The Politics of Single Payer Health Care – "Medicare for All"

In the single payer systems, private doctors and hospitals deliver the services and government pays their bills for your services. We have a next-door neighbor, Canada, with a single payer system that works reasonably well. Medicare is a single payer system for the elderly and disabled and works well for them. Some well-run European systems like France and Norway are single payer, and their citizens are reasonably happy with the results.

Single payer is not the only way to universal coverage. The Germans, Dutch and Swiss all have universal coverage using private insurance, whether through employers or individuals.

The British have the only truly socialized medicine system. The government owns and operates the hospitals and the doctors and nurses are government employees. That is not even on the table for discussion and debate in the US.

The case for single payer is pretty simple as follows. It costs less, covers everyone and gets better health outcomes. Right now the US health system costs a lot more per capita or as a percent of GDP than any other system; it gets significantly worse health outcomes, and it does not cover everyone. https://www.commonwealthfund.org/chart/2017/health-care-system-performance-rankings Moreover there is wide variability among the states, with top performers like Minnesota and Vermont far out performing the bottom ranked states like Mississippi and Oklahoma. https://interactives.commonwealthfund.org/2017/mar/state-scorecard/ California is one of the states that recently showed enormous improvement due to its stellar performance in implementing the Affordable Care Act (ACA).

Who's against it and why? First and foremost, the insurers are opposed because their roles (and profits) would be eliminated. Second, the hospitals, doctors and drug companies are opposed because their rates would be regulated and they believe their incomes would be less. Third, the employers are opposed because they would have to pay taxes to support the single payer system and they think government will steadily increase their taxes. Lastly, Republican politicians for the most part are opposed because it crosses so many of their red lines: taxes, government control, and regulation of provider rates.

Who's for it? The Nurses Union is a strong proponent as are many consumer groups. Some doctors and most public hospitals support it, so do many labor unions. The progressive wing of the Democratic Party is strongly supportive.

The public is becoming more supportive, led by enthusiastic young voters. However, the support erodes once it is clear that taxes would have to be increased to pay for it. https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/ The California Legislative Analyst's Office

projects the need to roughly double state taxes -- $200 billion in new taxes -- to pay for SB 562 (Lara) and that assumes that federal waivers are forthcoming to fold in all current federal health spending, a risky bet at best with the Trump Administration. https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/FINAL%20LAO.pdf When the proposals go to the ballot box via the initiative process, only about 1/4th of the voters support the higher taxes required.

What should single payer proponents do in California with a new Governor who spoke supportively of single payer during the primary? First, try to increase their allies, starting with small employers and then larger employers; find the elements of the provider community that could be supportive such as primary care and emergency room doctors and ob-gyns; can you win over the public health plans or the strong and effective non-profits like Kaiser. Second, develop a persuasive argument that the measure is cost neutral (the taxes are no more than the private costs that patients and employers already pay that would now be eliminated) or costs less than the existing system (other single payer systems and multi payer systems cost much less than the US) and then convince legislators and the voting public. Stop yelling at those who disagree, you're weakening your case; you need to convince people instead. You need a compelling economic argument and a modernized pro-growth financing mechanism. Third, show the American public the ways in which the poor outcomes and cost inefficiency of the existing systems are hurting them and how it can be improved under what you are proposing – after all the public and many employers and providers are fed up with high costs of care and medicine and insurance premiums, deductibles and co-insurance. People are fearful of losing their coverage at their job and afraid that Medicare will go bankrupt; how does this help your argument. Fourth, make the case to Congress; they control the purse strings, not the state of California. Build working alliances with Republican leaning business communities and independent professionals tired of escalating premiums. Fifth, develop an effective modern reimbursement system that rewards improved patient outcomes and greater cost efficiency and penalizes the outliers in terms of high cost and/or poor outcomes. Sixth, update your bill to incorporate the best lessons from systems around the world that can be adopted here. Lastly, think through the right incremental changes in the existing systems that get you towards where you aim to end up.

Prepared by: Lucien Wulsin

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Financing Medicare for All

Financing Medicare for All is far better done at the federal than at the state level.

It's much easier to consolidate the Medicare and Medicaid programs, but you do have to decide which model you are going to follow. And if you choose Medicare, there are many more copays and deductibles and a lot more uncovered services – e.g. dental care, vision care, and most long-term care. And states are going to need to stay in the long term care business.

At the federal level, it's much easier to replace the employer and employee financing for private employment based insurance with a payroll tax without fear of falling afoul of the federal rules governing large employer's ERISA health plans and also losing the substantial tax advantages associated with employment-based coverage.

The current private insurance system is very regressively financed. The premiums are exactly the same for the minimum wage workers as they are for the boss earning who may be six or even seven and occasionally eight figures. The tax advantages associated with it are designed in ways that help extend coverage for higher income employees and individuals the most because they are linked to your income tax bracket. The federal income and payroll tax system is still far more progressive than most states, other than outliers such as California. It would be a better way to pay for coverage.

The federal government is unique in its capacity to clamp down on the wild excesses of drug pricing that have plagued the health care system. The drug companies are not alone in increasing their prices at unsustainable levels; hospitals have done so as well. Medicare forfeited the opportunity to lead in regulating drug prices by farming out this role to Part D private insurers when it expanded Medicare to cover prescriptions. It will need to negotiate directly with the drug companies in Medicare for All.

Health Care Financing (2016)
Private health insurance – 34%
Medicare – 20%
Medicaid – 17%
CHIP, ACA, DOD and VA – 4%
Out of pocket – 11%
Other (e.g. school health, jail health, MCH, workers comp) – 8%
Public health – 2%
Investments – 5%

Health Care Spending (2016)
Hospitals – 34%
Doctors – 20%
Prescription drugs – 10%
Dentists – 4%

Other professionals – 3%
Nursing homes – 5%
Other residential care – 5%
Home health – 3%
Durable Medical Equipment – 2%
Government Administration and Net Costs of Insurance – 8%
Investments – 5%

Taxes
It will require an increase in federal taxes to replace current private insurance spending (34%). It might also require an increase in federal taxes to replace the role played by state taxes (6%). What kind of money are we discussing? It's a lot, but it is not new money; instead existing private insurance premiums would be eliminated and replaced by increased federal taxes. Consumer out of pocket spending for copays and deductibles and uncovered services (11%) could be reduced and replaced by federal taxes as well.

Total health spending is about 18% of GDP, about $3.3 trillion or over $10,000 per person. Over half of that is already financed by taxes that pay for Medicare, Medicaid, premium assistance in the Affordable Care Act, grants to community clinics, public hospitals, the VA, etc. Those taxes are in the system; most are federal taxes (a mix of payroll taxes and income taxes); the rest are state and local taxes, such as local property taxes and state income and sales taxes. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/PieChartSourcesExpenditures.pdf

The federal government spends over $4 trillion annually on everything such as defense and social security, from infrastructure to agriculture, from food stamps to the post office to research and development of new technologies. About 1/4th is already spent on health care. https://www.nationalpriorities.org/budget-basics/federal-budget-101/spending/

Replacing private insurance premiums
Just over a third of all health spending is private insurance, primarily employment-based coverage, but also private individual coverage. Private employment based coverage is paid 3/4th by employers and 1/4th by employees on average. Private individual coverage is paid 100% by individuals unless they qualify for premium assistance under the Affordable Care Act as many do. Consumer out of pocket, copays, deductibles and uncovered services, are a bit over ten percent. These are mostly paid by individuals with very serious medical conditions, and by many patients, overwhelmingly elderly, of long-term care.

To make matters more complicated, there are favorable federal tax breaks that help pay for employment-based coverage, for coverage of the self-employed and for those whose medical expenses account for a large share of their incomes. These tax expenditures are large, and they are deeply engrained in our current tax system, and they would need to be changed and melded into a Medicare for All system. They cannot be readily accessed by a state trying to establish a "Medicare for All" program.

One option to avoid financial disruption is to finance Medicare for All by staying close to the existing distributions of financial burdens– fewer winners and fewer losers. For example, financing of coverage for employees could be a payroll tax divided between 3/4th employers, 1/4th employees. Some employers (low wage employers) and some employees (low income employees) would get significant fiscal relief by moving from premiums to taxes based on a percent of payroll, while others with higher wage bases and salaries would pay more in taxes than they do now in premiums. The problems with payroll taxes are two fold: first we are an aging society with fewer workers to support the financing; second financing from employment impairs some hiring and job creation. We ought to look at other financing options, such as the VAT (value added tax) or closing loopholes and exemptions for the wealthy.

Likewise individuals who are self employed or not working could pay a Health Insurance surcharge on their federal income tax in lieu of private insurance premiums. The self-employed already do so for their Medicare Part A taxes, so there is a mechanism already in place.

The Health Insurance taxes paid by employers, employees and individuals would need to equal about $1.2 trillion to break even with current spending. Alternatively, individuals could pay their shares as premiums for Medicare for All, just as the elderly and disabled do for their Medicare Parts B and D coverage. They pay about 1/4th of the cost of the program. To put this in context, the payroll taxes that finance Medicare and Social Security currently collect about $1 trillion annually.

The current state financing of programs like Medicaid or county health might be able to be captured through a claw back provision from the states. This currently exists for Medicaid prescription drug coverage for the seniors and the disabled. This would need to be a very large claw back equal to 6% of national health expenditures (or $188 billion from the states). States, which have very different levels of Medicaid and CHIP financing and coverage already, will be doing their best to avoid or minimize the claw back. Or the federal government could offer states a 6% state match on the costs of coverage for their citizens. One would think few states could decline that offer, which would otherwise leave many of their citizens uninsured as Medicare and Medicaid coverage would be subsumed into Medicare for All. To avoid constitutional challenges, this may need to be optional for each state. Otherwise it would need to be another new federal tax; in that case states would experience very large fiscal relief; they could reduce their state taxes or could increase funding for vital services like infrastructure or public education, including college and pre-K. In California, that fiscal relief (general and special fund taxes) would be close to 15% of the state's budget.

Replacing Consumer Out of Pocket

To replace all consumer copays and deductibles and uncovered services costs about $340 billion. Congress would need to decide whether to retain copays and deductibles as Medicare and private insurance do or to make them nominal as Medicaid does. Should copayments be linked to incomes or should they apply regardless of any individual's ability to pay? There are a variety of uncovered services under Medicare –

dental, vision, hearing aids and the biggest single out of pocket cost for seniors is for long-term care.

Some employer plans cover dental and vision; many do not, and very few cover long-term care. Long-term care is fully covered under Medicaid, and it is one of the biggest components of many state's Medicaid programs. In California, Medi-Cal pays for about 70% of all nursing home residents. However many higher income seniors are not covered for long term care and pay out of pocket. Long-term care is a very expensive service and accounts for about 13% of the nation's health expenditures, now reimbursed with a mixture of Medicaid, Medicare tax dollars and individual out of pocket. Much of the benefits from reducing out of pocket will inure to seniors and the disabled who use the most services. A full scope Medicare for All would make Medicare Supplemental policies redundant. Seniors and the disabled should contribute towards these benefit expansions in the form of shared premiums.

Coverage of Immigrants

A big hot button issue, in addition to taxes to replace private insurance premiums, involves immigration – i.e. whether Medicare for All coverage includes the undocumented and whether it covers new legal permanent residents.

The 10 million undocumented in the US are primarily young low-wage workers. Some are part of mixed status families where the father or mother is undocumented, and some or all of the children are US citizens, and the other spouse may be a legal permanent resident or a citizen. In California, the undocumented are nearly 6% of the state's population (about 2.5 million persons); in states like Ohio, Vermont, Maine or New Hampshire less than 1% of residents are undocumented. http://www.pewhispanic.org/interactives/unauthorized-immigrants. Current federal law limits their potential Medicaid coverage to emergencies and childbirth and excludes them from Medicare coverage, if they reach 65 or become disabled, even though they have paid their Medicare taxes. The costs for extending coverage to undocumented persons is relatively low since they are for the most part healthy young workers who infrequently use the health care system. California now extends full scope MediCal coverage to about 200,000 undocumented children, but not to adults, many of whom have coverage limited to emergencies and deliveries..

There are 13 million legal permanent residents (green card holders) in the US, of whom 9 million would be eligible to become US citizens if they so chose. The standard waiting period to start the process of becoming a naturalized citizen is 5 years, less for spouses of US citizens. California is home to about 3.3 million green card holders. https://www.dhs.gov/sites/default/files/publications/LPR%20Population%20Estimates%20January%202014.pdf Federal law limits Medicaid coverage for new (less than 5 years) legal immigrants to emergency care and deliveries, but provides full scope to them through the Exchanges. The Trump Administration seeks to disqualify all legal permanent residents from becoming naturalized US citizens if they have received any federal funds for their health coverage. California provides full scope coverage to legal permanent residents who otherwise meet the income eligibility requirements.

If Medicare for All limited or excluded coverage for legal permanent residents, there would be strong incentives for all of them to become naturalized citizens. Twenty million US residents are already naturalized citizens, meaning they migrated to the US and eventually took and passed their citizenship exams and met eligibility requirements.

Nearly 10 million Californians (about 1/4th of the total state population) were born outside the US, and naturalized citizens make up half of all immigrants living in California. http://www.ppic.org/publication/immigrants-in-california/ Contrary to common myth, most recent immigrants coming to California are from Asia, and most have a very high degree of education. They contribute greatly to the state's and the nation's economic prosperity.

Savings

There are several areas of potential savings from adopting Medicare for All: the elimination of private insurance and improved administrative simplicity and changes in provider reimbursements.

Administration

Medicare for All would eliminate private health insurance and the multiple state and federal eligibility determinations. This could save about 5% of current health spending since Medicare spends only about 2.6% of program expenditures on administration and the US (including private insurance, Medicare and Medicaid) spends 8%. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/PieChartSourcesExpenditures.pdf Administrative simplification also refers to the back offices of hospitals, doctors and other providers that bill many different health plans and programs, and argue with insurers about how much they should be paid. There is great debate about the extent of total administrative savings; the estimates range from 7% to as high as 14% of National Health Expenditures. http://govinfo.library.unt.edu/ota/Ota_1/DATA/1994/9417.PDF The complexity of our current system could be radically reduced, and compatible IT could further simplify the billing and payment systems. Whether Medicare for All can actually capture these administrative savings is uncertain and would depend on cutting provider reimbursements to reflect the savings associated with better administrative simplicity.

Reimbursement levels

The biggest difference between the US and other developed nations is that we pay our doctors, hospitals, nurses, and pharmaceutical companies, durable medical equipment manufacturers much more. https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries/#item-on-average-other-wealthy-countries-spend-half-as-much-per-person-on-healthcare-than-the-u-s On average, we pay twice as much and Americans use fewer health services. We see doctors less frequently; we stay in the hospitals less frequently, and we use fewer days. We do use some higher technology care such as MRIs, knee replacements and C-section deliveries more than in other developed nations. It's the price difference on the very same health care that makes US health care twice as expensive as other highly developed nations.

For Medicare for All to reduce American health costs towards the levels of our peer nations, it would need to dramatically cut reimbursements to providers, and that is extraordinarily difficult to do. Whether through Congress and the federal or state governments, or through the private sector health plans, we have shown very little appetite or ability to control excessive provider reimbursements. In fact the cost control efforts of our private sector employer plans have proved to be far less successful than government coverage through Medicare and Medicaid. A new Medicare for All program will need to revise traditional Medicare fee for service reimbursement methodologies which are inherently inflationary. The Affordable Care Act made a start with bundled payments and ACOs; this would need to be extended and expanded. A model reimbursement system would encourage better quality and greater efficiency and reduce program costs. We don't have such a system, and it would need to be developed as a part of the federal legislation. In my opinion, it should be based on competitive contracting, which is far more flexible than trying to set, alter and change reimbursement rates.

The challenges of financing Medicare for All at a federal level are surmountable, but only after an honest, informed and reasoned dialogue and debate. That is not the hallmark of our President and our Congress, nor of many of the interest groups pro and con. The politics are very difficult and will require business, labor and consumers to ally with those providers favoring such a system.

Personally, I think it will be far easier politically and financially to build from the foundations of the ACA (Affordable Care Act).

Prepared by: Lucien Wulsin
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Medicare for All – A Single Payer Health Care System for California and the Nation

Medicare was established back in 1965 under the Johnson Administration. It's a program for seniors (65 and older) and for many of the nation's disabled. It has advantages such as freedom of choice of providers and regulated rates and disadvantages such as uncovered costs and services and shaky financing.

It consists of four parts: Part A covers hospitals; Part B covers doctors; Part D covers prescription drugs and Part C (Medicare Advantage) is a private insurance option consolidating Parts A, B and D. Medicare covers some but very limited nursing home care and some but again limited home health care. Most nursing home and long term care costs are covered by Medicaid, not by Medicare.

Medicare reimbursement rates are established by the federal government. For hospitals, rates are based on a provider's reasonable and necessary costs. For physicians, rates are based on their usual and customary costs. For prescription drugs, reimbursement rates are negotiated between the Part D health plan and the drug companies.

Medicare is based on freedom of choice of providers; basically you choose among the hospitals and doctors participating in Medicare. Most doctors participate in Medicare; some do not. Many doctors accept assignment, which means they agree to the Medicare billing schedule; some do not, particularly in affluent areas. This allows them to charge you the patient as much as they wish and you agree. Virtually all hospitals participate in Medicare.

Medicare is primarily a fee for service program with weak controls on excessive or inappropriate utilization. Medicare Advantage is only as good as the health plan you select, and there are both excellent and poorly performing plans. Insurers participate in the program in three important ways: prescription drug coverage, Medicare Advantage and Medicare supplement plans.

Medicare patients have a great deal of exposure to out of pocket costs. These are those sometimes hefty copayments and co-insurance that your doctor, hospital or pharmacist charges you whenever you seek care. There is a donut hole of uncovered costs in the Part D prescription drug coverage, Many seniors buy Medicare Supplement policies from private insurers that protect them from out of pocket costs. About 20% of seniors are not protected from high copays and co-insurance.

Medicare Part A is financed by federal payroll taxes from employees and employers. Part B and Part D are financed by federal taxes and by subscriber premiums. Part A is typically referred to as the Medicare Trust Fund that is in some danger of spending all its revenues, if not reformed. Its financial difficulties are two fold: 1) fewer workers per retiree and more baby boomer retirees, and 2) health costs that exceed the growth in the overall economy.

Medicaid (MediCal in California) covers the poor. This includes seniors, the disabled, parents, children and other adults whose incomes are below certain thresholds.

These are comprehensive benefits, including all long term care, mental health care, dental and vision care There are nominal copays on some services, no coinsurance and no deductibles. The undocumented are only eligible for emergency and maternity care.

Medi-Cal coverage is mostly delivered via public and private HMO's who compete for subscribers in each county. The private HMO's include: Blue Cross, Blue Shield, Kaiser, Health Net and Molina. The public HMOs include: LA Care, CalOptima, Inland Empire Health Plan, San Francisco Health Plan and many others set up by county governments.

Behavioral health coverage is delivered by county specialty plans for mental health and substance abuse conditions. Thus a patient suffering from schizophrenia, opioid addiction and heart disease may have to navigate care and coverage through three different health plans.

Fee for service reimbursement rates for hospitals are negotiated with a state agency; they are roughly equivalent to Medicare. Fee for service reimbursement rates for all other providers are set by the state. Reimbursement rates in the managed care plans are negotiated between the providers and the plans. Some providers choose not to participate in the Medi-Cal program, citing low reimbursements; however plans must assure adequate access to a sufficient range of providers. Provider shortages are most acute in rural regions where there are insufficient providers for all types of patients.

Financing includes a federal match and a state match paid by federal and state taxpayers. The state match includes state matching funds, county matching funds and fees/taxes paid by hospitals and plans.

Single payer as envisaged in the California legislation (SB 562) proposed by Senator Kevin DeLeon is a mix of the Medicare and Medicaid (MediCal) models. It would have comprehensive benefits like MediCal. It would have low or no copays like MediCal. It would cover full scope services for all California residents regardless of immigration status – a feature not present in either Medicare or MediCal. It would eliminate all insurance and all HMO's – comparable to both Medicare and Medicaid at their inception, but features not now present in either Medicare or Medicaid. The state would set reimbursement rates for providers; while this is typical of Medicare and Medicaid, both rely on contracting to some degree. It would be financed by taxes as both public programs already are.

So what's the problem; it's two fold. The first is financing. California would need to raise about $200 billion in new taxes – an amount equal to all current California taxes and it would need the agreement of the federal government to incorporate Medicare, Medicaid, Covered California and large self insured employers – an agreement from the Trump Administration and the Republican Congress that is highly unlikely. The second is political; it's opposed by the employers, insurers, and most providers and their potent state lobbying associations. It would need a vote of the people via a ballot initiative, and

past efforts have only received about 25% voter support due to the level of new taxes required.

What needs to be done to make it politically possible? The powerful coalition supporting it needs to include employers and unions and consumers that pay for private coverage at exorbitant rates. The financing needs to occur at the federal level, which controls and is the source of most current spending on health care, including the big tax expenditure for employment-based care. The discussions of controlling costs and improving need to get real – a fee for service system with weak controls on unnecessary utilization is not viable and is just as bad as the high deductible weak payer system that already plagues us. We need new models of paying for care that put the health system's spending on a trajectory that improves effectiveness of care, efficiency of care and reduces costs and prices of care. Other nations already do it and have much better health outcomes at far less cost. Let's get real.

Prepared by: Lucien Wulsin
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FURTHER THOUGHTS ON SINGLE PAYER

There are already many different models for single payer in this country – Medicare, Medicaid, the VA, public hospitals and Kaiser Permanente. If you prefer a single payer model which one do you want? What features do you prefer?

Medicare for All?

Medicare covers seniors and the disabled; it's a single payer system dating back to the mid 60s. It sets rates for hospital care and doctors. It offers a broad choice of any willing provider. It has copays and co-insurance out of pocket responsibilities for patients. It was originally set up to pay for doctor and hospitals bills; it covers limited long-term care services and does not cover dental care. Its Part D coverage for prescription drugs has a large donut hole where seniors must pay 100% of the costs of drugs 'til they reach the next level of coverage with limited copays. Part D is contracted out to insurers who in turn manage the costs of prescriptions via contracting; Medicare itself is barred from contracting or setting reimbursement rates for pharmacy services. Medicare is a fee for service system, which pays "reasonable and necessary costs" to providers. For those who prefer private insurance; there is a choice among Part C private insurers; in California many seniors and the disabled opt for Part C private insurance; this may restrict your choice of providers, more carefully manage the costs of your care and offer lower out of pocket responsibilities. Medicare is a federally run program, partially financed by payroll taxes from workers and employers as well as the federal General Fund taxes and subscriber premiums.

Medicaid for All?

Medicaid covers the poor (or some of the poor, depending on your state). It's a single payer system for its subscribers. It has nominal copays and no deductibles. In California, it covers a full range of health care, but not typically alternative health care like Eastern Medicine. It covers long term care in the home and in nursing homes. It covers dental care as well as prescription drugs and wheelchairs and other forms of durable medical equipment. It has special programs for the mentally ill, for those with developmental disabilities, children with special health needs and those individuals with substance abuse addictions. The state sets the rates it will pay providers; often these are based on the Medicare reimbursement formulas. Some doctors choose not to participate in the program, saying the reimbursement levels are not adequate to pay their costs. It is financed by federal and state taxes; the state pays a match ranging from 17% to 50% depending on its relative wealth (in California, the match is mostly 50/50). Each state decides its own level of benefits and who is eligible and how much to pay providers, subject to federal maximums and minimums. For example, under federal law doctors must be covered, but not dentists; hospitals must be covered but not nursing homes. States may choose to enroll their subscribers in HMOs and other managed care plans, and California has chosen to do so. Some plans are run by commercial insurers, and some by local public entities.

VA for All?

The VA system is the long-standing single payer for America's Veterans. The federal government finances it. Care is delivered by federally employed doctors and nurses

working in federally owned facilities. It negotiates the best prices on prescription medicine. The VA has some of the best care for severely wounded veterans and was a pioneer in developing electronic health records. It has also been plagued by a series of scandals in which veterans could not get urgently needed care because the system is overloaded, excessively bureaucratic, underfunded and underperforming. Some veterans can access private doctors and facilities for their care if they live more than a certain distance from the nearest facility.

Public Hospitals for All?

Public hospitals are the single payer for the uninsured. They are run by cities, by counties, by hospital districts and by local universities. Historically, they are financed by local governments through local property taxes. However in California, they are now primarily financed by the federal and state governments. Care is delivered by doctors and nurses employed by local governments in local governmentally owned facilities. They provide some of the best training residencies in trauma and emergency care and in Los Angeles operate one of the best Rehabilitation Hospitals. Many public hospital systems have underdeveloped primary care networks to support their inpatient services although San Francisco, Ventura and Riverside may be exceptions. Some believe in their mission, but see their cumbersome Civil Service, unionized workforces and politicized governance structures as obstacles to their successful spread.

Community clinics are the single payer for primary care to the uninsured in many underserved communities. These are non-profit facilities heavily dependent on federal, state and local financing. They employ doctors and nurses. In some low-income rural and underserved urban communities, they are the bulwark of primary care. They are highly decentralized, mission driven and autonomous, and have real obstacles to integrated and coordinated care.

The British National Health Service is one of the highest ranked, best performing health systems in the world and is built on publicly owned facilities and publicly employed doctors. It is possible to envision a model of collaboration of community clinics and public hospitals providing excellent service in medically underserved communities across the state of California. There would be huge turf wars over the governance and management of such collaboration. Local public managed care systems could serve that role if all the concerned stakeholders so chose.

Kaiser for All?

Kaiser Permanente is a high performing, long established HMO offering care and coverage to workers and their families throughout California. It is the exclusive single payer for those who choose it. It employs doctors and nurses and owns its own facilities. It is financed by premiums from Medicare, Medicaid and private insurance subscribers that choose its integrated delivery system. It combines the dual roles of insurer and provider and thus has unusual incentives to keep its subscribers healthy at the most efficient costs. It's a non-profit that must successfully compete with all comers for patient choice and loyalty. One model of single payer would offer all subscribers a choice among competing local Kaiser style systems. The competitive model may offer the best opportunities to improve quality and lower costs, but plan competition under the ACA

may be rewarding provider agglomerations rather than transparent improvements in provider quality and reductions in costs to subscribers envisaged.

Prepared by: Lucien Wulsin
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Financing Single Payer Health Coverage in California

Single payer health care in essence means Medicare for All, but with improvements to eliminate all copays and deductibles and to add long term care benefits. There has been fury about the Assembly Speaker's decision to take a pause and ask the proponents to figure out the financing. In my opinion, this is totally warranted and in fact overdue. This particular single payer proposal has been around the legislature nearly every year since 1988, and its financing to my best recollection has never cleared a single committee, and when it was put on the ballot in the 90's got only about a quarter of the vote – a pretty sound rejection by the state's voters and policy makers.

I helped work on the initial bill, helped analyze it for the Assembly Health Committee and discussed it later in a book I wrote called "California at the Crossroads: Choices for Health Reform" back in the early 90's. I am hardly an opponent, but in all honesty I have been frequently dismayed about the cavalier attitudes of the bill's sponsors and proponents about the very real political and policy challenges in financing single payer.

Health care costs in current dollars about $400 billion for California; most of that money is already in the health care system, but to finance a single payer you would need to turn it into taxes and then into revenues to be used for single payer and that's the rub. To put it in context, all state taxes in California now generate a bit under $180 billion for all of state government. So imagine the political difficulty of asking the state's voters to double their state taxes to pay for health coverage that over 90% already have in one form or another.

Let's discuss what needs to be done, then the challenging options about how to do it. Roughly a quarter of the state's health spending is in Medicare, another quarter is in Medicaid, a third is in employment based insurance, and a sixth is from individuals.

Medicare is financed 50/50 by employer and employee payroll taxes paid to the federal government. It pays hospitals and doctors at cost. There are substantial copays and deductibles in the Medicare program. Many seniors buy Medicare supp policies to reduce their exposure to out of pocket medical costs and over a third are enrolled in managed care plans. Some also buy long term care insurance to pay for nursing home care and in home care while most others pay out of pocket. To fold Medicare into a state-run single payer plan would require either an act of Congress or conceivably a federal §1115 waiver. These are extremely unlikely to occur in the age of President Trump, Senator McConnell and Representative Ryan and would face a wall of opposition even under a putative President Sanders.

In California, Medi-Cal is financed by our taxes paid to federal government, state government, county government, provider taxes and health plan taxes. It does cover all the services that the single payer bill would do; it has no deductibles and minimal co-pays. However nearly the entire program is enrolled in managed care plans, a far cry from the fee for service system envisaged by single payer proponents. Many providers

are paid less than cost. To fold Medi-Cal into a single payer would require a federal §1115 waiver or Medicaid block grant; this is possible in the era of Trump, McConnell and Ryan who would prefer to block grant the entire program to the state, but their terms are likely to be onerous for a state who would like to experiment with single payer since they wish to cut the program's funding by one third over the next two decades.

Now, the financing gets much, much, much harder. Employment-based coverage covers half of all Californians. It pays providers more than their costs, balancing their losses in delivering Medi-Cal services. It is financed by employer and employees' premiums, and 33% of its costs are subsidized by the federal and state governments through the mechanism of pre-tax purchasing. Most are unaware of the federal and state tax subsidies and even how much their employer pays for their coverage; general awareness is limited to how much do I, the employee, contribute and what are my copays and deductibles. Every employer has a different plan, different copays, different deductibles and different share of employer and employee financing, and some offer multiple plans from which their employees choose. While virtually all large employers offer coverage for full time employees, a far smaller percentage of small low wage businesses do so, and family coverage is very spotty for the employees of small low wage employers. Logically, these employer and employee premiums could be turned into a state payroll tax in a revenue neutral fashion. For example, employers could pay 75% and employees could pay 25% -- the approximate average share in today's private market. Or it could be recast as a 50/50 payroll tax like the Social Security or the Medicare payroll taxes.

Developing agreement on a payroll tax with business and labor at the table will be like herding cats and dogs, but it would need to be done. Here are a few cautionary thoughts. First, one needs to capture the federal and state funds associated with pre-tax purchasing; this will require Trump, McConnell, Ryan, Schumer and Pelosi – a highly unlikely pairing – and extremely difficult negotiations as there is not a line item in the federal or state budget for this particularly large tax expenditure. This will require federal legislation. Second, the major employer associations, such as the Chamber, Farm Bureau, Small Business Associations and the Business Roundtable need to forge a common ground with the California Labor Federation and SEIU on a payroll tax replacing employer and employee; these are the cats and dogs to be herded and it needs a bi-partisan, bi-cameral, strong executive consensus to do so. Insulting those politicians that you need to convince sometimes helps them get to "yes", but more frequently it turns them into "hell, no".

Finally, one sixth of the health pie encompasses private individual spending. This is at least $66 billion in individual health care spending in California. It includes the copays and deductibles that insured individuals pay albeit at very different rates; these fall heaviest on the very sick or serious accident victims. It also includes out of pocket spending on very expensive uncovered services like long term care. This uncovered service is most typically used by middle and upper income seniors and their family members who do not qualify for Medi-Cal and have substantial fast eroding assets. It also includes out of pocket expenditures on health care from the uninsured, mostly of low and moderate income, and a respectable share are immigrants. It also includes the individually insured who pay for their own coverage. In other words, out of pocket

spending encompasses both everyone and also discrete pockets of people and services left out of the subsidies in the current health care system.

How could you finance these out of pocket expenses through taxes? For example the individually insured and the uninsured could pay income taxes into the new health system in lieu of premiums just as the self-employed do under Medicare and Social Security; this would parallel the contributions of similarly situated employers and employees. The higher income seniors could pay a new Medicare Part E supplemental premium for their long-term care coverage; this would require Congressional action. To pay for eliminating the copays and deductibles for every Californian, one could consider expanding the state sales tax to services, which are not taxed. Services could be taxed equally to the purchase of goods – an important step in tax equity as our society steadily evolves from consuming goods to services.

The University of Massachusetts Research Team hired by the Nurses Association has two other suggestions. The first is a 2.3% sales tax. I think that we already pay significant sales taxes in California, and this is a non-starter with the public. The second is an interesting proposal for a 2.3% gross revenues tax. Insurers already pay this tax in lieu of other taxes. So do businesses in Los Angeles and Santa Monica, albeit at a much lower rate. The advantage of this tax would be to shift the onus from payroll taxes (which could reduce employment) to consumption taxes, which do not impact employment. One difficulty, which the authors do not discuss, is that a gross revenues tax is paid by in-state businesses and not by out of state businesses. So your neighborhood Von's or Ralph's would pay the gross revenues tax but their new out of state on line competitor Amazon might not do so – an unfair advantage for online and out of state sellers and merchants as opposed to in-state businesses.

Two other state constitutional impediments that must be overcome are the Gann limit and Proposition 98. The Gann limit circumscribes state spending and a single payer bill would put California far over the Gann limit. Proposition 98 guarantees the public schools a large share of state taxes; single payer tax revenues would need to exempt the new revenues from Prop 98.

There are some significant savings associated with a single payer system. The first and most important is the cost of insurance companies administration and profits. These are about 10% of premiums in the private insurance markets and could be reduced to 2-3% in a Medicare like model. The second is the bedeviling complexity of multiple health insurance plans and programs; some estimate this adds about 20% to the costs of running a hospital or doctor's office. Are we ready to cut their red tape and their reimbursements by 20%, or is this just a talking point? Consumers are trapped in the same paperwork nightmares and system complexity as providers so this would afford welcome relief. The third is the far higher prescription drug prices paid by Americans than any of the other countries that regulate the costs of prescription drugs. One could add that our doctors, nurses, and hospital personnel are also more generously compensated than their foreign counterparts. Fourth, we could rid ourselves of narrow networks, balance billing, surprise bills, catastrophic only coverage and impenetrably complex private and public bureaucracies.

The bill as currently constructed adds unnecessary and avoidable costs to the by far most expensive health system in the world. It returns to the hyper-inflationary days of fee for service medicine, cost based reimbursement and no out of pocket. It eliminates the important progress that has been made with integrated and capitated delivery systems such as Kaiser Health Plan and with payment reforms that incentivize the right care at the right time in the right place at the right cost. Thoroughgoing reimbursement reforms have to be a part of the bill.

The proponents might want to use the next year to fix the bill's financing, eliminate the inflationary aspects, and build on the great opportunities for better quality, improved outcomes and higher cost efficiency under a better and less costly health system. This would serve Californians well in the time of Trump.

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Prepared by: Lucien Wulsin

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