The Seven Percent Solution: Costing and Financing Universal Health Coverage in California

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As of 2017, California's uninsured rate stands at just over 7 percent.[3] Moving towards universal health coverage in California for the 3.72 million projected to be uninsured in 2020, of which about 1.5 million are undocumented, is a significant challenge but has considerable benefits. A healthier workforce will be more productive and absenteeism will decline.[4] Moreover, taxes collected from these healthier workers will increase. All Californians will have their risk of disease lowered. Universal coverage will allow all Californians to have improved access to care so they can prevent and treat illnesses that can be passed on to others. Children will have a better start to life and there will be less absenteeism in schools. In addition, the expensive treatment in emergency rooms would surely decline. Beyond these benefits for all Californians, it is the right thing to do. Most Californians support universal coverage, but have reservations about the cost of doing so.[5]

This Report starts with the current data available on who in California is not covered in a private or public plan. We then estimate the cost of providing coverage which is roughly $6 billion annually. To cover these costs, we suggest scaling the employer mandate used in the

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[3] https://californiahealthline.org/news/uninsured-rate-declines-in-california-remains-unchanged-nationally/
[4] https://www.cdcfoundation.org/businesspulse/healthy-workforce-infographic
[5] https://www.ppic.org/wp-content/uploads/ppic-statewide-survey-californians-and-their-government-december-2018.pdf

Healthy San Francisco program and imposing provider and payer taxes that have been used is other States to generate the required revenue. At each step along the way we explain the logic behind our estimates and the judgements we made. It is likely that others will have different views. Our plan can be revised to accommodate alternative views and will likely change as more precise data is available.

At the end of the day the plan we present cannot guarantee universal coverage. Since it is a public / private plan, there will be some who fall between the cracks or do not sign up for coverage or the subsidies that we finance in this plan. True universal coverage can happen if the Government passes a law on universal coverage for all Californians. But even in this case there is a role for the private sector in offering plans that extend coverage to services not included in government plans or in covering cost sharing requirements of a public plan.[6]

I. The Cost of Universal Coverage

A recent report by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center estimates there will be 4.02 million uninsured Californians in 2020.[7] The report considers partial coverage Medi-Cal enrollees uninsured and assumes a phase out of the individual mandate starting in 2019. We retain the definition of partial coverage Medi-Cal enrollees as uninsured. Since Governor Newsom's recently released health care plan would restore the individual mandate in California,[8] we drop the assumption of no individual mandate. Dropping this assumption would reduce the number of uninsured by 300,000, according to the

[6] A more detailed report on this subject titled "California Dreamin': Integrating Health Care, Containing Costs, and Financing Universal Coverage" is available here
[7] http://laborcenter.berkeley.edu/pdf/2018/CA-Coverage-Gains-To-Erode-Without-Further-State-Action.pdf
[8] https://www.sacbee.com/news/politics-government/capitol-alert/article224037840.html

UCLA/UC Berkeley report.[9] Of the remaining 3.72 million uninsured, 1,480,000 would be undocumented, 730,000 would be eligible for Medi-Cal coverage, 350,000 would be eligible for subsidized ACA exchange coverage, 410,000 would be eligible for non-subsidized ACA exchange coverage, and 750,000 would be eligible for employer coverage (see Figure 1).

The costs we estimate in what follows are costs to the state for covering insurance premiums. We have not included the cost of any program that would be used to lower the out-of-pocket spending of enrollees.[10] We do not allocate any cost to Californians eligible for employer coverage or eligible for non-subsidized ACA exchange coverage.[11] We estimate the cost of covering the undocumented to be $2.7 billion. According to data from the Department of Health Care Services, roughly 1 million undocumented adults are already enrolled in restricted-scope Medi-Cal coverage, which covers emergency and pregnancy related services.[12] A recent report by the California Legislative Analyst's Office estimates the total state cost of providing full-scope Medi-Cal coverage to 1.276 million undocumented to be $2.34 billion.[13] Scaling up this figure to 1,480,000 undocumented[14] and accounting for inflation results in a cost of $2.7 billion in 2020.[15]

We estimate the cost to the state of covering the 730,000 Medi-Cal eligibles to be $2.0 billion. Average Medi-Cal per enrollee spending was $5,368 in 2014. Assuming a 3.4% annual

[9] The report also provides a range of 150,000 to 450,000 additional uninsured in 2020 as a result of the phase out of the individual mandate.
[10] Covered California released a report in February 2019 which presents various options to enhance affordability and coverage for uninsured Californians. Specifically, Option 2 in their recommendations eliminates the tax-credit cliff, significantly expands cost-sharing subsidies, and adds the individual mandate penalty. See https://hbex.coveredca.com/data-research/library/CoveredCA_Options_To_Improve_Affordability.pdf for details.
[11] An individual mandate will likely increase take up for this group, but the rate of take up will depend on the strength of the mandate (i.e. level of penalties). Thus, our plan is a path to universal coverage.
[12] https://lao.ca.gov/Publications/Report/3827
[13] https://lao.ca.gov/reports/2019/3935/medi-cal-021319.pdf
[14] In order to cover all undocumented immigrants under Medi-Cal rather than just those estimated to be income-eligible.
[15] This assumes the proportion of the undocumented with restricted-scope Medi-Cal (80%) remains the same in 2020.

growth rate for Medi-Cal per enrollee spending,[16] Medi-Cal spending per enrollee will be $6,560 in 2020. Multiplying 730,000 by $6,560 and 41% (the amount of Medi-Cal covered by the state)[17] results in an estimate of $2.0 billion. It is worth noting that the state government is already liable for this amount towards covering Medi-Cal eligibles as an existing entitlement. Subsequently, although this $2.0 billion is already a part of the total funds that must be allocated to existing state funding sources, we include it in our estimates as an incremental cost to ensure coverage for unenrolled Medi-Cal eligibles.

Finally, a lack of affordability has been cited as one of the primary reasons for why the ACA exchange eligible uninsured have chosen not to sign up for coverage. As a way of increasing the affordability of ACA exchange coverage, we propose California further subsidize the premiums of ACA exchange enrollees who are already eligible for federal premium subsidies. This group currently pays $123 per month on average in premiums. We estimate it would cost the state $1.1 billion to cut the average per month premium of this group in half.[18] This additional California-funded subsidy would apply to the roughly 1.1 million subsidized current enrollees[19] and the 350,000 ACA subsidy-eligible uninsured. A recent study commissioned by Covered California proposes an alternative subsidy support program which leads to cost to the state of roughly $2 billion.[20] Overall, we estimate the total cost of covering the uninsured in California to be $5.8 billion (see Figure 1).

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[16] 3.4% 5-year average annual growth rate for Medi-Cal per enrollee spending. See https://www.chcf.org/publication/california-health-care-spending/ for details.

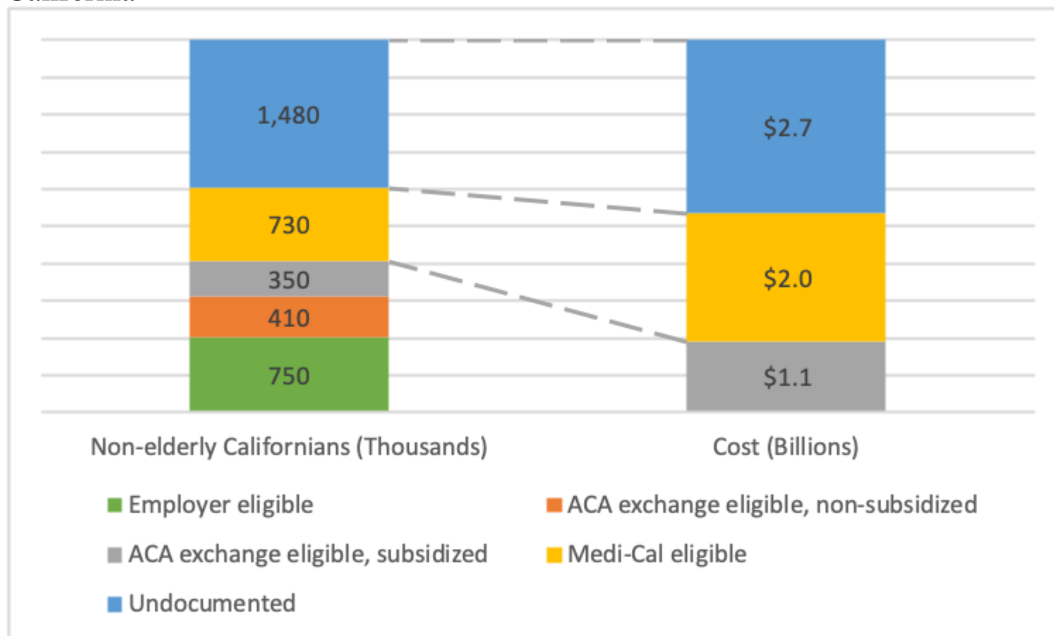
[17] https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[18] Assuming a growth rate of 4.4% (the 5-year average growth rate) in average subsidized ACA exchange premiums, premiums will be $128 per month on average in 2020. (1,100,000 currently subsidized enrollees + 350,000 ACA exchange eligible uninsured) x $64 per month x 12 months = $1.11 billion

[19] https://www.coveredca.com/newsroom/PDFs/CoveredCA_2019_Plans_and_Rates.pdf

[20] The plan focuses on eliminating the tax-credit cliff and expanding cost-sharing subsidies and reinsurance. See https://hbex.coveredca.com/dataresearch/library/CoveredCA_Options_To_Improve_Affordability.pdf for details.

Figure 1. Number of Uninsured (3.72 million) and the State's Cost of Coverage ($5.8 billion) in California



Source: Authors' analysis of data from multiple sources

II. Financing Universal Coverage

The cost to the state to cover the uninsured in California is estimated to be $5.8 billion annually. We propose two sources of public financing – (i) a provider and payer tax, and (ii) a state-wide employer mandate to raise these funds. Additionally, we briefly describe two novel potential sources of revenue – (i) an airport landing fee, and (ii) a rental car tax, to fund universal coverage in the state. These estimates are intended to provide a sense of the magnitude of what these taxes would produce in revenues.

Provider and Payer Tax

Provider taxes have been successfully implemented in various states such as Arizona, Colorado, Indiana, Louisiana, Minnesota, Oregon, and Virginia. As an example, Minnesota currently imposes a two percent tax on providers such as physicians, dentists, psychologists and other licensed and unlicensed healthcare workers, hospitals, surgical centers, and wholesale drug distributors[21]. The tax was introduced in 1992 and is set to expire in 2019, with the possibility of renewal. The two percent tax in Minnesota is imposed on the following categories of healthcare providers:

i. Physicians, dentists, nurses, psychologists, and other licensed and unlicensed healthcare staff,
ii. Hospitals
iii. Surgical centers
iv. Wholesale drug distributors

Revenues from the tax are directed to a Health Care Access Fund where they are used to provide subsidized healthcare to low income populations. The increase in enrollment due to expanded coverage in Minnesota resulted in substantial savings for providers, specifically in terms of reduced uncompensated care in hospitals to the tune of $58.6 million over a 5-year period.[22] Many other states also levy provider taxes, mostly in the form of hospital taxes, to fund expansion of coverage to uninsured populations.

We propose levying a similar provider and payer tax of one percent on commercial revenues of the following categories of healthcare providers and payers in California:

i. Institutional providers (such as hospitals, nursing homes, and home healthcare services),
ii. Large medical groups with over 25 physicians[23],
iii. Pharmaceutical sales, and

[21] https://www.house.leg.state.mn.us/hrd/pubs/ss/ssmcpt.pdf
[22] Blewett, Lynn A., Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. "Hospital provision of uncompensated care and public program enrollment." Medical care research and review 60, no. 4 (2003): 509-527
[23] Large dental practices could also be considered for inclusion in this provider tax. However, we have not included these calculations in our current estimates.

iv. Health plans for commercial payers in California

The provider tax would be in addition to any Medicaid-specific provider fee already in place in California. The tax will not be applicable on Medicare and Medicaid payments. It would raise approximately $2.5 billion in revenues which could be used to fund universal coverage (see Table 1). Hospitals will benefit from increased enrollment by having their charity care reduced. All institutions will benefit from an increased demand for their services.

Table 1. Estimated revenue from provider and payer tax in California, 2017 (in millions $)

	Institutional Healthcare Expenditure[24] (Commercial)	Pharmaceutical Retail Sales (Commercial)	Health Insurer Revenues (Commercial Enrollment)	Physician Gross Revenues
Expenditures/Sales	$62,561[25]	$14,069	$162,500[26]	$12,957
Tax Revenues (at 1.0%)	$626	$141	$1,625	$130
Total Tax Revenue	$2.5 billion			

Source: Personal healthcare expenditure data from State Health Expenditures by State of Residence, 2014, Centers for Medicare & Medicaid Services; includes author calculation
Pharmaceutical retail sales data from IQVIA on special data request by Kaiser Family Foundation; includes author calculation
Health insurer revenue data from Health Plan Financial Summary data 2015, Department of Managed Health Care (DMHC)
Physician gross revenue data from Medscape's Physician Compensation Report 2018 and SK&A data; includes author calculations

Employer Mandate

Healthy San Francisco is a healthcare access program created by the Gavin Newsom administration in 2007 with the aim of expanding healthcare access to all San Franciscans, irrespective of employment status. A large portion of the revenues for the program are obtained

[24] This represents 52% of the total personal healthcare expenditure ($120 billion) and includes expenditure on Hospital Care, Nursing Home Care, Home Health Care, and Other Health Care
[25] Projected figure for 2017 using 2014 CMS data and applying an annual growth rate of 5%
[26] Total insurer revenues from commercial enrollment in 2015 as per CHCF

from Employer Spending Requirement (ESR) payments by employers in compliance with a city-level Health Care Security Ordinance (HCSO)[27]. The HCSO requires all for-profit employers with over 20 employees and non-profit employers with over 50 employees to make healthcare contributions on behalf of their employees. Preliminary calculations to scale up this mandate at the state level are presented in Table 2.

As per Table 2, around $3.3 billion can be generated annually from a state-wide ordinance requiring ESR payments from all businesses with more than 20 employees. Some restaurant businesses in San Francisco financed their ESR payments by levying a 4% surcharge on customers (median amount that around 27% of restaurants in San Francisco charge their customers as a 'health fee'[28]). A similar approach could be adopted by businesses in California to spread out costs among high-income payers.

Table 2. Estimated Revenue from a State-wide Employer Mandate, 2017

Number of Employees in Firms with 20+ employees in California	12,852,737
Number of Employees in Firms with 20+ employees in San Francisco	551,851
City Option Revenue in San Francisco	$ 143.2 million
Estimated Revenue from employer payments in California[29]	=($143.2 million) X (12,852,737/551,851) **= $ 3.3 billion**

Source: Number of employees from California Employment Development Department's Labor Market Information; City Option Revenue from Healthy San Francisco Annual Report 2016-17

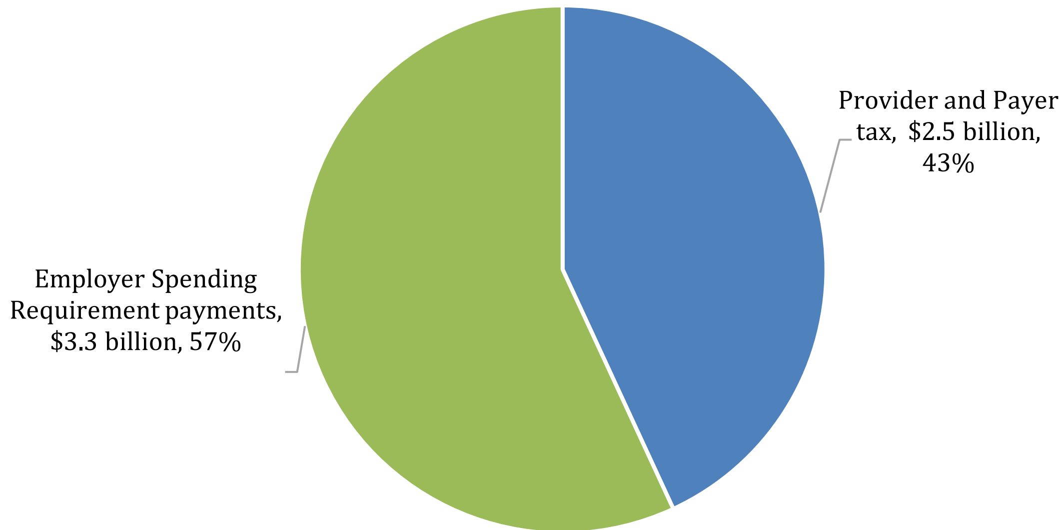
[27] https://sfgov.org/olse/health-care-security-ordinance-hcso

[28] Colla, Carrie H., William H. Dow, and Arindrajit Dube, "How Do Employers React to a Pay-or Pay Mandate? Early Evidence from San Francisco." Forum for Health Economics and Policy 14, no. 2 (July 2011). http://www.nber.org/papers/w17198.pdf

[29] This is a conservative estimate given that the percent of adults who do not receive the offer of health benefits from their employer is higher in California (20.4%; with a 95% Confidence Interval of 18.6%-22.1%) as compared to San Francisco (6.5%; with a 95% Confidence Interval of 1.9%-11.1%). Thus, employer payments are likely to be higher than this estimate when scaled up to the state-level.
Source: AskCHIS

In sum, the annual amount of $5.8 billion required to cover all uninsured Californians can be raised through a combination of provider and payer taxes, and a state-wide employer mandate. Figure 2 illustrates the distribution of revenues generated from the sources described above.

Figure 2. Sources of public financing to achieve Universal Healthcare Coverage in California ($5.8 billion)



Source: Authors' calculations from multiple sources

<u>Additional Revenue Sources</u>

Airport Landing Fee

A novel source of financing coverage for the uninsured is revenues from an airport landing fee on all flights in California. The idea of a 'solidarity tax on airplane tickets' was introduced in 2005 by the French president at the World Economic Forum as an additional surcharge levied on civil aviation tax whose proceeds are directed to fund a global health initiative working on ending epidemics across the world[30]. The amount levied varies from €1.13 - €45.07 per ticket depending on destination and class of travel. After France began

[30] http://leadinggroup.org/rubrique177.html

implementing the tax in 2006, it was adopted by several other countries and is currently levied by nine countries, namely Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger and the Republic of Korea[31]. The list of countries levying this surcharge consist of a mix of traditional donor countries as well as developing countries who can benefit directly from the initiative. The revenues generated are allocated to support UNITAID, an organization that invests in innovations to prevent, diagnose and treat HIV/AIDS, tuberculosis, and malaria. Almost 70% of the initiative's funds come from the airport tax revenues, which present a sustainable and long-term source of funding as compared to traditional one-time grants or donations.[32]

We propose applying a similar landing fee on all flights landing in California. Preliminary calculations suggest that if we apply a rate of $1000-$2000 on each flight landing in California, it could raise $0.95 billion - $1.90 billion annually.[33] Further, these rates could be varied based on the size of the airplane with larger airplanes being charged a higher landing fee since they have higher administrative costs.

The legality of this fee requires additional study. It falls under Sections 40116(c) and (e)(2) of the US Code Title 49 on transportation that would potentially allow the state to impose "landing fees" on airplanes that terminate at California airports without distinguishing between in-state, out-of-state, and foreign flights.[34]

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[31] http://www.fondationchirac.eu/en/2013/09/the-fondation-chirac-applauds-the-increase-in-the-solidarity-contribution-on-airline-tickets/
[32] https://www.who.int/immunization/programmes_systems/financing/analyses/Brief_18_Airline_Ticket_Tax.pdf
[33] As per data from the US Bureau of Transportation Statistics, around 950,000 airplanes landed in California airports in 2017; https://www.transtats.bts.gov/
[34] https://www.law.cornell.edu/uscode/text/49

Rental Car Tax

Over 40 states impose a tax or fee on rental cars, with the revenues being used for a variety of purposes. Some states direct the revenues into transportation related funds while others direct them into the state general fund to be used at the discretion of the state legislature for purposes such as construction of stadiums. [35] As an example, the state of New York imposes a tax of 6 percent on rental cars in addition to regular state and local sales taxes. This tax on auto rentals generated an annual revenue of over $48 million in FY 2017. [36] Similarly, Texas imposes a 10 percent tax on gross receipts from rentals up to 30 days, and a tax rate of 6.25 percent on gross rental receipts from rentals exceeding 30 days but no longer than 180 days. [37] This generated revenue worth around $300 million in FY 2018. [38] California does not currently impose any charges on auto rentals, presenting a viable option for funding universal coverage in the state. If the state were to impose a tax on rental cars at rates similar to the state of Texas, it could potentially raise revenues to the tune of $600-800 million annually.

The additional funds generated from these two sources could be used towards covering out of pocket expenses, such as co-payments, deductibles, and co-insurance amounts for new and low-income enrollees.

III. Conclusion

We believe that our cost estimate for universal coverage of $5.8 billion is within reach of what California can reasonably afford. Using a shared public and private mix of funding, this plan is based on things that have worked in California before and new approaches that have

[35] http://www.ncsl.org/research/fiscal-policy/rental-car-taxes.aspx
[36] https://www.tax.ny.gov/pdf/2016-17_collections/2016_17_Collections_Report.pdf
[37] https://comptroller.texas.gov/taxes/motor-vehicle/gross-rental.php
[38] https://comptroller.texas.gov/transparency/revenue/docs/96-571.pdf

worked in other States. More work on how to implement and enforce the individual mandate is needed. We call on the legislature and governor's office to move California forward to achieve universal coverage.

Author Bios

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Richard M. Scheffler is a Distinguished Professor Emeritus of Health Economics and Public Policy and Professor of the Graduate School at the School of Public Health and the Goldman School of Public Policy at the University of California, Berkeley. He is also the Director of the Petris Center for Healthcare Markets and Consumer Welfare endowed by the Office of the Attorney General for the State of California in 1999. Dr. Scheffler has been a visiting scholar at the World Bank, the Rockefeller Foundation in Bellagio, and the Institute of Medicine at the National Academy of Sciences and a consultant for the World Bank, the WHO, and the OECD. He has been a Fulbright Scholar at Pontifica Universidad Catolica de Chile in Santiago, Chile, and at Charles University, Prague, Czech Republic. He received the Carl A. Taube Award in 2004, honoring distinguished contributions to the field of mental health services research, American Public Health Association's Mental Health Section. He was awarded the Chair of Excellence Award at the Carlos III University of Madrid in 2013. In 2015, Dr. Scheffler was awarded the Gold Medal for Charles University in Prague for his longstanding and continued support of international scientific and educational collaboration. He was also awarded the Astor Visiting Fellowship by Oxford University in 2016. He is an elected member of the International Health Economists Association and National Academy of Social Insurance. In 2018, Dr. Scheffler was awarded the Berkeley Citation, among the highest honors the campus bestows on its community presented on behalf of the Chancellor to individuals whose contributions to UC Berkeley go beyond the call of duty and whose achievements exceed the standards of excellence in their fields.

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Stephen M. Shortell is the Blue Cross of California Distinguished Professor of Health Policy and Management Emeritus and Professor of the Graduate School at the School of Public Health and Haas School of Business at University of California-Berkeley where he also co-leads the Center for Healthcare Organizational and Innovation Research (CHOIR) and the Center for Lean Engagement and Research (CLEAR) in healthcare. From 2002 to 2013 he served as Dean of the School of Public Health at Berkeley. In 2013, he was awarded 4 the Berkeley Citation presented on behalf of the Chancellor to individuals whose contributions to the University go beyond the call of duty and whose achievements exceed the standards of excellence in their fields. A leading health care scholar, Dr. Shortell and his colleagues have received numerous awards for their research examining the performance of integrated delivery systems; the organizational factors associated with quality and outcomes of care; and the factors associated with the adoption of evidence-based processes for treating patients with chronic illness. He is currently conducting research on patient engagement and the performance of Accountable Care Organizations (ACOs) and on Lean applications in healthcare. He is Co-PI on a five year AHRQ funded Center of Excellence award (with The Dartmouth Institute and the High Value Health Care Collaborative) to examine the adoption and implementation of innovations to create high performing health systems. In 2007, he was a Fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford. He is an elected member of the National Academy of Medicine and a recent recipient of the AHA/HRET TRUST Visionary Leadership Award.