



## **AMSA PA Lobby Day 2008**

### **In support of H.B. 1660 / S.B. 300: The Family and Business Health Security Act**

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## **AMSA PA Lobby Day 2008 Schedule**

- 9 – 9:35 AM** Press Conference on SB 300/HB 1660 in Capitol Rotunda  
Medical students will be joined by members of the League of Women Voters, PA Council of Churches, and the AFL-CIO to demonstrate our support for guaranteed, publicly-funded healthcare for all and brief the press on this bill.
- 9:45 – 10:25 AM** Legislative briefing by Chuck Pennacchio, PhD,  
Executive Director of Healthcare For All PA  
Dr. Pennacchio will brief us on the bill. Because time is very limited, this session will focus on Q & A. Please read and discuss the background information on the bill in advance, and come ready with questions!
- 10:25 – 10:50 AM** How to Talk With Legislators  
Mary Carol Jennings, AMSA Jack Rutledge Legislative Director
- 11:00 AM – 3 PM** Appointments with Legislators  
In small groups (3-4 students), we will be meeting with House and Senate representatives from Philadelphia, Pittsburgh, Hershey, and other PA districts where our students are registered to vote. We plan on at least two appointments per group, though this will depend on the availability of the representatives. Between appointments, you will be:
- Writing thank you cards to the legislators – follow-up is critical!
  - Strategizing with your team about what to different in the next meeting.
  - Eating lunch
  - Dropping in and make your voice heard with members of the print media. Their offices are at the top of the Rotunda stairs -- off to the left.
  - Stopping by offices of members of the House Health and Human Services Committee to leave short, hand-written notes.
  - Talking with Chuck Pennacchio: he will be available to talk with you about whatever you'd like to know – the history of the bill, political strategy looking forward, his own amazing background in politics and organizing.
  - Talking with Mary Carol Jennings: she will be available to discuss how she and national AMSA could best support the efforts of your school in doing education and advocacy around health policy and legislation and answer any questions you have.
  - Leadership training with Wes Fisher
  - Socializing with fellow students from across PA
- 3 – 3:30 PM** Debrief: share our experiences from the day

## American Medical Student Association



### S.B. 300 / H.B. 1660: Family and Business Health Security Act

#### **Current system**

- Access to healthcare is becoming increasingly uncertain
  - More than 1 in 4 Americans went without health insurance at some point in the last two years
  - Even more were underinsured -- not protected against catastrophic health care expenses
  - In PA, median wages increased 13% since 2000 while health insurance premiums increased 76%
  - Rising premiums → rising number of uninsured Pennsylvanians, now nearly 1 million
- Unsustainable growth in health spending
  - The US spends at least twice as much on healthcare as most industrialized countries.
  - Our health spending is growing more than 3x as fast as the average industrialized country

#### **Only a single-payer solution will adequately resolve both of these increasingly urgent problems**

- Massive administrative cost reduction
  - Insurance companies spend over 3x as much on administration as single payer systems like Medicare due to the enormous cost of trying to identify and deny coverage to potentially costly patients – e.g., patients that have even minor "prior conditions," such as allergies
  - The fragmented system of hundreds of insurance plans, each having its own rules, also contributes to administrative costs, for both insurance companies and for doctors and hospitals, which have to employ large billing departments simply to obtain reimbursement.
- Completely eliminates the expense of insurance industry profit and advertising.
- Negotiated pharmaceutical prices: Much lower prescription drug prices that will result from the bargaining power of 12.5 million Pennsylvanians united to negotiate with pharmaceutical companies. Nearly all other industrialized countries bargain on behalf of their citizens to lower the costs of prescription medication, and the Veteran's Administration already does this here in the U.S.

#### **Truly universal, comprehensive, and affordable**

- No deductibles or co-pays, and no caps
- Covers all costs of hospitalizations, physicians/outpatient care, prescription drugs, dental, mental, optical, vision, preventive, emergency services/transport, addiction, transplants, medical equipment/supplies, rehabilitation services (including speech, occupational, and physical therapy), long term care, home health care, and hospice.
- Governor's plan, by contrast, cannot guarantee care to everyone and provides only "basic" care, while preserving insurance industry waste and cost inflation.

#### **More freedom**

- Public financing, private delivery of care
- Freedom to choose any doctor without the restrictions of insurance lists
- Freedom to start a business – no risk of being without health access; may increase innovation
- Freedom from endless, expensive malpractice suits: no-fault program providing a reasonable and immediate set of benefits to anyone injured by their medical care regardless of how careful the health care provider may have been; freedom from defensive medicine
- Freedom of information: electronic medical records and data analysis at the system level to reduce errors, improve coordination of care, track public health outcomes, systems improvement
- Freedom from haggling with insurance companies to provide good care
- Freedom from the leading cause of personal bankruptcy – healthcare expenses.

**For more information please contact:** Chuck Pennacchio, Executive Director, Healthcare for All PA  
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## **Highlights of SB 300 / HB 1660**

### **The Family and Business Health Security Act**

#### **Comprehensive coverage:**

Provides comprehensive universal health coverage, single payer, no deductibles or co-pays, and no caps. Covers all costs of hospitalizations, physicians/outpatient care, prescription drugs, dental, mental, optical, vision, preventive, emergency services/transport, addiction, transplants, medical equipment/supplies, rehabilitation services (including speech, occupational, and physical therapy), long term care, home health care, and hospice. There is no coverage for purely cosmetic procedures except where deformity is trauma related. Replaces private insurance, Medicaid, Adult Basic, PaCHIP, and all other government programs except Medicare and VA. The Plan plugs all holes in Medicare and VA coverage. Parties to collective bargaining agreements with benefits at least as generous as SB 300 may opt out. Private insurers may sell insurance to cover anything not covered by the Plan.

#### **Completely free choice of physician:**

Preservation of the private health care system and the right of patients to choose their doctor. Providers unwilling to accept the reimbursements established by the Plan may choose to be Non-Participating but must fund their own medical malpractice coverage.

#### **Improved efficiency:**

Use collective buying power of 12.5 million Pennsylvanians to lower drug costs and costs for durable medical equipment. Eliminate most of the administrative costs associated with private insurers (~25%) by harnessing economies of scale associated with a single payer like Medicare (~3% administrative costs). Completely eliminate the expense of private insurer profit and advertising.

#### **Cost containment & Disparity reduction:**

Cost containment through a certificate of need requirement to avoid wasteful and duplicative capital investment in medical equipment or services in over served areas while encouraging, and even underwriting, development in under served parts of the Commonwealth.

#### **Malpractice solution:**

Current malpractice system is replaced with a Constitutional program allowing a consumer choice between: (1) An administrative no-fault program providing a reasonable and immediate set of benefits to anyone injured by their medical care regardless of how careful the health care provider may have been, and (2) Retaining their traditional fault based remedies. The Plan will fund both the no-fault and fault approaches thus eliminating malpractice insurance premiums for Participating Providers except for those who elect to purchase additional coverage to insure traditional claims exceeding the \$3 million/\$6 million limits provided at no charge by the Plan.

#### **Error reduction:**

Medical error reduction through an aggressive and fully funded program to investigate all claims of errors, to order and enforce better practices to reduce avoidable health care related injuries, and to seek license revocation where appropriate.

**Electronic medical records:**

Funding of a 21st Century digital medical record system that will be cost-efficient, eliminate redundant testing, and will reduce prescription and treatment errors.

**Wellness:**

Total commitment to establishing a culture of wellness through: (1) A fully funded K through 12 health education and physical fitness curriculum that is considered no less important than any other “core” subject, and (2) Identifying and eliminating environmental health risks.

**Transition:**

Generous transitional assistance to workers displaced by the move to a single payer system. Adoption of this legislation will also create tens of thousands of excellent new jobs in health care, education, substance abuse treatment, and long term care.

**Funding:**

Dedicated funding of the program through a 10% Health Care Levy on payrolls (including the self-employed) plus a 3% Wellness Tax on all personal income. This is reduced to just 1% each for employers and employees where there is a qualifying collective bargaining agreement.

## Proposed Funding for SB 300 / HB 1660

<b>Source</b>	<b>Revenue generated</b>
10% Healthcare Levy on payrolls (paid by employers):	\$30 billion
3% Wellness Tax on personal income:	\$10 billion
Federal sources (Medicaid, SCHIP):	\$6 billion
Tobacco settlement:	\$2 billion
<b>Total annual revenue generated:</b>	<b>\$48 billion</b>
Total annual cost of program:	\$45 billion
Excess revenue (to ensure sufficient funding):	\$3 billion

### **Sources of savings over current system**

*Figures are for first year; savings increase over time with the growth of healthcare costs.*

Administrative savings:	\$7 billion
Prescription drug cost savings (through bulk purchasing):	\$3 billion

## **Our "Asks"**

### **AMSA PA Lobby Day 2008**

In each appointment, after discussing SB 300 / HB 1660, hearing the legislator's perspective, and trying to address his or her concerns, we will be asking for three things:

1. Will you co-sponsor SB 300 / HB 1660? If so, please notify Kathy Manderino, who is the head sponsor in the House, or Jim Ferlo, who is the head sponsor in the Senate.
2. Will you host/co-host a hearing in your area on SB 300 / HB 1660? [Targeted areas are now Philly, Pittsburgh, Scranton/Wilkes-Barre, Reading, and Lancaster.]
3. Will you sponsor an economic impact study of the bill to be conducted by an independent firm so we can establish the true costs of the plan and have a basis to compare other proposals? If so, please notify Kathy Manderino / Jim Ferlo.

# TWO PLANS FOR PENNSYLVANIA: ONLY ONE IS BEST FOR ALL OF US

HealthCare4AllPA.org

**FAMILY AND BUSINESS  
HEALTH CARE  
SECURITY ACT**

**ED RENDELL'S  
PRESCRIPTION FOR  
PENNSYLVANIA**

Guarantees health care protection for all Pennsylvanians	●	●
Delivers quality <u>comprehensive</u> healthcare	●	●
Preserves the right of patients to choose their own doctors	●	●
No deductibles, co-pays or lifetime caps	●	●
Prescription drug coverage + behavioral health coverage	●	●
Uses the collective buying power of 12.5 million Pennsylvanians to lower drug costs and costs for durable medical equipment	●	●
Covers dental, mental health, optical, emergency transport, addiction, transplants, DME, hospice, and long term care	●	●
Reduces or controls the administrative costs, executive salaries, and profits which now consume 20-30% of every premium dollar.	●	●
Cuts workers compensation premiums by up to 50%	●	●
Lowers auto insurance rates for everyone	●	●
Eliminates extra expenses caused by “defensive medicine”	●	●
Reduces malpractice insurance costs via an optional no-fault program	●	●
Provides long term care coverage	●	●
\$1000 annual tax rebates for active volunteer first responders	●	●
Solve unfunded future health liability accounting crisis	●	●
Constitutes a true single-payer health system”	●	●
Does away with excessive private insurance surpluses	●	●
Eliminates waste and inefficiency inherent in multi-payer systems	●	●
Provides transition assistance workers displaced by the plan	●	●
Avoids wasteful and duplicative capital investments in medical equipment or services in over-served areas	●	?
Establishes a culture of wellness	●	?
Funds a digital medical record system to eliminate redundancies and reduce prescription and treatment errors	●	?
Makes health care more efficient by reducing medical errors	●	●
Redirects state money	●	●
Places new emphasis on infection control	●	●
Levy on payroll	●	●
Levy on personal income	●	●
Contains costs through quality control and enforcement	●	●
Bans smoking in restaurants, bars and workplaces.	●	●
Requires difficult changes (47+) to state laws and regulations	●	●
Relies on federal money	●	●
Incremental plans available for private purchase	✖	●
Relies on a new 10-cent-per-pack increase in the cigarette tax	●	●
Retains the employer sponsored/administered health plan model	●	●
Relies on tax payer subsidies for the purchase of private insurance	●	●
Insurance industry remains in control	●	●
Permits “Wal-marting” of coverage, where poor and low income individuals are funneled into low level “basic” insurance plans	●	●
Covers Pennsylvania’s estimated 150,000 illegal immigrants	●	●
Covers cosmetic procedures	●	●

● Limited or partial      ✖ Unnecessary in this plan

# Potential Objections and Responses

## Compiled by Physicians for a National Health Program

*This discusses national health insurance, but it is also relevant to state single-payer plans*

### **Is national health insurance ‘socialized medicine’?**

No. Socialized medicine is a system in which doctors and hospitals work for and draw salaries from the government. Doctors in the Veterans Administration and the Armed Services are paid this way. The health systems in Great Britain and Spain are other examples. But in most European countries, Canada, Australia and Japan they have socialized health insurance, not socialized medicine. The government pays for care that is delivered in the private (mostly not-for-profit) sector. This is similar to how Medicare works in this country. Doctors are in private practice and are paid on a fee-for-service basis from government funds. The government does not own or manage medical practices or hospitals.

The term socialized medicine is often used to conjure up images of government bureaucratic interference in medical care. That does not describe what happens in countries with national health insurance where doctors and patients often have more clinical freedom than in the U.S., where bureaucrats attempt to direct care.

### **Won't this raise my taxes?**

Currently, about 60% of our health care system is financed by public money: federal and state taxes, property taxes and tax subsidies. These funds pay for Medicare, Medicaid, the VA, coverage for public employees (including police and teachers), elected officials, military personnel, etc. There are also hefty tax subsidies to employers to help pay for their employees' health insurance. About 20% of health care is financed by all of us individually through out-of-pocket payments, such as co-pays, deductibles, the uninsured paying directly for care, people paying privately for premiums, etc. Private employers only pay 21% of health care costs. In all, it is a very “regressive” way to finance health care, in that the poor pay a much higher percentage of their income for health care than higher income individuals do.

A universal public system would be financed in the following way: The public funds already funneled to Medicare and Medicaid would be retained. The difference, or the gap between current public funding and what we would need for a universal health care system, would be financed by a payroll tax on employers (about 7%) and an income tax on individuals (about 2%). The payroll tax would replace all other employer expenses for employees' health care, which would be eliminated. The income tax would take the place of all current insurance premiums, co-pays, deductibles, and other out-of-pocket payments. For the vast majority of people, a 2% income tax is less than what they now pay for insurance premiums and out-of-pocket payments such as co-pays and deductibles, particularly if a family member has a serious illness. It is also a fair and sustainable contribution.

Currently, 47 million people have no insurance and hundreds of thousands of people with insurance are bankrupted when they have an accident or illness. Employers who currently offer no health insurance would pay more, but those who currently offer coverage would, on average, pay less. For most large employers, a payroll tax in the 7% range would mean they would pay slightly less than they currently do (about 8.5%). No employer, moreover, would gain a competitive advantage because he had scrimped on employee health benefits. And health insurance would disappear from the bargaining table between employers and employees.

Of course, the biggest change would be that everyone would have the same comprehensive health coverage, including all medical, hospital, eye care, dental care, long-term care, and mental health services. Currently, many people and businesses are paying huge premiums for insurance so full of gaps like co-payments, deductibles and uncovered services that it would be almost worthless if they were to have a serious illness.

### **Isn't a payroll tax unfair to small businesses?**

The payroll tax means a cost increase for businesses that are not currently insuring their workers. However, it is much less than they would pay at present for adequate coverage for themselves and their workers. For most small (and large) businesses already providing coverage, the payroll tax will mean substantial savings.

### **Won't this result in rationing like in Canada?**

The U.S. already rations care. Rationing in U.S. health care is based on income: if you can afford care, you get it; if you can't, you don't. A recent study by the prestigious Institute of Medicine found that 18,000 Americans die every year because they don't have health insurance. Many more skip treatments that their insurance company refuses to cover. That's rationing. Other countries do not ration in this way.

If there is this much rationing, why don't we hear about it? And if other countries ration less, why do we hear about them? The answer is that their systems are publicly accountable, and ours is not. Problems with their health care systems are aired in public; ours are not. For example, in Canada, when waits for care emerged in the 1990s, Parliament hotly debated the causes and solutions. Most provinces have also established formal reporting systems on waiting lists, with wait times for each hospital posted on the Internet. This public attention has led to recent falls in waits there.

In U.S. health care, no one is ultimately accountable for how the system works. No one takes full responsibility. Rationing in our system is carried out covertly through financial pressure, forcing millions of individuals to forego care or to be shunted away by caregivers from services they can't pay for.

The rationing that takes place in U.S. health care is unnecessary. A number of studies (notably a General Accounting Office report in 1991 and a Congressional Budget Office report in 1993) show that there is more than enough money in our health care system to serve everyone if it were spent wisely. Administrative costs are at 31% of U.S. health spending, far higher than in other countries' systems. These inflated costs are due to our failure to have a publicly financed, universal health care system. We spend about twice as much per person as Canada or most European nations, and still deny health care to many in need. A national health program could save enough on administration to assure access to care for all Americans, without rationing.

### **Who will run the health care system?**

There is a myth that with national health insurance the government will make the medical decisions. But in a publicly financed, universal health care system, medical decisions are left to the patient and doctor, as they should be. This is true even in the countries like the U.K. and Spain (or in U.S. systems like the VA) that have socialized medicine.

In a public system, the public has a say in how it's run. Cost containment measures are publicly managed at the state level by elected and appointed agencies that represent the public. This agency decides on the benefit package and negotiates doctor fees and hospital budgets. It also is responsible for health planning and the distribution of expensive technology. Thus, the total budget for health care is set through a public, democratic process. But clinical decisions remain a private matter between doctor and patient.

### **What about medical research?**

Much current medical research is publicly financed through the National Institutes of Health. Under a universal health care system this would continue. For example, a great deal of basic drug research, for example, is funded by the government. Drug companies are invited in for the later stages of "product development," the formulation and marketing of new drugs. AZT for HIV patients is one example. The early, expensive research was conducted with government money. After the drug was found to be effective, marketing rights went to the drug company.

Medical research does not disappear under universal health care system. Many famous discoveries have been made in countries with national health care systems. Laparoscopic gallbladder removal was pioneered in Canada. The CT scan was invented in England. The treatment for juvenile diabetes by transplanting pancreatic cells was developed in Canada.

It is also important to note that studies show that, in the U.S., the number of clinical research grants declines in areas of high HMO penetration. This suggests that managed care increasingly threatens clinical research. Another study surveyed medical school faculty and found that it was more difficult to do research in areas where high HMO penetration has enforced a more business-oriented approach to health care.

Finally, it appears that the increasing commercialization of research is beginning to slow innovation. Drug firms' increasing reliance on contract research organizations (and for-profit ethical-review boards) has coincided with a sharp drop in innovative new drugs and a spate of "me-too" drugs - minor variations on old drugs that offer little benefit other than extended patent life.

### **Won't this just be another bureaucracy?**

The United States has the most bureaucratic health care system in the world. Over 31% of every health care dollar goes to paperwork, overhead, CEO salaries, profits, etc. Because the U.S. does not have a unified system that serves everyone, and instead has thousands of different insurance plans, each with its own marketing, paperwork, enrollment, premiums, and rules and regulations, our insurance system is both extremely complex and fragmented.

The Medicare program operates with just 3% overhead, compared to 15% to 25% overhead at a typical HMO. Provincial single-payer plans in Canada have an overhead of about 1%.

It is not necessary to have a huge bureaucracy to decide who gets care and who doesn't when everyone is covered and has the same comprehensive benefits. With a universal health care system we would be able to cut our bureaucratic burden in half and save over \$300 billion annually.

## **How will we keep costs down if everyone has access to comprehensive health care?**

People will seek care earlier when chronic diseases such as hypertension and diabetes are more treatable. We know that both the uninsured and many of those with skimpy private coverage delay care because they are afraid of health care bills. This will be eliminated under such a system. Undoubtedly the costs of taking care of the medical needs of people who are currently skimping on care will cost more money in the short run. However, all of these new costs to cover the uninsured and improve coverage for the insured will be fully offset by administrative savings.

In the long run, the best way to control costs is to improve health planning to assure appropriate investments in expensive, high-tech care, to negotiate fees and budgets with doctors, hospital and drug companies, and to set and enforce a generous but finite overall budget.

## **How will we keep doctors from doing too many procedures?**

This is a problem in any system that reimburses physicians on a fee-for-service basis. In today's health system, another problem is physicians doing too little for patients. So the real question is, "How do we discourage both overcare and undercare?"

One approach is to carefully control new capital expenditures. Once a hospital or imaging center purchases a multimillion-dollar CT scanner, it will try to generate enough scans to pay off the fixed cost. Explicit health planning should be done to assure that expensive machines and facilities are sited where they are needed and not where they are redundant and likely to generate overuse.

Another approach is to compare physicians' use of tests and procedures to their peers with similar patients. A physician who is "off the curve" will stand out. A related approach is to set spending targets for each specialty. This encourages doctors to be prudent stewards and to make sure their colleagues are as well, because any doctor doing unnecessary procedures will be taking money away from colleagues.

In addition, expert guidelines by groups like the American College of Physicians, etc., can help shape professional standards - which will certainly change over time as treatments change. This really gets to the heart of "how do you improve the quality of health care," which is a longer topic. Suffice it to say that single-payer, universal coverage provides a framework for achieving thoughtful quality improvement.

## **What will happen to physician incomes?**

On the basis of the Canadian experience under national health insurance, we expect that average physician incomes should change little. However, the income disparity between specialties is likely to shrink.

The increase in patient visits when financial barriers fall under a single-payer system will be offset by resources freed up by a drastic reduction in administrative overhead and physicians' paperwork. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board.

## **How will we keep drug prices under control?**

When all patients are under one system, the payer wields a lot of clout. The VA gets a 40% discount on drugs because of its buying power. This “monopsony” buying power is the main reason why other countries’ drug prices are lower than ours. This also explains the drug industry’s staunch opposition to single-payer national health insurance.

## **Why shouldn’t we let people buy better health care if they can afford it?**

Whenever we allow the wealthy to buy better care or jump the queue, health care for the rest of us suffers. If the wealthy are forced to rely on the same health system as the poor, they will use their political power to assure that the health system is well funded. Conversely, programs for the poor become poor programs. For instance, because Medicaid doesn’t serve the wealthy, the payment rates are low and many physicians refuse to see Medicaid patients. Calls to improve Medicaid fall on deaf ears because the beneficiaries are not considered politically important. Moreover, when the wealthy jump the queue, it results in longer waits for others. Studies in New Zealand and Canada show that the growth of private care in parallel to the public system results in lengthening waits. Additionally, allowing the development of a parallel, private system for the wealthy means the creation of a permanent lobby for underfunding public care. Such underfunding increases the demand for private care.

## **What will be covered?**

All medically necessary care would be funded through the single payer, including doctor visits, hospital care, prescriptions, mental health services, nursing home care, rehab, home care, eye care and dental care. We also advocate a sharp increase in public health funding.

## **What about alternative care, will it be covered?**

Alternative care that is proven in clinical trials to be effective will be covered. For example, spinal manipulation for some lower back conditions would be covered, but not chiropractic care of the neck (which is unproven and possibly dangerous). Antioxidant vitamins would be covered for people with macular degeneration, but not for the general population (where they appear to be harmful). In general, coverage decisions will be made by the health care planning board or another public body. New kinds of treatments will be added to the benefits package over time as they are shown to be effective, including “alternative” treatments. Similarly, ineffective or harmful care can be removed from the benefits package, such as high dose epo for cancer.

## **Can a business keep private insurance if they choose?**

Yes and no. Everyone has to be included in the new system for it to be able to control costs, reduce bureaucracy, and cover everyone. In Canada, businesses can purchase additional private insurance that covers things not covered by the national plan (e.g. private rooms, orthodontia, etc.). However, we support a comprehensive benefit package for the single-payer program that would eliminate the need (and most demand) for supplemental coverage.

Insurance companies would not be allowed to offer the same benefits as the universal health care system, a restriction contained in the traditional Medicare program. Allowing such duplication of coverage weakens and eventually destabilizes the health care system. It undermines the principle of pooling the risk. Health care systems act as universal insurers. At

any one time the healthy help pay for those who are ill. If private insurers are allowed to cherry-pick the healthy, leaving the public health care system with the very sick, the system will fail.

This, in fact, is what we see happening to Medicare through the Medicare Advantage program. The government pays Medicare HMOs 13% more than it pays traditional Medicare, yet the HMOs care for a healthier mix of seniors. This is leading to privatization of Medicare and funding shortfalls for the traditional Medicare program.

### **What will happen to all of the people who work for insurance companies?**

The new system will still need some people to administer claims. Administration will shrink, however, eliminating the need for many insurance workers, as well as administrative staff in hospitals, clinics and nursing homes. More health care providers, especially in the fields of long-term care, home health care, and public health, will be needed, and many insurance clerks can be retrained to enter these fields. Many people now working in the insurance industry are, in fact, already health professionals (e.g. nurses) who will be able to find work in the health care field again. But many insurance and health administrative workers will need a job retraining and placement program. We anticipate that such a program would cost about \$20 billion, a small fraction of the administrative savings from the transition to national health insurance.

PNHP has worked with labor unions and others to develop plans for a jobs conversion program which would protect the incomes of displaced clerical workers until they were retrained and transitioned to other jobs.

### **How will we contain costs with the population aging?**

Studies show that aging of the population accounts for only a small fraction of the increases in health costs. Japan and Europe are already facing the problem of an aging population head-on and are doing fine. They have a much higher percentage of elderly than we do, and still spend far less on health care.

The best way to approach this is to regard it as a societal problem, one that needs a solution with everyone in mind. Germany and Japan recently adopted single-payer long-term care systems to cover the long-term care needs of the elderly at home and in specialized housing. Germany is pioneering a program that pays family members to care for the elderly at home.

### **What about ERISA? Doesn't it stand in the way of states implementing universal health care plans?**

No. ERISA (the Employees Retirement Income Security Act) prevents a state from requiring that a self-insured employer provide certain benefits to their employees. However, a single-payer plan would not mandate the composition of employer benefit plans - it would replace them with a new system that would essentially be "Medicare for all." The state would require employers to pay a payroll tax into the health care trust fund, which is clearly legal.

### **How will the Health Planning Board operate?**

A health planning board would be a public body with representatives of patients and medical experts. The representatives would decide on what treatments, medications and services

should be covered, based on community needs and medical science, and allocate capital for major new investments based on assessments of where need is greatest.

**Since we could finance a fairly good system, like the Norwegian, Danish or Swedish system, with the public money we are already spending (60% of health costs), why do we need to raise the additional 40% (from employers and individuals)?**

There are three reasons why the U.S. health care system costs more than other systems throughout the world. One, we spend two to three times as much as they do on administration. Two, we have much more excess capacity of expensive technology than they do (more CT scanners, MRI scanners, and surgery suites). Three, we pay higher prices for services than they do.

There is no doubt that we do not need to spend more than we currently spend to cover comprehensive care for everyone. But the initial transition to a universal system would be very disruptive if we spent less. That is because we have a tremendous medical infrastructure, some of which would likely retain its excess capacity during the transition phase. Secondly, we would likely retain salaries for health professionals at their current levels. Thirdly, we would cover much more than most other countries do by including dental care, eye care, and prescriptions. And for these reasons we would need the extra 40% that we are already spending - but NOT more. We could cover all the uninsured and improve coverage for those who have skimpy coverage for the same amount we are currently spending!

**How much of the health care dollar is publicly financed?**

Over sixty percent (60.5 percent) of health spending in the U.S. is funded by government. Official figures for 2005 peg government's share of total health expenditure at 45.4 percent, but this excludes two items:

1. Tax subsidies for private insurance, which cost the federal treasury \$188.6 billion in 2004. These predominantly benefit wealthy taxpayers.
2. Government purchases of private health insurance for public employees such as police officers and teachers. Government paid private insurers \$120.2 billion for such coverage in 2005: 24.7 percent of the total spending by U.S. employers for private insurance.

So, government's true share amounted to 9.7 percent of gross domestic product in 2005, 60.5 percent of total health spending, or \$4,048 per capita (out of total expenditure of \$6,697).

By contrast, government health spending in Canada and the U.K. was 6.9 percent and 7.2 percent of gross domestic product respectively (or \$2,337 and \$2,371 per capita). Government health spending per capita in the U.S. exceeds total (public plus private) per capita health spending in every country except Norway, Switzerland and Luxembourg.

(Source: Himmelstein and Woolhandler, "Competition in a publicly funded healthcare system" *BMJ* 2007; 335:1126-1129 [1 December] and Woolhandler and Himmelstein, *Health Affairs*, 2002, 21(4), 88, "Paying for National Health Insurance - And Not Getting It.")

## **Why not MSAs/HSAs?**

Medical savings accounts (MSAs) and similar options such as health savings accounts (HSAs) are individual accounts from which medical expenses are paid. Once the account is depleted and a deductible is met, medical expenses are covered by a catastrophic plan, usually a managed care plan.

Individuals with significant health care needs would rapidly deplete their accounts and then be exposed to large out-of-pocket expenses; hence they would tend to select plans with more comprehensive coverage. Since only healthy individuals would be attracted to the MSAs/HSAs, higher-cost individuals would be concentrated in the more comprehensive plans, driving up premiums and threatening affordability. By placing everyone in the same pool, the cost of high-risk individuals is diluted by the larger sector of relatively healthy individuals, keeping health insurance costs affordable for everyone.

Currently, HSAs offer substantial tax savings to people in high-income brackets, but little to families with average incomes, and thus serve as a covert tax cut for the wealthy.

Moreover, MSA/HSA plans discourage preventive care, which generally would be paid out-of-pocket, and do nothing to restrain spending for catastrophic care, which accounts for most health costs. Finally, HSAs/MSAs discriminate against women, whose care costs, on average, \$1,000 more than men's annually. Hence, on the MSA/HAS plan, the average woman pays \$1,000 more out-of-pocket than her male counterpart.

## **Why not use tax subsidies to help the uninsured buy health insurance?**

The major flaw of tax subsidies is that they would be used to help purchase plans in our current fragmented system. The administrative inefficiencies and inequities that characterize our system would be left in place, and we would continue to waste valuable resources that should be going to patient care instead. Moreover, even with tax subsidies, moderate- and lower-income individuals would be unable to afford good coverage, leaving them with modest benefits and high cost-sharing that would often make health care unaffordable. Instead of perpetuating our current inequities, tax policies should be used to create equity in contributions to a system in which everyone is assured access to comprehensive beneficial services.

If the tax subsidies are granted to individuals, employers would be motivated to drop their coverage, and most individuals covered would have merely rotated from employer coverage to individual coverage. The net reduction in the numbers of uninsured would be small. If the tax subsidies are granted to employers, a major shift in funding passes from employers to taxpayers without significant improvements efficiency or fairness. We can use the tax system to create equity in the way we fund health care, but we should also expect equity and efficiency in allocation of our health care resources. Distributing health resources according to human needs is possible only if we eliminate the private health plans and establish a publicly administered system.

## **Won't competition be impeded by a universal health care system?**

Advocates of the "free market" approach to health care claim that competition will streamline the costs of health care and make it more efficient. What is overlooked is that past competitive activities in health care under a free market system have been wasteful and expensive, and are the major cause of rising costs.

There are two main areas where competition exists in health care: among the providers and among the payers. When, for example, hospitals compete they often duplicate expensive equipment in order to corner more of the market for lucrative procedure-oriented care. This drives up overall medical costs to pay for the equipment and encourages overtreatment. They also waste money on advertising and marketing. The preferred scenario has hospitals coordinating services and cooperating to meet the needs of their communities.

Competition among insurers (the payers) is not effective in containing costs either. Rather, it results in competitive practices such as avoiding the sick, cherry-picking, denial of payment for expensive procedures, etc. An insurance firm that engages in these practices may reduce its own outlays, but at the expense of other payers and patients.

### **Why not make people who are higher risk pay higher premiums?**

Experience-rated insurance requires higher risk people to pay higher premiums. This approach says that people who have had cancer in the past, or who have chronic conditions like diabetes and hypertension, or who have had dangerous exposures to substances like asbestos, must pay more because they are at higher risk of using health services. Experience rating allows insurance companies to cherry-pick the healthiest people and either refuse to insure the sickest or, what amounts to the same thing, charge prohibitively high rates. This approach makes no sense. The whole point of insurance is to spread the risk so that everyone is covered. If you raise premiums - and thereby exclude from coverage - those people unfortunate enough to be sick, you defeat the point of both insurance and the health care system. Genetic conditions, childhood diseases, accidents, injuries and income distribution (or how much equality there is in a society) play a much bigger role in people's health than "individual lifestyle" factors. And we know that even for motivated patients, alcohol and tobacco cessation are difficult, and medical weight loss nearly impossible. We need public health, primary care and education programs to try to prevent disease, but punishing patients once they are ill is inhumane and counterproductive.

Community-rated health insurance is the socially fair approach. It spreads the risks evenly among all the insured. It removes the punitive element. It does not discriminate against the very sick, nor against those of us who are at higher risk because of our age (say, over 50) or our gender (reproductive-age females have higher health expenses than men, for obvious reasons).

Health care should be organized as a public service, like a fire department. A health system organized as a business is discriminatory and accountable to no one. At some point in our lives all of us will predictably need health care. Hence health insurance is unlike any other form of insurance; we all are involved.

### **Walter Reed Army Medical Center has been in the news lately for poor care and treatment of returning soldiers from Iraq. Won't national health insurance have similar problems?**

As we consider what we can learn from the Walter Reed Army Medical Center debacle with regard to government-run efforts, some clarifications should be made:

1. Walter Reed Army Medical Center is an Army hospital and is run by the Department of Defense. The VA hospitals are run by the Veterans Administration (Veterans Health Administration), a separate organization. The news media has clouded this fact and has led the public to presume that all government-run health efforts fail. The VA health system continues to receive the best quality scores of any segment of the U.S. health system, with the most satisfied patients. It beats the best HMOs in quality ratings, has a model information system, and focuses

on primary care. It has led in addressing medical errors and in its application of AHRQ quality guidelines to both inpatients and outpatients. In 2004 it won the Baldrige Prize for quality and patient-safety improvements.

2. There is a lot we can learn from the Walter Reed disgrace. Its operation was outsourced to a Halliburton-connected company in 2002, over the objections of some Army medical personnel and leadership, with a subsequent drastic reduction in staff and loss of government employees with institutional experience. There was also some hanky-panky with the contracting process; when the government employees' bid for the operations contract came in lower than the Halliburton company's bid, the bids were "recalculated" to make the private company the lowest bidder.

(This section was contributed by Dr. Anne Carroll.)

### **What about incremental reform of the health system?**

As a matter of policy, PNHP expressly opposes many so-called gradual steps towards single-payer. Many well-meaning supporters often push these bills as "feasible steps" to move us towards single-payer, but the history of these kinds of health reform efforts - Hawaii in 1974, Massachusetts in 1988, Oregon in 1989, Tennessee in 1992, Minnesota in 1992, Maine in 2003, etc. - shows that despite their claims of pragmatism, incremental reforms have consistently failed for more than three decades. Incremental reforms cannot garner administrative savings and redirect them to care. Hence they always founder on the shoals of cost. In addition, these reforms distract attention from the economically realistic, if politically challenging, option of single-payer reform.

### **What happens to investor-owned hospitals under national health insurance (NHI)?**

"The NHI program would compensate owners of investor-owned hospitals, group/staff model HMOs, nursing homes and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI. Investor-owned providers would be converted to nonprofit status. The NHI would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements." (Physicians' Proposal, JAMA, August 13, 2003.)

### **What proportion of health spending is for undocumented immigrants?**

Very little. All foreign-born people, including immigrant workers who have legal status and who have lived in the U.S. for years, account for somewhat less than one-quarter of the uninsured, according to the Census Bureau. We do know that foreign-born people in the U.S. are, on average, healthier and utilize little health care - about half of the health care (per capita) of U.S.-born persons. Surprisingly this is true whether or not they have insurance. Immigrant children receive very little care, 74 percent less overall than other children. So, if the foreign born are less than one-quarter of the uninsured, only one-eighth of health spending on the uninsured is going to the foreign born, which translates into a tiny fraction of all U.S. health spending. In fact, most immigrants have health insurance coverage, and 30% of immigrants use no health care at all in the course of a year. Undocumented immigrants are politically unpopular and hence a convenient target, but they are not the cause of rising health care costs.

**The insurance industry says that PNHP's figures on administrative costs are outdated. Is this true?**

PNHP has published a series of peer-reviewed studies over the past 20 years showing a steady increase in health administrative costs. While some aspects of administrative cost estimation (e.g. physicians' billing costs) require special studies, others, such as insurance overhead, can be easily tracked from publicly available data. These figures show no evidence of a fall in administrative costs since our most recent (2003) comprehensive estimate that administration consumes at least 31% of U.S. health care spending.

Recently, right-wing "think tanks" have released studies claiming that Medicare's administrative costs are far higher than the official 3% estimate. These estimates add to Medicare's costs a share of the salaries of the President and members of Congress, the cost of running the Internal Revenue Service, etc. But none of these added costs would go away if Medicare were abolished, or up if Medicare were expanded to cover everyone. Most economists agree that such expenses should not be included in calculating Medicare's overhead.

**How much could the states save on administrative waste by adopting a statewide single-payer program?**

Data on total health expenditures by state (excluding administrative spending) is available at: [http://www.cms.hhs.gov/NationalHealthExpendData/05\\_NationalHealthAccountsStateHealthAccounts.asp](http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp)

Estimates of state administrative costs (a few years old, but the best available) are in an article by Drs. David Himmelstein and Steffie Woolhandler from 2003.

## 101 Reasons Why SB 300 / HB 1660 Works for PA

1. Protect Pennsylvania jobs - by capping the employer contribution to the Health Trust at 10% of payroll. Those Pennsylvania employers currently paying for employee health insurance coverage will enjoy a substantial savings and will no longer be at a competitive disadvantage to those paying nothing toward the cost of health care coverage. This also completely eliminates the administrative overhead costs associated with employer paid health insurance.
2. Reduce the cost of prescription drugs - by using Pennsylvania's 12.5 million citizens as a formidable bargaining entity in dealing with drug companies.
3. Eliminate uncompensated care - by assuring that health care providers are paid for all of the services they provide.
4. Assure comprehensive care for all - through a universal health care system. Approximately one million out of our 12 million citizens have no health coverage of any kind.
5. End wasteful "defensive" medicine - which, according to a recent survey, 90% of Pennsylvania physicians admit to. We address this by replacing the fault based malpractice system with a no-fault program that emphasizes broader availability of compensation, quality assurance instead of punishment. Those who believe they are better off retaining their traditional fault based right to sue may opt out of the no-fault system, but the Balanced Plan adopts the no-fault approach as the default position and thus the vast majority of Pennsylvanians will participate in the no-fault program.
6. Address racial disparity - through universal access and a commitment to assuring the availability of quality providers in all communities.
7. Dramatically reduce wasteful administrative costs - through a single payer approach that eliminates the unnecessary and redundant overhead of the existing myriad of public and private payers. Major studies have agreed that approximately 20% of our health care dollars are wasted due to the inefficiencies of the current system.
8. Remove health care as a recurrent union/management issue in collective bargaining - by providing automatic, comprehensive, and universal health care independent of the employment relationship. This legislation does permit unions and employers to opt out of the Commonwealth Plan so long as the benefits included in the collective bargaining agreement are at least as comprehensive as the Commonwealth Plan.
9. End health care expenses as the leading cause of personal bankruptcy - thus preserving the dignity and savings of Americans who already face the burdens directly associated with family illness or accident.
10. Preserve the volunteer firefighter and emergency responder base, especially in rural areas of the Commonwealth - through a \$1,000 per year state tax rebate to active volunteers we encourage the retention and recruitment of this vital resource.
11. Reduce the cost of workers' compensation insurance - with universal coverage that meets an injured employee's health care needs independent of the employer's workers' compensation insurance. By eliminating the health care expense and administrative overhead workers compensation premiums will drop dramatically.
12. Eliminate duplication of facilities in over-served communities - by requiring a certification of need communities already adequately served with high tech diagnostics or surgery centers

will not see another (which would only threaten the financial viability of both) and instead would-be investors will be encouraged to build in under-served areas.

13. Restore the concept of a true “emergency room” - through universal coverage that assures that all citizens will have ready access to primary care physicians. Thus ending the wasteful and inefficient practice of using hospital emergency rooms as primary care centers.

14. Reduce the cost of automobile insurance for business and consumers - universal health care access eliminates the need to ever file suit to cover past and future medical costs thus removing that risk from the vehicle insurance coverage and leading to dramatically lower premiums.

15. Restore and enhance the traditional physician/patient relationship - by ending the unfortunate and counterproductive environment where every patient is seen as a potential plaintiff.

16. Reduce infant mortality through better pre-natal care - and a universal health access system that assures full and complete pre-natal management thus reducing the number of avoidable low weight and premature deliveries.

17. Preserve the family farm - by eliminating the need for a farm family to seek a “city” job that provides health care benefits and by avoiding financial failures of farm families faced with uninsured or underinsured health care expenses.

18. Retain high-risk specialists in the Commonwealth - by eliminating entirely the burden on providers to fund a dysfunctional medical malpractice system.

19. Support the home care model - where a family is willing to provide a loving environment in a non-institutional setting. A universal health system committed to emotional wellness as well as physical health will provide the training and the specialized services required.

20. Provide sufficient substance abuse treatment facilities - by including substance abuse as a covered component of the universal health system we dramatically expand the funding for facilities and trained personnel.

21. Preserve our investment in higher education - by separating health care coverage from employment more economic opportunities are created. When our college graduates are unable to find worthwhile employment in the Commonwealth our investment in their training is wasted and the Commonwealth loses more of its intellectual capital. Additionally, new graduates will not suffer a gap in health coverage while they search for that first job.

22. Encourage early retirement to open opportunities for younger people - by making it possible for a worker to retire before they qualify for Medicare at age 65. If a person is otherwise financially able to retire before age 65, the universal coverage system will make it possible to do so thus opening an employment position for a younger person.

23. Encourage the best and the brightest to enter the health care professions - through the elimination of the specter of financial ruin due to a malpractice action, assured payment for all services, and reduced overhead costs through a simplified and efficient single payer system, the health care professions become more attractive career options.

24. Level the competitive playing field between large and small businesses - through a universal health care system that moots the existing health care insurance premium costs between large and small employers.

25. Reduce the cost of home-owner's insurance - by assuring that a person injured at your home has automatic health coverage and thus eliminating the need for a homeowner's insurance policy to insure against the risk of being sued for medical costs. Lower risk equals lower premiums.
26. Permit lawmakers to move on to other critical matters by finally resolving the health care crisis - since every year the General Assembly devotes substantial time to debating, again, the issues surrounding access to health care, Medicaid allowances, coverage for Commonwealth employees, and medical malpractice reform. All of which distracts from other critical issues of the day. A bold move to resolve the health care dilemma through a balanced and fiscally responsible solution opens the legislative agenda for other matters.
27. Allow Pennsylvania manufacturers to compete more fairly against foreign manufacturers - most of whom have a government sponsored health care system independent of the employer and thus manufacturers in those countries do not have the overhead burden of providing health care to their workers. By capping a Pennsylvania employer's contribution to health care at a fully deductible 10% of payroll, we dramatically reduce the anticompetitive effect of the higher premiums currently being paid by our hard-pressed manufacturers.
28. Shift health provider revenues from administrative to clinical work - an estimated 20% of provider revenue is squandered on billing and administrative paperwork required by the existing inefficient and overlapping system of third party reimbursements. Those same resources could be redirected to clinical care.
29. Encourage entrepreneurship - through a universal health care system that eliminates the risk of being without health access for the aspiring small business person and their family.
30. End the practice of requiring those in need to spend themselves into poverty to qualify for long-term care assistance - by including long term care in the universal health coverage package. This will end the current humiliating practice of forcing an already sick, usually elderly, person to spend themselves into poverty before qualifying for assistance.
31. Accelerate the transition to a paperless "electronic health care record" - through a single payer system it becomes easier to track, document, and access an individual's health care history. An electronic health care record would be immediately available to any authorized health care provider thus eliminating the delays and errors associated with paper records scattered over a number of offices and ultimately lost over time.
32. Enhance a new culture of health awareness and responsibility - by using part of the trust funds to use the media and school system to teach and encourage better health habits and by creating a sense of social responsibility not to engage in self destructive or unhealthful behaviors that add to the common cost of health care.
33. End the competitive advantage of those businesses which have refused to provide health care insurance - by requiring all employers to pay the same 10% of payroll health care levy as a percentage of payroll. Small employers paying minimum wage would pay just 52 cents an hour more, less net of taxes, toward a universal health care plan.
34. Create a sophisticated health care society - through the creation of an age appropriate K through 12 curriculum with an emphasis on health equal to any other area of study.
35. Establish dedicated funding sources used exclusively for health care - thus assuring that the Trust will be fully funded and not endlessly debated year to year. By establishing dedicated

funding sources for health care the interest of health will not have to compete against other government priorities for funding and taxpayers will be less resistant to paying the health specific taxes if confident that all of such revenues will be used exclusively for health care.

36. Reduce drug related crime - by assuring adequate and effective drug treatment services for those supporting their addictions through criminal activity or by becoming drug pushers themselves.

37. Assure available specialists in all geographic parts of the Commonwealth - through a single payer system committed to assuring universal availability of quality coverage through-out the Commonwealth. For example, Providers who establish practices or build facilities in underserved areas can be rewarded with bonus reimbursements.

38. Reduce employment discrimination based on age and health - through a universal health care system that ends the concern of employers over the potential increase in group health insurance premiums should they hire an older person or someone with a personal or family illness. This resolves the individual underwriting process now in use which takes the cost savings out of many group plans.

39. End the COBRA irony - through a universal health system that continues regardless of employment status and which ends the absurdity of requiring a newly unemployed or divorced person to pay substantial sums to continue health care for themselves and their families when they are least able to afford it.

40. Preserve patient choice - by permitting the patient to choose their physician among any Participating Provider.

41. Support the ability of charitable organizations to recruit and retain staff - as all employees will automatically be covered under the Plan. Non-profit organizations will no longer lose employees and prospects to private industry solely due to the employee's need for health care benefits.

42. Free up capital for research and development - by capping the employer contribution to the health care trust at 10% of payroll, thus assuring employers will have cash available for the research and development costs that are at the heart of future growth and competitiveness.

43. Better coordinate epidemiological data - through a single payer system that best captures in one database the occurrence of environmental, viral, or bacteriological illnesses.

44. Reinforce and support primary care - through a reimbursement system that emphasizes wellness and preventative medicine primary care providers will be in greater demand and more appropriately compensated.

45. Accelerate the introduction of new technology to improve diagnostics - by providing a financing means for hospitals and providers to acquire new technology even where the obsolete equipment may not have been fully amortized.

46. Infinite and immediate adjustability of the revenue sources to meet a disaster - with health care taxes adjustable in tenths of a percent as needed, in the event of a natural or man-made disaster the required revenues to meet the urgent medical needs can be instantly and temporarily raised through a simple adjustment in the percentage. Similarly, where Trust surpluses accumulate beyond what is required downward adjustments in the taxes can also be readily and easily made.

47. Free the courts from protracted medical negligence litigation - through the introduction of an optional no-fault administrative mechanism to compensate those injured by their care. We thus remove from the court dockets the many and complicated medical malpractice cases that consume a disproportionate share of judicial resources.
48. Reduce state, local and school board expense - through the adoption of a universal health care system whereby governments of all sizes will be relieved of the annual angst of debating, providing, and funding health care benefits.
49. Improve worker productivity - by providing ready access to care for workers and their families. Less time will be lost from work due to untreated conditions that ultimately worsen leading to extended absences.
50. Improve highway safety - by fully funding substance abuse treatment. With a reduction in impaired driving the frequency of motor vehicle accidents will drop and with it the expense related to the care and treatment of those injured.
51. Humanitarian treatment for migrant workers - through the inclusion of critical but under appreciated migrant workers and their families in the health care system. In doing so we assure the responsible support of those who otherwise would be at the mercy of illness and ultimately burden the emergency facilities of our hospitals.
52. Encourage and support the arts - by assuring that talented individuals pursuing a career in the arts, or as independent performers, are covered through a plan of universal health care.
53. Restore the spirit of joy and service to the health care professions - through the elimination of the specter of malpractice suits and the obsessive concern about whether or not a patient has adequate insurance, health care professionals can again focus on the patient.
54. Reduce abusive access to narcotics - through a unified electronic health record system that immediately identifies situations where a patient is seeking multiple prescriptions from different physicians.
55. Increase self reporting of medical errors - by eliminating the fear of financial ruin. Errors can be more readily reported and thus corrective action taken to limit the harm and to develop protocols to eliminate recurrences.
56. More swiftly identify previously unknown drug side effects or dangerous combinations of drugs - through a single payer system that tracks patients and medications as well as the symptoms that are later reported which may be the clue to adverse chemical reactions.
57. Eliminate the wasted motion of the specialist referral for responsible consumers - by granting all patients the right to self refer to a specialist, and then only limiting that right for those who abuse it, the Plan assures that access to specialists is not delayed by procedural barriers that punish the many for the conduct of the few.
58. End the "same sex" and "domestic" partner health care debate - by automatically covering everyone under the universal plan.
59. Eliminate suicides related to the cost of health care - through a universal health care system that relieves the chronically ill patient of the guilt associated with potentially bankrupting their family with health care expenses.

60. Reduce the incidence of chronic diseases that could have been avoided or prevented through early intervention - by eliminating the cost of care barrier, individuals with the early symptoms of a disease, such as cancer, will more readily seek care and enjoy an earlier diagnosis and better prognosis.
61. Reward the development of enhanced skills and experience - by adopting a reimbursement structure that adds an incentive bonus to those health care providers who invest in themselves and acquire enhanced skills and experience.
62. End the wasted motion and paperwork associated with point of service deductibles and co-pays - through the elimination of the ritual of collecting and accounting for these charges.
63. Eliminate wasted employer management time - by ending forever the annual dreaded ritual of receiving and analyzing the group health insurance premium increase, shopping around for a lower premium, evaluating how much of the premium cost can be shifted to the employees through premium sharing, a reduction in benefits, an increase in co-payments and the like.
64. End the “food or medicine” choice - through the inclusion of a full prescription drug benefit covering all citizens.
65. Assure full access to mental health treatment - by fully funding mental health therapy and treatment.
66. Maintain the continuity of care - by eliminating constant switching of providers to accommodate different health plans.
67. Guarantee divorced spouses and their children have access to health care - through universal health care marital status is irrelevant to health care access.
68. Improve nurse retention - by reallocating funds from malpractice insurance premiums and administrative overhead. Hospitals will be able to use those resources to assure a rational patient to nurse ratio, eliminate mandatory overtime, and enhance training.
69. Annuitize compensation for persons injured by their medical treatment - by making compensation payments through monthly disbursements, rather than by lump sum. This assures that the money cannot be squandered over a short period of time, which is often the case, and is more consistent with the concept of replacing what was lost rather than granting a lottery type pay-off.
70. Assured coverage for those working multiple part time jobs - by detaching health care access from employment there is no difference in coverage based upon whether a person is working one full time, or two part time, jobs.
71. Protection for domestic employees - through universal coverage that assures that housekeepers, cooks, drivers, gardeners and others working as domestic servants enjoy comprehensive access for themselves and their families.
72. More extensive quality assurance review of errors and complications - because every patient claim will be carefully investigated for evidence of correctable mistakes and patterns. By changing the emphasis to care improvement rather than blame all involved can contribute to a more constructive analysis of what went wrong, and what can be done to prevent a reoccurrence.

73. Preserve the free market system while assuring cost containment - with a Plan that does not contemplate public ownership of health care facilities or public employment of health care workers. Rather, the free market system will be allowed to work such that the providers with the best quality of service will attract the most patients.
74. Assured dental coverage - through inclusion of non-cosmetic dental services in the program.
75. Eliminate the health care coverage handcuffs that limit workers' ability to change jobs - and replace it with the freedom to offer your services to the highest bidder thanks to universal coverage that is independent of the employer.
76. End uncompensated care for providers - and instead assure Participating Providers that they will be paid for 100% of the services rendered to program beneficiaries.
77. Assured vision and optical care - through inclusion of eye health services as an integrated part of the health care package.
78. Eliminate the financial insecurity and fear associated with the aging process - by assuring that gaps in the Medicare program will be filled through the Plan and no Pennsylvanian will suffer needlessly simply based upon their ability to pay.
79. Create tens of thousands of high paying new jobs in health care and health education - required to provide services to the approximately one million currently uninsured Pennsylvanians and to teach a "wellness curriculum" in our schools.
80. Fully protect the catastrophically ill or injured - through a health care system that does not have the usual life time caps that are easily exceeded by those with serious and chronic illnesses or disabilities requiring intensive skilled care.
81. Saving Pennsylvania's share of the 18,000 who die annually in the United States due to inadequate access to health care - through a universal health care program that assures that every person who needs care will receive it.
82. Expand the availability of compensation more equitably to those injured by their health care providers - through a no-fault system that does not require a tedious and expensive litigation process committed to finding someone to blame and which allows only a few to recover anything at all. Rather, the optional no-fault program assures expedited claim handling and eligibility with lower attorney fees and other costs of traditional malpractice litigation.
83. Encourage the unemployed to accept entry level positions by removing the fear of losing Medicaid or Adult Blue coverage - with universal care automatic for all, there need no longer be a concern that by accepting a modest paying entry level position a worker will disqualify themselves or their families from access to health care.
84. Assuring that the newly disabled, but under age 65, have access to health care while they wait two years for Medicare eligibility - through a universal coverage approach that does not go away when the disabled lose their jobs.
85. Prompt payment of reimbursements to providers - through electronic billing and electronic fund transfers within one week health care providers have ready access to their money and avoid borrowing costs.

86. End the practice of overcharging the uninsured - which is an ironic and absurd reality in the current system. Many hospitals and doctors charge uninsured patients a higher rate than the reimbursement accepted from private insurers and government programs. As a result the patients least able to pay have been charged the most and often are driven into bankruptcy. Universal coverage through a single payer ends this disparity once and for all.
87. Eliminate the need for outside billing and collection services - thus saving the average physician up to 5% of their gross collections otherwise paid to an outside collector.
88. Pay for Performance incentives - through a reimbursement system that rewards excellence based upon objective performance criteria. Providers who adopt best practices and achieve lower complication and readmission rates will be rewarded and those who do not measure up will be paid less.
89. Create millions of qualified first responders - through enhanced health care education every graduating high school senior can be a certified first responder ready and able to assist a family member, friend, or even a total stranger until help arrives. This can mean the difference between recovery and a lifelong disability or death.
90. Assure that every injured person is rehabilitated to their maximum potential - by incorporating full rehabilitation within the standard program benefits. In addition to being morally right, a commitment to full rehabilitation will reduce the overall cost of care as many more patients will be able to return to the workforce or at least be better able to attend to their own physical needs.
91. Keep qualified and experienced physicians on the job - by eliminating the burden of malpractice premiums and by simplifying the billing and collection system.
92. Assure well baby care - with comprehensive post-natal care included in the universal health care program.
93. Reduce the incidence of sexually transmitted diseases - by simplifying access to primary and specialist care. STDs can thus be diagnosed sooner and treatment initiated to reduce the spread of the disease and to assure proper counseling to the affected patients and their partner. Enhanced wellness education also leads to reduced infection transmission.
94. Permit providers to challenge the adequacy of reimbursements through an administrative process whereby single providers or groups can offer evidence in support of higher reimbursements.
95. Full transparency in the error investigation process - by assuring that a complaining patient is afforded every opportunity to be heard and is kept advised of the investigation and any corrective actions that are ordered in response to an avoidable injury or complication.
96. Implementation of Pennsylvania Cost Containment Council recommendations - through a process whereby all such recommendations are reviewed and where providers are required to implement necessary reforms.
97. Humane end-of-life care - by including hospice care within the comprehensive health care package.
98. All licensed providers can compete - through a universal system that does not try to artificially lower prices by freezing out providers from networks in exchange for lower prices from other providers.

99. Protect early retirees who were promised health care coverage by now defunct employers - through a universal health care system that protects the young retiree from being left out in the cold by a broken promise of retirement health coverage.

100. Prepare Pennsylvania for more cuts in Federal health care support - by preparing our Commonwealth to be more self sufficient and reliant on its own resources and efficiencies as Congress bit by bit reduces grants to states for Medicaid and CHIP programs.

101. No more bake sales to fund health care - instead we embrace health care as a community responsibility and a communal right through a system of universal access.