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COMMENTARY

Beyond The ACA: Paths To Universal Coverage In California

ABSTRACT **California has long sought to achieve universal health insurance coverage for its residents. The state's uninsured population was dramatically reduced as a result of the Affordable Care Act (ACA). However, faced with federal threats to the ACA, California is exploring how it might take greater control over the financing of health care. In 2017 the state Senate passed the Healthy California Act, SB-562, calling for California to adopt a single-payer health care system. The state Assembly did not vote on the bill but held hearings on a range of options to expand coverage. These hearings highlighted the many benefits of unified public financing, whether a single- or multipayer system (which would retain health plans as intermediaries). The hearings also identified significant challenges to pooling financial resources, including the need for federal cooperation and for new state taxes to replace employer and employee payments. For now, California's single-payer legislation is stalled, but the state will establish a task force to pursue unified public financing to achieve universal health insurance. California's 2018 gubernatorial and legislative elections will provide a forum for further health policy debate and, depending on election outcomes, may establish momentum for more sweeping change.**

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There is a long-standing debate about the role states can play in ensuring universal health insurance coverage for their residents. The main argument in support of using states to achieve universal coverage is that it allows local experimentation, which can accommodate variation in states' resources, needs, and policy preferences while also limiting the impact that an error in policy could have on the entire US.[1] Progress at the state level faces many challenges as well—most notably, limited fiscal capacity, requirements for balanced budgets, and the need for full federal support for any proposal that would change the operation or financing of Medicare and Medicaid.

Amid shifts in policy priorities under changing federal administrations, the level of energy devoted to state versus federal coverage expansion and health reform efforts has fluctuated. Before passage of the Affordable Care Act (ACA) in 2010, many saw state efforts as the most promising way to reverse national trends in the growing numbers of uninsured people.

The passage of the ACA temporarily relieved states of the need to take the lead in expanding health care coverage. However, many states have returned to the issue in the wake of the threat by the administration of President Donald Trump to repeal the ACA. California has been in the vanguard of states pursuing policies to preserve gains in coverage under the ACA, as well as policies that would expand upon them by making coverage available to all residents. One view is that the time is right for the state to assume financial responsibility for the care of all its res-

idents through some version of a single-payer approach. California and other states have explored such an option previously, but no state has yet enacted and implemented a single-payer system.

In this article we describe the conditions that have rekindled a policy debate in California regarding the state's role in financing health care. We describe features of California's health care system that influence the debate as well as the financial, political, and pragmatic barriers California would face in attempting to establish a stand-alone state health system. We conclude with observations about the conditions under which a state-based effort is most likely to succeed, and we offer implications for other states.

California's Coverage Gains And Remaining Gaps

In 2017 California had a population of 39.5 million people and was estimated to spend more than $400 billion, or about $10,000 per person, on health care across the state from all sources (exhibit 1).[2] More than half of this amount came from public sources, of which the largest were Medi-Cal (the state's Medicaid program, which accounted for more than $100 billion) and Medicare ($75 billion). Employer-sponsored coverage accounted for the largest share of private health care spending ($125 billion). In addition, consumers paid $10 billion in premiums for individual insurance and $30 billion in out-of-pocket spending.

After the ACA was enacted, California became the first state to establish an ACA-compliant health benefit exchange (Covered California) and expanded eligibility for Medi-Cal to take full advantage of new eligibility opportunities and federal matching funds under the ACA. Covered California has been a leader among ACA exchanges, using standardized benefit packages and an active purchaser model to keep premium growth below the national average.[3] Also, Medi-Cal enrollment has nearly doubled under the ACA, reaching 13.3 million in 2017.[4]

More recently, California has asserted leadership in expanding and protecting gains in health insurance coverage. In May 2016 California used state funds to expand Medi-Cal with full benefits and not just on an emergency basis to undocumented children up to age eighteen,[5] adding an estimated 216,000 children to the Medi-Cal rolls.[6] To protect coverage gains in the individual market, soon after the Trump administration announced that it would end cost-sharing reductions, California rapidly implemented a surcharge on silver-tier health plans participating in Covered California.[7] This surcharge triggered increased premium subsidy support from the federal government, which enabled insurers to recoup the lost reductions at no additional financial cost to consumers. Covered California enrolled over 1.5 million people in each of the 2017 and 2018 open enrollment periods, sustaining participation at levels that compare favorably to those in states that rely on HealthCare.gov, the federally facilitated exchange.[8]

Taken together, these policy choices and implementation steps have reduced the percentage of uninsured Californians from 17 percent in 2013, the year before the implemention of the ACA's major insurance coverage provisions, to 7 percent in 2017.[9] Despite this progress, approximately three million Californians do not have health insurance coverage (exhibit 2).[10] About 1.8 million Californians are ineligible for public coverage programs because of their immigration status; the vast majority of them would be eligible for either Medi-Cal or premium tax credits in Covered California based on income requirements. More than 700,000 uninsured Californians are eligible for either Medi-Cal or subsidies to purchase coverage in Covered California yet are not enrolled.

California's Universal Coverage Quest

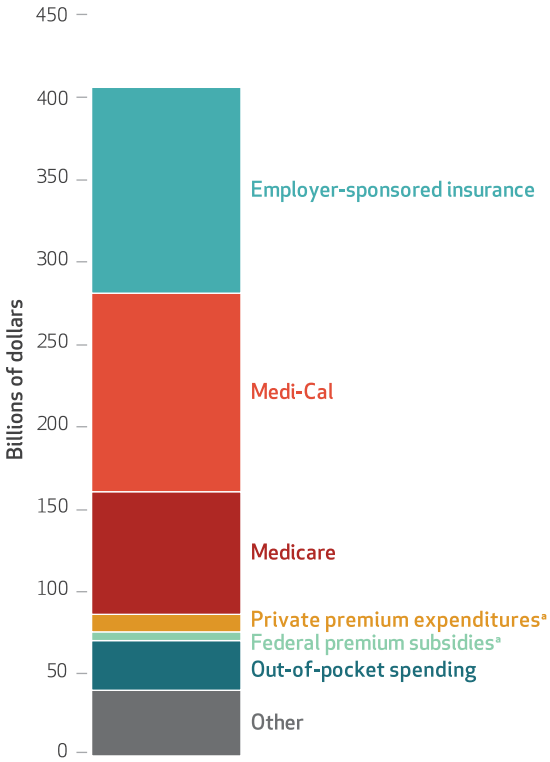
Californian politicians and stakeholders have actively pursued universal coverage for decades.[11] Achievements under the ACA gave many a sense of momentum toward that long-held goal. Threats to overturn the ACA reminded California constituencies that gains could be reversed by forces outside their control.

Faced with those threats, in the fall of 2017 the state Senate passed SB-562, the Healthy California Act,[12] which called for California to adopt a single-payer health care system and opened a new chapter in the public debate about the need for a dramatic overhaul of health care. The bill was promoted by the California Nurses Association, which has criticized the ACA for what its members see as the law's prioritization of insurers' profit motives over patients' financial and health needs.

Notwithstanding the enthusiasm of its supporters, leaders in the state Assembly were reluctant to take up SB-562 because it did not include a financial plan, specify design features, or offer any details on how the state could transition to a single-payer system. Assembly Speaker Anthony Rendon appointed a Select Committee on Health Care Delivery Systems and Universal Coverage to identify options for achieving universal coverage and reforming the delivery system in California. All options, including single payer, were open

EXHIBIT 1

California health care expenditures in 2017–18, by source of funds



SOURCE Authors' analysis of data from California Legislative Analyst's Office. Financing considerations for potential state healthcare policy changes (note 2 in text). **NOTES** "Employer-sponsored insurance" includes premium spending by employers and employees. Medi-Cal is California's Medicaid program. "Out-of-pocket spending" includes copayments, deductibles, and other health care expenses not covered by insurance, but not health insurance premiums. "Other" includes payments by and for military members and veterans, state expenditures for the uninsured, and workers' compensation. [a]In the individual insurance market, including Covered California.

for discussion. The Select Committee held six hearings in the period October 2017–February 2018. The witnesses at the first five hearings were health policy experts from academic institutions, foundations, and state government. They provided an overview of health care coverage in California; lessons from international models of health care delivery; experiences with cost containment, access to care, and delivery system reform initiatives in other states, along with implementation challenges in achieving universal coverage. The last hearing provided an opportunity for stakeholder groups, including the California Nurses Association, to present proposals for achieving universal coverage.

The authors of this article were retained by the Assembly to summarize the content of the hearings and to assist the Select Committee in identifying options for a sustainable and affordable universal health care system. We issued a report to the Assembly on March 12, 2018.[13]

Approaches To Achieving Universal Coverage In California

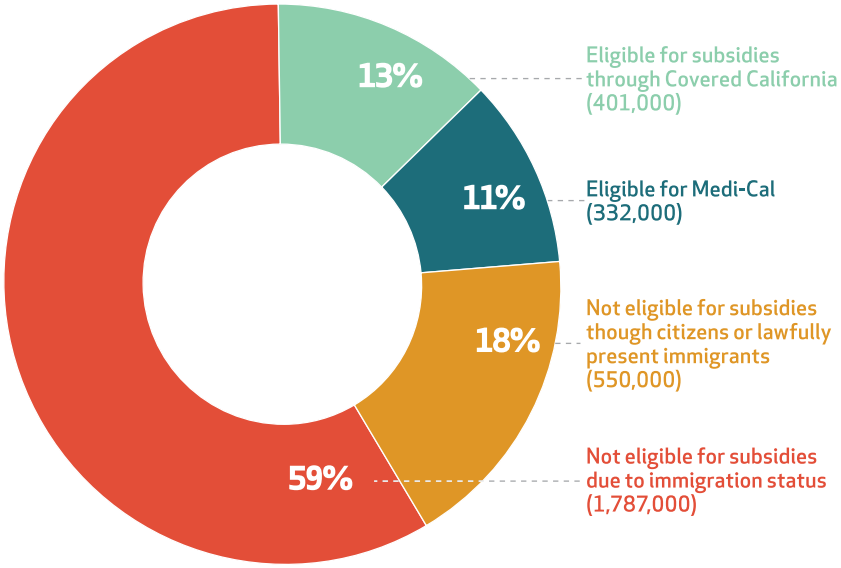
The 2017–18 Select Committee process provided an opportunity to explore coverage expansion policies as well as approaches to streamlining financing and improving care delivery. The question of whether more Californians should be enrolled in coverage was not deeply debated; instead, energy focused on how to achieve that goal. Two main types of approaches to achieving universal coverage were considered: first, incremental approaches that built on the status quo by addressing remaining gaps in coverage; and second, approaches that fundamentally restructured health care coverage and financing, ending Medicare, Medi-Cal, employer-sponsored insurance, Covered California, and the individual market as distinct sources of coverage and providing coverage for all residents of California through some sort of unified system. To a large extent, the hearings focused on the second approach, exploring the rationale and prospects for a bold restructuring of health care. Although this article reflects that emphasis, we note that incremental approaches to expanding coverage are more likely to be enacted and, if they are, would represent a substantial step toward universal coverage in California.

FRAGMENTED CARE Like other states, California has a fragmented financing system, which limits its ability to make progress in solving fundamental problems in its health care delivery system. Among these problems are inequities within and across payers; churning among sources of coverage, with accompanying disruptions in care; high billing and insurance-related administrative costs; inconsistent and often conflicting incentives for providers; and limited ability to engage in health planning or systemwide quality improvement efforts.

UNIFIED PUBLIC FINANCING A system of unified public financing—in which all Californians would receive health care coverage by virtue of residency in the state and the distinctions between Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage would be eliminated—could provide a solution to many of the problems created by fragmentation. Unified public financing could be either a single-payer system (in which the government made direct payments to hospitals, physicians, and other health care providers) or a multipayer system (in which the government paid health plans to provide coverage on behalf of people

EXHIBIT 2

Estimated uninsured population of California in 2017 younger than age 65, by category



SOURCE Authors' analysis of information from Dietz M et al. Preliminary CalSIM v. 2.0 regional remaining uninsured projections (note 10 in text). **NOTES** The total uninsured population was estimated to be 3,049,000. Subgroups do not total to this amount and percentages do not sum to 100 because of rounding. Medi-Cal is California's Medicaid program. Covered California is the state's health insurance Marketplace.

who selected those plans—which in turn would make payments to providers to furnish health care services).

The distinction between a single-payer system and a system of unified public financing is reflected within the Medicare program. Medicare started as a single payer that made direct payments to providers, but with the advent of Medicare Advantage, many beneficiaries now voluntarily choose health plans that act as intermediaries. As a result, multiple payers reimburse providers, even though Medicare remains a unified publicly financed program. Similarly, many state Medicaid programs, including Medi-Cal, started as single-payer systems but now are multipayer ones that require beneficiaries to use health plans as intermediaries.

A unified publicly financed approach to health care coverage, whether single- or multipayer, would need to pool funds from a variety of payment sources to eliminate the differences among Medicare, Medi-Cal, and employer-sponsored insurance in terms of consumer cost sharing and benefits. A unified publicly financed approach would reduce the considerable administrative burden that today's financing arrangements impose on purchasers, consumers, and providers. Taken together, these changes would almost certainly create a more equitable health care system. Furthermore, they would likely increase efficiency and produce better health outcomes, although these results would depend on how well the system was managed and on mechanisms of accountability.

Many single-payer advocates see health insurers as the primary source of access and cost problems in the health care system. A major advantage of a single-payer system, they argue, is that it can bypass health insurers entirely. However, California is deeply invested in health maintenance organizations (HMOs) and managed care. More than 60 percent of all insured Californians are enrolled in HMOs—which is a higher share than in most other states. Fifty-one percent of people with employer-sponsored insurance, 39 percent of those insured in the individual market, 43 percent of Medicare beneficiaries, and 80 percent of Medi-Cal enrollees are in HMOs.[14] Over eight million Californians are enrolled in Kaiser Permanente alone.[15] It seems likely that a unified publicly financed system in California would follow the patterns established by Medicare and Medi-Cal: publicly financed systems that have chosen not to be single payers but rather to rely on health insurers in an attempt to improve quality and efficiency, albeit in a highly regulated environment.

Barriers To Unified Public Financing

California would need to overcome daunting technical and political challenges if it were to transition to a system of unified public financing, whether single- or multipayer. It would be doubly challenging to accomplish this transition at the state level, in part because political agreement would be needed from two levels of government—state and federal. Concerns about providers fleeing the state or sick people being drawn to the state complicate the technical challenges of establishing a unified publicly financed health care system at the state level. These concerns would be minimized if unified public financing were enacted at the federal level.

Accomplishing such a sweeping transition would require substantial and unprecedented changes in federal and state law as well as decisions regarding many design parameters. To implement such a system, Congress would need to pass legislation to redirect payments away from individual Medicare beneficiaries and providers to whatever state agency was operating California's unified public financing program.

Current federal law might allow federal waivers to redirect federal funds for Medi-Cal and subsidies for individuals in Covered California into a unified state pool, but such waiver requests would be unprecedented. In addition to establishing an initial set of assurances about

payments, determining the rate at which the federal payment to California would grow over time would require political agreement. It is hard to imagine that the current Congress or administration would approve such requests. Even with a hypothetical Democratic Congress and president, such approvals would be far from certain.

At the state level, a move to unified public financing of health care would also face significant political challenges. Very large new state taxes would be required to generate program revenue to replace employer-sponsored insurance funding, support those who are currently uninsured, and cover the administrative costs of operating the program. Given anticipated savings from reduced billing and insurance-related costs and potentially (at least eventually) some reduction in low-value care and in the rate of growth of prices, it seems likely that total spending would be less over time than under the status quo. But even if total health spending declined (or at least did not increase), transforming employer-sponsored funding into public funding would be a massive undertaking.

Other challenges include developing processes to match the rate of spending growth to the rate of revenue growth and to determine the "right" revenue growth rate. Physicians, other providers, and some patients would be concerned that a system of unified public financing would overly constrain spending growth, denying Californians the benefits of outcome-improving technology. On the other side, some would be concerned that as a result of regulatory capture, health spending would increase more quickly than justified by the rate of improvement in outcomes, leading to tax increases that did not produce commensurate increases in value or to squeezing out other government spending.

The Select Committee hearings convened to explore these and other issues did not delve into the details of how new taxes might be constructed to support unified public financing; however, the California Legislative Analyst's Office provided broad tax alternatives with ballpark estimates.[2] Assuming that the current amounts being spent by Medicare and Medicaid could be contributed to a unified public financing approach, new taxes would be needed mainly to substitute for the current employer and employee contributions. Because employer and most employee contributions are made with pretax dollars, purchasers of employer-sponsored coverage benefit today from a discount in the form of a federal tax subsidy. Other methods of financing might increase Californians' federal income tax burden. Based on the Legislative Analyst's Office estimates, a 3 percent gross receipts tax levied on all sales and services at all stages of production would generate approximately $120 billion—an amount similar to that spent in California for employer-sponsored insurance. Alternatively, a similar amount could be generated with a 9 percent payroll tax.

A payroll tax could be applied uniformly to all employers, or the state could consider a firm-specific payroll tax in which the tax rate for each firm approximated the percentage of the payroll that the firm pays for health benefits under the status quo—with a plan to narrow the gap between high- and low-rate firms over time. A firm-specific payroll tax would have the political advantage of creating fewer winners and losers, compared to most other financing approaches, and would also minimize any effect on federal income tax liabilities.

Amendments to the California constitution would be required to implement unified public financing in the state.[16] Proposition 98 requires that a portion of any new taxes, regardless of the stated rationale for them, must be directed to K–14 education. The Gann limit, passed by voters via a 1979 statewide ballot initiative, sets appropriation limits on state budget categories supported by taxes. A new tax to support unified public financing would almost certainly exceed the limit. Therefore, adequate funding for unified public financing would require a majority vote of the state's population to modify the limit.

Even if an amendment to the California constitution were not required by Proposition 98 and the Gann limit, support from California voters for a system of unified public financing would be important for at least two reasons. First, as we have seen with the Affordable Care Act, opponents of change will likely not concede after a legislative loss and will continue to litigate, both in court and in the court of public opinion. A statewide vote in support of change would not prevent that activity but would reduce its effectiveness. Second, and more important, obtaining the federal legislative changes and administrative approvals needed to implement unified public financing would be challenging, and a statewide expression of support could increase the chances of success.

A Path Forward

At the hearings, Peter Shumlin, a former governor of Vermont, recommended that California establish a public commission to address how provider payment levels would be set and adjusted, as well as whether and how payments and delivery-system arrangements might be allowed to vary based on regional differences and local preferences and need.[17] He also recommended that a commission consider the extent to which

integrated managed care arrangements would be encouraged and the role, if any, for health plans; how the quality of and access to care would be ensured; the extent to which the needs of special populations would be prioritized; and the governance structures and management tools that would be required to ensure accountability and effective oversight.

In the aftermath of the Assembly hearings and the issuing of our report, Speaker Rendon reiterated that the Assembly would not consider SB 562 during the 2017–18 session. While the bill envisions a less complex health care system than the status quo, the process of transitioning to it would be a substantially more disruptive way to expand coverage than building upon the foundation of the current system.

In the desire to increase coverage through actions that are within the state's control, members of the legislature introduced a number of bills focused on short-term incremental strategies to improve coverage, access, and affordability within the context of the current multipayer system. One bill would expand coverage to income-eligible undocumented adults through Medi-Cal.[18] Others would use state funds to lower the cost of purchasing private coverage through Covered California including for those with incomes up to 600 percent of the federal poverty level.[19] These approaches, combined with efforts to increase enrollment among those who are already eligible for Medi-Cal or for subsidies in Covered California, could move California very close to universal coverage.

A 2018–19 budget agreement between Gov. Jerry Brown and the California State Legislature did not provide funding for these proposals, and they are unlikely to advance this year. However, proposals for incremental coverage expansion are expected to be revisited in future years. Further, the 2018–19 budget does fund the establishment of a task force to continue work on unified public financing to achieve universal health care.[20] One way to make this difficult task a bit easier would be to leave Medicare funding as is for now and focus instead on unifying all other payment sources. This would reduce the need for federal statutory change yet would be a major step forward in simpiflying the state's fragmented financing of health care.

Discussion

Health policy debates often begin with visions of sweeping reform. In the face of practical obstacles and political realities, however, broad ambitions frequently give way to accepting incremental change. The substantial impediments to state-based unified public financing suggest that California's current policy debate may conform to that model.

Although incremental progress along California's current path may be the most likely future scenario, it is worth considering what might spur the state toward a unified publicly financed health care system. In our view, such a transformation could occur only if it were championed by persistent state leaders at the highest levels, a broad set of stakeholders were compelled to negotiate in good faith, and an informed public was aware of the stakes and invested in the outcome.

STATE CHAMPIONS The recently elected California Senate president pro tempore, Toni Atkins, was a sponsor of SB-562 and is on record in support of a single-payer approach. In the 2018 governor's race, whether and how to achieve universal health care coverage in California has been a subject of voluble debate. The state's current lieutenant governor, Gavin Newsom, who secured the most votes for governor in the state's June primary, has used the phrase "single-payer" to describe his vision for universal coverage. Few details beyond that phrase have been offered to clarify how reforms would be pursued. Depending on how November state and federal elections unfold, California's next governor and the state's legislative leadership may enter 2019 with a perceived mandate to tackle sweeping health reform.

The actions of California's elected leaders will be influenced by national political developments. Many of California's elected leaders view themselves as engaged in active conflict with the Trump administration on a number of policy fronts, including immigration and health care. The Assembly embraced an opportunity to express disagreement with federal policies by voting in May 2018 to expand Medi-Cal benefits to the largest remaining group of uninsured Californians—undocumented adults, many of whom are Latino—if they meet income standards.[21] Similar full-throated legislative support may emerge in 2019 if a governor who is receptive to unified public financing of health care takes office.

STAKEHOLDER ENGAGEMENT During California's 2017–18 Assembly-led process, many stakeholder groups (for example, the California Medical Association, California Association of Health Plans, hospital and clinic associations, and organizations representing employers) remained largely on the sidelines. Because options were discussed in the abstract, stakeholders had the space to observe rather than engage.

Providers are unlikely to respond uniformly to a proposed transition to unified public financing, either single- or multipayer. Those with a strong bargaining position in negotiations with

fragmented purchasers may feel financially threatened. However, provider groups with less bargaining power may welcome a more level playing field and—particularly if payments are established at or above Medicare payment levels—a shift to unified public financing. The benefits of a simplified, more efficient, and more equitable system may also influence some providers to support change.

Thus far, California's employers have not played a leadership role in reorganizing health care finance. Faced with a specific proposal, however, employers are likely to respond in a variety of ways, based on cost implications and labor force considerations.

Health plans are unlikely to embrace their own elimination under a single-payer proposal. However, depending on the terms of the debate, a continued robust single-payer discussion might encourage health plans or other stakeholders to entertain multipayer unified public financing as a less disruptive alternative.

If a fundamental restructuring of health care financing is to advance in California, some or all of these stakeholders will need to feel enough urgency to join negotiations. A broad review of policy options will not cause deeply invested stakeholders to reexamine their positions, whereas a credible threat to the status quo might.

INFORMED PUBLIC A move to unified public financing would also cause worry for the tens of millions of Californians who now have coverage. Notwithstanding the ferment in Sacramento around single payer, the public has not yet been educated about the implications of eliminating Medicare, Medi-Cal, and employer-sponsored insurance. In addition to cost implications, Californians will want to know if they can retain their provider relationships under the new arrangement.

The case for universal coverage and state-driven health care finance made by the supporters of SB-562 has catalyzed a new round of debate about the appropriate role for state versus federal leadership on health policy. California's 2018 gubernatorial and legislative elections will provide a forum for further health policy debate and, depending on election outcomes, may increase momentum for sweeping change. If the public prioritizes the issue and stakeholders feel compelled to join the debate, California may find itself in a better position than most states to overcome the inertia inherent in the status quo.

Lessons For Other States

The California State Assembly's recent deliberations have implications for efforts in other states to achieve universal coverage. The process reinforced the limitations of incremental solutions in addressing the complexity, inequity, and cost of health care today. But it also underlined the challenges states would encounter in moving toward unified public financing of health care.

The potential benefits of integrating funds, reducing inequities in access to care, and improving efficiency in care delivery were both the starting point for the Assembly's process and a persistent theme throughout its deliberations. While incremental tactics can be used to extend coverage to more people, fundamental improvements in simplicity and fairness for both consumers and providers will remain out of reach as long as multiple coverage systems are in place.

Accepting that reality, we offer several observations related to moving toward unified public financing. There are no working examples to draw upon at a state level, so any state that dares to be first will face a steep learning curve. A state can take steps on its own to get ready for unified public financing, but it cannot independently implement such a program. For that, a state would need the full and enthusiastic partnership of both the executive and legislative branches of the federal government.

Despite these challenges, state action toward universal coverage and unified public financing is not beyond reach. States can take several steps to make such a transition more feasible. To begin, a state could establish a multiyear process, including a campaign to help the public understand the issues and not just the rhetoric. Political leaders and stakeholders would need to engage in designing not only a better system in the end, but also a responsible transition to the new approach. Data would be needed to increase understanding of the status quo and to support the monitoring and management of a new system.

Conclusion

Implementation of unified public financing in California is technically feasible, but leadership, vision, and persistent public and private commitment—both in California and in Washington, D.C.—are needed to make it happen. Recent deliberations within the California legislature demonstrated both the compelling logic of and the growing emotion associated with movement away from today's unequal, complex, and fragmented health insurance arrangements. It remains to be seen whether the proponents of change can overcome status-quo interests, renegotiate state and federal responsibilities, and set a new course toward universal coverage. ■

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