PHIERS

California Financial Research Addendum

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Fund complete care. Retain savings. Put those savings to work.

The California proposition connects routine telehealth, local primary care, therapy, medication purchasing, comprehensive protection, and coordinated support. Retained savings would help replace lost federal support, create paid community work, expand community-school benefits across districts, and strengthen an all-ages safety net.

PHIERSale, the People's Marketplace, extends cooperative purchasing to goods and services, local businesses, and supply-chain resilience. MAP, PCC, PHIERWorks, school nurses, and wider community teams remain part of the full model.

A large opportunity with a practical pathway

New public sources now supply a California Medicare expenditure benchmark, a current Medi-Cal benefits/caseload table, and the original commercial medication analysis behind the 67% figure. The statewide 50% / 75% / 100% adoption structure and $7,000 net annual savings projection are preserved.

The opportunity: PHIERS projects $7,000 in annual net savings per participating beneficiary after complete care. Across the retained adoption scenarios, that means **$57.6B to $115.2B annually** to pursue through better delivery and purchasing. The proposal directs retained savings toward funding replacement, paid work, stronger communities and further savings from improved outcomes.

1. The new California cost evidence

Pool / period	Published measure	Use in the model
Medicare, calendar 2024	$19,830 medical expense per member/year	California full-market benchmark; not a low-need cohort quote.
Medicare Advantage, 2024	$17,767 medical expense per member/year	Medical expenditure, not a CMS capitation rate.
Traditional Medicare, 2024	$21,850 medical expense per member/year	Actual expenditure mix; not a premium or a participant-specific saving.
Medi-Cal, fiscal 2026-27	$10,517 benefits-table cost per eligible	Scoped estimate; listed exclusions require reconciliation.
California employer coverage, 2025	$10,033 single; $28,397 family premium	Separate commercial pool and policy units.

HCAI published the Medicare figures on October 7, 2026. Its new Medi-Cal managed-care figure ($4,108 for 2024) has narrower scope, excluding Medi-Cal fee-for-service and specified payment categories. It must not be mistaken for complete Medi-Cal care cost. [1]

DHCS pairs $145,906,791,870 with 13,873,600 eligibles in its benefits table. Its broader caseload table shows 13,882,000 average monthly eligibles for 2026-27, including additional categories. Keep the table's own denominator. [2]

Why the opportunity is large: these public-program benchmarks exceed $10,000 per person annually, while routine telehealth access is priced below $600 per membership year. PHIERS combines that access with affordable medications, local care and comprehensive protection to reduce the total cost of meeting people's needs. The remaining care budget is shown explicitly on page 7.

[1] HCAI, October 7, 2026 interim spending report; 2023-2024 data

[2] DHCS, May 2026 Local Assistance Appropriation Estimate, refreshed July 16

[4] KFF, 2025 California Health Benefits Survey

2. Pool differences and the savings target

DHCS aid category	2026-27 annual benefits estimate
Title 19 children	$5,191
Title 21	$4,564
Title 19 adults	$8,695
ACA expansion adults	$10,470
Seniors and persons with disabilities	$22,046
Long-term-care aid codes	$27,861

Source: DHCS benefits table, printed pages BY 57-58. These are estimated category averages with exclusions, not prices for a PHIERS package. [2]

The $7,000 projection is a weighted participant average. Different aid categories contribute different savings. The weighting work will combine cohort results across participants, accounting for their different care needs and starting costs. That work remains to be completed; $7,000 is the proposed weighted participant-average projection.

Use mutually exclusive cohorts: Medi-Cal without Medicare; Medicare without Medi-Cal, separated into Advantage and traditional coverage; dual enrollees, separated by Medicare arrangement. Commercial overlap is flagged rather than counted as another person.

For dual enrollees, count the person once and assign each distinct payment once. Reconcile Medi-Cal's Medicare-payment/buy-in lines against Medicare financing so the same transfer is not treated as two separate purchases of care.

Baseline spending and participant eligibility must refer to the same period and benefit scope. Historical low utilization does not itself predict next year's risk. AHRQ found that the bottom half accounted for 2.8% of 2022 spending; that supports examining concentration, not presuming 80% clinical suitability. [12]

[2] DHCS, May 2026 Local Assistance Appropriation Estimate, refreshed July 16

[12] AHRQ Statistical Brief 560, spending concentration in 2022

[13] DHCS, CY 2026 managed-care rate certification

2A. Employer and ACA costs stay distinct

The California employer survey verifies the historical single and family premiums shown earlier. No 2026 California employer survey amount was established in this research. The 2025 figure remains dated evidence; it is not increased using ACA percentages.

Covered California now states that enhanced premium tax credits ended December 31, 2025, with monthly premium changes effective January 1, 2026. This supersedes the older conditional language about whether they might expire. [5]

ACA measure	Published figure	Interpretation
2026 gross rate change	10.3% weighted average	August 2025 rate announcement; underlying marketplace premiums.
Subsidy-loss projection	66% net increase	August estimate of subsidy-loss impact for assisted enrollees.
Later household projection	97% average increase	October 2025 estimate for assisted enrollees absent extension; not a new public-program price.
2026 bronze benchmark	$706/month; $8,472/year	Age-weighted official benchmark, not observed average premiums across all plans.

Gross premiums describe the plan price. Net premiums describe the household payment after assistance. The reduction in federal assistance changes who pays; it is not an equal increase in provider costs. Do not stack the gross and net percentages or apply either to employer, Medicare or Medi-Cal spending.

Employer and ACA opportunities remain in the full California vision. Their expansion calculations require their own enrollment, benefit costs, and overlap checks. No commercial headcount has been added to the historical public population merely because it carries another insurance label.

[4] KFF, 2025 California Health Benefits Survey

[5] Covered California, current federal changes page

[6] Covered California, August 14, 2025 rates announcement

[7] Covered California, October 30, 2025 enrollment announcement

[19] Covered California, 2026 Proposition 22 bronze-premium benchmark

3. Statewide adoption arithmetic retained

HCAI's December 2023 coverage snapshot: 15,338,897 Medi-Cal + 6,941,606 Medicare - 1,700,234 in both = **20,580,269 unique beneficiaries**. Publication: January 27, 2026. This remains the historical scenario population, not a newly verified October 2026 count. [3]

Proposed candidate share: 80%. Candidate scenario: 20,580,269 x 0.80 = 16,464,215.2. Adoption applies to that candidate pool, not again to all Californians.

Adoption of candidate pool	Participants, rounded	Projected annual savings
50%	8,232,108	$57,624,753,200
75%	12,348,161	$86,437,129,800
100%	16,464,215	$115,249,506,400

Formula: unique population x suitable candidate share x adoption x weighted net saving. Dollar calculations retain fractional scenario counts; public participant counts are rounded.

The projected annual savings are enormous: $57.6B at half adoption, $86.4B at three-quarter adoption, and $115.2B at full adoption of the candidate pool. Payer-specific retention arrangements direct the resulting resources into funding replacement and community investment.

A current replacement population requires Medicare and Medi-Cal counts plus dual overlap for the same month, with compatible definitions. The newer fiscal-year average Medi-Cal caseload cannot simply replace the December 2023 snapshot while keeping the old Medicare and overlap counts.

[3] HCAI, January 27, 2026 HPD update; December 2023 coverage

4. Medication purchasing belongs inside care

The October 8, 2026 3 Axis analysis used employer claims with available Cost Plus prices. It reports 67% lower gross charges on addressable claims, about $42M potential savings, and nearly 10% of overall drug spending. Generic comparisons averaged 37% savings. Brand/bioequivalent net comparisons lack payer rebate data; Cost Plus sponsored the work. These findings support the purchasing lever, not a statewide 67% assumption. [8]

The 2024 Medicare study compared 2021 Part D spending with August 2023 pricing, estimating $8.6B potential national savings using 90-day generic supplies. It is neither California's savings nor a current all-drug rate. [9]

Medi-Cal Rx already consolidates pharmacy purchasing and receives mandatory and supplemental rebates. Compare alternatives with existing **net** expenditure, including dispensing and delivery, rather than retail list prices. [10]

A major lever for public beneficiaries: access to Cost Plus-style purchasing offers Medicare and Medicaid participants a pathway to lower medication costs on eligible products. Cooperative purchasing can extend those gains across many beneficiaries. Savings flow into the complete-care calculation, alongside routine access and coordinated local services.

The calculation to use

For each identical drug, strength, dosage form, quantity, and supply period:
Net drug saving = existing paid amount minus rebates/credits minus alternative all-in cost.
Include shipping, dispensing, administration, stock availability, and benefit/payment treatment. Aggregate only with actual utilization weights.

For the general chronic-condition analysis, a useful research basket covers hypertension, lipid disorders, diabetes, asthma/COPD, and mental-health treatment. These proposed research categories will be evaluated using utilization-weighted claims. Individuals may appear in multiple categories; unique drugs and claims are counted once.

Medication improvements lower the complete-care cost. They are not added again after subtracting that cost from the baseline. PHIERSale can compare multiple qualified purchasing channels; no vendor has been selected.

[8] 3 Axis Advisors, October 8, 2026 Cost Plus commercial-payer analysis

[9] Drug Pricing Stewardship, 2024 publication; PMID 39167355

[10] LAO, Medi-Cal Pharmacy Spending, March 25, 2025

5. Complete care: making the savings work

Required complete cost = comparable baseline - $7,000 target. This expresses the procurement and delivery requirement without inventing a forecast.

Budget condition	Complete-cost ceiling	Balance after $588 routine access
Illustrative $11,000 baseline	$4,000	$3,412
DHCS published $10,517 benchmark	$3,517	$2,929

The $11,000 planning illustration leaves $4,000 for complete care while retaining $7,000 in savings. After $588 for routine access, $3,412 remains for the other care components. The DHCS benchmark supplies a second transparent budget test. Both rows allocate one membership per participant; any contracted family-sharing benefit would improve those economics.

OurDoctor advertises starting at $49/month for an employee plus up to seven dependents; the page title says $39. $49 x 12 = $588 per membership year. Its family unit may improve the economics, but enrolled family size and contract eligibility must establish any per-person allocation. Access and discounts do not price all care. [11]

Costs that must fit inside the complete package

Routine access; local/in-person primary care; therapy and behavioral care; medications; labs and imaging; specialty, emergency, inpatient and catastrophic protection; appropriate long-term support; clinical coordination and necessary staff; administration, technology, reserves or risk-transfer premiums; and transition expense.

If comprehensive insurance premiums remain unchanged, a telehealth subscription does not free that premium as cash. The model must document lower paid claims, repriced coverage, redesigned purchasing/payment, or enforceable shared savings. When retained insurance already funds a service or risk reserve, count it once.

For fee-for-service, measure avoided or reduced paid claims. For capitation, establish the actual purchaser/payment change and retention agreement. Check the residual high-need pool after any enrollment shift; do not leave its financing outside the ledger.

[11] OurDoctor, advertised employer/family telemedicine offer

[13] DHCS, CY 2026 managed-care rate certification

6. Retention, jobs and community expansion

Complete care first. Then funding replacement and expansion. Necessary care-coordination staffing is included in care cost. Additional nurses, counselors, therapists, social workers, mentors, tutors, navigators, and community-school capacity financed from the remainder are expansion expenditures.

For each payer/cohort, track gross savings, legally/contractually retained savings, timing, and recipient. Medicare savings, Medi-Cal federal/state savings, employer savings, and household relief are separate accounts. Retention arrangements determine the reinvestment budget.

Available expansion funds = retained savings - approved funding-replacement allocation - other approved allocations.
Funded positions = workforce allocation / fully loaded annual position cost.
The denominator includes compensation, benefits, supervision, training, clearances, insurance, equipment and administration. This formula translates the workforce budget into paid positions as staffing costs are established.

The cascade: savings create capacity for further savings

IMPaCT's randomized-trial-based economic analysis estimated $2.47 in Medicaid payer return per dollar invested in its specific community health worker model. It provides evidence for the cascade: paid community support can improve outcomes and reduce later healthcare spending. The reported return applies to that study model. [14]

The Community Guide's school-based health center economic review reports societal benefit-cost ratios of 1.38:1 to 3.05:1. NASN cites a Massachusetts school-nursing study finding $2.20 societal savings per dollar. Productivity and education benefits are not all cash available for reinvestment. [15-16]

The full proposition remains: school nurses linked with telehealth and local providers; shared assessment, referrals and follow-through; community-school benefits across districts; all-ages support; paid service pathways through MAP/PCC/PHIERWorks; and PHIERSale opportunities for goods, services and local businesses.

[14] IMPaCT community health worker economic analysis, 2020

[15] Community Guide, school-based health centers economic review

[16] NASN, evidence of school nursing value

7. Methods disclosure and implementation inputs

LAO describes food-assistance cost shifts by effective date: lower federal administrative support begins October 2026; the benefit-cost state share begins October 2027 and depends on payment-error rates. Its estimate at a 15% share is about $2B annually, distinct from reduced benefits. January CalHHS materials describe tens of billions of annual Medi-Cal funding at risk. These are dated estimates, not one verified present-day loss total. [17-18]

Do not add overlapping cost shifts, multiyear grants, threatened cuts, blocked freezes and annual benefit losses. The expansion budget must compare retained savings and replacement needs for the same year.

Remaining input	What is needed to close it
Current unique public population	Same-month Medicare, Medi-Cal and overlap data; annual member months for cost weighting.
Comparable net baseline	Cohort spending, rebates, carve-outs, transfers and retained insurance reconciled to one ledger.
Prospective care/risk cost	Qualified package quotes or actuarial costings for all benefits; reserve and residual-pool financing.
Medication basket	Utilization-weighted identical products; existing net prices and current all-in alternative quotes.
Retention and timing	Payer-specific authority and sharing terms; transition financing before savings arrive.
Jobs and expansion	Approved allocations and role-specific fully loaded staffing/program budgets.

Methods disclosure: These are proposal projections using the documented December 2023 population, an 80% candidate share, 50% / 75% / 100% adoption, and $7,000 weighted annual net savings after complete care. Published benchmarks have different periods and scopes. Cohort weighting, complete-package pricing, medication net costs and retention agreements refine the implementation budget. Additional outcome-driven savings are described as the cascade and are not added to the statewide totals. The $7,000 projection is preserved throughout.

[17] LAO, 2026-27 Food Assistance Programs analysis

[18] CalHHS, January 13, 2026 federal-impact webinar

8. Recovery and implementation

Benefits-first language to preserve

California can turn healthcare savings into a stronger future. More care. More paid work. Stronger communities. PHIERS proposes combining affordable routine care, local providers, therapy, lower-cost medications and comprehensive protection. Retained savings would help replace lost support, pay people to meet community needs, expand community-school benefits, and strengthen local businesses through PHIERSale.

The goal is for California to emerge better off than expected, with a model other states can use. Accountability creates leverage. Solutions create capacity. Together they create power.

The scale of the proposal

The statewide scenario uses a documented December 2023 public population of 20,580,269, a proposed 80% candidate share, adoption of 50%, 75% or 100% of that pool, and a projected $7,000 weighted net saving after complete care. That yields $57.6B, $86.4B or $115.2B annually. The projection funds complete care first, then directs retained savings into a stronger California.

The public proposal leads with recovery from federal funding losses. This addendum supplies the financial methods: complete care first, measurable net savings, enforceable retention arrangements, and funded recovery and expansion.

Survey = Direction. Petition = Strength. Covenant = Commitment. The PAM = Accountability. Preserve the existing 500 House / 1,000 Senate organizing triggers and three-calendar-day initial response rule from formal delivery.

PHIERS proposes a national recovery model with California as the first worked example. California supplies a practical path: deliver complete care more affordably, retain savings, build community capacity, and extend the cooperative model to other states and other purchases.

Source register

[1] HCAI, October 7, 2026 interim spending report; 2023-2024 data

[2] DHCS, May 2026 Local Assistance Appropriation Estimate, refreshed July 16

[3] HCAI, January 27, 2026 HPD update; December 2023 coverage

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[19] Covered California, 2026 Proposition 22 bronze-premium benchmark

Primary sources checked during this continuation. Click the source titles to open them. Study results retain their original dates, populations and comparators. Public data do not supply private contract prices or PHIERS retention agreements.