Testimony of Professor Gerald Friedman to the Rhode Island House Finance Committee in support of H5387, May 26, 2015.

My name is Gerald Friedman. I am a professor of economics at the University of Massachusetts at Amherst. I have lived in New England since August 1978, when I moved to Cambridge to attend Harvard, where I was awarded a Ph.D. in economics in 1986. Since 1984, I have taught at the University at Massachusetts at Amherst where I have specialized in labor economics, public policy, and economic history. Currently, I am department chair.

At the time of this hearing on May 26, 2015, I will be in Boston where I am appearing in a documentary film on health care. I appreciate that you have allowed me to submit this testimony in absentia.

I have been involved in the debate over health care financing since the 1970s when I went to Washington to support Senator Ted Kennedy's proposed national Medicare-for-all system. Since then, every Democratic presidential nominee and president has proposed reforming our health care system to address the toxic combination of rising costs and declining coverage. Yet, the situation has only become worse: we now spend about 18% of our gross domestic product on health care, and rising health care costs have swallowed up much of the increase in wages over the past decades as well as a disproportionate share of state and local spending (see Figure 1). Throughout the country, we are reducing spending on our children's education and our investment in vital infrastructure to feed the rising cost of health care.

Worse, we are not getting our money's worth for our spending because health care spending is much less efficient in the United States than elsewhere. Compared with the average for other affluent countries, we spend over twice as much but have a life expectancy 2.5 years less. If we are only going to settle for the life expectancy of people in Chile, then why are we spending over $7,000 more per person (see Figure 2)?

This is a national problem and I do not envy your position because state and local officials have to deal with the cost of our failure to enact a sensible national health care program. Indeed, Rhode Island has done well in providing greater access to health care, although less well in controlling costs so that there is a continuing squeeze on the budgets of families, businesses, and governments.

Of course, we will control health care spending and we will do it in one of two ways: either we will control administrative bloat, monopoly pricing and excessive profits, or we will reduce access to health care services. So far, as a nation, we have been doing the latter, reducing access to services with higher copayments and deductibles to the point where Americans are less likely to see a physician than residents of other affluent countries and thousands die for lack of care. This is clearly wrong. While these policies discourage people from using health care and will

make us less healthy, they do not address the source of America's out-of-control health care spending. International studies make it clear that our health care spending is not high because we use too many services; instead, our spending is out of line with other advanced economies because our health care *prices* are so high. The McKinsey Global Institute has found, for example, that drug prices in the United States are 60% higher than elsewhere and that we spend about $30 billion more on medical devices because of inflated prices - over 25% higher than the world average.[1] The Massachusetts Attorney General's office has found enormous variation in hospital prices for the same procedures reflecting the bargaining power of privileged hospitals.[2] Other business-oriented researchers have similarly found that inflated prices and monopoly power, *not* utilization, account for high and rising health care costs in the United States.[3]

High and rising prices for health care in the United States are due to our reliance on a for-profit financing system that necessarily generates waste and cannot control monopolistic practices. I do not mean to name-drop, but of course, I will. My graduate-school professor, then Harvard Professor and Nobel-laureate Kenneth Arrow, showed 50 years ago that health care is not a commodity like shoes; because of risk and uncertainty, we cannot expect health insurance markets to function like those of other commodities.[4] Insurance companies do not profit by selling more; instead, they profit by screening their customers so that they sell less insurance to people who will need it.[5] In his coffee business, for example, my father tried to provide quality coffee at a reasonable price because his profits grew when he sold more coffee to more people.

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[1] McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007, http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp; Diana Farrell et al., "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More" (McKinsey Global Institute, December 2008); Commonwealth Fund, "A High Performance Health System for the United States," November 15, 2007, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Nov/A-High-Performance-Health-System-for-the-United-States--An-Ambitious-Agenda-for-the-Next-President.aspx.

[2] Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers," January 29, 2010, http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf.

[3] Robert Kelly, "Where Can $700 Billion in Waste Be Cut Annually from the U.S. Health Care System?" (Healthcare Analytics, Thomson Reuters, October 2009), https://healthleadersmedia.com/content/241965.pdf; "Bloomberg Best (and Worst). Most Efficient Health Care: Countries," n.d., http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-countries; Institute of Medicine (US) Roundtable on Evidence-Based Medicine et al., "Prices That Are Too High," Text, (2010), http://www.ncbi.nlm.nih.gov/books/NBK53933/; Steven Brill, *America's Bitter Pill: Money, Politics, Back-Room Deals, and the Fight to Fix Our Broken Healthcare System* (New York: Random House, 2015); "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America - Institute of Medicine," accessed May 10, 2013, http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx; Donald Berwick and Andrew Hackbarth, "Eliminating Waste in US Health Care," *JAMA: The Journal of the American Medical Association* 307, no. 14 (2012): 1513–16.

[4] Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53, no. 5 (December 1963): 142–49.

[5] The Affordable Care Act includes restrictions on screening practices by requiring insurers to sell policies without regard for pre-existing conditions and forbidding rescissions, or the cancellation of policies because of illness. While welcome, these restrictions cannot prevent more subtle exclusionary policies such as targeted marketing and the use of bureaucratic barriers to access.

Health insurance companies increase profits by *reducing* sales, by identifying those likely to be sick and *denying* them coverage. Over 70% of what insurers call their medical "losses," payments made to providers, go for as few as 10% of people covered. This creates a powerful incentive for insurers to identify those people and get them to drop their coverage or change insurers. If you can do this, if you can "cherry pick" healthy people and "lemon drop" those who will become sick, you can dramatically lower your "losses" (what we call insurance benefits) and increase profits. Expensive practices, like clinical review and requirements for prior authorization, practices that demean the sick and needy while wasting valuable provider time and insurance resources, are not accidents or mistakes but are practices designed to lower insurance company costs by driving away those who may need insurance the most.

Waste, therefore, is intrinsic to our for-profit health care system and our system of private health insurance. Even without any ill will or malice by insurers, their business model depends on driving out the needy. Companies that fail to screen their enrollees risk plunging into an "insurance death spiral" where a less-healthy population leads to rising costs and higher premiums that discourage the healthy from buying coverage making the population enrolled less healthy, raising costs further and requiring higher premiums. Similarly, investors will quickly replace any drug company executives or hospital administrators who fail to focus on branding and the search for monopoly profits because their business is not to provide health care but to create profits.

Our health care cost crisis is driven by administrative waste due to the insurance industry and to monopolistic pricing. The Affordable Care Act limits administrative costs and profits to only 15% of the standard group insurance plan, a rate that is nearly ten times the administrative rate of Medicare, with nearly $200 billion dollars of extra costs. The fastest increases in cost in the American health care system over the last decades have been in drug prices and administrative activities.[6] Administrative costs have risen in the United States at a rate of over 11% a year since 1971, rising from a bit over 1% of GDP to over 5% now. Compared with Canada's single payer system, administrative cost increases account for over two-thirds of the excess increase in our health care costs. Perhaps most revealing, there is no difference between the cost increases in Canada's Medicare single-payer system and our Medicare single-payer-system for the elderly; had all of the US health care system behaved like our Medicare system, we would be spending a third less than we spend now, about what Canada spends per person to gain longer life expectancy than we have in the United States.

[6] Commonwealth Fund, "A High Performance Health System for the United States"; Woolhandler S Himmelstein DU, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," *Archives of Internal Medicine*, October 29, 2012, 1–2, doi:10.1001/2013.jamainternmed.272; Gerald Friedman, "Universal Health Care: Can We Afford Anything Less?," *Dollars and Sense*, June 29, 2011, http://dollarsandsense.org/archives/2011/0711friedman.html.

Rising administrative costs are the price we pay for a broken system of private health insurance, a system designed to increase industry profits even while denying adequate health care to growing numbers of our citizens. Ask yourself and your constituents, what do we get in exchange for handing billions of dollars over to the insurance industry and to monopolistic drug companies and others? Fortunately, there is an alternative to this bloated and inefficient system. A single-payer health insurance system would dramatically lower costs by eliminating much of the administrative burden both within health insurance companies and within provider offices' billing and insurance operations. Combined with savings to be realized by reducing administrative costs in the operation of health insurers and in providers' offices and by reducing market power in areas like prescription drugs, Rhode Island could reduce health care costs by nearly $3 billion (see Table 1 and Figure 3). Even after expanding coverage to all residents, this would leave savings of over $1.5 billion. We could lower health care spending by nearly 15% while *improving* access for all residents of the State. What are we waiting for?

We could finance a universal insurance system in Rhode Island covering everyone without copayments or deductibles in a variety of ways while leaving more money for most Rhode Islanders. Two such funding plans are suggested in Table 2 which gives estimates of moneys collected from an 8 percent across-the-board income tax (applied to capital gains as well) or a 10% payroll tax combined with a 10% tax on capital gains, interest, profits, and rents.[7] Either of these would replace insurance premiums and most out-of-pocket spending so that over 80% of residents would save money. And it would give the state the tools to control future health care costs.

Most Rhode Islanders will save thousands of dollars a year compared with what they and their employers currently spend on health insurance premiums and out-of-pocket spending. Because many low-income households are already receiving subsidized health care through Medicaid and the Affordable Care Act, the largest savings will go to working families and to middle-income households, especially those with children. Income after health costs and taxes will increase by 32% for middle-income families; and even households with income of over $100,000 will save. Only a small number of the richest, and best able to pay, will pay more (see Figure 4).

Employers will also benefit from the single payer plan. They will save nearly $80 million on the administrative expense of operating employer-provided health insurance plans. Freed from the uncertainty and stress of having to negotiate health insurance, they will be able to concentrate on their businesses. (This is especially true for small employers who, because of the small size of their risk pool, pay the highest insurance rates and face the greatest rate-uncertainty in annual renegotiations.) Employers will also save money on insurance premiums. If the second

[7] After establishing a working reserve, surplus revenues would be returned to the public through a premium holiday at the end of the year.

financing alternative is chosen the payroll levy will be substantially less than most employers now pay for health insurance.[8] On average, employment-based health insurance costs employers nearly 13 percent of payroll, with the heaviest burden on small employers who pay the highest cost for health insurance.[9] Counting both public and private sectors, employment-based health insurance will cost over $3.2 in 2015; a single payer system would save them $700 million dollars. Reducing the burden of health insurance premiums will help Rhode Island businesses compete, attracting investment and jobs to the state. Businesses would also benefit because a payroll tax of 10% would lower payroll costs by nearly 3% compared to what they are paying now for health insurance. When added to significant administrative savings within companies, single-payer would dramatically enhance the competitiveness of Rhode Island companies. A conservative estimate would be that by lowering the cost of business these savings would lead to an expansion in sales and production that would increase employment in the state by nearly 3%, or over 14,000 additional jobs. Do we want these jobs, or would we rather Massachusetts or New York get them by reforming their health care systems first. What are we waiting for?

Because health insurance is an especially large share of local government expenditures, the state's cities and towns would be among the biggest winners from adopting a single payer health program. Local governments will be spending over 20% of payroll on health insurance; a single-payer system would bring these costs down to 10% of payroll. Do you have another way to provide this much help for your districts' localities. To repeat myself: what are we waiting for?

[8] The savings will be even greater for covered employees; there will, of course, be greater expense for employers who currently do not provide health insurance.

[9] Of course, some do not provide health insurance to their workers. These free-riders are subsidized because their employers are covered through free care programs, by government programs, or through coverage provided by another business to a family member.

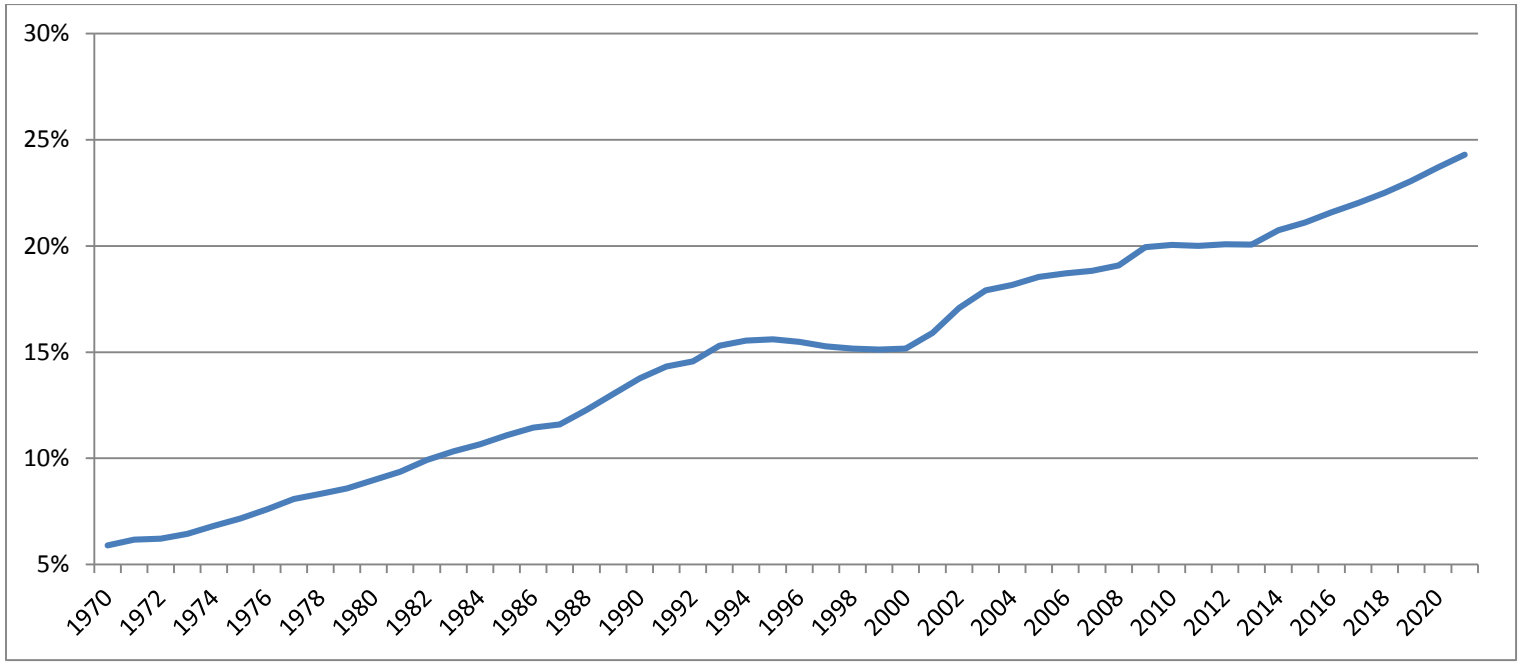

Figure 1. Per-Capita Health Care Spending to Average Wage, United States since 1970.

Note: This figure shows the ratio of per capita health care spending to the average wage reported to the Social Security Administration.

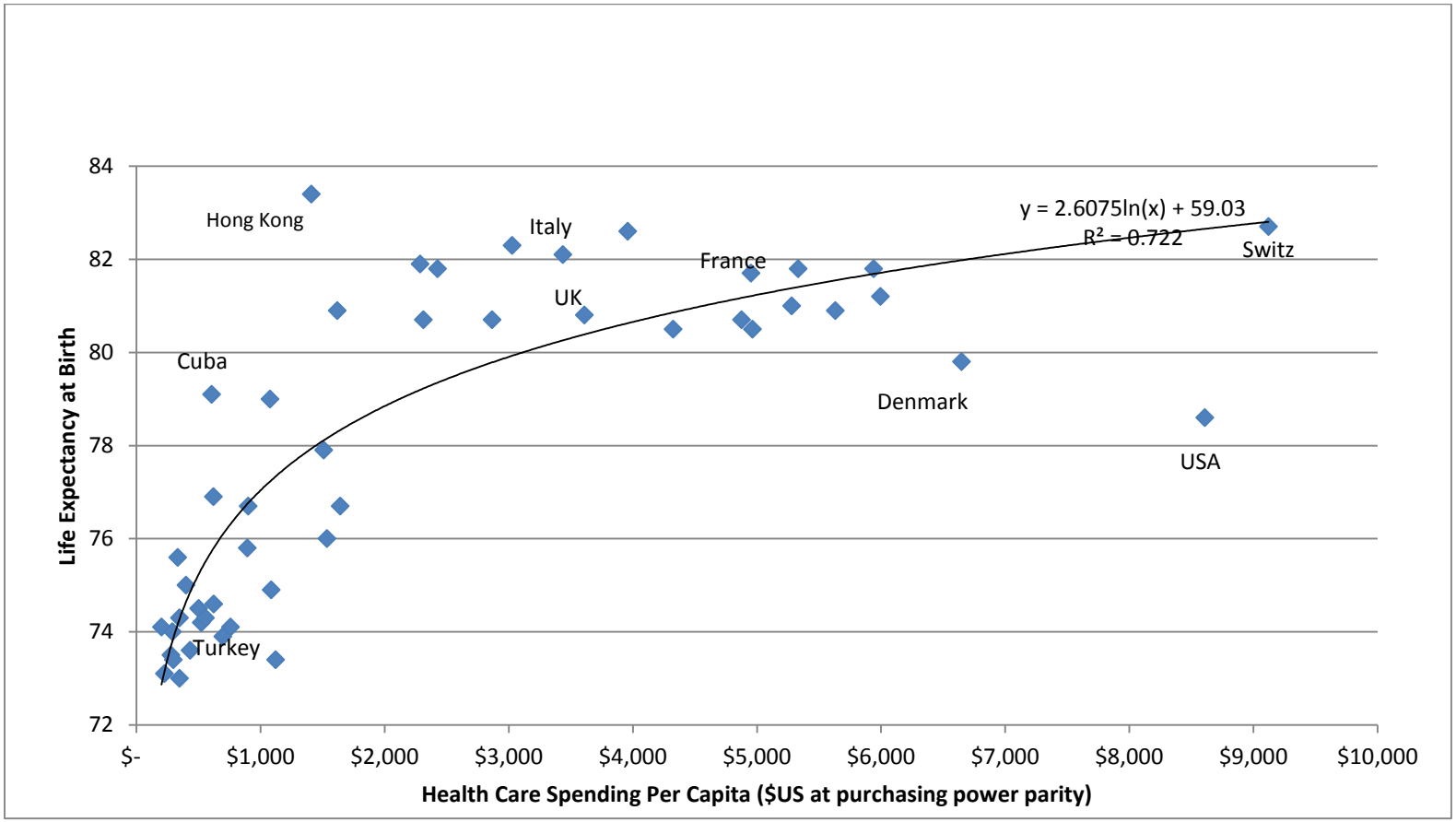

Figure 2. Life Expectancy and per-capita Health Care Spending, National Averages.

Note: This figure compares average life expectancy at birth to per capita health care spending around 2010. The regression line gives the average life expectancy value for each level of spending. Note that the United States is significantly below the line, indicating that we have a life expectancy over two years less than would be expected given our level of spending.

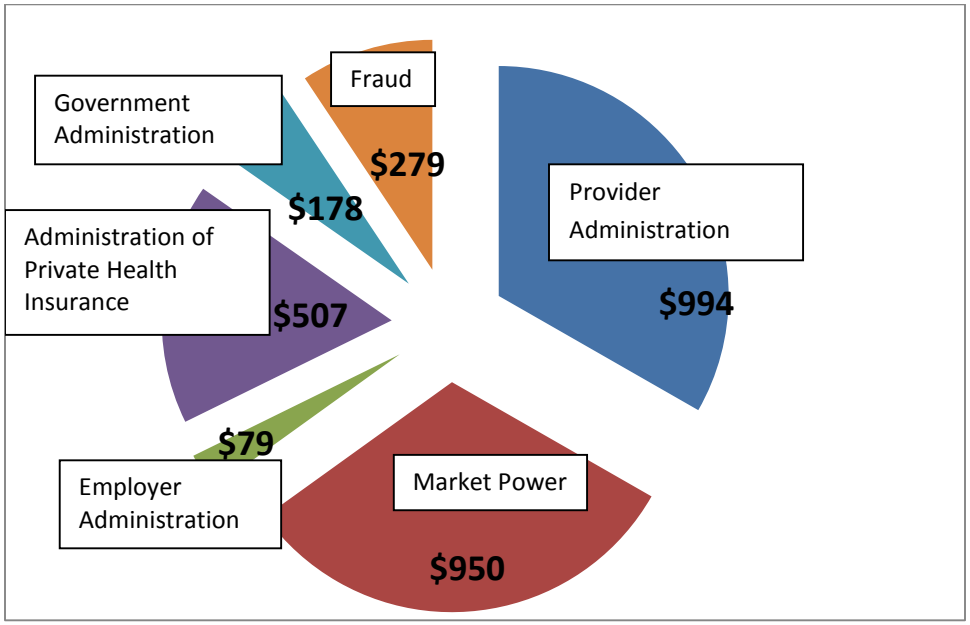

Figure 3. Savings in $millions from Single Payer, Rhode Island 2015.

Note: This figure represents anticipated savings from a single payer system in Rhode Island in 2015.

Table 1. Health care spending with single payer, Rhode Island, 2015

Personal Health Expenditures, current system	$	12,238
Private administration	$	477
Government	$	474
Total	**$**	**13,189**
Savings from single payer		
Provider Administration	$	994
Monopoly pricing of drugs and devices	$	950
Sponsor Administration	$	764
Reduced fraud	$	279
Total savings	$	2,989
Net spending without program improvements	**$**	**10,200**
Program Improvements with single payer		
Universal coverage	$	102
Medicaid rate equalization	$	905
Increased utilization	$	444
Single payer health care spending total	**$**	**11,651**

Table 2. Alternative funding options for Rhode Island Single Payer Plan

Personal Income and sources, Rhode Island 2015		
State personal income	$	53,569
Wages and salaries	$	25,388
Dividends, interest, rents, profits	$	13,775
Capital gains	$	2,100
Anticipated revenue from suggested state single payer premiums compared with estimated net program costs		
Flat income tax rate of 8% (including capital gains)	$	4,454
Surplus	$	719
Payroll tax of 10%	$	2,539
Tax on dividends, etc. of 10%	$	1,378
Capital gains tax of 10%	$	210
Surplus	$	391

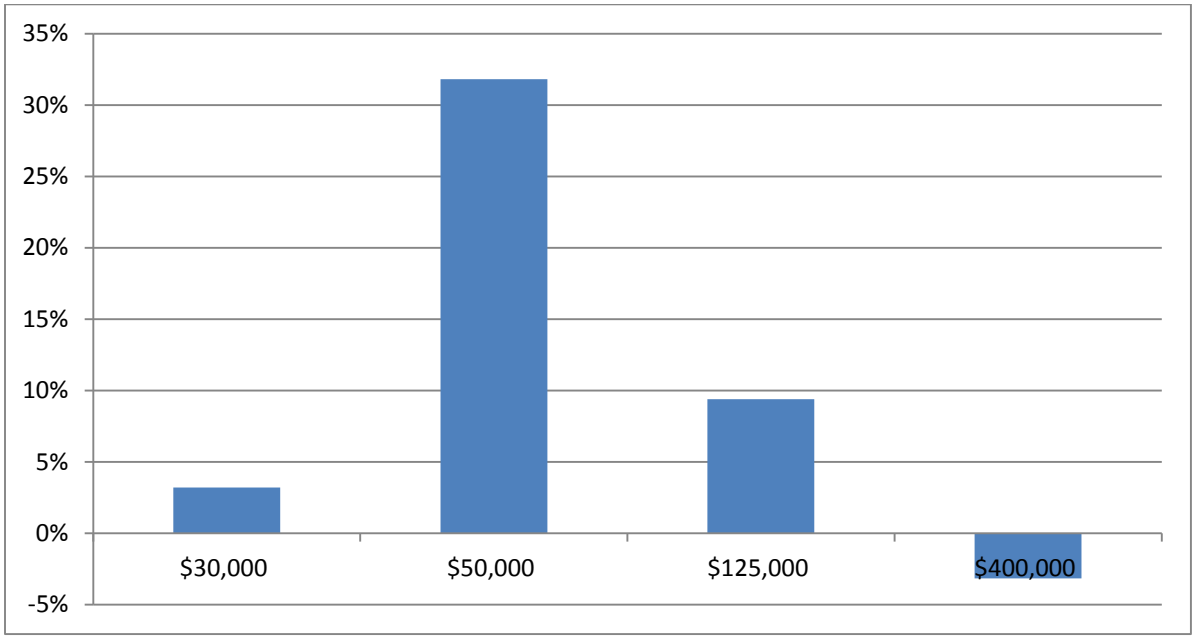

Figure 4. Effect of single-payer financed with 10% payroll tax and 10% tax on rents, dividends, profits, capital gains. Effect on income by income level.

Note: This shows the percentage change in income after taxes and health care expenses of a single-payer program in Rhode Island that replaced all health expenditures except 20% of out-of-pocket costs with a state program funded with a 10% payroll tax and a 10% tax on income from dividends, interest, profits, and rents.

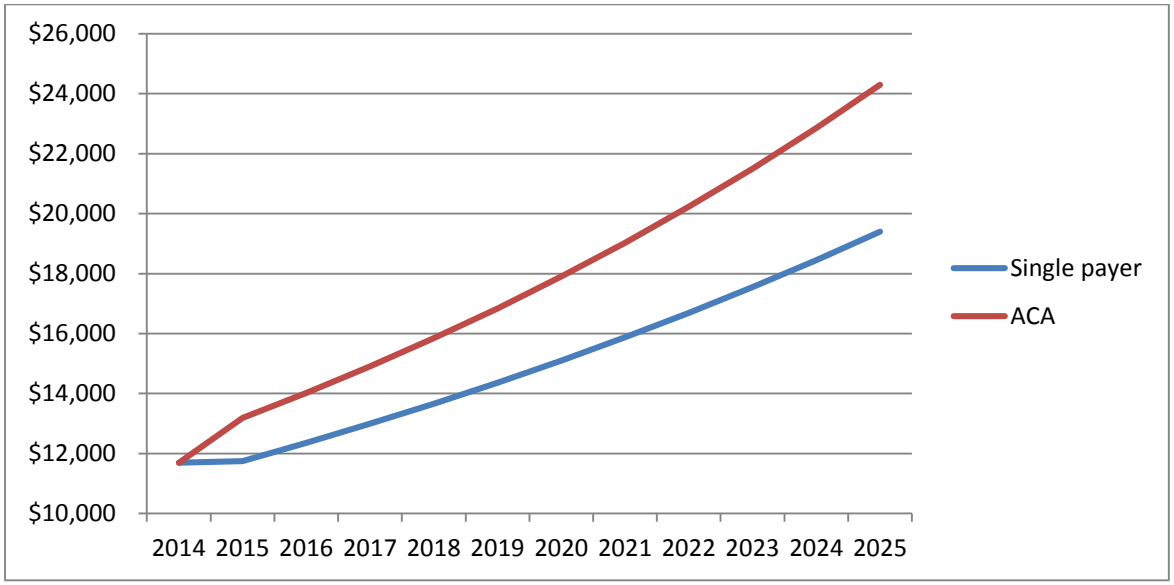

Figure 5. Projected health care spending, Rhode Island, 2014-25; current system and single payer