Testimony in support of SB 631, May 4, 2015

Prepared by Charlie Swanson of Eugene, Oregon (HD 11)

Thank you, Chair Monnes Anderson and members of the committee. I am Charlie Swanson, a member of Health Care for All Oregon (HCAO). I have been part of a team that has been working on Senate Bill 631, which is a revision of HB 2922 introduced by then Representative Michael Dembrow, and which establishes a universal, comprehensive, publicly funded health care system in Oregon.

I will connect my written testimony with the power point presentation that I will make during the hearing, by indicating the slide number to which the written testimony pertains.

Slide 2. I will describe the problem addressed by this bill, describe how this bill will help, and discuss steps that could help us move forward.

Slide 3. The major problem addressed by SB 631 is that health care costs have been rising rapidly for a long time. This growth is unsustainable. Figure 1 below shows projections of health care costs increasing 50% more than the state economy over the 35 years ending in 2025.

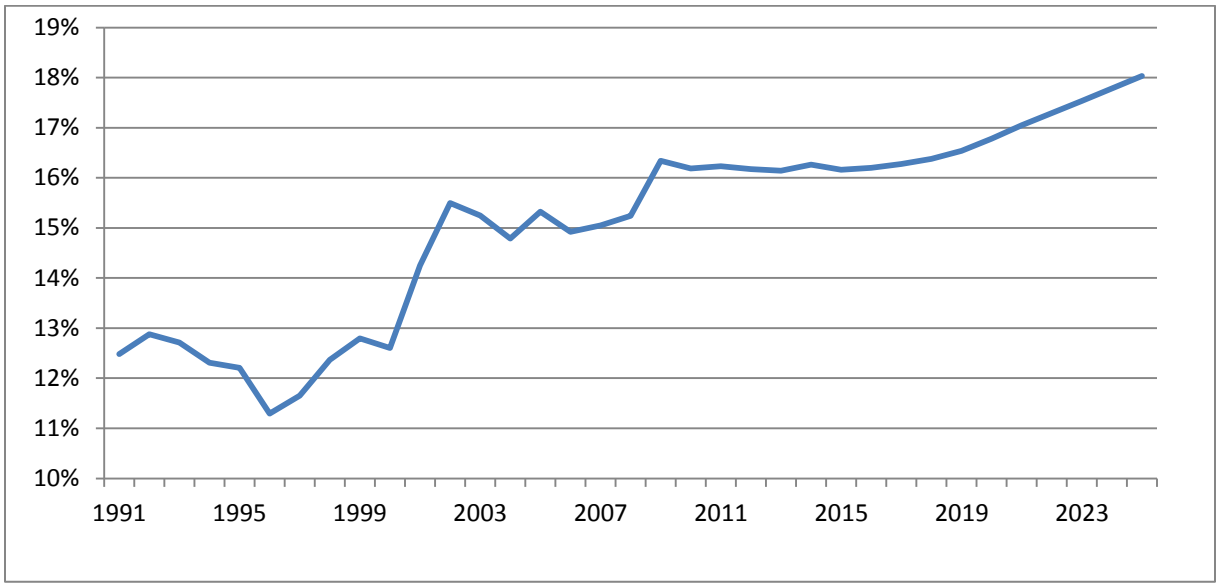

Figure 1. Health care expenditures, Oregon, 1991-2025 as share of gross state product. This gives health expenditures in Oregon divided by total income (GSP) in the state. Data for years after 2009 is a projection under current law

Figure 1 was prepared by Gerald Friedman, an economist from the University of Massachusetts (http://www.umass.edu/economics/friedman.html), who has been helping HCAO understand health care finances. Dr. Friedman has prepared many of the plots presented in the power point and also in this written testimony. In Figure 1, annual personal health care expenditures from 1997-2009 are from the Centers for Medicare & Medicaid Services, Office of the Actuary at http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf

Expenditures beyond 2009 have been projected assuming the same rate of increase in per capita expenditures as for the nation as a whole from the CMS.[1] Total health consumption expenditures have then been estimated as the state population times projected per capita expenditures. Population data are from the United State, Bureau of the Census: http://www.census.gov/popest/estimates.php

Slide 4. All categories of health care costs have risen much faster than inflation, wages, or per capita income, as shown in Figure 2 below. Two categories have risen substantially faster than the rest. Prescription drug costs have increased 1950% from 1980 to 2005, well over 5 times more than per capita income. Health care administration costs have risen 1300%, nearly 4 times more than per capita income.

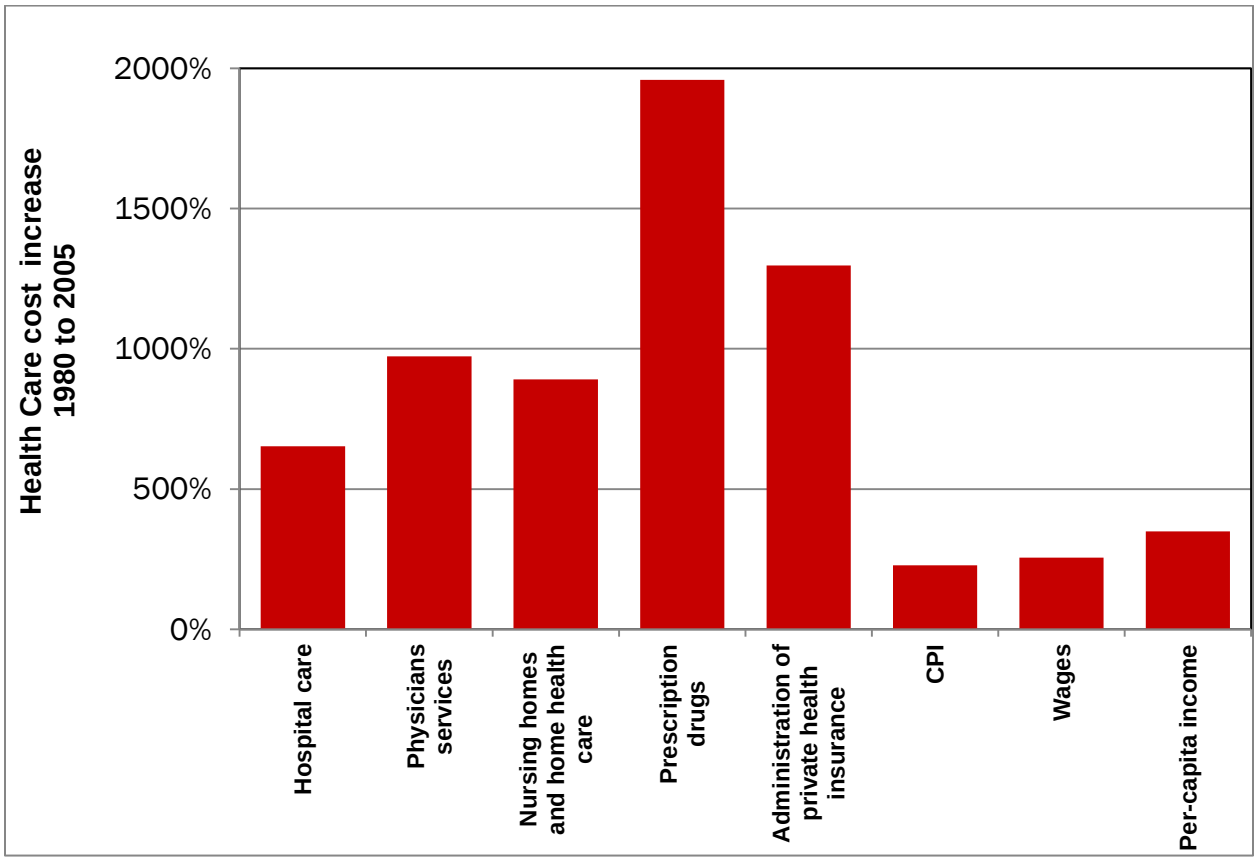

Figure 2. Rise in Health care expenditures compared to inflation, increase in wages, and per capita income (1980 to 2005). These are national data, but things are not better in Oregon, and the last decade has not reversed this trend.

[1] Sisko et al., "National Health Spending Projections"; Center for Medicaid and Medicare Statistics, *National Health Expenditure Projections 2013-2023* (Washington, D. C.: Centers for Medicare & Medicaid Services, Office of the Actuary, n.d.), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf.

Again, Figure 2 was prepared by economist Gerald Friedman, using health care data from http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf.[2]

Slide 5. The rise in health care costs has led to hardships and even disasters for individuals. Before the expansion of Medicaid and health insurance under the Patient Protection and Affordable Care Act (PPACA), it was estimated that about 45,000 Americans died each year due to lack of health insurance.[3] Oregon's population share of these deaths is 560. Although the death rate due to lack of health insurance in Oregon has surely gone down since the implementation of the PPACA, primarily because of the expansion of Medicaid, large deductibles, co-insurance, copays, or other out of pocket costs also have a negative effect.

Large deductibles and other out of pocket costs discourage many from accessing health care in a timely manner. Dr.Friedman has estimated the effect of this by looking at county by county mortality rates as a function of the proportion of the population that has cost related access problems.[4] Figure 3 shows a plot of this, along with a best fit linear equation. Using this best fit equation for Oregon counties, he calculates that as many as 12,000 Oregonians die each year because of economic barriers to accessing health care. Although the correlation shown in Figure 3 does not demonstrate effect, it is reasonable to suspect that practitioners do actually provide a service related to what they are paid to do – help with their patient's health. The 12,000 extra deaths annually due to economic barriers to health care is probably an overestimate (those of lower income may well have other reasons for increased mortality than just lack of access to health care), but the real number of excess deaths is likely between 560 and 12,000.

Estimates of bankruptcies due to medical costs vary widely. A good discussion of this, with a reference to a full bibliography, can be found at http://theincidentaleconomist.com/wordpress/where-we-stand-divided-on-medical-bankruptcy/. Estimates of medical bankruptcies range from 17% to 62% of all bankruptcies, while up to 75% of those undergoing medical bankruptcy had health insurance at the onset of their injury or illness. The high estimates lead to 25,000 Oregonians in families that become bankrupt due to medical events each year. More conservative values from the American Enterprise Institute yield the 8,000 Oregonians that I presented on slide 5.

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[2] Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum. "Slowing the Growth of U.S. Health Care Expenditures: What are the Options?", Prepared for The Commonwealth Fund/Alliance for Health Reform 2007 Bipartisan Congressional Health Policy Conference. http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf

[3] Andrew P. Wilper, Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein. " Health Insurance and Mortality in US Adults". American Journal of Public Health: December 2009, Vol. 99, No. 12, pp. 2289-2295.

[4] These data are from the County Health Rankings and Roadmaps site at http://www.countyhealthrankings.org, which is a project of the Robert Woods Johnson Foundation and the University of Wisconsin.

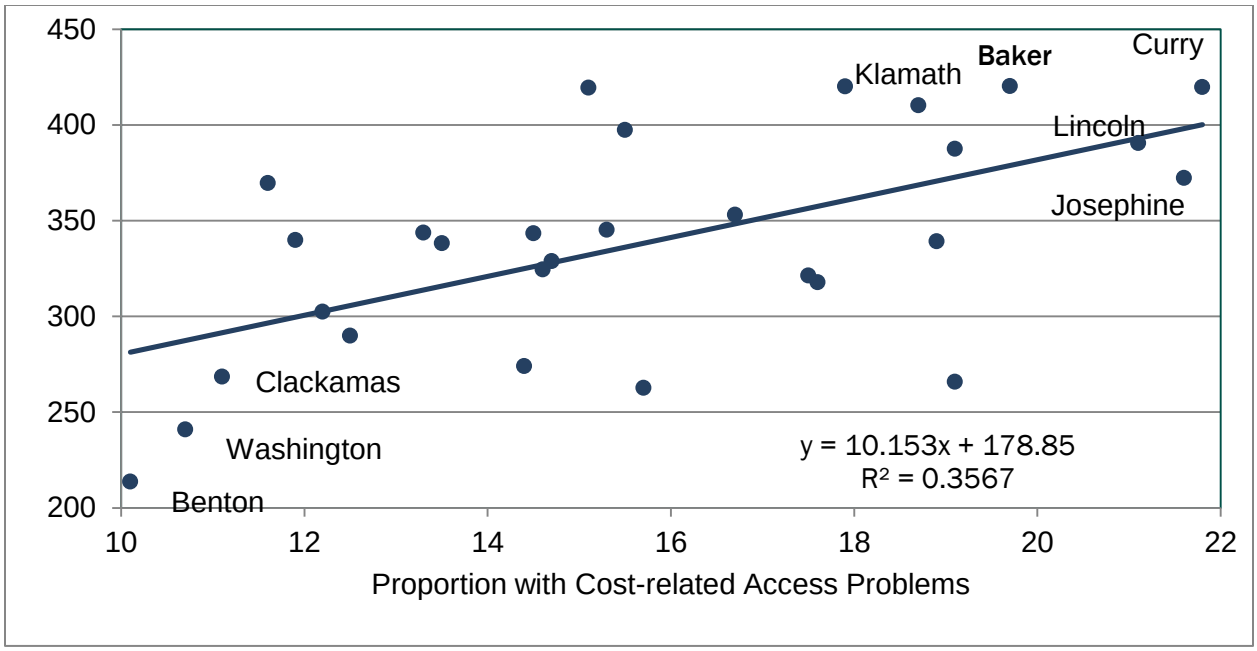

Figure 3. Age adjusted mortality as function of the population with cost related access problems, plotted for each county in Oregon. The linear fit equation is given on the plot. There is clearly a correlation between mortality and cost-related access problems. It is not clear how much of that correlation is due to cause and effect.

Slide 6. Figure 4 shows why being "covered" – that is having insurance – is not enough. Many families do not have enough liquid assets to cover the growing size of deductibles and copays, especially those families that are near poverty level but do not qualify for the Oregon Health Plan (OHP). These data are from http://blogs.wsj.com/washwire/2015/03/11/health-care-deductibles-climbing-out-of-reach/, which is based on the Kaiser Family Foundation analysis of 2013 Survey of Consumer Finances. The PPACA has increased the number of families that have health insurance, but deductibles have actually increased on average. The expansion of Medicaid in Oregon has certainly helped many of those below 138% of federal poverty level who previously did not qualify for the OHP, so things have improved greatly for that group, but there are still many who have sufficient economic barriers to health care that they do not get care in as timely a manner as would be most helpful.

Slide 7. The rise in health care costs has also created difficulties for government. A rising portion of revenue is dedicated to health care, leaving less for every other activity.

Slide 8. Businesses are also impacted, with health care costs shrinking profits even as employees pick up a larger share of health care costs.

Slide 9. Oregon has become a leader in moving towards more universal health care, and in trying to control health care costs. This bill will continue Oregon's leadership. But the bill will require more stakeholder input to be ready for implementation.

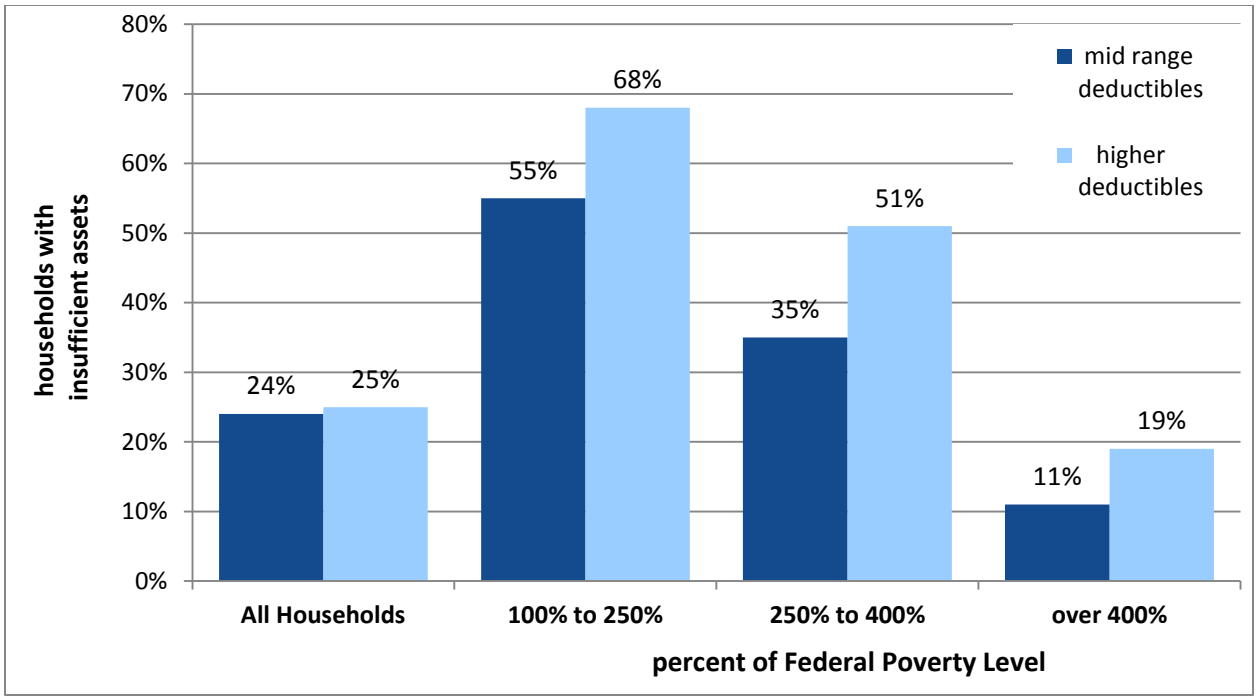

Figure 4. Fraction of households with insufficient liquid assets to pay their health insurance deductibles, as a function of income and whether their plan has mid-range (averaging $1,200 per person and $2,400 for the family) or high range (averaging $2,500 per person and $5,000 for the family) deductibles.[5]

Slide 10. The purpose of Senate Bill 631, the Health Care for All Oregon Act is "to ensure access to comprehensive, quality, patient-centered and affordable, publicly funded health care for all Oregonians; to improve population health; and to control the cost of health care for the benefit of individuals, families, business and society."

Slide 11. The Plan will cover all who reside or work in Oregon full time. The intent is that the board has the authority to make others eligible, perhaps those that work nearly full time in Oregon.

All people who are in Oregon are currently covered for acute emergency care – this is a legal, ethical, and moral imperative. But such care is expensive. This bill will cover care that can prevent many emergency room visits, saving money as it helps maintain health. There is also an emphasis on preventative care and other methods to maintain health.

Slide 12. A major theme of the bill is to simplify administration. This will happen because the Plan is universal (everyone is covered), it is comprehensive (all medically necessary services are covered), there is a single payer, providers get the same payments for providing the same services, and there are no copays and deductibles.

[5]Drew Altman. "Health-Care Deductibles Climbing Out of Reach". Wall Street Journal, March 11, 2015. http://blogs.wsj.com/washwire/2015/03/11/health-care-deductibles-climbing-out-of-reach/

Administrative overhead for private health insurers in Oregon averages 12%.[6] Medicaid in Oregon has an overhead of about 6%.[7] Medicare overhead is close to 2%. Some argue that Medicare overhead is low because its costs are so high, but a fairer comparison is the 1% overhead in the government run portion of Medicare, and a 6% overhead in the privately run portion.[8] The evidence suggests that quite a bit of savings would occur with publicly financed health care replacing health care financed through private insurance. In fact, Dr. Freidman projects that replacing a private insurance with a publicly financed system would be sufficient to extend necessary services to all in Oregon who in are not currently covered.

Perhaps an even larger savings would occur in provider office health care billing because a single-payer system, or at least a single set of rules, would greatly simplify administration.[9] I will leave projections of the actual savings due to administrative simplicity to the study that was approved as HB 3260 in the 2013 session. Having the same payments for the same services should also simplify things in provider offices – providers will not have to differentiate between Medicaid covered, Medicare covered, private insurance covered, or uninsured.

If a plan is designed to not provide universal coverage, it will add to administrative costs, because there will be some effort and paperwork involved in deciding who not to cover. More importantly from a cost viewpoint, it will likely lead to more emergency room provided services rather than cheaper, timelier, more effective services. Studies suggest that over the long term, providing services to those who currently cannot afford them leads to savings.[10]

This bill does not include any deductibles and copays. There are competing arguments related to forcing patients to "have some skin in the game." Will patients overuse services and thus drive up costs if they don't have to pay anything for services? Will patients inappropriately forego care

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[6]Government Accountability Office. "PRIVATE HEALTH INSURANCE: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers

and Enrollees." July 2014. http://www.gao.gov/assets/670/664719.pdf

[7]Kaiser Family Foundation. "State Health Facts." http://kff.org/other/state-indicator/medicaid-mco-average-medical-loss-ratios/

[8] Physicians for a National Health Plan. "Setting the record straight on Medicare's overhead costs." http://www.pnhp.org/news/2013/february/setting-the-record-straight-on-medicare%E2%80%99s-overhead-costs

[9] Woolhandler et al. have found that provider's administrative costs are much lower in Canada with plan like that envisioned here than in the United State and they estimate that a third of medical costs in provider offices in the United States are due to administrative costs, triple the rate in Canada. See Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada"; Dante Morra et al., "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers," *Health Affairs* 30, no. 8 (2011): 1443 –1450, doi:10.1377/hlthaff.2010.0893; health-care providers spend nearly eight times as much collecting bills as do other businesses; see Blanchfield et al., "Saving Billions Of Dollars—And Physicians' Time—By Streamlining Billing Practices."

[10] Cathy J. Bradley, Sabina Ohri Ghandi, David Newmark, Sheryl Garland, and Sheldon M. Retchins. "Lessons For Coverage Expansion: A Virginia Primary Care Program For The Uninsured Reduced Utilization And Cut Costs." Health Affairs, February 2012 vol. 31 no. 2 350-359. http://content.healthaffairs.org/content/31/2/350.abstract?rss=1

because they have upfront costs, and thus drive up costs because early detection will not happen as often? Will the cost of keeping track of deductibles and copays be larger than the revenue brought in? These questions should be wrestled with before a bill is passed, and it is a question that we should recognize will likely need tweaking even after a system is implemented.

Another important savings that results from a single-payer system is fraud reduction. Hsiao et al[11] "We estimated that a single-payer system could save 5 percent of health spending from reduced fraud and abuse, which is consistent with estimates from the Federal Bureau of Investigation and experience in other countries."[12,13]

Slide 13. One of the important directives in SB 631 is that there will be flexibility in the payment systems for provider reimbursement, to best meet the needs of the providers, patients, and the system. The board, in collaboration with the Oregon Health Authority and the board's advisory Committees, is obligated to *"Investigate alternative methods for reimbursing health care providers, including global budgeting, capitation payments and fee-for-service payments, to determine the appropriate method for reimbursing providers in a manner that best promotes the policies and principles described in section 2 of this 2015 Act."*

Oregon is already involved in the process of moving towards better health care payment systems, in part through its coordinated care organizations. What we learn from what is happening now in Oregon will be important as we move towards payment systems that provide the incentives that we think are best.

One general notion about incentives that should be emphasized is that those who are designing and administering the system envisioned in SB 631 will be covered by the system, so they will have an incentive to make sure it covers people well, and they will also be paying for the system, so they will have an incentive to make sure it is efficient.

Slide 14. Figure 5 shows the percentage growth in the number of health care administrators compared to physicians since 1970. The number of people employed in health care administration has grown at least 15 more than the number of physicians.[14]

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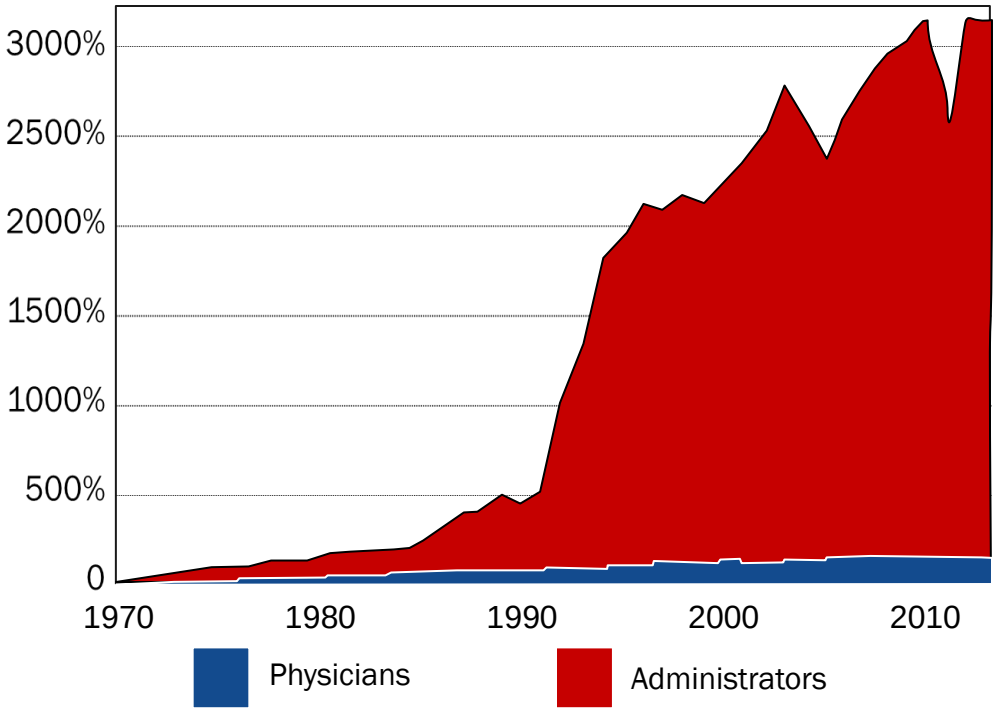
[11] William C. Hsiao, Anna Gosline Knight, Steven Kappel, Nicole Done. "What Other States Can Learn From Vermont's Bold Experiment: Embracing A Single-Payer Health Care Financing System." Health Affairs, July 2011, vol. 30 no. 7 1232-1241.

[12] Lu J.F.R., Hsiao W.C. "*Does universal health insurance make health care unaffordable? Lessons from Taiwan. Health Aff (Millwood)." Health Affairs 2003; 22(3):77–88.* http://content.healthaffairs.org/content/30/7/1232.full#ref-20.

[13] *Federal Bureau of Investigation. Financial crimes report to the public 2007 [Internet]. Washington (DC): FBI; [cited 2011 Jun 9]. Available from: http://www.fbi.gov/stats-services/publications/fcs_report2007*

[14] This figure was compiled by Gerald Friedman with data from the Bureau of Labor Statistics, the National Center for Health Statistics, and Himmelstein and Woolhandler's analysis of the Current Population Survey.

Figure 5. This shows the percentage growth in the number of health care administrators compared to physicians since1970.



Slide 15. For most purposes, simplifying health care administration leads to an increase in equity. For example, in this bill all residents are covered equally and all services are covered equitably. Having the same payments for the same service means that there is equity for providers as well as patients – currently, charges and reimbursements are different when services are provided to those covered by private insurance, Medicare, by the Oregon Health Plan, or by no plan at all. This has led to Medicare and Oregon Health Plan participants having some trouble finding willing providers.

Slide 16. There is also an issue with rural and urban equity. To address this, SB 631 defines Regional Planning Boards to continually address the conflict between providing sufficient services in rural areas and controlling system costs. This system replaces the Certificates of Need program for services that are covered, and it may also be able to address other geographically related health issues. Although most of the time increased equity leads to lower costs, sometimes it can increase costs, and it is still worth it.

Slide 17. Oregon will not be alone in moving towards providing universal coverage. The United States is the only developed country in the world that does not do so. There are at least 17 states currently pursuing single-payer, and 9 of these states have a bill in this year's legislative sessions.

Slide 18. What are the next steps? In this session, the most important step to moving towards controlling health care costs is to fund the study of health care financing that was authorized in the 2013 session – in particular, to pass HB 2828 with funding. The study will give us guidance to improving and completing the Plan. We will use the best ideas from this bill and the 2011 bill that established coordinated care organizations (HB 3650), use information from successful systems worldwide, and engage stakeholders and experts.

Slide 19. What can we learn from other countries? All other countries spend less. A lot less, as can be seen in Figure 6, where the U.S. is health care spending as a percent of GDP is shown in red.[15]

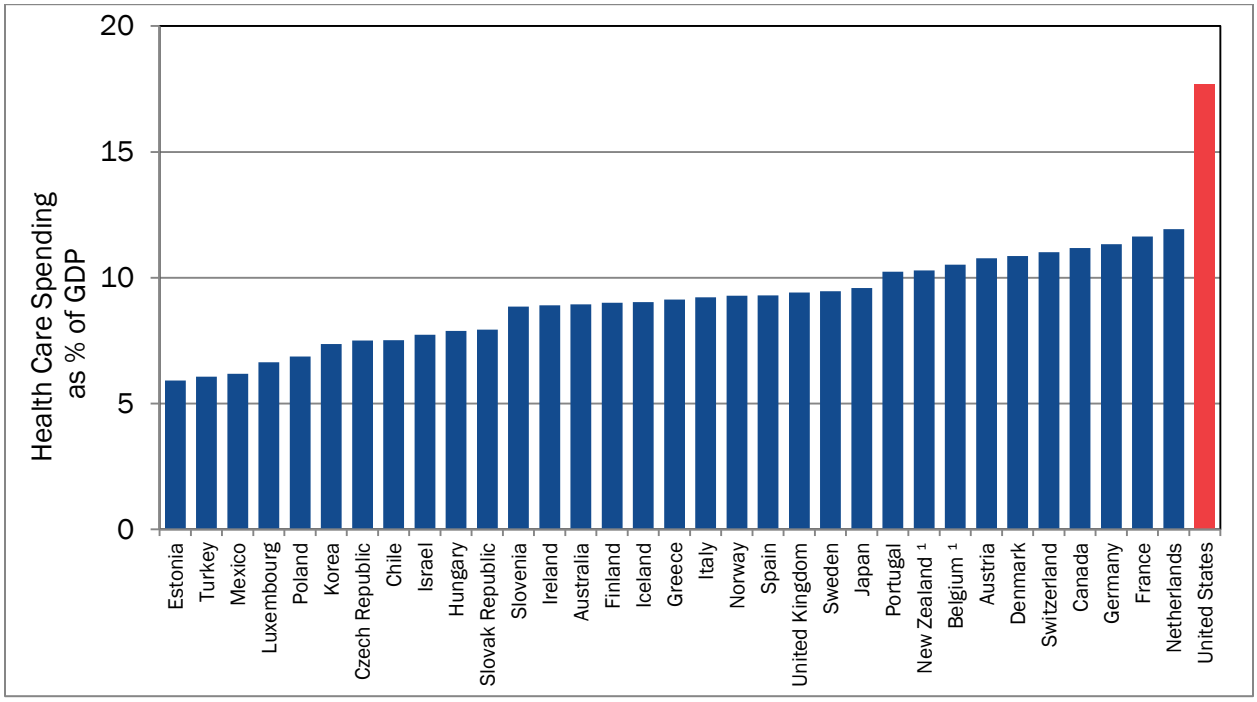


Figure 6. Total health care spending in OECD countries as a percent of GDP. U.S. health care spending is anomalously larger than all other countries.

Slide 20. Most other developed countries have systems that are better liked by participants in the system. Figure 7 shows the percentage of participants saying that their system works well, with only minor changes needed.[16] Although in this measure, the U.S. system is better than one of the countries (Australia), even Australia has fewer participants saying it needs to be completely rebuilt.

Even though most other systems have higher approval than the U.S., all but the United Kingdom and the Netherlands have a majority of participants saying that the system needs fundamental changes or needs to be entirely rebuilt. Thus we need to look carefully to find the best parts of various systems, and recognize that there can always be improvements.

[15] From OECD data in 2013. https://data.oecd.org/healthres/health-spending.htm

[16] From "International Profiles of Health Care Systems, 2013: Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States". http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/nov/1717_thomson_intl_profiles_hlt_care_sys_2013_v2.pdf

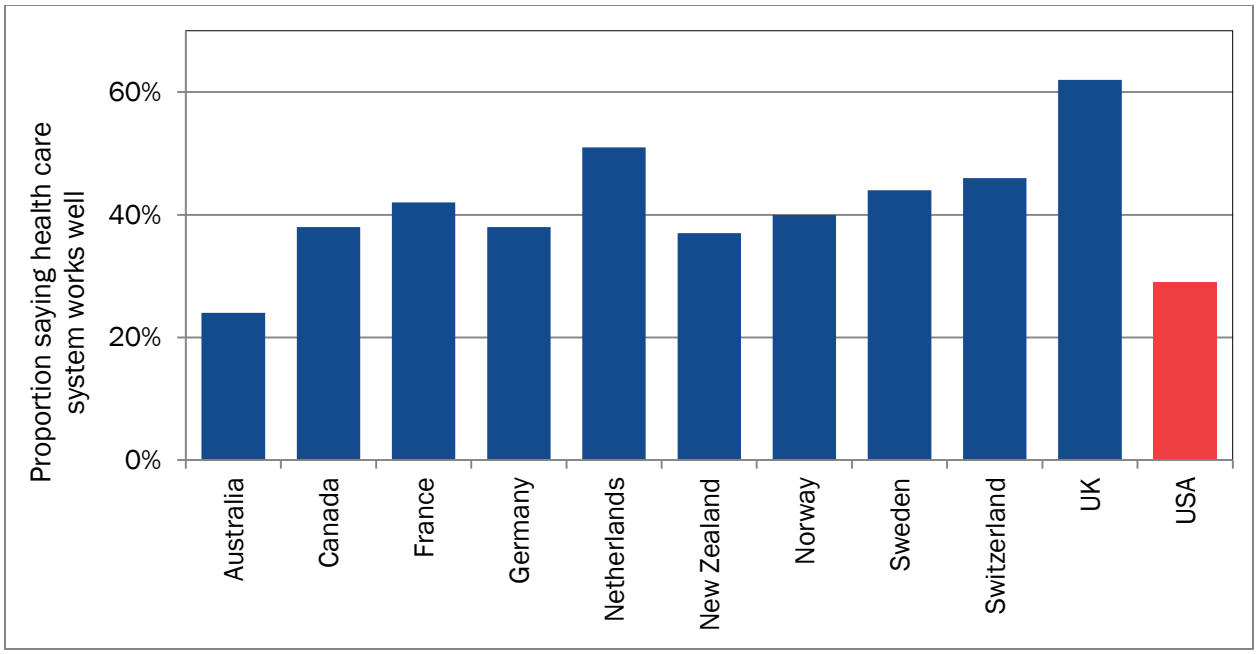


Figure 7. Proportion of public saying their health care system works well, needing only minor changes. The United Kingdom clearly has the most liked system.

Slide 21. Most developed countries get better results. Figure 8 shows female life expectancy at birth for OECD countries. Other measures of effectiveness show similar results.

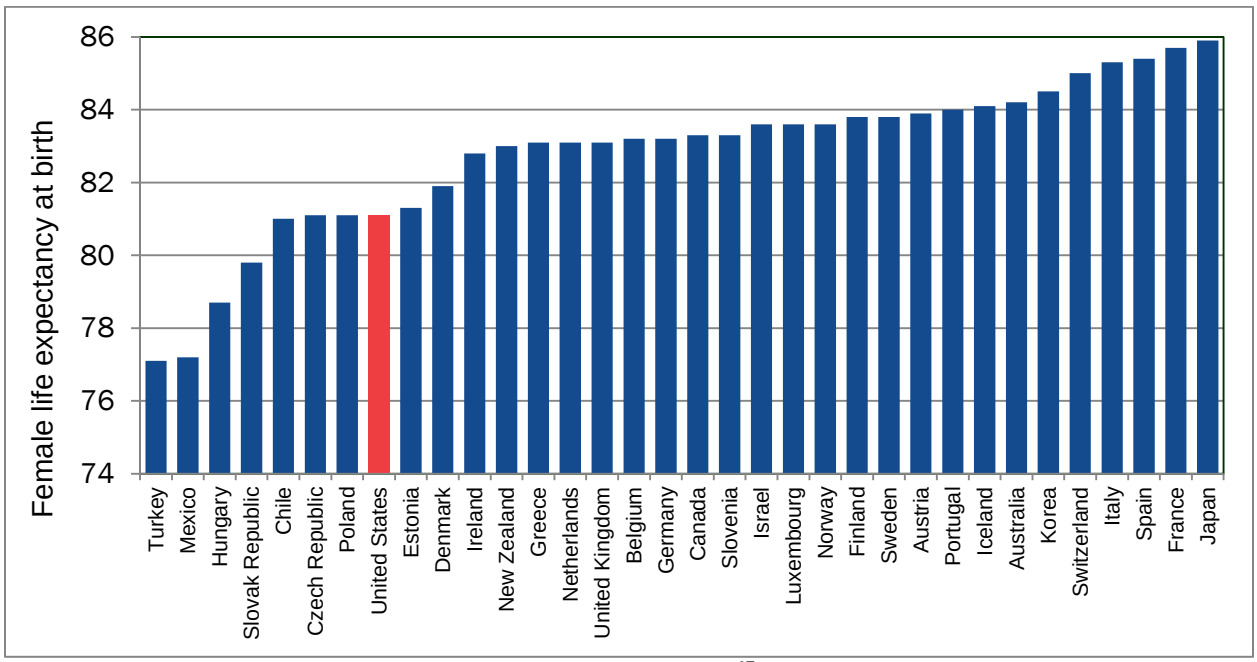


Figure 8. Female life expectancy at birth for OECD countries.[17] Other measures of health care system effectiveness show similar results, with the U.S. in the bottom portion of OECD countries.

[17] http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm November 2013 update

Slide 22. What are the benefits of the system described in this bill?

- There would be enough savings in societal health care expenditures to extend services to all in Oregon.
- The largest cost savings would come from administrative simplification, yielding savings from both sponsor administration (the entities responsible for the payments) and in provider offices.
- There would be savings due to fraud reduction, since a single-payer system is expected to be able to detect and deal with fraud more effectively.
- There would be savings due to greater market power when dealing with financially powerful providers. One example of this would be that the Oregon Prescription Drug Program would be expanded to all drug purchases in Oregon. This would help address the portion of health care with the largest cost increases.
- There would be greatly improved equity, with no differentiation between the various systems that might cover the patient.
- Deaths and adverse health results due to economic barriers to health care would be eliminated, or at least greatly reduced.
- Bankruptcies and other severe economic hardships due to medical costs would be eliminated.
- The increased competitiveness of Oregon businesses is projected to lead to 50,000 new jobs outside of health care, more than offsetting the job loss in health care administration.
- Alternative methods for reimbursing health care providers will be investigated and implemented to create the best incentives for improving quality and efficiency of health care, including shifting the focus toward health promotion, primary care, and prevention, and away from more expensive, less effective later stage treatments

Slide 23. How will the system be financed? The health care financing study defined in HB 3260 from the 2013 session, and potentially funded with HB 2828 in this session, will help to determine that. The financing details will need input from many stakeholders. We expect that the study will show that there is a better financing scheme than currently exists in Oregon.

Because of federal tax laws, it is likely that an employer payroll tax that generates revenue that is nearly as great as the average that employers currently pay for employee health care would be implemented. Details will need to be determined with careful scrutiny. On average, employers and individuals will pay less towards a universal system than they would pay if a universal system is not implemented. Besides decreasing the total health care expenditures in Oregon, a universal single-payer system will tend to shift costs from those who are seriously ill or injured to those who are most able to bear the costs.

Among the system details that will need to be decided is how comprehensive the system will be. Successful systems from around the world cover varying categories of health care services, and Oregon will have to decide what is best for our state. It is likely that the system will evolve in what is covered, and we will need to be open to learning and adapting as the system is implemented.

Slide 24. The video shown at the hearing can be found at https://www.youtube.com/watch?v=ddiLwvxpFEI. It was produced by Physicians for a National

Health Plan (PNHP), and the Oregon version was posted by Dr. Mike Huntington, who is a retired radiation oncologist and a leader in both PNHP and HCAO.

Slide 25. In summary:

- The most important action to take this session that will continue moving Oregon's health care system towards better service with lower costs is to pass HB 2828 with funding.
- We ask that the state and other stakeholders will continue to help with planning beyond the study.
- It is probably useful to seriously explore negotiations for federal waivers, certifications, and permissions that are probably necessary to successfully implement a system and not lose federal financial support.
- Some may help to explore more details related to the Regional Planning Board concept, or perhaps some other way to move towards rural/urban equity.
- Once the study is complete, a major task will be to outline a tax structure that is fair and provides sufficient funding to finance a universal system that matches how comprehensive Oregon wants the system to be.
- It will be useful to explore incremental steps that are consistent with what we expect will be the nature of a universal system.
- Among the items to explore are expanding the Oregon Prescription Drug Program to those paying with insurance, and broadening Oregon Health Plan eligibility, as is currently being considered in Cover All Kids (HB 3517).

Thank you for the opportunity to present testimony to the committee. I will be happy to answer any questions related to the material in this presentation.