

## STATEMENT OF THE HEALTHCARE ACTION COMMITTEE TO THE HEALTHY CALIFORNIA FOR ALL COMMISSION

We are a neighborhood organization in East Bay made up of citizen activists who share a common belief that our existing health care system is dysfunctional and unfair. Our ranks include people who work in the health care field, union members who have seen the impact of skyrocketing health care costs on workers' living standards, and ordinary people who have seen firsthand the impact of a market-driven health care system on people we know and love.

We regarded the creation of this commission with cautious optimism, hoping the state of California might be prepared to take the necessary steps to create a system that treats health care as a human right rather than a commodity. Our own work doing grass roots education and organizing persuades us that there is widespread public sentiment for such a system, and we believe public opinion polls confirm that belief.

Clearly a number of legal and financial barriers must be overcome if California is to establish a unified financing system for health care that is workable and sustainable, particularly where the federal government is involved. We hoped that the commission would develop a strategy to deal with these barriers.

We therefore read the final draft of the Environmental Analysis with disappointment. The first section gives an excellent summary of the failures and inequities of our health care system and how COVID-19 has exposed and exacerbated them. But the remedies it proposes sometimes seem to have been offered with another agenda in mind.

A key passage of the report refers to the "significant gap between existing health care delivery, financing, and legal realities and the conditions required for sustainable implementation of unified financing." The report's recommendations seem less concerned with closing the gap than with accommodating it. The role of private insurance in our jerry-built health care system is acknowledged but not seriously addressed. Instead, the report devotes a great deal of attention to the high costs imposed by health care providers, the lack of both transparency and consistency in setting prices for medical treatment, and the need for performance metrics to determine whether we are in fact getting our money's worth.

Rather than suggest anything that would supplant private insurance, it recommends consolidated financing for the state's three largest publicly-funded health care programs: MediCal, Covered California, and CalPERS. Presumably, this would create administrative efficiencies and promote consistent standards of care, eliminating at least some of the inequities of our current system.

Unfortunately, all three of these programs rely on contracts with private insurers. Third parties with no involvement in health care delivery siphon off public funds that could and should help pay providers directly. This is a waste of tax dollars that the state can ill afford.

A bigger problem is the report's embrace of performance metrics as a way to cut costs. This approach has already been tried, and it doesn't work. At the federal level, the Center for Medicare and Medicaid Services has been using performance metrics for Medicaid since the Obama administration. It has also used the federal government's bargaining leverage to rein in compensation to Medicaid providers. The result? Providers saddled with onerous paperwork burdens to satisfy government bureaucrats that their treatments conform to the proper standards.

Unfortunately, the algorithm has not yet been invented which can adequately assess the nuances of a patient's medical condition or determine which treatment strategies are appropriate. Large hospital chains are adept at manipulating coding systems to maximize their compensation, but individual practitioners or small group providers rarely have the resources to do so. The policing function of performance metrics fall most heavily on those who arguably bear the least responsibility for rising health care costs.

An approach that is supposed to save money and improve standards of care has the opposite effect: it encourages providers to avoid patients whose treatment is likely to be more costly and complex and less assured of a positive outcome. Worse, a growing number of physicians are reluctant to accept Medicaid patients at all, having concluded that private insurers, for all the headaches they bring, are still easier to deal with.

Like many publicly funded programs, both MediCal and Covered California are designed to serve those whom the private sector has deemed unprofitable. Making these programs subject to rigid cost-benefit formulas further entrenches a two-tier system of health care, and exacerbates the structural inequities of race and class that the Environmental Analysis quite properly condemns.

Replacing fee for service compensation with metrics-based payment system does not lower costs. It merely shifts the burden of risk from insurers onto providers. The best way to control costs and ensure equal access to care is to bring everyone into the same risk pool, so that no one stands to profit from privileging one sector of the population over another.

The Environmental Analysis identifies the extreme fragmentation of California's health care system as a major source of inequity and waste. But fragmentation is a symptom, not a cause. The disease is the use of market criteria to determine who has access to care and what kind of care they will receive. If a universal funding system is not truly universal, market forces will continually undermine it, and the abuses of the current system will only reproduce themselves.

We are in substantive agreement with the criticisms of the Environmental Analysis made by Commissioner Carmen Comsti. In particular, we want to emphasize three of her points.

First of all, the Environmental Analysis puts the cost of a single payer system in California at \$400 billion, citing a study by the legislative analyst's office. But the legislative analyst's report made no attempt to calculate the cost savings under single payer. The actual cost, according to a recent study by the Political Economy Research Institute, would be \$331 billion. The state, it should be noted, currently spends \$368 billion on health care.

Second, the report incorrectly states that fee for service is to blame for the serious financial losses suffered by hospitals and other provider groups during the COVID-19 pandemic. The real reasons for lost revenue are twofold: one, many who lost their jobs as a result of the pandemic lost their health coverage along with it, leaving them with no way to pay for treatment. And two, people who might otherwise have sought treatment could not do so without risking infection with a potentially deadly virus.

The final point is something that should not need to be repeated: the Commission has been charged with "prepar[ing] for transition to a unified financing system." It needs to remain focused on its original mandate.

The experience of a number of other countries has demonstrated the dramatic cost savings that are possible under a single payer system—to say nothing of the better health outcomes and equitable standards of care. Commissioner William Hsiao was instrumental in designing a successful system in Taiwan. We hope the commission as a whole will make full use of his expertise.