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:

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[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 percent[13] 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]

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[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.modernhealth care.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*.

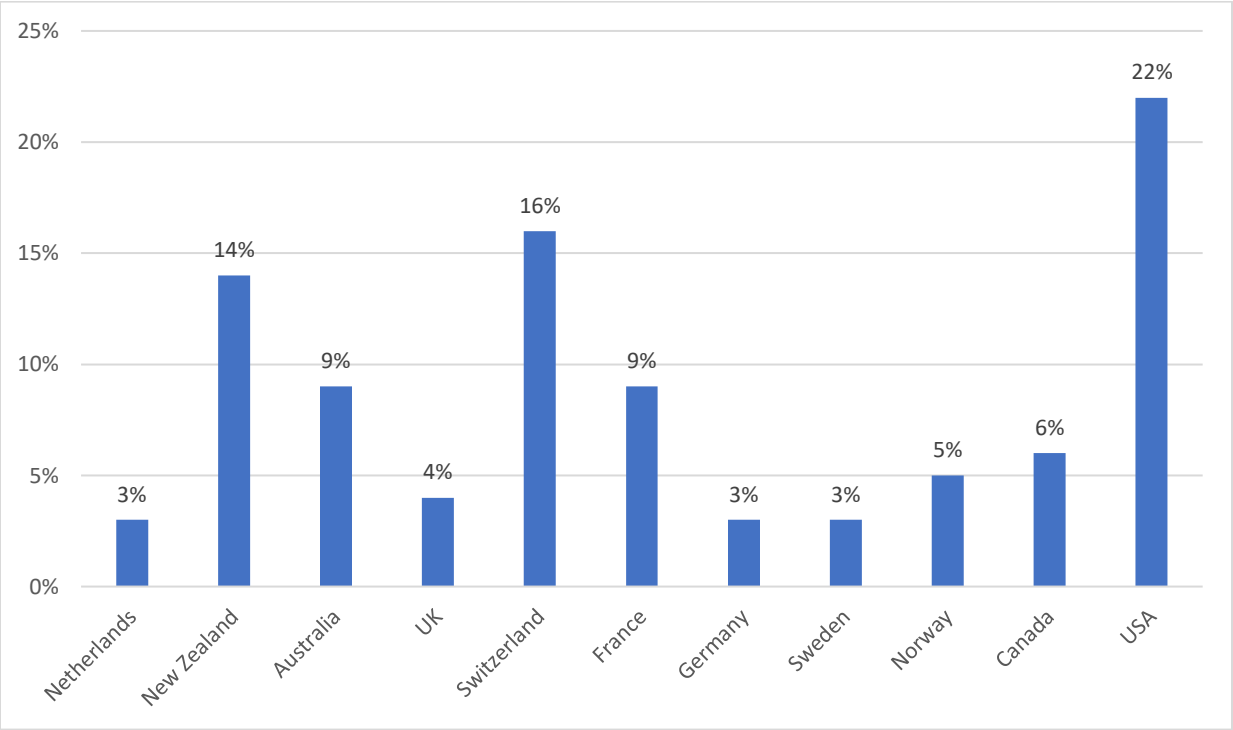

Figure 1. Proportion reporting that they did not receive medical care in the past year because of cost.

Source: Commonwealth Fund[58]

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

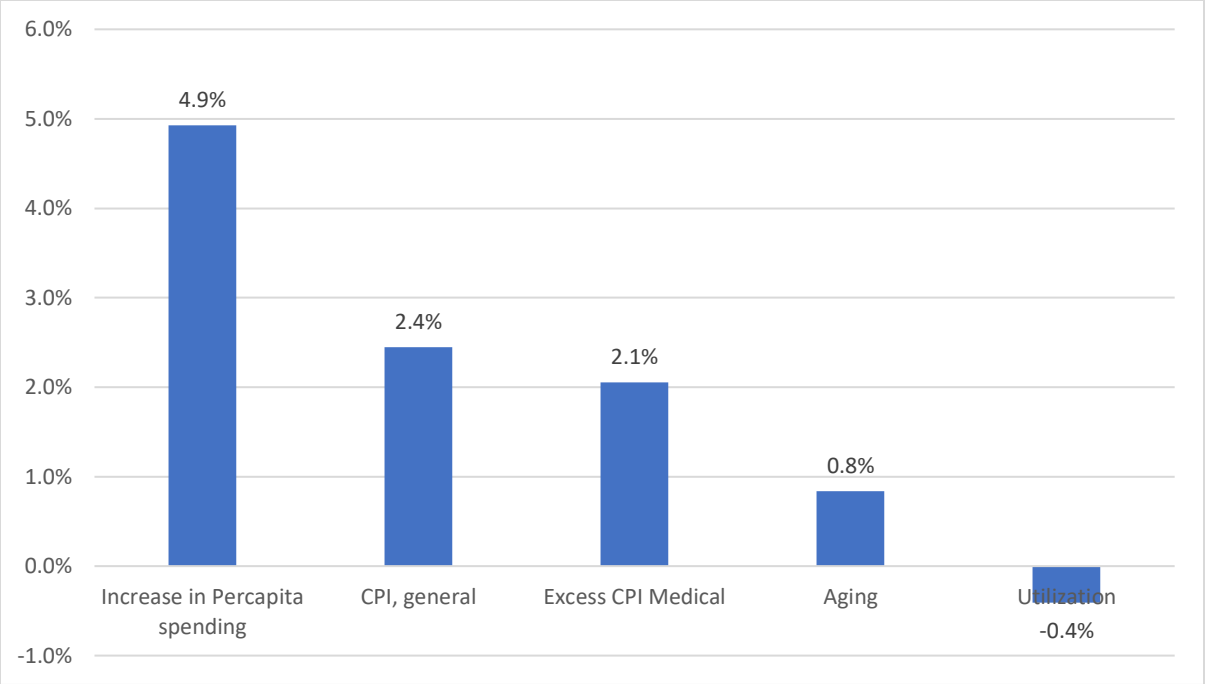

Figure 2. Decomposing Annual Increase in Per-capita Health care Spending 2000-2020 in the state of Washington

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.

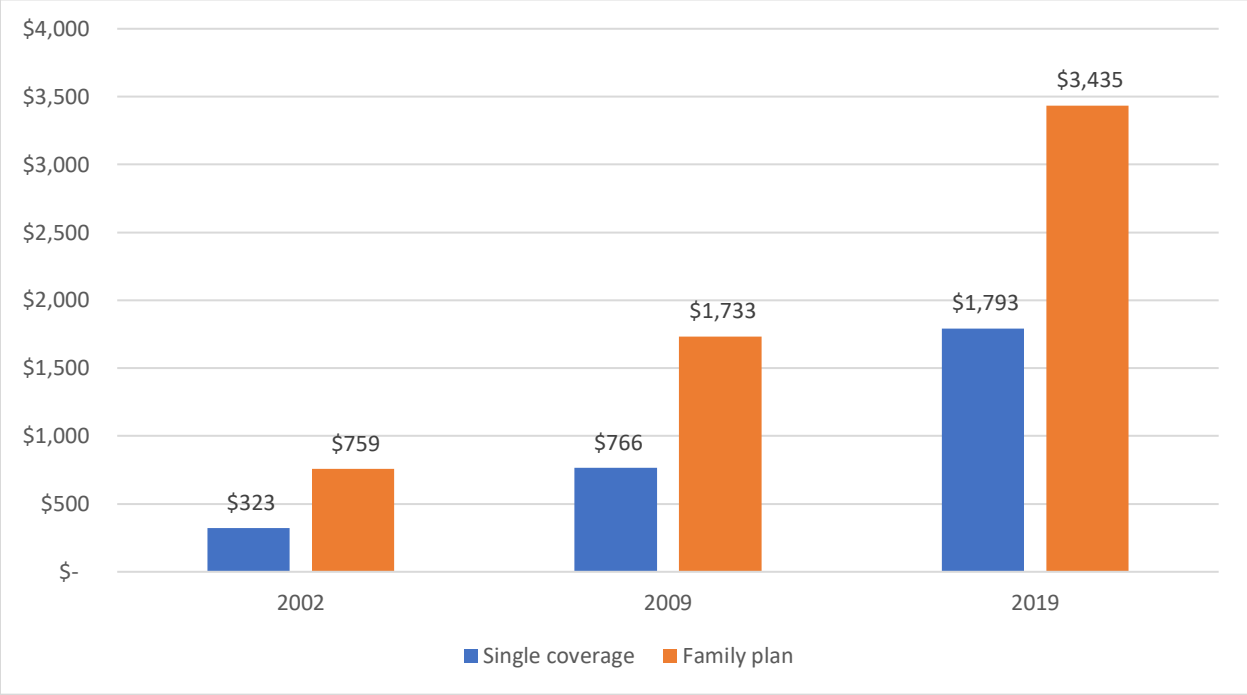

Figure 3. Average Deductible, Private-sector Employer-provided Health Insurance, Washington

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."

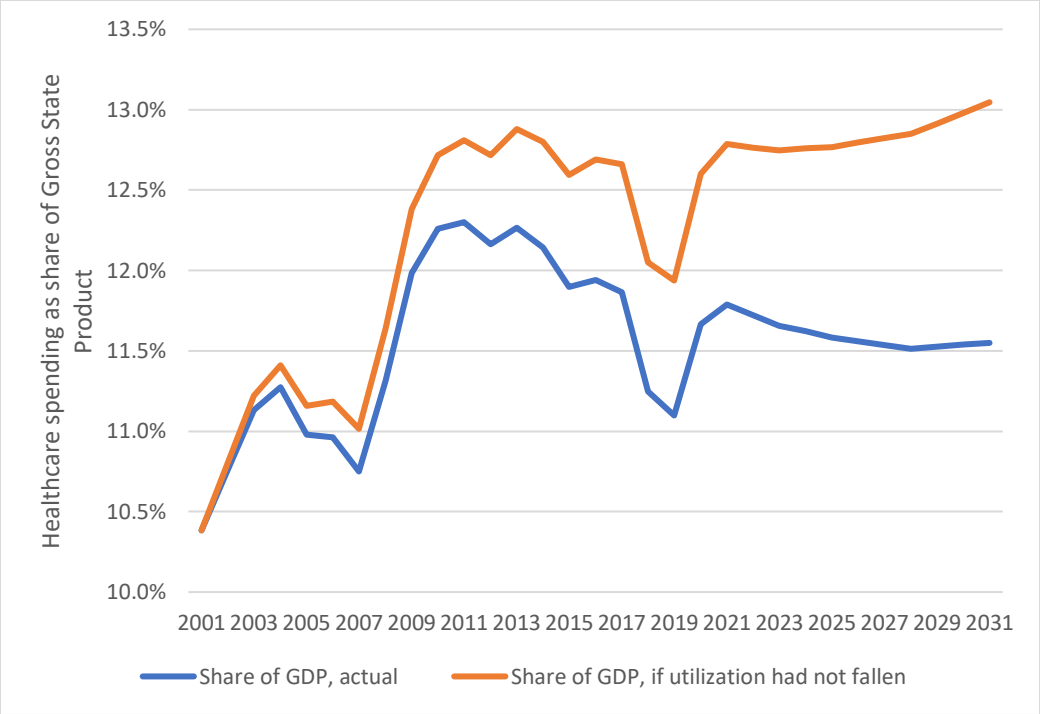

Figure 4. Personal health care spending as share of gross state product, actual and share if there had been no reduction in utilization of health care.

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.

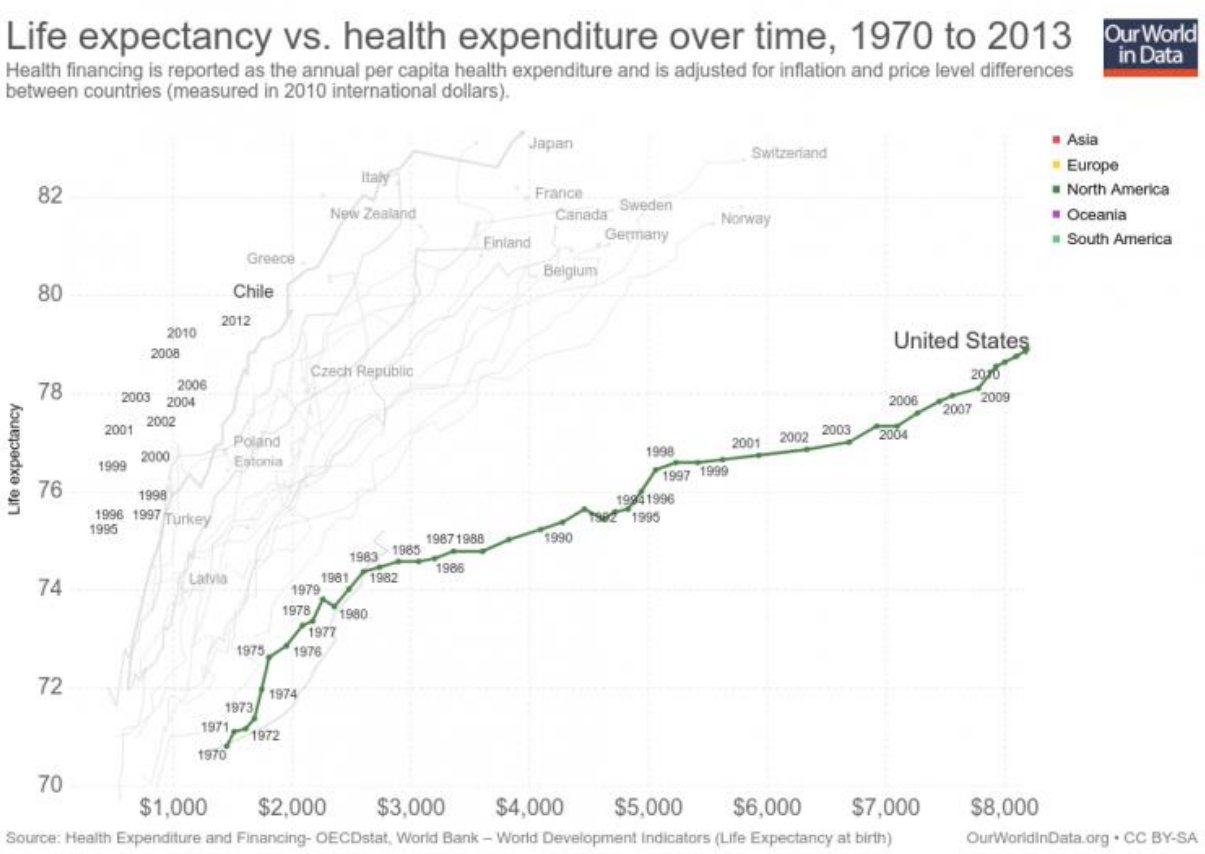

Figure 5.Changing life expectancy and health care spending, United States compared to other affluent countries.

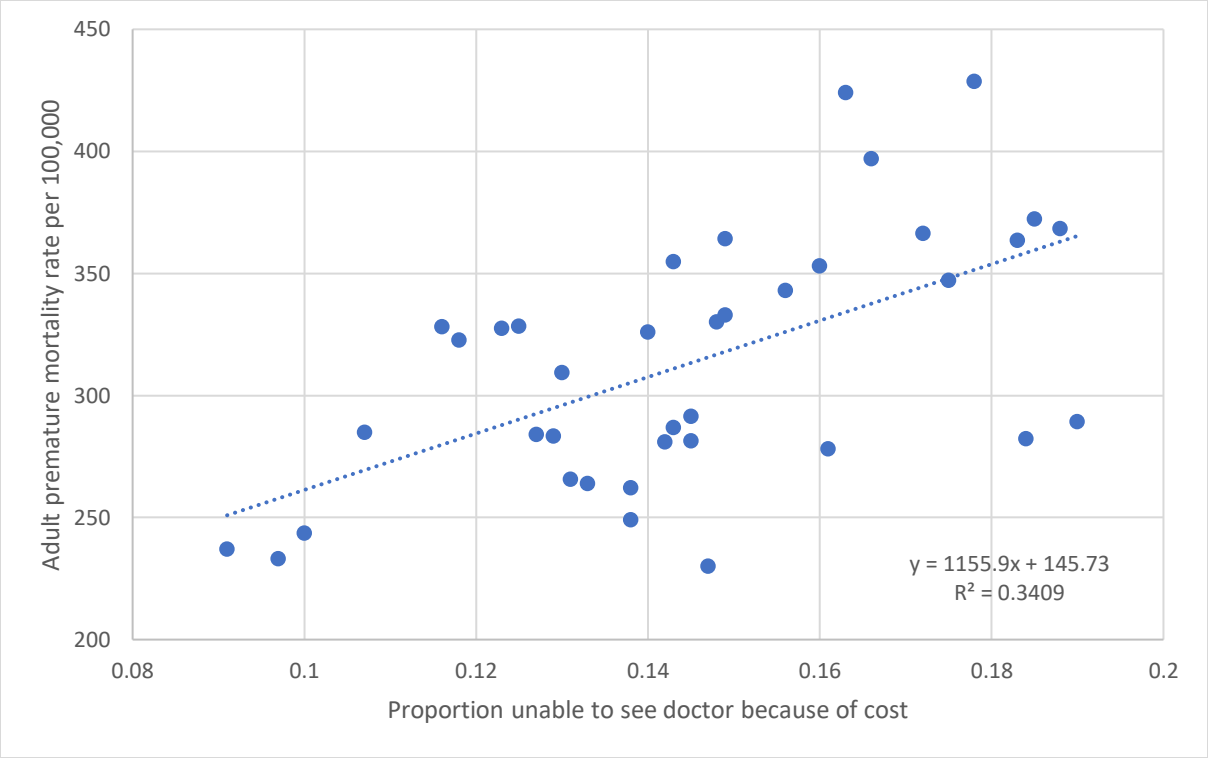

Figure 6. Age-adjusted mortality and population unable to see a doctor because of cost, counties in Washington, 2012

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 rankings[60]

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

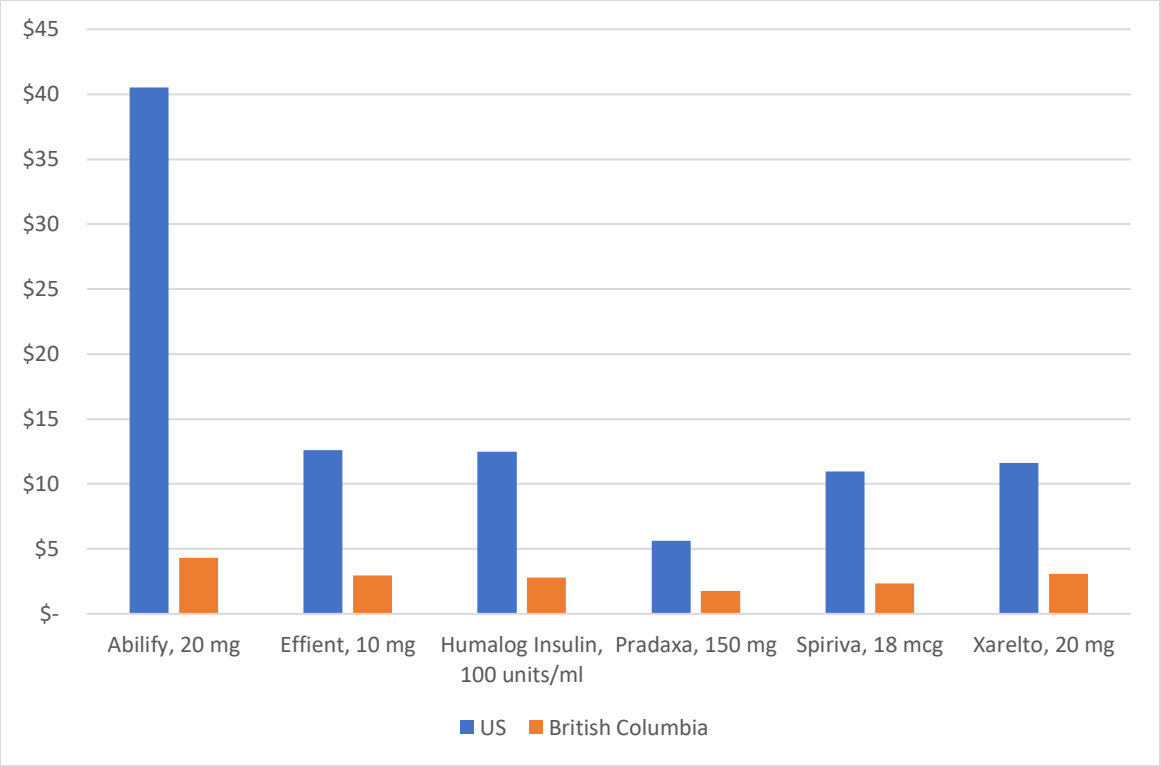

Figure 7. Prices for common prescription drugs, US vs. British Columbia, 2014.

Source: http://truecostofhealth care.org/the_pharmaceutical_industry/

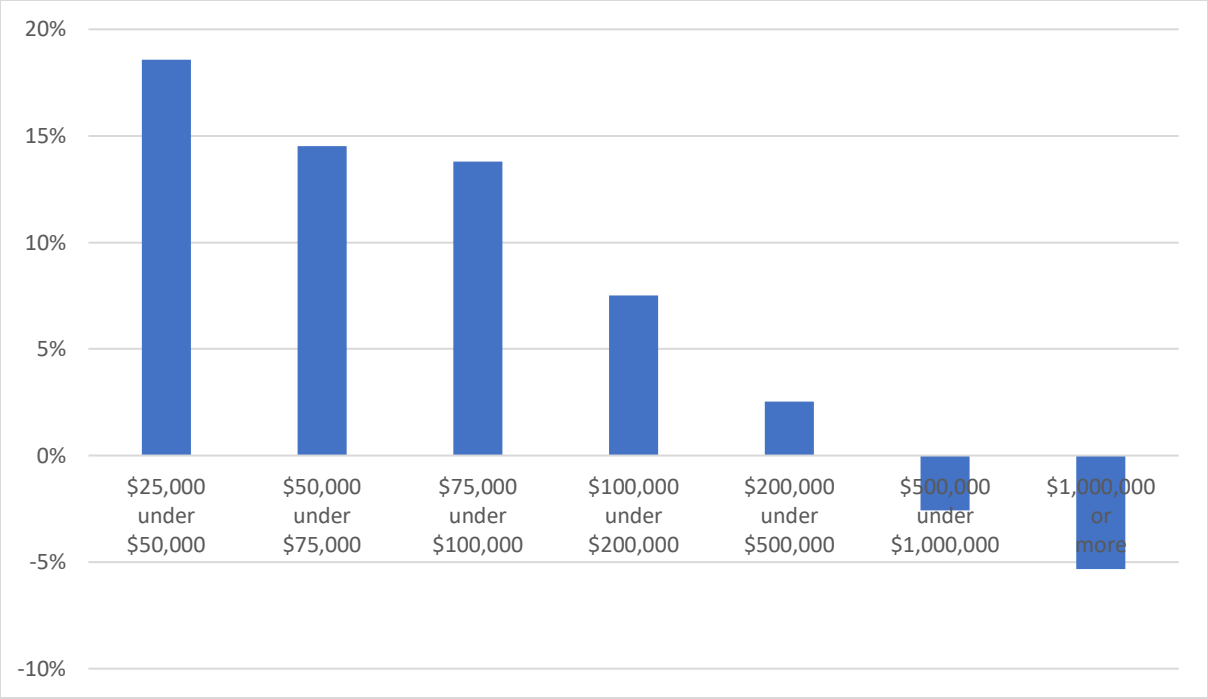

Figure 8. Net effect of Washington Program on Income After Taxes and Health care spending

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.

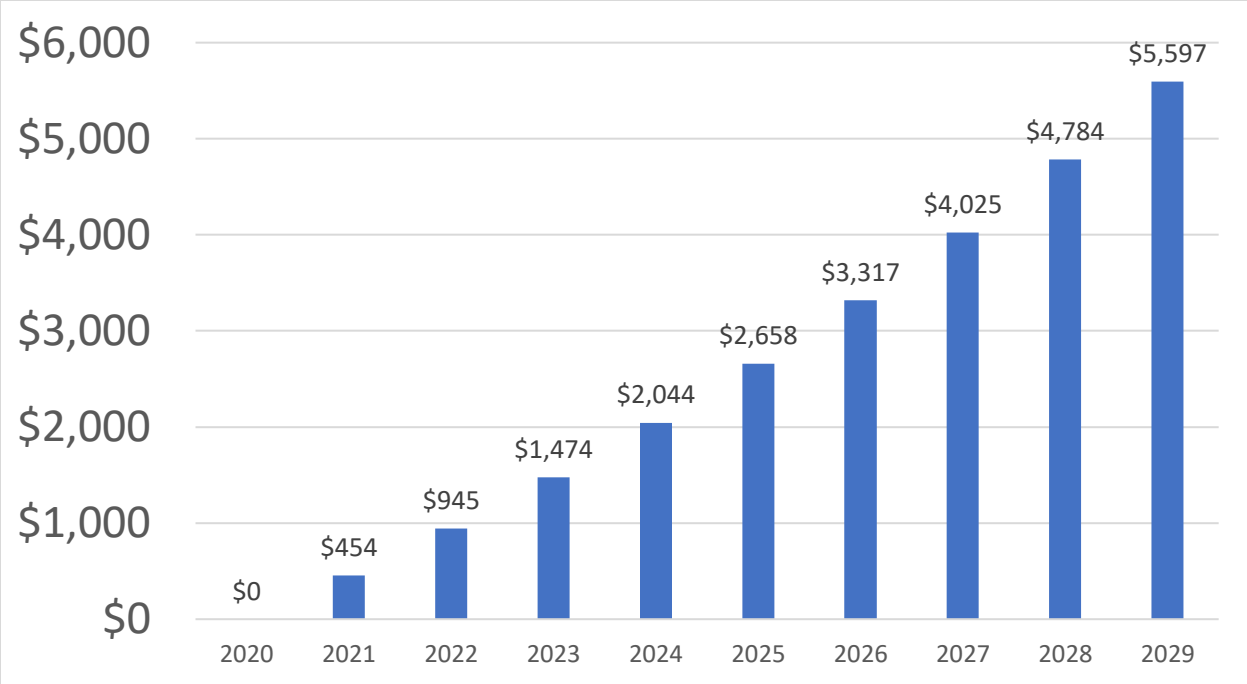

Figure 9. Per capita increase in personal income coming from improvement in health due to Washington Program

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

Spending with universal coverage, existing system	
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
Savings from existing system, with universal coverage	
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)
Funding of Washington Trust	
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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