Statement of Peter S. Arno, PhD

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My name is Peter Arno. I am a health economist living in New York and for the past few years I have worked with my colleagues at the Political Economy Research Institute at UMass-Amherst on analyzing the economics and financing of Medicare for All proposals for the state of California and the nation.[1,2]

The waste in the US healthcare system is staggering. Numerous evidence-based studies estimate that it falls in the range of 25 to 35 percent of total expenditures.[3,4,5,6] In our current 3.5 trillion dollar healthcare enterprise this waste equals $875 billion to $1.2 trillion dollars a year. In New York this translates to between $75 and $100 billion dollars per year. Clearly not all waste can be eliminated, but even a 10, 20, or 30 percent reduction would yield substantial savings.

The largest source of waste comes from the time, money, and personnel dedicated to billing and insurance-related activities. The areas of inefficiency and redundancy include: contracting, claims processing, credentialing providers, and payment validation. These high administrative costs result from operating in a system with hundreds of insurance providers, each with its own sets of rules and claims-processing requirements (see the claims processing diagram in the appendix). Moving to a single-payer system would largely eliminate the vast administrative complexity required by attending to the payment and reporting requirements of various private payers and public programs. There are two broad sources of administrative savings: 1) the reduced administrative costs to *providers* (i.e. physicians, hospitals, clinics, nursing homes etc.) associated with a move to a single payer system; and 2) reduced administrative costs and mark-ups associated with the *provision of health insurance*. This is clearly illustrated when comparing the administrative overhead of private commercial insurers estimated at about 12 percent of expenditures[7,8] versus the traditional Medicare program, which last year spent a mere **1.3** percent on administrative costs.[9]

Another large source of potential savings in moving to a single payer framework is reducing the price of prescription drugs. As the public has become acutely aware, in the US, we pay the highest prices for drugs in the world. **On average, we pay about double compared to what Europe pays for their medications** (see Appendix). This is not just an economic problem—we know that three in ten adults (29 percent) report not taking their medicines as prescribed because of the cost[10] —this is a public health disaster.

How can this be? As complex as the US healthcare system is, the answer is not that complicated. It has to do with uncontrolled PRICES AND PROFITS. We are the only developed country in the world that exerts so little control over the prices and profits generated in our massive $3.5 trillion dollar health care system. There is no better example of this than what we pay for our prescription medications.

Under a universal single payer framework such as the New York Health Act, we can use the negotiating power of 20 million New Yorkers to lower the price of our medications and ensure

access to needed healthcare for all our residents.

There is one more issue, which as far as I know has never been addressed in New York before—the impact of the NYHA on reducing poverty. Under the New York Health Act virtually all out-of-pocket (OOP) medical expenses—e.g. premiums, copays and deductibles—are eliminated. According to recently released US Census data,[11] eliminating these OOP costs would reduce the number of people living in poverty by nearly 20 percent (19.3%) or more than 500,000 people in New York State. [12]

In summary, we can replace our current financing system with a single, efficient, equitable, publicly-financed and publicly-administered system as proposed in the NY Health Act. This would eliminate the profound administrative waste, reduce extortionate drug pricing, make healthcare universally available and affordable and, at the same time, lift half a million New Yorkers out of poverty. What's stopping us?

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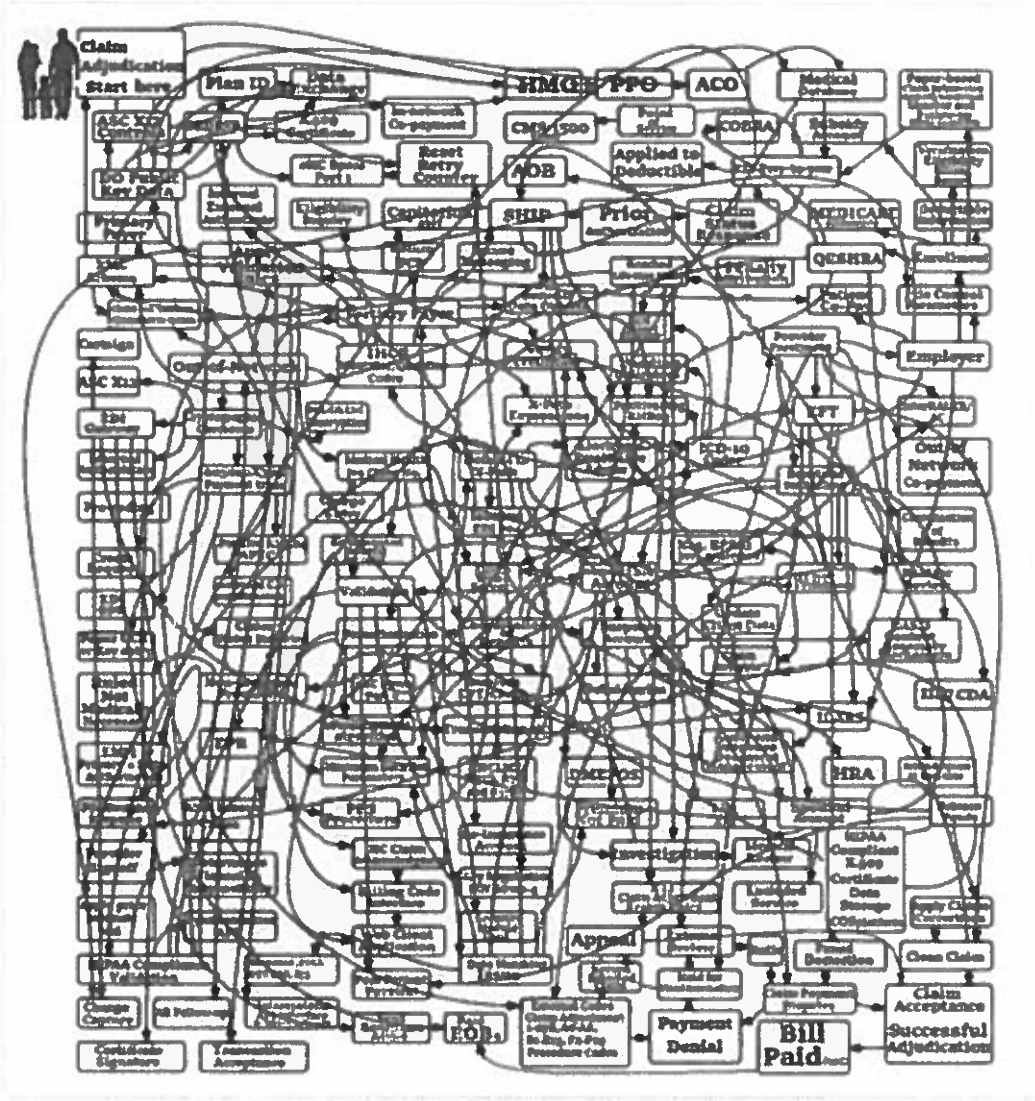
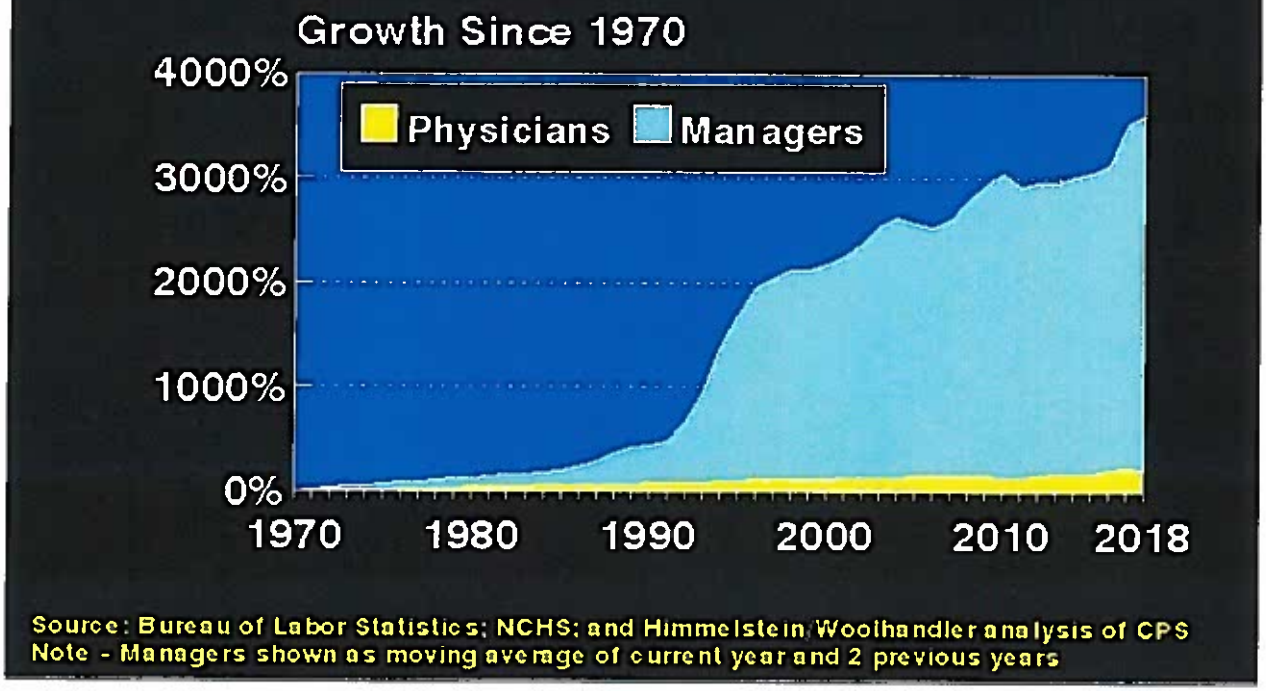
Appendix

U.S. Healthcare Claim System Payment Infrastructure



Note: Claims adjudication is the process by which a third-party payer receives the claims of an insured member's medical bills. Claims for those bills are then accepted or rejected based on the member's insurance policy. In the US there are hundreds of Payers, each offering perhaps hundreds of differently structured health insurance policies. This means that for each Payer there are tens of thousands of permutations based on the benefit structures they offer. Providers and insured plan members alike must navigate their system in order to be assured of payment for any insured service. In the United States, the healthcare claim payment infrastructure for any one Payer looks something like this figure, but all Payers have their own unique architecture and mechanisms for completing the adjudication process.
Henry Broeska, forthcoming.

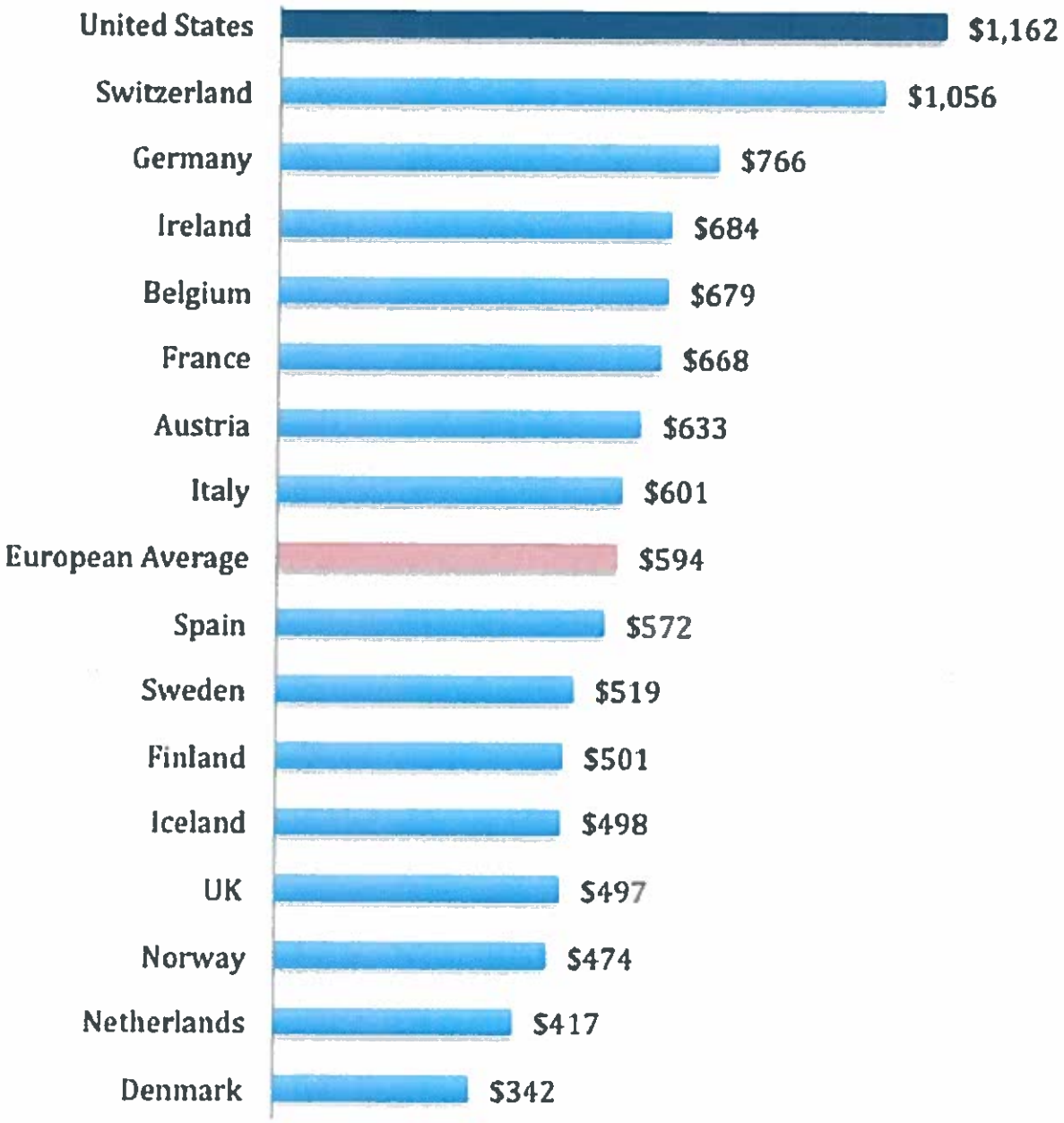
Growth of Physicians and Administrators 1970-2018



Source: Bureau of Labor Statistics; NCHS; and Himmelstein Woolhandler analysis of CPS
Note - Managers shown as moving average of current year and 2 previous years

Per Capita Prescription Drug Expenditures

US vs. Europe, 2015 (US $)



Source: OECD (2018), Pharmaceutical spending (indicator). doi: 10.1787/998febf6-en (Accessed on 13 May 2018). https://data.oecd.org/healthres/pharmaceutical-spending.htm

Note: All values are expressed in U.S. dollars based on purchasing power parities (PPPs), which are the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries. In their simplest form, PPPs show the ratio of prices in national currencies of the same good or service in different countries. This indicator is measured in terms of national currency per US dollar.

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[12] According to national Census data, in 2018 medical out-of-pocket (OOP) expenses accounted for 8 million out 41.2 million people living in poverty or 19.3%. Applying this percentage to the number of people living in poverty in New York (2.73 million), amounts to 527,000 persons who would be lifted out of poverty by eliminating OOP expenditures under the New York Health Act.