Healthy California for All
October 11, 2021 Virtual Commission Meeting
Public Comment

1. **The following table shows public comments that were made verbally during the October 11h Commission meeting:**

Count	Name	Verbal Comment
1	Hector Flores	I'm Hector Flores, a family physician in East Los Angeles. Great presentations today. What I would recommend for the commission to look at is two models that apply those principles presented today that are already here in California. One would be to invite Kaiser Permanente, and probably at a polar extreme, and the opposite would be the public health hospitals. Kaiser Permanente has been around for 80 years; I'm not affiliated with them, so I have no particular bend for them. But they've been around for 80 years. And I think they were the first Accountable Care Organization before the ACO term was coined, and certainly have performed great for the last 30 years. They have the concept of global budgeting for their hospitals, as well as global budgeting for their physicians with the incentives built in for physician value-based performance. Obviously, they struggle with Medicare, and they struggle with the uninsured being an insurance company. But there's a lot to be learned, especially because they're in eight different states. Secondly, just inviting the public hospitals, the waiver, the PRIME program, which was the redesign of the public hospitals, and then looking at global payment, is the public system, the ultimate safety net approaching this global budgeting strategy? And are they getting the right actuarial support to make sure that they're negotiating the right budgets? Because that'll be how they sustain long term thinking.
2	Charles Weber	I think there's some roadblocks to how we move forward. Some of it is political. There are obviously some very different approaches to this. Some of it is economic. There are going to be some strong economic forces against moving to a single payer system. To me, I just throw everything aside and say, how much money is coming in? What does it cost us right now to do the various aspects of our health care system in California today? And then add up that and then add up, what does it cost to have a new single payer health care system in California, administrative costs and so forth, and then subtract those out, and then you know what you got to work with. But we need some real concrete figures on where we can go. And it seems like we're avoiding a lot of just nailing down the basics that we need.
3	Dr. Bill Honigman	Thank you, commissioners. I'm Bill Honigman, retired Kaiser emergency physician from Orange County. My comments

Count	Name	Verbal Comment
		relate to COVID-19 as the most pertinent and pressing example of why we need to move ahead with the modeling for providing reimbursement that does exist in AB 1400. The glaring inadequacies of commercial payers to allocate direly needed health resources in the pandemic, not just for PvE universal testing and contact tracing that have been inadequate but also assurance that chronic comorbidities that compound a risk to the public at large of contracting ultimately suffering or dying from COVID-19. This shows that such market-based systems need to be cut out altogether not bargained with some rate setting or otherwise depending on any market-based entities to allocate these resources. And more generally, this is, as Commissioner Comsti said, what creates our healthcare deserts. Thank you. Please move forward with the modeling in AB 1400.
4	Mari Lopez	Thank you so very much appreciate the time. To prioritize patient care, the system must minimize providers profit motive and ensure that health care dollars go towards care. Checks on the provider profit motive can be built into the system. A single payer system can pay providers closer to cost, they are less incentivized to consider profits in care decisions. They can be paid annual negotiated budgets through a global budget system. They do not need to push their doctors to diagnose patients with illnesses. They get risk adjusted bonuses or to up code services to maximize profits for shareholders, executive pays or marketing. Transparent direct rate negotiations between the system and providers would reduce inflated rates and minimize the distortionary effect of overpaying for some specialties and services and underpaid for others. Thank you.
5	Patty Harvey	I am co-chair of Healthcare for All and Physicians for a National Health Program in Humboldt County. I have a question around the concept of provider responsibility to lower cost. Why hasn't the commission addressed a huge source of rising costs that drive out of control healthcare spending, namely, the profit overhead administrative waste and abuse by corporate health insurance companies to the tune of 30 cents on the dollar, for example, Medicare Advantage has been overpaid $143 billion in the past 20 years, and health insurance companies have paid out penalties of 350 billion for fraud. Why do we need these middlemen? So why couldn't the AQC structures described by Dana and the global budgeting described by Joshua be administered by a not-for-profit government agency thereby obviating insurance, profit overhead and waste and abuse? Incidentally, AB 1400 is a vehicle that would deliver those concepts. Thank you.
6	Dr. Tim Bilash, MD	Thank you for an exceptional program. My name is Dr. Timothy Bilash. I'm an obstetrician gynecologist based in

Count	Name	Verbal Comment
		San Diego. California has fewer nurses per 1000 population below the national average and also slightly lower than the average American levels. How does the nurse staffing in hospitals and outpatient settings impact total costs, the outcomes and quality care in the settings of the global budgeting that have been proposed here?
7	Craig Simmons	I have two questions. The first is how many commissioners would be in favor of recommending a ballot measure for implementing a payroll health care tax to fund a unified financing system for inclusion in the final report? The second question is global budgeting / standardization of cost is an integral part of a single payer system. How many commissioners agree? And how do we accomplish cost standardization for inclusion in the final report? Thank you.
8	Beatriz Sosa Prado	Happy Indigenous Peoples Day. My name is Beatriz Sosa Prado from California Physicians Alliance. And the commissioners have engaged in numerous and important discussions about the problems in our healthcare system. And so now focusing on solutions, I remind you that in 2019, CaPA's leaders authored the roadmap to Golden State Care, a strategic, approachable and realistic proposal to achieve a healthcare system that is universal, just and equitable in California. The COVID 19 pandemic and renewed racial reckoning have brought further urgency to us writing a second version of this roadmap, which we will share with you in the next few days. To ensure that the transition to an improved healthcare system is as smooth as possible, CaPA's roadmap is carried out in three phases that focus on the following five policy categories: universality, responsible private insurance behavior, reasonable cost and prices, improved efficiencies in public systems and lastly, improved workforce support. We look forward to working with the commission to achieve an equitable health care system for all Californians. Thank you.
9	Kayla Westergard-Dobson	Hi, thank you. My name is Kayla Westergaard Dobson. I live in Los Angeles my comment relates to AB 1400 system of global budgets to fund hospitals and facilities in our state. The current system we have where insurance companies and massive healthcare corporations work to drain profit from patients is not just immoral, it's also inefficient and a terrible use of our money. Providers deserve fair payment across the board and patients deserve treatment that doesn't come with a side of bankruptcy. Last year, my son Arthur was born via emergency c section at a large Los Angeles hospital, and he died three days later. Instead of focusing on grieving my son I've spent the last nine months fighting with insurance and hospital billing. My son's death has cost over $10,000 because insurance improperly billed me, and the hospital overcharged me for services. The lack

Count	Name	Verbal Comment
		of transparency in our current system punishes both patients and providers because my 10 grand didn't go to the wonderful doctors and nurses who treated my son, and now lines the pockets of overpaid executives. Global budgets, as outlined in AB 1400 ensures that health care dollars go to improving care and not excessive executive compensation. Please discuss AB 1400. Thank you very much.
10	Ruth Carter	First of all, thank you commissioners for your commitment to finding a path forward to quality, affordable health care for all. I'm the chair of the California Democratic Party senior caucus. And I noted that all of the presentations talked about the need for profit. It is unclear to me why there is a need to make a profit. Who is really benefiting from that profit? Additionally, it was mentioned during the first presentation in the United States, the high cost of healthcare with terrible outcomes is particularly problematic. However, it's also interesting to note that this changes at the age of 65. Costs go down. Outcomes compare favorably to other countries. What happens at the age of 65, the traditional Medicare system, which is a model that can be replicated on a larger scale, and actually must have no intermediaries as well as privatization. In the wealthiest country in the world, the COVID-19 pandemic has exposed the core of a healthcare system that is incapable of dealing with it. A for profit healthcare system does not uphold the ideal of service to humankind. Thank you.
11	Don Cherf	Good afternoon. I think that this commission, which seems to overwhelmingly favor a single payer health care system for California, has spent more than enough time debating, and supporting Medicare for all Californians. We should begin the implementation already. We can't keep kicking this topic down the road. We can't just keep talking about it without any forward momentum. It's past time to stop the conversation and begin the action. Californians can wait no longer. Implement Cal Care for all now. And for those concerned about financing, we have plenty of countries that have successfully implemented health care for all. We can easily discuss with them how they finance their systems. This is a doable action now if we would just decide to do it. Thank you.
12	Jeffrey Tardaguila	Please get a better explanation of how Kaiser is doing the global planning. Because as much as you've talked about it, you really haven't brought it out, just like for mental health, how you do things. I agree that you need to find a way to do this, and you have less than three meetings to do this. So please come up with a better solution than what I'm hearing so far. I hear few proposals, and hear few actual occurrences that the governor can actually do. I hope that

Count	Name	Verbal Comment
		you achieve that in these next three meetings of this subject. And thank you, Dr. Ghaly. Goodbye.
13	Dennis Pocekay	Thank you. I live in Petaluma. I'm a physician and Petaluma city council member. AB 1400 was introduced to create a single payer health care system that would fulfill the mission of this commission. And instead of pondering different design considerations that AB 1400 already addresses, I believe this commission should focus on studying and proposing different methods of financing the costs of single payer beyond available federal dollars. To this end, 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 California. So again, you should discuss AB 1400 further, you should include it in your final report, and you should help California guarantee health care for all in this urgent time of need. We need single payer now. Thank you.
14	Brynne O'Neal	Brynne O'Neal, CNA. I want everyone to remember that capitation incentivizes care denial and quality metrics just can't fix it. Value based payments claimed to incorporate quality measures into payments to providers. But in reality, quality metrics systems failed in inequity through race norming and other mechanisms because they're all built on data from our systematically biased healthcare system. Over reliance on these metrics incentivizes teaching to the test by providers who maximize reimbursements rather than provide the best care for each patient. Additionally, metrics-based incentive payments increase administrative complexities, which wastes our doctors and nurses time and rewards large healthcare corporations who can afford to find ways to game the system. We should minimize the profit motive, maximize patient freedom of choice, add in democratic control and create a system focused on getting equitable access to health care for all. So, we don't need to rely so heavily on metrics to ensure quality. Thank you.
15	Tim Jouet	Good morning, thank you for the opportunity to speak. My name is Tim Jouet. I am calling in from San Luis Obispo assembly district 35 this morning. Good presentation, I just want to go back to the chart I think it was Don had in his presentation with all the discussions. If you look at that chart, if we wanted to be simple, we could close our eyes and throw a dart at that chart and wherever it landed, we would have a better system that we have now. So, we're kind of wasting a lot of time nitpicking this, which is really fun for people at random policy and getting wonky and discussing all those things. Which leads into my other point. I don't hear a lot of talk about ease of this for the consumer and the average person who isn't interested in a meeting like this. If anyone's ever had to deal with health insurance

Count	Name	Verbal Comment
		as one of the previous commenters did before, we need to discuss making a system that people don't have to think about they don't think about the fire department. They don't think about the police department things that we consider public goods. Health care should be the same. So, we need a single payer system and we actually have a bill in our assembly coming up AB 1400 that addresses this. Thank you.
16	Ryan Skolnick	Hi, everyone, Ryan Skolnick. And I want to get straight to the point: risk adjustment incentivizes complex diagnoses, not complex care. Providers can game risk adjusted capitation payments that the Commission seems to be so fond of by diagnosing patients with severe illnesses and then providing as little treatment as possible. And the degree of control that providers have over inputs to risk adjustment limits savings from these systems, while the mechanisms to prevent care denial are ineffective. And then in response to what Mr. Scheffler said earlier, healthcare professionals serving patients under Medicare Advantage plans have been reported being pushed by management to go back through their care notes and retro actively diagnose patients with serious conditions to increase payments from Medicare, whether or not services are actually provided to treat the condition. This increases the cost to the system and may have ramifications for the care that patients receive. Most of the extra revenue from upcoding goes to plan profits not to care or to providers themselves. And despite so called payment reform, the California Health Care Foundation found that the quality of care and Medi-Cal managed care was stagnant at best between 2009-2018 This isn't the solution that you all think it is.
17	Eric Vance	Thank you. My name is Eric Vance. I live in the East Bay. I should note that I no longer represent any organization in a professional capacity. So I'm just commenting as a California citizen who's currently on Medical since January 2020. You've heard me and hundreds of others articulate pragmatic and passionate arguments for single payer with no incrementalism nor intermediaries. The data and the demand is overwhelmingly apparent. So to further transparency, I like to focus on the inherent paradox of having perhaps the two most powerful commission members in terms of moving potential legislation such as AB 1400 forward, ex officio members, Doctors Jim Wood and Richard Pan have as officials in the state assembly and state senate respectively, received a significant portion of their campaign donations from the very billion dollar industry behemoths that stand to lose some of their current astronomical inequitable profit if single payer were to be implemented. I'll post some links. Senator Pan, you mentioned political will and drivers are making decisions.

Count	Name	Verbal Comment
		And to be frank, I see cartoon dollar signs in your eyes when you argue and I believe bad faith, even to the point of belittling or at least dismissing all the data and comments, in particular, the report from your fellow Commissioner Dr. Hsiao, who truly has the expertise and experience to address this. It seems clear to me that Commissioners Pan and Wood are serving their corporate donors at the expense of not only their constituents, but the 40 million people in the state of California and perhaps the nation by being antagonists to California leading on single payer.
18	Phillip Kim	Philip Kim with the California Nurses Association. We should not use any type of payment model that gives a financial incentive to deny care. I just want to clarify as Carmen mentioned, that the global budgeting included in AB 1400 is different from the BlueCross BlueShield or Maryland models that were presented on. In AB 1400, institutional global budgeting would fund the medical needs of our communities and pay for the true cost of care. And these funds cannot be used for profit. Global budgeting would pay hospitals and other health care facilities through annual operating budgets based on historical volume of services, actual expenditures, wages, projected changes and other factors. Global budgets would ensure that our safety net hospitals that provide care to low income, rural, and minority communities are sufficiently funded and resourced. In AB 1400, there would also be separate funding for capital expenses like building new facilities or buying equipment. And there would be a special projects budget that would address needs in medically underserved and health professional shortage areas. Each of these budget components can take healthcare disparities into account and in the long term, a single payer system like CalCare AB 1400, will more fairly and effectively distribute care across the system. Thank you.

Count of verbal comments: 18

2. The following table reflects public comments that were entered into Zoom Chat during the October 11th Commission meeting:

Count	Name	Comment
1	Phillip Kim	Thank you, Don Moulds for your presentation. As Don explained, utilization is not a contributor to high levels of health care spending. And most of the past risk-based payment schemes over the last 10 years have been failures; they have not reduced health care spending and they put patients in danger of not receiving the care they need. The real problem is the prices and administrative costs in our fragmented, profit-driven system. The commission should

Count	Name	Comment
		recommend the payment methods featured in AB 1400. A single-payer health care program can control costs and guarantee high quality health care to all Californians through a combination of institutional global budgets, fee-for-service or salaries for doctor practices, capital expense funding, and special projects funding for rural and medically underserved communities.
2	David Leibowitz	Great meeting Secretary Ghaly! How can we access the materials that were sent to the commissioners prior to this meeting? Thanks very much, David Leibowitz MD
3	Dr. Tim Bilash	I am Dr Timothy Bilash an Obstetrician Gynecologist based in San Diego. California has fewer Nurses per 1,000 population, which is below the National Average, and also the slightly lower than average Maryland levels. How does Nurse staffing in Hospital and Outpatient Settings impact Total Costs and Outcome & Care Quality
4	Sally Gwin-Satterlee	A state-wide global healthcare budget, regional planning for distribution of health services, and publicly controlled and accountable capital budgets, are essential elements to ensure equitable access to services that are cost-effective, and which replace market-based approaches that allocate services based on ability to pay and profitability.
5	Joshua Sharfstein	Thanks for inviting me today. josh
6	Isabel Storey	the top of this meeting, Chair Ghaly said we needed to identify important topics for the remaining three commission meetings. One glaring omission in the deliberations so far is AB 1400, the Guaranteed Healthcare for All bill. Members of the public have brought this up repeatedly and we continue to do so because we have not been given a valid reason for why this piece of legislation is not considered. AB 1400 outlines payment mechanisms for institutions as well as individual providers. Why not consider them? The single-payer bill that passed in Vermont was extensively discussed at a previous commission meeting. The discussion was very informative and there were lessons to be learned for us. Why not discuss the California bill?
7	Carmen Comsti	Here's the link to the full Obermeyer study.
8	Stephen Vernon, MFT	This seems to have been primarily about institutional funding structures. The individual/small group community ensconced practices need to be considered. And in this, fee-for-service is an appropriate reimbursement structure that minimizes onerous admin requirements. Above and beyond the present state of affairs, there is the looming disaster of further administrative burden/diversion of resources and distraction from good clinical practice by the unproven concept of supposed performance-based compensation structures. Not only is this reimbursement approach unproven it is logically and demonstratively

Count	Name	Comment
		discriminatory. The reality is that the insurance corporations and government administrators are now in charge and, in general, have no clue about the delivery of clinical services. What they know is outcomes and value-based number crunching. And what they know is wrong. Such approaches make logical and administrative sense but not only make no clinical sense--they are destructive clinically and
9	Isabel Storey	AB 1400 is a bill that could actually be implemented. Considering it falls within your mission of creating a plan that "advances progress" toward a new health care delivery system. The legacy of this commission could be an academic tome that is relegated to a dusty shelf. Or it could be a roadmap for a better tomorrow in which quality healthcare is provided for every Californian. Which it will be is up to you to decide.
10	Sylvie Hurat	I come from a Single Payer Healthcare country (France), and the overhead of insurance coverage above medical costs is several times lower that the overhead of insurance coverage here… The money we save here can be used for patient care. AB1400 can help us do that.
11	Sylvie Hurat	CA Indivisible State Strong and Santa Clara County Single Payer Coalition
12		Doctors simply want to care for their patients, but they have to deal with insurance companies. Byzantine bureaucracy is expensive to manage, especially for hospitals with few resources to spare. Risk based payments just accelerate the cycle of systemic inequalities. It is more expensive to care for low-income patients, people of color, or those in rural communities, so profit-driven healthcare disincentives providers from caring for them. Providers focus on quantitative metrics instead of quality.
13	Judy Jackson	I think global budgeting is the best system I have heard about so far. My problem has always been Insurance interfering with what my doctor prescribes.
14	Sandy Kurtz	While it is vital that payment systems should be designed to provide equitable services to all populations, it is also important to include protections for providers. In other words, appropriate staffing guidelines should be included. Safe staffing for nursing ratios should be built-in, as should appropriate productivity requirements for providers such as physicians, physical therapists and mental health providers. Without such guidelines, patients don't get enough time with providers, and providers become burned out and likely to leave the profession.
15		It is also essential to eliminate intermediaries which only add a layer of administration without adding any value to consumers or to providers.
16	May Kandarian	AB 1400

Count	Name	Comment
17	Michelle Grisat	Kaiser is being investigated by the Department of Justice for upcoding
18	Sally Gwin-Satterlee	I am asking the commission to please discuss AB 1400. I support AB 1400 and Single Payer/medicare for all system
19	Eric Vance	Quick recommendation: a recent PBS / Frontline special: The Healthcare Divide that documents many of the issues that were brought up today.
20	Allan Goetz	The commission witnesses have confirmed that Single payer/ Medicare for all, healthcare provides the best solutions to the problems. Why have we not done an in depth system analysis of the 30 countries that have more efficient healthcare systems.
21	David Leibowitz	Link to obermeyer paper.
22	Beth Sweetwater	Now this must be translated to a simple public message that doesn't create to either simplify nor complicate the plan to get public support and patience
23	Joni Simon	we can move forward by a robust discussion of AB 1400
24	Stephen Vernon, MFT	We are "still in a pretty crappy state" with healthcare costs because insurance corps and Big Pharm are still running the show. Single Payer puts the People in as the Director of the show. disparities by disproportionately penalizing practices that care for lower-income or sicker patients." (Emphasis mine).
25	Stephen Vernon, MFT	Remembering that this Commission is about Unified Financing—not multiple "All Payer" financing--- Global budget are an appropriate approach to hospitals and large institutions. But--Hospitals should not "MAKE MONEY." Hospitals and the healthcare system should make people healthy and be supported by the entire community. "If you don't use it you can keep it" incentivizes restricting services.
26	Stephen Vernon, MFT	Re: Price driven increase in Healthcare costs-- Insurance corporations and Pharm are incentivized to drive prices upward… There is little downward price competition between the corporations or the drug companies. For insurance--the higher the cost of healthcare the more their percentage of costs return to them. For pharm the more they can charge the more they profit. Physician Group consolidation is being driven by the need to represent/protect themselves from power of insurance corporations and hospitals.
27	Allan Goetz	We now spend $400 B/year in CA a single payer system would cost about $350 B/year and provide better outcomes.
28	Stephen Vernon, MFT	Hospital consolidation is both similarly driven and a driver of the admin heavy managed care health funding system. No, Senator Pan, Public Health is not unified financing-- As Behavioral Health Director for Family Services San Francisco I had anywhere from 5- 10 primary funding streams I had to coordinate each year… Including Insurance, Medi's, County funding, county and state grants, foundation funding…etc….

Count	Name	Comment
		And re: the school nurses—See Dr Marya's neoliberal comment.
29	Reisa Jaffe	We need to be careful that decisions on how to proceed are not based on the current system that is driven by profits over people.
30	Allan Goetz	MARI! MATRI!
31	Melanie Osby	I would like to hear more about AB1400 and how this could help resolve many of the issues of the uninsured, underinsured and those who are denied medications, procedures and other services.
32	Allan Goetz	Single payer/Medicare for all, healthcare provides better comprehensive universal care for less cost and divorces care from employment. Why can't we have it?
33	Carol Mone	AB1400, yes.
34	John Greg Miller	Overreliance on quality metrics incentivizes "teaching to the test" by providers, who can choose what diagnoses to give, what care setting to use, which patients to treat, and otherwise make the metrics that determine what they get paid look good, whether or not those choices are best for the patient overall. If we minimize the profit motive, maximize patient freedom of choice, add in democratic control, and create a system focused on getting equitable access to healthcare for all, then we will not need to rely so heavily on metrics to ensure quality.
35	Francoise Coulton	We need AB1400.
36	Allan Goetz	See PNHP.org for data on M4A costs.
37	Betty Toto	The refusal to consider AB1400/CalCare is deliberately ignoring what is a plain and simple path to a single unified healthcare program for California. Your work is done. Please consider AB1400/CalCare to expedite your report to the Governor so we can get it passed and implemented.
38	Jeffery Tardaguila	you need to explain global budget like Kaiser how beyond Hospitals $$
39	(h)Dr Bill AD68 Honigman	My comments relate to COVID19 as the most pertinent and pressing example of why we need to move ahead with modeling for provider reimbursement as exists in AB1400. The glaring inadequacies of commercial payers to allocate direly needed health resources in this pandemic, where not just PPE, universal testing, and contact tracing have been inadequate, and also assurance that chronic comorbidities, that compound risk to the public at large of contracting and ultimately suffering or dying from COVID19. This shows that such market-based systems need to be cut out altogether, not bargained with for rate-setting or otherwise depending any market-based entities to allocate those resources. More generally, this is what has established our "healthcare deserts", in particular in our inner cities and rural areas of the state, and results in so much of the inequities and disparities,

Count	Name	Comment
		as we've seen even magnified with COVID19. It's past time to move on with modeling what we have at hand that does that in AB1400. Thanks.
40	Allan Goetz	A UNIVERSAL CHARGE MASTER will solve the funding issues. Study how to create and maintain it. Block grant funding of hospitals will save about %30 of the total costs with elimination of billing and collection costs.
41	Pat Herndon	So, we need to transfer the concept of incentives from money and the financial intermediaries for providers to clinical incentives for the providers, since >80% of the physician providers are already paid on a salaried basis. And it makes sense to address the risk assignment to the financial intermediaries as long as they are the actual place where fee for service is billed and collected. I'm glad to hear address to "fee for service" distortions of medical care and medical outcomes and recognizing that there are always multiple payers involved and not "single payers". Part of the reason medical law is so complex is that the medical systems of finance is are so complex and chaotic. And, yes who benefits from that chaos in regulation and finance? All providers and many patients know exactly what the answer is!
42	Allan Goetz	The strategy of the Healthcare Cartel is DELAY, DELAY,DELAY.
43	Betty Toto	You commissioners and we activist/advocates know that a healthcare program like AB1400/CalCare will save money and save lives. It is proved over and over again in example after example, study after study, plain and simple a single payer healthcare system will deliver what you all are deliberating about with this commission.
44	Don Cherf	I think that this commission which seems to overwhelmingly favor a single-payer, healthcare system for California has spent more than enough time debating, no, supporting a Medicare For All Californians that it should begin the implementation already. We can't keep kicking this topic down the road. We can't just keep talking about it without any forward momentum. It's past time to stop the conversation and begin the action. Californians can wait no longer. Implement CalCare for All now. And for those concerned about financing, we have plenty of countries that have successfully implemented Healthcare for All. We can easily discuss with them how they finance their systems. This is a doable action now if you would just decide to do it.
45	May Kandarian	Yes, an online calculator
46	Michelle Grisat	Agree, the public needs to be able to explore different approaches to financing single payer in California
47	David Openshaw	Please give more time to specifically discussing the models that are already laid out in AB 1400. As a low-income resident in San Francisco (I work as a substitute teacher in

Count	Name	Comment
		the public school system), I want to hear more discussion regarding a genuine single payer system that will provide quality health care universally throughout the state, using AB 1400 as a blueprint.
48	Marian Mulkey	As we approach end of comment period, please note that public can also submit written comments to HealthyCAforAll@chhs.ca.gov.
49	Ann Harvey	I am a retired family physician, primary care provider in a public system. The higher cost with no higher quality care delivered by Medicare Advantage plans should rule out any system with risk-assuming intermediaries. Market based outcomes based payments have likewise had unintended consequences, pushing providers to prioritize documentation of those outcomes over providing excellent comprehensive care. We definitely need to fund social programs (food, housing, basic income, daycare, education) city planning/infrastructure (walkable, bikeable neighborhoods with all usual needs within 15 minutes, safe parks, buildings and transportation that run on clean ply sourced electricity), environmental cleanups all MUCH MORE and health care which attempts in an expensive way to undo the damage done by the lack of all these as well as by systemic racism and the terrible income and wealth maldistribution in our state. Please evaluate AB 1400's payment mechanisms even though you won't discuss the bill as a bill.
50	Brynne O'Neal t	Institutional global budgeting could stabilize funding for distressed hospitals and prevent health care funds from being siphoned off for big profits for corporations, huge executive pay and bonuses, marketing, campaign contributions, union-busting consultants, or other uses unrelated to care. Many countries with publicly-funded health care—Canada, Scotland, Wales, New Zealand, Australia, Denmark, Sweden, Switzerland, Norway, Iceland, Ireland, and Singapore—use institutional global budgets as key components of their hospital payment methodologies. Many single payer bills, including AB 1400, include global budgets for each institutional provider to ensure that hospital receive the funding required to meet all needed care for their patient population and allowing the public to know where our health care dollars are being spent.
51	Thomas Nguyen	I worry that millions of Californians neglected to do COVID testing or seek treatment for other respiratory illnesses (flu, asthma, etc.) due to difficulties in our healthcare system. How would single payer/global payment help with the next infectious disease pandemic?
52	Allan Goetz	The Healthcare Cartel can (and does) always game the individual chargemaster system.

Count	Name	Comment
53	Shahrzad Shishegar	We need AB1400 to be openly discussed and seriously considered NOW!
54	Brynne O'Neal	Limiting access to health care through managed care or capitation is not a necessary or effective way to control costs. Study after study has shown that the problem with skyrocketing costs in our current system is about prices, not overuse. Even the consultant's draft analytic findings showed that a direct payments model (which is the single payer model), would save more money and cost less than a model that includes a role for managed care and health plans. Under a single payer system, we can use savings from system-wide price negotiations, lower administrative costs, and cutting corporate bloat to provide more care. Insurer costs such as care denial and containment, marketing, profit, and executive compensation would be eliminated. Health care providers would no longer need large billing departments to manage the manifold insurance cost sharing schemes, collect unpaid bills from the uninsured and the underinsured, or obtain preauthorization for tests and treatments. Health care professionals can use the time saved on administrative complexity to provide more care for patients. Single payer saves money. We don't need a payment system designed to get my doctor to tell me the care I need is too expensive.
55	Charles Victorio	The pandemic has shown me the dangers of putting profit over people. Insurance companies complicate the process for both doctors and patients. Under-served communities do not receive the care they deserve. We need AB1400!
56	Karin Bloomer	There will be time for one more speaker, so please use this time to enter comments in chat.
57	Michelle Grisat	People
58	Carol Mone	Oops, elephant in the room.
59	Allan Goetz	CORRUPTION! We should choose Single payer with no middlemen intermediaries to deny care. Decisions are made between a patient and their health care professional, not by a third party who profits from care denial. Reductions in costs from so-called "managed care" come from denial of care -- and the money not spent on care gets spent on administrative costs instead. Integrated care, where a patient's providers talk to each other, can be achieved at institutional providers with global budgets or through fee codes for coordination and warm hand-offs. Professional services to help a patient arrange all the care they need can also be paid for through a single payer system but will be much less necessary when patients do not have to navigate the administrative complexity of insurance networks.
60	Pilar Schiavo	I want to make sure we're being clear that making comparisons to our public health system and single payer systems is obviously not an equal comparison. Single payer

Count	Name	Comment
		systems have a revenue stream through taxes that is dedicated and not part of the general fund that is the current public healthcare system. It's a very different situation to find when you have a dedicated and protected revenue source. Also, Kaiser nurses I believe are also taking strike votes. Strikes happen in the private sector all the time. And negotiations with workers continues in any system, what we can remove though, is administrative waste that serves no purpose with single payer.
61	Eric Vance	I encourage people to visit https://FollowTheMoney.org and search for Commissioners Wood followthemoney.org, you'll see that the top industry donors for both, in the Broad Sector listings, are "Health" and "Finance, Insurance, and Real Estate," including heavy-hitting usual suspects from Big Pharma and corporate hospitals: Blue Cross / Blue Shield, "Medical Insurance Exchange of California," California Association of Hospitals and Health Systems, California Permanente Medical Groups, AstraZeneca, Pfizer, Nor "Association of California Life and Health Insurance Companies," Aetna, Health Net, etc., etc.
62	Michelle Grisat	The will of the people of California is for single-payer healthcare. Our politicians need to get on board.
63	Pat Herndon	Yes, we should have been thinking of medical care and access to safe and effective medical care for at least five decades, as a PUBLIC UTILITY, just like power, water, and other public services like policing, fire, social services, etc.
64	Tim Jouet	Pay to play. Pay to win.
65	Eric Vance	Commissioners: You can't take your money with you when your health fails you just as it has everyone else throughout time — let your legacy be something truly monumental, a tremendous and nearly immediate benefit to the health and material conditions of the multiracial working class, that will help provide them safety and security, and some measure of health justice.
66	May Kandarian	People who receive monies from the private healthcare industry do NOT belong on this commission. Move forward with AB 1400.
67	Cheryl Tanaka	Thank you, everyone!
68	Maz Hadaegh	AB1400 now!
69	Jenni Chang	Dr. Pan, Kaiser nurses are on strike with that private employer!

Total Count of Zoom Chat comments: 69

3. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address before the October 11th Healthy California for All Commission meeting:

Count	Name	Comment
1	Cheryl Tanaka	The fight to maintain abortion rights continues even if I won't be demonstrating this time. This is about quality of life, a woman's right to have agency, decision making over her own body and life! OMG! Men, especially those with $ and power, take that for granted! THAT IS ENTITLEMENT, (Dr. Pan!). Wanting equity/parity/justice via sharing of power/resources is not! Social welfare/Human Services are not entitlements either, but ways we must care for our entire population documented or not! (People are always going to try to abuse systems. Limits must be set/trade offs made. However, currently those who abuse the systems most are those with $ and power. Also medical tourism, if you will, and migration go both ways. The rich looking for deals or services not offered here for a "vacation." Others are simply looking for accessible services to survive.) It is hypocritical for some to advocate "life" from conception (including rape and incest) to birth (although is quality pre-natal care already accessible to all? And we know that delivery is fraught with misunderstandings, miscommunications, etc., which put the life of even Serana Williams and her daughter at risk and killed my aunt, an RN, and her son [birth canal was blocked when water broke, they weren't able to respond quickly enough and she drowned]) and thereafter ignore the needs for quality of life including universal healthcare/single payer/unified financing and equitable social determinants of health.
2	Gerald Rogan	I invited another former Medi-Cal Contractor medical director to listen to your next meeting. He was also a Blue Shield medical director and a managed Medi-Cal medical director. I was a Medicare contractor medical director and a PPO medical director, and Medical fraud consultant to the Calif Med Bd, OIG and US Attorney. Both of us were primary care physicians in California. Please review my comments previously sent and make them available to the public. I can correct typos if you wish. A SPP will not achieve your objectives. Social problems that adversely impact health cannot be corrected by any medical care system.
3	Cheryl Tanaka	Forgot what prompted this email, "Meditations on Enough" from Yes magazine. For some people there is never enough. We need to set limits on those abusers of power and resources, because enough is enough. We need to make it enough so that everyone has a fair share. How Much is Enough article
4	Cheryl Tanaka	I'm a huge fan of Call the Midwife for it's moral and heartwarming stories. Yet it also shows us the beginnings of the NIH and does

Count	Name	Comment
		include topical issues. In the Season 10 opener, Nonnatus House is at a crossroads. Continue as non-profit (Dr. Turner is adamant) or turn to or at least cooperate with for profit? Also soldiers unknowingly exposed to radiation, and its effects upon them and their children, is revealed. https://www.pbs.org/video/call-the-midwife-season-10-episode-1/ Health and Human Services is an enormous umbrella. We see the mid-wives work to deliver both health and human services as they give pre-natal, delivery and post-natal care to mothers, families, their community and their babies. All become community issues and harken back to times when neighborhoods/communities were more unified, provided jobs, schools, hospitals, etc., and were not as spread out (due to city/urban/etc. planning that needs to be reimagined once again toward a more sustainable and eco friendly model).
5	Cheryl Tanaka	A lot of inequities highlighted here. Immigration and the host of challenges living undocumented, ICE being only one of them. Ashley needs to work both in the fields and in a food processing plant to help her mom keep their family afloat and they don't have much. Yet Ashley continues to dream and better herself as well. Her ancestors were curanderas/healers, they solved problems, often with herbal/food medicine/magic. Thus the community garden in a food desert area that doesn't have easy access to healthy food. (We need more community gardens.) That community is poisoned by the processed, low in nutrition, high in preservatives, bad fat, sugar and salt food, high in sugar or alcohol drinks, tobacco in all its forms readily available to it. Teenaged pregnancy happens everywhere especially when the teens want something of their own. Love how the high school teacher says that FDR's New Deal didn't protect farm laborers or domestic laborers, i.e., black, brown, (yellow, etc.), and that's why children of 12 can still work in the fields where they may be exposed to toxic chemicals. Love the reference to the United Farm Workers. Viva la huelga, but where is it now? I remember boycotting lettuce and table grapes in the day. These are the survey participants for whom healthcare may not be the top priority although Sra. Solis did benefit when she 1st arrived. Then there are nail salons that are an economic lifeline for many and an affordable/accessible spa treat for many, yet expose workers to toxic chemicals as well.
6	Cheryl Tanaka	Immigration or Migration? Definitely things to think about, because language matters and frames our thought processes and points of view! Immigration or Migration?

Count	Name	Comment
		Futurist/activist/author and the late futurist/activist/organizer Grace Lee Boggs mentee Andrienne Maree Brown posted about Movement Generation Justice and Ecology Project on IG. A pdf for the slides she shared are attached. I've been thinking the same thing. That the natural order of things is for species to migrate from areas not conducive to life to areas conducive to life. That for the human species that often is because of war and political terrorism is of dire concern, because just as in the wild there can be overgrazing and over watering. In the wild measures are sometimes taken to help. We must do the same for the human species as well. Where there is war/political strife and terrorism with the ills that kind of unrest can cause, we must try to take in as many as need to flee while also taking a look at sanctions, etc. that might make a positive impact on the countries they're leaving. Where it is about lack of potable water and food, I've long thought of desalinating sea water as some countries already do. If sea levels are rising and rainfall is becoming less regular, it seems a logical solution we need to devote time and resources to research, study, experiment. Another thought is harnessing, storing and shipping flood waters. On the food supply side, there are community gardens we need to fund and multiply and there are hydroponics and other innovative and technology-driven ways to raise food. Borders or Frontiers? Pati Jinich has a new series where she'll be traveling to the border to take a look at food and culture. In one segment she talks with author/editor/teacher Sergio Troncoso who says that there is a mix or mash up of cultures which is enriching. I agree. Buttermilk with its globs of butter fat is richer than homogenized milk where everything is the same. We need to embrace and integrate our many cultures and differences in the US. La Frontera
7	Jean Molina	Yes for Medicare for all!! I support single payer healthcare. Please let's get rid of health for profit! Corporations have no business in healthcare. It is a human right to have healthcare! I support single pair healthcare. Get rid of the insurance companies greed and corruption. Please.
8	Zrebric Humphrey	As a family we are totally in support of healthcare for all. This is a reasonable thing to do.
9	Karen Stone	Dear Decision Makers, It's time for California to prove that Medicare for All is cheaper and better than the current for-profit healthcare system!

Count	Name	Comment
		We have often been on the cutting edge and shown the way forward. NOW is the best time to show that it works better and helps more people to a healthy and productive life. Without your health, you can do very little...but with it, even the sky isn't the limit! Get going NOW! Whatever you call it, make it for everyone! California can lead the nation, again!
10	Marilú Carter	“Insurance companies want to insure people who don’t need insurance.” — By Marilú Carter, 5 October 2021. When Americans desperately need medical care — but they can’t afford insurance — they turn to the Emergency Room for help. But without preventative care, even heroic measures in the E.R. may be too little, too late. As COVID-19 exposes our substandard health care system, over 700,000 people have died. Untold millions suffer. Since many lack medical insurance and adequate policies, they lack access to preventative care. On June 12, 2019, Dr. Don Berwick, former administrator of Centers for Medicare and Medicaid Services, told Congress, “I’m a little worried about the public option for a kind of technical reason. Insurance companies want to provide insurance to people who don’t need it. That’s how they make money.”* The insurance industry games its risk. The profit model works exceedingly well — for insurance businesses, for Wall Street, for shareholders. But it ain’t working so great for millions of Americans. Insurance companies want to insure the young, the healthiest policyholder. Some companies reward employees who find plausible reasons to deny coverage to policyholders. Insurance companies profit as government (the public option) cares for the sickest patients — the cancer- stricken, the disabled, the wounded veteran, the mentally ill, the aging. The government (We, the Taxpayers) takes the riskiest groups. The public option (Affordable Care Act, 2020-2021, ACA or Obama Care), lets healthy groups opt out. Testifying for "Pathways to Universal Health Coverage," Dr. Berwick told Congress why the public option won’t work. Instead, the United States needs a comprehensive, national, universal, preventive care health system — as other wealthy, advanced nations offer. The public option — as advanced as it is by covering pre-existing conditions — offers a superb business model for insurance companies. In 2020 alone, pharmaceutical executives, e.g., profited $12.5 million each — $400 million collectively.** Americans — particularly hard hit minority groups — are the biggest losers in the insurance high stakes, life-and-death risk-game.

Count	Name	Comment
		Retrieved 1 October 2021 from: Youtube: Dr. Don Berwick explains why the public option won't work Retrieved 3 October 3021 from: Patients for Affordable Drugs Now.org
11	John Douglas	Healthy Calif. for All Commission: I urge you to focus on single-payer healthcare as laid out in AB1400 CalCare as the only viable system that will achieve universal, high-quality healthcare for all Californians, at the same time gaining significant cost savings and an end to intermediaries interfering in the doctor–patient relationship. Thanks for considering my views.
12	Michael Chaskes	Dear Commissioners, As a Californian and a voter, I am very strongly in favor of a robust single-payer health system being instituted in our state, at the soonest possible time. The private health insurance system is both wasteful and inequitable, and Californians deserve better: namely, universal access to high-quality care, regardless of ability to pay or citizenship status. I specifically want to speak in favor of the following two points: 1) Transparency of process: Critical conversations with consultants and input from “stakeholders” should be public, not behind closed doors. 2) No “intermediaries”/no role for insurance companies: Insurers and so-called intermediaries add nothing of value to our health care system - they increase costs and reduce access and quality of care. Please don’t model a system that has a role for them. A system with a role for multiple health insurance plans would be neither single payer nor unified financing. Thank you for your attention.
13	Millie Braunstein	Dear Dr. Ghaly and Commissioners, I appreciate the Commission’s work as it reviews the evidence that will guide your work in the development of a unified financing mechanism for health care in California. Through the existing publicly financed programs in the United States and California, much knowledge has been gained about how to design a reimbursement system that is equitable and can minimize waste and fraud. The use of a state-wide global healthcare budget, with regional planning for distribution of health services and capital

Count	Name	Comment
		expenditures, has been found to be essential to the provision of services which are both accessible and cost-effective. It has been suggested that payment methodologies, such as fee for service, per capita payments and salaries, can all be utilized as long as clear guardrails are established, including guaranteeing a single standard of safe, therapeutic culturally competent care to all, without financial or other barriers. Additionally, to provide universal assess, provider payments must start from the premise that there can be no incentives to limit access or deny care. Governor Newsom made a campaign promise of universal health care in California. He has frequently stated that decisions in his administration are based on data and facts. The health of the workforce and the economy depends on sound policy that can be sustained into the future. It is now the time for social justice. Health care for everybody. Eliminate intermediaries that restrict access to care and the profits of the corporate stakeholders.
14	Ross Ward	Dear commission for Healthy California for All, My name is Ross Ward and I urge you to discuss the benefits of the Assembly Bill 1400, CalCare, as it meets most of your defined criteria for insuring California. It also is a bill that has been put forth in committee already, an important step in passing any legislation for insuring California, as is your ultimate goal. AB 1400 also has clauses to address financial transparency, more fair pay to primary care physicians which would aid more diverse and rural populations, as well as insure the cannabis industry. This industry is heavily taxed and it would be a boon for all of California if the burden of providing employer based health insurance were removed from all businesses, especially cannabis. There are many more important features of AB 1400 that address different aspects your stated goals that committee members Consti and Marya have brought attention to, as they can do so more eloquently than myself. This single payer option is overwhelmingly popular and I support it, and encourage the committee to discuss it as well. Best regards,
15	Scott Johnson	Healthy California for All meeting The following comments are relevant to the subject of the October 11 commission meeting. Systemic underfunding is causing increasing numbers of hospitals and clinics in rural and medically underserved areas to

Count	Name	Comment
		close or reduce services. By using institutional global budgets, single-payer provider reimbursements can be designed to correct this systemic underfunding. AB 1400, for example, uses institutional global budgets to create reliable funding streams for facilities in underserved areas by paying hospitals and other health care facilities. Institutional global budgets would cover all the health care facility's operating expenses and tailor payments to each facility's specific resource requirements to ensure they can continue to operate and provide high quality care. Global budgets add essential transparency to provider payments, ensuring that health care dollars go to increasing and improving care and not excessive executive compensation, marketing, or political contributions. Institutional global budgets will provide equity for rural and urban underserved areas which currently do not have sufficient resources and staffing to meet demand in their areas. The current system allows a few massive health care corporations to consume more and more of the health care dollars. Institutional global budgets have been proven to be effective in several countries that use them as key components of their provider payment methodology, including in Canada, Scotland, New Zealand, and more. Institutional global budgets can like those called for in AB1400 can provide reliable funding for underserved hospitals and clinics, fund capital improvements for the construction or renovation of health care facilities in rural or medically underserved areas and to address health disparities. AB 1400 would also have additional special projects payments which could be provided to facilities in medically underserved areas to address any issues with accessibility and availability of care. This special projects funding could be used to increase staffing, expand operating hours, to upgrade or build new facilities, or for other services targeted to address health inequity. California should adopt the model of doctor and clinician payments in AB 1400, which has two payment options for individual providers and group practices -- fee-for-service reimbursements or salaries. Both would be directly negotiated with CalCare annually. Another provider reimbursement option in AB 1400 is that doctors, doctor groups, or individual providers can opt to receive a salary for their work instead of tying their payment to performance metrics, risk-based payments that commodifies the doctor-patient relationship, or service-based reimbursement.

Count	Name	Comment
		AB 1400 has provisions to increase payment rates in areas that have provider shortages and to stabilize funding in rural and underserved areas. Under CalCare, the Board can increase payment rates to providers or use special projects funds to improve the availability and accessibility of health care services in rural or medically underserved areas. Under our current multi-payer system, doctors waste precious time fighting with insurance companies to get the services that their patients need covered as well as managing deductibles, copayments, and other billing issues. Under CalCare, doctors will have more time to spend caring for patients and other reimbursable services while their insurance and billing-related costs will fall. There is no reason to delay passage of single payer legislation, nor is it necessary to stall the move to a single-payer system just because we have not yet been granted federal waivers. For example, once AB 1400 is signed into law, the governance structure will be implemented right away, but the rest of the program would not take full effect until it is fully funded. There is no reason to stall the process of establishing the structure of a single payer system while we wait for federal waivers. There is no reason to stall the process of establishing a single payer system while we wait for federal waivers. Indeed, we should not expect HHS to approve a waiver application for a program that does not even exist yet. The federal government would not and, according to the procedural requirements under the law, could not approve federal consolidation waivers until California passes a law creating the single-payer program. Asking the federal government to approve a waiver on a program now before passing a law creating that program would be the equivalent of attempting to enter into a contract without having established what the contract would actually do. 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

Count	Name	Comment
		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, combined with existing federal funding. 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 discuss it and let Commissioner Comsti present on it and not just federal waivers. This commission should use AB 1400 and work on completing it with financing when drafting its report.
16	Jeffery Tardaguila	I have asked repeatedly for high contrast pp So I can read font 20 or something like that you have 4 meeting left to explain How to finance a single payer medical system for everyone ? So much undone!!!?

4. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address during and after the October 11th Healthy California for All Commission meeting:

Count	Name	Comment
17	Allan Goetz	Why has the commission not examined how the 30 Single Payer countries generate their universal chargemaster and provide payments based on it to the providers? France, Switzerland, and Netherlands are examples.
18	Patty Clark	A single payer system of healthcare in the United States is inevitable. California has the 5th largest economy in the world. There is a way that we can independently fund healthcare for our residents. The commission needs to find a way that we can move forward as the example to the country on a humane healthcare system that does not involve insurance companies. Please be bold enough to solve the logistics of bringing single payer to California.
19	Chrys Shimizu	Don Moulds asked (paraphrasing) should our goal be to reduce spending on healthcare to free up resources for social services, or should we be looking at addressing other needs through the health system? The money saved through ditching the employer based health insurance model for a single payer model will be

Count	Name	Comment
		enormous. The money we could get just from compelling rich individuals and corporations to pay their fair share of taxes would be enormous as well. So with all that potential money why not do both? Why not have the goal both to spend money on social services as well as provide new types of health services through a single payer system? By the way, AB1400 addresses this and it should be discussed. Thanks!
20	Philietz Liu	Dear Speaker and Panelists of today's presentation, As a parent deeply concerned and profoundly involved with health issues in our school districts, I am wondering when Rapid Antigen Test kits can be paid for by the public funds and sent to localities for free school Covid testing at the campus? Right now only PCR tests are made available free here in California, but with the Biden administration announcing last week 1 billion of extra investment on top of the $2 billion investment earlier to ram up of testing capabilities, especially for rapid antigen tests, it is hoped that California will use full benefits of these federal investments and align with our efforts to make it happen soon. "Antigen test is not a medecine, but public health in health infrastructure", per Harvard epidemiologist Michael Mina. Thank you for today's presentation.
21	Jeffery Tardaguila	Since Kaiser is HMO model. How does Kaiser do global budgeting ? Methods, procedures, process?
22	Chrys Shimizu	Richard Pan pointed out that a private hospital saved the day in Maryland by taking over providing the school nurses. He was implying that the government paid program (the schools) failed and the private company had to save the situation. However, the private hospital was incentivized to pick up the nurses because they were under a Global Budget which was controlled by the government. So his example doesn't support his conclusion at all. Thanks!
23	Chrys Shimizu	Jennie Chin Hansen had a question about the execution of creating a single payer system. If the participants had been allowed to discuss AB1400, the CalCare bill, which will be voted on in the Assembly in January 2022, they would see that a blueprint, that addresses Hansen's concerns, is in that bill. Thanks!
24	Michael Lighty	Dear Commissioners, I'm surprised at the currency given to ACO's and Medicare Advantage in the readings for this meeting. As Commissioner

Count	Name	Comment
		Moulds pointed out, the results of the ACO experiment has disappointed the expectations CMS had for this reform. That conclusion was definitively shown by the recent article, Promise vs. Practice: the Actual Financial Performance of Accountable Care Organizations Journal of General Internal Medicine, August 13, 2021 By James G. Kahn and Kip Sullivan, which collected and compared financial performance data from all four CMS ACO programs from 2005 to 2018, examining net CMS cost. They found that overall, ACO programs roughly broke even from the CMS perspective. That is, when bonuses CMS paid to ACOs are subtracted from gross savings, the programs lost money or saved no more than a few tenths of a percent. Combined with the demonstrated negative impact of ACO's and so called "value based purchasing" on safety net hospitals, high needs/low income patients and the huge racial inequities in access to healthcare revealed by the COVID pandemic, it would be counterproductive and against the Commission's own mission, to pursue models that rely on ACO-based approaches. The former head of CMS, Donald Berwick, has also pointed out the deficiencies of the Medicare Advantage program, which essentially puts care decisions and access in a profit-first environment subsidized by taxpayers. In short, payments must start from the premise that there can be no incentives to limit access or deny care. Risk-based payments should not have a role. The new bottom line has to be patient needs, not defining "trade-offs." The concept that low-income people are used to making healthcare trade-offs as in they don’t get whatever antibiotic they “want” and therefore trade-offs can continue is offensive and misses the primary problem of restricted access to care. COVID vaccination rates illustrate the problem – if someone does not have regular access to a primary care doctor or medical services, urging them to vaccinate may seem like a non-sequitur, with no obvious way to do so. Moreover, payments to providers cannot be separated from the disproportionate lack of medical services in Black and brown communities, illustrated by the ultra-low Medi-Cal reimbursement payments set by the legislature, which reduces the number of providers accepting Medi-Cal, and thus reduces the number of providers in low-income communities.

Count	Name	Comment
		Global budgets, fee for service, per capita payments and salaried providers can be utilized as payment methodologies provided that clear guardrails are established, including guaranteeing a single standard of safe, therapeutic culturally competent care to all without financial or other barriers. Global budgets should be a prospective payment system with retrospective, cost-based true-up. We start out paying hospitals exactly what they earn now and use global budgets to control future costs. Global budgets, in a payment system not based on risk, without profits and without intermediaries that can divert revenues from patient care, specifically in which capital budgets are controlled by the single payer, may very well serve both patients and the system the best. A state-wide global healthcare budget, regional planning for distribution of health services, and again publicly controlled and accountable capital budgets, are essential elements to ensure equitable access to services that are cost-effective, and which replace market-based approaches that allocate services based on ability to pay and profitability. SImply put, we should start from the premise that there is no role for intermediaries that restrict access to care based on financial incentives, or that allocates services based on insurance risk. We should be especially skeptical of private intermediaries that distort performance measures based on their own imperatives. Peer review is also essential to implementation of any payment system, including global budgets, and can be utilized to ensure appropriate service delivery. A key element in making this work is a cost accounting system that goes down to the service level (not just to “cost centers,” as Medicare Cost Reports do). Let’s utilize the Office of Affordability and expand its role. If we can keep hospital revenue at current levels, through health planning, we can begin to close the divide between hospitals, as Commissioner Hsiao has argued, who have coy ponds and waterfalls to public hospitals for example that are cash strapped. Currently the hospital industry is orientated around capital expansion. Once the system separates out capital and research expenses, this changes the incentives toward a focus on service levels instead, which should be the only place for any “surplus” income to go.

Count	Name	Comment
		Protecting the wages of healthcare workers must be a foundational principle for payment system reform, just as is providing economic security to displaced workers. Instead of financial incentives to deny care and reward cherry-picking of healthy patients - as Medicare Advantage plans are designed to do - California should adopt the proven approaches of other national healthcare systems: uniform benefits, simplified financing, removal of profit for primary insurance, regulation of pharmaceutical prices, and public control of capital investments. These elements are essential to promote equity and would create resources for public health and addressing the social determinants of health. Through global budgets that create a new level of transparency, the payment system can fund primary care and prevention, preserve the professional clinical judgments of providers, meet the individual needs of patients with culturally competent care, and especially improve community health, without private plans that use risk to create financial incentives to deny care.
25	Chrys Shimizu	Richard Scheffler was once again advocating for risk based capitation as something we should continue to consider even though it's been discussed and proven that it does not save money or improve health outcomes. It needs to be made perfectly clear, in order for single payer to have the outcomes we know we can have, we cannot have any insurance companies acting as intermediaries using risk based capitation to pay the healthcare providers. Thanks!
26	Willam Honigman, M.D.	Thank you, Commissioners. My comments relate to COVID19 as the most pertinent and pressing example of why we need to move ahead with modeling for provider reimbursement as exists in AB1400. The glaring inadequacies of commercial payers to allocate direly needed health resources in this pandemic, where not just PPE, universal testing, and contact tracing have been inadequate, but also has any assurance that chronic comorbidities, that compound risk to the public at large of contracting and ultimately suffering or dying from COVID19. This shows that such market-based systems need to be cut out altogether, not bargained with for rate-setting or otherwise depending on any market-based entities to allocate those resources. More generally, this is what has created our “healthcare deserts”, in particular in our inner cities and rural areas of the state, and results in so much of the inequities and disparities, as we’ve seen even magnified with COVID19.

Count	Name	Comment
		It's past time to move on with modeling the legislation we have at hand that does exactly that. Eliminate the commercial market-based interests that are not acting on the interests of the public rather than their bottom line in their reimbursement practices. Accept the payment plan modeled in AB1400, global budgets for institutions and options of fee-for-service restricted only to individual Healthcare providers or salaries for individual or small group providers. Thank you.
27	David Leibowitz MD	Great meeting today Secretary Ghaly! How can we access the materials that were sent to the commissioners prior to this meeting? Thanks very much,
28	May Kandarian	People who receive monies from the private healthcare industry do NOT belong on this commission. Move forward with AB 1400.
29	Shahrzad Shishegar	Hello, my name is Shahrzad Shishegar and I live in assembly district #48. I am a member of the San Gabriel Valley Progressives and Progressive Democrats of America as well as the United Democrats of the San Gabriel Valley. I would urge the commission to forego its focus on alternatives to AB 1400 and begin seriously discussing this bill in earnest. We NEED to move forward with a single payer system that does not involve intermediaries that siphon off our Healthcare dollars. Healthcare is a human right and should not be profit-driven. Our current system is so complicated and my personal experience is one of many examples of how the insurance system is broken. My dad, who was being abused by his wife, was not able to stay with me for a couple weeks because his dialysis treatments could not be transferred to an "out-of-network" treatment center. It took over a week for him to get his treatments transferred to a center near my home, causing much stress and heartache for us both. We need change that puts people ahead of profits. Please look into CalCare (AB1400) and find ways to implement it.
30	Tom Michel	Hello Commissioners, My name is Tom Michel, I am so very tired of listening to you finds ways to implement a health system that continues the status quo. Let California lead the nation, find away to a Single Payer System. AB 1400 would work, so would any single payer system that is just. As a patient I am sick of being continually victimized by our current system. I am willing to pay more in

Count	Name	Comment
		taxes for a system that works for everyone. Such a system will bring more people and entrepreneurship to California. Thank you,
31	Robin Sunbeam	As demonstrated in the report by Don Moulds of CALPers, our for-profit healthcare hodgepodge system costs the nation significantly more while providing pitifully less in health outcomes. The existing healthcare system is an embarrassment for the USA in the world. As a Maternal-Child nurse, it was the blatant racism in the delivery of obstetrical services that has driven me over the last 3 decades to advocate for universal, unified publicly financed healthcare. To me, it is obvious that racism and classism are the main causes to the 90-year delay in instituting universal single-payer healthcare. It seems that the elites in control believe they are better than the common people and therefore not only deserve better, but also have the right to deprive the poor and People of Color from the same rights. Racism and classism drive a lot of policies here in the USA. We have been proposing single-payer health systems in California since 1992. Each time the effort is shot down, the proposal is refined and improved. The latest, most improved version is now AB1400, CalCare. AB1400 includes financing with federal waivers for Medicare, Medi-Cal and Covered California funding. Governor Newsom has already applied for those waivers. I was delighted to hear all the favorable discussion about global budgets and salaried doctors, and that prevention saves money, since that is already written into the existing bill up for consideration. I demand that the Healthy California for All Commission include reflections of the provisions, as written in AB1400, into every category of discussion. Thank you for bringing it up, Mark Ghaly. Private health insurance can be available for things like luxury hospitals and elective cosmetic surgeries.
32	Ann Harvey, MD	Dear Commissioners. I appreciated the excellent presentations at today's meeting. I am a care family physician, retired from Contra Costa County Hospital and Clinics where I worked in primary care as well as dedicated clinics for treatment of HIV and opioid use disorder. I am currently a Kaiser patient. A couple comments: 1. Physician and other provider salaries allow the provider to focus fully on care of the patient and/or community rather than, even subconsciously, on financial implications of clinical decisions. I think it is especially crucial that surgeons not be rewarded for recommending operations, which may not be the

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		safest or best option for a patient but are yet so lucrative under our current system. 2. Near the end of the meeting, somebody suggested interviewing Kaiser about how they manage their system. I think that is a great idea. HOWEVER, I strongly recommend that if you do, you hear from Kaiser doctors who can comment on how their nonprofit hospitals and clinics could continue to provide the same high level of efficient and coordinated care WITHOUT the for-profit Kaiser insurance arm—in fact, they could provide it more efficiently. You might have to offer them anonymity. Sincerely,
33	raikouneo	To whom it may concern, 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 discuss it and let Commissioner Comsti present on it and not just federal waivers. 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 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 discuss AB 1400, include it in your final report, and help California guarantee health care for all in this urgent time of dire need. Single payer now! PS. Any Californian legislator who wants to leave behind a legacy worthy of historical recognition (and not just be anti-Larry Elder) will support this bill. Anyone who OPPOSES this bill will endanger their seats and will fuel community challengers against them.
34	Cheryl Tanaka	Happy Indigenous People's Day! Everyday!

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		Thank you to Secty. Ghaly, Commissioner Don Moulds, Dr. Dana Safran, Dr. Josh Sharfstein and all commissioners. Those were dangerous words, Bob Ross! We shall see what we shall see. It's currently 1/1. Tom Cruise came to watch game 2 at Oracle Park. We'll see if he puts in an appearance at Dodger Stadium. Go, Giants! Thank you so much for the research regarding global budgets, all-payer reform, value-based payment, Massachusetts' AQC and Maryland's global budget all-payer system at least in their rural areas. It sounds like money from CMA/Medicare/Medicaid play an important role and are accessible to states using the 1115 waiver. IF health insurance companies remain, then having a system where they pay monthly sums based on what they historically paid, with adjustments made thereafter, sounds like a better system than the current one in which they behave more like financial institutions, The money they receive in premiums, etc. is then theirs to do with as they please, not to provide us with healthcare coverage. My concern would be IF the monthly sum were not enough. How to make up for that shortfall in a timely manner when current healthcare insurance companies are anything but. Like that global budget all-payer systems seem to favor preventative and community care over filling beds/inpatient volume which is the retail, fee for service healthcare we have now that profits from those who are ill, in need, at risk. Predatory. Although there are many steps, these pieces do show a road map toward transforming our healthcare system via a value-based, global budget, all-payer system. Page 8-9 "An Emerging Approach to Payment Reform" I feel argues for 1 value-based, global budget, all-payer system (without fee for service private healthcare providers/systems or insurance companies) with the goal of transformational results. "An important consideration is whether there are alternative and more readily available payment mechanisms capable of achieving the same transformational results. One reason the Medicaid managed care program started several decades ago was to encourage greater attention to preventive care. However, a major limitation of managed care has been the separation of the payer from the provider, so that health systems are unable to capture savings that can sustain transformation. There are efforts in some states, including New York, to require managed

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		care plans to pass incentives to clinical systems capable of managing risk. This may create new opportunities for large urban safety-net systems. Another recent development is the rise of accountable care organizations in the Medicaid program. Massachusetts, Rhode Island, and Vermont all have 1115 waivers under Medicaid to support risk sharing by health systems acting as accountable care organizations. The use of this tool can be part of an “a la carte” approach to value-based payment, along with structuring payment for the uninsured so that it is not based on inpatient volume. Patching together such a system without a single global budget does not require the degree of public and private coordination needed for an all-payer hospital global budgeting program. A key consideration, however, is whether the patchwork covers an adequate share of patient volume seen by inpatient facilities. If it fails to do so, health systems can be stuck with the proverbial “one foot in each canoe,” unable to transform to leave fee-for service medicine behind. Furthermore, a patchwork approach may create undesirable challenges for risk management, if patients move back and forth between value-based and fee-for-service reimbursement." Ibid p. 9 "A third consideration is whether there is a path to a credible administrator for an all-payer global hospital budgeting system. Long-standing disputes between hospitals or between hospitals and insurers may complicate the development and implementation of an all-payer global hospital budgeting model. Well-trusted private or quasi-public agencies are best suited for taking on such a role. The leadership of such organizations will need to bring in professional staff to provide oversight to the system in a credible fashion." p. 8 "Lower v Higher-Income Populations in the Alternative Quality Contract" "Ultimately, social and environmental factors are recognized to play a larger role than health care in determining the health of populations. This suggests that efforts to reduce disparities in poverty, education, and related factors would be an important complement to interventions in the health care system. Conclusion: During the first four years of the Alternative Quality Contract in Massachusetts, improvements in quality of care for enrollees in areas with lower socioeconomic status were comparable or greater than those in areas with higher socioeconomic status, without statistically significant differences in spending trends. These results suggest that in its early years, the AQC likely contributed to a narrowing of disparities in some dimensions of quality, notably as reflected by process measures

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		in the contract. Moreover, our results suggest that in a population-based global budget model, sufficiently large quality incentives with an overall adequate budget could be important factors in giving physician organizations the financial resources necessary to intensify efforts toward improving quality of care for disadvantaged populations." "Addressing Social Risk Factors in Value-Based Payment" seems to address provision for healthy food to those socio-economically disadvantaged "A health plan or provider group that cares for a population with greater average social risk would receive higher monthly payments than if they enrolled a population with equivalent medical risk but lower social risk. Quality performance targets would be identical. Although achieving the same outcomes may be a greater challenge in the population with greater social risk, the additional upfront payments would give plans and providers the resources to invest in activities that support their populations' needs. This would have the additional benefit of creating opportunities for plans and providers to incorporate the social determinants of health into the care they deliver. For example, Geisinger Health System has found that patients with diabetes who receive healthy food directly from their providers have improved control of blood sugars, blood pressure, and cholesterol. This payment approach would create not only the opportunity but the obligation to seek out these kinds of solutions." Enjoyed the pre-meeting reading provided and the 3 speakers. "All-payer" is already happening on some scale in some states. It's not the Single Payer non-profit ideal, but is moving away from fee for service to patient/population/community-based healthcare with any savings used for re/investment. It seems that in both Massachusetts and Maryland there was legislation as it took a lot to set all important strategies/guidelines/policies/etc. for transforming from fee for service to value-based patient/population/community centered healthcare. It also seemed that risk adjustment meant more $ for those areas more at risk and didn't necessarily employ racial stereotypes. I understand that this commission is preliminary, advisory, exploratory and not for setting policies. Have not read the 1st commissioner survey yet, but look forward to it as well as the subsequent one. Don't expect commissioner stand points to change too much. They do run the gamut from pro Single Payer to for profit/fee for service. Hopefully all can agree that our fragmented system isn't serving us well especially in light of the additional stresses from our current pandemic. It's what to do about it and how going forward.

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		Will it take passage of AB 1400 to get the ball rolling and bring providers onboard as a growing sector of the population is in favor of a Single Payer/Unified Financing/All Payer system? Certainly a change to global budgeting (which could translate to salaries with bonuses for providers not affiliated with a hospital) seems to change the point of view from fee for service/filling beds/profiting from those who are ill, at risk, in need, etc., to patient/community/population/value based care that can lead to preventative measures, better outcomes and head off chronic conditions which are currently one of the drivers of healthcare costs along with pricing which I understand Maryland had addressed prior to its global budget movement. It also seems to narrow the quality of care gap between advantaged and disadvantaged. As healthcare intersects, among others, public health and human services, transportation, housing, nutrition, etc., any savings can be re/invested as in the case of the school nurses fired by the school district and rehired by the hospital working for the best interests of the community as a whole. If they could address asthma at the school level it would benefit the hospital and community as a whole. All services support each other in supporting the community, common/greater good. Know these days that's an old school and out of step ideology, but is alive in some places and hopefully can be grown and spread. An All-Payer system would bring transparency for metrics and assessment. Aiming to weed out racial/cultural/gender/sexual orientation/ableist, etc., biases in data gathering and management would be key. Sensitivity to same in restrooms, literature, etc., would also be key. We're still talking about equitable access and services which many do not yet have. Many would take preventative healthcare services as a trade off to no services at all. All they have to trade off, as they have historically, is their well being and lives. I'm still waiting for a clear delineation, enumeration of those "trade offs." That this will mean a transformation in thinking, $ and power is a given. Time to share $ and power. California is the 5th largest economy in the world. We have enough resources to share. Now is the time to do that! The will of the people is for this change. Political will is another thing. As we see in DC so it is in Sacramento? Hope not!
35	Jenni Chang	Jenni Chang with California Alliance for Retired Americans and Healthy California Now. I am also an Eboard member of the California Democratic Party.

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		Creating resources for public health will require California to assert itself and to adopt new levels of transparency and regulation—that commitment from all the commissioners is important. Please be more serious about getting rid of the private, profiteering insurance companies and stay steady on single payer to create the most cost effective, equal and equitable system with uniform benefits without barriers. Global budgets can help clinical providers to do what they need to do, as well as help the serve individuals with culturally competent care, improve overall community health. A response to Dr. Richard Pan: The Kaiser nurses are also voting to strike that private employer. Upon Dr Pan's comment about the value of the private hospital vs the public school in employing the nurses, there were private conversations between advocates pointing out that public health is NOT A unified financing system with a dedicated funding source. The problem with public health is that it's part of the general state budget—no taxes or funding are specifically designated for it. Single payer would be separate from the general budget and would have taxes and revenues that go directly into that are used to pay for services. Regarding the transition to a unified financing system, since our system is so complicated and regions are diverse, I wonder if it would be good to do some “beta testing” in contrasting regions first, and then do a full overhaul. I think this makes more sense than implementation by single regions at random or in a completely segmented manner. I ask our commissioners to be brave. The political currents will always be rough on this issue—look how stealthy and aggressive the private insurance companies are in their pursuit of Medicare, as well as trying to undermine the public health systems of other countries. Consider how callously Moderna works to keep its vaccine out of reach for those without means. Government has to regulate on behalf of the people. Have courage. And thank you to the commissioners who continue to do strong work outside of the commission space to make these meetings productive, to get us to make the big leap—keep pushing!
36	Craig Simmons	How many commissioners would be in favor of recommending a ballot measure for implementing a payroll healthcare tax to fund a unified financing system for inclusion in the final report? Global budgeting/standardization of healthcare costs is an integral part of a single payer system. How many commissioners

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		agree, and how do we accomplish cost standardization for inclusion in the final report?
37	Cheryl Tanaka	I'll be honest and say that "Squid Game" got onto my radar because of a piece about how some important meaning gets lost in translation, although I'm sure the acting and context would make up for it. If you watch (subtitled) C, J and K dramas (and other Asian, Spanish/Mexican/Latin American telenovelas, Scandinavian [Wallander, Beck], Italian [Montalbano]), you begin to pick up a few words here and there. And because of the dalgona cookie challenge. Like Julia Child, I love to eat. According to one Korean creator I follow on Youtube, dalgona cookies have a camping connection just like s'mores, so could see them being this fall/winter's answer to s'mores. S'mores using dalgona cookies instead of graham crackers or adding dalgona cookie crumbs? YES! Back to "Squid Game" and its commentary that could fit our current healthcare system. Squid Game has a winner take all cash prize that all contestants are desperate to win no matter what as these are people at risk, in dire need. Sound familiar? They're asked to play familiar children's games. Still sound familiar: mother may I (referral/denial of services especially rare, acute, terminal and reproductive); hide and seek a provider in your network; tag you're it, i.e., have pre-existing conditions that keep you chasing insurance/premiums/deductibles/etc, Get the picture? 1 of the lead characters believes he is so exceptional that he deserves to win at any/all costs and he has nothing more to learn, so forget everyone else. The other feels that a debt is due to all who participated in the games because they all taught lessons about our humanity. Guess whose ideology I favor? Yet so many feel like the 1st lead. That is not a sustainable way just as our current healthcare system(s) are unsustainable with their ever increasing costs that aren't because of an increasing accessibility or quality of care. I'd say let them eat dalgona cookies, but they are basically pure sugar and even using coconut sugar, which would technically make them Paleo, Marion Nestle would still say sugar is sugar. *SIGH!*

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