

SB 810 Questions and Answers
Prepared by Sara Rogers (Senator Leno's office)

Does Federal Health Reform allow us to still do single payer?

Yes. Federal health reform expressly included an opt-out provision for states if they can demonstrate that they will achieve the same level of coverage. This opt out clause will not be implementable until 2017, which is about the earliest date that California would realistically be able to implement single payer.

Don't Canadians and British hate their health care system?

They rate their systems far higher than we rate ours. A 2003 Gallup Poll looking at consumer perspectives regarding their health care system found that **far more people are very dissatisfied** with their health care system in the United States (44%) than in Great Britain (25%) or Canada (17%). Similarly, the poll found that **far fewer people are very satisfied** or somewhat satisfied (25% in the US vs. 57% in Canada and 43% in GB).

Similarly, polling in Canada shows that, when asked whether they would prefer an American style health care system to the Canadian single payer system, opposition ranges from 92%-97%.

UC Irvine's commencement address was given by Dr. Sherif Emil who left UC Irvine and moved to Canada in 2008. In his address Dr. Emil commented:

It was interesting for me, as an American physician practicing in Canada, to see the recent negative depictions of the Canadian system in TV ads and law media, depictions that bore absolutely no resemblance to the actual environment in which I practice daily. My reality is very different. I can see any patient and any patient can see me – total freedom of practice.

Aren't Americans just harder to please? Don't we actually have the best most cutting edge quality of care?

No. Study after study shows that on Americans receive substandard care compared to other industrial nations – even when controlled for variables like insurance.

Citations:

1. WHO organization rankings from 2000, US ranks 37th in the world.
2. Commonwealth study looking at 7 industrial nations. US ranked last or next to last on every measurement.
3. Commonwealth survey of primary care. US found to lag in terms of access to care, use of health information technology, and quality of care policies.
4. OECD (Organisation for Economic Co-operation and Development) data shows:
 - If you're born in the United States, chances are that you'll die younger than in other industrialized nations. The US has the lowest life expectancy of 14 nations measured by the World Health Organization. U.S. life expectancy in 2001 was 77.1; Canada, 79.7; Italy, 79.8; Japan, 81.5
 - The infant mortality rate is higher in the United States than in other industrialized nations. In 2003, seven infants died for every 1,000 live births in the United States -- the worst rate of 19 countries measured by the OECD.

- In 2006, the Commonwealth Fund reported that “despite spending more than twice as much per capita as other countries do on health care, the U.S. health care system ranks lower than other countries in patients’ perspectives on the safety, efficiency, equity and patient-centeredness of health care”.
- The Commonwealth Fund recently reported that “a study of more than 10,000 primary care physicians in 11 countries finds that the United States lags far behind in terms of access to care, the use of financial incentives to improve the quality of care and the use of health information technology. In other countries, national policies have sped the adoption of such innovations”.

For our high level of spending, **we do not get more care.** According to OECD data we have fewer doctors per capita, fewer hospital beds per capita, fewer doctor visits per capita, and shorter hospital stays.

The LAO said SB 810 would cost \$200 billion dollars and be \$40 billion in the red in the first year:

This is a gross distortion of what the LAO found. Our health care system *currently* spends \$200 billion. This bill would take that same money and eliminate insurance company overhead and complicated administrative waste in order to direct that money into actual health care. There is **NO NEW SPENDING** under this plan. It is fully funded with the health care dollars that employers, individuals and government already pay. The Lewin report showed that this plan could actually reduce health care spending by \$8 billion in the first year, and \$345 billion over a decade.

Opponents claim that the LAO says this will have a \$40 billion dollar deficit. This is also a distortion. The LAO was asked to evaluate whether the funding structure modeled to fund the plan in 2005 would be sufficient to fund it if it were implemented in 2011, following 6 years of health care inflation. Lacking a universal health care system that can effectively contain costs, health care costs have continued to rise faster than wages. We are now spending over 17% of GDP on health care, and that will soon rise to 20%. The longer we wait the more we will be spending and the higher the numbers will have to be. The \$40 billion estimate is really the cost that Californians and their employers are paying for the Governor’s veto of this bill.

Given the passage of national health care, shouldn’t you wait on SB 810 until national health care is fully implemented?

Federal health care reform represents a tipping point for achieving universal health care – but it did not achieve the goal.

FHR dramatically expanded health care coverage, but it will also bring millions of Californians into a health care system that wastes nearly half of every health care dollar on clinical and administrative waste.

As health care costs continue to grow 3-5 times faster than wages, federal health care reform will actually increase the urgency for single payer. Single payer is the only model of health care financing that has been proven to contain the growth of health care spending while guaranteeing high quality patient centered health care for all.

How will SB 810 prevent people from flocking to California for the free health care and bankrupting the system?

It's interesting how, on the one hand, opponents claim that everyone will hate universal health care and flee the state, and then in the same breath worry that everyone who needs medical care will flock to California.

I think the latter is the more realistic concern, and that is why SB 810 provides that eligibility shall be based on residency in the state with intent to reside. If there is a surge of people from outside the state that threatens the fiscal stability of the system then the bill allows for the Commissioner to establish an eligibility waiting period for new residents. This problem will be greatly diminished under federal health reform because a significantly greater proportion of medical indigents will be eligible for Medi-Cal or subsidized coverage. Even if people come to California because of our excellent universal health care system, federal funding is likely to follow them.

Why does single payer have to be "one size fits all"? What about those people who want to pay a little extra for special services like immediate access to doctors, private hospital rooms, concierge services, etc?

First, SB 810 allows for providers to opt out of the program if they choose and for patients to purchase additional special services like concierge medical care. Providers will have to choose to be in or out. However, if they opt out, there are allowed to bill patients out of pocket.

Second, SB 810 is in no way a one size fits all health care delivery system. On the contrary, SB 810 empowers health care providers to innovate and take responsibility for improving our health care delivery system in a patient centered manner. Health care providers will control delivery of care, and patients will be free to choose any available provider so there will be true competition on the basis of quality.

The single payer system will be responsible for setting and measuring quality standards and outcome goals, but health care providers will replace mega-consolidated HMO bureaucracies as the managers of our health care delivery system.

It is your doctor who will decide what medical care you need and when you need it – and it is your doctor who will decide how to best organize care coordination and delivery. Patients retain the ultimate control since they can freely choose the providers that give the best care.

Providers will be free to establish integrated systems that reduce clinical and administrative waste, better integrate care delivery and care coordination, promote evidence based care, improve outcomes, and contain spending.

Cost containment is achieved because the system promotes capitated reimbursement structures and the purchasing power of consumers is maximized – while consumer choice over their providers ensures quality based competition. The key to an effective delivery system under single payer is to combine true consumer choice over providers with an expanded freedom for providers to design better delivery systems.

How does the system ensure that providers are reimbursed adequately and ensure that providers don't leave the state?

A 2008 poll published in the *Annals of Internal Medicine* found that 59 percent of U.S. doctors support a "single payer" plan that essentially eliminates the central role of private insurers. They have good reason for supporting single payer.

First, SB 810 explicitly requires that the system provide actuarially sound reimbursements that include a just and fair return (pg 39.33). This is better protection for providers than they have now with insurance companies.

Second, SB 810 calls for provider reimbursement rates to be adjusted in order to recruit and retain adequate provider networks (Pg. 40.8, 42.13), and calls for reimbursements to consider geographic variations network adequacy. This means that if doctors are unsatisfied and leaving the state due to poor reimbursement rates, then the system is specifically required to adjust reimbursement rates to attract and retain appropriate numbers of providers.

Third, under single payer, providers will be allowed to negotiate collectively for appropriate reimbursement rates which will give providers a healthy amount of market leverage as they negotiate for reimbursement rates. This will substantially increase the market power of providers who are currently disadvantaged in their negotiations with a health insurance oligopoly.

Finally under single payer there will be no more uncompensated care and providers will no longer have to spend billions of dollars fighting insurance companies who deny 30% of all claims the first time around. SB 810 is estimated to save \$20 billion in the first year on reduced administrative costs – this money is redirected toward health care providers.

How can the state afford SB 810 in view of the enormous budget deficit? And how can workers and businesses afford universal health care in this economic climate?

Two things:

1. Billionaire Warren Buffett recently said that health care costs are a major drain on U.S. businesses and act like an "economic tape worm." This is exactly right – health care costs are growing 3-5 times faster than our economy is growing and neither taxes nor profits can keep up with the rising costs.

This is the only model for financing health care that has been demonstrated to contain health care costs while providing comprehensive universal care.

2. A recent study showed that enacting a single payer health care system in the United States would create 2.6 million new jobs and stimulate \$317 billion in business revenue. (Institute for Health and Socio-Economic Policy).
3. Note: IHSP is a research entity of California Nurses Association.

Under single payer, wasteful health care spending that currently creates no value added for our health or our economy would be redirected into meaningful investments in health care delivery and health care infrastructure. This will create value added jobs and stimulate economic growth.

In a budget crisis, like we are experiencing now, won't the legislature just vote to cut our benefit structure, shift costs to consumers in forms of premium and co-payment and deductible increases?

Sounds familiar doesn't it? That is exactly what is happening now – each year the level of benefits in a typical health insurance plan is eroding.

The Kaiser Family Foundation recently found that premiums in the individual market increased by 20% on average, yet insurers recorded huge profit gains in the first three months of 2000 compared to a year earlier.

A different study also by the KFF found that:

- Forty percent of the employers surveyed said they would likely increase the amount their workers pay out of pocket for doctor visits.
- Almost as many said they are likely to raise annual deductibles and the amount workers pay for prescription drugs.
- Nine percent said they plan to tighten eligibility for health benefits; eight percent said they plan to drop coverage entirely.
- Forty-one percent of employers said they are “somewhat” or “very” likely to increase the amount employees pay in premiums — though that would not necessarily mean employees would pay a higher percentage of the premiums.

Enacting a single payer system would minimize this trend by ensuring that our health care dollars are redirected from wasteful administration and toward direct medical care.

Why not include Worker's Comp (the medical portion) in the SB 810's system?

Constitutional and statutory laws pertaining to workers compensation create significant challenges for integrating the medical portion of workers compensation into the general health care system. For example, Workers Compensation has a constitutionally protected higher standard of medical care (i.e. workers compensation is characterized by a “cure and relief” standard of care vs. “medical necessity or medical appropriateness”).

In addition the relationship between WC medical and WC indemnity poses significant administrative challenges to bringing WC medical into the general health care system.

However, integrating Workers Compensation makes good financial sense in many respects – A recent study commissioned by the Commission on Health and Safety in WC finds that administrative overhead accounts for more than half of the premiums paid. Nationally it was estimated that integration of the medical portion of WC into the general health care system would save over \$500 billion over a 10 year period.

So the benefits of integration are substantial and the potential for integrating the two health care finance mechanisms will continue to be investigated. In fact, the bill explicitly instructs the Commissioner to investigate integrating the two systems. However, at this time, SB 810 is seeking to make significant changes to how basic health care is financed in the state, and taking on the additional challenge of revamping workers compensation in the same legislation may be too much for one bill.

Medical Malpractice/defensive medicine is the real problem in our health care system.

California has one of the strictest limitations in the nation on Medical Malpractice under MICRA.

Nationally, medical malpractice is indeed seen as a cost driver; however it is not a primary one. Studies have shown, based on Medicare data, that malpractice reforms that directly reduced provider liability pressure led to reductions of 5-9% in medical expenditure, potentially reflecting both the practice of less defensive medicine and lower professional liability insurance costs, without substantial effects on mortality or medical complications.

The uninsured already can get care – so we don’t need universal health care.

Health expenditures *per capita* for the uninsured are roughly half of those for the fully insured (Hadley and Holohan, 2004). Uninsured persons are less likely to receive preventative and screening services, less likely to receive appropriate care for chronic conditions, and are more likely to die from cancer, largely because such persons tend to be diagnosed when it is more advanced (Bernanke, 2008; Institute of Medicine, 2002).

The uninsured also receive inferior treatment. For example, Doyle (2005) found that uninsured victims of car accidents received 20% less treatment in hospitals and were 37% more likely to die of their injuries than the insured. Comparing hospital admissions for “nondeferrable” conditions on either side of the Medicare qualification threshold, Card *et al.* (2007) found that those who were just over the threshold (and therefore almost all insured) enjoyed significantly more treatment and a 20% reduction in the 7-day mortality rate than those just under the threshold. Glied and Mahato (2008) finds that differences in rates of insurance coverage between high-and low-wage workers are the main factor accounting for the increasingly large differences in access to health-care services between these two groups (Box 2).

The delay in treating the uninsured not only reduces the effectiveness of treatment, as noted above, but also increases costs. Insofar as the conditions concerned are communicable diseases, these delays in prevention and treatment also expose the rest of society to health risks. Another factor that unnecessarily raises the costs of treating the uninsured is that they often get treated in emergency rooms for conditions that could have been treated more cheaply elsewhere.

Why is long-term care limited to 100 days? Why is there a limit?

SB 810 limits long term care coverage to 100 days in skilled nursing to be consistent with the level of coverage guaranteed under Medicare. Medi-Cal beneficiaries will retain their current levels of LTC coverage.

The reasons for this limitation is that inclusion of LTC as a covered medical benefit would be a substantial expansion of coverage beyond traditional health insurance coverage, and there are significant uncertainties regarding how costs and utilization would be affected were LTC to be included. Thus, without reliable cost estimates available, it is difficult to integrate LTC as a covered benefit.

Federal health reform establishes a national voluntary insurance program for purchasing Community Living Assistance Services and Support (CLASS program), a long-term care insurance program to be financed by voluntary payroll deductions that would provide limited benefit vouchers to purchase LTC services.

If insurance companies have long-term leases on their buildings/property, how is that handled in an orderly transition to single payer?

The bill calls for a two year transition – after the Secretary of the Health and Human Services Agency determines that the system has sufficient funding. Additionally, the bill provides that the state may choose to contract with third party administrators for the purpose of processing claims and reimbursements – some of the existing infrastructure will be needed under a single payer system.

Will the billing clerks/office staff of private physicians be re-trained for new jobs? What about for hospital billing/collection staff?

Page 23 line 13 of the bill calls for the commissioner to “implement means to assist persons who are displaced from employment as a result of the initiation of the system, including determination of the period of time during which assistance shall be provided and possible sources of funds, including funds from the system, to support retraining and job placement. That support shall be provided for a period of five years from the date that this division becomes operative.”

How can we be sure that the Commissioner won't be captured and influenced by special interests; i.e., insurance, drug, & medical device companies as well as hospital or physician interests?

Currently, there is no capacity for consumers to participate or oversee the management of their health care finance system because it is not democratically accountable. We can't un-elect insurance company executives who run our health care system. Insurance company bureaucrats decide what benefits you can receive and when you can receive them, they decide what doctors you can see and when, they decide what medications you can be prescribed and what medical procedures to allow you to receive. They regularly overturn the medical determinations made by your provider – all with no democratic accountability.

Under a single payer system, those decisions would all be made via democratic processes that are accountable to open-meeting laws and voter accountability.

In addition the legislation implements strong conflict of interest provisions to protect the integrity of the governance structure.

What will happen to malpractice costs under national health insurance?

They will fall dramatically, for several reasons. First, about half of all malpractice awards go to pay present and future medical costs (e.g. for infants born with serious disabilities). Single payer national health insurance will eliminate the need for these awards. Second, many claims arise from a lack of communication between doctor and patient (e.g. in the Emergency Department). Miscommunication/mistakes are heightened under the present system because physicians don't have continuity with their patients (to know their prior medical history, establish therapeutic trust, etc) and patients aren't allowed to choose and keep the doctors and other caregivers they know and trust (due to insurance arrangements). Single payer improves quality in many ways, but in particular by facilitating long-term, continuous relationships with caregivers.