February 2007 as a funding mechanism for SB 840 and proposed various taxes including on employers and employees. One of its provisions stated that it created "a health care coverage premium paid through the imposition of taxes on wages."
[10] There was no companion bill introduced in 2011 to create a funding mechanism for SB 810.

Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
in Year 1, at time of potential enactment	$282 billion in 2016		estimate) $331 billion in 2017
Potential Cost Impact in 2021 $	$311.4 billion, or $7,880 per capita	Unknown	$356.5 billion, or $9,057 per capita

Source: California Health Benefit Review Program, 2021

Differences Between AB 1400 and Previous Single-Payer Attempts in California:

All three proposals above (SB 840 of 2007, SB 810 of 2011, and SB 562 of 2017) included comprehensive benefits, and attempted to achieve universal coverage for all California residents (including the undocumented) by redirecting revenues from individual and employer premiums, federal and state government programs, and taxes into a fund set aside for each proposed single-payer system. In some cases, the actual financing mechanism is vague or unknown, but in all three bills, a health care board would determine benefits and negotiate reimbursement rates for private providers. All three bills would require the state to negotiate waivers in Medicare and Medicaid to allow for the pass through of federal funds to the new single-payer system.

SB 562 did not propose any cost sharing or coinsurance for services received, whereas the other two bills allowed them in the third year of implementation. The financing mechanism for each bill varied, with SB 562 not including a specific financing plan, whereas SB 840 called for additional taxes on payroll, self-employed income, and unearned income. All analyses suggest that cost savings will be incurred due to simplification, administrative savings, and negotiated prices with providers. Although these savings do not fully offset new spending, they do reduce the need for additional revenue.

Revenue sources proposed by SB 840 included certain new taxes[11] and the redirection of funds from existing government programs. State payments for services would be paid directly to the state government system, which then bears responsibility for delivering all benefits, items, and services. Formulas would be established to ensure equitable contributions from all California counties and other local health jurisdictions by a Commissioner.

Under the SB 840, physicians and other individual providers (such as dentists) generally would be compensated for their services by the single-payer system as fee-for-service providers or as providers employed by, or under contract with, health care systems that provide comprehensive coordinated services, such as Kaiser Permanente or potentially other medical practice groups.

SB 840 would establish budgets for hospitals, certain clinics, and medical provider groups, such as independent practice associations or Kaiser Permanente. These budgets would include components for operating expenses and capital expenditures.

The LAO (2008) cost estimate for SB 840 indicated that that the bill would result in a net shortfall of $42 billion in 2011–2012 (the first full year of operations) and $46 billion in 2015–2016. These shortfalls resulted largely from a faster rate of growth for health benefits costs relative to the single-payer program revenues.

The University of Massachusetts, Amherst, Political Economy Research Institute (PERI) provided an economic analysis of the proposed measure. The authors (Pollin, et al., 2017) estimated that through

[11] SB 840 provides for taxes on payrolls, self-employed income, and unearned income.

implementation of Healthy California (SB 562), overall costs of providing full health care coverage to all Californians could fall by about 18% relative to spending levels under the existing system. There would have been two broad areas of cost saving under Healthy California. The first is a set of structural changes in the areas of: 1) administration; 2) pharmaceutical pricing; and 3) fee structures for service providers. PERI estimated that overall utilization would have risen by 12% under SB 562.

PERI's report suggests that two new taxes could be used to generate the revenue required to offset the loss of private insurance spending: a gross receipts tax of 2.3% and a sales tax of 2.3% (Pollin et al., 2017). However, SB 562 did not explicitly create a funding mechanism.

However, the California Senate Committee on Appropriations estimated that if the bill was financed "through a new payroll tax (with no cap on wages subject to the tax), the additional payroll tax rate would be about 15 percent of earned income." (McCarthy, 2017). Regardless, any analysis of the bill is necessarily speculative and incomplete; the way that California would actually finance its health care system if SB 562 was enacted is entirely ambiguous.

The second assumption on how SB 562 would be financed is through reductions of inefficiency in the current multipayer system. PERI assumed that reductions in unnecessary services, inefficiently delivered services, missed prevention opportunities, and fraud would save roughly 5%.

PERI also estimated the long-term care services that would be covered under AB 1400 in a follow-up study to SB 562. These include, among others, nursing homes, home health care services, rehabilitation, and personal care. Within the CMS Health Consumption Expenditures accounts, spending in these areas are mostly covered within the two categories of nursing home services and home health care. In 2017, spending in these two categories totaled to $265 billion, that is, nearly 8% of all Health Consumption Expenditures.

Given such uncertainties in coverage within SB 562, Pollin and his co-authors believed it "is prudent to allow, as a high-end approximation, that long-term care spending under Medicare for All will increase by the same 12 percent level that we have applied for other categories of Health Consumption Expenditures (Pollin et al., 2018)."

On the whole, the PERI analysis predicted that although SB 562's single-payer system would be expensive, its cost in taxes would ultimately be cheaper than the costs that Californians currently pay to private insurers. The study did not, however, analyze the effects of SB 562 on employment. Impacts on employment would impact the state's tax base and other revenues (Pollin et al., 2017).

The Senate Committee on Appropriations analysis predicted total annual costs of about $400 billion per year, including all covered health care services and administrative costs, at full enrollment. PERI, on the other hand, estimated, "The overall annual costs of this single-payer system for California would be $331 billion as of 2017," and $356.5 billion in 2021 dollars.

The range of cost estimates varies from $7,200 to $9,057 per person in 2021, suggesting that the overall amount spent by AB 1400 is lower than average spending on health care each year throughout the United States from all payers.

The Lewin Group (2002) prepared analyses of multiple health care reform options for the state of California, ranging from Medi-Cal expansion to single payer. Their single payer modeling indicated between $9.6 billion to $14.4 billion in new spending would occur due to new utilization of acute and long-term care in 2002. Adjusting for inflation, that is the equivalent of $14.2 to $21.3 billion dollars in 2021. The Lewin Group report also calculated cost offsets to finance the three single payer reform proposals, which included tobacco taxes, payroll taxes, income taxes, taxes on unearned income, and administrative efficiencies (Lewin Group, 2002).

Evidence From Other State Single-Payer Proposals

Nine states currently have single-payer proposals under consideration. Four of the nine states are in New England. Connecticut's 2021 Regular Session proposal[12] would establish a self-insured universal single-payer health care program that operates on a fee-for-service basis with individual providers. It would be funded through taxation in lieu of premiums and would request a waiver from the federal government pursuant to Section 1332 of the ACA. Similarly, Rhode Island's proposal[13] proposed a universal single-payer health care insurance program (Rhode Island Comprehensive Health Insurance Program, RICHIP), modeled as a "Medicare-for-all" type of program. The proposal would be funded through the consolidation of government and private payments to insurance carriers. Massachusetts also has an introduced bill in the 2021–2022 Regular Session, HD 2656/SD 546, which would establish a Medicare for All Program in the state, establishing the Massachusetts Health Care Trust.[14] Vermont's H 276, introduced in the 2021–2022 Regular Session, would implement a publicly financed health program for all residents over time. HB 602, introduced in the 2021 Texas Legislature, would provide comprehensive health care benefits coverage through a publicly funded program called the Healthy Texas Program. Maryland's HB 534, introduced in the 2021 Regular Session would establish a state Program to provide comprehensive universal health coverage for every resident and be funded by certain revenue.

Virginia, Washington, and Hawaii have introduced studies (Virginia HB 2271) or created commissions (Washington State SB 5399) or pilot programs (Hawaii SB 2980/ SB 3128),

IMPACT OF AB 1400 BASED ON EXISTING EVIDENCE

High-Level Meta-Analysis

A high-level meta-analysis[15] (Cai et al., 2020) identified 22 modeled predictions (over the past 30 years) of the cost of single-payer financing in the United States. This analysis focused on the cost estimates of single payer financing proposals, but did not consider financing or revenue plans. Cai et al. found that 19 of the 22 studies (86%) predicted net savings during the first year of operation, with a range of 7% higher net costs to 15% lower net costs. The range of cost increases due to insurance coverage improvements resulting in higher use of services ranged between 2% and 19%. Simplification of payment administration, reduced prescription drug costs, and other components resulted in net savings of 3% to 27%. Overall, the authors estimated that net savings averaged 1.4% per year.

Net financial impacts during the first year of single-payer implementation ranged from a 7.2% increase in costs to a 15.5% decrease (net savings. The study found the median value was 3.5% in net. They also found that 19 of the 22 plans would result in savings. , Higher use of health services increased costs by 2.0% to 19.3% (with a median of 9.3%) and offsetting savings due to simplification, lower drug costs, and other cost reductions ranged from 3.3% to 26.5% (with a median of 12.1%) in net savings (Cai et al., 2020). The costs and savings varied by the number of newly insured people, benefit generosity, increase use of services and cost sharing decisions.

All 22 studies predicting savings due to simplified payment administration (ranging from 1.2% to 16.4%, with a median of 8.8%). Other sources of savings were lowered prices for medications and durable medical equipment, reduced fraud and waste, and lowering prices based on Medicare payment rates (Cai et al., 2020).

[12] HB 5340 has been introduced in the Connecticut 2021 Regular Session.
[13] Senate 233 has been introduced in the Rhode Island 2021 Regular Session.
[14] The Trust would establish health care taxes on employers, workers, and residents that will replace spending on insurance premiums and out-of-pocket spending for services covered by the Trust,
[15] A meta-analysis is a statistical method combining the results of several scientific studies that focus on the same question.

Over a longer time horizon of ten years, projected net savings increase for all 22 models, even in the three estimates for proposals that had net costs in the first year, (Cai et al., 2020).

Table 2: CBO and Urban Institute Analyses of Similar Single Payer Proposals

Name	Population Expected to Enroll	Estimate of Total Spending	Year of Analysis	Benefits/ Comprehensiveness	LTSS Included	Excluded Groups
CBO Option 5	All US residents	$6.92 trillion in 2030	2019, 2020	Comprehensive	Yes, SNF and LTSS	None
Urban Institute, Reform 8	All US residents	$4.22 trillion in 2020	2019	Comprehensive	Yes, LTSS	None

Source: California Health Benefits Review Program, 2021.

Key: CBO, Congressional Budget Office; LTC, long-term care; LTSS, long-term services and support; SNF, skilled nursing facility.

LONG TERM CARE

AB 1400 and Long Term Care

AB 1400 would greatly enhance the coverage for long-term care services throughout the state, but it would not only cover the costs from existing payers, it is likely to subsidize families providing caregiving on their own who do not benefit from one of the existing coverage programs (Medi-Cal, Medicare, or private long-term care insurance) or social services programs (e.g., In-Home Supportive Services). Because long-term care is not a traditional benefit for employer-based or private individual market plans, the change in service use and spending would be sizable if AB 1400 were implemented.

AB 1400 would have to consolidate the roughly $25 billion per year spent by Medi-Cal and Medicare, provide additional funding to address self-pay services[16], private long-term care insurance, and the gaps in services that people cannot easily access. In addition, all of the funding allocations for social services and developmentally disabled programs might need to be consolidated under the health care umbrella for AB 1400 to be efficient. The actual cost of private long-term care insurance premiums and self-payment by long-term care users who are not receiving custodial care through Medi-Cal or rehabilitative care through Medicare is unknown.

If someone is eligible for Medi-Cal due to the cost of skilled nursing care effectively lowering their income, they are considered to have a share of cost. The share of cost is the amount paid by individuals on Medi-Cal for their skilled nursing services, and are not currently borne by the Medi-Cal program itself.

[16] Self-pay is another significant source of spending for long-term care services. Families also “spend down” due to expensive long-term care needs, meaning they expend so much of their family income and savings that they become eligible for Medi-Cal for the remainder of their custodial long-term care service needs. Having a comprehensive long-term care benefit may be expensive, but it will drastically improve the ability of families to retain savings and alleviate the economic burden that often falls upon children and spouses of individuals needing long-term care services.

Analyses of Federal Single Payer Options

Recent analyses of multiple single-payer model approaches by the Congressional Budget Office (CBO) and Urban Institute provide estimates of cost and insurance impacts in the United States. Two of the models selected by CBO and Urban Institute are comparable to AB 1400, and the results from the CBO and Urban Institute models are instructive for those assessing the feasibility and cost of AB 1400.

In December of 2020, CBO modeled five illustrative options for single payer based on a Medicare for All approach. The model results varied due to differences in providers' reimbursement rates, patients' cost sharing, and the coverage of LTSS. CBO estimated how these five approaches could impact the federal budget in 2030 and assessed other outcomes. One of the options produced by the CBO (Reform 5) is quite similar to the underlying direction of AB 1400. Reform 5, as scored by the CBO is a single-payer program with additional benefits and no cost-sharing. It eliminates all cost-sharing requirements, adds adult dental, vision, hearing, and LTSS benefits. It also assumes high payment rates to providers and drug companies. This option covers all U.S. residents, including undocumented immigrants. National spending on health care would grow by approximately $290 billion in 2020. Based on California's share of national health spending (11.39%) according to the 2014 Health Expenditure data, California's health spending would be projected to increase by $33 billion in 2020 (or $33.46 billion in 2021 dollars).

The CBO projected that the percentage of revenues spent on administration by hospitals would decrease by 7 percentage points (from 19% to 12%). Relatedly, physician administrative costs as a share of revenue would decrease from 15% to 9% (a 6% percentage point decrease). In addition, it estimated that physicians would spend 4.8% fewer work hours and nurses would spend 18.4% fewer work hours. These assumptions build on a large evidence base showing high administrative overhead among U.S. health care providers relative to other nations (Bruenig, 2020).

In October of 2019, the Urban Institute estimated the effects of eight varying health care reform options. The analysis uses their Health Insurance Policy Simulation Model (HIPSM)[17] and new Medicare simulation model, MCARE-SIM, and the Dynamic Simulation of Income Model (DYNASIM).

CHBRP's summary focuses on the Urban Institute's analysis of a comprehensive single-payer reform similar to the Medicare for All Act of 2019. This is called Reform 8: "Single-payer with enhanced benefits and no cost-sharing requirements," (Blumberg et al., 2020). This option includes all U.S. residents, eliminates all cost-sharing requirements, and adds adult dental, vision, hearing, and LTSS benefits (Blumberg et. al., 2019). The LTSS benefits modeled were likely less generous than those proposed in AB 1400.

Table 3: Urban Institute's Estimates of "Reform 8 Single Payer with Enhanced Benefits and No Cost Sharing"

	Health Care Spending (Billions)		
Current Law	**Federal**	**State**	**National**
ACA	1,284.3	302.3	3,496.8
Single Payer enhanced with broad benefits and no cost sharing	4,128.9	42.7	4,216.5

Source: Urban Institute, 2019

[17] HIPSM is a detailed microsimulation model of the U.S. health care system designed to predict the cost and insurance coverage impacts of proposed health care policy reforms.

Estimating Changes in Payment for Services Based on Reimbursement Levels and Changes in Utilization

Over recent decades, numerous studies focused on the U.S. case have shown that people do vary their utilization of health care, at least to some degree, depending on how much they must pay out-of-pocket for their care. Perhaps the most well-known study of this issue is the RAND Health Insurance experiment. This project was conducted between 1974 and 1982. During those years, nearly 6,000 U.S. households were given health insurance, but with different arrangements with respect to cost sharing. The experiment showed that health care use and individual spending tended to fall as the amount of cost sharing increased (Manning, et al., 1988). Following from the results of the RAND study and subsequent relevant literature, we would expect average health spending to increase if cost sharing were reduced, as proposed in the draft legislation for the Healthy California program.

But that then raises the more precise question — that is, *how much* would we expect utilization rates to rise through the CalCare program, relative to current utilization rates, especially among the uninsured and underinsured? The extensive literature that has emerged following from the RAND study is highly informative here. Some of this subsequent literature, building from the RAND study, has utilized additional data and modeling assumptions, to produce a broad finding that, on average, a 10% increase in out-of-pocket costs would be associated with a 2% decrease in health expenditures. Conversely, this result suggests that a 10% decrease in out-of-pocket costs would be associated with a 2% increase in health expenditures.[18]

Impact on Provider Supply and Hospitals

Total spending on health care would be lower if provider payment rates under a single-payer system were set at Medicare FFS rates rather than at a higher level, such as average commercial health insurance reimbursement rates. However, Medicare rates are higher than Medi-Cal rates. Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates most providers receive. If Medicare rates were not sufficient to cover the actual cost of delivering services for a provider, such a reduction in provider payment rates could result in providers leaving the market (closing practices, relocating to other states, or trying to provide care outside of the single-payer program), reducing services, and reduce the quality of care (Ellis and McGuire, 1986; Rice, 1997). It could also result in providers attempting to bill for more services with a low marginal cost to generate additional revenue. Studies have found that increases in provider payment rates lead to a greater supply of medical care, whereas decreases in payment rates lead to a lower supply. However, those studies are based only on changes in Medicare's payment rates in our existing multipayer system. These results may not be relevant for a single-payer system because of the lack of ability to avoid certain lower-paying patients or payers. Provider responses to payment changes are challenging to predict under a state-based single-payer system because providers might be able to offset losses in one payer by increasing their rates for other payers or seeing more patients from other payers in a multipayer system. Those opportunities would no longer exist in a single-payer system (CBO, 2019).

Legal and Financial Hurdles for State Single-Payer Health Care

To finance these universal and comprehensive benefits, state single-payer bills use several strategies similar to AB 1400 to capture health expenditures from the existing multi-payer system, while navigating a number of financial and legal impediments. The state bills combine federal funds from Medicare, Medicaid, and the ACA marketplace tax credits and cost sharing reductions into the single-payer plan using waivers in those federal programs (Wiley, 2018). The U.S. Department of Health and Human Services (DHHS) has substantial flexibility over approving or negotiating state waivers in Medicaid,

[18] At the same time, several studies have raised significant concerns with respect to relying on a single, static estimate of the relationship between out-of-pocket expenditures and overall health care spending. For instance, it has been shown that the extent to which people will alter their health care utilization rates will be responsive to the specific types of cost-sharing arrangement being used.

Medicare, and Section 1332 of the ACA. However, proposed legislation usually does not have substitute revenue to “fall back” on were the agency to deny the waivers. Instead, the waiver’s failure would typically undermine the ability to deliver the single-payer program as proposed. State budget rules often harm a state’s ability to maintain spending levels during economic recession or downturn (Bagley, 2017). That means that without a series of federal waivers related to Medicare, Medicaid, and Affordable Care Act requirements and federal funding, the revenues to support AB 1400 will not exist at the state level.

State single-payer proposals also face challenges in redirecting premiums for employer-sponsored health plans due to the Employee Retirement Income Security Act (ERISA) (KFF, 2019b). ERISA pre-empts all state laws that “relate to” employer-sponsored benefits, such that “states cannot simply mandate that employers cease offering health benefits,” (Gaffney et al., 2021). States do retain broad power to regulate health care providers and health insurers, but ERISA preempts the application of state insurance regulations to employers’ self-funded health plans, which now comprise more than 60% of all employer-sponsored health benefits (KFF, 2019b). ERISA challenges states’ abilities to capture employer health spending — a source of funding that would be critical to the viability of a single-payer system.

The labyrinth of ERISA pre-emption has inspired creative drafting of state single-payer bills to do indirectly what ERISA prohibits them from doing directly (Fuse Brown and McCuskey, 2019). State single-payer proposals appear to use three strategies for state bills to capture employer health spending and shift employees into the state single-payer system:

- Payroll taxes on employers;
- Income taxes on employees; and
- Restrict providers from accepting reimbursement from private insurance companies.

Nearly all states’ bills include one of these strategies; most include a combination of them.

KEY CONSIDERATIONS AND UNKNOWNS

CHBRP’s analysis is not intended to make recommendations regarding the appropriateness or feasibility of AB 1400. However, in reviewing the analyses and evidence from numerous studies, CHBRP offers these key considerations and remaining unknown impacts to inform the Legislature.

Integration Considerations

Plan Design in AB 1400 that eliminates premiums and cost sharing will likely 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. Findings from the RAND Health Insurance experiment and more recent work on the impact of cost sharing and coinsurance in reducing the use of health care suggest that removing cost barriers through a single-payer system could trigger new use to be paid for by the system. Much of that use may be necessary, but it is not currently occurring or is being delayed due to cost barriers for a segment of the population. In addition, reduced premiums are likely to draw new enrollees into the health care system, so that they have increased access to care in contrast to being uninsured (MACPAC, 2015).

Provider Impact and Hospitals. Although a single-payer system allows for private providers to continue operating as private entities, the payment sources will be limited to the new CalCare single-payer program. Currently, hospitals and health care providers negotiate reimbursement rates with private insurance companies (including Medicare Advantage and Medi-Cal managed care plans), receive lower, fee-schedule-based payments from fee-for-service Medicare and Medicaid, and also receive cost sharing

payments from insured patients, and partial or full payment for self-pay services from uninsured or out-of-network patients. Consolidating all Californians under one single-payer system would require price setting that takes the previous multipayer rates into consideration, adjusts them downward to address administrative efficiencies, and pays hospitals and providers a new, blended payment rate for services rendered or people cared for.

A single-payer health care system in California could help the state meet a number of goals — universal health care coverage, comprehensive benefits, increased equity, greater access and quality, improved affordability, lower administrative costs, and slower growth in health care costs (CHCF, 2017).

Fiscal Uncertainties

The ability to manage costs is predicated on a single government entity budgeting for the health care costs of a single risk pool that has the potential to centrally impose cost controls. If that single risk 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. It may be difficult to achieve system wide 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 system-wide improvements if this population is excluded and program goals are not well aligned.

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 depends on robust revenues. 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.

Health spending (the sum of public and private spending, including personal out-of-pocket spending by consumers) under a single-payer system could increase or decrease, depending on the extent to which:

- Health care benefits improve relative to currently available coverage;
- Utilization of health care services increases due to reduced out-of-pocket costs and additional insured people;
- Reduced provider reimbursement rates; and
- Administrative costs of health insurance and health care delivery can be reduced.

The productivity of the health care workforce and administrative costs in health care delivery and health insurance impact total expenditures devoted to health care.

Administrative and Legal Questions

Revenues:

CHBRP assumes federal revenues via a waiver agreement.

The bill does not establish the revenue model for financing AB 1400. The Legislature pledges to enact legislation that would develop a revenue plan to fund AB 1400, with considerations for federal revenue available to support CalCare. CHBRP assumes those federal revenues would be obtained through subsequent waivers of Medicaid (Section 1115), Medicare, and ACA (Section 1332) requirements and regulations such that California would rely on federal matching revenue and financing based upon the current federal share of funding for Medicaid, Medicare, and Covered California tax credits and subsidies. In addition, California would need to leverage potential savings from the implementation of AB 1400 such that the federal cost of Medicaid, Medicare, and Covered California plan tax credits would decrease, allowing federal savings to be allocated to California for the purposes of financing the single-payer

system. The federal government would also receive previously foregone tax revenues from individuals and employers who were receiving tax-exempt or tax-deductible employee health benefits. While California would receive a share of tax revenues on newly taxable payroll or income through state taxes, a substantial amount of revenue would be collected by the federal government. The state would benefit from capturing those funds to ensure they flowed into the CalCare program through one of the federal waivers mentioned above. AB 1400 also requires that all state revenues from CalCare would be placed in an account within the CalCare Trust Fund Account. CHBRP is aware of existing provisions in the state's Constitution that affect the California's ability to raise and spend revenues. Two additional legal considerations raise additional uncertainties.

The first legal consideration is regarding Proposition 4 of 1979. Proposition 4 established a constitutional limit on spending known as the "Gann Limit." The Gann Limit was later updated by Prop. 98 of 1988 and Prop. 111 of 1990. According to the state Senate Appropriations Committee analysis of SB 562, "the very large tax revenues that this bill would require…would clearly exceed the Gann Limit." While CHBRP does not provide legal analysis, overcoming this obstacle may require California voters to repeal the Gann Limit or exempt new single-payer-related taxes from the limit, as the Senate Appropriations Analysis of SB 562 suggests. AB 1400 would it seem, offer similar interactions with the Gann Limit as SB 562 did.

The second legal consideration is Proposition 98 of 1988 (which was subsequently modified by Prop. 111 of 1990). Prop. 98 amended the constitution to require a minimum level of funding for K-12 schools and community colleges. The state Senate Appropriations Committee analysis of SB 562 (McCarthy, 2017) stated taxes raised to support the single-payer program would be "considered the proceeds of taxes and would be subject to the requirements of Proposition 98." Prop. 98 would require some of the new tax revenues raised by SB 562 (or the proposed AB 1400) would have to support to K-12 education and community colleges. If voters wanted funds to go directly to the state single-payer program, California voters would have vote to change the funding guarantee in Prop. 98 or explicitly exempt the new taxes from Prop. 98-eligible tax revenues.

Other Uncertainties

The scale and challenge of the implementation of AB 1400 may result in unanticipated impacts in the following categories:

- Reduced investment in hospital capacity/investment if provider rates are set lower than costs;
- Reduced technology adoption;
- Disruption and upheaval in health care workforce (including IT, insurance…)/ loss of jobs; and
- Reductions in health care workforce pay.
- Changes in provider reimbursement rates in a single-payer system could have long-term effects on provider supply. If provider reimbursement rates were significantly lower, people could decide not to enter the medical profession or locate in California. Supply of hospitals and health care facilities could decline due to closures, or investments in facility improvements or construction might be limited. If health care prices decreased, additional Californians gained coverage, and cost sharing was eliminated the state could face shortages due to increased demand for services and fewer providers.
- Consumer protections: It is unclear whether CalCare would be subject to existing consumer protections, including existing Medicaid due process rights and other Medicaid protections as well as the consumer protections to which seniors and others are entitled under Medicare. It is unclear whether the federal waivers would waive or preserve existing Consumer protections under Medicaid and Medicare. Although the statutes would stay in place, it is unclear whether CalCare would need to abide by the state standards developed over many decades. Although AB 1400 acknowledges that consumers need timely access to care, AB 1400 would need to adapt existing bodies of law to ensure a long list of consumer protections continue.
- Integrated care and salaried providers: As drafted, AB 1400 appears to eliminate integrated care delivery systems and rely exclusively on fee-for-service. It allows a group practice, county

organized health system (COHS), or local Medi-Cal managed care initiative to be paid on a salaried basis but does not clarify the role of these entities in the new single-payer health system envisioned by AB 1400.

- Other consequences of AB 1400 could include the need to develop new information technology to administer the program. This new information technology could cost billions of dollars according to estimates from the California Senate Committee on Appropriations (See Senate Committee on Appropriations Analysis of SB 562 in 2017 [McCarthy, 2017]).

CONCLUSION

CHBRP's synthesis of evidence provides policymakers with some consensus estimates of costs and potential savings, and details many of the implementation questions and uncertainties that all states would experience in implementing legislation as complex as AB 1400. In addition, CHBRP's also highlights some of the unique legal and financial constraints that California would face if it enacted AB 1400.

Implementation Considerations

The meta review and other studies suggest that single-payer health care would reduce financial burden, increase efficiency, and result in net savings. An initial net cost reduction (3%-4%) is estimated to grow over time, resulting in longer-term savings over 10 or more years. This uncertainty around immediate benefits, however, creates significant challenges for state implementation, in particular. The evidence illustrates that maximizing performance and savings will require a very complex and intensive undertaking.

Further, to achieve the cost reductions identified in the studies CHBRP reviewed of single-payer proposals, payment processes should be simplified, drug prices reduced, and data used to reduce inappropriate or improper care and payment (Cai et al., 2020). All of these are enormously challenging undertakings. The authors of the Cai et al. (2020) meta-analysis note that "the logical next step is real-world experimentation, including evaluation and refinement to minimize transition costs and achieve modeled performance in reality."

Considerable research and analysis has highlighted some of the potential benefits, pitfalls, and uncertainties for states considering single-payer proposals. Some of the key uncertainties facing policymakers in considering AB 1400 include the following:

It may be difficult to achieve system-wide access and quality goals if a substantial portion of the population is excluded from the single-payer program. Similarly, single-payer design notions that eliminate or reduce premiums and cost sharing would need to secure offsets. The ability to manage costs is predicated on a single risk pool that has the potential to centrally impose cost controls.

On the funding side, 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.

Other potential concerns are economic in nature, but also impact current health care delivery. Disruption to the state's health care workforce, safety net providers, integrated health care systems, health care providers, insurers, and residents may be significant. Uncertainties in capital needs and funding may dampen investments in innovation, technology, and public health, during an extended period of uncertainty.

As the body of literature demonstrates, there are legal and financial hurdles for state single-payer legislation, such as AB 1400. Successful implementation of CalCare would require the consolidation of

federal funds from Medicare, Medicaid, and the ACA exchanges into the state single-payer plan using waiver provisions in those federal programs. Proposed state single-payer plans generally lack fallback plans for capturing federal funds should the federal government deny the waivers. In addition, state constitutional prohibitions on deficit spending, constrain state plans when tax revenues fall during economic recession.

The scale and risks of managing hundreds of billions of dollars in health care spending provide a live experiment with opportunity but also unanticipated risks and costs. CHBRP is aware of existing provisions in the state's Constitution that affect the California's ability to raise and spend revenues. The CBO (2020) itself noted that "a high degree of uncertainty surrounds its own estimates. That uncertainty stems from many factors, including estimates of how providers and patients would respond to the single-payer system, administrative costs under the system and under current law, how regulations and other administrative actions following enactment of the legislation creating the system would affect costs, health care spending and economic conditions in the future under current law, spending on certain components of health care today, and after effects of the current coronavirus pandemic.

New health care utilization might be induced by lower copays/deductibles/patient cost (and the removal of utilization management. This would create financial and access challenges. The CBO projected that some offsets may be achieved in hospital costs, as the share of revenues that hospitals spend on administration may fall under a single-payer system. Similarly, physicians' and other health care providers' administrative overhead may fall, and physicians and nurses could spend less time on administrative activities.

Long-Term Care Conclusions

Although spending information from Medicare and Medicaid on custodial and rehabilitation-related long-term care is available, there is limited information on the informal caregiving, private long-term care insurance premium costs and spending, and out-of-pocket costs for individuals and families. Therefore, it is difficult to predict the monetary impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide. There is no available evidence to estimate the level of pent-up demand for publicly-funded long-term care services there might be were AB 1400 to be enacted. Therefore, it is challenging to assess the level of long-term care supply that would be needed to quickly respond to pent-up demand and new demand for long-term care services due to the expansion of benefits proposed by AB 1400.

Upfront Reserve Estimate

Overall health care spending in California is estimated to be between $284 billion and $358 billion in 2021 dollars. Spending is likely to increase due to comprehensive of benefits and reduced cost sharing, which means utilization will increase too. Some estimates suggest another $33 billion in spending due to the removal of cost sharing and demand for services increasing. Given the need to spend state dollars to leverage federal matching funds, and the new spending projected, CHBRP estimates that 50% of the current estimated health care spending plus the additional spending due to the implementation of AB 1400 should be placed in a reserve fund to ensure benefits can be offered to California residents. That amounts to $158.5 billion to $195.5 billion in reserves.

APPENDIX A TEXT OF BILL ANALYZED

On March 3, 2021, the California Assembly Committee on Health requested that CHBRP analyze AB 1400. CHBRP has included the bill summary, below. For the full bill language text, you may access it at: https://chbrp.org/completed_analyses/index.php.

Introduced by Assembly Members Kalra, Lee, and Santiago
(Principal coauthors: Assembly Members Chiu and Ting)
(Principal coauthors: Senators Gonzalez, McGuire, and Wiener)
(Coauthors: Assembly Members Friedman, Kamlager, McCarty, Nazarian, Luz Rivas, and Wicks)
(Coauthors: Senators Becker, Cortese, Laird, and Wieckowski)

February 19, 2021

An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1400, as introduced, Kalra. Guaranteed Health Care for All.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, 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. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children’s Health Insurance

Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board to convene a CalCare Public Advisory Committee with specified members to advise the board on all matters of policy for CalCare. The bill would establish an 11-member Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports.

This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person.

This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget.

This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org