

Single-Payer (Public Payer/Private Provider) Health Insurance v. 208 Commission Mandate for Private Multi-Payer Insurances

The only Systemic, Quality-Centered Health Care Reform

- Single-risk-pool (Public Payer, Private Provider) insurance replaces fragmented, costly, administratively wasteful multiple insurance bureaucracy.

Cost-Effective

- Directs 95 percent of health care dollars to health care.
- Eliminates wasteful insurance administrative, profits, lobbying & marketing costs.
- Provider/hospital savings - single billing form to single location; eliminates pre-authorizations; creates single drug formulary; streamlines provider credentialing.
- Financed by sliding scale taxes, at less than current out-of-pocket costs to most.
- Streamlines multiple insurance categories into single risk pool, and eliminates means testing, etc.
- Permits negotiation of annual facilities budgets, fair provider reimbursements & pharmaceutical/medical bulk rates.

Consumer / Social Cost Savings

- Eliminates deductibles that often force under- and uninsured into delayed, costly crisis ER care.
- Consumers save inflated costs of goods and services.
- True choice of all providers and hospitals.
- Financial Security: Eliminates fear of medical bankruptcies.

Business / Employee Savings

- Greater business competitiveness - freed from managing health plans.
- Employees freed from shifted health costs and job-dependent coverage.

Comprehensive, Affordable Coverage for All Residents

- Covers all medically necessary health care (includes drugs, mental health, dental, long-term and home health care, etc.)
- Provider-patient health care decisions - eliminates insurance middlemen.
- Transparent/accountable data permits Health Information Technology system for assessment of best medical practices, outcomes.

More Info: www.healthcareforallcolorado.org

Massachusetts-Style Mandate for Profit-Centered Private Insurance

- Steep tax penalty for noncompliance (1 year's cost of insurance)
- Taxpayer subsidies to private insurances
- Moves uninsured to 'underinsurance' -- Minimum Benefits Plans with high out-of-pocket costs
- Lack of insurance cost controls - portends continued annual premium rate increases. Colorado rates more than doubled over 7 years.

Cost-Inefficient

- Over 1/3 of premium dollars go to profit and overhead (American Medical News, 03/06/06).
- Adds new categories of coverage and means testing that increase administrative costs.
- Rising premiums (4x faster than wages) prompt employers to switch to Minimum Benefit Plans, increasing health/financial risk to families; small employers drop coverage completely.
- Increasing numbers of uninsured move into public programs (e.g., Medicaid), shifting more costs to taxpayers, who already pay more than 60% of all health care costs.

Consumer / Social Costs

- Increase of under- and uninsured shift costs to consumers/ taxpayers.
- Barriers to preventive care lead to costlier delayed, crisis ER care.
- Lower-income families choose food and housing over health insurance.
- Choice of providers / hospitals limited by employer's health plan.
- Greater risk of personal bankruptcy (50% due to medical bills).
- Adds to consumer costs of goods & services (e.g., more than \$1,500 to each U.S.-made car).

Business / Employee Costs

- Employer-provided health plans reduce business competitiveness.
- Greater costs shifted to employees, reducing effective take-home pay.

Complex, Multi-Tiered Health Coverage

- Insurance middlemen game the system, denying and reneging on claims; 30% of initial provider claims are denied (Wall St. Journal 2/14/07).
- Pre-authorization delays or denial of treatment
- Private insurance proprietary data fails to contribute to transparent, accountable Health Information Technology system.