TESTIMONY FOR SENATE BILL 133, "WISCONSIN UNIVERSAL HEALTH PLAN"
BEFORE SENATOR MOEN'S COMMITTEE
Wednesday, February 20, 2002

The United States and especially Wisconsin has some of the worlds best medical/health care providers and technology. Unfortunately the "system" or non-system in which this care is provided is extremely inefficient and costly – it is the world's most expensive, complex, bureaucratic, administratively top heavy and rationed health care system – a system that leaves about 40+ million people without health care insurance coverage of any kind and another 50+ million underinsured and at risk for personal bankruptcy because of health care costs. Because of its administrative complexity and inefficiencies Americans pay more in taxes and out of pocket expenses for health care than do residents of any other western nation – nations that cover all their inhabitants.

I support this bill, SB 133 because – **It is time to stop making piece-meal changes** to our present patchwork system, changes that increase the complexity and overhead costs at all levels of providing care. **It is time we respond to the real needs** of farmers, small and large businesses, the self-employed and the recipients and providers of health/medical care. **It is time we assure all are covered**, whether rich or poor, well or ill, old or young, employed or unemployed. **It is time we allowed people to choose their own doctors** and to remain with them as long as they want regardless of decisions made by their employers or insurers. **It is time for a real structural change of the way the "system" is financed** and administered. **It is time we enable all residents of Wisconsin to benefit** from the presently available excellent services of those who provide health care.

You, who have excellent, in part tax supported, health care coverage, must not hide behind the mantra that says "government can do nothing right" – if that is true it means you, our legislators, or "we the people" through you our legislators can do nothing right – if that is the case we should continue with the complexities, inefficiencies and costly inequities of our present corporate controlled and rationed health care system. **"Leave it to Enron" is not an appropriate approach.**

Please address the needs of all Wisconsin residents and businesses, make the needed structural changes in our health care "system", and make "health care security for all" not just politically feasible, but a reality by actively supporting the passage and implementation of SB 133. You and we can and must make a change for Wisconsin.

Thanks,

Eugene S. Farley, Jr., MD, MPH
Professor Emeritus Family Medicine UW-Madison
2299 Springrose Road
Verona WI 53593
608-845-8724

TESTIMONY OF DONALD SCHALCH, MD BEFORE SENATOR MOEN'S COMMITTEE
IN SUPPORT OF SB 133
February 20, 2002

Dear Senator Moen,

I regret that I will not be able to testify today, February 20, at the hearing for Senate bill 133 because I have a busy afternoon taking care of prison inmates in my clinic.

Throughout my 42 years of practicing medicine in the states of New York, Colorado, and Wisconsin, I have been a steadfast proponent of a universal health care system here in the United States. I have traveled in most of the countries in Europe including Russia, in the Middle East, and in several counties in Africa and Central America, often investigating their health care systems and attempting to answer questions about our own lack of one. I have found no way to explain how the U.S., the richest country of the world, has not yet been able to guarantee every citizen the right to adequate health care.

When we moved to Wisconsin almost 20 years ago, I knew we were moving to a state with a long and proud history of progressive ideas and an equally responsive government. We still have a chance to be the first state, the most progressive state, in leading our nation to finally developing a universal health care system that is accessible to every human being.

Sincerely,

Don Schalch, M.D., Emeritus Professor of Medicine, Univ. of Wisconsin
263-2468 (office); 233-5696 (home)

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Senate Committee on Health, Utilities, Veterans, and Military Affairs

Public Hearing on SB 133

February 20, 2002

My name is Frank Newgent, Portage, WI, and I support SB 133. I have two major points to make: 1. SB 133 has a long history heavy with private citizen participation It studied health system problems, and used the knowledge and experience of a major Wisconsin state agency executive to design a program.

2. SB 133 is not socialized medicine. I will expand on these two major points.

Background of SB133

The father of this bill was the South Central Wisconsin Health Planning Council, covering 20 southern and western counties with representatives from each. The rest of the state was covered by similar agencies. They were organized to study and propose changes on the health services systems. Federal money finances them.

I was appointed to represent Columbia County in 1984 by the county board of supervisors. Shortly after my appointment I was assigned to a task force to study the medically indigent and make recommendations on their problems. We analyzed various state studies of the problem, but mostly importantly, we decided to hear directly from the people who had poor health care. We reached these people through public health nurses, community action agencies, welfare departments, and hospitals. Three public hearings were held in Beloit, Dodgeville and Madison. Over

120 people attended and 63 gave testimony. As you might guess the speaker had some dramatic stories to tell. One particular one struck me at the Beloit hearing. A man testified who was married, had 3 daughters, and worked in the maintenance department of Beloit college. His youngest daughter, then 3 years old, had been born with many serious, chronic, and expensive health problems. The health services for her were paid for under a special federal program that used family income guide lines. The man had just been offered a promotion in his job with a good increase in in salary. This placed him in a hopeless dilemma. If he took the promotion his income would be higher than allowed by the federal program for his daughter. If he did not take the promotion he deprived the whole family of a chance for a better income level. He turned down the promotion after much discussion in the family.

The Medically Indigent Task Force finished it's 27 page report in July, 1986. The first recommendation it made for Wisconsin was " to develop a plan to make health services available to all persons within 15 years." We have missed the goal by one year, with SB 133.

Several weeks after the Health Planning Board approved our report the agency was forced out of business when the federal money was stopped nationwide. This left no agency to work on carrying out the report's recommendations. So three of the health agency's task force members took on the responsibility of working on the recommend-dations. I was one of the three. We created the Coalition for Wisconsin Health, and started a drive to get organizations to join the work for the Coalition. We contacted people statewide and the last time I looked there were over 50 organization members.

Many were local unions, senior citizen groups joined and the Wisconsin Catholic Conference and the Lutheran office on Public Policy in Wisconsin enlisted. We had community groups like the League of Women Voters. Professional groups and AARP became members.

We at first concentrated on educational activities. During this phase I spoke to between 40 and 50 groups. We studied the Canadian health system mostly through reading the myriad of articles on Canada that appeared in the New England Journal Of Medicine. A chunk of our efforts went in 1988 to having a public referendum on the ballot through the Madison Common Council. The result? 76% of the voters supported universal health services. Finally we began work on what became the scores of drafts for state legislation, working closely with the Wisconsin Legislative Council. SB 133 is the product for that long time effort. It is a comprehensive proposal that spells out many details for a Wisconsin operation. Your discussions of it and amendments to it make it even better.

Now about socialized medicine. This bill does not set up socialized medicine, as some people will claim. Doctors will not be employed by the state. Hospitals will not be owned by the state. Doctors will practice medicine and not have to be clerks and accountants like they do now. They will make the medical decisions. There will be free choice of doctors and their fees and the budgets of the hospitals will be negotiated

with the state. Pharmaceutical drugs will be handled the same way. If SB 133 is anything it is socialized health insurance. It would be similar to the life insurance plan set up by Wisconsin decades ago, where the commissioner of Insurance administers it, has no advertising, pays no commissions to sales agents, has simple forms, low premiums, and is available to every state resident

Today's health insurance companies, many of which are just a small part of the parent insurance companies business, and the new insurance companies called HMO's, are a significant factor in rising health care costs. High paid executives administer them, there are many well-paid vice- president level staff, dividends for stock holders are important, profits are a major goal, advertising budgets are high, and scores of different forms have to be handled by large clerical staffs.

As with the recent W-2 program, where Wisconsin was a pioneer, universal health services could show other states a model to follow and the federal goverment could discover that health care cost can be lower and when under control of both bureaucrats and consumers. in a public agency

Please give SB 133 serious reading, discussion, and understanding. We stand ready to help in any way possible.

Frank Newgent

N4088, County U

Portage, WI 53901

608-742-7890

Linda Farley, MD; 2299 Spring Rose Rd., Verona WI 53593; 608-845-8724

My name is Linda Farley. I am a member of Coalition for Wisconsin Health, Physicians for a National Health Program, and Wisconsin Citizen Action. In my 47 years as a Family Doctor I have practiced in many places with large numbers of underserved patients, including rural areas in NY state and Wisconsin, inner city Rochester, NY and Denver, CO., the Navajo Indian Reservation, and currently I volunteer at the Madison Community Health Center and at the Medic Salvation Army clinic. Also it is important to note that I and my husband, Dr. Gene Farley, practiced before the advent of Medicare and Medicaid when the elderly and the poor could not afford health care. I saw the great difference those two programs made, both for the patients and for the income of doctors and hospitals.

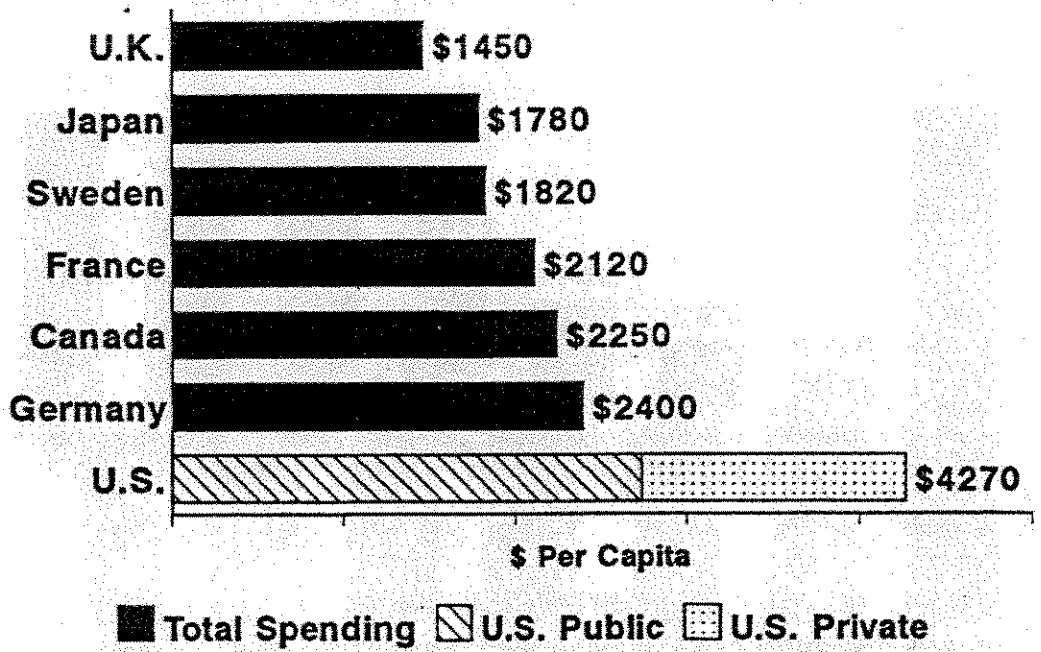
In the early '90's we were all hopeful that the U.S. would catch up with the other industrialized nations and enact a National Health Care Program. There were 37 million uninsured people in the US then. But the powerful special interests of the Medical Industrial Complex, using false propaganda, defeated that effort, promising control of the escalating costs of health care by instituting Managed Care. We all know what has happened instead: Health Care, once considered a service profession, has been re-defined as a business, and where it is a for-profit business, the responsibility to investors has taken precedent over responsibility to patients. There are now more than 40 million uninsured in the US, from 300,000 to 500,000 uninsured in Wisconsin (depending on whose figures you read), many more not adequately insured, and the costs of health care are again escalating in the double digits. Most of those without insurance are employed and those who do have insurance are being asked to bear much more of the burden of high premiums.

There is no plan on the horizon which will actually curb rising health care costs, offer comprehensive, quality care, and cover everybody regardless of income, place of employment, age, or race, except a plan like our own SB 133. As legislators in a state with financial problems and knowing that health care is very costly, I urge you to look at the cost savings to the state which would accrue if we adopted a publicly funded, publicly accountable system such as proposed in the Wisconsin Universal Health Plan. And add to that the renewed acclaim for Wisconsin's progressive tradition, if all residents of our state qualified for non-means tested quality health care. The states of Vermont, Massachusetts, Maryland, California, and Maine have done studies looking at the cost savings to their states of a public insurance system such as outlined in our bill, and have found that they could insure everyone and still save. If you are interested I can supply you with these studies.

You have before you some charts which indicate why this is a feasible plan. Most people do not realize the current extent of government funding for health care. The government (tax money) already assures coverage for 45% of the population, including the premiums public employees receive, Medicare, Medicaid, Veterans health care, Native American's health care, and special programs like Badger Care and others. Because many of these groups are high cost – the elderly, the poor, the diabetic who needs dialysis etc. the government actually covers 65% of the total health care costs in this country, the total now about 1.3 trillion and growing. Medicare has been a very successful example of universal coverage, though for only people over 65 and people with disabilities and needing updating to include prescription drug coverage and long term care. So think of Medicare before you say that universal health care is not feasible. The people are in favor, it is feasible economically, and now must be made feasible politically.

You also have before you some charts showing the difference in overhead when there is a publicly funded and administered program. The savings come from cutting out the enormous overhead necessary for administering our very complex non-system and from eliminating the profits to investors who contribute nothing to the health care of any person. The US could save about 80 billion and Wisconsin about 1.5 billion dollars each year on hospital billing and administration alone. Prescription drugs, one of the reasons for rapid escalation of costs, are controlled, as in other countries, by contracting with pharmaceutical companies, using a countrywide or as we propose, a statewide, population base. There isn't time for me to outline all the other savings in such a system, savings which would go towards insuring everybody, emphasizing preventive care, adequate mental health coverage, long term care etc. Thus if we spent the same amount as we do now we would surely have the "best health care" in the world. Such a system would offer care according to need rather than ability to pay. I and most physicians and other providers would feel our commitment to caring for the health of the people would be fulfilled.

U.S. PUBLIC Spending Per Capita for Health is Greater than TOTAL Spending in Other Nations

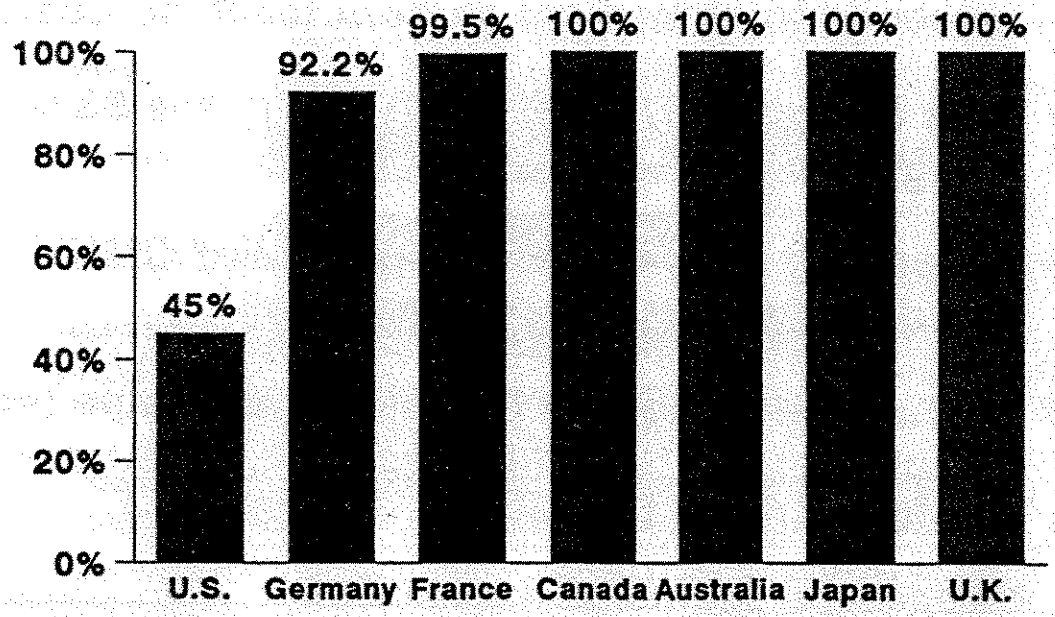


Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

Source: NEJM 1999; 340:109; Health Aff 2000; 19(3):150

Government plays a much larger role in financing health care in the U.S. than is commonly acknowledged. In fact, ***government*** health spending in the U.S. - $2544 per capita in 1997 - exceeded ***total*** health spending in any other nation except Switzerland. Government spending includes Medicare, Medicaid, Veterans Administration programs, as well as insurance premiums for government employees and tax subsidies for private insurance. Americans already pay enough in taxes to fully fund a national health insurance system more generous than Canada's. Then we pay an additional $1551 per capita out-of-pocket and to private insurers

Percent of Population with Government-Assured Insurance, 1997



Note: Germany does not require coverage for high-income persons, but virtually all buy coverage
Source: OECD, 1999

The U.S. is the only developed nation without universal health coverage. Note that while virtually all Germans are covered by health insurance, about 8% choose private insurance rather than enrolling in one of the quasi-public insurance funds

Who Pays for Healthcare?

	Amount in 1998 (billions)	Percent
Government	**$736.8**	**64.1%**
Medicare	**$216.2**	
Medicaid	**$170.6**	
Premiums for public employees	**$67.3**	
Tax subsidy for private insurance	**$124.8**	
Other*	**$157.9**	
Private employers	**$216.5**	**18.8%**
Individuals (excludes tax subsidy)	**$195.8**	**17.0%**
Total	**$1149.1**	**100%**

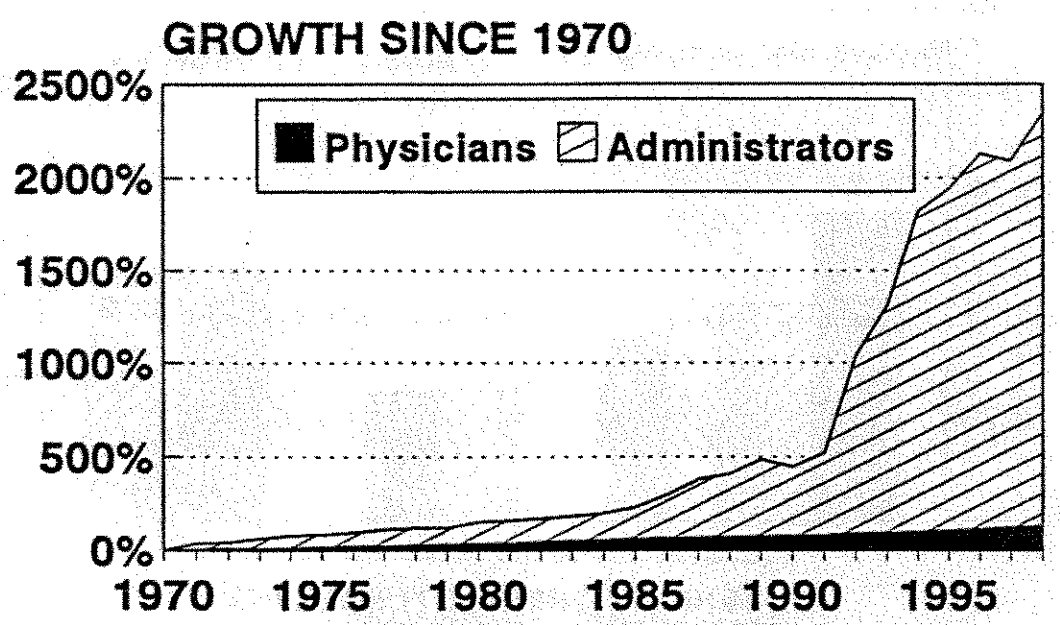
Source: Himmelstein & Woolhandler - Unpublished analysis of NCHS data, Health Affairs 1999;18(2):176
*** Includes VA, NIH, subsidy for public hospitals, worker's comp, health departments etc.**

Federal, state and local governments currently pay nearly two-thirds of health costs, and government's share of spending has been gradually increasing in recent years.

Private employers' role in paying for health care is smaller than commonly believed - accounting for less than one-fifth of total spending - and hardly justifies their decisive influence over health policy. Though "employer-sponsored" private health insurance covers about 60% of Americans, this widely cited figure overstates private employers' role. First, it includes over 20 million government employees (e.g. teachers, police, firefighters) and their dependents whose private coverage is funded through our taxes. Second, it includes workers who purchased their coverage through an employer-sponsored plan, but whose employer made no financial contribution towards the coverage. Finally, it includes a large number of individuals with employer-paid supplemental coverage (Medigap), but whose primary insurer is Medicare. Hence, only about 40% of Americans have their primary health insurance coverage paid wholly or in part by a private employer.

Both Republicans and some Democrats have advocated market-driven health policies, i.e. turning over most of Medicare and Medicaid to private HMOs, and encouraging for-profit care. Yet it is an odd free market that relies so heavily on public dollars. In effect, U.S. healthcare is publicly funded but privately controlled.

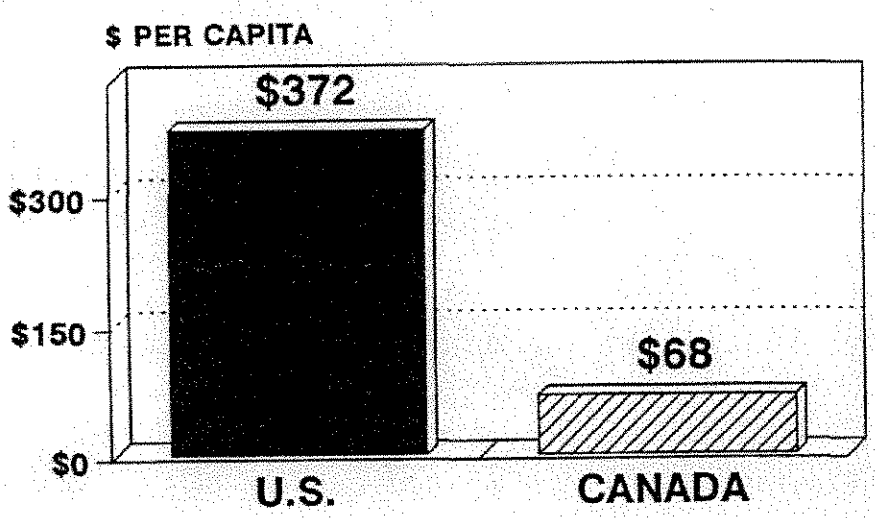
GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-1998



source: Bureau of Labor Statistics & NCHS

Administrators are the most rapidly growing segment of the health care labor force. Between 1970 and 1998 the number of health administrators increased more than 24 fold, while the number of physicians and other clinical personnel increased about 2 1/2 fold. This is part of the excessive overhead costs in this country.

Hospital Billing & Administration United States & Canada, 2000

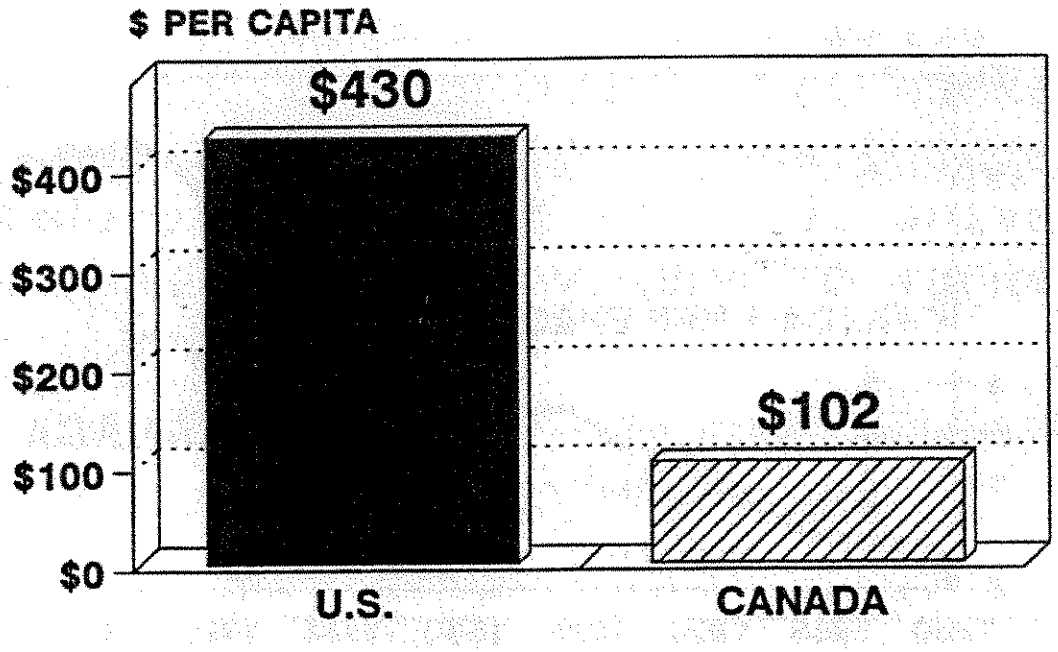


Source: Woolhandler/Himmelstein NEJM 1991; 324:1253 & 1993; 329:400 (updated)

Canada's single payer system has greatly simplified hospital payment, because everyone has the same insurance coverage. Canadian hospitals are paid on a global, or lump sum budget basis rather than billing for each individual service or patient. Since hospitals send few bills to individual patients (other than Americans who get sick while visiting Canada) billing departments are tiny. The average U.S. hospital employs about 50 billing personnel; the average Canadian hospital employs 3 or 4.

In Canada, each hospital negotiates its total annual budget with the provincial health insurance program, and receives a single check each fortnight to cover virtually all costs. Hospitals need not track which patient gets each bandage or bottle of IV fluid, eliminating much of the need for detailed internal cost accounting and expensive computer billing equipment. The U.S. could save about $80 billion each year on hospital billing by adopting a similar global budget system.

Physicians' Billing & Office Expenses United States & Canada, 2000



Source:Woolhandler/Himmelstein NEJM 1991;324:1253 (updated)

Physicians' billing is far simpler in Canada than in the U.S. Each Canadian provincial health program designs a simple billing form that is used for all patients. The physician uses the patient's insurance card to stamp the form, checks a single box, and sends all forms to the provincial insurance program by mail or computer.

All patients are covered, and bills are paid promptly. The provinces perform only minimal utilization review, and do not interfere in the doctor-patient relationship. As a result, office administration and billing is far less expensive for Canadian physicians than for doctors in the United States.

The provincial government and the provincial medical association set the physicians' fee schedule through (sometimes acrimonious) negotiations. The average Canadian physicians earns about 4.5 times the average Canadian industrial wage. The average U.S. physician earns about 5 times the average U.S. industrial wage.

SENATE COMMITTEE ON HEALTH, UTILITIES, VETERANS, AND MILITARY AFFAIRS

Public Hearing on SB 133
February 20, 2002

I am a Charter Member of the National Association of Social Workers and have held offices at local, state, and national levels. I am pleased to represent the Wisconsin Chapter in endorsing and actively supporting SB 133.

Chapter members have helped in drafting some of the language of SB 133 and and will be involved in communicating with others the importance of having a Wisconsin Universal Health Plan. SB 133 has years of drafting and redrafting in its history. We believe it to be one members of the Wisconsin Legislature and the Governor will find to be a model for other states to follow.

In addition to being universal, SB 133 is also comprehensive. Its governance will be by a Policy Board comprised of five members appointed by the Governor with Senate concurrence and six members elected from regional councils made up of persons appointed by County Boards of Supervisors. Grassroots involvement is assured. Those who receive health care will have a voice through the six regional councils. Those who provide health care services will have a voice through contracts made with the state agency that will administer the Plan. Checks and balances are built into the administrative functioning. Cost containment, budget oversight, program review and evaluation, professional standards and review, appeals processes, and health professional involvement in such activities as regular modifications to a statewide formulary and health- and surgery-related definitions are specified.

The Wisconsin Chapter of the National Association of Social Workers follows a long tradition of caring for all persons regardless of social, economic, or other status while simultaneously recognizing fiscal and other responsibilities. At the national level, NASW was involved in drafting with Senator Dan Inouye a national plan that did not get out of the Senate committee to which it was referred. In Wisconsin, the state NASW Chapter trusts that SB 133 will be allowed to be voted on by the Legislature. The need is now, the need is known. Health care is a right to which Wisconsin must respond as a right for all of its citizens.

Paul H. Kusuda, ACSW; 200 Tompkins Dr.; Madison, Wisconsin 53716-3255.

Date 2/20/2002

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_____ MD
Cynthia Haq

DEA# _____

608-263-6546

INTEROFFICE MEMORANDUM

TO: DIRECTOR PETER BLEWITT

FROM: AUDRA MILLEN

SUBJECT: EMPLOYEE HEALTH CARE COSTS

DATE: 02/20/2002

CC: MICHELLE NATE

Ken Black was able to provide the numbers for you. Employee Health Care Costs, including medical and dental, totaled $136 million for 2001-2002. The cost for 2002-2003 is projected at $162 million, a 19% increase. Dental coverage comprises approximately $7 million of this.

Let me know if you need any further information.

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Health costs a threat to MPS budget

Insurance could leave district $30 million in red

By SAM SCHULHOFER-WOHL
of the Journal Sentinel staff

Last Updated: Jan. 29, 2002

Milwaukee Public Schools largely succeeded in its two-year campaign to stop fiscal bleeding with $45 million in spending cuts, but a constant nemesis - soaring health care costs - could put the district $30 million in the hole next year, the School Board learned Tuesday night.

An expected 20% increase in health expenses will throw MPS into another headlong collision with state-imposed spending limits, Finance Director Michelle Nate told the board in an annual report that set work on next school year's budget in motion.

"There's no end in sight," Superintendent Spence Korte said. "There is no revenue cap on health care."

Board members, meeting as the Strategic Planning and Budget Committee, suggested everything from closing schools to lobbying for national health care as ways to solve the problem.

If not for health care, MPS would be in relatively good financial shape, Nate said.

Sharp drops in enrollment have ended, giving the district more breathing room under state-imposed spending caps tied to the number of children it educates.

Utility, transportation and special education costs are stable.

Even wages aren't expected to rise faster than the 3% increase in per-student funding that MPS officials expect next year.

But medical costs will leap $26 million next year, to $155.5 million, Nate said. Throw in $7.5 million for dental care, and MPS will spend 15% of its $1 billion-plus budget on keeping employees healthy.

Korte, after the meeting, said it may be time to change MPS' employees' generous benefits, such as by asking them to pay a share of their insurance premiums.

"Not only do we have excellent health benefits; from an employee's point of view, it's totally free," he said. "I think it's for the unions to answer the question about whether it's time to put that on the table. Their people have as much interest as we do in keeping us economically viable."

Milwaukee Teachers' Education Association President Bob Lehmann said teachers have already suffered enough under a 1993 state law that limits their pay raises.

"I think it's in everybody's best interest to have some serious discussion about what this means," he said in a phone interview. "I know the solution is not to put more health care costs on the backs of teachers."

"It's a can of worms. It always has been," board President Lawrence O'Neil, who has been on the board since 1977, said when asked whether the district should cut benefits.

O'Neil said MPS should consider reorganizing the central office to balance the budget.

Board member Jeff Spence said, "We may need to consolidate some schools, and, you know what, we may have to close some schools."

But officials appeared frustrated that after zeroing in on transportation routes, enrollment, unnecessary central office work and other factors that threw the budget out of whack, they still faced ballooning costs in an area they can't easily control.

"Health care is killing us," said board member Peter Blewett, who advocated lobbying for national health care.

MPS anticipates having $886 million in its operations fund next year, but would need $916 million to continue all existing programs without changes, Nate said. The figures don't include other district funds where deficits aren't an issue.

State government decisions could change the numbers. Wisconsin will get an infusion of aid under the education bill that President Bush signed this month; much of that money could come to MPS. But Gov. Scott McCallum's budget plan would, if adopted, force MPS to cut an extra $2.3 million, Nate said.

The gap also could be smaller depending on the outcome of ongoing labor negotiations.

Of MPS' expected $30 million shortfall, Nate pinned $26 million on the health care increase and the remaining $4 million mostly on an expected 232-student drop in enrollment. The enrollment change is minuscule compared with the district's total of more than 100,000 students, and compared with a 1,203-student drop that was predicted for this school year but never came to pass.

Under state law, MPS cannot close the $30 million gap by raising taxes unless city voters approve a proposal to do so. The last time MPS requested more money in a referendum, in 1993, the proposal failed by a 3-1 margin, and most district officials think it would be futile to try again.

Plans call instead for cutting $9 million to $10 million from central office spending, and $20 million to $21 million from schools, Nate said.

Appeared in the Milwaukee Journal Sentinel on Jan. 30, 2002.

Wisconsin State AFL-CIO

CHARTERED 1958

6333 W. BLUE MOUND RD., MILWAUKEE, WISCONSIN 53213 PHONE (414) 771-0700 FAX (414) 771-1715

David Newby, President • Sara J. Rogers, Exec. Vice President • Phillip L. Neuenfeldt, Secretary-Treasurer

TO: Members of the Senate Health, Utilities, Veterans and Military Affairs Committee
FROM: David Newby, President
DATE: February 20, 2002
RE: SUPPORT FOR SB 133, WISCONSIN UNIVERSAL HEALTH PLAN

Thank you very much for the opportunity to testify this afternoon.

Usually Phil Neuenfeldt, our Secretary-Treasurer and Legislative Director would be giving this testimony, but since this is an issue I began working on in the mid-1980's when I was Secretary-Treasurer, and since I am personally chairing our newly-established Wisconsin State AFL-CIO Health Care Committee, I wanted to provide this testimony myself.

I am here today to call for fundamental change in our health care system. TheWisconsin State AFL-CIO has a long history of support for universal health care. Just in recent years our 1984 Convention passed a Resolution calling for Universal Health Care. I worked with former Representative Lou Fortis in 1989 on AB 476, a "pay or play" bill which would have required employers either to offer basic health insurance to their employees or pay an equivalent tax that would be used to provide health insurance to the uninsured. We were also strong supporters, along with the Coalition for Wisconsin Health, of the first single-payer bill introduced in the 1991-92 Session, AB 555.

In fact, in the packet of information I'll be distributing to you, I've enclosed a copy of the testimony I gave in support of AB 555 in 1992. I hope you'll read it carefully, because I could have simply changed the heading and date and given the same testimony today, almost ten years

later. It's truly astounding, but ***nothing has changed–neither the nature of the problem nor the basic principles of its solution.***

Union workers are considerably more likely to have health insurance that is comprehensive and affordable than are non-union workers. That is simply because they have a voice on the job and can negotiate with management as a group for health care rather than have to accept what management decides to offer. But I can't think of a major union-management conflict in the past couple years in which the cost of health insurance was not a central issue. More than one union has had to accept pay raises that are less than the additional costs for health insurance that are shifted to them. And to be quite honest, some manufacturing firms which have been especially hard hit in the current recession simply can't afford health insurance premiums that are not uncommonly being raised twenty, thirty, or even forty percent. Of course premium increases of this magnitude are not limited to industrial firms–as we are well aware, since the premiums for the PPO for our State AFL-CIO employees went up 42% this year.

Retirees are losing health insurance too: employers are either withdrawing their coverage or shifting insurance costs to the retirees, many of whom can no longer afford it.

And then there are the uninsured. "Only" 7.4% of Wisconsin residents in 2000 were uninsured, compared to 14% nationally–but that still is an unacceptable 170,000 people. Hundreds of thousands more have inadequate coverage. That leads to a phenomenon unthinkable in any other advanced industrialized country in the world: community fundraisers being held to help those who can't afford medical care or prescriptions.

Our health care system is in crisis. Or perhaps it would be more accurate to say that we have a health care crisis because we don't have a coherent system of health care at all.

Think of the absurdity of our current situation. In the United States we pay about one third more than any other country, per person, for health care (twice as much per capita as Canada). Yet according to the World Health Organization of the United Nations, our life expectancy is lower than twenty-three other countries! (A statistic which many in the general public would not expect–or perhaps even believe. If it's any consolation, we're 15th in overall "health attainment".) We have similar low comparative rankings for other measures of health, including infant mortality. What's the difference? How can we spend so much more on medical care but have such inferior health outcomes? The answer is relatively simple: every one of those twenty-three countries whose residents are healthier and who have a life expectancy longer than ours have some form of a publically-funded universal health care system that guarantees top quality care to every one of its citizens.

Here very briefly are the damning statistics on the health care "system" in the United States:

WORLD RANKINGS FOR LIFE EXPECTANCY

COUNTRY BY RANK	% GDP SPENT ON HEALTH CARE	$ PER CAPITA SPENT ON HEALTH CARE	LIFE EXPECTANCY
1) Japan	7.1	2372	74.5
5) Spain	8.0	1071	72.8
7) Greece	8.0	905	72.5
12) Canada	8.6	1783	72.0
16) Belgium	8.0	1918	71.6

22) Germany	10.5	2713	70.4
24) USA	13.7	4187	70.0

Something's wrong. We're paying far more per person for health care–but we're getting far less.

SB 133 would fix what's wrong with health care in Wisconsin and in the United States. It would establish a true health care **system.** It would control costs through a negotiation system in which health care consumers would have power at least equal to that of health care providers, hospitals, and drug companies. Its administrative efficiency would cut total health care costs by about 10%, according to a Government Accounting Office study (among others)–and that would be enough to extend full health care coverage to everyone who currently has no insurance or inadequate coverage. The Wisconsin Universal Health Plan would cost no more than we are paying in aggregate today, yet everyone in Wisconsin would have all the health care they need–and deserve.

The result would also be a powerful tool of economic development. Imagine if we could tell current employers, or firms thinking of expanding or locating in Wisconsin, that their health care costs for employees would be comparable or lower than other states–and that they would have no administrative costs or responsibilities for the health care of their workers! We would not only have a stronger economy, but we would have eliminated the current incentive for employers not to offer health insurance or to shift costs to their employees in order to save money and be more "competitive".

Establishing a universal health care system **should** be an issue on which labor and management agree. And indeed we are seeing more and more employers who do agree with us. Perhaps the best evidence for this is an op-ed piece on the health care crisis published last week

which states that "our unified goal is to make the problem of the uninsured our nation's top health priority and to help America solve it." This article was co-authored by John Sweeney, President of the National AFL-CIO and Thomas Donohue, President of the U.S. Chamber of Commerce.

Is SB 133 the only solution to our health care crisis? Is there no other way to solve the problem? No doubt there are other models we could adopt that would also contain and eventually cut costs and provide universal coverage. And in fact the Health Care Committee of the Wisconsin State AFL-CIO is investigating other models too. But no system will be successful unless it provides universal coverage and establishes effective cost controls that do not compromise the quality of health care provided. SB 133 meets those tests and it deserves your enthusiastic support. The burden is on its opponents to prove that they have a better solution.

Wisconsin State AFL-CIO

CHARTERED 1958

6333 W. BLUE MOUND RD., MILWAUKEE, WISCONSIN 53213 PHONE 771-0700

Jack B. Reihl, President • Joseph A. Gruber, Exec. Vice President • David Newby, Secretary-Treasurer

TO: Members of the Assembly Special Committee on Reform of Health Insurance
FROM: David Newby, Secretary-Treasurer
DATE: March 6, 1992
RE: SUPPORT FOR AB 555, THE WISCONSIN UNIVERSAL HEALTH PLAN

We're very pleased that you are holding this final hearing on AB 555, the Wisconsin Universal Health Plan, and we hope that you will take prompt executive action on this path-breaking proposal so that the full Assembly has the opportunity to vote on it before the Legislature adjourns at the end of this month. Clearly, the Wisconsin Universal Health Plan would solve the health care crisis in Wisconsin -- and it would do so in a responsible, cost-effective way. The bill itself is quite modest: it establishes the basic parameters of a unified, cost-effective, modified (and improved) Canadian-style single-payer health care system for Wisconsin; and it sets up a careful and deliberate planning process for the implementation of this new health care system.

The basic question which you, as our representatives, must deal with is: why should Wisconsin establish a fundamentally new way of organizing and paying for health care for its citizens? Let me attempt to answer that question.

1) The problem we're attempting to address, the health care crisis, is a multi-faceted one--but one whose separate elements are closely interrelated. Those elements of the larger problem include a significant portion of our population with no health insurance at all, an even larger portion with inadequate health insurance protection, a lack of emphasis on routine and preventive care (which results in higher medical costs in the long run), inadequate distribution of health care facilities and services (particularly in our rural areas and inner cities) caused by our inequitable current system of payment for health care services, lack of coordination and control over capital expenditures in the health care system, and a rate of health care cost inflation that remains twice the rate of general inflation. You can either approach these as discrete, largely unrelated problems (as all other proposals considered by this Committee do), or you can recognize the interrelationships between these problems and solve them through systemic change. Attempting to solve the problems separately is both more costly and less effective than solving the problems by changing the system which created the problems in the first place.

2) The rising cost of health care is the central problem that must be solved at the same time that we solve the problem of inadequate access to health care. Rising costs are responsible for denying an increasing percentage of our citizens timely access to health care services--and rising costs are identified by the general public as the most important of the health care issues we face today (as indicated most recently in last year's St. Norbert/Wisconsin Public Radio poll). Past experience, as well as even the most superficial analysis of other health care proposals, shows clearly that in order to control costs you have to do four things:

a) negotiate fair and reasonable set fees with health care providers in such a fashion that providers are prevented from cost-shifting

b) establish global budgets for hospital care

c) control the diffusion of expensive medical technology so that appropriate access is assured while at the same time you eliminate duplication and perverse incentives for overutilization

d) eliminate the incredibly expensive red-tape and bureaucracy we currently have--which is necessary only because of the need to process complicated insurance claims and to figure out who owes who what. In other words, it's the basic fact that we pay for health care through a private health insurance system which splits responsibility for costs in thousands of incredibly complicated ways which accounts for the high--and rapidly rising--cost of health care.

3) Because all other plans retain most of the medically unnecessary overhead and administrative costs inherent in a private health insurance-based system, they are all expensive--and still they don't provide all medically necessary health care to everyone who needs it. The Health Care Forum proposal, for example, costs an additional $248 million--not counting out-of-pocket expenses of either the newly-insured or the currently insured. In stark contrast, the Wisconsin Universal Health Plan costs nothing more than we're paying currently--and yet absolutely everyone gets all the medical care they need and out-of-pocket costs for necessary medical care are completely eliminated -- for everyone. That is possible because of the immense savings from a single-payer plan, savings which come from the negotiation of reasonable fees for provider services, rational establishment of hospital budgets and services, control of technology, emphasis on preventive health care, and the elimination of administrative, billing, and marketing costs that are inherent in our current private health insurance system but which do nothing to promote health or provide medical services.

Eliminating these unnecessary administrative costs alone will cut our health care expenditures by about 10%, a figure confirmed by the General Accounting Office report ("Canadian Health Insurance") and the fact that in the United States, 23¢ of every dollar spent on health care goes for administration, while Canada spends less than 13¢ of every health care dollar on comparable expenses.

Some may protest that the Wisconsin Universal Health Plan requires larger public expenditures of tax dollars than any other plan. That is absolutely true. But once again we must insist that if you are going to be objective and rational about solving our health care crisis, you have to consider total social costs of providing health care--employers' costs for health insurance premiums, individual costs for health insurance premiums, individual costs for co-pays and deductibles, individual direct payments for health care services, and the total of government expenditures for health care at all levels (including Medicaid, Medicare, Healthy Start, and every other targeted or means-tested publicly-financed health care program). So while the Wisconsin Universal Health Plan will require far greater tax expenditures, it will eliminate all other current health care expenditures and will require a smaller total expenditure than any other health care system--and yet at the same time provide better health care services to more people than any other plan. Thus the advantages of the Wisconsin Universal Health Plan over any other plan are immense.

4) We need a state-level universal plan such as the Wisconsin Universal Health Plan. Because of the enormity of our health care crisis and because of the deadlock and inaction on this issue at the federal level, every state in the country is grappling with the health care crisis just as you are. Twenty other states are considering legislation nearly identical to the Wisconsin Universal Health Plan (AB 555). Wisconsin will probably not be the first to adopt a universal health care plan, and the different plans adopted in different states will give us important experience and data for finally adopting a national health care system--which, ultimately, is what we so desperately need. In the meantime, adoption of the Wisconsin Universal Health Plan will put additional pressure on the federal government to act. Indeed, the more decisive and comprehensive the plan we adopt here (and in other states), the greater the pressure we apply on Congress and the President. In the meantime, we will have ensured excellent, comprehensive health care for all our citizens at a cost we can afford--an achievement which would be monumental in importance and historical in its significance.

DN/ep/opeiu #9 afl-cio

Let's Insure America

By Thomas J. Donohue and John J. Sweeney

Tuesday, February 12, 2002; Page A25

When representatives of business and labor meet, it's usually across the table. Today there is an issue in America that compels us to sit side by side. It's a major health problem that plagues us despite the fact that the United States has the most advanced health care system in the world. It imperils the lives and health of the 39 million who are its immediate victims, and it endangers the well-being of our nation as a whole.

It is the quiet crisis of the uninsured. For all our miracle cures that are saving lives every day, we have failed to solve our biggest health problem -- the fact that so many Americans lack access to even the most basic care because they lack health coverage. It has gotten worse despite good economic conditions, and it certainly won't improve during a downturn. Today, we are urging our fellow Americans and elected leaders in Washington to join with us and begin the hard work needed to solve this problem.

When you're uninsured, life turns out differently. For some, it's already too late. Betsy Rotzler died, leaving three children without a mother in Binghamton, N.Y. Even though she and her husband worked hard, they had no health coverage. By the time she could get a lump in her breast diagnosed, her cancer had become terminal.

Nancy Potter was proud to provide health coverage for 20 employees in her New Glarus, Wis., bakery, until rising costs reached the point where she could no longer keep up with the premiums and had no alternative options to offer her staff.

Joseph Mosqueda of San Diego kept his sons, ages 7 and 8, off the local soccer team to avoid the risk of injury. Mosqueda knew a broken bone could break their family budget because they lacked the security of health coverage.

There were 39 million uninsured Americans at the end of 2000, before the economic downturn began. All indications show the recession is making a bad problem worse. But even during the economic boom of the 1990s, the number of uninsured grew by 10 million.

While the recent rise in unemployment has added to the number of uninsured, perhaps the larger and longer-term problem is the rising number of uninsured workers. Eight out of 10 uninsured Americans are in working families with modest incomes. They pay taxes and contribute to the productivity of thousands of businesses and the economic health of our nation. But either their jobs don't provide health benefits or they can't afford the premiums. They cannot afford private insurance on their own and are not eligible for public programs.

Many employers are in a bind, too. They voluntarily provide health benefits to 177 million employees, retirees and their dependents, because doing so helps maintain a stable workforce and increases productivity. But with a sluggish economy and soaring health costs -- premiums rose an average of 11 percent last year, and much more for small employers -- many businesses face tough choices.

The uninsured live sicker and die younger. Uninsured women who develop breast cancer are twice as likely to die as their counterparts with health insurance. Uninsured men are nearly twice as likely to be diagnosed at a later -- and potentially deadly -- stage for colon cancer. The uninsured are four times more likely to experience an avoidable hospital stay or visit to the emergency room. Often they arrive too late and at a point where treatments are more complicated and expensive than if the problem had been caught earlier.

This situation is untenable for the uninsured, and it amounts to an indirect tax on those with coverage as costs are passed along to providers, insurers, businesses and consumers.

There are other costs as well. Uninsured working families lack the economic security that comes with health coverage. According to bankruptcy experts, the inability to pay medical bills is a top reason for one out of two personal bankruptcy filings.

Few national problems simply solve themselves. Meeting this challenge calls for real leadership. It calls for bipartisanship, and for working through the very real policy differences that have kept us from solving this problem.

We have different perspectives on the problem, as do our partners in this effort -- employers and workers, insurers and consumers, doctors, hospitals and nurses. Though we will undoubtedly disagree on specific solutions, our unified goal is to make the problem of the uninsured our nation's top health priority and to help America solve it.

Some may argue that progress on such a tough issue is impossible in an election year. We disagree. We've seen America come together to ensure the security of our nation. Let's build on the can-do spirit to ensure health security for our families. Let's get America covered.

Thomas J. Donohue is president and CEO of the U.S. Chamber of Commerce. John J. Sweeney is president of the AFL-CIO.

SYLVIA


the WOMAN with A Positive HEARING PROBLEM.
What's SAID...
seems Like EVERYone's GOING to HAVE to CARRY A NATIONAL I.D. CARD.
10-31
WHAT SHE HEARS...
Looks Like we're GOING to HAVE NATIONAL HEALTH INSUTANCE.. EVERYone's GOING to be COVERED.
It's About time.

I hoped to testify but must leave at 3:00 p.m. I hoped to speak to the following issues:

1. I was greatly helped during the depression of the 30's. FDR's legislative provisions enabled me to get my B.A degree. I am not afraid of the government as so many seem to be.

2. My husband + I spent $7800 last year for health care. I am tired of at least 25% going to administer the program when Medicare only spends 1%.

3. I believe SB 133 would improve things immeasurably and my subsequent taxes would be far from $7800. My hassle with the present system would be over, I believe.

Jane G Forsyth

[redacted] inc.

February 20, 2002

Senator Rodney Moen
Senate Committee on Health,
Utilities, Veterans and Military Affairs
State Capitol
Room 411 South
Madison, WI 53707

Dear Senator:

The issue of health care costs in Wisconsin has reached the critical stage. For a number of reasons, old solutions to controlling costs of health delivery are no longer working and must be addressed.

Here are compelling reasons why a larger-scale solution between government, industry and labor must be found:

- Small businesses can no longer afford health care costs, which often rise to as much as $10,000 per family unit. Therefore, they are either dropping coverage or shoving major portions of the cost back on their employees.
- Union contracts are getting hung up on who pays for health care, causing undesirable labor strife.
- More people are going uninsured.
- The payer of last resort is becoming the state under BadgerCare, as more people seek refuge after private employers terminate plans. BadgerCare is one of the fastest growing segments of state government costs at a time when revenues are in scarce supply.

A number of broad-scale solutions have been proposed, such as the universal per employee charge aired by Tom Resch of the steelworker's union or the "managed competition" model promoted by Mayor John Norquist. All of these have merit. Yet not enough research has been brought to bear as to the best solution for Wisconsin.

As Wisconsin has done so many times in the past, it appears there is an opportunity for reform of a system that could lead the nation. What is needed is a coalition of leaders from government, education, business labor and the farm community to come up with a comprehensive plan that puts a tourniquet on costs and provides a remedy for the uninsured.

Thank you for addressing this critical issue. It has to be dealt with in a decisive manner in the near term.

Sincerely,

John B. Torinus Jr.

John B. Torinus Jr.
Chief Executive Officer

Corporate Headquarters – Decorating Technologies & Design Institute
3801 E. Decorah Rd., P.O. Box 436, West Bend, WI 53095-9597 Phone (262) 335-7200 Fax (262) 335-7699

SENATE LEGISLATIVE HEARING
SENATOR MOEN, CHP.
FEBRUARY 20, 2002
SUBJECT: Senate Bill 133, Universal Health Care Plan

My name is George Robson. I live at 127 Vilas Hibbard Parkway, Lodi, WI. 53555. I am speaking for both the United Methodist Federation for Social Action and for myself.

At our denomination's 2000 General Assembly a resolution regarding health care was passed. I quote three brief paragraphs from the Book of Resolutions pages 257 and 265.

"We all recognize the need for adequate health care for ourselves and our families. In the last two decades there have been many options brought before the people of this nation and some have been serious attempts to provide for all. However, most proposals have continued to exclude some portion of society from access to adequate health care. The debates seem to have subsided, but problems of providing adequate care to individuals are actually increasing with time." (p.257)

"For all persons to have adequate access to needed health-care services, public financing must be a significant part of an overall health insurance plan. Public funding is necessary to pay for insuring those who cannot pay part or all of the necessary premiums required." (p.265)

"Now is the time for a comprehensive single-payer health care program that will provide adequate health care to all without placing further barricades to access." (p. 257)

Underlying these resolutions is our conviction that a healthy America is good for all of us, that health care is a right, that each individual deserves adequate health care

no matter what their circumstances may be. We also believe it good for employers.

We dare not let profit to be the bottom line. We want medical professionals to be free to administer appropriate medical care. The patient's health must be the bottom line. Most industrialized nations provide medical care for everyone. Why can't we?

A family medical concern has dramatized the need for me. My son who is 39 had to quit his job seventeen months ago because of health problems. Before and after leaving his job, he was given a run-around by his HMO. After twelve months without an income, he has finally gotten some action. Even now, he has to wait six weeks to two months after each procedure or test. To me, this seems to be rationing of medical care. No thought is given to the fact that he has had no income during this time.

I believe we could do much better. Perhaps we could learn from the Health Care Plan that they have in Manitoba. I was impressed with both the care and the low cost when I was involved in an accident in that province about three years ago. I am convinced that Senate Bill 133 would go along way toward meeting our health care needs in an equitable way.

EPILEPSY FOUNDATION
SOUTH CENTRAL WISCONSIN

7617 MINERAL POINT ROAD
MADISON, WI 53717-1623

February 20, 2002

Senator Moen, Chairperson
Health Committee Hearing
411 South State Capitol
Madison, WI 53701

Dear Senator Moen,

Thanks you very much for conducting a hearing on SB 133. As Executive Director of the Epilepsy Foundation South Central Wisconsin for the past eleven years, I can tell you that there is no legislation I have followed more closely the the Wisconsin Universal Health Plan.

People with epilepsy are underemployed and unemployed at much higher rates than the general public, making employer based health care inaccessible. Nearly 70% of seizure disorders are diagnosed by the age of eighteen, causing it to be a preexisting condition and a cause for insurance denial.

People with epilepsy who go on disability at some point in their lives, have tremendous difficulty ever getting off disability. Not because of disability payments but because of the medical assistance component. By providing universal health care to all residents in Wisconsin, we remove a huge obstacle that prevents many people with chronic health conditions from becoming full participants in the workforce.

Finally, as a small employer myself, I can tell you that nothing troubles me more or causes more budgeting problems at a small nonprofit, than double digit health care increases year in and year out. No other costs escalate as uncontrollably and affect, ultimately, the ability to provide employees with cost of living increases, merit increases, or improved benefits. I believe that SB133 will be a step in the direction of controlling these spiraling costs that are hamstringing Wisconsin employers.

Thank you again for providing this valuable opportunity to support SB133.

I urge your committee to send the bill on, and provide Wisconsin legislature with the opportunity to evaluate a solution to the dilemma of affordable access to quality health care for all Wisconsin residents, regardless of race, color, creed, disability, or employment status.

Sincerely;

Arthur J. Taggart
Executive Director