My name is Fritz Stephens-Tiley. My wife and I are residents of Sweet Home Oregon. I am a Certified Healthcare Financial Professional, a designation through the Healthcare Financial Management Association (HFMA) demonstrating my knowledge of the business of Healthcare. I have worked in the Healthcare industry since 1984 in various capacities from outpatient facility administration to managing large revenue cycle operations. I am currently a Data Scientist working with Healthcare payments data developing provider reimbursement methodologies in the Workers Compensation industry across the country.

Today I am here representing Mid Valley Health Care Advocates as an at large board member and co-chair of the Outreach Committee.

As I move through my testimony I will use the term provider to include any entity, or person, who provides healthcare services to a patient.

The Problem

The primary responsibility of the CEO of any for profit, publicly traded company is to maximize shareholder value. This profit motive is contrary to the primary purpose of Healthcare, delivery of quality services to patients. As a result companies who deliver, or pay for services, create a structure that focuses not on benefits to patients, but rather on their financial bottom line and shareholder profit. This dynamic is rampant throughout the industry from hospitals, large physician groups, pharmaceutical companies, durable medical equipment, and insurance companies. What has fueled this is the prevalence of people with an MBA after their name making policy decisions that impact the ability of licensed medical providers to make appropriate decisions for their patients. Simply put, they have turned us, people who use the healthcare system, into a commodity.

Health Insurance CEOs: 2021 top 7 avg CEO compensation, $40.4M:
https://www.statnews.com/2022/05/12/health-insurance-ceos-raked-in-record-pay-during-covid/
This would pay for ~1300 total hip replacements or ~5152 non-cesarean child births

Using a Freedom of Information request, I was able to obtain annual reports insurance companies in Oregon are required to submit to the Division of Financial Regulation.

What I discovered was that the top 5 Health Insurance companies in Oregon spent a total $24.6M on marketing and advertising in 2021. These costs are paid for by patients, and companies who provide medical coverage to their employees, in premiums to these insurance companies.
https://dfr.oregon.gov/Pages/index.aspx Oregon State Division of Financial Regulation
A few examples:

- MODA $3.1 M
- Kaiser $8.1 M
- Regence $4.9 M
- Providence $2.2 M

- Pacificsource $6.3 M

Again, funds that should be used to pay for medical services to patients.

Patient Issues

So how does this effect Oregonians and their choice to seek medical care or put food on the table?

A couple of recent surveys, from CNBC and Gallup, demonstrate 1 in 3 to 1 in 4 Americans avoided medical care due to cost:
https://www.cnbc.com/2020/03/11/nearly-1-in-4-americans-are-skipping-medical-care-because-of-the-cost.html
https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx

2019 Census data showed 19% of US households cannot afford to immediately pay their portion of healthcare costs even with medical insurance:
https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html

Debt.com reports 23 million people in the US are currently holding healthcare related debt in the amount of $5.75 Billion: https://www.debt.org/medical/collections/

Provider Issues

How does this current structure impact providers and their ability top deliver quality care AND efficiently manage to keep their doors open.

Every service a physician provides to a patient is assigned a value based on the time and resources it takes to provide that service. This is called a Relative Value Unit or RVU. That RVU is then multiplied by a standard, a conversion factor. The result of that calculation is what the physician receives from any payor for that service.

Medicare CV in 1996 averaged $36.948. In 2023 it is $33.8872, a 8.3% decrease in that time.
https://www.ama-assn.org/system/files/2021-01/cf-history.pdf

Cost of doing business, inflation, during that time increased by 36.9%.
https://www.bls.gov/data/home.htm

Medicare represents ~54% of a providers sources of revenue. An element of the analysis done by the 770 Task Force is to include Oregonians covered by Medicare in the plan.

A provider may have a dozen, or more, insurance companies to collect from. Each insurance company has their own payment policies. This variation in policies can be a nightmare for a providers revenue cycle operation to follow up on unpaid submitted claims.

Currently the healthcare industry cost to collect is ~3.3% of net patient revenue.

https://www.advisory.com/-/media/Project/AdvisoryBoard/shared/Research/FLC/Resources/2019/Examining_2019_Revenue_Cycle_Benchmarking_Results.pdf

Per the American Hospital Association, "Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's bad debt and the financial assistance it provides."
In 2020 the AHA published a study specific to uncompensated care. The most recent year in the study, 2020, 5139 hospitals provided $42.67B in uncompensated care or $8.3M each. With every Oregonian covered by Universal Healthcare the impact of uncompensated care on a hospitals revenue would be significantly decreased. A hospital could use these additional funds for additional patient care and/or hiring additional staff to assure quality care to its patients.
https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf

The Solution

If Oregonians are all covered by one Universal Healthcare Plan, providers will have fewer insurance companies to follow up with for reimbursement. All providers have contracts with multiple insurance companies with differing reimbursement rates. They may also provide services to patients whose insurance does not have a contract with the provider (out of network). From a forecasting and budgeting perspective, having less variability in reimbursement levels would be a benefit to a provider.
This would have a positive impact on their ability to lower their cost to collect, freeing up revenues that can be used to improve patient care and decrease their cost of doing business.

Conclusion

The United States pays more per person for healthcare than every other country on Earth, yet we rank 30th in quality.
https://worldpopulationreview.com/country-rankings/health-care-costs-by-country
https://ceoworld.biz/2021/04/27/revealed-countries-with-the-best-health-care-systems-2021/

We are not getting our monies worth because our Healthcare industry has become dominated by for profit companies whose primary goal is to maximize profits, not provide cost effective medical services for all citizens. Insurance companies are in the business of denying care, not paying for it. We are a commodity.

Universal healthcare is not socialized medicine. In a system of socialized medicine the government is not only the payer, but also owns and operates the mechanisms for healthcare delivery. All hospitals would be government owned. All physicians would be employees of the government.

https://www.verywellhealth.com/is-universal-healthcare-the-same-as-socialized-medicine-3969754

The State of Oregon has the opportunity to be a pioneer by changing the way medical services are paid. That said, moving to a single payor system is not new. The US is the only western industrialized country that does not have a comprehensive single payor system. I urge the passage of SB 704 so we can establish the Governance Board and implement our Universal plan by 2027 which will benefit all Oregonians. I have referenced numerous studies and resources in this written testimony. I ask that you don't just believe what I say, look it up yourself.