



How Can We: Care for All California & Lead the Nation?

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www.health-access.org



Biggest Congressional Action for Consumer Protections; Coverage Expansion; Cost Containment

CALIFORNIA UNDER THE ACA

Millions with new consumer protections; financial assistance

4+ million Californians with new coverage already

Biggest drop in uninsured rate of all 50 states

CA IMPLEMENTED AND IMPROVED:

- Covered CA negotiating on behalf of consumers
- Shop & compare health plans & benefits
- Medi-Cal express lane enrollment options
- Oversight over health plan rates & networks
- State coverage expansions: immigrant kids, newly qualified immigrants

If we can prevent ACA repeal,
stop Medicaid cuts, and resist attacks

how can California drive forward?



ACA Repeal Proposals Mean Devastation for CA

Each of the 2017 repeal proposals--American Health Care Act (AHCA), Better Care Reconciliation Act (BCRA), Obamacare Repeal and Replace Act (ORRA), Graham-Cassidy Heller Johnson (GCHJ)--would have had catastrophic impacts on our health system:

MASSIVE CUTS TO CALIFORNIA'S HEALTH CARE SYSTEM

- Phase out/Zero out ACA funding: Medicaid (Medi-Cal) expansion funds & Marketplace (Covered California) affordability assistance
- GCHJ: \$23 billion/year by 2026; \$53 billion/year in 2027 and beyond

CUT AND CAP MEDICAID

- End 50-year federal matching guarantee, threatening all 14 million Californians in Medi-Cal—and all of their services
- Per capita cap doesn't take into account medical inflation, aging population, public health emergencies, or other costs

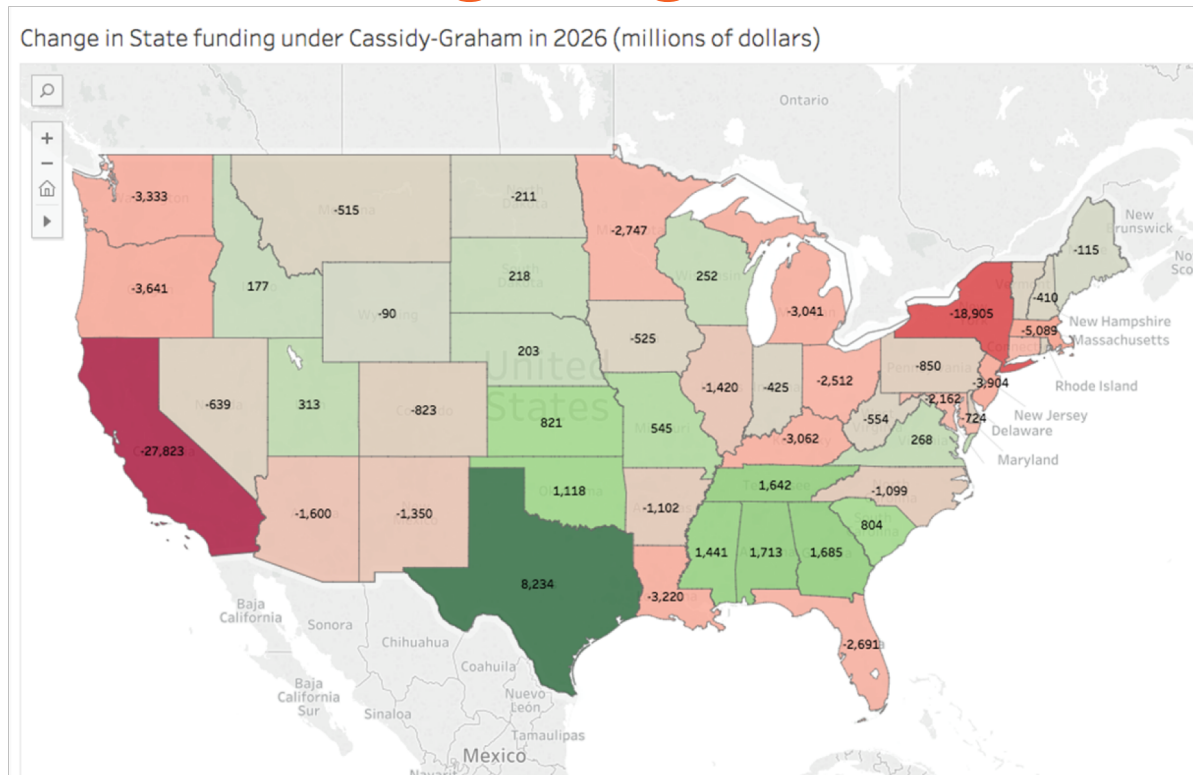
LEAVE 4-7 MILLION MORE UNINSURED & INCREASE PREMIUMS

- Four million would lose coverage from the elimination of Medicaid expansion; More from cutting Covered California affordability assistance
- Zeroing out individual (& employer) mandates, and further impacts on coverage & premiums

REPEAL KEY CONSUMER PROTECTIONS

- Give states discretion to undo: essential health benefits, lifetime limits, no surcharges for people with pre-existing conditions, maximum out-of-pocket costs, etc.
- Without funding, even California would face pressure to scale back benefits.

Graham-Cassidy: Bad For All Patients, But Targeting California



Opposition



The Ongoing Threat to Medi-Cal

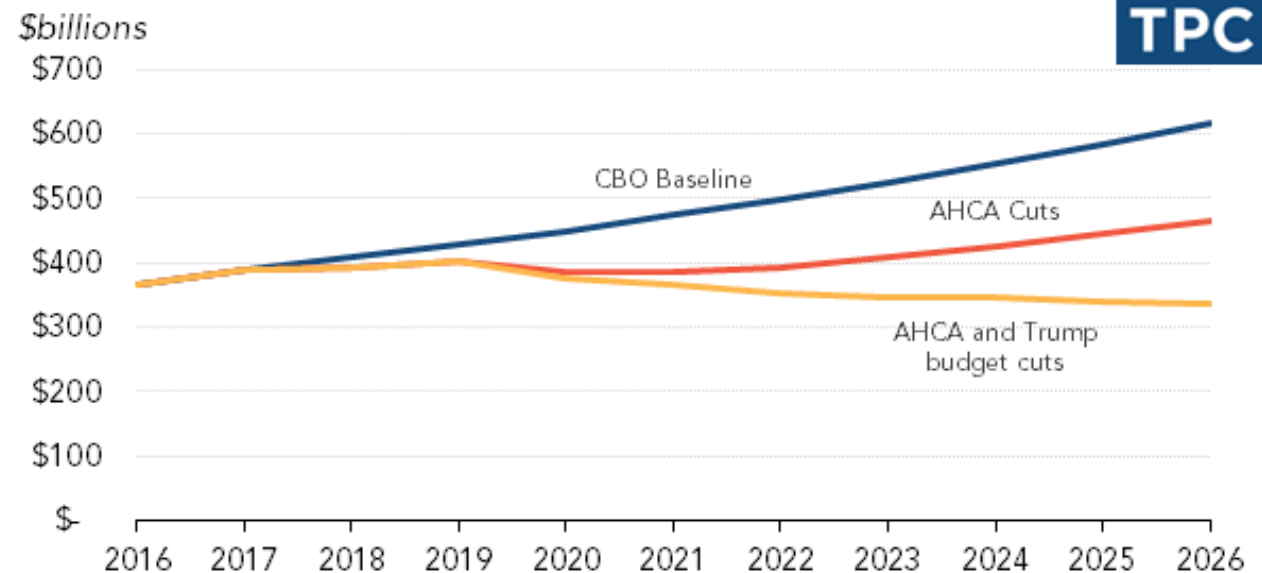
Congress' vote for the American Health Care Act would've cut Medicaid 25% in ten years.

The Trump budget and House budget resolution outlines Medicaid cuts twice as severe as the ACA repeal bill—cutting Medi-Cal in about a half in a decade.

The vote on the tax bill not only repeals the ACA individual mandate, but the tax giveaway build pressure for more cuts.

Thus, the threat continues for Medi-Cal which covers over 13.5 million: 1/3 of state, 1/2 of children, 2/3 of nursing home residents.

Medicaid After Proposed Cuts



Source: CBO, OMB.

Note: CBO's estimated AHCA cuts (\$834 billion) end in 2026. OMB's estimated budget cuts (\$610 billion) end in 2027; the last year (\$165 billion) of those cuts are not shown on the graph.

Holding Californians Harmless From Administrative Attacks

If the framework and financing of the ACA is intact, California has the will & wherewithal to withstand sabotage of individual insurance market:

Already In Place:

Cost-Sharing Reductions &
Covered California
workaround

Open enrollment: CA
keeps 3-month open
enrollment period (AB 156,
Wood)

Marketing & Outreach:
Federal budget cut by 90% to \$10M vs. Covered
CA's \$110 Million Campaign

Insurer exits: Extend
continuity of care protections to
individual market (SB 133,
Hernandez)

Contraceptive Coverage: While Trump
executive order impacts ERISA plans,
existing law requires CA-regulated
plans cover preventative care without
cost sharing. (SB 1053, Mitchell)

Holding Californians Harmless From Federal Administrative Attacks

Bills Signed by Governor Brown in 2018

- **“Junk” Substandard Insurance:**

SB 910 (Hernandez) to ban so-called “short term” insurance

SB 1375 (Hernandez) to limit Association Health Plans

- **Medical Loss Ratio**

AB 2499 (Arambula) to ensure 80% of premium dollars go to patient care, not administration and profit.

- **Medi-Cal Waivers & Work Requirements**

SB 1108 (Hernandez) on preventing Medicaid waivers from including eligibility barriers, like work requirements

Renewed Focus on Universal Coverage & Medicare for All

Since its founding, Health Access has been a strong supporter of multiple vehicles to get universal health care and quality, affordable health care to all Californians—including a Medicare for all single-payer system, such as bills by Senator Kuehl (SB971, SB810), Leno (SB840), Petris, and Proposition 186 (in 1994). SB562 (Lara/Atkins) renewed this effort.

When we work for single-payer we are fighting for:

- a **universal system**,
- a **publicly and progressively financed system**,
- a **cost-effective system**,
- a **comprehensive coverage system**
- a **simpler and more efficient system**,
- a **system focused on prevention not profits**.



Overcoming Obstacles to Health Reform

Big health reforms—single-payer or otherwise--have faced tough odds over a century—the equivalent of threading a multiple needles at once:

- **Political forces**, industries and stakeholders who oppose with \$/influence
 - **Industry opposition:** Insurers, Employers, Providers, Etc.
 - **Ideological opposition**, Some oppose taxes, social programs, government, immigrants
- **Public perception:** People's anxiety about health care actually make them more protective of what they have—and make them susceptible to opposition arguments.
- **Principles/Policy:** Trade-offs and policy decisions on any health reform--particularly how to **fund** and **finance**, how to **govern**, how to **structure** and how to **transition** to any new system..
- **Process:** There are some structural and constitutional barriers at the state level:
 - **Financing:** 2/3 legislative vote to enact taxes; (single-payer requires significant funds to replace all premiums/cost-sharing)
 - **Voter approval:** Likely needed to avoid state **constitutional** issues: Prop 98, Gann Limit, taxes(?)
 - **Federal permissions** (both administrative and Congressional): ERISA, Medicare, Medicaid, ACA.May be easier policy-wise (if much tougher politically) to do at the federal level. **State efforts much tougher without a friendly federal partner**

Care4All Legislative Priorities

Aspirational & Achievable Without Federal Approval



1. PROTECT PATIENTS FROM FEDERAL SABOTAGE OF OUR HEALTH SYSTEM
2. COVER ALL CALIFORNIANS, INCREASING UNIVERSALITY AND AFFORDABILITY
3. REDUCE HEALTH CARE PRICES, IMPROVING QUALITY & EQUITY THROUGH ACCOUNTABILITY



Building Upon the ACA Fight and CA's Progress



ON DAY ONE, GOVERNOR NEWSOM PROPOSED:

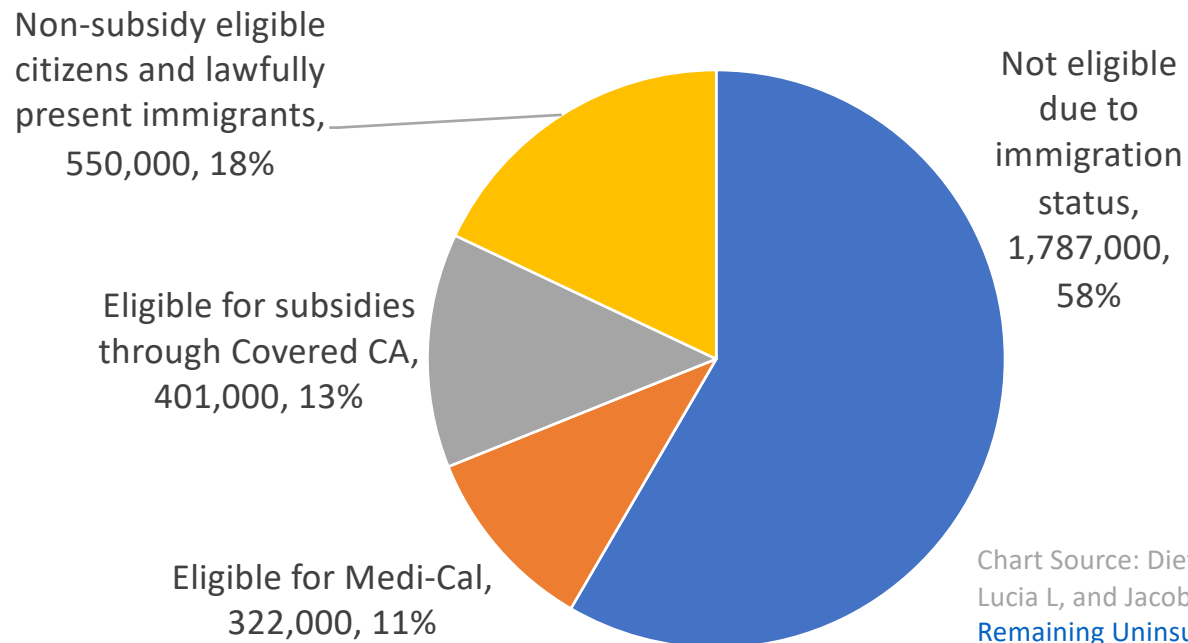
- Requesting federal permissions for “Medicare for All”
- Expanding affordability assistance in Covered California
- Instituting a state-level individual mandate
- Extending Medi-Cal to undocumented young adults
- Pooling state prescription drug purchasing
- Creating a California Surgeon General
- And more...

California launch of the Health Care for America Now (HCAN) Campaign to win what became the Affordable Care Act, with Mayor Gavin Newsom, highlighting Healthy San Francisco as a model, July 2008.



Covering the Remaining Uninsured

California Projected Uninsured Ages 0-64, 2017



Take-Up and Affordability Matter:

Medi-Cal:

- * Enrollment today: 13.8 million
- * 322,000 eligible but not enrolled
- * Less than 3% eligible not enrolled

Covered California:

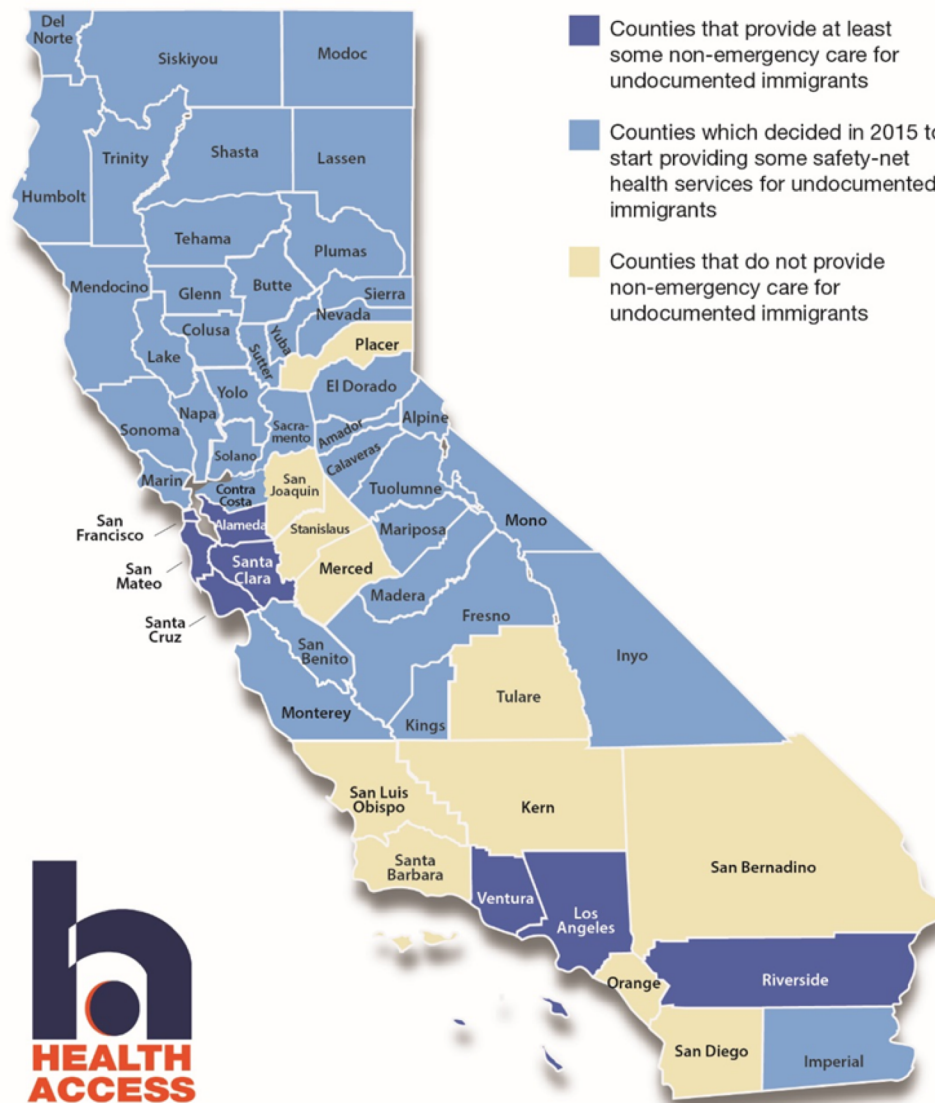
- * Enrollment today: 1.2 million
- * 401,000 eligible but not enrolled
- * Around 1/4 of those eligible for Covered California subsidies are not enrolled

Chart Source: Dietz M, Graham-Squire D, Becker T, Chen X, Lucia L, and Jacobs K, [Preliminary CalSIM v. 2.0 Regional Remaining Uninsured Projections](#), UC Berkeley Labor Center and UCLA Center for Health Policy Research, August 2016.

Our Current Safety-Net

- *The uninsured live sicker, die younger, are one emergency from financial ruin; Health & economic impacts on families & communities.*
- **Emergency Rooms:** But only to stabilize; Bill and debt afterwards
 - 2006 Fair Hospital Pricing Law www.hospitalbillhelp.org
- **A Safety Net That Survives and Thrives:** Private providers: clinics, hospital charity care, etc.
- **Counties often the last resort for the “medically indigent.”**
 - Counties have a “17000” obligation to provide basic care
 - **California’s 58 counties vary widely on their service to the uninsured, on:**
 - **How they provide care; What care they provide; and to who, on income & immigration status.**
 - Amidst 58 counties: 12 have public hospitals;; 12 “Article 13” counties just have clinics, or contract with private providers; or are a hybrid; 35 small rural counties in County Medical Service Program





California's Steps to #Health4All

PROGRESS WON:

County Safety-Net Reforms and Expansions

Counties are setting up more inclusive and smarter safety-net programs. Sacramento, Contra Costa, Monterey and CMSP all created new limited-benefit pilot programs that newly cover the undocumented. Others like LA and Santa Clara are improving existing programs. Ventura, Kern, and others are looking at new programs.

Won #Health4AllKids: Medi-Cal For All Children Under 266% FPL

Now covering an estimated 200,000 more children.

Continuing California's Coverage of "Deferred Action" Immigrants

DACA eligibility for state-funded Medi-Cal is reaffirmed under PRUCOL (Permanently Residing Under Color of Law)—even if DACA is rescinded.

In 2019, legislative #Health4All efforts **SB 29 (Durazo)/ AB 4 (Arambula/Chiu/Bonta/Gibson)** seek to **expand Medi-Cal to all income-eligible adults**, regardless of immigration status.

Previous stalled efforts:

- In 2018, the Assembly budget focused on young adults up to 26, the Senate on elders over 65. Neither was adopted
- A §1332 waiver withdrawn in 2017 would have allowed undocumented adults to buy unsubsidized Covered CA plans.

Who Needs More Help-- To Enroll in or Afford Coverage?

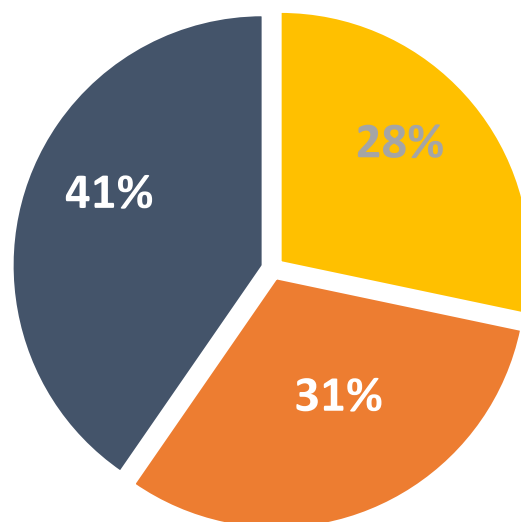
Uninsured citizens ages 0-64 with household income at or above
139% FPL, California, 2016

*2019 Proposals to
Increase Affordability:*

- AB174 (Wood)
- SB65 (Pan)
- New Covered California report

In 2018, the Assembly
budgeted \$500
million in general
fund dollars for
affordability
assistance.

401%+ FPL
\$47,500+ single



139-250% Federal Poverty Level (FPL)
\$16,500 - \$29,700 single

Another Issue: "Family Glitch"
of unsubsidized spouses/children
of worker with job-based coverage
but not family coverage.

251-400% FPL
\$29,700 - \$47,500 single

Source: California Health Interview Survey 2016

Beyond Governor Newsom's Outline: The Path to Care for All California

In 2018, Governor Brown signed 8 of 20 #Care4AllCA bills and budget items, but no new health expansions or investments.

On day one, Governor Newsom adopted much of #Care4AllCA's agenda, including several first-in-the-nation steps. That said, we will continue our advocacy to our goals:

- **#Health4All:** Expansion of Medi-Cal to all, regardless of immigration status
- **Ending Medi-Cal's "Senior Penalty":** Full-scope coverage up to 138% of poverty level, regardless of age or disability. (Both Senate & Assembly supported in 2018.)
- **State-level Individual Mandate:** Continue the ACA requirement; collect the penalty that the federal government zeroed out, to help fund enhanced subsidies.
- **Additional Affordability Assistance:** The mandate should not be the only source of funds, ideally no one pay it. (Assembly proposed \$500M general fund in 2018.)
- **Enrollment Reforms:** Keeping Californians Covered During Income Changes; Addressing Churn; Outreach Funding; WIC Express Lane Enrollment

2018 Bills ENACTED on Cost/Quality/Equity

PASSED BY THE LEGISLATURE AND SIGNED BY GOV. BROWN:

More Work on Prescription Drug Prices

- Regulate Pharmacy Benefit Managers (AB 315, Wood)
- Maintain co-pay caps, (SB 1021, Wiener).

Health Plan Consolidation and its Impact on Costs

- Health plan merger oversight (AB 595, Wood)

Public Option Feasibility Study

- Conducted by Health Care Delivery System Council (AB 2472 Wood)

VETOED: Medi-Cal Managed Care: Accountability for Quality & Equity

- (AB 2275, Arambula)

Not Just Coverage: Cost, Quality, Equity, Delivery

PASSED BY THE LEGISLATURE AND SIGNED BY GOV. BROWN:

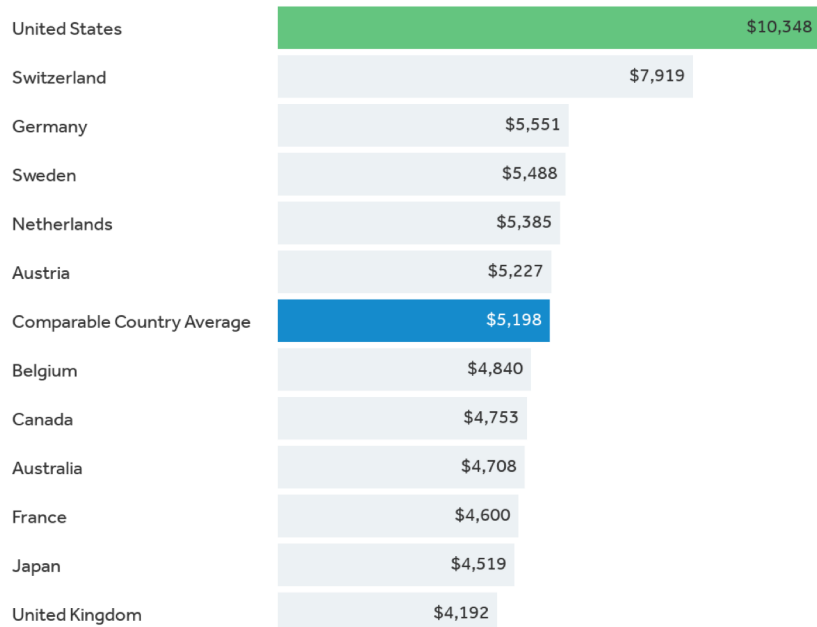
- * All Payers Cost Database**
- * Health Care Delivery System Council**
- * Public Option Feasibility Study (AB2472 Wood)**

GOVERNOR NEWSOM'S PROPOSALS

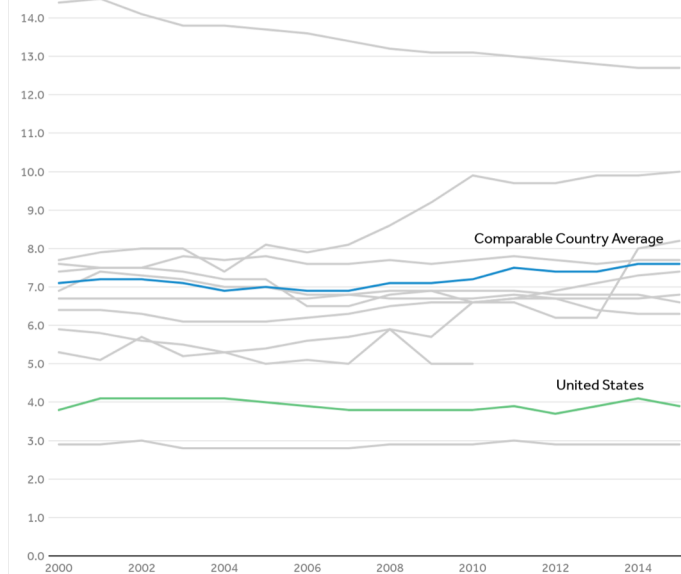
- * California Surgeon General**
- * Prescription Drug Purchasing Pool**
 - Broader Efforts on Cost/Consolidation/Cost-Sharing/Etc?**
- * Waiver Requests to the Federal Government**

United States: Costs More, Less Care

Total health expenditures per capita, U.S. dollars, PPP adjusted, 2016



Doctors consultations per capita, in all settings, 2000-2015



Notes: Break in series for France in 2013 and the Netherlands in 2014. In cases where data were unavailable, data from the countries' closest available year are shown. United Kingdom not included in average for 2011-2015. Data for Switzerland not available.

Source: Kaiser Family Foundation analysis of data from OECD Health Statistics and the AHRQ Medical Expenditure Panel Survey (Accessed on 31 January 2018).
[Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Health Costs a Major Concern

In focus groups:

- Health care—and especially costs--consistently arose as a top concern
- Many expressed a sense of powerlessness, a lack of security & control.
- On a \$225K hospital bill: “never seen so much money on one sheet of paper.”
- Exasperated with profiteering, *many* people brought up Martin Shkreli.
- “It’s not something you can price shop for. You just get the bill.”
- “I had no idea what the bill would be... no way to budget for it.”
- One participant “Didn’t have an epidural because of cost.” She always thinks “What can I go without?”
- Others: “A lot of people hold off getting care.” “I’m just going to wait it out.”

Why Health Costs Are So High

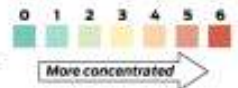
- Employer-sponsored health care went up 234% from 2002-16.
- 83% of 2017-18 large group increases is price inflation—only 16% utilization.
- 75% of premium dollars to doctors and hospitals (+ another 16% on drugs)
- Average in-patient procedures 79% higher in NorCal's concentrated market; Hospital prices 70% higher; Physician prices 25-65% higher.

Unhealthy trend?

Consolidation in the health care industry has increased across California. Each county's score reflects both hospital mergers and the purchase of doctors' practices by hospitals.

MARKET CONCENTRATION SCORE

A higher score means that health systems are more concentrated.



2010



Source: Health Affairs

2016



John Blanchard / The Chronicle

Consumers Largely Don't Experience Health Care Choice & Competition

- Limited ability to say “no” or to comparison shop
- Little price transparency, notice—pricing often only appears after treatment

Consolidation in the industry

- Rural/smaller/underserved areas that simply can't sustain too many plans, hospitals, or providers
- Trend to integrated care tends to correlate with consolidation

As a result, health care prices are largely determined not by the cost to provide the care, or quality, or outcomes—but the relative monopoly power of a plan or provider. Incentives drive even more consolidation.

MergerWatch: Consumer Concerns

It's Our Money!

Signal of Excess Reserves
Could Have Gone To Reduce Premiums;
Investments in Quality/Equity

Reduced Choice/Competition

Anti-Trust Analysis
Concentration Concerns Can Lead to Higher Cost

Corporate Behavior

Anti-Competitive
Consumer Protections & Customer Service
If They Want to Get Bigger, They Must Get Better

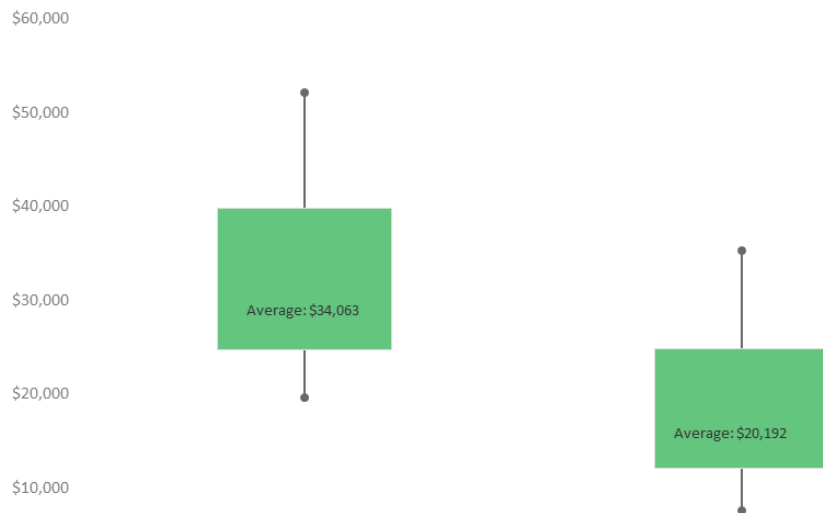


State Administrative Authority & Actions



- Governor Signed **AB 595 (Wood)** to Increase DMHC Authority over Health Plan Mergers
 - Explicit Ability to Approve, Reject, or Impose Conditions
 - Requires Hearing, Health System Impact Analysis for Major Mergers
- Attorney General Becerra Sued Sutter Health For **Anti-Competitive Practices**
 - Related bill on unfair contract provisions, SB 538 (Monning), stalled

Huge Price Variation

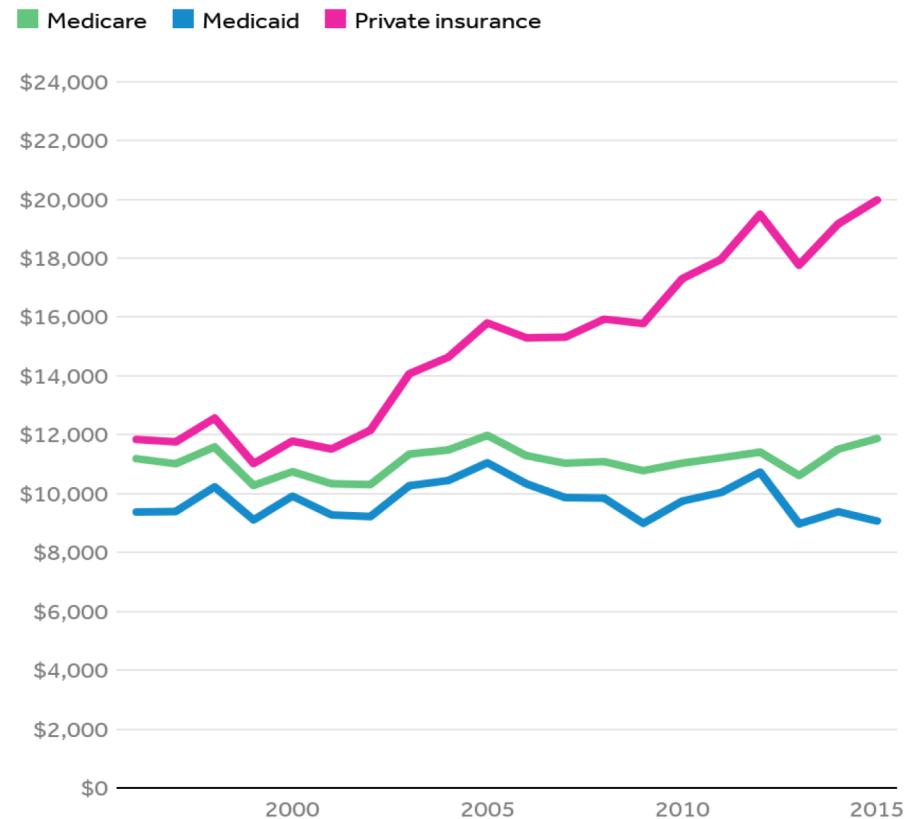


	Knee Replacement	Laparoscopic Appendectomy
25th Percentile	\$24,743	\$12,088
90th Percentile	\$52,181	\$35,308
10th Percentile	\$19,619	\$7,528
75th Percentile	\$39,786	\$24,847

Source: Kaiser Family Foundation analysis of Truven MarketScan data, 2016

Peterson-Kaiser
Health System Tracker

Average inflation-adjusted, standardized payment rates per inpatient hospital stay, by primary payer, 1997-2015



AB 3087 (Kalra): CA Health Care Price Relief Act

Creates a Health Care Cost, Quality, and Equity Commission, to set prices paid to hospitals, doctors, health plans, etc.



California
LABOR
Federation



AB 3087 (Kalra): It's the Prices, Stupid.

The California Health Care Cost, Quality & Equity Commission

- Members appointed by Governor, Assembly, Senate, with anti-conflict rules
 - Advisory Committee would have representation from health industry, purchasers, consumers. (Proposal includes a consumer participation program.)
- Would Set a “Benchmark” Price as a % Higher than Medicare
 - Medicare Advantage would be benchmark for health plans & insurers.
- Insurers, Hospitals, Doctors Could Appeal to Charge Above Benchmark
 - Factors could include innovations, geographic & population health, equity, quality
- Global Budgeting

AB 3087 passed Assembly Health Committee; Author held to negotiate.

Many of the Benefits of Medicare for All... Without Some of the Obstacles

AB 3087 would yield much of the savings found in most industrialized nations

- **Single-payer or not, all universal coverage countries have price-setting—often based on Medicare**
- **Uses the government's regulatory rather than bulk purchasing power.**
- **Sets a standard rate & contract leads to simplification and streamlining of our health system.**

For supporters of Medicare for All, AB 3087 provides a major step forward, without some obstacles.

- **No Loss Aversion:** AB 3087 doesn't replace coverage they have now, which can alarm voters.
- **No Need For: Financing/Taxes, Voter Approval/Constitutional Changes, Federal Approvals**

THE MAJOR OBSTACLE THAT REMAINS:

- **Broad industry opposition,** led by doctors and hospitals, also including insurers.
- **Ideological opposition** also.

Strong Industry Response

LA TIMES: An ambitious California bill would put the state in charge of controlling prices in the commercial healthcare market

By [MELANIE MASON](#)
APR 09, 2018 | 12:05 AM
| SACRAMENTO

Dr. Theodore M. Mazer, a San Diego ear, nose and throat specialist who is president of the California Medical Assn., called the bill a "poorly conceived, unprecedented threat to patient access to health care."

"This dangerously flawed legislation would result in government-sanctioned rationing of care and higher out-of-pocket costs for patients.. It would also likely cause an exodus of practicing physicians, which would exacerbate our physician shortage and make California unattractive to new physician recruits."

Focus group participant: "Sounds like someone making a lot of money off the current system."

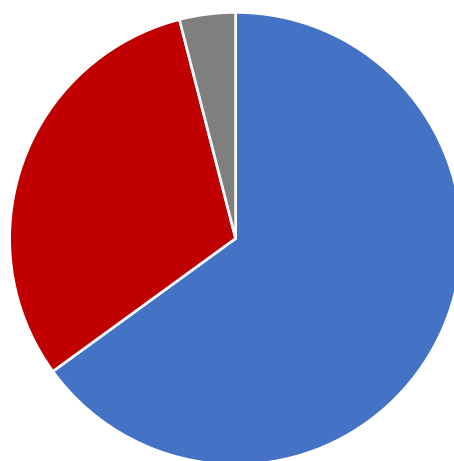
Health Care Focus Group & Polling

- Funded 50/50 by Health Access California and SEIU California
- David Binder & Associates
- Focus Groups Each in: Los Angeles (Southern California)
Fresno (Central Valley),
Walnut Creek (Northern California)
- Mixed Phone/Online Poll. Demographics:
 - 54% female, 46% male
 - 46% Democrat, 27% Republican 23% NPP
 - 54% White, 22% Latino, 3% Black, 8% API; 5% Mixed
 - 39% Progressive/Liberal; 29% Moderate; 25% Conservative
 - 22% under 35; 29 % 35-54; 18% 55-64; 24% 65+
 - 10% HS or less; 27% some college; 27% college; 34% postgrad+



Broad Support for Oversight on Health Prices

Do you support or oppose establishing an independent commission to review and approve the prices hospitals, doctors, and other providers of health care can charge?



**68% Support
Before Arguments
65% After**

■ Support

■ Oppose

■ Don't Know

Focus Groups Supportive of Price Controls

- “We do need to regulate it, just a cap would be good. You can’t really shop around.” –Republican Female, Fresno
- “If it was regulated, more people would be able to afford it.” –Latina, Fresno
- “Somebody has to do it—oversight of all these insurance companies and health providers, and provide transparency.” –Asian Male, Walnut Creek.
- “Everybody deserves to make money, but there’s a point where they’re making a killing.” –White Male, Walnut Creek
- “If the government didn’t regulate utilities, guess how much money you’d pay for a gallon of water.” –Latino Male, Los Angeles
- “Never seen a utility go bankrupt, and those executives make a lot.”-LA male
- “We need to do something.” -Multiple

Broad Support for Government Action

	Total Agree	Total Disagree	Don't Know
The government should act as a check on health care providers to get costs under control	72	25	3
The government needs to step in and put limits on what health care providers can charge	67	30	3
Health costs are lower when everyone has coverage, so we should make sure everyone has coverage they can afford	63	32	5

Earlier Health Access California Legislation Regulating Prices

Hospital Fair Pricing Act (AB 774, Chan, 2006)

- Prevent the overcharging of the uninsured/underinsured (under 350% FPL)
- For qualified, hospitals can only collect Medicaid or Medicare rates.

Health Insurance Rate Review (SB 1021, Leno, 2010, etc.)

- Not prior approval, but actuarial review for individual/small group premiums
- Purchasers/patients notices about unretracted unreasonable rate findings
- Different review efforts for large group coverage (SB 546, Leno)

Physician Surprise Medical Bills (AB 72, Bonta/Wood/etc., 2016)

- Prevent bills from out-of-network doctors in in-network facilities
- Uncontracted payments 125% of Medicare with dispute resolution process

Prescription Drug Price Transparency (SB 17, Hernandez, 2017)

- Require justification for price hikes above 16% cumulative over 2 years

Prescription Drugs

PASSED BY THE LEGISLATURE AND SIGNED BY GOV. BROWN:

- Ensure Prescription Drug Price Transparency (SB 17, Hernandez)
- Regulate Pharmacy Benefit Managers (AB 315, Wood)
- Maintain co-pay caps, (SB 1021, Wiener).

PROPOSED BY GOVERNOR NEWSOM:

Single State Prescription Drug Purchasing Pool

- Governor's Executive Order: DHCS, DGS, etc..
- Greater Negotiating Power of 15 Million+
- Ensuring Rebates/Discounts/Savings Go to the Program and Public

Potential Other Ideas for 2019

AS A REGULATOR:

- **Plan & Provider Price-Gouging**
 - Rate Review: Extending to Large Group, Improving Data, Including Kaiser, Etc.
 - Addressing Other Big Issues
- **Surprise Out-of-Network ER Bills**
- **Health Consolidation**
- **More Work on Prescription Drug Prices**
 - “Pay for Delay”

AS A PURCHASER

- **Continued Medi-Cal Managed Care Accountability**
- **Further Use of CoveredCA Purchasing Power**— for value, for cost, quality, and equity, and for simplification. (Model contract, Attachment 7)

An Aspirational Agenda— Achievable Without Federal Approval

“What we are getting here is not a mansion but a starter home. It’s got a good foundation: 30 million Americans are covered. It’s got a good roof: A lot of protections from abuses by insurance companies. It’s got a lot of nice stuff in there for prevention and wellness. But, we can build additions as we go along in the future” –Senator Tom Harkin

- * Stabilizing the Market/Resisting the Sabotage/Prevent Premium Spikes and More Uninsured
- * Universality: Getting Under 5% Uninsured Like Other Developed Nations
 - * Removing Exclusions Due to Immigration Status
 - * Increasing Affordability Assistance in Covered California
 - * Guaranteeing Affordability of Premium as % of Income
 - * Bright Line on Medi-Cal Eligibility to 138%, Including Aged & Disabled
- * Continued Progress on Consumer Protections; Cost Containment & Regulation
- * Industry Accountability: Hospitals Contracts, Rx Costs, Etc.
- * Quality/Equity Reporting & Requirements
- * Improved Health Care Delivery System: Quadruple Aim: Value, Outcomes, Quality, Equity
- * Public Option?





Slippery Slope? Or Scaling a Mountain...

Structural Steps to the Mountaintop of Medicare for All:

- More People Covered & In the System
- More Pooled Purchasing
- Ceilings/Limits on Cost-Sharing
- Consumer Protections & Expectations
- Definition of Coverage/Essential Benefits
- Additional Public/Progressive Financing
- Public Program Expansions
- Price Review and Regulation

For More Information



Website: <http://www.health-access.org>

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