Dear Healthy California for All Commissioners,

I am a retired Social Worker wishing to provide you with some observations about achieving the goals of universal, high quality, equitable, sustainable health care in California.

I am a volunteer with the advocacy group Health Care for All - California. Over the past 20 years, I have followed the ever-growing movement toward and acceptance of the single payer model by both politicians and voters, doctors and nurses, people on Medicare and with private employer provided health plans.
I have read study after analysis after op-ed that point to single payer as being the only way to achieve universal coverage, expand the benefit package, improve quality, access and outcomes, pay providers adequately, and avoid unnecessary wait times to receive care.

I assume that you have seen the same evidence, from the Lewin Report in the early 2000's to the Health Care Options Project here in California, to national studies by the OMB, to countless other studies in other states.
I will acknowledge that the for-profit sector has also produced studies with opposite conclusions. I would refer you to the New Yorker article by Jill Lapore called "The Lie Factory. See

https://www.newyorker.com/magazine/2012/09/24/the-lie-factory

and search the article for the American Medical Association.

The private health care sector has fiercely fought against single payer, using Joe McCarthy-like fear tactics, predicting the destruction of the health care system and transition of our government to Communism.

Of note, the AMA Board of Directors recently voted on the issue, and by a narrow margin of 53% against to 47% for, continue their opposition. But the AMA does not represent all physicians, and other physician organizations are coming out in favor of single payer. Regarding the American College of Physicians please see:
https://www.acponline.org/advocacy/where-we-stand/better-is-possible-acpsvision-for-the-us-health-care-system

The average citizen is also coming around to understand and support single payer, and increasing numbers of politicians are signing on as supporters. This support is a bit harder to gauge because surveys and polls are so easily designed and worded to produce the desired answer, but even at that, approval for single payer continues to rise.

As for incremental improvements, we are currently on the brink of losing all of the gains achieved by the Affordable Care Act. And even there, the supporting politicians were outflanked by opponents and a large swath of the country that most needed to expand Medicaid coverage was able to decline doing so.

Obviously this issue is a tough nut to crack. But the reason is NOT because there aren't workable proposals, and certainly NOT because there are no examples around the world we couldn't build upon. As you have well documented, our country compares very poorly with other developed nations in health outcomes, maternal death rates, infant mortality rates, and equality of access. And as for fairness of financing, we were rated 54th by the UN health survey in the year 2000. Given the COVID impact on low-income groups and people of color, I doubt that a new survey would show any improvement.

Lastly, much has been made of the arguments regarding the complexity of transition and where will we ever find the money to finance a single payer system. For anyone who has studied the issue, this should be seen as an obvious distraction. "We would love to cover everyone for everything, but how will we pay for it?" Again, countless analyses show that we already spend twice that of other countries, and that much of the excess we spend is to cover the cost of administering an obviously inefficient model, while at the same time paying too much for medication and medical equipment.

As for the complexity of transition, I like to cite that fact that in 1966, the US transitioned to Medi-Care and Medicaid, and from cash grants to poor families and the disabled by states and counties to Supplemental Security Income (SSI). At the same time, the budgeting for the cash grants became the job of Eligibility Workers, and social work services were provided by social workers. This was done in a year, not with super computers, but with index cards. It wasn't perfect or without glitches, but within a short time, the snags were worked out.
My last reference I would like to draw your attention to is a conversation that was taped at the Sanders Institute between Michael Lighty and UMass. Amherst economist Robert Pollin. A summary of major points is also viewable at this website. Please see:

https://www.sandersinstitute.com/blog/medicare-for-all_-i-like-it-how-do-we-pay-for-it

My point here is that Dr. Pollin lays out a very smooth and easy transition to a unified finance system for health care. We already know that there is an excess of money now being spent on health care, more than enough to expand coverage to everyone, and to widen the benefit package for everyone.

Of the 19% projected savings as estimated by Pollin, which were intentionally

minimalized, 9% would result from administrative cost reduction, 6% would come from reduced drug prices, 3% would come from lower costs of provider care, 2% from fraud reduction. The numbers are rounded, so don’t quite add up correctly.

In addition to paying for the expansions, there would remain and addition 8% net savings. Pollin suggests an initial transition asking businesses that are currently paying premiums to private insurers to cover employee health insurance to pay that premium to the new Federal Medicare for All system, minus a reduction in "premium" of 8%. The mechanism already exists with businesses to pay payroll taxes. This would be a simple additional entry.

Thank you for taking the time to consider my comments.

Yours,

Peter Conn