Testimony in support of SB 704, partly in response to corporate opposition

Chair Patterson, Vice-Chair Hayden, and members of the committee:

I am writing in support of SB 704, and especially in support of the notion that it makes sense to spend some money planning for what Oregon's health care system could look like in the future. By learning from successful systems in other countries, and carefully planning how we might transform to a more equitable and cost effective system here, we can save billions of dollars in the not too distant future.

I will begin by noting that there have been numerous studies in the U.S. that indicate a single-payer system could save money while providing more care to more people.[1] Similarly, numerous comparisons have shown that the U.S. system costs more and is less effective than essentially all systems in other high-income democratic nations.[2]

Some representative of the health care industry have submitted testimony opposing SB 704 that essentially argue that thinking about the future will harm efforts to incrementally improve our current system. I will note that there are 74 bills currently being considered by the Senate Committee on Health Care, of which 73 are dealing with efforts to incrementally improve our current system, and only one (SB 704) that is intended to look far enough into the future to consider substantial reforms. Similarly, the House Committee on Behavioral Health and Health Care has 161 bills assigned to it, of which 160 are dealing with efforts to incrementally improve our current system. This seems to suggest that the legislature already agrees that *"the state's focus should be to stabilize our system and the health care markets through supportive and predictable policy making,"* as health insurance industry representatives are arguing. This is not a rational basis on which to oppose SB 704.

The Oregon Health Authority budget for the 2019-2021 biennium is $29.8 billion. Spending a fraction of 0.1% of that to plan how we might save a billion or more every year, while delivering better health care to more people, seems like a wise investment.

From testimony submitted by Tom Holt, signed by Julianne Horner, President of the Oregon Association of Health Underwriters:

> *We agree that there is significant room for improvement in our market-based health benefits and payment system, which is in a state of constant flux as stakeholders strive to make improvements.*

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[1] For example, here is a 2018 review of numerous such studies - https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013#pme

[2] For example, see this 2022 report - https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022

Presumably many of the 233 health care bills being considered by the legislature will try to improve our market-based health benefits and payment systems.

Holt/Horner go on to say:

> *It is unfortunate that the Task Force's report largely ignores the benefits of such market forces, while at the same time rests its recommendations on a series of heroic assumptions, among them: Nearly $1 billion of "administrative savings" magically would materialize, providers will stand still for cuts in compensation, the federal government would allow Oregon to disenfranchise Medicare beneficiaries, and that middle- and upper-income Oregonians would accept an enormous tax increase and disruption of their own health benefits on the promise that this time the state successfully will execute an exceedingly complex entitlement program at which no other state has succeeded.*

There are so many corporate talking points to dismantle in the paragraph above, but I will address at least some of them. First, they are somewhat correct that market forces are ignored – the Task Force did not have sufficient time to look into the benefits of something like a multi-state public pharmacy benefit manager, which could, through market forces, help lower prescription drug costs by creating more power in the purchaser's side to counteract the immense market power of pharmaceutical manufacturers. Such a public PBM could be, and perhaps should be, pursued independently of a single-payer system. But other market forces were not ignored – insurance companies have been able to insert themselves between government payers and providers, skimming money that could otherwise be used to provide desperately needed services. As economists would say, getting these rent-seeking entities out of the market increases efficiencies. The Task Force proposal would remove these entities not only from Medicaid and Medicare, but would also transform the rest of health care to remove them from all basic health care, except perhaps to get paid for actual administrative services provided.

Regarding the comment "*Nearly $1 billion of "administrative savings" magically would materialize"* – apparently they did not read the Task Force report. First – the financial modelling was done by the professional actuarial firm Optumas, a firm that does not deal in the magical. Second – the Task Force identified $4 billion in administrative savings, which is slightly less than what the Oregon RAND report found literature would suggest for administrative savings from single-payer. From page 101 of the RAND report:

> *One recent study looked across 18 published studies of cost and savings estimates related to national single-payer models, averaging the study findings to develop an overall range of annual savings estimates (Liu, 2016).[3] These calculations yielded an*

[3] Liu, Jodi L., Exploring Single-Payer Alternatives for Health Care Reform, Santa Monica, Calif.: RAND Corporation, RGSP-375, May 2016. As of December 19, 2016: http://www.rand.org/pubs/rgs_dissertations/RGSD375.html. Note that Liu was one of the co-authors of the RAND report.

average savings estimate of $334 billion in administrative savings (or an approximately 11-percent decrease) under a national single-payer model

Note that $4 billion is smaller than 11% of projected Oregon health care costs in 2026, so the $4 billion in administrative savings is on the conservative side. The $1 billion number that Holt/Horner use is net savings. Most of the administrative savings would be used to fund more health care, and so costs would not go down as much as the administrative savings would suggest. Many people would be happy to have more of our expenditures go to providers for more health care rather than to more paper pushing, claims fighting, CEO compensation, and health insurance company profits.

Regarding the statement "[assuming] *providers will stand still for cuts in compensation* – the Task Force proposed increases in net provider compensation, not cuts. Some providers might see gross payments go down, but their administrative savings due to substantially less time spent on billing and insurance related activities would result in higher net compensation.

As an example of administrative savings available on the payer (sponsor) side, an analysis of publicly available Medicaid expenditure data[4] shows that we can expect, on average, 9% overhead in a state Medicaid program that does not use private managed care organizations (MCOs), rising to 20% if all Medicaid money were to flow through such insurance companies. A state single-payer system with decent waivers should be able to dispense with eligibility determinations, and thus cut its administrative costs substantially below the 9%. Note that these overhead costs are as a fraction of the extraordinarily low reimbursement rates for serving Medicaid patients, and would be smaller relative to reasonable reimbursement rates. These data are consistent with the notion that eliminating rent-seeking middlemen can save 11% of total costs due to administrative simplification.

Regarding the statement "[assume] *the federal government would allow Oregon to disenfranchise Medicare beneficiaries"* – the Task Force presented three options for including Medicare. We agree that one of the options might essentially disenfranchise Medicare beneficiaries, and we will continue to point out problems with that option. The other two would not. Rather, they would improve coverage for Medicare beneficiaries while eliminating out-of-pocket costs at the time of service.

Regarding the statement "[assume] *that middle- and upper-income Oregonians would accept an enormous tax increase and disruption of their own health benefits on the promise that this time the state successfully will execute an exceedingly complex entitlement program at which no other state has succeeded* – a well done poll suggests that Oregonians might indeed accept

[4] From NHEA - https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence
and MBES - https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence

that enormous tax increase for a well-designed system. The main reason that voters might not is that the medical industrial complex will spend enormous sums of money to ensure that they will not, producing uncertainty through repeated misinformation. Not only will the medical industrial complex spend money to thwart this at the state level, they will spend money to make sure that federal laws continue to make it difficult for a state to succeed with a well-designed single payer system.

We need to pass SB 704 with sufficient funding to do the difficult but rewarding work of designing a single-payer system in Oregon. The small amount spent now for the possibility of a billion or more in savings every year is worth it. We can look to many other countries to know that it can be done, unless we assume that the U.S., and Oregonians in particular, are that much less capable than those in other developed countries.