

Summary

This proposal describes a “single payer” health care reform option, as part of the Health Care Options Project convened by the Department of Health Services, State of California. Proposals for single payer health care reform in California have been debated for more than ten years; a key version was Proposition 186, a statewide ballot initiative in 1994. A primary principle is to provide universal or near-universal health care coverage. The proposed option paper builds on Proposition 186.

The proposed strategy is as follows: “Single payer” incorporates all Californians in a single, publicly-financed health insurance pool. The benefits package is comprehensive. Revenues for the pool derive from current health care spending, earmarked taxes that take the place of current out-of-pocket expenditures, and other sources. Copayments (modest and low income-exempted) are used for most services. The scores of public and private funding streams will be replaced by a single, integrated system with standard reimbursement rates and simplified administrative functions. Savings due to simplified administration and other cost-saving features will finance the increased care for the previously uninsured and under-insured. Spending is limited by global budgets at the state and regional levels and for facilities. Health care is provided, as now, by private physicians, group practices, integrated delivery systems, and the public system. Provider reimbursement is based on negotiated rates (fee-for-service, capitation, and facility global budgets) that are risk-adjusted as appropriate. Administration of the single payer system is by an elected health commission and public state board and regional boards.

In addition to maintaining health care spending at current and projected levels while expanding coverage, other anticipated outcomes include: heightened quality of care through improved data on and analysis of health care outcomes; advances in public health and innovative technologies; and improved responsiveness to public concerns.

1. Introduction

Proposals for single payer health care reform in California have been developed and debated for more than ten years. Key versions include bills sponsored by State Senator Nicholas Petris; Proposition 186, The California Health Security Act, a statewide ballot initiative in 1994; and Senate Bill 2123. The proposed option paper builds on these past efforts, in particular Proposition 186. We are adapting important details (e.g., revenue calculations) to reflect the current status of the California health care system and economy.

2. The single payer reform option

2.a. Key policy components

This strategy is summarized as follows: Single payer envisions including all Californians in a single, publicly-financed health insurance pool. The benefits package is comprehensive (phased in over several years). Revenues for the pool derive from current health care spending, earmarked taxes that take the place of current out-of-pocket expenditures, and other sources. Copayments (modest and low income-exempted) are used for most services. Savings due to simplified administration and other cost-saving are adequate to finance the increased care for the previously uninsured and under-insured. Spending is limited by global budgets at the state and regional levels and for facilities. Health care is provided, as now, by private physicians, group practices, integrated delivery systems, and the public system. Provider reimbursement is based on negotiated rates (fee-for-service, capitation, and facility global budgets), risk-adjusted to reflect population demographics and health status..

2.a.i. Objectives

The single payer strategy aims to:

- provide universal coverage through universal eligibility;
- include all covered individuals in a single financing pool;
- provide a comprehensive benefit package;
- maintain overall health care spending at current (projected) levels, but use substantial administrative savings to fund expanded services;
- leave clinical decision-making with providers and patients, by using tested global financing approaches rather than individual provider utilization review to control spending;
- improve quality of care through improved data and analysis of health care patterns and outcomes;
- foster advances in public health and prevention and in innovative technologies through earmarked funding; and
- improve public responsiveness of the health care system through public hearings and accountability to the electorate.

2.a.ii. Target populations and eligibility

(a) Single payer has no specific target populations. In fact, a primary principle is to provide universal or near-universal coverage. This inclusive approach permits maximum administrative savings, and assures broad political support for a well-functioning system.

(b) Eligibility is conferred based on residence in California. All state residents are eligible for coverage after a 3-month waiting period; longer length-of-residency restrictions apply for certain services (e.g., long-term care 3 years). Individuals lacking legal immigration status (i.e., “undocumented”) are included in the single payer pool if they can document residence, and are also provided care through a safety net system. Emergency services are covered during the waiting period.

(c) Coverage is provided for individuals temporarily visited California, after billing of available out-of-state insurance. Coverage is provided for Californians receiving care out of state for up to 90 days per calendar year.

2.a.iii. Mechanism for expanding coverage

Coverage is expanded by establishing and implementing the residence-based eligibility rule. Establishing the rule is accomplished by legislative action, as part of setting up single payer. Residence will be defined as documentary evidence of residing in the state (e.g., employment papers, official correspondence, etc). Implementing the eligibility rule is accomplished by a concerted campaign involving public service advertising, workplace benefits information, enrollment at health care providers and at government offices (e.g., social service agencies and the DMV), and other strategies. Expanded coverage should be achieved quickly due to broad and simple eligibility rules; lack of public assistance stigma; absence of requirement for regular recertification; lack of significant financial burden to participants; and presumptive eligibility of impaired individuals. Implementation of Medicare eligibility was very rapid and may be a model.

2.a.iv. Insurance and risk

The insurance function of distributing risk is assumed primarily by the single payer pool, which is publicly administered. Providers and provider groups reimbursed fee-for-service are not at financial risk unless they exceed pre-determined high income caps. Provider, provider groups, integrated delivery systems, and hospitals reimbursed based on capitation or global budgets do assume risk. For these providers, financial risk adjustment methods are used to modify payments for older and/or sicker patient populations.

2.a.v. Administration and state regulation

Administration of the single payer system is by an elected health commissioner, public state board, and regional boards. The boards include elected and appointed members, including individuals representing providers, consumers, and employers. This administrative structure is responsible for financial management of the system; establishing eligibility and benefits; negotiating reimbursement; and other functions. There are additional advisory groups, such as on immigrant issues, quality assurance, and clinical guidelines. Funds would be appropriated annually in the State Budget Act, potentially using a special fund and regulations.

Current state regulatory mechanisms not supplanted by single payer provisions remain in place. Thus, for example, agencies that oversee the care quality, licensing, and financial soundness of providers will remain largely unaffected. Coordination is anticipated with the single payer system, e.g., data collected on health service utilization and outcomes.

The issue of what type of organizations can participate as capitated integrated health delivery systems is important. Limiting such IHDS to those that employ providers is problematic, due to the existence and advantages of arrangements other than employment (e.g., contracting with a provider group, which may be dispersed or share clinical space.). Instead, this plan limits participation of IHDS to those accepting a reasonable rate of return and spending less than a specified percent of revenues on administration. Both levels will be defined, and limits set or negotiated, by the health commissioner based on a

determination of the best interests of the health system. Capitation rates will be inclusive of administration and profits.

2.a.vi. Benchmark for health benefits

The benefit package is comprehensive, with some limitations and flexibility for cost-control purposes. Specifically, all medical care determined to be medically appropriate by the patient's health care provider, including:

- (a) Inpatient and outpatient health facility or clinic services;
- (b) Inpatient and outpatient professional provider services;
- (c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.
- (d) Prenatal, perinatal and maternity care.
- (e) Durable medical equipment and appliances including prosthetics, eyeglasses and hearing aids, as determined by the Commissioner.
- (f) Podiatry.
- (g) Chiropractic.
- (h) Dialysis.
- (i) Emergency transportation and necessary transportation for health care services for the disabled, as determined by the Commissioner.
- (j) Rehabilitative care.
- (k) Language interpretation for health care services, including sign language, for those unable to speak, hear or understand English, and for the hearing impaired.
- (l) Blood.
- (m) Education and screening services, including but not limited to:
 - (i) Children's preventive care, well-child care, immunizations, screening, outreach and education.
 - (ii) Adult preventive care including mammograms, Pap smears and other screening, outreach and educational services.
- (n) Prescription Drugs
 - (i) Pharmacological products of proven pharmaceutical effectiveness pursuant to a System formulary composed of the best-priced prescription drugs of proven efficacy for particular conditions.
 - (o) Long-Term Services necessary for the physical health, mental health, social, and personal needs of individuals with limited self-care capabilities, including:

(i) Institutional and residential care including Alzheimer's Disease units.

(ii) Home health care, if meeting definitions and standards established by the Commissioner.

(iii) Adult day care.

(iv) Hospice care.

(v) Individual needs for long term care shall be determined through a standardized assessment of the individual's abilities for self-care and need for a particular level of care. This assessment shall occur at the time of discharge planning, if applicable, and otherwise shall occur before provision of long term care services, and will include Medical examinations, environmental and psycho-social evaluations, case management

(vi) The Health Security System shall not cover that portion of long term care expenses incurred for room and board, unless an individual has no resources for payment as determined by the Commissioner. Persons with low income and assets shall be charged for basic room and board at a reduced rate corresponding to a percentage of Social Security or other income, as determined by the Commissioner. Additional amenities for room and board may be purchased at individual expense.

(p) Mental Health Care Benefits.

(i) Mental health care services that are medically appropriate, including, but not limited to, treatment for substance abuse and treatment for diseases of the brain.

(ii) Covered mental health care benefits in this chapter shall include Crisis intervention, including assessment, diagnosis, brief emergency treatment, and referral; outpatient services, including, but not limited to, adult day care, detoxification services, home health care, psycho-social rehabilitation and professionally sponsored and professionally supervised self-help and peer-support programs; intermediate-level care, including, but not limited to, intensive day and evening programs and institutional and residential services (excluding expenses incurred for room and board); inpatient health facility services; professional provider services, including, but not limited to, individual, family, and group psychotherapy, medical management, psychological testing and mental health case management and coordination of care; diagnostic imaging; prescription drugs;

(q) Dental Benefits, including the following: emergency dental services; preventive dental services for individuals over the age of 18, and restorative care; and excluding orthodontia.

(r) Vision care, including standard exams; prescriptions; and minimum cost lenses and frames once yearly or as needed.

(s) Excluded Benefits: Services determined to have no medical indication by the Advisory Board; elective services at the determination of the Commissioner (e.g., cosmetic or ineffective therapies).

2.a.vii. Financing mechanism

The single payer system is financed using the following mechanisms:

- Folding in, to the extent possible, current public health care spending, including federal-stated funded public insurance (e.g., Medi-Cal and Healthy Families), federal insurance and service programs (e.g., Medicare, CHAMPUS, Indian Health Service, Veteran's Administration, Federal Employees Health Benefits Program); federal and state categorical programs (e.g., Ryan White CARE Act, Family PACT); state general health care safety net funds (e.g., Realignment); and county safety net funds to the extent not needed for residual safety net services;
- Folding in private funds intended for health services (e.g., as part of retirement packages), to the extent individuals covered by these funds participate in the single payer system;
- For public and private programs not folded in, billing those programs for services delivered by the single payer system to individuals participating in those programs to the extent those services are covered by the programs, at prices above costs if folded in (to provide an incentive to fold in, and to cover added administrative costs);
- A special tobacco tax;
- A payroll tax of 8% on employers (private and public), exempting firms with annual gross incomes of less than \$75,000. These are likely to replace employer and employee payments now made to private insurers.
- A personal income tax for all heads of households and persons subject to California income tax, of 0.3% of taxable income, but not less than \$50 per household per year.
- A state income surtax of 0.3% on net taxable income in excess of \$250,000.
- Copayments: Requires a co-payment of \$5.00 for ambulatory care visits (including vision and dental) and \$5.00 per prescription; \$100 per hospital admission; and room/board for long-term care. Individuals meeting Medi-Cal/Healthy Families financial tests are exempted. No co-payment required for preventive services including immunizations, pap smears and mammography.

2.a.viii. Description of subsidies for coverage

The financing mechanisms for single payer will exempt lower income people from health care payments that constitute a significant financial burden. Such exemptions will apply, for example, to payments for long-term care room and board.

2.a.ix. Extent to which replaces existing coverage mechanisms

Single payer is intended to replace existing coverage mechanisms (while capturing relevant funds), with the exception of excluded services (e.g., cosmetic surgery). However, some existing coverage mechanisms cannot be compelled to participate. In the public realm, this includes federal programs (e.g., Medicare, Veteran's Affairs program, Federal Employees Health Benefits Program, military care, and the Indian Health Service). In the private realm, this includes retirement-associated health benefits. All efforts will be made to provide incentives for existing programs to entirely fold into the single payer system or to facilitate individual participants' so electing. As necessary, the single payer system will bill for services provided to individuals who continue to participate in other coverage programs; they will be billed at higher rates that reflect the lack of administrative savings achieved by those programs which do opt to fold in. Safety net services for non-participating individuals will be assured.

2.a.x. Budgeting and cost control

(a) The global budget for this program will start at the total of health care spending in California, for services covered under this plan regardless of payers, and grow no faster than the state gross domestic product.

(b) Global budgets will be instituted at several levels: for the entire system; for the fee-for-service and capitated sectors; for geographic regions; for integrated health delivery systems; and for facilities in the FFS sector (acute care hospitals and other care facilities). The budgets will be set to reflect the best available risk adjustment estimates of costs adjusted for demographics and disease prevalence.

Detail is as follows: Each regional budget shall include allocations for each of the following: fee-for-service providers; capitated providers; and health facilities and associated clinics that are not part of a capitated provider network. The Global Budget for fee-for-service providers in each System Region shall be further divided among categories of licensed professional providers, thus establishing a total annual budget for each category within each region. Each of these category budgets shall be sufficient to cover all included services anticipated to be required by eligible individuals choosing fee-for-service within the region, at the rates negotiated or set by the Commissioner. The Global Budget for capitated providers shall be sufficient to cover all eligible individuals choosing an integrated health delivery system within the System Region, at the capitation rates negotiated or set by the Commissioner. Each health facility and clinic in a System Region, apart from those that are part of capitated integrated delivery systems, shall have a Facility Budget that encompasses all operating expenses for the health facility or clinic.

In preparing the budgets, the Commissioner shall consider anticipated increased expenditures and savings including, but not limited to, all of the following: projected increases in expenditures due to improved access for underserved populations and improved reimbursement for primary care; projected administrative savings under the single-payer mechanism; projected savings in prescription drug expenditures under competitive bidding and a single buyer; projected saving in health facility and clinic costs

due to decreased acuity of hospitalization in some cases, and appropriate availability of long term care facilities in other cases; projected savings from termination of reimbursement of procedures of no documented benefit or for which appropriate indications are not present; projected savings from diminished reimbursement for procedures and services of marginal benefit, as determined by the Advisory Board; projected savings from decreased reimbursement of specialty care relative to primary care; and projected savings due to regionalization of high-technology and experimental services.

Commencing with the second budget year, the administrative costs of the Health Security System incurred by the Health Commissioner shall be 4 percent or less of the total funds appropriated for the Health Security System.

(c) Facility budgets will be set as follows:

Health facilities and clinics registered with the Health Security System may choose to be reimbursed on the basis of either a Facility Budget for all covered services rendered under the Health Security System, or as part of a capitated integrated professional provider network (or integrated health delivery system). The facility budget shall be negotiated with each participating health facility or clinic on an annual basis, with adjustments during the year made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population, at the discretion of the Commissioner. Surplus generated from the operating section of a health facility's or clinic's Facility Budget shall not be used for the payment or reimbursement of any capital cost; surplus as a health facility and clinic may be able to generate through increased efficiency of operation may be used to develop new and innovative programs, as approved by the Commissioner, or shall be returned to the Health Security System.

Health facilities and clinics shall inform the Commissioner as soon as evidence suggests that operating expenses will exceed the Facility Budget provided; real or projected operating deficit as a result of a health facility or clinic exceeding the Facility Budget shall be investigated by the Commissioner. If it is determined that the deficit reflects appropriate increased utilization of services, the Facility Budget for the health facility or clinic shall be adjusted and appropriately revised in the current or subsequent year, or both, to cover the anticipated shortfall. To the extent that it is determined that the operating deficit was not justifiable under the policies and terms of the Health Security System, such adjustments in the Facility Budget shall not be made; instead, recommendations for improved efficiency or other changes necessary to bring costs within the health facility or clinic's Facility Budget, or other changes, may be made by the Regional Administrator. Implementation of these recommendations may be a precondition for funding in the next Health Security System year.

(d) Global budgets for providers and integrated health delivery systems will be set as follows:

Physicians, advanced practice nurses and other independent professional providers may choose from a variety of payment mechanisms for reimbursement. These payment methods may include fee-for-service, capitation, or a salary from a globally budgeted health facility or clinic for a defined level of service.

An individual professional provider or a group of professional providers, as with an integrated health delivery system (see below), may elect to be paid a prospective payment on a capitated basis for all individuals enrolling for care from those providers. Providers accepting payment on a capitated basis cannot also be paid on a fee-for-service basis. All patients receiving care from professional providers participating under prepaid arrangement must do so on a capitated basis. A formal enrollment process shall be adopted whereby individuals voluntarily designate the individual professional provider or group of professional providers for prepaid care. Individuals enrolling under prepaid arrangements must receive their care from the designated prepaid practice or professional providers authorized by the prepaid practice.

The fee level for capitated reimbursement shall be negotiated annually by professional provider organizations and the Commissioner, or set by the Commissioner, and shall apply uniformly to all professional providers in the System Region. The capitated fee level shall be adjusted based on health risk of enrollees, scope of ambulatory services provided by the professional provider, and any other relevant factors. At a minimum, the scope of services covered by the capitated payment shall include all primary care services. Capitated contracts may include stop-loss measures for catastrophic expenses and such other measures as necessary to maintain fairness and fiscal stability.

Compensation for professional providers who provide services as employees of, or under contract to, health facilities or clinics, shall be covered under the Facility Budget of those health facilities or clinics.

Fee-for-service provider fees will be set as follows: The Commissioner shall recognize professional associations to represent licensed professional providers in each System Region in negotiations with the Commissioner on reimbursement and other professional issues. All professional provider organizations may participate in annual negotiations. All professional providers within a category shall be bound by the results of the negotiations between the Commissioner and the organization representing that category of professional provider. In the event that negotiations with professional providers and others are not concluded in a timely manner, the Commissioner may set rates, fees and prices for services reimbursed by the Health Security System.

Notwithstanding the preceding, the Commissioner shall establish a limit on the aggregate annual payments to an individual professional provider, or discounts on reimbursements above a specified amount of aggregate billing, as negotiated with the professional associations. An individual professional provider whose billing volume or distribution suggests the possibility of impropriety may be subject to investigation by the Commissioner.

Integrated health delivery systems (IHDS). A health facility or clinic and a group of physicians and other professional providers, or a care coordinating organization, may organize as an IHDS providing the full spectrum of health care services to a defined

population of enrollees. Such integrated systems may be paid by the Health Security System on a capitated basis to provide at least the full spectrum of benefits covered by the Health Security System. The fee level for capitated reimbursement shall be negotiated on a regional basis by professional provider organizations and the Commissioner, based on health risk of enrollees, and any other relevant factors, and shall apply uniformly to all professional providers in the region. Health facilities and clinics participating under this capitated arrangement as part of an integrated delivery system are exempt from negotiating separate operating budgets with the Health Security System, but are not exempt from regulation of capital investment.

(e) Capital Allocation will be as follows.

Capital spending (> \$750,000) will require approval from the Commissioner. Funds appropriated for capital expenditures pursuant to the Capital Expenditures Budget shall be placed in the Capital Improvement Account. Once a capital expenditure request has been approved by the Commissioner, it may be funded either from the Capital Improvements Account or from other sources. All capital improvements made from the Capital Improvement Account shall remain the property of the state of California under the Health Security System. The Commissioner shall report on the capital needs of health facilities and clinics in each System Region.

(f) Formulary.

In order to achieve the lowest possible cost for prescription drugs the Commissioner shall do all of the following: Establish a Health Security System formulary composed of the best-priced prescription drugs of proven efficacy for a particular condition. Enter into purchase contracts for prescription drugs, using his or her bidding power to negotiate directly from the manufacturer the lowest possible prices for drugs provided under the Health Security System.

(g) Bulk purchasing

The Commissioner shall use his power to make bulk purchases of selected medical supplies and equipment, or to negotiate high-volume discounts for participants in the health care system, when doing so is deemed likely to reduce costs.

(h) Enforcement of global budgets will be according to the following procedures.

The budget will operate on a calendar year basis. Ongoing monitoring and projections of expenditures will be conducted throughout the year. If projections of spending 4 months into the year suggest a substantial risk of exceeding the global budget, the Commissioner will immediately make a determination of the causes; adjust reimbursement rates and services and take other actions as indicated below; and monitor and adjust the cost-control mechanisms as necessary. A reserve fund will be used to make up for shortfalls and will be the repository of budget surpluses.

Cost control enforcement procedures shall be governed by the following:

The Commissioner shall not carry out any cost control measure that limits access to care that is needed on an emergent or urgent basis or is clearly medically indicated;

In order to control costs the Commissioner shall strive at all times to first do all of the following: eliminate administrative and other costs that do not contribute to health care; and identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care;

He or she will then place restrictions on, and co-payments for, elective services and for vision and low priority dental care, in order of increasing efficacy;

As a last resort, the Commissioner will adjust payments to providers according to an assessment of the geographic and provider sector(s) in which costs are expected to exceed budgets, and only to the extent estimated to be required to stay within budget for the year.

2.b. Implementation

2.b.i. How the approach will be implemented

Implementing single payer will require a far-reaching one-time transition. Steps include:

- legislative action to formally establish the system;
- setting up the new governance system, with a state board, regional boards, and advisory groups;
- negotiating with existing public and private programs, most importantly the federal government, to fold in and/or coordinate financing;
- budgeting for the new system;
- establishing provider groups for negotiating reimbursement;
- establishing reimbursement rates;
- retraining of displaced health insurance workers;
- a formal transition period of 12-24 months, during which the new structures will be put in place; and
- a transition fund estimated at \$2-5 billion.

2.b.ii. Feasibility of implementation

Implementation of single payer will require a significant and carefully designed effort. In favor of feasibility is the shift to a profoundly simpler system. The current morass of scores of public and private funding streams will be substantially replaced by a single, integrated system with standard reimbursement rates and simplified administrative functions (e.g., very straightforward eligibility determinations, little marketing after the initial phase, broad benefits and hence streamlined payment approvals, and no utilization review). A barrier to implementation will be resistance from portions of the health care

industry; extensive discussions and likely program adaptations will be needed to persuade them to accept single payer.

2.c. Key assumptions for feasibility

The feasibility of single payer – mainly the ability to provide broad universal coverage – depends most of all on three factors. *Administrative savings* must be substantial, to make current administrative spending available for clinical care. Adequate administrative savings have been estimated in previous analyses of single payer. *Utilization increases* (especially outpatient) for the newly and better insured must be moderate. Past single payer evaluations have identified moderate increases. Utilization can also be controlled with copayments. Finally, *global budgets must contain costs*. We believe, as seen in Canada, that global budgets are an effective mechanism for cost control, as long as the political will for single payer exists.

2.d. Why single payer will affect health care coverage for Californians

The current California health care system is a complex, poorly integrated amalgam of health insurance and funding programs. Dr. Kahn and colleagues recently estimated 69 separate funding streams in the public sector alone. There are at least as many private health plans. This fractured system results in substantial gaps in coverage and administrative waste. There are more than 6.5 million uninsured, the largest portion being working poor. Many of those with insurance are under-insured. Avoidable administrative costs (of insurers and providers) consume 10-15% of state health spending.

Single payer addresses both problems concurrently, thereby freeing up the resources needed to extend coverage to the uninsured and allowing for the increase in care expected with universal coverage. In providing universal eligibility, single payer assists those individuals and groups which are currently uninsured.

Single payer changes the role of the market in health care. Currently in California, individuals choose among health plans, which compete on the basis of price and services. The result is, in part, tiering (richer people buy up to better care) and inefficiency (it is costly to offer multiple plans). Under single payer, individuals will have choice of provider rather than of insurer, as they primarily desire. Competition will be based on quality and service rather than cost.

3. Additional issues

3.a. Policy and implementation issues

For the single payer system to work optimally, there are two essential policy and implementation issues: inclusiveness and effective transition. Inclusiveness is important in several realms: enrollment; providers; and existing programs. *Enrollment* in the single payer system must be as inclusive as possible, via both eligibility criteria and procedures. This broad enrollment reduces administrative complexity and costs, as noted above. It also is an essential feature of maintaining political support for the system, since a system that provides health care for all California residents, including the wealthy and politically

empowered, will have strong constituencies to work well. *Provider* participation must be inclusive, too. All current licensed providers must have a place in the single payer system, and integrated health delivery systems should be given a fair opportunity to participate. This approach will maximize political support. Further, providers who participate in the single payer system must not be permitted to be paid for covered services except through the system; this reduces gaming and assures that system participants are treated fairly. Finally, *existing programs* (federal, state, and other established insurance) should be folded in to the extent possible. As with broad enrollment, this improves political support and decreases administrative complexity and costs. Incentives for programs to fold in include a broad benefit package and lower costs than would be charged if their enrollees use the single payer system without a fold-in.

The transition to single payer – i.e., implementation – must be managed as professionally and effectively as possible, to build support and avoid the cost of administrative adjustments. This is discussed in the next section.

3.b. Systematic approach of moving from the current system to the proposed plan

The transition from the current system to single payer is major; it must be managed thoughtfully and effectively. Key elements of the transition include: A detailed but adaptable time-table, probably over 12-18 months. A transition fund, probably \$2-5 billion, to pay for planning, procedure development and training, meetings and education, retraining of displaced workers, and early implementation. Establishment of oversight structures, hiring of staff, and development/testing of enrollment and billing and other procedures. Extensive media and workshop education of the public, providers, and employers. Testing of procedures, perhaps via geographically staged implementation. Despite inevitable glitches, the transition must be mandated to occur in a limited period of time, and managed firmly. It may be advisable to provide financial incentives for early participation, e.g., a 1% higher payment rate for 6 months for the providers and IHSD that officially join by an early sign up date.

3.c. Major federal/state legal and regulatory changes necessary

The largest desired change in federal and state regulation is folding in existing health insurance and service programs. The state can be compelled by the enabling legislation to do so. The federal government and many private programs can only be enticed. The enticements are several-fold: At the *participant* level: broader (or as broad) benefits than in existing programs; easier and permanent enrollment; eliminated cost-sharing; simplified administration. At the *program* level: lower costs than would be charged these programs for services they cover if no fold-in occurs; and simplified administration (just transfer funds).

In addition, there are two legal issues which may require attention. There is a chance that the federal ERISA law may be interpreted by some magistrates as restricting the ability of the State to mandate employer contributions (via a payroll tax) to the single payer fund. We believe that the payroll tax, which enters a global and not employee-specific fund, is consistent with ERISA, which limits state regulation of employee benefits. We appreciate

HCOP support of a legal analysis to consider this issue and perhaps provide guidance on how to clarify ERISA compliance or how to structure the taxes to most clearly comply with ERISA.

In addition, some of the negotiations regarding provider reimbursement may be perceived by some legal experts as representing unacceptable restraint in trade. We believe that the voluntary nature of provider participation in the single payer system overrides this interpretation.

3.d. How financial resources would be shifted

Contributions to paying for health care would shift to smaller employers and to wealthier families. Standard payroll tax rates (for employers with > \$75,000 in gross income) would most directly affect those not currently paying for health care – smaller employers. (Economists indicate that these payments are transferred eventually to employees, but we don't quantify that issue here.) Individuals overall would pay less (no longer having copremiums, deductibles, uncovered services, and lack of insurance), but would be subject to the 0.3% income tax and, depending on income, 0.3% surtax. Individuals with high income (those who currently often pay the least) would pay the most, due to this moderately progressive tax rate structure (as well as due to the indirect effects of the flat payroll tax). Poor and working class individuals would pay the least, and those of them not currently on public insurance would experience the largest drop in costs.

Payments to providers would be distributed similarly as now, with a shift of funds to clinical employees and a decrease in funds for administrative functions and employees.

3.e. Administrative complexity of the proposed design

A compelling strength of single payer is administrative simplicity. Administrative functions that are eliminated or greatly simplified include insurance marketing; eligibility determination; enrollment; individual provider contracting; billing; payment; and appeals. The system's administrative burden is likely to drop to 4% or less, and there will be 10% or greater savings for providers. Dozens and dozens of private insurers and public programs will be reduced to two: single payer, plus a safety net system.

3.f. How single payer will be an improvement on recent incremental reform efforts.

Single payer will be inclusive and universal. As described above, this generates several desirable traits: simplicity, equity, and broad political support. And, of course, essentially all individuals will be covered, so there will be few uninsured – just individuals in waiting periods and unwilling to participate in the system. The system will require an initial disruption, but will then be much less onerous to administer and navigate.