



## Talking Points for July 8<sup>th</sup> Healthy California for All Commission Meeting

### Vermont

- In our judgment, the relevance of the Vermont experience for the Commission is limited to its framing of certain choices in the design of single payer health care delivery and payment policies.
- As Dr. Hsiao has shared, Vermont's ultimate failure to establish a single payer system has little relevance to California except as an example of the power of corporate healthcare to preserve its profits and block reform, and as an example of the pitfalls of not considering delivery and financing options at the same time and moving them forward expeditiously for resolution by policy makers and the public.
- The facts are that Vermont has a population close to that of Fresno, and is not its own CMS region, which California is.
- And despite claims to the contrary, Vermont's inability to establish a single payer system was not due to its failure to control costs -- which is something that could not have been established since single payer was never implemented there.
- The three-year delay (2011-2014) between policy adoption and consideration of financing reflected the Governor's political failure, culminating in the loss of his legislative majority in 2014, and showed the power of healthcare industry special interests to thwart change.

### Payment Methodologies

- As a principle, there is no place for financial risk-bearing managed care in a single payer system. No provider or intermediary should be incentivized to realize profits by withholding needed services.
- However, well-coordinated care -- quality-driven and patient-focused care coordination, if you will, is fundamental to achieve the promise of single payer. It is essential both to the wellbeing of enrollees and to the fiscal stability of the overall health system.
- In the present system, large majorities of people for whom English is a second language, when they are given a choice, choose integrated care systems for health coverage. Many find such systems easier to navigate, with less confusion finding the right providers and services.
- Care coordination goes beyond navigating a complex system. It is essential to receiving effective treatment. Programs that try to ensure medical advice is followed up on, and that bridge the gap between medical offices and people's homes and workplaces can make huge differences in health for individuals and groups.

- None of this coordination happens effectively in a health care model where enrollees have to find their own way from provider to provider and to drive collaboration among multiple providers by themselves. California needs a single payer health system that supports the organization of care.
- That organization of care must not be done in a way that incentivizes providers to withhold services.
- Nor should providers be allowed to write their own paychecks. In many places outside California, where fee-for-service reimbursement is the norm, union health funds and self-insured employers often struggle to deal with providers that pile up unnecessary and potentially harmful services.
- These providers are a minority, but such providers inflict huge costs on the health system.
- Some union health plans have had to invest heavily in systems to discourage this outlier behavior, going so far as to establish clinics of their own to give patients a choice when they no longer trust traditional providers.
- The earliest efforts to organize care and keep it accountable grew out of the labor movement – witness the health system the Mine Workers built in the 1940s. The universal, single payer health system we need in California should build on those experiences, not turn back the clock.
  
- **Certain mandates that have been enumerated in AB 1400 and California's prior single payer health care bills are essential to preventing incentives to deny care, including:**
  - Guaranteeing access to healthcare with no administrative barriers to securing services;
  - Establishing a single standard of therapeutic and equitable care;
  - Providing services based on patient need and medical necessity as determined by the provider
  - Ensuring that the professional clinical judgment of licensed providers cannot be overridden by administrative fiat;
  - Maintaining fully comprehensive benefits, with no carve outs that allow private insurance entities to contract for covered services;
  - Prohibiting incentives to deny care;
  - Funding hospitals and clinics through cost and experience-based global budgets that require funds be dedicated to service delivery;
  - Banning private capital budgets outside the single-payer fund, which exclusively funds capital expenditures.
  
- **Other guardrails the Commission could adopt to make per capita payments equitable include:**
  - No value-based purchasing as currently practiced or ACOs as currently constituted (as HCN detailed in our response to the Commission's environmental analysis last year, such cost-control mechanisms are inherently discriminatory);
  - Integrated delivery systems that include hospitals and clinics should not exert administrative or financial control over medical groups;