Healthy California for All
September 28, 2021 Virtual Commission Meeting
Public Comment

1. **The following table shows public comments that were made verbally during the September 28th Commission meeting:**

Count	Name	Verbal Comment
1	Dr. Bill Honigman	My name is Bill Honigman from Orange County. Sadly, commissioners your presentations never stated the obvious that commercial interest in health care, not just in risk bearing insurance company intermediaries but also in drug companies and large hospital provider group conglomerates are killing black and brown people in California. As a retired emergency room physician I saw, over decades in my practice, the inequities firsthand in those patients who were presented to me, with nowhere else in our system to go for needed care, often too late or after other very inadequate care was attempted for various medical problems, and with no place to go to follow up on their emergency care afterward. The indisputable fact is that these commercial interests are exactly the problem in our broken health care system that prioritize resources to areas of more market share rather than the areas of human need, which has created the health care deserts and for proprietary reasons has blocked the sharing of medical data that largely has impacted our communities of color so adversely and so unfairly in the inner cities and rural parts of our state.
2	Leah Schwinn	I'm going to read a quote from AB 1400 that pertains to today's discussion. "The Special Projects budget shall be used for the construction or renovation of healthcare facilities, major equipment purchases, staffing in a rural or medically underserved area, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socio-economic status." This is why we need to be discussing AB 1400. It addresses all these issues. Thank you very much.
3	Sean Broadbent	Sean Broadbent of DSA-LA's Healthcare Justice Committee. This year the committee along with the Progressive Asian Network for Action, LA, and Health Care for All Los Angeles, worked to pass informed community impact statements in support of a resolution at LA City Hall for AB 1400 CalCare. 17 neighborhoods representing a broad collection of the city's diverse communities participated in the process, reviewing LA public health data, alongside key metrics: uninsured rates at the zip code level from USC's price center to understand the link between lifetimes of no insurance in the community and the rapid spread of COVID-19 in their neighborhood. In 17

Count	Name	Verbal Comment
		neighborhoods support was unanimous for moving to a system as described in AB 1400 where healthcare is guaranteed under a single payer financing. A single payer system like the one detailed in AB 1400 would be able to ensure underserved communities are fully funded and have the resources that they need by targeting additional resources to begin addressing long standing systemic healthcare disparities. Thank you.
4	Caroline Sanders	Hi, Carrie Sanders with the California Pan Ethnic Health Network. I want to start by thanking Dr. Ross for referencing our report centering equity and payment reform. And also to align our comments with Dr. Ross and Dr. Antonia Hernandez. With regards to race in order to reduce disparities, we have to accurately measure and tie payment to reducing them. Covered California has been experimenting with this over the past seven years. But the truth is progress has been extremely, maddeningly slow not for lack of effort, but because the state health plans and providers have simply not invested appropriately in the technology and measurement systems that would allow for the use of patient health records and quality improvement efforts. In shorthand, we're still relying on surveys with sample sizes of just 411 people to understand and grade how health plans and providers are doing. Additionally, although more than three quarters of those served by Medi-cal are communities of color are our Medi-cal programs missing a critical opportunity to tie payment to achieving equity goals as part of the state's current procurement process. We need to tie payment to improvement. I also agree with Dr. Ross's point about investing in place. We support a sustained investment in regional publicly accountable approaches to health care delivery. CACHI in California is a great model. But there are other models and other states as well. These regional systems should center communities and governance structures and should talk to communities about what their healthcare needs are.
5	Ryan Skolnick	This commission has spent a lot of time today discussing some of the issues that come with inequities in our system. But I feel like everyone's been going, for the most part, out of their way to avoid addressing the root issue here, which is that structural inequities require structural not piecemeal solutions. And when you have a fragmented system of healthcare like we have, fragmented intermediaries of insurers, you're going to result in a fragmented standard of care. The reality is that if you want to address structural inequities in our healthcare system that disproportionately impact communities of color, we need to structurally transform our health care system. We need to guarantee health care for all as is called for under AB 1400. You cannot address racial, gender, socio-economic, geographic

Count	Name	Verbal Comment
		or any other health inequities in a system that perpetuates and encourages tiered health care where the wealthy and well connected can purchase the best and highest priority care at the expense of everyone else. Our system shows that and systems around the world that allow tiered care show the same inequities. The way to address these structural issues is to guarantee everyone the same high-quality care through a single payer health care system.
6	Craig Simmons	After the last meeting on the 23rd, last Thursday I believe it was, I put forth a proposal to implement a payroll health care tax to pay for a unified financing system for all California residents, regardless of immigration status, income, ethnicity, or anything else. And I'm just putting it out there to the commissioners to see if there would be an interest in and work in pursuing that payroll health care tax along with wealth taxes and corporate taxes to help fund a unified financing system. And if you have any questions, I'd be happy to answer them if we could open up another discussion at another time. The other issue was standardization of health care costs. There's never going to be a single payer system unless the health care costs are standardized like Medicare does. And I would also like to get feedback on that from the commissioners. Thank you.
7	Michael Lighty	Thank you, Karin. Michael Lighty, President of Healthy California Now. Guaranteed healthcare is the foundation for equity. Eliminating the financial barriers to care lays the groundwork for eliminating all barriers. As the survey of low-income Californians showed, affordability is key. But also key is, in fact it's the number one priority, the need for safe and effective treatment. You can only do that through a single standard of safe effective care. That doesn't mean that one size fits all. It means that you don't have a multi-tiered system that allocates care based on ability to pay, as does Covered California. It institutionalizes that denial of care based on ability to pay, if you have a bronze plan, that is not the same standard of care as a platinum plan. It's that simple. And we have to address racial disparities directly not through incentives, but by actually guaranteeing people the health care they need in their communities. The present system misallocates care based upon place. We must end that. Thank you.
8	Dr. Henry Abrons	Doctor Abrons from Physicians for National Health Program. I want to go back to the values survey that Secretary Ghaly referred to. I'm extremely concerned about the statement that there was some divergence of view about including risk bearing intermediaries in a future system. Risk bearing intermediaries have an incentive to deny care and this is a structural flaw in any conception of an equity healthcare system. So, I really think that the Commission needs to

Count	Name	Verbal Comment
		refocus on this question. And I think that I'd be very interested in having you publish not just a summary of the survey results, but actually the detailed views of those people who feel that risk bearing entities have a constructive role to play. In the opinion of Physicians for a National Health Program, they do not. The only risk bearing entity is the state's health care trust fund, which is under public jurisdiction.
9	Peter Shapiro	I'm with the California Alliance for Retired Americans and Healthy California Now. Mention has been made of the way that our weak social safety net in this country and our systematic disinvestment in public higher education here in California have contributed both to healthcare inequities, and criminal shortage of primary care physicians. But the fact remains, the money we are left to spend on health care could be spent far more effectively and efficiently. Every study that has been done, including the one presented to the commission back in May anticipate significant savings from a unified financing system. Now, why not use that money to put resources where they're most needed? Why should we squander our resources trying to incentivize private entities, that ultimately are concerned with their bottom line, to do the right thing, when we could do it much more effectively and directly with direct public investment? And while we all want accountability, we all want good data, I think it's worth noting that Medicare has been experimenting with the complicated metrics in recent years to try to get the bigger bang for our buck in terms of how we compensate physicians. It has created a horrible costly paperwork mess that interferes with the doctor patient relationship. It does not save money. And I think we need to look at accountability in a different kind of way than that.
10	Dr. Tim Bilash	My name is Dr. Timothy Bilash from San Diego County. I am an obstetrician gynecologist. I need to echo many of Dr. Pan’s and Carmen Comsti's comments. And I support health funding with a sales tax. But today I'd like to raise a difficult question on social equity. How would you feel as a male physician or a male nurse when a patient places a females-only sign on their door? Women's health care has not replaced the dedicated men who have served them for many decades. Isn't gender, ethnic, and racial identification at the heart of systemic inequity? Please think about it. Thank you.
11	Mari Lopez	Mari Lopez, California Nurses Association. Prior to coming to CNA, I worked in the nonprofit industry advocating on behalf of immigrant communities LGBT, low income. And frankly, I'm insulted by this presentation. We have been talking about the same issue for over at least 20 years that I been working on it. And I know decades prior to that. It

Count	Name	Verbal Comment
		seems to me it's very clear that we should be focusing on the solutions and not the problem. Everybody on this panel and members of the Commission knows the problem, knows the issues, has experienced it for themselves as I have myself. So this is a very emotional issue for me. Single payer would begin to address health care disparities by eliminating barriers to care that were created by a fragmented market driven system of private insurance, and single payer addresses this historical structure that drives racial and other injustices in our health care by guaranteeing comprehensive health care benefits to all regardless of income, race, ethnicity, gender identity, the language you speak. This is what we should be focusing on.
12	Pilar Chiavo	Hi Pilar Chiavo, Healthy California Now coalition and just ditto to what everyone else has said in public comment. We already know the answer. We know what addresses inequities in health care: single payer does. We have examples all over the world, and many, many studies that show that. But I wanted to go back to a comment that Senator Pan said, where he said, "The people in power make the rules" and you are the people in power. You have an opportunity right now to create a path that the governor can follow to get us to health equity, to get us to a more equitable system, to get us to a system that will not collapse our economy in California in 10 years. And so, we cannot miss this opportunity. And I just want to implore everyone on this commission, please do not have this be another study or report that goes into a file and never gets used. This needs to be a path to address all of the problems that you have been talking about for over a year. Thank you.
13	Brynne O'Neal	Hi, Brynne O'Neal, CNA. I want to echo what my colleague Mari and Pilar said that we've heard the problems and it's time to act. A single payer program can address structural racism in health care by allocating healthcare resources based on need, not profit. AB 1400 includes mechanisms to identify health inequities and direct resources to rebuild our healthcare infrastructure in medically underserved communities. With all care in one system, we can identify gaps in access, we can use our collective power to end our tiered system of health care and demand that resources go to our most vulnerable communities. A global budgeting process and special projects fund can prioritize projects to address healthcare disparities in rural or medically underserved areas, and pay for additional staff, direct resources, pay for hospital construction, finally combat the epidemic of hospital closures for communities of color and rural in less affluent areas.
14	Phillip Kim	Hi, Phillip Kim with the California Nurses Association. I just want to highlight that the community voices report

Count	Name	Verbal Comment
		commissioned by the Commission showed extremely high levels of support among low-income Californians of color for a single statewide government run program to cover health care for all people who live in California, and to replace Medicare, Medi Cal, Covered California and job-based insurance plans. 71% of Latinos, 76% of African Americans, 73% of Asian Pacific Islanders and 65% of Native American respondents would support such a plan. Support was even higher among representatives of community-based organizations who work on health equity issues. 83.9% support a single government run program. Large majorities of the people most impacted by racial health inequities want a single system. The Commission has a mandate to act, it must recommend that the legislature enact a strong single payer system now like AB 1400. Thank you very much.
15	Nancy Greep	Thank you, I would just like to point out several ways in which a single payer system would help solve some of the problems that you've been talking about today. First of all, it would allow one to collect the data that is needed. At the present time data is in a whole bunch of silos of private insurance companies and lots of different programs. And a single payer system would unify data and this data could then be used to identify areas of need. Secondly, in terms of improving equity, a system which is based on a progressive tax, rather than premiums, which are extremely regressive, because everybody pays the same premium, whether you're rich or poor. So we need to get rid of insurance companies' premium systems. And thirdly, in terms of needing simplification, what could be simpler than having a card which shows that you are insured? Thank you.
16	Ruth Carter	Thank you, commissioners, for your work. I'm the chair of the California Democratic Party Senior Caucus, and I can assure the commissioners that our cohort is as desirous of dignity, respect, and affordability as other groups. Additionally, simplicity of design is paramount. Medicare was originally designed to be for everyone, not just seniors and those with disabilities. Actually, President Johnson used it to desegregate hospitals in the United States. Today, traditional Medicare is being threatened by more and more privatization, which erodes the quality of care that is delivered because more and more of our taxpayer dollars are going into the pockets of health insurance companies. California single payer system as in AB 1400 would make for equitable quality health care for all members of our California community. Thank you.
17	Hilary Siebens	Hello, I'm Hilary Siebens, I'm a physician, geriatric primary care and rehabilitation medicine. And I have volunteered for many years with the California Physicians Alliance, and we're updating our roadmap on a way to get to universal

Count	Name	Verbal Comment
		coverage and fair equity coverage. I so appreciate these discussions. They are fantastic. And we would just like to comment that among the externalities that have been alluded to by many of you commissioners, are the gross distortions of capitalism that are fostering the ill health and deaths of despair. These distortions and possible solutions are described by the economists Case and Deaton in their text of the same name, and therefore, I just would like to call their book Deaths of Despair to your attention. Thank you very much.

Total Count of verbal comments: 17

2. The following table reflects public comments that were entered into Zoom Chat during the September 28th Commission meeting:

Count	Name	Comment
1	Phillip Kim	Great discussion on racial inequity in the health care system, but all of this is for show unless you address the fundamental problem of having a fragmented, profit-driven system. We need one publicly funded health plan that guarantees high-quality, comprehensive care for ALL. The second you start allowing multiple insurance plans (including risk bearing entities / "intermediaries" / "integrated delivery systems" / HMOs) you create tiers of health care and you make it more difficult for people of color and working class people to get the care they need. Separate but equal is not equal. The commission should model AB 1400 (CalCare) and make a strong recommendation for single payer.
2	Stephen Vernon	CalAIM—Social and Health goals -Yes!.... Managed Care (culture)Approach- Antithetical to the goals!
3	Don Cherf	We are limited by the choices of the companies we work for which healthcare plan we want. We spend a lot of time comparing and contrasting these plans in selecting which plan we think will work for us. When we are laid off, terminated, or quit a job, we lose our healthcare until we finally gain employment at another company where we have to spend time selecting once again which plan we think works best for us. And when we start at another company, we don't always immediately get healthcare. There is sometimes a 30-90 day waiting period before being able to get healthcare. As an older American who will be signing up for Medicare shortly, it astounds me the amount of time that I will need to spend and how little Medicare covers. A subset of insurance is burgeoning because Medicare doesn't cover 100% of our healthcare. So there are about 10 different Medicare plans that I am supposed to review and compare in order to select

Count	Name	Comment
		the plan I want. Then I have to compare and contrast approximately 10 different companies that offer Medigap coverage. Finally, I have to decide what separate coverage I want to secure for dental and vision and home care etc. So I have to research these plans and those healthcare companies. It is ridiculous to think of all that wasted time.
4	Louise Mehler	Today's presentation and discussion have illuminated the complexity and difficulty of designing and running an equitable health care system. Clearly, addressing equity will be an ongoing challenge. Only a unified system has any ability to grapple with equity. If we continue to maintain a spectrum of options, it is inevitable that the people with the least resources will be shunted into the options that deliver the least.
5	Dr Tim Bilash	My name is Dr Timothy Bilash MD from San Diego. I am an Obstetrician Gynecologist. I need to echo Dr Pan's and Carmen Comsti's comments. I'd like to raise a hard question on social equity: How would you feel as a Male Physician or Male Nurse when a patient places "females only" on their door - meaning that only someone who looks like a woman on the outside is acceptable? Why have we lost a whole generation of expert, dedicated men from Women's Health Care and not replaced them? What good is equity without Doctors to attend them? Gender and Ethnic/Racial Identification is at the heart of systemic Inequity?
6	Stephen Vernon	Physician Value-Based Payment Modifier Program had no effect on the quality or efficiency of care provided and likely exacerbated health care disparities by disproportionately penalizing practices that care for lower-income or sicker patients. According to the March 13, 2018 article in JAMA (Rita Rubin MA) --"The problem, health policy researchers say, is that evidence about how best to evaluate health care quality is lacking and currently used measures fail to account for differences in patients' socioeconomic and health status that could skew quality scores in favor of practices that care for higher-income, better-educated, and less-complex patients. … J. Michael McWilliams, MD, PhD, a general internist and professor of health care policy at Harvard Medical School…In a recent study in Annals of Internal Medicine, McWilliams and his coauthors found that the … Physician Value-Based Payment Modifier Program had no effect on the quality or efficiency of care provided and likely exacerbated health care disparities by disproportionately penalizing practices that care for lower-income or sicker patients."
7	Al Saavedra	Why do you keep saying "unified finance" and not "single payer"? Is "single payer" a forbidden term? By whom?

Count	Name	Comment
8	Betty Toto	Special Screening of The Power to Heal a documentary about how the Civil Rights Movement and the new Medicare helped desegregate our hospitals an example of how AB1400/CalCare can be used to build equality and equity for all Californians Join us for a discussion with film creator https://bit.ly/PTH-FTBSFV
9	John Greg Miller	As a retired staff nurse, I have long been aware of how profiteering poisons health care. The system we create should focus single-mindedly on improving all people's health, with a special emphasis on addressing disparities.
10	Nel Benningshof	Thank you Leah.
11	Don Cherf	I would like to reiterate that California's CalCare will be able to tap funds from companies that currently provide healthcare for their employees since they won't have that cost any more and should not be able to use those needed funds for their own purposes. California's CalCare should require those funds be diverted to CalCare for use in providing 100% healthcare for Californians.
12	Dr Bill Honigman	Our tragic experience with COVID19 in California clearly shows how we were unable to provide the comprehensive care to especially our BIPOC communities, with more than 68 thousand who have died statewide, and according to experts, an estimated 27 thousand Californians who would still be alive today if we already had a Single Payer system in place to deal with this public health emergency. Clearly, it's past time to eliminate these destructive and immoral commercial forces and allow a public system of allocating resources as we will have with unified Single Payer financing, that gets medicines, clinics, hospitals, and personnel to areas of public need. It's past time to pave the way for AB1400 to be applied in its basic design and moved through the legislature, now before anyone else unnecessarily, whether by design or inadvertently, is allowed to fall through the cracks and end up in the Emergency Room for basic care. Thank you. William Honigman, M.D., North Tustin CA 92705
13	Ellen Schwartz	#1: Dr. Ghaly, you can see raised hands by looking at the Participants panel, instead of looking for them on the video thumbnails. Zoom puts people who have raised hands up at the top of the list, right after yourself and the host -- in the order they pressed the Raise Hand button. You can cut the number of thumbnails you see, saving bandwidth, while keeping good track of who wants to speak.
14	Robert Vinetz	I hope these thoughts may be helpful in your work a Commissioners:
15	Ellen Schwartz	Today you've decided to "solve" racism. Up and down the line, there are examples where the current health care system AND OUR ENTIRE SOCIETY are stacked in favor of white people. White men, particularly. But absolute lack of

Count	Name	Comment
		access to health care is surely a really big one. I remain baffled why the commission is blocked from considering AB1400. But instead of looking at, "The Answer That Dare Not Speak Its Bill Number," you are examining every grain of sand, trying to find answers to every question. Meanwhile many thousands of people, disproportionately people of color, are unable to receive needed health care right now. Can you move this along a little bit? Ellen Schwartz, Sacramento, California
16	Betty Toto	Betty Toto of Single Minded for Single Payer & Feel the Bern - SFV -AB1400 includes stipulation for cultural sensitive health care and special programs that can be used to serve Rural and Underserved communities. AB1400 is a huge step to equality and equity that can be passed in our state of legislature and implemented for the State of CA. Stop the nonsense.
17	Leah Schwinn	Great comment Ryan. Yes structural change!
18	Paul Newman	Well said Ryan Skolnik
19	Kathleen Healey	Single payer with no insurance intermediaries is the most equitable and least expensive system of healthcare.
20	Leah Schwinn	Yes Michael Lighty
21	Ellen Schwartz	Thank you, Michael Lighty!
22	Betty Toto	Betty Toto of SM4SP & FTB-SFV - It has been proven over and over again that a healthcare system as laid out in AB1400 the CA Guaranteed Health Care for All bill will save money and save lives. I take offense that this Commission is not expediently drawing up their report based on AB1400/CalCare, this will save us time money and lives…
23	Don Cherf	I would also suggest that the commission, in trying to determine how CalCare can be funded, look to the 30+ countries around the world with healthcare for all their citizens for the answers how they are able to support healthcare for all. Take the CalCare Solidarity Action! We are building commUNITY solidarity for AB1400 CA Guaranteed Health Care for All https://bit.ly/SM4SP-CSP Thank you Phillip Kim!
24	Robert Vinetz	Values and Financing - Upstream and Downstream. Values are the upstream-most source of everything downstream. (Values can be explicit or implicit.). Financing is immediately downstream to values and upstream to everything else. Financing literally controls (or at the very least largely determines) everything downstream. Words and Definitions Matter: Consider the value of distinguishing between “public” and “private”. Consider the values of distinguishing between “financing and “delivery”. Consider the value of distinguishing between public financing vs private financing. Consider the value of distinguishing between public delivery vs private delivery….For example: “A unified system of public financing of health care and of public health.”…”A unified system of

Count	Name	Comment
		private and public delivery of health care/prevention/public health" (on a spectrum and under rules established by the public.); A publicly financed, with a privately AND publicly delivered unified system of health care.
25	Cheryl Tanaka	Thank you, everyone.
26	Don Cherf	Please do not pay for CalCare with a sales tax which unfairly targets the poor as well as people of color. Sales taxes by their very nature are racist and sexist and should be outlawed and no longer used to generate funds. The same goes for toll roads, too.
27	(h)Dr Bill Honigman	Once again, the indisputable fact is that these commercial interests, are exactly the problem in our broken Healthcare system that prioritize resources to areas of more market-share, rather than areas of human need, which has created the "Healthcare deserts", and for proprietary reasons has blocked the sharing of medical data, that largely has impacted our communities of color so adversely and so unfairly in the inner cities and rural parts of our state. It's past time to eliminate the commercial interests that make Healthcare so inequitable in our state.
28	Betty Toto	Yes Mari it is offensive….You tell it Lady!!! It is emotional…especially when this commission with the exception of a few is willfully ignoring AB1400 which in my minds eye is there turning a blind eye to the inequality and inequity in our profit first healthcare system.
29	Leah Schwinn	Great point Pilar Schiavo!
30	Betty Toto	This Commission is turning it's back on BIPOC communities by not considering AB1400/CalCare!
31	John Greg Miller	In our current health care system, profit-seeking corporate health systems and health insurers fail to invest resources in facilities and staff in communities of color because communities of color are seen as risks to their bottom line. A single-payer health care system allows us to move more easily identify gaps in access and distributional shortages that result in racial and other health inequities; and a single payer health care system would allow us to target additional resources and financial support to address the specific racial and other inequities that are identified. For example, with a single payer system, like the one detailed in AB 1400, we can direct funds to build new health care facilities where they are needed, as well as to health care facilities that need to hire more staff, and increase reimbursement rates to incentivize providers to practice in underserved areas.
32	Carol Moné	Agree with Phillip Kim
33	Winchell Dillenbeck	The long slow road of analysis about the problems when studies constantly show that Single payer is the solution. More time should be spent on how to implement Single Payer rather than debate the issues. It is the first big step in implementing all the changes the Commission wants.

Count	Name	Comment
34	Leah Schwinn	Great use of their own statistics Phil!
35	Mari Lopez	Racial equity means that everyone has access to licensed health care providers who speak our languages and come from our communities – and that people from underserved communities are fully supported to access education and training programs to become licensed health care professionals. Importantly, we must ensure that our health care workers, who are disproportionately women of color, are employed in good union jobs, with fair wages and safe working conditions.
36	Betty Toto	YES PHIL!!! And this commission is ignoring the research and reports from their own hired hands. There is no way around it and now polling even better Single Payer/Medicare for All is needed and wanted.
37	Mari Lopez	We must design a system that can direct funding to increase the number of nurses, doctors, and health care workers from underserved communities who come in with diverse cultural and linguistic competencies. For example, we can financially support and expand access to two-year associates' degree programs in nursing and we can ensure that safety net hospitals have the resources to hire nurses in full-time union jobs. We can build in worker protections in health care provider conditions of participation. And, like AB 1400, we must ensure that our system supports safe staffing and health and safety programs to protect our health care workforce and patients. And we must structure our payment system to ensure that health care workers are fairly paid, fully resourced, and have the tools and time they need to provide culturally
38	Don Cherf	The time to start Healthcare for All was last year when this commission started. Let's quit delaying and coming up with reasons to not start it, and just start it already. We have waited far too long as more and more countries enact healthcare for their citizens. We are lagging because too many of our legislators are in the back pockets of healthcare corporations which have a lot of money to delay and kill all healthcare initiatives.
39	Ellen Schwartz	Yes, Phil! A new stalling tactic - the commission has to solve racism before they can move ahead with a recommendation for health care.
40	Brynne O'Neal	The Community Voices report shows that, all too often, low-income people of color are being disrespected by health care providers and disempowered when they receive health care. People with physical disabilities often have difficulty accessing facilities, people with limited English proficiency frequently cannot get a doctor who speaks their language or even an interpreter, and it's nearly impossible for LGBTQ+ people to find affirming care. One woman on Medi-Cal said her family goes to see doctors and they "take one look at us

Count	Name	Comment
		and not see us but our weight/sex/race." We need big, structural, anti-racist change. Under AB 1400, the CalCare Board would be responsible for ensuring that every patient can access cultural and linguistically competent care. Not only does this mean education and training for all providers. It also means devoting funding to increase licensed providers from every culture and language. And, fundamentally, it means that the Board would be accountable for how people are treated.
41	Ellen Schwartz	Meanwhile, thousands of BIPOC live are lost because of lack of access to health care at all.
42	Leah Schwinn	Yes Ruth, medicare was intended to be for everyone.
43	Carol Moné	Medicare for all! Single Payer now.
44	Betty Toto	Tell Ruth yes!!! And AB1400 can bring better equity and equality in CA just like Medicare did and does.
45	Brynne O'Neal	More than half of Californians with low incomes surveyed for the Community Voices report identified long waits at doctors' offices and a lack of available appointments as top challenges to accessing care. This was a particular challenge for people of color. Community-based organization leaders explained that many providers refuse to take Medi-Cal patients. They also identified the complexity of insurance requirements and network coverage as a huge obstacle to accessing care. Putting everyone under a single system would mean that no one would face discrimination or disrespect based on their coverage type. And the system could direct resources to fill gaps in underserved communities. Getting rid of networks means that no one would go without care because they could not figure out which providers are available to them. Instead of providers picking and choosing among patients based on profit, patients would have more freedom to choose our providers and reward cultural and linguistic skills.
46	Louise Mehler	If the "natural experiment" of comparing health systems had been a clinical trial, it would have ended long ago. Americans are dying of our dysfunctional profit-motivated health delivery.
47	Winchell Dillenbeck	Eliminate the private insurance companies to obtain simplicity.
48	Phillip Kim	Hello, health care advocates! If you're reading this in the comments report, please join the Nurses' campaign to pass single-payer guaranteed health care in California. You can read our plan here: Nurses' Campaign to Win CalCare: Our Plan for Fall 2021
49	Betty Toto	Special Screening of The Power to Heal a documentary about how the Civil Rights Movement and the new Medicare helped desegregate our hospitals an example of how AB1400/CalCare can be used to build equality and equity for all Californians Join us for a discussion with film creator.

Count	Name	Comment
50	Brynne O'Neal	Complexity in our system of private health insurance is a major barrier to care for low-income communities of color and other underserved communities. But we can significantly address this problem of complexity by ending fragmentation and adopting a single payer health care system. In the Community Voices report, low-income communities of color and advocacy organizations emphasized that the complexity in our current system shuts people out of receiving care. The single most important measure that could be taken to address this issue of complexity is to simplify the system through a single universally guaranteed system where there is one plan with no cost-sharing and one network for all. Instead of wading through the complex web of insurance networks, copayments, and deductibles, culturally competent community based organizations could funnel resources into helping people find culturally competent licensed health care providers and helping people from their community become licensed health care professionals
51	Susan Meyer	In slide 25 it refers to five years for implementation. What is the exact time period.
52	Ellen Schwartz	Regarding Hilary Siebens: please, commissioners, please do not decide to solve capitalism before moving ahead with a Single Payer program!!!! Yes capitalism is the ultimate problem but you folks aren't going to fix it.
53	Hilary Siebens	Deaths of Despair by Case and Deaton. Thank you for great discussion.
54	Betty Toto	Take the CalCare Solidarity Action! We are building commUNITY solidarity for AB1400 CA Guaranteed Health Care for All Solidarity Action
55	Paul Newman	Come to Office Hours every Sunday from 5-7 PM http://bit.ly/calcare-office-hours
56	Corinne Frugoni	AB 1400 eliminates disparity and promotes diversity
57	Betty Toto	Take the CalCare Solidarity Action! We are building commUNITY solidarity for AB1400 CA Guaranteed Health Care for All Solidarity Action

Total Count of Zoom Chat comments: 57

3. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address before the September 28th Healthy California for All Commission meeting:

Count	Name	Comment
1	Deborah Perkins-Kalama	To the Healthy California for All Commission: I am a resident of California and a long time advocate for health care as a Registered Nurse for 30 years. For 30 years I've watched in horror at the inadequacies of our health care system which is a for profit system which shuts out many and creates a direct path for the two tiered system of healthcare we have seen in this country forever. We know that the rest of the developed world has taken another path and we had hopes that this commission, and this state could help lead our nation down another path that puts people before profits. We have seen the scourge that has occurred with our outdated for profit system in this time of Covid and we have seen how our failure has affected people of color much more than those with white skin and resources. I want to know why this commission is not seriously addressing the existing bill AB1400!! Your commission has reported statistics that show 65% of Californians support as do 72 % those of color, a single government run healthcare system. A singer payer system will better address the disparities in health care we see throughout this country. I ask this commission to seriously address AB1400!

4. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address during and after the September 28th Healthy California for All Commission meeting:

Count	Name	Comment
2	Frances Hillyard	A friend of mine, an African American woman, was unable to get any doctor to see her when she believed she had COVID -19 which she did, and she has to use an inhaler which is not covered by her insurance, because of that. Things like this should not happen, but they do all the time, especially to marginalized people including anyone with a very low income, such as myself. Health care as a business is uncaring and does not prioritize the health of patients. We need AB1400 to make health care affordable Accessible, universal, and high quality. We should all

Count	Name	Comment
		be able to choose doctors we trust. We all deserve a single payer health care system. Here it is—AB1400 Thank you for listening,
3	Alberto Saavedra	Why do you keep saying "unified finance" and not "single payer"? Is "single payer" a forbidden term? By whom?
4	Jeoffry B. Gordon, MD,MPH	Tell Dr. Pan that in 1971 or 1972 Gov Reagan did just what you said. He capped MediCal in mid year interrupting care for hundreds of my patients from the San Ysidro Health center. Also such budget strategies are in play in several states in the deep South. It can be worse than you think!
5	Danett M. Abbott-Wicker	Thousands of Californians from around the state signed the HCN petition, calling on Governor Newsom to lead the way on Medicare for All in the Golden State by engaging at the federal level to move forward on necessary funding waivers. We delivered these petitions at the HUGE action on June 15, where the Governor's staff announced that Gov. Newsom has written to the Biden Administration regarding waivers and in support of legislation that would remove some potential hurdles for California to transition to Medicare for All. "California has the structures and the will to supply health care for all," the Governor's representative said during the rally. "We just need federal support and waivers allowing us to move to universal health care." The Governor and this commission must use the tools you already have to engage the federal government and to build a Medicare for All system for California. As Healthy California Now (HCN) has moved forward, we also brought some hard facts to the debate. First we released a poll showing that 84% of Democrats support Medicare for All, and only 11% (yes, just 11%) oppose it. A report released showed that California will save $223 BILLION with single payer. Stop putting up roadblocks to passing SP in California and insure that ALL Californians have this human right.
6	Ann Levy. RN, BSN	Thank you for your service! It is unanimously concluded there is a drastic, unethical disparity in access, delivery, and quality of uninsured and underinsured. As many of you know, that even people with “state of the art” insurance with varied premiums, co-pays, deductibles, capitations, and coverage that experience denials, delays, and an intensive appeal process. Insurance is primarily interested in profit under the guise of “cost efficiency “ I also consider the differences in medical charges

Count	Name	Comment
		and payment for surgeries, procedures, hospitalizations depends on insurance policy coverage is not only ludicrous but unethical. Healthcare was never meant to be a business and it is….at the sacrifice of healthcare. Absurd and obscene
7	Michael Lighty	On the question of relationship between "unified financing" of healthcare and social services, it is at the heart of what we must confront in California, and directly related to equity. The issues on the state's to do list that the media most often cite as causing voters' dissatisfaction with California's direction are homelessness, crime, and housing prices. But what underlines those issues is the profound social and economic inequities revealed and worsened by the COVID pandemic. A transformational politics would focus on inequity. The pandemic is a public health crisis, which points toward a focus on healthcare as key to solving the states problems. Homelessness is exacerbated and sometimes generated by mental health crises. Crime rooted in addiction is also a public health issue. Healthcare is rationed based on ability to pay, accessed through fragmented systems that underserve Black and brown communities, and disregarding the specific needs of AAPI communities. Fundamental to solving California's problems is addressing the inequities in healthcare. As the Nobel prize winning economist Angus Deaton has argued, how healthcare is financed and delivered in the US is a driver of inequality. We need the resources and a system for behavioral health treatment, we must expand the funding for local public health interventions, improve education and childcare with new resources, and build lots of affordable housing. Where will the money come from? Literally hundreds of billions of dollars could come from savings generated by single payer financing of health care. In fact, a recent study by the Healthy California for All Commission showed that the present healthcare system would cost $800 billion a year in 2031, and still not cover everyone. A universal system of guaranteed healthcare financing through a single, dedicated trust fund would cost $223 billion less in 2031, and save those hundreds of billions in the meantime. And relieve the state and local governments of over $90 billion in unfunded retiree health liabilities. More important, such a system would guarantee healthcare and save lives: mental health treatment to keep people off the streets; robust public health programs to create healthier, more

Count	Name	Comment
		resilient communities; substance abuse treatment to prevent overdose deaths and reduce desperation leading to property crimes; and, fewer people incarcerated leading to less spending on prisons. The virtuous circle of resources to solve California's pressing problems and improving our health is within reach. To transform California, guarantee healthcare to all our residents.
8	Jeffery Tardaguila	What are proposals from Healthy California Commission? I am confused beyond uniformed Finance for
9	Ellen Schwartz	I heard a lot of good things today. It was a good meeting. Someone said that if the system contains structural racism, we should replace it with a different system. Bravo for that idea! I think Dr. Ross's presentation showed well the extent of the problem of racism, and gave excellent aims and plans for eliminating it, with health care as part of the context. However (did I misunderstand?) it seemed like it was a blanket of inclusive and equitable programs placed on top of the existing exclusive, inequitable and needlessly expensive system of private insurance determining who gets what treatment. If anyone can walk into any provider's office and get care without having to prove ability to pay, there will still be problems, such as allocating access to "the doctor of your choice" -- a problem if everyone chooses the same one. But the problem surely won't be solved by extending indefinitely the lack of meaningful access caused by lack of money. This commission doesn't have to invent something from scratch. There are examples of universal, publicly funded health care programs all over the world. Where they fall short, the reason is largely that they are underfunded, as private insurance companies lobby to keep funding as low as possible, attempting to strangle the public system so they can get an opening for for-profit insurance. Today you've decided to "solve" racism. Up and down the line, there are examples where the current health care system AND OUR ENTIRE SOCIETY are stacked in favor of white people. White men, particularly. But absolute lack of access to health care is a really big one. I remain baffled why the commission is blocked from considering AB1400. But instead of looking at, "The Answer That Dare Not Speak Its Bill Number," you are examining every grain of sand, trying to find answers to every question. Meanwhile many thousands of people, disproportionately people of color, are unable to receive needed health care right now. Can you move this along a little bit?

Count	Name	Comment
10	Virginia Madsen	I am a 70 year old, 3rd generation from Alameda County who has been a consumer of health care in California ALL of my life. In light of today's Commission hearing topic, I guess I should say I am Caucasian and I don't want better healthcare than anybody else – I just want to be included. I do not feel I have had good healthcare in my adult life. I didn't have employer assisted health insurance until I was in my 30's in the late-1980's, previously it just wasn't an option at my level – and I worked for teaching MD/PhDs at UCSF. From 1996 through 2009 I had adequate coverage – Kaiser mostly because it was what I could afford, and mostly I just got preventive care. I am still haunted by a clear memory of an early SF Kaiser gynecologic exam in which I was in a large room with about 30 other women, all naked from the waist down with our feet in the stirrups and in full view of each other, as a single doctor went from table to table doing pelvic exams. Was this better than the charity clinic that I had previously gone to where I waited for 5 hours? No it was not. Herding people and treatment environments that are like roundups build mistrust with the system. Vaccine hesitancy has roots in mass treatment conditions. I've had some very good doctors that understood me as a human being and treated me – but they retired, died, moved away, or stopped taking my insurance because it didn't pay enough. And there really was no one to replace them. I have learned that doctors who have been trained in other countries are actually better at treating me, and prefer physician’s assistants and nurse practitioners and nurses. I often had to change doctors because companies changed plans, were bought out, or I had to change jobs. After the 1990s I and many co-workers often felt that we were working FOR health insurance. When it was offered and as I got older, it was not. I am the ONLY repository of my past health care information because whatever records may have existed appear to be unavailable to me or practitioners. I tried for 10 years to get my Kaiser records and my request was always 'lost'. Found out inadvertently after a traffic accident that those records do exist and lawyers can get them fairly easily. What does this say about HIPAA? And, when I am provided past medical records they are not accepted as valid by providers. Catch 22. I was one of the first to go to the HealthyCA website and sign up - what I experienced and reported made that system better eventually. But paying for that insurance only gave me access to a doctor who was dismissive and unprofessional, and actually

Count	Name	Comment
		did harm. I ran back to a charity clinic which was now an FQHC because the doctor there at least seemed to know what they were doing. It was better to have to wait on the sidewalk in the cold and the dark at 4am in order to be one of the first people in line and not turned away from treatment that day, than it was to have the insurance. When I finally made it to Medicare age I thought my options for care would improve - they did not. Dealing with Medicare on my own was a major trial - appalling customer interface, unwritten rules, much more confusing, almost impossible to get an answer from about treatment that was covered, largely uninterested in my medical needs - and I am a college graduate who had worked in many bureaucracies. One of the reasons I signed up for a Medicare Advantage program was because THEY have to try and talk to Medicare, try to get an answer, not me. And now I find that the insurance companies can't even deal with it and have inserted another layer to interact with - the IPA. Now I have THREE entities that often are too busy and suggest that I call back at another time – always. I actually understand why no doctor wants to treat older people. I get told all the time to go to an emergency room for care. The only time I have been able to see a medical practitioner since March 2020 is to go to an urgent care clinic. Is the doc-in-a-box my future medical care? Pay for service only? The customer interface is crucial to how people feel about the healthcare system. I ask that you think about making it possible to engage with the healthcare system without a smart phone or great internet access. - I can't afford them and neither can MANY people. 800#s work, community organizations to help and provide computer access to the healthcare system, simple well-designed computer interfaces that don't take a whole lot of bandwidth to access, Internet coders' look and feel - their bells and whistles, - are FAR less important than solid functionality and timely information and multilanguage support. Thank you for reading and working on this issue. I believe AB1400 gives direction on all of these things.
11	William Honigman, M.D.	Commissioners, Thank you once again for looking at the subject of inequities in Healthcare in California, and specifically in racial inequities. This subject has been covered exhaustively in public health and social science analytic venues, with conclusions that we've all heard on countless occasions over years and years of discussion and debate on this issue.

Count	Name	Comment
		Sadly, your presentations never stated the obvious, that commercial interests in Healthcare, not just in risk-bearing insurance companies intermediaries, but also in drug companies, and large hospital and provider group conglomerates, are killing black and brown people in California. As a retired Emergency Room physician, I saw over decades in my practice the inequities first-hand in those patients who presented to me with nowhere else in our system to go for needed care, often too late or after other very inadequate care was attempted for various medical problems, and with no place to go to follow up on their ER care. The indisputable fact is that these commercial interests, are exactly the problem in our broken Healthcare system that prioritize resources to areas of more market-share, rather than areas of human need, which has created the “Healthcare deserts”, and for proprietary reasons has blocked the sharing of medical data, that largely has impacted our communities of color so adversely and so unfairly in the inner cities and rural parts of our state. Our tragic experience with COVID19 in California clearly shows how we were unable to provide the comprehensive care to especially our BIPOC communities, with more than 68 thousand who have died statewide, and according to experts, an estimated 27 thousand Californians who would still be alive today if we already had a Single Payer system in place to deal with this public health emergency. Clearly, it’s past time to eliminate these destructive and immoral commercial forces and allow a public system of allocating resources as we will have with unified Single Payer financing, that gets medicines, clinics, hospitals, and personnel to areas of public need. It’s past time to pave the way for AB1400 to be applied in its basic design and moved through the legislature, now before anyone else unnecessarily, whether by design or inadvertently, is allowed to fall through the cracks and end up in the Emergency Room for basic care. Thank you.
12	Robert Vinetz, MD	Dear Commissioners: As pediatrician, I hope these thoughts may be helpful in your efforts on the Healthy California for All Commission. Thank you all for your hard and consequential work! A few imperatives: Values: Start with values. List them in order of priority.

Count	Name	Comment
		Financing: Finance with a method that maximizes use of the money for actual care and prevention...and minimizes the spending on administration and other non-care, non-prevention expenditures. Values and Financing - Upstream and Downstream: Values are the upstream-most source for everything downstream. (Values should be explicit.) Financing is immediately downstream to values and upstream to everything else. Financing literally controls (or at the very least largely determines) everything downstream. Words and Definitions Matter: Consider the effect of distinguishing between "financing" and "delivery": Consider the effect of distinguishing between "public" and “private" Consider the effect of distinguishing between public financing and private financing Consider the effect of distinguishing between public delivery and private delivery Consider the effect of distinguishing between not-for-profit and for-profit For example: "A unified system of public financing of health care and of public health” "A unified system of private and public delivery of health care/prevention/public health" (on a spectrum and under rules established by the public) A publicly financed, with a unified, hybrid system of privately and publicly delivered health care. Thank you…Take good care and…Be well,
13	Don Cherf	We are limited by the choices of the companies we work for regarding which healthcare plan we want. We spend a lot of time comparing and contrasting these plans in selecting which plan we think will work for us. When we are laid off, terminated, or quit a job, we lose our healthcare until we finally gain employment at another company where we have to spend time selecting once again which plan we think works best for us. And when we start at another company, we don't always immediately get healthcare. There is sometimes a 30-90 day waiting period before being able to get healthcare.
14	Don Cherf	As a older American who will be signing up for Medicare shortly, it astounds me the amount of time that I will need to spend and how little Medicare covers. A subset of insurance is burgeoning because Medicare doesn't cover 100% of our healthcare. So there are about 10 different Medicare plans that I am supposed to review and compare in order to select the plan I want. Then I have to compare and contrast approximately 10 different

Count	Name	Comment
		companies that offer Medigap coverage. Finally, I have to decide what separate coverage I want to secure for dental and vision and home care etc. So I have to research these plans and those healthcare companies. It is ridiculous to think of all that wasted time.
15	Don Cherf	I would like to reiterate that California's CalCare will be able to tap funds from companies that currently provide healthcare for their employees since they won't have that cost any more and should not be able to use those needed funds for their own purposes. California's CalCare should require those funds be diverted to CalCare for use in providing 100% healthcare for Californians.
16	Don Cherf	The time to start Healthcare for All was last year when this commission started. Let's quit delaying and coming up with reasons to not start it, and just start it already. We have waited far too long as more and more countries enact healthcare for their citizens. We are lagging because too many of our legislators are in the back pockets of healthcare corporations which have a lot of money to delay and kill all healthcare initiatives.
17	Don Cherf	Please do not pay for CalCare with a sales tax which unfairly targets the poor as well as people of color. Sales taxes by their very nature are racist and sexist and should be outlawed and no longer used to generate funds. The same goes for toll roads, too.
18	Don Cherf	I would also suggest that the commission, in trying to determine how CalCare can be funded, look to the 30+ countries around the world with healthcare for all their citizens for the answers how they are able to support healthcare for all.
19	Gerald N. Rogan, MD	1. What reimbursement change might motivate primary care providers to locate offices in medically underserved communities? Consider conducting a survey of independent physicians and integrated medical groups. I suggest issues the determine where a provider opens an office include reimbursement potential from the local population, facility safety, etc. Ask the providers. 2. Can medical care providers afford to address social determinants of health? What is the "lowest hanging fruit" in this area then consider how this may work. One example: a homeless person cannot receive his prescription refills through the mail. Should a PCP establish a medical dispensary? 3. Should we use the public health service to pay for all immunizations and vaccines instead of using financing them through insurance? Free covid vaccines may be an example of how we should handle all vaccines. Vaccines used to be providers in school when I was a child. 4. We need to a process to perform root cause analysis of fraud/abuse cases of high dollar loss or high patient damage to figure out how our institutional safeguards failed. Then we can decide how to fix the problem.

Count	Name	Comment
		5. Taxing providers to pay for unmet needs of the population, makes no sense. An example is the fee medical care providers must pay to help finance the CURES program. 6. How can we measure equity of care provision as a medical care quality measure? Would the physicians showing the best equity be those who speak a second language commonly spoken the local community, such as Hmong, Spanish, Vietnamese, etc.? Should medical school require fluency in a foreign language for entry? High school Spanish helped be care for patients at San Joaquin General Hospital. College German did not help me. Can we find a way to motivate docs to speak a second language fluently? How about a scholarship? Fluency for a foreign language is a requirement to work in the U.S. State Department. The U.S. State Department has a language training institute. 7. To motivate more primary care, should California review the RVUs for medical services. Why accept the decisions of the AMA RUC. 8. Can we provide free tuition in exchange for locating a medical practice in a medically underserved area? 9. Why do we a tax to motivate people to not drink sugary beverages? 10. To reduce dirty air that affects those who live near freeways, we can motivate more electric car use. Electric cars will also reduce noise pollution. I recommend we start with a tax on Harley Davidson Motorcycles to reduce the toxic effects of excess noise. 11. Is it financially feasible for an independent primary care physician to take care of Medi-Cal patients? The answer was "No" when I opened my PCP practice in 1980. But, had Medi-Cal paid me $100 per patient per month for each Medi-Cal patient who joined my practice, I would have opened an office in Pittsburg in addition to mine in Walnut Creek in 1980. Medi-Cal also needed to make it as easy to bill as it is for Medicare. 12. Every nurse graduate should be offered an internship like medical student graduates enjoy. Currently too many nurse grads cannot find jobs because of inexperience. One is my step-daughter. How many nursing grads cannot find jobs today? Please conduct a survey. Thanks for considering my comments.
20	Jerry Rogan MD	Sorry for typos. Opening a medical practice requires capital. Medi-Cal rates were too low for my practice to "pencil" circa 1980. My retail rates were reasonable. Many hairdressers paid cash. Point: a medical practice is a business, not a public charity.
21	Jerry Rogan, MD	The talented, hard-working Mexican artisans who remodeled my swimming pool in Sacramento van-pooled from Tracy where they lived. Some developed covid and missed work, delaying the work. Meanwhile, I worked from home on the internet, phone, and zoom as a Medicare consultant, without covid exposure.

Count	Name	Comment
		This disparity of outcomes was not due to racism. Not all health outcome disparities are due to racism as some speakers today implied. To fix this disparity, best to vaccinate all residents of California through the public health service, not through insurance. Race must be irrelevant to protect our residents. We are all human beings.
22	Cheryl Tanaka	Thank you, Secretary Ghaly, Commissioners Ross, Antonia Hernandez and all commissioners. Looking forward to reading the results of the current Commissioner survey and Oct. survey. Did want to comment on, I believe, Don Mould's question from the 9/23/2021 monthly meeting about those surveyed who did not respond that healthcare was a top priority. It could be that immigration status, housing, work, trying to keep their families together and fear of deportation currently outweigh all else. Thank you, Commissioners Ross and Antonia Hernandez for compelling and heartfelt reports. All of us who look/are "different" have similar experiences and stories of disrespect and ill treatment, on both the macro and micro levels, in "the land of the free and home of the brave." Some aims of the Single Payer movement are: Everyone in, no one out (documented or not). Since everyone is in and no one out, this provides a base/platform for negotiating lower prices for medication for instance. Care from cradle (I would say womb) to grave. Non-profit healthcare (no insurers/middle men, no for-profit hospitals, health organizations, etc.), so that healthcare can be community/patient-driven as opposed to profit-driven. (To me, the Mayo Clinic is an example. All doctors are salaried. Payment is on a sliding scale, those with more pay more to help pay for those with less-which is not the case now. Fundraise [we will need to be creative with financing] to keep up with innovation.) No denial of (reasonable, medically/clinically indicated) services and procedures. Accessible (could mean community-based/nearby/in the neighborhood or transportation provided free or at low cost [some senior {and other} centers already provide paratransport-we need more]), affordable (could be sliding scale), quality, culturally appropriate/sensitive, dignified, respectful healthcare. Affordable, accessible, quality (which includes cultural appropriateness/sensitivity, dignity and respect) healthcare is a human/civil right. (I have buttons that say it in English and Spanish/ I wore them canvassing for Single Payer.)

Count	Name	Comment
		Dr. Ross, like your holy trinity of Race, Place and Power. That sums it up. We need to create systems of power sharing, of putting power into the hands of the people/users of systems, to level out social determinants of health. We need to have a say in design, implementation and accountability/reform. We also need accurate, timely data that can be shared responsibly, taking privacy into consideration, across different healthcare, public health and social welfare systems for coordinated, cooperative, integrated care. We already have data that indicates geographic/demographic areas most in need. We do know those areas. It just hasn't been politically expedient or it's been overwhelming to address those areas most at risk until the pandemic which impacts public health, i.e., the health of everyone everywhere. Good healthcare/public health/human services matters for everyone, not just during pandemics! Secretary Ghaly's example of finding/coordinating resources for the Salinas Valley during the pandemic shows it's possible. We've heard other examples of at risk communities using "creative" means (born out of necessity) to provide quality care for their communities. It is doable! Therefore it should not just be an activity for pandemic/emergency situations. The Salinas Valley, etc., are just as deserving of ongoing, assured, affordable, accessible, multicultural/dignified/respectful, quality healthcare/public health/human services. Commissioner Antonia Hernandez, I agree that healthcare/public health/human services must reflect California's diversity. We have a long way to go on that score. Luckily some community organizations have already taken ownership. We need to support them. We need to also recruit from within communities, grooming/encouraging kids and adults and maybe offering or finding scholarships/paying for education, etc. in return for community service for x number of years, for instance, like a Job Corps, etc. I also agree that affordable, accessible, quality (which includes culturally appropriate/sensitive, respectful, dignified) healthcare is a human and civil right! Our "life, liberty and the pursuit of happiness" are curtailed if we do not feel well in any way. We're learning from the current pandemic (and many areas learned during AIDS, SARS, Ebola, etc.) that public health matters. We all must be able to maintain our individual and community health for the good of all as any "new flu" could become a global pandemic and then endemic. Commissioner Moulds, no, the healthcare and even public health systems alone cannot address all social determinants of health.

Count	Name	Comment
		Human services and other services must coordinate and cooperate also like IT/data/information services. This must be an integrated response from all systems. Commissioner Dessert, thank you for your comment about healthcare systems not being designed for many and in fact stigmatizing them. Goes across the board. Registration questionnaires not pertinent to you or your community. Attitude you receive when seeking services. Services not available, etc. Commissioner Wood, we already have data to go on. And yes, there are "outside" influences aka corporations preying on communities with food deserts, etc. Pushing sugar, alcohol, tobacco, quick fixes for hunger and deprivation. That's capitalism, free enterprise, and definitely a system we need to address as it directly impacts social determinants of health by maintaining class, race/ethnic, socio-economic, etc., divides that keep widening. Agree we need a Jobs Corp for healthcare/public health/human services with incentives such as encouragement, recruitment and enrichment programs starting at least in high school (but the earlier the better), scholarships/tuition payment, etc. Commissioner Scheffler, thank you for making equity the lens through which we must view this challenge and make decisions! I also agree that cutting inefficiencies would provide money to reinvest for trade-offs which have not been explicitly described except that some providers won't be happy not being able to charge whatever they please. Tough! This is not a popularity contest! This is about doing what's right! Commissioner Comsti, agree that we must fund the healthcare/public health/human services workforce pipeline, especially from underserved/underrepresented communities and that all in the communities must be able to aspire to high ranking jobs too like CEO, CFO, COO, scientist, MD, DDS, RN, RD, etc., as the communities are already disproportionately represented at lower levels certificated and not. Agree with institutional global budgets based on needs assessments - so necessary. Also agree that the promotora is an important player in community-based healthcare. We need more for cultural responsiveness, sensitivity. Dr. Sandra Hernandez, love your equity index is the "tip of the possible!" Agree that racism/ethnocentricity/hate/discrimination impacts all systems. Although I maintain that we do have data, we do need efficient and integrated data systems so that appropriate and timely information (being careful about privacy) can be shared for interoperability across all systems. So glad you were part of SF's response to the AIDS epidemic wherein

Count	Name	Comment
		community groups were given money and created an effective support network for those in need. Interesting observation about the success of Covered California in which the people/users are given a voice/say/power/agency/control. Dr. Pan, everything you said is true. Without data we do not exist, do not count. Asian American/Native Hawaiian/Pacific Islander group is not monolithic. Each group must be disaggregated and counted separately, not lumped together especially as Other. Currently Primary Care Physicians, who to me are our backbone, are disrespected totally even though, in some healthcare systems, they are the determiners and drivers of patient health and services. As for structural, historical and entrenched racism, we are currently at a crossroads looking back on centuries of racism/colonialism/imperialism. During the pandemic some of us have had to confront it. Now we must work forward to build anti-racist systems despite opposition from those working to maintain the unsustainable status quo. Equity and equality are not the same. You were good at math and science so were able to become an MD. I was not, so was not able to become a geneticist even though that field interested me greatly and still does. We are not equal, the same. However, there is equity, equal opportunity, access, so that even though I don't have great math/science aptitude, I still had access and the opportunity to go to college and earn a degree also. Equity is about equal opportunity and access. That's what we're asking from healthcare as well. I must echo the public comment that if as you said, those with power make the rules, then as you have power, make rules for equity, parity, equal access/opportunity. I also believe that we must build systems with power sharing, so that all of us can help make the rules. Takes the onus/responsibility off only a few individuals. It certainly sounds like you feel burdened by responsibility for unpopular legislation. This is not a popularity contest. This is about doing what's right! Commissioner Baass, so glad equity is the fundamental aim of CalAIM! Agree that healthcare can be the glue for other services. And it is not fair for prisons, jails, criminal (in)justice, homelessness, etc. to be the plight of so many denied basic human services. Managed care organizations must identify and remedy racial/etc., disparities and inequities. Commissioner Wright, while the ACA was a monumental feat of legislation, it is not without its faults. Yes, those of us with pre-existing conditions could not be denied healthcare coverage, however, we paid for it. I paid $1,000+ a month in premiums which was half my income at the time. I had to go back to work to

Count	Name	Comment
		pay that premium and the rest of my monthly bills. Do agree that navigators are important and necessary. There must be ways/mechanisms maybe like certification, and fines/unfund, to hold providers accountable. Hopefully if we do make healthcare affordable, accessible and equitable (including culturally appropriate/sensitive, respectful, dignified) health outcomes will also improve. We need to try! Dr. Ross, yes, Unified Financing is the hub with many, many, many spokes. Love your idea for using the $1 billion in recovery money to invest in the multicultural workforce pipeline. I also wanted to comment on Dr. Pan and what sounds to be a very challenging practice where his patients want the moon and then some. For almost a year until the pandemic hit, I worked at check out and guest services at Target. My least favorite guest was the one who brought an item with no price tag or any price codes at all and then was already telling me it was also on sale. Well, any percentage of 0 is still 0 which meant to me that they wanted it free. Can't do that in retail. It was often quite a chore to find a price code. I got so tired of their "the price is right, let's make a deal" attitude. Sometimes I would just ask them baldly what they wanted to pay. Some had a ready answer, some would back down. Wouldn't you rather have a system that took that out of your hands rather than have to continue to play those games? I would imagine Unified Financing would also mean unified pricing. Then it's not your fault, it's the government. The same might go with unreasonable requests for medication, procedures, etc. There would be protocols to follow. If you disobey, the government will put you out of business (as could happen even now). Do they want that? Where would they go for healthcare? Guilt trip them back! What exactly are the trade off's many keep threatening? 3 topics not discussed: Immigration/documented/legal status has only been touched on. The Single Payer movement is for covering everyone documented or not. That's sound public health policy. Needs of LGBTQIA and particularly transgender/gender neutral. Often registration questionnaires don't ask questions/address issues pertinent to the community. The community can be stigmatized, shamed. I'm cisgender. I more or less conform within accepted "norms" and don't feel, for instance, that I'm not in the right body to match the way I think/feel. I cannot begin to imagine how that would feel and how that could affect physical, mental, emotional health. Abortion must be covered. A woman must be able to choose for herself without coercion, and have time to make that heavy

Count	Name	Comment
		decision. This is a quality of life issue affecting the life outcomes for both parent(s) and child! There also seems to be concern about people gaming and abusing the system. Like they don't already do that. There are some who will or will try. What about patient/user abuses? I finally want to ask that we approach this not from a scarcity, binary, zero sum view point, but one that is more expansive and inclusive of the vast diversity of California without passing moral, etc., judgements. We are the 5th largest economy in the world. We have enough for everyone. Can everyone live in Beverly Hills, eat caviar daily, drive a Tesla, wear brand names, etc. NO! Of course, not. But should everyone have a decent place to live, enough to eat and be clothed and shod? YES! We're asking for basic health services like regular, routine preventative exams, so people don't have to go to the ER as their only resort by which time they might be so sick it could mean life or death.
23	Gerald Rogan, MD	Good morning. Mike Magee's book Code Blue is worth reading. On page 102 he talks about the failure of the JACHO to assure patient safety and quality of care. This is what we discovered at the Redding Medical Center, 1998-2002. Dr. Magee also mentions the number of unnecessary deaths in hospitals, claiming they are now more than 100,000 per year and the third leading cause of death in the U.S. I almost died at a hospital in Sacramento due to mismanagement of my anticoagulation to prevent death post op THA. I refused a dose of coumadin by diagnosing my leg hemorrhage while an inpatient. The nurses and the doctors missed it. One of the inventors of the artificial heart valve, a professor at Sac State, died of an iatrogenic coumadin overdose. If California develops a single payer plan, it should consider a more effective way to reduce inpatient errors. To begin, it should develop a method to collect data about the current error rate. When errors are found, a root cause analysis of the cause of error persistence is warranted. Perhaps the concept of normalization of deviance applies in some circumstances.
24	Jerry Jeffe	Dr. Ghaly said during the September 28, 2021 meeting that the results of the survey filled out by the Commission members would be posted right after the conclusion of yesterday’s meeting. He gave the impression it would be posted yesterday afternoon. Only the agenda and the slide presentation were posted. When will the survey responses Dr. Ghaly discussed at the beginning of the meeting be posted? Thank you.

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25	Jenni Chang	Thank you Commissioners for your work and today's discussion. I am an E-board member of the California Democratic Party and the Communications director at the California Alliance for Retired Americans. My family struggled quite a bit with the medical system while my late father was hospitalized just before the pandemic. Culturally competent care is very important. I do think we need more data when it comes to AAPI communities. I tend to have some fundamental differences with Dr. Pan but I do agree with him there—AAPIs need more consideration. My dad wasn't going to eat strawberry yogurt and lasagna, and his health deteriorated to the point that my mother had to quit her job. She had to go into early retirement and take care of his meals and translations while he was hospitalized—again, while he was in the care of nurses and doctors, she quit her job to take care of my dad. So I do think culturally competent care is important, but the bigger fear was finances. Part of that fear for my family stems from the fact that my parents, many years ago, had to take out a third party loan in order to not go bankrupt from medical bills. It took my mother 20 years to pay that loan down, and I have deep fear and resentment of our system as a result. She took care of a family of 5 with such limited means, education, language skills, resources. Single Payer is the type of system that benefits someone like her the most. It is so terrifying that our government doesn't do more to stop the merciless greed in our system. We need to make healthcare free—yes, paid by taxes—but completely accessible to everyone. No barriers to care. I think this body should engage with the Feds now and consult with experts who have done the Single Payer deep dive (perhaps some of those suggested by Gov Shumlin) who might act as guidance counselors so that we can make the strongest waiver application possible. We should get moving on this and make it as easy as possible for Governor Newsom to lead the way to Single Payer. Thank you for your time.
26	Dr Tim Bilash MD	1) I have questions about the UNIFIED FINANCING SUMMARY (or UFS) report, and also a reference paper comparing different Countries to offer. Where can I send them? The UNIFIED FINANCING SUMMARY sent to us indicates a +10% increase in commercial HMOs, Medi-Cal managed care plans, and Medicare Advantage plans. +5.9% increase in expenditures is applied to all Personal Health Care expenditure categories except other non-durable medical products

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		Q: Why will there be an increase in the cost of Commercial HMO's. Medi-Cal and specifically Medicare Advantage?, while the 2017 Pollin Report indicates that Commercial Insurance is 20-40% Higher than Medicaid already? Won't any single payer system also face cost increases? 2) I have a link for a published review from the Commonwealth Fund and would like to quote a brief item. How can we attend the the deterioration in Quality of Services, not assume what we have now is adequate and can just go from there? "For healthcare system performance rankings overall,... the United States was last. Our country also was the worst performer overall for spending growth—spending as a share of gross domestic product (GDP). We also sank to a low rating [in] healthcare system performance" The United States also rates last on access to care, which includes measures of healthcare's affordability and timeliness. The Netherlands ranks first." EXERPTED FROM: 'Mirror, Mirror' on the Healthcare Wall: The U.S. Ranks Last in Key Areas I would hope to engage the Committee more directly in the weeks ahead given the opportunity. Sincerely,

Count of email comments: 26
Count of verbal comments: 17
Count of Zoom Chat comments: 57
Total count of public comments: 100