



Medicare-for-All in California - Economic & Policy Considerations

Comprehensive health care reform is closer to reach in California than it has been in many years. Governor Newsom campaigned on a pledge to tackle the challenge of transitioning the state to a single payer-financed system, and on his first day in office petitioned then-President Trump to allow California to move forward. Long-time single payer supporter Xavier Becerra now heads Health and Human Services – the federal department with the most regulatory power over state reform efforts. Meanwhile, polling shows a strong majority of Californians favor a “Medicare for All” style health plan¹, with support for such a system growing nationally as well.²

Turning single payer from slogan into reality is a difficult undertaking, however. As policy makers consider practical steps forward, they must balance many interrelated challenges – ranging from finance and taxation, provider reimbursement and regulation, and legal considerations. In this paper, we review some of the key factors California must weigh as it charts a course forward.

Updating economic models, we see not only has spending on health services continued to grow well above the pace of inflation, but so too have potential savings from single payer financing. Using conservative estimates, California could reduce total health spending by \$223 billion to \$764 billion over the coming decade – lowering its annual bill 7% to 19% by 2031 and giving its economy a strong competitive advantage over states that continue along current trends.

Achieving this will be complex. But broken down to individual steps, the path forward becomes clearer. We identify some of the key political, administrative, and legal challenges faced by a state Medicare-for-All system, and conclude that with gubernatorial and legislative leadership (in partnership with the federal government) these obstacles are surmountable.

Moreover, key elements are in place that allow California to move forward immediately. Governor Newsom already has statutory authority to initiate negotiations with the federal government that are necessary to any universal health plan. The state’s Healthy California for All Commission provides the infrastructure for resolving key operational and fiscal questions.

Contents

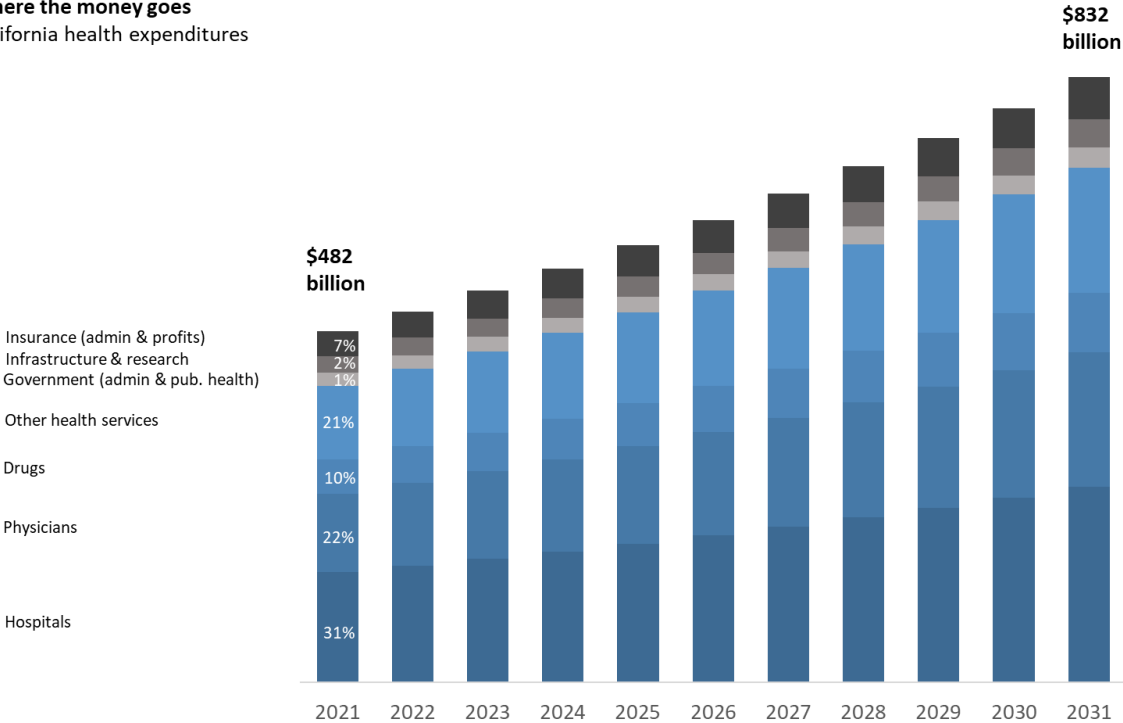
1. What California pays for health care.....	3
3. The cost of achieving universal coverage under the current system.....	5
4. Sources of savings from a Medicare-for-All system	7
5. Spending forecasts under single payer financing.....	12
6. The challenge of long-term care	13
7. Impacts of a Medicare-for-All system on families and businesses.....	15
8. Fiscal impacts on state and local budgets	17
9. Federal legal hurdles	19
Appendix A: Estimated California health spending (2014-2031)	21
Appendix B: Estimated spending by payer and plan type (2021).....	22
Sources.....	23

1. What California pays for health care

We estimate that California’s health care system will cost about \$482 billion in 2021.³ That amounts to \$12,060 per person, or just under 16% of the state’s gross domestic product. Of that total, health services make up around \$407 billion, and overhead costs (administration and insurance company profits) make up another \$40 billion. Infrastructure spending, research, and public health programs make up the balance.

Health expenditures have grown much faster than the general rate of inflation. Between 2014 and 2019, total health spending is estimated to have gone up 5% per year. By comparison, the California Consumer Price Index rose less than 3% per year.⁴ National projections suggest costs will grow even faster in the coming years. If California follows those trends, we predict the state’s health care bill will reach \$832 billion by 2031 – an increase of \$8,737 per resident.

Where the money goes
California health expenditures



These figures understate the actual cost of the current health system in at least two ways. First, they do not include additional expenditures that would be paid to federal and state governments but for the tax exclusion of employee health benefits. This exemption amounts to around \$40 billion a year for California residents.⁵

Second, these estimates do not include unfunded liabilities that accrue to state and local balance sheets for future retiree medical benefits. Such liabilities amount to about \$92 billion for the State of California, and an additional \$42 billion for local governments.⁶

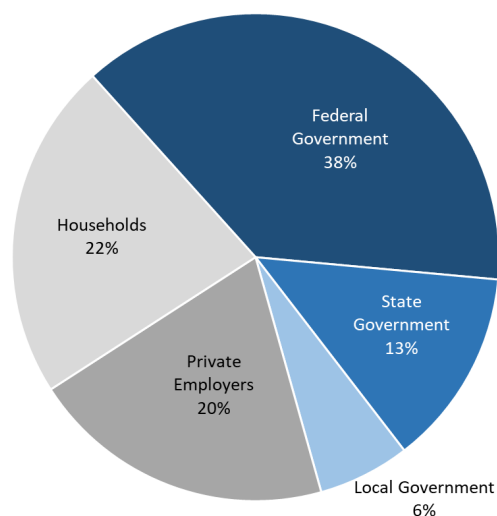
2. Who pays for California’s health care today

Excluding research and infrastructure, California will spend roughly \$460 billion in 2021 on health care services. Analysis of a variety of federal and state data sources shows that government budgets fund more than half of that total. Individual households pay for close to one quarter (through insurance premiums and out-of-pocket costs). Private sector employers pay for almost all the rest.

The federal portion of these payments is close to \$177 billion. That includes \$68 billion through Medicare and the Indian Health Service, plus a \$93 billion for Medi-Cal and similar public programs. Federal subsidies to Covered California plans totaled close to \$8 billion.ⁱ The federal government also spends around \$8 billion a year to cover its California-based employees, retirees, and veterans.

California’s own state and local governments finance around \$91 billion in health services. The state’s budget for Medi-Cal, about \$53 billion, is by far the biggest portion. But the state also spends \$7 billion on employee health benefits. Local governments (cities, counties, school districts and the like) fund \$11 billion in public health programs and \$17 billion in employee benefits.

California families pay \$104 billion straight out of their pockets. About \$60 billion of that goes to insurance premiums (the portion not paid by their employers). The other \$44 billion is paid out in deductibles, copays, and expenses not covered by insurance. Private sector businesses spend another \$94 billion a year to provide health coverage to their employees (including workers compensation).



This chart has profound implications for how any health reform can take shape. No practical plan can move forward without resolving how the federal government continues to play a role in financing the state’s health system. Among the key questions: how will Medicare and Medicaid funds continue to be distributed to California? And how will the federal government as an employer relate to the state’s health plan? These questions cannot be resolved absent negotiation with a variety of agencies.

Similarly, California will have to decide how it will reallocate its own taxpayer dollars. A Medicare-for-All health plan would be a boon to cities, counties, and school districts – relieving them of billions in annual costs, not to mention huge unfunded liabilities currently on their books. But the state will have to recoup some of those funds to finance the new system. How those costs are spread out over its taxpayers is a crucial question.

ⁱ This estimate predates additional subsidies provided for by the American Recovery Act.

3. The cost of achieving universal coverage under the current system

Before modeling single payer financing, we consider what it might cost to provide universal care under today's insurance-based system. By "universal", we mean a program that provides access to all necessary medical services (including long term care) for all California residents, with no premiums or point-of-service costs that would serve as a barrier to getting care.

For these purposes, we set aside the question of long term supports and services. As we discuss later in this paper, modeling a universal LTSS benefit is an especially complex undertaking. Moreover, it is unclear to us whether such a program could be established without far-reaching changes to the existing health system.

A universal health program, whether insurance-based or state-financed, would raise total spending on behalf of populations who currently forego medical services due to cost barriers. These include people who are currently uninsured, but also people for whom copayments and deductibles serve as a deterrent to seeking care.

An estimated 7.7% of California's population, or 3 million people, have no health insurance today.⁷ Assuming that this population could be enrolled in "silver" (70% actuarial value) Covered California plans, it would cost \$19 billion to insure this population.⁸ At a "gold" (80% actuarial value) benefit plan, the total would reach \$22 billion. This additional spending would be partially offset by reduced out-of-pocket payments currently made by the uninsured.

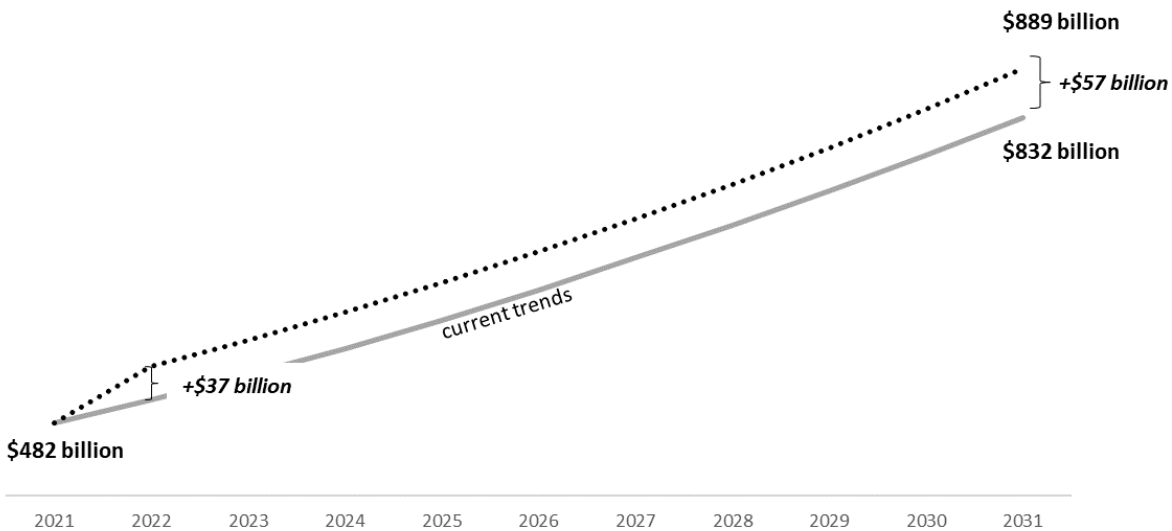
While this expansion would provide universal insurance coverage, it would not remove barriers to care faced by people unable to meet the cost of deductibles or copayments. For purposes of estimating how much utilization would go up by removing those barriers, we rely on a study of one large employer health plan that converted from free coverage to a high deductible arrangement.⁹ This study found that the change in benefit structure lowered total spending by 11.8% to 13.8% percent. Presuming that privately-insured and Medicare populations would increase their utilization of services by 13.8% as a result of eliminating cost-sharing, we estimate the elimination of out-of-pocket payments would induce an additional \$34 billion in health spending in 2021.ⁱⁱ

The net result of expanding insurance to all, as well as eliminating cost barriers to care, would be a \$37 billion increase in costs starting in year 1 – or 7.3% of total spending. That cost would grow to \$57 billion annually within a decade. Depending on how such a program were enacted, these amounts would be paid for by some combination of households, employers, and taxpayers.

ⁱⁱ This estimate is close to the high end of the Congressional Budget Office's projections of utilization-induced cost increases under a national single payer system. (The CBO calculated a \$407 billion increase by 2030 from increased use of care, over a baseline of \$6,631 billion – or 6.2%).

Projecting the cost of universal care under an insurance-based system

Total health spending (excluding expansion of long-term care benefits)



It is unclear to us whether it is actually possible to create a universal health system based on an insurance model. Extending coverage to all residents (through income-based insurance subsidies and/or a highly punitive individual mandate) would have to be financed without the administrative efficiencies associated with single payer financing. Moreover, it would likely require stringent employer mandates (or else face accelerated dumping of employer-sponsored plans) – an approach that would encounter major legal obstacles.

Perhaps most importantly, California’s health system as currently designed would be challenged to absorb such a utilization increase over a short period. Provider shortages – for example, in the area of behavioral health – would constrain the ability of new patients to obtain timely care. These potential shortages suggest to us that an insurance-based expansion would accelerate the high inflationary trends that afflict California’s health system. As we discuss below, systemic changes associated with a Medicare-for-All like plan are essential to meeting this increased demand.

4. Sources of savings from a Medicare-for-All system

A variety of studies have found single payer financing would reduce overall health spending. One review of academic literature described “a high degree of analytic consensus that it would result in a favorable outcome for system financial burden” and that “net savings would be expected to occur, if not immediately, certainly within a few years”.¹⁰

These savings come primarily from two sources: administrative efficiencies (by eliminating insurance company bureaucracy and simplifying reimbursement systems) and reduced reimbursement rates (made possible by lowering providers’ overhead costs and by leveraging the power of government to reduce rates). We describe the potential scale and manner of these savings below.

There are several other ways in which a Medicare-for-All like system could lead to cost reductions. These include eliminating unnecessary infrastructure, reducing fraudulent billing, and improving overall population health (particularly by expanding access to care to the currently un- and under-insured). While some studies have found the impact of these quite significant, we have not attempted to model them.

Administrative efficiencies

By far the largest source of savings associated with single payer financing, at least initially, comes from eliminating insurance industry bureaucracy. In 2020, California regulators oversaw 142 different insurance providers¹¹, each with its own payment rules and systems. In addition, 5.6 million Californians are covered by hundreds of self-insured employer-sponsored plans that are unregulated by the state.

This complexity is estimated to add close to 15% to total medical spending. About half of that falls on physician practices, hospitals, and other providers.¹² Each of these must currently support operations to bill and collect from a wide array of insurers, as well as from patients who owe out-of-pocket payments.

The other half of California’s surplus administrative spending supports insurance companies, to which we estimate California will pay \$34 billion above and beyond the cost of paying benefits in 2021. Health insurers this year will spend roughly \$26 billion on administrative overhead (claims administration, advertising and sales, and so on), and will accrue another \$3-5 billion in net income.¹³

Replacing those insurers with a state-run administrator will require significant up-front investments. Such an agency would need to set up a claims payment infrastructure, monitor provider quality and billing, and establish reimbursement rates. It would also need to conduct an initial public education and enrollment process. Finally, we consider that the state may provide income support to personnel displaced from administrative jobs no longer necessary under single payer financing.

While this is an expansive list, we believe all these investments could be achieved for one third of what California presently spends on insurance companies every year. Our model therefore builds in \$12 billion over the first 24 months to allow for additional start-up costs. Using Medicare’s administrative costs as a benchmark (2% overhead for traditional fee-for-service Medicare), we believe that ongoing administration would cost the state an additional \$8 billion annually.

Even allowing \$1 billion annually in insurance industry payments (providing out-of-state coverage, wrap-around benefits, etc.), as well as the federal government’s own overhead costs, administrative spending would fall 50% in year 1, and 72% by year 3. That amounts to \$29 billion in ongoing annual savings, not including the reduced administrative burdens on physicians and other providers.

One-time changes in provider reimbursement rates

The US health care system is notorious for its wide range of prices. Medicare is often used as a benchmark for reimbursement rates because its payments (at least for hospital and physician services) are based on what it costs those providers to deliver services. Medi-Cal, for comparison, pays providers on average about half of what Medicare pays in direct reimbursement rates,¹⁴ but then makes up much of the difference through supplemental grants (“Medi-Cal matching funds”). On the other hand, private insurers (which negotiate rates based on market forces) pay 50% to 150% more than Medicare for hospital and physician services.¹⁵

Substantial savings could be realized by using the market power of a combined purchaser to bargain lower rates, or else by regulating reimbursements (for instance, pegging them to Medicare payments). For some providers, lower payments might be wholly made up by reduced administrative. For others, lower rates may reduce profit margins. Any rate setting agency would need to weigh these factors against the risk of incentivizing providers to exit the market.

We consider three potential rate scenarios:

The “high reimbursement” scenario assumes provider are paid on average the same rates they are paid today (using the statewide mix of government and private health plans). For providers who serve only privately insured patients, this would mean a modest reduction in reimbursements. Conversely, providers who serve only Medi-Cal or Medicare patients would see substantial increases in income. Providers who today have significant administrative overhead would likely see a fall in operating expenses, freeing up resources for increased capacity, employee compensation, or higher profit margins.

The “medium reimbursement” scenario assumes modest reductions in payments to certain providers. This includes bringing California’s pharmaceutical drug spending in line with the rates currently paid by Medicare. It also includes reductions that recognize the savings that hospitals, physicians, and other providers will obtain from a simplified administrative system.

The “low reimbursement” scenario assumes more substantial reductions. Even in this scenario, though, we did not adopt the deepest rate reductions proposed in other studies of Medicare-for-All systems. Instead, we used what we consider conservative assumptions about the extent to which provider payments can be lowered without affecting California’s health system capacity.

Some notes describing our assumptions follow:

Pharmaceutical drugs:

The biggest plausible reduction in prices is for pharmaceutical drugs. US drug prices are more than double those in most other rich countries, including Canada¹⁶. Even allowing for rebates paid to

insurers by the pharmaceutical industry, savings of 28% off current drug spending or more may be possible by adopting Canadian price levels.¹⁷ Indeed, the Veterans Administration has been able to achieve pricing of near 50% below Medicare rates, albeit on a narrower set of drugs and a particular population.¹⁸ For our “medium reimbursement” scenario, we assume just over 15% savings are possible – reflecting the rates currently paid by Medicare.ⁱⁱⁱ For our “low reimbursement” scenario, we reduce drug spend by 28%, bringing it in line with Canadian pricing. We believe both are conservative assumptions, generous to pharmaceutical manufacturers.

Hospitals:

Hospital prices span a wide range across different payers. Nationally, private insurers pay hospitals roughly double what Medicare does (excluding DSH and similar payments).¹⁹ California is no different: one study of state hospital filings found that private insurers pay 109% more than Medicare, with net payments by all payers to hospitals exceeding costs (including both operating and capital costs) by 8%.²⁰

We assume for purposes of the “medium reimbursement” scenario that hospital rates are reduced on a statewide average by 3%. Under such a rebalancing of payments, the average hospital would receive 27% higher reimbursement for Medicare patients, 23% higher for Medi-Cal patients, and 39% less for privately insured patients. Based on current cost structure, a 3% reduction would lower profit margins to around 5%. However, simplified administration would substantially lower their administrative overhead costs, thereby raising hospital company margins above their current level.

Our “low reimbursement” scenario calculates spending on the basis of a 5% reduction in hospital payments. This level of payments would recapture about half of the administrative savings hospitals would obtain from single payer financing.

Physicians:

Payments to physician groups also vary widely by payer and by geography. One recent analysis found commercial payments in California average 128% of Medicare. While Northern California insurers pay between 148% to 173%, however, other regions (such as the Inland Empire) are closer to parity with Medicare.²¹ Considerable debate also exists as to whether Medicare’s rate-setting process overcompensates physicians – particularly specialists.

ⁱⁱⁱ We used the Congressional Budget Office’s estimate of 16% lower spending as a result of Medicare drug rates, and revised this downward to reflect the prevalence of Kaiser Permanente in the California market. As a large integrated care system, Kaiser not only has negotiated relatively low rates for its pharmaceutical drug supply, but also effectively steers prescribing patterns toward lower cost options. A portion of these savings are passed on to purchasers, reducing slightly the scope for savings relative to other states.

We do not venture into this debate, nor as to the best mechanism for setting rates.^{iv} We do assume however that net reimbursements could be lowered by 5% (in our “medium reimbursement” scenario) or 7% (in our “low reimbursement” scenario). These reductions represent between one third and one half of the spending physician practices incur for billing and insurance-related functions.²²

Other services:

“Other health services” make up nearly one fifth of all personal health spending. They include a diverse set of categories, including dental care, skilled nursing facilities, behavioral health, and durable medical equipment. These categories feature a diverse set of market dynamics. For some (such as dental practices), the potential for reduced administrative overhead is substantial. For others (such as behavioral health), the commercial insurance system provides such low reimbursements that most services are paid for out-of-pocket²³ and provider capacity is strained. For the “medium reimbursement” scenario, we have assumed a variety of net rate adjustments, which result in a 0.6% reduction across all these categories combined. For our “low reimbursement” scenario, we have assumed reductions that average 1.2%.

Ongoing changes to inflationary trends

Substantial savings – about \$21 billion based on the “medium reimbursement” scenario above – could be realized simply by reducing current net reimbursement rates. The biggest impact on system-wide spending, though, results from lower cost trends. Across all categories of spending, CMS projects annual inflation to average 5.6% in the coming years. Not only is this well over twice the overall rate of inflation, it is substantially more than GDP forecasts – meaning that health costs will continue to consume a growing share of the economy.

A small and diminishing portion²⁴ of these increases is due to growing need for services by an aging population.^v Rising prices, plus increased quantity and intensity of services, are the primary driving factors – together making up more than 75% of total increases. For all three scenarios, we model an initial surge of utilization associated with eliminating out-of-pocket payments – averaging 6% across all categories.

Under our “high reimbursement” scenario, cost trends during the initial ten-year period are reduced to those seen during 2013-2018 (following expansions of Medicaid and insurance coverage under the ACA). This results in overall spending growth of 4.4% annually (in addition to an initial surge in utilization due to the elimination of out-of-pocket barriers).

^{iv} The manner of reimbursements has important consequences for physician-induced demand, and for geographic disparities in access. Other single payer financed health systems are increasingly experimenting in alternatives to fee-for-service reimbursement. Canada, for instance, has used alternative payment plans as a mechanism for incentivizing physicians to practice in rural areas with relatively few patients.

^v The absence of universal long term care in the US results in that category increasing at a far slower pace than in other comparable countries. See Nisha Kurani and Cynthia Cox, “What drives health spending in the U.S. compared to other countries”, Peterson-KFF Health System Tracker, September 2020.)’.

Our “medium reimbursement” scenario assumes cost trends can be reduced by an average of 1.4% annually, resulting in overall growth close to that of California’s wider economy (around 4.2%). This presumes that the initial surge in utilization, and associated decoupling of health care from family budgets, might lead to a stabilization of use and intensity of services (relative to disease condition).

Under our “low reimbursement” scenario, we assume cost trends are reduced by 1.6% (resulting in overall trend of 4.1%). This reflects not just the pricing reductions considered in the “medium reimbursement” scenario, but also that reduced duplication of services and fraudulent billing can yield an additional 2% savings over the initial ten-year period.

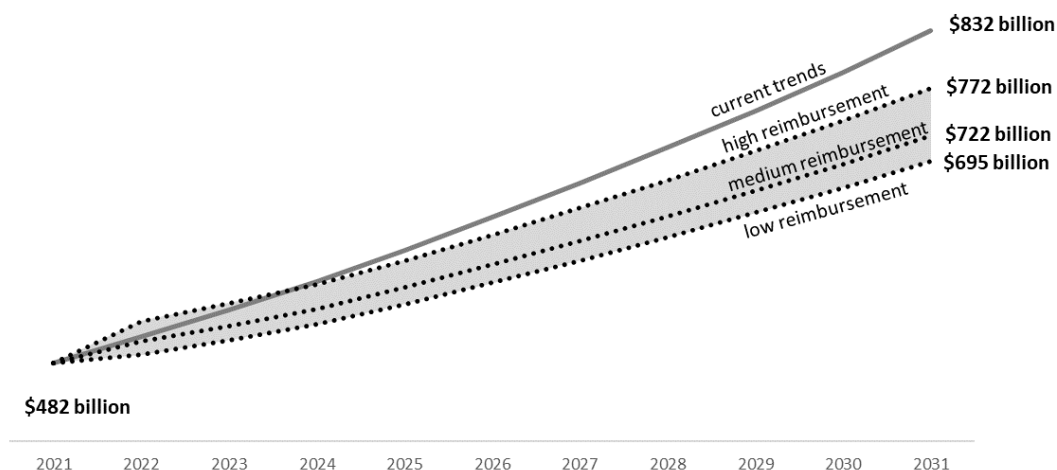
5. Spending forecasts under single payer financing

Like other studies, our model shows a state Medicare-for-All health system would likely generate large savings over the medium and long term. Under current trends, spending on personal health services in California will grow from \$482 billion in 2021 to \$832 billion in 2031. As we discussed above, providing for universal coverage through an insurance system would add \$57 billion or more to that figure.

By contrast, even our “high reimbursement” scenario (wherein providers continue receiving the same average rates they do today) reaches cost neutrality within three years. This grows to \$60 billion (7%) annual savings by year 10. Our “medium reimbursement” scenario yields \$5 billion savings within the first year of operation, growing to \$110 billion (14%) annually in the tenth year. Our “low reimbursement” scenario generates \$19 billion immediately, and \$137 billion (19%) after a decade.

Modeling single payer financing

Total health spending (excluding expansion of long-term care benefits)



Such changes would be transformational both to California’s health care system and its economy. The biggest savings under single payer financing are generated by eliminating costs associated with insurance administration and by reducing inflationary pressures. Meanwhile, spending increases are directed toward patient care and provider capacity. This would lead to improved population-wide health; it would also mean a greater portion of California’s health spending goes to in-state providers.

Who realizes the net savings from a single payer system, however, is a complex question. Households and employers, which pay for 42% of health care today, would see large savings. But those savings would be offset by taxation necessary to finance the statewide system. Similarly, state and local governments (which spend \$89 billion a year on health services) would undergo a large rebalancing of their own budgets. We discuss these issues later in this paper.

6. The challenge of long-term care

It is exceedingly difficult to predict what a universal long-term care program would cost in California. For one, baseline costs are uncertain. Long-term support services (LTSS) are diverse in nature and in place of service, so extracting them from national health statistics is challenging. In addition, Medi-Cal (which pays for most LTSS in the state) does not separate out the LTSS costs of its managed care plans.

Future costs also depend very largely on benefit design. Key programmatic questions include, for example: Will the program require “vesting” in the form of a minimum periods of residency or tax contributions? Will it provide day-one and indefinite coverage, or will it only pay benefits during part of the time a person needs care? Will health-based eligibility triggers be more expansive than under current federal law? And what pay increases will be necessary to ensure a sufficient workforce will exist to provide LTSS care?

Nonetheless, with a fast-growing elderly population, California faces a largely unfunded liability when it comes to long-term care needs. Less than 3% of Americans have long term care policies in place²⁵, and Medi-Cal only covers about 20% of the over-65 population. Out-of-pocket spending and, above all else, uncompensated labor by family caregivers currently fills in the gaps.

California’s Long-Term Services and Supports Subcommittee recently commissioned an analysis of what it might cost to create a social insurance program based on payroll tax contributions.²⁶ This study concluded that the state and federal governments spent between \$25-30 billion on LTSS in 2017. It went on to forecast that a long-term care insurance scheme could be financed for 75 years with a payroll tax of around 0.50% to 0.90% - suggesting costs of roughly \$16 billion at current prices (once beneficiaries are fully vested and receiving benefits). That could rise several-fold if out-of-pocket requirements were reduced or eliminated completely, but would also offset close to \$10 billion in Medi-Cal spending.

It is important to note that such a social insurance model would not, at least initially, amount to “universal” coverage. The plans modeled for the Subcommittee exclude people who have not paid into the hypothetical fund – leaving out most of the 6 million Californians currently over age 65. Also, crucially, the consultants’ analysis did not consider provider wage increases that would be triggered by such an expansion of LTSS services.²⁷

Another recent report, by the Urban Institute, examined the likely costs of a LTSS program as part of a national, single-payer financed health system. This study concluded that, depending on benefit design and provider rates, such a plan would increase total LTSS spending by 53% to 150% (with a comprehensive benefit package and mid-range provider rate increases raising systemwide costs by 104%).

The last and most recent analysis we have used to guide our modelling is that of the Congressional Budget Office.²⁸ The CBO assumes an 8% increase in average payments rates for home and community based services would be necessary to support an adequately expanded workforce (bringing rates closer in line with those paid by Medicare). Combined with a large increase in paid LTSS services, the CBO concluded that the program would result in a 78% increase in spending in this category, or 7% of total health spending.

CBO's estimates should not be translated directly to the California context, given this state's high Medicaid spending on long-term care compared to other states. However, using this analysis as a guide in combination with that published by the Urban Institute, we suggest that a universal and comprehensive long-term care program could be developed for California at a net cost of between \$30-40 billion.

Given the importance of this subject and the speculative nature of any projections, much more detailed analysis is necessary. But it appears to us that the cost of a universal long-term care program would be substantially less than the savings generated by even the most conservative model of single-payer financed health care.

7. Impacts of a Medicare-for-All system on families and businesses

Households and businesses together will spend about \$196 billion on health services in 2021. Absent dramatic reforms, we expect that figure will grow to near \$340 billion within a decade. A single payer system would avert much of that increase. But replacing private spending with taxpayer financing will require careful planning.

A variety of tax mechanisms have been proposed to accomplish this, including combinations of payroll taxes, income taxes, revenue-based taxes (such as sales or gross receipts), and others. Evaluating the relative merits of these is beyond the scope of this paper. However we note that any tax system will reapportion what each sector pays for health services.

Of the \$196 billion that households and businesses spend on health care today, \$104 billion is paid by families: \$60 billion in the form of premiums (including those paid by Medicare beneficiaries), and a little over \$44 billion in copays, deductibles, and uninsured services. The other \$92 billion is paid for by private-sector employers^{vi}.

That varies widely by company, however. According to Kaiser Family Foundation's annual survey of employers, 56% of all companies offer health benefits. But 99% of large firms offer at least some of their workers coverage, while only 48% of very small companies do so.²⁹ The amount employers pay and what portion of employees take up that coverage also vary across industries and within firms, particularly in relation to employee unionization.

Whether a family's health insurance is paid for in whole or in part by employers has a huge impact on that family's economic security. But economically, these payment sources are hard to distinguish.³⁰ Total employee compensation is more crucial to a company's bottom line than wages or benefits in isolation – and whether benefit costs are deducted dollar-for-dollar from wages or offset through benefit reductions, it is the family budget that is ultimately most impacted.

We believe the current health system is a highly regressive burden on families, hitting lower income workers hardest and benefiting insurance companies most. A taxpayer financed plan at its heart would be a redistribution of that burden. It would dramatically reduce financial pressure on working families and on employers who currently pay a large share of health costs. At the same time, it would require higher spending of businesses that today pay little or nothing of their employees' health costs.

Providing for universal health care requires California's leadership to decide how those tax obligations are distributed across different firms, different industries, and different income brackets. That is not a simple matter. For instance, a gross receipts tax has relatively large impacts on businesses with low labor-to-sales ratios (such as technology companies, but also retailers), as compared to those

^{vi} In addition to these annual expenditures, businesses and households hold back large sums in health fund reserves. Analyzing filings by welfare funds associated with private-sector California-based unions, we found that in 2019 these funds held over \$100 billion in liquid reserves. That is just a portion of the private sector funds that would be freed up for other purposes if they were no longer needed to guard against health insurance risk. *(Based on study of Department of Labor ERISA-5500 and LM-2 filings)*

with a higher proportion of labor costs (such as hospitality businesses). It also more heavily affects sectors that rely on layers of contractors and subcontractors.

Complex though it may be, models exist for navigating these decisions. Los Angeles and San Francisco have both implemented gross receipts taxes and have gone through the process of adjusting tax rates to account for sectoral factors. And every level of government routinely debates giving special tax consideration to certain subsets of businesses or households (for example, the federal government's indirect subsidy to small business by making Medicare a primary insurer for older workers). Designing an appropriate tax structure for California's health plan is principally a matter of political will and focus.

Ultimately, families and businesses will be the chief beneficiaries of savings associated with single payer health care – through taxpayer programs, insurance premiums, or out-of-pocket costs, they are the ones on the hook for California's out-of-control health costs. How exactly those savings are passed on will vary widely by industry and by company. But whether through wage increases, business expansion, lower prices, or higher corporate profits, they will reshape California's economy.

8. Fiscal impacts on state and local budgets

State financing considerations

Before it decides on appropriate financing mechanisms, California must first determine how it will relate to the nearly \$270 billion of government spending that already goes to health services. The big majority of that – \$177 billion – is federal money, including Medicaid, Medicare and similar entitlements^{vii}, Affordable Care Act subsidies, and federal employee benefits.

California must reach agreement with several federal agencies before it can implement a statewide health plan. Foremost among them is the Department of Health and Human Services, which must consent to how the state's health plan overlaps with Medicare, Medicaid, and the Affordable Care Act. Also included are the Department of Veterans Affairs (which spends over \$7 billion a year in California) and the Office of Personnel Management (which pays for other federal employee benefits).

Among the key fiscal issues at stake in this negotiation:

Will federal funds continue to adjust based on utilization? (Currently, federal programs carry the risk associated with the age and health status of their enrollees. This could shift to California if funding took the form of block grants.)

How will Medicare rates be impacted by California's rate-setting system? (Will savings associated with reduced provider rates be shared with the federal government, or will they accrue just to California?)

There is a clear path to resolving these questions and ensuring that federal funds continue to support California's health system. The Centers for Medicare and Medicaid Services has statutory authority to waive various state obligations under those two programs (subject to budgetary constraints), and all these agencies have operational latitude that allows for new contractual relationships. California's governor has authority to initiate waiver applications and related negotiations at any time. Given today's relatively cordial relationship between Sacramento and the White House, we believe the political table is set for California to move forward in partnership with the federal government.

In addition to negotiating a framework with the federal government and developing its own tax structure, California must develop an operational plan. This plan will have key fiscal consequences. Elements include:

How will provider rates be set? (As discussed above, this will have big ramifications for the long-term cost of the new health system. In particular, the relation of provider rates to state GDP growth is a crucial factor.)

What are appropriate reserve levels given any particular mix of taxes and federal funding? (The state will need to raise reserve funds to guard against fluctuations in revenue and utilization. This

^{vii} This does not count \$23 billion a year that senior and disabled Californians themselves pay in Medicare premiums.

borrowing will be offset by the \$92 billion California currently carries on its balance sheet toward future retiree benefits.)

How will quality of care and fair billing be guaranteed? (The state will need to expand oversight of providers to ensure quality care and deter fraud.)

As with federal financing, these matters are complex, but the state has infrastructure in place to move quickly to resolve them. In 2019, the legislature established a commission charged with recommending a path toward unified financing of health care. While that body has delayed its work during the COVID crisis, the stage is set for it to pick up its pace.

Offsetting local government spending

Cities, school districts, counties, and special agencies spend about \$28 billion a year on health services. \$11 billion of that funds public health programs.^{viii} Another \$17 billion is spent on employee health benefits – a figure that does not include the \$42 billion in unfunded liabilities that local governments carry on the books for future retiree health benefits.

A single payer health system could relieve local governments of almost all these obligations.

County public health systems would be the biggest beneficiaries. Today, public hospitals and clinics make ends meet on low reimbursement rates from Medi-Cal supplemented by other public funds. Unified state financing would instead put them on par with providers who today serve predominantly insured patients. The result would be a huge infusion of resources into communities that need them most, assuming county governments retool their health systems to put these resources to best effect. The fiscal impact would be enormous – an average of 15% savings to overall county budgets statewide.³¹

Single payer health care would also relieve local governments of nearly all employee benefit obligations. The eleven largest counties in California are expected to spend \$729 per employee on health benefits in 2021.³² If current trends persist, that figure will rise to over \$1200 within a decade – driving total spending by local governments on employee health benefits from \$17 billion to \$29 billion annually. That would be obviated under a state system, saving local governments a further 19% of total expenses. So too would the \$42 billion in unfunded retiree liabilities that currently weigh on local government balance sheets (at discount factors ranging from 3.5% to 7% or more).

Public health programs and government employee benefits are governed by a complex web of state and local laws as well as voter-approved charter provisions. In addition, a realignment of state and local budgets will almost certainly be necessary, given that the state will be assuming the burden of providing coverage currently paid for out of county and municipal budgets. Nonetheless, local governments (and therefore taxpayers) stand to be among the biggest winners of any Medicare-for-All type system.

^{viii} Counties actually spend close to \$18 billion for public health, but the state subsidizes around \$7 billion (through realignment funds and other budget items).

9. Federal legal hurdles

Beyond fiscal considerations, a variety of federal and state laws pertain to California's ability to establish a universal health care program. In some cases a combination of waiver authority and plan design can be used to accommodate existing statutes. In others, legislative changes may be necessary. We provide the following list as an outline of the matters that need to be considered:

Affordable Care Act (ACA)

The ACA requires states to establish or participate in a health insurance exchange, and provides for two income-based subsidies (premium tax credits and cost-sharing reductions) to people who buy coverage through that exchange. Section 1332 of the ACA allows CMS to authorize pass-throughs of these tax credits. The way that is done, however, will need to be negotiated (for example, California would likely want to avoid the bureaucracy of individual means testing). The ACA also allows for CMS to grant waivers for states to establish "all-payer payment reform" (Section 1315a). Such a waiver would permit California to establish a uniform set of provider reimbursement rates which extended to Medicare beneficiaries as well as other plans.

Medicaid

Medicaid requires states to provide a minimum set of benefits to certain "mandatory" populations and it provides federal matching funds to pay for those benefits. The HHS Secretary is given broad authority under Section 1115 ("Demonstration Waivers") to enable states to test alternate models of coverage, provided they are budget neutral to the federal government. Under current regulations, which specify a per-member-per-month cost test over a five year period³³, a single payer health plan would very likely be able to meet these requirements on an ongoing basis. As with the ACA, California would likely want to ensure that its Medicaid waiver authority allowed it to abolish individual means testing.

Medicare

Allowing for a state health plan to integrate Medicare beneficiaries may be the biggest federal administrative hurdle facing California. Because Medicare is designed to operate independent of the states, its waiver authority does not obviously provide a mechanism for integrating doing so. Section 402 does allow for demonstrations of "new benefits, fee-for-service or Medicare Advantage payment methodologies, and/or risk sharing arrangements that are not currently permitted under Medicare statute". There are few examples of this authority being used to advance comprehensive health reform (Maryland's hospital payment system is a very notable exception to this). Moreover, Section 402 does not provide for pass-throughs of federal funding. It is imaginable that a California health plan could contract with CMS as a Medicare Advantage plan option (given its cost-free and comprehensive plan design, it would presumably be far more attractive to beneficiaries than traditional Medicare or other Medicare Advantage plans). But that would leave California providers having to identify patients in legacy Medicare plans, and bill them separately. Given the potential for large savings under a statewide health system, and the fact that some of those portion savings could be shared with the federal government, it may be that enabling legislation turns out to be the best course.

Employee Retirement Income Security Act (ERISA)

This legislation established a common set of regulations for employee benefit plans, including welfare plans. Its broad preemption clause has been interpreted to nullify state laws that either reference ERISA-regulated plans or otherwise compel them to be designed in a certain way.³⁴ However, we have strong reason to believe a California single payer health system would not trigger ERISA pre-emption. In reviewing an employer health spending mandate in San Francisco, the federal Ninth Circuit observed that that County's health plan ("Healthy San Francisco") was an entitlement program rather than an employee benefit plan. Given this, and the fact that San Francisco did not compel employers to create or modify their benefit plans in any way, the court determined that this spending requirement was not enjoined by federal law. A California-wide single payer health plan would be even less intrusive into employee benefits than San Francisco's ordinance. It would create a public benefit program, but would not necessarily compel employers to participate in it in any way beyond uniform taxation (a power unambiguously given to the states).

Federal Employees Health Benefits Plan (FEHBP)

This plan, administered by the Officer of Personnel Management, governs most federal employees' health benefits. Its founding Act contains a very restrictive preemption clause, constraining states' ability to affect federal employees. Congress has regularly amended FEHBA to shape the scope of its benefits, the amount it pays (currently 75% of typical health plan premiums), and the OPM's contractual authority. Additional amendments would be necessary to accommodate a state single payer plan, or else covered federal employees may need to be treated as out-of-state residents.

Appendix A: Estimated California health spending (2014-2031)

Estimated California health expenditures (based on NHE 2014 state estimate and NHE annual cost trends)

(in \$ millions)

	2014	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Hospitals	106,487		151,533	160,623	170,148	179,957	190,745	202,741	214,618	227,300	240,411	254,279	268,946
Physicians and clinical services	76,688		107,816	113,738	120,033	126,676	134,001	141,404	149,334	157,624	166,092	175,015	184,417
Prescription drugs	36,924		47,456	50,171	53,075	56,207	59,452	63,039	66,827	70,754	74,492	78,427	82,570
Dental services	14,557		19,814	20,659	21,580	22,526	23,511	24,535	25,596	26,696	27,873	29,101	30,383
Nursing home care	14,799		18,625	19,518	20,460	21,383	22,354	23,412	24,568	25,850	27,059	28,326	29,651
Home health care	11,253		16,521	17,702	18,976	20,290	21,723	23,249	24,921	26,713	28,586	30,591	32,737
Other professional services	8,376		12,221	12,897	13,603	14,350	15,127	15,945	16,813	17,711	18,664	19,668	20,727
Other health, residential and personal care	19,164		28,107	29,777	31,485	33,167	35,052	37,050	39,176	41,377	43,650	46,049	48,579
Durable medical equipment	3,740		5,286	5,598	5,926	6,279	6,647	7,032	7,464	7,880	8,354	8,856	9,388
Personal health care	291,989		407,380	430,683	455,287	480,835	508,612	538,406	569,316	601,905	635,181	670,311	707,398
Administration (government)	4,832		6,278	6,680	7,105	7,518	7,967	8,506	9,069	9,643	10,213	10,816	11,455
Administration and profits (insurance)	22,310		33,996	35,914	37,948	40,050	42,272	44,590	47,040	49,579	52,219	55,000	57,929
Public Health programs	9,367		11,641	12,055	12,482	12,907	13,404	13,944	14,451	14,957	15,467	15,995	16,540
Health consumption expenditures	328,499		459,294	485,332	512,822	541,309	572,255	605,446	639,876	676,085	713,080	752,122	793,322
Research	5,255		7,055	7,595	7,974	8,365	8,791	9,227	9,699	10,193	10,745	11,326	11,940
Structures & equipment	11,846		15,872	16,733	17,618	18,572	19,585	20,653	21,768	22,928	24,099	25,330	26,624
National health expenditures	345,600		482,221	509,660	538,414	568,246	600,630	635,326	671,343	709,206	747,924	788,779	831,886

Appendix B: Estimated spending by payer and plan type (2021)

Estimated California health consumption expenditures

(in \$ millions)

	Federal	State	Local	Businesses	Families	Total
Public health programs						
Medicare and Indian Health Service	68,139				35,416	103,556
Medicaid and other public programs	93,117	53,482	11,861			158,460
Affordable Care Act (Covered CA)	7,521	429			6,243	14,193
Employment-based coverage						
Employer sponsored plans	7,896	6,936	18,007	80,631	41,677	155,147
Workers compensation (medical)				11,448		11,448
Individual plans						
Individual health insurance					13,313	13,313
Other out-of-pocket spending					7,165	7,165
TOTAL	176,673	60,847	29,867	92,079	103,815	463,282

These estimates were developed from a variety of non-CMS sources, and exceed strictly CMS-based projections by a net \$4 billion or 0.9%.

Distribution of Medicare spending relies on MedPAC estimates for out-of-pocket expenses (which are calculated on fee-for-service Medicare, but extrapolated to all Medicare enrollees).

Medicaid and other public spending is projected using the Governor's budget proposal for 2021-22.

Employment based coverage is calculated using CMS private health insurance estimates, adjusted for Kaiser Family Foundation surveys of premium sharing, out-of-pocket costs. Federal employment-based spending includes Veterans Administration benefits as well as FEHB spending. State and local employee spending is calculated using data from the California State Controller's office, and includes OPEB pre-funding payments (assuming a 50% average employer share).

Other sources include: CMS Marketplace public use files, CMS Medicare Trustees Report, Office of Personnel Management, Workers' Compensation Insurance Rating Bureau of California, San Francisco Controller's Office.

Sources

- ¹ Institute of Government Studies, April 2020 Survey of California Registered Voters about Single payer Healthcare.
- ² Kaiser Family Foundation, “Public Opinion on Single payer, National Health Plans, and Expanding Access to Medicare Coverage”, October 2020.
- ³ This estimate was developed by using the Center for Medicare and Medicaid Services (CMS) National Health Expenditures. We extrapolated CMS’s State Health Expenditure Data Files for 2014 across the range of Sources of Funds, and projected these forward to 2019 and then to 2028 (using CMS national estimates for those two years). See Exhibit A for more detail.
- ⁴ Department of Industrial Relations, California Consumer Price Index, All Urban Consumers (2014-2019, annual).
- ⁵ Andrea Sorensen, Narissa J. Nonzee, and Gerald F. Kominski, “Public Funds Account for Over 70 Percent of Health Care Spending in California”, August 2016. See also: US Congress, Joint Committee on Taxation, “Estimates of Federal Tax Expenditures for Fiscal Years 2019-2023”, December 2019.
- ⁶ California State Controller, “GASB Nos. 74 and 75 Actuarial Valuation Report” as of June 30, 2019, and Local Government Financial Data files.
- ⁷ State Health Access Data Assistance Center (SHADAC) analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
- ⁸ This calculation uses uninsured population figures by age range from California Health Care Foundation’s “California’s Uninsured – 2018” dataset (<https://www.chcf.org/wp-content/uploads/2019/02/UninsuredAlmanac2018Data.zip>, retrieved May 15, 2021). Average silver plan premiums are calculated from Covered California 2021 Individual Product Prices dataset (https://hbex.coveredca.com/data-research/library/2021_QHP_Individual_Rates_File_for_Posting-09-30-2020.xlsx, retrieved May 15, 2021).
- ⁹ Zarek C. Brot-Goldberg, Amitabh Chandra, Benjamin R. Handel, Jonathan T. Kolstad, “What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics”, The Quarterly Journal of Economics, Volume 132, Issue 3, August 2017.
- ¹⁰ Christopher Cai et al, “Projected costs of single payer healthcare financing in the United States: A systematic review of economic analyses,” PLOS Medicine, January 2020.
- ¹¹ California Health Care Foundation, “2020 Edition — California Health Insurance Enrollment”
- ¹² Aliya Jiwani, David Himmelstein, Steffie Woolhandler & James G Kahn, “Billing and insurance-related administrative costs in United States’ health care: synthesis of micro-costing evidence”, BMC Health Services Research, November 2014.
- ¹³ Based on review of publicly-traded health insurer income statements, SEC Form 10-K for 2020.
- ¹⁴ Kaiser Family Foundation, Medicaid-to-Medicare Fee Index 2016.
- ¹⁵ Based on the authors’ study of a large, California-based multi-payer claims data warehouse (2019 data). See also: Eric Lopez and Tricia Neuman, “How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature”, Kaiser Family Foundation, April 2020.
- ¹⁶ Andrew Mulcahy et al., “International Drug Price Comparisons”, RAND Corporation, January 2021.
- ¹⁷ OECD Health Data: Pharmaceutical spending, 2018.
- ¹⁸ US Government Accountability Office, “Prescription Drugs: Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017”, December 2020.
- ¹⁹ Lopez & Newman, 2020.
- ²⁰ Richard Kronick and Sarah Hoda Neyaz, “Private Insurance Payments to California Hospitals Average More Than Double Medicare Payments”, May 2019.
- ²¹ Bill Johnson et al, “Comparing Commercial and Medicare Professional Service Prices”, Health Care Cost Institute, August 2020.
- ²² James G. Kahn, Richard Kronick, Mary Kreger, and David N. Gans, “The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals”, Health Affairs, November 2005.
- ²³ Steve Melek, Stoddard Davenport, T.J. Gray, “Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement”, Milliman Research Report, November 2019.
- ²⁴ Sean P. Keehan, et al, “National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth”, Health Affairs, March 2020.
- ²⁵ National Association of Insurance Commissioners and the Center for Insurance Policy and Research, “The State of Long-Term Care Insurance: The Market, Its Challenges and Future Innovations”, May 2016.

-
- ²⁶ Christopher Giese et al, “Long-Term Services and Supports Feasibility Study”, Milliman on behalf of California Department of Health Care Services, September 2020.
- ²⁷ See Sarah Thomason and Annette Bernhardt, “California’s Homecare Crisis: Raising Wages is Key to the Solution”, UC Berkeley Center for Labor Research and Education, November 2017.
- ²⁸ Congressional Budget Office, “How CBO Analyzes the Costs of Proposals for Single payer Health Care Systems That Are Based on Medicare’s Fee-for-Service Program”, December 2020 (Section 8).
- ²⁹ Kaiser Family Foundation, 2020 Employee Benefits Survey.
- ³⁰ See Laurel Lucia and Ken Jacobs, “Increases in health care costs are coming out of workers’ pockets one way or another: The tradeoff between employer premium contributions and wages”, January 2020.
- ³¹ California State Controller County Data 2019 (<https://counties.bythenumbers.sco.ca.gov>). City and County of San Francisco spending from the SF Controller’s Comprehensive Annual Financial Report, Year ended June 30, 2020.
- ³² San Francisco Health Service System, 2020 10-County Survey. (The City and County of San Francisco pegs its employee benefit spending to the average of the other 10 largest counties in the state).
- ³³ “SMD # 18-009RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects”, Timothy B. Hill, Acting Director, Centers for Medicare and Medicaid Services, August 22, 2018.
- ³⁴ District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 129 (1992), and N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55 (1995).