



SB 840: FREQUENTLY ASKED QUESTIONS

I. AFFORDABILITY

Q. How does SB 840 provide coverage to all Californians without increasing spending?

A. By correcting the current health care finance system which currently spends nearly 50% of each health care dollar on administrative and clinical waste, excess drug prices and fraud. SB 840 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 support the delivery of high quality care and establishes an Inspector General for Health Care with strong investigative tools to uncover fraud.

Q. Why is there no new spending?

A. There is more than enough money now being spent on health care to finance benefit rich universal health coverage. We spend over \$6,000 per capita, or more than twice the amount spent in other countries that insure everyone. By correcting health care mis-spending, SB 840 is able to direct money into health care and make the health system very efficient.

Q. How does SB 840 control spending growth?

A. The foundation for controlling spending growth is the streamlined administration made possible by having a single insurer, use of purchasing power to lower prices, provision of universal health coverage so everyone gets preventive care, and consolidated budgetary authority with statutory spending limits. SB 840 does all of this and adds an array of other fiscal tools including capital health investment management, a health payment board to establish provider reimbursement, and a referral policy for specialty care. If necessary, SB 840 gives authority to impose limits on provider and manufacturer reimbursement, to increase premiums, delay the introduction of new benefits and delay capital investments.

Q. Can we afford this reform at a time of budget deficits?

A. Budget deficits are caused in part by our dysfunctional health finance system and health care mis-spending. We can't afford NOT to do this and SB 840 would be a major step toward deficit reduction and a balanced budget. The Lewin Group forecasts that a single insurer model would save the state \$44 billion dollars in the first ten years.

Q. Will people pay more?

A. Most would pay less for health care and 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

Q. How many Californians have no health insurance?

A. About 5 million Californians have no insurance at any time during the year, with an additional 2 million lacking insurance for part of the year. 1.2 million without insurance are children. A disproportionate number of those without insurance are people of color and those with low income.

Q. Who doesn't have health insurance?

A. More than 80% of Californians without health insurance are in families where there is at least one person working. A disproportionate number are from the black and Hispanic community, and over 20% of children have no health insurance. Many are low-wage workers, but many are also solidly middle class.

Q. I have insurance, so why should I want to change a system that is working for me?

A. The health care crisis affects all of us. Last year, 2 million Americans went bankrupt because of medical bills and most of those had health insurance. Each year it is estimated that as many as 500,000 people die from preventable medical errors and infections and the misapplication of technology. The Institute of Medicine, the government health advisor, says we are suffering from an "epidemic of sub-standard care". The price of health insurance is rising many times faster than wages, as much as 59% over the last 5 years. Employment is adversely affected because employers avoid hiring full time employees to avoid having to pay for expensive insurance for them. US products are becoming less competitive in global markets because of high employer health care costs. Emergency Rooms aren't available when you need them because they're filled with uninsured Californians who have no where else to get care. We all have a big stake in fixing the health care crisis.

Q. Why is it better to pay into a publicly administered health care system than to pay a private health insurance premium?

A. You get a lot more health care from your contributions to a publicly financed system than from a private health insurance premium. When you pay a premium to an insurance company a large portion of it, 20% to 30%, goes to administration, shareholder dividends, executive reimbursement, marketing and to pay for additional administrative costs borne by doctors and hospitals. Only 70% to 80% is spent on health care. When you contribute to a state health fund, much more money goes to provide health care. It is a more efficient use of limited health care resources.

Q. Does SB 840 (Kuehl) cover undocumented immigrants?

A. Yes. It costs California less to insure undocumented immigrants than to exclude them. People without health insurance don't get preventive care and, consequently, use expensive emergency rooms and hospital care when they get sick. 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. And 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

Q. What about waiting lists in Canada?

A. Canada spends about 1/3 as much as we do per capita on health care and uses waiting lists to manage limited resources. California spends more than enough to avoid waiting lists, although we will have to plan our resource use carefully.

Q. Does this reform ration health care?

A. Under SB 840 (Kuehl), care will be affordable for every Californian, and health system planning will be done by a public, representative Health Policy Board. Care will only be "rationed" in the sense that the care you get will be based on the sound medical judgement 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? Today, insurance and pharmaceutical companies and HMOs ration care and medications to those who can afford them.

IV. SOCIALIZED MEDICINE

Q. Is this socialized medicine?

A. This is definitely not socialized medicine, where 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.

Q. Is this government-run health care?

A. No. A publicly administered finance system 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 840 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 and connections to for profit insurance and pharmaceutical companies 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.

What makes a government program unpopular is inadequate funding, complex eligibility rules, means testing, periodic eligibility lapses, poor provider participation, low provider reimbursement and the stigma of being "on welfare." A publicly administered consolidated insurance system will not have these problems.

Q. Won't the Commissioner be a "czar" with too much power?

A. No. The Commissioner is elected. 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 Consumer Advocate represents consumer interests. All meetings are open. All documents, except privacy-protected documents, are public. All system officers may be impeached for malfeasance of office.

V. BENEFITS

Q. Is a full pharmaceutical benefit without a co-pay affordable?

A. Yes. By using the state's purchasing power for 35 million Californians, it 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.

Q. Will drug discounts adversely affect pharmaceutical companies?

A. No. There are 10 million Californians who now have no prescription drug benefits but who will have them under SB 840 (Kuehl). This expansion of the market offsets losses from lower prices.

Q. Will lower drug prices hurt the ability of pharmaceutical companies to do research?

A. No. 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.

Q. How will the plan help seniors who already have health coverage through Medicare?

A. Under SB 840 (Kuehl), seniors get benefits that Medicare doesn't cover, such as full prescription drug coverage and dental 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.

Q. Will anyone lose benefits they now have?

A. The intent is that no one should lose any benefit they now have.

Q. Who decides what the medical benefits will be?

A. The Chief Medical Officer and other physicians recommend the benefits they think are appropriate. The Commissioner and the Health Policy Board vote on whether to accept their recommendation.

Q. Will Kaiser still exist under SB 840?

A. Kaiser will provider 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

Q. Will SB 840 (Kuehl) stifle innovation?

A. SB 840 will stimulate innovation in several ways. SB 840 will expand health markets, by freeing up private dollars that now pay for care for the uninsured and by creating a well-funded state budget for R and D. Partnerships for Health will provide health care grants to communities for innovative programs. Pharmaceutical companies will have the incentive to redirect the 40% of 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.

Q. How will your system decrease medical errors?

A. By eliminating many of the causes of errors such as understaffing, lack of readily accessible medical information, and lack of coordination of medical services. Your primary care provider will be responsible for coordinating the care you need.

Q. How will SB 840 address the nursing shortage?

A. No one can solve the nursing shortage overnight. A well-managed single insurer system would, however, have funds to invest in nursing education, the shortage of which is the heart of the problem.

Q. Can the Commissioner close a hospital over the objections of the community?

A. No. 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 standard.