Healthy California for All
February 23, 2022 Virtual Commission Meeting
Public Comment

1. **The following table shows public comments that were made verbally during the February 23rd Commission meeting:**

Count	Name	Verbal Comment
1	Peter Shapiro	I'm with the California Alliance for Retired Americans and Healthy California Now. I'm also a lifelong Kaiser patient. And I don't share Peter Lee's rosy view of Kaiser, I've seen it at its best and its worst. But I think it's important to realize that Kaiser is really three different entities. And it's important that we not confuse them. You have the Permanente Medical Group and the Kaiser hospitals, which actually treat patients and then you have the Kaiser Foundation Health Plan, which holds the purse strings, which decides what kind of coverage, what kind of treatments are coverage, what kind of co-payments are going to be demanded, where the facilities are going to be located and so forth. Unfortunately, the people with the purse strings make the critical decisions. When my doctors at Kaiser are allowed to do their job, when they can work collaboratively, they can do very good work. But I want to share this. Last year I looked up Kaiser's plans. And I discovered that on the state insurance exchange under the Affordable Care Act, it was no fewer than 26 Kaiser nongroup plans six bronze, ten Silver, six gold, four platinum.
2	Leah Schwinn	Hi, my name is Leah Schwinn. I'm a member of Healthcare for All California. I appreciate Commissioner Scheffler bringing up the issue of profits and corporate profits. But what I want to say is when he talks about a doctor making a profit, everybody wants to be properly compensated for their work. And they should be and they should be compensated well, for care coordination. Our doctors right now are dealing with all kinds of technology dealing with multi payer system, they could certainly handle a state run coordination system. And I think we need to talk about how the problem with the corporate profits and having a corporate entity do this is that they've gotten outrageous profits, they've gotten up to the point of obscene profits, there is no ethical balance between making a profit and being fairly compensated.
3	Patty Harvey	I would just like to reiterate what Leah just said. My name is Patty Harvey, and I'm with Healthcare for All California, and Physicians for a National Health Program in Humboldt County. And there is a big difference between doctors making a profit and corporations making profit. Corporations deliver nothing we all know very well that the less care that they pay for the more money they make. And one prominent corporate administrator recently was heard saying that our most important metric is revenue, not healthcare, not saving money for participants, but revenue for the corporation. And these corporations have been fined over and over again, millions of dollars. They don't care. It's

Count	Name	Verbal Comment
		a slap on the wrist. It's a cost of doing business. We have to make sure that corporate profit does not become an impediment.
4	Jamie Maraviglia	Thank you for the opportunity to speak. My name is Jamie Maraviglia. I live in San Luis Obispo County. And I just wanted to share my personal experience with cost sharing. I'm a state worker. I'm under a CalPERS PPO plan. A lot of people would consider that great insurance with low out of pocket costs. But I've learned over the years that that is all relative. I have a daughter who was born in 2017, with a congenital disease called Hirschsprung disease. And she basically does not have a functioning large intestine and has had multiple resection surgeries, and is frequently hospitalized for dehydration. As a result, we have racked up over $25,000 in medical debt over the last five years. And while we are slowly paying it off, it affects almost every aspect of our life and influences all of our financial decisions. The worst part to me is that every time she gets sick, my thoughts automatically go to how much it's going to cost me rather than being able to focus on her health. And we question if we should bring her in? We don't know if the symptoms are life threatening or not. And I don't think it's fair that I always constantly have to think about those decisions. I shouldn't be in that position to know if I can afford it. Thank you.
5	Michael Lighty	Thank you, Karin. And thank you commissioners for another enlightening discussion. My name is Michael Lighty, I'm president of Healthy California Now. I share the concerns about cost sharing and its effect on patients receiving the care they need and deserve, even small out of pocket costs deter care. Any administrative costs may outweigh the savings, see the PERI study from 2017. Let's remember that the only appropriate cost sharing is based on ability to pay, which is what progressive taxation does. So it's not true there's no cost sharing, since virtually everybody pays something under that system. Finally, I think based on the pandemic experience and other public health issues, we've seen regional variations in things and I think this suggests there can be a useful role played by regional authorities and the functions that we want to do in terms of coordinating entities. And such an approach was envisioned by SB 810 And SB 840. And that could provide a guide that I suggest you consider. Thank you very much.
6	Dr. Bill Honigman	Bill Honigman from Orange County. I'm a retired emergency room physician who worked for Kaiser Permanente for over 30 years. I'd like to say that the co pays and deductibles implemented there in the later years of my tenure were a disaster. These perverse cost shifting tools served only to push my patients to delay their care and produce hostility that became directed at the caregivers, further promoting distrust and a further disruption in an already strained patient provider relationship that I witnessed to be getting worse every day that I was on the job. It also was a perverse business model for a provider group that

Count	Name	Verbal Comment
		claimed to be about keeping their members healthy, as recommended tests and treatments were refused by patients when faced with what they thought was an unaffordable personal expense. And finally, Dr. Ghaly's summation of this issue of cost sharing. I may have missed it, but I didn't hear a mention specifically, what would be the elevated costs due to delay or refusal of care?
7	Terry Winter	I'm a registered nurse as well as a graduate of Dr. Scheffler's Department at Berkeley, and the co chair of the Healthcare for All working group in Sonoma County. And I spent decades actively involved in designing and implementing care coordination in the Bay Area for Kaiser. I witnessed dramatic improvements in health as well as the delivery of care. And I agree with commissioners Lee, Chin-Hansen, and Baass of the need for high quality team based accountable systems of coordination of care. Yet we need to remove insurance components that suck billions from care and create and set incentives that eclipse that needed care. I'm a passionate supporter of single payer system as the only way to create an equitable, high quality and sustainable system. A single payer system that removes the insurance intermediary and integrated high quality coordinated care need not be contradictory. We need both designed into a unified financing system.
8	Beatriz Sosa-Prado	Good afternoon. My name is Beatriz Sosa-Prado and I'm the executive director of California Physicians Alliance, CaPA. We believe that health care is a human right. CaPA was founded in 1987 by progressive physicians in the Bay Area with the mission to reform our health care system and achieve single payer. Our approach to improve the healthcare system is short, medium and long term. Since the ACA's implementation CaPA has supported it. Our student organization, the California Health Professional Student Alliance, our future healthcare leaders, now assists individuals and families enroll in health plans with the support of Covered California. CaPA organizes California physicians and amplifies their voices so their legislators could hear from them by supporting bills and legislation that improve the health care system. We believe that we can reform our Golden State health care system and make it the best in the nation. That is why our long term goal and mission is to work with others to create and achieve a universal health care system in California. We need universal health care. Thank you.
9	William Bronston	My name is William Bronston, I'm a physician, I was the medical director for two state departments in California for 25 years. First of all, to commodify and monetize suffering and illness is barbarous. The rest of the world that is capitalist has universal health care systems and national systems in place. And nobody is talking about capitalism as the rationale for changing that. We must put an enormous amount of money into a public health development system, our public health system is crippled and

Count	Name	Verbal Comment
		has been so since around 1980, and that should be a top priority. We need to decentralize the empires of our system in order to return care to local levels, to neighborhoods and to blocks. We need to radically change the workforce in the system, to develop cultural sensitivity to expand and build capacity to work in health deserts. And fundamentally to establish a California Health Corps for providing tuition coverage for training. We need single payer, we need CalCare, we need to really look at a much larger picture of a healthcare delivery system, not a wellness versus a death system.
10	Linda Bohara	Hi, thanks so much. My name is Linda Bohara. I'm a physical therapist and I live in Contra Costa County. As a health care provider, I really want to emphasize the fact that people avoid needed care even with low levels of cost sharing. I frequently see patients recovering from major orthopedic injuries like car accidents or fractures who self limit their own rehabilitation care because of co pays of even 10 or $15. When patients avoid proper rehabilitation due to cost share, they're much more likely to develop chronic pain and chronic conditions which in turn leads to significantly higher costs down the road, not to mention the needless pain and suffering that causes. And I see this every day. This is the true cost of cost sharing. The only equitable solution is zero cost share at point of service under single payer health care. Thank you so much.
11	Craig Simmons	Craig Simmons, and I would like to propose a vote by the commissioners to draft legislation for inclusion in the June 22 primary election or the November 22 general, for inclusion of a ballot measure to implement a payroll health care tax and a corporate wealth tax to fund a unified financing system. Thank you.
12	Robert Skinner	Thank you. My name is Robert Skinner I live in Atascadero, California. I'm a retired high school history teacher. For 26 years, both my wife and I worked for a school district, we were both self-insured. We did not have to pay any co-expenditures or anything. Proponents of cost sharing claim that is unnecessary measure that will reduce costs. And for redundant visits to doctor's office. I think this is a wrongheaded comment. First, even though my wife and I were dual insured, we never had the time to take off work for a non-essential or elective procedure. People only go to the doctor when they're sick or when they want to prevent being sick. When your kids are sick. It is essential. Second, when I turned 50, my primary care doctor recommended I get a colonoscopy. He stated he had no reason to believe I had colon cancer, but it was a preventative measure. Because I was dual insured. I didn't have to pay any co pays. I went ahead and got that. Three polyps were discovered. If I if I did not do that I would probably would be having cancer, I might not even be here today. Compare myself to my colleague, who was under the

Count	Name	Verbal Comment
		same circumstances as I. He was not co-insured. He did not get a colonoscopy. Three years later, he was 53 years old, he died.
13	Janice Rothstein	Thank you, commissioners, for the public hearing and this comment section today. I'm a California licensed vocational nurse and a member of National Nurses United. Business models of healthcare provision make as much sense as subjecting fire departments to the vagaries of the risk bearing private business market. Rationing and denial of care already occurrs today under our system of private insurance. It's often self-imposed. As you've been hearing because people cannot afford health care, the main purpose of which is to enrich stockholders, even those who do have good insurance, even the best insurance, delay care because they cannot afford the onerous burden of co-payments, deductibles, and premiums. Because these three barriers to care would be eliminated under a properly designed single payer system, self-imposed delays in care related to affordability would no longer occur. So called abuse or overuse of healthcare services is an insult to the US public. Government financed and operated single payer systems in comparable economies around the world post magnitudes better health indices than the United States.
14	Brynne O’Neal	A single payer system can directly pay for the coordinating functions that integrated delivery systems claim to provide. But integration of corporate interests, the risk sharing, is not necessary to have care coordination. Through direct payment methodologies, a unified financing system can reimburse providers for the tools they use to let patients book appointments and view their medical records. For communication systems to help providers within the institution coordinate and spare time for doctors to talk to each other. We can keep the coordinating functions of integrated delivery systems while getting rid of the deadly parts of existing integrated health care corporations. We must get rid of risk sharing that incentivizes cherry picking and care denial, we must get rid of the closed networks that prevent patients from choosing their own providers and may make it impossible for rural patients to find a provider at all. We do not need restrictions on care to get care coordination. Thank you.
15	Ellen Karel	I'm Ellen Karel with Healthcare for All and we are part of the coalition Healthy California Now. And it's very exciting to think of what's going to be possible with unified financing, which for us means a single payer system. On the subject of cost sharing, progressive financing of our healthcare system can easily provide adequate funding for a great system without the need for cost sharing, which undermines administrative simplicity and equity and on care coordination. The role of care coordinator was left out of the latest single payer bill. It had been envisioned that coordination could occur in many places, depending on the way people got their care, including from primary care doctors and I was just disturbed that the previous commission discussion

Count	Name	Verbal Comment
		which I thought was helpful about the need for certain populations, including patients needing behavioral health support has somehow morphed into a blanket endorsement of plans and ACOs which contribute to fragmentation and limited network use that we need to move away from.
16	Robin Sunbeam	Hi, I'm Robin Sunbeam, and thank you for allowing me to speak member of NNU, National Nurses United. Healthcare for profit is a crime against humanity. We have a moral imperative to provide Californians with health care, which is not access. The point of providing health care is to is to serve people and not make profit. Cost sharing under unified financing is about reducing utilization while maximizing profits. This is the opposite of the moral imperative to provide health care prevention, and health promotion using primary care saves money by avoiding and mitigating illness. Instead of cost sharing to control costs, a single payer health care system will reduce costs with streamlining, removing the administrative bloat and profit seeking middlemen, both purchasing of prescription drugs and guaranteeing the ability of all Californians to receive primary care without having to consider their ability to pay for it. Thank you.

Count of verbal comments: 16

2. **The following table reflects public comments that were entered into Zoom Chat during the February 23rd Commission meeting:**

Count	Name	Comment
1	Stepen Vernon, MFT	If cost sharing would require $20B oop why would no cost sharing require $39B more from state? Especially when cost sharing would necessarily incur additional admin costs on funding and service side? Kaiser is only nominally non-profit. They have billions of dollars of "surplus" net income every year that should go towards service and/or reduced insurance costs. https://www.healthcaredive.com/news/kaiser-record-net-income-covid-nonprofit/618783/
2	Robin Sunbeam	I am Robin Sunbeam, RN, member of NNU. Healthcare for profit is a crime against humanity that was illegal until 1973. We have a moral imperative to provide Californians with healthcare, which is not "ACCESS." The point of providing healthcare is to serve People, and not make profit. Cost sharing under unified financing is about reducing utilization while maximizing profits. This is the opposite of the moral imperative to provide healthcare. Prevention and health promotion using primary care saves money by avoiding and mitigating illness. Instead of cost sharing to control costs, a single-payer healthcare system will reduce costs with streamlining, removing the administrative bloat and profit-seeking middlemen, bulk purchasing of Rx drugs, and

Count	Name	Comment
		guaranteeing the ability of all Californians to receive primary care without having to consider their ability to pay for it.
3	Stepen Vernon	Even an inappropriately funded Postal Service is more reliable and extends more deeply into the rural population than the for profit services. Appropriately funded/structured single payer will do the same in healthcare.
4	Danett Abbott-Wicker	I feel like I'm in that movie Groundhog Day, same arguments and same old same. When do we learn that M4A is desperately needed? NOW?
5	Robert Vinetz	Messaging and Public Education are crucial to the acceptance of the Commission's recommendations (or any subsequent modifications) Facts are necessary, but not sufficient for healthcare reform: Please include a component in your report for designing and financing this messaging and public education activity. There will be honest questions and self-serving "blowback" to your recommendations. These questions and blowback must be effectively managed. Robert Vinetz, MD, FAAP California Physicians Alliance (member) “Everybody Deserves Healthcare” ***Medical bills bankrupted mom. So, 5-year-old Mason became homeless.***
6	Isabel Storey	Our health care system in the United States is sorely lacking. We have worse health outcomes than any other advanced country. We can and should do better. The Commission’s own consultants have concluded that a single-payer model would substantially reduce costs while guaranteeing health care to every Californian. The final report should emphasize this cost savings as well as the benefit of substantially improving health outcomes. “Coordinating entities” have no place in this system. They don’t add value but do increase bureaucratic bloat and cost.
7	Ruth Carter	While capitalism might be appropriate for certain industries, necessary healthcare SHOULD NOT be profit driven.
8	Isabel Storey	Cost sharing also has no place in this new system. Even small copays and deductibles discourage patients from seeking early or preventive care, resulting in more severe health problems later. We don’t have a problem of overutilization of services in our country now. Our health care is so expensive because of out-of-control pricing, administrative complexity, and profit-seeking. The Commission needs to recommend a single-payer system that reduces bureaucratic waste, eliminates profit-seeking middlemen, and guarantees health care to all without having to consider ability to pay. Isabel Storey Indivisible California
9	Gerald Rogan	I will send you my comments via an e-mail.

Count	Name	Comment
10	Bruce McLean	Wouldn’t the primary care physician be the logical point for patient coordination in a single payer system?
11	Angela Gardner	The purpose of universal, single payer healthcare system is to provide the people of California access to healthcare services they need. The population of California is diverse and so is their healthcare needs. A child's healthcare needs are different than an adult. Seniors have different needs than non senior adults. Immigrant communities with limited English speaking members have different needs.
12	Gerald Rogan	I would be very worried were The State of California to administer benefit.
13	Christine Shimizu	Richard Scheffler compared using Fedex rather than USPS for getting something important delivered. His argument was that for the same reason people would use Fedex rather than USPS we should trust for profit insurance companies rather than our government for our healthcare coordination. This argument has many holes. Most importantly is that the process of mailing a document is so much simpler and less expensive than the administration of our healthcare that the two can't really be compared. We have gone over ad nauseum why the spaghetti system of private insurance company run coordination is insufficient for what we need. We have yet to even try a Single Payer system and the bar to improve upon the current system is so low that we really need to try it.
14	Susan Cieutat	Somebody needs to be asked to mute. They are talking over the public comment.
15	Gerald Rogan	I would be very worried would the State of California to administer my Medicare benefit.
16	Martha Kuhl	As a RN who has worked in hospitals for more than 40 years I have seen health care change for the worse. My non profit employer has become no different than for profit employers as the market and making money has become the sole driving force in this industry. There is very little charity left since health care is just a business. Try as we might to provide a single high standard of care to patients, that is not the focus of our employers. Maintaining cost sharing and insurance intermediaries will only continue the disparate treatment and poor and worsening outcomes for all of us. These are solely used to ration and deny care and maintain profit. Single payer would be a first step in providing all of us a health care system instead of a health care market. We need the commission to study how to finance single payer and eliminate the financial barriers to care. This is a first step in addressing the deep disparities in access to care. Martha Kuhl RN
17	Stepen Vernon, MFT	There has been a move away from the traditional “fee for service” model as a result of the desire to align incentives

Count	Name	Comment
		between payers and providers in order to achieve better overall outcomes, both financial and clinical. As the payment methodologies to providers move from fee for service to capitation, each of these different methodologies has the potential to shift risk from the payer to the provider. This document is intended to assess the level of risk of each of these methods for the healthcare provider. (Risk Assessment of Emerging Payment Arrangements Financial Solvency Standards Board (FSSB) Meeting November 18, 2013 p.2) But the very nature of outcomes based services is inequitable and, depending on the financing structure, often incentivizing of over or under-service…
18	Martha Kuhl	We need a single payer system, that is transparent and focuses on maintaining health and promoting healing for all of us. If the covid pandemic has taught us anything it is that our healthcare system is broken. It left the public not protected and nurses and all essential workers without PPE. It laid bare the many disparities in health care. The current system left all of us dangerously close to no care at all with the result that many were infected and many died needlessly. It is more important than ever to guarantee comprehensive, high quality health care free at the point of service for every person in the state and the country. Our patients can't wait. Martha Kuhl RN pediatric hematology oncology nurse.
19	Stepen Vernon	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."
20	Peter Shapiro	Kaiser's group plans for small business feature deductibles that run as high as $12,500. How do you reconcile a $12,000 deductible with Kaiser's vaunted commitment to preventative care? Kaiser's providers are trying to provide coordinated care, the health plan is trying to manage risk and control costs, and these objectives are often in serious conflict. I'd like to see Kaiser get out of the insurance business and am curious if it's necessary for Kaiser to function as a membership organization in order to do its job properly..

Count	Name	Comment
21	Jean Perry	my name is ronnie perry I am massage therapist. I do not support cost sharing. my husband has net health and his co payment everytime he goes to the doctor he has to pay 80.00! not to mention no dental, no vision. ER is 300.00. Premiums are 116.00 per month. he is low middle class. another issue is those that want to work some on Social Security but so not cannot lose their Medicare. We need a single payer medicare for all system now. it is an emergency
22	Alan Lubow	Thx Jamie..
23	John Miller	Our health care system is obscenely expensive not because of overutilization of services but because of out-of-control pricing. We spend more on health care than any other country, and price gouging, administrative complexity, and profit seeking are the reasons why. A single-payer healthcare system will reduce the cost of our system by streamlining it, removing the administrative bloat and profit-seeking middlemen, and guaranteeing the ability of all beneficiaries to receive primary care without having to consider their ability to pay.
24	Sally Gwin-Satterlee	Sally Gwin-Satterlee retired RN representing medicare for all - Santa Cruz 800 members and Sc4bernie with 2000 members We support Medicare for all/Single Payer system without any Cost sharing. I had a patient who lack of urination,back pain and fever and I consulted with an MD and she had to go to ER and admitted to hospital. When doing my assessment she had pain and burning with urination for an week and did not come in because of 25 co-pay. so cost sharing does not work. ended up causing patient more pain and serious life threatening symptoms of kidney failure.
25	Luca de Sanctis Barton	No cost sharing! Let's make healthcare a human right! There are better, more community-centered ways to work with communities than jumping to cost sharing. Cost sharing will stop our people from getting the healthcare they need. *No cost sharing!
26	Michael Lyon	In addition to universal coverage, Single Payer or Guaranteed Healthcare for All, AB 1400, aims to bring equality to healthcare: Equality for patients because there'd be a single standard of care for all patients. This could mean no more 3rd-class care under Medi-Cal. But also equality for providers, because there'd be a single schedule of reimbursement for all providers. This could mean all providers would treat the population now on Medi-cal, and public hospitals and clinics would get equal reimbursement. It could mean providers would come to unserved poor urban and rural areas. Finally, we could equalize reimbursement between different levels of care, and get rid of the incentive for both profit and "non-profit" hospitals to drop preventive and primary care in favor of higher-paying care like surgeries etc.

Count	Name	Comment
27	Sheryl Soong	We need single payer like Calcare for ethical reasons (like bridging the class or racial inequity gap). But if we have to retain a class division system because of… the usual disappointing reasons, then we need at least a true public option system.
28	C. T. Weber	Big Pharma push doctors to prescribe drugs. They over produce them and as a result many of them end up in the black market. TV advertising has increased consumer demand. Please ban drug advertisements on TV, radio, and print.
29	(h)Dr Bill Honigman	Also, as regards care-coordinating entities, again the entire intention of a unified financing system is eliminating the waste of third parties, as well as the potential for fraud and abuse. We should let the care-coordination be handled by the providers or provider groups themselves. Commercial risk-bearing and other unlicensed entities, in particular, must absolutely be prohibited in the care decision-making process of this new system. And In conclusion, it is clear that the implementation of a Single Payer system will derive the sufficient savings by eliminating waste fraud and abuse, and allowing consumer bargaining power for pharmaceuticals, medical devices, and medical services needed. COVID19 is proof that we have already waited too long to implement such a system here in California, and here in the United States.
30	Janice Rothstein	Business models of healthcare provision make as much sense as subjecting fire departments to the vagaries of the risk-bearing private business market. Rationing and denial of care occur today under our system of private insurance. It is often self-imposed because people cannot afford health care the main purpose of which is to enrich stock holders. Even those who have insurance delay care because they cannot afford the onerous burden of co-payments, deductibles and premiums. Because these three barriers to care would be eliminated under a properly designed single-payer system, self-imposed delays in care related to affordability would no longer occur. So-called 'abuse' or 'overuse' of health care services is an insult to the U.S. public. Government financed and operated single payer systems in comparable economies around the world post magnitudes better health indices than the U.S., which ranks #11 in the Commonwealth Fund's survey of major industrialized countries.
31	Kathleen Healey	How is current family income determined in a gig economy? How much would this cost to investigate and fairly administer statewide? The downsides already presented overwhelm any possible benefit from share of cost.
32	Carmen Brammer	I'm a resident of San Jose and a member of Santa Clara County Single Payer Healthcare Coalition I do not support cost sharing Californians deserve a single payer healthcare system that is focused on healthcare over greed and profits.

Count	Name	Comment
		It is critical to remove the inequities that our current system and one with cost sharing that continues to disproportionately impact the African American community and has led to long term neglect by the healthcare industry
33	Michael Lyon	But I'm very critical of the single-payer movement's preoccupation with cost reduction and promises to bring workers and bosses together, saying we both have the same interests. Under single-payer, the bosses would certainly continue to push to drive down expenses and restrict care. If the bosses try to starve Medicare, they'll also try to starve Medicare for All. Single payer would help to have all workers in the same boat, but it will not make class struggle around healthcare go away, and the single payer movement's promising this will disarm us if we do get single payer.
35	Barbara Commins	One People, One Plan…NOW!! No more stalling for investment Wealth in Heakth/Insurance stocks
37	Tim Jouet	go man!
38	Tara Covington	Is there a group working toward single payer in San Diego?
39	Danett Abbott-Wicker	YAY Dr. Bronston!
40	Betty Toto	Let's talk in the short-term people are dying!! Single Payer Now!
41	Henry Abrons	The income of a doctor's practice or partnership is considered "profit" in tax accounting. But it must not be confused with corporate profits that go to shareholders whose goal is to treat health care purely as an money-earning investment. "Profit" for doctors is a form of compensation. Shareholder profit for investors is exploitation of sickness for personal gain.
42	Luca de Sanctis Barton	If we do not build a single-payer system like CalCare, healthcare will be segregated. We need everyone under one insurer whose mandates are equal, quality healthcare for everyone. If the wealthy are able to get into a different healthcare, then healthcare for everyone else will not be what it could and what our international consensus since 1948 with the UDHR and international law since 1966 with ICESCR.
43	Margie Hoyt	Thank you Dr. William Bronston!
44	Terry Brady	Well said Dr. Bronston.
45	Marcia Bookstein	Yes! Thank you!
46	Robert Vinetz	The term "Profit" needs definition and clarification. "Profits" can be "extractive" (removing money from the actual delivery of health care)…or be reframed as "reimbursement" for care and services…that actually help people.
47	Kathleen Healey	Care coordination should be local where the local services available are known.
48	C. T. Weber	Thanks Bill B
49	Ellen Schwartz	My name is Ellen Schwartz, I live in Ken Cooley's assembly district in unincorporated Sacramento. I know even AB1400

Count	Name	Comment
		didn't deal with Workers Comp but this was a strong example of the dangers of involving insurance companies in health care. In April of 2019 my daughter then a special ed teacher was beaten on her head, severely, over a period of 45minutes by one of her students. The school nurse was a witness to much of this and when the student was finally pulled away, the first thing the nurse did was call the workers comp insurance company. Those people told her to take my daughter to urgent care. Not to an ER for a CT scan. Urgent care sent her to the Workers comp clinic which wrote that she was fine and sent her home with a raging headache and dizziness. It's no thanks to a badly broken healthcare non-system that her concussion did not involve a Brain bleed. It subsequently took a year before the insurance company approved physical and occupational and cognitive therapy for her.
50	Tim Jouet	Follow the money of those opposing progress. Is healthcare a public good, or just a business opportunity?
51	Luca de Sanctis	Separate but equal healthcare or any human right, is not equal. Everyone under one equal, quality healthcare system. No more segregation of healthcare by socioeconomic factors. Time to take a huge step in making healthcare a human right with single-payer healthcare with no cost sharing under CalCare.
52	Pilar Schiavo	Thank you for this important discussion. The conversation about cost sharing has left out a focus on the important cost sharing that will occur under progressive taxation, since almost everybody pays something based on what they can afford. Charging co-pays will not improve compliance with appointments and is not worth the costs in delayed and discouraged care. Regional entities, not health plans, are well-suited to carry out some coordinating functions discussed. Primary care needs to be the basis for care coordination. Public health needs to be a key part of ensuring population health. Thank you.
53	Angela Gardner	Cost sharing prevents people from getting access to healthcare they need. The burden of cost fall on the people. It defeats the purpose of changing our healthcare system making it less accessible. The purpose of changing our healthcare system is that cost sharing makes healthcare out of reach for many people and too expensive. Coordinating care must be provider based not third party privatized coordination of care by nonmedical professionals. It would improve patient outcomes, more efficient care, and reduce healthcare cost. I agree that healthcare providers need a shared data infrastructure and health information data. Care coordination must be funded to providers as well. I agree with Dr. Pan about healthcare being a entitlement not a budgetary category. I remember Gov. Schwarzenegger using the

Count	Name	Comment
		budget to eliminate/cut healthcare Medi-Cal, IHSS, and Adult Day Health. It was a disaster and the people of Californians suffered. When the draft report is released public comment is essential.
54	Betty Toto	If anyone here is interested in working towards a Ballot Initiative for CA Single Payer. Please contact me Betty Doumas-Toto Betty@singlemindedforsinglepayer.com Interested parties are meeting on a bi-weekly basis at this time.
55	Juli Dickey	I am Juli Dickey, a retired geriatric care manager and long-time supporter of single payer. Opponents of single payer talk about high cost of transitioning to single payer. We have high health care costs right now because of administrative complexity and industry profit-taking is the main reason that our current health care is so expensive and the reason the U.S. pays more than most other countries for health care, and with much worse results.
56	Terry Brady	I would strongly encourage the commission and it's leadership listen closely to all the comments being made during this public session. There is clearly a common theme with significant concerns by most all that the current system of profit over people screams for reform. We clearly need to have a single payer system that puts people over profits.
57	Allen Cooper	The diamond merchants ship their diamonds via USPHS not the for profit FedEx. They felt it was safer!! Capitalism is not an excuse. The non-profit, govt run VA health care system has excellent out comes then most for profits and “not for profits”
58	Alyssa Kang	The Commission should recommend a Unified Financing system with no cost sharing. Studies show that even small copays disincentivize patients from seeking medical care, including necessary care. Cost sharing does not just result in patients skipping so-called low-value care but also results in patients skipping and delaying necessary care because patients, as non-healthcare professionals, cannot make determinations on whether care is needed or not on their own. Patients mistake heart attacks for heartburn and appendicitis for bad cramps.
59	Jean Jackman	What a sadness that more of the public did not have time to tell their stories.
60	Alyssa Kang	Research shows that skipped and delayed care has consequences, including increased use of the emergency room. If we want to encourage primary care and avoid expensive emergency room care, then we need to get people to go in for advice and tests before their conditions get so bad that they have no choice. Utilization is not why our health care costs are so high – prices are. The unified financing system should not put up barriers to care.

Count	Name	Comment
61	Betty Toto	We cannot depend on Commissions and Legislators to save our lives we need direct democracy now through a ballot initiative in CA!
62	Alyssa Kang	See: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
63	Carmen Brammer	We are making healthcare more complicated than it needs to be. There are successful examples of a single payer healthcare system around the world. Our leaders can make this happen by not listening to those who want to keep healthcare out of reach for most of us. As Dr. Martin Luther King Jr said "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death." The decisions made by this commission has a direct impact on the life and death of every Californian. Also, I am disappointed and find it unfair that this commission has not done a better job of ensuring all residents in California were aware of the work you're doing- instead it has kept this process sheltered from true public comment and engagement.
64	Betty Toto	We cannot depend on Commissions and Legislators to save our lives we need direct democracy now through a ballot initiative in CA!
65	Peter Shapiro	Appreciate Richard Pan's comments about the hoops doctors treating MediCal patients are forced to jump through. This is a consequence of having a separate system for those who do not have the political clout to make sure their treatment is adequately funded. If rich and poor were in the same risk pool, there would be no incentive for those who pass on state budgets to skimp on treatment for the poor.
66	Stepen Vernon, MFT	Tara Covington-- contact me at stephenavernon@gmail.com to help connect in SanDiego/SoCal
67	Betty Toto	We can not depend on Commissions and Legislators to save our lives we need direct democracy now through a ballot initiative in CA! Contact Betty Doumas-Toto at Betty@singlemindedforsinglepayer.com to meet with others to work on a SP Ballot Initiative.
68	Marcia Bookstein	500,000 medical bankruptcies per year in this country! I see the results of this downtown where so many homeless people live. Tragedy. Cost sharing is a solution aimed at the wrong problem. We do not have a problem of overuse but a problem with price gouging. Decades of analysis has consistently shown that the U.S. spends more on health care than any other country because of the high prices we pay not because of overuse. Health care utilization in the U.S. is actually similar to comparable countries. And in 2017 Medicare's Payment Advisory Commission found that private insurers pay prices 50% higher than Medicare. Even from a cost standpoint, reducing utilization is counterproductive: as we

Count	Name	Comment
		see under our current system, when patients skip or delay care due to cost they are more likely to end up in the emergency room or need more costly care. In a single payer system, we can get prices down through bulk negotiation, ending administrative complexity, and reducing industry profit-taking – and we can do so without discouraging patients from using health care services.
69	Barbara Commins	Click on 20y above this graph to see, 20 years on Health profiting on Wall Street, https://www.barchart.com/stocks/quotes/$SRHC/technical-chart
70	Sheryl Soong	We need single payer healthcare or calcare in california for infinite reasons, but this would be one of the best ways to combat social stratification and racial inequity, and would create community solidarity in this era where like, fascism and political extremism is returning. In addition to single payer being the most ethical system out of the possible options, the pandemic proved tying employment and class to healthcare is disastrous! The nurses are heroes who dealt with every complicated failing of bureaucracy and privatization during this whole crisis, listen to them!
71	Tara Covington	Why hasn't the focus of this discussion been on reducing the suffering of those who are un or under insured instead of cost sharing? We need universal healthcare NOW!
72	Reisa Jaffe	One of the commissioners quoted numbers that looked great for Kaiser but the measure was limited to a small number of diseases. We need to look beyond whether or not a person dies as a measure of quality of health care. Kaiser, for example, has serious problems with their delivery of mental health care. Medical care providers deserve compensation. That's different from the profit motives that happen when care choices are made by corporate entities removed from the people needing care. Please implement a system where decisions are made close to the patient
73	Brynne O'Neal	A patient's doctor or treating clinician should decide what care a patient needs. When a patient requires multiple health care professionals to deal with a chronic or emergent condition, the unified financing system should pay providers directly for the time the care team members spend discussing the patient's case and that doctors and nurses spend making sure the patient understands their treatment plan and following up as appropriate. Care coordination must be done by the professionals who are trained to know what care the patient needs. It is inappropriate to have profit-seeking middlemen making rules to decide if a patient will be denied access to care. Unlicensed workers, like health system administrators, should not be responsible for deciding what doctors you can see and when. Only license professionals

Count	Name	Comment
		are qualified to decide what specialists a patient needs to see and to explain the details of treatment plans.
74	Barbara Commins	No more investing off HC delivery. Put your Capital into Climate Control!!!
75	Brynne O'Neal	We must not accept any risk sharing or closed networks in the name of care coordination. Risk-adjustment incentivizes complex diagnoses – not complex care. Closed networks do not facilitate integrated care. Rather, closed networks create disruption for patients as doctors change networks, close off patient choice, and make it hard for rural patients to find care. Moreover, we know from Medicare Advantage, which introduced intermediaries into Medicare, that intermediaries with closed networks are rife with fraudulent upcoding as they compete for the healthiest and avoid the sickest and most costly. Intermediaries game risk-adjusted capitation payments by diagnosing patients with severe illnesses and then providing as little treatment as possible. Care coordination needs to be done by treating health care professionals with the clinical education and experience necessary to know what kinds of care a patient needs, not by algorithms and insurance adjusters trying to save money for a corporation.
76	Mari Lopez	When publicly presenting single payer to the public not a single hand would go up when I asked who liked going to the doctor. There is not going to be a problem of overuse.
77	David Krissman	Yes, we live in a market economy, but healthcare does not in any way behave like a normal market. And it never will. The profit incentives in our current system are directly at odds with good patient outcomes. If you really want to improve our system, you must take the general profit incentive out and reward value. Anything else is small band-aid on a gushing wound. dkrissman@gmail.com
78	Linda Bohara	Thank you for this opportunity to comment. I am a health care provider and work at a very large health care organization, though I represent only myself today. Within this organization, providers constantly have to fight administration in order to be able to provide appropriate high level care for our patients. It is clear that administration is not interested in high level care, but only meeting their departmental goals that never include positive patient outcomes. Many health care providers and workers are leaving the health care field due to the burnout caused by fighting just to simply provide quality healthcare to our patients. Coordination of care for profit simply does not work.
79	Alan Lubow	This is public input. Just a half hour???
80	Margie Hoyt	I truly miss the U.S. Public Health Service Hospital system I experienced as a retired Army depended. It had a walk in clinic for urgent care needs and a hospital full of doctors for specialties. I loved it.

Count	Name	Comment
81	Elsa Schafer	Care Coordination needs HIEs state- and nation-wide to allow efficient flow of information among care providers including capture of that information for later reference as well. An integrated delivery and financing system with HIEs can also provide an analytical application using only 0.002% of the elaborate EHR information, the diagnostic data only, to improve care by arming frontline physicians/nurses with granular data to understand where what symptoms they haven't seen before, to see what other physicians have diagnosed, which have been accurate, and what protocols delivered helpful care, not killed a patient. See the PAMF System of which I used to be President.
82	Carmen Brammer	++Alan…unfair that we only get 30 mins

Total Count of Zoom chat comments: 82

3. **The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address before the February 23rd Healthy California for All Commission meeting:**

Count	Name	Comment
1	Gerald Rogan, MD	Would the commission consider a proposal to establish a commercial insurance plan administered by the State of California open to all people who reside in California? Leave Medi-Cal, Medi-Care, commercial plans, and California connect alone. Run the plan as you wish, such as with no co-pays and on a fee for service basis. Negotiate with suppliers and providers and establish a fee schedule. See how well it works. If it works well, consider rolling Medi-Cal into it. If that works well, commercially insured persons could elect to enroll in it. Legislation could allow them to use the money their employer pays via an ERISA or other commercial plan. My idea may be more politically feasible. Rationale: Medicare works well, so why include it in your plan? KP works well so why attempt to destroy managed care? Medicare inclusion will require federal legislation and break a covenant between Medicare beneficiaries and the federal government whereby beneficiaries paid into Medicare during their working lives and receive their benefit when age 65 or disabled. There are many stakeholders who rely on this covenant. I for one, would not want to State of California to interfere with my covenant, particularly because I do not want to be insured by Medi-Cal and because the State of California cannot properly administer the EDD and struggles with the DMV. Medi-Cal has abandoned FFS Medi-Cal in favor of managed

Count	Name	Comment
		care, in part because the State of California could not contain Medi-Cal waste, abuse, and fraud in a FFS system. Medi-Cal reimbursement is too low to support physicians who own their own practices. Medi-Cal providers principally are FQHCs for primary care. Reportedly, they are paid on a cost plus basis, not fee for service. You know better than I. There are many reasons we collectively pay too much for medical care. Changing how it is financed is not likely to fix the problem. Many other incremental changes are required to mitigate the conflicts of interest to provide more care than a patient needs, or follow inefficient and outmoded methods of care. Note that Medi-Cal is now asking medical care providers via an RFP to address social factors that adversely affect health, including homelessness and food insecurity. I am not sure how a medical care provider or a medical care plan can provide food and shelter under the current budget for medical care. Maybe they will develop more hospitals like Laguna Honda in SF? I think to fix our problems we must work incrementally, rather than change how our system is financed for those who are happy with their systems of care.
2	Gerald Rogan, MD	God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine Victoria Sweet, MD How to provide effective medical care to homeless people who cannot heal while living on the street.
3	Linda Desrosiers	Dr. Mark Ghaly, You'll do a reassessment in two weeks! Do it now. Numbers are down. Go sit in a class with a mask on all day. Then, continue to wear your mask during after school activities. Don't hold the kids as hostages. All children should be able to breathe again WITHOUT A MASK! Do what's best for the children! Now not later!
4	Julie Kiser	Single payer now I am family practice physician in California continuous practice since 1993 Working in FQHC full time. Single payer now
5	Patty Harvey	Dear Commissioners, My personal affliction with the current non-system of health care is the more than $50,000 my husband and I have spent on dental work in the past decade. Medicare, as you know, does not help with this. That's an average o $5,000/yr to add to the more than

Count	Name	Comment
		$800/mo we pay for Medicare and supplement. This keeps us barely financially functioning. More important are the many thousands of Californians (and the rest of the nation) who cannot afford ANY care, either because they lack insurance or because their insurance deductibles are so high. I have dedicated my life to working for a single-payer system that would solve these problems and save the state (and the nation) billions of dollars. THIS IS A WELL-DOCUMENTED FACT.: Current studies and the experience of other wealthy nations attest to less cost and better health outcomes. Now, while we work to improve our single-payer system, Medicare, that program is under dire threat from so-called Medicare Advantage and Direct Contracting Entities. If we don't implement a system that obviates for-profit schemes like those, the Traditional Medicare we are trying to save will cease to exist. As long as ANY profit motive is mixed into health care there will be no savings and the quality of care will continue to suffer. Our only hope is single-payer: our biggest asset at this point in time is your Commission taking a stand for people over profits. Please support a SINGLE-PAYER system and make California a bellwether for the nation!
6	Jim Burfeind	Dear Healthy CA for All Commission, I am a facilitator for NAMI Butte County's Family Support Group and the president of CTA/NEA-Retired for Butte, Glenn, and Plumas counties. I just attended the monthly meeting of the Butte County Behavioral Health Advisory Board. The board had an excellent discussion of ways to support our recently expanded 24/7 crisis line. One obstacle discussed is the time clinicians spend when people first call in asking what insurance they have and deciding what services are covered. Pause and read that sentence again. A person in crisis or a family member trying to get help for them has to spend time discussing different insurance plans and how they reimburse! The program coordinator reported many private insurance companies refuse to pay for services like emergency counseling anyway for many reasons This is not ok! We need Single Payer insurance for everyone. Everyone in! Nobody out!

Count	Name	Comment
7	Sally Gwin-Satterlee	Myself and 2000 members of Santa Cruz 4 Bernie strongly support a Single Payer/Medicare for all healthcare system for the State of California. I am a retired RN and I saw people die needlessly because they could not get the care they needed. This continues today and it must stop. We believe Healthcare is a human right.
8	Alicia Telford	Why not make CA the leader in what could become the national standard for Healthcare? We truly need a system that allows Americans to be more healthy with affordable healthcare. I pay $1,000 per month to Kaiser and my yearly income is $50,000. So my take home pay after healthcare is $48K. Then there are taxes, phone, internet, food, transportation, housing that come out of that income… Wouldn't it be amazing to only pay $200/month for single-payer healthcare, similar to civilized countries, like Europe, Canada or Australia? Think how we could actually afford to go to the doctor and buy other essential items more easily. This could help with the homeless crisis, too. Let's get this ball rolling!
9	Andra Whipple	Hello! I'm writing in support of the CalCare bill. As a writer who often freelances, and a union member who knows just how much of the WGA's bargaining power goes towards healthcare, and as a Californian who has many times needed to rely on the exchanges only to find them ridiculously complicated and expensive, my full support is behind single payer healthcare. I am currently getting healthcare through Covered CA and the whole process has been unnessecarily complicated and wildly expensive. I was just quoted $400/month for subpar care if my husband and I make $60k this year. First of all, we all know $60k isn't much in Los Angeles (our rent alone is 1/3 of that at least), $400 a month is not affordable for us, two working adults. How could it possibly be affordable for a family, or someone who is struggling with health conditions and unable to work full time? Healthcare is a human right. As I have bounced back and forth between my union plan and the covered ca plan, I have seen firsthand how messy and unhelpful insurance is. I have had to switch doctors many times, had to delay working in order to try to figure out banal and ridiculous insurance charges, and haven't been able to rely on continuity of care to help manage my health, and I am worse off for it. As a state, we must do better. We are in the dark ages of healthcare. We must improve. To all of our lawmakers, I must say I am deeply disappointed we haven't gotten further, and I must remind you that this is your job. Your constituents desperately need your help. I need your help. My family needs your help.

Count	Name	Comment
		This issue is so important to me, it is the number one issue I vote on. We must have healthcare for all that is truly accessible. Thank you for your time,
10	Elizabeth Martin	As a union member, I have excellent health insurance...when I work enough to qualify for coverage. But that doesn't happen every year. Which means I change health plans and doctors frequently. It's hard to establish any rapport or even have consistent care under these circumstances. If we had Medicare for all here in California, my health coverage would be stable. This would mean everything in terms of time and energy saved. In terms of making sure my chronic conditions are managed properly. Please, make this dream a reality. Sincerely,
11	John E. Douglas	Dear Healthy Calif. for All Commissioners: All the studies and the examples of the healthcare systems of virtually all of the rest of the developed nations of the world, including Canada, show that SINGLE PAYER HEALTHCARE covers residents universally, is more efficient and costs less than the complex for-profit, insurance-run system that we are stuck with in the USA. Please recommend a SINGLE PAYER system to the governor in your report. Thanks for considering my views. Sincerely,
12	Daniel R. Hilsinger	Hello My name is Daniel R. Hilsinger. I'm a young adult bone cancer survivor and I believe healthcare should be a RIGHT, not a privilege. Anything else but calcare, improved Medicare for all, is a bow to the moneyed interests that profit off of sickness and suffering. Do not reward them for their wrongs. I speak for hundreds of people I know in various groups all across California. Please make the time to watch my music video. https://youtu.be/EsWk6wMph-g Best, Daniel

Count	Name	Comment
13	Collin Thormoto	Dear Commissioners, I hope you are well. My name is Collin Thormoto and I wanted to email to encourage you to recommend a single-payer/unified financing proposal to the Governor. There are many reasons, the first one being that single-payer healthcare is, objectively, the best option from an economic standpoint. Paul Krugman, noted Economist, has mentioned time and again that single-payer is the most cost-effective option from a health economics standpoint because it improves health outcomes for the most people while also saving the most money. Your own expert analysis has shown this and it has been the best option since before the ACA was enacted as an ugly compromise. Secondly, this benefits unions by taking healthcare off the negotiating table. The employees which are covered by unions today are forced to sacrifice negotiations on safe work conditions, work environment, hours, and countless other things because healthcare dominates the negotiations of almost every union. Removing this would be a huge boon for unions because they would be able to focus on other things that matter to them and their members without having health coverage held hostage. Thirdly, this would be a massive benefit to small businesses and small business ownership. For many, myself included, what keeps people at their jobs is the benefits and primarily that means healthcare. Even modest coverage is usually far better than what can be afforded by individuals in the marketplace provided under the ACA. I, myself, when I was a healthy 25 year old man with no pre-existing conditions of any kind took COBRA coverage at great expense because even minimal coverage in the exchanges was over $200/month. Nobody should have to pay that much for substandard care. Providing healthcare for all Californians would allow people to leave jobs they dislike and would likely trigger a small business renaissance, not to mention any potential for bringing people in from other states. And finally, I want this for my friends and loved ones who have had to ration insulin, inhalers, and other life-saving medication because it was too expensive even with employer provided insurance. The State can definitely do better for its citizens, and it has an obligation to do so. So please recommend single-payer without cost-sharing or coordinating entities. Thank you,
14	Ana Davis	As a massive state and economy, we can and should lead the way on healthcare for everyone. Not having healthcare tied to a

Count	Name	Comment
		job would give some many people the chance to lead better lives.
15	Marilú Carter	Dear Commissioners, In 2006, I worked for the University of California, Department of Community Development, and for Professor Jacob Olupona in African American and African Studies. I had a diagnosis of Non-Hodgkins Lymphoma and I was insured. I started chemotherapy, but I had to work at least 20 hours a week while taking out-patient chemotherapy. I brought my editing work with me while receiving the very toxic cocktail of chemicals. I asked the nurses to inject into my left hand so I could work and write editorial comments with my right hand free to edit. I was horribly sick, needed to be hospitalized for blood transfusions. But if I failed to work 20 hours in any one week during the six-month treatment, the insurance company would have cut me off treatment. I would have had to sell my house to continue being treated. This barbaric medical bankruptcy only occurs in the United States. Please, I implore you Commissioners, let us introduce, at least in the State of California, comprehensive health care for all who reside in California. Thank you sincerely,
16	Scott Johnson	Myself and members of my family as well as colleagues and friends have all suffered from the negative health impacts of delaying care because of deductibles and copays. These type of cost sharing measures are cruel and do not result in cost savings. They only increase profits for insurance companies. Cause of high cost in healthcare. Price gouging administrative complexity profit taking Overuse is not the driving factor in high costs Cost sharing results in patients avoiding preventative and primary care making us sicker and driving up healthcare costs. With single payer we can increase preventative and primary care by ending price gouging, administrative complexity and profiteering.

Count	Name	Comment
		Third party administrative entities are unnecessary and counterproductive. Those with a financial stake in denying care should not engage in care coordination work. Providers should be compensated directly for care coordination. There is no need for expensive middle men who profit from denying care and add administrative costs. Narrow networks created by third party administrative entities do not improve care or reduce cost. We need public comment on the final report prior to the report being submitted. Report should include the commissions conclusion that single payer will be less expensive even covering everyone with no cost sharing. The California people support single payer The report should recommend single payer financing to the legislature All data and comments should be included in the report Public comment on the final report should be allowed and included in final report. What should not be in the report Any roll for intermediaries Any cost sharing Any delay or half measures
17	Patricia Clark	I am the mother of a son who caught a rare virus and it left him with life long medical needs. Because of this both he and I have been held hostage to the insurance companies our whole lives. I had to keep the job I held when he got sick no matter what they paid and turn down promotions because they were in an area not covered by the same employer-based insurance. He currently is on Medical and has to keep his income below the poverty level to stay alive. This is a crazy system and is wrong. And I am one of the lucky ones...I at least could work and keep him covered until he aged out. Please do the right thing for us all and recommend a single payer solution to our broken health care system. Patricia Clark Long Beach CA 90802 "This isn't the kind of fight you win, it's the kind of fight you fight." Cory Doctorow "radicalized" 2019

Count	Name	Comment
18	Sheila Smith	I worked on the Prop 186 campaign in 1994. I have been waiting for 30 years for everyone to have access to healthcare. I'm sick of both parties refusing to enact this life-saving (and money-saving) transformation in CA. I am appalled that Gov Newsom, who campaigned on AB1400, has betrayed us. I feel bitter anger at the lack of decency and respect for humans that pervades the politics if America. Instead, there is a worship for private profit that ensures the working class continues to suffer and die for that profit to accrue to those who already have more than their fair share. I find it truly disgusting that politicians prefer to support private profiteers rather than the people they are supposed to represent and provide government to. When will the permission, the encouragement for corporations' greed be controlled? CA could lead the nation in the right direction but has been dodging its responsibility and power to make change far too long.
19	Nancy Greep	As Don Moulds showed, overuse from FFS is not the problem with our rising health care costs. As a state, we undertreatment is more of a problem than overtreatment. The solution is not t get rid of FFS and replace with various managed care arrangements with insurance companies controlling care, It is single payer, plain and simple. It is a no brainer. The only reason legislators and the commission hold on to insurance company intermediaries is because our leaders have been bought out by the insurance and pharmaceutical industry. Polls show that the majority of California voters want single payer-even if the majority of the assembly does not.
20	Robert Skinner	Dear Commission Members: Attached is a copy of the comments I plan to make at your meeting on February 23. Please download and submit them. I will be in attendance at the meeting. However, I anticipate that I will have some sort of problem with ZOOM which will make it difficult for me to be recognized to speak.
21	Robert Skinner	Dear Commission I write these comments in the event that I am unable to speak at today's meeting due to technicalities I have with my laptop and Zoom meetings. I am a retired high school history teacher. My wife is also a retired elementary school teacher . For 26 years, we both worked in the same school district. We were both insured by Self Insured Schools of California (SISC). We were dual-insured. Our three kids were also covered under our policy . We understand our situation was unique and fortunate. This is because we were exempt from cost-sharing measures such as co-pays, co-insurance, and other deductibles. My wife's policy would cover my cost sharing expenses and vice-versa.

Count	Name	Comment
		Proponents of cost sharing claim it is a necessary measure that will reduce costs associated with redundant visits to the doctor's office for unnecessary or elective medical procedures. This an absurd and disingenuous claim. The reality is cost sharing measures discourage patients from seeking treatment because the co-pays, deductibles, and co-insurance payments are too expensive. I have two examples from my life to support this. First, even though my wife and I were dual insured, we never had the time to task off work to go to the doctor or undergo a non-essential or elective procedure. People only go to the doctor when they are sick or when they want to prevent being sick. When you or your kids are sick it is essential. Second, when I turned 50 my primary care doctor recommended, I get a colonoscopy. He stated he had no reason to believe I had colon cancer but that a colonoscopy was a preventative measure. If I wasn't dual insured, I would not have gotten a colonoscopy . Because the co-pays and deductibles were too expensive. Plus this is an unpleasant procedure.. However, because I was dual insured, I had a colonoscopy. Three polyps were discovered–they were removed. To be clear, I am grateful to the medical professionals who performed my colonoscopy. I am thankful they removed the polyps. Because if they hadn't, by now those three polyps would be three tumors. And I would be undergoing chemo-or radiation therapy to have them removed. Or I might very well be dead. Compare my situation to that of my colleague. His name was Gregg. He taught three rooms down the hall from me. He and I were the same age. We taught the same subject. We both were very health conscience about diet and exercise. The major difference I was dual insured, he was not. He had to pay cost sharing measures. When he turned fifty he did not get a colonoscopy because he could not afford the copays, and deductibles. By the time he was fifty-three he was diagnosed with colon cancer. He feared bankruptcy because he still had to pay cost sharing measures for his treatment and hospitalization. And one year later, he died. For the insurer cost sharing is a valid short term money saving practice. But in the long run for the patient cost sharing is expensive and deadly
22	Heather Glosier	Please support Medicare for all! Every Californian deserves and needs healthcare, regardless of their job. Please save lives, and also make it easier for people to leave bad workplaces, pursue an education, and support their families!

Count	Name	Comment
23	Peter Shapiro	My name is Peter Shapiro. I am a retired postal worker and a member of California Alliance for Retired Americans. I sit on the board of Healthy California Now. I have been enrolled in a Kaiser Foundation Health Plan since I first entered the work force nearly 50 years ago. Kaiser has been described as the mother of all health maintenance organizations and a model of coordinated care. Since the Commission's charge today is to examine coordinated care and the role of cost-sharing, I want to share my own experiences with Kaiser over the years. In many ways I suspect it has been typical. I've seen Kaiser at its best and worst. If I had to sum up my experience over the years, I would draw the following conclusions. First, to the extent that Kaiser's model of health care delivery is intended to encourage a collaborative approach to medicine and make it as easy as possible for the patient to navigate the system, it has much to recommend it. To extent that Kaiser, and HMOs in general, are driven by a desire to reduce costs, the results are negative and even toxic. As a young man, I enrolled in Kaiser for the same reason many young people today choose bronze plans on the health insurance exchange—because of its convenience and its low premiums. As a union member, I was attracted by Kaiser's history as a health plan specifically designed to serve working people; I also appreciated its emphasis on preventative care, which seemed eminently sensible to me. In those days Kaiser had made a business decision to brand itself as the cheapest health plan on the market. The consequences became apparent once you'd spent any amount of time in the Kaiser system. Your primary care doctor was supposed to perform triage, performing an initial diagnosis and determining whether or not you needed the attention of specialists and if so, what kind. In practice because primary care physicians were under real pressure to keep costs down, they too often practiced what was often referred to as assembly line medicine. Timely appointments could be hard to get, and I quickly learned that it was absolutely critical to find a primary care physician who put the patient's needs first and was not there simply to act as a gatekeeper. Friends enrolled in the Kaiser system all had horror stories to tell about indifferent care that resulted from Kaiser's tendency to cut corners. For myself, I vividly remember the birth of my first son, when my wife was left standing unattended in the hallway of the obstetrics ward in the middle of a violent contraction.

Count	Name	Comment
		A doctor friend who worked for Kaiser for years recently told me that Kaiser's doctors finally revolted and threatened to leave the system if Kaiser did not change its business model. The Kaiser Foundation Health Plan stopped selling itself as a low-cost option, and began giving its physicians more say over care. He told me that Kaiser's salaried physicians themselves developed methods of sharing the work load that would minimize the incentive to avoid more difficult patients or skimp on their treatment. There is no question that my own experiences with Kaiser improved over time, even as my premiums rose. When my granddaughter was stricken with Kawasaki syndrome, I was deeply impressed with the way her team of doctors responded. My daughter-in-law's experience with childbirth was far better than my wife's had been. But serious problems remain. Kaiser's mental health care remains atrocious, simply because chronic mental illness does not lend itself to "cost-effective treatment." I live a few blocks from Oakland Kaiser, and it is a regular part of the life of the neighborhood to see informational picket lines by its mental health care workers, protesting understaffing and shoddy patient care. In the absence of sufficient safeguards, Kaiser Foundation Health Plan's practice of compensating its hospitals and outpatient services on a capitated basis creates a powerful incentive to avoid patients who will be costlier to treat, something that is usually accomplished by writing policies that do not adequately cover their treatment. This tendency has been greatly exacerbated by Kaiser's growing reliance on deductibles, something that was actively encouraged by the Affordable Care Act's tiered approach to coverage. Covered California lists no fewer than 26 Kaiser non-group, plans—six bronze, ten silver, six gold, and four platinum. Administering so many plans wastes a lot of money, much of which is borne by the taxpayers in the form of federal subsidies. Kaiser also offers eleven group plans for small businesses; the majority of them feature deductibles that can run as high as $12,500. It goes without saying that a $12,500 deductible makes a mockery of Kaiser's commitment to preventative medicine. High deductibles discourage patients from getting treatment when they need it. They also create terrible inequities in access to care, forcing those who can't afford higher premiums to gamble on staying healthy enough to avoid expensive treatments.

Count	Name	Comment
		One of my in-laws struggled for years with bipolar disorder. He worked as a security guard. Through his employer, he was enrolled in one of Kaiser's low-end plans. Short of being told, "in a life-threatening emergency, dial 911," his mental health treatment consisted of being referred to therapy groups which sometimes did not even have the benefit of a licensed therapist. I don't know if better care could have prevented his suicide, but there is no question in my mind that his Kaiser plan did absolutely nothing to prevent it. For me, one of the most compelling arguments in favor of unified state financing and direct payment of providers is that it would allow Kaiser to get out of the insurance business and do what it does best, namely, offer collaborative models of treatment, care coordination, and easily accessible care. The big problem I have with coordinated care as currently practiced is that it continues to be promoted mainly as a way of cutting costs, presumably as a safeguard against costly overtreatment. I will say quite frankly that the high cost of health care in this country is not due to overtreatment, but undertreatment—far too many of us simply cannot get the care we need because of the gatekeeper function of private insurance, which not only rations care but greatly increases its administrative costs.
24	Paula Rainey	Dear Sirs and Madams, I strongly support any effort to arrive at legislation that will provide healthcare for all Californians. We have seen the devastation that came from Covid, and some communities experiencing tremendously more health consequences than others. We know that inequity only exacerbates health problems. We see this in chronic conditions like heart disease and serious debilitating conditions like dementias that affect the patient and ability of family members, careers to function well with all the added stressors. Access for all the people is critical. Co-pays must not be barriers, everyone needs to benefit.
25	Michelle Verne	Hello, Thanks for giving me the opportunity to email my comments in regard to the final commission report. I would just like to reiterate as I did in previous emails that I worked in the Health Insurance Industry for 20 years. 12 at Health Net from 1989 to 2001, and nine, at United Health Group from 2011 to 2020. In those twenty years, I never did anything to provide quality healthcare to anyone. In the last seven years of my employment, my three children were on MediCal because UHG was not paying me enough wages to afford their insurance premiums. This is unbelievable and atrocious, and believe it or not, I wasn't the only one. The employees also have premiums deducted from their paycheck which is paid right back to health insurance

Count	Name	Comment
		company, which also includes the part of the premium they pay to themselves. They have 325,000 employees. In my mind, that is unreal and corruption at its finest. Luckily, I was able to quit that job in 2020 and would never ever go back to working for any for profit health insurance corporation again. The lack of dignity I incurred over that length of time has caused serious anxiety. We have been at this for over a hundred years, the time for a single-payer system is now, we cannot wait any longer. The final Commission report should NOT include an intermediary option. Intermediaries add nothing of value to our health care system. They increase costs, make care harder to manage for patients because of narrow networks and insurance barriers to care, and make it harder for patients to get the care they need because decisions on care are based on profit-making and not based on what is best for the patient. The Commission's own consultants have concluded that moving to a direct-payments (single payer) model of health care would substantially reduce the costs of our health care system while guaranteeing health care as a right to all Californians. Those facts about the savings potential of a single payer system should be emphasized clearly in the final report. Discussions about how to finance a single-payer health care system have never been more important, as the benefits of the system become increasingly obvious. To help foster this discussion, the Commission should include various financing options to help inform the legislature as it considers single payer legislation in future sessions. It's very important that the Commission's final report and the process of adopting it be as open and transparent as possible. Therefore, the Commission should publicly establish a very clear process for considering Commissioner and public comments on the draft report. All data and calculations that inform the final report should be published in its entirety and in a clear and concise manner. Finally, dissent from and disagreement among Commissioners and the public must be allowed, accommodated, and addressed in the final report. The band aids our legislators keep putting on this healthcare system will not sustain. We need single-payer now. Sincerely,
26	Jamie Maraviglia	I would love to share about my personal experience with cost-sharing. I have private, employee sponsored insurance. In comparison to many other plans, it would be considered "great insurance" with "low" out-of-pocket costs. I have learned over the years that is all relative. You see, my daughter was born in 2017 with a congenital disorder called Hirschsprung's Disease. This disease has left her without a functioning large intestine and she has had multiple re-sectioning surgeries. She is also frequently hospitalized for dehydration following any viral infection such as

Count	Name	Comment
		norovirus or rotavirus. Each time she's hospitalized, we obviously have had to pay our deductible and co-insurance. As a result, we have racked up over $30,000 in medical debt over the last five years. This is beyond the $22k a year that we pay for our insurance premiums. While we are slowly paying off the debt we have accumulated, it affects almost every aspect of our lives and influences all of our financial decisions. The worst part is that every time my daughter gets sick, my thoughts automatically go to how much it is going to cost me instead of just being able to focus on her health. We question if she should be brought in – even though we have been told that some symptoms can be life-threatening to her – because we don't know if we can afford it. No parent should ever be put in the position of deciding if they can afford to potentially save their child's life and this is EXACTLY what cost-sharing does. The cost of cost-sharing is our health. It results in patients avoiding necessary care, making us sicker and driving up our health care costs. Please do not choose to put us all in this unnecessary position. Thank you,

4. The following table reflects public comments that were emailed to the HealthyCAforAll@chhs.ca.gov email address during the February 23rd Healthy California for All Commission meeting:

Count	Name	Comment
27	Mary McDevitt	Have any countries started with Cost Saving and then dropped it?
28	Patty Harvey	Can we dispense with the idea that no-cost causes overuse? Japan has 3 times the usage that we do and still spend way less on care. If you've ever spent a night with a sick child wondering if you should call a doctor, worrying about advancing fever and severe repercussions weighed against the fear of the cost of seeking care.... no one should go through such agony. And then there's long term care . . . we all live in abject fear of facing thousands of dollars/mo in cost for care--having to divest ourselves of all assets, burdening our children with the cost, etc. WHEN WILL WE BE DELIVERED FROM THIS ANXIETY?????
29	Patty Harvey	And let's consider the impediment to care via "wait lines." Right now, for millions of Americans, the wait line is LIFE TIME. They will NEVER get care! So why are we worried about the rest of us waiting maybe a few weeks longer for non-emergency care? We who can pay, already do a pretty good amount of waiting! --
30	Chrys Shimizu	Richard Scheffler made a point that capitation systems save money and the cost savings could mitigate the need for cost sharing. However, the problem with capitation systems is that they put financial pressure on providers to prescribe tests and treatments according to what the capitation system will cover

Count	Name	Comment
		rather than what is best for the patient. I have personally experienced this when my doctor's response to a complaint about tingling in my fingers and toes was to order an enormous number of tests, including a colonoscopy. Contrary to Mr. Scheffler's conclusion, the capitation system ends up costing the whole system more in this way. In addition, in order to figure out what treatment gets covered and how much it should be covered for, a body of middlemen are made necessary to make these decisions. This adds additional cost and takes away the benefit of having doctors decide what is best for their patients rather than middlemen. Respectfully,
31	Mario from 91352	A wide range of studies show that even small copays discourage patients from seeking care they need. Delayed or skipped care increases risk of death or serious injury and illness, particularly as people avoid care for chronic conditions, and increases the cost of the system because people are more likely to end up in the emergency room or need more costly care because a minor health issue leads to a more serious one. For aforementioned studies see below: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/ Sincerely,
32	Marcia Bookstein	Dear Commission, I wanted to make some comments regarding the conference today: Several of my colleagues in the San Diego Symphony are from Taiwan and they rave about the healthcare there. What kind of healthcare system do they have? Could we have the same one here? I do understand that it's highly used, but this makes the population more relaxed and therefore there would be fewer illnesses related to anxiety. Going to work I see many, many people who are homeless. Sometimes I can have a conversation. Harley had walking pneumonia and was in the hospital for quite some time. We are all paying for his healthcare. Another fellow asked me for money. "Why should I give you money?" "My wife had a life-threatening disease that our insurance wouldn't cover. I lost my house trying to pay for her care, but she died. Now I'm homeless." How is this allowed in the wealthiest and most militarized country in the world? My daughter has started a new business. How does she afford a salary and health insurance for others participating in her business? This is anti-capitalist. (I'm personally anti-capitalist

Count	Name	Comment
		as a witness to the hundreds of homeless people on our streets contrasted with the $13,300,000 yachts over by The Shell. (Azteca) Doctors who become family physicians and practice in underserved communities should have their medical school debts forgiven.
33	Marc Silverman	I am a strong supporter of a single payer solution to healthcare. Multiple studies have proven that a co-pay system both discourages patients from seeking care and places administrative costs and burdens to the system that a single payer system avoids. Single payer systems SAVE MONEY and puts patients first--we need to reduce bureaucracy by eliminating third parties getting involved between doctor/patient relationships. Middlemen do not add any value or quality but merely add costs to the system--this is what we are trying to avoid. It's been proven that eliminating co-pays does not increase the costs nor does it create overuse of the system but, in fact, eliminating co-pays saves the system money and helps eliminate medical issues from getting worse by addressing issues earlier. Furthermore, co-pays are a regressive taxation of the public. The longer it takes to transition our medical system to a single payer system the more people will continue to suffer and avoid care and the system will NOT save money. We also need to ensure the public is engaged in the decisions about how healthcare works at every step of decision making for our health care system. California residents overwhelmingly support a single payer system which has been proven it will save us money. All data should be available to the public throughout the entire process of decision making that is for the public! Thanks!
34	Barbara Commins RN	I am a SHIP/HICAP counselor and I encounter people rationing RXs all the time! We have had Medicare Part D since 2006 and it should have been regulated from Day One and we would not see this (see attachment) Profit first!!! NOTE: it's been out of control since 2010 with ACA and increased numbers aging into Medicare at 10,000 a day 2011-2029
35	Isabel Storey	Dear Commissioners: Thank you for your work on this important issue. As you formulate your final report, here is my input:

Count	Name	Comment
		Our health care system in the United States is sorely lacking. We have worse health outcomes than any other advanced country. We can and should do better. The Commission's own consultants have concluded that a single-payer model would substantially reduce costs while guaranteeing health care to every Californian. The final report should emphasize this cost savings as well as the benefit of substantially improving health outcomes. "Coordinating entities" have no place in this system. They don't add value but do increase bureaucratic bloat and cost. Cost sharing also has no place in this new system. Even small copays and deductibles discourage patients from seeking early or preventive care, resulting in more severe health problems later. We don't have a problem of overutilization of services in our country. Our health care is so expensive because of out-of-control pricing, administrative complexity, and profit-seeking. The Commission needs to recommend a single-payer system that reduces bureaucratic waste, eliminates profit-seeking middlemen, and guarantees health care to all without having to consider ability to pay.
36	Barbara Commins RN	People delay care with financial disincentives!! Esp with insulin and asthma inhalers. Shameful!!!
37	Jeoffry B. Gordon, MD, MPH	(1) Given the well known issue of RX non-compliance a real health oriented finance system would pay enrollees to take their meds. (2) In terms of copay burdens, I am fully insured with Medicare and a supplemental and I take 2 common meds (branded) which cost ~$100 and $400 for 30 days each (in the donut hole with the subsidies) - and I have 8 other meds as well. (3) In terms of health status outcomes in Canada the way their system is structured with current OOP costs, there is well proven established peer reviewed literature which shows far better outcomes with cancer care and cystic fibrosis, for instance. (4) The imposition of all OOP costs are primarily structured to max insurance company's profits, not to motivate patient's health behavior.

Count	Name	Comment
		(5) It was biased or myopic for Dr. Wood and Pan to talk about MediCal no shows and blame it on "free care." Due to their common socio-economic circumstances, my MediCal patients would no show because of the lack of or difficulty with transportation, lack of child care, a sick child, language confusion, no acceptable clothing, court appearances, no phone, etc.
38	Jeffery Tardaguila	Lt services, nursing homes assistance living many for profits vs np entries. How do we get profits out of Medical decisions? How does California keep track of 40 million California when we can't do it for working force EDD unemployment less then 20 million... But DMV tracking drivers and cars also not working. How we do better?
39	Dessa Kaye	Regarding cost sharing: A $5 or $10 upfront co-pay to access care in order to make sure that patients "buy in" to care will actually continue to discourage especially low-income patients from accessing the system just as it does under the current dysfunctional system. Instead, why not make use of the system free at point of service/purchase but charge a cancellation fee for patients that don't show up/follow through/fill prescriptions/etc. (i.e., don't take their health care seriously because it is "free" and therefore not valued)? Providers want to provide care and their time is valuable, but there shouldn't be a monetary barrier before a patient can seek care. Sincerely,
40	Barbara Commins RN	These entities today are all a business overlay to offset care and increase profits. You need teams of socio-health professionals to coordinate care.
41	Barbara Commins RN	No more healthcare according to income, class, etc. Healthcare entities should not put people in different categories!
42	Kenneth Saffier, MD	What can we learn from the “The elephant in the room”? The 3 visually impaired people (previously considered “blind”) come across the elephant. The first one, the health care provider, (traditional doctor, sometimes represented by the CMA) feels the trunk and says, “this is a snake!”. The second one, the health care industry, (health maintenance organization, e.g., Kaiser, etc., Pharma) feels the leg and exclaims, “It’s a tree!”

Count	Name	Comment
		The third one, the politician and policy maker (in CA and nation), feels the tail and says, “No, this is a rope!, not a tree or a snake…” In our system, the elephant is the person who is a patient. Elephants are graceful, primarily peaceful, family and community oriented, and have excellent memories. People across the county, and growing numbers of physicians and other health care providers, when polled in an appropriate, accurate manner, vote for an “improved Medicare for all”, a single payer system. When will the visually impaired among the above “see the light”?
43	Dessa Kaye	Regarding care coordination: ONE SIZE DOES NOT FIT ALL! I am a very pro-active patient, daughter of a doctor and cancer survivor. I have picked my health care team very carefully and don't want to be assigned a bureaucratic coordinator to control my medical access. I want nothing to do with the Kaiser model. Others are very comfortable handing over their care management to someone else. Individual choice is an important element of AB 1400 and any single-payer system. Sincerely,
44	Jean Jackman	Dear Commissioners, I have good healthcare however, I want single payer and unified financing —healthcare for all. I still fear spending myself into poverty if I need long term care. I’m not healthy if my neighbors aren’t healthy. It is so unfortunate that in our country, our poor healthcare is more expensive than for people in other countries because of the profit making. We pay more, have lower longevity and poorer health than so many countries. We need to eliminate all of the middlemen. Pay the doctors compensation to coordinate. Right now, minor issues don’t get treated because of the copays and cost sharing. We pay so much for administration, high priced drugs. With single payer, I believe it will be cheaper and we will save money even if we cover long term care. We will need to transition rapidly, in a year, looking at the model of Taiwan. No intermediary act.

Count	Name	Comment
		Please make sure that the last policy meeting is a clear process with public engagement. We need to be able to comment on the draft and give feedback. Thank you for your work.
45	Barbara Commins RN	Profit first… Care? Maybe! Health sector is in Top Four sectors on Wall Street and should not be! Money taken from patients to give shareholders!
46	James Sarantinos	Many physicians are involved in research resulting in intellectual property such as patents, licenses etc.. Is there a way that this income can be harnessed and funneled into the state healthcare funds as an additional revenue stream? With regards
47	Chrys Shimizu	Carmen Comsti referred to Dr. Hsiao's mention of the paperwork from the government in a single payer system and compared it to the paperwork from the current multiple private company administered health plans. Her point is very well taken. No matter what, the coordination of care requires paperwork. But I would rather only have one entity, the government, and one set of rules (that of the government) to have to deal with when my care is coordinated. In either case, dealing with paperwork and different rules and requirements is daunting and time consuming. But at least if it's just one consistent entity for everyone everywhere the paperwork only needs to be done once. Not over and over again as the private companies change their rules or get bought out or drop me as a member. Thanks!
48	Barbara Commins RN	Disconnected from the job Free at point of service Comprehensive - Vision, Dental and Long Term Care State of the Art… just like our weapons industry!!
49	Michelle Famula, MD	Commissioner Peter Lee stated: The Medical Home model “hasn’t shown the lift we hoped”. My question: I am curious how the fidelity with implementation has been tracked for the data showing this. Given the incredibly fragmented care driven by employer changes to plan networks, employee job changes that change insurance plan availability, regional mobility of patients driven by work, school, family obligations…etc. How are we measuring Medical Home fidelity when we are saying that this coordination system isn’t able to work any better than random care providers?

Count	Name	Comment
		Thank you
50	Stephen Adair Vernon, MFT,	Even an inappropriately funded Postal Service is more reliable and extends more deeply into the rural population than the for profit services. Appropriately funded/structured single payer will do the same in healthcare.
51	Adair Vernon, MFT,	-- Environmental health issues become more clear and addressable in a unified financing model.
52	Adair Vernon, MFT,	There has been a move away from the traditional "fee for service" model as a result of the desire to align incentives between payers and providers in order to achieve better overall outcomes, both financial and clinical. As the payment methodologies to providers move from fee for service to capitation, each of these different methodologies has the potential to shift risk from the payer to the provider. This document is intended to assess the level of risk of each of these methods for the healthcare provider. (Risk Assessment of Emerging Payment Arrangements Financial Solvency Standards Board (FSSB) Meeting November 18, 2013 p.2) But the very nature of outcomes based services is inequitable and, depending on the financing structure, often incentivizing of over or under-service… 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." (emphasis mine) Aurum nostrum non est aurum vulgi
53	Adair Vernon, MFT,	-- Kaiser is only nominally non-profit. They have billions of dollars of "surplus" net income every year that should go towards service and/or reduced insurance costs. https://www.healthcaredive.com/news/kaiser-record-net-income-covid-nonprofit/618783/

Count	Name	Comment
54	Adair Vernon, MFT,	Thank you-- --If cost sharing would require $20B oop why would no cost sharing require $39B more from state? Especially when cost sharing would necessarily incur additional admin costs on funding and service side? --With any co-pay or other cost sharing people will not know what it will cost them… so they will avoid that unknown and avoid treatment. Removing that anxiety of not-knowing will allow more people to access service. --Under status quo multiple, fragmented programs often promote multiple, fragmented and clinically and administratively contradictory data, QA, reporting requirements --Care coordination does not require fiscal intermediaries. Aurum nostrum non est aurum vulgi
55	Martha Kuhl RN	As a RN who has worked in hospitals for more than 40 years I have seen health care change for the worse. My non-profit employer has become no different than for profit employers as the market and making money has become the sole driving force in this industry. There is very little charity left since health care is just a business. Try as we might to provide a single high standard of care to patients, that is not the focus of our employers. Maintaining cost sharing and insurance intermediaries will only continue the disparate treatment and poor and worsening outcomes for all of us. These are solely used to ration and deny care and maintain profit. Single payer would be a first step in providing all of us a health care system instead of a health care market. We need the commission to study how to finance single payer and eliminate the financial barriers to care. This is a first step in addressing the deep disparities in access to care. We need a single payer system, that is transparent and focuses on maintaining health and promoting healing for all of us. If the covid pandemic has taught us anything it is that our healthcare system is broken. It left the public not protected and nurses and all essential workers without PPE. It laid bare the many disparities in health care. The current system left all of us dangerously close to no care at all with the result that many were infected and many died needlessly.

Count	Name	Comment
		It is more important than ever to guarantee comprehensive, high quality health care free at the point of service for every person in the state and the country. Our patients can't wait.
56	Chrys Shimizu	Richard Scheffler compared using Fedex rather than USPS for getting something important delivered. His argument was that for the same reason people would use Fedex rather than USPS we should trust for profit insurance companies rather than our government for our healthcare coordination. This argument has many holes. Most importantly is that the process of mailing a document is so much simpler and less expensive than the administration of our healthcare that the two can't really be compared. We have gone over ad nauseum why the spaghetti system of private insurance company run coordination is insufficient for what we need. We have yet to even try a Single Payer system and the bar to improve upon the current system is so low that we really need to try it.
57	Marian Shostrom	Thank you for continuing this conversation. My comments are below. Cost Sharing: cost sharing keeps people from getting the care that they need; it requires an infrastructure that is costly. In general, I am opposed to cost sharing. If there is cost-sharing, it needs to be done to keep patients/consumers from getting care that is unnecessary or harmful, such as excessive use of antibiotics, MRIs and scans. Coordinate social drivers of health: housing, food insecurity, transportation, pollution. Care Coordination: Health Care Providers should share information, decide on diagnoses, medication, testing, etc. Give health care professionals paid time to do this. Care decisions should not be made by entities that are not health care professionals. Corporations (profit and non-profit) should not be involved in care coordination. We are retired, with good insurance, and our out-of-pocket costs are in excess of $25,000. We would gladly pay higher taxes for everyone to have health care.
58	Nina Eliasoph	Greetings. I had to leave the meeting to go to work (I'm a sociology professor at USC who studies relations between states, markets and nonprofits). Here are links to some peer-reviewed articles (among many—please let me know if I can send you more) that compare the US' and Canada's healthcare costs. Specifically, my point is that if "coordinating entities" includes insurance companies, the health system would be much too

Count	Name	Comment
		expensive. It would just add administrative costs, without adding any health benefits. Doctors and nurses should be funded to coordinate without asking permission from insurance companies. The below links show that single-payer is much more cost effective than a system that involves insurance companies in any capacity at all. As we know, with our byzantine insurance policies, American hospitals spend five times more per person on bureaucracy than Canadian hospitals. The average American business spends over $16,000 a year on each employee's healthcare—far more than Canadians pay in extra taxes. Canadian businesses' healthcare expenses? Zero. Because of these astronomical administrative costs, healthcare is most businesses' second largest expense. That is the single most important reasons that Americans are much less likely to work in small businesses than people in Canada and other wealthy nations are, and less like to be self employed. Europeans are over twice as likely as Americans to be self-employed; South Koreans, over four times as likely, and the difference is mainly due to health care costs, which, in turn, are due to administrative costs. If insurance corporations oversee doctors' and nurses' own coordination of care, this will only add to administrative costs, when the point is to lessen them. Since single-payer would be cheaper (and save lives, of course), the Commission should continue to push for it, by continuing to publicize its benefits. Sincerely,
59	Gerald Rogan, MD	Good meeting today. If one needs a network to coordinate care, pay the network. I assign my Medicare benefit to KPMG with satisfactory coordinated results. Copayments. Figure out a way to motivate patient's keep their appointments. Fee-for-service payment is not going to fill our future goals. – I agree with Dr. Lee. Zero copayments for an office visit for all patients is not going to work. High deductibles are an offset to higher premiums- a viable option for those who want to self-insure part of their care. More effective medical staff peer review will improve quality.

Count	Name	Comment
		Analysis of institutional failures to control overutilization will help improve quality and reduce payment for medically unnecessary services (cost). The barriers to access to services that Dr. Pan mentioned Medi-Cal imposes are not acceptable to folks who have resources to pay for their medical care or buy other insurance. The State of California may not have authority to make private medical care insurance illegal or to gain control of my Medicare benefit. I am happy with my Medicare and my assignment of my benefit to KMPG. A unified payment system must not make my medical care worse. The standard of care is independent of the Health Plan that pays those who deliver the care- so I disagree with Carmen Comsti on this point. Abuse will remain no matter what system is developed. Ongoing mitigation will be required. Providers can coordinate care so long as they are paid to do it. I agree with Dr. Pan and Richard Scheffler. I agree the State of California cannot control coordination of care. I agree with Richard Scheffler. Care coordination is local. Integrated delivery systems work, fee for service is less coordinated. I agree with Richard Scheffler and Peter Lee. Medi-Cal billing in Fee for Service was a nightmare for my PCP practice 1980-1997. It cost more to bill Medi-Cal than to bill Medicare or private plans. Care coordination can start with a PCP referral, but a care coordinator person can do most of the work to set up the referrals and appointments. Capitation works better when the group is large enough to accept the insurance risk. Accurate measure of illness burden can help avoid cherry picking of healthy enrollees. Quality of care requires a measure of illness burden to know where one begins. Mayo Clinic is driven by what is best for the patient. I am not convinced we need a single funding method to meet these goals. I would be very worried were the State of California to administer my Medicare benefit, so much that I would vote against it. Consider paying a PCP or his/her medical group for each patient enrolled with his/her practice, whether individual or a group. Limit the total number of enrolled patients, such as to no more than 2500 patients per doc, adjusted by age. Older patients see the doctor more often, so adjust for this. Keep what works and improve what does not work. Patients often do not know the best kind of specialist to help them. I agree with Anthony Wright. Which system best treats my neighbor's diabetes? Which system has the best outcome for my

Count	Name	Comment
		total hip arthroplasty? Which system can best manage my first wife's smoldering multiple myeloma? I agree with Anthony Wright- I would be afraid were the State of California finance my medical care. I would fear "Medi-Cal for All." This is one reason I attend your meetings. Currently fee-for-services pays more for medically unnecessary office visits, tests, drugs, treatments, etc. Transparency, I agree with Andy Schneider. I asked my provider about her system's data regarding infections following a total hip arthroplasty. I should have asked for the data regarding pulmonary embolism following a THA. My system prescribed Arixtra (Fondaparinux) as a prophylactic which failed. Robust data can show which anticoagulant works best to prevent THA post-op PE. Medi-Cal RFP. I don't know how a medical care provider system or health plan can mitigate homelessness or food insecurity. Good luck! Can we have several medical care financing systems that helps us meet our overall goal (e.g Medi-Cal, commercial individual, commercial ERISA, Medicare FFS, Medicare advantage, VA, and others)? Conflict of Interest Disclosure: I don't invest in publicly traded commercial insurers because their profits and dividends are too low. A public utility, such as Southern Company, is a better investment. What's next- maybe start with those who have the greatest need. Once your system works, then maybe Medicare can join in.
60	Sandra Trinidad	Co-pays amount to a tax on the sick and injured. My 19 year old son last month had an emergency. A few weeks later, the hospital billed him for $100 in co-pay. Had he been older and not in our insurance, it would have been a $5000 visit to the ER. Even with a $100 co-pay, he told me he would hesitate on getting care knowing the co-pay. He was billed $1800 by the ambulance provider. I told him to call the provider and give them his insurance information, provided by his father. Had he been older, this would have been a very large expense to manage. Many people have medical debt in this country, which is immoral. My other son, who is autistic, has MediCal as his secondary insurance. Last week his ear hurt, so we went to the doctor. Had he not had MediCal, we would have paid $60 in co-pay and the price of the medication. Prior to MediCal, we had to pay $3000 annually in out of pocket expenses before insurance would pay. This was in addition to

Count	Name	Comment
		paying $6000 annually in employee paid premiums, not to mention employer paid premiums. Co-pays are meant to penalize and deter people from getting care that they need. Delaying care will end up costing more in the long run. As for wait lists, we have wait lists now. My autistic son has been on multiple provider wait lists for ABA for 10 months now because providers pay behavior therapists barely above minimum wage. My other son scheduled an appointment with a cardiologist and has to wait two months for the appointment. I am speaking out in favor of a single payer system that is a more efficient and equitable system that cuts out middlemen who profit off denying and delaying payment of healthcare.
61	Michael Lighty	February 23, 2022 To: Healthy California for All Commission Fr: Michael Lighty, President, Healthy California Now I share the concerns expressed by many commissioners about cost-sharing and its effects on patients receiving the care they need and deserve. Even small out of pocket costs deter care, and the administrative costs may out-weigh the savings (see PERI study). Let's remember that the only appropriate cost-sharing is based on ability to pay, which progressive taxation is uniquely able to do. Almost everyone pays something, so it is not the case that absent co-payments there is no cost-sharing. Regarding coordinating entities, I start with my personal experience getting treated for a rare disease in an PPO/FFS system that has included a high level of coordinated care, with my primary physician and primary treating specialist playing key roles. In fact, my doctors "see everything," even from different health systems. Unlike the assumption by some commissioners that FFS cannot coordinate care, my experience shows otherwise. I also start from the premise that health plans are responsible for major problems in the current system - barriers to care, administrative waste, fragmented quality initiatives, profit-making that shifts resources away from patient care, narrow provider networks and high-cost sharing – so they cannot be part of the solution. A medical home can in fact exist under different payment models. Like the approach under SB 562 and the New York Health Plan proposal, healthcare service organizations,

Count	Name	Comment
		community clinics, and primary care practices can be paid to be a medical home and coordinate care even among providers who practice in different health systems and be held accountable. Fundamentally, care coordination should be based on primary care. This approach can also ensure that risk-bearing and financial incentives to select only healthier patients do not come into play and restrict access. Based on the pandemic experience, and other public health issues, we've seen significant regional variations in infection rates, vaccine uptake, hospitalization rates, etc. This suggests that there can be a useful role played by regional authorities in the functions of quality improvement, care coordination across the full continuum of providers and services, population health improvement, and disparities reduction, and funnel that information into the state-wide UF entity. Such a regional approach was envisioned by single payer legislation of the mid-2000's SB 810/SB 840 that could provide a guide. Finally, Commissioners should remember that many capitalist countries have non-profit healthcare systems.
62	William Honigman, M.D.	Dear Commissioners: Thank you once again for your in depth look at aspects in unified financing that would contribute or detract from the stated goals of providing more equitable and comprehensive medical care for all Californians. As a retired Emergency Room physician who worked for Kaiser Permanente for over 30 years, I would like to say that co-pays and deductibles implemented there in the later years of my tenure were a disaster. These perverse cost-shifting tools served only to push my patients to delay their care, and produce hostility that became directed at the care-givers further promoting distrust and a further disruption in an already strained patient-provider relationship that I witnessed to be getting worse every day that I was on the job. It also was a perverse business model for a provider group that claimed to be about keeping their members healthy, as recommended tests and treatments were refused by patients when faced with what they thought was an unaffordable personal expense. And finally, in Dr. Ghaly's summation of this issue of cost-sharing, I may have missed it but I didn't hear him mention specifically what would be the elevated costs due to delay or refusal of care. This is absolutely a necessary consideration for any fair assessment of its impact.

Count	Name	Comment
		As regards care-coordinating entities, again the entire intention of a unified financing system is eliminating the waste of third parties, as well as the potential for fraud and abuse. We should let the care-coordination be handled by the providers or provider groups themselves. Commercial risk-bearing and other unlicensed entities, in particular, must absolutely be prohibited in the care decision-making process of this new system. In conclusion, it is clear that the implementation of a Single Payer system will derive the sufficient savings by eliminating waste fraud and abuse, and allowing consumer bargaining power for pharmaceuticals, medical devices, and medical services needed. COVID19 is proof that we have already waited too long to implement such a system here in California, and here in the United States. Thanks again.
63	Beatriz Sosa-Prado	My name is Beatriz Sosa-Prado, executive director of the California Physicians Alliance (CaPA). We believe that health care is a human right. CaPA was founded in 1987 by progressive physicians in the Bay area with the mission to reform our healthcare system and achieve single-payer. Our approach is to improve the healthcare system in the short-, medium-, and long term. Since the ACA's implementation, CaPA supported it because millions of Americans NOW have access to healthcare. Our student organization, the California Health Professional Student Alliance (CaHPSA) assists individuals and families enroll in health plans with the support of Covered CA. CaPA organizes California physicians and amplifies their voices so their legislators hear them in efforts to support health bills and legislation that help people get health care and improve their health. We believe that we can reform our Golden State's health care system and make it the best in the nation. That is why our long-term goal and mission is to work with others to create and achieve a universal healthcare system in California. We call the system, "single-payer", a unified financing system, or Golden State Care is not that relevant. What's important is that we establish a just, equitable, and inclusive healthcare system where every person who calls California home has coverage and access to healthcare.

Count	Name	Comment
		CaPA looks forward to reading your final report! We hope our road map has been helpful to you. Onward. Adelante.
64	Janice Rothstein	Dear Commissioners, Thank you for the public hearing and comment section today. Business models of healthcare provision make as much sense as subjecting fire departments to the vagaries of the risk-bearing private business market. Rationing and denial of care occur today under our system of private insurance. It is often self-imposed because people cannot afford health care the main purpose of which is to enrich stock holders. Even those who have insurance delay care because they cannot afford the onerous burden of co-payments, deductibles and premiums. Because these three barriers to care would be eliminated under a properly designed single-payer system, self-imposed delays in care related to affordability would no longer occur. So-called 'abuse' or 'overuse' of health care services is an insult to the U.S. public. Government financed and operated single payer systems in comparable economies around the world post magnitudes better health indices than the United States, which ranks #11 in most health indices on the Commonwealth Fund's survey of major industrialized countries; https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly. A properly designed single payer system would actually prevent denials of care - which are now rampant in our current private business mediated healthcare system. A well integrated single payer system would place health care decisions where they belong - in the hands of patients and their health care professionals rather than in the hands of insurance companies and health care corporation boardrooms. It is the responsibility of the lawmakers on the Commission to protect the professional judgment of doctors, nurses, and other health care professionals when designing a single-payer system so that government bodies cannot single-handedly slash budgets and deny care. I urge you to write the recommendations in your final report to reflect the leading role California can take on provision of healthcare. Let's remedy this broken health care system that even the best insured in our state and in our country are demanding relief from. Legislate health care as the public right that it is.

Count	Name	Comment
		Thank you,
65	Jenni Chang	Jenni Chang, Eboard Member of the California Democratic Party Rather than charging everyone a copay, I wonder if it would make sense to charge graduated fees for no shows, just the way there's a fee for not paying taxes on time, or the way tickets are issued for not feeding the parking meter, and etc. This way people who are properly utilizing the system do not have to pay copays and we can encourage respect for a system that strives to make healthcare accessible and free for everyone. Also, Richard Scheffler calling out profit-driven doctors but not these profit-driven so-called non-profit insurance companies makes no sense. Nor does it make any sense to prop up Medicare Advantage when it is rapidly, deliberately undermining the Medicare system as we know it. Companies like Blue Shield that manipulate networks and access are not looking out for people like me. I pay full price out of pocket for Blue Shield gold plan (no subsidies) and I cannot access the same Blue Shield networks that my friends have through their larger employer accounts. We do not need to hear about HOW FedEx, DHL and private insurance companies are the status quo. The focus here should be a public Single Payer payer system to be run in a responsible, competitive, sustainable way. I ask the commissioners and responsible powers to please stay focused, be brave and produce the most aspirational report possible. Because we know no matter how perfect that document is, it is going to only get us so far. The monied opposition to single payer is relentless and wickedly savvy. Kudos to Mark Ghaly for his focus and leadership: It has been encouraging to hear serious discussion on the details and the deeper, broader engagement from the commissioners on Single Payer.
66	Genevieve Ameduri	My family of 5 are enthusiastic supporters of a single-payer CalCare program for EVERY SINGLE Californian through a progressive tax. We want quality, free at-the-point-of-service healthCARE with no conditions of being tied to employment and we want it to comprehensively cover the whole human such as mental and behavioral health, dental, vision, hearing, hospice and home healthcare. The insurance industry currently pits my daughter's need to breathe against her need for shelter (do we pay for her 3 daily asthma medications, her life-saving EPIPENS or do we pay our

Count	Name	Comment
		price-gauged rent?) The profiteering insurance industry currently pits my family's need for shelter against my children's caregiver's health needs (do we pay for mom's OOP lock jaw treatment or do we pay our rent?) The only current fix is by design and just as threatening to our safety and well-being: we are force us into debt. The injustice of profiteering insurance being legally permitted to impose such terrible AND TERRIBLY COMMON dilemmas for Californians must end. The absurdity of persisting in requiring healthcare be tied to employment in a time of global health pandemic when our nation saw unprecedented unemployment numbers further underscores the need for urgent change. California can lead the country in a sane solution that work for literally every human in our state while bolstering the wellness of the collective with CalCare. You, our representatives, can choose to act with political will to deliver single-payer CalCare to every single Californian for less tax money. My family implores you courageously and pragmatically muster the political will for what best serves ALL Californians: healthCARE for everybody covering everything. Thank you very much! Sincerely, Genevieve Ameduri
67	Genevieve Ameduri	I'd like to respectfully submit dissenting comment on the notion stated by Richard Scheffler on today's important zoom meeting namely his assertion that capitalism is culture and that a single-payer CalCare healthCARE program covering every Californian cannot replace the Billion dollar insurance and pharmaceutical industries because capitalism-culture cannot be betrayed. I point to impacts on our entire human species of capitalism's human-caused global warming and ask 'Shall we not betray capitalism-culture to end threat to our ecosystems and human existence?' and I will answer my own question with a resounding 'of course we must betray and replace the culture of Big Pollution practices that inflict mass harm, this is common sense and it is high-stakes if we don't. Similar to this life or death matter of urgent import is that of healthCARE for every Californian presently under the dictatorship of the for-profit insurance industry that has at its center the health of its own bankroll at the directly-conflicting priority of our individual AND collective health and wellness needs. We must right this wrong by implementing immediate coverage of everybody for every human health need. We can make health and wellness our culture instead of greed. Let's do it with single-payer CalCare! Thank you,
68	Genevieve Ameduri	As I attend today's zoom meeting I'm appalled by comments that attempt to paint for-profit middlemen as the most effective "coordinators of care" for a patient, because this is plainly false. In fact, the latter is cause for a documented number of

Count	Name	Comment
		coordination of care failures due to the profit motive of the insurance industry presently leaving so many without comprehensive healthCARE. I respectfully submit that the coordination of patient care must be on the level of doctors, nurses and the healthcare workers who directly deal with we patients. Non-clinicians, and certainly not those “entities” which prioritize serving the healthiest among us further marginalizing and endangering the sickest, that is to say the profiteering insurance industry “health plans” are not to be in charge of patient care, which will be coordinated under CalCare by clinicians and healthcare teams paid for by a progressive tax so that everybody in California is served. Thank you,
69	Genevieve Ameduri	Good morning, I am writing in enthusiastic support of single-payer healthcare for all Californians through the CalCare program (AB1400). A progressive tax structure that eliminates the profit motive/profit actors is the only acceptable path to implement and efficiently pay for quality, free at-the-point-of-service healthCARE. I join the California majority in respectfully demanding that the whole human body be comprehensively covered meaning that dental, vision, hearing, mental health, hospice and home care be included in healthcare coverage. Presently, I am being treated by a dental specialist for TMJ dysfunction including lockjaw. When my jaw locked closed in 2021 it immediately rendered me at the mercy of debilitating headaches, ear aches, as well as invasive neck and shoulder pain, all of which adversely impacted my daily life. I learned in the Urgent Care what I never fully registered before, that my medical doctor and also my general dentist cannot treat this ailment or the jaw at all (absurdly) due to insurance industry norms. Therefore, I was forced to seek out an expensive specialist, grapple to compare treatment plans with other specialists —because there is no standard of care for what isn’t covered by insurance— then suffer a lengthy wait of 2+ months for an appointment opening only to endure sticker shock because treatment would cost $5,000.00 - all out of pocket (OOP). This was the most miserable unrelenting pain of my life and my PPO insurance did not meet my health needs whatsoever; my sustained pain was caused by the Billion dollar insurance industry and its profit motive and, further disturbing, I consider myself FORTUNATE given the severity of other more serious health ills that afflict my fellow Californians whose treatment is obstructed by a for-profit system that prioritizes economics above health and wellness a.k.a. healthCARE. I want to make clear that I have what is considered “good” insurance through my spouse’s employer and it only paid out a portion of one MRI leaving us to pay the rest, which was $5,000.00 OOP.

Count	Name	Comment
		This cost hit us just as our rent was raised and as I learned my 8 year old daughter is allergic to nuts necessitating two EPIpens, one for home and one for her school, in addition to her two daily inhaler medications, also needed both at home and at school, plus one daily pill medication all which are already needed to treat her serious asthma, as well as her existing medications for the eczema with which she also lives. To face these expenses during a global health pandemic that threatens all of us in our family of five is stressful as it pits my daughters' need to breathe against her need for shelter (!) then forces us into debt, which also threatens our well-being in the long run. I think most of us agree this is an unjust, absurd and totally solvable dilemma; yes? Politicians seem persuaded and influenced more by Billion dollar industries than by the opportunity to implement the pragmatic, affordable solution of CalCare. Our family is but one story in this state that demonstrates the urgent need for CalCare so that all our health needs are served while boosting our collective health and safety. Across the various political ideologies and differences in my family, friends and immediate community, the majority mirrors what polls show about our state, we overwhelmingly agree that quality healthCARE —without economic tiers— must be a reliable deliverable as a return on our taxes; a profiteering middleman obstructing medical treatment, as the profiteering insurance system does, is unjust and untenable (as studies also bear out). All that's left to confront is the, thus far, lack of political will to implement what every Californian urgently needs, CalCare. Single-payer healthcare that saves tax-payer money to cover all of our people and comprehensively cover the whole human body must be implemented therefore, you must act with the necessary political will to deliver it for Californians. My family is watching what decisions get made under supermajority Democratic 'representation' on this matter of urgent import. Thank you for your work and time, Genevieve Ameduri
70	C. T. Weber	Comments of C. T. Weber supporting High-Quality, Comprehensive, Universal, Single-Payer Health Care As known, there are at least three major distinct health care systems used in the United States and each of its states. The costliest of these is our multi-payer private health insurance system because of complex administrative procedures, the profit system itself which leads to less care for patients, and cost-sharing. As a result, people stay away, and their health situation gets worse and more costly in the long run. A single-payer health care system is somewhat used by our Medicare system. Even so, the administrative costs are greatly reduced. And there is socialized medicine, used by the U. S. military and Veterans

Count	Name	Comment
		Administration where the government owns the clinics, hospitals, and equipment, and the government employees the doctors, nurses, and staff. I advocate a high-quality, comprehensive, single-payer health care system for all California residents. This is not socialized medicine. Various studies show that after three years of transitional costs, the single-payer health care system is less costly yet covers every resident in California. Finally, let me say that those who have a monetary motivation to deny health care must not be involved as a coordinating entity. As a side note, let me recommend that drug advertising be prohibited on television, radio, and print.
71	Robert Vinetz, MD	Dear Commissioners: Messaging and Public Education are crucial to the acceptance of the Commission's recommendations (or any subsequent modifications) Facts are necessary, but not sufficient for securing a system of unified public financing for health care...and the values we seek in healthcare reform. In your report, please include a component for creation and for financing this messaging and public education activity. There will be both honest questions and also self-serving "blowback" (misinformation and disinformation) to your recommendations. These questions and blowback must be effectively managed...both preemptively and in real time. Thank you for all your work. With best wishes,
72	Tim Jouet	I did not get an opportunity to give a verbal comment due to time constraints. I want to express my deep disappointment with the lack of urgency and continued acceptance of the status quo of our bizarre healthcare "non-system". Plenty of talk, study, but not much action, while actual people continue to suffer/die due to lack of care. In today's meeting I heard lots of concern that people over-use care and that they skip out on appointments (non-use?) when there is no direct cost-sharing.... Blame the patient both ways-nice. It would take many paragraphs to list my own experiences and those of people I know regarding the hurdles and pointless decisions I've seen people make when it comes to getting healthcare. I also noticed that the focus wasn't so much on which groups are literally benefiting from the status quo and are spending millions on preventing us from moving towards an real system that puts care of people first. One commissioner let his view slip when he said that in effect we live in a Capitalist controlled system and you can't really do anything that interferes with its values and

Count	Name	Comment
		goals. What a sad state of affairs that this passes for a viable argument to continue allowing people to suffer. Tim Jouet
73	Chrys Shimizu	Another comment I want to make about Richard Scheffler's comparison of choosing who will deliver one's mail vs. choosing who will coordinate one's healthcare: Fedex, USPS, UPS, and DHL all compete for the business of regular people and their services are simple and easy to compare. However, private health insurance companies are not competing for the business of regular people to provide their care coordinating services. The market they are targeting is employers. What is most important to employers is not what would be most important to individual regular people. Furthermore, private insurance companies offer menus of possible plans that vary widely from each other making it impossible to compare apples to apples. Thanks!
74	Elizabeth Connors-Keith	Hello, In regards to the concern Jim Wood (and maybe others) voiced about a lack of co-pays causing more patients to not show up for their appointments, an easy solution would be to charge a no-show fee of, say, $35-$40 if they don't keep the appointment. That would be more of an incentive to show up for an appointment than a co-pay. My CoveredCA premium for one of the lowest cost plans is over $1,000/mth. While the subsidy I qualify for covers it, my yearly deductible is $7000. This means that potentially I could have to pay $7000 every 12 months for healthcare, in addition to the cost of dental work and any care from providers who don't take my insurance (such as my current physical therapist). Does the government really think that I can't afford the premiums but I can afford those costs? The Affordable Care Act made it a really good deal for the insurance companies, who keep raising the premiums and the deductibles every year, potentially without a lot of the public being aware of it because they are getting subsidies (or their employers are paying for their insurance). I would rather the same money that the government is paying the insurance companies for my premiums (which largely goes to their huge administration and profits) go to a (single payer) pool of money to be used for healthcare. Thank you for considering our comments,
75	Gerald Rogan, MD	Dear HCFA (not to be confused with the Health Care Financing Administration, currently known as CMS), I respectfully submit this additional comment following today's meeting.

Count	Name	Comment
		I suggest the Committee recommend California establish a state sponsored medical care insurance program, premium based with support from government funds. The delivery of care would be reimbursed as follows: Paid through capitation, not fee-for-service. To medical care delivery organizations that engage sufficient providers to integrate care across all specialties or contract for specialists and pay them. That are willing to meet the quality measures required, Using quality measures that measure the quality of care including medical decision-making, not only preventive care. Where the capitation rate and quality measures are adjusted by the illness burden of the patient upon their enrollment, subject to review for accuracy by a plan committee established for this purpose, Where any unreasonable limitation to access to care is measured and is mitigated, Where delay of providing elective procedures may be greater than that available through competitive plans. For the insureds, the program would limit the deductible to an affordable amount per individual and family, which could be determined by a sliding scale based on income, family size, and other relevant parameters. The program would limit the copayment to provider services rendered in outpatient places of service, to a reasonable amount such as $10.00. Emergency department visits would require a higher copayment, such as $50.00, which could be reduced for certain situations, such as were the patient admitted as an inpatient or found to have a potentially life-threatening condition that is treated without admission. No copayment would apply to diagnostic tests ordered by the practitioners. Providers would be subject to review and education were one to order excessive diagnostic tests unsupported by the standard of care as determined by a peer review committee established by the plan. The copayment for prescription drugs would be a flat rate for each 30 days of treatment, regardless of the cost of the drug to the pharmacy benefit under the plan. The copayment for physician administered drugs would be limited to a flat co-payment but higher than the self-administered drug co-payment. Drugs that are usually self-administered by the patient, as determined by the Medicare contractor administering Medicare for California, currently Noridian, would not be covered when administered in a physician's office, but would be covered under the pharmacy benefit. Engaged hospital systems would be required to provide effective medical staff peer review of inpatient services and their hospital outpatient networks and encouraged to use non-parochial

Count	Name	Comment
		reviewers whose findings would be reported to the hospital system/ contracted group medical staff committee. The plan would establish a preferred self-administered drug formulary. Deviation from it would be permitted upon evidence of medical necessity, subject to appeal to an independent expert panel, the failure of which to approve would result in self-pay by the patient. Timeliness would be mitigated by allowing the first 30 days of treatment for a non-preferred drug to be covered as if it were the preferred drug. The plan would be allowed to negotiate with drug companies for price. The use of PBMs would be reviewed. If needed the State could establish its own PBM. Drug that have an over the counter self-pay equivalent would not be covered, such as acetaminophen and miconazole cream. The benefit package initially would be congruent to that established by Medicare. Additional benefits would be developed for services not used by most Medicare beneficiaries, when needed, such as obstetrical care. Inpatient care would be subject to a fixed co-payment per admission. For those who stay long in an emergency department or holding area, such as more than 48 hours, a hospital inpatient stay would be defined by relevant Medicare rules. No effort would be made to change or take control of the premiums paid to Medicare or Medi-Cal, commercial plans, ERISA plans, or VA system, or any other existing system. Enrollment in the California plan would be voluntary. The success or failure of the plan would be determined by the plan. If it works patients may elect to change their coverage into the California Plan. In this way, our government would offer a choice, but not force patients into it. Eligibility for enrollment would be independent of documentation (immigration) status. My proposal is not a single source of funding plan. I oppose such a plan at least until such time when California can prove it can administer a plan as well as my current plan, which is administered by CMS. Provision would be made for coverage of plan members who are out of state for emergency care, but not out of the country. For out of country medical care, the patient would find other coverage or self-insure. International travelers visiting the U.S. could be covered during their visit for payment of a actuarily sound premium. Other ideas in this area may be available through managed care plans such as KP. All vaccinations and immunizations approved by the USPSTF/ CDC/ NIH or other authorized entity would be covered and reimbursed to qualified providers through a separately enacted public health law applicable to all residents of California. Covered

Count	Name	Comment
		vaccinations and immunizations would no longer be financed through coverage by medical care insurance. As a condition of enrollment, patients would agree to submit claims for medical negligence to an administrative process, not through TORT law. The plan would be required to review the medical negligence history of all licensed providers and take appropriate action for enrollment, supervision, or procedure privilege, as determined by the plan. Hospital facility fees for services provided in a non-emergency setting would not be covered and could not be billed to the patient. Out of network providers who are not chosen by the patient would only be allowed to bill the patient the amount that an in-network provider could bill. For the balance, out of network providers would negotiate with the health plan for payment. Most of these ideas came from listening to the meeting today 2/23/2022 You may share my comment as you wish. Thanks for reading my comment.
76	Louise Mehler, MD, PhD	Dear Commissioners, Thank you all for the huge investment of time and effort you have made in analyzing California's health care needs and ways to meet them. Sometimes I have thought some members were trying to reinvent the wheel. But we can feel confident that the subject has been fully explored. In assembling the final report, I hope you will make clear that evidence demonstrates insurance companies and other intermediaries to add cost and limit care availability. They also burden care providers with procedures and paperwork that vary from one system to another. Whatever form the unified system ultimately takes, it must avoid interposing a profit-seeking bureaucracy between the unified financing authority and the providers of care. I would also like to reemphasize the many comments by commissioners and others that documented, individually and statistically, the harmful effects of "cost sharing". To have the intended effect of promoting health for all Californians, health care must be free at the point of service. A single-payer model would simplify the task of identifying people and institutions that try to "game the system" and collect unmerited payments. For

Count	Name	Comment
		everyone else, we need to address under-utilization much more than over-utilization. For far too long, US healthcare has been the outlier among developed countries. Our citizens have paid the price, both financially and in disability and premature death. Please use your report to argue as forcefully as possible for a transition to the type of system that everyone else uses to manage costs and improve outcomes. Once again, my thanks
77	Sandy Neumann	Thank you for today's thoughtful Commission discussion on cost sharing and other important topics. It was illuminating to watch most of us evolve as the meetings became more instructive and respectful. Once Mark Ghaly assumed the leadership role from the consultants, we got back on track. The power of people with multiple perspectives planning together with skilled guidance is key to long term success. My request is to include Care Coordinators chosen by citizens to track and oversee each individual's care and support system and pay them for that service. With gratitude,
78	Ronnie Tiner	I am opposed to cost sharing because all it does is discourage people from getting needed care. Especially early when it more likely to be successfully treated; it is also administrative waste. I don't know anyone who enjoys going to the doctors. There is no problem with overuse. And it is wrong to ask a layperson to diagnose themselves and make the decision if an aliment is serious or not. My husbands co pays are 80.00 each time. No vision, no hearing. ER: 300.00 he is low middle class does not have that kind of money at his disposal. We need a single payer medical system. Its AN EMERGENCY!

Count of email comments: 78
Count of verbal comments: 16
Count of Zoom chat comments: 82
Total count of public comments: 176