Your needs vs the 'financial incentives of your insurance plan?'

“Unless you establish a truly, not just universal coverage, but a truly universal guarantee of health care and that people have the right to health services on the same basis, it cannot be equitable.” - Michael Lighty

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Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** This time on Code WACK! What’s happening on the healthcare front since California Senate Bill 770, which paves the way for a single-payer healthcare system, was signed last year by the governor? What approvals are now needed to make Medicare for All a reality in the Golden State and what would it mean for equity? To find out we spoke to the one and only **Michael Lighty,** president of the **Healthy California Now** coalition and former healthcare constituency director for Bernie 2020.

Welcome to Code WACK! Michael.

Lighty: Thank you Brenda. Great to be back.

Q: Great to have you and get caught up with everything that's going on. There's been a lot happening on the healthcare front in California, but it seems to be behind the scenes, so we'd love to hear what's up with Senate Bill 770, which was sponsored by the coalition that you head, Healthy California Now.

Lighty: It is behind the scenes process because the key dynamic, right, that SB 770 established was to figure out the policy issues for actually designing what we want as a single-payer system. And so by the nature of that, you have to go through a policy development process and what the Department of Healthcare Services has done in California is contract with the UCLA Center for Health Policy Research to address key system design issues. At the same time, the SB 770 coalition established a policy work group so that we can provide our own perspective on key system design issues and the issues that will come up in waiver discussions with the federal government. So that process is currently underway. The Department of Healthcare Services under (SB) 770 is required to submit a report to the chairs of the budget and health committees in the Assembly and Senate by Jan. 1.

So they're going to be continuing to solicit input through probably [the] November, December period. And UCLA consultants will present their report in November. They have done interviews with informants who are health policy experts to help them come up with recommendations and analyses of the key system design issues. And so, some of the folks from SB 770 coalition have participated in that. We have suggested names to them for that process. So there's a lot going on and by its nature it has to be somewhat internal because that's what the policy development process requires. However, once these reports are presented of course to the legislature, it then becomes a very public process. So, 2025 will look very different.

Q: Hmmm. Oh good. Okay. That's good to know....Can you remind us what the ultimate goal is of Senate Bill 770?

Lighty: Well, the ultimate goal is to come up with an approach to what the bill calls unified financing, what we intend to be a single payer system for

consideration by the federal government in informal discussions over the terms of federal support, what is called a waiver. And those discussions will occur next year and what will come out of them is by June of 2025, a report to the legislature on kind of a draft waiver framework and system design issues, subject to public comment, and then a final report due at the end of 2025. And then in 2026, the legislature will consider the adoption of what we hope to be a single-payer program. And then that should it be adopted, ultimately of course go to the voters. So the whole purpose of this is to answer all the questions that legislators have had about what will the federal government support, how do we finance it, and then present a comprehensive proposal with the imprimatur of essentially of the governor's office for the legislature to consider knowing what the Feds will support and knowing what the recommendations are of the key health policy experts as well as stakeholder engagement so that there'll be plenty of opportunity in 2025 for the public to comment. So it'll be a very robust process of policy development, stakeholder input, agency work, and most important federal government input.

Q: That's great. And so [regarding] what the legislature will be voting on, would it be a separate policy bill related to SB 770 or would it be something like the actual approval of the financing that SB 770 is gonna put forth?

Lighty: It would be number one, you know, approval of a formal waiver application so that the federal government can provide formal approval and the [state] legislature will have a framework for that waiver authorization in January of '25. So they authorize the formal waiver application, and then once that is, you know, officially approved, they'll be in a position to adopt a program knowing what the federal government's going to provide in terms of financing and knowing what California has to raise to fully fund the program.

And just given, you know, the constitutional requirements for revenue in California, it's probably unlikely that that bill gets a two-thirds vote of support, which is required to raise revenue in California, and so that is one reason why it would have to go to the ballot. And realistically, probably the soonest it could get to the ballot is in 2028. So the legislature prior to that will have approved a

financing plan inclusive of the federal contribution, and a program that, you know, is funded by that financing.

Q: **Mm-Hmm,*<Affirmative>. Great. And so the waiver discussions that will be going on ultimately will determine how much the federal government is willing to contribute towards a single-payer system. And is that using both Medicare and Medicaid funds?***

Lighty: Well, there's a number of sources of federal funding that come into California to pay for health care. Obviously Medicare is a large source. Medi-Cal depends on, you know, 50% of its funding comes from the federal government. The Children's Health Insurance Program or CHiP is a federally subsidized insurance program for kids. There are, of course, subsidies that are provided to Californians under the Affordable Care Act. And all of those, with the exception of Medicare, are subject to the waiver procedures under the Affordable Care Act. And so the idea is to pool all those monies from the federal government into a single pot – into a single payer. And the question obviously is to what extent would Medicare be integrated in that? And there are real legal barriers to fully integrating Medicare, some believe. And so that's one of the things that has to be explored for the Center for Medicare and Medicaid Services, is to what extent Medicare can be integrated into the system.

And that's part of the policy development process I mentioned, is exploring different alternatives as to how to do that and how to make sure that everyone under 65/over 65 in California has the same coverage and benefits and that the program is as administratively simple as possible. So it gets pretty complex at one point and I think as single-payer advocates, we may have emphasized the vision and even some of the particulars of a program of what single payer would look like. But when you actually dive into the terms of a possible waiver, what existing law mandates, what the federal government is likely to do, what they can do under the authority of the Affordable Care Act and the Social Security Act, which governs Medicare and Medicaid, these things get complex pretty quickly. And that is why we're taking our time to be able to address all aspects of this process.

Q: This is the farthest I think California has ever gone towards a single payer system in its history and it's had multiple, multiple tries, right?

Lighty: Oh, it's definitely the farthest 'cause we're actually setting up a process to engage with the federal government, which is a foundation for actually being able to do single payer in California. So as much as we've been clear on what kind of program we want and how we would structure it, ultimately it's subject to federal approval. And so unless we engage with the federal government, we don't really know what the legislature can approve. And so that's why we've always felt that this is a more productive process.

And Oregon is doing the same thing. They've got a universal healthcare governance board that's meeting as we speak, that is developing an approach to a single-payer system in Oregon, and they're gonna go to the federal government as well. And so we're in conversation with them about how these states and possibly, you know, Washington state as well, if they want to get on board, could do this. And 'cause the issues are obviously essentially the same. The scale is quite different, <laugh> 4 million versus 40 million people. But nonetheless, it's a very useful process and I think it's instructive to know that single-payer advocates have realized this is the most productive path to get us there. Now we don't know exactly where we're gonna end up because of course all these variables are in play with the federal government, but it does, as you say, get us farther than we've been before and it's based in real policy development.

Q: Why is this legislation SB 770, which was signed by the governor last October, so important to the effort to achieve healthcare equity in California?

Lighty: Well, unless you have a single standard of care with guaranteed benefits and coverage the same, right, and unless you pay providers sufficiently so that they can maintain services and you don't have hospitals closing rural areas so that, you know, in other words, financing is equitable you can't have equitable health care. I mean, it's just that simple. If you don't guarantee health care on the same basis with the same coverage and benefits to everyone, then you're going to have disparities. And even if you do that, there are going to be inherent disparities as a result of history and, and social determinants of health. And so you're gonna have to address those as well. But unless you establish a truly, not just universal

coverage, but a truly universal guarantee of health care and that people have the right to health services on the same basis, it cannot be equitable. And so that's why it's so essential to achieve health equity. We have to adopt this kind of approach to financing.

Q: Right. You mentioned rural hospitals closing, which I can't even imagine. Already, there's so few rural hospitals and once they close, I can only imagine they have to travel even farther to get the care that they need. What other glaring examples of inequity are we facing today?

Lighty: Well, we have healthcare deserts in urban areas as well as rural areas, right? And we have completely in some ways different coverage based upon the kind of insurance plan you have. I mean, I've talked to many doctors, particularly in the ER who will tell you, well, if you have a Cadillac, you know, really high-end insurance plan, you're gonna get different treatments. And so you have inequities kind of at all levels of the system. You have a lack of facilities. You have under-resourced facilities, you have disparate treatment options because of the kind of insurance you have. And you have fewer choices of providers, either because Medi-Cal doesn't sufficiently reimburse providers, or your plan has a narrow network, so you can't go to all providers. So everything within the present system is ultimately determined by financial incentives of your insurance plan. And so eliminating those financial incentives to deny or restrict care and guaranteeing, you know, standard benefits and coverage, is essential to our project here.

And if you don't do that, then you're going to replicate the existing disparities based upon insurance plan and geography. And the social determinants of health, of course, are very much in play based, again, on geography and discrimination, historic discrimination. And it's not enough simply to finance health care on this basis, you have to provide culturally competent care. So when we look during the commission at how do people experience the healthcare system in particular, how do low income Californians experience the healthcare system. First they experienced these disparities in what kind of care and treatment they can get. And probably in some ways even more prominent was their experience of discrimination and culturally insensitive and incompetent care by institutions and

providers. So culturally competent care is the other cornerstone of what we have to achieve in the system. Unless you establish parity of services, it's then very difficult to provide culturally competent care. But you have to do both. And there are distinct programs required for each.

Q: Is that something that SB 770 would look at or not – culturally competent care?

Lighty: Yeah. It is part of the mandate under SB 770. And it does mean that when you design a system, you're going to have to do things... well, one of the things you do, of course, is you basically bring Medi-Cal reimbursement rates up to the standard for the whole system. So there's not a Medi-Cal rate and a Medicare rate and a private commercial insurance rate. You essentially want to standardize those rates to the greatest extent possible. But it absolutely wipes out the Medi-Cal difference and the lower rates. So that's all of a sudden Medi-Cal recipients can go to any provider, and those providers who treat Medi-Cal patients would have the ability to, you know, finance their operations in a way they can.

Same with rural hospitals, if they don't have sufficient commercial insurance. A lot of these rural hospitals can't survive. But once you provide for a global budget for those hospitals, right, so that they have the revenues necessary to provide the services to their area, then you don't have that problem and so that does go a long way. But you also have to, of course, educate and ensure that the providers are culturally competent and to do that often means having providers that are more diverse.

Q: Great. It sounds like things are chugging along with implementation of Senate Bill 770. How pleased are you with how everything is shaping up so far?

Lighty: Well, I'm very pleased at the process that we're going through in terms of policy development because it really has the advantage of being rooted in reality. And so that's you know, that's important <laugh> 'cause we kind of wanna just wish into existence the system that we know is better. And for many of us advocates who've been doing this for a long time, we're like, ‘come on, what are you doing? The policy case is airtight, the moral imperative is overwhelming. Obviously it saves money. So why haven't we done it?’ And what we're of course solving is the political roadblocks to that by taking away any excuses, answering

all questions, and then saying, ‘okay, well we know that the case is powerful. Let's get rid of these financial incentives that are killing people – let's be honest – and denying us care that we need and let's change the system to guarantee health care to everyone on an equitable basis.’ We are maintaining the vision, but we're grounding it in a process that will get us there.

Q: Great. Wonderful. Thank you so much, Michael. Is there anything else you want to mention?

Lighty: Always got to mention that Healthy California Now sponsors a calculator at healthyca.org/calculator and folks can go there, put in what you currently spend on health care, and find out how many thousands of dollars each year you would save.

Yes, that was healthyca.org/calculator. Thank you. Michael Lighty of the Healthy California Now coalition.

By the way, a Senate Bill 770 public input meeting will be held via webinar on Friday, August 30th, from 9:00 AM to 1:00 PM. Registration details will be available in our show notes.

Stay tuned for next time when we discuss with Michael what our healthcare system would likely look like under a Trump presidency versus a Harris one.

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