Healthy California for All
Commission Meeting
June 25, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: [video recording of June 25, 2021 Healthy CA for All Commission meeting].

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Sandra Hernandez, Rupa Marya, Andy Schneider, Carmen Comsti, Antonia Hernandez, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Will Lightbourne, Don Moulds, Richard Pan, Cara Dessert, Bob Ross, Peter Lee (commissioner biographies can be found here: Healthy California for All Commissioner Biographies)

1. Welcome and Introduction

- Virtual meeting protocols and roll call
  - Karin Bloomer, a member of the consulting team, reviews the virtual meeting protocols and conducts roll call for the commissioners.

- Introductory remarks and agenda overview
  - California Health and Human Services Agency (CHHS) Secretary, Dr. Mark Ghaly welcomes the group and frames the work of the commission as follows:
    - The work is to envision a health care system that is no longer fragmented, that brings together different pieces that today function in silos. A single pool of financing and coverage for all with a single risk pool and set of expectations for the health care system that all Californians can take hope in. This is an opportunity to think of equity, access, quality, and affordability.
    - Governor Newsom sent the Biden administration a letter asking for our federal partners to lean in and take important steps around giving states like California the flexibility to dream differently**.**
    - Secretary Ghaly expresses his commitment to take a more visible and clear leadership role of the Commission, facilitating each meeting to pull out a rich set of conversations and inviting commissioners to speak on their expertise. The consultant team will listen closely to the themes, points, and comments made by Commissioners and capture those in the final report.

- While legislative considerations are important and will be discussed, specific legislative bills in their entirety will not be the focus of this commission.

2. Roadmap for Future Meetings

- Presentation by Commission Chair
  - In July, the use of intermediaries will be discussed, not in their traditional role as health plans, but as ways to think about overall risk and accountability and who is responsible for populations, not just individuals.
  - In August, the topic will be systems of accountability around core deliverables and outcomes i.e. access, quality, equity, and related issues.
  - In September and October, the focus will be on provider payments and federal engagement.
  - In November, financing will be the topic.
  - In December, the Commission will review the draft report and discuss any other topics that arise, such as social drivers of health, the future workforce, and how we link public health, physical health and mental health services together.

- Commissioner discussion
  - Secretary Ghaly invites commissioners to comment on the new approach and strategy, what sounds encouraging or if there are any gaps. Commissioner comments:
  - A financing roadmap for the legislature is critical and the final report needs to include a variety of financing plans, a mix of tax and fee options for generating revenue to fund a unified financing single payer program.
  - This commission can help the governor navigate the process of federal waivers in the report, describing federal waiver authorities the state can use without the need for congressional action.
  - The governor has an opportunity to move the cause for single payer unified financing by supporting the pursuit of federal waivers and backing state single payer legislation.
  - Racism is baked into our healthcare system. This is an opportunity to build something new.
  - Every study in the last 20 years comparing a multi-payer to single payer system has shown time and again that single payer is the way of creating health equity and quality health care.
  - To make the final report a useful document there needs to be consensus on the outline of what it is expected to contain. Because the report can't be about everything, the commission must focus on the things that are most important, have something significant to say, and tie it all together in a unified message. The report should be drafted with commissioners instead of for them, utilizing the commissioner's skills and expertise to draft what that looks like. Questions:

Will there be in-person meetings? What is the process for developing an outline for the final report? How long will the report be?

- Secretary Ghaly responds that there has been no commitment yet to an in-person meeting, though it is being considered for the final meeting. The outline will be a living document that commissioners can add to, move things around, and refine. To make the report usable and something that guides the future, maybe it's 15-25 pages in length, but that is flexible.
- There are dozens of decisions to be made, and the commission must flesh them out based on the overall direction, then offer some commonality, consensus, and a clear range of options. This will provide comfort and alleviate the uncertainty legislators, patients, and healthcare professionals may feel about a transition to a new system.
- There needs to be level setting around understanding what the obstacles, tools, and capabilities are at hand that don't require legislation/congressional action because not all commissioners have a common understanding of that.
- As each path is discussed, it is important to talk about tradeoffs; ultimately the public will have to decide which tradeoffs they support.
- It may be helpful to review the history of various health programs in terms of their political legislative history. Why is Medicare the way Medicare is right now? Then discuss the range of options we find acceptable, considering how things become real policy vs. ideal policy.

- Public comment
  - Karin Bloomer invites verbal and written public comment.
  - Note: For a transcript of all public comment provided during the meeting, please go to Transcript of Public Comment from June 25 2021 meeting.
  - Secretary Ghaly thanks the public for their testimony and notes the vital importance of public input, that it needs to be broad and inclusive and touch parts of California that don't always have a chance to be represented.

3. Unified Financing: Direct Payment Models

- Presentation by Commissioner William Hsiao
  - Secretary Ghaly introduces Commissioner Bill Hsiao to share his decades of real-world expertise organizing single payer programs, particularly focusing on Taiwan and Vermont. He asks commissioners to think about a few questions during the presentation: In the system we will discuss, how do we prioritize things like public health and population health? How do we think it supports health equity, the closing of disparities, and social drivers of health? And how would employers or consumers react to this presentation? And if California were to choose to go down this road, what specifically would it need to do?
  - Commissioner Hsiao states that he will discuss: 1) the key decisions that the commission must consider in designing a single payer system; 2) the importance of the provider payment system and how it affects the supply side

of the equation; and 3) the advantages and disadvantages of different approaches. For the presentation, please go to Commissioner Hsiao's Presentation from June 25 2021 meeting.

- Commissioner questions and discussion:
  - Is Taiwan using a capitated program? Answer: No, as it was not politically viable. To control costs, Taiwan used a total budget divided into portions to each hospital and physician center, and then for every service.
  - Does Taiwan have a countrywide data information exchange so that a physician or a hospital knows a patient's medical history everywhere in the country? Answer: Yes.
  - Having spoken to primary care doctors in Taiwan, I've heard them say that they dislike being primary care doctors because they essentially just distribute prescription pills. The system incentivizes volume since the model is using fee-for-service. Doctors try to see the greatest number of patients in the shortest amount of time and try to keep patients happy so they keep coming back, since that's how their business survives. They control prescriptions by delaying approval of new drug. These tradeoffs must be discussed.
  - Taiwan tried to go to an integrated system and couldn't due to political obstacles. People like fee for service as they can go and get what they want, but despite rising chronic disease and greater need for coordination, there's a lot of fragmentation. If you're healthy and only want a prescription that model might work, but with a chronic disease not so much.
  - What is going to happen with innovation in Taiwan with its rapidly aging population? Taiwan was doing better until a decade ago, before single payer insurance was run by a government agency. That's why the question of innovation is an important one.
  - Long term care is a big piece of the pie. It's not been easy for Taiwan to address this.
  - One model to consider is fully globally capitated payment both for health and health related services, i.e., social services, because it is not just about health care dollars. Health is a function of many things, such as whether you have food, housing, basic things, and such integration has so far been not expressed in the Taiwan model and the Vermont model. When talking to older people, those social services are the bulk of what they need. There are many children who have co-morbidities, both clinical co-morbidities, as well as behavioral health co-morbidities. The payment system is more complex when you have Medicare and Medicaid covering dual eligibles with behavioral health care needs. Perhaps we might test out a global approach for a population subgroup, use global capitation to bring in a manageable approach to integrated care delivery, accountability, and quality.
  - The current system is not financially sustainable for consumers, employers, taxpayers.

- How is the political culture different in Taiwan? Answer: Taiwan was successful in developing a single payer system because it had not built up such powerful, wealthy stakeholders who can mobilize and organize so well to oppose change.
- As a consumer advocate, if somebody has a problem, where do they go for help in Taiwan? Is it a political process or a regulatory process? Answer: Taiwan has very active local representation, people complain to their local representatives; secondly, they can complain to the government agencies and newspapers.
- Taiwan's governance structure allows for a lot of industry influence and self-regulation. We would need to figure out how to assure that industry lobbyists don't have too much political influence.
- There are current legislative proposals addressing a lot of the issues in the Taiwanese system, including value-based payments for primary care physicians and specialists, using global budgets for hospitals, and having an option of the government paying salaries to doctors.
- The important elements of a single payer system are simple. Pay less and get more, achieve universal coverage, provide comprehensive benefits in a single high-quality standard of care for all people, eliminate administrative waste from our fragmented system of insurance, rein in health industry profiteering, and by so doing save families and small businesses in California thousands of dollars every year in health care costs. Many studies show this.
- Professor Hsiao defined single payer as one single risk pool, and this should be highlighted as a key feature and strength of a single payer program that is lost when entertaining hybrid models. In a multi-risk pool model there is no collective power to negotiate fair healthcare prices, drug prices, and to ensure that decisions are based on patient need rather than economic incentives and financial risks.
- A key benefit of a single payer system is to protect the health and the lives of the black, brown, and indigenous people that have borne the brunt of this inequitable system of private health insurance. That is important to understand when talking about these different choices and design models. The freedom to choose doctors and hospitals through eliminating all the narrow networks and co-payments and deductibles and other barriers to care, all these things that health insurers and other middlemen impose.
- The potential disadvantage of a single payer system is well understood; a single public agency with too much focus on government bureaucracy. But we need to compare that to what we have today. There is an intense insurer and corporate health industry lobby of government regulators and lawmakers. In terms of accountability to the public, with a single public agency, the public can demand the system is accountable to us. Creating a legal guarantee for health care for all as a right can be done through a single payer system, as

opposed to the status quo which puts the accountability in disparate corporate boardrooms and with insurers whose business model is to limit care.

- The most important slide of the presentation was the one that emphasized that provider payment methodology and rates affect access, efficiency, and quality. Cost inflation and equity should be added. Clearly, there are medically underserved areas. Single payer, and the payment system within it, can be used to help redistribute those resources, balance specialist and primary care and family doctor pay. Some hospitals have incredibly high rates next door to a hospital that can't charge the same. How can a system balance that out while ensuring that people are getting good care?
- In terms of the workforce, the commission must make sure there is enough going to hospitals and providers so that workers are able to make a living wage, that the system is not containing costs on the backs of workers.
- There is going to be an increase in the use of services and services in different areas of the state by different populations, many of whom haven't had access to care. This would be a massive change, to get people of diverse backgrounds who speak lots of different languages in different areas of state into the healthcare profession, having career ladders, having training, and having different levels of practitioners able to provide care.
- Professor Hsiao's presentation stressed that the source of financing is unified, but what it costs is based on three factors: 1) what is being paid for (the benefits), 2) what kind of system we want, and 3) the methods and amounts of payments. It is critical to design a system that means all people get the right care at the right time, every time. It is worrisome to not talk about design systems that are about integration of care.
- There are many ACOs that are primary care centric, that are run and controlled by primary care doctors that do a much better job than an ACO structure run by hospitals.
- With pure fee for service payments there is a worry that there will be no integration of people's chronic care. It is important to have financing that fosters that.
- Gatekeepers are seen as an obstruction to people getting the right care at the right time, versus having a comprehensive primary care system that focuses on prevention and early care and screening, that has the ability to be integrated fully so that patients get the specialty care when needed, and is fundamentally focused on a medical home, which provides for an array of integrated services.
- Fee for service does not incentivize integration of care. Rather, it drives up costs.
- In the Taiwanese system, what happened to the workforce after they went to a universal system? Did Taiwan provide a workforce that keeps their population healthy? Answer: Taiwan paid attention to the distribution of family physicians and did shift resources to train more specialists. On average, an individual in

Taiwan sees a doctor 15 times per year, compared to only 6 times in the United States. This is because physicians depend on the fee for service payments. The commission will need to work through that dilemma and make recommendations.

- It is important that the Commission elevate the importance of integration of health care and social services – and understand how those impact health. Healthcare starts in the way we're farming and the food accessibility that people have. There is exciting potential in innovating a system that brings in ideas around food and housing as integral components of health care.
- One key slide of the presentation was the one that showed that a hybrid system both decreased equity and increased cost. To be serious about containing costs and centering equity, it is important to follow where all the data is pointing and focus time on these details around payment structures, like whether payments should be handled through a government entity or a government adjacent entity.
- Given Taiwan's success in managing the pandemic and their death rates compared to California, what made them more resilient in the face of this, and how might that portend for California in the future? Answer: First, Taiwan had a pandemic control plan. After SARS, which took place in 2003, many countries set up an agency to handle such a situation, and Taiwan set up a very effective one. That agency is there for when an emergency occurs, led by the Vice President, and the Vice President is a doctor. He had the medical expertise as well as the respect to call on the public and instruct them on what to do. Second, Taiwan used a totally different strategy; they closed their borders and quickly introduced testing, and once tested, they tracked and quarantined whomever might have been in contact. That's the strategy island countries can do like New Zealand, Taiwan, and also Japan.
- When thinking about doctors and providers affecting the price and the volume of the services that are available, it is important to think about regions that are underserved, and that being underserved is linked to lack of healthy food and housing and the social services that have been discussed. From a practical primary health care perspective, it's hard to get doctors to these places, so what is the plan to improve equity and access and impact for these Californians?
- Is there enough time set aside to talk about financing? And will that conversation include specifically a discussion on the reserve? That's a critical piece of establishing any system moving forward.
- The equity issue doesn't come naturally, even if switching to single payer. That's going to require extra attention, diligence, and structure. The commission needs to build in and anticipate a consumer feedback loop.
- A key intermediary should be community health centers. They have more diverse health workforces and a better orientation to health equity. They've been treating everyone who comes in through their doors for years. They are

far more interesting as a type of intermediary. The commission must keep equity front and center.

- A bridge needs to be built between public health and health care. The pandemic provided an opportunity to think about how systems are financed and to think about that more closely with equity in the middle. Employers play a big role in today's system. How do they respond and think about this model shift? What questions are they struggling with? Answer: The short answer is employers are reluctant to change, but also frustrated with the existing system, and its cost, and what it means for competitiveness, as well as frustration about not being able to get the care for employees that they are paying for. A sizable community of employers is hungry for a health system change. Some are looking for something that builds off the existing system, some are looking for radical change.
- There is a lot of differentiation in the systems being considered here. There needs to be a conversation about what is being built upon and what the goal state is, and what a pragmatic transition looks like to get from one system to a system that is vastly different.
- If mandatory enrollment is a predicate for a single payer system, are there lessons from Taiwan for how to get mandatory enrollment in California? At the national level, there has been a 10-year conversation about the individual mandate in both the courts and the legislatures that is not over. How does that work in Taiwan and what pieces of that could work in California? Answer: In Taiwan, they were able to enroll a large portion through employers, but also through civic associations, like taxi drivers, which have their own union. Because the government paid for a third of the premium, that enticed those organizations to join. For the homeless, they recruited community workers to go under the bridges and into abandoned houses. In Taiwan, when going to see a practitioner, it only takes two minutes to go through the administrative process. Bottom line, you need to work through every organization possible, and for those still left out, make a special effort. Taiwan was able to achieve 95% in a year. In another five years, 99% enrollment.
- Over 2% of the entire gross national product of the entire country is spent in California's healthcare system. There are only 25 countries that have a larger budget than the health care budget in California. The health care budget of California is the same size of the total budget of Ireland. There is some general agreement here that it is better to retain our capitated system in a single payer system, because 65-70% of the healthcare system in California is already on it. The questions are: How is it going to be set up? Who's going to do it? How is it going to happen? Answer: Focus on changing the delivery system through a payment reform. One of the first things to do is to put a cost target in California. Second, change the way capitation is calculated. Right now, California has calculated capitation based on fee for service, so you pass the savings on to the system, not to the people. Those are two quick ideas on

the financing side. Next, hold the providers accountable for the prevention and treatment of patients in terms of both health outcome and quality of care. Both are important.
  - On the issue of equity, as a system is being developed, should people who have means be able to buy out of it? That is true in many other countries where they have single payer systems with equity issues.
  - Professor Hsiao stated that 25-30% in our current system is waste, but how do you define "waste?" There are expenses that have to do with equity and geography, including surge capacity, other types of things.
  - It is important to note even if government was running single payer, there will still eventually be utilization controls.
  - Secretary Ghaly summarizes: That was a good discussion on the benefits of unified financing with a lot of good questions about how to build equity as a core feature in the system. How do we deal with fee for service versus capitation? There's a lot of confusion and opportunity to delve deeper into that question. It is key to design a system that is focused on the patient's needs, not a system with administrative waste. There was discussion about who does the job. In terms of managing care, it is important to talk about the workforce issues, who is doing work in our system and where they do the work. How do we broaden our understanding of healthcare, to talk about social services, social drivers, social determinants, and how do we extend and bring closer the public health system that often is on the fringe of healthcare delivery? There was not time to dig into Vermont, which is worth discussing at the next meeting and building into our work moving forward.
- Public comment
  - Karin Bloomer invites verbal and written public comment.
  - Note: For a transcript of all public comment provided during the meeting, please go to Transcript of Public Comment from June 25 2021 meeting.

4. Adjournment

- Secretary Ghaly thanks the public and commissioners for their contributions. He notes that the commission will return in two weeks to have further discussions.
- Secretary Ghaly adjourns the meeting.