

Testimony on House Bill 6303:

MARY JANE LUNDGREN: Mary Jane Lundgren. Senator Murphy, Representative Sayers, Members of the Public Health Committee, I am here today to testify on behalf of Connecticut National Association of Social Workers.

NASW strongly supports Proposed House Bill 6303, AN ACT ESTABLISHING A SINGLE PAYER HEALTHCARE SYSTEM.

Our healthcare system delivery is not only inadequate, but [Gap in testimony. Changing from Tape 3A to Tape 3B.]

--we are the richest nation in the world and the only industrialized nation that does not provide universal healthcare.

We spend nearly twice as much per person on healthcare than any other country. We are still ranked near the bottom, 37th, among developed countries in such measures as infant mortality and life expectancy.

Meanwhile, our population is more obese and sedentary, with higher and higher associated healthcare costs. Substance abuse is at an all-time high. And our failure to deal adequately with mental health contributes to our rising prison population.

Profits assume primacy over what is best for our citizens. The United States is nearing 50 million Americans without health insurance. Most of these people are from the working class.

Seventy-point-four million Americans aged 16 to 65 report problems with medical bills. Nearly 62% said the bills were incurred for themselves or a family member who had health insurance coverage. The second-highest reason for personal bankruptcy is debt from healthcare.

In Connecticut alone, there are approximately 370,000 residents without health insurance. In the past year, 3,500 Connecticut residents became uninsured, bringing the percentage of uninsured in our State 10.5%.

Of this group, 80% come from households where one or more persons work either full or part time.

Those most at risk for being uninsured are the very poor who do not have Medicaid and individuals from households between 100% and

200% of the federal poverty level, where 30% of such households have no insurance.

Women comprise the largest group of poor people in the country, and have the highest proportion of part time, and are the highest proportion of part-time workers. And women of color also face additional barriers because of racism.

Many large businesses no longer offer coverage. Many small businesses do not offer health insurance coverage.

Those that do offer coverage continually increase the share of the cost of the premiums that the employee must pay, while decreasing the amount of the coverage.

We are all aware of Wal-Mart and similar companies who place the burden of healthcare on the State of Connecticut.

We have a piecemeal system, Medicare, Medicaid, HUSKY, SAGA, tax credits, etc. Our current system has extremely high administrative costs. Americans are being forced to become healthcare beggars. The overriding ethic of healthcare in America has become the pursuit of profit.

We can do better. We need true universality, everybody in, nobody out. Connecticut has a great opportunity to become a leader in the pursuit of a single-payer universal healthcare system.

There are many options to consider such as tax-based financing similar to Medicare, a full choice of providers, and a delivery system that remains a mix of private and public, simplified administration with greatly reduced administrative costs, leaving 90% to 95% of healthcare funds for patient care, research, and prevention.

Let's treat healthcare as a public good instead of a market commodity. NASW urges you to support Proposed House Bill 6303.

And I'd just also like to say, I am also a registered nurse. I work in an intensive care unit, aside from being a social worker.

And I can tell you, people who come in on an overdose from a drug with no insurance sit in our intensive care unit for approximately a week before we can find placement for these people, at great expense to

everybody, to the community, to the taxpayers, to the hospital.

And I just think it's pathetic that a person who doesn't have insurance has to face this and spend a week in our intensive care unit and they're delaying their treatment, they're using up their time for treatment, and nobody wants to take them. There's no place to put them.

So I urge you to really, really consider this bill. Thank you very much.

REP. SAYERS: Thank you. Any questions from Members of the Committee? Next speaker is Tom Beveridge, to be followed by Dr. John Battista.

TOM BEVERIDGE: Good afternoon, Senator Murphy, Representative Sayers, and Members of the Public Health Committee.

I'm the Reverend Tom Beveridge. I live in Bloomfield. What I am about to tell you is very personal and very raw. I need you to know that I have my son's permission to share it with you. His name is also Tom.

In 1980, Tom was a very bright fourth-grader with everything going for him. Then in March that year he developed encephalitis after a bout with chicken pox. Nothing was ever the same again.

Since his illness, Tom has had to deal with a learning disability, and a seizure disorder. Today, with the help of medications, his seizures are less severe than they once were, but they are a constant source of worry.

Tom also has an inflammatory bowel disease called ulcerative colitis. With colitis, you bloat, you cramp, you bleed, you lose control. Medication helps, but the only known cure is surgery and a permanent colostomy. So far, Tom has not needed the surgery.

Tom is an Eagle Scout. He is intelligent, persistent, highly motivated, and very courageous. At the age of 29, he finished college and was hired as a high school math teacher.

But high school students can be very unkind to a teacher who forgets things, spaces out, and occasionally soils himself.

Tom struggled with classroom discipline. His students tested poorly, and he lost his job. Tom now teaches math at a community college in another state.

He loves teaching, and at the college level he doesn't face the disciplinary problems that did him in as a high school teacher.

But higher education is an expensive business. To save the costs of pension plans and health insurance, community colleges rely heavily on part-time adjunct faculty like Tom.

On top of that, Tom just received word that he will not be rehired this fall because he does not have a master's degree.

Tom's options for health insurance are about exhausted. He is single, so there is no other group plan to cover him. His preexisting conditions put private insurance out of his reach.

He has been turned down for disability compensation. And his mother and I do not have the personal wealth that it would take to be his private insurance company.

Fortunately, there are some stop-gap programs available to Tom to help get him get his medications, which is a good thing, because their out-of-pocket costs would run between 70% and 80% of his income.

But even with that, his medical costs continue to drive him deeper into debt. It is no surprise to me at all that lack of health insurance accounts for half of all personal bankruptcies in the United States.

There are about 350,000 uninsured people right here in Connecticut, about 46 million in the U.S., and that number is going up at the rate of over a million a year.

Because, besides the economic impacts, those uninsured folk are at double the risk of death from some serious illnesses. This is a monstrous injustice.

I urge your support of House Bill 6303, which calls for a single-payer healthcare system in the State of Connecticut. Thank you very much.

REP. SAYERS: Thank you. Any questions from Members of the Committee? Okay. Next is Dr. John Battista, to be followed by Justin McCabe.

DR. JOHN BATTISTA: Good afternoon. I'm Dr. John Battista, practicing physician in Connecticut since 1983.

I have advocated for a Connecticut single-payer universal healthcare insurance program throughout the State as the President of the Connecticut Coalition for Universal Healthcare.

I co-authored a detailed single-payer legislative proposal passed by the Labor Committee in a previous Session.

I'm thus pleased to speak with you in support of single payer in Connecticut, and would welcome the opportunity to answer your questions about it.

The striking advantage of single-payer over multi-payer insurance is its ability to fund universal healthcare with equivalent or improved quality at a reduced cost.

The United States spends around twice as much per capita on healthcare as industrialized single-payer countries with below-average results.

There are three basic reasons for this. First, single payer decreases administrative costs from the 25% characteristic of the American system to 10% or less.

Second, single payer saves about 5% of total healthcare costs by negotiating the price of prescription drugs.

Third, universal health insurance lowers healthcare costs and improves outcomes by preventing illness, treating disease early, while avoiding the unnecessary hospitalizations and high utilization of emergency services characteristic of the uninsured.

As a result, it is possible to fund comprehensive healthcare for all Connecticut residents through single payer and save money.

A study of single payer for Connecticut under the Wiecker Administration predicted savings of over a billion dollars a year.

Every state and federal study on single payer supports this conclusion, which is consistent with the experience of single-payer countries throughout the world.

Connecticut's extensive medical infrastructure, generous supply of healthcare practitioners, and very high per-capita healthcare expenditures make it an ideal state for single payer.

However, the success or failure of single payer in Connecticut is in the details. In my opinion, for single payer to work effectively in Connecticut, the fee-for-service system must remain intact and the insurer must be administered not by the state government, but a not-for-profit trust governed by a board representing healthcare providers, healthcare organizations, healthcare advocates, taxpayers, and the State of Connecticut.

Additionally, issues of funding, quality of care, fraud, displaced workers, eligibility, coverage, and access to services must be meticulously addressed.

I have provided you with the Connecticut Healthcare Security Act as an example of a single-payer proposal that addresses these issues in detail.

Additionally, I have provided you with answers to commonly asked questions about single payer to address some of the concerns you may have about it.

I conclude with the words of Winston Churchill. You can count on Americans to do the right thing, after they've tried everything else.

We've tried everything else. I urge you to do the right thing, pass House Bill 6303 and establish a commission to bring single-payer universal health insurance to Connecticut. Thank you.

REP. SAYERS: Thank you. Any further questions? Representative Olson.

REP. OLSON: Good afternoon, Doctor.

DR. JOHN BATTISTA: Good afternoon.

REP. OLSON: Thank you for your testimony. I think this is one of the most important issues we have facing us this year, this Legislative Session, and quite frankly, until we do something in perpetuity.

I have a question for you, just simply if you could expand just really briefly on the decrease of administrative costs.

You give us some numbers in your testimony, and I'm just, if you could just briefly summarize where that information came from and how the costs would be decreased.

DR. JOHN BATTISTA: Well, estimates of the current U.S. healthcare system administrative costs range anything from a low of 15% to a high of 35% to 40%.

Most people agree that it's 25% or more. A lot of the disparity comes from the fact of whether you count just the insurer's side or whether you also count the provider side.

Administrative costs clearly can be reduced dramatically, extensively, overwhelmingly to, for example, Medicare, which most people think of as inefficient, actually spends about 3% of the money it expends on administration.

Single-payer countries, when you look around the world, Canada, every other industrialized country with the possible exception of Germany, is a single-payer country, spend on average between 8% and 10%.

But they're not really comparable to our 25% because they get much more bang for the buck. When we talk about 25%, we mean billing.

When they talk about administrative 8% to 10%, they mean not only billing. They mean preventive outreach. They mean smoking prevention. They mean extensive services, prenatal services for people who are at risk.

What, we have essentially none of that. They're spending 6% to 8% on that, which is part of why their healthcare system is more effective, efficient, and has better outcomes than we do.

The general message is, this is, administrative costs is just one way, but you can, by cutting the administrative costs from what they are now about 25% to 8%, let alone to 3%, which could be done, you will have more than enough money to cover all the uninsured.

And catch this. Not only that, have free prescription drugs for the entire population and long-term healthcare. The choice is simple. Do you want our current system with grotesque dissatisfaction, or do you want a system which has been showed the world around to provide increasing quality of care, which I'd love to explain to you how that works, and at a lower cost, and be more effective.

REP. OLSON: Just briefly, just so that I understand. You're talking about not only decreasing administrative costs for state-administered

programs, but also for the providers who are offering services.

DR. JOHN BATTISTA: Oh, yes.

REP. OLSON: I would imagine there's quite a bit of time spent dealing with billing issues, dealing with reimbursement issues, all that sort of thing--

DR. JOHN BATTISTA: Right. We studied, the Connecticut Coalition for Universal Healthcare did a study of practitioners in the State. We asked them to, how much billing overhead do you have in terms of employees per physician in your group.

The answers varied between one and two. So there are one to two people employed for every physician who are doing nothing but billing.

The overhead expenses for physicians and other practitioners in the state is phenomenal. It's at least 10% of money when you calculate it in time.

And the hassle factor is incredible because you're dealing with literally hundreds if not thousands of insurers with different provisions, with changing populations, the inefficiency is phenomenal.

Just as a vignette. When Canada passed single payer, it had essentially the identical healthcare system to the United States, and the population of Canada is more similar to the United States than any other industrialized country.

At that point, Canada had spent the same percent of GNP on healthcare as the United States, but had poor infant mortality and poorer longevity than the United States.

Now some-35 years later, Canada spends half as much per capita as the United States, and has infant mortality rates which are much better than the United States'. In fact, their average is better than our best quarter in our population. And on top of that, has longevity higher than the United States.

This is the power of a single-payer universal healthcare system. Canadians, when asked, would you like to switch to an American-style system. Over 90% say no.

When you ask Americans, wouldn't you like to switch to a Canadian

system, a majority say yes. It is the most effective, efficient, and has the best outcomes in the world.

Every other industrialized country has it. I'll tell you, the State of Connecticut is perfect because it's the insurance capital of the world, and because it would work here like a charm, because we have the number-two per capita healthcare expenses in the United States, only surpassed by Massachusetts. We have everything it takes to work. It would work like a charm, if properly administrated.

REP. OLSON: Thank you so much, Doctor. Thanks for your hard work too.

REP. SAYERS: Senator Murphy.

SEN. MURPHY: Do you think there's an ability to run a single-payer healthcare system through at least one existing insurance company, i.e., when we do our, when all the companies self-insure, they self-insure themselves but run it through a company for administrative purposes to be an administrative service organization.

Do you think that capability exists here? I mean, obviously the big stumbling block here is that any plan that cuts out the insurance industry in this State runs into some pretty serious political difficulties.

Is there a way to construct a single-payer system that includes some role for the insurance industry, or does that just eviscerate any administrative cost savings that you may achieve otherwise?

DR. JOHN BATTISTA: Yes and no. You can put the billing system out to bid to existing insurance companies in this State and give them a 3% cap, not a problem.

So for example, Medicare traditionally was billed in Connecticut through travelers. It isn't anymore, but for decades it was done by that.

You could do that under a single-payer system. But there's a lot of other issues that the administrative structure has to address. It isn't just billing. There's benefits packages.

We're talking about negotiating fees. We're talking about deciding a structure, who decides who gets access to that benefit package. Is it totally unmanaged?

Do you have a primary care gatekeeper model? Do you have a managed care model, which would absolutely never fly. You'd never get physicians to agree to that. They'd flee the State before they did that.

There are quality assurance issues. There are all these things that the administrative structure must attend to.

Think about all the things that the Department of Social Services does with Title XIX. Think of all the things that Medicare does to assure quality assurance to deal with fraud, etc., etc.

All of these things must be done. I would not put that for a moment in the hands of insurers. The overhead of insurance companies ranges from 15% to 25%

Their salaries are higher. They market. They do a variety of things which do not occur in the public sector. Even a not-for-profit public institution that administers healthcare does it at 8% to 10%. Medicare does it at 3%.

I understand the need to deal with insurance companies and to kind of, if you will, suck up to them in the State of Connecticut, the insurance capital of the world.

However, you can throw them the bone of billing, but no way should you let them administer the system, because it is going to involve, two work you must, must, must, absolutely must have healthcare providers, healthcare organization, taxpayers.

People are going to pay for this system, and they want to know they're getting their bang for their buck.

And the State of Connecticut, who's got big dollars in this system, they've got to get together and hammer out some serious things on a board.

You need a collaborative relationship. You cannot have an arbitrary insurer decided, oh, we're going to pay this and we're going to pay that, and we're going to cover this, and we're going to cover that. That is not going to fly.

And the only way you'll get physicians and healthcare providers on board is to give them a meaningful voice in the administration and

decision-making structure.

REP. SAYERS: Yes, Senator.

SEN. SLOSSBERG: Good afternoon. Thank you for your testimony today. This issue is so important to so many of us.

One of the big things that we always hear as an obstacle to single-payer universal healthcare is, oh, no, if we put the system in the quality of care that is so wonderful that we have in our great United States is going to be horrible.

We're going to have long lines and we're going to have to wait, and it's going to be, you know, a terrible system. Can you address that?

DR. JOHN BATTISTA: I certainly can. And I point out to you that I've dealt with this basic question in question 5 and 6 of commonly asked question about single payer. Let me deal with lines, because everybody likes to talk about lines in Canada.

And there are lines in Canada. There are lines in Canada for, you know, non-critical elective surgeries. Okay, there happen to be equal lines in the United States, but that isn't really the point.

Would there be lines in Connecticut if we passed single payer in the State of Connecticut. The answer is absolutely, unequivocally no.

Why not? The State of Connecticut funds healthcare probably two and a half times what Canada does, certainly well over twice per capita what Canada does currently.

Under a single-payer system, we're not talking about decreasing the per capita expenditures in the State, at least I for one. I'm talking about keeping them flat for now, but covering everybody and expanding health insurance coverage.

You can clearly increase demand in the State of Connecticut with our insurance system and have no lines. Put the other way around.

If Canada funded its health insurance system by twice what it currently is doing, there would be no lines in Canada.

The only reason there are lines in Canada is because it is under-funded

and because they have not developed a medical infrastructure in Canada, particularly surgical beds and diagnostic equipment, that already exists in the State of Connecticut.

Quality of care. This is a great one. Okay. How many times have you heard that the United States has the best healthcare system in the world? Hundreds, thousands, everywhere, right?

The best healthcare is available in the United States. We do have the best infrastructure. We do have the best-trained physicians.

However, when you talk about the best healthcare system, you must compare the population of one country, the United States, with the population of another, Canada, Germany, Spain.

When you do that, and do it fairly among the 29 industrialized countries, you find that the United States ranks in the 20's with regard to the two most widely accepted criteria of overall health, those being infant mortality and longevity.

The United States has fallen from first in the world in both of those categories since 1946 to now being in the 20's, in the period where each and every one of those countries enacted a single-payer universal healthcare system.

When quality of care is done, now not globally, but specifically on results after myocardial infarction, cancer for whatever, you name it, you know, prostate, breast cancer, anything you can, and you compare the United States to Canada, for example, the usual fall guy in this discussion, you find that the outcome rates in the United States and Canada are as fundamentally equivalent.

In some areas Canada surpasses the United States. In other areas the United States surpasses Canada.

Why? Because medical care is fundamentally standardized across the industrialized world, and as long as you can fund it properly and people can have access to it, something which the United States lack relative to other industrialized countries, you find the outcomes are the same.

When you talk about particular populations, what do we know about quality of care among Title XIX recipients, something you just know a fantastic amount about and hear much about, I would think.

We know that the poor are in poor health and spend a higher percentage of their income relative to the wealthy in this country.

We know that people under Title XIX experience difficulty accessing care and have inferior quality care because most, the best healthcare providers, in fact, most healthcare providers won't accept Title XIX patients because the fees which are charged do not even meet their overhead let alone provide them profit.

Under a single-payer system, since everybody's going to have the same health insurance, guess what? You've improved the quality of care for the poor in the State dramatically.

Think about the uninsured. The uninsured are triply screwed in this system of ours. They can't access care. When they do, they get charged the highest prices.

And we know that they cost the average, they cost on average \$100 a pop to the healthcare system a year because they are uninsured through other kinds of expenses. We would solve the problem of the uninsured with a single-payer system.

Now think about Medicare recipients, right? Oh, this is not a state issue. Yet Medicare recipients in the State of Connecticut spend on average 20% of their out-of-pocket money accessing healthcare.

Guess what would happen in single payer? All their healthcare prescription benefits would suddenly be covered.

And the same system that could do that without causing increased cost in the system, and by funding it in a way which is more equitable than our current system in which the poor pay the highest percentage of their income for healthcare and the rich pay the least. That's how we do it now.

Okay. Think about people who are bankrupted in the current healthcare system, right? You just heard through reports, over 50% of bankruptcies are directly attributable to healthcare costs.

It is estimated that 25% of people of this state and every other state would be bankrupted by a major medical illness, even if you have insurance. Even if you have insurance.

Go to St. Francis Hospital and get a coronary artery bypass procedure, and you think you have good health insurance, wait until you find out the story, because the story is 25% of you are going to be bankrupted.

Guess what? Under single-payer health insurance, no bankruptcy. Catch this. A large majority, a large minority of people in this State who are insured work in jobs in which they are only working because they cannot get healthcare benefits if they leave the job, so-called job lock, 25% to 35% of our population.

Guess what? Under single payer there would be no need to do that because it's affordable. We would increase productivity. It is estimated the economics of the State would improve, not get worse.

I'm sure there are many other examples if I had the presence of mind that I could come up with, but you get the basic drift of the answer to that conversation.

SEN. SLOSSBERG: Thank you very much, Doctor. I appreciate your very impassioned answer. I just, one of the other things that you always hear about with regard to single payer is while this sounds like a great system if we can implement it and if we can pay for it, what happens when, you know, you hit a bad economy and suddenly we as a state don't have the money to pay for it. Are we going to then start doing what we always do and chipping people off and cutting people out and making changes, and suddenly we can't pay for the whole system anymore.

DR. JOHN BATTISTA: Gotcha. Question 4, how would you finance single payer and how would that whole thing work. And you've got to understand this.

Four sources of income will be used to pay for a single-payer system. First would be existing state and federal programs, right?

Currently, currently, currently in the United States, state and federal funding represents the majority of dollars in healthcare. Over half of total healthcare dollars come out of state and federal governments.

Second, there would be excise fees on activities detrimental to health, at least if I had my way.

Third, there would be employer payroll premiums, right? You've heard

of pay or play. I'm sure you're going to be voting on pay or play hopefully this year.

Pay or play is certainly is put into this system, or at least could be put into this system.

And fourth, you tax families. I mean, get real. We're going to tax people to pay for their health insurance.

The beauty of single payer is that they're going to pay less, but they're still going to pay.

But another virtue is is they're going to pay more equitably because almost all single-payer advocates advocate essentially for a flat family income tax to pay for the healthcare system.

The state is, this is not part, oh, spare me if you want a single-payer system to be part of the state budget. Don't even think about it. We want a completely independent trust.

The money's going to be collected through the state, but it's not state money. It's not state money. It's not state money. Get this through your head.

Have a system over here which is run by an independent, not state, group, nonprofit trust, over here. That gets the money directly. It gets the taxes from the families. It gets the contributions from the employers.

It gets capitated state expenditures. It gets federal capitated expenditures. And it gets excised taxes on activities detrimental to health to the extent that they can be shown to contribute to healthcare costs.

Do you know that each pack of cigarettes costs the healthcare, causes healthcare expenditures of \$1 a pack? I say tax it at \$1 a pack, put that money into the healthcare system, and let it contribute to the healthcare costs which are caused by the people who do that.

When the economy turns down, there may be problems, but, boy, would they be a lot less in this system than what you're facing now with the economy turning now and you've got more people poor.

You've got the State scrimped. You've got the federal government not wanting to fund Title XIX, a triple whammy on the poor. And we've got

more and more uninsured, who are going to only go bankrupt and only go on the poverty list and only end up on Title XIX.

Many of these problems are avoided in single payer. It's an insurance policy against the downturn in the economy.

SEN. SLOSSBERG: Thank you. The question that I have then as a follow-up is would you then suggest that this separate entity that is not the state have the ability to tax in order to raise the money to pay for the system or would that still be left with the Legislature?

And if it's still left with the Legislature, it still runs into the problem of, you know, that, gee, we don't want to raise taxes, we don't want to have taxes, we don't want to deal with this.

And then in a bad year, your Legislature's looking around and saying we are not going to tax adequately to raise enough funds to cover the system.

DR. JOHN BATTISTA: Gotcha. Even though I think it would be dandy if you'd delegated the taxing capacity to such a nonprofit independent trust, I really, even I being the wild-eyed idealist that I am, do not think that is about to occur.

I think the taxing capacity must remain where it's constitutionally placed, in the hands of the Legislature with the approval of the Executive Branch.

However, you must understand that when we're talking a healthcare tax, we're talking about a tax which is separate from the State tax.

When you fill out your federal tax system, you know that you pay a federal tax, you pay, I pay a self-employment tax, and in addition, you pay a Medicare premium. This would essentially be the same.

There would be a separate premium administered through the State which was a tax approved by the State on some basis, yearly, at least every two years, every three years, that would fund this system.

But it would not be directly, if you will, part of the State budget. Yes, if you, yeah, maybe the State wouldn't want to raise taxes, if that would happen, although I believe, think about it.

This would be the single biggest piece of legislation to pass the State of Connecticut in 100 years probably. You would have so much attention on this State. You would get research and funding and looking at this forever.

And every person in the State and every provider would be paying extremely close attention to how this system worked.

And if you do as I suggested and you have a board where representatives of all the, all the groups who have a vested interest are right there, they have a vehicle for paying that attention.

And so they're going to want to know, hey, are you going to increase my healthcare insurance tax? And we're going to look at whether that increase is less than or more than what my friends and neighbors in New York who have a private insurance system are getting under Aetna.

And I think you'll find out, in fact, we were so confident when we wrote a bill on this, we demanded that any increases in the tax structure of the State of Connecticut be less than the prevailing increases in the country, because we knew.

And it's obvious when you look into it that any increases in such a system, if it's properly administered, will save money.

Don't be skeptical. It's been administered fundamentally better than the United States has administered its non-system in every other industrialized country of the world. You have to do really badly.

The problem is if you were the first state to pass it, which really Connecticut would be the greatest of all states. Honest to God. I am not kidding you. It would be a gas to the insurance industry, first off. That would be really cool.

But seriously, I'm not kidding you. It would work here, because don't forget, we're a wealthy state. And why does it work?

Because guess what? When you tax a flat rate on family income, you're going to generate a lot of money from the wealthy that is fundamentally subsidizing health insurance for the poor, so much so that some people say, well, we really ought to cap that, right.

We have 30 billionaires in the State of Connecticut. Not gross, I mean,

we've got 30 people in this State who made a billion dollars last year, right?

Now generally we say if you do it at the federal level, right, and no activities detrimental to your health, you would fund a system by a 2.5% tax on personal, on family income, and a 6.5% payroll tax.

Watch this. The average person, people making up to something between \$150,000 and \$200,000 would save money under that system. They would pay less for health insurance than their currently paying.

Large corporations who now pay 12% would pay fundamentally less. Who would lose? I'll tell you who would lose. People who make over \$200,000 a year would lose. People who make over a billion dollars a year would lose really big.

And people who have corporations which currently don't provide any healthcare benefits to their employees would lose, because essentially we would mandate at some level that they make such a contribution.

Although most people say, well, look, let's charge the small corporations, you know, 2%, let's charge the medium ones 4%, and let's charge the big ones 6%. That's cool.

The point is because we know, this is like I'm no flake. I've really, I've studied this. I, honest to God, if you look at this, we know. It's not a question.

The stuff that comes, well, we can't have single payer because we can't afford it. That's total propaganda. There's no evidence in support of that. None, zero, absolutely nothing. No studies, nothing.

Every study, there are hundreds of studies all show the same thing, single payer saves money. Single payer saves money in general.

People predict that if you left the healthcare system alone this year and funded it through a single-payer mechanism instead of the multi-insurance mechanism we had now, you would save, on average, 10% right off the top.

All you did was change that, left everything else the same. You would save, you would have 10% of the 15% of the gross domestic product of the United States in your pocket to do something else with.

So we know, we know that the money is there. The problem is political will. What's the number-one and number-two contributors to politicians? The pharmaceutical industry and the insurance industry.

SEN. SLOSSBERG: Thank you, Doctor. One last question, and that is--

DR. JOHN BATTISTA: Oh, okay.

SEN. SLOSSBERG: --gee, I'm sorry.

DR. JOHN BATTISTA: That's fine, fine with me.

SEN. SLOSSBERG: You know, it happens to be a favorite subject.

DR. JOHN BATTISTA: I love this stuff.

SEN. SLOSSBERG: Do you have, you know, I have your testimony here. Do you have any numbers to back up the things that you're saying, you know, in terms of a model for the State of Connecticut?

DR. JOHN BATTISTA: Do I have any numbers to back up the model? What are we talking about?

SEN. SLOSSBERG: You know, in terms of we're talking about cost savings.

DR. JOHN BATTISTA: Yes. I mean, I can, if you want, I'll provide you everything you want. I'll e-mail you studies. I'll e-mail you the study for the State of Connecticut, the State of Massachusetts, the State of Maryland, the State of California and about 13 other states.

And I'll mail you studies on, prospective studies on, federal studies, all of which show essentially monstrous savings. It was \$1.3 billion in the State of Connecticut.

And if you take, you know, comparisons of U.S. to other countries, you find the same thing. And you see that a country like Canada, remember they were the same, 8.5%.

Well, now you see the U.S. goes up to what we are now, 14% or something of GDP. Canada is currently, you know, I don't know, 9.7% or something like that, and we spend, on average, twice as much as they do and they have better outcomes and longer longevity.

SEN. SLOSSBERG: Thank you. I was interested in numbers, I've seen the numbers of the federal level. I was interested--

DR. JOHN BATTISTA: On the state level?

SEN. SLOSSBERG: On the state level.

DR. JOHN BATTISTA: I think I have the state study. I mean, it's pretty old by now. But there are plenty of, there are much more recent state studies. But, you know, ultimately they come to the same thing.

They show that there's vast administrative savings when you have a single entity. And there are, first of all, because you can administer it more cheaply, and secondly, because providers don't have to hassle with all kinds of other systems.

And you're cutting out of the for-profit system, so you cut the profits out of it. You get the marketing out of it. You get all the inefficiencies of people changing providers out of it.

And don't forget, in a single-payer system you're going to presumably negotiate prescription drug costs on behalf of the entire population.

Since that represents about 10% of total healthcare expenses, and since we know that you can save about 50%, you know, the State of Connecticut does this and saves 40% to 60% with the ConnPACE program.

We all know that prescription drugs in Canada are, on average, half of what they are here. Guess what? We can save that 5% too. You've got that pool there. That's the way, and all those studies show the same thing.

But to show that I'm a fair guy, I want to point to you something which is not on the other side, which none of these studies point out, but I think it's fair to point out to you.

If you pass single payer in the State of Connecticut, it isn't going to be just the same healthcare system. You're going to increase demand.

And why are you going to increase demand? Because think of all the unmet medical situations which have not been met under the current situation. Think of all the knee replacements, cataracts surgeries, dental

bridges. Oh, God, dental problems are monstrous.

And so in the first few years you are doing to regretfully flood such a system with increased demand, and that's a problem.

But because we know that single payer will save about 10%, we hope at least that the demand won't be more than 10%. It'll all come out the same, which is why I suggest we, excuse me, fund it at the same level.

But don't also forget that some of the demand will be decreased because when people have health insurance nationwide, there will be 18,000 hospitalizations which were unnecessary that will be avoided.

There'll be untold emergency room visits which no longer will occur because people will have a primary care physician to call and go to. And so there are many aspects of the system which will decrease demand or decrease utilization also.

And we know that in the long run, as the power of preventive care occurs, as people getting seen early for their illnesses occur, that the saving accrue and accrue and accrue and accrue and accrue so that 5 and 10 and 15 years down the line, you save some serious buckaroos.

REP. SAYERS: Thank you, Doctor.

DR. JOHN BATTISTA: Thank you. Let some other people talk.

REP. SAYERS: Are there any more question?

DR. JOHN BATTISTA: Dr. McCabe here is equally as expert as I am.

REP. SAYERS: Okay. Justine McCabe, to be followed by Gretchen Vivier.

DR. JUSTINE MCCABE: Good afternoon, all of you. I'm Dr. Justine McCabe. I'm the I think quieter half of this Battista-McCabe team.

I'm a clinical psychologist in private practice in New Milford, and a member of the psychiatry department of New Milford Hospital.

I've long advocated for single-payer healthcare with John. I'm the co-author of the Connecticut Healthcare Security Act, which we wrote in 2000-2001.

I just want to present to underscore a point that I think is really the basis for all of us. And I want to start with a little article that appeared in *The New Yorker* recently.

Reporter Nicholas Lemann quoted the experience that editor-in-chief of the *Chicago Tribune*, Ann Marie Lipinski had before Lemann was about to interview her about media bias.

He wrote [Gap in testimony. Changing from Tape 3B to Tape 4A.]

--who had been unable to get health insurance for her depression. Editor Lipinski played back a voicemail message she'd received in response to the story.

The message said, I'm really quite disgusted with the article you wrote on the uninsured. I think it's very socialistic. Healthcare is not a right in this country. We are not Sweden and we are not Canada. I do not like these heart-tugging stories about people who don't have healthcare. Are you a socialist?

This vignette points to the fundamental question I think that's raised by the bill, is healthcare a right for all Connecticut residents, or is it a privilege only for those who can afford it.

Sadly the facts right now say that it is a privilege. As several of us have said, there are over, there are nearly 11% of people who are uninsured. Nearly 400,000 of those are, nearly 400,000 people, most of whom are employed.

The number is double for African and Asian Americans and triple for Hispanic Americans. That's just the uninsured.

But consider the social disparity inherent in our system for those who are insured. That is, we have at least four tiers of care in our multi-payer system.

We have people insured by HUSKY and Title XIX, people with Medicare, people in private HMOs, people who are insured for fee-for-service.

The point I'm making is that besides wastefully duplicating administrative costs that could be spent on care, from a more important point of view and psychologically and in terms of the future of

Connecticut as a just society, our current healthcare system has created healthcare castes, which essentially tell individuals where they stand in terms of worth among their fellow citizens.

This is a really essential point that I see every day in terms of people who come to me as a psychologist.

With every disparate access to care that each of these categories imposes, we as a society are saying some people are inherently better, more worthy than others.

And to those in the bottom health insurance caste, those who are poor and especially those who are minorities, our State is saying your time, your body, your life are not worth as much in this particular health caste as compared to others.

Nowhere is this disparity more apparent than in mental health. Research shows that 60% of employee absences are due to psychological problems, that medical complaints arise from psychological factors at least as often as from physical problems, and that 50% to 70% of visits to primary care physicians are from medical complaints stemming from psychological problems, depression and anxiety particularly.

These difficulties are treatable and cost-effective, yet the uninsured have no access to this care, and depending on where you are in this caste system, you have very poor care to limited care.

The point is that the U.S., including Connecticut, has the best healthcare in the world but only if you can pay for it.

I believe that healthcare is a right, and I believe that each one of you do too. This is not a left or right issue. It's not a blue state or red state issue. It's neither conservative nor socialistic. At bottom, it's a most American idea.

It's an issue of fairness and democracy. It's the basic human right on which the American ethos of life, liberty, and the pursuit of happiness most fundamentally rests.

Only a single-payer health insurance system can guarantee this right. It's the only one that is democratic, fair, and ethical.

Martin Luther King said, of all the forms of inequality, injustice in

healthcare is the most shocking and inhumane. I urge you to pass this bill and become a leader that other states will follow. Thank you.

REP. SAYERS: Thank you, Doctor. Any questions from Members of the Committee? Okay. Thank you very much. Next speaker is Gretchen Vivier, to be followed by Larry Deutsch. Thank you.

GRETCHEN VIVIER: Good afternoon, Representative Sayers and Members of the Committee. My name is Gretchen Vivier. I'm the Director of the Healthcare for All Coalition.

As our name implies, we support affordable quality healthcare for all of Connecticut's residents.

The following are the principles we have agreed to stand by in our coalition. There must be universal and equal access to healthcare. Benefits must be comprehensive. Costs must be effectively controlled.

Healthcare industry workers must be provided decent wages, benefits, and working conditions. There must be single standards of high-quality care. The structure of financing must be equitable and efficient.

Consumers must have a choice of providers. And the system must have strict accountability to the public.

And though our Coalition is open to other solutions, most of our members believe a single-payer system is the most simple, cost-efficient, and equitable.

You know, you certainly heard really more of the expert testimony earlier, so I'm not going to go on. There is attached to this a statement by a doctor in Hartford, saying why he believes in it.

And I'll just talk in more general terms of why it's important to have universal coverage, because right now there's gaps. And there's no really way to fill those gaps and be sure that you've filled every single gap without having a seamless system.

So, you now, any of us could find ourselves in a situation where we don't have insurance, whether recently graduated, laid off from work, self-employed, divorced, or taking early retirement, for some examples.

And increased access to primary care increases the likelihood that

there'll be a stable supply of providers for everyone, keeps cost down through prevention and administrative savings, frees up emergency room use for true emergencies, and adds to a vital economy.

Healthy children learn better and stay in school longer. Healthy workers are more productive and have higher annual earnings.

It's a matter of the system working better when everybody's in it, like public education working better, like public roads working better.

When the truck melted the bridge in Bridgeport, that was a gap to the system that caused trouble for anybody. I mean, it didn't matter whether you had a good car or a bad car, whether you were rich or poor. There was a gap. It affected the entire system.

Healthcare's a system just like that. And I think, you know, part of my answer to the what happens in poor times, his was more specific, but in general don't you think if we ever had a system where everybody was covered, everybody was covered, that anybody would ever go back on that. We'd have to find a way to cover it. That would be our priority.

So thank you. And as you go forward in this Session, I know that healthcare's a priority for this Committee, and we hope we find a good solution.

REP. SAYERS: Thank you very much. Any questions from Members of the Committee? Okay. Thank you. The next speaker is Larry Deutsch.

UNIDENTIFIED SPEAKER: Larry Deutsch signed up in case he could make it. He was not going to be able to make it until 4:45, and is Martha Kelly next?

REP. SAYERS: Martha Kelly is next.

UNIDENTIFIED SPEAKER: She had to leave at two.

REP. SAYERS: We do have, nope. We're going to go back to Senate Bill 1205 for Steven Thornquist because it was left off.

STEVEN THORNQUIST: Thank you. I've got a tough act to follow here. Thank you, Representative Sayers and the surviving Members of the Committee.

My name is Steve Thornquist. I'm a pediatric ophthalmologist and I practice in Trumbull, Connecticut, and I'm board certified in ophthalmology.

And my printed testimony will tell you that I'm board certified in internal medicine, but I let that lapse because it cost me \$800 to do that and I don't practice internal medicine anymore.

But I am here to represent the Connecticut Society of Eye Physicians, and I am, in fact, their President-Elect.

And we are in support of Raised Senate Bill 1205. You heard Dr. Battista speak eloquently about all that overhead that we have to go through to file all these claims with all these thousands of different policies.

One of the things that is a problem through us is that claims are often denied on the basis of routine protocols at the insurance company.

What Senate Bill 1205 promises to do is to address that issue. It's an issue that's been frustrating the medical community for a very long time.

The issue is that what happens right now in the law is that you can file appeals for denials through the state, and the law that does that prohibits filing one appeal for multiple denials. You have to file an appeal for each denial.

And it's common for physicians to receive multiple denials for the same procedure and diagnosis based on a protocol or a systemic decision at an insurance company, not based on medical review of each individual case, but because simply you've submitted that procedure with that diagnosis and it's denied.

And so what we're asking for is some relief for these classes of denial, if you will. Currently the external appeals process in Connecticut requires patients or physicians filing on behalf of patients to submit a separate external appeal on a state mandated form with a \$25 billing fee for each appeal.

That fee is returned to the patient or provider if the ruling is made in favor of the patient or provider.

The managed care organization must then pay the claim and forfeit the

\$25 filing fee that they also posted. So essentially, we're both posting bond and whoever loses pays.

If the ruling upholds the denial, the claim is not paid and the patient then pays that, or the physician forfeits their filing fee.

But as I said, some of these denials are systemic. They're based on a protocol and not on a per se medical decision, and as such, essentially form a class, if you will, of denials.

And what we're asking for is the ability to file an appeal for that class of denials as a group, and therefore file a one-time filing fee of \$25 and have the insurance company post their \$25 as well, rather than, say, for 1,000 claims filing \$25,000 worth of fees.

Just to give you an example so you have a clearer understanding of what I mean. Last year the Connecticut Society of Eye Physicians received numerous complaints from our members that optical coherence topography, which is, if you will, sort of an ultrasound, CAT scan of the retina, it's a digital scan of the retina that was being denied by a certain carrier in this State.

This procedure's a state-of-the-art test which detects retinal problems such as macular holes that may require surgery and can be essential in determining whether or not a patient goes to surgery or not.

The test is noninvasive. It doesn't require any injections or any other potential reactive or hazardous manipulation.

And it can actually save the patient from having to go through a fluorescein angiogram or some other invasive procedure, and sometimes can obviate the need for surgery.

But this provider was routinely denying all OCT claims because they claimed it was experimental.

And it's important to note that no other carrier in the State has denied OCT as experimental. Just this one.

This capricious denial of a well-accepted study is bad enough, but to add insult to injury, the carrier refused to meet with us for roughly 11 months.

And as we speak today, many physicians are waiting for thousands of dollars based on these denials, which are in the process of appeal.

I realize my bell rang, so I'm going to shut up with a quick summary statement here, which is that this also costs the State of Connecticut a ton of money.

According to our, the Insurance Commissioner's Office, apparently it costs the State about \$500 to \$750 to adjudicate each claim.

And so each time we have to file a separate appeal for each separate denial for each of these thousands of claims, we're costing the State that money.

So potentially by filing one claim, which you get adjudicated once for \$750, maybe even \$1,000, because it would be a big claim, we're saving the State maybe \$50,000 to \$75,000 by not running through it individually.

So we ask that you support this important piece of legislation which will potentially save the State thousands of dollars and most of us our stomach lining and hair. Thank you.

REP. SAYERS: