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A Voice for Nurses. A Vision for Healthcare.

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June 19, 2020

Andrew Bindman, MD
Consulting Team Lead
Attn: Mark Ghaly, Chair
Healthy California for All Commission

RE: Commissioner Comments on Consulting Team Draft First Report for the Healthy California for All Commission

Dear Chairman Ghaly, Dr. Bindman, and consulting team members,

Please find my comments below on the draft of the first Healthy California for All Commission report that was sent to Commissioners on June 3, 2020. In my work as Regulatory Policy Specialist at the California Nurses Association, I have researched, written, and drafted numerous analyses and briefs on issues related to single-payer health care programs that are discussed and examined in the draft report, and I would be happy to share these with the consulting team and the other Commissioners.

Sincerely,

Carmen Comsti, Commissioner
Healthy California for All Commission

I. Procedural Comments

At the outset, I would like to address broader issues on the process by which the report draft has been developed. The process by which the consulting team determined to interview Commissioners individually, in lieu of holding more Commission meetings and establishing advisory committees as permitted by statute, has made it difficult—if not virtually impossible—for the Commission to discuss the important policy issues to be addressed in the report. Moreover, the sheer lack of the public's ability to comment in writing or to otherwise provide input to the Commission is troubling. Additionally, I want to flag that the version of the draft report for which I am providing comment today is the document sent to Commissioners from the consulting team on June 3, 2020. I have noticed, however, that the June 3 draft appears to be different than the draft posted publicly on the Commission's website on June 11, 2020.

A. Further Public Comment and Input are Necessary

First, I believe that there should be transparency in the development of the report as well as more opportunity for public input to the Commission generally and on the draft report. Transparency and public accountability for the work of the Commission and the consulting team, which the California Health and Human Services Agency has contracted to write the Commission's reports, is critically important for a topic that will impact the health and the lives of every Californian.

I call on the consulting team to more clearly and publicly explain, to both Commissioners and the public at large, its process for researching, developing, and drafting the Commission's report. As discussed in the consulting team's interview with me, I expected that the Commission would be able to establish advisory committees to openly and transparently delve deeper into the questions posed to the Commission by statute. I also expected that advisory committees would have experts among the Commissioners, and outside of the Commission as necessary, participate in advisory committees and include members of the public generally.

To this end, the Commission should do the following to engage with the people of California:

- Hold more Commission meetings and hold them more frequently with meaningful time for oral public comment.
- Establish statutory advisory committees subject to open meetings law.
- Ensure that advisory committees include substantive public participation that reflects the diversity of California.
- Create a mechanism on the Commission webpage for the public to submit written comment on the draft report and future reports.
- Make public comment accessible to Commissioners.

B. Additional Meetings, Discussion, and Comment Among Commissioners Needed

The consulting team's interview process was insufficient to meet the Commission's most basic needs to discuss and share views and expertise among Commissioners. I am sure that the brief and truncated summary of the interviews during the June 12 meeting did not do justice to the ideas, questions, and expertise represented among Commission members.

In the development of the statutorily required reports and in the Commission's work overall, I believe that we need more discussion among Commissioners so that we can (1) share our respective expertise with each other, (2) understand where there is disagreement among Commissioners, and (3) identify areas of expertise that Commissioners may not have. To this end, I urge Chairman Ghaly to schedule additional Commission meetings beyond the statutory minimum of quarterly meetings and to hold such meetings more frequently. Additionally, Commissioner comments on the written draft should also be circulated among Commissioners.

C. Recognition of Commissioner Disagreement

The last procedural issue around development of the Commission's report that I want to raise here is the anticipated disagreement among Commissioners on analysis and recommendations that the consulting team has made in the report. I have several areas of disagreement with both the consulting team's recommendations in the draft report as well as the consulting team's discussion, analysis, and overall characterization of issues within the report. I believe two actions are necessary with respect to such disagreements: (1) the consulting team must specifically recognize within the narrative of the report where Commissioners disagree and (2) given that the consulting team has been tasked to write the Commission's report, the Commissioners should be allowed to issue dissenting comments which should be included as attachments to the report.

II. General Comments on the Draft Report

I believe that the draft report, for the most part, takes the Commission in the opposite direction that is needed to provide health care to all Californians in the most expedient, effective, and financially prudent manner. As the draft report itself acknowledges, it is not health care utilization that is the main driver of outsized health care costs in our current health care system but prices, high administrative costs, and high market concentration inherent in our massively complex multi-payer system. The COVID-19 pandemic has shown us that we must take what the consulting team described at our June meeting as the "big leap" to a single-payer health care system immediately. Thus, any preparatory steps that we take should be the necessary steps that would lead us to the "big leap."

The draft report, however, mischaracterizes continued piecemeal reforms of private insurance plans, as well as other small steps to create the appearance of uniformity across

disparate programs, as bold or necessary steps to reach a unified financing health care system. Much of the consulting team's recommended "preparatory steps" were thinly sketched and, at times, difficult to decipher. But this is not the time to be imprecise. In my interpretation of the draft, many of the measures outlined—including uniformity in insurance plan networks, uniformity in reporting, and adoption of risk-based reimbursement schemes—are unnecessary to reaching a unified financing system and would not bring us closer to achieving a unified financing system (unless one makes assumptions about the design of said system).

However, I do agree with some of the options briefly mentioned in the report as steps that the legislature and the Governor can and should be taking. These steps should be discussed in greater detail in the report and among the Commissioners in dialogue with the public. Specifically, I agree that the following steps would bring the state closer to a single-payer health care system.

First, the legislature and the Governor can and should pass legislation to establish a state single-payer program. The Commission, as suggested in Section 2, can assist in identifying the design elements of such a single-payer program. In addition, the Commission should be helping the state draft legislation and federal waiver applications rather than talking about alternative steps that fall far short of single payer. As a model, the Commission could use H.R. 1384, the Medicare for All Act of 2019, which was introduced in the U.S. House of Representatives this Congressional session.

Relatedly, the Commission can and should help identify both potential sources of federal funds and non-federal funds. To be clear, my mention of non-federal revenue sources here does not mean that California would, as other Commissioners have described, "go it alone" with respect to funding. Indeed, identifying additional sources of revenue would be a prudent step for the state to take. I discuss the issue of financing in more detail below.

Second, California can and should apply for federal waivers, both to secure federal health care dollars and unify federal programs within a state single-payer program. The Commission could and should spend its energy helping the legislature and the Governor navigate the complex—although not unnavigable—nature of the Medicare, Medicaid, and Affordable Care Act waiver options. As I mentioned at a previous Commission meeting, I know that Commissioner Hsiao has written on the topic of federal waiver options for his work in Vermont on a state single-payer program. I also have written analyses that I would be happy to share with the consulting team and other Commissioners.

These two steps—passing state legislation and applying for federal waivers—are the biggest preparatory steps that California can and should be taking to transition to a single-payer health care system.

A. Lessons from the Pandemic

As I said in my comments at the June 12 meeting, the COVID-19 pandemic should be a wake-up call that we must make the "big leap" to a single-payer health care system now. Again, the pandemic has reinforced what we already know—that private health insurance forces millions to live on a health care precipice. We know that our multi-payer system creates a situation in which, at any moment, a working family could experience a financial or job loss that causes them to lose their health coverage or makes health care coverage even more unaffordable.

The Commission can and should ensure that California takes immediate steps to provide guaranteed universal health care under a single-payer system and to take private insurance out of health care. Further regulation and reform of private health insurance is a distraction from these important goals.

i. Millions lost their employment-based health insurance.

A clear lesson from the pandemic is that health care should not be linked to employment. With the COVID-19 pandemic, this loss of health care just happened to countless working families in California in one fell swoop. Millions of Californians and their dependents have just lost their employment-based health insurance. Coverage under COBRA is likely to be unaffordable for an overwhelming majority of those suddenly unemployed. COBRA coverage, even for the few who may have the finances to afford full COBRA premiums, is only temporary. Even those who may be able to afford a new private insurance plan or those who may be eligible for Covered California subsidies will be subject to disruptions in care and changes to their doctors.

Millions of others who may still have employment-based coverage have lost income in the past few months and may not be able to afford out-of-pocket health costs. Out-of-pocket private health insurance costs, including copayments, coinsurance, and deductibles, continue to make private health insurance unaffordable for millions, and, for working families who have lost income loss during the pandemic, these financial barriers have increased.

ii. Means-tested public programs create an unreliable safety net.

The pandemic has also underscored the injustice and unnecessary complexity that results from means-tested public health programs. Many Californians who have lost their employment-based coverage may not be eligible for Medi-Cal and many may not be able to afford a Covered California plan. When we have multiple health programs like Medi-Cal and Covered California that are means-tested, this creates discontinuity in people's health care as they attempt to navigate the complex eligibility processes for multiple programs while dealing not only with a pandemic but also financial loss and upheaval in their lives and livelihoods.

iii. The profit-driven, multi-payer system is incapable of allocating health care resources based on need.

Additionally, COVID-19 has shown that our fragmented system is unable to allocate resources based on need. Under a single-payer system, we would have had the reliable funding for supplies and equipment needed to respond to the pandemic. Nurses and other health care workers would not have died unnecessarily because of health corporations' reliance on a "just-in-time" supply model, which failed to get them the necessary personal protective equipment (PPE) that would have kept them and their patients safe. With a single-payer health care system, we could have more equitably addressed the pandemic and avoided the disproportionate deaths and infections in Black, Latino, and Native American communities. We could have ensured that testing and treatment was both accessible and free in all communities. We would have known where medical and PPE supplies were located and where testing and treatment were available.

iv. Industry profiteering, not payment models, caused the decrease in the volume of health care services.

The consulting team makes a repeated point regarding lost provider revenue in their discussion of the pandemic that I take issue with, and I urge the consulting team to delete this assertion from its analysis of the pandemic. The draft report claims repeatedly that revenue shortfalls for providers during the pandemic are a function of a "volume based" or fee-for-service model. This assertion is entirely unfounded. (I discuss the problems with value-based payments further below.) The consulting team ignores why people may not be receiving services during the pandemic in the first place. Nonemergent and outpatient procedures were halted because these services could not be provided in a manner that is safe for both workers and patient. This not a function of the payment model. Put simply, hospitals and other health industry employers are not giving nurses and other health care workers the PPE necessary to provide such services safely for themselves and in a manner that would not further hasten the spread on COVID-19. Appallingly, some of the services that currently are reopening still do not have sufficient PPE on hand to protect health care workers and patients. The consulting team implies that hospitals and other providers should continue to generate revenue despite the fact that they are providing fewer services and less care and despite the fact that they are failing to take measures to protect workers and patients from COVID-19. Indeed, providers that are reimbursed on a capitated basis may be seeing massive revenue increases even though they are providing little care except in their emergency rooms and for COVID-19 patients. Some health care providers are receiving emergency financial support from federal, state, and local governments even as they reduce services, furlough health care workers, and permanently eliminate health care services.

One could argue that health providers need continued revenue during the pandemic despite the lower volume of services in order to more adequately address the immediate issues of the pandemic. However, without a single-payer system, there is little accountability as to how these providers are spending their revenue during the pandemic. We know that many providers have received financial support from the federal stimulus package, with no conditions, but have

not used this support to provide additional protections for nurses, other health care workers, or patients. Yet, nurses and other health care workers have been making the same pleas for PPE and other protective measures since February.

v. Existing health care safety nets may be financially unstable without the savings that would be captured under a single-payer system.

With the number of people who now need public health care programs, it makes much more financial sense to transition to a single-payer health care system as expediently as possible so that we can capture the massive savings that are not achievable under expanded health insurance subsidies and reforms that leave private health insurance intact. Streamlining all public programs into a single-payer system would mean that we would save on significantly reduced administrative costs; eliminating insurer marketing costs, shareholder dividends, and profits; negotiating reasonable provider payments; and purchasing pharmaceuticals in bulk. These changes would leave more money to spend on care. As massive numbers of people who lost employment-based coverage move on to existing public programs, the multi-payer insurance system will be financially untenable. Small-bore insurance reform measures fail to capture the savings that a single-payer system would produce.

B. Continued insurance reform does not bring us closer to a unified financing system.

I believe that the draft report mischaracterizes several measures in Section 2 as "bold preparatory steps" towards unified financing. Many of the suggested "bold preparatory steps" to unified financing in Section 2 are a continuation of private insurance reform efforts and are not steps that would bring California closer to unified financing. Indeed, some of these suggested measures may ultimately detract from the work and financing that is necessary for a unified financing system. The consulting team recommends actions such as creating uniform contracting plans and uniform provider networks presumably among private insurance plans under Covered California, Medi-Cal managed care, and CalPERS. These private plans within public programs or publicly managed programs are a huge source of complication within our current fractured health care financing system. Further regulation of these plans does not move us closer to unified financing. I provide more specific comment below.

C. State budget priorities must be reevaluated and additional revenue sources for health care identified.

Section 2 should discuss how the legislature and the Governor should be (1) reexamining state budget priorities and (2) identifying additional revenue sources for a unified financing system.

On the first point, Californians, including our elected officials, are seriously reevaluating our state's budget priorities. With protests across California and the country against police violence, we should take this opportunity to prioritize funding for health care for all and redirecting funds from policing and incarceration. Additionally, we can and should also be examining our state budget to increase state health care dollars. To increase state health care dollars, we could:

- Redirect funds from policing and incarceration into health care
- Redirect corporate tax subsidies into health care
- End health provider tax breaks for community benefits and redirect those funds and other charity care funds into a single-payer system

We should also begin to identify new potential revenue sources such as:

- Corporate taxes
- Gross receipts taxes
- Wealth taxes
- Progressive payroll taxes
- Non-profit provider fees (transfer of money that currently goes to charity care as it will no longer be required)

Of course, the suggestions above are non-exhaustive and many other revenue sources may exist. To confine ourselves to existing health care revenue sources, as the draft report does, is unnecessarily limiting. The Commission, with its range of expertise and perspectives, should engage in this kind of creative and bold thinking that could assist the legislature and the Governor in identifying these potential other sources of financing that could supplement existing state and federal health care dollars. I discuss this more below.

D. The presumption that so-called "value-based payments" can and should be used in a unified financing system is misguided and problematic.

Finally, before I delve into specific comments on the draft report, I want to raise my deep concerns about the presumptive discussions that the consulting team has included throughout the report on so-called "value-based payments", which I will call risk-based payments here.

Such risk-based payments, which are not explained in the report, attempt to shift at least some insurance risk to doctors and hospitals, thereby making them quasi-insurers. These risk-based payments typically reward providers based on their ability to reduce costs while meeting performance metrics. These metrics are supposed to provide quality guardrails against the incentive to reduce costs by reducing care. Yet, evaluating provider care through a limited set of population-based metrics is insufficient to ensure that <u>all</u> patients are receiving quality care based on their individual needs and wishes.

Large health care providers also readily game these measures. As discussed in greater detail below, these kinds of payments incentivize doctors and hospitals to cherry-pick the healthiest patients and to avoid those who are most vulnerable or costly. In other words, risk-based payment systems ask doctors and hospitals to focus on the risk to their pocketbook when they provide patient care.

I can certainly provide a more detailed analysis of, and citations to, research on the issues around risk-based payments. In brief, I outline below my primary concerns with risk-based payment models. Many of these issues overlap and feed into one another. Specifically, risk-based payment models do the following:

- Undermine the doctor-patient relationship. By treating doctors as strictly self-interested economic actors that operate on financial risk rather than healers, risk-based payments undermine the doctor-patient relationship.
    - Turn doctors and providers into insurers. Risk-based payments shift the financial risk of providing care, an insurance function, to providers.
    - Create incentives to cherry-pick healthy patients and avoid the sickest. To meet so-called "quality" metrics, risk-based payments incentivize doctors and providers to cherry-pick the healthiest patients and to avoid the sickest. Using risk adjustment to counter these incentives makes health care financing more complicated and while remaining easily gamed.
    - Inappropriately incentivize restricting utilization.
    - Encourage "teaching to the test" rather than making care decisions based on an individual patient's needs and wishes. Again, to meet so-called "quality" metrics based on limited sets of population-based outcome measures, risk-based payments incentivize doctors to view patients not as individuals with particularly health care needs but as data points in population-based statistics that could reduce or increase reimbursement rates.
    - Utilize proprietary algorithms that make it impossible for the doctor or other clinician to access and evaluate the reasoning behind actions (such as grouping patients into various categories) or recommendations.

- Lead to greater market consolidation in health care. Risk-based payment models incentivize and hasten health provider consolidation and concentration, including both vertical and horizontal mergers, acquisitions of health providers, and physician alignment with corporate hospitals (i.e., the corporate practice of medicine).
    - Risk-based payment models are administratively complex, burdensome, and expensive. Large health corporations have more resources, including time and money, to meet the administratively complex and burdensome reporting requirements of risk-based payments.

  - Large health care providers can game the system with complex algorithms and technology. Large health corporations have more resources, including time and money, to purchase technology and hire the analysts needed to ensure that they meet "performance" and "quality" measures necessary to secure bonuses and avoid penalties in risk-based payment models.

- Corporatize the practice of medicine. Smaller practices cannot readily implement the complicated metrics required in risk-based payment models. Doctors are encouraged to engage in a dashboard population-based health approach rather than focusing on the doctor-patient relationship.

- Shift care inappropriately to lower cost care settings. Risk-based payments encourage doctors to push patients into less regulated health care settings inappropriately, which often cost less because they use less-skilled health care staff and/or are not required to have the medical resources on site to provide emergency care or other services. This is particularly true with the risk-based payments that are based on vertical integration of providers (i.e., where payments and penalties are shared among different kinds of care providers).

- Exacerbate health care disparities and inequities.
  - Safety-net providers with limited resources do not perform as well on metrics and are then penalized. This hurts the providers that serve the most vulnerable populations.
  - Risk-based payments prioritize "teaching to the test" and gaming of metrics over individualized care, which can exacerbate health care disparities.
  - Risk-based payments rely heavily on metrics on outcome and cost efficiency. This hurts providers who start with sicker populations and small practices that may not have capacity to deal with complex algorithms and excessive reporting requirements (i.e. to game the system).
  - Risk-based payment models' reliance on clinical decision-making algorithms can entrench systemic health care inequities, particularly racial bias, in the provision of health care. Two studies, one public just this week, examine the issue of racial bias in clinical decision-making algorithms.[1]
  - Social determinants of health such as racism, inequality, poverty, unemployment, housing/homelessness, access to healthy food, all affect health outcomes but are not readily addressed through value-based provider payments.

[1] See Vyas et al. "Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms." *New Eng. J. of Med.* (Jun. 17, 2020), available at https://www.nejm.org/doi/pdf/10.1056/NEJMms2004740, and Obermeyer et al. "Dissecting racial bias in an algorithm used to manage the health of populations" *Science* (2019) 366(6464): 447-53, available at https://science.sciencemag.org/cgi/doi/10.1126/science.aax2342.

- Fail to create savings as advertised and fragments the risk pool.

- Raise serious racial and other bias concerns. We know from recent studies that there are serious racial bias problems with algorithms that health corporations have purchased and deployed in order to meet the population-based metrics required of risk-based payment schemes.[2]

- Attempt to solve problems that do not exist.
    - Prices and administrative complexity drive outsized health care costs not overutilization.
    - Payment integration across provider types are not necessary to integrating actual care.

Without justification, the draft report implies that fee-for-service payment models must (and will) be replaced by risk-based payments and performance metrics. This assertion by the consulting team relies on the faulty premise that high health care expenditures in the U.S. are caused by fee-for-service payment systems that incentivize volume over value. As noted previously, the draft report itself acknowledges that it is not utilization that is the main driver of outsized health care costs in our current health care system, but prices, high administrative costs, and high market concentration inherent in our massively complex multi-payer system. In sum, risk-based payments are a solution to a problem that largely does not exist—the contention that there is significant provider-induced over utilization.

There are other payment models that the Commission should consider that do not require providers to take on insurance risk, and importantly, there are other ways to hold providers accountable especially in a single-payer system. Other payment models that should be explored in the program design discussions include hospital global budgeting as outlined in H.R. 1384 and physician salaries paid by the single-payer system. Additionally, a single-payer system can have strict accountability measures for billing and conflicts of interest as well as penalties for fraud and abuse to deal with the hospital systems and private equity corporations that regularly game the system and the few clinicians that may be overutilizing the system in order to increase their revenue. In H.R. 1384, for example, checks on provider misbehavior with respect to payments included reporting requirements and comparative measures among providers.

In short, risk-based payments are not necessary for a single-payer or unified financing system. Providing health care should be based on human need not distorted and profit-driven economic incentives.

[2] See note 1.

III. Comments on Section 1 (Pages 7-67)

Draft Report, Section 1, In general:

Comment: Section 1 lays bare the numerous and intractable problems inherent in our multi-payer system including deep racial and ethnic inequities, massive fragmentation, high numbers of uninsured and pervasive underinsurance, and discontinuity of care caused by individuals shifting among different sources of health insurance. I agree with the bulk of the analysis in this section with a few exceptions, discussed below, but find that it falls short on highlighting the necessity of a single-payer system in rectifying them. Although the state faces budget challenges, a single-payer financing system that can bargain for the people of California as a whole would be far better equipped to manage these difficulties than a collection of separate firms or individuals. Given the dramatic upheaval caused by the pandemic, now is the time to make the transition.

Draft Report, "Key Health Indicators", Pages 9:

Comment: The last paragraph on the social determinants of health should be deleted. Other than health-related behaviors, the social determinants of health listed in this subsection—socioeconomic factors (e.g., education or income level) and environmental factors (e.g., air and water quality, transportation or housing)—are best addressed by public programs that target their structural causes rather than by piece-meal payments to health plans, hospitals, or physicians.

Draft Report, "Health Insurance Overview", Page 10-14:

Comment: The report should include a discussion of the increase in the number of Californians who are underinsured in addition to the reduction of the number of uninsured here and/or in the "Remaining Affordability Challenges" section.

Draft Report, "Covered Benefits", Page 17:

Comment: The last paragraph on workers compensation should be deleted. Integrating workers compensation with health care coverage may create a moral hazard on the part of employers such that employers would fail to meet their legal and moral obligations to provide healthy and safe workplaces if occupational injuries were paid for through health care coverage. Integration of workers compensation into health coverage should be addressed with great care to ensure that employers bear the cost of workers injured on the job.

Draft Report, "Who Pays?", Page 19:

Comment: The aggregate dollar amounts for the state and federal Covered California subsidies should be included here.

Draft Report, "Remaining Affordability Challenges", Pages 22-25:

Comment, Pages 22-25: This subsection should include a discussion of the dramatic increase in the number of Californians who are underinsured in addition to the reduction of the number of uninsured here and/or in the "Remaining Affordability Challenges" section.

Comment, Page 23: In the last paragraph, the report should note that excluding premiums from the calculation of underinsurance neglects the impact that out-of-pocket premium payments have on a person's ability to afford health care.

Draft Report, "Synthesis: Demographics and Coverage", Pages 26-27:

Comment, Page 26: In the bolded paragraph, the report should note that underinsurance has increased.

Comment, Page 27: The report should note that single-payer financing is the only way to address the problems mentioned in the last paragraph of this section.

Draft Report, "California's Health Care Delivery System", Page 27:

Comment, Page 27: As part of the discussion in this subsection, the report should consider the role that the current profit-driven health care delivery system plays in the epidemic of burnout, suicide, and moral distress and injury among nurses and doctors. These problems are being exacerbated during the pandemic by the failure of this system to provide nurses, doctors, and other health care workers needed health and safety protections beginning with appropriate PPE.

Draft Report, "Hospitals, Physicians and Clinics", Pages 27-32:

Comment, Pages 27-32: The report should note that our multi-payer system allocates resources based on profitability, but a single-payer system would provide funding based on need. This would ensure that rural and public hospitals have the necessary resources to care for patients in their service areas and would enable adjustments to remedy the disparity in access to physicians by region and source of insurance.

Draft Report, "Health Plans and Insurance Carriers", Pages 33-41:

Comment, Page 33, Figure 15: This figure should note the number of enrollees for each market segment for each insurer in addition to totals.

Comment, Page 34: The first paragraph on this page should be deleted. The discussion of IHA in the draft report makes clear that the IHA data is unreliable. On page 34, the draft report states "IHA's analysis of value does not incorporate measures of patient

experience" and, on page 41 states "While these data can be informative, their value is somewhat limited because reporting is voluntary and does not include Medi-Cal. This introduces the potential for bias in what is reported (higher quality providers are more likely to voluntarily report) and limits the usefulness of the data for monitoring differences across all payers."

Comment, Page 34: In this paragraph on IHA data, the draft attributes HMO use of "more sophisticated care management infrastructure, such as information technology and data systems" as a reason for "better…value". In addition to the problem of HMO's inappropriately curtailing utilization, numerous studies show that the use of information technology and data systems, typically through clinical decision-making algorithms, exacerbate racial inequalities in health care. An article published just this week in the *New England Journal of Medicine* analyzes how a number of these kinds of clinical algorithms produce racial bias through race-adjustment and can amplify race-based health inequities.[3] For this reason and because of IHA's unreliability, this paragraph should be deleted.

Draft Report, "Quality of Health Care", Pages 36-37:

Comment, Pages 36-37: The report should discuss here how the "Let's Get Healthy California" initiative demonstrates that so-called value-based payment models fail to markedly improve quality and may exacerbate racial and ethnic disparities. On the latter issue, see the October 2019 study by Obermeyer et al. on racial bias in health algorithms that were deployed by hospitals under risk-based contracts and derived from past utilization.[4]

Draft Report, "California's Health Care Workforce", Pages 42-46:

Comment, Pages 42-46: The report should discuss the inefficiencies and limited progress possible in our multi-payer system regarding physician number, composition (such as the imbalance of primary care physicians and specialists), and distribution and the ways that a single-payer system could readily address these problems.

Comment, Page 46: The paragraph beginning with "Some health care jobs involve…" should be deleted. Reference to national estimates of potential insurance jobs lost in the adoption of a national single payer program is misplaced in a discussion of a California unified financing health care program. Additionally, a discussion of potential insurance jobs lost should not be discussed without similarly discussing the jobs created by the adoption of a unified financing system. It is notable that Pollin and his colleagues report

[3] Vyas et al. "Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms." *New Eng. J. of Med.* (Jun. 17, 2020), available at https://www.nejm.org/doi/pdf/10.1056/NEJMms2004740.
[4] Obermeyer et al. "Dissecting racial bias in an algorithm used to manage the health of populations" *Science* (2019) 366(6464): 447-53, available at https://science.sciencemag.org/cgi/doi/10.1126/science.aax2342.

on the Medicare for All Act of 2017 also recommend and discuss provisions within that bill and plan options for a "just transition" for displaced workers.

Draft Report, "Provider Consolidation", Pages 46-51:

Comment, Pages 46-50: The report should discuss the role of so-called value-based schemes in vertical integration including how it compels clinicians to leave private practice and seek employment with large organizations that have the necessary infrastructure to support the measurement and reporting requirements, which are often of questionable value, and how this leads to further consolidation of the health care sector and contributes to higher prices.

Comment, Page 50: In the last paragraph, the consulting team refers to "quality improvement" and "care management processes" as if they were unambiguously positive developments. They are not. These issues merit more in-depth discussion and analysis among the Commissioners. I can provide the consulting team with research studies that address these issues.

Comment, Pages 50-51: There are several areas of discussion that are missing from this section.

- This section of the report should discuss how payment integration is not necessary for care integration.
- This section of the report should discuss the problems with capitation including the incentive to limit utilization inappropriately and avoid sicker and more costly patients. Even without adverse selection, fragmented risk pools make it more likely that the population under a provider's care may cost more than the payment received thereby threatening financial solvency. In such cases, the provider may be forced to choose between curtailing needed care or bankruptcy.[5]
- This section of the report should discuss how DMHC fines do not deter the bad actions, including improper denials of care, of managed care plans. These DMHC fines are so minimal that they are comparable to no more than a rounding error in total business expenses. For example, DMHC fines against 12 insurers who were found to have improperly denied care were fined only between $5,000 to $450,000 despite their multi-billion-dollar annual business operations.[6]

Comment, Page 51: The first paragraph on this page should be deleted. The last sentence on this page that refers to the IHA analysis should be deleted. The discussion in the draft

[5] Cox, T. "Legal and Ethical Implications of Health Care Provider Insurance Risk Assumption." *JONA's Healthcare Law, Ethics, and Regulation* (2010) 12(4): 106-16, available at https://journals.lww.com/jonalaw/Abstract/2010/10000/Legal_and_Ethical_Implications_of_Health_Care.5.aspx.

[6] California Department of Managed Health Care. "DMHC Fines 12 Health Plans $1.9 Million for Improperly Denying Care to Enrollees." Press Release (Dec. 18, 2019), available at https://www.dmhc.ca.gov/AbouttheDMHC/Newsroom/December18,2019.aspx.

report makes clear that the IHA data is unreliable. On page 34, the draft report states "IHA's analysis of value does not incorporate measures of patient experience" and, on page 41 states "While these data can be informative, their value is somewhat limited because reporting is voluntary and does not include Medi-Cal. This introduces the potential for bias in what is reported (higher quality providers are more likely to voluntarily report) and limits the usefulness of the data for monitoring differences across all payers."

Draft Report, "Synthesis: California's Health Care Delivery System", Page 52:

Comment: The following sentences should be added to the end of this subsection: "A single-payer system is the only way to eliminate these inequities."

Draft Report, "Comparison of California and U.S. Spending", Page 53:

Comment: In Table 4, public health expenditures should be broken out within the "Private Insurance" and "Other" categories. Breaking out these public health expenditures will avoid downplaying the amount of health care that is currently funded publicly. Also, the Table 4 should include dollar amounts as well as percentages. There may be an issue with some of the Medi-Cal funding figures in this section. I suggest that the consulting team review 2018 data from the Medicaid and CHIP Payment and Access Commission (MACPAC).[7] I can provide more detailed analyses if needed.

Draft Report, "Public Sector Spending on Health Care in California", Pages 55-57:

Comment, Pages 55-57: Again, there may be an issue with some of the Medi-Cal funding figures in this section. I suggest that the consulting team review 2018 data from the MACPAC.[8] I can provide more detailed analyses if needed.

Comment, Pages 56-57: Either Table 6 should be edited or an additional table should be created to provide (1) a comprehensive overview of both state and federal contributions to public spending in California including the amounts mentioned in Page 56, footnotes 2 and 3, and (2) the amounts spent by California as specified in the paragraph at the top of Page 57. The consulting team should retrieve data from Covered California directly for federal premium tax credits rather than using Kaiser State Health Facts. Table 6 should also show both state and federal contributions to public spending in California and include both dollar amounts and percentages.

[7] 2018 MACPAC date is available here https://www.macpac.gov/publication/medicaid-spending-by-state-category-and-source-of-funds/.
[8] 2018 MACPAC date is available here https://www.macpac.gov/publication/medicaid-spending-by-state-category-and-source-of-funds/.

Draft Report, "Why is Health Care So Expensive in the United States?", Page 59:

Comment, Pages 59: The last paragraph in this section should be deleted or the report should provide context that distinguishes between the profits of large insurers and small insurers as well as between large hospital systems, underfunded small hospitals, and public hospitals. Here the report should provide profit information of largest health insurers and hospital systems. Additionally, the figures in this paragraph are incorrect. OSHPD data shows average net income for all California hospitals for 2015 through 2017 to have been $6.2 billion (not $5.3 billion), accounting for 6.2% of hospital revenues (not 5%).[9] Furthermore, OSHPD's 2018 data is available and it shows hospitals received $8.3 billion in net income, amounting for 7.4% of total operating expenses.[10]

Draft Report, "Synthesis: How the Money Flows", Page 65:

Comment: The following sentence should be inserted after the first sentence in the bolded paragraph:

"This system results in reduced access and worse outcomes for Black, Latino, and Native American groups than for the white population in the state."

Draft Report, "How Will a Pandemic Affect California Health Care?", Pages 65-66:

Comment: In general, please see my comments above on lessons from the pandemic.

Comment, Pages 65-66: The paragraph that spans the bottom of Page 65 and the top of Page 66 should be edited as follows:

"Because providers failed to stock a sufficient supply of personal protective equipment for health care workers to provide care safely, Californians were forced to defer non-urgent care~~, providers that rely extensively on fee- for-service payments find themselves on shaky financial footing.~~"

As noted above, the fee-for-service model is not responsible for financial problems that some hospitals and other health industry employers are facing during the pandemic. Rather, financial problems resulted from the failure of health facilities to provide sufficient PPE to health care workers and, thus, health care facilities could not provide health care services safely and in a manner that would not further hasten the spread on COVID-19.

[9] See Office of Statewide Health Planning and Development. "Hospital Annual Financial Data – Selected Data & Pivot Tables." California Health and Human Services Agency, available at https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.
[10] *Ibid*.

Comment, Page 66: I have several line edits for this page.

- The paragraph beginning "Unified financing" should be deleted.
- The following sentences should substitute for the sentence at the end of the last paragraph that begins "The priority placed" as follows:

"However, a single-payer financing system that can bargain for the people of California as a whole would be better equipped to manage these difficulties than a collection of separate individuals. Moreover, by eliminating billing and administrative costs associated with our multi-payer system, there would be more money available to provide care."

Draft Report, "California's Health Care Environment: Implications for Unified Financing", Pages 66-67:

Comment, Page 66: The paragraph beginning "Fragmented financing leads to" should be edited by noting that the 30% difference between California and Canada means that under a single-payer system money spent on billing and insurance related costs would be allocated to providing health care. It should also be noted in the report that, unlike our current multi-payer system, a single-payer system could exert its bargaining power to reduce drug spending and to ensure that hospitals and other providers that are currently overcharging for their services are held to reasonable payment rates.

Comment, Page 67: The following sentence should be added to the end of the last paragraph:

"Given the massive disruption to our health care system and loss of health care coverage of so many Californians in the wake of the current pandemic, now is the right time to shift to a single-payer system."

IV. Comments on Section 2 (Pages 67-76)

A. In general – "big leap" versus "preparatory steps"

Draft Report, Section 2, Pages 67-76:

Comment, In General: As I explain in further detail below, I disagree that some of the measures outlined in Section 2 are indeed "bold preparatory steps". Some suggestions in Section 2 made by the consulting team are not steps that prepare us for a unified financing system.

First, I do not consider further regulation and reform of private insurance to be steps that bring California closer to a unified financing system. The consulting team should not describe such insurance reforms as steps moving the state towards unified financing.

Rather than unifying financing of our health care system, measures that maintain or preserve private insurance entrenches fragmentation in our health care system. I urge the consulting team to delete such suggestions that California make further insurance reform measures from the report or, at minimum, to characterize such suggestions honestly by stating that these measures do not aid California in the establishment of or transition to a unified financing health care system.

Second, many of the suggested measures regarding "preparatory steps" made by the consulting team inappropriately assume that certain design features will be adopted in a unified financing system. This report should not make such design assumptions about a unified financing system, especially given that the Commission has been tasked to discuss and detail in the second report options for system design features. I urge the consulting team to delete such suggested "preparatory steps" or, at a minimum, to describe such assumptions about program design clearly and to state clearly when such measures are unnecessary in the establishment of a unified financing system.

The steps that California can and should be taking to transition to a unified financing system, which I also described above, include (1) drafting and passing state legislation to establish the single-payer program, and (2) drafting and submitting a federal waiver application. Indeed, passing state legislation is one of the statutory requirements for the state to secure pass through federal funds that are available under the Patient Protection and Affordable Care Act's state waiver application process (which is sometimes referred to as a "1332 waiver").

Draft Report, Page 68: "*To implement unified financing, California would need to […] address limitations under the Employee Retirement Income Security Act of 1974 (ERISA) on the state's ability to impose requirements on employer benefit programs.*"

Comment: As an initial comment on Section 2, I believe there are two separate legal analyses regarding ERISA's preemption and savings clauses. I provide further comment on these legal questions below. There is case law in the Ninth Circuit, the federal court of appeals which has jurisdiction over California, including *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008), that provides pertinent and important insight into what kinds of state health care funding from corporate employers and regulation of employer-sponsored insurance are permissible under ERISA. An analysis of mandatory legal authority in the Ninth Circuit should be examined by the Commission.

B. Comments on "Redirecting Medicare, Medicaid and Other Federal Funds"

Draft Report, Page 68: "*Existing federal law does not grant the federal Secretary of Health and Human Services authority to redirect Medicare's funding streams or trust fund dollars to states. Therefore, bringing the approximately 20 percent of funding for Californians' health care that is*

currently paid by Medicare into a unified state-based financing pool would require federal statutory changes."

> **Comment:** This statement, as alluded to later in the draft report when "workarounds" to federal statutory changes are mentioned, is fundamentally false and should be deleted from the report. Commissioner Hsiao has previously written on Medicare waiver options in his work in developing Vermont's state single-payer plan.[11] I have more detailed analyses of the issue of Medicare and other federal waivers, which I can share with the Commission. The consulting team has not thoroughly analyzed the question of federal waivers in the draft report, and it would behoove the Commission to discuss the options for federal waivers in more detail.
>
> To briefly describe Medicare waiver options, several waivers and provisions under Medicare may be used by a state to capture Medicare dollars under a state single-payer program. California could apply for Medicare waivers in varying combination with Medicaid and ACA waivers to align federal funds with a state program. A state can apply for a waiver under 42 U.S.C. § 1395b-1, which is sometimes called a "traditional" Medicare waiver or a Section 402 or Section 222 waiver (named respectively after sections of the Social Security Amendments of 1967 and the Social Security Amendments of 1972). The state could also pursue a Medicare Innovation Waiver (Social Security Act § 1115A, 42 U.S.C. § 1315a) to align Medicare payments and delivery requirements with Medicaid. Another waiver available is an administrative Medicare contract/waiver (42 U.S.C. § 1395kk-1), which may allow the state to administer Medicare benefits and payments.

Draft Report, Page 68: "*Actions required for continued compliance with existing federal Medicaid rules would be burdensome for consumers and would make it difficult or impossible to develop a simple, universal and equitable program. To achieve California's vision of a Healthy California for All, a change in federal law allowing greater state flexibility in the use of Medicaid funds would likely be required*."

> **Comment:** These sentences should be deleted because the consulting team does not explain their assessment of Medicaid rule requirements. As presented in this draft report, there is no basis for the Commission to evaluate the validity of the consulting team's proclamations that a change in federal law is "likely…required." Similar to the consulting team's statement with regard to Medicare waivers, the statement that a change in federal law "would likely be required" regarding Medicaid is internally inconsistent with the later statement that "workarounds" to federal statutory changes are available. Indeed, the first sentence quoted here simply states that compliance with Medicaid rules would be "burdensome" and that a simple system would be "difficult or impossible". Neither of

[11] Hsiao, William et al. "Act 128: Health System Reform Design, Achieving Affordable Universal Health Care In Vermont." Submitted to Vermont Agency of Human Services Health Care Reform (Feb. 2011), available at https://hcr.vermont.gov/sites/hcr/files/FINAL_REPORT_Hsiao_Final_Report_17_February%202011_3.pdf.

those assessments, which again are unexplained, provides proof that a change in federal law would be necessary.

Even if the consulting team's assertion that Medicaid waivers would be burdensome or complex is correct, that does not mean California should not pursue such waivers. As I have mentioned before, the fact is that millions of Californians have lost their health insurance or cannot afford their out-of-pocket costs even if they have a plan and millions of Californians may become ill or die as we lament regulatory complexity. We need to act now and, at minimum, owe it to the people of California to initiate discussions with the federal government on the question of streamlining Medicare and Medi-Cal into a unified financing system.

Again, Commissioner Hsaio has previously written on the issue of Medicaid waivers and I can also provide a more detailed analysis to the Commission on the topic of federal waivers. To briefly describe the options here, California currently has several Medicaid waivers for its Medi-Cal program, including a Medicaid demonstration waiver.[12] Applying for complex Medicaid waivers is nothing new to our state government. Under the Medicaid program, states have consistently used waivers (Social Security Act § 1115, 42 U.S.C. § 1315) and state plan amendments to expand program benefits, to change service delivery, and to create new types of provider payment methods.

Draft Report, Page 68: "*Subsidies through Covered California might be redirected to a unified financing pool under existing Section 1332 waiver authority, if ACA statutory guardrails are met. Among those requirements is the need to assure that changes will not adversely affect the federal deficit*."

Comment: It is important to note here that, as part of the ACA, Congress envisioned that any individual or small business premium tax credits, cost-sharing reductions, or small business credits could be converted into pass-through funding to states that develop innovative health care programs with health benefits as comprehensive as those required under the ACA. Congress codified this intention in Section 1332 of the ACA.[13] Several states, including Hawai'i, Alaska, Minnesota, and Oregon, have Section 1332 ACA waivers approved to receive pass through federal funds to the state programs that would otherwise have been distributed under the ACA.[14]

[12] A list of and links to California's current Medicaid and CHIP waivers are available at https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx.
[13] State single-payer programs, in particular, were always a quintessential kind of state innovation that would qualify under Section 1332 State. During reconciliation discussions in the Senate on the ACA, Senator Sanders, among others, pushed for the inclusion of these state innovation waivers specifically to use in his home-state of Vermont in anticipation of the passage of state single-payer legislation.
[14] As of January 2019, eight states have had 1332 Innovation Waiver applications approved. See National Conference of State Legislatures. "State Role Using 1332 Health Waivers" (updated Dec. 14, 2018), available at http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx.

Additionally, of the handful of explicit statutory requirements of a Section 1332 waiver application is a requirement that the state make assurances that state legislation to implement the plan described in the waiver has been enacted.[15] This requirement in the Section 1332 waiver statute that a state enact legislation makes the need for California to draft and pass legislation establishing a single-payer program as the first step towards unified financing critically important.

Again, I have further research on the issue of ACA waivers that can be shared with the Commission.

Draft Report, Page 68: "*To redirect federal funds that currently support special populations such as TRICARE enrollees would involve revisiting long-standing expectations regarding benefits, and would also require federal statutory change*."

Comment: If TRICARE funds cannot be redirected, California can make those military service members, veterans, and their families who may be eligible for TRICARE and who are residents of California eligible to enroll in the state program. The draft report should clarify that allowing TRICARE eligible individuals to enroll in a state single-payer program does not require changes in federal law.

C. Comments on "Redirecting Employer Contributions and Obligations"

Draft Report, Page 69:

Comment: In general, the premise of this subsection is faulty. The consulting team poses the issue regarding ERISA as one of directly capturing employer contributions into a unified financing system. It is wrong to assume that a state single-payer system must capture existing employer premium contributions on a dollar-for-dollar basis. There is no requirement that a state unified financing system require employers to specifically pay into a state health care fund in lieu of making premium payments towards employer-sponsored health insurance. The state could capture financing from corporate entities through other revenue generating mechanism such as gross receipts taxes, ending corporate tax subsidies, or through the establishment of other corporate taxes.

Similarly, there is no requirement that a state unified financing system change or regulate employer health care obligations specifically. It is difficult to make a specific analysis of the draft report because the draft is unclear as to what is meant by "redirecting employer…obligations". Missing from the draft report is a discussion of what kinds of state regulation of insurance would both meet the ERISA savings clause and would allow employers to meet ERISA obligations with respect to employee health benefits.

[15] 42 U.S.C. §§18052(a)(1), (b)(2).

Moreover, broad and unexplained statements in the draft report that federal statutory changes to ERISA are required are unhelpful at best. These statements give the legislature, Governor, and the public an incomplete, unnuanced, and incorrect impression of federal preemption under ERISA and relevant case law. Indeed, the savings clause in ERISA, Section 514(b)(2)(A), is instructive here. ERISA's savings clause states that "nothing in [the preemption clause] shall be construed to exempt or relieve any person from any law of any State which regulates insurance."[16] In general, a state unified financing system that regulates insurance rather than "relat[ing] to" employer health benefits plans would not be exempted under ERISA. Relevant case law has interpreted the limits of ERISA's preemptive reach and would assist in identifying both what kinds of financing and what kinds of employer health benefit requirements may or may not be permissible under ERISA. Two cases in particular are helpful here, *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) and the U.S. Supreme Court's rejection of a broad, literalist interpretation of ERISA's preemption language in *Gobeille v. Liberty Mutual*, 136 S. Ct. 936 (2016). The Commission should engage in a real analysis of the legal questions at issue before making broad proclamations that a federal statutory change in ERISA is required in order to achieve a unified financing system in California.

The Ninth Circuit's decision in *Golden Gate Restaurant Association*, which upheld the employer health care expenditure requirements in San Francisco's Health San Francisco program, may also provide a starting point for analyzing whether there are employer-based financing options that would not be ERISA preempted.

Draft Report, Page 69: "*Intended to assure that multi-state employers can provide consistent benefit programs across multiple states, ERISA preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by ERISA."*

Comment: The citation to this sentence should be changed to the relevant ERISA section, Section 514(a). The endnote references commentary on ERISA and not the statute itself.

Draft Report, Page 69: "*How ERISA's complex provisions would apply within the context of a specific state policy construct would be subject to court interpretation*."

Comment: The phrase "would be" should be edited to "may be". Litigation and court interpretation are not inevitable.

Draft Report, Page 69: "*The practice of self-funding affords more flexibility in benefit design, allows the employer to earn investment income from reserves set aside for employee health expenses, and reduces some administrative costs. Very large employers are most likely to self-*

[16] 29 U.S.C. § 1144(b)(2)(A).

fund because their size better positions them to forecast and spread risk, and because it allows them to offer uniform benefits to their employees nationwide, avoiding both state benefit mandates, and state-imposed insurance taxes."

> **Comment:** These sentences should be deleted. It is unclear how the pandemic may impact the use of self-funded plans. Additionally, a state unified financing program could and should extend eligibility to all Californian's regardless of whether or not a self-funded plan is available to them.

Draft Report, Page 69: "*At least 5.5 million Californians are covered through self-funded employer arrangements. In order to assure that these individuals and the funds currently spent by employers on their health care could be integrated within unified financing, either the federal ERISA statute would need to be amended or California would need to devise financing approaches that do not run afoul of ERISA legal challenges*."

> **Comment:** Again, the consulting team incorrectly presents the issues around employer health care coverage as primarily one of directly capturing current employer health expenditures for self-funded plans, and thus, incorrectly implies that statutory changes to ERISA are necessary in order to have a unified financing system. California need not prohibit self-funded employer plans and need not write statutory provisions that call for the perfect capture of health care dollars currently spent on self-funded plans. Rather, a unified financing system can and should offer benefits to all Californians regardless of whether that individual can enroll in a self-funded plan. On the financing question, corporate taxes, gross receipts fees, or the range of financing options mentioned through my comments could be imposed onto corporations in a manner that does not run afoul of ERISA. Again, there are legitimate employer financing options that may not be preempted by ERISA, as the draft report later eludes to, and that should be explored based on the Ninth Circuit law regarding the employer health care expenditure requirements in San Francisco's Health San Francisco program.

Draft Report, Page 70: Paragraph beginning with "*State single payer proposals offer a range of strategies to reach their goals without ERISA preemption.*"

> **Comment:** The points briefly mentioned in this paragraph provide the most helpful discussion of ERISA in the draft report. The Commission should more closely investigate and provide further examples on options there may be for California to work within the contours of ERISA preemption both with respect to financing and with respect to regulating health insurance in a manner that enables employers to meet the requirements under ERISA.

Draft Report, Page 71: "*California's path toward unified financing will encounter challenges related to the redirection of federal Medicare and Medicaid funds, ERISA law, and state spending limits. Definitive resolution of these issues will require political will for federal statutory change and to make changes to California's constitution via ballot initiative.*

Workarounds may be possible but will have to be carefully crafted to balance feasibility and sustainability against the goals of simplicity, equity, and universality that motivate the state's interest in unified financing."

Comment: This paragraph is internally contradictory and should be deleted; federal statutory changes are not necessary.

It cannot hold true that federal statutory changes and ballot initiatives are both "require[d]" but "workarounds" are possible. It is the responsibility of the Commission to examine such challenges and identify options for financing and program governance which would reasonably meet the requirements of Medicare, Medicaid, and ACA waivers and of ERISA's savings clause. Moreover, the consulting team should not characterize these options that are consistent with federal and state law as legal "workarounds".

Additionally, there are actions other than waiting for "political will" that could answer the questions around federal funds, ERISA, and state spending requirements. These actions include developing, writing, and applying for federal waivers and engaging in discussions with the federal government on the question of federal health care funds. The state can also engage in the legislative process with a bill establishing a single-payer program in hand.

Finally, I would like to reiterate here as I and other Commissioners mentioned in past meetings, it is not the role of the Commission to make assessments of political feasibility or political will, and the Commission should not alter our presentation of options around financing, governance, program design, and other issues on the basis of such political soothsaying. To raise the specter of "political will" here serves only to justify inaction. The Commission's role and responsibility is not to identify excuses to deviate from the path towards single-payer health care; rather, the Commission's statutory purpose is to help the legislature and Governor plan for and navigate these admittedly complex but not impassable bumps along the road.

D. Comments on "State Capacity to Raise and Use Revenues for Health Care"

Draft Report, Page 70: Paragraph beginning with "*In 2018, the Legislative Analyst's Office (LAO) estimated that a state-run publicly financed healthcare program would cost $400 billion in total. The LAO estimated that $200 billion was potentially available for redirection from existing public programs and that the state would need to raise an additional $200 billion in new revenues*."

Comment: The LAO report did not include any of the savings that would result from implementation of a single-payer health care program in California. The $400 billion estimate reflected how much it would cost to cover everyone under the current multi-

payer health care system. Additionally, the LAO study should be compared to current spending.

During the 2017-2018 California legislative sessions, a team of University of Massachusetts, Amherst economists, led by Dr. Robert Pollin, also developed a financial analysis on California single-payer health care legislation.[17] Pollin and his team reported that health care spending in California was $368.5 billion in 2016 and that it would cost $400 billion to cover all Californians. Using fairly conservative assumptions about savings under a state single-payer health care program, Pollin estimated that cost would drop to $331 billion. Thus, using 2016 dollars, California would have spent $37 billion less in health care costs ($368.5 billion minus $331 billion) and would have covered all Californians if we had a single-payer program.

Pollin's study also had higher estimates on the amount of existing public funds available than the LAO report, concluding that $105 billion in new revenue would need to be raised. Importantly, this study identified two potential new taxes that could generate this revenue: a 2.3% gross receipts tax on businesses (with an exemption of the first $2 million in business receipts so that small businesses would pay no gross receipts tax) and a 2.3% sales tax increases (with exemptions for spending on housing, utilities, and food, and a 2% income tax credit for low-income families).

Since the LAO's report was published, numerous researchers from across the country have produced a wide range of economic and financial analyses of the potential costs and savings of single-payer health care programs both on the state and federal levels. Additionally, different design options can result in different savings and costs in a unified financing system. This should be noted in the report.

The Commission report should either delete the reference to the LAO report or, at minimum, mention the limited usefulness of the LAO's estimate given its failure to consider savings. The report should also mention the analysis by Pollin and his team and its estimates on savings from a single-payer health care program.

Draft Report, Page 70: "*Proposition 98 of 1988, as amended by Prop. 111 of 1990, guarantees a minimum funding level for K-12 schools and community colleges. Prop. 4 of 1979 (the "Gann limit"), as amended by both Prop. 98 and Prop. 111, sets limits on certain state appropriations.*"

Comment: The specific issues listed here should be explored more in depth by the Commission. It is the responsibility of the Commission to identify options that California can take with respect to financing that would not require a ballot initiative. The

[17] Pollin, Robert et al. "Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562)." Political Economy Research Institute: University of Massachusetts, Amherst (2017), available at https://www.peri.umass.edu/publication/item/996-economic-analysis-of-the-healthy-california-single-payer-health-care-proposal-sb-562.

consulting team's gives no explanation as to their assertion that a ballot initiative is required.

E. Comments on recommendations for "establishing legal pathways"

Draft Report, Pages 72-73: "*The rationale for focusing on preparatory steps is that there is a substantial gap between existing health care delivery, financing, and legal realities and the conditions required for the sustainable implementation of unified financing*. *California's ambitious vision for unified financing depends on political constituencies that may take time to build and on federal actions not subject to state control*."

Comment: The Commission's statutory role is not to provide political predictions. I believe the Commission's discussion of the state's options to achieve a unified financing system should not be subject to such armchair analysis of political will.

Also, it is inaccurate to imply that California is a passive agent in the process of securing federal waivers. California is completely in control of when and how action by the federal government on federal waivers are initiated. The federal government will not approve a federal waiver without a state first applying for it. Moreover, as I have discussed above, the federal waiver application for pass through ACA funds requires that the state enact legislation on the underlying health care program. In short, the onus is on California, not the federal government, to take the first actions—passing legislation and applying for federal waivers—towards unified financing.

Draft Report, Page 73: "*California could take steps to establish a legal pathway through which changes in financing and delivery could be negotiated and clarified within the state and with the federal government. This could include the development of policy options and draft legislative language that assert California's intent to develop requests for a Section 1332 waiver under the ACA, a Section 1115 Medicaid waiver, and/or an application for a Center for Medicare and Medicaid Services Innovation Grant*."

Comment: I agree that the state could take these steps. The Commission should be focusing our energy into developing such options for California to take with regard to federal waiver options. The commission needs to aggressively analyze these options so that we as a state can get past this handwringing stage and get to writing waiver applications and passing state legislation.

The legal questions regarding ERISA and federal waivers should be viewed not as absolute barriers on the road to single-payer but rather as potholes that we need to navigate.

Draft Report, Page 73: "*California could also develop legislative proposals for Congressional consideration that would redirect federal Medicare, Medicaid, ACA premium tax credits and cost sharing reductions, and TRICARE funds to a California unified financing trust fund.*

> **Comment:** I disagree that developing proposals for Congressional legislation is time well spent. California can act now without waiting for Congress. We should focus our energies on identifying what we can do now without changes to federal law. We should also develop federal waiver applications and state legislation that fits within a reasonable interpretation of the law. We should not, however, negotiate against ourselves based on predictions on what Congress or the White House may or may not do. It is ill-founded to change our initial negotiating position—i.e., the ideal and preferred unified financing system—with the federal government based on predictions as to the future composition and disposition of Congress and the White House.

Draft Report, Page 73: "*In addition, the state could take steps to identify strategies by which unified financing could be implemented without change in ERISA law. Another potential avenue involves steps to address existing restrictions under the Gann Act and Prop. 98, in order to ease obstacles to collection and distribution of state funds that would be combined with captured federal resources in order to support a unified health care system*."

> **Comment:** The question that the report should explore is: How can we capture revenue from corporations generally or other sources to fund a unified financing system? As I discussed above, there are several options with regard to non-federal financing that can and should be examined.

F. Comments on recommendations on "greater consistency in health care delivery and financing arrangements"

Draft Report, Page 74: "*As a preparatory step to achieving unified financing, California might take steps toward unifying, or, at least, aligning, existing public programs. Greater consistency and more uniform quality among existing public programs could give Californians not covered by these programs – primarily those covered by employer sponsored insurance and by Medicare -- confidence that unified financing would serve their needs well*."

> **Comment:** The suggested "preparatory steps" in this subsection of the draft report are unclear and I am unsure what is meant by alignment and consistency in existing public programs. In general, it is inappropriate for the consulting team to make such assertions about the benefits of aligning existing public programs without (1) recognizing that such changes may not ultimately be carried forward to a unified financing system, and (2) without the Commission first having discussed and examined program design options. California should not pursue uniformity among existing public health programs for uniformity's sake. This is particularly true given that it is unknown whether such "alignment" to public programs will or will not be adopted under a single-payer program.

Creating superficial similarities in current public programs does not help us reach single payer. This is particularly true because the suggested changes in this subsection appear to be continuations of existing private insurance reform efforts. However, eliminating private insurers from current public programs and having the state pay doctors, hospitals, and other providers directly would be a step toward unified financing.

More specifically, I strongly disagree that "uniform quality"—particularly if tied to payment schemes—is helpful and, as described above in my general discussion regarding risk-based payments, tying "quality" to payment mechanisms has many problems that must be raised and analyzed by the Commission. The second sentence in the above quoted language should be deleted.

Additionally, the public support and demand for a single-payer health care system is clear. It is perplexing why the consulting team would believe that public "confidence" in existing public programs has any bearing on a state single-payer system. Problems with financing, benefits, coverage, administrative complexity, etc. that enrollees face under existing public programs would better be addressed under a single-payer system.

Draft Report, Page 74: "*Steps toward greater consistency and stronger demonstration that publicly run programs can produce high value care could include*:"

Comment: I urge the consulting team to stop using the ill-defined terminology of "value" and "quality". The terms have been used *ad nauseum* as euphemisms for risk-based payments. While collecting and evaluating health outcomes is important, as I describe above, linking outcome and performance metrics to payments raises serious problems.

Draft Report, Page 74: "*Alignment and tighter coordination among the state's major coverage programs (Medi-Cal, Covered CA, CalPERS). For example, state programs could impose common health plan contracting requirements to improve quality outcomes, bring into greater alignment provider networks and payment arrangements, or streamline purchasing for pharmaceuticals or specialty services. State-regulated employer-sponsored coverage could also be encouraged or required to participate in aligned efforts*."

Comment: It is difficult to respond precisely to this section of the draft report because it is unclear what the consulting team precisely means by "common health plan contracting requirements to improve quality outcomes" and by "bring into greater alignment provider networks and payment arrangements." I interpret this language to suggest that California further regulate private health plans under Medi-Cal (managed care plans), Covered CA, CalPERS, and employer-sponsored plans. As I have explained throughout these comments, steps that further regulate private insurance plan, even if such reforms would "align" private health plans, should not be characterized as "preparatory" steps towards unified financing. Even if plan networks, quality requirements in contracts, and payment

schemes were "aligned" among all the private health plans in the state (whatever "aligned" may actually mean), our health care system would still be fragmented. California would not be able to capture the savings that a single-payer system would produce, people would still be subject to the unpredictability of losing coverage and disruptions in care, prices would not be controlled, and out-of-pocket costs would still make health care unaffordable for millions.

Alignment among public programs that eliminates private insurers, for example direct contracting between state programs and providers, could be more closely examined by the Commission.

Draft Report, Pages 74-75: "*The development of a common approach for creating sub- regions in the state for price-setting and quality assessment could support a transition to a system that financially incentivizes population-based outcomes rather than volume of service delivery*."

Comment: Again, I have serious concerns about risk-based payments, please refer to my above comments. Population-based approaches are fundamentally at odds with an approach that focuses on individual needs and are often riddled with biases. Moreover, providing a veneer of "quality" by meeting "population-based outcomes" may leave large numbers of individuals with untreated health issues that fall outside any particular set of outcome measures. This sentence should be deleted.

Draft Report, Page 75: "*A comprehensive strategy for integrating behavioral health and medical care. This could include continued progress toward integrating publicly and privately-delivered services for Medi-Cal enrollees, as well as alignment of performance reporting and value-based payments across multiple public programs*."

Comment: Again, I disagree with the suggestions that California should transition existing public programs to a risk-based payment model. Please refer to my above comments on risk-based payments. The Commission should examine other payment models.

G. Comments on recommendations to "expand tools and resources"

Draft Report, Page 75: The paragraph starting "California could also take steps to *expand tools and resources*…"

Comment: From the sentence beginning "As discussed in Section 1" to the end of the paragraph should be deleted. Current healing arts educational programs in California effectively prepare high quality primary care and behavioral health providers. New or different classifications of providers are unnecessary to meet the future need for additional primary care and behavioral health providers under a single-payer system. This need could be addressed through the wise use of public funds to create scholarships and

other *direct* financial support, preferably non-loan-based aid, for primary care and behavioral health professional providers who agree to work in medically underserved areas of California. The California Future Health Workforce Commission report contained numerous proposals, estimated to cost $3 billion, focused on studying process expansion, problem assessment, and oversight costs rather than *direct* financial support of students in the health professions. Directly linking financial support for a racially and ethnically diverse group of students and post-licensure service to medically underserved areas of California would help to address the needs of underserved populations. Recruiting and supporting students from underserved areas of medical needs could increase the number of health care practitioners who remain in these areas to serve community needs.

Draft Report, Page 75: "*Information exchange and care management transitions across different delivery settings are imperfect. As a result, patient experience, clinical quality and cost of care can suffer. Under the status quo, California's health care workforce is stretched thin and not aligned with population needs.*"

Comment: Having uniform outcomes reporting and data are not necessary to establishing a uniform financing system. Collecting this kind of data for the purposes of making workforce decisions and/or to create financial incentives (1) do not help us to transition to unified financing, and (2) are problematic in and of themselves. Moreover, we do not need portable IT systems to reach unified financing, particularly when tech companies have made these systems proprietary and because we know that there are serious bias concerns, as well as many other problems, with population based clinical decision-making algorithms.

Draft Report, Page 75: "*Development of information technology and tools (e.g. master patient index, master provider index) to support patient care management and smooth handoffs among service providers and across care settings*"

Comment: The recommendation that information technology and tools should be developed to support patient care management should be deleted. As I mentioned above, many recent studies show that clinical software and technology, often packaged as clinical decision-making or clinical support software to support risk-based payment models, have serious racial and other biases that replicate and amplify racial and other health care inequities. Just yesterday an article was published in the *New England Journal of Medicine* analyzing the dangers of racial bias in 13 widely used clinical algorithms and tools.[18]

Draft Report, Pages 75-79: Workforce statements including, "*Under a universal, unified financing approach, the need for an expanded and more flexible workforce would likely*

[18] Vyas et al. "Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms." *New Eng. J. of Med.* (Jun. 17, 2020), available at https://www.nejm.org/doi/pdf/10.1056/NEJMms2004740.

increase." and "*Investments to expand health care workforce capacity, particularly in underserved areas (in coordination with next steps emerging from the California Future Health Workforce Commission)*"

> **Comment:** These statements on "flexible workforce" and use of non-clinical providers should be deleted. I am concerned by the consultant team's references to a "flexible workforce" and "greater use of non-clinical providers" on pages 75 and 79. These references are made in the context of an overarching argument for getting "better value" for California's "current spending on public coverage programs" by shifting to a capitated per-member, per month payment model rather than a fee-for-service payment model. Capitated payments are not "value"-based they are risk-based and require doctor groups to become quasi-insurers. "[G]reater use of non-clinical providers" similarly is not about "value" but, rather, is about reducing costs by inappropriately using unlicensed personnel who lack the education and clinical experience necessary to providing high-quality care as substitutes for nurses and other licensed health care providers.

Draft Report, Page 76: Statements regarding health information technology including "*As illustrated by the COVID-19 pandemic, fragmented financing and care delivery make it difficult to take coordinated action across the delivery system. Tools for information-sharing, outcome-tracking, and workforce coordination could support a more effective response to public health emergencies*." and "*Development of information technology and tools (e.g. master patient index, master provider index) to support patient care management and smooth handoffs among service providers and across care settings*."

> **Comment:** On health information technology, portable IT systems are not necessary for California to reach unified financing. This is particularly true given that medical technology companies have made these HIT systems proprietary and given that these programs pull clinicians away from the bedside and increase administrative burdens on our providers. They have also been cited as major causes for increased burnout and decisions to leave health care.

Draft Report, Page 75: "*Efforts to understand cost drivers, including those related to provider consolidation (in coordination with next steps emerging from the OSHPD Healthcare Payments Database and other state efforts to improve cost transparency)*"

> **Comment:** Identifying "cost drivers" has already been done—it's the prices. High administration and billing costs of insurance, inflated costs for specialty care and procedures, and paying for insurer and provider profit all contribute to high prices. It is not clear how conducting more research on this topic would help us move towards unified financings. Indeed, the issue of controlling high prices would be better addressed in single-payer legislation.

V. Comments on Section 3 (Pages 76-79)

Draft Report, Page 78: "Expand Covered California Affordability Assistance"

Comment: Funding that would be directed towards additional premiums subsidies for private insurers that offer plans through Covered California would be better spent on providing additional care under other public programs and under a unified financing system.

Draft Report, Pages 78-79: "Getting Better Value within the Current System"

Comment: This recommendation for the further adoption of so-called value-based payment models should be deleted. As I discuss above, there are myriad problems with these kinds of risk-based payment models.