Healthy California for All
July 8, 2021 Virtual Commission Meeting
Public Comment

1. **The following table shows public comments that were made verbally during the virtual meeting:**

Count	Name	Verbal Comment
1	Peter Shapiro	I'm with the California Alliance for Retired Americans, I'm on the board of Healthy California Now. Governor Shumlin kept emphasizing the need to have cost controls built in. You can do that by eliminating waste, or you can do it by rationing care. Right now, we do it by rationing care. It is not working very well. We have a very costly system. I've been with Kaiser all of my working life, and I have an ambivalent relationship with it. When I first started out many years ago, I was attracted to it because their model is easy to navigate, the doctors collaborate well, and the emphasis is on preventative medicine. Back when I first joined there, they marketed themselves with the cheapest plan on the market, and it showed in the quality of care they gave it was perfunctory at best, it was downright negligent at times, but their doctors revolted in the 90s and demanded a higher standard of care. So now they have it, but they also have higher premiums. They have introduced deductibles, some of which are quite large. They have 26 plans on the Covered California market and 11 more in the small business market. Some of them with deductibles as high as $12,000. For a family plan, how on earth are you supposed to reconcile a commitment to preventative care with a $12,000 deductible which is discourages people from getting it?
2	Mary McDevitt	I'm a retired physician living in Sonoma, California, and I was really appreciative of the governor's presentation. I was impressed that he started out talking about financing and the importance of federal dollars. And then when he went on to waivers, we know waivers are very complicated. He talked about both financial waivers and program waivers and then sort of made a blanket statement that he's gotten all these waivers. I need clarification because the press at the time, pointed out that the Affordable Care Act in the law precluded any state asking for a waiver until 2017. And the press went on to say that the governor went back to Washington to see if he could get that changed and was unable to. So my question and the clarification, I would ask, did he actually get the affordable care subsidy dollars from the federal government? And if he did, or if he would have, would that have made it unnecessary to increase sales tax and employer taxes?
3	Ryan Skolnick	Yes, my name is Ryan Skolnick. And I got to say this commission is having the wrong conversations. The primary driver of cost is not the fee-for-service Boogeyman, it is

Count	Name	Verbal Comment
		administration. A full third of US healthcare dollars go to administration, capitation will not fix that. We have heard about how much better things would get if we just did more capitation, a reimbursement model literally predicated on the reduction and denial of care. We heard a commissioner talk today about how patients cannot be trusted to make their own decisions about providers. We are talking about forcing providers to juggle their care obligations with their personal financial interests. This commission is focused on everything except for the whole point of health care system care. Our for-profit system has created millions of uninsured and underinsured Californians, while the insurance drug and hospital corporations enjoy record profits. Create a single entity and you curb the cost growth by negotiating the lowest drug prices and providing the most efficient, high quality care possible, as outlined in AB 1400. Take that bill up, model it, use it to inform your report. It'll be a much more fruitful use of your time.
4	Dr. Bill Honigman	Thank you. I would like to add testimony on the subject of integration and care coordination, particularly as regards to HMOs. I'm a retired emergency room physician who practiced in the provider group model known as Kaiser Permanente for over 30 years. And I can tell you that the provider side of that organization was excellent and exceptional. We were entirely focused on the quality of care delivered to our patients using scientific evidence based shared best practices in interdisciplinary teams to keep our patients healthy, true to the original idea of a health maintenance organization. However, the side note at Kaiser is specifically the health plan, business side that limited resources to us as providers was where all our frustrations were. During my tenure there, insurance products like co pays and deductibles were introduced to entice market share that undermined our practice model of keeping our members healthy. That insurance side of Kaiser is the part that needs to be reformed to exclude that third party or financial intermediary, as I believe you are calling it. Without the commercial insurance function of Kaiser Permanente, I'm sure it could carry on exceptionally well in a single payer or unified financing system. Thank you.
5	Patty Harvey	I'm a family physician up in Humboldt County in Northern California, where it was mentioned that there's a dearth of providers, I would say, under a single payer system, there are ways that we could get many more doctors up into rural areas where there's a dearth by providing better salaries, by making it much easier to run a practice. There is no perfect form of payment, what we need is diversity of payments, including fee-for-service, which is not the driver of the expenses as is shown in Canada and other countries that do have fee for service. That is not what causes all the

Count	Name	Verbal Comment
		expenses. We need to look at that evidence. There was a mention of quality, that there's great quality metrics, well look at our statistics, they are terrible in this country, so I don't think the quality metrics that have been made are really working. We need to set up a single payer system where everyone has equal access, and then look at oversight that can look at fraud, that can look at practitioners that are not providing quality medicine. Right now, in medicine, there are a lot of doctors stepping out of the system to provide concierge medicine. I'm not a fan of concierge medicine, but I understand why doctors are doing it because they want to provide that quality care which we can do under single payer. Thank you very much.
6	Pilar Schiavo	I'm an organizer for Healthy California Now. I just wanted to express my appreciation for Governor Shumlin, he made some really important points. And important points to be heated right now at this moment in time. Especially in the current political context, he raises important points about the need for us really to move as quickly as possible, at the federal level, that this is not the time to wait. We all know that the 2022 midterm election is coming up, and traditionally, there has been a shift in terms of the control at the federal level in those midterm elections. As much as we can do and as far forward as we can get in terms of a waiver process right now is really critical. I've been organizing on this issue around single payer for a decade now, which is hard for me to believe. And when I first started organizing around this 10 years ago, I remember seeing old information of when there had been a campaign to get LA Unified School District Board to support single payer, and they actually costed out how much they would save with it, noting millions of dollars. And it is hard to think about how much would have been saved if we had actually done it then. And now is really the time for us to do it. And so, I hope there will be urgency around this movement forward at the federal level.
7	Michael Lighty	Thank you, Karin. And thank you, commissioners for deeply engaging discussion. I think we should name the American health care industry as the defining name for what we say is a non-system. And that industry has created things like narrow networks, which are promoted by Covered California. It's created things like the underfunding of MediCal which limits access to specialists. These are drivers of inequities, these high deductibles that people have mentioned. And so, when we talk about attributes of the system, we need to first, as others have said, take out the administrative waste, take out the profits, it is a distraction to focus on health care workers' salaries. The driver of high prices is the fact that the prices are unregulated and single payer financing of course, provides the means to do so. Dr.

Count	Name	Verbal Comment
		Ghaly has talked about attributes of the system, we need to be clear. A key attribute has to be guaranteed access to healthcare with no administrative or financial barriers to secure and services, establishing a single standard of therapeutic and equitable car, providing services based on patient need and medical necessity as determined by the provider. Not by algorithms, not by protocols. Thank you very much.
8	Beatriz Sosa-Prado	Good afternoon, everyone. This is Beatriz Sosa-Prado from California Physicians Alliance. This was a great discussion about unified financing. It's a conversation that you all need to be having. I also want to say that I appreciate all of the comments from the commissioners, Dr. Ghaly and Governor Shumlin. California can create a healthcare system that is socially just, and a system that is universal to ensure quality and accessible health care for all Californians. And I'd like to remind everyone that this is CaPA's mission. CaPA is a statewide nonprofit organization of progressive physicians and healthcare professionals who advocate for a single payer system and an improved health care system for all. Thank you.
9	Maria Behan	Hi, my name is Maria Behan, and I co chair the Health Care for All working group here in Sonoma County. I'd also like to remind everyone that of something that Rick Kronick said, he presented some pretty dramatic numbers two meetings back. He estimated that if California had unified financing that used direct payments to providers, it would save $42 billion on administrative costs in a single year. Leave what he termed health plans slash health systems in the mix and those savings are more than halved. To raise a related question, if a bully were ripping off a child's lunch money, what would you do? Would you end the outrageous extortion or take up a collection so the community covers the bullies demands? I hope the commissioners use their expertise and insight to disrupt the cycle that enables for profit intermediaries to prey on patients and taxpayers. Thank you.
10	Tracey Rattray	I'm Tracy Rattray from the California Alliance for Prevention Funding. Thank you, Secretary Ghaly and commissioners for today's discussion. Many on today's call have mentioned the importance of outcomes-based payment and population health in redesigning healthcare delivery. Investing in health equity and community-based prevention programs is one of the best ways to achieve these goals. Just one example, the unequivocal success of tobacco prevention programs. Much of the success has been driven by partnerships between the state and community-based organizations working together to reduce youth access to tobacco, increased taxes on tobacco products, and prohibit predatory marketing and

Count	Name	Verbal Comment
		other risks for tobacco use among communities of color and low-income Californians. The result? Over 1 million California lives saved and 134 billion in health care costs avoided by preventing chronic conditions such as heart disease, cancer and stroke that are associated with tobacco use. Imagine the decrease in health inequities and healthcare costs if we invested at the same level in community-based strategies to prevent diabetes. I would like to thank everyone on today's call who shares this vision, especially those who have supported AB 1038 and an accompanying budget request to create a California Health Equity and Racial Justice Fund.
11	Patty Harvey	Hi, my name is Patty Harvey and I am with Health Care for All and Physicians for a National Health Program in Humboldt County. And I am with Rupa, Sara, and Carmen on the issue of intermediaries and whenever I hear the words "business model" for those intermediaries, I get very nervous. I wish that I were beating a dead horse here, but I think it bears repeating the words of Wendell Potter who is a former vice president of corporate communications at Cigna and he wrote a book called "Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR is Killing Healthcare and Deceiving Americans." And what he said really bears repeating over and over: "Our health insurance companies are not essential. They don't treat anyone they don't prevent anyone from becoming sick. They don't take you to the hospital and make sure you take your pills. They don't discover medical innovations. They're simply middlemen we don't need and in the industry, we always dreaded the day American businesses and patients would wake up to that reality. That day has come."
12	Brynne O'Neal	Thank you, Brynne O'Neal, NMU. Commissioner's spoke about care coordination. Now the insurance industry often uses terms like care coordination or managed care as euphemisms for care rationing, but we can make sure that the system provides for services that genuinely help patients navigate the medical system. It's important that primary care physicians and nurse practitioners who have the clinical training necessary to know what kind of care a patient needs are the ones coordinating their care. We should be training people from diverse communities to be culturally competent, licensed professionals who speak different languages, who patients can trust to play that role, not creating a two-tier system where only the affluent get trusted coordination from actual licensed providers. To get to equity, we need a massive educational program to train more professionals for medically underserved communities. A single payer system is best suited to identify gaps in the workforce and directory sources to remedying Thank you.

Count	Name	Verbal Comment
13	Craig Simmons	Hi, I'm Craig Simmons, and I'd just like to offer the commissioners a couple of questions. One is if there would be consensus for the drafting of a ballot measure for implementation of a payroll healthcare tax to facilitate a single payer system? And if the answer to that question is yes, then if there would be consensus for standardization of cost, which seems to be a big topic, especially with Peter Lee, and I have had some experience in both of those areas. And I would like to offer my services either as a staff or consulting position to get a single payer health care tax implemented and voted on by people in California. Thank you very much.
14	John Douglas	Thank you, folks. I'm John Douglas is Santa Barbara, California. I'm a member of DSA Santa Barbara, Health Care for All California, Santa Barbara, and Physicians for a National Health Care Plan started by our wonderful Nancy Griep. Dr. Nancy here in Santa Barbara. Everything is contained in AB 1400. It's a well written bill with the possible exception that it should be specified that doctors serve on the governing panel. I agree with that point of view from doctors in California from what I've heard. We are going to be we're meeting with Salud Carbajal, our congressman, next week to urge him to co-sponsor the role on a state based universal health care bill so that we can ease the way for the waivers. Thanks for letting me speak. We need healthcare now. We need single payer. Thanks very much.
15	Phillip Kim	Thanks Karen and hello commissioners and fellow single payer supporters. My name is Philip Kim, I'm in Sacramento with the California Nurses Association. As Professor Hsiao told us last month any system that uses a so-called hybrid model with competing insurers and corporations that make money off of managing your care, would create tiers of health care and lead to unequal access and higher costs. And that goes against the equity goal everyone here has agreed on. Hybrid models use health plans and other risk bearing entities to divide up the risk pool, while single payer has a single risk pool, everybody in, nobody out. And in a single risk pool we, as a society, protect the most vulnerable. A multi payer divided risk pool would require risk adjustment which has been tried extensively and proved to be unreliable, it would encourage risk bearing entities to cherry pick healthy patients, find ways to drop the sickest patients, and incentivize under treatment. We do not need that. A multi payer model rewards corporate consolidation and punishes small independent practices who cannot manage the fluctuation of risk in a divided pool. So, what we really need is a single payer system like AB 1400. A system with far less administrative costs, that is not profit driven, where providers will be able to focus on patient care. And as far as care coordination goes, as Carmen said, much of that

Count	Name	Verbal Comment
		can be done through primary care providers in a single payer system where everyone can see a doctor and there are no restrictive networks.
16	Zac McDonough	My name is Zac McDonough. I am from the Silicon Valley Democratic Socialists of America. And I put in a comment last meeting, and at this one, that between Senator Richard Pan and Assemblymember Jim Wood, you just look at their donor records and their comments at these commission meetings and the history of what they have done in in their positions. And I do not understand why they're part of this commission if they're just going to try to talk about why private insurance and private health care and everything is the way to go. Like we need administrative oversight. He went after commissioner Comsti today, and I thought it was really inappropriate. She had some really good facts and he just made arguments for seven minutes about how money needs quality and that's why we have admin, and I don't really see what the deliverable of this commission is, if we have if we have people like this involved that are going to detract from the conversations that need to happen. I just don't want my family to die. I don't want to die early. I want everybody in California to have guaranteed health care. Thank you very much.
17	Isabel Storey	Isabelle Storey, I really want to thank you for focusing the deliberations today on single payer coordinated health care. And while I think it is important to consider many options, I believe the example of Vermont that we talked about has limited application in California. Besides other differences, it may just be as valuable an example of what did not work. Single payer never happened in Vermont. And that's because the corporate health industry was able to block it to preserve its profits. There was a three-year delay between adoption of policy and consideration of the financing, which led to a political failure. So I would just advise considering both of these policy and implementation and financing at the same time. Thank you.
18	Ruth Carter	Hi, thank you chair Ghaly and commissioners for this very important meeting. I am Chair of the California Democratic Party senior caucus. And as you may know, our party has been a supporter of single payer health care for a long time. We can all agree that our health care system is not working effectively and is fractured and broken. Many of us, including me, could not wait until we were 65 and eligible for Medicare so that our individual medical costs would be kept under control. While Medicare has some problems, not the least of which is the privatization of it through the Medicare Advantage plans, which also cost the government much more. Medicare is a model that has worked since July 30, 1965. There are no intermediaries whose goal is to be

Count	Name	Verbal Comment
		profitable. Today, it is unconscionable that insurance companies have made their biggest profits in history during the pandemic. No provider or intermediary should be incentivized to release realized profits by withholding needed services. Thank you.

Total Count of verbal comments: 18

2. The following table reflects public comments that were entered into Zoom Chat during the July 8th Commission meeting:

Count	Name	Comment
1	Leading Resources	Public can submit comments to HealthyCAforAll@chhs.ca.gov. Additionally, members of the public will have opportunities to provide verbal comment during the meeting.
2	*Rupa Marya:	What a summary Sarah!
3	Phillip Kim	Vermont's failure to work out financing for its single-payer system is a strong argument for this Commission to provide financing options to the legislature and Governor. The legislature will need to make the final decision on how to finance the bill but we should use this Commission to get the math and logistics worked out so they just need to pick among options. The commission should use its budget to create a publicly available online calculator for members of the public and legislators to explore financing options.
4	Ellen Schwartz	I thank the Commission for finally talking about single payer. Look, it cannot be impossible to set up a system where providers don't have an incentive to overtreat (fee for service) or withhold treatment (capitation); several speakers addressed this -- e.g., it's cheaper and more effective to monitor outcomes and costs if there's only one reporting system and revenue flows from one source. The countries that have adopted a universal health plan have better health outcomes than we do, include everyone, and spend substantially less than we do. Let's do it.
5	Ellen Schwartz	My employer promised me "health care for life" if I took early retirement. I should have read the fine print, because as soon as I turned 65 they cut off the retiree insurance and pointed me to an insurance brokerage to help me sign up with private Medicare supplement insurance or advantage plan. My former employee provides (so far) a $3000 allowance each year to cover my health care costs. It helps, but only because I am enrolled in a
6	Joslyn Maula	Comments can be sent to healthycaforall@chhs.ca.gov
7	Dessa Kaye	Thank you, Gov. Shumlin: The work to create a single-payer system and the people who did the work already exist; you don't have to reinvent the wheel!!!

Count	Name	Comment
8	Phillip Kim	California has the advantage over Vermont. Because we have a larger risk pool, funding needs should be lower per capita and more consistent and predictable.
9	Ellen Schwartz	...low premium advantage plan. Anything else would hurt me financially.
10	Brynne O'Neal	Peter Shumlin explained that Vermont could use Medicare and Medicaid funds under existing waiver laws. The law has changed to make it easier since the Vermont attempt to implement state single payer. Section 1332 of the ACA, which had not gone into effect yet during the Vermont waiver attempt, provides for a consolidated waiver application process for all federal funding and gives clear requirements for what states need to show to be allowed to redirect ACA funds. Section 1332 was written with state single payer programs in mind. CA needs to pass legislation with 1332 requirements in mind and then apply for a waiver.
11	Jeffery Tardaguila	Communication is so important and still missingI
12	*Rupa Marya	We can also get $$$$ from Wealth Tax.
13	Jenni Chang	^^^
14	Nicki Davis	Where can I get a copy of the 107-page report that Gov. Shumlin referred to?
15	Jenni Chang	State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis, 107 pages - https://commed.umassmed.edu/our-work/2013/01/24/state-vermont-health-care-financing-plan-beginning-calendar-year-2017-analysis
16	*Rupa Marya	Look into Oil Severance Tax.
17	Norma Wilcox	Norma Wilcox from Chico Commissioner Peter Lee mentioned that US drs & nurses get paid more than in other countries. Most wealthy countries pay secondary education with tax dollars. In the US Drs & nurses and dentists are required to pay-out-of pocket and spend years paying off student lands. Tax supported education would increase diversity of providers.
18	Phillip Kim	In a single-payer system, patients will have the freedom to choose the doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is “in-network.” No one will have to switch doctors just because they lost their job. If someone wants to switch doctors, they will be able to choose someone new based on the qualities that matter to them, instead of having insurers decide based on maximizing their profits. If you keep intermediaries and managed care, you keep barriers that stop every patient from finding and keeping a doctor we trust.
19	Michelle Grisat	Interesting JAMA article on how Medicare Advantage upcodes compared to Medicare fee for service: https://jamanetwork.com/journals/jama/fullarticle/2760499. “Most Medicare beneficiaries have access to multiple

Count	Name	Comment
		clinicians across a wide variety of specialties in a year, with each clinician making independent clinical decisions irrespective of their cumulative effect on the facilities, health systems, or health plans that CMS deems responsible for patients at the end of the year. However, the potential for gaming does exist in Medicare Advantage health maintenance organizations or accountable care organizations that possess the analytic sophistication to nudge clinicians into modifying their behavior to maximize reimbursement. This is a valid concern with an increasing number of eligible patients enrolled in Medicare Advantage. The coding intensity is greater in the Medicare Advantage population than in the traditional fee-for-service population."
20	Brynne O'Neal	Under single payer, each Californian would only have to sign up once in their lives, and it would be much simpler than figuring out insurance paperwork. Keeping the burden of signing up with an intermediary or network and navigating their system before accessing care is inequitable. It throws up barriers to care for people who do not have the time, literacy, or language skills to understand complex paperwork. A single payer system means no one has to change networks when their life circumstances change. Frequent changes in employer and income are the rule, not the exception, for many people today. Adding complicated, high-consequence, decisions about insurance adds stress and leads to care delays. Under single payer, new residents and residents during transition will have to go through a simple sign-up process one time only. No extra paperwork. Enrollment will be automatic at birth. One-time one-choice enrollment takes a source of stress away from every Californian.
21	Sandy Kurtz	There was a statement during the meeting that Kaiser does a good job with quality of care. I would strongly disagree with that since they do such a poor job of providing mental health care. Patients have to wait significant times for initial appointments and longer for follow-up care. That is not adequate mental health care and should not be a model that is emulated for the state as a whole.
22	Louise Mehler	The profit motive is powerful, and the temptation to try to harness it is great. But it is very dangerous. I have yet to hear of a mechanism that can manage it without building in an incentive to restrict care. Erecting barriers to care is the natural result.
23	James Sarantinos	Netherlands with a regulated insurance system spend around 25% more than UK, which is mainly single payer with similar outcomes
24	Patricia Clark	Kaiser has over time only hired doctors that did their residencies at Kaiser. They started with the gate keepers, and have gradually worked into the specialties. Very scary. And the insurance end certainly does affect patient care! The

Count	Name	Comment
		covid vaccine has a varied effectiveness on people with compromised immune systems, but Kaiser will not test for antibodies. So patients do not know if they have any antibodies or not.
25	Nel Benningshof	In Vermont the perfect became the enemy of the good. Often good is good enough and perfectly acceptable, as long as it's done well. We in California are big enough, have enough talent and ability to do a good job. Put that team together and get to work. We all understand the work on improving the system will never be done, but that should not stop us from creating it now.
26	Brynne O'Neal	Commissioners spoke on the importance of integration of care. But there is a difference between care integration that helps patients access care and navigate the system and managed care that uses middlemen to limit care. A single payer system, which is compatible with several methods of payment and not just fee for service, can encourage close coordination between a patients' care providers. For example, as Commissioner Comsti explained, a monitored fee-for-service system can get integration by paying for health information exchanges, consultations with patients, consultations between providers, and for transfers of patients between providers. Or with hospital global budgets, like in AB 1400, an entire institution works under one annual budget based on costs which covers its hospital, staff, and associated outpatient clinics.
27	Mary Alice Bisbee	No, he did not get these waivers because they were not available at that time. I live in Vermont.
28	Peter Shapiro	Kaiser's best features would become paramount if the hospitals and Permanente Medical Group were separated from the Kaiser health plans and funded directly by the state with global budgets.
29	Mary McDevitt	My understanding is that he did not get the ACA federal dollars.
30	Jorge De Cecco	Single payer is the best system.
31	Danett Abbott-Wicker	@Peter, exactly
32	Jenni Chang	Thank you Dr Honigman
33	Danett Abbott-Wicker	Thank you Dr. Bill!!!!
34	Virginia Madsen	++++ Peter Shapiro's last statement
35	Barbara Commins	This Commission needs to take a seminar from Medicare on how to DO IT!!
36	Christine Shimizu	THANK YOU RYAN SKOLNIK AND DR. HONIGMAN!
37	John Douglas	Thanks, Dr. Honigman!

Count	Name	Comment
38	Emily Olanoff	In response to Richard Pan, we must ban drug makers from advertising to the general public. No other country allows this direct marketing of pharmaceuticals, and we shouldn't allow it here in California either! Biotech companies spend much more money on advertising than they spend on R&D. We can negotiate much lower drug costs if we didn't have to pay for their commercials!
39	Christine Shimizu	Yes Ms. Frugoni!!!! This is the way we can resolve issues with dirth of care!
40	Al Saavedra	The Commission is good at getting lost in the trees and not looking at the forest. Let's put the big load in the truck and then the smaller objects. Let's pass AB 1400 and then figure out the details.
41	Laura Turiano	I agree with the idea that the “new” health system we are discussing should have a population focus, addressing root causes, public health and prevention. To achieve that it is important to include testimony from community health centers, other community based providers, and public heath department leaders regarding what would support them to improve and expand their services.
42	Danett Abbott-Wicker	@Emily, I second that heartily! That's all I see nowadays, is Pharm ads.
43	Norma Wilcox	Norma Wilcox from Chico. The demise of the Vermont bill shows me the importance of introducing a bill that has both the policy and the financial parts with details of benefits and costs per individual an household. Afterhte policy ill was based the VT Governor Shumlin realized that creating a financial plan was more complicated than anticipated, and allowing for-profit entities to remain became more expensive than vermonters could afford. That caused a loss of credibility.
44	Barbara Commins	How many commissioners hold Health/Insurance stocks? Same for CALPERS and CALSTRS. The investor money has to come from someone!!!
45	Christine Shimizu	AB1400 answers so many answers to these questions. It should be the center of our discussions.
46	John Douglas	EMILY OLANOFF: AGREED AGREED AGREED. Doctors should be prescribing meds, not patients “ask your Dr. about . . .”
47	Danett Abbott-Wicker	@Barbara, YES!!!
48	James Sarantinos	Dr pan said details matter. This is semantics. We can start with best existing systems and adjust in time. We cannot plan for everything until a system is in place
49	John Douglas	Christine Shimizu: YES AB1400!
50	Cheryl Tanaka	Thank you all. Please invite Anya Rader Wallack to speak!
51	Ellen Schwartz	@James Saranti -- yes, Dr. Pan is just looking at reasons to do nothing.

Count	Name	Comment
52	Danett Abbott-Wicker	@James, I disagree. Existing systems DO NOT WORK
53	Barbara Commins	Fee for Service Original Medicare improved with vision, dental and Long Term Care DO IT!!!
54	Ana Turetsky	Medicare is costing me more than I ever paid for health costs in my life and so I don't qualify for all the discounts in drugs and I don't get access to needed durable equipment. This is a huge problem. I'm in favor of single payer, nationalized health ins, but I cannot support a medicare model.
55	Zac McDonough	I believe that it is irresponsible and unethical to continue to have Senator Richard Pan involved in this commission. His contributions to this commission have been obviously motivated by the political and possibly financial incentives that are associated with him undermining this single payer discussion. His contributions to this commission have been obviously motivated by the political and possibly financial incentives that are associated with him undermining this single payer discussion. His contributions to this commission have been obviously motivated by the political and possibly financial incentives that are associated with him undermining this single payer discussion. https://www.followthemoney.org/show-me?dt=1&c-t-eid=13008437&c-t-id=238326#[{1|gro=y,d-eid,d-ccb
56	Danett Abbott-Wicker	Dr. Pan just gives lip service, that is all
57	Dr Bill Honigman	Thanks all. My full comments sent to commission by email.
58	Zac McDonough	https://www.followthemoney.org/show-me?dt=1&c-t-eid=13008437&c-t-id=238326#[{1|gro=y,d-eid,d-ccb
59	Martha Kuhl	Any new system should not include care coordination, integrated care and managing care that is based on financial incentives to limit or deny care to increase profits. Insurance corporations and some big provider systems both are in the business of making profits. AB 1400 would prevent denials of care based on the requirements of a market and the sale of health care as a commodity. Care must be based on health needs not $$$$ needs. Martha Kuhl RN
60	Ellen Schwartz	@Danett? You mean existing systems in Europe and elsewhere where costs are lower and health outcomes are better? I'll take that.
61	Danett Abbott-Wicker	@Zac, 100%!
62	Zac McDonough	Richard Pan's current term ends in 2022, in his 2018 campaign he collected: $17, 600 from the California Dental Association $8, 800 from Abbot Laboratories (Pharmaceuticals) $8, 800 from the California Association of Hospitals & Health Systems $8,800 from Gilead Sciences (Pharma and Medical Devices)

Count	Name	Comment
		$8, 800 from Pfizer $8, 800 from the California Association of Health Underwriters $8,800 from the California Medical Association $8,800 from The Doctors CO $8,800 from Blue Cross Blue Shield of CA $8,800 from the California Permanente Medical Groups $8,700 from the Pharmaceutical Research & Manufacturers Association of America
63	Danett Abbott-Wicker	@Ellen, me too!
64	Emily Olanoff	When Dr. Pan introduces himself and his background, he should also disclose that he has taken more than $1 MILLION from the private healthcare complex. https://www.followthemoney.org/entity-details?eid=13008437
65	Isabel Storey	I'm Isabel Storey, representing Indivisible California, a coalition of 80 groups statewide. Commissioners, thank you for focusing your deliberations today on a coordinated single-payer health care delivery and payment system. Though it's worthwhile to consider many options, the example of Vermont has limited application to California. And it may be just as valuable as an example of what didn't work. Single payer was never implemented in Vermont because the corporate healthcare industry was able to block it to preserve its profits. The three-year delay between the adoption of this as policy – and the consideration of financing – was a political failure and allowed the healthcare industry to thwart its implementation. The Vermont example points up the pitfalls of not considering delivery and financing options and moving them forward along with policy. I urge the commission to continue considering comprehensive healthcare systems with different methods of financing the costs of single-payer that can't be recou
66	Barbara Commins	GRAFT and CORRIPTION
67	Isabel Storey	Can't be recouped with federal dollars. We in California deserve no less.
68	Danett Abbott-Wicker	@Emily, thanks for bringing this forward
69	Dr Bill Honigman he/him	Commissioners please, do get on with the modeling and planning needed to move forward with our Single Payer system and AB1400. There are countless lives and precious resources to be saved, with the fierce urgency of now.
70	Nicki Davis	Thank you Jenni Chang!
71	Ellen Schwartz	@Danett -- you meant existing "systems" in this country don't work. Yes, and yet the powers in this state and in D.C. are afraid to try anything else. Because anything else would be bad for the insurance companies.

Count	Name	Comment
72	Danett Abbott-Wicker	@Ellen, I am talking about here in the US. Sorry I didn't clarify
73	Norma Wilcox	Norma Wilcox, Chico ACOs operating through a chain of hospitals, clinics, or groups of doctors that accepts more and more insurance risk becomes more like an insurance company that will require financial reserves and government regulations. ACOs have no place in a Classic single-payer bill.
74	Ellen Schwartz	@Danett - gotcha.
75	Danett Abbott-Wicker	@Ellen, :-)
76	Ana Turetsky	Also, I cannot support an HMO like Kaiser that has lack of transparency, takes advantage of labor groups, employs their own ombudsmen/women and is accountable to their own interests.
77	Christine Shimizu	@Zac WOW! Pan shouldn't be listened to. His is the voice of the opposition to SinglePayer: the health insurance companies, the corporate of hospitals, and the pharmaceutical companies. Pan - instead of accusing the doctors of waste by complying with patients' requests for drugs, how about fighting to get drug commercials off the tv's and then that the drug companies would lower their prices to reflect their "savings"
78	Jenni Chang	The insurance industry is coalescing to talk Healthcare reform, likely to counter our efforts to accomplish single payer in California. I hope our legislators on this commission DO NOT engage. We know they have invited Jim Wood and Richard Pan and other legislators as panelists.
79	Norma Wilcox	Norma Wilcox from Chico Could you send a link to the Taiwan single-payer bill?
80	Barbara Commins	Jim Wood$1 M in 10 years
81	Patricia Clark	Think how much money we could save if we didn't have insurance and pharma buying politicians??
82	*Rupa Marya	Also—PUBLIC SMOKING BAN
83	Barbara Commins	Richard Pan $1.5 in 10 years
84	Barbara Commins	Gavin Newsom $2M
85	Danett Abbott-Wicker	SHAME on Pan and Wood! No shame apparently
86	*Rupa Marya	Imagine if we did the same with pesticides.
87	Christine Shimizu	^^^
88	Christine Shimizu	SHAME ON PAN AND WOOD!
89	Mary Alice Bisbee	Amen.

Count	Name	Comment
90	Barbara Commins	Wall street Health/insurance in 2021 $$ 8.Tr. It was $2 Tr in 2010 before the ACA
91	Tracey Rattray	Many on today's call have mentioned the importance of outcomes-based payment and population health in re-designing health care delivery. Investing in health equity and community-based prevention programs is one of the best ways to achieve these goals. Just one example - the unequivocal success of tobacco prevention programs. Much of this success has been driven by partnerships between the state and community-based organizations working together to: a) reduce youth access to tobacco, b) increase taxes on tobacco products, and c) prohibit predatory marketing and other risks for tobacco use among communities of color and low-income Californians. The result - over 1,000,000 California lives saved and $134 billion in healthcare costs avoided by preventing chronic conditions such as heart disease, cancer and stroke that are associated with tobacco use. Imagine the decrease in health inequities and health care costs if we invested at the same level in community-based strategies to prevent diabetes.
92	Angela Gardner	The former Governor of Vermont tried implementing a single payer healthcare system during the Affordable Care Act which I feel competed with one another. Unfortunately, it was poor timing. His payment plan was a contract with Blue Cross Blue Shield, still involving private healthcare plans. He had lack of simple cohesive message about single player healthcare. He had too much fear about alienating insurance companies and lobbyist. He did not plan properly in developing a payment system run by the state.
93	Emily Olanoff	Blaming high healthcare costs on fee-for-service payments is a red herring. Numerous peer-reviewed studies have shown that our prices are too high in the U.S. -- not that we use more care from doctors abusing the fee-for-service system.
94	Emily Olanoff	There are several different mechanisms that can be used to hold the few providers who abuse fee-for-service reimbursement accountable under a single-payer system, and AB 1400 would establish these kinds of checks on all forms of reimbursement, including fee-for-service. For example, AB 1400 includes fraud prevention and enforcement mechanisms, reporting requirements that allow review of healthcare use and comparison across the entire state, measures that eliminate problematic payment incentives, and strong coding transparency features, as well as a duty of patient advocacy that requires providers to prioritize patient needs over economic factors.
95	Patty Harvey	Thanks for that, Angela! This should be more publicly shown!
96	Zac McDonough	Jim Wood's current term also ends in 2022 and is continuously pushing Health Information Exchanges, I would

Count	Name	Comment
		suggest that you check out all of his donors as well. Mckesson was one of his donors in his 2020 campaign. They are a massive medical information system company that builds info HIEs. Please have them removed, I'm tired of hearing them shilling for their donors. https://justfacts.votesmart.org/candidate/campaign-finance/71013/jim-wood
97	Christine Shimizu	thank you Mr. Douglas!!! We need to pass AB1400. get on the Office Hours Zoom call every Sunday from 5-7 to learn about AB1400!
98	Danett Abbott-Wicker	@Zac, AMEN
99	Zac McDonough	get jt phil!
100	David Leon	and overload the public system
101	Barbara Commins	Thank you, PHILLIP!!
102	James Sarantinos	Why aren't you discussing AB1400 and its funding? One plan will flatten out the kinks in risk. Insurance will cherry pick or deny care. We know this
103	Dr Bill Honigman	@Phil, absolutely. No more financial intermediaries, rationing care, and siphoning off precious resources.
104	Norma Wilcox	Norma Wilcox thank you Phil Kim.
105	Judy Rice	Health insurers are businesses that profit on use of our bodies isn't that a form of slavery? We are paying to be slaves of insurers--see those who have lost their jobs
106	Christine Shimizu	Thank you Zac!
107	Joni Simon	Thank you, Zak !!
108	Danett Abbott-Wicker	Thanks Zac and Phillip!!! Well said
109	James Sarantinos	Why ask a fox how to manage chickens.
110	Mary Alice Bisbee	As a Vermonter, thank you for the opportunity to hear you all!
111	Angela Gardner	Governor Brown eliminated Community Based Health Services and replaced it with Cal Mediconnect which California Dept. of Aging to develop a whole new system of services which they are still working on 10 years later. Gov. Brown wanted a cheaper program. They could have expanded the PACE program which was efficient and provided good healthcare outcomes. The Governor refused. He put money before patient healthcare needs.
112	John Douglas	Amen, James Sarantinos!
113	Phillip Kim	Thank you to all the single payer advocates speaking in support of AB 1400! Please be sure to join CNA's upcoming CalCare Statewide Strategy Call on July 22nd. https://bit.ly/CalCareJulyCall The politicians aren't going to do

Count	Name	Comment
		this on their own. It's going to take a movement! Let's do this!!
114	Jeffery Tardaguila	if you don't understand difficult in communication please contact me . jefftard22@gmail.com thanks
115	Mary Alice Bisbee	We are not all very happy with Shumlin who let us down!
116	Barbara Commins	This commission needs to have Medicare figure out how to give us a state ORIGINAL MEDICARE model. They are the experts. Fee for Service, not Capitation!!
117	Maria Behan	Rick Kronick presented dramatic numbers two meetings back, estimating that if CA had unified financing that used direct payment to providers, it would save $42 billion on administrative costs next year. Leave what he termed “health plans/health systems” in the mix, and those savings are more than halved. To raise a related question: If a bully were ripping off a child’s lunch money, what would you do? End the outrageous extortion? Or take up a collection so the community covers the bully’s demands? I hope the commissioners use their expertise and insight to disrupt the cycle that enables for-profit intermediaries to prey on patients and taxpayers. Please lay the foundation for a single-payer system that saves lives and money.
118	Dr Bill Honigman	@Isabel, good point. Vermont failed to implement, not administer their plan.
119	Stephanie Thornton	Stephanie Thornton with Community Health Councils: Thank you Secretary Ghaly, and the Commission members today who uplifted the need to prioritize care coordination and navigation. We hope to continue the conversation about the critical role of navigators and care coordinators in a unified system, and specifically how that workforce can support with managing chronic conditions and reaching communities in provider deserts and underserved areas of the state. We hope to have more discussion and time on care coordination and chronic disease management during the August Commission meeting on access and equity.
120	Barbara Commins	Great job, Ruth!!!
121	Dr Bill Honigman	@Ruth, absolutely. Medicare for All, now!!!
122	Mary Alice Bisbee	As a Vermonter, thank you for the opportunity to hear you all!
123	Angela Gardner	Governor Brown eliminated Community Based Health Services and replaced it with Cal Mediconnect which California Dept. of Aging to develop a whole new system of services which they are still working on 10 years later. Gov. Brown wanted a cheaper program. They could have expanded the PACE program which was efficient and

Count	Name	Comment
		provided good healthcare outcomes. The Governor refused. He put money before patient healthcare needs.

Total Count of Zoom Chat comments: 123

3. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address before the July 8th HCFA Commission meeting:

Count	Name	Comment
1	Gerald N. Rogan, MD	Dear Commission, I would like to learn about the realistic possibility that a "single payer/funder" system in California will have access to or control of Medicare funds, commercial insurance funds, corporate funds that underwrite medical care under ERISA, VA funds, and any other funding sources envisioned in the plan. In my view, none of these funds will be made available for control by a California single payer plan. The necessary legal changes will not be supported by the voters and relevant federal law will not change to accommodate the change. Our problems with medical care financing and delivery are not so bad that the changes a single payer/funding plan requires is warranted. California has already improved medical care delivery and value substantially by changing Medi-Cal financing into a managed care system. Increasing numbers of Medicare beneficiaries are choosing to assign their benefits to a Medicare Advantage plan. CMS is encouraging fee for service systems to improve value, with limited value improvement. Armed with realistic expectations, the Commission could focus on more practical solutions that might mitigate current deficiencies in medical care delivery and financing. I have provided several ideas based on my experience as a Medicare and Medi-Cal fiscal intermediary medical director, and from 23 years as a self-employed emergency, general, and urgent care physician, and as a volunteer physician for thenty clinic of Sacramento. Ideas include root cause analysis of medical disasters, effective medical staff peer review, changing medical malpractice litigation into an administrative law judge process for publicly financed delivery system, and providing sufficient funding of public health departments. The Covid Pandemic shows us that immunizations and vaccinations might be financed through public health departments than through medical care insurance financing. A California sponsored plan for Medi-Cal for all who want it may allow more workers to free themselves from the constraints of an employer based plan on a volunteer basis. If the State and its

Count	Name	Comment
		contractors can perform well, and providers accept the patients, the plan could succeed. If not, it should not succeed. Eliminating choice through a single payer constraint risks making access and quality of medical care substantially worse.
2	Gerald N. Rogan, MD	Sorry for the typos, but I was clear enough. When I was in private practice, my company provided urgent care services as an alternative to the emergency department at a retail price of 1/5 of the charge of the John Muir Hospital emergency department. We could not afford to accept Medi-Cal because the reimbursement covered only the overhead. The Innova medical care delivery outpatient facilities in Fairfax County do not take Virginia Medicaid recipients. Medi-Cal rates paid to capitalist physicians (those who invest in their medical offices and are self-employed) is the lowest in the Country expect for Mississippi. I suggest the committee focus on a plan to provide Medi-Cal for all who want it, instead of a single payer plan, as an incremental improvement, rather than risking total failure of your deliberations.
3	Gerald Rogan	In 2011 the State of California did not enforce an existing requirement that hospitals disclose in advance of the service its hospital outpatient facility fee. For example, UCSD hospital system failed to comply with State law following my complaint to L&C and its subsequent investigation. (I was an uninsured patient at a UCSD hospital outpatient facility.) I can provide evidence. In 2011 UC Davis hospital system also failed to disclose its hospital outpatient fees on line and in their offices. I know this because I visited one of their facilities and asked. I suggest the Committee ask DHCS and L&C about enforcement of current state law which requires facility fee disclosure in advance of a service. If our statute is not currently enforced, the Committee should consider whether the State of California can effectively manage all the money Californians pay for medical care.
4	Norma Wilcox	I am originally from Vermont and my brother and wife still live there. We had many conversations about the single payer movement which led to a bill which was signed by Governor Shumlin. Ultimately the package died due to political and management difficulties designing the financial part and not organizing an education campaign throughout the whole process.

Count	Name	Comment
		I called my brother to tell him that we would be discussing the barriers to the implementation of the Vermont plan during our next Healthy California for All Commission meeting. He sent me the policy review on the rise and fall of Vermont's Single Payer Plan. This article will help you prepare for the Commission meeting this Thursday
5	Melissa Beuoy	Dear Commission, I write to you today to advocate for universal healthcare with a single payer system that eliminates the insurance involvement. We must get profit out of our healthcare system and join the numerous other wealthy countries with a healthcare system that cares for all, not just those who can pay. This commission must study and propose different methods of financing the remaining costs of single payer that can't be recouped with federal dollars. I'm sick of the excuse "How do we pay for it?" We must eliminate the "intermediaries" with a profit motive and ensure all Californians are taken care of by our healthcare system. AB 1400 has specific structures for governance, reimbursement, etc. in the bill. Please focus on finding a method of financing that eliminates intermediaries.
6	Erin McNellis	Dear committee members, I am a resident of California (Long Beach, 90802) and I demand that California lead the nation in healthcare reform by adopting a single payer system with no insurance involvement. This is the only ethical way to distribute healthcare, and it's what every other civilized nation in the world does. It is shameful that in America and America only, a predatory insurance industry stands between people and their right to health care. With change unlikely to come from Washington, California must lead on this reform as we have on so many other issues. Thank you for your time and your service to our state.
7	Robert Vinetz, MD, FAAP	For Dr. Hsiao, here are several questions for July 8 meeting of the Healthy California for All Commission: What are the essential goals, values and features that you recommend HCFA needs to incorporate into whatever system(s) it recommends? What are the related important (but not absolutely essential) goals and values? What impact would a single payer system ("classical" 100% publicly-funded and/or a "hybrid" mix of publicly- and commercially-funded) have on the private practice of medicine...where physicians own their practices and are not employees? Could single payer help save or make private-practice more viable?

Count	Name	Comment
		What protections should be incorporated into a "classical" single-payer, a "hybrid" single-payer, or any system to minimize its disadvantages and risks? For all Commissioners and Consultants/Advisors: What are your thoughts about the usefulness of the below and attached "Tool for Rating the Goals, Values and Features of an Optimal Health Care System vs Various Proposed Systems"? It is intended as rating/scorecard tool for evaluating how well a particular proposed system or legislations meets the specified goals/values/features desired in a health system:
8	Edith Frederick	Single Payer means a single administrative cost. That underlines the key savings that no other plan offers, cost efficiency. One administration means a 3% cost which no other plan can come close to matching. That is the bottom line. No other plan can offer the same services at a lower cost because they all have multiple administrations. End of arguments
9	Susan Pelican	i support a healthcare for all with NO intermediaries-- one payer, all citizens in and no body out.
10	Richard Connelly	I support SB 1400 and single-payer health care financing.
11	Steph Cauchon	No risk bearing intermediaries. To reach the goal of providing an efficient and equitable health care system, we should not use “risk-bearing intermediaries” that might consider their financial risk in decision making. We need a cost-effective and patient-centered single-payer system. It’s long overdue for a healthy, vibrant democratic economy. Health care considerations stifle innovation and risk in career and business decisions. Lack of affordable and consistent health care weakens our communities and economy.
12	Richard Dawson	Is the purpose of the Healthy California For All commission to implement a system of universal health care in California, or just to spin its wheels and postpone the day when California provides for its citizens what most European countries, some with smaller economies than our own, provide for their citizens. The statement on your website.....work to develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to a single payer financing system," certainly sounds like the latter. Study after study has shown that a single payer system such as that proposed in SB1400 will provide universal, comprehensive care and will save money at the same time. Stop wasting time reinventing the wheel, and turn your attention to the remaining problem, how to finance it.

Count	Name	Comment
		I urge the committee to adopt SB1400 and turn its attention to solving the financing.
13	Patricia Clark	Instead of pondering different design considerations that AB 1400 already addresses, this commission should focus on studying and proposing different methods of financing the remaining costs of single payer that can't be recouped with federal dollars.
14	Edith Frederick	**Single Payer** means **a single administrative cost**. One administration means a 3% cost which no other plan can come close to matching. Single Payer means **no profits driving up costs.** All insurance companies are driven by profit making. That is the bottom line. **Single Payer is the most cost effective healthcare system** as proven by every other developed country that all have Single Payer Healthcare Systems.
15	Carole Roberts	I am writing in support of SB 1400. We need a single-payer health care system. Health care should be a right, since it's implied in the right to life. There are 3 million Californians with no insurance, millions more underinsured and we're in the middle of a pandemic. Private insurance companies add nothing but cost and complication to the providing of medical services. We should cut out the middleman. I hope that you will take the time to listen to the public before making a decision since we are the ones affected by health care decisions. Thank you for your time and consideration.
16	Mary Josephine Guzzetta	The Governor's Commission on Health is meeting this week and tomorrow is the deadline to submit comments on SB1400. We are asking everyone to send an email to the commission in support of SB1400. Talking points are below and here is the email to send comments: HealthyCAforAll@chhs.ca.gov We have an opportunity to move this forward but they need to hear from the residents that we want this passed. Every comment counts. Thank You, Long Beach Gray Panthers Talking Points on a Single-Payer Financing Plan

Count	Name	Comment
		Instead of pondering different design considerations that AB 1400 already addresses, this commission should focus on studying and proposing different methods of financing the remaining costs of single payer that can't be recouped with federal dollars. The commission should design an interactive calculator with various options for financing AB 1400, and how much each different financing mechanism would raise. This would make it easy for the public and legislators alike to weigh the pros and cons of the various proposed financing options and to see which combination of them would be suitable to fully fund the program. The most common question the public has about any sort of unified financing proposal is "how do you pay for it?" This commission should provide assistance in answering that question by creating a public online calculator with various combinations of financing options so that when crafting a system, legislators and the public can see different combinations of potential revenue sources and how they could be used to fund a single payer system. The commission should use some part of the consultant's contract to create a publicly available online calculator to explore multiple combinations of financing options for single-payer in CA. Let health care advocates, legislators, and other members of the public see what different types of progressive taxation would look like (in addition to federal funds). Talking Points about AB 1400 (CalCare) The commission ignoring AB 1400 is a mistake; it is a ready-made piece of legislation that can and should be used as a template for the commission's recommendations. Instead of ignoring AB 1400, the commission should model it. AB 1400 addresses most of the questions this commission has devoted its time to discussing. It addresses specifically how we reimburse providers, how governance works, what the waiver process would look like, and more. We've got your well developed blueprint for unified financing right here, friends. AB 1400, the California Guaranteed Health Care for All Act. It has specific structures for governance, reimbursement, etc. It's all spelled out in the bill. You just need to plug in the financing. "Unified financing" means health care financing comes from one source. That is just another way of saying single payer. And we already have a single payer bill, AB 1400. It's the only "unified

Count	Name	Comment
		financing" bill that's been introduced in this session of the California legislature. The whole structure of the statewide health care system is in the bill: a CalCare board to govern the system, comprehensive benefits, service delivery, it's all in there. This commission should use AB 1400 and work on completing it with financing when drafting its report. AB 1400 was introduced in the CA legislature back in February and it would create a single-payer health care system that would fulfill the mission of the commission. There are 3 million Californians with no insurance, millions more underinsured, and we're still in the middle of a deadly pandemic. You should model AB 1400 and help California guarantee health care for all in this urgent time of dire need. Single-payer now! Talking Points about "Intermediaries" "Intermediary" is another word for "insurance company." Insurers and other so-called intermediaries add nothing of value to our health care system: they do not increase access or quality, nor do they make care more affordable. In fact, they will likely include narrow networks with limited choice of doctors and hospitals. Insurers and other so-called intermediaries increase the cost of the system by maintaining our fragmented, multi-payer system with its large administrative complexity and higher costs. Insurers and other so-called intermediaries do not provide meaningful choices: the choice people care about in health care is who provides that care. Using intermediaries will likely mean narrow networks. Freedom to choose your care doctor or nurse practitioner is never positively impacted by an unnecessary middleman. Insurers and other so-called intermediaries "control costs" by denying and delaying health care., while increasing administrative costs and diverting money to profits, executive compensation, and shareholder dividends. Insurers and other so-called intermediaries are middlemen that make decisions on care based on the bottom line rather than on our health care needs as patients. Decisions on care should be made by you and your treating health care professional not by insurers or in corporate health care industry board rooms. Funding middlemen that interfere with the doctor-patient relationship is not unified financing to me.

Count	Name	Comment
		Don't model a system that has a role for health plans as "intermediaries". A system with a role for multiple health insurance plans would be neither single payer nor unified financing. Introducing so-called intermediaries--which is just another name for insurance companies and other risk bearing entities-- is not the "choice" that we want. We want to be able to choose our providers. There's no reason to sacrifice the quality of the system for the sort of "choice" that patients don't even care about. This commission has already identified deficiencies that come with a model that has a role for health insurers as intermediaries. Including an intermediary role for insurers is not the "choice" patients want. Patients want to choose their doctors and where they go for care, having a choice of insurers that pay for care on the back end isn't important to them. No reason to sacrifice the quality of the system for the sort of "choice" that patients don't even care about. This is how Merriam-Webster defines "unified." Definition: "brought together as one." It seems like if a "unified financing" system consists of multiple insurance plans or HMOs, then it is hardly unified financing. Furthermore, if some of the "intermediaries" are paid by capitation and have a financial incentive to deny health care, then I find that really troubling. Patient care decisions should be based on patient need in a system that lets medical professionals do their job without influence from managers trying to save money. Talking Points about Commissioner Objections to Single-Payer (for any objections to single payer not addressed below, see our full set of FAQs here) In response to the downsides of fee for service reimbursement Blaming high healthcare costs on fee-for-service payments is a red herring. Numerous peer-reviewed studies have shown that our prices are too high in the U.S. not that we use more care because of doctors abusing the fee-fee-for service system. There are several different mechanisms that can be used to hold the few providers who abuse fee-for-service reimbursement under a single payer system, and AB 1400 would establish these kinds of checks on all forms of reimbursement, including fee for service. For example, AB 1400 includes fraud prevention and enforcement mechanisms, reporting requirements that allow review of healthcare use and comparison across the entire state, measures that eliminate problematic payment incentives, and

Count	Name	Comment
		strong coding transparency features, as well as a duty of patient advocacy that requires providers to prioritize patient needs over economic factors. Provider payment options included in AB 1400, the current single payer proposal before the legislature, include more than fee for service. Under AB 1400, hospitals and other institutional providers would instead receive reimbursement through quarterly institutional global budgets that are tailored to the needs of the provider's patients. Only individual providers are eligible to accept reimbursement on a fee-for-service basis, and individual providers can opt to receive negotiated salaries instead of fee for service payments. Providers eligible to receive reimbursement via fee-for-service can also opt to be paid a negotiated salary directly from the single payer system under AB 1400. In response to the arguments in favor of capitation/value-based/risk-based payments (see also talking points on "intermediaries") On the whole, so-called value-based payments have not been shown to save money or improve quality, but have been shown to penalize safety net hospitals and doctors caring primarily for patients from black, brown, and low-income communities. A reimbursement model predicated on capitation, risk-based payments, or financial incentives changes the doctor-patient relationship from one based on care to one based on economics. These payment schemes corporatize the practice of medicine and health care. Capitation pays the same amount to a provider or group of providers for each patient regardless of the amount of care actually provided--this model creates an incentive for providers to reduce costs by reducing care. The incentive to cut costs under capitation results in reduced time for patients to see their doctors, and encourages limiting referrals, testing, and treatment. In other words, capitation leads to rationing of care and rewards providers when they ratio care. Capitated payments, risk-based payments, and so-called "value-based" payments are administratively complex, burdensome, and expensive. These payment schemes incentivize and hasten health provider consolidation and concentration because large health care corporations have more resources to game the administratively complex and burdensome reporting metrics of these payment schemes.

Count	Name	Comment
		In response to the argument that the government would deny care under a single payer system The business of private health insurance is built on the denial of care. Our fragmented system of private health insurance views health treatments, life-saving medications, and each and every doctor's visit or diagnostic test as a liability to their bottom line. To increase profit margins, health insurers erect every barrier to stop patients from going to the doctor or hospital. They create complex schemes to deny care. Denial of care is what copays, deductibles, preauthorizations, and provider networks are meant to accomplish. Rationing and denial of care occur today under our system of private insurance. This is often self-imposed because people cannot afford health care. Even those who have insurance delay care because they cannot afford the copayments or deductibles. Because financial barriers imposed by premiums, deductibles, and cost-sharing would be eliminated under a single payer program like AB 1400, self-imposed delays in care related to affordability, which are common in our current private insurance system and public programs, would no longer occur. A single payer system under AB 1400 would prevent denials of care as a result of budget cuts by making all necessary and appropriate care a right for every resident of California. If designed correctly, like AB 1400, a single payer system would place health care decisions into the hands of patients and their health care professionals rather than in the hands of insurance companies, and healthcare corporation boardrooms. It's the responsibility of the lawmakers on the Commission to protect the professional judgment of doctors, nurses and other health care professionals when designing a single payer system so that government bodies cannot single-handedly slash budgets and deny care. AB 1400 should be your model on how to do so. Talking Points about the Commission Process There is a severe lack of transparency in the commission's process. Too many critical conversations are being held by hired consultants behind closed doors. The commission's work lacks public input and meaningful community engagement. The commission is not even planning on talking about whether to seek community engagement until the fall when the commission's work is almost complete. Last year, there was a lack of adequate public discussion by commissioners and lack of public feedback on the commission's

Count	Name	Comment
		first report. The incredibly important topic of health care in California should be discussed and debated in an open and transparent manner. The commission's final report should be made public well in advance, so there is adequate time for engagement, discussion, and debate before it is adopted. The commission is going out of its way to not put forward a strong recommendation for single payer health care, despite overwhelming demand from those who attend these meetings and make public comment that they do so. Ultimately, it appears that much of the work of this commission, rather than intending to have genuine discussion on reaching solutions to guarantee health care to all Californians via single payer health care, is actually an attempt to deflect and distract proponents. More of the commission process and the role of the consultants should be made public. We keep talking about "stakeholders" but the ultimate stakeholder of health care reform is the public at large. There needs to be a public discussion on the analysis and design options. It seems like the consultants are just making decisions on their own without real input from commissioners or the public. Aside from this very limited public comment, will community members and the public have a chance to engage directly with the commission on what we think is important for a single-payer health care system? What happened with the commission's plans to meet with various community groups? It's important that the commission has a chance to substantively engage with real world constituencies in the community. What happened to the plans to meet with community groups? Commissioners should be meeting with the community based organizations, who advocate for people of color and low income populations, as a priority. The health care system does not belong to the legislators, it belongs to the people. It is the public that you should be having meaningful engagement with to get their feedback on what they're looking for in a single-payer health care system. Also, whatever feedback has been provided by stakeholders should be made available to the commissioners in an unbiased format.
17	Mario Yedidia	Dear Commissioners, In light of your forthcoming discussion about integrated care, we wanted to share our union's experience and perspective. This is a crucially important topic, and one that deserves clarity and nuance.

Count	Name	Comment
		UNITE HERE represents over quarter of a million hospitality workers, including 50,000 in California. Our not-for-profit health plans administer coverage for the big majority of those workers and their families – not just in the US, but also in Canada. We spend enormous energy trying to make a broken health care system work for our members. To be clear, we do not believe there is a place for risk-bearing managed care in a single payer system. No health plan should be incentivized to profit by withholding needed services. However, we cannot afford to throw out the baby with the bath water. Well-coordinated care is essential both to the wellbeing of enrollees and to the fiscal stability of the overall health system. Ours is a union largely made up of people for whom English is a second language. When they are given a choice, large majorities (in excess of 70%) consistently choose integrated care systems for their health coverage. Many find such systems easier to navigate, with less confusion finding the right providers and services. Care coordination goes beyond navigating a complex system, though. It is essential to receiving effective treatment. Our union has invested in programs that try to ensure medical advice is followed up on, and that bridge the gap between medical offices and people's homes and workplaces. When someone is diagnosed with prediabetes, persistent follow-up is often necessary to make sure they consult with a nutritionist – especially when the person is working two jobs and raising a family. When the nutritionist's recommendations are poorly received at the family dinner table, peer support makes a big difference in helping the person integrate health advice into their daily life. None of this coordination happens effectively in a consumerist style health model, where enrollees have to find their own way from provider to provider. California needs a single payer health system that supports institutions that organize care. Again, that should not be done in a way that incentivizes providers to withhold services. But nor should providers be allowed to write their own paychecks. Outside California, where fee-for-service reimbursement is the norm, our health funds have struggled to deal with providers that pile up unnecessary services. They are a minority, but such providers inflict huge costs on the health system. Just as bad, they undermine patients' confidence in the advice of practitioners in general. UNITE HERE health plans have had to invest heavily in systems to discourage this kind of behavior, going so far as to

Count	Name	Comment
		establish clinics of our own to give patients a choice when they no longer trust traditional providers. Our union certainly isn't alone in confronting these problems. Indeed, the earliest efforts to organize care and keep it accountable grew out of the labor movement – witness the health system the Mine Workers built in the 1940s. The universal, single payer health system we need in California should build on those experiences, not turn back the clock. Medicare for All in California cannot come soon enough. The financial costs of our current insurance system are devastating. The human toll is worse, as we saw when tens of thousands of our members lost health coverage last year in the midst of a global pandemic. We hope the Commission will move quickly to recommend what a single payer system for our state would look like, and we hope you will make sure that system properly serves and is accountable to ordinary working people.
18	Jim Burfeind	My name is Jim Burfeind and I live in Chico, CA. I'm a volunteer with the Butte County chapter of the National Alliance on Mental Illness. Last night we had a meeting of our Family Support Group and a mother tearfully described two instances where her son was denied mental health treatment because he had Medical and not private insurance. Type of insurance should not be a factor in medical treatment. I agree with the comment at the last meeting that there is no reason to re-invent the wheel in designing a reimbursement system. AB 1400 provides a good starting point. Here are three principles to include: Guaranteed access to healthcare, including mental health, with no insurance company interference. Establish a single standard of therapeutic and equitable care. Provide treatments based on patient need and medical necessity, solely determined by the provider.
19	Henry Abrons, MD	Mark Ghaly, MD, MPH and Commissioners Healthy California for All Commission July 6, 2021 Dear Commissioners: A focus of the July 8 meeting of the Healthy California for All Commission will be Vermont's efforts in 2010-2015 to adopt single payer health care.

Count	Name	Comment
		We are attaching two articles analyzing Vermont's experience. They conclude that the failure to enact single payer was primarily a political failure, as subsequent studies demonstrate that it would have resulted in cost savings to most Vermonters. From Vermont's experience we can conclude that the following are essential elements of a successful state-based single payer program: - education of state residents to understand the benefits and net cost savings of single payer; - waivers to put contributions to federal healthcare programs into the state-based single payer fund; - and stable political support for elected officials who champion a state-based program. PNHP-CA is concerned that the Commissioners might be asked to misinterpret Vermont's missteps as evidence of either political or economic infeasibility of single payer. That would be a false narrative. It is better to regard Vermont's experience as lessons learned, and move forward with single payer for California. Sincerely, Kathleen, Healey, MD Corinne Frugoni, MD
20	Collin Thormoto	Dear Healthy California for All Commission, I hope you are well. My name is Collin Thormoto, and I'm a resident of Hayward, California and I am writing in regards to the use of "risk-bearing intermediaries" in our healthcare system. When considering healthcare from an economic standpoint, I understand that it is important to look at multiple models of care. Around the world, there are many different countries using many different systems, and they all warrant exploration. However, I have grave concerns about including risk-bearing intermediaries (hereafter referred to as "private insurers") in any universalized healthcare plan because they have economic incentives to deny care to people to avoid paying money for that care. While I understand that Germany, and likely other countries as well, has a system which allows private insurers to operate, they need to be heavily regulated in a way that, given this country's history with lobbying, seems problematic to implement. This is also a more expensive model as there will continue to have to be layers of administrative costs to fight insurance disputes, do medical coding, and any number of other things that are necessary whenever private insurers are involved. Instead, I encourage the Commission to consider a single-payer public plan for all Californians. This has the benefit of increased oversight as a public agency, no incentive to deny care to

Count	Name	Comment
		anyone as it is not a for-profit entity, and has significantly reduced administrative costs as it would be the primary insurer for most, if not all, Californians. A single-payer plan also has the benefit of allowing Californians the freedom to continue using whichever hospital or doctor they choose (as opposed to a NHS-style plan). So with all that said, I want to encourage the Commission to reject the idea of using risk bearing intermediaries of any kind and instead consider a public single-payer program. It will be more equitable, less expensive, and require legislative effort. Thank you for your time and I look forward to one day having the opportunity to live in a state with affordable healthcare for all. Regards,
21	Judy Reynolds	Please do not include health plans or health systems to act as "risk-bearing intermediaries" in any way that could interfere with the direct payment model of a single payer health care system. Considering financial risks in making health-care decisions has, in the past, resulted in a more expensive and less reliable health care system (think private insurance companies). Health care for all means a single payer system that pools all healthcare dollars with one standard of care for everyone without risk-bearing intermediaries.
22	Jean Severinghaus	Regarding your meeting today on Single Payer I am very concerned about this threat: The words, "risk-bearing intermediaries," suggest **a possible role for private plans, accountable care organizations, or others that might take into account their financial risk when weighing care decisions and are historically inequitable.** This could be a serious threat to a well-designed, cost-effective, and patient-centered single-payer system. My late father Dr John W. Severinghaus, Professor Emeritus of Medicine at UCSF, noted in a recent interview that California has 9000 health insurance companies who pay 9000 CEOs. This leads to our wasting 30% of our health care money on intermediaries. A world famous anesthesia researcher, he pointed out after a long career that we now have excellent scientists, but no funding to pay for research because the waste on intermediaries prevents us from investing in critical life saving research. Please do not include intermediaries in our single payer California plan. Make it truly single payer by our government. Thank you for your consideration.

4. **The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address during and after the July 8th HCFA Commission meeting:**

Count	Name	Comment
23	Alberto Saavedra	Why not AB 1400? Let's do it.
24	Jerry Rogan, MD	Peter Shumlin mentioned the need to reduce costs to deliver medical care. Please consider establishing a state sponsored plan (Medi-Cal Plus) in which medical care is delivered only through managed care delivery systems, which will grow based on popularity and competent administration. If we have Medicare for all, it should be delivered exclusively through managed care delivery systems, in order to control costs. (Beneficiaries who have elected traditional medicare will object) If the State is to take control of Medicare dollars, I want to be assured the State of California is as competent as CMS to administer the benefit. Performance matters, not promises. I suggest you leave Medicare alone. Medicare works, so leave it alone. Focus on those persons who are not on Medicare for eligibility for the Medi-Cal plus program. If you must have the Medicare money to make the rest work, I fear the Medicare allowances to managed care plans will be reduced, which will jeopardize my benefit. Can we fix the financing system before we control costs, or not? Governor Shumlin says NO. Change from FFS to an outcome based system of reimbursement from providers. Dr. Rader can talk about this effort. Per capita payment system, not fee for service. Control denial of care to prevent abuse. Will capitation work to reduce medical care costs? Yes, the State must contract out the payment process, not run it directly. No problem- Medi-Cal and Medicare both use fiscal intermediaries. Medicare works, so if you leave it alone, there will be less unhappiness. Focus on the unmet need, which is not Medicare beneficiaries. Fee for service does not reward healthy outcomes. We cannot fix our medical care system without eliminating fee for service. So start with managed care for those who want it through Medi-Cal plus. I elected Medicare Advantage because my health outcome is better than under traditional Medicare. Plus my managed care

Count	Name	Comment
		provider is more willing to improve than were the docs where I worked in FFS in Walnut Creek. I have stories to tell if you are interested. Bill Hsiao talked about increasing the benefit package and reducing copayments- which increased the costs.
25	Wesley Falatoonzadeh, RN Case Manager	Hello, Please submit the following as my public comment for today's commissioner meeting: I am a primary care registered nurse case manager working at the Anderson Valley Health Center here in Boonville, California. I graduated from UC Berkeley, then UPenn and have trained at UCSF and the San Francisco Department of Public Health. I work every week within our current healthcare system and a significant driver of poor health outcomes derives from our multipayer, pay for service, fragmented financial structure. The system we have now is hurting people and it is hurting them disproportionately. I struggle everyday working around insurance companies, around a fragmented and incomplete safety net, around a broken healthcare finance system to provide my patients with what they need to survive. We need change now. I urge the commission to work more transparently, and in public view. I urge the commission to push hard for a single payer system without intermediaries. I urge the commission to use AB 1400 as a model to develop guaranteed healthcare for all. As both a provider of services and healthcare consumer, we need what has been proposed by AB 1400 to provide ethical and affordable healthcare to our constituents! To expose some fragmentation in our system here is a list off the top of my head of entities I am forced to navigate to provide necessary services to my patients: Dozens of private insurance companies each with different formularies, reimbursement rates, authorized services, pre-approved providers that confuse my patients with formulas of premiums, co-pays, co-insurances, out-of-pocket maxs, in-network vs out-of network, prior authorizations, covered vs non-covered benefits, gap insurances, etc. MediCare Part A,B,D,… - Secondary Insurances - MediCal/Medicaid - Emergency MediCal - Managed MediCal - Partnership Health Plan

Count	Name	Comment
		- Beacon Health Services - Operation Access / Aunt Bertha (findhelp.org) - CHDP - Family PACT / Every Woman Counts - Lions Eye Foundation - RQMC - Sliding Scale Fee Programs - Hardship Fee Waivers - Hospital Charities - Community Foundations (Angel Funds) - Optum RX - Express Scripts - Veterans Affairs - Various Community Non-profits - Kaiser Permanente - Specialty Pharmacies - DME Suppliers We need to simplify our system to a single payer by using AB 1400. Please help.
26	Dessa Kaye	Thank you, Gov. Shumlin: The work to create a single-payer system and the people who did the work already exist; you don't have to reinvent the wheel!!!
27	William Honigman, M.D.	Commissioners, I would like to add testimony to the subject of “integration and care coordination” in particular as regards HMO’s. As a retired Emergency Room Physician who practiced in the provider group model known as Permanente Medicine for over 30 years, I can tell you that the provider side of that organization was excellent and exceptional. We were entirely focused on the quality of care delivered to our patients, using scientific evidence-based shared best practices in interdisciplinary teams to keep our patients healthy, true to the original idea of a “Health Maintenance Organization”. However, the side known as Kaiser, and specifically the “Health Plan” business side that limited resources to us as providers, was where all of our frustrations were. During my tenure there, insurance products like copays and deductibles were introduced to entice market share that undermined our practice model of keeping our members healthy. That insurance side of Kaiser is the part that needs to be reformed, to exclude that third party or “intermediary” as I believe you are using the term. Without the commercial insurance function of Kaiser Permanente, I’m sure it could carry on exceptionally well in a Single Payer or unified financing system, and truly thrive.

Count	Name	Comment
		So, please, do get on with the modeling and planning needed to move forward with our Single Payer system and AB1400. There are countless lives and precious resources to be saved, with the fierce urgency of now.
28	Chrys Shimizu	Hello, Anthony Wright made a comment that we shouldn't make patients deal with a buyer beware system when we leave the health insurance system...the current system is worse than a buyer beware system. The current system forces patients to go to whoever the insurance company allows them to go to and my personal experience is that the providers my insurance made me use have often been less than ideal for me. His reference to "protections" that health insurance provides, is misleading and false. Allowing people to choose their providers and change providers to whomever they like if they aren't happy is a much more sane and compassionate system.
29	Chrys Shimizu	Don Moulds asked about what would happen to the areas that have so few providers that even CalPERs (he is the Chief health director) can't put together an HMO. If this commission would look at AB1400 his question would have been answered. AB1400 actually addresses this and lays out a plan for getting hospitals that have been closed to be opened again and for building new hospitals in places where they are badly needed.
30	Chrys Shimizu	Senator Pan dwelled on the definition of "waste" in healthcare. He referred to providers complying with requests from patients for drugs that the provider doesn't really think the patient needs. This really isn't the waste at all. The waste happens when providers have patients go through a bunch of expensive tests that they don't really need in order to be able to bill for those tests. That is purely because of the way the health insurance system is set up. Providers writing prescriptions for individual patients' requests is miniscule and probably not really a problem compared to this. Let the providers deal with their patients. The intermediaries do not have an MD and have no place deciding what providers should comply with or be incentivized to do.
31	Chrys Shimizu	Mr. Scheffler's said that you have to have capitation in order to have an integrated system. I disagree. A global budget would make an integrated system very possible.
32	Jorge De Cecco	Dear Commission: Health insurance companies should not operate. Calling them "intermediary" does not help the discussion. “Intermediary” is another word for “insurance company.” The switch from discussing “intermediaries” to discussing managed care, accountability, integration, and care coordination feels like a Trojan horse to have the same conversation, but make it more palatable.

Count	Name	Comment
		Single-payer is the way to go. With single-payer, we can provide comprehensive care to all Californians while saving money by eliminating administrative waste and increasing bargaining power to reduce healthcare costs, including prescription drug prices. In contrast, managed care increases administrative waste and divides the risk pool, dividing our power to negotiate for fair healthcare prices. The process of receiving health care is never positively impacted by the existence of middlemen who profit from denying or limiting care. If we're talking about unified financing, the system should look like one single entity that finances all essential care, that pays doctors or institutional providers directly for care. In other words, a single-payer system. All too often, when people say "managed care" or "care coordination" they mean "allowing middlemen like insurance companies or accountable care organizations to do the coordinating," which results in denial of care. Our care providers should communicate and collaborate with each other, and there are ways to make sure healthcare practitioners are fairly compensated for doing so, such as paying them for the time they spend engaging in care coordination work. But care coordination should never be done by an entity that profits from denying or limiting care. Insurers and other so-called intermediaries or care managers add nothing of value to our health care system: they do not increase access or quality, nor do they make care more affordable. In fact, they will likely include narrow networks with limited choice of doctors and hospitals. Insurers and other so-called intermediaries or care managers increase the cost of the system by maintaining our fragmented, multi-payer system with its large administrative complexity and higher costs. Insurers and other so-called intermediaries or care managers do not provide meaningful choices: the choice people care about in health care is who provides that care. Using intermediaries will likely mean narrow networks. Freedom to choose your doctor or nurse practitioner is never positively impacted by an unnecessary middleman. Thanks you for the opportunity to make these comments.
33	Chrys Shimizu	Sara Flocks spoke in direct opposition to RN Carmen Comsti when she said she didn't think that doctors or providers should control care coordination. I agree with Ms. Comsti and

Count	Name	Comment
		completely disagree with Ms. Flocks. Only the providers will know what the patients need. Thus it's only appropriate for providers to coordinate the care of the patient. It's much less work and in the end much less complicated for providers than the current system when they would like to influence the coordination of patient care but are hamstringed by a Health Insurance representative telling them what their patients can and cannot have. In fact, the providers spend way more time fighting for appropriate care coordination as things are now.
34	Gerald Rogan, MD	All managed care is capitated. In my experience, capitation does not work for the provider when the delivery system has a fee for service mentality. The capitation amount is too low- there was no effort to be efficient. My experience was with HEALS 1990-1995. The mentality was fee for service. There was no provider integration. Each doc tried to game the HMO to maximize reimbursement. They did not work together or help each other. If the capitation payment amount for an individual person is based on his/her illness burden, cherry picking of healthy patients by the plan may go away. Efficient delivery systems may prefer to enroll sicker patients in order to generate higher profits. When I was in primary care practice, HEDIS measures did not measure excellence in medical care, such as making the correct diagnosis or applying the correct treatment. Measuring the latter is difficult. Measuring process is easier. Kaiser offers good care coordination- a person was assigned to my family member for this purpose- not a PCP. When I was a PCP in a FFS payment system, I provided this service to my patients without pay because it created good will and brought me more patients. I could not afford to take Medi-Cal patients. A fully integrated provider network paid by capitation will be able to address Anthony Wright's concerns. Government oversight cannot provide this service. For clarification, a delivery system and a financial system are different. A unified financial system is not the same as a unified delivery system. Do not confuse the two. (Comment on Don Mould's comment). Rural Care: You might motivate hospitals in Chico and Redding to form integrated delivery systems. - Maybe offering Medi-Cal plus delivered only through managed care will provide the motivation? Comments to Carmen Comsti- administrative costs are not high enough to reduce costs of medical care significantly. But to reduce administrative costs, payment by capitation may help.

Count	Name	Comment
		Even if the State ran a Medi-Cal for all who want it, it will require administration. If it is via FFS, DHCS has been there done that and rejected it in favor of managed care. Global budgeting of hospitals is not going to motivate efficiencies. Managed care will. Staff inside a hospital are best situated to recommend efficiency improvements. Example, KP required THA patients to have their dental cavities fixed 2 months before surgery in order to reduce the post-op infection rate. Bar coding of the patient and the drug may reduce pharmacy errors. Higher capitation adjusted by poverty areas makes sense. Integration of care is the key. Government monitoring of hospitals under a global budgeting system to save costs will not work, based on my experience. DHCS did not monitor outlier doctors in Redding. Ms. Comsti puts too much faith in government oversight. Sara Flocks- Medicare does not pay providers to remotely monitor patients to assure medication compliance. Lots of companies have asked me to help them gain coverage from Medicare for remote patient monitoring to assure compliance with medication and physical therapy. Coverage of this service will run up the bill. There is no evidence of improved health outcomes. At some point, patients must be accountable for their own actions. Kaiser is now automatically sending me E-mails to remind me to order my medication refill to assure I do not run out. This discussion was the best ever.
35	Jerry Rogan, MD	Peter Shumlin mentioned the need to reduce costs to deliver medical care. Please consider establishing a state sponsored plan (Medi-Cal Plus) in which medical care is delivered only through managed care delivery systems, which will grow based on popularity and competent administration. If we have Medicare for all, it should be delivered exclusively through managed care delivery systems, in order to control costs. (Beneficiaries who have elected traditional medicare will object) If the State is to take control of Medicare dollars, I want to be assured the State of California is as competent as CMS to administer the benefit. Performance matters, not promises. I suggest you leave Medicare alone. Medicare works, so leave it alone. Focus on those persons who are not on Medicare for eligibility for the Medi-Cal plus program. If you must have the Medicare money to make the rest work, I fear the Medicare allowances to managed care plans will be reduced, which will jeopardize my benefit.

Count	Name	Comment
		Can we fix the financing system before we control costs, or not? Governor Shumlin says NO. Change from FFS to an outcome based system of reimbursement from providers. Dr. Rader can talk about this effort. Per capita payment system, not fee for service. Control denial of care to prevent abuse. Will capitation work to reduce medical care costs? Yes, the State must contract out the payment process, not run it directly. No problem- Medi-Cal and Medicare both use fiscal intermediaries. Medicare works, so if you leave it alone, there will be less unhappiness. Focus on the unmet need, which is not Medicare beneficiaries. Fee for service does not reward healthy outcomes. We cannot fix our medical care system without eliminating fee for service. So start with managed care for those who want it through Medi-Cal plus. I elected Medicare Advantage because my health outcome is better than under traditional Medicare. Plus my managed care provider is more willing to improve than were the docs where I worked in FFS in Walnut Creek. I have stories to tell if you are interested. Bill Hsiao talked about increasing the benefit package and reducing copayments- which increased the costs.
36	Al Lubow	I'm with HCA-Ca and missed most of meeting. How can I view the recording. **And,** thx for all you're doing. It feels like the direction/thrust has improved appreciably in dealing with this difficult and complicated issue.
37	Cheryl Tanaka	Please invite Anya Rader Wallack to speak! Did feel today's meeting highlighted the diverse and impressive backgrounds of committee members. And we cannot say that the group is not politically diverse as according to chat at least 2 members are funded by insurance and other 3rd party interests. Right now centuries of historic, systemic racism/ethnocentricity and inequity weigh heavily on everyone. We would like to work to right as many of those wrongs as possible. We just have to remember that it's one baby step at a time. And as we've seen during this pandemic, that healthcare is an international/national/public/community health and safety issue.

Count	Name	Comment
		Appreciated Don Moulds' comment that while we talk about various "healthcare systems," the US does not have a national healthcare system. Sadly even though nationalism is a cause dear to many hearts, that does not include a national healthcare system. Appreciated Rupa Marya's comment that the commission is imagining (into being) a system that does not currently exist. Therefore I'm hoping that things won't be set in stone as we'll need flexibility and the ability to make and repair mistakes as we all work together to co-create a system that can work for everyone. So maybe a periodic review and amend clause/system also needs to be written in. There are many organizations which are providing coordinated/integrated and/or community based healthcare. I don't see how they are at risk if the basis for what we are talking about is a single payer (not provider) system. It should be a relief to Kaiser (if it is willing to become non-profit), et. al. not to have to worry about billing multiple insurance companies and government agencies, although I don't believe they or any provider can do away with their billing department. We know that President Obama's push for the ACA was that his mother could not get insurance because she had cancer. No organization should be able to deny or delay care especially for those in dire need. (Believe the GOP calls those death lists as indeed they are.) They also cannot be allowed to gouge those in dire need. Because I have a pre-existing condition, I had to go back to work for a time to pay for my increased ACA premium which cost 1/3-1/2 of my income. I still had to pay any deductibles, co-pays and for dental and vision separately. Another tenant of Single Payer is that healthcare be non-profit. We can look to the Mayo Clinic as an example where all staff are salaried and payment is on a sliding scale according to ability to pay, so that those who can pay more help cover the costs of those who cannot. In general we are talking about redistribution of wealth. If we have a general pool of funds, and know/assess community needs, we can do that also. Another tenant is coverage from womb to grave and across the whole spectrum, medical, pharmacy, vaccinations, mental, dental, vision, hearing, long-term care, traditional and non-traditional. Medicare covers Parts A and B. You still need supplemental and part D insurances along with dental, vision, hearing. We need to provide universal basic coverage. For those who want more there is already "medical tourism" and repairing leases to international "spas" which in the past also included safe and hygienic pregnancy terminations while those less fortunate

Count	Name	Comment
		went to questionable practitioners in dubious locations or tried to take care of things themselves with deadly results. It would be great to have a "medical home" where you could go to get any services you might need. Currently many doctors are affiliated with Kaiser, an HMO or a hospital, so you can get services within that "network" or outside it. We are all required to have a PCP who is supposed to coordinate our care and in the instance of an HMO must make referrals. A coordinated/integrated system is best. The Cancer Centers of America boast that type of care for a disease that requires a multi-prong approach as does mental health/substance abuse/homelessness and the process of living and aging. There does need to be better data collection, analysis and sharing. Community healthcare clinics/organizations/groups can play an important role helping inform local hospitals about community needs: how many women are expecting and when for prenatal and delivery, how many children are there for childhood illnesses/vaccinations, how many elders, what illnesses are prevalent, what preventative care/education is needed, etc. There's a long way to go to make up for centuries of historic/systemic abuses and neglect. This is one important step.
38	May Kandarian, MPH	Thank you for streaming the meeting. Direct Payment Single Payer only No HMOs No “Risk Based/outcome metrics No financial incentives Profit making entities out of healthcare. Direct Payment Single Payer only Please invite Anya Rader to the next meeting.
39	Linda Chapman	I will be participating with CARA's San Francisco CAT meeting at the time of the July 8 commission meeting. I have conveyed to CARA how alarming it is to see a nonprofit group usurp authority of the state by renaming a government appointed commission, in messages that demonstrate intent to confuse the public. The recent commission meeting made clear the intended function is NOT to impose on Californians a fee-for-service model that is the fundamental cause for our country's incurring costs double what comparable nations pay-- and experiencing worse health outcomes. As a former federal benefits specialist, educated in how providers focusing on profits exploit fee-for-service Medicare,

Count	Name	Comment
		and the bodies of their patients, leading the government to respond by diverting beneficiaries from "traditional" Medicare to Kaiser and other HMOs-- As an observer of the malpractice and suffering that FFS providers inflicted on my friends and relations-- As an observer of unscrupulous doctors who billed Medicare for patient contacts serving no medical purpose, each time Kaiser referred me out-of-plan to FFS operations-- As a victim who was originally driven to enroll in the prepaid managed healthcare system by malpractice of three specialist physicians conspiring to extract every cent a FFS health plan would pay for their harmful, extensive responses to minor symptoms that a Kaiser doctor later resolved with advice to drink more water-- As a 50-year observer of practices in a prepaid managed healthcare system-- As a consumer of any information that is readily available about the fraud and bad care perpetrated by FFS providers and the alternative systems of comparable nations with universal healthcare, which generally are not FFS-- I find it concerning to hear the confusion and denials expressed--during and after a recent commission meeting--by proponents of the fee-for-service systems: AB 1400; "Medicare-for-All," which is no more than a campaign slogan some senators adopted in reaction to Senator Warren's call for developing a Single-payer system. Worse-- I saw non-profits encourage threats to the governor's election prospects, should he fail to inflict their preferred model of FFS healthcare on our whole population. I heard advocates of FFS models pronounce the reverse of conclusions that were actually stated in Q and A between the commission and its expert presenter-- which exposed negative consequences from doctors exploiting a FFS system that was adopted for Taiwan when "we were not able to win enough support" for the alternative.
40	Gerald Rogan, MD	Dear Committee- I listened to the last two calls. Thank you for the opportunity. I recommend the committee consider a "Medi-Cal for all who want it" plan. It would be financed by general tax revenues and subscriber premiums. It would provide a benefit package no more robust than Medi-Cal provides. Its delivery system would be exclusively through integrated managed care provider groups-no fee for service. It would not replace existing plans, but would compete with them for subscribers. It would not provide 100%

Count	Name	Comment
		reimbursement without a copayment. Its fee schedule would be consistent with Medicare reimbursement rates, and sufficient to motivate providers to open outpatient clinics in underserved areas. I recommend leaving Medicare revenues alone because it works, and many beneficaries are likely to object to comingling their benefit with others who currently are ineligible. I recommend against a single source of funding because that solution has not been shown to be necessary to fix our current problems. The potential reduction in overhead by changing a fee for service payment system from commercial plans to a government plan is unproven and may be a fantasy. Commercial plan profits are not large enough to finance the current unmet need. Instead, we must find a way to reduce the total expenditure for medical care. I recommend the committee consider other solutions to address the issues brought before it, for both quality improvement, better access, and cost containment. I propose the following considerations: - Improved effective hospital medical staff and outpatient peer review to improve quality and reduce provision of medically unnecessary services. - Clinically relevant measures of quality outcomes (v. process measures) to identify top performers who others may emulate. - Removal of medical malpractice litigation regarding medical care financed by government sponsored plans to an administrative law judge process unless the plaintiff agrees to pays all the costs of the litigation when the verdict is for the defense.. - Elimination of direct to consumer advertising of prescription drugs. - Drug formula limitations of coverage. Medi-Cal, Medicare, and California connect would remain unchanged.
41	Gerald Rogan, MD	Instead of adopting the current Medicare physician fee schedule for a new plan "Medi-Cal for all who want it", the Committee should consider altering it to address overpayment for procedures and imaging and underpayment for cognitive services. The current medicare fee schedule is based on findings of the relative update committee of the AMA, which is biased toward procedures and imaging. The California plan should engage its own RVU committee.
42	Gerald Rogan, MD	I spoke with one of my colleagues today who initiated the MolDx program for Medicare. The program has been adopted by several Medicare Administrative Contractors (MACs) in order to determine which molecular diagnostic tests are reasonable and necessary and, therefore, eligible for Medicare coverage. Coverage of specific tests varies depending on the location of

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		the lab performing the test because not all MAC decisions are the same. CMS has not established a national coverage policy for many of these tests. CPT has developed some codes, Aetna and Palmetto use their own code lists, neither of which are HIPPA compliant. Correct billing of Medicare fee for service is complicated. This week two attorneys have contacted me to help with litigation regarding incorrect billing by providers. Medi-Cal billing is more complicated. I attempted to improve it when I worked for Xerox LLC as its Medical Director, but DHCS was not interested. Medi-Cal has given up on fee for service payment because, in part, it could not control waste, fraud, and abuse. When I practiced Medicine with my company, Family and Urgent Care of Walnut Creek Medical Group (1980-1998) the cost to bill insurance and patients for copayments was about 8% of the amount we collected, or about 16% of our overhead. We did not accept Medi-Cal. Managed care providers are not so burdened. My friend's family doc does not accept insurance. She requires payment at the time of service. A routine visit is $45.00. She orders tests via the patient's insurance. She does not send out any bills. Her practice, in South Carolina, is doing well. She is not a concierge doc. Fee for service billing will be simpler a bit under a State sponsored single payer plan if it is like Medicare, but will be worse if it is like commercial or Medi-Cal fee for service. This is another reason why a state sponsored "Medi-Cal for all who want it" should be exclusively provided by integrated managed care networks, not fee for service providers. Several times a week new companies contact me to ask for my help to gain access to Medicare funds. Requests include remote monitoring for compliance with physical therapy, coverage for meditation services, coverage for stress headache reduction via a self-administered on-line program. I recommend finding incremental solutions to the problems identified, such as the 7% who have no insurance coverage. Create practical options for patients and see what happens. Incremental change and improvement is the way forward, not a radical change of re-financing Medical care for 33 million people. The California government is not capable of managing such a change and then administering it, even with contractors. The change is not warranted. CMS is struggling with Medicare which began in 1965 and it has more resources than California has.

Count	Name	Comment
		So be realistic and fix problems incrementally without endangering everyone.
43	Gerald Rogan	Here is the CMA position. This tells me any single payer/funder plan will fail due to CMA opposition or fail because it will cost too much. Note the use of "Benefit/coverage". These are two distinct issues, which tells me the CMA people involved do not understand the difference. Example, eyeglasses are not a benefit under Medicare even though they are medically necessary for many people. RECOMMENDATION:: That CMA adopt the following policy on a single-payer health care financing and delivery system: CMA will only consider a single-payer health care financing and delivery proposal, if the following elements, at a minimum, are in place: 1.Appropriations for the single-payer system shall not be subject to limitations, and an adequate level of funding (with appropriate inflation adjustments) should be guaranteed. There must be a clear path to ongoing financial support and viability; 2.Physicians must be provided a means to ensure payment through usual and customary charges as defined by the Gould criteria whether delivered downstream through fee-for-service, capitation, or other payment options; 3.Pluralistic payment options for all types of physician practices must be retained and physicians must maintain the choice of how to organize their practice; 4.Physicians must be permitted to collectively negotiate; 5.Benefit/coverage design decisions should be made by a scientific, apolitical body comprised primarily of physicians and updated in a timely fashion based on current information. 6.There should be a basic benefit/coverage package outlined in the law that is developed with significant input from practicing physicians. These benefits should include, at a minimum, reproductive health, maternity, mental health, substance use disorder prevention and treatment, and preventive health services. Pharmaceutical services should be included. Appeals of adverse coverage decisions should be adjudicated by an independent medical review processed by practicing physicians of like specialty; 7.Patients are allowed to purchase supplemental coverage in addition to the \"single\" plan; 8.Access to care must be protected by ensuring there are mechanisms in place to address physician training, workforce shortages, capital investment, and infrastructure building; 9.Co-payments that promote effective care and appropriate utilization should be considered. Co-payments should be on a sliding-scale and waived for low-income individuals. Cost-sharing should not be applied to primary and preventive care; 10.There must be a system to evaluate quality of care and cost containment

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		mechanisms to ensure that there are no disincentives for physicians to provide the highest quality care and that patients have access to appropriate care not driven by cost considerations but best patient outcomes; and 11.There be a mechanism for addressing fraud. RECOMMENDATION:: That CMA adopts the following policy on a public plan as a health plan option: That CMA will consider a public plan as a health plan choice, if the following elements, at a minimum, are in place: 1.Physicians must be provided a means to ensure payment through usual and customary charges as defined by the Gould criteria whether delivered downstream through fee-for-service, capitation, or other payment options; 2.Pluralistic payment options for all types of physician practices must be retained and physicians must maintain the choice of how to organize their practice; 3.In order to promote competition, the public plan should be funded by premiums paid by employers and/or individuals. Any premium and cost-sharing subsidies should be equally available to the public plan and individuals choosing a private, commercial plan in the individual market; 4.Any reinsurance funding available to commercial plans in the individual market should be equally available to the public plan; 5.Any public option, if created, be done without undue restrictions on its ability to compete fairly with other plans; 6.Access to care is protected by ensuring that any willing provider can participate in the public plan. Physician participation in the public plan must be voluntary; participation in public programs must not be conditioned on participation in the public plan; 7.Network data must be publicly reported to ensure plan network adequacy; and 8. (NEW) The public plan does not undermine consumer choice of destabilize the commercial market. Resolution: MI-1B-1
44	Jon Li	The DAY Stella Lobo MD MPH epidemiology PhD operations research gave our paper at Oregon State, the Economist DEMANDED that NHS England shift to what Peter said: **Economist, June 29, 2019: Britain: The future of health care: What's up doc?** **St Austell: The role of the family doctor, front line of the NHS, is being reinvented** The National Health Service is free, so it is also rationed. Family doctors, known as general practitioners (GPs), act as the first port of call for patients; friendly gatekeepers to the rest of the service who refer people to specialists only if needed. But in some parts of the country, including St Austell on the Cornish coast, access to the rationers is itself now rationed. "You can't book an appointment to see me here," explains Stewart Smith, a

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		39-year-old GP, one of a team in charge of an innovative new medical center. "You go on a list and then we triage you." It is an approach that will soon be familiar to more patients. Simon Stevens, chief executive of NHS England, has said that being a GP is arguably the most important job in the country. There is, however, a severe shortage of them. According to the Nuffield Trust, a think-tank, there are 58 GPs per 100,000, down from 66 in 2009 – the first sustained fall since the 1960s. Only half of patients say they almost always see their preferred doctor, down from 65% six years ago. The average consultation lasts just nine minutes, among the quickest in the rich world. Although the NHS hopes to train and recruit new family doctors, the gap won't be plugged any time soon. A new five-year contract to fund GP practices will eventually include 891 million pounds ($1.1 billion) a year for 20,000 extra clinical staff, such as pharmacists and physiotherapists, with the first cash for such roles arriving July 1st. To access the money, practices will have to form networks which, it is hoped, will help them take advantage of economies of scale and do more to prevent illnesses rather than merely treating them. When the four practices serving St Austell merged in 2015, it was an opportunity to reconsider how they did things. The GPs kept a diary, noting precisely what they got up to during the day. It turned out that lots could be done by others: administrators could take care of some communication with hospitals, physios could see people with bad backs and psychiatric nurses those with anxiety. So now they do. Only patients with the most complicated or urgent problems make it to a doctor. As a result, each GP is responsible for 3,800 locals, compared with an average of 2,000 in the rest of Cornwall. Although few practices have made changes on the scale of St Austell Healthcare, across England the number of clinical staff other than GPs has grown by more than a third since 2015. The logic behind the introduction of these new roles is compelling, says Ben Gershlick of the Health Foundation, another think-tank. The NHS estimates that 30% of GPs' time is spent on musculoskeletal problems, for instance, which could often be handled by a physiotherapist. Another estimate suggests 11% of their day is taken up by paperwork. Doctors complain that they are overworked, and growing numbers retire early. They are also expensive: starting salary for a GP is 57,655 pounds, whereas a physio costs around half as much. NHS leaders hope the new workers will help practices play a more active role in their community, linking up with services

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		provided by local authorities and charities. Each network will be responsible for a population of 30,000 – 50,000. The plan is that they will use data analysis to intervene early to prevent illness, and that practices will often share the new staff with others in their network. Those that are further down the road sing the benefits of the new approach. Caroline Taylor of the Beechwood Medical Center in Halifax says that the new roles quickly show their worth. Her practice took in a "work wellness advisor" employed by the council. The adviser's goal was to help ten people over the age of 50 with poor mental health back to work in a year – a task which she completed in just six weeks. In St Austell two pharmacists last year helped to cut more than 140,000 pounds from prescribing costs. Far few staff now report that they are burned out. Working in a team will nevertheless require a big shift in mindset for many doctors, particularly those in surgeries that have never before employed anyone else aside from the odd nurse. One worry is that practices will end up doing what they must to get the extra funding, but little more. There are also more practical problems. Seven in ten GPs say their practices are too cramped to provide new services, and it is not clear where some of the extra staff will be hired from. Perhaps the biggest problem is that patients have grown used to having a doctor on demand. Although those who no longer have to queue for an appointment may be happy, others might feel fobbed off if diverted to another clinician. A study published last year by Charlotte Paddison of the Nuffield Trust, and colleagues, in the *British Medical Journal* found that patients had less trust in the care provided by a nurse if they initially expected to see a doctor. Patients who have a close relationship with their GP tend to be more satisfied and enjoy better outcomes than others. But other evidence suggests that, for some conditions, nurses provide better care that is as good as or better than that provided by GPs. The aim, says Nav Chana of the National Association of Primary Care, which helped develop the new approach, is therefore to use small teams of doctors and other clinical staff to replicate the sort of relationship with patients that used to be more common. Just parachuting in "a lot of people who look like doctors" will not raise the standards, he warns. The shortage of GPs leaves the NHS with little choice but to try something new. "A lot of the world has either copied or is trying to copy English primary care," in particular its openness to all and the continuity of care that it provides, says Dr Chana. Keeping these strengths, while changing how primary

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		care works, is the task NHS officials are now facing up to. Even if they succeed, it will take time for the public to adjust. Having explained the benefits of the new way of doing things, one GP pauses, before adding, "I should say, though, patients don't love it." [Better good care from an RN than waiting for a GP.] Simon Stevens, chief executive of NHS England Stewart Smith, St Austell Healthcare, info.sahc@nhs.net, Nuffield Trust, a think-tank, info@nuffieldtrust.org.uk, Ben Gershlick of the Health Foundation, another think-tank, info@health.org.uk, Caroline Taylor of the Beechwood Medical Center in Halifax, calccg.beechwoodmedicalcentre@nhs.net Charlotte Paddison of the Nuffield Trust, and colleagues, in the British Medical Journal Nav Chana of the National Association of Primary Care, napc@napc.co.uk, Jan 20, 2016 · As a **proportion of GDP** it will fall to 6.6 per cent compared to 7.3 per cent in 2014/15. Link to article called "UK health spending compared to France and Germany" Sep 23, 2016 · Public spending on the **NHS** across the **UK** is **projected** to go from 7.3% of **GDP** in 2015/16 to to 6.7% of **GDP** by the end of this parliament. That's not because public spending on healthcare is falling, but because it's predicted that other **parts of GDP** will **grow** faster. Mark Littlewood of the Institute of Economic Affairs writes (Letters, 15 July) that the NHS has poorer outcomes than countries with social health insurance systems, such as Germany and Belgium. Strangely, he neglects to state that Belgium spends 10.6% of its GDP on healthcare and Germany 11.3%, compared with the UK's 9.1% (World Bank 2014 figures), Uninsured rate, US states: National: 2018: 8.5%, (2017: 7.5%) CA 2018: 7.2% Mass 2018: 2.8% Vermont: 4% Oklahoma: 14.2% Texas: 17.7% Bee, 9/14/19
45	Barbara Commins RN	I've listened to hours of rhetoric and wonder why. We have had Medicare for 56 years.We have a good bill this time AB 1400.

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		When do they start doing something?Is it Wall Street wealth?Is it lobbyist $$$ flowing to Dr. Pan and Dr. Wood?Are there commission members who have Health investments? How much does CALPERS hold in Health/Insurance stocks? Any non-profits on the Commission also holding Health investments?
46	Emily J. Plympton	Dear Dr. Ghaly We are writing to you on behalf of Healthcare For All - Los Angeles to express our grave concerns regarding the conduct and efficacy of this Commission. Thus far, it has failed to produce any policy directives or legislative suggestions to support its mission of exploring unified finance healthcare mechanisms, including, but not limited, to single payer healthcare, as defined in its remit. The Commission appears to have made a deliberate decision to bypass robust discussion of AB 1400, single payer legislation to ensure the delivery of comprehensive, cost-effective healthcare to every Californian. Not only has the Commission essentially ignored single-payer reform, but it has failed to offer any viable policy alternatives. Since the experience in the industrialized world has repeatedly confirmed that single payer is the most cost-effective and efficient way to deliver quality healthcare, it is unclear what the Commission hopes to achieve by ignoring AB 1400. Every healthcare financing model in the developed world that includes unregulated health insurance has worse health outcomes and is substantially more expensive. "Market choice" does not materially exist in the realm of intermittent, immediate, and unexpected human health care needs. People are patients not customers who can shop around for the best deals. They either need healthcare or they don't. We also, express our grave objections to certain vested interests in this Commission whose testimony and commentary border on the absurd. In particular, the ex officio member Dr. Richard Pan, who has received over $1.6 million in contributions from the Health care sector/insurance/ pharmaceutical/ hospital/ nursing home sectors profiting in the current system. Why are ex-officios with obvious conflicts of interest sitting on this Commission? For instance, Dr. Richard Pan MD has claimed many Taiwanese doctors desperately want to flee Taiwan to practice in America to avoid their healthcare system and its alleged widespread

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		problems with integrated care. He has only provided anecdotal hearsay to support his claims. Dr. Pan also indicated that the Taiwanese healthcare system is only good for very basic healthcare. This is demonstrably false because it comprehensively covers primary and preventative care, clinical and hospital care, and pharmaceuticals. He even casually dismissed the fact that the overwhelming majority of Taiwanese citizens approve of their healthcare system. This approval rating is also mirrored by evidence in the rest of the developed world. During the Commission meeting on July 9, Dr. Pan commented that "Details matter," but failed to offer any solutions whatsoever. He later unfurled an irrelevant discussion regarding surplus obstetric nurses when babies weren't born at a given point in time to argue a theoretical point that this waste would not be reduced in a single payer system if in fact, it is waste at all. Please consider the administrative waste generated by the health insurance billing and approval processes. Not to mention the waste on unnecessary and costly E.R. visits which would better be served in a clinical setting. Taxpayers expect relevant, fact-based commentary supported by research and data, not personal opinions and musings. We expect that Commission members make solid, rational contributions to these discussions. Ex officio members with no observable contribution to the Commission mission should be removed. They waste time, taxpayer money, and erode public confidence in this process. Dr. Jim Wood DDS has run on a single (albeit valid) concern of cost control and price inflation. This question has an abundance of real-world answers via bulk purchasing of pharmaceuticals, hospital, clinical, and preventative care services with pricing caps... as in Medi-care (except for pharmaceuticals). The single payer savings of price control and reduction of administrative waste has been demonstrated with reliable data in every available policy recommendation from health care experts, economists, and policy experts. The healthcare systems in the developed world have uniformly confirmed this conclusion by demonstrating lower costs with better outcomes once the profit motive has been removed from healthcare and once rational, equitable expenditures are implemented. It is disingenuous that Dr. Wood has repeatedly litigated this question because it appears he is either unwilling or incapable of accepting professional recommendations and actual global evidence.

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		The introduction of global budgets for hospitals and large scale service providers and fee for service for independent practitioners and physician groups will curb the inflation-busting, runaway price inflation of the unregulated private sector. Competition has not lowered prices. This is a hallmark of AB 1400 legislation. The private sector repeatedly claims that artificially high prices are essential for medical innovation, yet fail to acknowledge their highly favorable tax treatment, corporate investment, and the substantial injection of public research funds via universities, research institutes, and medical and healthcare charities into that innovation. The pharmaceutical industry has repeatedly lobbied against the importation of drugs for "fear of persistent quality issues" of which they have failed to provide any large scale evidence, and despite the fact that a substantial number of their own products sold in the US are produced in overseas laboratories. Carmen Comsti and Dr. Rupa Marya have made reasoned cases regarding costs, inflation, innovation, and integration of care, so much of the counter discussion of these topics during these Commission hearings is duplicative, wasteful, and irrelevant. Public confidence in the integrity of this process is at risk. Diversionary and obfuscatory tactics, allowing incoherent and unfounded commentary, and denying the prominence of qualified discussion about the global successes of single payer reform are examples of poor governance, wasted time, misuse of tax dollars, and the exhaustion of public tolerance. We propose that the Commission solution is to focus on a solid discussion of the CalCare AB 1400 legislation at hand that incorporates the decades-long global successes of single payer systems into state based reform. This Commission under your leadership, Dr. Ghaly, has the opportunity to become champions of the people by addressing our most vital needs, currently ignored, which have been codified as human rights in the 1947 Declaration of Human Rights. That right is violated everyday in our current deplorable system of extraction of resources away from the delivery of necessary care to our CA population. This is the State's chance to lead the country in healthcare reform. It is not experimental or filled with untested variables. The genuine answer to reforming our unsustainable health insurance system and determining the finance model is for this

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		Commission to examine current AB 1400 legislation, offer improvements, and provide support and assistance to the CA legislature in attaching a finance portion to AB 1400, the Guaranteed Health Care for All Act (CalCare). We need to hear more from Carmen Comsti JD as a principal speaker. Esquire Comsti is the voice with expertise on developing and explaining this current CA AB 1400 single payer legislation, awaiting reintroduction in January. Now is the time for AB 1400 CalCare information to be presented for robust discussion. And now is the time for providing guidance in developing a solid finance plan for that legislation. This would be meaningful Commission work in service of CA residents. Rehashing the decades-old rationale for the type of reform is unnecessary. We don't need another study. What we need is a financing plan for what we know works all over the world for over 100 years, single payer. The case for health care system reform is urgent. Everyday is a life-altering emergency for numerous individuals, families and entire communities suffering the consequences of our abhorrent for profit insurance system, draining finances, bankrupting families, and destroying lives while enriching stakeholders. Please act on this urgency and schedule Carmen Comsti as a principal presenter for AB 1400 discussion in the next meeting. We must move on this reform. Lives depend on it. Every day matters. And it matters to all of us, everyday.
47	Michael Lighty	Dear Healthy California for All Commission, I found the discussion with former Vermont governor Peter Shumlin very instructive and hopeful for establishing a system of single-payer financing in California; in fact, Governor Shumlin confirmed the urgency and opportunity that California has. Regarding the discussion of intermediaries and attributes of the health care system we envision, we need to start by acknowledging that our is not simply a non-system, but is instead a healthcare industry that drives policy based on commercial and profit interests. This is reflected in Covered California with its reliance on high-deductible, narrow network commercial health plans, and on non-profit plans that generate billions of dollars in net income for capital expansion, and in the for-profit HMO's that expropriate billions of dollars from the Medi-Cal system that restricts beneficiaries access to specialists and all providers by underpaying those providers. Huge non-profit hospital corporations provide less charity care than the value of their tax exemptions, and also generate net income for capital projects, high executive salaries, expensive marketing campaigns,

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		concierge services, high-tech equipment and other services geared toward wealthy patients. This industry model has created a fragmented, wasteful system that relies on tax subsidies and market mechanisms to the detriment of equity, quality and universality. As a principle, there is no place for financial risk-bearing managed care in a single payer system. No provider or intermediary should be incentivized to realize profits by withholding needed services. However, well-coordinated care -- quality-driven and patient-focused care coordination is fundamental to achieve the promise of single payer. It is essential both to the wellbeing of enrollees and to the fiscal stability of the overall health system. In the present system, large majorities of people for whom English is a second language, when they are given a choice, choose integrated care systems for health coverage. Many find such systems easier to navigate, with less confusion finding the right providers and service. Care coordination goes beyond navigating a complex system. It is essential to receiving effective treatment. Programs that try to ensure medical advice is followed up on, and that bridge the gap between medical offices and people's homes and workplaces can make huge differences in health for individuals and groups. None of this coordination happens effectively in a health care model where enrollees have to find their own way from provider to provider and to drive collaboration among multiple providers by themselves. California needs a single payer health system that supports the organization of care. That organization of care must not be done in a way that incentivizes providers to withhold services. Nor should providers be allowed to write their own paychecks. In many places outside California, where fee-for-service reimbursement is the norm, union health funds and self-insured employers often struggle to deal with providers that pile up unnecessary and potentially harmful services. These providers are a minority, but such providers inflict huge costs on the health system. Some union health plans have had to invest heavily in systems to discourage this outlier behavior, going so far as to establish clinics of their own to give patients a choice when they no longer trust traditional providers. Let's remember that the earliest efforts to organize care and keep it accountable grew out of the labor movement - witness the health system the Mine Workers built in the 1940s. The universal, single payer health system we need in California should build on those experiences, not turn back the clock. Certain mandates that have been enumerated in AB 1400, California's prior single payer health care bills and other

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		guardrails are essential to preventing incentives to deny care, including: - Guaranteeing healthcare with no administrative or financial barriers to securing services - Establishing a single standard of therapeutic and equitable care - Providing comprehensive benefits and services based on patient need and medical necessity as determined by the provider - Ensuring that the professional clinical judgment of licensed providers cannot be overridden by administrative fiat; - Maintaining fully comprehensive benefits, with no carve outs that allow private insurance entities to contract for covered services - Prohibiting incentives to deny care; - Funding hospitals and clinics through cost and experience-based global budgets that require funds be dedicated to service delivery; - Banning private capital budgets outside the single-payer fund, which exclusively funds capital expenditures - No value-based purchasing as currently practiced or ACOs as currently constituted (as HCN detailed in our response to the Commission's environmental analysis last year, such cost-control mechanisms are inherently discriminatory) - Integrated delivery systems that include hospitals and clinics should not exert administrative or financial control over medical groups Thank you for your consideration of these ideas, and for your on-going work.
48	Ellen	I'd like to than the Commission for finally talking about single payer. It cannot be impossible to set up a system where providers don't have an incentive to overtreat (fee for service) or withhold treatment (capitation): I believe every country that has adopted a universal health plan has better health outcomes than we do. Let's do it. As for myself: my employer promised me "health care for life" if I took early retirement (my supervisor's words). I should have read the fine print, because as soon as I turned 65 they cut off the retiree insurance and hooked us up with an insurance brokerage that would help us sign up with private Medicare supplement insurance. To pay for that, my former employee--so far--provides a $3000 allowance each year. It helps me, but only because I am enrolled in a cheap Medicare Advantage plan. Original Medicare, with or without supplemental insurance, would cost me a bundle. I'm eager for California to adopt a better way!

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