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Gerald Friedman

Professor of Economics

204 Gordon Hall

University of Massachusetts at Amherst

Amherst, MA. 01003

gfriedma@econs.umass.edu

413 218 2701

## Introduction

My name is Gerald Friedman. I am a professor of economics at the University of Massachusetts at Amherst. I have lived in Massachusetts 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 Amherst where I have served as department chair, undergraduate program director, chair of the personnel committee for the college of social and behavioral sciences, among other positions.

### Overview: the long debate over funding healthcare

I have been involved in the debate over health care financing since my graduate school days. Since then, I have worked with national groups and groups within a dozen states to help them develop plans to reform our health care system to address the toxic combination of rising costs and declining coverage. With this perspective, I would say that in the last decade, we have made some progress on two fronts: understanding and policy.

On the understanding side, the debate is over. I think it is reasonable to say, that the real debate is over. A great many research institutions have weighed in and all have concluded that a single-payer system would save money while extending coverage. Before it was purchased and closed down by an insurance company, the widely respected Lewin group estimated the effects of single payer in overa dozen states and found savings in every case. Just last year, the RAND Corporation modeled single-payer systems in two states, Oregon and New York, and found significant savings even after taking account of the cost of covering the uninsured and improving coverage for the underinsured.[[1]](#footnote-1) While the projected savings vary depending on the assumptions made, even the most conservative studies project that a publicly financed universal health insurance program would save money even while providing greater access to needed care. Charles Blahous of the Koch Brothers funded Mercatus Institute, projects savings from Medicare for All of $2 trillion over 10 years.[[2]](#footnote-2) In short: it is settled. A publicly financed universal coverage system will save money while providing better healthcare.

We have also made some progress in policy. The Affordable Care Act has slowed health care cost inflation and reversed the decline in the share with health insurance, especially in states that have accepted Medicaid expansion. In Ohio, for example, the number of people without health insurance has fallen from 1.4 million to 600,000 since 2013. You are saving nearly 1000 lives per year by extending health insurance to more Ohio residents.

### The continuing challenge of healthcare coverage and finance

Notwithstanding the progress made, we still face an impending healthcare crisis in the United States, and in Ohio in particular. We now spend twice as much of our GDP on health care (nationally nearly 18%, more in Ohio) as do our OECD partners. And we receive worse health care. Women’s life expectancy is 2.5 years shorter than most of the OECD. Compared with affluent countries, we look even worse, with female life expectancy over 3.4 years short of the average. Adjusting for our greater health care expenditures, we are nearly 6 years short. Given the level of health care spending in Ohio, Ohio women should live 86.4 years if our health care system was as effective as in other countries. Instead, they can expect only 80.2 years.[[3]](#footnote-3) Those 6.2 years of lost life are one price people in Ohio pay for our failing health care system.

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? Worse, health care costs are continuing to grow, swallowing our salaries as well as our state and local budgets (see Figures 2 and 3). Despite a few dips, the share of state income going to health care has risen inexorably, even faster than for the nation. In 1991, 13% of Ohio state income went to health care. Now 19% is spent on health care. Current trends indicate that by 2026, 23% of state income will go to health care. This is money that people in Ohio will not have to spend on vacations, home improvements, or, perhaps most important to my occupation as a college professor, tuition. Between 1991 and 2014, the faster growth of health care costs and health insurance took $2000 per employee away from wages. If trends continue, by 2029, this will rise to $6000. Money that Ohio businesses will not have to pay their workers in wages because it is going to pay for health insurance.

Worse still, employer-provided health insurance covers less and less of the needs of people in Ohio. The average deductible on an individual plan has more than doubled since 2002; and the deductible on a family plan has soared to almost $3000 (see Figure 4). Of course, for many, these numbers are irrelevant because fewer have health insurance through work. The share of private-sector workers covered through employment has dropped from 60% to 45%. Even fewer family members are now covered (see Figure 5). Family coverage has dropped from 55% of employees all the way down to 31%. As a system to cover the people of Ohio, our old system of employer provided health insurance is collapsing.

The decline of private health insurance, both in quantity of people covered and the quality of coverage, is directly linked to poor health. There is a direct link between the ability of people to see a doctor, and good health. This is shown in Figure 6 which shows, for every county in Ohio, the proportion of residents who report they could not see a doctor because of cost, and the county’s age adjusted mortality. There is a direct link between these two as shown by the regression equation reported on the Figure; over 40% of the variation in age adjusted mortality is explained by ability to see a doctor. Declining health insurance, and declining quality of insurance, kill.

Rising health care costs are creating a crisis for Ohio because they are squeezing out other activities and literally killing people by reducing insurance coverage. Policy has been directed at expanding access to health insurance and, secondarily, regulations to protect the quality of coverage.[[4]](#footnote-4) While this has been a worthy effort, and successfully expanding coverage through a public provision and support has saved many lives, the steadily rising cost of care confronts us with a problem that can no longer be ignored. We can no longer separate the extent of coverage from quality because rising costs are pushing people out of health insurance and degrading the quality of the coverage they receive. Even beyond the fiscal and household problems created by rising health care costs, we need to contain soaring costs to save lives by protecting the quality of healthcare itself.

## Why US is healthcare so expensive

We will control health care spending and we will do it in one of two ways: either we will make the system better (increasing efficiency and controlling monopoly pricing and excessive profits) or we will reduce access to health care services. For decades we have tried the latter until we have reached the point where Americans use substantially less healthcare than do people in other countries. Our spending is not out of line with other advanced economies because we go to the doctor too often or spend too much time in hospitals. Instead, the problem is that health care *prices* are so high. Prescription drug prices, for example, are much higher in the US than elsewhere. The Trump administration has found that we pay prices 80% higher than those paid elsewhere.[[5]](#footnote-5) The gap between what we pay, and prices elsewhere may even be widening. A decade ago, in 2007, the McKinsey Global Institute found that drug prices in the United States were 60% higher than elsewhere and that we spent over $25 billion more on medical devices because of inflated prices.[[6]](#footnote-6) Hospitals have also been raising prices. In a 2010 pioneering study, the Massachusetts Attorney General’s office found enormous variation in hospital prices for the same procedures reflecting the bargaining power of privileged hospitals.[[7]](#footnote-7) Here too, there is evidence that the problem is getting worse. The Congressional Budget Office recently found that hospital prices paid by private health insurance are now nearly double what hospitals get from Medicare, and there is other evidence that the gap is widest areas where a few companies control larger share of hospitals and physician practices.[[8]](#footnote-8) 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.[[9]](#footnote-9)

## The failure of the market turn in health care

Concerned with rising costs, policymakers have turned to economists for help in restructuring healthcare. Like the man with a hammer for whom all the world is a nail, economists have recommended increased market competition to discipline healthcare providers to be more efficient and to restrain prices. The result has been disastrous, as could be predicted, and was predicted, decades ago. [[10]](#footnote-10)

I do not mean to name-drop, but of course, I will. My graduate-school professor, the late-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.[[11]](#footnote-11) 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.[[12]](#footnote-12) 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. Health insurance companies increase profits by *reducing* sales, by identifying those likely to be sick and *denying* them coverage.

While widely cited, I fear that few economists or policymakers read Arrow’s seminal works.[[13]](#footnote-13) For our purposes, I would suggest a few points to consider inspired by Arrow’s analysis:

### Policies focused on saving money by reducing “overutilization” are likely to fail and lead to declining quality of healthcare

There is waste in the health care system, and much unnecessary care, but increasing cost-sharing saves money only by reducing health.[[14]](#footnote-14) Because people don’t know whether they need to see a doctor or whether healthcare cannot help them, they are just as likely to cut back on necessary care as unnecessary care. Overall, Americans use less healthcare, go to the doctor less frequently than do people in other countries (with longer life expectancy), and we suffer from extra mortality because of *underutilization* (see Figure 6).

Higher consumer cost sharing leads people to economize on health care, but they often economize on the wrong things

People do not know whether they need health care services, or which services they need. That is why we go to doctors.[[15]](#footnote-15) Higher cost sharing leads people to cut out healthcare services across the board, getting rid of the wheat as well as the chaff.

It is possible to improve on the efficiency of our health care system, but measures that try to do so by promoting competition can be counterproductive

Wasteful spending is often due to failures of care coordination and lack of communication between patients and doctors, especially in new relationships. Market competition can make this problem *worse* because it leads to churn in the private insurance system and the spread of restrictive networks.

The problem of adverse selection means that market competition is more likely to undermine healthcare and raise costs then to lead to economies and efficiency

The most profitable health insurers are not those that are most efficient, but those that have the healthiest enrollment. Since most health insurer medical costs, what they call medical losses, are associated with the few people, the best way for a private health insurer to increase profits is not to invest in efficiency, but to identify the people who are likely to be expensive and drive them away. Most healthcare spending is incurred by a very small part of the population. Five percent of the population accounts for half of spending, and 18% accounts for over 80% of spending (see Figure 7). Insurers know this, and they know that they can dramatically increase their profits if they can identify those relatively few people who will account for most of their medical losses and get them to go to a different insurance company or otherwise just leave.[[16]](#footnote-16) Insurers will gain nothing with policies that improve the quality of care if such policies attract more sick people. Instead, they gain with programs of utilization review and prior authorization if these inefficient programs drive away those who will be using health care. Effective health policy, therefore, needs to be directed not at promoting competition that will undermine health and lead to excessive bureaucracy, but providing health insurance that promotes preventive care and restrains monopoly pricing. This is generally not competitive, for-profit health insurance.

Payment reform must be used cautiously because, insurers and providers, adverse selection works better than efficiency improvements

Because so much of the cost of health care is due to a few people, the best way to save money and increase profits (or retained reserves) is to screen more carefully, to “lemon drop” and “cherry pick”. Only a single-payer system has a full incentive to promote health.

Competing insurance companies cannot control monopoly pricing even when they try

Insurers are too small, and it is easier for them to pass along higher costs. Only a single-payer system can take on powerful monopolies.

## The case for single payer

Rather than a solution to the problem of high and rising prices for health care, our reliance on a market-based financing system that necessarily generates administrative waste, excessive and punitive utilization review, while not controlling monopolistic practices.

Waste, therefore, is intrinsic to our 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 not due to overutilization, and it will not be helped by promoting more competition, because it is driven by administrative waste due to the insurance industry and to monopolistic pricing by providers (including drug companies) more powerful than any insurer. The fastest increases in cost in the American health care system over the last decades have been in drug prices and administrative activities.[[17]](#footnote-17) 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.

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.[[18]](#footnote-18) Combined with savings to be realized by reducing administrative costs in the operation of Medicaid and by reducing market power in areas like prescription drugs, Ohio could reduce health care costs by over $38 billion, or 28%, by establishing a single-payer health insurance system (see Figures 8). Even after expanding coverage to all residents and assuming the cost of Medicare premiums now paid by the elderly and disabled, this would leave savings of $25 billion. We could lower health care spending by nearly 18% while *improving* access for all residents of Ohio. What are we waiting for?

A single-payer system would benefit all residents of Ohio. By liberating doctors and nurses from the dead weight burden of excessive administration and freeing the public from the cost of drug company and hospital monopolies, more health care could be provided at lower cost (see Figure 10). The standard response by critics is that it would take intolerable tax increases to fund a public program. There is something fundamentally wrong with this argument because, if single-payer is less expensive than the current system, then we will be paying less in new taxes than we pay now for private funding. Regardless of how we collect the money, we will be spending less. What we save by reducing or eliminating out-of-pocket spending and insurance premiums will exceed any new taxes. We will merely be substituting fewer public taxes for the larger volume of what is, in effect, private taxes assessed by the for-profit health insurance system.

The worst thing is that in a state like Ohio, we are already paying for a single-payer system but without getting the benefits. We are already paying so much for inefficient and overpriced private-sector healthcare that simply shifting existing government spending could cover nearly 70% of the cost of a state single-payer system. We are already paying most of what we need for a better healthcare system in Medicare, Medicaid, the tax subsidy for employer-provided health insurance, Affordable Care Act Exchange subsidies, SCHIP, Medicare drug benefits, and other programs (see Table 1). Not even counting the nearly $7 billion spent by state and local governments for employee health insurance.

Additional revenue could be raised in a variety of ways. In my report, I suggest two, both modeled on different aspects of the Social Security system. Both rely on payroll taxes, but with exemptions for low-wage workers. In one, there are premiums like those paid for Medicare part B; in the other there is a progressive income tax (see Table 2). Both programs generate enough revenue for 2019 and surpluses in later years. Both will benefit Ohio businesses by reducing the cost of health insurance, a burden limiting employment and economic growth in the state. Both will save money for Ohio residents with incomes up to or above $100,000 (see Figure 11).

Frankly, it is not difficult to produce a funding plan for single-payer system. The bottom line is that if Ohio can pay for the status quo with all its inefficiencies and inequities, it can pay for a health care system that would be cheaper and will provide better healthcare. The question is not can Ohio afford single payer? The question is what are we waiting for?

Figure 1. Female Life Expectancy and Logarithm of Healthcare Expenditures, OECD 2016

*Note: This figure shows female life expectancy at birth and the logarithm of per capita health care expenditures for each member state in the OECD. Each country is represented by a circle on the graph except for the United States which is represented with the USA. In addition, a simple regression line of health care expenditures and life expectancy for the non-USA countries is shown along with the equation. This indicates that for the rest of the OECD health care expenditures account for nearly half of the variation in life and, given the positive association between spending and life expectancy, the United States should have life expectancy of around 86 years, rather than the less than 80 years that American women can expect to live.*

Figure 2. Health Spending as Share of GDP, USA and Ohio

*Note: GDP data through 2017 are from the Bureau of Economic Analysis; projections for later years are based on national projections from the Congressional Budget Office. Health care spending data through 2016 are from the Centers for Medicare and Medicaid Statistics. National projections through 2026 are from CMS; state projections for later years on my own based on assuming Ohio per capita spending will increase at the same rate as the national.*

Figure 3.Cost of Excess Health-care Spending per Employee.

*Note*: Average wage and the cost of private health insurance 1991-2014 is from the Bureau of Economic Analysis; projections for later years assume growth will continue at the same rate as 1991 – 2014.

Figure 4. Rising Cost of Deductibles, Private Sector, employer-provided health plans, Ohio 2002 and 2016

*Note: Data from the Medical Expenditure Panel Survey for Ohio.*

Figure 5. employer-provided health insurance coverage, Ohio 1999 – 2016: declining coverage of employees and disappearing extension to family members.

*Note: Data from the Medical Expenditure Panel Survey for Ohio.*

Figure 6. Age adjusted mortality rate and access to care, Ohio counties.

*Note: Data from the 2012 County health rankings, Robert Wood Johnson Foundation and the University of Wisconsin.*

Figure 7. Concentration of health care spending, distribution of spending within total population

*Note: Data from the Medical Expenditure Panel Survey for 2016.*

Figure 8. Single Payer Savings, 2019 ($millions)

*Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

Figure 9. Single Payer Quality Improvements, 2019 ($millions)

*Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

Figure 10. Distribution of Payments under Current System and Single Payer

*Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

Figure 11. Effect of Ohio single-payer on net income after taxes and healthcare spending

*Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

Table 1. calculation of revenue needs Ohio single payer, 2019

|  |  |
| --- | --- |
|  | 2019 ($millions) |
| Personal health expenditures |  $ 127,372  |
| Insurance and government administration |  $ 11,527  |
| Employer administration |  $ 1,378  |
| Uncompensated care |  $ (638) |
| **Total spending status quo** |  $ 139,639  |
| ***Savings*** |  |
| Provider administration |  $ 10,032  |
| Market Power (Pharmaceuticals and Hospitals) |  $ 15,529  |
| Insurance Administration |  $ 9,310  |
| Employer administration |  $ 1,378  |
| Fraud reduction |  $ 2,217  |
| *Subtotal of savings* |  $ 38,467  |
| ***Program improvements*** |  |
| Universal coverage |  $ 1,551  |
| Utilization (removal of copays and deductibles) |  $ 5,798  |
| Medicaid rate |  $ 1,713  |
| Assumption of Medicare premiums |  $ 3,894  |
| Transition costs for UI and retraining |  $ 178  |
| Cost of program improvements |  $ 13,136  |
| ***Net spending, single payer, 2019*** |  $ 114,309  |
|  |  |
| **Existing revenues** |  |
| Medicare |  $ 34,895  |
| Medicaid |  $ 24,823  |
| SCHIP |  $ 522  |
| VA |  $ 4,511  |
| Fed share of Medicaid rate adjustment |  $ 1,191  |
| New Federal Medicaid for utilization |  $ 441  |
| Other third party (local public health, TRICARE, IHS, charity, etc.) |  $ 2,403  |
| Remaining out-of-pocket (actuarial value of 96%) |  $ 4,572  |
| Current state spending |  $ 626  |
| ACA subsidies |  $ 711  |
| **Available revenue** |  $ 74,694  |
| Needed revenue |  $ 39,614  |

 *Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

Table 2. alternative tax programs to fund Ohio single-payer.

|  |  |  |
| --- | --- | --- |
|  |  Less Progressive Program  |  More Progressive Program  |
| 11% with 25,000 exempt and 50% sliding exemption |  $ 21,002,339  |  |
| 11% with 25,000 exempt and 50% sliding exemption |  $ 728,437  |  |
| 11% capital income (for AGI>$50,000) |  $ 3,062,898  |  |
| 10% with 25,000 exempt and 50% sliding exemption |  |  $ 19,093,035  |
| 10% with 25,000 exempt and 50% sliding exemption |  |  $ 662,216  |
| 10% capital income (for AGI>$50,000) |  |  $ 2,831,767  |
| Income tax with 25,000 exempt and 50% sliding exemption |  |  $ 9,279,017  |
| Double Gross Receipts Tax (CAT) |  $ 2,091,041  |  $ -  |
| High income surtax of 5.5% |  $ -  |  $ 4,938,911  |
| Sin taxes: alcohol, marijuana, tobacco |  $ 2,843,698  |  $ -  |
| Premiums at Medicare rate with low income and children deduction |  $ 7,494,399  |  $ -  |
| Capture insurance health costs |  $ 2,876,366  |  $ 2,876,366  |
| Total revenue: |  $ 40,099,177  |  $ 39,681,311  |
| Needed revenue: |  $ 39,614,381  |  $ 39,614,381  |
| Surplus (deficit) |  $ 484,797  |  $ 66,930  |

*Note*: *Estimates from Friedman, “Economic Analysis of Single Payer Health Care in Ohio”*

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