

To: Healthy California for All Commission
Re: Key Design Considerations for a Unified Health Care Financing System in California
_final Report April 2022

From: Timothy Bilash M.D, M.S., F.A.C.O.G.
Date: April 23, 2022

I thank the Committee and all involved for their efforts in producing the report. I offer some comments at this time.

1) HCFAC - Concern about Narrow Fields of Commission Members

The Commission is dominated with Executive, Administrative, Academic (PhD, JD and Economics) members. It appears to presume a primarily Outpatient and Non-Physician perspective. I do not find adequate attention to important Clinical Providers and impacts to Cost Centers: Inpatient Care, Surgery, Endocrinology, Gynecology, Orthopedics, Neurology, and Emergency Care. Rupa Marya M.D. does not appear to have maintained her active certification in Internal Medicine, for example.

Jessica Altman, MPP
Michelle Baass, MPPA
Jennie Chin Hansen, RN (inactive)
Carmen Comsti, JD Caroline (Cara) Dessert,
JD Sara Flocks, MPA Antonia Hernández, JD Sandra R. Hernández, MD
William C. Hsiao, PhD
Rupa Marya, MD
Donald B. Moulds, PhD
Senator Richard Pan, MD, MPH
Robert K. Ross, MD
Richard M. Scheffler, PhD
Andy Schneider, JD
Anthony E. Wright
Assembly Member Jim Wood, DDS

2) SB-562 was presented to the Assembly as a Blueprint for State Single Payer in 2017. Has the Commission accessed enough of this information?

I offer my color markup for SB-562 (-CaMarkup2.pdf).

3) The California Nurses obtained 2 important evaluations of Single Payer from the PERI center at the University of Massachusetts/Amherst.

Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562)

by: Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim (PERI)
<https://peri.umass.edu/publication/item/996-economic-analysis-of-the-healthy-california-single-payer-health-care-proposal-sb-562>

<https://peri.umass.edu/economic-analysis-of-the-healthy-california-single-payer-health-care-proposal>

Economic Analysis of Medicare for All

by: Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, Michael Ash

November 30, 2018 | Research Report

<https://peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>

4) A Committee of experienced individuals put together our extensive Report that includes a Historical Review and Funding of Health Care.

California Universal Health Care Workbook - 2018

Committee Member Contributors:

Timothy D. Bilash MD MS FACOG (Committee Chair)

Philomena Lin MSW LCSW

George Phillips EE

John Kaplan MD FACOG

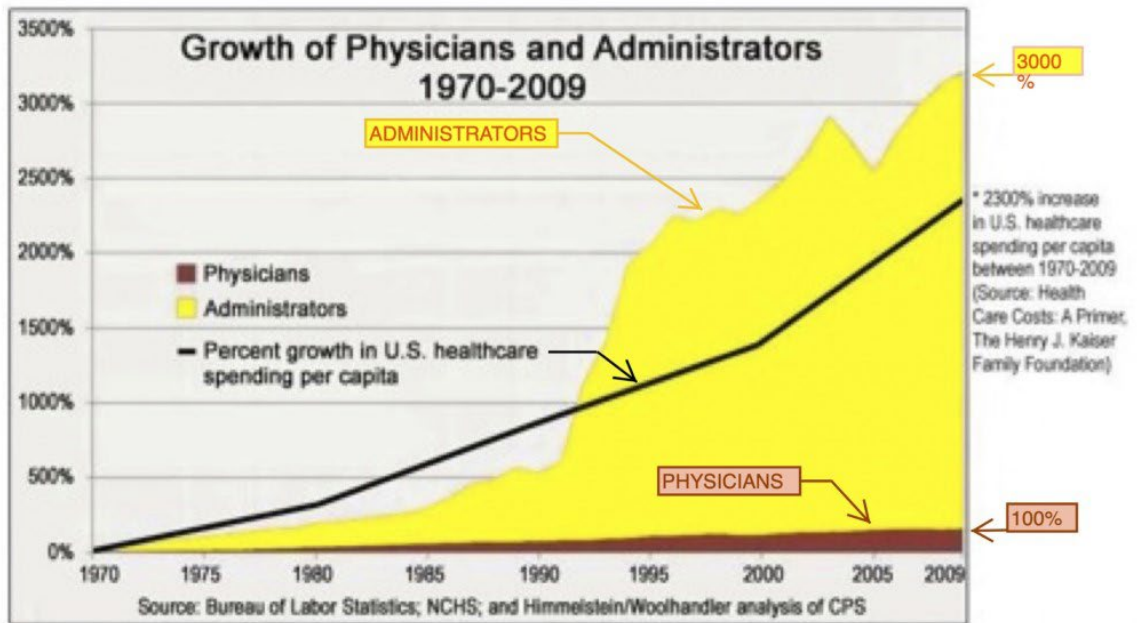
Marilyn R Lyons MPP JD Financial Services Representative

<https://www.CaSinglePayerInfo.com>

I am sending 2 separate emails with pdf copies for the CaSinglePayerInfo.com Report in 2 parts (-18.02.06HSCFINAL1.pdf, -18.02.06HSCFINAL2.pdf).

5) I offer 2 points in particular we highlighted in our Report:

-The increase in cost for Health Care in the U.S. is driven by increased Administrative Cost, not Physician Cost (and most recently Electronic Systems). WE would be concerned that the effort described in the Commissions proposal do not sufficiently control costs because it maintains an extension of the current Commercial Insurance coverage (payroll deduction with income taxation).



"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication, somehow think that we can afford to pay for doctors, hospitals, medication, and a government bureaucracy to administer it." -Thomas Sowell

-The data indicates that Fee-For Service has lower total cost because of lower overhead. As Family Medicine and OB/GYN became Capitated, the overhead went up.

Total Operating Cost as a Percentage of Total Medical Revenue Trends Vary across Specialties

Total operating cost as a percentage of total medical revenue has remained fairly stable for Orthopedic Surgery through the last five years. Cardiology, Family Medicine, and Pediatrics report a decrease in total operating cost as a percentage of total medical revenue from 2012 to 2013 (2.10%, 5.56%, and 2.62%, respectively), while OB/GYN reports an increase of 8.09% between 2012 and 2013.

Total Operating Cost as a Percentage of Total Medical Revenue Per FTE Physician



If quality of Care is the Goal, then changes made over the past 10 years with the Collaborative model and elimination of Physicians and Registered Nurses from Primary care does not show improvement or fulfilling the stated need to provide for the underserved, other than paying for their insurance; If Cost Containment is the goal, the case is not made.

Sincerely,
 Timothy D. Bilash M.D., M.S., F.A.C.O.G



May 20, 2022

Dear Chairman Ghaly and Commissioners,

Thank you for the opportunity to provide public comments to the Healthy California for All Commission on the Final Report, Key Design Considerations for a Unified Health Care Financing System in California.

Licensed health insurance agents help millions of Californians find and utilize affordable health care coverage, reducing the percentages of those who are uninsured to record lows. Through this work, agents are intimately aware of the importance of health coverage and affordability of that coverage. California Agents & Health Insurance Professionals (CAHIP) previously the California Association of Health Underwriters (CAHU) is the state's largest association of health insurance agents, brokers, and other health insurance industry professionals.

CAHIP shares the Commission's objective to ensure that all Californians have access to high quality, affordable healthcare and to improve transparency and stability in pricing. While we have strong concerns with some of the proposals that have been put forward, our comments focus on viable market stabilization strategies that will help California continue to lead the nation in successfully administering the Affordable Care Act (ACA) and achieving universal coverage. To that effect, we offer the following six considerations on the proposed stages to "Lay the Foundation" for California's path to Unified Financing:

1. Fortify the Public Health System

Support Efforts to Fix the ACA "Family Glitch" and Extend ARPA

Independent agents are an important driver of Covered California's success. Half of all consumers enrolling in Covered California do so through independent agents. Agents are the faces of Covered California and year after year are the largest and customer-preferred source of enrollment. As the individuals that have been working hard to make the California Exchange the most successful marketplace in the nation, agents know firsthand what works and what can be improved.

A weak spot within the current ACA structure is commonly referred to by agents as the "family glitch." The ACA guarantees "affordable coverage" but affordable coverage is not yet a reality for everyone. The "glitch" occurs when an employer pays for health coverage for their employee, but not for the employee's dependents. This glitch happens often when small business employers, who are not required to provide health benefits, choose to offer health insurance to their employees, based on what they can afford. Currently, because a member of the household (the employee) is offered affordable health insurance through their employer, the glitch will not allow spouses and dependents access to ACA subsidies. This gap increases the number of uninsured, especially among children. In instances where coverage is not extended to dependents in employer-based coverage, the family should not be denied "affordable coverage" in the form of premium assistance that they need.

The Biden Administration recently announced that it would release a proposed rule to fix the family glitch. This proposed rule is a result of President Biden's Executive Order from 2021 calling on the federal agencies to strengthen the Affordable Care Act. The Department of Treasury is using the proposed rule to revise the definition

of "affordability" of employer sponsored coverage as it applies specifically to family members of the employee. Under the proposal, the earliest this change would be enacted would be January 1, 2023. We encourage elected officials and regulatory experts in California to support the proposed rule change currently in the rulemaking process.

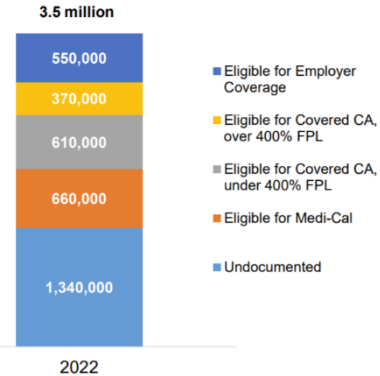
The ACA can be strengthened by permanently extending the American Rescue Plan Act of 2021 (ARPA), which substantially improved affordability through enhanced premium assistance for 2021 and 2022. ARPA also limited consumer's required contribution to no more than 8.5% of household income, which means that more individuals and families are eligible for more financial help. Extending ARPA subsidies and fixing the "Family Glitch" would help California move closer to the goal of affordable universal coverage.

Close the Uninsured Gap

Using UCLA-UC Berkeley CalSIM data, the first Commission report projected that in 2022 there would be 3.5 million uninsured Californians. Per the Figure below, other than individuals that would be eligible for other coverage sources (through the exchange or their employer), undocumented Californians make up the remaining uninsured. Under AB 133, California recently became the first state in the nation to expand full-scope Medi-Cal eligibility to low-income adults 50 years of age or older, regardless of immigration status. This was a major milestone in the state's progress toward universal health coverage, and approximately 235,000 Californians aged 50 years and older are newly eligible for Medi-Cal. Combined with legislation from 2019, California also extends Medi-Cal coverage to all eligible undocumented young adults up to the age of 26.

The Governor's most recent budget proposal would close the existing age gap of 27-49 and give an additional 700,000 undocumented Californians access to health insurance. The expansion would make California the most inclusive state for health coverage in the country and the first to achieve universal access to healthcare coverage.

FIGURE 1



2. Implement Cost Containment Measures

Health Insurance Costs Are Contained Through the Medical Loss Ratio

It is important that Commissioners and stakeholders become familiar with the minimum medical loss ratio (MLR) percentages established by the ACA in 2011 that are currently applicable to health care service plans and health insurers in California. For all individual and group health plans, at least 80% of the premium dollar must be spent on direct patient care. For large groups with at least 100 employees, at least 85% of the premium dollar must be spent on direct patient care. The remaining 15%-20% is used for overhead costs, such as administrative costs, sales expenses, and profits. Health plans and health insurers annually submit their ratios of incurred losses to earned premiums, or MLRs, to the federal Department of Health and Human Services (DHHS).

Existing law also requires a health care service plan or health insurer to provide an annual rebate to each enrollee or insured under their coverage, on a pro-rata basis, if the MLR is not met. Decreases in the minimum MLR have been attempted in legislation (AB 2499, Arambula, 2019), but were ultimately found to limit the incentives to

reduce medical costs, and ultimately contribute to higher medical cost and premium trends. This is because the only way to increase margins with an MLR minimum is to allow claims to trend upward, so that premiums grow, and the allowed administration and profit percentages can be based on a larger number. As a result of lower MLRs, carriers may also limit spending on cost containment measures like network management, quality and outcome analyses, provider negotiations, and fraud waste and abuse studies, or exit the California market entirely.

Further, carriers with higher MLRs should not necessarily be considered more efficient; often they have simply done less to reduce medical cost trends, which have continued to outpace non-medical consumer price inflation by a wide margin despite the federal MLR floors. If MLRs are set too high, carriers will simply leave the market. Accordingly, agents are concerned that related efforts would cause those currently insured in the large group and individual markets to lose their health care coverage if their plan is forced to exit the market.

Alternative Pricing Models

With consideration that some providers may leave practice in California if they are required to work for a particular wage, further exasperating an existing shortage of providers, CAHIP proposes that the Commission not set the price that doctors and facilities can be paid. Instead, we recommend you gather information on pricing, and suggest a price that would be deemed fair. This would be comparable to the example of the automobile manufacturer's suggested retail price (MSRP). This suggested price would provide significant pricing clarity for both consumers and plans when negotiating fair and appropriate payment.

We propose that the Commission require all doctors and facilities to use Medicare pricing as the reference point when they bill for services. There would be flexibility to charge rates that account for regional needs and specialty skills, but they would have to indicate what that price is compared to what Medicare pays. This reference-based pricing (RBP) has become widely used in the self-insured market and has reduced costs substantially. Self-insured RBP plans use a stated percentage above Medicare rates, such as 200% of the Medicare rate, when paying providers. This is a consistent and cost-effective referenced rate that is widely accepted and easy to understand.

For example: Hospital A charges \$75,000 for a hip replacement which is 250% of what Medicare pays and Hospital B (a research hospital) charges \$150,000 for the same procedure, which is 500% of what Medicare pays, but has significantly better outcomes in more complex cases. This would allow for consideration of specialties that have outcomes that may warrant a higher cost. This model allows providers to charge rates that appropriately reflect their expertise, while still providing consumers with appropriate price disclosures that allow them to make informed decisions about their care. This method could also be used to provide incentives for providers to serve underserved communities. The state could commit to higher percentages of reimbursement to fund quality care in facilities with providers serving Californians with the greatest needs.

CAHIP appreciates the Commission's consideration of a model based on the success that Maryland's Commission has on reducing the prices for hospital services, which continues to be a significant driver of healthcare costs here in California. The Maryland model sets prices for hospital services, and includes Federal payers, which is an important part of its success. For these reasons, we request consideration of proposals focusing the Commission's authority to create price recommendations for medical providers and facilities; not secondary and tertiary service providers where medical care is not administered. Health insurance is expensive because health care is expensive, and this would provide regulation of the cost drivers.

3. Establish Equity and Quality Standards

Equality is Not Equity

While it has been asserted that a single payer approach to healthcare is the only path to equity, we caution that equality should not be confused for equity. Meaning that although a one-size-fits-all approach, like single payer

may provide all Californians with a single “equal” option for healthcare coverage, that should not be misunderstood to produce equal outcomes. Since one of the commendable objectives of this Commission is healthcare equity, we encourage support of health plans with cultural competence and an appreciation for the uniqueness and diversity throughout California.

An example of an existing health plan that serves regional needs is Chinese Community Health Insurance Coverage (CCHP) which is a non-profit plan option for people in the Bay Area offered through Covered California. CCHP’s enrollees receive a robust offering of personalized services in a way that is culturally competent and linguistically appropriate and with 60%+ of members identifying themselves as Chinese, this plan demonstrates an effective targeted model.

As earlier illustrated in Figure 1, many Californians that are uninsured already qualify for healthcare that they are not utilizing. Targeted communication to uninsured individuals is key to achieving universal coverage and equity in access and outcomes. Simply handing someone an insurance card does not translate to equity. The healthcare that the card represents must be meaningful to the covered individual or the impact will never be realized. There are numerous plans that are currently offered both on and off the exchange whose purpose is the promotion of high-quality health care that reflects cultural diversity with respect and competence. Specialized healthcare services such as Indian Health Service and plans such as Molina, CCHP, LA Care and others, embrace and reflect diversity in ways that are making meaningful improvements in the communities they serve.

In the Fall of 2021, Covered California announced the proposed premium rates for 2022 and in a sign of market strength, yet another health plan joined the California exchange, and some existing plans expanded their service areas. Every Californian will have at least two health plans to choose from, and a vast majority will have four or more plans to choose from. This is significant because when consumers have options, it drives health plans to keep costs down. Alternatively, market consolidation does not reduce costs, despite “reduced overhead;” rather, condensed, or single market monopolies produce inadequate benefits at a high cost. Consider the recent examples of the DMV, EDD and PG&E.

Social Determinants of Health (SDOH)

The disproportionate and tragic impact COVID-19 and natural disasters have had on the most vulnerable populations demonstrates that health insurance for all falls way short of guaranteeing health equity for all. Resources that enhance quality of life can have a significant influence on population health outcomes. We know that poverty limits access to healthy foods and safe neighborhoods, and we know more education is a predictor of better health. Differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity. Access to transportation, a warm meal and maybe someone with a friendly ear is good healthcare.

Our members know that health insurance is only one dimension of a person’s healthcare needs. We know that addressing SDOH has the potential to lower healthcare costs, while improving health outcomes for everyone. Accordingly, we encourage the Commission to discuss health insurance as one component of whole-person care, it cannot improve outcomes in a vacuum.

4. Demonstrate Pharmaceutical Cost Savings

Reduce the Cost of Healthcare by Reducing the Cost of Prescription Drugs

Of nearly 200 countries in the world, the United States is one of only two that allow direct-to-consumer advertising on pharmaceuticals. A Kaiser Family Foundation analysis of data from the Centers for Medicare and Medicaid Services and Truven Health Analytics shows that drugs account for 10% of U.S. health spending and represents 19% of the cost of employer insurance benefits. Celebrity endorsements or rose-colored commercials can lead to

patient requests for costly medications influencing prescriber behavior. The proliferation of name-brand drugs is costly and troubling when other less expensive alternatives are available and effective.

Given the significant percentage of healthcare spending that prescription drugs account for, CAHIP supports additional efforts to build on the momentum of California reforms chaptered in 2017. Those reform bills include AB 265 (Wood), which prohibited drug manufacturers from offering coupons for pharmaceutical drugs when other FDA-approved drugs are available and less expensive. Additionally, transformative regulation came from SB 17 (Hernandez), which improved transparency in the health care system by requiring drug manufacturers to give prior notice to purchasers before raising prices and required additional data submission on costly and frequently prescribed drugs.

We would encourage the Commission to petition the Food and Drug Administration to not allow direct consumer advertisements, particularly TV or radio commercials, for prescription drugs. Commercials have numbed consumers to side-effects as serious as death, and according to Dartmouth College, has done so to the tune of \$30 billion annually. The idea to ban pharmaceutical ads is not new and has been supported by the American Medical Association since 2015. “(Support for) an advertising ban reflects concerns among physicians about the negative impact of commercially-driven promotions, and the role that marketing costs play in fueling escalating drug prices,” said AMA Board Chair-elect Patrice A. Harris, M.D., M.A. “Direct-to-consumer advertising also inflates demand for new and more expensive drugs, even when these drugs may not be appropriate.”

5. Collect and use healthcare payments data

Address the Cost of Health Care with Price Transparency

Health insurance is expensive because healthcare is expensive. To address the root causes of affordability, CAHIP recommends strong enforcement of existing federal government orders for hospitals to publish prices. The New York Times recently published [an article](#) that highlighted abuses in plan and hospital negotiations and billing practices. Some examples are as egregious as charging lower costs to people who forgo insurance all-together, which undermines the objective that insurance is for the consumer’s benefit.

Without comprehensible price transparency, it is impossible for consumers to choose the coverage that is right for them. Employers and individuals may be choosing a premium that is “right” for them without any ability to confirm that the applied coverage is working to their benefit. Charges need to be consistent, predictable, and transparent. In addition to the alternative pricing models discussed earlier, CAHIP recommends stronger penalties for failed compliance with existing federal price posting requirements. Existing penalties are capped at \$109,500 per hospital, per year, so financially perverse incentives presently outweigh the punishment. Further, the published data should be in a format that is transparent to consumers and their agents to ensure that coverage is selected based not just on premium affordability, but on healthcare affordability.

6. Build Expanded, Culturally Sensitive Workforce

Providing insurance to all Californians is an important milestone, however for that coverage to be fully realized we must also increase the number of providers who are available to provide care. We are confident that other stakeholders more closely aligned with patient treatment will be able to comment on ways to increase the number of providers our state desperately needs.

Ask an Agent

Agents are present in virtually all communities of our state, including in over 500 Covered California storefronts. Agents also reflect the diversity of our state with nearly three out of five agents speaking more than one language. Some 11,000 agents’ contract with Covered California and are required to meet a stringent certification process that includes the obligation to help consumers find the health plan and coverage that is best for the consumer and

commit to serving ALL Californians, regardless of their age, disability, race, ethnicity sexual orientation or gender identity or ability to pay.

Agents are playing a vital role in making sure Californians are aware of the additional premium assistance made available by the American Rescue Plan offered through the entire 2022 coverage year. This additional coverage will largely absorb the nominal average expected premium rate increase of 1.8 percent on and off the exchange. Further, consumers that use agents to shop and switch can see premium reductions. Using an agent's professional advocacy costs consumers nothing additional.

Agents are available to help people sign up for the coverage that is right for them, their families, and businesses. They also provide the ongoing service and support necessary for individuals to effectively utilize their healthcare coverage. Agents assist with group coverage, Medicare, no-cost Medi-Cal, and Covered California plans; some with premiums as low as \$1 per month for individuals that received unemployment assistance. Additionally, agents were a cornerstone of ensuring that all Californians were able to maintain coverage throughout the unprecedented COVID-19 pandemic, when coverage and an advocate have never been more essential.

These men and women are trained and licensed professionals who operate diverse storefronts throughout California and offer in-person and remote enrollments and consumer advocacy services. Their expertise is increasingly important to consumers because they make complex issues understandable. Agents often reflect the diversity of their communities and serve as the friendly face for what can otherwise feel like an intimidating and cold government/corporate transactional mandate. Health insurance agents bring the irreplaceable human touch necessary to providing a true quality service experience to their individual and employer-based insurance clients.

Conclusion

While CAHIP ardently agrees with the objective of containing costs, improving quality, and reducing disparities, we respectfully caution against unintended consequences of harmful cuts to services and decreased access that would likely occur if related legislation is drafted in error. CAHIP is available to discuss options to help to repair problems encountered by Californians who are trying to obtain and pay for health insurance coverage. Thank you for the opportunity to provide feedback on this final report. We appreciate the partnership in helping Californians get the coverage and care that is right for them.



May 20, 2022

Re: Comments on Key Design Considerations Report

Dear Healthy California for All Commissioners and Consultants,

Thank you for the opportunity to provide feedback from the California Association of Health Plans (CAHP) to the Commission's Final Report (Report). Our members have worked for years toward achieving affordable universal coverage for Californians and welcome the conversation to achieve this shared goal.

The below comments and questions are not an exhaustive analysis of the Report, just initial comments we have been able to compile under the relatively short time window offered for comments given the magnitude of the cost, complexity and consequences of overhauling California's health care system.

At the outset, we must note that flaws pervade the Report which fatally undermine its credibility and utility in helping California achieve our health care goals.

Failure to Answer Fundamental Policy Questions

The Report claims a number of supposed benefits of universal financing – but fails to answer the foundational policy questions that will determine whether a unified financing (UF) system will deliver such promised benefits.

For instance:

- The Report claims UF will make health care more affordable for consumers – but is silent on whether UF should require cost-sharing of consumers.
- The Report claims UF will improve health outcomes – but fails to recommend what quality and accountability metrics or governance structures should be used to help improve those outcomes.
- The Report claims UF will eliminate “complexity and administrative burden” due to reducing or eliminating the role of health plans – but is undecided on whether to eliminate or reduce the role of health plans.
- The Report claims UF will moderate the growth of health care spending – but is silent on how to structure provider payments, and undecided on whether to use fee-for-service or capitation.

This is just a small sample of the questions unanswered by the Commission.

The ability of our health care system to provide access to affordable, quality health care depends on these and many other “policy levers”, as the Report terms them – many of which are “crucial” to determining whether UF will work. These levers do not exist in a vacuum, independent of one another, but interact and impact one another.

Absent some decision or recommendation on these fundamental questions; absent a clear vision and systemic proposal, the Report is simply an a la carte collection of individual policy considerations and cannot credibly assert that a supposed UF “system” will lead to lower costs, better outcomes or improved access or equity.

The Report’s silence on key policy questions also leaves Californians and stakeholders in the dark about what is actually being proposed and how their health care might be impacted.

Failure to Recognize California’s Progress on Health Care

California is closer than ever to achieving universal coverage and is leading the nation in developing and implementing efforts to improve affordability, including the very successful launch and continued operation of Covered California, expanding Medi-Cal to more undocumented adults, enhancing state premium and ARP subsidies and the State creating the Office of Health Care Affordability to identify and control costs of our current health care system.

The recent addition of federal subsidies combined with state action by Governor Newsom have shown we can reach universal health care by building on the current system.

The Commission proceedings and Report are almost universally dismissive of this progress.

The Commission had an opportunity to use the costs of getting to universal health coverage using the existing system as a baseline for comparison, as we recommended in our 2021 Comments on the initial Cost Analysis. Even if the Commission didn’t use this as a baseline, it could have compared the costs of obtaining universal coverage under the Affordable Care Act to those of creating an entirely new universal financing system.

It did neither.

Failure to Engage Millions of Californians

Studies consistently reveal that the vast super-majority of Californians (more than 70% - nearly 30 million) are satisfied with their health care. The Commission effectively ignored these Californians and their viewpoint, marginalizing their concerns and needs in the health care system.

This is reflected in its overall findings, which recommend the dismantling of our health care system and replacement with an unfounded and vague concept, but as importantly in its process. None of the stakeholder or community engagement focused on the actual impact these changes would have on the coverage these Californians receive today.

The Commission frequently used the language of universality and inclusion but fell far short of its rhetoric.

Failure to Acknowledge the Severity of Threshold Concerns

The failure of the Commission – a politically insulated body unaccountable to voters or others – to achieve consensus recommendations for fundamental policy questions raises serious doubts that policymakers in other more accountable forums will be able to do so in the future. However, even in the unlikely event future policymakers are able to find consensus where the Commission was not, there are other well-chronicled obstacles that must be cleared whose severe difficulty effectively precludes the possibility UF is viable.

The Commission acknowledges some of these, but not in proportion to their severity or the degree to which they overhang the UF debate.

Federal Waiver

The entire premise of shifting California's health care system to universal financing rests on the assumption that California will be able to obtain federal waivers to shift nearly \$200 billion / year in funding from Medicare and Medicaid to California's new government-run health program.

As your prior analysis noted, this will require Congressional action and Presidential signature to amend federal law.

- One, no Administration to date has supported such a change to federal law, including the current Administration, who is not supportive of single payer. While the question has never been called in Congress, the polarized nature of the health care debate in Congress in recent years suggests such a waiver is highly unlikely.
- Two, in the unlikely event California obtains Presidential support, majority support in the House, and filibuster-proof support in the Senate for the needed changes to federal law, there are no guarantees that a future Administration and Congress won't revoke the waivers. In this event, what would the consequences be to health care in California, including cost, quality and access to care?
- Three, in the unlikely event that federal law is changed and the even more unlikely event that no political change occurs in Washington which jeopardizes California's waiver, what guarantees

are there that the federal government pay California the full amount on a regular basis. What would the impact be of delayed federal funding?

The methodology document fails to mention ERISA even once. What is the impact on overall design and cost to the system if either a) the federal government refuses to provide a waiver for ERISA-plan enrollees, or b) California does not require ERISA-plan enrollees or employers to participate in the system?

Additional prerequisite actions

The politically fraught, likely costly and harmful transition to Unified Financing would require several key additional steps beyond creation and implementation legislation, including:

- Voters approving a Constitutional amendment to Prop 98 (school funding protections).
- Voters approving a Constitutional amendment to Prop 4 (the state spending limit).
- Voters approving new and higher taxes in the tens to hundreds of billions of dollars per year.
- Voters amending the tobacco tax.

What happens if voters don't approve any one or more of these measures? As important, what happens if voters revoke their approval for any of these measures?

Deficit Spending

If California is able to obtain the changes to federal law, the required federal waivers, approval from California voters for the Constitutional amendments, the required legislation and the higher taxes – in short, the necessary changes to divert hundreds of billions of dollars a year to the new state-run program – what guarantees are there that the program won't spend more than the existing sources of revenue? California does not have the ability to run deficits like the federal government, so in the event of cost-over-runs there would either need to be additional taxes beyond those already contemplated or cuts to other important programs.

Failure to be Candid with Californians About Cost

The Commission declares categorically UF will lower overall health care costs, despite its failure to achieve consensus or make policy recommendations on fundamental questions.

The Commission's certainty in these assertions is belied by the enormous uncertainty in the Commission's cost projections, which are dependent on many highly improbable yet very significant assumptions that could leave taxpayers on the hook for hundreds of billions of dollars.

The analysis often uses flawed, out of date or non-California data to predict California costs. A number of the assumptions simply don't square with reality or come with severe but glossed-over trade-offs for access to health care, as noted by the CBO report.

A significant portion of the report's projected cost savings under UF appears to come from significant cuts to provider payments and from pharmaceutical savings. Putting aside the unrealistic nature of these assumptions, they would harm the access Californians would have to both providers and prescription drugs.

The analysis appears to omit various considerations which could drive up costs even further under UF, including a) lost revenue to the state from the loss of the hospital waiver and MCO tax, b) the lost revenue from the insurance tax, bank and corporations tax, local property taxes and income taxes no longer paid by health plans and their employees, and c) the potential for medical tourism to California.

And finally, the assumption that federal funds would arrive in a timely manner and are not at risk is an overly optimistic assumption about how funds will flow from the federal government. The state would likely have to front load billions in funds to get the program going.

Failure to Engage Providers and Health Plans

As health coverage providers who have fought for affordable universal coverage for years, our members have deep experience with all facets of California's health care system yet have not been contacted by the Commission to help inform your analysis of this or other issues. The Commission eliminated its plans for engagement with employers and for engagement with providers, and, instead, appears intent on listening only to a very small number of activist voices that do not represent the residents of California or the hundreds of thousands of health care professionals working in California.

The result is a Report uninformed by the expertise and experience of the people who actually provide or deliver health care to Californians.

Summary

The Final Report of the Commission fails to present a coherent proposal or vision for health system reform, much less make the case for dismantling California's current system and replacing it with UF or single payer. This failure perhaps reflects the severity of the challenges and the difficulty in balancing various trade-offs, but could also reflect a simpler truth: California's health care system is working well for the vast majority of its residents.

There are things our health care system can do better to lower costs, expand access and improve outcomes. We strongly recommend future policy makers focus their energy on what policy we can

achieve together to have a positive impact on people's lives, rather than waste more of the state's time and resources on the impossible journey which is UF or single payer.

May 19, 2022

Mark Ghaly, Chair

Healthy California for All Commission

RE: Healthy California for All Commission, “Key Design Considerations for a Unified Health Care Financing System in California”

Dear Chair Ghaly,

The California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses, appreciates the opportunity to submit comments regarding the Commission’s final report, “Key Design Considerations for a Unified Health Care Financing System in California”. We are pleased that the final report once again confirms that single-payer health care systems outperform both the status quo and a system that includes health insurance companies or health systems as risk-bearing intermediaries.

The law establishing the Healthy California for All Commission calls for the Commission “to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians.” Given the explicit requirement that the plan include a single-payer financing system as an option, CNA expected that the report would fully analyze the role that the health insurance industry plays in California’s current system and compare that to a financing system in which the State of California serves as the single payer. Thus, in our view, the report includes two key deficiencies:

- it glosses over critical differences between a financing system with a single payer and a financing system that retains risk-bearing intermediaries such as health insurers or health systems and
- it fails to identify formal, concrete steps for implementing a single-payer system option.

CNA believes that these deficiencies reflect the influence of the consultants who performed the analyses of the two approaches and wholly drafted the final report under the “guidance” of officials within Governor Newsom’s administration who “reviewed and edited multiple drafts”.^[i] Additionally, as noted in various places within the report and detailed in a survey of the Commissioners, the report does not reflect a consensus among the Commissioners.^[ii]

- **The report fails to identify critical differences in the two approaches to financing health care that it models.**

The section entitled “Analytic Approach and Findings” presents two different approaches to health care redesign: a single-payer system in which the state would pay doctors, hospitals, and other providers directly (the “direct payment” approach), and an intermediary-based system in which the state would pay health plans or health systems a flat fee per enrollee (the “intermediary” approach). Yet, throughout this section, the discussion refers to unified financing generally without any distinction between the two different approaches. Additionally, where it does distinguish between the two approaches it refers to them as similar.

First, the report fails to identify important differences between the direct payment approach and the intermediary approach. Information presented in the report and at Commission meetings show that expenditures under the intermediary approach are consistently higher than under the direct payment approach. In addition, under the direct payment approach, patients would receive more care, administrative savings would be higher, and overall expenditures would be lower. The report misleadingly glosses over these critical differences, claiming: “These increases in spending are largely balanced by an estimated increase in utilization in the direct payment scenario due to the elimination of risk-based capitation and the elimination of health plan efforts at reducing low-value care, which is accompanied by an increase in spending for services.”^[iii]

Second, the report fails to acknowledge that the business model of insurance company intermediaries is to limit all care, not just potentially “low-value” care. Thus, including insurance companies is fundamentally at odds with the vision of a unified financing system that “provides safe, timely, efficient, equitable and person-centered health care that advances the mental and physical health and well-being of all Californians” endorsed by the Commission.^[iv] Health insurance companies treat payment for medical care as “medical loss”. Data from the Department of Managed Health Care (DMHC) requests for independent medical review (IMR) confirm that insurers are not merely denying low-value care, but care that is medically necessary. According to DMHC: “Approximately **68% of enrollees** that submitted IMR requests to the DMHC received the service or treatment they requested.”^[v] Requests for IMR have three possible results, DMHC may uphold an insurer’s denial, DMHC may overturn an insurer’s denial, or an insurer itself may reverse its decision to avoid the IMR. This means that DMHC upheld only 32% of insurer denials and that insurers were wrongfully denying enrollees services or treatments that should have been provided in 68% of cases.

Given the hurdles an enrollee must clear to get an independent medical review, CNA believes that the IMR data documented by the DMHC represent only a fraction of the medically necessary services and treatments being denied by insurance corporations. Without sustained efforts by an enrollee, insurance company care denials never even come up for independent medical review. Here is a summary of DMHC’s process for seeking an IMR:

Before filing an Independent Medical Review (IMR)/Complaint with the DMHC you are first required to [File a Grievance/Complaint with Your Health Plan](#).

Once you have participated in the 30-day process with your health plan, if the issue has not been resolved or you are not satisfied with the decision, you can proceed with filing an IMR/Complaint with the DMHC. If your health problem is urgent, you may seek immediate assistance from the DMHC.^[vi]

Moreover, even if an enrollee files a grievance, the insurer frequently fails to respond in a timely manner. Indeed, the most frequent violation in the DMHC enforcement action database is failure to resolve an enrollee grievance within 30 days, followed by failure to establish and maintain a DMHC approved enrollee grievance system.^[vii] The report fails to recognize the harm that insurer company denials cause patients. Even if an enrollee

eventually prevails and receives the care they need, the delay in care may have profound consequences for their health.

In sum, insurance companies use care denial, administrative preauthorization, utilization review, and narrow provider networks as barriers to care of all kinds by design and do not limit denial of health care services only to care that is deemed “low-value”. Increased administrative costs and reduced utilization are not incidental to the differences between the direct payment approach and the intermediary approach. Rather, increased administrative costs are, in large part, a result of insurance industry efforts to reduce utilization. Thus, administrative costs and utilization are defining features of the different approaches. For these reasons, the relative merits and deficiencies of the two financing approaches should have been thoroughly discussed in the report.

- **The report fails to provide formal, concrete steps for implementing a single-payer system option**

The report should have provided formal, concrete steps for implementing a single-payer financing system option. Instead, the “Steps on the Path to Unified Financing under State Authority” section reiterates current and proposed patchwork actions for increasing health insurance coverage and health care access. Not only are these steps unnecessary to establishing a unified financing system, they leave the current wasteful and fragmented multi-payer system largely intact. Additionally, the “Priority Actions and Next Steps” section incorrectly implies that, before pursuing a unified financing system in any form, the State must first engage in informal discussions with the leadership within the U.S. Department of Health and Human Services regarding whether California could utilize federal waivers to direct federal funds to a unified financing system. Moreover, the report prioritizes informal federal waiver discussions over drafting policy legislation despite the conclusion in “Appendix C: Legal Memo on Unified Financing of State Health Coverage” that under current law “there are relatively straightforward paths with respect to Medicaid and the ACA-covered population” and multiple paths for potentially covering the Medicare population. The report should have clearly identified the need for policy legislation early in the process of establishing a unified financing system rather than putting it in the “Implement and Sustain” stage that follows the “Lay the Foundation” and “Obtain Federal Permissions and Refine Design” stages.[\[viii\]](#) Indeed, policy legislation is necessary for applying for federal waivers.

In closing, CNA expresses appreciation for another confirmation that a single-payer health care system would create more equitable health care access, allow doctors and nurses to spend more time on patient care, eliminate medical debt, and save lives.[\[ix\]](#) However, we are deeply concerned that the current multi-payer system, with the insurance industry in control, maintains its central place for at least the near- and medium-term. In so doing, the report represents a tremendous disservice to the people of California, the Governor, and the legislature.

Sincerely,

Michelle Grisat

Michelle Grisat
Director of Health and Regulatory Policy
California Nurses Association/National Nurses United

Endnotes

[i] See report p. 2, “Authorship and Review Process”.

[ii] See the commissioner survey here: <https://www.chhs.ca.gov/wp-content/uploads/2022/04/HCFA-Commission-March-Survey-Report-2022.pdf>

[iii] Report, p. 30, footnote reference omitted. The footnote acknowledges that determining what constitutes low-value care “involves a degree of subjectivity and nuance”.

[iv] Transferring insurance risk to health systems would result in similar issues.

[v] Emphasis in original. <https://wpsso.dmhc.ca.gov/Dashboard/ComplaintsIMRs.aspx>

[vi] <https://www.dmhc.ca.gov/FileaComplaint.aspx>

[vii] <https://wpsso.dmhc.ca.gov/enfactions/violation.aspx>

[viii] See report p. 81, “Table 7: Stages on California’s Path to Unified Financing”.

[ix] See slides 40-44: <https://www.chhs.ca.gov/wp-content/uploads/2021/05/Healthy-CA-for-All-May-21st-Commission-Meeting-Slides.pdf>

Dear Commissioners,

I am unable to attend today's final commission meeting and wish to make the following comments.

While I appreciate the report and the evidence it once again provides for the clear benefits of a single payer system, I am disappointed that the Commission failed to clearly describe the benefits that a single payer system has over a fragmented system with health plans, including the significant cost benefits.

As a small business owner, health care coverage is one of my biggest concerns. Choosing among health plans which change every year creates confusion, anxiety and drives up cost. I want to be taxed for my health care and then have care be free at the point of service *without an intermediary* and I want to be able to choose my providers – all things that can happen under a single payer system and are threatened any time intermediaries and health plans are introduced. There is no benefit to the intermediary model except profit for those intermediaries – which takes away from what the State can and should invest in health care for its citizens.

As I understand it, the Commission was supposed to develop a plan to include options for “advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, ***including, but not limited to, a single-payer financing system, for all Californians.***” The report does not present clear and concrete actions the state can take to achieve a single payer system in California. The lack of a real plan is even more disappointing given that the legal analyses describe a viable pathway to financing a single payer system in California without any change in federal law.

California can and should move forward with a single payer health care system which is the least costly, most fair and highest quality way for all Californians to be fully covered. The Commission seems to know this but won't say it. *Please complete the job and lay out the path for how the state can move to a single payer system as quickly as possible.* It is what I and a majority of Californians want.

Katharine Gale
Katharine Gale Consulting

From: Healthy Care for All - California

Cc: Governor Gavin Newsom, Senate President pro Tempore Toni G. Atkins, Assembly Speaker Anthony Rendon

Date: May 20, 2022

Dear Commissioners:

Let's hope the final version of the report from the Healthy California for All Commission marks a turning point in California history.

The report unequivocally demonstrates that a publicly financed single payer system is the most cost-effective way to guarantee high quality, accessible, equitable health care to all Californians.

Trust in government today is in serious jeopardy and with it our democracy. California can model not only what a successful healthcare system looks like, but what bold, responsible political leadership can accomplish.

We call on Governor Newsom and legislative leaders to fully commit NOW to moving to a single payer system as soon as possible.

Will it take time to develop the system's design, to find answers to questions noted in the Commission's report, and to ultimately make a just transition? Yes! And that's exactly why the governor and the legislature must make enacting single payer their nonpareil priority.

We applaud the commissioners for staying the course, difficult as it was during the pandemic—alarming proof of the urgency of their mission. We appreciate Dr. Mark Ghaly's introduction to the report, both heartfelt and direct, and his devoted leadership of the Commission.

We expect assemblymembers and senators to focus attention and energy on building a supportive climate in the legislature for single payer. And we call on Governor Newsom to use the full strength of his office to make single payer his signature achievement, to engage immediately with "federal partners," and to collaborate with legislators to ensure single payer universal health care is realized for our great state.

With gratitude and tremendous hope,

Ellen Karel, Chair

Health Care for All – California

www.healthcareforall.org

Hello, I am a senior who has disabilities and a low income. I was shocked and saddened to see that intermediaries are considered an option as part of a unified financing system. Especially when there are different plans they contribute to the inefficient, costly, inequitable nature of our health care system. They are focused on making profits and cutting costs. To those of us who have least, less will be given. Single payer is what we need to make health care in our state truly accessible, affordable, high quality, equitable comprehensive and universal.

Thanks for your attention to these issues.

Frances Hillyard

Dear Commissioners,

Thank you for your work to evaluate the expectations in proceeding with establishing a system of unified financing of Universal Healthcare for all Californians. I think we can all appreciate now that a Single Payer system without commercial intermediaries will best provide the most comprehensive care that will be both more efficient and more equitable than what we have at present.

COVID19 has shown us the imperative to take action to affect these changes now, while many still suffer from this pandemic, and many more will suffer from those pandemics yet to come, and other public health maladies that we will see in particular with climate change.

Please move this report to the Governor and the legislature now, with no further delay, while we can still save so many lives and so much money that can be used for other public needs.

Thanks again.

William Honigman, M.D.

Dear Commissioners,

Thank you for your work.

Have you noticed what CEO's of insurance companies are earning? In a recent email, I received a photo and name and salary for 2016.

Cigna - 21.9 million

Centene - 32.2 million

Humane - 17 million

United Health - 31.3 million

Aetna - 41.7 million

Anthem 17 million

So in a day, the Ceo's could earn more than a salaried worker earns in a year.

A single payer system would save billions after getting started with no cost sharing at the point of service. The final report seems to bury the benefits of single payer because it uses other words or phrases like direct payment.

Can this report please be modified, reread for clarity.

If you allow 3rd party intermediaries to mangage the system it will interfere with the doctor patient relationship and is not unified financing.

Please modify the report for clarity. This is so very important.

Thank you,
Jean Jackman

As a health care provider (now retired) I am acutely aware of the need for a single payer health care system in California and in the country. We will never have a decent health care system until the profit motive is removed from healthcare and until paperwork costs are significantly reduced by having a clear, uniform billing/payment process. I am appreciative of all the work the Commission has done and am happy, but not at all surprised, by the finding that a single payer health care system is fiscally sustainable and will save billions of dollars.

I am very pleased that the work the Commission shows that there is a viable path for dealing with federal waivers and ERISA without having to change federal law. This was a significant concern that is now resolved and that resolution is an important step toward a single payer system.

It was good to see, but not surprising, that the public clearly favors a single payer system over the horrible, fragmented, expensive, profit driven system that is currently in place. A great many health care providers, myself included also favor a single payer system.

The Commission report needs to do a better job of emphasizing the benefits of a single payer system and the ways that it will save money.

The term "unified financing" is confusing. It seems to conflate single payer with some kind of a system that involves payment intermediaries. What we don't need is some kind of 'middleman' financial system. A series of 'middleman' entities won't add value and has the potential to create barriers to care, just as our current, fragmented system creates barriers to care. Allowing third party "middlemen" with a financial stake to manage the system will guarantee more of the same mess we have today where the goal is to maximize private profit by denying care. It will also force providers to do what they have to do today - waste time battling the system to try to get patients what they need.

The Commission report would be improved if it articulated clear, step by step actions the state can take to achieve a single payer system. Such steps must include steps the Legislature should take since it is key to assuring that a single payer system moves forward and becomes law.

Thank-you for this opportunity to comment and for all the work the Commission has done.

Sincerely,

Karen N. Jacques Ph.D.

As a nurse who works at a safety net hospital I see the problems with our market based payment systems daily. Anything short of a true single payer system will not level the field on financing health care. Without clear steps to transition to a single payer system the horrible inequities and fragmentation of the market will continue. Please make recommendations to the legislature and the Governor to adopt and sign legislation that is the first step to health care justice.

Martha Kuhl RN

Pediatric Hematology Oncology Transplant nurse

May 1 2022

To: Healthy California for All Commission
HealthyCaforAll@chhs.ca.gov

From: Deborah LeVeen, PhD
Professor Emerita, San Francisco State University
dleveen@earthlink.net

Re: Comments on Key Design Considerations Report, Final.

The Healthy California for All Commission (HCAC) has proposed a radical, and badly needed, transformation of California's health care system. The Commission was mandated to develop a plan "that includes options for advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians." (p.7¹) The final report lays out key steps which will both bring immediate, urgently needed gains *and* help lay the foundation for the health care system we all seek: one that provides universal coverage for high-quality care that is accessible, comprehensive, affordable, equitable, respectful, efficient, and sustainably financed. Under UF, coverage would be universal and benefits would be significantly expanded, with options for Long Term Care and Social Services—LTSS—and cost-sharing possibilities. Two models of unified financing (UF) are considered: (1) direct payments to providers and (2) payment through "intermediaries" such as health plans. Under both options, the system established would specify requirements—e.g. for coverage, benefits, payment—which all participants would have to meet. The consultants' analysis found that under both UF options, and including all but the most costly coverage options (e.g. no cost-sharing), the UF system would cost less than our current system, with its fragmentation, coverage gaps, high prices and administrative costs, and revenue imperatives. The report provides a detailed analysis of the steps needed to create a completely universal financing system, incorporating all of the revenue flowing into California's health care system. And it concludes with a set of recommendations for more immediate steps that could be taken while exploring that broader goal, building on progress that California has already been made.

The Commission's work, and that of its consultants, was fabulous. As a (retired) scholar of health policy, I found the consultants' reports to be a rich source of information and analyses of our health care system. The Commissioners' comments (verbal and written) as well as special presentations were extremely insightful, and grounded in evidence and experience. As a long-time advocate for universal care, I was especially inspired by the Commissioners' discussion of the final report during its last meeting on April 26. All but one supported sending the report to the Governor and the Legislature, including the radical changes entailed even in its recommendations for "transitional" steps toward UF, such as implementing a state health care spending target, aggregating purchasing power among payers to negotiate prices, establishing global budgets and all-payer rate-setting, and much more. (See pp. 76-77)

¹ All page references are from the Final Report.

The near-unanimity of the Commissioners was all the more impressive given the positions in the health care system they represented: the major state offices and legislators, the major foundations, major health care advocacy groups, and nationally respected academics, including Bill Hsaio, the Harvard professor who designed the single payer system in Taiwan and the all-but-financed system in Vermont. Many Commissioners, including Secretary Mark Ghaly, urged strong followup and promised to commit resources to the effort. The breadth of their institutional positions suggests real possibilities for significant progress.

The only obstacle to full consensus came from Commissioner Comsti, representing the CNA, who objected to the inclusion of the intermediaries model as an option for unified financing. While other Commissioners shared her concerns about the dangers of risk-bearing health plans, and those concerns— withholding care, recruitment efforts targeting healthier populations—must be addressed, no other Commissioners supported the exclusion of private insurance at this point. The heading for the UF intermediaries option in the final report is “Continued but Reimagined Role for Health Plans and Health Systems.” (p.52) Under UF, they would be required to provide the same set of benefits, the same copayment structure “if copayments are used at all,” and use the same contract with all contracted providers. While administrative costs would be higher, we could achieve our overarching goals without taking on what I see as the futile challenge of eliminating the private insurance industry—particularly in our current political environment!

As I see it, choosing to make a “pure” single payer policy bill the first step in the Commission’s followup—and in fact *the only* step, since all private insurance would be excluded—would prevent us from making the kind of near-term, and urgent, gains proposed in the final report (e.g. pp. 67-73). I too once argued exclusively for single payer, starting in 1993 with Prop 186. But when Obama offered the opportunity for historic change at the national level, I shifted to focus on the ACA. And despite intense Republican efforts to destroy it, the ACA has not only brought life-saving gains in coverage but has provided opportunities for significant system change—opportunities which California has probably made better use of than any other state.

And it is those kinds of changes which provide the strongest possible evidence for what some Commissioners called a “building blocks” approach to UF. Like expanding Medi-Cal coverage under the ACA, then going beyond the ACA to include all Californians, regardless of immigration status. Like choosing an “active purchaser” role for the health insurance exchange, Covered California, which has then imposed significant requirements regarding benefits, payment, quality improvements, and so on in its contracting with insurance companies. Like developing an all-payer claims database as the foundation for developing an all-payer rates and payment system. (Again pp. 67-73)

To conclude: I believe the recognition of California’s major progress in reforming its health care system, and the foundation this offers for significant additional gains “on the way to” a more complete system of Unified Financing, is the Commission’s greatest contribution. And the near-unanimous support of the Commissioners, with their broad representation of the major groups seeking radical improvements in our health care system, offers realistic hope for real progress toward the transformative goals they have endorsed.

I thank you all, for all of your work!

Healthy California for All Commission final report evaluation

1. It is better than I expected. The report is an accurate assessment of today's political realities. It reflects the best intentions of the Commission liberal status quo majority to take steps to improve the current system, and even includes some of the ideas advocated by the more progressive voices on the Commission.
2. It is the State of the Art until the Oregon State Task Force on Universal Care comes out with their report in a few months.
3. This is not in any way the Commission's report, in the way that the State Commission on Aging decided what the report would be about and then they decided what would be in the report. The Commission has only been a passive spectator to Secretary Ghaly's word to word to word mini-micro-management, including imposing his authority with a reprimand and even threats of removal when the progressives tried to expand the discussion to include AB 1400.
4. This is only the Agency's and the consultants' report. The consultants served the Secretary, and individual Commissioners were left to fend for themselves. The "group" work was done by the Foundations that have a vested interest in the status quo. In the name of change. The Commissioners have the honor to have their names included in the report for the work the consultants did under the Secretary's direction.
5. Currently in the report, the Commissioners names adorn the cover page, with the Agency, staff and consultants listed on page two. That is using the Commission as political cover; the Commissioners should be listed on Page 2. The Consultants wrote the report.
6. Somewhere in the California Legislature in 2023, Jim Wood is going to start listening to people talk about the report until he is forced to lead having the Assembly Health Committee actually pursue omnibus health care legislation enough that the Governor is forced to support it. Only the final report justified all the rhetoric.

The report surely damns the present health care jumble-- based on excessive costs and profits.

It does not mention single payer-- but "unified financing." As SenatorPan says, if we believe that healthcare is a human right, we need to talk about and focus on single payer.

It is a big thing to go for Single payer-- but necessary and desirable.

JUST VOTE FOR IT!

Thank you--



May 19, 2022

Dear Dr. Ghaly and Members of the Commission;

We are writing as representatives of the California chapter of Physicians for a National Health Program (PNHP-CA). We represent primary care physicians, specialists, surgeons, public health officers, health economists, and administrators. We believe that a public, non-profit, unified financing system is the most efficient and cost-effective way to provide comprehensive health care services equitably to all Californians. We appreciate the time, dedication, and effort that the commissioners have invested to study and promote such a system.

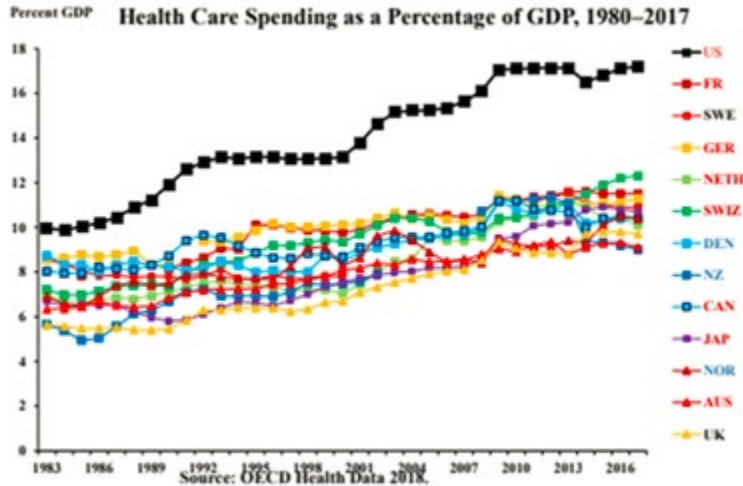
The Commission's Environmental Analysis reviews the major factors that contribute to the most expensive health care system in the world (pages 60-75). Our costs are high and getting higher because we allow prices to be set by suppliers of health services, drugs and medical supplies and paid by private insurers. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144#:~:text=A%202003%20a%20titled%20%E2%80%9CIt's,mainly%20by%20health%20care%20prices>.

We are concerned that some commissioners may have assumptions about payments to providers that we believe could interfere with developing an efficient and cost-effective healthcare program while failing to address the true sources of excessive costs. Therefore, we wish to emphasize five points.

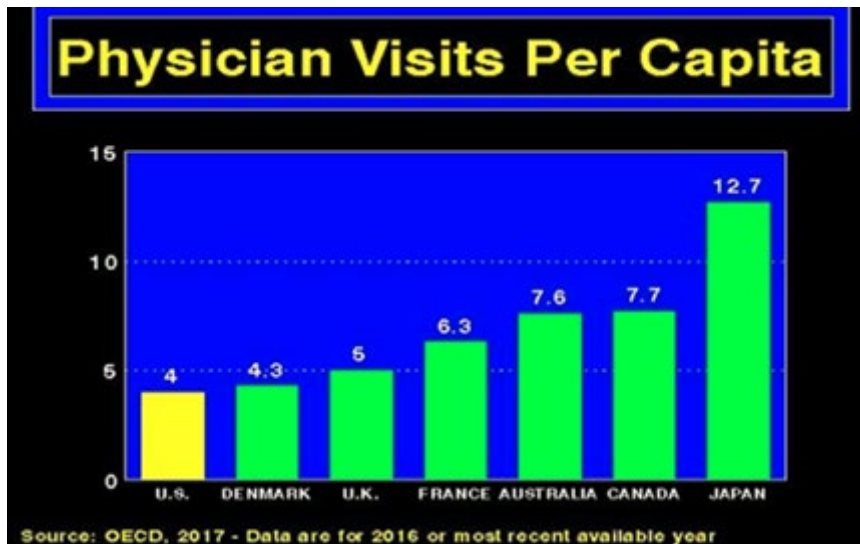
1. Fee for service is not a major driver of costs.

Some have argued that fee-for-service increases costs by providing an incentive to over-treat.

The following graph shows healthcare spending in 12 OECD countries that use fee for service as a form of provider payment. Spending in other countries is much lower than in the US, implying that many factors influence cost besides payment method.



That higher US costs are not due to overtreatment is implied by the chart below, showing that physician visits are far lower in the US than in other OECD countries.



In a single payer system a trust authority negotiates a binding fee schedule with clinicians which can be reviewed at intervals or during times of crisis that require increased use of services and costs. This authority can draw on a number of tools that other countries have found effective in monitoring fee-for-service, including: looking for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on high-value vs. low value medical interventions.

No payment system is perfect. One can easily find stories of physicians paid with FFS providing marginally necessary care. The vast majority of physicians do follow a code of professional ethics to serve the best interests of their patients. Most doctors are too busy providing necessary care to add unnecessary care since their time can't be expanded.

Fee for service promotes small private practices which are attractive to many physicians and patients. It preserves the autonomy of the physician-patient relationship and preserves continuity of care. Both are vital components for care quality and cost savings.

We understand that every mode of payment has pitfalls. Other countries have found fee-for-service, capitation, and salaried practices compatible with quality and cost containment as long as the fees do not unduly reward procedure-oriented specialists over primary care and cognitive specialists.

Recommendation: Include fee for service as a provider payment method.

2. Financial incentives to limit spending on care risk under-treatment and rationing.

To provide patient care that is individualized, evidence-based, and high quality, physicians must not be incentivized to limit or deny care. Decisions should always be governed by the standard of care and the best interests of the patient, and most medical trainees take an oath to do exactly that. Rewarding physicians for quality and productivity may be virtuous, but financial rewards tied either positively or negatively to the volume of services present a potential – and often real – conflict of interest.

A Cochrane review “. . . *found no evidence that financial incentives can improve patient outcomes*”.

(Flodgren et al. “An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors and patient outcomes, Cochrane Collaboration, July 6, 2011. Accessed at <https://pubmed.ncbi.nlm.nih.gov/21735443/>.)

Recommendation: Uncouple positive and negative financial incentives from patient care.

3. Capitation has not been demonstrated to be the preferred method to control health care costs. Evidence favoring capitation as a method to control costs is lacking.

With fee for service or salaries, physicians are paid for the services they provide. FFS has not been shown to contribute significantly to patients overusing these services or by physicians charging for them. Capitation shifts risks to physicians because a lump sum is paid to the physician for a specified number of patients. Transferring financial risk to providers creates conflicts of interest that interfere with a physician’s intrinsic motivation and best clinical judgment. This can lead to rationing of care because imposed constraints to stay within the capitation budget can result in “cherry-picking” low risk patients and “lemon-dropping” high risk patients. Capitation requires patient and physician membership and membership restricts choice for both.

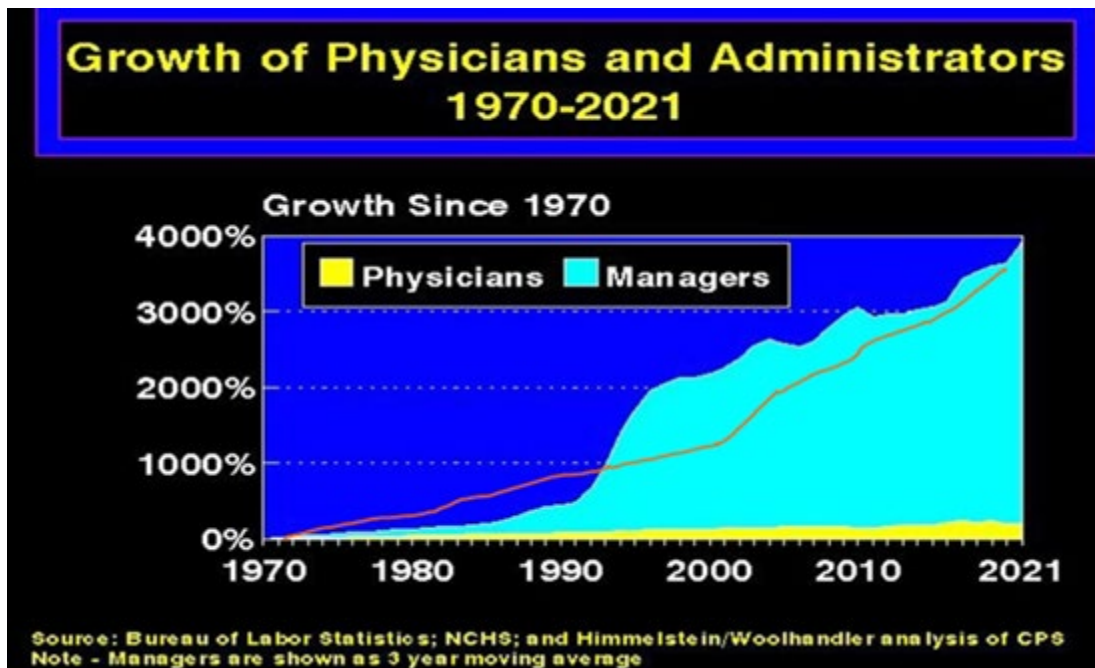
Fee-for-service is far more transparent than capitation because abuse is much easier to detect with FFS than with capitation.

Recommendation: Support fee-for-service and salaries as preferred forms of payment for physician services and capitation independent of financial incentives and disincentives.

4. Risk bearing fiscal intermediaries are potentially harmful.

Intermediaries add to healthcare costs and one must be cautious in assuming that health care savings with intermediaries are greater than their costs, when historically they have not been. Despite having fewer physician visits than other nations, we spend more than twice as much on healthcare. Clearly, paying middlemen to “manage care” and “control costs” has not worked. In addition they contribute to administrative complexity and burdens for providers and hospitals. Coordination of care can be achieved without third parties and is best carried out at the local level where providers are familiar with community and regional services.

We need to eliminate as many intermediaries as possible as they only contribute to bureaucratic complexity and cost. We need to focus on creating a simplified payment system. Please note below that the number of administrators has increased exponentially compared to the number of physicians between 1970 and 2021 and continues to spiral upwards.



Red line=cost per capita, from KFF.

Recommendation: Eliminate risk bearing intermediaries and pay providers directly to reduce costs and simplify administration. For physician services this can be done with fee-for-service or salaries. For institutions, this can be done with global budgets

5. “Value-based” metrics to improve quality are being misused.

Performance measurement has become increasingly popular in recent years with the aim of improving health outcomes and containing costs. Quality metrics are based on small population samples and/or specific diseases which distort their worth. They do not add value to health care.

These payment models shift the onus of cost containment to doctors and hospitals. They raise administrative costs by requiring more data collection and documentation. The length of medical notes in the U.S. is on average about three times the length of those in other countries. They lead to closure of small practices and consolidate practices in order to deal with the added expenses of consultants, extra staff, and software to create and monitor the metrics. All health care providers become frustrated with the weight of reporting requirements and many learn how to “play to the test.”

Figure 1

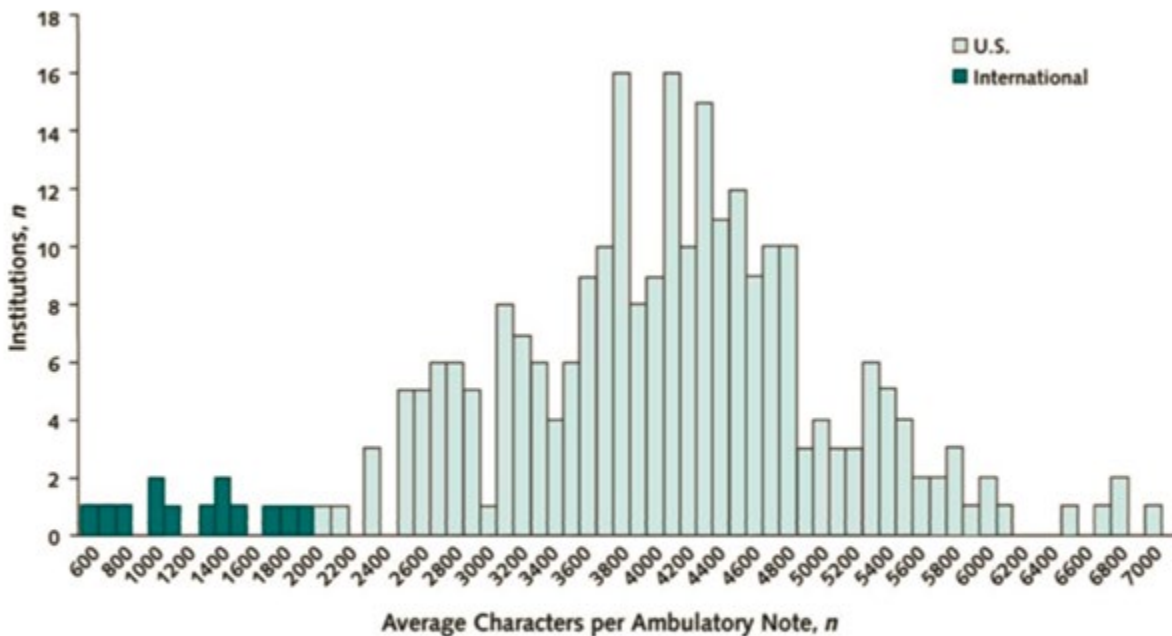


Figure. Average characters per ambulatory progress note in U.S. and international health systems.

Column height represents number of organizations. Dark columns represent 13 organizations outside the United States (140 000 notes from Canada, the United Kingdom, Australia, the Netherlands, Denmark, the United Arab Emirates, and Singapore). Light columns represent 254 organizations in the United States (10 million notes). Downing e. al. Ann Intern Med 2018;169(1).

The metrics worsen disparities by promoting a tendency to choose healthier patients, avoid sicker patients, and limit care to complex patients. They can result in over-focus on some diagnoses to the detriment of caring for others.

<https://jamanetwork.com/journals/jama/fullarticle/2646718>.
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05406>.

When value-based metrics are confused with treatment outcomes, health care institutions and individual health care providers begin to focus on increasingly narrow patient data. Value based metrics impact physicians and hospitals—not patient outcomes.

Recommendation: Recognize that a single-payer system has consistent access to rapidly available encounter data that allows government regulatory authorities to check for quality of individual and population care and patient and public health treatment outcomes.

In conclusion, our recommendations to the Commission are to

- Include fee-for-service and salaries as provider payment methods;
- Abolish financial incentives such as capitation that can risk care rationing and under-treatment;
- Eliminate intermediaries in order to save most of the health care dollar for health care;
- Eliminate value-based care, which is expensive, labor intensive, and results in crude measures that do not accurately reflect outcomes;
- In summary we recommend striking all references to risk-shifting schemes that only perpetuate the competitive insurance business model that is the root cause of the high cost of our health care system.

We agree with the following statement: “We recognize that the active support of doctors may not be a sufficient force to change the US system, but it is probably a necessary one. At a minimum, universal coverage and health care will be far less likely if physicians are opposed to it.”(<https://www.medscape.com/viewarticle/551708>). We hope that the above recommendations help gather the political will of all parties to actively support a single payer system.

PNHP-CA is grateful for the Commissioners’ tremendous effort and thought expended on this most significant, urgent and fundamental issue facing all Californians. In order for a publicly financed, not-for profit system to contain costs and be successful, it must be a truly **single** payer system that can offer a diversity of payment models with a minimum of intermediary bureaucratic layers. It must monitor and promote equity. As always, we offer our PNHP physicians and health policy economics experts as well as our extensive fund of research to the Commission as a resource.

Respectfully,

Physicians for a National Health Program-California



May 19, 2022

Dear Dr. Ghaly and Commissioners:

Senate Bill 104, approved by the Governor on July 9, 2019, established the Healthy California for All Commission. Their charge was to develop “*options for advancing progress toward achieving a health care delivery system*” that provides coverage and access for all Californians through a unified financing system including, but not limited to, a single-payer system. Physicians for a National Program California (PNHP-CA) has followed the work of the Commission since its first meeting. We have found the Commissioners to be conscientious in their work, and most of the presentations to be informative and supportive of a unified financing, or single payer health care system.

As physicians we have researched single payer systems and have access to multiple health policy and economics resources. We are submitting to you our impressions of the Key Design Considerations for a Unified Health Care Financing System in California, Final Report, April 2022, which include points of mutual agreement, areas of disagreement, and issues that we feel remain unaddressed.

In its Final Report the Commission recognizes that:

- Unified financing will make healthcare more affordable for employers and households, and will be equitable and less complex. Money saved could be used for other medical benefits and/or improving social determinants of health.
- A unified payment system can be leveraged to address the inequities of health care access and quality.
- Unified financing will save thousands of lives .
- Changes in financing are necessary but not sufficient to address problems with our health care system. Improvements in health care coordination, communication, and cultural competence are also needed.
- It will be necessary to partner with other agencies to address social determinants of health.
- Health care should be comprehensive and include dental, vision, and hearing, which are not currently routinely covered by insurers, including Medicare.
- A state health plan should Ideally include LTSS (long term services and supports).

- Community involvement is important in the design and governance of a system. The Commission’s community engagement survey of marginalized communities demonstrated 65% approval for a single payer system.
- Funding should be sustainable.
- Financing to replace non-federal dollars will best be achieved by a progressive mechanism (payroll tax, income tax) and would amount to less than the health care costs it is replacing.
- Coverage will be universal, and include undocumented residents.
- Unique confidential patient identifiers will be established.
- A seamless Electronic Health Record will need to be available statewide.
- A commission to clarify the process of obtaining federal dollars is needed.
- Global budgets for hospitals work well to manage costs and protect against shortfalls during periods of decreased volume as in the pandemic, or in rural communities. They allow hospitals to focus on community needs, not the most highly reimbursed procedures.
- More focus should be given to population health and preventive health care.
- Monitoring costs, access, quality, demographics, and outcomes is necessary for assessing system performance.
- Diversification and expansion of the workforce is needed.

The Commission’s Final Report falls short in its examination of unified financing in the following areas:

- Assumptions were made about capitation and value based models as preferred modes of payment, cost containment and accountability. No evidence was presented to demonstrate superiority of capitation over fee for service, and no distinction was made regarding straight capitation and capitation with positive and negative financial incentives, which can result in withholding of care.
- There is no mention of the evidence that paying for quality is not only ineffective but possibly counterproductive, as revealed in this New England Journal of Medicine series of three articles: [NEJM QA Articles](#).
- Cost-sharing is included as one option of controlling costs despite the recognition that it can lead people to forgo needed care.
- The report claims that “unwinding managed care” would lead to an increased expenditure of 3.9% due to “the elimination of risk-bearing capitation and health plan efforts at eliminating low-value care” (p.22). As researchers and practicing clinicians we strongly believe that risk-bearing capitation can limit needed care as well. The report does not weigh this against the savings that result from eliminating the administrative costs and profits made by the intermediaries.
- There is no discussion of the need to eliminate for-profit entities from the health care system. In the final draft report, examples of unified financing include Canada (single payer), Great Britain (national health service), Germany and the Netherlands (non-profit insurers). The for-profit insurers in the US drive up the cost of healthcare and eliminating them should be the cornerstone of any unified financing plan.

- “Intermediary” was never defined, leaving the door open for third party involvement in the health care system. Using insurance companies as intermediaries adds nothing to healthcare and can be associated with decreased quality, increased administrative complexity, and higher costs. There is a role for care coordination, but this is best handled locally, not with a centralized for-profit insurer.
- Insertion of the proposed Office of Health Care Affordability at the end of the report appears to defy the mission of the Commission. Unified financing implies the end of third party payers. The OHCA will be collecting data from these payers for many years. This suggests that establishing a unified financing health care system in California is not being seriously entertained. The drivers of health care cost increases are already well known.
- The unified financing benefits to business and local government were not sufficiently recognized.
- Cost controls under a single payer system were not adequately addressed. This will be achieved by setting an overall budget, using global budgets for hospitals, controlling drug prices, and setting standard reimbursements—not by unregulated capitation and cost-sharing.

Finally, the report’s “Steps on the Path to Unified Financing under State Authority” are a series of expansions of existing MediCal and Covered California programs and new funding for behavioral health. While laudable that more Californians will be insured, there is nothing to suggest movement to unified financing or single payer apart from the formation of the Health Information Exchange. The Commission admits as much in its “North Star” section:

“However, despite an ambitious agenda of actions under state authority, described in the previous section, incentives and requirements imposed by fragmented payers would continue to impose administrative burden, dilute efforts to improve outcomes, and provide opportunities to game the system. Thus, a system of unified financing must be the “North Star” toward which future policy and programmatic efforts are directed.”

The North Star is 323 light years from earth, and we are not any closer to unified financing in California.

Sincerely,

Physicians for a National Health Program-California

To whom it may concern,
I'd like to submit my public comment as follows:

- The legal analyses—on federal waivers and ERISA—attached appendices at the end of the report describe a viable pathway to financing a single payer system in California without any change in federal law. These legal appendices present several options for HHS to reasonably exercise its authority and allow states to use Medicare dollars in a single payer system. Congress does not have to pass any new laws for California to pursue state single payer.
 - The final report backs up Vermont Governor Shumlin's comments to the Commission about ERISA. There are multiple ways to design a single payer system without running afoul of ERISA preemption.

4/25/2022

Healthy California for All Commission.

HealthyCAforALL@chhs.ca.gov

Dear Commission Members:

Thank you for creating a participatory process.

Achieve improvement of medical care equity, access, and quality at a lower overall cost through incremental changes to our current various systems of finance and medical care delivery, not through a single payer/source of funding plan or by eliminating all profits from stakeholders.

I suggest the following:

1. Underwrite all immunizations and vaccinations approved by the USPSTF through our public health departments, not commercial insurance, Medicare, or Medi-Cal.
2. Institutionalize [root cause analysis](#) of medical disasters.
3. Motivate medical staff peer review through [non-parochial methods](#).
4. Motivate further integration among medical care providers.
5. Create a working medical-marketplace as robust as we enjoy in automobile repair services.
6. Create Medi-Cal fees that reflect reasonable provider costs.
7. Develop a Medi-Cal provider advisory board similar to Noridian [Medicare](#).
8. Consider allowing hospitals to directly employ physicians to facilitate integrated care.
9. Limit Medi-Cal [prior authorization](#) for prescription drugs as feasible.
10. Apply Medi-Cal funds only to medical care.
11. Finance mitigation of social factors that adversely affect health outcomes through other programs.
12. Restructure the [Medi-Cal manual](#) similar to the CMS [internet only manual](#).
13. Amalgamate the various Medi-Cal programs into one.
14. Recue Medi-Cal enrollment systems into one data base.
15. Adopt a more transparent Medi-Cal coverage policy process like Medicare's.
16. Measure the quality of medical decision-making.
17. Allow subscribers who are happy with their insured medical care delivery systems to keep them.
18. Recognize the benefit of long-term care facilities such as [Laguna Honda](#), particularly for homeless people.
19. Consider redeveloping mental health care facilities.
20. Solicit and promulgate innovations that works well.

Respectfully

Gerald Rogan, MD
Rogan Consulting

Clarification about Medicare from a former Medicare Administrative Contractor (MAC) Medical Director. Medicare has been a model for a single payer plan. These comments are to clarify Medicare.

Medicare is not a single payer plan.

Claims are paid by several Medicare Administrative contractors, not CMS. Care for an individual beneficiary can be made by three contractors, Parts A and B, Part D, and DME.

Medicare is funded from many sources, including beneficiary premiums for Part B.

Medicare does not pay for all useful medical interventions, such as eyeglasses. Dental care, or hearing aids.

Medicare does not cover long term nursing homes.

Medicare does not cover assisted living costs or home health aides.

Medicare policy vests with Congress with most decisions delegated to HHS to CMS. Congress micromanages Medicare, such as the age of eligibility for a preventive Mammogram. Micromanagement can be driven by political considerations include responses to propaganda. An example is the campaign against "death panels" which was never proposed.

Some coverage decisions are delegated by CMS to unelected Medicare Contractor Medical Directors whose decisions require the advice but not the consent of medical expert advisors. Advisors are nominated by their respective medical societies and approved by the CMD. Participation is voluntary, without pay, and subject to conflict of interest disclosures. An example was initial coverage of deep brain stimulation for the treatment of selected beneficiaries with drug refractory Parkinson's disease. Local coverage policies drive innovation and help control waste and abuse, but not fraud. Medicare CMDs must provide meetings with public stakeholders. All coverage policies are subject to notice to and comment by the public, which published response by the CMD to public comments received in writing.

Medicare requires copayments for some services which may be voluntarily insured. Congress has enacted price controls for physician fees, laboratory tests, and medical imaging regardless of cost, but not for drugs or ambulance transport. Allowances attempt to mirror market rates. Some are above market, some below. Sometimes excessive fees drive abuse, such as happened for implanted pain pumps. Excess payments attract providers.

Medicare offers a separate benefit for drugs that are not usually self-administered by the patient, under Medicare part D. It has delegated the decision of which injectable drugs are not covered by Part B to MAC medical directors without stakeholder appeal rights.

Medicare premiums increase for a beneficiary who elects to forgo coverage, so that beneficiaries are encouraged to enroll when they become eligible, even if well.

Medicare does not exclude coverage of pre-existing conditions. Medicare covers selected disabled persons and dialysis patients who otherwise would not qualify for Medicare.

Medicare suffers from 7% fraud. It has not implemented a **root cause analysis of medical disasters**. It can decline to cover a drug the FDA has approved, such as aducanumab.

Medi-Cal does not pay the 20% Part B Medicare copayment. The providers typically write it off. This limits access of dual eligible Medicare beneficiaries to some physicians, especially psychiatrists and for

office based outpatient oncology infusions. A few physicians do not accept Medicare beneficiaries, mostly psychiatrists.

Traditional Medicare overpays for certain services, especially medical imaging. Physicians may self-refer for medical imaging to make a substantial profit from unnecessary imaging, driven by patient demand. Traditional Medicare does not effectively constrain unnecessary medical imaging.

Thirty percent of Medicare beneficiaries have voluntarily enrolled in Medicare Advantage, which is managed care. The percentage has been gradually increasing.

Traditional Medicare attempts to integrate medical care across providers, with limited success. Motivated providers groups organize to do this in order to avoid Medicare penalties for unnecessary hospital readmissions for selected conditions, such as heart failure and pneumonia.

Medicare attempts to measure quality but does not effectively measure medical decision-making, they key driver for quality. Secondary preventive care is measured, which is an administrative process.

Medicare does not use a prior authorization process but may decline to pay a claim for a service discovered to be medically unnecessary, or recover overpayments 1-2 years later.

Large scale fraud happens more frequently when the beneficiary pays no copayment, especially dual eligible patients. When large scale fraud is discovered and fraudsters prosecuted, Medicare does not routinely analyze the **root cause** of its overpayments in order to improve its program integrity.

Institutions purported to offer high quality have settled with law enforcement for abusing Medicare.

Traditional Medicare enrolls all qualified providers, even those who provide low quality care, so long as the Medical Board of California does not object.

Traditional Medicare pays for quality of medical decision-making: the lower its quality, the more Medicare pays, so long as the beneficiary lives. CMS attempts to change this situation, with limited results.

Gerald Rogan, MD
Rogan Consulting

CMS, like the Committee, share a similar vision, but implemented without “single payer”. CMS is not advocating for a unified source of revenue. It contracts with several companies to pay its claims and offers fee-for-service and managed care options. In order to achieve its vision, California State Government must not disrupt those who are happy with their medical care insurance plans, attempt to change payment to fee-for service, eliminate copayments or deductibles, or attempt to declare for-profit insurers illegal. The basic postulate some Committee members have promulgated: that for-profit medical care insurance companies are the “bad guys” is unproven. The postulate does not justify disrupting the lives of the 93% of Californian’s for whom medical care financing works reasonably well. **Incremental changes** to improve our current variety of options is the correct path forward. I recommend the State not waste its time with additional deliberations regarding “single payer”. Instead focus on more practical options.

One incremental change I recommend to the California Nurses Association is to focus on creating internships for new nurse graduates, so that our graduates need not relocate out of our state to find initial employment.

CMS sent me this statement today.

*Please join the Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, and her leadership team, who will provide updates on the CMS Strategic Vision and key accomplishments during the first quarter of 2022. The Administrator’s vision is for CMS to serve the public as a trusted partner and steward dedicated to **advancing health equity, expanding coverage, and improving health outcomes** as we engage the communities we serve throughout the policymaking and implementation process. We invite you to join us for this third national stakeholder call to learn more about how **you can partner with us** as we implement our vision.*

Gerald Rogan, MD
Rogan Consulting

It is inappropriate to extract funds from Medicare and commercial plans in order to subsidize Medi-Cal through a single payer/single source of funding plan.

This data from California Health Cares shows 33 of 841 physicians have selected private solo practice: 3.9%. This data is consistent with a conclusion that current Medi-Cal reimbursement, delivered through managed care plans, is insufficient to support the financial requirements of a physician in private solo practice.

Gerald Rogan, MD
Rogan Consulting

April 26, 2022

My comments assume that all federal and state healthcare subsidies; Medicare, Medi-Cal and Medicaid remain unchanged with no requirement to apply for waivers.

INFRASTRUCTURE

According to the August 2020 environmental analysis, the purpose of the Commission is to establish an entity by which health care payments could be reviewed, regulated, and established. Additionally, to develop information technology and tools for a master patient index and a master provider index, a health data exchange.

FRAGMENTED FINANCING

Commissioners Sara Flocks and Anthony Wright agree that the current system is fundamentally broken and unsustainable in its' present form. 2022 healthcare expenditures are estimated to be \$517 billion with an additional \$158 billion by 2031. Expenditures include insurance premiums, costs for diagnosis and treatment, outpatient services, surgeries, and prescription drugs. Capitation and fee for services are the predominant methods of controlling healthcare costs, both of which account for the half trillion-dollar unsustainable system that is pervasive throughout the United States.

COST CONTROLS

The April 2022 final report states, "cost controls must be put in place on insurance companies and other system players that many believe contribute to affordability issues due to their priority for increasing profits." Standardization of healthcare costs is the single most important factor for implementation of a single payer unified financing system. Cost standardization is utilized in other countries for surgeries, work force salaries, outpatient services and prescription drugs. England, for example, pays physicians \$200,000 annually for their services. A "global budget" must be established for healthcare services in the United States.

UNIFIED FINANCING

A method for providing quality healthcare as an entitlement for all California residents and their families can be accomplished by implementation of a unified financing system funded by the creation of new revenue streams. Employer provided and private insurance can remain in place for those who want to keep it. Medicare and Medi-Cal can also remain in place. The ACA and Covered California have proven to be successful and should remain unchanged for those who want to keep their coverage.

The new revenue streams can be voted on by ballot measure. Two of the most significant for voter consideration are a payroll healthcare tax, and a corporate wealth tax. It would be up to the body politic and state legislatures to establish the details for implementation.

ELIGIBILITY

All California residents, regardless of immigration status or income level would be eligible by voluntary sign-ups.

BACKGROUND

In the late 1960's and early 1970's I worked as an organizer for a Teamsters Union and Kaiser Family Foundation project in California. The project employed a full staff of physicians and nurses who traveled throughout the state on three mobile medical units to fruit and vegetable canneries. A complete diagnostic exam was given to the cannery workers with results sent to each employee's private physician within two weeks of the exam for further diagnosis and treatment. Between 250 and 500 people a day took the voluntary multiphasic exam. The project was funded by a one cent per hour payroll deduction.

According to the Bureau of Labor Statistics, sixty percent of the U.S. population are employed. In California, utilizing the same statistic, 24 million out of our population of 40 million are employed. If a \$.25 cent per hour payroll healthcare tax was approved by voters, \$6 million per hour would accrue into the state treasury. Based upon a 40 hour work week, \$48 million per week, or \$192 million per month would accrue into the state treasury. More than enough to cover surgeries, outpatient services, preventive care including behavioral and psychiatric care including drug addiction and prescription drugs with standardized costs. Direct payments to providers would provide accountability and protection against waste fraud and abuse.

IMPLEMENTATION

The question foremost in the minds of commissioners is, what are the next steps toward implementation of a unified financing system in California? How can the federal government participate? I believe the next steps should be the drafting of a ballot measure for inclusion on the ballot of the November 2022 general election. If implemented, the federal government can consider California's unified financing system as a template for the other 49 states, in particular the states with fewer populations in need of healthcare subsidies.

CONCLUSION

Covered California is the perfect organization for implementation of a unified financing system in California. I am willing to relocate to Sacramento either in a staff position, or on a

consulting basis to, 1. draft a ballot measure for inclusion on the November 2022 ballot. 2. Work on standardization of healthcare costs which would be included in the text of the ballot measure and 3. work with the state legislature to ensure compliance with all state laws regarding taxes.

Thank you for your interest and consideration. I look forward to a timely response.

Craig Simmons

Dear Commissioners:

I've attended most of the public meetings of the Healthy California for All Commission Public meetings with great interest. While the Commission explored many worthwhile topics and the final report has some good aspects, overall the report falls short.

The report does confirm what many of us already know – that a single payer healthcare system will save California billions of dollars while providing more benefits and covering everyone.

However, the report buries the benefits of single payer and fails to describe action steps to achieve such a system in California.

First of all, the report fails to clearly describe the benefits that a single payer system has over a fragmented system with health plans. The use of the umbrella term “unified financing” wrongly conflates single payer with a health plan intermediary option. Including two very different, not comparable systems (single payer and a fragmented system with intermediaries) under the umbrella of unified financing is misleading.

The lives and dollars saved through single payer should not be attributed to a system that includes health plan intermediaries. It's buried in the footnotes that a single payer system would save billions of dollars MORE each year than a fragmented system that has a role for health plan intermediaries.

Also, an intermediary option, particularly one that includes health plans, is NOT “unified financing.” By definition, a system cannot be called unified financing if there is room for multiple middlemen to manage health care dollars. Middlemen do not add any sort of value to our health care system: they do not increase access or quality, nor do they make care more affordable. They create more administrative bloat, waste, and barriers to care.

With single payer, we can provide comprehensive care to all Californians while saving money by eliminating this administrative waste.

Finally, in this report, the Commission does not live up to its mission of presenting clear and concrete actions the state can take to achieve a single payer system in California. The Commission was tasked with developing “a plan that includes options for advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians.”

The Commission's final report contains no clear recommendations to the legislature, nor does it recognize that legislation is a key step on the path to single payer. As the Commission has heard several times, the first step in moving to a system of unified financing is to pass a policy bill. Everything else follows. Federal waivers follow. Financing plans follow. The Commission should have more clearly highlighted this in the final report.

I urge the Commission to revise its final report to more clearly highlight the benefits of a single payer health care system – and outline clear steps that can be taken to achieve that for all Californians.

Isabel Storey
Indivisible California
Lead, Healthcare & Reproductive Rights Workgroup

Thank you to the Commissioners, consultants, and staff for their dedication and contribution of their time and effort. Hopefully, the Commission's final report will result in timely action by the Governor and the Legislature.

Here are my remarks on the Commission's final report, "Key Design Considerations for a Unified Health Care Financing System in California." If you wish to follow up with me I can be reached at the email address and cell phone number below.

1. **Revenue sources.** The "Road Map to Golden State Care" of the California Physicians Alliance (CaPA) has a greater diversity of revenue sources for the unified system. I recommend that Commissioners, the Governor and his relevant staff, and legislators and key staff look closely at the Road Map.
1. **Trust Fund.** Page 62 of the Commission's final report states that a "special fund" could be created as a workaround for Propositions 98 and 2. That is too weak a measure and a more robust solution is required. A trust fund must be created. This concept was first proposed in 2019 in the original version of the CaPA Road Map and which was even adopted by the authors of AB 1400. A trust fund would protect health care funding for the unified system from being used for other budget priorities. A trust fund would also protect health care financing from the annual state budget and from political battles accompanying the annual budget process. The federal Social Security Trust Fund was created for just this purpose. States already use trust funds for other purposes so there is precedent. Instead of a tax the contributions by individuals, families, and businesses would be called a "public premium" (not a tax) that would replace private premiums and other out of pocket payments. Like FICA, this "public premium" would appear on every paycheck and annual tax form. It would also make everyone aware of exactly how much they pay for their health care.
1. **One risk pool.** This should be a key lens through which the process to unified financing is viewed. The larger the risk pool, the lower the cost. The largest risk pool yields the lowest cost – a nation or at least a very large state like California. There should be a clear and well-defined process for steadily merging risk pools by shrinking down the myriad risk pools that exist until one risk pool is reached. Social solidarity and cohesion would increase with one risk pool. Multiple risk pools in a zero-sum competition with each other can be exploited by those with an interest in keeping people divided.

1. **Capitation, Health Plans, and Managed Decline.** I strongly support moving away from fee-for-service and towards capitation and centering a unified system of financing on non-profit integrated delivery systems and health plans. Dr. Scheffler has eloquently stated the evidence-basis for both points. There is no reliable evidence basis for grounding a unified system on fee-for-service. Some reimbursement exceptions might be permitted but this would be rare. Value-based instead of volume-based reimbursement would also be far more effective on a platform of a unified financing that is not oriented towards profiteering. Over time there must be a “managed decline” of private health insurance financing like the managed decline of reliance on fossil fuels.
1. **Commercial Determinants of Health (CDOH).** Much has been written about the importance of the social determinants of health (SDOH) but it is time to address CDOH as well. Several excellent recent articles have appeared in the American Journal of Public Health, the British Medical Journal, and other sources on CDOH. CDOH directly impact SDOH. We cannot achieve equity, affordability, high quality, accessibility, and universality without strong and effective regulation of CDOH. The Commission’s final report should have addressed CDOH.
1. **The Growing Danger of Mergers & Acquisitions (M&A) and Private Equity (PE).** The Commission’s final report does not address the growing and corrosive impact of corporate control of the healthcare system and those who work in it. Commissioner Richard Scheffler has done much work to demonstrate this negative impact on this as have others. Organized medicine and others are also sounding the alarm. More than 75% of US physicians now work for corporate entities or hospital systems. There has been a resulting erosion of physician autonomy in clinical decision-making and a degradation of labor for all who work in health care. PE is the major player in this process. PE ownership has had a detrimental impact on the quality and cost of health care. And it has been responsible for the closure of rural hospitals nationwide and for the layoff of thousands of health care workers before and during the pandemic. PE and M&A are virtually unregulated. California must address this threat with strong regulation. Commissioner and Assemblymember Jim Wood apparently is taking some steps in this direction. Rapid and effective government action is needed before it is too late. It may already be too late.

1. **Stepwise approach.** The Commission's final report did not outline a stepwise process of how precisely California will get to unified financing. Some Commissioners pointed this out (Anthony Wright, Richard, Scheffler, Bob Ross). As the future of the Commission's final report is considered, there should be attention focused on just such a pathway. There should be clearly defined phases, a focus on key strategic policy areas, and needed legislative and non-legislative (system) changes for each strategic policy area and for each phase. The CaPA Road Map proposes one approach. It was written to provide guidance and ideas for just a situation like the Commission.

Again, I am grateful for the work of the Commission. This has been a monumental and historic process and product. I support the final report with the added suggestions above.

Respectfully submitted,
Stephen F. Tarzynski MD MPH FAAP
President
California Physicians Alliance



Transmittal via email to: HealthyCAforAll@chhs.ca.gov

Dear Secretary Ghaly:

On behalf of the board and staff of The California Endowment (TCE), thank you for your skilled and respected leadership of the Healthy California for All Commission. I was pleased to serve as a Commissioner and appreciate the thoughtfulness of the Commission's deliberations.

As a health foundation, TCE is committed to our mutual goals of transforming our health system into one that is accessible, affordable, equitable, high quality, and universal. We recently completed an intensive stakeholder process to create a framework for our health system [social bond](#), to **transform our health system** and support the movement for health and racial justice in California. Three key areas that align with the goals of the Commission include:

- **Health for all reforms** - establishing a statewide grassroots network dedicated to universal health coverage and health systems reform, crafting messages/narratives that are carried by trusted sources, and helping people to understand and insist on shifting the incentives toward prevention and health equity;
- **Health workforce** - supporting a local/regional health infrastructure that can plan for geographic-specific “grow our own” workforce needs, leverage state dollars, and explore new ways to support people who will not qualify for state investments, such as traditional healers and social justice advocates. We will also support a public-private health workforce policy entity to advocate for state policy changes that will strengthen and diversify California's workforce; and
- **A system of prevention that places communities at the center of public health and broadens the overall health system** - support for collaborative, community-rooted power-building and policy advocacy efforts, strengthening public health institutions and community partnerships for health and wellness, and identifying long-term and durable financing streams for prevention and health equity.

As you share the report with the Governor, we envision the following as important action steps the State can lead on (in partnership with philanthropy), to keep the momentum of a transformed health system moving forward:

1. Stakeholder, consumer, business, labor, and community participation. With the support of fellow foundation colleagues at the California Health Care Foundation and the California Community Foundation, we successfully infused grassroots and community voices into the Commission process. We should maintain and enhance this participation as we move towards implementation.
2. Further expand coverage to get to 100%, “For All” coverage – by whatever means necessary.

3. Put together an “A-Team” of high caliber consultants, as needed, to get to work on the necessary groundwork for a federal waiver submission to advance a Unified Financing mechanism. As I mentioned during the final Commission meeting, it is my hope that aligning the potential purchasing and contractual power of Medi-Cal, Covered California, and Cal PERS might be considered as a parallel step.
4. Assemble a public-private implementation effort on the health workforce pipeline that leverages the state’s investments in health workforce.
5. Build upon and expand the terrific efforts to modernize the Medi-Cal program, addressing the social drivers of health, and advancing health equity.
6. Resource the Office of Health Care Affordability so that it emerges as a meaningful force for consumers to control costs, in synergy with Unified Financing.
7. Assure accountability in the pursuit of racial equity and health equity in our system by investing in a much-improved data platform with robust integration.

As I noted in my letter submitted for Appendix E of the report, time is of the essence and I remain hopeful that the good work of the Commission will move forward with expediency. TCE looks forward to collaborating on our mutual interests to improve health for *all* Californians.

Warmly,

A handwritten signature in black ink, appearing to read "Robert K. Ross".

Robert K. Ross, MD
President and CEO
The California Endowment

From: Francesca Wander

Sent: Monday, April 25, 2022 1:00 PM

To: HealthyCAforAll@chhs.ca.gov <HealthyCAforAll@chhs.ca.gov>

Subject: Comments on Key Design Consideration Report

I am a member of CAStateStrong Indivisible and a voting constituent in CA Senate District 06, Richard Pan, who is NO friend of healthcare for all and who has fortunately been termed out of office.

I have countless stories I can share with this committee about the horrors of our for-profit, corporate-driven "health care" system, but the one of which you should all be most ashamed is that which just happened to my good friend.

After contributing to her community and paying taxes for 19 years as a high school science teacher and as a single mother with a 10-year-old daughter with Type I diabetes, my friend was forced to quit her job three years ago, at the age of 46, to take care of her 86-year-old mother who suffers from dementia. Over the past three years, she has depleted her meager retirement savings (on which she had to pay a 20% early withdrawal penalty) while she provides full-time care for her mother, who relies on her for her every need, including daily bathing, clothing, and feeding, because **NO ASSISTANCE IS AVAILABLE FOR IN HOME HEALTH CARE.**

To add insult to injury, she was recently evicted from her home of seven years, so the property owner could sell it, at which point she spent the next 30 days desperately looking for health care facilities for her mother, because she clearly couldn't take care of her mother and child if they were all homeless! Not a single facility would take her mother, because she was on MediCal/Medi Care; they would **ONLY** accept patients who were covered by costly and profitable private insurance! The **ONLY** solution that was offered to her by the countless public agencies she contacted was to literally **ABANDON** her own mother at the emergency room of a hospital, in which case the hospital would be forced to find a bed for her somewhere in California. The first bed to become available was located in a facility down in Anaheim. So, in the dead of night, her mother was herded into the back of an ambulance and shipped off to Anaheim, hundreds of miles from her daughter, where her daughter can't even check in on her to make sure she is being well cared for. As the daughter, myself, of a father who was literally murdered as a result of negligent nursing home care, I have very little hope for how this story will end.

As my friend told me this story, I thought I was listening to something that would happen in a third-world nation - not in the 5th largest economy in the wealthiest nation in the world! The fact that this committee has been having the same discussion about healthcare for the past decade is clear evidence that its members care far more about the vested corporate interests that line its pockets during campaign season - and I include Dr. Richard Pan in this - than in the health, safety, and well-being of the 40 million Californians you are all sworn to protect and represent! The fact that we couldn't even get a floor vote on **AB1400** this past February is

further evidence of that complete disregard. Every single one of our State legislators on up to the Governor should be **ASHAMED** of themselves. I certainly am. Instead of spending half of this meeting patting yourselves on the back for a job well done, how about if you actually make healthcare for all a reality.

Francesca Wander

CA State Strong Indivisible, Indivisible San Francisco, Indivisible Sacramento, Indivisible Yolo

Thank you to the Commission for the work over the last two years, and for the final report. I want to commend the community voices section in particular - thank you for highlighting the fact that Californians want single payer, and we all feel the urgency of ending the profit-driven health care system NOW.

I have shared my story, and that of my son Arthur's, with the commission before. He died as an infant in 2020, and dealing with our fragmented, predatory, expensive private system has been as traumatizing as my son's death. My story of medical trauma at the hands of private insurance is one of millions. My story can and does happen to anyone. Our public deserves so much better. Our public deserves lives free from middle men, third parties, and insurance board rooms denying us healthcare and profiting off our pain. We need single payer.

The Commission's final report contains no clear recommendations to the legislature, nor does it recognize that legislation is a key step on the path to single payer. The first step in moving to a system of unified financing is to pass a policy bill. Everything else follows, including federal waivers and financing plans. The Commission should have more clearly highlighted this in the final report.

Thank you for your time.

Kayla Westergard-Dobson