

Statement of  
The Hospital & Healthsystem Association of Pennsylvania  
Before the  
Senate Banking & Insurance Committee  
James M. Redmond  
Senior Vice President, Legislative Services  
The Hospital & Healthsystem Association of Pennsylvania  
Harrisburg, PA  
December 16, 2009

Mr. Chairman and members of the Senate Banking & Insurance Committee, I am Jim Redmond, Senior Vice President, Legislative Services, The Hospital & Healthsystem Association of Pennsylvania (HAP). HAP represents more than 250 member hospitals, health systems, and other health-related organizations serving patients across Pennsylvania.

Mr. Chairman, thank you for seeking our views on a single-payer health system, like that proposed in Senate Bill 400. My testimony will cover the following topics:

- Overview of Senate Bill 400
- Experience with National Health Insurance
- Overview of Federal Health Legislation
- Questions and Concerns

**Senate Bill 400—The Family and Business Healthcare Security Act**

A single-payer health system is a health care delivery and financing mechanism sponsored and administered by a single entity, usually the government of a state or nation. Single-payer plans also are referred to as “universal coverage plans” or “socialized medicine.” Senate Bill 400 is a comprehensive bill that establishes a statewide health care system providing universal health care coverage financed by increases in personal and business taxes. Key provisions in the legislation include the following:

Governance—Senate Bill 400 establishes an 11-person Pennsylvania Health Board with the following duties and responsibilities:

- Implementing eligibility standards for benefits.
- Adopting a benefits package for all participants.
- Administering all claims for health care services.
- Setting health care provider reimbursements.

- Establishing statewide databases to support health care services planning.
- Developing mechanisms and incentives to assure culturally and linguistically sensitive care.
- Establishing a no-fault patient compensation system for injuries or complications of care.
- Evaluating technical innovations, medications and procedures.
- Approving all expenditures for new health care facilities and capital investments over \$1 million.
- Imposing a temporary increase in taxes in the event the General Assembly has not responded to a request by the board for an increase in funding in anticipation of projected expenses.

Eligibility—All Pennsylvania citizens, legal aliens or immigrants, full-time out-of-state students, homeless persons and migrant agricultural workers and their families are eligible under the plan.

Benefits package—A single health benefits package includes, at a minimum, all of the following:

- All medically necessary inpatient and outpatient care and treatment.
- Emergency services.
- Emergency and other medically necessary transport to covered health services.
- Rehabilitation services, including speech, occupational, physical, and massage therapy.
- Inpatient and outpatient mental health services and substance abuse treatment.
- Hospice care.
- Prescription drugs and prescribed medical nutrition.
- Vision care, dental care, and hearing care.
- Diagnostic medical tests, including laboratory tests and imaging procedures.
- Medical supplies and prescribed medical equipment.
- Immunizations, preventive care, health maintenance care, and screening.
- Home health care services.
- Chiropractic, massage therapy, complementary and alternative therapies.
- Long-term care.

Limitations—All copayments and deductibles, and exclusions for pre-existing conditions are prohibited.

Financing—The bill replaces existing insurance premiums and out-of-pocket expenditures with a 10 percent tax on gross payroll, including self-employment profits, and a 3 percent income tax.

Exclusions—Employers who are part of a collective bargaining agreement where the benefits are no less generous than those provided under the plan are excused from paying 90 percent of the gross payroll tax.

### **Experience with National Health Insurance**

Some Americans, such as the proponents of Senate Bill 400, want the United States to adopt a single-payer health system as a means to cover the uninsured, to establish equality of care, and to control health care costs. Proponents highlight the imperfections of the current health care system and contrast it with a plan in which these imperfections disappear and everyone has access to “free” health care. Although this view holds appeal for some Americans, it would impose government control of the production and distribution of health care goods and services.

Looking at other countries and their health care experiences, can provide guidance as we examine how to reform our health care system.

There is no single model for national health care systems in other countries. Each country's system is the product of its unique conditions, history, politics and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland, to the single-payer systems of Great Britain, Canada and Norway. Some countries have a true single-payer system, prohibiting private insurance. Others are multi-payer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others do not. Some require consumers to share a significant portion of health care costs through either high deductibles or high copayments. Others subsidize first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians, but require referrals for specialists.

*The only system one cannot find is the type of system described in Senate Bill 400; a system that provides unlimited care with no premiums, deductibles, or copayments, from the physician of one's choice.*

Michael Tanner of the Cato Institute notes in his recent article, *The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World*, that nearly all health care systems worldwide are wrestling with problems of rising costs and lack of access to care. He concludes that overall trends from national health care systems around the world suggest the following:

- Health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have long waiting lists for treatment.
- Rising health care costs are not a uniquely American phenomenon. Although other countries spend considerably less than the United States on health care, costs are rising almost everywhere, leading to budget deficits, tax increases, and benefit reductions.
- In countries weighted heavily toward government control, people are most likely to face waiting lists, rationing, restrictions on physician choice, and other obstacles to care.
- Countries with more effective national health care systems are successful to the degree that they incorporate market mechanisms such as competition, cost sharing, market prices, and consumer choice, and eschew centralized government control.

### **Federal Health Reform**

President Obama has made comprehensive health reform one of his top three domestic agenda items. Economic recovery and energy conversation are the other two domestic issues. Congress is currently well into the process of passing legislation that contain the President's goals of controlling rising health care costs, guaranteeing choice of physician, and assuring high-quality, affordable health care for all Americans. There are two major health reform bills pending in Congress:

- Patient Protection and Affordable Care Act (H.R. 3590); and
- Affordable Health Care for America Act of 2009 (H.R. 3962).

Neither of these bills are single-payer health systems. Both bills build off the present employer-based system and the government-sponsored programs of Medicare, Medicaid, CHIP, Indian Health Service, and the Veterans Administration.

Changes in Health Insurance Coverage—Both the House and Senate proposals would decrease the number of uninsured, primarily through expansions in the Medicaid program, premium subsidies

provided to people with incomes up to 400% of the federal poverty level buying health insurance through newly-created purchasing exchanges, and a requirement that everyone (with some exceptions) be insured.

Under the House bill, 94 percent of non-elderly people would be insured. Under the Senate bill, 92 percent of the non-elderly population would be insured. A number of people under each of the proposals would buy insurance through the new purchasing exchanges. These would include primarily people buying coverage on their own, as well those whose employers elect to arrange for coverage through an exchange. Both the House and Senate bills include a so-called “public option” plan that would compete with the private insurers in the exchanges (states could opt out of the public option in the Senate proposal).

Cost of Expanding Coverage—The Senate bill is estimated to cost \$848 billion over 10 years, whereas the House bill is estimated to cost \$1.052 trillion over 10 years.

Financing—The largest element of the financing of the House plan is surtax on high income taxpayers, a proposal not included in the Senate bill. The Senate plan includes two proposals not in the House bill – an increase in the Medicare payroll tax for high income workers, and a new tax on high-premium employer-sponsored health plans. Both proposals contain new excise taxes on various health industries, though the scope of the taxes varies. The House bill taxes only medical device makers, while the Senate bill also includes taxes on brand-name drug companies and health insurers. A major financing component of both proposals is a reduction in federal spending on existing health programs such as Medicare and Medicaid (\$456 billion in the House and \$491 billion in the Senate).

### **Questions and Concerns**

The U.S. health care system clearly has problems. Costs are rising and are distributed in a way that makes it difficult for some people to afford the care they want or need. Far too many Americans go without health insurance. And while the U.S. provides the world’s highest quality health care, that quality is uneven, and too often Americans don’t receive the standard of care that they should.

- *But would a government-run single payer health care system be any better?*

Senate Bill 400 replaces current health insurance premiums and government subsidies with an increase in payroll taxes and personal income taxes.

- *Are these two sources of funding adequate?*
- *What happens if these two sources do not provide sufficient funds for adequate access and quality?*
- *Why would Pennsylvania embark on establishing a single-payer system, as proposed in Senate Bill 400, when Congress is about to adopt a multi-payer approach?*

Mr. Chairman and members of the committee, thank you for the opportunity to comment about this legislation. We appreciate your help in trying to ensure that affordable quality health care is available to all Pennsylvanians. I would be happy to try to answer any questions you may have.