

Universal Health Care Commission's Finance Technical Advisory Committee meeting

March 14, 2024

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Tab 1

**Universal Health Care
Commission’s
Finance Technical Advisory
Committee (FTAC)**

Agenda

Thursday, March 14, 2024

Zoom meeting 2:00 – 4:30 PM

FTAC members:

<input type="checkbox"/> Pam MacEwan, FTAC Liaison	<input type="checkbox"/> Eddy Rauser	<input type="checkbox"/> Kai Yeung
<input type="checkbox"/> Christine Eibner	<input type="checkbox"/> Esther Lucero	<input type="checkbox"/> Robert Murray
<input type="checkbox"/> David DiGiuseppe	<input type="checkbox"/> Ian Doyle	<input type="checkbox"/> Roger Gantz

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call	1	Angela Castro, Senior Health Policy Analyst Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 01/12/2024	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25-2:35 (10 min)	<ul style="list-style-type: none"> Review 2024 workplan Commission’s direction for FTAC on Benefits & Services 	4	Liz Arjun, Principal Health Management Associates
2:35-3:35 (60 min)	Benefits & Services under the Washington Health Trust (SB 5335) <ul style="list-style-type: none"> Q&A FTAC discussion 	5	Andre Stackhouse, Whole Washington
3:35-3:40 (5 min)	Break		
3:40-4:30 (50 min)	Benefits & Services discussion <ul style="list-style-type: none"> Considerations for actuarial analysis 	6	Liz Arjun, Principal Health Management Associates
4:30	Adjournment		Pam MacEwan, FTAC Liaison

Tab 2

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

January 12, 2024

Virtual meeting held electronically (Zoom)
2-4:30 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the [FTAC webpage](#).

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle
Kai Yeung

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, welcomed members to the seventh meeting, and reviewed the agenda.

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the November 2023 meeting summary**.

Public comment

Kathryn Lewandowsky, Co-Chair, Whole Washington, encouraged FTAC to look at Connecticut's work to transition their Medicaid program from managed care to fee-for-service. This has generated administrative savings and reduced administrative costs.

Jen Nye, Whole Washington, expressed concerns over the current pace of decision-making for the future system, and encouraged a more urgent, tangible, and transparent choice be given for a “real” alternative.

Commission updates

Liz Arjun, Health Management Associates (HMA)

In December, the Commission re-grouped and sequenced transitional solution topics. The Commission agreed that in 2024, FTAC should continue their focus on universal health care system design topics, the first of which is benefits and services. The Commission’s 2024 work plan will be approved at their February meeting.

Presentation: Understanding Medicaid waivers in a universal coverage context

Dan Meuse Deputy Director, State Health and Values Strategies, Princeton University

1115 waivers give states broad authority to waive Medicaid requirements to carry out a demonstration project. Waivers must be “budget neutral” (costs to the federal government must be the same with or without the waiver) and promote the objectives of the Medicaid program. Waivers are tools to obtain policy goals. Like waivers, state plan amendments (SPA) allow states to choose new populations to serve or new benefits to provide, but don’t require budget neutrality. Expanding coverage through a SPA will open federal financial participation (FFP) funds but will require state match, whereas waivers allow states to receive matching funds for otherwise unallowed expenses and to use indirect spending as match for Medicaid FFP. SPA expansions will also require specific mandatory and optional benefits to be provided based on the expansion, whereas waivers allow states to design different benefit packages for expanded populations. A SPA is relatively permanent. A waiver covers a five-year period. Other states have used SPAs or waivers to eliminate asset tests for Classic Medicaid, e.g., via SPA in Arizona and via waiver in California.

A waiver implementation of expansion advantages the state’s general revenue compared to a SPA. In a waiver negotiation, Washington would have to prove to the federal government that a unified system meets federal requirements, or that a certain requirement(s) does not need to be met and why.

Presentation: Washington’s experience with 1115 demonstration waivers

Mich’l Needham, Chief Policy Officer, Health Care Authority (HCA)

Washington has a long history of using demonstration waivers to achieve policy goals. The waiver development process is extensive, involving concept design, data collection, CMS completeness review, tribal consultation, public comment and transparency, and CMS negotiations (which can range from three months to two years). There are many steps after waiver approval and hundreds of deliverables due to CMS. These include protocol documents and implementation plans for each program, legislative authorization/spending authority, quarterly and annual reports, and external evaluation reports. Program implementation may also take several years depending on design complexity. Implementation of a waiver is much more administratively burdensome than a SPA. It can be beneficial to the state to examine what parts of a waiver can “graduate” to permanent authorities (SPA) to reduce administrative burdens. Demonstrating budget neutrality is an extended process and negotiation is not a straightforward process.

Presentation: Avoiding Medicaid - characteristics of primary care practices with no Medicaid revenue

Steven Spivack, PhD., MPH, Director of Quality Measurement and Data Analytics, Lewin Group

Prior research has demonstrated that up to one-third of all physicians refuse to accept new Medicaid patients. Commonly cited reasons for this include low reimbursement rates and burdensome administrative and billing requirements. This study examined the proportion of primary care practices with no Medicaid revenue and how

those practices compare to practices with Medicaid revenue across key organizational characteristics and population health capabilities.

Practices were categorized based on their Medicaid revenue as a proportion of total revenue, including zero percent, between zero and 10 percent, and more than 10 percent. Out of 1,731 practices, 17 percent had zero Medicaid revenue. Practices with no Medicaid revenue were on average smaller, independent, had a higher proportion of primary care physicians, and were more likely to be urban, in low poverty areas, and in states that have not expanded Medicaid. Some reasons for not accepting Medicaid patients may be a lack of organizational capabilities and infrastructure, access to a large enough patient base outside of Medicaid, or less advanced population health and IT capabilities. Possible interventions to increase uptake in Medicaid participation include increasing reimbursement rates (most challenging to implement) or focusing efforts on smaller, independent practices and what they need. Practices residing in areas with more Medicaid-eligible individuals may be more likely to move from the zero percent category to between zero and 10 percent. It may be helpful to engage practices in areas with higher proportions of Medicaid-eligible individuals but who aren't accepting as many patients as they could.

Discussion and votes on Medicaid guidance to the Commission

Washington's Medicaid program provides the richest benefit of any payer and could be something to aspire to for coverage under Washington's universal health care system (though members largely agreed, that(?) including long-term care services as a covered benefit is not likely – at least not at the start). Administrative processes would need to change to integrate Medicaid into a unified financing system. Members agreed that both 1115 waivers and SPAs should be considered as vehicles to achieve this and other policy goals.

FTAC members voted to recommend that the Commission consider pursuing, when appropriate, waivers or SPAs as needed to include Medicaid enrollees in Washington's universal health care system, details of which will need to be developed once benefits and services are determined. Members agreed that it's not possible at this time to provide more specific guidance until benefits and services are determined.

Members agreed that access to care issues persist for Medicaid patients, though it would be a mistake to recommend targeted provider rate increases without first understanding where the issues are and why, and potential unintended consequences of increasing rates. **FTAC members voted to recommend that the Commission pursue analysis to understand Medicaid provider reimbursement in Washington and how it impacts provider willingness to accept Medicaid enrollees.**

Different administration across payers can be burdensome for providers. **FTAC members voted to recommend that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.**

These votes are intended to provide guidance to the Commission on Medicaid options that allow the design process to advance. This guidance is not binding indefinitely, and Medicaid will be revisited. FTAC members will develop a Medicaid Memo to the Commission that will be shared with the Commission at their February meeting.

Adjournment

Meeting adjourned at 4:46 p.m.

Next meeting

March 14, 2024

Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Public comment

**Universal Health Care Commission’s
Finance Technical Advisory Committee
Written Comments**

Received From December 30

Written Comments Submitted by Email

K. Lewandowsky 1
R. Collier 2

Additional Comments Received at the January FTAC Meeting

- The Zoom video recording is available for viewing here:
<https://www.youtube.com/watch?v=zUyv1EWMAE&feature=youtu.be>

Public comments received since (December 30) through the deadline for comments for the March meeting (February 29)

Submitted by Kathryn Lewandowsky

1/12/2024

Hello, my name is Kathryn Lewandowsky. I am an RN here in Washington state and I am the co-chair of Whole Washington.

I want to encourage you to continue to look at the work that Connecticut has been doing in their Medicaid reform. If you remember that back in 2012 they decided to move their traditional Managed Medicaid program to a self insured Managed Fee-for-Service Model. In an article written by Fady and Mandy Sahha just last fall, the state did this because they “believed that the existing managed care system was riddled with issues like inadequate provider networks, poor care coordination, insufficient oversight, and growing administrative costs. Patient advocates complained about denied services, beneficiaries expressed their frustration at the lack of access to care, and state officials became disgruntled with health plans’ refusal to share data on costs and claims.”

After canceling their 800 million dollars in contracts with private insurers in 2012 and adopting a self insured system similar to those used by large employers, they entered into contracts with three companies to administer the new plan.

The results of this has been a savings of 50 million in the first year with a consistent 2-3% reduction in costs each year since. They saw reductions both in the cost of care and in administrative savings.

Their Medicaid Beneficiaries also have seen an improved quality of care, and because of the decreased administrative burdens for providers, there are 7% more providers willing to take Medicaid patients.

I will include a link to their article and I hope that you really examine their results closely. These are the types of gains we can also hope to achieve by taking back our healthcare system.

<https://www.thevbpblog.com/connecticut-is-taking-a-different-approach-to-managed-care/>

Thank you for allowing me to speak today.

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board Vice-Chair
One Payer States- Treasurer

Sign up for a \$5 recurring donation and receive a "Healthcare that's Always There" pin as a thank you.



SB 5335 establishes the Washington Health Trust and outlines funding, benefits coverage, provider reimbursements, and implementation. Whole Washington works to build legislative support for the Washington Health Trust, requiring majority support in the House, Senate, and from the Governor. [Read more about SB 5335](#). We also work through the Ballot Initiative process when our legislative process fails us.

Submitted by Roger Collier
2/27/2024

February 27, 2024

Dear FTAC members --

I was encouraged that the UHCC at its last meeting recognized the obstacles facing inclusion of Medicare and ERISA enrollees within a universal State system and agreed at this time to exclude these groups.

(The UHCC also delayed consideration of providing supplemental coverage for Medicare and ERISA enrollees, but to do so fully would require some \$5 billion in new funding for each of the two groups.)

This means that FTAC's recommendations for benefits will apply for the foreseeable future only to individuals and fully insured groups, and to Medicaid eligibles (although Federal approval of inclusion of the latter in a universal system may be dependent on demonstrating success with the former).

The UHCC's decision after two years is a major milestone, but further efforts to accelerate the process seem appropriate. [In an attempt to clarify issues relating to benefits](#) I have prepared the attached paper. I would be happy to discuss it with the committee.

Thank you,

Roger Collier

ROGER COLLIER rcollier@rockisland.com

SIX QUESTIONS FOR FTAC ON BENEFITS

ROGER COLLIER rcollier@rockisland.com

1. HOW DO WE DEFINE “BENEFITS”?

If we define benefits as services that enrollees are entitled to receive (perhaps with limitations), then are each of the following parts of the definition?

- Covered services
- Access to services (e.g. are they reasonably available?)
- Restrictions on provider and facility types
- Prior authorization requirements
- Limitations on services (e.g. frequency)
- Deductibles
- Copays and coinsurance
- Waiting periods (e.g. from date of enrollment)
- Retroactivity (e.g. as for Medicaid)

2. SHOULD ALL ENROLLEES HAVE THE SAME BENEFITS?

- Some mandated Medicaid benefits are not typical of most health insurance
- Should all Medicaid benefits be extended to all enrollees?
- Alternatively, if all Medicaid eligibles are included in the total enrollment, should their long-term-care benefits be segregated and not available to non-Medicaid enrollees?

ROGER COLLIER rcollier@rockisland.com

3. SHOULD THE SAME PAYMENT RATES AND RULES (FOR THE SAME SERVICES) BE APPLIED TO ALL PROVIDERS FOR ALL ENROLLEES?

- There are significant regional variations in providers' costs.
- "Universal financing" implies the same payment rules for all providers.
- This would likely mean payment increases for providers with many Medicaid eligibles and payment reductions for providers with mostly commercial patients. The risk is that the latter may prefer not to accept patients at the (new) lower rates.

4. SHOULD THERE BE A MORE AFFORDABLE "LOWER TIER" OF SERVICES OR PROVIDERS? OR A "HIGHER TIER"?

- This approach would perpetuate current "metal levels."
- Allowing a more affordable "lower tier" would be at odds with a goal of universal coverage
- If coverage is financed primarily by income taxes, affordability for the enrollee is no longer an issue.
- If State funding is insufficient for very generous coverage, a "base level" for all might be set, with an additional premium for more provider choice (as in the French system) or additional services.

ROGER COLLIER rcollier@rockisland.com

5. SHOULD INSURERS BE ALLOWED TO OFFER SIMILAR BENEFITS? OR ADDITIONAL BENEFITS?

- In the US currently, ~~Medicare~~ **MediGap** policies are permitted, subject to certain rules, to provide supplemental payments for hospital and other care for Medicare beneficiaries.
- Some nations (e.g. United Kingdom) allow commercial insurers to offer benefits that duplicate the state system, but provide better access to providers, and/or provide additional benefits.
- Other countries (e.g. Canada) explicitly ban such duplication, arguing that it undermines the state system.

6. WHAT CAN WE AFFORD?

- If coverage is financed primarily by income taxes, affordability for the enrollee is no longer an issue at the point of service. However, affordability for the State may be.
- To provide comprehensive benefits (as in the Washington Health Trust proposal) for non-Medicaid enrollees¹ would increase payments over and above what employers and employees are now paying by some \$2 billion (based on HHS analysis of MEPS data), excluding any effects of administrative simplification or more effective price competition.

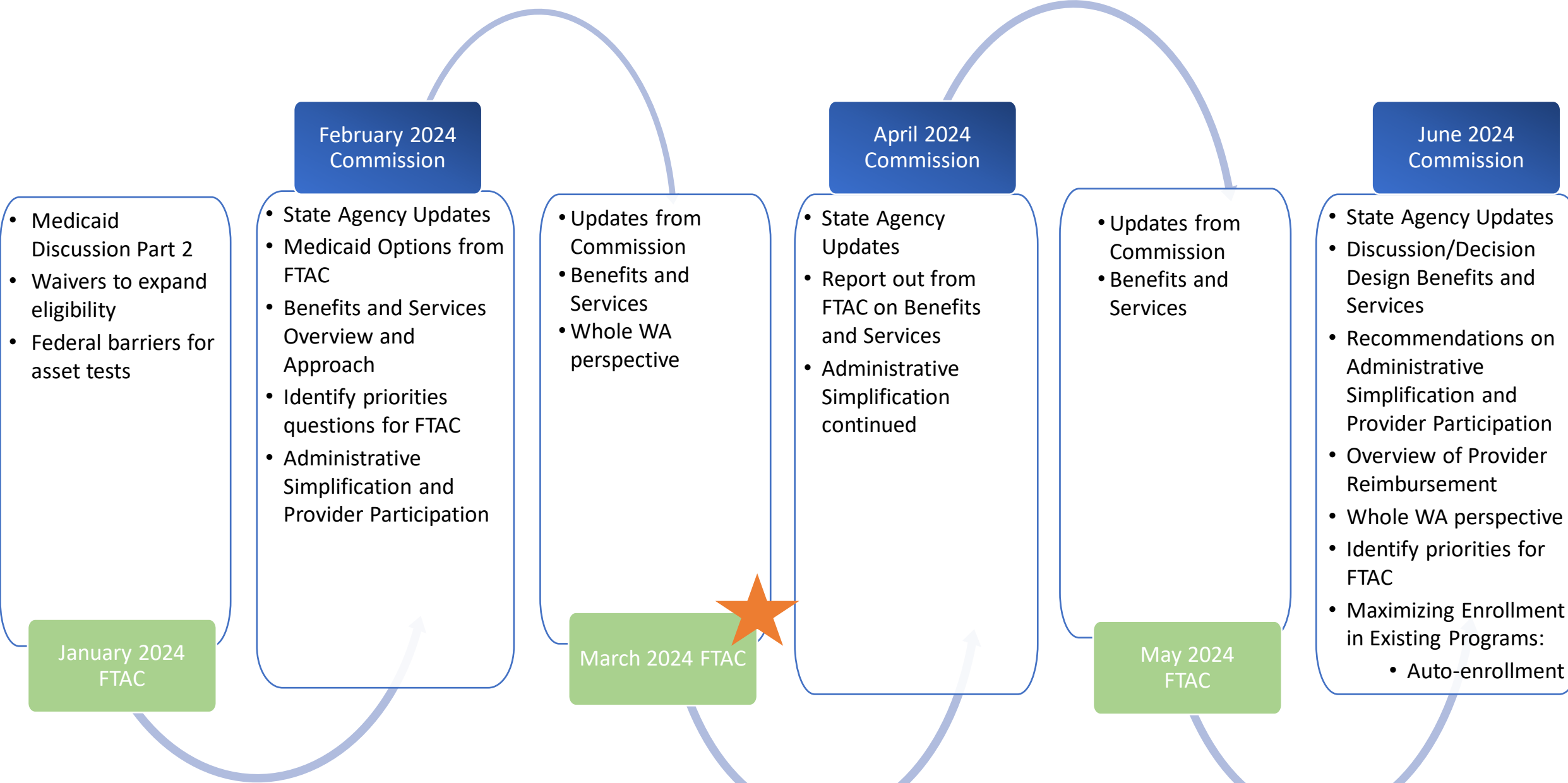
¹ Also non-ERISA and non-Medicare

Roger Collier was formerly CEO of a national health care consulting firm. His experience includes responsibility for managing the implementation of new state and federal health care programs for millions of enrollees.

ROGER COLLIER rcollier@rockisland.com

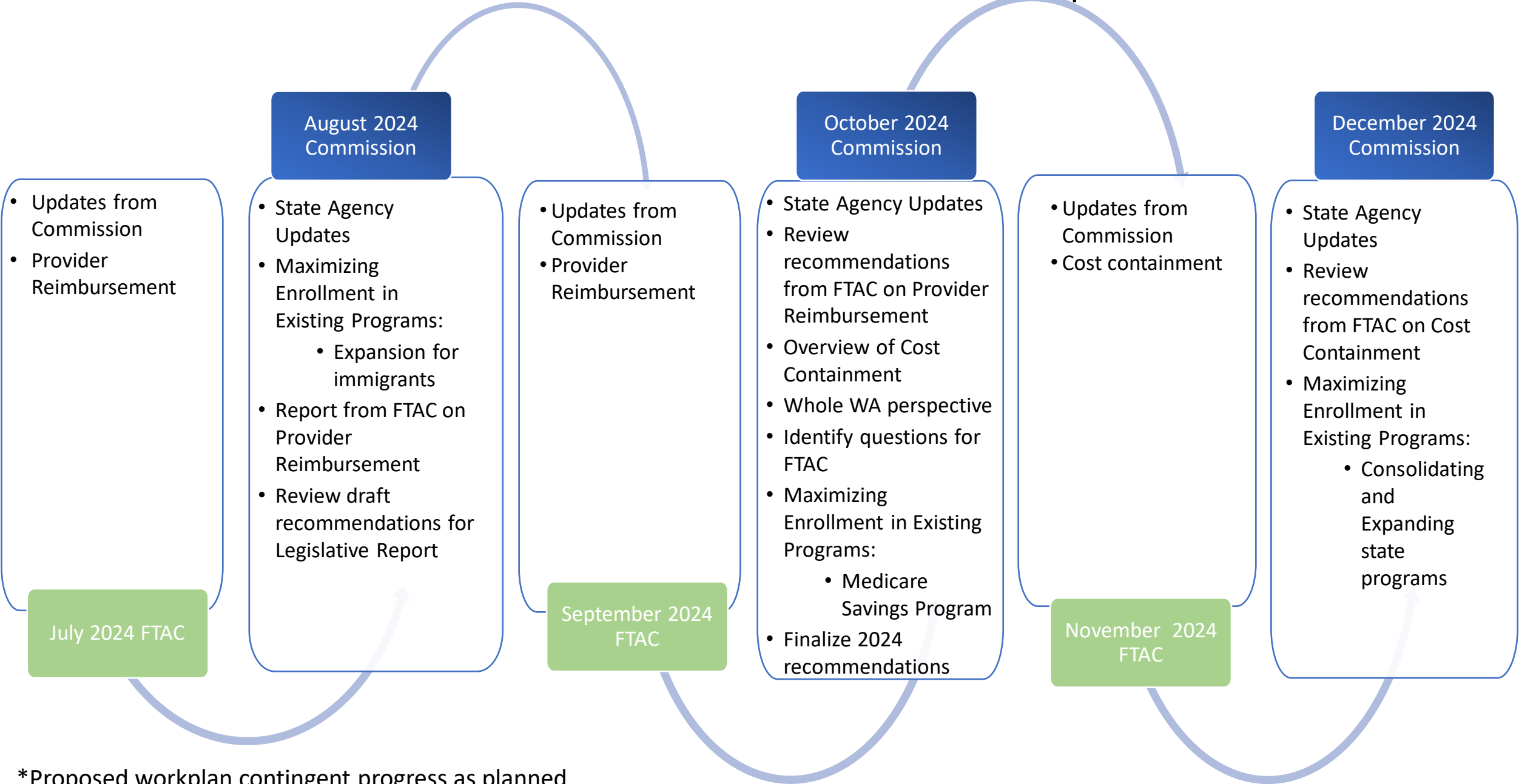
Tab 4

2024 Universal Health Care Commission Workplan



*Proposed workplan contingent progress as planned

2024 Universal Health Care Commission Workplan



*Proposed workplan contingent progress as planned

Meeting objectives

- Review Benefits & Services approaches by
 - Whole Washington, Washington Health Trust (SB 5355)
 - Universal Health Care Work Group (predecessor to the Commission)
 - Other states

- Assess preliminary comparison of Benefits & Services across Medicaid, EHB (EHB) under the Affordable Care Act (ACA) and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB) as an example of large group market

- Identify gaps in preliminary benefits comparison

- Develop considerations for the Commission for a path forward including an actuarial analysis

Tab 5

The Washington Health Trust **Financing**

The economics of universal healthcare & SB.5335

Slides submitted 3/5/2024

Presentation on 3/14/2024

For the latest version of these slides go to
wholewashington.org/uhcc-presentations

Email:
info@wholewashington.org



Dr. Gerald Friedman

- BA in Economics from Columbia University
- PhD in Economics from Harvard University
- Professor of Economics U Mass Amherst
- 2018 economic analysis
- 2021 economic analysis

Our goals

Today

- A comparative analysis of the Friedman studies and the Universal Health Care Work Group report
- A breakdown of The Washington Health Trust's proposed financing
- Discuss and answer questions about core values that guide financing decisions

The future

- A co-developed 10-year cost analysis, budget, and public financing plan
- Support the UHCC in their June 2024 report back on SB.5335
- Jointly-backed legislative recommendations in the November 2024 report

Bills that died with the end of the 2024 session

- **SJM 8006** - died on the House floor without a vote
- **SB 5335** - died in the Senate Health & Long Term Care committee (not introduced in the House)

Defining Universal Healthcare

Defining Universal Healthcare: World Health Organization

“Universal health coverage means that **all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.**”

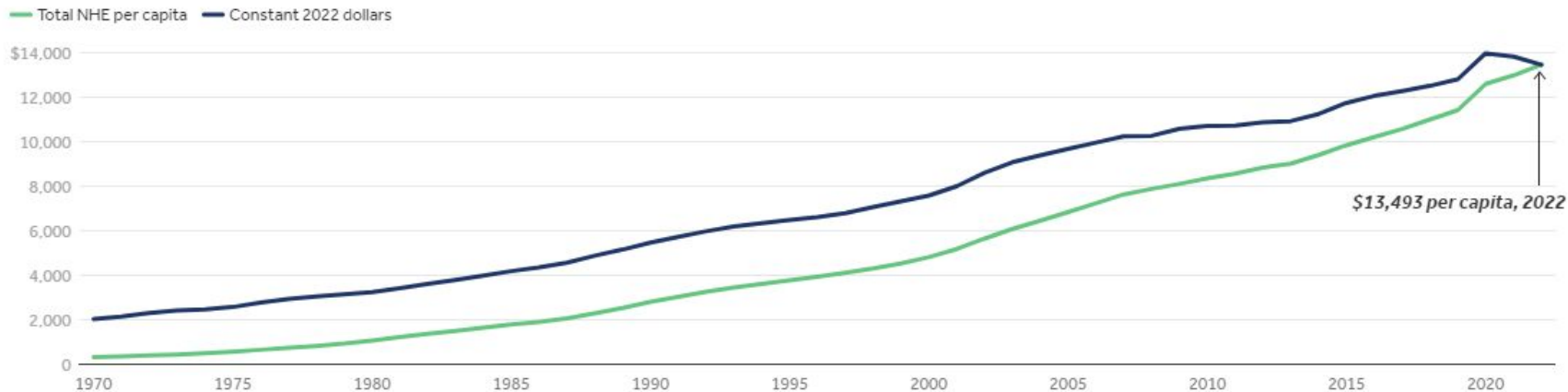
Key elements found in successful models:

1. Everyone is eligible to enroll or automatically enrolled
2. Universal set of essential health benefits
3. **Uniform billing and reimbursement**
4. **Significantly publicly-funded**
5. **Non-profit**



Per person health spending reached \$13,493 in 2022

Total national health expenditures, US \$ per capita, 1970-2022



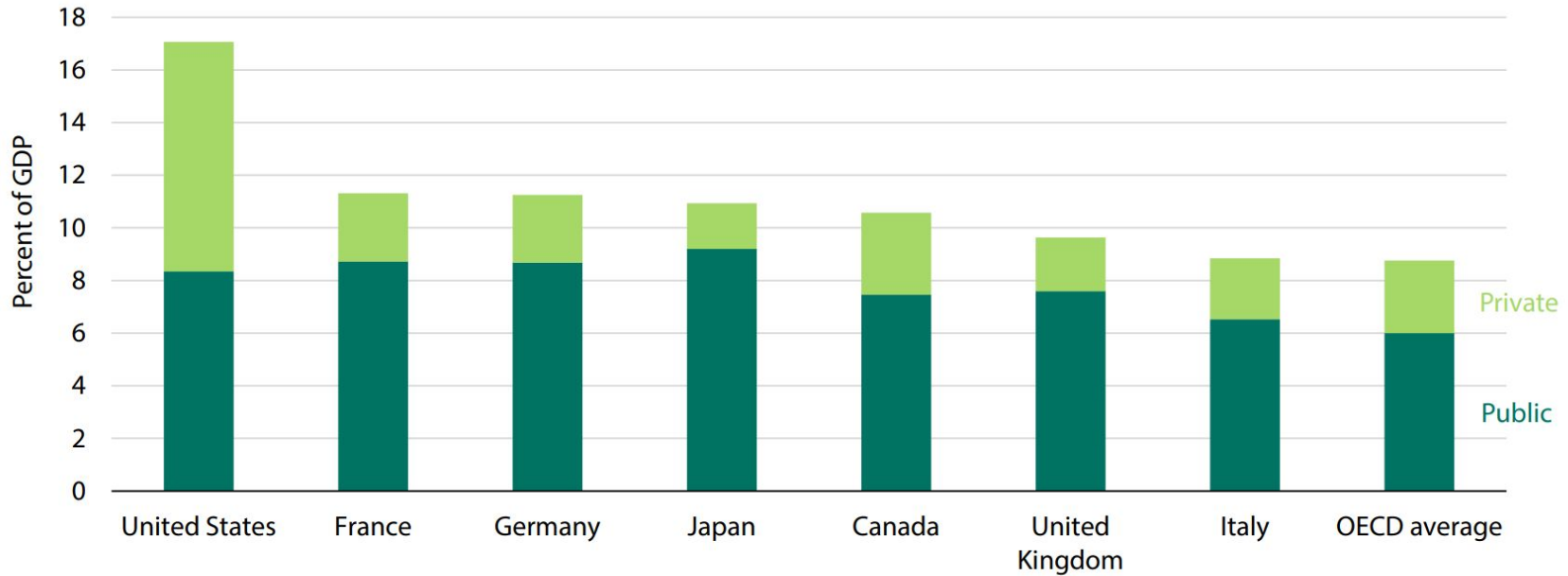
Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

Source: [KFF analysis of National Health Expenditure \(NHE\) data](#) • [Get the data](#) • [PNG](#)

Peterson-KFF
Health System Tracker

FIGURE 2.

Public and Private Health-Care Expenditures as a Share of GDP, by Country



Source: World Health Organization (WHO) 2019a.

Note: Data are for 2017. Figure shows selected Organisation for Economic Co-operation and Development (OECD) countries; OECD average includes all OECD member countries as of 2020. Public expenditures include: expenditures on government schemes and social health insurance schemes. Private expenditures include compulsory private insurance schemes, voluntary health care payment schemes, household out-of-pocket payments, and rest of the world financing schemes (non-resident). See WHO (2019b) for details.

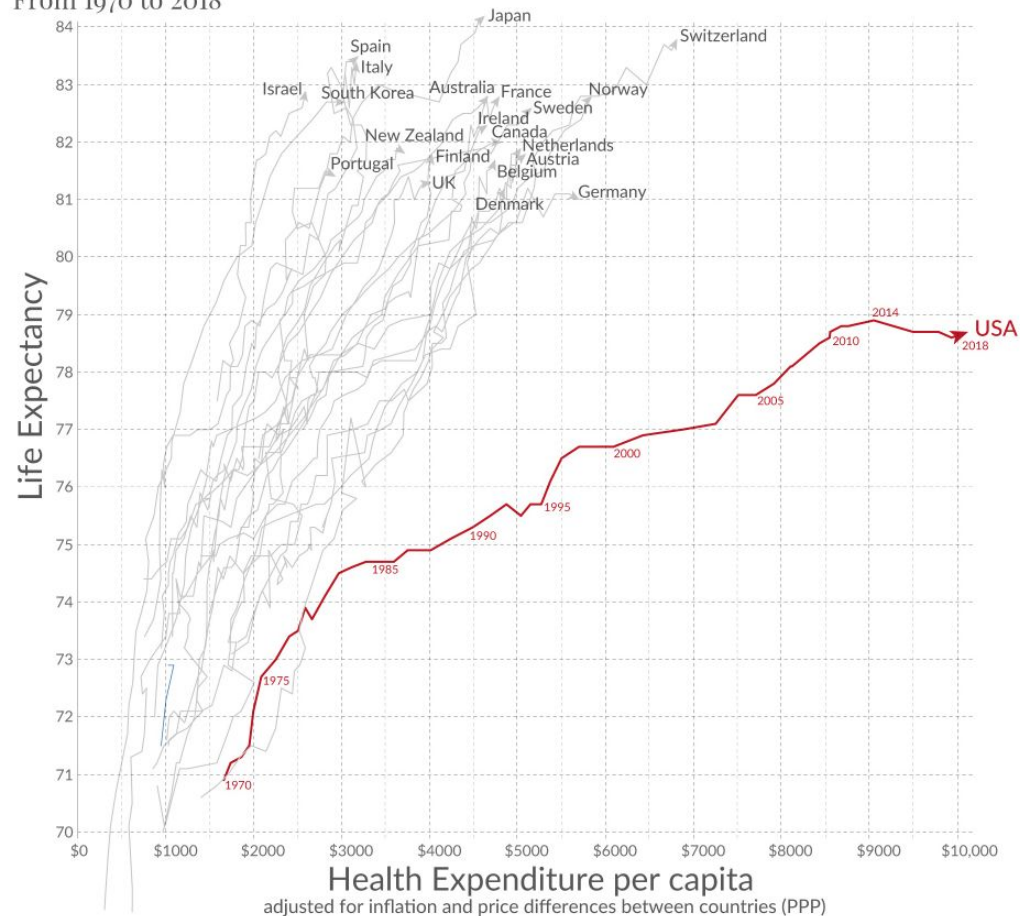


Cost analysis **must** always be based
around **total health care spending**.



Life expectancy vs. health expenditure

From 1970 to 2018



Cost & access

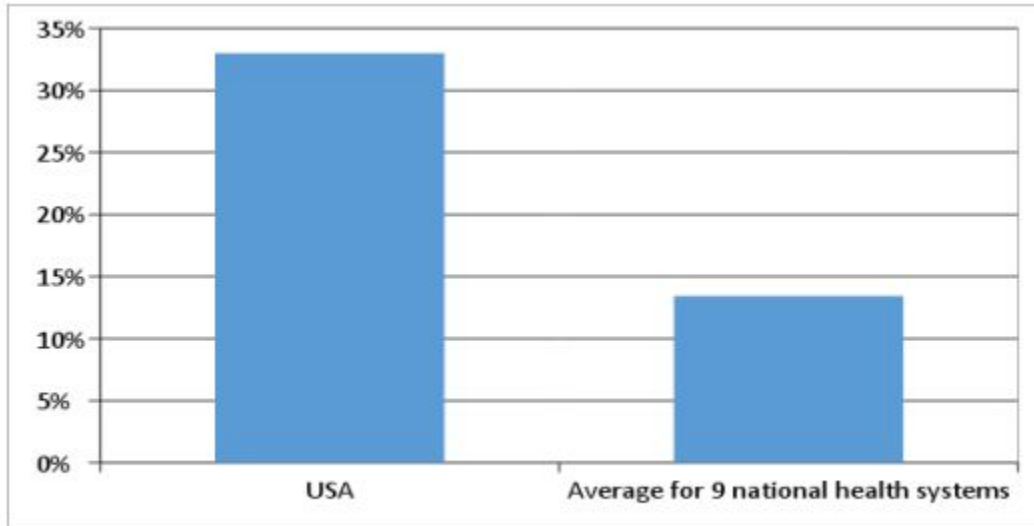


Figure 5. Proportion of population reporting they experienced access barrier because of cost in past year, the United States and nine countries with national health systems

Access & premature death in Washington

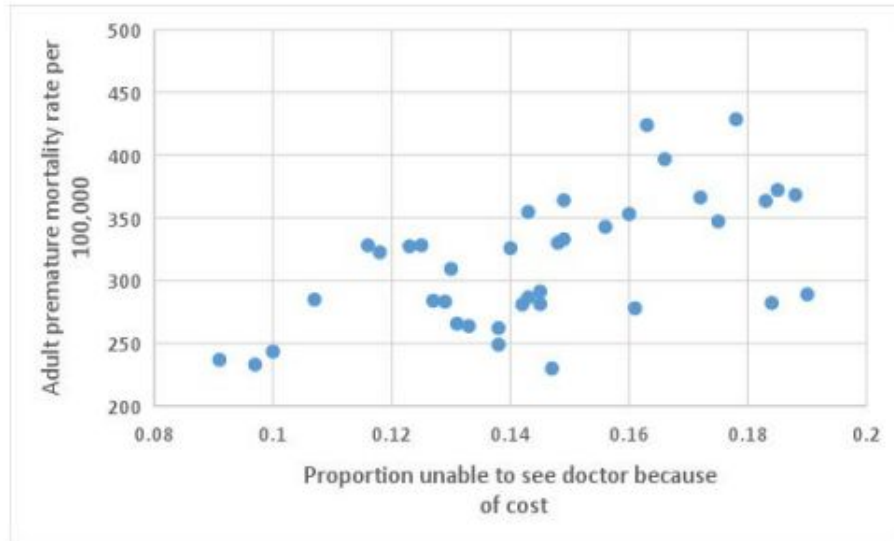
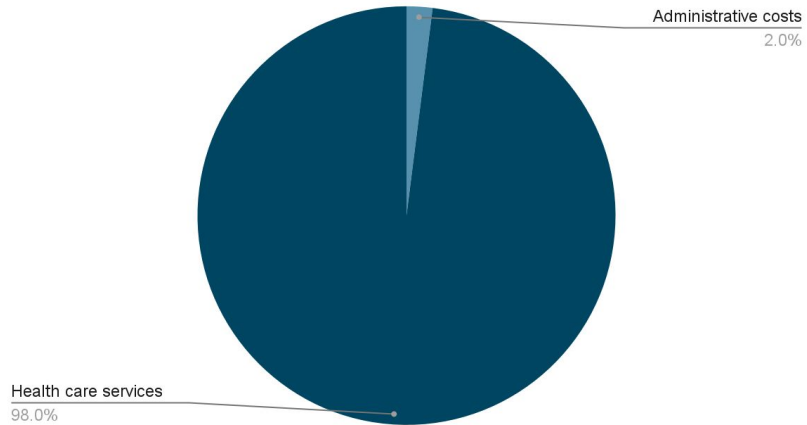


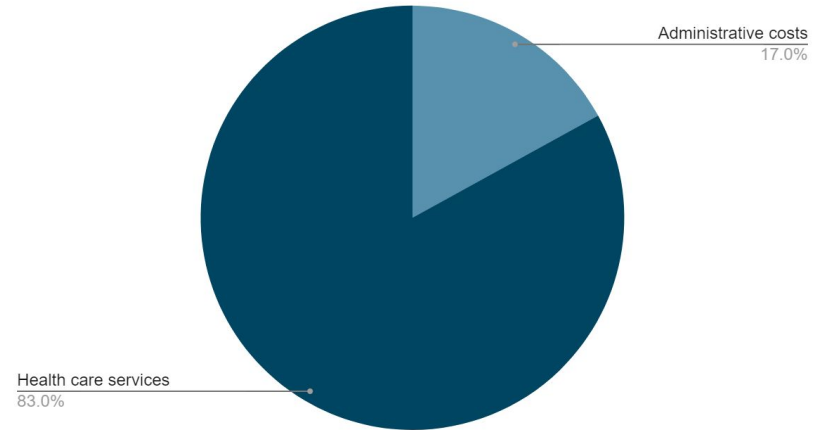
Figure 10. Premature mortality rate and access to care, counties in the state of Washington

Cost of administration

Medicare



Private insurance



Bottom line

- The Washington Health Trust (WHT) has a financing plan and is fully paid for
- The WHT is 100% publicly funded
- The financing structure of the WHT is progressive
- The WHT will cost Washingtonians less than the existing system
- The WHT will do all this while achieving universal and comprehensive coverage

Cost analysis

How much does the current system cost?

(in millions of dollars)

Universal Health Care Work Group Report (2022)

Category	Expenditure
Medicaid	\$15,492
Medicare	\$15,478
CHIP	\$83
Private health insurance	\$22,900
Uninsured	\$133
Undocumented	\$45
Out of pocket	\$3,046
Out of pocket (Medicare)	\$1,156
Indian Health Services	\$80
Other private revenues	\$3,004
Total	\$61,417

Friedman Analysis (2018, 2021)

Category	Expenditure
Hospital	\$28,415
Physician	\$18,980
Other Professional	\$2,979
Dental	\$4,579
Home Health	\$1,729
Drugs	\$7,311
Durable Medical	\$1,343
Nursing Home	\$4,248
Other	\$3,182
Private health insurance	\$5,475
Public health programs	\$1,117
Employer expenses	\$622
Total	\$79,980
2021 adjustment	\$78,440

What is the impact of universal healthcare?

Universal Health Care Work Group Report

- Cost reduction of \$5.6 billion (Model A)
 - \$2.476 billion - implementation year
- Cost reduction of \$738 million (Model B)

Friedman Analysis

- 2018 - Cost reduction of \$9.095 billion
- 2021 - Cost reduction of \$12.752 billion

Savings (UHC Work Group Report)

	Status quo	Model A	Model A Difference	Model B	Model B Difference
Medicaid	\$15,492	\$17,253	\$885	\$17,748	\$2,256
Medicare	\$15,478	\$17,950	\$1,520	\$18,465	\$2,978
CHIP	\$83	\$99	\$10	\$102	\$18
Private health insurance	\$22,900	\$14,889	-\$8,952	\$15,316	-\$7,583
Uninsured	\$133	\$411	\$250	\$423	\$289
Undocumented	\$45	\$794	\$69	\$816	\$771
Out of pocket	\$3,046	\$3,175	\$42	\$3,266	\$220
Out of pocket (Medicare)	\$1,156	\$1,205	\$16	\$1,240	\$84
Indian Health Services	\$80	\$77	-\$7	\$80	\$0
Other private revenues	\$3,004	\$3,089	-\$105	\$3,178	\$174
Total	\$61,417	\$58,942	-\$6,272	\$60,634	-\$793

Savings (Friedman Analysis)

- 2018 - Cost reduction of \$9.095 billion

Table 3. Cost of projected program improvements under Washington single payer program (\$millions, 2019).

Universal coverage	\$	1,336
Utilization (removal of copays and deductibles)	\$	3,249
Medicaid rate	\$	680
Assumption of Medicare premiums	\$	1,878
Public administration of program improvements	\$	91.71
Transition costs for UI and retraining (first year)	\$	92
Cost of program improvements	\$	7,327

Table 2. Projected savings (in \$millions) from single payer in Washington

Provider administration	\$	5,527
Market Power (Pharmaceuticals and Hospitals)	\$	3,536
Insurance Administration	\$	5,282
Employer administration	\$	622
Fraud reduction	\$	1,455
Total savings	\$	16,423

- 2021 - Cost reduction of \$12.752 billion

Table 1. Projected cost of health care, Washington 2021, current system and with universal coverage at high actuarial value (\$000,000s)

<i>Spending with universal coverage, existing system</i>	
Personal health care, current utilization	\$ 78,440
Improved access	\$ 9,189
Total personal health care	\$ 87,629
Insurance admin	\$ 10,363
Total, existing system with full access	\$ 97,992
	\$ 78,440
<i>Savings from existing system, with universal coverage</i>	
Hospital price adjustment	\$ (10,828)
Physician price adjustment	\$ (2,042)
Drug and device pricing	\$ (5,121)
Provider admin	\$ (7,943)
Medicaid price adjustment	\$ 3,617
Insurance admin	\$ (9,075)
Fraud	\$ (912)
Total savings	\$ (32,304)

All single payer savings:

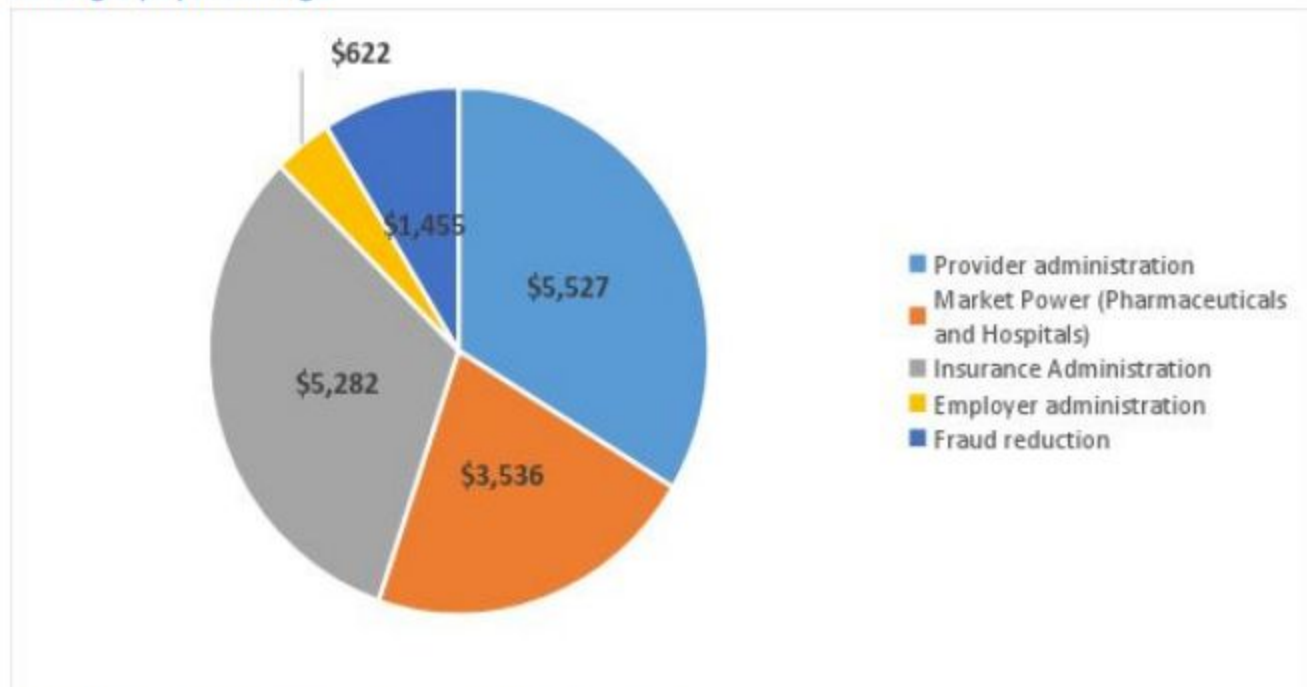


Figure 13. Projected single payer savings, Washington, 2019 \$millions.

Essential benefits package

Determining essential benefits

- Based on ACA standards
- Designed to align with benefits of federal single-payer legislation like HR.676
- Language added to explicitly cover certain people and types of care including gender-transition care, reproductive care, and the incarcerated
- Includes all Washingtonians, no gaps
- Coverage is comprehensive
- Decouples coverage from employment
- Shifts coverage from private payers to public
- Maximally consolidated to realize greatest cost-efficiency

Financing

Needed revenue

<i>Funding of Washington Trust</i>	
Net spending, 2021, M4All	\$ 65,688
Including Medicare Part B	\$ 67,173
Existing revenue	\$ 46,686
Needed revenue	\$ 20,487

Existing revenue

Table 2. Existing revenue sources, projected 2021 (\$000,000s)

Medicare	\$ 17,216
Medicaid	\$ 16,996
SCIP	\$ 201
VA	\$ 1,882
Other	\$ 7,093
remaining OOP	\$ 2,687
ACA subsidies	\$ 612
Total existing revenue	\$ 46,686

Note: Medicaid includes adjustment for Federal share of Medicaid price and coverage increases, but not state share.

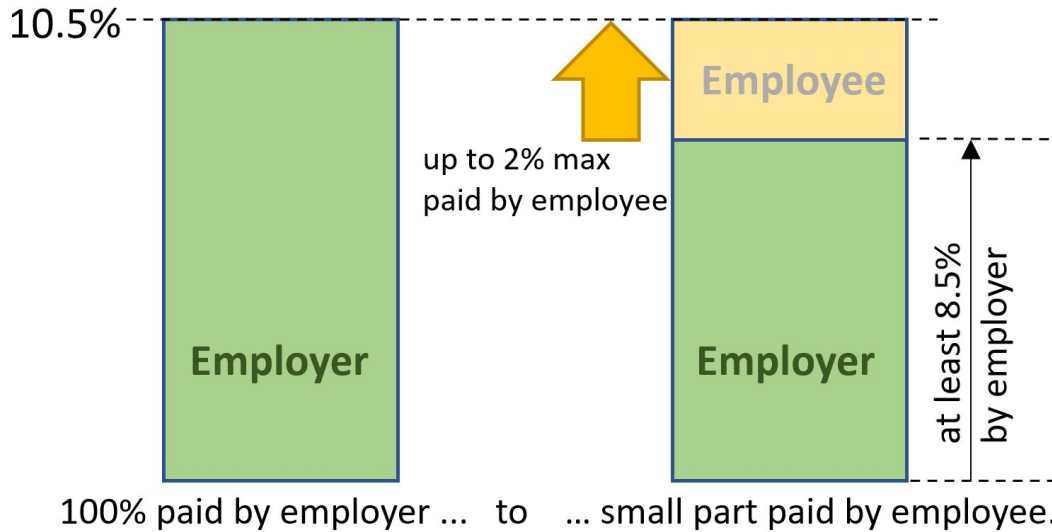
Other includes state and local public health, workplace health care, Indian Health Service, charitable contributions, and others.

Medical spending through Workers' Comp, Homeowners', and Auto Insurance has been removed.

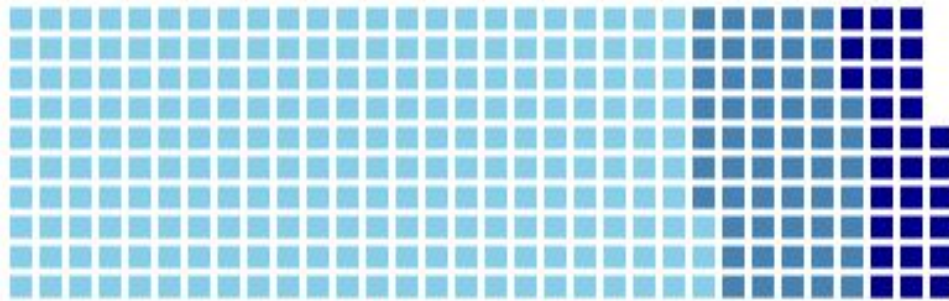
Financing

Employers will contribute	10.5% of wages	<ul style="list-style-type: none">• Relieves administrative burden, unpredictable costs of insurance plans for employers• May deduct up to 2% from employee payroll
Employees may contribute	Up to 2.0% of wages	<ul style="list-style-type: none">• Employers may cover all or a portion• Payroll deduction, not an out-of-pocket expense• Contributes to the 10.5% employer contribution
Sole Proprietors will contribute	2.0% of earnings	<ul style="list-style-type: none">• The first \$15,000 won't be taxed
Investors will contribute	8.5% of capital gains	<ul style="list-style-type: none">• The first \$15,000 won't be taxed• Home sales, retirement accounts and more won't be taxed

Employer / Employee Contribution Flexibility



The bulk of new funding comes from employers



- Employer pays 8.5% of payroll: \$23,334m
- Employee pays up to 2% of payroll: \$5,490m
- 2% of sole proprietorship: \$0.82m
- 8.5% of capital gains: \$2,993m

1 square = \$100 million

*Under \$15k exempt in all categories

Employer responsible for 10.5% but may pass up to 2% to employees

Examples of Employer Expenditures

10.5% with up to 2% paid by employees - Graduated exemption: \$3,750 - (25% of total quarterly pay)

Employee's Gross Annual Pay	Earning Percentile	Employer Contribution (8.5-10.5%) per month	Max Employee Contribution (0-2%) per month	Employers Total Required Health Spending per Employee / month
Up to \$12,000		\$0	\$0	\$0
\$20,000	<25%	\$73.83 - \$87.50	\$0 - \$16.67	\$87.50
\$40,000	25th	\$247.91 - \$306.25	\$0 - \$58.34	\$306.25
\$60,000*	50th	\$425.00 - \$525.00	\$0 - \$100	\$525.00
\$100,000		\$708.33 - \$875.00	\$0 - \$166.67	\$875.00
\$275,000	90th	\$1,031.25 - \$2,406.25	\$0 - \$1,375.00	\$2,406.25

Context

Currently, **the average WA employee earns \$57,290 annually**. The average WA employee pays a monthly average of \$475 for individual plans and \$1,174 for families. The average cost of employer-sponsored health insurance for employers' annual premiums was **\$7,739 for single coverage** and **\$22,221 for family coverage**. The report also found that the average annual deductible amount, for employees, was \$1,669 for covered workers.

Working with ERISA

ERISA laws prevent WA from requiring employers who provide ERISA protected health benefits to participate directly in the WHT. However, Washington State Can:

- Require employers to provide coverage for minimum essential coverage.
- Require employers to spend an amount on each employee's health care equal to the cost for enrolling the employee in the WHT.
- Define the health spending that counts towards employers' required health care spending.
- Create a framework to provide Health Coverage & Cost Equity for employees that are not enrolled in the WHT (as well as those who are uninsured or underinsured).
- Cover all kids. This is a benefit to working families that supports all of their employers too.

The Washington Health Trust's ERISA workaround was modeled after Healthy San Francisco's city-option which has survived legal challenges based on ERISA.

Employer Health Spending Equity

All employers are required to pay the **same** percentage of each employee's payroll toward the employee's health care.

Required
Health Care Expenditure

10.5%

Private Insurance
Option

Direct employee
healthcare funding

WA Cares
(Long Term Care)

If the employer-sponsored coverage or contributions don't meet or exceed 10.5%, the difference must be paid to the ESD.

Revenue by source

Table 4. Revenue sources, 2021 (\$millions)

8.5% employer payroll	\$	23,334
2% employee payroll	\$	5,490
2% sole proprietorship	\$	0.82
8.5% capital gains	\$	2,993
\$200 premium enrollees above 19 and 200% FPL	\$	890
Total revenue	\$	32,708
Surplus (deficit)	\$	12,221

Questions

Economic Analysis of Single Payer Health Care in Washington State:
Context, Savings, Costs, Financing

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healthcare is a human right

I am grateful for research support from Joseph Kane and Tai Spargo.

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Introduction

This economic analysis explores the implications of a single payer health plan in the state of Washington if it were to go into effect in 2019. The Act would replace Washington's current multi-payer system in which individuals, private businesses and government entities pay public and private insurers for health care coverage. The Act would establish a state health plan to finance medically necessary care including hospitalization, doctor visits, dental, vision, mental/behavioral health, prescribed occupational and physical therapy, prescription drugs, medical devices, and rehabilitative care.¹ The Plan would offer this comprehensive coverage to all residents and would pay for it with broad-based, progressively graduated premiums assessed by the State on payrolls and on non-payroll income.

The Washington Health Plan would finance medical care with substantial savings compared with the existing multi-payer system of public and private insurers. By reducing administrative and other waste and eliminating health insurance company profits and excessive prices for drugs and medical devices, the Plan would increase real disposable income for the vast majority of residents. It would simultaneously increase employment by reducing the burden of health insurance on business. Some of these savings would be used to extend coverage to the 9% of Washington residents still without insurance under the Affordable Care Act; other savings would be reinvested in the health-care system to improve coverage for the growing number with inadequate coverage. In addition to improving residents' health by reducing barriers to access to health care, the Plan would eliminate the financial penalty associated with health problems. It would also reduce economic inequality by replacing the current regressive system of health insurance finance with contributions proportional to income and ability to pay.

Context: health care spending and quality in the United States with markets

Rising health care inflation

Personal health care spending has been rising at an unsustainable pace in the state of Washington. Between 1991 and 2001, total health consumption spending rose at nearly 7% a year with per-capita spending rising at over 5.0% a year (see Figure 1).² The rate of increase in

¹ Long-term care will be added under a plan to be developed within two years of the Act taking effect.

² Expenditures are estimated from the Centers for Medicare & Medicaid Services, Office of the Actuary, data on personal health expenditures by state linked to national expenditure projections; see appendix for details.

total health consumption slowed after 2001, but only to 6.2% a year, including increases of nearly 5% in per-capita spending.

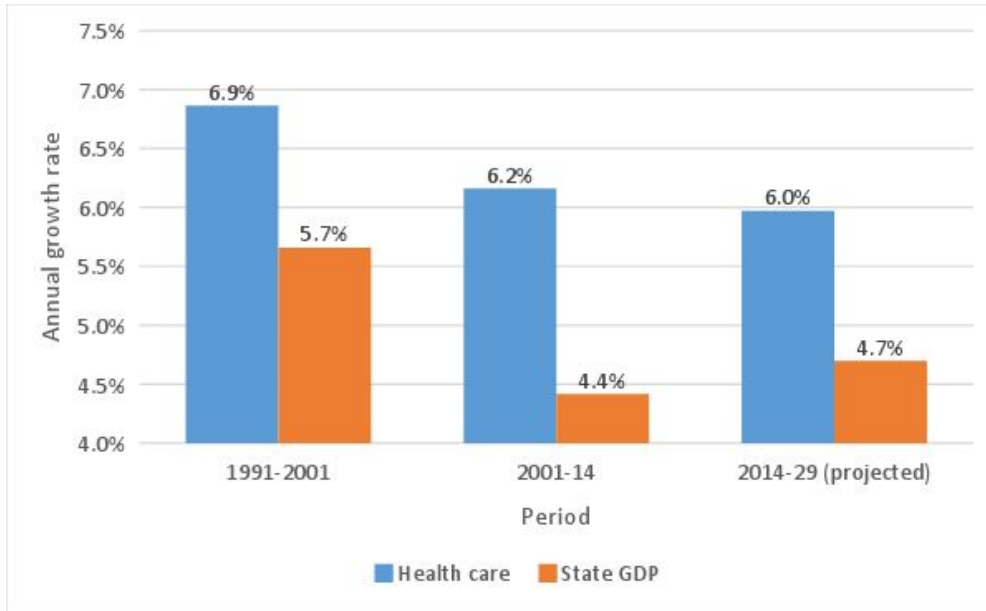


Figure 1. Growth in health care spending and gross state product, 1991-2029, projected

Note: This shows the average annual increase in health expenditures (personal plus insurance administration) and Gross State Product income since 1991. GSP is from United States Bureau of Economic Analysis; health spending is from United States, Center for Medicare and Medicaid Statistics, National Health Expenditures data, <http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf>

Even at a slower rate of increase, health care spending absorbs a growing share of the state’s income, and a rising share of wages and salaries (see Figure 2). As a share of state product, health care costs have risen since 1991, from under 10% of state income to over 14% in 2014. With current policies, it is projected to rise to almost 17% of state income in the next decade (see Figure 2).

Health care cost inflation is squeezing disposable income for residents of Washington. If health care spending per person had risen only as fast as income, then spending in 2014 would have been 29% less, saving the average person \$2,526, or more than \$10,000 in savings for a family of four. Spending projections for 2029 suggest that spending will be more than double what it would have been at the 1991 rate, costing each person in Washington over \$7,000.

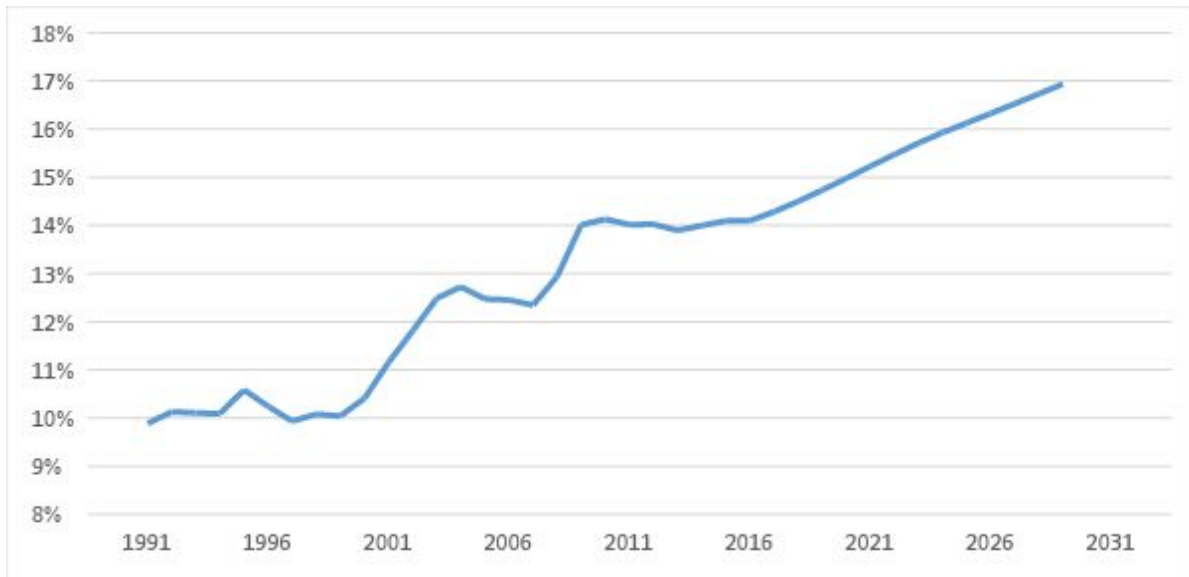


Figure 2. Health spending as share of GDP

The system of employment-based health insurance places the burden of health care inflation especially hard on wages and salaries.³ As a share of employee compensation, health care spending rose from 18% in 1998 to 27% in 2014 and is projected to pass a third in 2029.⁴ Every person who has engaged in collective bargaining, or even individual bargaining over wages, knows what these increases in health care spending mean for wages. Higher health care spending costs the average worker in Washington over \$2,846 in 2014, and is expected to cost \$8,387 in 2029 (see Figure 3).⁵ Higher health care spending is reducing the funds employers have available for wages, pensions, training programs, or for other employee benefits.

³ 52% of health care spending in 2014 was through employment, including the medical share of workers compensation.

⁴ Compensation data only go back to 1998. Only including expenditures directly tied to employment, the share rose from 9% to 14% and is expected to reach 17% in 2029.

⁵ This assumes that employment-related spending will continue to be 52% of total spending.

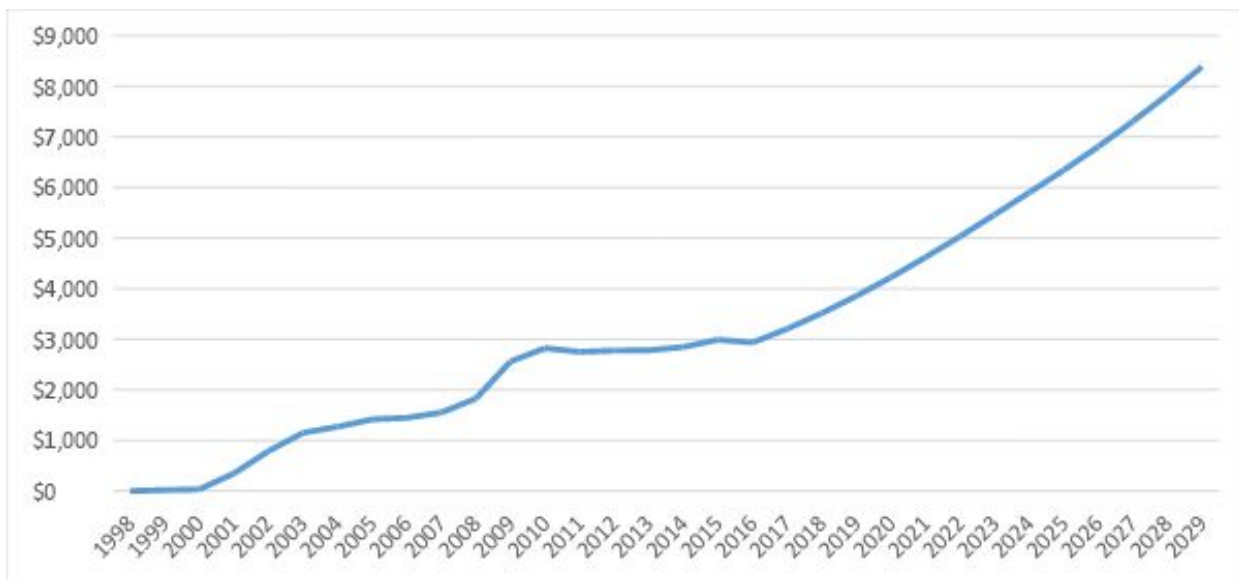


Figure 3. Cost per employee of excess health-care spending, 1998-2029 (projected).

Note: This shows for each year beginning in 1998, the average cost per employee in the state of Washington of the growth in employment related health care spending, estimated as 52% of total health care spending, above the share of state compensation going to health care in 1998. Estimates after 2014 are projections using CMS projections of health care spending and assumes employee compensation will grow at the 1998-2015 rate.

Declining efficiency in health care delivery

Increased health care spending might be justified if it reflected increasing utilization of quality care. Instead, however, health care spending in the United States has been increasing due to higher costs with little or no improvement in care. After controlling for general inflation, only a fifth of the excess increase in health care spending since 1971 reflects increased utilization; almost half of the increased spending reflects the higher inflation rate for health care compared with other products.⁶ Excess inflation is almost entirely due to the private market, where costs have risen significantly faster than in Medicare, either the United States’ or the Canadian’s version. Since 1969, private health insurance spending per enrollee on a common set of benefits has increased seven times as fast as the price of other commodities, and nearly twice as fast as the increase for Medicare. Had all health care prices increased only as fast as Medicare’s, health

⁶ Between 1971 and 2009, the general consumer price index rose at an annual rate of 4.4% while the medical inflation rate rose 6.2% per year, 1.8% per year faster. Over the same time, the inflation rate for Medicare rose only slightly faster than the general inflation rate, but the inflation rate for private health insurance rose 1.26% per year faster than the Medicare rate. For comparison, in Canada, with a government-financed, single-payer health care system, there is almost no difference between the general inflation rate and the inflation rate for medical care.

care spending in the United States would have risen only slightly faster than the rate of growth in national income.⁷

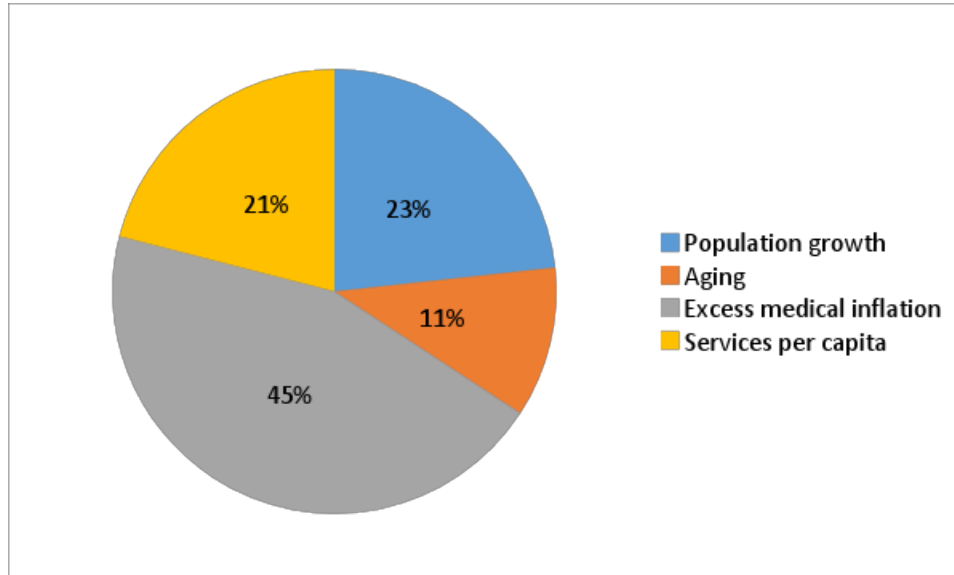


Figure 4. Sources of increase in after-inflation health care spending, 1971-2015

There is direct evidence that rising health care costs in the United States are not due to excessive utilization. Compared with residents of other affluent countries, residents of the United States are less likely to see a doctor (see Figure 5); and a survey by the Commonwealth Fund confirms that people in the United States report more financial barriers to access than do residents of other countries.⁸

⁷ David U. Himmelstein and Steffie Woolhandler, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," *Archives of Internal Medicine* 172, no. 22 (December 10, 2012): 1764–66, <https://doi.org/10.1001/2013.jamainternmed.272>; Diane Archer, "Medicare Is More Efficient Than Private Insurance," *Health Affairs*, accessed September 4, 2017, <http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/>; Diane Archer and Theodore Marmor, "Medicare And Commercial Health Insurance: The Fundamental Difference – Health Affairs Blog," *HealthAffairs Blog*, February 15, 2012, <http://healthaffairs.org/blog/2012/02/15/medicare-and-commercial-health-insurance-the-fundamental-difference/comment-page-1/#comment-165108>.

⁸ Sara Collins et al., "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse, Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014," May 2015, http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1817_collins_problem_of_underinsurance_ib.pdf; Sarah Thomson et al., "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" (Commonwealth Fund, November 2013),

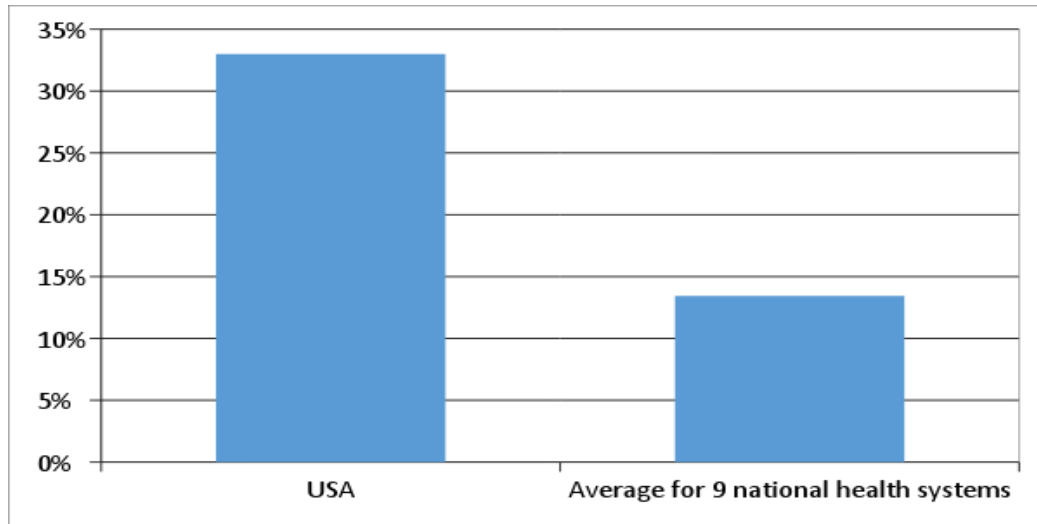


Figure 5. Proportion of population reporting they experienced access barrier because of cost in past year, the United States and nine countries with national health systems

The restrictions on access come directly from policy decisions made to control health care costs by promoting market competition among health insurers. One idea behind this new approach was that health care inflation comes from the over-utilization of care by “consumers” who, because of first-dollar insurance coverage, do not pay the cost of their care. Furthermore, economists recommended market competition among health-care providers to promote greater efficiency by giving providers profits as an incentive for innovation.⁹

Residents of Washington have experienced this shift towards market-oriented health care. As recently as 1999, it was so common for employers to offer health insurance without deductibles that the national survey of employer-provided health insurance did not include a question about the size of deductible.¹⁰ When they did begin asking about deductibles, the average was fairly low; in 2003, 37% of employees were in plans without deductibles, they had “first-dollar coverage,” and the average deductible in a plan with a deductible was \$569. By 2014, the

http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/nov/1717_thomson_intl_profiles_hlt_care_sys_2013_v2.pdf.

⁹ These new policy developments came from the emerging field of health economics. The founding-father of the sub-discipline, Kenneth Arrow, must have been shocked at how his ideas were transformed and even abused. See Kenneth J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *The American Economic Review* 53, no. 5 (December 1, 1963): 941–73; Amy Finkelstein, *Moral Hazard in Health Insurance: Developments since Arrow (1963)*, Kenneth J. Arrow Lecture Series (New York: Columbia University Press, 2014).

¹⁰ This is the Medical Expenditure Panel Survey by the Agency for Healthcare Research and Quality; see https://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=38&year=2003

proportion without deductible had fallen to 7%, and the average deductible for an employee in a plan with a deductible had more than doubled in size to \$1,341. Including the zero cost for plans without deductibles, the average deductible for an employee in an employer-sponsored health insurance plan rose from under \$400 to over \$1,200 (see Figure 6).¹¹

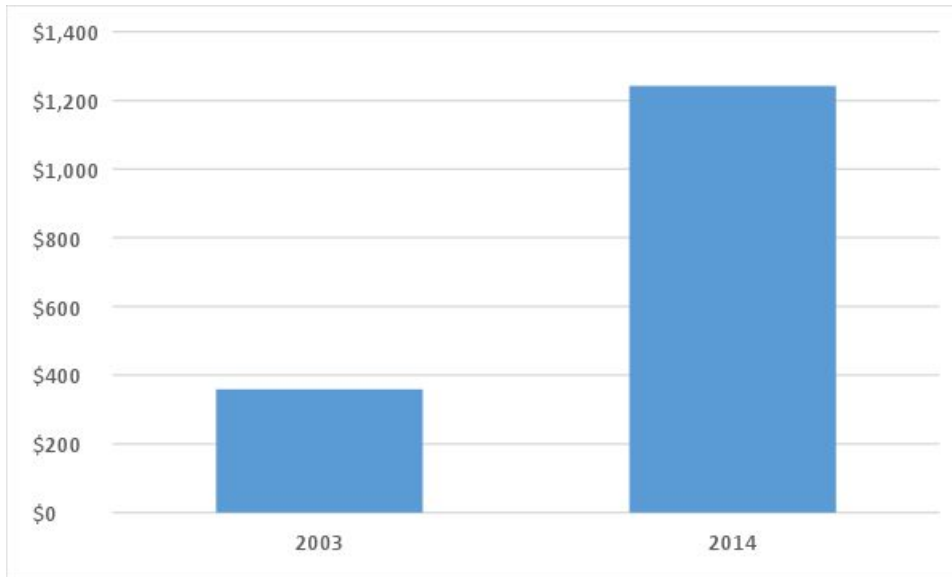


Figure 6. Average deductible, Washington state employees in employer-sponsored health insurance plans

The declining coverage of employer-sponsored health insurance matters less for Washington’s workers because of the gradual decline in employer-sponsored health insurance. Fewer people have employer-sponsored health insurance. As recently as 1999, over 60% of employees in Washington had employer-sponsored insurance, and 29% covered their entire families. By 2014, however, the proportion with any coverage fell to under half, with only 13% having family coverage (see Figure 7). Instead of employer-provided insurance, more people in Washington are seeking coverage through individual plans (about 6% of the population in 2015). Perhaps of most concern, more are receiving coverage through public programs like Medicaid (22%) or Medicare (14%).¹²

¹¹ This is from the MEPS survey referred to above.

¹² Census data from

<http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

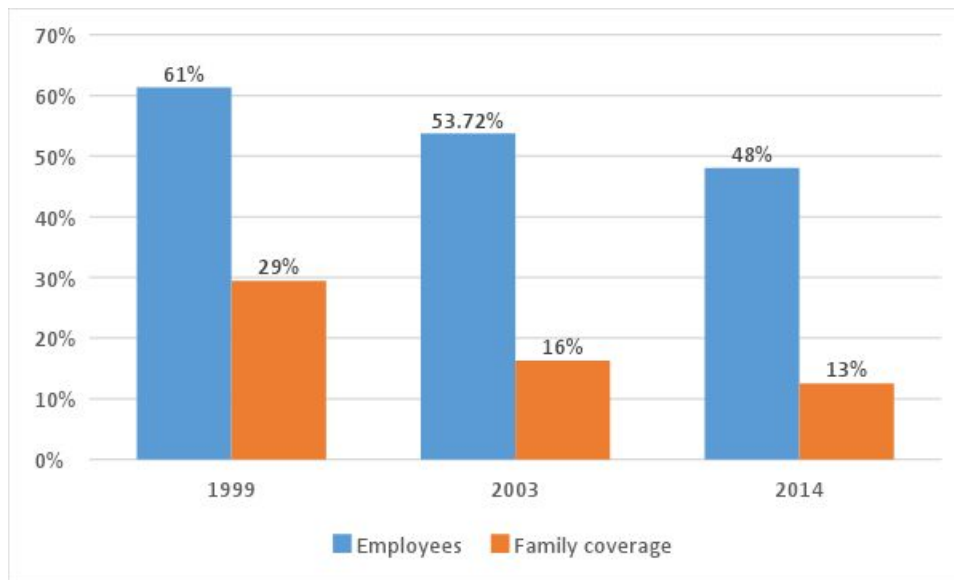


Figure 7. Employer provided health insurance coverage, Washington 1999-2014

The market turn in American health-care and the health of Americans

Guided by the new economic thinking, in the early 1970s American states have opened up health insurance markets to competing providers, and have removed price and other regulations on health care providers -- including hospitals -- to promote for-profit behavior and market competition.¹³ Even the federal government's Medicare plan was opened to market competition, through Medicare Part C or Medicare Advantage; and states put their Medicaid plans out for bids by private contractors. The number of competing health insurers has increased dramatically. Instead of universal access at set prices, or community rating where insurers are required to sell coverage to all and at the same rate, as with the Blue Cross-Blue Shield monopoly, states allow insurers to offer an exploding number of plans so that individuals and businesses have choice of coverage and can buy coverage they think appropriate for their expected health care needs. This allows the healthy, or those who anticipate being healthy, to avoid plans popular with the sick and disabled, giving them lower rates at the expense of abandoning part of the insurance function of health insurance.

¹³ Robert Cunningham and Robert M. Cunningham, *The Blues: A History of the Blue Cross and Blue Shield System* (DeKalb: Northern Illinois University Press, 1997); Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (New York, NY: Cambridge University Press, 2015); 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); Jill S Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, Oxford University Press pbk (Oxford ; New York: Oxford University Press, 2006).

The result of our national experiment in free-market health care has been a relative decline in our health, and an increase in the cost of care. Higher spending is associated with longer life expectancy in other affluent countries; but life expectancy in the United States is over 5 years short of what would be expected from its spending. Our poor performance can be quantified in dollars and cents: if we spent what other countries spend to achieve our life expectancy, we would save over half of what we currently spend (see Figure 8). Furthermore, our performance is getting worse; compared with other affluent countries we are spending more to get less (see Figure 9). In a comprehensive comparison of health care systems in eleven affluent countries, the Commonwealth Fund ranked the United State/s last, with an overall score of -0.75, compared with +0.08 for the other ten. In the comparison, the US received a score of -0.76 for health outcomes, compared with 0.09 for the other countries, and -1.21 for administrative efficiency, compared with +0.11.¹⁴

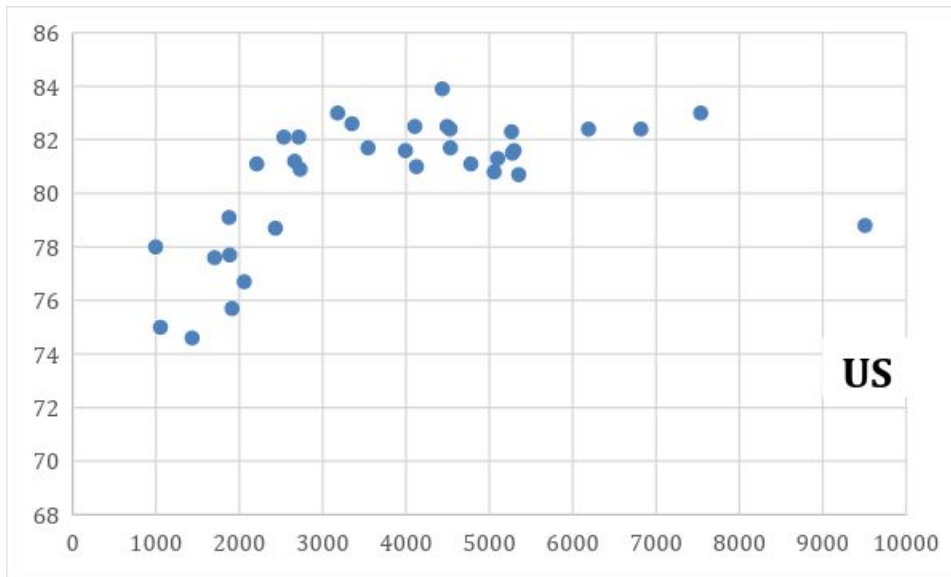


Figure 8. Life expectancy and health spending OECD member nations, around 2011

The poor performance of our health care system is largely a post-1971 phenomenon, since we began to rely on for-profit medicine and market-incentives. Compared with other affluent countries with public programs providing universal health insurance coverage, our great national

¹⁴ Eric C. Schneider et al., “Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care” (Commonwealth Fund, 2017), <http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/?omnicid=EALERT1243408&mid=gfriedma@econs.umass.edu>.

experiment in the use of markets to provide health care has failed to provide quality health care to Americans. Since 1971, the shortfall in US life expectancy compared with affluent members of the OECD has grown from 5 months less to over 31 months less. Over the past 40 years, other countries with national health systems have increased female life expectancy by over 7 years with an increase in real, that is after-inflation, annual per-capita health expenditures of \$446; we have increased female life expectancy by less, only 5 years, while our real spending has increased much more, by \$748 (see Figure 9). We continue to do worse even while we are spending more.

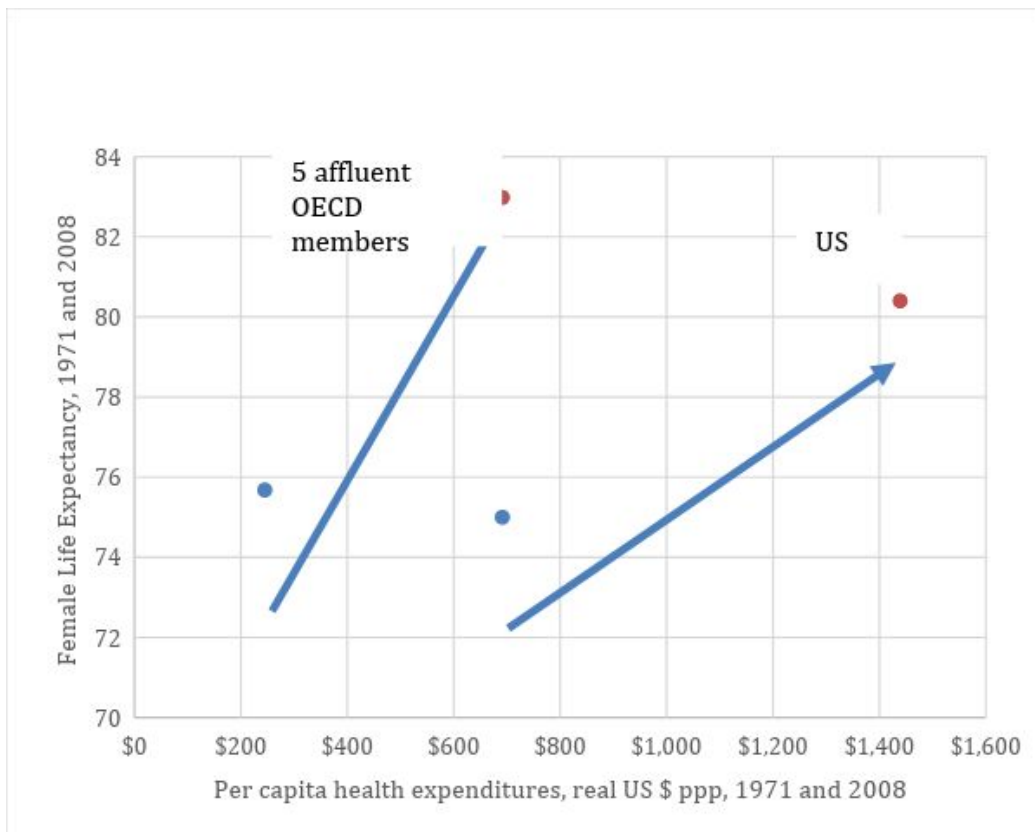


Figure 9. Increasing life expectancy and health care spending, US and other countries, 1971 and 2008

The burden of our failed health-care experiment falls on the poor and the sick. Relying on for-profit insurance, the United States distributes much of the burden of health care costs as fixed charges on individuals through premiums, deductible charges, and copays rather than as taxes related to income or wealth. The result is to widen the disparity between access to health care between the rich and others, and, as a result, to widen the gap between the health of rich and poor

Americans. For the United States as a whole, life expectancy has increased for men and women but far larger increases have gone to the affluent.¹⁵ For men, life expectancy has increased at all income levels, with the poorest gaining a few months while the richest Americans have had increases of over 5 years. For women, however, increases in life expectancy have been exclusively for the affluent; life expectancy has been falling for the poorest 40% of American women.

Low-income and working people have the greatest difficulty accessing our health care system, and their short life expectancy accounts for much of the shortfall in our relative life expectancy. The life-expectancy correlation with income has been increasing in the United States, and the access problem has become greater, because a growing share of the cost of health care has been pushed onto the sick through direct cost-sharing and by experience-rating (linking insurance premiums to health status).¹⁶ In the state of Washington, for example, there is a close link between higher mortality and rising copayments, deductibles, and other charges.¹⁷ In counties where more people report that they cannot afford to see a doctor, the mortality rate is higher; the

¹⁵ Barry P. Bosworth and Kathleen Burke, "Differential Mortality and Retirement Benefits in The Health And Retirement Study," The Brookings Institution, accessed April 21, 2014, <http://www.brookings.edu/research/papers/2014/04/differential-mortality-retirement-benefits-bosworth>; Anne Case and Angus Deaton, "Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the 21st Century," *Proceedings of the National Academy of Sciences* 112, no. 49 (December 8, 2015): 15078–83, <https://doi.org/10.1073/pnas.1518393112>.

¹⁶ Across over 3000 US counties, there is a strong positive relationship between age-adjusted mortality and the proportion unable to see a doctor because of cost. A regression of mortality on access difficulty has an R2 of .35. Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings," County Health Rankings & Roadmaps, accessed April 28, 2014, <http://www.countyhealthrankings.org/rankings/data>.

¹⁷ There is abundant evidence that increased cost sharing hurts people's health because most people are unable to distinguish between high-value and low-value care and reduce both to save on copayments and deductibles; see Jonathan Gruber, "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond" (Kaiser Family Foundation, October 2006), <http://www.kff.org/insurance/upload/7566.pdf>; Collins et al., "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse, Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014;" Amy Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year" (Cambridge, MA, July 2011); Katherine Baicker and Dana Goldman, "Patient Cost-Sharing and Healthcare Spending Growth," *Journal of Economic Perspectives* 25, no. 2 (Spring 2011): 47–68; there is also evidence that higher cost sharing leads to higher costs over time by moving people into more expensive hospital and other inpatient care, see Amal N. Trivedi, Husein Moloo, and Vincent Mor, "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine* 362, no. 4 (January 28, 2010): 320–28, <https://doi.org/10.1056/NEJMs0904533>; Brian Schilling, "Hitting the Copay Sweet Spot," accessed December 5, 2017, <http://www.commonwealthfund.org/publications/newsletters/purchasing-high-performance/2009/november-3-2009/featured-articles/hitting-the-copay-sweet-spot>.

number of preventable deaths per 100,000 increases by 11 for every percentage point increase in the proportion of residents who report they could not see a doctor because of cost. Going from the county with the lowest share reporting they could not see a doctor (Whitman County at 10%) to the county with the highest share (Adams at 19%) results in 114 fewer deaths per 100,000, or 22 more deaths in Adams and 53 fewer in Whitman.

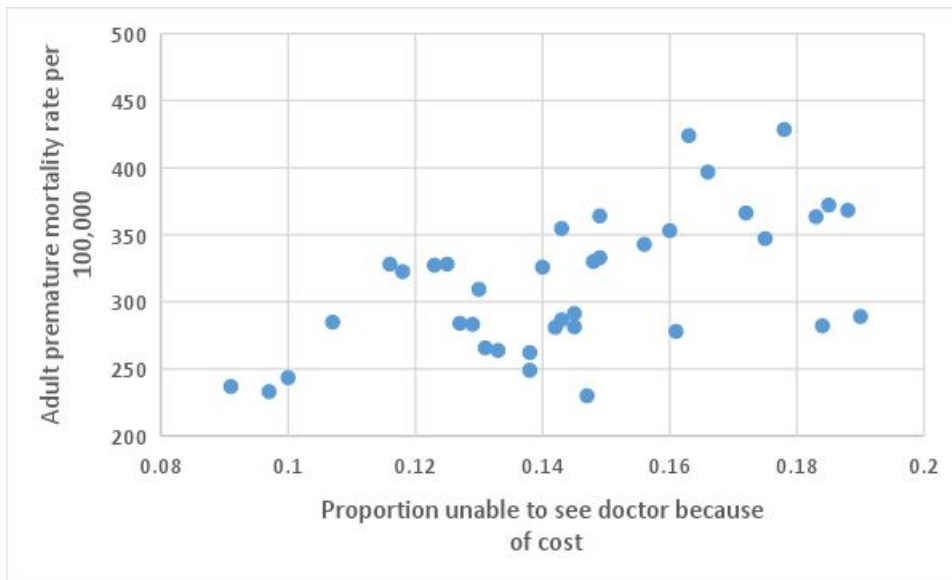


Figure 10. Premature mortality rate and access to care, counties in the state of Washington

Higher mortality is concentrated among the poor. Increases in the poverty rate among children in the county are closely associated with higher mortality. Across counties in Washington, there are over 8 additional deaths per 100,000 for every percentage point rise in the child-poverty rate. Going from one standard deviation below the average county rate, about 18%, to one above, about 28%, the premature, age-adjusted mortality rate rises by over 80 people per 100,000, or by over 25%.¹⁸ The county with the lowest child poverty rate in the state (Snohomish County) has over 1,100 fewer deaths because of its low poverty rate compared with the county with the highest child poverty rate (Ferry County).

¹⁸ The mean value of the premature, age-adjusted mortality rate for 39 Washington counties is 313 per 100,000, with a standard deviation of 51.

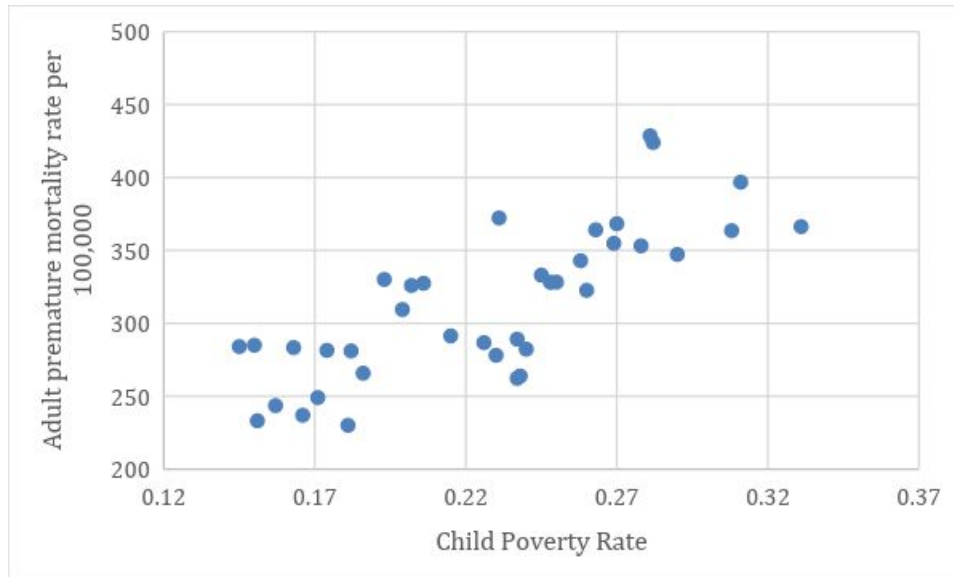


Figure 11. Premature mortality rate and poverty, counties in the state of Washington

The market turn and rising health care costs

Health care is increasingly expensive for Americans, including the population of Washington, because our fragmented private health care finance system is increasingly inefficient and unable to limit charges by monopoly providers. In Washington 13 different private companies now offer health insurance, with a total of 154 separate plans.¹⁹ The proliferation of different plans inflates costs for insurers and providers, even while limiting the ability of any insurance company to limit monopoly pricing. Multiple plans inflate insurer expenses by raising marketing costs, saddling insurers with the administrative costs of managing an average of almost 12 plans per company, and by limiting scale economies in claims processing. The proliferation of plans also raises costs for providers, who are forced to maintain the administrative apparatus to bill all of these different plans.²⁰ The proliferation of different insurance programs also limits the ability of any insurer to limit monopoly pricing by providers, whether it be pharmaceutical companies, medical equipment manufacturers, hospitals, or other providers.

The cost of for-profit health care can be evaluated in Washington under these headings: administrative waste in insurance and in provider offices, and the public cost of monopoly

¹⁹ Mike Kreidler, “13 Health Insurers File 154 Plans for 2017 - 13.5 Average Requested Rate Change | Washington State Office of the Insurance Commissioner,” May 16, 2016, <https://www.insurance.wa.gov/news/13-health-insurers-file-154-plans-2017-135-average-requested-rate-change>.

²⁰ This is, of course, in addition to billing public programs like Medicaid, Medicare, and SCHIP.

pricing. Data on spending by function are available for Washington (and other states) for 2014.²¹ Using projections from the Centers for Medicare and Medicaid Services, health care spending per capita is expected to increase between 2014 and 2019 by about 25%, and total spending is expected to increase by about 33%.²² Including the cost of administering insurance plans, spending in 2019 is expected to be nearly \$80 billion (see Table 1).²³ Nearly a quarter of this spending is waste associated with the for-profit health care system.

Table 1. Health care spending, non-investment, Washington State, 2019, current system, in \$millions

Projected personal health expenditures		
Hospital	\$	28,415
Physician	\$	18,980
Other Professional	\$	2,979
Dental	\$	4,579
Home Health	\$	1,729
Drugs	\$	7,311
Durable Medical	\$	1,343
Nursing Home	\$	4,248
Other	\$	3,182
Projected health insurance administrative expenditures		
Private health insurance	\$	5,475
Public health programs	\$	1,117
Employer expenses	\$	622
Health consumption expenditures		
	\$	79,980

²¹

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>

²²

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

²³ In addition, spending by employers -- on consultants and other administrative costs related to health care benefits -- are expected to come to nearly a billion dollars; see Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, no. 349 (2003): 768–75.

Fixing health care with single-payer finance

Eliminating the waste associated with the administration of private health insurance

In the current system, over 9% of total spending is on the administration of the payment system -- including private insurance and employer-sponsored self-insured plans (which are administered much like insurance) -- as well as on government insurance programs. Private health insurers account for the bulk of this spending; they spend nearly 15% of premiums on administrative activities, including inflated managerial salaries, redundant bill reviews, medical review programs, and other overhead, plus profit.²⁴ The head of the Centers for Medicare and Medicaid Services, who administers health insurance programs covering nearly half the people in the United States, is paid a bit less than \$250,000; by contrast, the CEOs of seven large health insurers average over \$16 million a year in compensation in 2016.²⁵ The average CEO was paid more in a week than the head of CMS was paid in a year.

Private insurers also waste resources in other ways. Competition leads them to spend money on advertising and marketing their competing plans; and many insurers are too small to realize the scale economies possible with a large billing network. Traditional Medicare operates with a medical loss ratio of over 98%, which means that less than 2% of its spending is for administrative activities. Despite this greater efficiency, the private system of administrative waste has spread to Medicare (through the Medicare Advantage plans) and to Medicaid (through managed care programs). Public safety-net programs like Medicaid and CHIP also spend significant funds policing eligibility. The limited range of public insurance has undermined their

²⁴ The Affordable Care Act sets limits on administrative waste with minimum Medical Loss Ratios of 85% for group plans and 80% for individual plans. Nationally, health insurers refunded over \$332 million in excessive administrative charges under the ACA in 2013 to nearly 7 million subscribers; In 2015, insurers in Washington refunded \$464,382 to 3,328 households. See <http://kff.org/health-reform/state-indicator/mlr-rebates-total/>. Even under the ACA, government measures of insurance company medical loss ratios leave extensive scope for insurance companies to pass off administrative costs as medical costs. Allowable expenses include “educational outreach to members, utilization management, case management, disease management, and quality management.” In addition, the time period allowed for medical expenses, net premiums and re-insurance recovery are not consistently defined, leaving room for companies to inflate their Medical Loss Ratio; Families USA, “Medical Loss Ratios: Evidence from the States” (Families USA, June 2008), <http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf>; Eric Naumburg, “Medical Loss Ratios in Maryland,” July 12, 2010; an estimate for California was that the MLR is only 82%, James G. Kahn et al., “The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals,” *Health Affairs* 24, no. 6 (November 1, 2005): 1629–39, <https://doi.org/10.1377/hlthaff.24.6.1629>.

²⁵ Shelby Livingston, “Health Insurer CEOs Score 2016 Pay Raises despite Uncertain Future,” April 27, 2017, <http://www.modernhealthcare.com/article/20170427/NEWS/170429877>; FederalPay.org, “Centers for Medicare & Medicaid Services Salary Statistics,” accessed September 11, 2017, <https://www.federalpay.org/employees/centers-for-medicare-and-medicare-services>.

efficiency by leading individuals to seek private coverage. Overhead costs are even higher in the individual insurance market, including the Medigap policies purchased by many seniors to cover insurance costs not covered by Medicare.

In 2019, administering the third-party payer system will cost governments and businesses in Washington over \$6.5 billion; lowering administrative costs to the level of traditional Medicare (1.8%) would save over \$5 billion in 2019, plus another \$600 million saved by employers who will no longer have to identify and administer health insurance plans.²⁶

Waste in billing and insurance-related expenses in provider offices

American health care providers (hospitals, physicians, etc.) spend significantly more time on administrative tasks than do their counterparts in countries with universal coverage systems. Physicians in the U.S., for example, devote one-sixth of their work hours on administration, including bill processing, and four times the time spent by their Canadian counterparts.²⁷ It costs much more to process bills in our system than in other countries; the Commonwealth Fund reports that doctors report “wasting time on billing and insurance claims.” Even other countries that rely on private health insurers, like the Netherlands, reduce the administrative burden for providers through regulations that standardize benefit packages.²⁸

²⁶ Note that the entire Medicare program has higher administrative costs because of the costs of administering Medicare Advantage plans. Also note that there are additional administrative savings because the entire health care sector will be smaller because of savings in other areas. Archer, “Medicare Is More Efficient Than Private Insurance”; Archer and Marmor, “Medicare And Commercial Health Insurance: The Fundamental Difference – Health Affairs Blog.”

²⁷ David U. Himmelstein et al., “A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far,” *Health Affairs* 33, no. 9 (September 1, 2014): 1586–94, <https://doi.org/10.1377/hlthaff.2013.1327>; Woolhandler, Campbell, and Himmelstein, “Cost of Health Care Administration in the United States and Canada”; Aliya Jiwani et al., “Billing and Insurance-Related Administrative Costs in United States’ Health Care: Synthesis of Micro-Costing Evidence,” *BMC Health Services Research* 14, no. 556 (2014), <http://www.biomedcentral.com/content/pdf/s12913-014-0556-7.pdf>; 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; In addition to hiring billing and insurance workers, American doctors also spend much more time on billing activities than do physicians in Canada, Steffie Woolhandler and David Himmelstein, “Administrative Work Consumes One-Sixth of U.S. Physicians’ Working Hours and Lowers Their Career Satisfaction,” *International Journal of Health Services* 44, no. 4 (January 1, 2014): 635–42, <https://doi.org/10.2190/HS.44.4.a>.

²⁸ Schneider et al., “Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care,” 3.

Simplifying the reimbursement process would save physicians nearly six hours a week, equivalent to more than a 10% increase in the available supply of physicians.²⁹ If Washington health care providers were to spend, proportionally, only as much on administration as do physicians in Canada, or 14% of revenue instead of 24%, they would save over \$5.5 billion in administrative costs.³⁰

Waste associated with monopoly power: drugs, devices, hospitals

Not only is US health care spending inflated by the inefficiency of our administrative system, but also by the higher prices extorted by providers with market power. In his seminal article on health economics, Nobel-prize winning economist Kenneth Arrow warned that health care markets have a tendency toward monopoly because of the combination of asymmetric information -- where the sick lack information about the proper treatment of their illnesses -- and economies of scale in medical facilities, like hospitals.³¹ Until the 1970s, monopoly pricing was restrained by state regulations, by the force of professional mores, and by the culture of not-for-profit communities.³² The demise of rate setting, and the replacement of mores and

²⁹ There may be a substantial increase in the number of physicians because frustrations with the insurance industry drive many physicians from medicine. The lower administrative burden would draw physicians back to medicine and would attract physicians in neighboring states to practice in Washington Woolhandler and Himmelstein, "Administrative Work Consumes One-Sixth of U.S. Physicians' Working Hours and Lowers Their Career Satisfaction"; Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations"; a 2005 study found that California physician practices spent 41% of their revenue on administrative activities, including 14% directly on billing and insurance related expenses Kahn et al., "The Cost Of Health Insurance Administration In California."

³⁰ Woolhandler, et al., found that providers' administrative costs are much lower in Canada with a plan like that envisioned for Washington, and they estimate that a third of costs in provider offices in the United States are administrative, triple the Canadian rate. 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): 1443–50, <https://doi.org/10.1377/hlthaff.2010.0893>; Health care providers spend nearly eight-times as much collecting bills as do other businesses; see Bonnie B. Blanchfield et al., "Saving Billions Of Dollars—And Physicians' Time—By Streamlining Billing Practices," *Health Affairs*, April 29, 2010, 10.1377/hlthaff.2009.0075, <https://doi.org/10.1377/hlthaff.2009.0075>.

³¹ Arrow, "Uncertainty and the Welfare Economics of Medical Care."

³² J E McDonough, "Tracking the Demise of State Hospital Rate Setting," *Health Affairs* 16, no. 1 (January 1, 1997): 142–49, <https://doi.org/10.1377/hlthaff.16.1.142>; David A Moss, *When All Else Fails: Government as the Ultimate Risk Manager* (Cambridge, Mass.: Harvard University Press, 2002); Paul Starr and Council of Learned Societies American, "The Social Transformation of American Medicine," *ACLS Humanities E-Book*, 1982, <http://libproxy.smith.edu:2048/login?url=http://hdl.handle.net/2027/heb.00104>; Steffie Woolhandler and Dan Ariely, "Will Pay For Performance Backfire? Insights From Behavioral Economics," *Health Affairs*, accessed August 1, 2016, <http://healthaffairs.org/blog/2012/10/11/will-pay-for-performance-backfire-insights-from-behavioral-economics/>.

non-profit values with financial incentives, has liberated the managers of hospitals and pharmaceutical and equipment manufacturers to use monopoly power to raise prices and profits, and to expand their power through forming alliances and through collusion.

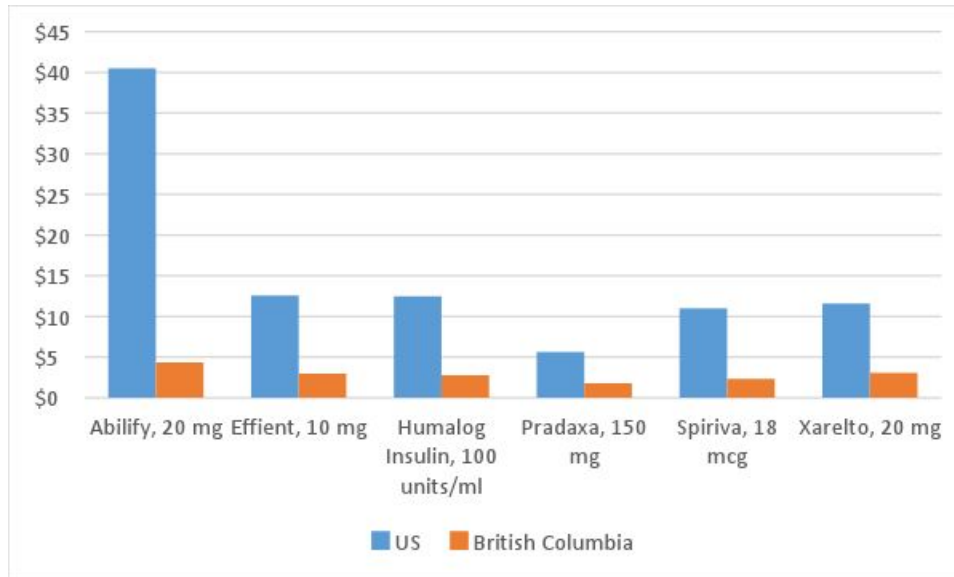


Figure 12. Prices for common prescription drugs, US vs. British Columbia

The unfettered exercise of monopoly power has raised prices for Americans using health care. A comprehensive survey published in 2007 found that drug prices are about 60% higher in the United States than in Europe or Canada.³³ More recent studies suggest that this now understates the penalty Americans pay for excessive drug prices. Over 40% of the revenue for 12 leading multi-national pharmaceutical companies comes from the United States, and direct comparisons

³³ McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States,” January 2007, 56, http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp; International Federation of Health Plans, “2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country” (International Federation of Health Plans, 2014), <http://static.squarespace.com/static/518a3cfee4b0a77d03a62c98/t/534fc9ebe4b05a88e5fbab70/1397737963288/2013%20iFHP%20FINAL%204%2014%2014.pdf>; In a 2016 study, Kesselheim, et al., suggest that US prices are more than double those of other countries; see Aaron S. Kesselheim, Jerry Avorn, and Ameet Sarpatwari, “The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform,” *JAMA* 316, no. 8 (August 23, 2016): 858–71, <https://doi.org/10.1001/jama.2016.11237>.

of particular drugs shows American prices are often dramatically higher.³⁴ Prices in the United States range from 3.2 times the Canadian price to 9.3 times as high (see Figure 12 referencing British Columbia prices). The International Federation of Health Plans found that, for eight common drugs, the price in the United States is on average over three times the average price in Canada, England, or the Netherlands. In no case is the United States' price lower and, in only two drugs (Enbrel and Humira), prices in United States are less than twice the price paid in other countries.³⁵ For example, a treatment of cancer drug Gleevac costs \$6,214 in the United States, but only \$1,141 in Canada; a multiple sclerosis drug Copaxone costs \$3,875 in the United States, but only \$862 in England; and an acid reflux drug Nexium costs \$215 in the United States, but only \$23 in the Netherlands.³⁶

Inflated drug price reflect the market power of companies whose brand reputation is reinforced by patent protection and the lack of an effective check by our fragmented insurance industry. Inflated prices derived from market power are charged by producers who could still profit from providing the same product even at a much lower price.³⁷ When market power is reduced with the removal of patent protection, for example, patients can buy the same drug for much lower prices. When a drug goes "off patent," the entry of two new producers typically lowers prices by 50%, and prices fall by 80% or more when there are eight or more producers.³⁸ The large

³⁴ David Belk, "The Pharmaceutical Industry," True Cost of Healthcare, accessed September 19, 2017, http://truecostofhealthcare.org/the_pharmaceutical_industry/; David Belk, "Brand Name Medication Prices," *True Cost of Health Care* (blog), accessed February 6, 2016, <http://truecostofhealthcare.net/brand-name-medication-prices/>.

³⁵ International Federation of Health Plans, "2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country."

³⁶ International Federation of Health Plans.

³⁷ At \$1000 per pill in the United States, \$84,000 for a full course of treatment, Gilead Science's new Hepatitis C drug Sovaldi has produced more profit in one year than Gilead spent on R and D for over a decade. Almost half of all revenue to Gilead in 2014 was profit. Despite large sales elsewhere, 84% of Sovaldi revenues were in the United States because of hard bargaining by foreign governments and insurers to secure lower prices than are paid by Americans; see David Belk, "Gilead Sciences: A Profile in Congressionally Guaranteed Profiteering," *The Huffington Post*, accessed February 9, 2015, http://www.huffingtonpost.com/david-belk/gilead-sciences-a-profile_b_6641194.html; Jaimy Lee, "Gilead's 2014 Profit Margin Nears 50%, Fueled by Hep C Drugs," *Modern Healthcare*, accessed February 15, 2015, <http://www.modernhealthcare.com/article/20150203/NEWS/302039949&cachebust=JHMQ>; Andrew Pollack, "Gilead Revenue Soars on Hepatitis C Drug," *The New York Times*, April 22, 2014, <http://www.nytimes.com/2014/04/23/your-money/gilead-revenue-soars-on-hepatitis-c-drug.html>.

³⁸ Center for Devices and Radiological Health, "About the Center for Drug Evaluation and Research - Generic Competition and Drug Prices," WebContent, accessed August 1, 2014, <http://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm129385.htm>.

penalty paid in the United States for drugs still under patent protection suggests that even the 60% figure understates the role of market power in inflating drug prices.

Some Americans pay less for drugs. Negotiating directly to buy drugs in bulk, the Veteran's Administration is able to provide drugs at half the price paid by other Americans.³⁹ With a population of 7 million, the state of Washington is comparable in size to the number of veterans receiving health care from the VA (about 9 million).⁴⁰ A single agency negotiating prices for 7 million residents of Washington should negotiate dramatically lower prices. If the state negotiates prices that are 37% lower, less than the savings achieved by the Veterans Administration, it would save over \$7 billion; similar bargaining over the price of medical equipment would save a further billion.⁴¹

The growth of for-profit hospital chains, and of not-for-profit chains focused on building "reserves," has also led to the increasing exercise of monopoly power by elite hospitals.⁴² In

³⁹ Austin Frakt, Steven D. Pizer, and Roger Feldman, "Should Medicare Adopt the Veterans Health Administration Formulary?," SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, April 14, 2011), <http://papers.ssrn.com/abstract=1809665>; David Blumenthal and David Squires, "Drug Price Control: How Some Government Programs Do It," accessed May 15, 2016, <http://www.commonwealthfund.org/publications/blog/2016/may/drug-price-control-how-some-government-programs-do-it?omnicid=EALERT1034812&mid=gfriedma@econs.umass.edu>; Congressional Budget Office, "Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs," December 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf.

⁴⁰ Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet" (Congressional Research Service, June 3, 2014), <https://fas.org/sgp/crs/misc/R43579.pdf>; a study of 11 countries found those with single-payer insurance system had lower drug prices and bargaining power largely explains higher drug spending in the United States Steven G. Morgan, Christine Leopold, and Anita K. Wagner, "Drivers of Expenditure on Primary Care Prescription Drugs in 10 High-Income Countries with Universal Health Coverage," *Canadian Medical Association Journal* 189, no. 23 (June 12, 2017): E794–99, <https://doi.org/10.1503/cmaj.161481>.

⁴¹ McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," 56. As is done with the VA, the state would establish a formulary list of covered drugs and negotiate prices with producers. It would then make these drugs available at the reduced prices to pharmacies and other private vendors. National Committee to Preserve Social Security and Medicare, "Price Negotiation for the Medicare Drug Program: It Is Time to Lower Costs for Seniors," (National Committee to Preserve Social Security and Medicare, October 2009), http://www.ncpssm.org/pdf/price_negotiation_part_d.pdf.

⁴² 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; Reed Abelson, "Merged Hospitals Gain Both Power and Critics," *The New York Times*, September 26, 2002, sec. Business, <http://www.nytimes.com/2002/09/26/business/merged-hospitals-gain-both-power-and-critics.html>; Ge Bai and Gerard F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios," *Health Affairs* 34, no. 6 (June 1, 2015): 922–28, <https://doi.org/10.1377/hlthaff.2014.1414>; Erica Coe et al., "Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums," McKinsey Center for U.S. Health System Reform (McKinsey Corporation, December 14, 2013); Brill, *America's Bitter Pill*; hospital rate setting is having effects on aggregate US economic performance by driving up prices; Jonathan Rothwell, "No Recovery: An

most places competitive health insurers lack the market clout to resist the demands of networks and elite hospitals. This was apparent during the debate over the Affordable Care Act when insurance industry lobbyists -- notably Karen Ignagni of America's Health Insurance Plans (AHIP) -- supported many of the Obama Administration initiatives in alliance with Administration economists who sought to strengthen insurance companies against hospitals and drug companies.⁴³ These efforts largely failed, and most insurers do little to resist the demands of monopoly providers who will, in some cases, charge four or more times the charge in other hospitals for the same services.⁴⁴

Washington could lower health care costs significantly by reducing inflated prices at those relatively few hospitals with monopoly power. While we do not have data for individual hospitals in Washington, we do have data for charges in other states, notably Massachusetts and Ohio, where there is a wide range in the prices charged for the same services in different hospitals.⁴⁵ It is also possible to compare charges at hospitals for Medicare and other billings; Medicare pays significantly less than does private insurance, although more than the variable cost associated with providing care to Medicare recipients, or, presumably, patients with private insurance.⁴⁶ Washington hospitals collect 85% as much from Medicare as from all payers.⁴⁷ After deducting 12% for the administrative cost of processing bills for the private insurance

Analysis of Long-Term U.S. Productivity Decline," (Gallup, 2016), 87,

<http://www.gallup.com/reports/198776/no-recovery-analysis-long-term-productivity-decline.aspx>.

⁴³ Bob Herman, "Seismic Changes in the Health Insurance Industry Bring Opportunities and Friction," accessed September 10, 2017, <http://www.modernhealthcare.com/article/20160130/MAGAZINE/301309964>; Paul Starr, *Remedy and Reaction, the Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), <http://site.ebrary.com/lib/amherst/Doc?id=10506565>; Brill, *America's Bitter Pill*.

⁴⁴ Barry Meier, Julie Creswell, and Jo Craven McGinty, "Hospital Billing Varies Wildly, U.S. Data Shows," *The New York Times*, May 8, 2013,

<http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html>; Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers."

⁴⁵ Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers;" the Ohio Department of Health provides billing data for 2010 by diagnostic group for every hospital in the state.

⁴⁶ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," (Washington, D. C.: Medicare Payment Advisory Commission, March 2017),

http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf; "Do Medicare And Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?," Health Affairs Blog, accessed March 2, 2015, <http://healthaffairs.org/blog/2012/10/02/do-medicare-and-medicaid-payment-rates-really-threaten-physicians-with-bankruptcy/>.

⁴⁷ Center for Medicare and Medicaid Services, "Inpatient Charge Data FY 2015," (Washington, D. C.: Center for Medicare and Medicaid Services, n.d.),

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2015.html>.

system, savings we have already counted, this leaves 3% for overcharging. Using this formula suggests that Washington could save \$795 million by restraining monopoly pricing by hospitals.

Waste from fraud

Fraudulent billing -- including duplicate billing and billing for services not rendered -- accounts for between 3 percent and 10 percent of health care spending in the United States, including an error rate in Federal programs of over 9 percent.⁴⁸ This includes the “accidental fraud” caused by duplicate billing due to the confusing nature of the insurance process.⁴⁹ A single payer authority would reduce fraud in three ways. Eliminating multiple payers would immediately eliminate the possibility of duplicate billing. It would also simplify the process of tracking bills. In addition, public authorities have greater subpoena and prosecutorial powers, giving them more power to stop fraud. By reducing fraud and “accidental” overcharging, Washington could, conservatively, save 2% of total costs, adding to over \$1.4 billion.⁵⁰

⁴⁸ Kathleen King and General Accounting Office, “Medicare and Medicaid Fraud, Waste, and Abuse,” (United States Senate, Subcommittee on Federal Financial Management, March 9, 2011), <http://www.gao.gov/new.items/d11409t.pdf>; National Health Care Anti-Fraud Association, “Testimony of the National Health Care Anti-Fraud Association to the House Insurance Committee,” (Harrisburg, PA: House of Representatives, Commonwealth of Pennsylvania, January 28, 2010), <http://www.docucu.com/view/7d4b3344492e717c21f4767dcad3ae16/National-Health-Care-Anti-Fraud-Association.pdf>.

⁴⁹ Anyone who has tried to interpret a hospital bill can appreciate how easy it would be to make mistakes.

⁵⁰ This savings estimate is made after taking account of increases in utilization due to the universal coverage plans, extension of coverage, and removal of copayments and deductibles. The estimate of savings from fraud reduction is conservative compared with, for example, the Lewin Group, which regularly assumes that 5% of claims are fraudulent. 20% of these errors would be detected with enhanced subpoena powers without taking account of the reduction in duplicate claims under a system like that proposed here for Washington.

All single payer savings:

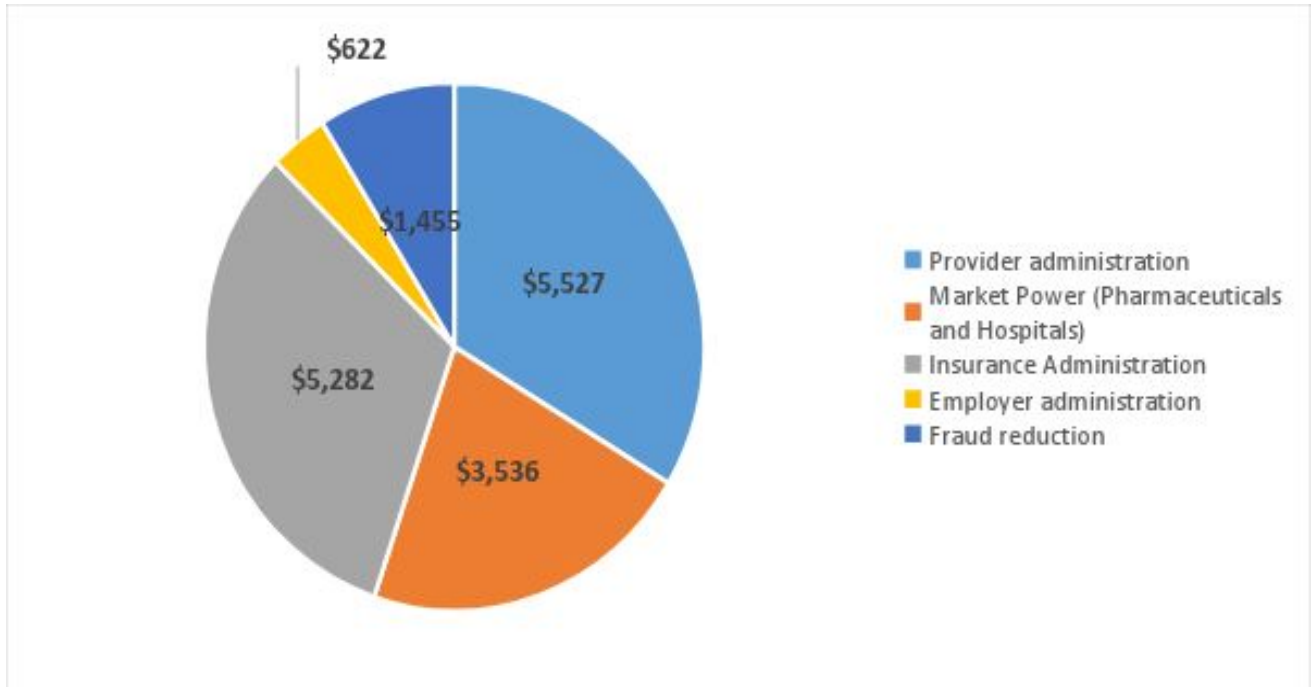


Figure 13. Projected single payer savings, Washington, 2019 \$millions.

Altogether, projected gross savings on current health care activities come to almost \$16 billion for 2019, which is 20% of projected health care spending in that year. These are gross savings, calculated before any expansions or improvements in the provision of medical services. They are itemized in Table 1 and Figure 13:

Table 2. Projected savings (in \$millions) from single payer in Washington

Provider administration	\$	5,527
Market Power (Pharmaceuticals and Hospitals)	\$	3,536
Insurance Administration	\$	5,282
Employer administration	\$	622
Fraud reduction	\$	1,455
Total savings	\$	16,423

Expanded and improved coverage under Washington single payer

Gross savings would come to nearly \$2,234 per resident, achieved largely by reducing excessive prices and unpleasant/wasteful administrative forms and bureaucratic barriers to care.⁵¹ Savings accrued would allow Washington to expand access to care for those still without insurance, to pay all providers fairly, to reduce out-of-pocket costs and barriers to access for those with insurance, and to finance an extensive program to help workers displaced by the transition.

The Affordable Care Act makes it easier to establish a single-payer system in Washington because it has already significantly expanded health insurance coverage. Between 2013 and 2015 Medicaid expansion and new enrollments through the state exchange nearly halved the number of people without insurance, from 879,000 to 493,200.⁵² (The full effect of the ACA may be greater than this, and the uninsurance rate might have increased without the ACA; Charles Gaba estimates that repeal would increase the number without health insurance in Washington by between 734,000 and 775,000.⁵³) This still leaves nearly 500,000 people without health insurance in Washington, leading to 500 extra deaths each year due to the lack of health insurance.⁵⁴ Nor does the ACA expansion significantly address the problem of *underinsurance*, where thousands die because high deductibles and copays leave the insured unable to afford needed care (see Figure 10).⁵⁵

Universal coverage

While the uninsured do use doctors and hospitals, their per-capita health care spending is only 55% of the average for the population as a whole. Because of the average age of the uninsured (much younger than those with health coverage), we calculate that, when insured, their care would cost 85% as much as for a currently insured person.⁵⁶ The difference, 30% of per-capita

⁵¹ The following discussion shows how much spending will increase because of health care improvements. After deducting these increases, net spending would fall by about \$1,560 per resident.

⁵² Kaiser Family Foundation, "State Health Facts.org," n.d.

⁵³ "ACASignups.net," Text, ACASignups.net, accessed April 1, 2014, <http://acasignups.net/>.

⁵⁴ This includes undocumented immigrants without insurance in addition to uninsured citizens. Mortality is estimated by applying a 40% higher mortality rate to the estimated mortality rate for the insured population; see Andrew Wilper et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (n.d.): 1–8; Note that this 40% figure is higher than the 25% estimated by an earlier study, Institute of Medicine (US) Committee on the Consequences of Uninsurance, "Estimates of Excess Mortality Among Uninsured Adults," 2002, <http://www.ncbi.nlm.nih.gov/books/NBK220638/>.

⁵⁵ The county mortality rate would be almost 40% lower if the proportion reporting could not see a doctor because of cost was the UK average (4%) instead of the county average of 15%; a difference that would account for 24,000 extra deaths. See Figure 10 and Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings."

⁵⁶ Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending," (Kaiser Commission on Medicaid and the Uninsured, May 10,

spending (85%-35%) times the number of uninsured, is the cost of covering the uninsured with universal coverage. Thus, expanding coverage to the over 493,200 uninsured in Washington under the ACA will cost over \$1.3 billion.⁵⁷

Increased utilization

Expenditures may increase if eliminating deductibles, copayments, limited provider networks and other restrictive insurance policies leads to more utilization among those already insured.⁵⁸ Utilization may increase more in Washington in 2019 than might have happened to the extent that increased “cost-sharing” by insurance companies – imposing financial barriers to care – has contributed to the slowdown in health care spending since 2008.⁵⁹ Removing these higher barriers to access -- deductibles and copays -- likely will, lead to more utilization.⁶⁰ There is also

2004), <http://www.thesoutherninstitute.org/docs/publications/Policy%20Resources/KaiserReport.pdf>. Coverage expansion is relatively inexpensive because the population without insurance is relatively young, and would spend only about 85% as much on health care as the general population, and they currently spend 55% as much as the average.

⁵⁷ It is also possible that expanded access will eventually lower health care costs. There is a jump in health care activity when people reach Medicare age, followed by a drop after new Medicare recipients address pent-up health care needs. There is also evidence that continued access to primary care reduces long-term health care spending; see Donald Fruge, “Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review,” (Rhode Island Department of Health, February 23, 2012), <http://www.health.ri.gov/publications/literaturereviews/ImpactOfPrimaryCareOnHealthcareCostAndPopulationHealth.pdf>; James Reschovsky et al., “Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve?,” Issue Brief (Commonwealth Fund, March 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1585_Reschovsky_paying_more_for_primary_care_FINALv2.pdf.

⁵⁸ There would be no increase in utilization if usage is supply driven, or depends on the supply of medical services, as is sometimes argued by the Dartmouth group (see <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2937>). A correction to this approach is David Squires, “Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality,” (Commonwealth Fund, May 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf.

⁵⁹ The proportion of those with insurance reporting that they have put off medical treatment because of cost has risen sharply in the Gallup survey; Rebecca Riffkin, “Cost Still a Barrier Between Americans and Medical Care,” *Gallup* (blog), November 28, 2014, <http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx>; in Taiwan and Quebec there was little change in utilization after the enactment of a single-payer health insurance program with minimal copayments: S. H. Cheng and T. L. Chiang, “The Effect of Universal Health Insurance on Health Care Utilization in Taiwan. Results from a Natural Experiment,” *JAMA* 278, no. 2 (July 9, 1997): 89–93; Philip E. Enterline et al., “The Distribution of Medical Services before and after Free Medical Care — The Quebec Experience,” *New England Journal of Medicine* 289, no. 22 (November 29, 1973): 1174–78, <https://doi.org/10.1056/NEJM197311292892206>.

⁶⁰ And removing these restrictions may also save lives, as in the discussion of the county mortality data above.

an extensive literature in health economics relating utilization to the level of cost sharing.⁶¹ To be sure, much of this literature is myopic and short-sighted to the degree that some of this increased utilization --especially of primary care -- will lead to savings in other areas of health care, and some will lead to savings in the future.⁶²

Utilization will increase for the population that was constrained in their use of health care because of cost, including copayments and deductibles. In the county data, this is about 14.5% of the population of Washington; in national data, the share who are cost-constrained may be over twice as high, or as much as 33%.⁶³ A study by Brot et al. found that moving people to a high-deductible plan with significant cost sharing was associated with a reduction in spending of between 11 and 15%.⁶⁴ Applying this to Washington, and moving in the opposite direction, removing cost constraints are assumed to raise spending for people currently constrained by

⁶¹ The slowdown in spending growth sometimes attributed to rising cost sharing may overstate the effect on utilization because there would not be the same change for the 24% of health care that is already funded through Medicare and the Veteran's Administration. This may also overestimate the long-term impact, because greater utilization may, over time, lead to some savings from better health. There is a substantial literature on the effects of copayments on utilization. See William Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77, no. 3 (June 1987): 265; Robert Brook et al., "The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment," (Rand, 1984), <http://www.rand.org/pubs/reports/R3055/>; B. Harris, A. Stergachis, and L. Ried, "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care* 28, no. 10 (1990): 907-17; D. Cherkin, L. Grothaus, and E. Wagner, "The Effect of Office Visit Copayments on Utilization in a Health Maintenance Organization," *Medical Care* 27, no. 7 (1989): 669-79; Leighton Ku, Elaine Deschamps, and Judi Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," (Center on Budget and Policy Priorities, November 2, 2004), <http://www.cbpp.org/cms/index.cfm?fa=view&id=1398>; Gruber, "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond," 6; William Hsiao, Steven Kappel, and Jonathan Gruber, "Act 128: Health System Reform Design. Achieving Affordable Universal Health Care in Vermont," January 21, 2011, <http://www.leg.state.vt.us/jfo/healthcare/FINAL%20VT%20Draft%20Hsiao%20Report.pdf>; Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," Working Paper (National Bureau of Economic Research, October 2015), <http://www.nber.org/papers/w21632>.

⁶² Studies of the Medicare and the Medicaid populations have found that increased access to primary care can lead to very large reductions in health care spending; see Fruge, "Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review;" Reschovsky et al., "Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve?"

⁶³ Gallup reports that 33% of Americans put off medical treatment because of cost in 2014, Riffkin, "Cost Still a Barrier Between Americans and Medical Care;" the Commonwealth Fund finds that 23% of insured non-elderly adults, or 10% of the entire population, were underinsured in 2014, Collins et al., "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse, Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014."

⁶⁴ Brot-Goldberg et al., "What Does a Deductible Do?"

between 11% and 15%, or an increase in total spending of between 1.59% (.11*.145) and 5.00% (.33*.15). Choosing a conservative approach, I assume an increase in utilization of 5%, or \$3.2 billion.

Medicaid and Medicare rate equity

For some time Medicaid and Medicare have paid physicians, hospitals, and other providers significantly less than commercial insurers do. In 2016, for example, Medicaid paid Washington physicians only 71 percent as much for the same services as Medicare paid; and Medicare pays physicians only 80 percent as much as private insurers.⁶⁵ By folding Medicaid into a single state program, the legislation would raise overall spending by about 1% or \$680 million.⁶⁶ This will benefit recipients as well as providers, because current low reimbursement rates threaten Medicaid's viability by forcing a growing number of physicians to stop accepting patients with Medicaid insurance.⁶⁷

Unemployment and job training for displaced billing and insurance workers

I estimate that, in 2019, there will be over 249,000 workers employed in health care in Washington, and over 37,000 employees of health insurers.⁶⁸ While many administrative workers will be displaced by the more efficient single-payer plan, employment in health care will change little because of the increase in utilization by newly insured workers and those no longer subject to constraint by copayments and deductibles. The displacement of about 8% of workers due to administrative efficiency will be balanced by the creation of positions equivalent to 7% of

⁶⁵ The Medicaid rate index is from <http://kff.org/medicaid/state-indicator/medicaid-fee-index/?state=WA>; Medicare rates relative to private insurers are from Will Fox and John Pickering, "Hospital & Physician Cost Shift Payment Level Comparison Of Medicare, Medicaid, And Commercial Payers" (Milliman, December 2008).

⁶⁶ The cost of provider reimbursement equity is estimated as the share of percentage adjustment needed to reach equity, multiplied by the share of spending on Medicaid physician services after taking account of savings achieved and anticipated increases utilization from the expansion of coverage and the removal of barriers to access.

⁶⁷ Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," August 2006, <http://www.hschange.com/CONTENT/866/#ib10>; American Academy of Pediatrics, "Medicaid Reimbursement: Medicaid Rates and Provider Participation," July 2009,

<http://www.sdsma.org/documents/MedicaidSummerStudy.final.pdf>; Kaiser Family Foundation, "State Health Facts.org"; Ken Coleman, "Medicaid Acceptance by Healthcare Providers Drops to 1-out-of-3," *InfoStat* (blog), February 26, 2015,

<http://www.healthpocket.com/healthcare-research/infostat/medicaid-acceptance-doctors-health-care-providers-2015>; Fox and Pickering, "Hospital & Physician Cost Shift Payment Level Comparison Of Medicare, Medicaid, And Commercial Payers;" "Do Medicare And Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?"

⁶⁸ Some of these work for out-of-state insurers and will not be displaced; Bureau of Labor, "Occupational Employment Statistics: OES Research Estimates by State and Industry, 2017," n.d., http://www.bls.gov/oes/2012/may/oes_research_estimates_2012.htm.

healthcare employment due to the increased demand for health care workers coming with the expansion in coverage and increased utilization.

Dramatically reducing the cost of health care for Washington will improve the position of employers, especially small businesses. Implementing a single-payer program would improve the overall employment climate in Washington, and lead to the creation of enough new jobs to more than off-set the loss in insurance company and health care administrative positions.⁶⁹ Nonetheless, provision should be made for workers who will be displaced by the change. The current Unemployment Insurance system will provide support for these workers for six months; even in the depths of the Great Recession, this was long enough for 74% of the unemployed to find new jobs and, in periods of lower unemployment, it is long enough, for over 90% to get new work.⁷⁰ By funding an additional 78 weeks of unemployment compensation with job training to the remaining unemployed, then it would cost less than \$92 million in the first year and \$21 million in the second. By the end of the second year, over 99% of the displaced workers will have found new jobs.

Medicare Part B premiums

About a million Washington residents are over age 65, and most are eligible for Medicare, including hospitalization (Part A), doctor visits (Part B), and the Medicare drug benefit (Part D).⁷¹ All have to pay premiums for Part B -- although low-income recipients have their premiums paid by Medicaid -- and some have premiums for Part A (because of lack of sufficient coverage) and Part D (depending on income and the plan chosen).

I am assuming that the Washington single-payer program would receive Federal Medicare funds by establishing itself as a Medicare Advantage plan open to all currently eligible for Medicare. Because this program, and other medical services, would be available for any resident, none would have reason to continue to pay Medicare premiums. But for the single-payer program to continue to receive Medicare payments, the population would have to be enrolled in Medicare, and someone must pay the premiums.

⁶⁹ Over 5% of workers in the financial services sector (including insurance) change jobs every month. The weekly re-employment rate from unemployment in November 2014 was 5.1%. Applying this rate, 26.5% of the unemployed will remain out of work after 26 weeks and 7.1% after 52 weeks. "Occupational Employment Statistics Home Page," accessed November 4, 2014, <http://www.bls.gov/oes/>.

⁷⁰ Randy Ilg, "How Long before the Unemployed Find Jobs or Quit Looking?," Bureau of Labor Statistics, May 2011, https://www.bls.gov/opub/iils/summary_11_01/unemployed_jobs_quit.htm.

⁷¹ U. S. Census Bureau, "American FactFinder - Results," accessed May 23, 2015, <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>.

I assume that the single-payer state program will pay these premiums, at an estimated cost of \$1.9 billion in 2019. This is a transfer rather than a cost because the spending will raise the net income of Medicare recipients. While it raises costs for the Washington state program, it is an equivalent reduction in cost to Medicare recipients without increasing overall health care spending.⁷²

Table 3. Cost of projected program improvements under Washington single payer program (\$millions, 2019).

Universal coverage	\$	1,336
Utilization (removal of copays and deductibles)	\$	3,249
Medicaid rate	\$	680
Assumption of Medicare premiums	\$	1,878
Public administration of program improvements	\$	91.71
Transition costs for UI and retraining (first year)	\$	92
Cost of program improvements	\$	7,327

Single payer and the distribution of health care spending in Washington: more equitable and efficient spending

A single payer program in Washington will shift major categories of spending from their current sources to a more equitable cost-sharing system. Central to the task is to replace insurance premiums -- now paid as fixed amounts per person by private and public employers, employees, and individuals -- or as amounts reflecting age and health status, so as to penalize the elderly and the sick.⁷³ These will be replaced by broad-based funding through assessments on payroll and

⁷² I estimated average premiums for the country as a whole from Boards of Trustees, "2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," (Washington, D. C., June 22, 2016), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>; the cost to the Washington program is estimated assuming that premiums will rise at the rate of per-capita personal health care spending.

⁷³ The concentration of health care spending among a few individuals is discussed in Emily Mitchell and Steven Machlin, "Concentration of Health Expenditures and Selected Characteristics of High Spenders, U.S. Civilian

taxable upper-bracket non-payroll income, based on ability to pay. Other key elements of the program reflect the same principle of equity. The new system will replace out-of-pocket spending on deductibles, copays, out-of-network charges, and spending by uninsured patients; thus the poor, the elderly, the sick, and the disabled will no longer be penalized financially by the health care system. Instead -- recognizing that misfortune may befall any of us, and will eventually come to all of us -- we will all share in the financial cost of poor health and disability according to our ability to bear this cost.⁷⁴

A single payer program would involve a dramatic shift in Washington health expenditures; while *total* expenditures would *fall*, there would be more spending on the actual delivery of health care services. . Instead of paying for corporate executives, advertising, insurance company profits, and other administrative expenses unrelated to health care, payments to providers will increase by over \$5 billion, rising from 66% of spending to 82% percent. Under the current system, administrative costs account for almost 30% of total health care spending, and overcharging for drugs and hospitals comes to another 5 percent. Under a single-payer program, administrative spending would be reduced by over half, down to 15 percent (administrative costs of the plan, plus reduced administrative costs of health care providers), making more money available for the provision of health care (see Figure 14).

Noninstitutionalized Population, 2015," 506, Statistical Brief (Washington, D.C.: Agency for Healthcare Research and Quality, December 2017), https://meps.ahrq.gov/data_files/publications/st506/stat506.pdf.

⁷⁴ Moss, *When All Else Fails*; David A Moss, *Socializing Security: Progressive-Era Economists and the Origins of American Social Policy*. (Cambridge, Mass.: Harvard University Press, 1996); Archer and Marmor, "Medicare And Commercial Health Insurance: The Fundamental Difference – Health Affairs Blog;" Theodore R. Marmor, *Social Insurance: America's Neglected Heritage and Contested Future*, Public Affairs and Policy Administration Series (Thousand Oaks, California: SAGE/CQ Press, 2014); John Rawls, *A Theory of Justice*, (Cambridge, MA: Belknap Press of Harvard University Press, 1971).

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healthcare is a human right

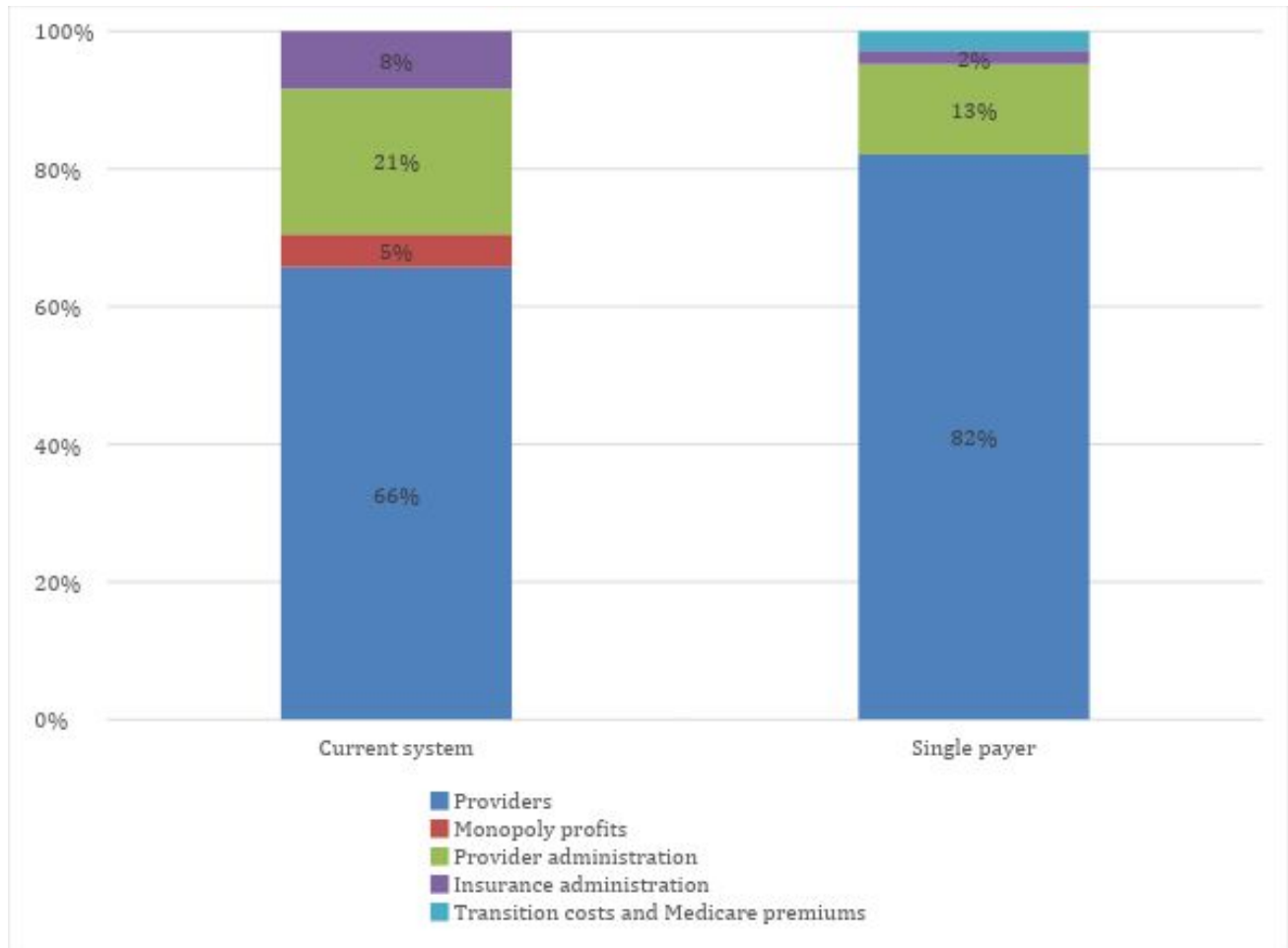


Figure 14. Distribution of Payments under Current System and Single Payer.

Beginning with projected spending under the current system and, adjusting for savings and program improvements, single payer will lower health care spending by 11 percent, saving almost \$9 billion in the first year. This is itemized in Tables 2, 3, and 4.

Table 4. Financing Washington single payer, 2019.

	2019 (\$millions)
Personal health expenditures	\$ 72,766
Insurance and government administration	\$ 6,592
Employer administration	\$ 622
Total spending	\$ 79,980
<i>Minus savings (from Table 1)</i>	\$ 16,423
<i>Plus cost of program improvements (from Table 2)</i>	\$ 7,327
Net spending, single payer	\$ 70,885
Existing revenues	
Medicare	\$ 13,793
Medicaid	\$ 14,205
SCHIP	\$ 140
VA	\$ 1,609
Fed share of Medicaid rate adjustment	\$ 420
New Federal Medicaid for utilization	\$ 219
Other third party (TRICARE, IHS, charity, etc.)	\$ 8,825
Remaining out-of-pocket (actuarial value of 96%)	\$ 2,835
Current state spending (other than public health)	\$ 120
ACA subsidies	\$ 494
Available revenue	\$ 42,660
Needed revenue	\$ 28,225

Paying for better health care

A single-payer program in the state of Washington will require \$71 billion in 2019, including \$43 billion in existing revenue and \$28 billion in new revenue. The \$28 billion in new state revenues will replace nearly \$41 billion in “private taxes” currently paid into the private health insurance system. The new system will provide better health care to more people because single-payer will save billions in administrative waste and monopoly profits built into the current system.

The question, then, is not whether Washington can afford single payer. Rather it is whether the people of Washington can continue to pay for an inefficient and wasteful health care system that

often fails to care for them? Because they can certainly afford one that is more effective and less profligate with their money.

Available resources

A funding program for single payer in Washington begins with considerable funds already committed to paying for health care in the state. These include:

- *Medicare.* The new state agency could operate as a Medicare Advantage (Medicare Part C) plan. With its large scale and economies, it would offer benefits superior to those of any existing plan, so as to attract virtually all Medicare recipients in the state. Because of the formula used to reimburse Medicare Advantage providers, these are reimbursed at a *higher* rate than traditional Medicare; by offering to provide services at the traditional Medicare rate, the new state program would be saving the federal program money.⁷⁵
- *Medicaid.* The new state program will require a waiver to enroll all of the state's Medicaid enrollees. In practice, the federal government has been very accommodating to state initiatives in Medicaid, as shown by the very long list of state waivers already in place.⁷⁶
- *Veteran's Administration, Indian Health Service.* These will continue to operate separately from the state program with their own funding and service providers.
- *Additional Federal spending.* Universal coverage will enroll a number of poor people eligible for Medicaid; and half of the cost of raising reimbursement rates will be reimbursed by the federal government under the Medicaid program. While these programs will increase federal spending in the state, they are accepted practice under the Medicaid law, where states set reimbursement rates and are free to manage enrollment.

⁷⁵ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy;" Kaiser Family Foundation, "Medicare Advantage," *The Henry J. Kaiser Family Foundation* (blog), October 10, 2017, <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>; Fred Schulte, David Donald, and Erin Durkin, "Why Medicare Advantage Costs Taxpayers Billions More than It Should," Center for Public Integrity, June 4, 2014, <https://www.publicintegrity.org/2014/06/04/14840/why-medicare-advantage-costs-taxpayers-billions-more-it-should>.

⁷⁶ Medicaid.gov, "State Waivers List," accessed November 24, 2017, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>. The ACA has provision for state initiatives, see Ron Wyden, "State Waivers: How a State Could Do Health Reform Its Own Way," (Washington, D. C.: Office of Senator Ron Wyden, United States Senate, n.d.), <http://www.wyden.senate.gov/download/?id=6073398f-c82c-42f4-8da5-e004a867e01a&download=1>; John E. McDonough, "Wyden's Waiver: State Innovation on Steroids," *Journal of Health Politics, Policy and Law*, May 19, 2014, 2744824, <https://doi.org/10.1215/03616878-2744824>.

- *Other health care spending.* In addition to the IHS, this catch-all category includes TRICARE/Defense Health Agency, the Federal Employee Health Benefits, local government public health spending, NIH and NSF research, and other. The various public insurance programs could continue to operate on their own or they could offer better benefits and a higher actuarial rate to their enrollees through the state plan. It is assumed that the research and other spending will continue.
- *Remaining out-of-pocket spending.* While the Washington plan would cover most medical services, it would not cover over-the-counter medications, such as aspirin, non-durable medical devices (facial tissues, band aids, etc.), or optional medical devices and services (cosmetic surgery, designer eyewear, etc.). With an estimated actuarial value of 96%, the state plan would provide more coverage than an ACA platinum plan (actuarial value 90%), and much more coverage than the Federal Employee Health Benefits (average about 82%) or traditional Medicare (80%).⁷⁷

Options for additional revenues

After taking account of savings, spending on program improvements, and remaining revenue sources, the Washington single payer program needs nearly \$29 billion in additional funds. There are many ways to raise these funds. One particular program modeled on the funding of Medicare is summarized in Table 5, based on projected income streams for 2019:

Table 5. Funding options, Washington single payer program, 2019, in \$millions

8.5% payroll premium on wages, salaries, and business net income, with \$15,000 exempt on sliding scale and exemptions for small businesses	\$ 18,019
8.5% payroll premium on partnership income, with \$15,000 exempt on sliding scale and exemptions for small businesses⁷⁸	\$ 1,102
8.5% premium on capital income, with \$15,000 exempt on sliding scale	\$ 2,915
1% income tax with \$15,000 exemption	\$ 2,839
Premiums with low income exemption and sliding scale for lower-middle income	\$ 4,375
Total new revenue:	\$ 29,250

⁷⁷ Frank McArdle et al., “How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update,” *Kaiser Family Foundation: Medicare Policy* (blog), April 2012, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7768-02.pdf>.

⁷⁸ This will be an estimated \$100 million less because of the hardship exemptions being provided small businesses.

Surplus	1,025	\$
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The above proposed funding sources described more fully:

- The 8.5% payroll premium is less than employers and their employees *now pay* for health insurance; it is less than half the 18% now paid for covered workers.⁷⁹ The exemption shields low-wage workers from any payment. The exemption phases out at a rate of \$0.25 for every dollar, so that it disappears completely at \$60,000 in wage/salary income.⁸⁰
- The 8.5% premium on capital income (including business net income) balances the assessment of wage/salary income, so that all categories of income are treated equally. The basic exemption of \$15,000 is also the same, assuring that virtually all with family incomes of less than \$100,000 will be exempt from this charge.
- The 1% income tax assures all income sources will contribute and provides the threshold \$15,000 exemption to protect the poorest households.
- Premiums will be paid by all adults in the labor force with an income above twice the poverty level. For those above 300% of the Federal Poverty Line, the premium is set to the rate for basic Medicare Part B (\$134/month). For those between 200% and 233% of the FPL, the premium is 25% of the Medicare Part B level; for those 233-267% of the FPL, the premium is 50%; for those 267-300%, it is 75%.⁸¹

The additional revenues are expected to generate \$29,742 million, or \$1,517 million more than is needed to fund the Washington State universal coverage program.⁸²

Distributional effects of single payer

More than 95% of the population of Washington will save money even while enjoying better access to health care under the single-payer program. Savings come from two sources: the efficiency gains from the single-payer program and from shifting the basis of funding -- from

⁷⁹ This is from the MEPS survey for Washington; Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey," 2017, http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=18&year=-1.

⁸⁰ For the first few years, small employers will be able to apply for hardship exemptions if they have not been providing health insurance to their workers and now face a significant new payroll cost.

⁸¹ Revenue estimates are made assuming that the distribution is flat for those between 200-300% of the FPL so the average premium for those is 50% of the full premium.

⁸² Revenue estimates are made using 2015 IRS data; I adjusted these to 2019 by assuming all income sources would rise at projected GDP growth rates; Internal Revenue Service, "SOI Tax Stats Historic Table 2," accessed November 24, 2017, <https://www.irs.gov/statistics/soi-tax-stats-historic-table-2>.

fixed premiums per covered individual and cost-sharing -- to a system where charges are related to ability to pay (see Figure 16). Most will save thousands of dollars a year, compared to what they and their employer currently spend on health insurance premiums and out-of-pocket costs. The largest savings will go to working families and to middle-income households, especially those with children, because the burden of family health insurance coverage and cost sharing is particularly heavy on them.⁸³ Businesses will also benefit, with the greatest savings going to those that have been paying the highest health insurance premiums. These include small and mid-sized private establishments that offer health insurance at relatively high cost. Taxpayers will also benefit because local governments and the state will save money from reduced health insurance premiums for public employees.⁸⁴ Family members will, of course, receive coverage, like all Washingtonians. However, the cost will be spread across all payroll and non-payroll income, and not concentrated on certain employers.

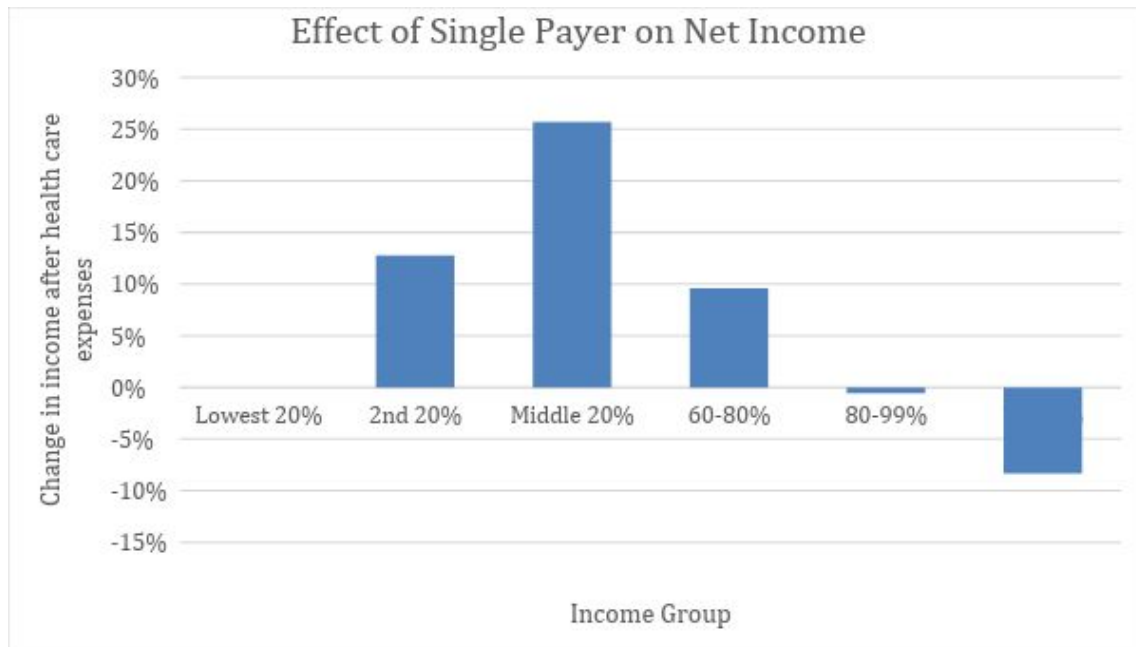


Figure 15. Percentage change in income from single-payer program.

⁸³ The program’s benefits are targeted at the working middle class. Lower income families have received larger public subsidies through Medicaid, SCHIP, and the ACA. Higher income families can support their health expenses more easily.

⁸⁴ Public plans are expensive because there is a high take-up rate and because public employees are more likely to enroll their family members. These plans provide a significant subsidy to private employers because they enroll family members of public employees who then do not take up private employers’ insurance plans.

Lives saved

Greater than the dollars saved by paying less for health care, are the benefits to those who have been denied access to health care because of lack of insurance or inability to pay their cost sharing (deductibles, copayments, and out-of-network charges). This includes the nearly 500,000 still without health insurance under the ACA and the 900,000 unable to see a doctor because of cost.⁸⁵ Based on the analysis reported in Figure 10, by lowering the share unable to see a doctor to 4%, (the rate in the United Kingdom with its universal health insurance system), we would lower the premature mortality rate by as much as 12%, saving as many as 7,500 lives. Poor and rural areas would benefit the most, because these are the locales with the largest number unable to see doctors because of cost (see Figure 11). The United States government assesses a human life as worth about \$10,000,000.⁸⁶ The economic benefit from this reduced mortality can be roughly estimated at \$75 billion, a figure greater than total health care spending in the state.

Single payer and the Washington economy

The analysis thus far understates the economic gains from single payer in Washington, because it uses a static model that neglects likely changes in economic parameters. These parameters might include changes in the locus of investment, employment, and entrepreneurial activity generated by adopting a reform that would dramatically lower the burden of health care costs. In particular, single payer would increase employment and income by reducing inefficient waste, putting money back into the economy, and making businesses more competitive. It will also lower the cost of government, allowing lower taxes and increased investment in infrastructure and education.

Opening the door to entrepreneurship

The current system of employer-provided health insurance was established by employers looking to reduce competition for their workers and to discourage workers from quitting or changing

⁸⁵ There is, of course, overlap between these; about 2/3 of those without health insurance reported that they could not see a doctor because of cost, or about 330,000 people, so that leaves about 570,000 people with health insurance who could not afford to see a doctor because of the cost of copays or deductibles. Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings."

⁸⁶ The EPA recommends a valuation of \$7.4 million in \$2006; updating this brings the estimate to almost \$10 million in 2016, and more than that for 2019. Environmental Protection Agency, "Mortality Risk Valuation," Overviews and Factsheets, accessed April 25, 2017, <https://www.epa.gov/environmental-economics/mortality-risk-valuation>.

jobs.⁸⁷ Many workers in Washington currently suffer from job-lock, and are unable to change jobs or to open new businesses from fear of losing their current health insurance.⁸⁸ Employers too are discouraged from hiring some workers -- older workers or those with families -- from fear that they will add to their health insurance bills. Single payer would make the economy work more efficiently, and liberate entrepreneurial energies. It would free workers to seek more efficient employment or to open new businesses, and it will liberate employers to choose the best worker for the job.⁸⁹

Small businesses especially would benefit, because new and small businesses pay particularly high health insurance rates. Under the current system, a typical Washington start-up that employs a dozen or so workers could pay health insurance premiums of 20% of its payroll.⁹⁰ Washington's single payer plan would lower that burden to less than 7% in payroll assessments.⁹¹

Reducing medical bankruptcies

Washington's single payer plan would also improve the working of the economy for everyone by reducing the risk of medical bankruptcy.

⁸⁷ Richard B Freeman, "The Exit-Voice Tradeoff in the Labor Market: Unionism, Job Tenure, Quits, and Separations," *The Quarterly Journal of Economics* 94, no. 4 (1980): 643–73; Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, N.J.: Princeton University Press, 2003); Jennifer Klein, "The Business of Health Security: Employee Health Benefits, Commercial Insurers, and the Reconstruction of Welfare Capitalism, 1945-1960," *International Labor and Working-Class History*, no. 58 (2000): 293–313; Sanford M. Jacoby, *Modern Manors: Welfare Capitalism since the New Deal* (Princeton, NJ: Princeton University Press, 1997); Nelson Lichtenstein, *State of the Union: A Century of American Labor*, Politics and Society in Twentieth-Century America (Princeton, N.J.: Princeton University Press, 2002). Many businesses no longer value the worker loyalty purchased with health insurance and other benefits; see Rick Wartzman, *The End of Loyalty: The Rise and Fall of Good Jobs in America*, First edition (New York: PublicAffairs, 2017); Gerald F. Davis, *The Vanishing American Corporation: Navigating the Hazards of a New Economy*, First edition (Oakland, California: Berrett-Koehler Publishers, Inc, 2016).

⁸⁸ The Affordable Care Act helps by providing for improved access to individual health insurance through the exchange system.

⁸⁹ David Sterret, Ashley Bender, and David Palmer, "A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All," *Health Law and Policy Brief* 8, no. 2 (Spring 2014): 41–56.

⁹⁰ Estimated from data in Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey."

⁹¹ Note that this is lower than the 8.5% rate because of the exemptions. This is estimated using the average wage data and premium data from the BLS at http://www.bls.gov/oes/current/oes_ny.htm#00-0000 and the Medical Expenditure Survey from the Agency for Healthcare Research and Quality at <http://meps.ahrq.gov/mepsweb/>. Because this estimate uses the average health insurance premiums for this size of establishment, it underestimates the cost facing a new small business, and also underestimates the savings from single payer.

When combined with increased cost-sharing, rising health care prices have been associated with increased medical debt and personal bankruptcy over the last decades.⁹² From 2011 to 2016, an average of over 20,000 personal bankruptcies per year were filed in Washington.⁹³ For the United States as a whole, it is estimated that 29% of bankruptcies are directly due to medical bills, and in 35% of bankruptcies, medical bills come to over \$5000 or over 10% of family income.⁹⁴ Applying these estimates to Washington State, this would suggest that between 6,121 and 7,324 bankruptcies per year are due to medical bills. With 2.7 million households, this means an annual medical bankruptcy rate of between 0.23% and 0.27%. Over a 40 year span, this would mean between 9 and 11% of Washington adult household heads will go bankrupt because of medical bills.

Bankruptcy is a personal tragedy. At a minimum, it is humiliating. It can also reduce the ability to borrow for household investments, such as to buy a car, a house, or to pay tuition. It can make it harder to rent, or even to gain employment. By leaving debts unpaid, personal bankruptcy can also hurt medical providers as well as banks and the broader financial system. The threat of personal bankruptcy hurts everyone when it leads creditors, including medical providers, to raise interest rates and other fees to cover anticipated losses from bankruptcy. To the extent that it thus reduces the availability of credit and liquidity, personal bankruptcy undermines the working of the entire economy, slowing business and lowering income for everyone. By largely eliminating cost sharing, Washington's single payer plan would lift the cloud of bankruptcy off of the Washington economy, freeing liquidity and promoting economic activity.

Declining payroll costs will encourage hiring

Washington employers are burdened by some of the highest health insurance costs in the country, with family plans costing more than in 41 other states.⁹⁵ High health insurance costs have forced employers to reduce the value of coverage offered their workers, to lower wages, to lay off workers, and to reduce hiring. By lowering the overall burden of health care spending, and shifting the burden from premiums unrelated to ability to pay to graduated assessments,

⁹² David U. Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* 122, no. 8 (August 1, 2009): 741–46, <https://doi.org/10.1016/j.amjmed.2009.04.012> note that most of the bankruptcies were for people with health insurance but for whom cost sharing (deductibles and copays) posed too great a burden.

⁹³ American Bankruptcy Institute, "Bankruptcy Statistics | ABI," December 2017, <https://www.abi.org/newsroom/bankruptcy-statistics>.

⁹⁴ Himmelstein et al., "Medical Bankruptcy in the United States, 2007."

⁹⁵ Coverage costs more than in 40 other states; see Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey."

single payer would lower the relative cost of labor to employers, giving employers a competitive advantage against those based in other states.

Replacing current health insurance premiums with the proposed assessments would immediately save businesses over \$500 million currently spent on administering employer-provided health insurance, or nearly 0.3% of payroll costs.⁹⁶ In addition, single payer would be significantly less expensive than existing private insurance; after taking account of the exemption, the payroll assessment would cost businesses 6.4% of payroll, 2 percentage points less than current spending on health insurance premiums for all businesses, and 11.5 percentage points less than is paid for covered workers. Lower benefit costs will allow Washington businesses to lower prices, increase sales, and attract new businesses to the state. Lower benefit costs would also encourage businesses to adopt more labor-intensive technologies, employing more workers rather than machinery.⁹⁷ On balance, lowering health care costs by the single payer program could increase employment in Washington by almost 3% -- adding over 100,000 new jobs -- many more than the number of workers displaced from billing operations and insurance companies.

Lifting the burden of legacy costs

While businesses and governments in Washington have committed to provide health insurance to millions of retired workers, they have put aside relatively little to pay for these obligations. Legacy costs, the unpaid benefits associated with past work, burden current economic activity.⁹⁸ The Pew Charitable Trusts estimates, for example, that the State of Washington has liabilities of nearly \$11 billion in promised retiree health insurance benefits without providing any data on

⁹⁶ In 1999, employer costs of administering health insurance came to 4.2% of private health insurance premiums; I have applied the same ratio here: see Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada." Because employers bear about 75% of the cost of health care premiums, the savings is only 75% of the total.

⁹⁷ It is also likely that the shift from administrative occupations will increase employment in Washington (at the expense of jobs in other states) by bringing spending back to Washington from New Jersey, Connecticut, and other insurance centers. Comparing Bureau of Labor Statistics estimates of insurance employment with the state's population, Connecticut has nearly five-times as high a share of insurance jobs as it does population, while Minnesota, New Jersey, and Ohio have two to three times as many insurance jobs.

⁹⁸ Alicia Munnell, Jean-Pierre Aubry, and Caroline Crawford, "How Big a Burden Are State and Local OPEB Benefits," (Boston College: Center for Retirement Research, March 2017), http://crr.bc.edu/wp-content/uploads/2016/03/slp_48.pdf; Robert C. Pozen, "Unfunded Retiree Healthcare Benefits Are the Elephant In the Room," *Brookings* (blog), August 5, 2014, <https://www.brookings.edu/opinions/unfunded-retiree-healthcare-benefits-are-the-elephant-in-the-room/>.

current funding.⁹⁹ The weight of these unfunded benefits burdens many businesses, and is especially heavy on local governments. For retirees, anxiety about whether their employer will honor past commitments weighs heavily. By providing health care to all, including the elderly, single payer will remove this burden from business and from retirees. This will be an extra boon for businesses competing with rivals elsewhere.

Facilitating collective bargaining

The increasing price of private health insurance has become a particular contentious issue between labor and management, as well as a burden for unionized employers, who are significantly more likely to provide health insurance to their workers.¹⁰⁰ Health insurance also divides workers between older workers and those with families whose members use more health care than younger, healthier, and single workers. By separating access to health care from employment, single payer would ease this tension in the collective bargaining process. Labor unions would be able to shift their efforts from the increasingly difficult effort to protect health benefits, and concentrate on issues such as wages, pensions, and vacations.

The future of health care in Washington

Washington is at a crossroads. On one side is a health-care financing system that, despite improvements made under the Affordable Care Act, still provides care at an ever rising cost for a shrinking part of the population. On the other is a proven system that would provide more care, at a lower cost, to more people.

⁹⁹ Pew Charitable Trust, "State Retiree Health Care Liabilities: An Update," September 2017, http://www.pewtrusts.org/~media/assets/2017/09/oheb-liablity-brief_v3.pdf.

¹⁰⁰ Richard B Freeman, *What Do Unions Do?* (New York: Basic Books, 1984); Richard B Freeman, "The Exit-Voice Tradeoff in the Labor Market: Unionism, Job Tenure, Quits, and Separations," *The Quarterly Journal of Economics* 94, no. 4 (1980): 643–73; Richard B Freeman, *What Workers Want* (Ithaca: ILR Press, 1999); the burden of costs on business is discussed in Rodin and Meyer, *Health Care Costs and Spending in New York State*.

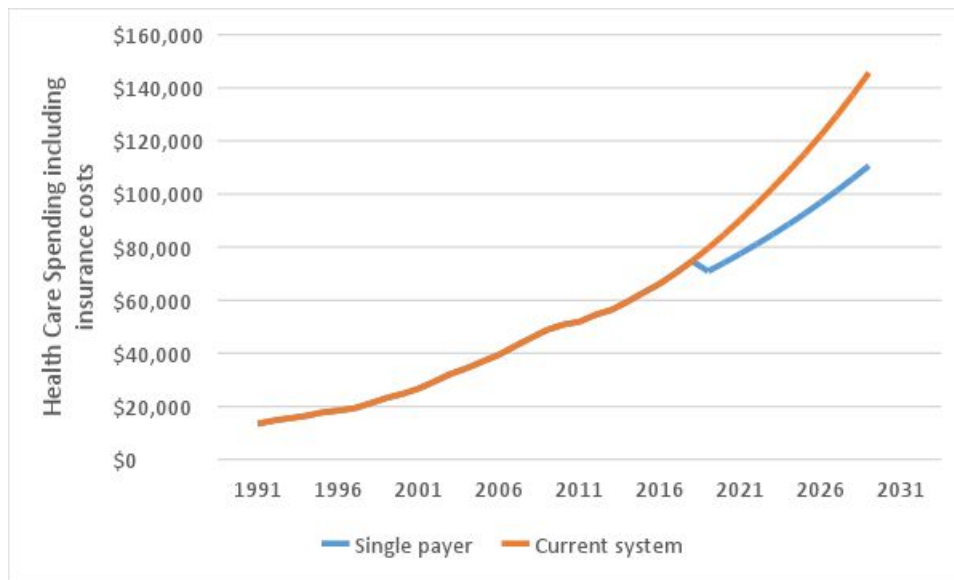


Figure 16. Health care spending under current system and single payer program.

Without reform, the cost of health care under the current system *is expected to double* over the next decade, increasing by over \$70 billion, and rising from 14% of the state output to 17% (see Figures 17 and 18).¹⁰¹ This increase will require that 3% of real state income be transferred from other activities -- schools, infrastructure, or vacation spending -- to pay for a bloated health care administration and to fund monopolistic profits in drugs, hospitals, and other medical activities. A single payer program would change this, because it will give the state the tools to limit bureaucracy and to negotiate reasonable prices for health care services. Even while providing care to everyone -- including those currently uninsured and the many more who are underinsured -- single payer would allow Washington to bring down health care costs and to restrain future health care inflation to about the level of increases in state income, i.e., the state's real ability to pay.¹⁰² In a word: single payer will save money and lives, and it will make health care sustainable.

¹⁰¹ This projection assumes that per-capita health care spending will increase in Washington as projected for the nation by the Centers for Medicare and Medicaid Services, and the population will grow at the rate forecast by the Census Department.

¹⁰² Health care inflation under single payer is estimated assuming that price increases will follow the same pattern as in Canada since 1974, increasing at a rate only 0.2 percentage points faster than the consumer price index as a whole, rather than the 1.7 percentage point differential in the United States.

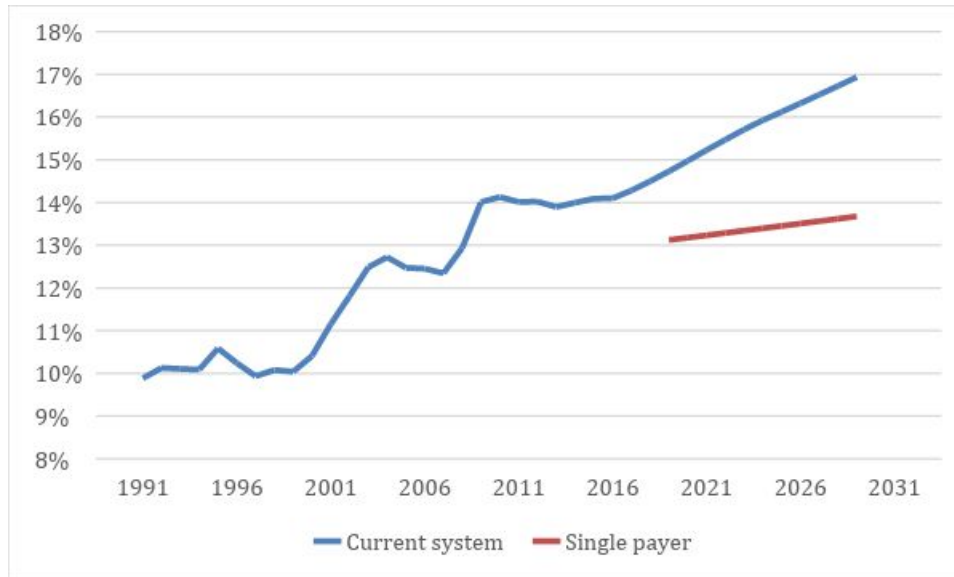


Figure 17. Health care as share of state GDP: Current system and proposed single payer

Note: It is assumed that the single-payer system is adopted for 2019.

Appendix 1: Estimating Washington health care expenditures

Annual personal health care expenditures from 1997-2014 are from the Centers for Medicare & Medicaid Services, Office of the Actuary at

<http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf>

Expenditures beyond 2014 have been projected assuming the same rate of increase in per-capita expenditures as for the nation as a whole from the CMS.¹⁰³ 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://quickfacts.census.gov/qfd/states/36000.html>

Appendix 2: Estimating the sources of Washington health expenditures

Spending for employer-based insurance in 2014 is from Medical Expenditure Panel Survey of the Agency for Healthcare Research and Quality.

Spending for 2014 for public sector programs (Medicare and Medicaid) is from the Center for Medicare and Medicaid Services.

Spending for 2019 is estimated by adjusting current spending for the increase in spending on these services as projected by the Center for Medicare and Medicaid Services.

Spending on individual insurance is estimated as the sum of the number of individual plans plus the number buying through the ACA exchange, and ACA subsidies are from the Kaiser Family Foundation, State Health Facts.

Other and out-of-pocket spending are calculated as a residual: total expenditures minus private health insurance and public spending. The allocation of spending between the two is estimated using national data from the CMS, “National Health Expenditures by Type of Service and Source of Funds.”

Appendix 3: Estimating savings from the Washington health plan

Savings have been calculated for 2019 in three steps.

¹⁰³ 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>.

First, expenditures for nine types of personal health care services have been calculated for 2019 from CMS data through 2014 on the assumption that expenditures for that service will increase from 2014-19 at the same annual rate of increase per capita as the CMS projects for the nation as a whole.

Table 6. Estimated 2019 personal health care expenditures (\$millions)

	Per capita 2001	Per capita 2014	Per capita spending, 2019	Total spending 2019
Personal health expenditures, NHE	4171	7913	9,873	72,766
Hospital	1354	3090	3,856	28,415
Physician	1134	2064	2,575	18,980
Other Professional	179	324	404	2,979
Dental	359	498	621	4,579
Home Health	69	188	235	1,729
Drugs	529	795	992	7,311
Durable Medical	91	146	182	1,343
Nursing Home	262	462	576	4,248
Other	193	346	432	3,182

Second, provider savings for each category have been estimated by applying a savings rate to each activity.

Table 7. Estimates of savings by activity, personal health spending, 2019 (millions)

	Savings rate
Hospital	9.1%
Physician	11.7%
Other Professional	10.6%
Dental	8.3%

Home Health	3.1%
Drugs	37.5%
Durable Medical	10.0%
Nursing Home	1.6%
Other	16.1%

The administrative savings rate is the difference between administrative costs in Canada and the United States. The Canadian rate is estimated by Woolhandler, Campbell, and Himmelstein.¹⁰⁴ For hospitals, I use the updated data from Himmelstein et al.¹⁰⁵ The United States rate is the share of salaries for administrative positions in the 2012 Bureau of Labor Statistics, Occupational Employment Statistics.¹⁰⁶

It is assumed that the Washington Plan board will use its bargaining power to lower prices. A savings of 37.5% is assumed for pharmaceuticals and medical devices.¹⁰⁷

Savings for each activity are calculated as the savings rate times the 2019 expenditures, except for uncovered services.

Administrative spending by insurance companies under the ACA is the difference between the personal health expenditures and the health consumption expenditures in the CMS National Health Expenditures. It is assumed that the sponsor administrative rate will be 1.8% of spending, the current rate under Medicare fee-for-service.

Total savings are the sum of the provider savings and administrative savings.

Appendix 4: Estimating the cost of program improvements

Three program improvements are necessarily associated with universal state coverage. The increase in the Medicaid reimbursement rate is described in the text above.

¹⁰⁴ Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada."

¹⁰⁵ Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations."

¹⁰⁶ *Occupational Employment Statistics: OES Research Estimates by State and Industry, 2013.*

¹⁰⁷ McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

Universal coverage

Currently, the uninsured spend about 55% of the average per-capita health care spending.¹⁰⁸ Because they are younger and healthier than the general population, it is assumed that their spending will rise to 85% when covered.¹⁰⁹ The increase in spending with universal coverage is estimated by multiplying the increase in spending (30%) by the uninsured by their share of the population. This proportion is applied to every category of personal spending *except* uncovered services, such as nursing home and long-term care.¹¹⁰

Change in utilization

Eliminating deductibles and copayments will allow the sick to utilize the health care system more. The increase in utilization is estimated as the share of the population who reports it did not see a physician because of cost, times 15.¹¹¹ This ratio is applied to every category of personal spending.

¹⁰⁸ Hadley and Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending."

¹⁰⁹ Ibid.; Rachel Garfield, Rachel Licata, and Katherine Young, *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low Income Americans and the ACA*, 47 Million (Kaiser Family Foundation, February 2014), ("File not found."); Kaiser Family Foundation, *The Uninsured: A Primer: Supplemental Data Tables*, October 2011, ("File not found.").

¹¹⁰ Note that the same procedure was used to estimate the increase in spending due to the ACA increase in coverage.

¹¹¹ Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," Working Paper, (National Bureau of Economic Research, October 2015), <http://www.nber.org/papers/w21632>; Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings," County Health Rankings & Roadmaps, accessed April 28, 2014, <http://www.countyhealthrankings.org/rankings/data>.

Appendix 5: Revenue sources for Washington Health Care Plan and the net burden of the plan

Adjusted Gross Income by source is from the Internal Revenue Service, Statistics of Income (SOI), 2014. Spending for health insurance is from the Agency for Health Care Research and Quality, Medical Expenditure Survey.

Personal income for 2019 has been estimated as the 2014 rate times the Congressional Budget Office projection of the change in income over that period.¹¹² It is assumed that income increases for all groups at the same rate.¹¹³

Revenues are estimated as the assessment rate for each bracket of income, multiplied by the income for each group.

¹¹² "An Update to the Budget and Economic Outlook: 2014 to 2024," *Congressional Budget Office*, accessed October 27, 2014, <https://www.cbo.gov/publication/45653>.

¹¹³ Because this understates income for higher groups with higher tax rates, this assumption understates revenue from the tax program.

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Funding universal health care in the State of Washington

Replacing an inefficient, inequitable, and destructive health care finance system with a fair system that will promote economic efficiency and better health

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Introduction: paying for health care

This economic analysis explores the implications of a single-payer health plan in the State of Washington that would have entered into effect in 2021. The Act would replace the state's current multi-payer system in which individuals, private businesses, and government entities pay public and private insurers for health care coverage. It would establish a state agency to finance medically necessary care including hospitalization, doctor visits, dental, vision, mental/behavioral health, prescribed occupational and physical therapy, prescription drugs, medical devices, and rehabilitative care. The state would offer this comprehensive coverage to all residents and would pay for it with broad-based levies assessed on payrolls and on nonwage income and with premiums similar to those assessed for Medicare Part B coverage on households able to pay.

This program would finance medical care with substantial savings compared with the existing multi-payer system of public and private insurers. By reducing administrative and other waste, including health insurance company profits and excessive prices for drugs, hospitals, and medical devices, it would save money on health care even while expanding access to all in Washington and eliminating financial barriers to care. Reduced health care spending and the shift from fixed premiums where everyone pays the same amount regardless of income to broad-based levies tied to ability to pay would raise real disposable income for most Washington households.

Some of the savings from lower administrative cost and reduced monopoly pricing and waste would be used to extend coverage to the six percent of residents still without insurance under the Affordable Care Act. Other savings would be reinvested in the health-care system to improve coverage for the growing number with inadequate coverage. By reducing barriers to access to health care, the program would eliminate the financial penalty associated with health problems, improving health and well-being. Improving access to health care, the program would improve the health of Washington residents, promoting higher labor productivity because healthier workers are more productive. The new program would also improve the business environment and promote faster growth in income by reducing the burden of health care costs on business. Higher worker productivity due to improved health and removing the burden of health insurance from business would increase employment, raising income in the state.

It's the prices

We spend more on health care in the United States because the price of care is higher in the United States.¹ For decades, policy has been missed this fundamental point and instead of addressing prices and underlying inefficiencies, have tried to slow rising costs by reducing the

¹ Anderson et al., "It's The Prices, Stupid"; Anderson, Hussey, and Petrosyan, "It's Still The Prices, Stupid"; Reinhardt, "Economists in Health Care"; Reinhardt, *Priced Out*; For a study of US prices in international context, see International Federation of Health Plans, "2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country"; Hargraves and Bloschichak, "International Comparisons of Health Care Prices from the 2017 IFHP Survey"; McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

utilization of health care with rising deductibles and other forms of cost sharing.² While this approach has slowed the growth in health care spending, it has often done so at the expense of reducing access to care (see Figure 1) while allowing prices to continue to rise (see Figure 2). The share of private-sector, employer-provided health insurance plans with a deductible has increased from 59% in 2002 to 89% in 2009 and 91% in 2019, while the size of the deductible has soared (see Figure 3).

Increasing the cost borne by the sick and disabled has slowed the growth in health care spending by reducing utilization by nearly 1% a year (see Figure 2). This has slowed the increase in the share of state income spent on health care, even lowering it from a peak of over 12% in 2012, but it has done so by reducing the ability of many in Washington to receive needed care (see Figures 4 and 6). No other country has performed so badly with sharply rising costs and relatively small increases in life expectancy (see Figure 5) because other countries have controlled health care prices while not reducing utilization of health care services. Within the United States, some states have been providing better health care. States like Washington have done more to expand access to health care for the poor and marginalized groups with policies associated with raising life expectancy by 2.8 years for women and over 2.1 years for men.³ But even within Washington, policies that have reduced access to needed care, rising cost sharing have increased mortality, especially for the poor and needy (see Figure 6).⁴ In Washington counties where 18% of the population reports that they could not afford to see a doctor, the age-adjusted mortality rate is 40% higher than in counties where only 10% could not afford to see a doctor. If we were able to lower the share unable to afford medical care to 5%, the rate in the United Kingdom with the National Health Service, we would lower the mortality rate by a further 20%.

Controlling costs while increasing access

We face two separate problems in health care: the high cost of care and the lack of access. By itself, expanding access without addressing cost runs into limited resources. Controlling cost by restricting access at best addresses one problem at the expense of the other. An effective policy must address cost of care even while expanding access.⁵ There are limits to our ability to transfer resources to health care from other activities, and therefore access to care can be assured residents of the State only if costs can be controlled. These costs can be controlled while access

² Rae, Cox, and Levitt, "Deductible Relief Day"; Kaiser Family Foundation, "Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance"; Abelson, "Workers With Health Insurance Face Rising Out-of-Pocket Costs"; Case and Deaton, "Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the 21st Century"; Case and Deaton, *Deaths of Despair and the Future of Capitalism*; About a third of the US population reports they could not afford to access needed healthcare; Riffkin, "Cost Still a Barrier Between Americans and Medical Care."

³ Montez et al., "US State Policies, Politics, and Life Expectancy."

⁴ Collins et al., "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014"; Collins, Bhupal, and Doty, "Health Insurance Coverage Eight Years after the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, but More Underinsured."

⁵ While he approaches these matters differently than I do, this has been the concern of Ezekiel Emanuel. See his Emanuel, *Which Country Has the World's Best Health Care?*; Emanuel, "What We Give Up for Health Care"; Emanuel, *Healthcare, Guaranteed*.

is increased only if the price of care can be contained, which can only happen if health care can be provided more efficiently and if we can squeeze monopoly rents out of the health care system.

The current system of fragmented private health insurance is the main obstacle to expanding access because it promotes administrative waste, both in the processing of bills by providers and in the administration of the health insurance system, and limits the ability of insurers to restrain noncompetitive pricing by elite providers. In Washington state alone, there are nearly 50 separate health insurance companies, each offering a large variety of separate plans, each plan involving separate pricing schemes.⁶ The large number of independent companies and health plans forces each provider to operate an entire back office with billing clerks and other personnel to deal with billing and negotiating prices for services. This administrative waste, labeled sludge, vastly inflates the cost of providing health care.⁷ But it is only the beginning of the waste associated with the private health insurance system. The private insurance system itself is an enormously expensive to operate, costing over \$200 billion a year in administrative cost, marketing expenses, and insurer profits. Furthermore, for all that expense, the inability of relatively small insurance companies to restrain pricing by giant hospital networks and equipment and pharmaceutical producers contributes to high prices and, increasingly, to rising health care prices. Ironically, by contrast, while health insurers are unable to restrain monopoly pricing by hospitals and other providers, they are able to limit access by the individuals who are sick and needy through “consumer cost-sharing” and utilization review. Thus, private health insurance fails to control pricing but is quite effective at limiting access.

Fortunately, the failures of the current private health insurance system allow many opportunities to do better. Our health care problems are not inevitable, not the result of technology or “consumers’” insatiable greed. They are the result of bad institutions: private health insurance and for-profit medicine. We have made mistakes in designing our health care system and we are paying for those mistakes. But that means that we can design a better system.⁸

The cost of coverage with the existing system of fragmented private health insurance
Estimates of the cost of health care with universal access through a public program begin with estimates of the cost of coverage under the existing system (see Table 1). For each activity, such as hospitals or pharmaceuticals, I use estimates from the Center for Medicare and Medicaid Services (CMS) available on the state level approximately every 10 years.⁹ Because the most recent of these data are available only for 2014, I adjust them to a 2021 basis by raising spending in each category by the rate of inflation in health care spending for Washington.¹⁰

I make two further adjustments to account for universal coverage and universal access:

⁶ McGregor Benefits, “List of Insurance Carriers in WA State.”

⁷ Pfeffer, “Magnitude and Effects of ‘Sludge’ in Benefits Administration”; Johnson, “Healthcare’s Administrative ‘Sludge’ Is Worse than You Think”; Tseng et al., “Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System”; Scheinker et al., “Reducing Administrative Costs in US Health Care”; Schulman and Milstein, “The Implications of ‘Medicare for All’ for US Hospitals.”

⁸ Friedman, *The Case for Medicare for All*.

⁹ US Government, CMS, “US State Estimates by State of Residence -- Health Expenditures.”

¹⁰ Center for Health Information and Analysis, “Health Information and Analysis.”

First, I assume that those who are currently uninsured, will increase their utilization of health care. While this includes six percent of the population who currently lack health insurance, it will increase spending by less than that because the uninsured tend to be relatively young and healthy, and because they are already using health care, either from charitable support or out-of-pocket.¹¹ For this reason, an increase in insurance of six percent would be associated with an increase in spending of less than two percent.

In addition, I assume that removing most cost sharing will increase utilization. While this will have real benefits in health and economic efficiency, and may lead to some reductions in complications and cost in the future, it will involve immediate expenses.¹² There have been many different attempts to project the effect of removing cost sharing on utilization. A study by Brot et al. found that moving to a high-deductible plan with significant cost sharing was associated with a reduction in spending of between eleven percent and fifteen percent. In Washington, nearly 60% of employees with employment-based health insurance now have high-deductible plans, and such plans cover about a third of the population suggesting an increase in utilization of between four and five percent¹³ An alternative approach would rely on estimates of the effect on utilization of changes in the actuarial value (AV) of insurance plans, or the share of course covered by insurance. In Washington, the current AV of plans of private health insurance plans is only eighty percent but including Medicaid and Medicare (including Medicare advantage and Medigap plans) raises the statewide AV to eighty-seven percent. Estimates from CMS are that moving up to ninety-six percent, the level of coverage in the proposed plan, would increase utilization by seven percent.¹⁴ To this we need to add an adjustment for activities outside of the CMS calculation of AV, including dental and home health care. Making a somewhat arbitrary guess, I raise the expected increase in utilization to over eight percent (see Table 1).

Integrating Medicare and Medicaid into a universal program

Medicaid currently reimburses at rates as low as seventy percent those of Medicare. Not only is this inequitable for Medicaid providers, it makes it difficult for Medicaid recipients to access care. This discrimination will no longer be possible when all residents are in the same health plan and the required price increase must be added to the cost of the program.

Currently Medicare recipients who are not dual eligible, that is are not on Medicaid, enroll at their own expense in Medicare Part B at a cost of over \$104 a month. Since Medicare recipients

¹¹ Hadley and Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending."

¹² Experience has been that new systems of universal coverage have had relatively small effects on total utilization. It may be that physicians have reallocated their time to needy patients previously unable to access care by reducing low value care provided relatively affluent patients. Cheng and Chiang, "The Effect of Universal Health Insurance on Health Care Utilization in Taiwan. Results from a Natural Experiment"; Enterline et al., "The Distribution of Medical Services before and after Free Medical Care — The Quebec Experience"; There is also evidence that increased access to primary care may lead to future cost savings. See Fruge, "Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review"; Reschovsky et al., "Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve?"

¹³ Brot-Goldberg et al., "What Does a Deductible Do?" The rest of the population is covered by Medicare or Medicaid or public-employee health insurance which is usually more generous.

¹⁴ Pope et al., "Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act."

would receive care under the same circumstances as other residents, there would be no for them to continue to pay these premiums. However, unless the premiums are paid, the Trust would lose access to Medicare Part B funds. The Trust, therefore, will have to pick up this cost.¹⁵

Savings from moving to the Washington Program: provider administration

American health care providers (hospitals, physicians, etc.) spend significantly more time on administrative tasks than do their counterparts in countries with universal coverage systems. Physicians in the U.S., for example, devote one-sixth of their work hours to administration, including bill processing, four times the time spent by their Canadian counterparts.¹⁶ It costs much more to process bills in our system than in other countries; the Commonwealth Fund reports that doctors report “wasting time on billing and insurance claims.” Even other countries that rely on private health insurers, like Switzerland or the Netherlands, reduce the administrative burden for providers through regulations that standardize benefit packages and payment systems.¹⁷ Furthermore, that this does not include the substantial expense borne by employers and plan enrollees for processing bills to the insurance industry.¹⁸

Simplifying the reimbursement process would save physicians nearly six hours a week, equivalent to more than a ten percent increase in the available supply of physicians.¹⁹ If Washington health care providers were to spend, proportionally, only as much on administration as do physicians in Canada, or fourteen percent of revenue instead of twenty-four percent, they would save nearly nine billion dollars on administrative costs.

I am assuming here that these savings from provider administration will be captured by the Program through lower reimbursement rates.²⁰

¹⁵ An alternative would be to make Part B premium payments a requirement for access to Trust benefits. This would mean that seniors would be the only ones charged a premium or access to the Trust.

¹⁶ Congressional Budget Office, “How CBO Analyzes Proposals for a Single-Payer Health Care System | Congressional Budget Office”; Shrank, Rogstad, and Parekh, “Waste in the US Health Care System”; Himmelstein, “A Comparison of Hospital Administrative Costs in Eight Nations”; Woolhandler, Campbell, and Himmelstein, “Cost of Health Care Administration in the United States and Canada”; Jiwani et al., “Billing and Insurance-Related Administrative Costs in United States’ Health Care: Synthesis of Micro-Costing Evidence”; Himmelstein, Campbell, and Woolhandler, “Health Care Administrative Costs in the United States and Canada, 2017”; Berwick and Hackbarth, “Eliminating Waste in US Health Care”; Woolhandler and Himmelstein, “Administrative Work Consumes One-Sixth of U.S. Physicians’ Working Hours and Lowers Their Career Satisfaction”; Morra et al., “US Physician Practices Versus Canadians”; Tseng et al., “Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System.”

¹⁷ Schneider et al., “Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care”; Shrank, Rogstad, and Parekh, “Waste in the US Health Care System”; Blanchfield et al., “Saving Billions Of Dollars—And Physicians’ Time—By Streamlining Billing Practices”; Emanuel, *Which Country Has the World’s Best Health Care?*

¹⁸ Pfeffer, “Magnitude and Effects of ‘Sludge’ in Benefits Administration.”

¹⁹ A 2005 study found that California physicians spent 41% of their revenue on administrative activities, including 14% directly on billing and insurance related expenses; Kahn et al., “The Cost Of Health Insurance Administration In California.”

²⁰ Note that this will have the perverse effect of locking in higher reimbursements for less efficient providers while penalizing those who are already operating efficiently in that billing activities.

Savings from moving to the Washington Program: insurance administration

In the current system, nearly twelve percent of total spending is on the administration of the insurance system -- including private insurance and employer-sponsored self-insured plans (which are administered much like insurance) -- as well as on government insurance programs. Private health insurers account for the bulk of this spending; they spend nearly fifteen percent of premiums on administrative activities, including redundant bill reviews, medical review programs, and other overhead, plus profit.²¹ Salaries are also much higher for managers in private health insurers. The head of the Centers for Medicare and Medicaid Services, responsible for health insurance programs covering nearly half the population of the United States, is paid a bit less than \$250,000; by contrast, the CEOs of seven large health insurers average over \$16 million a year in compensation in 2016. The average health insurance CEO is paid more in a week than CMS head is paid in a year.²²

Private insurers also waste resources in other ways. Competition leads them to spend money on advertising and marketing their competing plans, spending that cures no illness and provides no health care. Many insurers are too small to realize the scale economies possible with a large billing network. Traditional Medicare operates with a medical loss ratio (MLR) of over ninety-eight percent, meaning that less than two percent of its spending is for administrative activities, saving over ten percent compared to private insurance. Despite the greater efficiency of public programs, the private system of administrative waste has spread to the public sector through the Medicare Advantage plans and to Medicaid (through managed care programs).²³ Maintaining dual public-private systems also inflates the public costs because it requires eligibility checks for access to public programs. For Medicare, this can be done relatively cheaply by checking birth certificates. Public safety-net programs like Medicaid and CHIP, however, spend significant funds policing eligibility. The limited range of public insurance has also undermined efficiency by leading individuals to seek supplemental private coverage. Overhead costs are even higher in the individual insurance market, including the Medigap policies purchased by many seniors to cover insurance costs not covered by Medicare. Indeed, last year's MLR in the individual

²¹ Even under the ACA, government measures of insurance company MLR leave extensive scope for insurance companies to pass off administrative costs as medical costs. Allowable expenses include "educational outreach to members, utilization management, case management, disease management, and quality management." In addition, the time period allowed for medical expenses, net premiums and re-insurance recovery are not consistently defined, leaving room for companies to inflate their MLR; Families USA, "Medical Loss Ratios: Evidence from the States"; Naumburg, "Medical Loss Ratios in Maryland"; The Affordable Care Act sets limits on administrative waste with minimum MLR of 85% for group plans and 80% for individual plans. Nationally, health insurers refunded over \$2.6 billion in excessive administrative charges under the ACA in 2020 to nearly 8 million subscribers; Fehr and 2020, "Data Note"; a California estimate is that the MLR there is only 82%; Kahn et al., "The Cost Of Health Insurance Administration In California."

²² Baker, "Top Health Care CEOs Made \$1.7 Billion Last Year."

²³ Gruber, "Delivering Public Health Insurance through Private Plan Choice in the United States."

market fell to under eighty percent, with a little more one-fifth of all spending going to administration.²⁴

Raising the MLR to the level of traditional Medicare, ninety-eight percent, would save Washington nine billion dollars. In addition, eliminating the need to identify and administer private insurance plans would save Washington employers another billion dollars, and even more for their employees who would save the time and stress involved in dealing with the problems accessing benefits through the insurance industry.²⁵

Savings from moving to the Washington Program: eliminating monopoly rents: hospitals and other providers

In his seminal article on health economics, Nobel-prize winning economist Kenneth Arrow warned that health care markets have a tendency toward monopoly because of the combination of asymmetric information -- where the sick lack information about the proper treatment of their illnesses -- and economies of scale in medical facilities, like hospitals.²⁶ Until the 1970s, monopoly pricing was restrained by state regulations, by the force of professional mores, and by the culture of not-for-profit communities.²⁷ The demise of rate setting, and the replacement of mores and non-profit values with financial incentives, has liberated the managers of hospitals and pharmaceutical and equipment manufacturers to use monopoly power to raise prices and profits, and to expand their power through forming alliances and through collusion.²⁸

The unfettered exercise of monopoly power has raised prices for Americans using health care. Public attention has been focused on pharmaceutical and drug prices where even the Trump Administration charges that drug prices are about twice as high in the United States as elsewhere.²⁹ The attention paid pharmaceutical prices should not distract from other areas of monopoly pricing. A decade ago, the Massachusetts Attorney General warned that elite hospitals were charging prices four to five times as high as other providers for the same service.³⁰ Similar findings where the consolidation of hospital networks and physician practices have pushed up hospital prices and inflated managerial salaries. The median charge for inpatient

²⁴ Fehr and 2020, "Data Note."

²⁵ While they could be captured through employment fees, these savings are not included in our estimate of the funding program. They are left as benefits to employers and their workers; Pfeffer, "Magnitude and Effects of 'Sludge' in Benefits Administration."

²⁶ Arrow, "Uncertainty and the Welfare Economics of Medical Care"; Reinhardt, "Economists in Health Care."

²⁷ McDonough, "Tracking the Demise of State Hospital Rate Setting"; Anderson, "All-Payer Ratesetting"; Anderson and Herring, "The All-Payer Rate Setting Model for Pricing Medical Services and Drugs."

²⁸ There is always a danger that providers will gain control over ratesetting. To some degree this is happened for medical specialists; see Laugesen, *Fixing Medical Prices*.

²⁹ Amazingly, their recommendation is to raise prices elsewhere; Council of Economic Advisers, "Reforming Biopharmaceutical Pricing at Home and Abroad."

³⁰ Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers"; Coakley, "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b) Report, 2011."

procedures in California districts with market consolidation is nearly double that in districts with less market concentration.³¹

Individual health insurers lack the market clout to resist the demands of networks and elite hospitals. They acknowledged this during the debate over the Affordable Care Act when insurance industry lobbyists -- notably Karen Ignagni of America's Health Insurance Plans (AHIP) -- supported Obama Administration initiatives in alliance with Administration economists who sought to strengthen insurance companies against hospitals and drug companies.³² These efforts largely failed, and most insurers do little to resist the demands of monopoly providers who will, in some cases, charge four or more times the charge in other hospitals for the same services.³³

Only one insurer currently has market power to balance that of elite hospitals with control over provider networks: Medicare. Using its market power, Medicare has been able to restrain hospital price increases, and the smaller increases in physician prices, holding down the rate of inflation in health care. This has created a growing gap between the high prices charged private health insurers and the price hospitals charge Medicare although there is some evidence that Medicare rates may be as much as nine percent below the actual cost (including both variable and average fixed costs) of providing hospital services.³⁴

Lowering hospital prices to Medicare rates with an increase in these rates of ten percent would save over ten billion dollars in 2021. We anticipate saving another seven percent (\$1.6 billion) from eliminating monopoly pricing among some elite providers outside of hospitals. Eliminating monopoly profits in this way would reduce hospitals ability to accumulate reserves, to reimburse investors in the case of for-profit hospitals, and would compel them to lower their often-inflated managerial salaries and ambitious investment plans.³⁵ It may be difficult for hospitals to unwind

³¹ Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums"; Also see Bai and Anderson, "Extreme Markup"; Abelson, "Hospital Prices"; Meier, Creswell, and McGinty, "Hospital Billing Varies Wildly, U.S. Data Shows"; Lopez, Jacobson, and Levitt, "How Much More Than Medicare Do Private Insurers Pay?"; American Hospital Association, "Underpayment by Medicare and Medicaid Fact Sheet."

³² Bob Herman, "Seismic Changes in the Health Insurance Industry Bring Opportunities and Friction," accessed September 10, 2017, <http://www.modernhealthcare.com/article/20160130/MAGAZINE/301309964>; Paul Starr, *Remedy and Reaction, the Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), <http://site.ebrary.com/lib/amherst/Doc?id=10506565>; Brill, *America's Bitter Pill*.

³³ Barry Meier, Julie Creswell, and Jo Craven McGinty, "Hospital Billing Varies Wildly, U.S. Data Shows," *The New York Times*, May 8, 2013, <http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html>; Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers."

³⁴ Lopez, Jacobson, and Levitt, "How Much More Than Medicare Do Private Insurers Pay?"; Rand Corporation, "Hospitals Are Paid Twice as Much (or More) by Private Insurers than Medicare, Study Finds"; Berenson, "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets The Final Report of the Academy's Panel on Pricing Power in Health Care Markets"; Koller and Khullar, "The Commercial Differential for Hospital Prices."

³⁵ "Executive Compensation."

these activities quickly, however.³⁶ I present estimates, therefore, under two separate assumptions: an immediate price reduction and a reduction over a four-year period with prices reduced twenty-five percent each year.³⁷

Savings from moving to the Washington Program: eliminating monopoly rents: prescription drugs and medical devices

The unfettered exercise of monopoly power has raised been especially toxic for Americans who need prescription drugs. A comprehensive survey published in 2007 found that drug prices are about sixty percent higher in the United States than in Europe or Canada.³⁸ More recent studies, including by the Trump Administration, suggest that this now understates the penalty Americans now pay because drug prices may now be double those paid elsewhere. Over forty percent of the revenue for twelve leading multi-national pharmaceutical companies comes from the United States, and direct comparisons of particular drugs shows American prices are often dramatically higher (see Figure 8).³⁹ Prices in the United States range from 3.2 times the Canadian price to 9.3 times as high (see Figure 8). The International Federation of Health Plans found that, for eight common drugs, the price in the United States is on average over three times the average price in Canada, England, or the Netherlands. In no case is the United States' price lower and, in only two drugs (Enbrel and Humira), prices in United States are less than twice the price paid in other countries.⁴⁰ For example, a treatment of cancer drug Gleevac costs \$6,214 in the United States, but only \$1,141 in Canada; a multiple sclerosis drug Copaxone costs \$3,875 in the United States, but only \$862 in England; and an acid reflux drug Nexium costs \$215 in the United States, but only \$23 in the Netherlands.⁴¹

Inflated drug prices reflect the market power of companies whose brand reputation is reinforced by patent protection and the lack of an effective check by our fragmented insurance industry. Inflated prices derived from market power are charged by producers who could still profit from

³⁶ Cai and Kahn, "Medicare For All Would Improve Hospital Financing | Health Affairs Blog."

³⁷ This gradual reduction is the approach followed by the CBO in Congressional Budget Office, "How CBO Analyzes Proposals for a Single-Payer Health Care System | Congressional Budget Office."

³⁸ McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States"; International Federation of Health Plans, "2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country"; Kesselheim, Avorn, and Sarpatwari, "The High Cost of Prescription Drugs in the United States"; Schumock et al., "National Trends in Prescription Drug Expenditures and Projections for 2018"; The high cost of insulin in the United States has had well-documented tragic effects on diabetics. It is particularly shocking because Frederick Banting and his colleagues donated insulin to the world so that all diabetics would be able to use this life-saving drug; see T1International, "COSTS AND RATIONING OF INSULIN AND DIABETES SUPPLIES: FINDINGS FROM THE 2018 T1INTERNATIONAL PATIENT SURVEY"; Kelto, "Why Is Insulin So Expensive In The U.S.?"; Idlebrook, "Selling a Lifetime of Insulin for \$3."

³⁹ International Federation of Health Plans, "2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country."

⁴⁰ International Federation of Health Plans.

⁴¹ International Federation of Health Plans.

providing the same product even at a much lower price.⁴² When market power is reduced with the removal of patent protection, for example, patients can buy the same drug for much lower prices. When a drug goes “off patent,” the entry of two new producers typically lowers prices by half, and prices fall by over eighty percent when there are eight or more producers.⁴³

Some Americans pay less for drugs. Negotiating drug prices, the Veteran’s Administration is able to provide drugs at half the price paid by other Americans.⁴⁴ With a population of seven million, the State of Washington is almost as large as the number of veterans receiving health care from the VA (about nine million).⁴⁵ A single agency negotiating prices for seven million Washington residents could negotiate similarly lower prices. Bringing prices down by forty-five percent, less than the savings achieved by the Veterans Administration, would save over four billion dollars; similar bargaining over the price of medical equipment would save nearly another billion dollars.⁴⁶

Waste and fraud

Fraudulent billing -- including duplicate billing and billing for services not rendered -- accounts for between three and ten percent of health care spending in the United States, including an error rate in Federal programs of over nine percent.⁴⁷ This includes the “accidental fraud” caused by duplicate billing due to the confusing nature of the insurance process.⁴⁸ A single-payer authority would reduce fraud in three ways. Eliminating multiple payers would immediately eliminate the possibility of duplicate billing. It would also simplify the process of tracking bills. In addition, public authorities have greater subpoena and prosecutorial powers, giving them more power to

⁴² At \$1000 per pill in the United States, \$84,000 for a full course of treatment, Gilead Science’s Hepatitis C drug Sovaldi has produced more profit in one year than Gilead spent on R and D for over a decade. Almost half of all revenue to Gilead in 2014 was profit. Despite large sales elsewhere, 84% of Sovaldi revenues were in the United States because of hard bargaining by foreign governments and insurers to secure lower prices than are paid by Americans; Belk, “Gilead Sciences”; Pollack, “Gilead Revenue Soars on Hepatitis C Drug.”

⁴³ Health, “About the Center for Drug Evaluation and Research - Generic Competition and Drug Prices”; Baker, “A Free Market Solution for Prescription Drug Crises.”

⁴⁴ Frakt, Pizer, and Feldman, “Should Medicare Adopt the Veterans Health Administration Formulary?”; Blumenthal and Squires, “Drug Price Control”; Congressional Budget Office, “Comparing the Costs of the Veterans’ Health Care System With Private-Sector Costs.”

⁴⁵ Bagalman, “The Number of Veterans That Use VA Health Care Services: A Fact Sheet”; a study of 11 countries found those with single-payer insurance system had lower drug prices and bargaining power largely explains higher drug spending in the United States; see Morgan, Leopold, and Wagner, “Drivers of Expenditure on Primary Care Prescription Drugs in 10 High-Income Countries with Universal Health Coverage.”

⁴⁶ McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States,” 56. As is done with the VA, the state would establish a formulary list of covered drugs and negotiate prices with producers. It would then make these drugs available at the reduced prices to pharmacies and other private vendors; see National Committee to Preserve Social Security and Medicare, “Price Negotiation for the Medicare Drug Program: It Is Time to Lower Costs for Seniors.”

⁴⁷ King and General Accounting Office, “Medicare and Medicaid Fraud, Waste, and Abuse”; National Health Care Anti-Fraud Association, “Testimony of the National Health Care Anti-Fraud Association to the House Insurance Committee”; Shrank, Rogstad, and Parekh, “Waste in the US Health Care System” puts the number a bit lower, at about 1%, which is the savings rate used here.

⁴⁸ Anyone who has tried to interpret a hospital bill can appreciate how easy it would be to make mistakes.

stop fraud. By reducing fraud and “accidental” overcharging, Washington could, *conservatively*, save one percent of total costs, or seven-hundred million dollars.⁴⁹

Paying for a better system

Remaining revenue from existing sources

After taking account of the additional costs associated with universal access and the savings coming from improved administration and the reduction of monopoly profits, Washington would spend less than \$66 billion in 2021 with the full implementation of the Washington Program.⁵⁰ Should the state assume the cost of Medicare Part B premiums, this would bring the full cost of the program to a bit over \$67 billion. Spending in later years has been estimated on the assumption that spending increases will continue at the rate of the recent years.⁵¹ Two hypotheses are included, immediate price adjustments and price adjustments to hospitals and other providers over four years (see Table 3).

Existing revenue sources and remaining out-of-pocket spending will supply nearly \$47 billion in 2021 (see Table 2). Funding levels in 2021 have been estimated from the most recent data on the assumption that past rates of increase will continue.

There are a few particular issues to note:

- Medicare recipients cannot be compelled to receive coverage through the Program and, if many remain in traditional Medicare, it will compromise the Trust’s ability to capture savings from provider administration. The Trust can encourage recipients to join by offering itself as a Medicare part C program. With its very high actuarial value and comprehensive benefits, higher than virtually any commercial insurance and higher than existing Medicare, the Trust will be more attractive than any alternative.
- The state would be responsible for its Medicaid program, as is the case now. Medicaid payments will increase with higher reimbursement rates and higher enrollment under the program. This will involve increased federal funding to the State.
- The VA and the Indian Health Service will remain separate with their own funding and program.
- Under the ERISA statute, the state cannot compel private companies to drop their commercial insurance but there is no reason to think that any would continue to offer

⁴⁹ This savings estimate is made after taking account of increases in utilization due to the universal coverage plans, extension of coverage, and removal of copayments and deductibles. The estimate of savings from fraud reduction is conservative compared with, for example, the Lewin Group, which regularly assumes that 5% of claims are fraudulent. 20% of these errors would be detected with enhanced subpoena powers without taking account of the reduction in duplicate claims under a system like that proposed here.

⁵⁰ I am assuming an actuarial rate of 96% with 4% of health care spending remaining out-of-pocket, including over-the-counter medications and some non-medically necessary services, such as cable-television in hospital rooms or procedures of dubious value, like consuming bleach or swallowing lightbulbs to prevent Covid-19. This estimate ignores the effect of Covid-19 or other catastrophic pandemics on healthcare spending.

⁵¹ Public health systems in other countries, like Canada, have achieved much slower rates of health care inflation, as has the Medicare program in the United States.

their own coverage since employees can receive coverage at no cost from the state since the cost is already covered through public taxation. Should any employer continue to offer this redundant coverage, it would lower the cost to the state of the program by removing some of the demand for state services.

- Other is a catchall category that includes “worksite health care, other private revenues, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.” Lacking other information, I have estimated revenues under this heading as the same share of total spending as is the case nationally minus medical spending under workers compensation as well as homeowners and auto insurance. I have removed these on the assumption that they will no longer be available because medical care will be provided by the Trust.

New revenue sources

Remaining revenue must be raised from the State’s residents. I have estimated needed and available revenue over ten years under two alternative assumptions: immediate implementation of full savings including price reductions, and reduction of hospital prices over four years (see Table 3). Using reported income data from the Census and from the IRS, I have estimated revenue from five sources:

- 8.5% on payrolls, paid by employers.
- 2% on payrolls, paid by employers.
- 2% on income of sole proprietorships.
- 8.5% on capital gains income
- \$200 premium paid by all enrollees above age 18 and 200% of the Federal Poverty Line.

I have estimated revenue from each of these sources for the 10 years 2021-30 and calculated surpluses or deficits compared with needed revenue under both assumptions, immediate price adjustments and adjustments over four years. The results, revenue raised and projected surpluses, are shown in Tables 4 and 5. The revenue program in the Act is clearly sufficient to fund the state’s health care, with large and increasing surpluses.

While the Washington Constitution has been interpreted as forbidding progressive income taxation, the funding programs given here is strikingly progressive. Moving from a health care system financed through lump-sum payments to one where most payments are related to income will inevitably benefit lower and middle-income and even many higher-income households because these households spend a higher proportion of their income on health care and a fixed payment is a higher share of their income.⁵²

The progressive nature of the program here is demonstrated in Figure 8 which shows the change in net income, that is income after paying for health care and the Act’s revenue under the assumption that prices will be adjusted immediately and the tax program included in the Act is implemented. The great majority of residents of Washington will save money under this

⁵² Saez and Zucman, “Make No Mistake.”

program, including virtually all with household incomes below \$500,000, even while they have better access to health care.

Other considerations: productivity and health

Establishing the Washington Program will benefit Washington businesses and workers by lowering the cost of health care, removing the burden of unfunded and unpredictable retiree health care costs, and by eliminating job lock where workers are compelled to remain at a particular employment to maintain their health insurance.⁵³ Lowering the cost of operation will allow Washington businesses to compete more effectively on national and international markets, increasing employment and income in the State. Businesses will also benefit directly by removing the cost of selecting and implementing health insurance programs for their workers, a billion-dollar expenditure in the State.

As is demonstrated in Figures 5 and 6, improving access to health care will lead to reduced mortality and improved population health. These are ends in themselves. In addition, however, they have ancillary benefits. A healthier population is a more productive population. Healthy workers miss fewer days due to illness and lower stress is associated with better concentration and higher productivity.⁵⁴ An analysis across member nations in the OECD has found that not only is Preventable Years of Lives Lost (PYLL) associated with access to health care, but increases are associated with lower labor productivity.⁵⁵ Putting these effects together, lowering the share of Washington residents who cannot afford to see a doctor from seven percent down to five percent would be associated with a reduction in PYLL that would lead to an increase in labor productivity of ten percent, equivalent to almost a decade of productivity and income growth.⁵⁶

The positive association between productivity and health care access creates a virtuous cycle where treating people better is itself productive, beneficial not only to those who directly benefit but to the entire community.⁵⁷ Even those whose taxes will rise will benefit from living in a healthier community with more productive workers. And higher productivity and income will have the effect of allowing lower tax rates than those given here under the static assumption of no increase in employment, income, and productivity. Should this increase be realized, it would allow a reduction in the revenue needed to fund the Trust.

⁵³ Penn Wharton Budget Model, "Medicare for All."

⁵⁴ Penn Wharton Budget Model; Wilkinson, *The Spirit Level*.

⁵⁵ OECD, "Health Status - Potential Years of Life Lost - OECD Data" PYLL is the sum for all deaths in a year of the number of remaining years to live up to a selected age limit (age 70 is the age in OECD Health Statistics used here).

⁵⁶ Gordon, *The Rise and Fall of American Growth*.

⁵⁷ Friedman, *The Case for Medicare for All*.

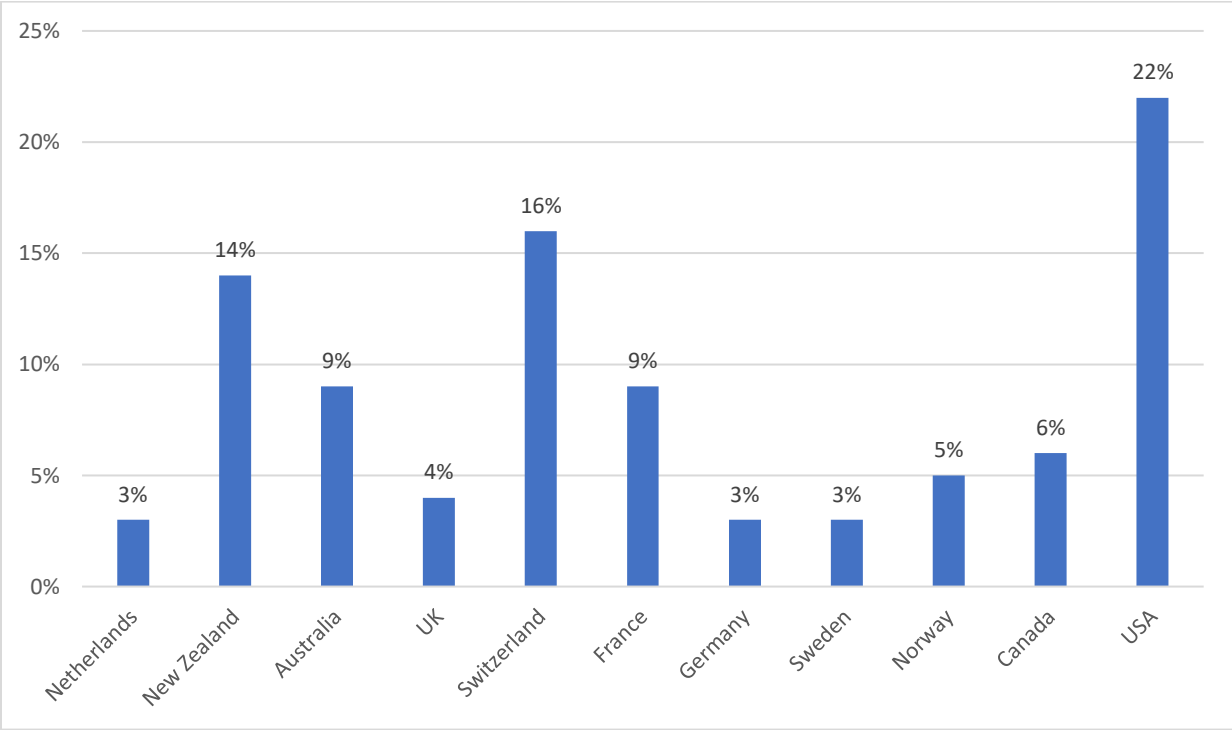


Figure 1. Proportion reporting that they did not receive medical care in the past year because of cost.

Source: Commonwealth Fund⁵⁸

⁵⁸ Commonwealth Fund, "International Profiles of Health Care Systems | Commonwealth Fund."

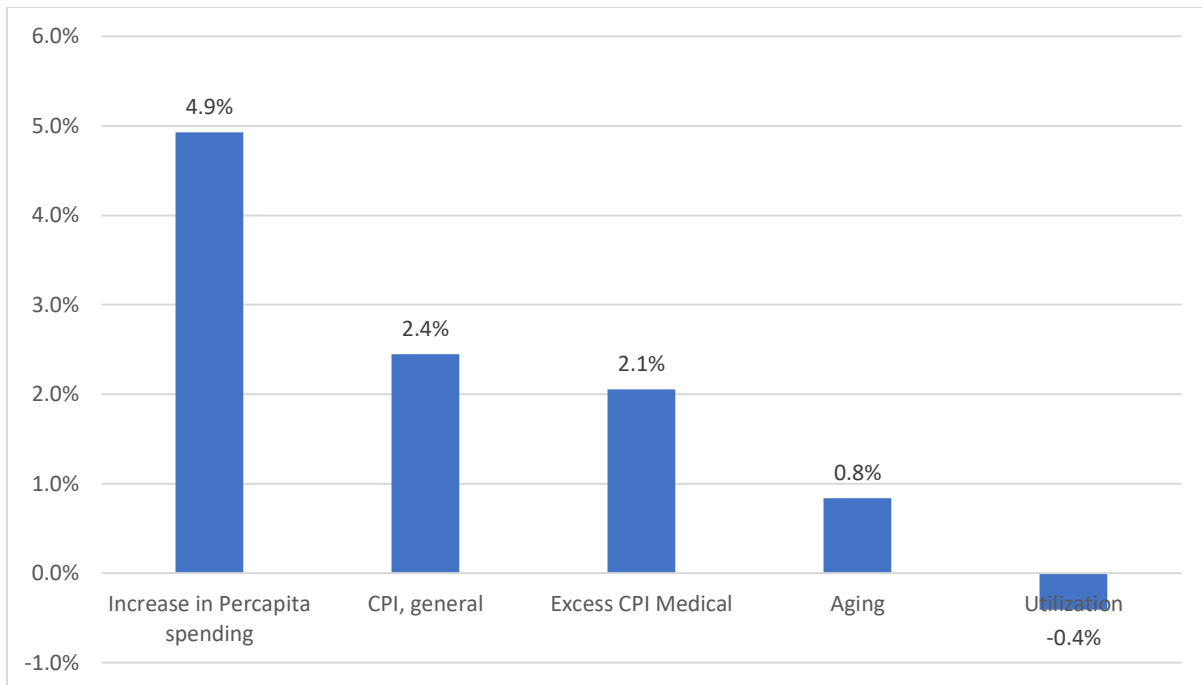


Figure 2. Decomposing Annual Increase in Per-capita Health care Spending 2000-2020 in the state of Washington

Note: Health care spending per person has risen by nearly 5% a year over the past 20 years. This is due to an increase in the general price level of 2.4% a year plus an increase in the price level for medical services of an additional 2.1% a year. Spending has increased another 0.8% a year because of population aging. Finally, reductions in the utilization of health care services of 0.4% a year have held down health care spending. Utilization changes have been estimated as the difference between actual per capita spending and the sum of Medical CPI and the aging effect.

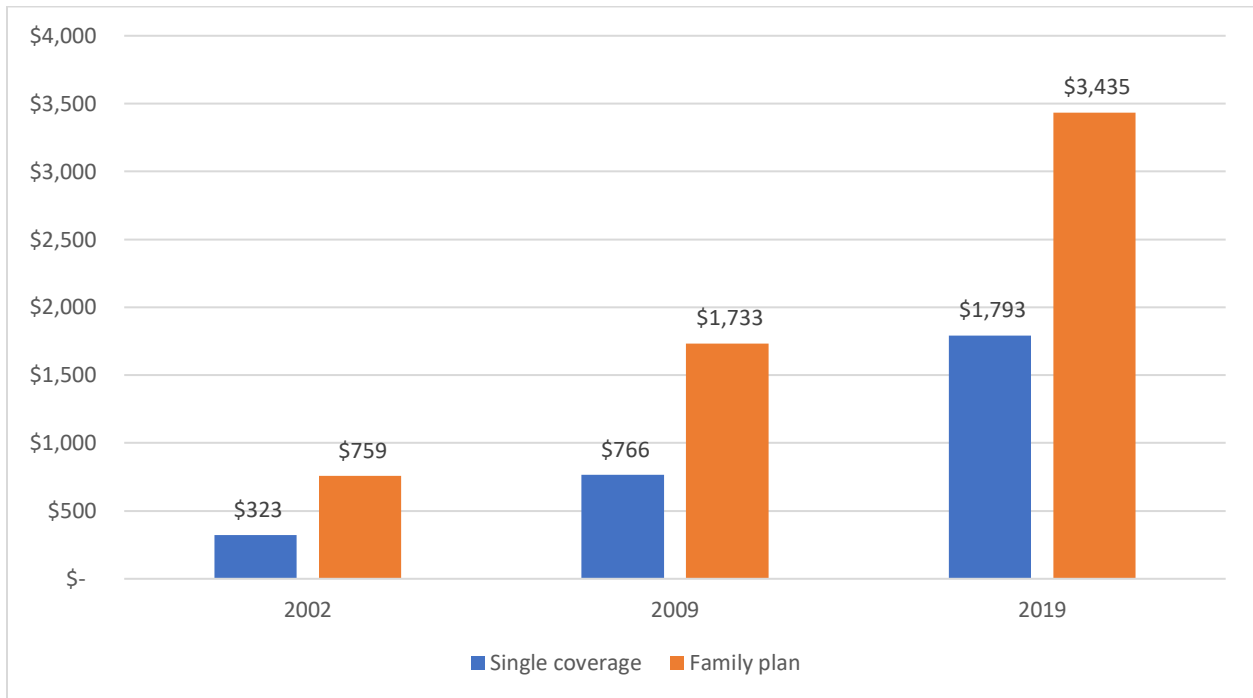


Figure 3. Average Deductible, Private-sector Employer-provided Health Insurance, Washington

Source: Agency for Health care Research and Quality, *Medical Expenditure Panel Survey*⁵⁹ These figures only apply to plans with deductibles, 59% in 2002, 89% in 2009, and 91% in 2019.

⁵⁹ Agency for Healthcare Research and Quality, “Medical Expenditure Panel Survey Insurance Component State Tables.”

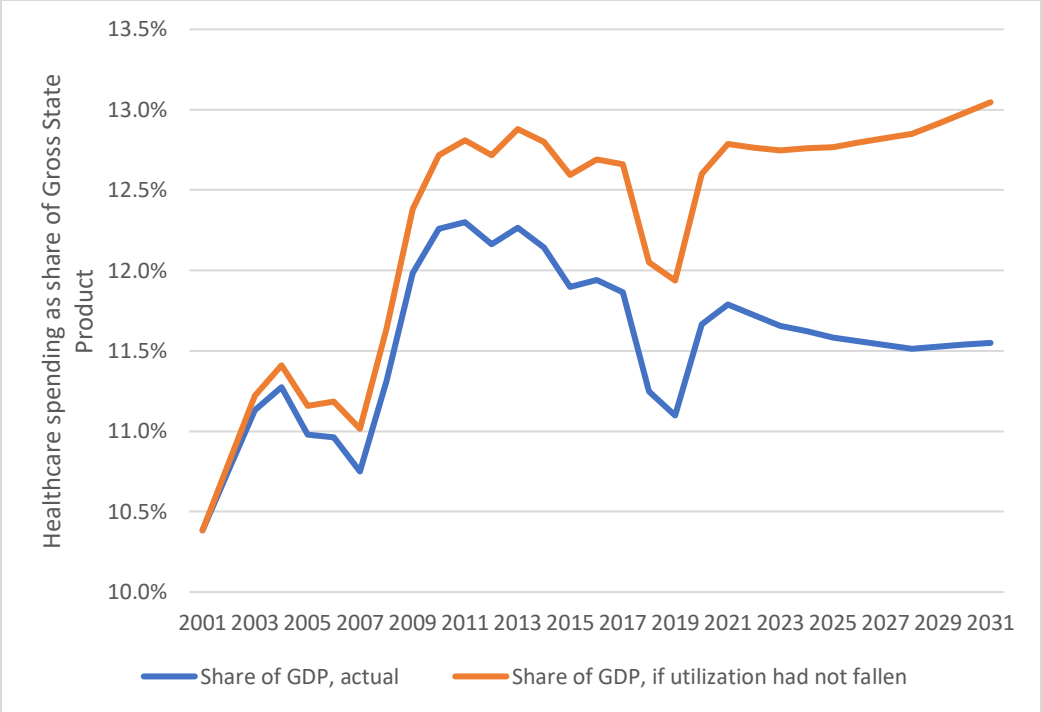
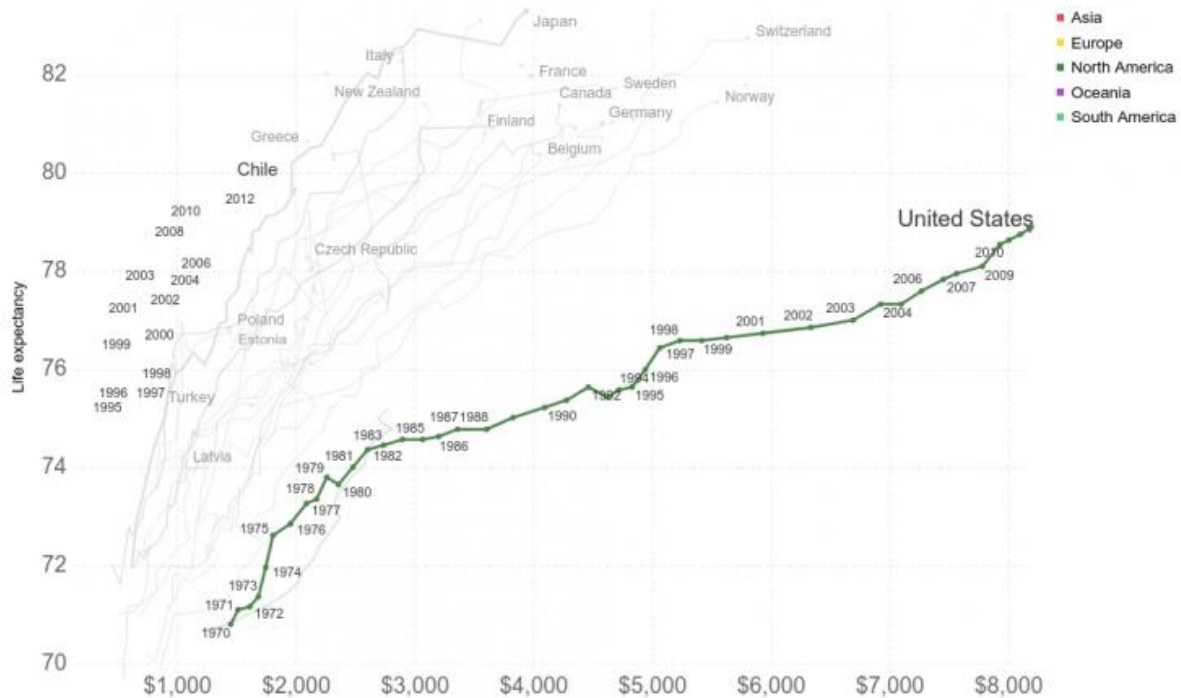


Figure 4. Personal health care spending as share of gross state product, actual and share if there had been no reduction in utilization of health care.

Note: This gives the actual share of GDP spent on personal health care and the share that it would have been had there been no reduction in the utilization of health care since 2000. Data beyond 2020 are projected assuming the inflation rates projected by the Center for Medicare and Medicare Services.

Life expectancy vs. health expenditure over time, 1970 to 2013

Health financing is reported as the annual per capita health expenditure and is adjusted for inflation and price level differences between countries (measured in 2010 international dollars).



Source: Health Expenditure and Financing- OECDstat, World Bank – World Development Indicators (Life Expectancy at birth) OurWorldInData.org • CC BY-SA

Figure 5. Changing life expectancy and health care spending, United States compared to other affluent countries.

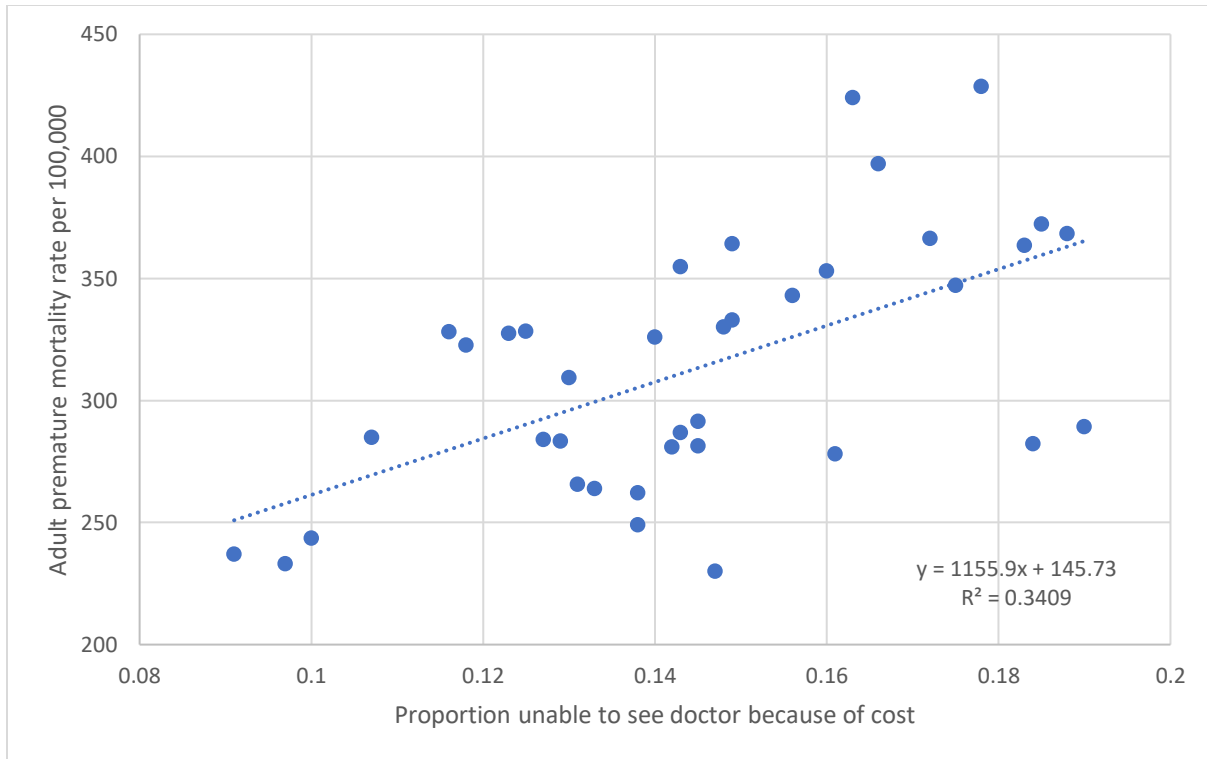


Figure 6. Age-adjusted mortality and population unable to see a doctor because of cost, counties in Washington, 2012

Note: the equation given is the regression of age-adjusted mortality on proportion who could not see a doctor because of cost.

Source: Robert Wood Johnson and the University of Wisconsin, County health rankings⁶⁰

⁶⁰ Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings."

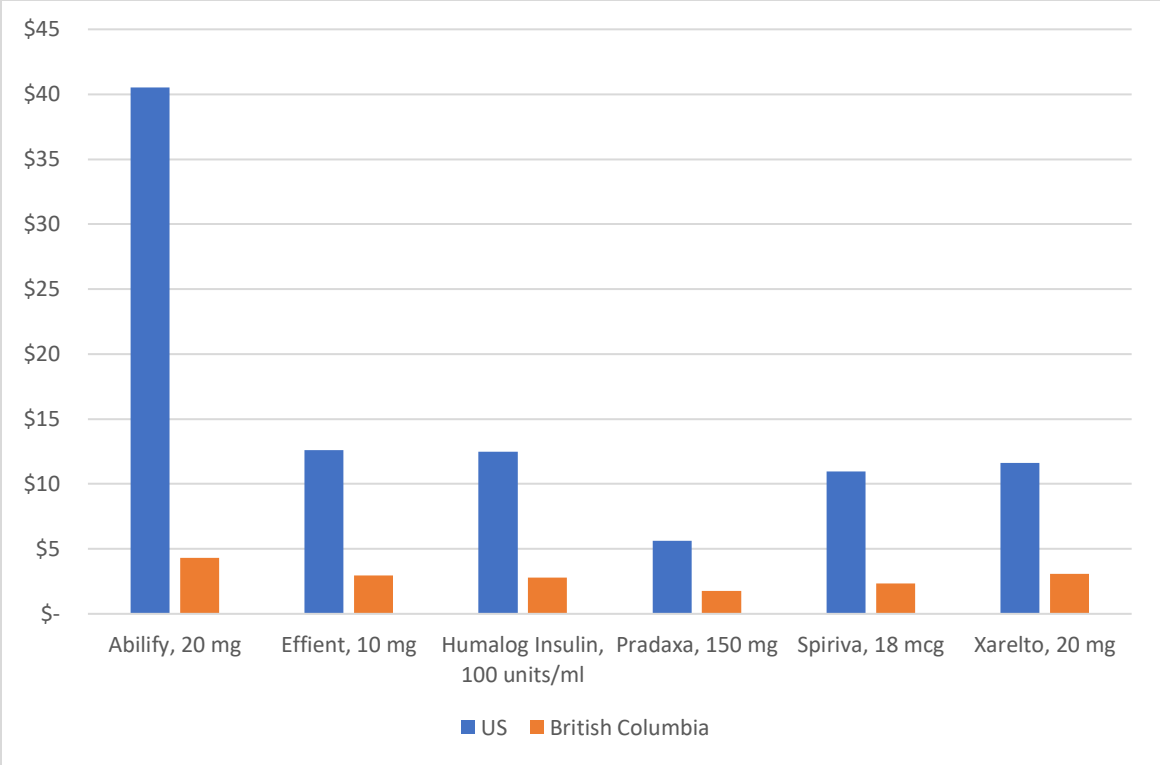


Figure 7. Prices for common prescription drugs, US vs. British Columbia, 2014.

Source: http://truecostofhealthcare.org/the_pharmaceutical_industry/

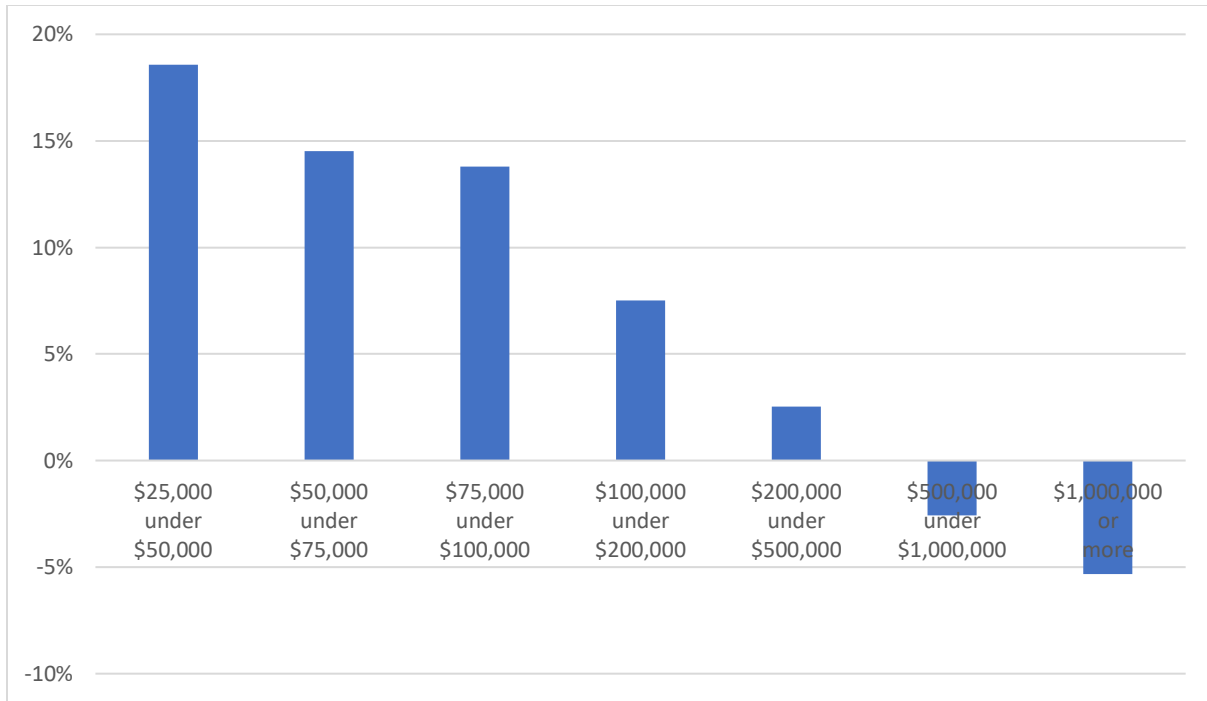


Figure 8. Net effect of Washington Program on Income After Taxes and Health care spending

Note: this figure shows the change in net income after health care costs including paying for health care, including insurance premiums and premiums paid by employers on behalf of employees, and taxes levied to pay for health care, including those paid by employers on behalf of employees. The tax rates used are those in the Act.

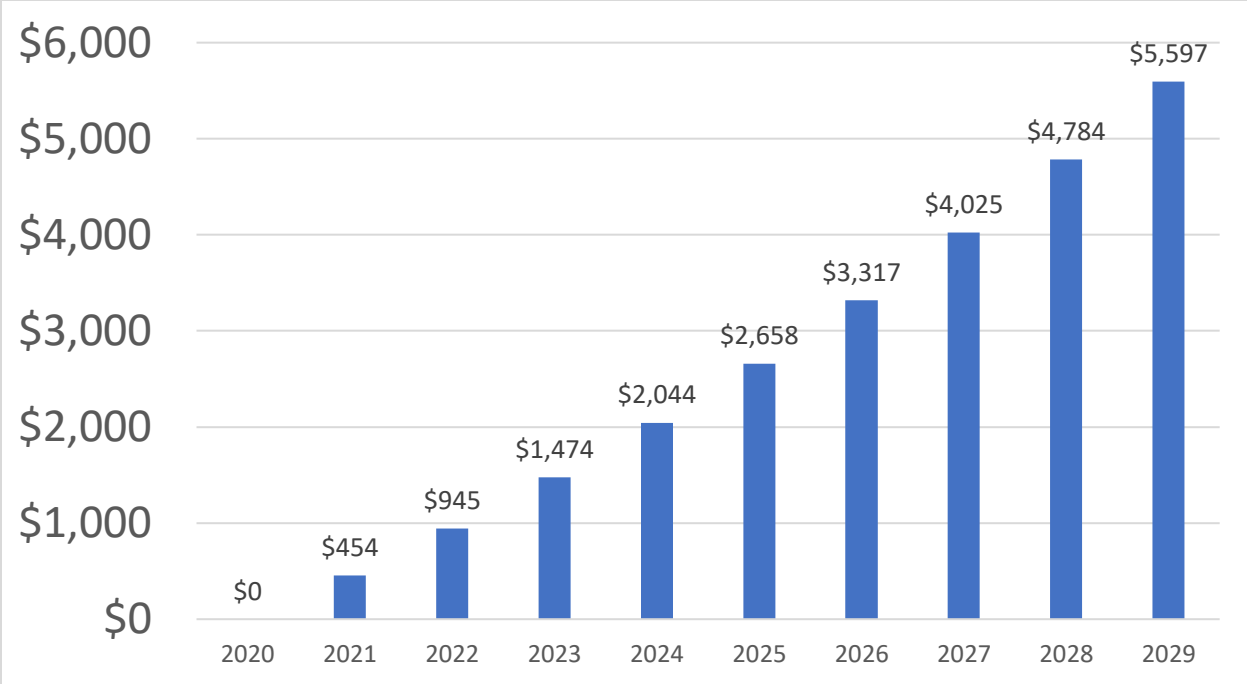


Figure 9. Per capita increase in personal income coming from improvement in health due to Washington Program

Table 1. Projected cost of health care, Washington 2021, current system and with universal coverage at high actuarial value (\$000,000s)

<i>Spending with universal coverage, existing system</i>	
Personal health care, current utilization	\$ 78,440
Improved access	\$ 9,189
Total personal health care	\$ 87,629
Insurance admin	\$ 10,363
Total, existing system with full access	\$ 97,992
	\$ 78,440
<i>Savings from existing system, with universal coverage</i>	
Hospital price adjustment	\$ (10,828)
Physician price adjustment	\$ (2,042)
Drug and device pricing	\$ (5,121)
Provider admin	\$ (7,943)
Medicaid price adjustment	\$ 3,617
Insurance admin	\$ (9,075)
Fraud	\$ (912)
Total savings	\$ (32,304)
<i>Funding of Washington Trust</i>	
Net spending, 2021, M4All	\$ 65,688
Including Medicare Part B	\$ 67,173
Existing revenue	\$ 46,686
Needed revenue	\$ 20,487

Table 2. Existing revenue sources, projected 2021 (\$000,000s)

Medicare	\$ 17,216
Medicaid	\$ 16,996
SCIP	\$ 201
VA	\$ 1,882
Other	\$ 7,093
remaining OOP	\$ 2,687
ACA subsidies	\$ 612
Total existing revenue	\$ 46,686

*Note: Medicaid includes adjustment for Federal share of Medicaid price and coverage increases, but not state share.
Other includes state and local public health, workplace health care, Indian Health Service, charitable contributions, and others.
Medical spending through Workers' Comp, Homeowners', and Auto Insurance has been removed.*

Table 3. Ten-year projections of total spending, Washington Program, 2021-30 under alternative assumptions of price adjustments for hospitals and physician practices.

Year	Immediate price adjustments	Price adjustments over 4 years
2021	\$ 67,173	\$ 75,294
2022	\$ 69,423	\$ 75,018
2023	\$ 71,747	\$ 74,545
2024	\$ 74,149	\$ 74,149
2025	\$ 76,632	\$ 76,632
2026	\$ 79,198	\$ 79,198
2027	\$ 81,849	\$ 81,849
2028	\$ 84,590	\$ 84,590
2029	\$ 87,422	\$ 87,422
2030	\$ 90,349	\$ 90,349

Table 4. Revenue sources, 2021 (\$millions)

8.5% employer payroll	\$	23,334
2% employee payroll	\$	5,490
2% sole proprietorship	\$	0.82
8.5% capital gains	\$	2,993
\$200 premium enrollees above 19 and 200% FPL	\$	890
Total revenue	\$	32,708
Surplus (deficit)	\$	12,221

Table 5. 10 year funding program based on projected spending, immediate and four year transition

Year	Revenue	Surplus or (deficit)	
		Immediate transition	4 year transition
2021	\$ 32,708	\$ 12,221	\$ 4,100
2022	\$ 34,175	\$ 13,003	\$ 7,407
2023	\$ 35,710	\$ 13,828	\$ 11,030
2024	\$ 37,314	\$ 14,700	\$ 14,700
2025	\$ 38,992	\$ 15,620	\$ 15,620
2026	\$ 40,745	\$ 16,591	\$ 16,591
2027	\$ 42,579	\$ 17,616	\$ 17,616
2028	\$ 44,496	\$ 18,697	\$ 18,697
2029	\$ 46,500	\$ 19,838	\$ 19,838
2030	\$ 48,596	\$ 21,041	\$ 21,041

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Tab 6

Meeting objectives

- Review Benefits & Services approaches by
 - Whole Washington, Washington Health Trust (SB 5355)
 - Universal Health Care Work Group (predecessor to the Commission)
 - Other states

- Assess preliminary comparison of Benefits & Services across Medicaid, EHB (EHB) under the Affordable Care Act (ACA) and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB) as an example of large group market

- Identify gaps in preliminary benefits comparison

- Develop considerations for the Commission for a path forward including an actuarial analysis

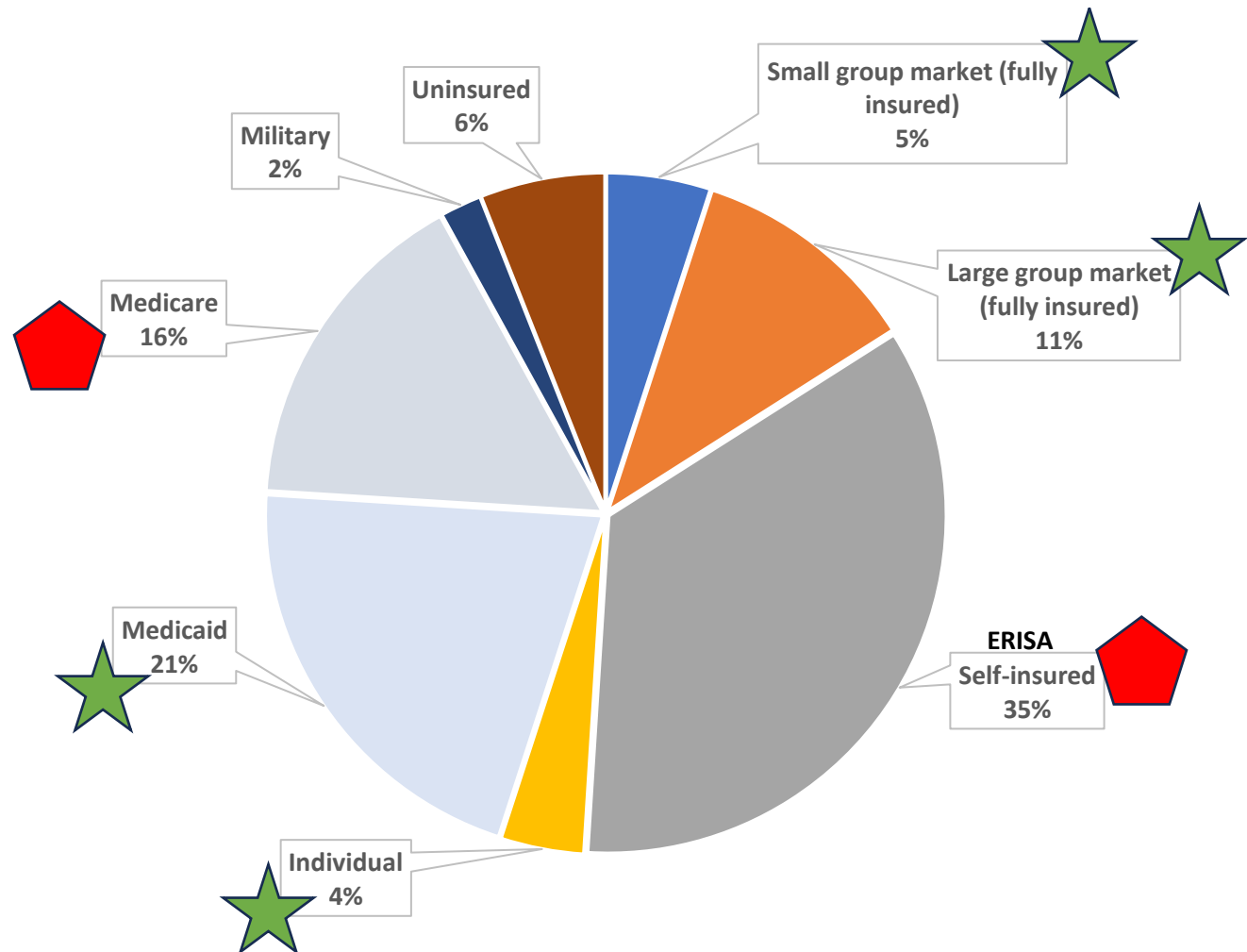
Benefits & Services

- FTAC assessed pathways to include individuals with Medicare, Medicaid, and self-insured employer coverage in Washington's universal health care system.
 - Medicare and self-insured employers – no pathway to access financing and move individuals to the universal system due to federal barriers at this time.*
 - Medicaid – pathways identified.*

- For the remaining populations for whom there is a pathway to access financing, the benefits and services vary and provide a starting place for determining the benefits & services in the Universal Health Care System.

- At this time, the Commission agrees that these individuals should have access to the universal system benefits and services that may not be covered by their primary source of coverage.
- FTAC identified tools available under Medicaid such as 1115 demonstration waivers and state plan amendments to include Medicaid in Washington's universal health care system.

A Starting Place: Comparing Benefits Across Remaining Sources of Coverage



Other States' Approaches to Benefits

- California
 - Used EHB
 - Included additional benefits including vision, dental, Long-Term Services and Supports (LTSS)
- Oregon
 - Used PEBB, considered “most generous”
- Vermont
 - Used EHB-like standard
 - Ran scenarios to include dental, vision and LTSS

Commission's discussion regarding benefit design

- Knowing the average provider reimbursement rate across payers may help identify inefficiencies.
- Some countries with universal health care systems offer a minimum essential benefits package without cost barriers.
- Plans offering additional benefits could be offered through the private market, introducing some cost-sharing, though this could perpetuate health inequities and disparities.
- What the state can afford may be a moving target.
- Begin with an aspirational benefits package to address population health and then determine the cost, or begin with budget/costs (which may change the outcome of the benefits package)?
- Whole Washington and the Universal Health Care Work Group conducted modeling that may be helpful to estimate costs to the state.
 - Both approaches used the Essential Health Benefits Silver Plan

Preliminary Comparison of EHB, Medicaid, and Large Employer

- Challenging for two key reasons:
 - Medicaid has benefits that are required by CMS in order to obtain federal matching dollars
 - Fully insured market plans (large and small employer plans) must provide state-mandated benefits that aren't required in the EHB

2025 Benefits	2025 Standard Silver
Deductible and Out-of-Pocket Maximum	
Medical/Pharmacy Integrated Deductible	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles (\$)	\$2,500
Medical/Pharmacy Integrated MOOP	Yes
Medical/Pharmacy Integrated MOOP (\$)	\$9,200
Office Visits	
Preventive Care/Screening/Immunization	\$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$30***
Specialist Visit	\$65
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	\$30***
Emergency/Urgent Care Services	
Emergency Care Services	\$800
Urgent Care	\$65
Ambulance	\$375
Outpatient Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$600
Outpatient Surgery Physician/Surgical Services	\$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	\$30
Outpatient Diagnostic Tests	
Laboratory Outpatient and Professional Services	\$40
X-rays and Diagnostic Imaging	\$65
Advanced Imaging (CT/PET Scans, MRIs)	30%
Inpatient Services	
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	\$800*
Skilled Nursing Facility	\$800**
Pharmacy	
Generics	\$25
Preferred Brand Drugs	\$75
Non-Preferred Brand Drugs	\$250
Specialty Drugs (i.e. high-cost)	\$250
All Other Benefits	
Speech Therapy	\$40
Occupational and Physical Therapy	\$40
Durable Medical Equipment (DME)	30%
Home Health	\$30**
Hospice	\$30**
All Other Benefits	30%
Estimated 2025 AV	70.75%

2025 EHB Silver Plan

Shaded Items are not Subject to Deductible.

Per day copay, maximum of five copays per stay

** Per day copay

*** Eligible for two visits at \$1 copay, after which stated cost-sharing applies

Apple Health Benefits

BENEFIT	NOTES
OUTPATIENT SERVICES	
Acupuncture	Not Covered
Ambulance Services	Covered
Cardiac and Pulmonary Rehabilitation Services	Covered for Cardiac Rehabilitation Not covered for Pulmonary Rehabilitation
Chiropractic Services	Not Covered
Dental Services	Covered
Diabetes Programs and Supplies	Covered
Diagnostic Tests, X-rays, Lab Services, and Radiology Services	Covered
Dialysis Services	Covered
Doctor Office Visits	Covered
Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	Covered
Emergency Care	Covered in the US and its territories and possessions
Hearing Services	Covered for Hearing Exam and Hearing Aids
Home Health Service (Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.)	Covered
Outpatient Mental Health Care	Covered
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Covered
Outpatient Services	Covered
Outpatient Substance Abuse Care	Covered
Over-the-Counter Items	Covered
Podiatry Services	Covered
Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	Covered
Urgently Needed Services (This is NOT emergency care and, in most cases, is out of the service area.)	Covered
Vision Services	Covered Eye exams and fitting and dispensing services Eye examinations for visual acuity and refraction once every 24 months for adults. These limitations do not apply to additional services needed for medical conditions. Not covered Eyeglass frames, lenses and fabrication services for adults.
Wellness/Education and other Supplemental Benefit Programs	Covered

Apple Health Benefits

BENEFIT	NOTES
INPATIENT CARE	
Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	Covered
Inpatient Mental Health Care	Covered
Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	Covered
PREVENTIVE SERVICES	
Health/Wellness Education	Covered
Kidney Disease and Conditions	Covered
Preventive Services	Covered
HOSPICE	
Hospice	Covered
Outpatient Prescription Drugs	Covered

**Additional Apple Health Benefits: Long Term Services and Supports, Interpretation, Non-emergency medical transportation.

There is no cost-sharing for Apple Health benefits

EHB and Large Employer Plan (PEBB UMP)

➤ Recent comparison conducted by Wakely for the Office of the Insurance Commissioner of PEBB (proxy for large-employer plan) and Washington's EHB found that the PEBB plan is approximately 0.24% to 0.54% more generous than the current EHB benchmark plan on an allowed cost basis (allowed costs)

Table 1: Comparison of Benchmark Plan and PEBB Plan

Benefit	Benchmark Plan	PEBB	Difference in Allowed Costs
Home Health Care Services	130 visits/year	No Limit	0.00% to 0.02%
Acupuncture	12 Visit(s) per Year	8 visits/yr	-0.01% to -0.02%
Bariatric Surgery	Not Covered	Once every 10 years	0.01% to 0.04%
PT / OT / ST / Massage	25/year Combined	60 visits/yr Combined	0.21% to 0.40%
Habilitative Services	IP 30 OP 25 visits/yr	60 visits/yr	0.00% to 0.01%
Cardiac Rehabilitation	Covered	Not Covered	-0.02% to -0.04%
Hearing Aids	Not Covered	Once every 3 years	0.04% to 0.12%
Routine Hearing Exams	Not Covered	Covered	0.00% to 0.01%
All Other Benefit Differences			0.00% to 0.00%
Total (%)			0.24% to 0.54%
Total (PMPM \$ estimate)			\$1.69 to \$3.87

<https://www.insurance.wa.gov/sites/default/files/documents/wakely-ehb-update-december-report-and-presentation-final-12272023.pdf>

Considerations for the Commission's Actuarial Analysis

The Commission will need an actuarial analysis to compare Benefits & Services across three primary payers in WA:

- Medicaid
- EHB
- UMP (PEBB)

Thank you for attending
the Finance Technical
Advisory Committee
meeting!