

## **Myths About SB 810 & Responses**

### **I. AFFORDABILITY**

*Myth: This is going to cost a fortune. How will we pay for it?*

Response: The current health care finance system wastes nearly 50% of each health care dollar on unnecessary administrative expenses, clinical waste, excess drug prices and fraud. SB 810 streamlines administration, uses state purchasing power to negotiate discounts on the price of pharmaceuticals and medical equipment, creates an agency to perform health planning, and establishes an Inspector General for Health Care with strong investigative tools to uncover fraud.

Funding will come from federal, state and county monies, which already pay almost 50% of health care costs, and by taxes which would entirely replace what businesses and individuals now pay in premiums, co-pays and deductibles.

We spend over \$7,000 per capita – more than twice the average amount spent by other countries that insure everyone. By correcting health care mis-spending, SB 810 is able to direct money into health care and make the health system very efficient.

[Statements regarding costs and savings are based on data from the Lewin Group economic impact study of Kuehl SB 921. SB 810 is modeled on SB 921. The principle findings of the report confirm every other study of single payer done in the U.S. Single payer can provide universal coverage and control the growth of spending over time.]

*Myth: This is going to require new taxes.*

Response: The graduated tax revenue necessary to fund the system will replace current health care premiums. The net cost to businesses and individuals that are now paying for healthcare will decrease. Businesses that do not now provide health insurance for their employees will pay their fair share to fund the system. Individuals who now cannot afford insurance will pay affordable premiums.

*Myth: Private health insurance controls health care costs better than a government system which is influenced by public pressure for more services.*

Response: Medicare costs have a lower inflation rate than private insurers even though Medicare must provide coverage for all who qualify by age or disability.

Private health insurance companies control their health care costs by minimizing their risks or shifting risk to individuals by:

1. “Cherry picking.” In the individual market, they provide insurance for those with no pre-existing conditions or by charging exorbitant premiums. Often these policies are discontinued once major expenses are incurred claiming false statements on the individual’s application.

2. Increasing premiums and plans with high deductibles and co-pays.
3. Down-coding diagnoses to pay doctors and hospital less.
4. For-profit health insurance companies' primary responsibility is to their shareholders, not to patients, doctors or hospitals.

The ways to control spending growth include: a) streamlined administration made possible by having a single insurer and one comprehensive plan of coverage; b) use of purchasing power to lower prices; c) providing low-cost preventive care; d) consolidated budgetary authority with statutory spending limits related to increases in population growth and GDP; e) capital health investment management; f) a health payment board to establish provider reimbursement; g) a referral policy for specialty care.

*Myth: We're facing budget deficits. We can't afford universal coverage.*

Response: We can't afford NOT to do this. Health care costs are the second largest driver of the budget deficit. The Lewin Group's study shows that the single payer model would be a major step toward deficit reduction and a balanced budget. The Lewin Group forecasted that a single insurer model would save the state \$44 billion dollars in the first ten years.

*Myth: People will end up paying more for healthcare than they do now.*

Response: Most would pay less for insurance than they do now. And, once one's health insurance premium is paid, there are no other costs, no co-pays, no deductibles.

## **II. INSURANCE**

*Myth: I have insurance, why would I want to change a system that is working for me?*

Response: The health care crisis affects all of us. Hospitals have closed trauma centers and emergency rooms because they no longer can bear the cost of services to uninsured patients. Between 1990 and 2004, fifty-four ERs closed in California. In Los Angeles County 10 Trauma Centers closed in ten years. The remaining ERs now close their doors 50% of the time due to overcrowding. Your insurance won't help if the care is unavailable when you need it.

Underinsurance: Last year, half of all personal bankruptcies were due to medical bills and most of those people had health insurance. If you become seriously ill you may not be able to keep your job. Without a job you have no health insurance. Middle class people file for bankruptcy; the poor don't have enough assets.

How long will you be able to afford your insurance? The price of health insurance is rising many times faster than wages. Many employers are eliminating health insurance as a benefit for their employees and retirees. Other employers avoid hiring full time employees to avoid having to pay for expensive insurance for them. We are becoming less competitive

in global markets compared to countries with universal health coverage. We all have a big stake in fixing the health care crisis.

*Myth: We should not pay for health insurance for illegal immigrants.*

Response: It is Federal law that anyone who shows up at an emergency room must be given care. SB 810 would provide much of that care in clinics and doctors' offices for far less than we are spending now. It is estimated that if every Californian got preventive care we could save \$3.4 billion dollars a year. Most undocumented Californians are employed in essential jobs and our immigrants pay \$80,000 more in taxes and fees over a lifetime than they will receive in local, state and federal benefits in their lifetimes. Also, like everyone else, they would be paying premiums according to their income. It's good public health policy to insure the entire population. It helps control epidemics or outbreaks that could expose everyone to disease.

### **III. ACCESS**

*Myth: There will be long waits for care like there is in Canada.*

Response: Canada spends about 1/3 as much as we do per capita on health care and uses waiting lists to manage limited resources. That being said, wait times in Canada are grossly exaggerated. California spends more than enough to avoid waiting lists, although we will have to plan our resource use carefully.

*Myth: Health care will be rationed.*

Response: Under the current system, health care is rationed by one's ability to pay. We should ask, "What is the basis for health care rationing?" and "Who makes these decisions?" Insurance and pharmaceutical companies and HMOs ration care and medications to those who can afford to pay for them. Insurance companies decide what is covered and what is not. They ration health care to secure profits. California has more money and health care infrastructure in its health system than most nations. Under SB 810, a representative health policy board would plan for providing affordable health care for everyone. Care will only be "rationed" in the sense that the care you get will be based on the sound medical judgment of your doctor. All health care systems now ration care and consider it to be sensible health care planning. The question is on what basis is care rationed and who makes the decisions?

### **IV. THE ROLE OF GOVERNMENT**

*Myth: A market-driven private healthcare system is better than a government run system.*

Response: Medical care cannot be considered a "market" because the consumer analogy does not hold; people become patients when they need medical care. Unlike other consumer items, patients rely on professional expertise and not on their own judgment when they are sick. We don't say someone is a consumer when they call the police or fire department. Furthermore, you get a lot more health care from your contributions to a publicly financed system than from a private health insurance system. When you pay a

premium to an insurance company, 20% to 30% comes off the top for administration, shareholder dividends, executive reimbursement, and marketing. Only 70% to 80% is spent on health care. With SB 810, by law at least 95% of revenue will go directly to providing health care.

*Myth: This would be socialized medicine.*

Response: This is definitely not socialized medicine. When the provision of health care services is socialized, the government owns all the health care facilities and trains and employs the health care workforce. This is a private health care system that is publicly administered and financed. Doctors and hospitals will continue to operate as private firms, just as they are now.

*Myth: This is government-run health care.*

Response: This plan will put medical decision-making back in the hands of medical professionals and their patients, unlike today when doctors have to get permission to order a test or a treatment from an insurance administrator with little or no medical training. SB 810 has provisions to protect the health care system from some of the problems that governments face. Strong conflict of interest rules, prohibitions on partisan activity or collusion with for-profit firms have been incorporated. Health system officers are protected from special interests and the entire health care system is exempted from oversight by other government agencies that might slow things down and make bureaucracies unresponsive. A publicly administered, consolidated insurance system will eliminate inadequate funding, complex eligibility rules, means testing, periodic eligibility lapses, poor provider participation, low provider reimbursement and the stigma of being “on welfare.”

*Myth: The Commissioner will have too much power.*

Response: The Commissioner’s appointment must be approved by the legislature. This provides a measure of accountability and the leadership system has checks and balances. The Commissioner is the chief administrative officer. A physician is the Chief Medical Officer. The Patient Advocate represents the interests of patients. All meetings are open. All documents, except privacy-protected documents, are public. All system officers may be impeached for malfeasance of office. Compare this with our inability to know or influence the decisions being made by private insurance company CEOs. Their power is unchecked by nothing except the government regulations they operate under.

## **V. BENEFITS**

*Myth: Full pharmaceutical benefits without a co-pay won’t be affordable.*

Response: By using the state’s purchasing power for 37 million Californians, the state can win large discounts on the costs of pharmaceuticals. Californians will then be paying what the Europeans, Scandinavians, Australians and Canadians pay for the same pharmaceuticals and, at those prices, pharmaceuticals are affordable. No longer will Californians need to travel to Canada or Mexico for affordable drugs.

*Myth: Drug discounts will adversely affect pharmaceutical companies.*

Response: There are 10 million Californians who now have no prescription drug benefits but who will have them under SB 810. This expansion of the market offsets losses from lower prices.

*Myth: Lower drug prices will hurt the ability of pharmaceutical companies to do research.*

Response: Pharmaceutical companies don't use profits to pay for research, so even if their profits were to drop from lower drug prices, it won't affect research. The search for new patented drugs is the life-blood of drug companies. Their marketing budgets may decrease, but not their research budgets.

*Myth: Seniors already have health coverage through Medicare.*

Response: Under SB 810, seniors get benefits that Medicare doesn't cover, such as full prescription drug coverage-no donut hole -, dental and vision coverage. For at least the first two years there will be no co-payments or deductibles for ANY services. Seniors will spend less than they do now for health care. There will be no need to buy supplemental insurance (Medigap).

*Myth: People will lose benefits they now have.*

Response: All necessary medical services will be covered including medical, dental, vision, mental health, prescriptions, hospitalization, home health care, therapy, diagnostics, hospice care and much more. The only services excluded are elective plastic surgery, single hospital rooms unless they are medically necessary, unlicensed procedures and long term care.

*Myth: I will lose my Kaiser-Permanente services.*

Response: Kaiser will provide health services just as it does today but it will no longer sell insurance policies. All licensed, accredited providers will still exist and may be chosen by patients through the system.

## **VI. QUALITY**

*Myth: SB 810 will stifle innovation.*

Response: SB 810 will stimulate innovation in several ways. It will provide a well-funded budget for R and D. Partnerships for Health will provide grants to communities for innovative programs. Pharmaceutical companies will have the incentive to redirect their research budget now spent on "copy cat" drugs and instead invest it in much needed research on treatments for diseases such as multiple sclerosis and breast cancer. The market for health care innovations would expand because all 37 million Californians would have health insurance and would get health care when needed.

*Myth: The system won't decrease medical errors.*

Response: SB 810 will eliminate many of the causes of errors such as understaffing, lack of readily accessible medical information, poorly coordinated medical services, and inadequately coordinated care. SB 810 can implement system-wide electronic record-keeping that will be accessible wherever you get medical services in the state. Statewide oversight for quality care is fundamental to helping reduce medical errors in both public and private hospitals.

*Myth: SB 810 doesn't address the nursing shortage.*

Response: No one can solve the nursing shortage overnight. Lack of funds for training nurses is a major part of the problem. SB 810 has a mechanism to set priorities that could include funds to invest in nursing education.

*Myth: The Commissioner could close a hospital over the objections of the community.*

Response: A hospital would only be closed if providers and patients choose not to use it or if the hospital fails to be accredited under California law. The Commissioner can hold back funds if a hospital fails to meet quality of care standards.

## **VII. POLITICAL VIABILITY**

*Myth: Politically it will be easier to build on the current system and pass legislation that incrementally covers more people over time. Eventually everyone will be covered.*

Response: After many years of incremental, piecemeal attempts to fix our deteriorating health care system, we have seven million uninsured in California (47 million in the U.S.), unsustainable increases in the cost of health insurance and poor quality of care. The facts speak loud and clear that the politically easy approach will not address the fundamental problems and may make them worse.

The 2004 Report of the National Coalition on Health Care concluded: "First, we would emphasize again our conviction that reform must be systemic and system-wide. The problems of our health care system are so closely interrelated that they must be addressed at the same time. One-dimensional reform will not work."

It's time to do the right thing.

Source: California OneCare  
<http://californiaonecare.org/>