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January 6, 2022

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The Honorable Dr. Jim Wood, Chair  
Assembly Health Committee  
State Capitol  
Sacramento, CA 95814

Re: AB 1400 (Kalra/Lee/Santiago)  
Support in Concept As Introduced

Dear Assemblymember Wood,

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians for over thirty years, supports in concept AB 1400 (Kalra/Lee/Santiago) which, as introduced, would create a single payer system that would cover all residents of California, regardless of immigration status, age, or income. We strongly support universal coverage, including the goal of establishing a single-payer "Medicare for All" system. The measure acknowledges that further work needs to be done on financing, potentially in another legislative vehicle. We suggest other improvements and adjustments as well.

AB 1400 envisions a comprehensive reform of the health care system, replacing employer-based coverage as well as current public programs including Medi-Cal, Medicare, Covered California and other public programs, with a single payer system in which the State of California funds health care for every Californian. AB 1400 would provide every Californian with comprehensive benefits including all of the benefits provided under existing public programs. The CalCare system set up in AB 1400 requires no cost sharing, no deductibles, and no premiums for any benefit. AB 1400 would also include long term care and supports, as well as regional center services for persons with disabilities. These services, including long term care now provided only to low-income individuals through public programs, would be available to all Californians regardless of income or assets.

For over thirty years, Health Access California has long supported a single-payer system, as an effective means to achieve multiple goals that would improve our current health system. In supporting AB 1400 and other single-payer proposals, we seek:

- **A universal system**, that offers coverage and care to everybody, rather than leaving millions uninsured, and more at risk of becoming uninsured—living

Anthony Wright  
Executive Director

Organizations listed for  
identification purposes

sicker, dying younger, and one emergency away from financial ruin. The Institute of Medicine has documented in detail the negative health and financial consequences not just to the uninsured individuals, but to their families and their communities as well. Our health system is stronger and more financially sustainable if everyone is included—regardless of age, geography, employment situation, income, immigration status, or other factors.

- **A progressively financed system**, where what we pay for health care is based on what we can afford, and where the tax structure is also progressive, capturing unearned income and not relying on regressive payroll taxes to finance it. Health care is expensive, and health benefits are notably regressive in terms of income. The regressivity is especially stark in high deductible plans where the sick by definition pay more than the healthy. In addition, the cost of a health plan is thousands of dollars, which can be a third or a half of a low-income worker’s annual income. The ACA made strides in addressing the regressivity of health benefits by providing Medi-Cal to all legal residents below or around the poverty level, and significant but still insufficient income-based subsidies to those under 400% of the poverty level. Depending on how the taxes to finance the single payer system are structured, a single payer system could finally assure that no individual pays more than a percentage of their income on a progressive sliding scale for the cost of financing the health system.
- **A comprehensive system**, where people can count on a standard of benefits, rather than wonder if their coverage will actually cover them when they need it. The ACA and existing California law now puts a minimum standard for benefits and a maximum ceiling on cost-sharing, but more work is needed to assure people can get care when they need it and that they can afford that care.
- **A cost-effective system**, which pools patients together and leverages their purchasing power to negotiate the best prices from providers and to drive improvements in quality and reductions in health disparities as well as reduced costs from other system improvements such as greater efficiency and effectiveness. A well-managed single-payer system has tools for managing and streamlining costs far greater than any individual insurer or provider. We appreciate the work of the author in looking at how other countries negotiate and/or set rates, with his previous bill AB 3087 (Kalra) of 2018 and this current proposal.
- **A simpler and more efficient system**, which streamlines some of the bureaucracy associated with the marketing, administration, and profit-taking of multiple private insurance companies. Our current fragmented system creates confusion, and while the ACA filled in many gaps, there is more to do. Having a “single payer” would avoid the continuing complications with regard to the churn between coverage types, as people shift from one employer to another job, between Medi-Cal income levels and those of

Covered California, and age from their parents' coverage or into Medicare. The administrative costs of so many payers include not just the overhead of the insurance industry, but the imposed burden on providers of navigating the many billing systems of multiple insurers and payers.

- **A system focused on patients, not profits**, which cuts out the middlemen of the insurance industry, as well as the adverse impacts of insurers attempting to avoid covering the sick or the benefits they need, rather than a proactive, mission-driven focus on keeping people well. The ACA stopped or limited the worst abuses of the old marketplace—the denial of care for pre-existing conditions—but we need an additional stage of health reform not just to prevent the worst practices but to encourage the best—a well-managed single-payer system would encourage the best care.
- **A prevention-oriented system**, which has the right incentives in place to invest in wellness and that moves away from false incentives for insurers from avoiding risk to encouraging health and addressing the social determinants of health through a wiser mix of health care and human services. A single-payer system would have the incentives to invest in prevention and public health generally, rather than simply disease management on issues like asthma, diabetes, obesity, or the opioid epidemic.

Health Access California has long worked on, helped develop, and advocated for single payer proposals in California, from our founding 35 years ago. Our policy and advocacy work led up to the Proposition 186 campaign in 1994, and continued through our work actively organizing to support bills by Senators Kuehl and Leno, including SB 921, SB 840, SB 810, and more recently, SB 562 by Senators Lara and Atkins. We support AB 1400 in that tradition. Throughout our history, we have also strongly supported multiple and complementary approaches to coverage expansion and steps to a universal health system, including employer requirements and public program expansions at the state level as well as local efforts like Healthy San Francisco and My Health LA to federal reform through the Affordable Care Act. We have been proud of California's implementation and improvement of the ACA which has brought us significantly closer to many of the goals listed above, while recognizing that there is more work to do to improve access, affordability, cost containment and equity under the Affordable Care Act. We were proud to work to expand affordability assistance for those Californians in Covered California, and to lead the #Health4All effort to expand Medi-Cal to cover all children and young adults regardless of immigration status as additional steps to universal coverage, and hope to continue this progress in California. While these and other elements are building blocks to a new health system, we recognize that these steps by themselves will not get us to the vision of a universal health system without a framework and plan. To that end, our Executive Director serves on the Healthy California For All (HCFA) Commission, which has detailed the benefits of a system of unified financing and deliberated on the various policy choices needed to be made when designing such a single-payer system, and the steps to get there.

AB 1400 includes elements of the framework of a single payer system. We do have questions about the current version because of the lack of specifics, or provisions that may run counter to goals for a universal coverage system that improves quality and equity while reducing system costs and providing universal coverage. These questions include:

- *Financing:* The current version does not include the revenue plan. We appreciate the introduction of Assembly Constitutional Amendment (ACA) 11 on January 5, 2022, and we are reviewing the specifics proposed in that measure. A single-payer system should save money in the aggregate by reducing administrative overhead as well as by assuring the costs of care are based on reasonable costs, not driven by profits, market concentration and other market failures. The financing should raise sufficient tax revenue to replace the money currently spent by employers and consumers on premiums and cost-sharing. Those revenues need to be raised through progressive and sustainable means sufficient to cover increasing costs needed to provide medically appropriate care. Sufficient financing is also contingent on receiving the dollars currently spent by the federal and state governments through Medicare, Medicaid and Covered California. As introduced, ACA 11 appears to propose a more progressive financing system than the current system, though more can be done in this regard. Even though the financing is in separate legislation, the level and type of financing necessarily will have impacts on AB 1400, from the benefits covered to the rates paid.
- *Federal approvals:* AB 1400 directs the state Administration to apply for federal waivers and approvals from Medicaid, Medicare, and the ACA subsidies. It does not in any way constrain what a governor negotiates with the federal government. For example, a governor could negotiate a block grant or a waiver that capped federal spending, enrollment growth or growth in health care costs without running afoul of AB 1400. Similarly, AB 1400 is silent on capturing the billions of dollars spent by the federal government on the exclusion of employer sponsored health benefits from taxation or more generally the role of employers in financing health care. While some of these federal approvals may be possible to do administratively, other changes may require a change in federal law. This was the experience of Hawaii in implementing its near-universal coverage system. We would suggest policy development of what steps to single-payer or what parts would be possible without the need of an Act of Congress. Californians would also want to know what could go forward before we get federal approval, or in the event certain approvals are not granted.
- *Transition:* The move to a simple health system from a complex one is necessarily a complex undertaking. Consumers will want the security of knowing how a transition would take place for various populations in employer-based coverage; union trusts; Medicaid; Medicare; Covered California and the individual market; CALPERS; and other sources of coverage. AB 1400 includes some provisions aimed at facilitating the transition, but given

the complexity of the health care system, many more specifics would be required to provide consumers the comfort and security consumers deserve.

- *Governance:* The current draft would place the governance of this system in an appointed but unelected board, raising questions about the appropriate role of oversight by elected officials, including the Governor and the legislative budget process. The Advisory Committee should have more consumer, patient and community representation and should not be dominated by health professionals as proposed.
- *Consumer Protections:* It is unclear if CalCare would be subject to existing consumer protections, including existing Medicaid due process rights and other Medicaid protections as well as the consumer protections to which seniors and others are entitled under Medicare. It is unclear whether the federal waivers would waive or preserve existing consumer protections under Medicaid and Medicare. While the statutes would stay in place, it is unclear if CalCare would need to abide by the state standards developed over many decades. While AB 1400 acknowledges that consumers need timely access to care, language access or other consumer protections, most of these are statutory obligations on health plans or insurers and since these entities would cease to provide covered benefits, AB 1400 would need to adapt those existing bodies of law to ensure a long list of consumer protections continue.
- *Integrated Care and Salaried Providers:* As drafted, AB 1400 appears to eliminate integrated care delivery systems and rely exclusively on fee-for-service. It allows a group practice, county organized health system or local initiative to be paid on a salaried basis but does not make clear the role of these entities in the health system envisioned by AB 1400. We would seek further changes to benefit from the decades of delivery system reforms, to move away from paying per procedure or per patient, but toward systems that reward and prioritize improvements in health outcomes, quality, and equity.
- *Purchasing for Cost, Quality and Equity:* One of the real promises of a single-payer system is to have the state use its purchasing power to obtain the best price while driving improvements in quality and equity. The provisions in AB 1400 that prohibit the use of financial incentives raise questions about how this vision of a single payer system would move California toward the triple aim of lower health care costs, improved health care outcomes and reduced health disparities. The reliance on fee-for-service payments, with global budgets for every public or non-profit hospital, raises questions about how care would be coordinated and organized. How would depending exclusively on the clinical judgment of individual practitioners allow a health system to target social determinants of health or prioritize treatments for particular conditions? Without preferred provider networks or payment incentives, how does the system reward quality, improve equity and reduce cost?

- *Cost Control:* AB 1400 relies on global budgets and capital expenditure budgets for hospitals and nursing homes but does not appear to contemplate the need for health services such as labs and imaging. AB 1400 relies on a “rebuttable presumption” that 100% of Medicare fee-for-service would constitute “reasonable” payment for fee-for-service rates. These are important concepts that could reduce health care spending very significantly: a recent Kaiser Family Foundation analysis found that relying on 100% of Medicare spending would reduce private health insurance spending by 40%<sup>1</sup>. This is in addition to the savings from the elimination of insurer overhead and profits. While we strongly support rate setting, including the concept of using Medicare rates as a basis for payment, starting with a percentage closer to the industry average to would lessen disruptions in the health system.
- *Role of the Safety Net:* California has a robust safety net system consisting primarily of county hospitals and community clinics that serve those on Medi-Cal and the remaining uninsured. In doing so, these health providers strive to be the providers of choice for low income communities and communities of color. AB 1400 references equity in a number of places but never addresses the role of the safety net, aside from including clinic representatives on an advisory committee. Among other provisions, we would recommend certain policies and payments to support those providers that serve a disproportionate percent of low-income Californians and other disadvantaged communities. These providers may need more generous funding than those serving affluent communities in order to effectively address the adverse impacts of health disparities and social determinants of health. A well designed system could accomplish this while the current fragmented system rewards more generously the doctors and hospitals that serve more affluent communities.
- *Definition of medical necessity:* AB 1400 contains in several provisions a definition of medical necessity that may inadvertently exclude care and treatment for those with degenerative conditions, such as those with multiple sclerosis or rheumatoid arthritis. We do not believe this is the intent of AB 1400 but other public programs, such as California Children’s Services, expressly limit treatment to those capable of improvement and indeed, a long battle was fought to expand Medicare to cover those who are in decline. AB 1400 in Section 100626 refers to “care, services, diagnosis, treatment, rehabilitation or maintenance of health” but sometimes the best that can be done is to slow deterioration or provide palliative care. AB 1400 includes hospice care so the exclusion is likely inadvertent.

The issues and questions raised here are meant in the spirit of improving the proposal, as Health

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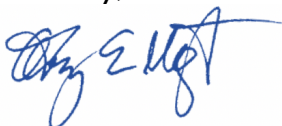
<sup>1</sup> Schwartz et al, Limiting Private Insurance Reimbursement to Medicare: [Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About \\$350 Billion in 2021 – Issue Brief – 9656 | KFF](#) March 1, 2021

Access California has done with numerous health reform proposals we have supported in the past, including the ACA. Also, the HCFA Commission has been wrestling with these and other questions and issues, and the upcoming report should be used to help inform this bill. Health reform is complicated, and the specifics matter to both secure broader support and to ensure the best implementation, given the myriad of decision points and policy considerations. However, we reiterate that the questions are in the context of strong support for the structure of a single-payer system, and the recognition of the continued frustration and inequities of the current system.

Fundamentally, we believe our health system works best for everyone when everyone is included. Californians with coverage are better able to get the care they need, without fearing financing repercussion—which has an economic toll on the family and the community’s economic vitality. Providers are able to get paid for all patients, and thus be better staffed and better serve all patients in return. Diseases don’t discriminate because of age, job type, income, or immigration status, and neither should our health system. We look forward to working with you to assure that not only is everyone included in coverage, as in the current version, but that any universal health system has the capacity and the direction to better provide primary and preventive care, to track diseases and public health issues, to drive delivery system reforms and systemic improvements.

While aware of the significant political, policy, and practical hurdles this effort faces, we are encouraged about the main intent of this bill, to advance our primary goal of quality, affordable health care for all. We support this bill and the goal of reaching a universal health system in California. We look forward to working with you to advance this historic effort.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Anthony Wright', with a stylized flourish extending to the right.

Anthony Wright  
Executive Director

Cc: Members and Staff of the Assembly Health Committee  
Assemblymember Ash Kalra, Author  
Assemblymember Miguel Santiago, Author  
Assemblymember Alex Lee, Author