Senator Melissa Murray, Chair
Senate Health & Human Services Committee
RE: Support for S2567

Dear Chairwoman Murray,

I am writing in support of S2567, the Universal and Unified Healthcare System Act.

The title of the bill, the Universal and Unified Healthcare System Act, explains the why this act is necessary: the phrase "U.S. health care system" is an oxymoron. It's not a system. Economist Jeffrey Sachs has described it as "a hodgepodge of overpriced monopolies whether for profit or not for profit." He priced the waste at $1 trillion per year[i].

As a practitioner of Lean process improvement techniques, I evaluate health care policy through a lean lens. While Lean is best known for its application to manufacturing, its method of maximizing cost-effective value by minimizing handoffs can be applied to any process. Since the use of insurance companies as intermediaries between patients and providers is a substantial contributor to administrative overhead, I advocate for a universal health care system.

To illustrate the point in the Medicaid program, we can look to our neighboring State of Connecticut. In 2009, an audit found that Connecticut overpaid managed care organizations (MCOs) by nearly $50 million. In 2012, the state discontinued using MCOs for its Medicaid program, saving in excess of $40 million. The gains were not solely financial. Moving from three MCOs to a common administrative entity consolidated patient data, allowing primary care doctors access to information about their patients' prescriptions, hospital admissions and treatment by specialists. That knowledge would "help doctors reduce duplication, avoid errors and ensure patients follow through with their treatment plans," according to (then) Social Services Commissioner Roderick Bremby.

In subsequent pages I've included relevant excerpts from my book, *A Public Sector Journey to Operational Excellence: Applying Lean Principles to Public Policy,* which further document reasons to support universal health care.

Sincerely,
Kate McGovern
Providence

Excerpts from *A Public Sector Journey to Operational Excellence: Applying Lean Principles to Public Policy*.[1]

U.S. health care is delivered by a multitude of disparate parts, among public, private, and non-profit institutions and individual providers. In contrast, as Dr. Michael Fine, Rhode Island's former Director of Public Health Services defines it: "A health care system is an organized set of services and products made available to the entire population and designed to achieve a predetermined set of outcomes."

Economist Jeffrey Sachs testified to the Congressional House Oversight and Reform Committee, explaining that U.S. health care is not a system, it's "a hodgepodge of overpriced monopolies whether for profit or not for profit." Dr. Sachs priced the waste at $1 trillion per year[ii].

The U.S. spends a far greater percentage of GDP on health care than any other country. In a study of 11 high income countries, The Commonwealth Fund reported that the United States ranked last in access to care, administrative efficiency, equity, and health care outcomes such as life expectancy and infant mortality. Ten of the countries spent 9-12 percent of GDP, while the United States spent 16.8 percent. Why this inverse relationship between cost and quality?[iii]

The Commonwealth Fund's report ranked the United States last in "how well health systems reduce documentation (paperwork) and other bureaucratic tasks that patients and clinicians frequently face during care." Such administrative obstacles lead to higher costs and lesser quality. From a lean perspective, it is useful to apply Deming's observation that uncontrolled variation is the enemy of quality. Complexity and waste go hand in hand.

Hundreds of insurance companies market a myriad of policies. Employers and individuals shop for policies, attempting to balance price and coverage.

Health coverage was out of reach for more than 46 million Americans prior to the passage of the Affordable Care Act (ACA). The combination of Medicaid expansion and subsidies for insurance purchases expanded coverage for nearly 20 million people.[iv] However, access to care remains out of reach for millions, as the wastes of complexity and variation in the private insurance market persist. A range of policies are available on the exchange, Healthcare.gov, color coded as bronze, silver, gold, or platinum to indicate the levels of deductibles. Plans may be in an HMO, PPO, POS, or EPO with specific in-network providers.

[1] Kate McGovern, MPA, Ph.D. (Routledge, 2024)

In addition to the administrative complexity, insurance company profits, executive salaries, lobbying and advertising further add to the costs unrelated to medical care.

Dealing with insurance companies as intermediaries requires time on the part of both patients and medical providers. For providers, it requires considerable effort unrelated to medical care. Significant resources are devoted to reconciling patients' medical needs with their available coverage.

Wasted expertise and effort

The waste includes the time and effort expended by medical personnel for non-medical purposes: [v]

- Physicians were spending 3.4 hours per week interacting with multiple payers, including to obtain prior authorizations.
- Nurses and medical assistants were spending 20.6 hours per physician per week interacting with health plans.
- Administrative costs per physician per year are estimated to be $82,975

… the patchwork maze of insurance plans continues to have negative consequences for many patients:

- One in 10 adults owed significant medical debt for a total estimated at $195 billion in 2019. High deductibles and other forms of cost sharing resulted in bills people were unable to pay, even if insured. A Kaiser Family Foundation study noted "that people with unaffordable medical bills are more likely to delay or skip needed care in order to avoid incurring more medical debt, cut back on other basic household expenses, take money out of retirement or college savings or increase credit card debt."[vi]
- A survey conducted by Stanford Professor Jeffrey Pfeffer and Gallup found that Americans were spending about 12 million hours per week on the phone with insurance companies.[vii]
- The cost of time spent by employees dealing with health insurance administration on and off the clock approached $33 billion. The consequent productivity impact on employee job satisfaction was estimated at $95.6 billion.[viii]

Universality applied to health care

Medicare, like Social Security, applies without regard to income. The principle of universality allows an overhead of less than two percent.[ix] However, the U.S. health care market is a hodgepodge of public programs and private insurance plans which generate massive overhead.[x]

FDR and his successor Harry Truman both proposed universal access to health care. Yet even incremental gains faced strong political opposition. It was not until 1965 that Medicare passed, and then, only for people 65 and older.

Using Medicare's lean design of universality, all Americans could have access to health care. As the Yale Public Health Study on pandemic mortality reported, such a policy change would save lives and money. The study characterized "Medicare for All as Pandemic Preparedness" concluding:

> The COVID-19 outbreak has underscored the societal vulnerabilities that arise from the fragmented healthcare system in the United States. Universal healthcare coverage decoupled from employment and disconnected from profit motivations would have stood the country in better stead against a pandemic… Universal single-payer healthcare is fundamental to pandemic preparedness. We determined that such a system could have saved 211,897 lives in 2020 alone. Strikingly, it would have done so at lower cost than the current healthcare system, saving the US $459 billion in 2020 at a time of economic tumult. To facilitate recovery from the ongoing crisis and bolster pandemic preparedness, as well as safeguard well-being and prosperity more broadly, now is the time to transition to a healthcare system that can better serve the American people.[xi]

Complexity. Access to medical care is only one part of a series of the complex factors that contribute to wellbeing. When life expectancy in the U.S. declined to lowest level since 1996, Dr. Steven Woolf explained, "We are unique from other countries also in the massive amount of money we spend on health care, much higher than other countries and much higher than countries in which people live longer lives and are healthier. So, this is a lesson that health care is only a partial answer. Studies suggest it only accounts for about 10 to 20 percent of health outcomes. Our health is really shaped by our living conditions, jobs, the wages we earn, our wealth accumulation, the education that enables us to get those jobs. And we're struggling in those areas.[xii]

What would a cohesive health care system look like?

A functioning system is not just about funding streams. Seeking to design an integrated system, Dr. Michael Fine, Rhode Island's former Director of Public Health Services, studied models in other countries. Drawing on a model used in Finland, he recommended a system of municipal health centers, each serving 10,000 people[xiii].

The centers would provide 90% of the area's health care needs, including medical, dental, behavioral, and preventive care. Staff would include social workers, counselors, nutritionists, and physical therapists. It would be open evenings and weekends. It would be

responsible for ensuring all immunizations and screenings for the entire population of that community were up to date. Services would include recovery and wellness programs.

The integrated model meets the lean criteria: more efficient, better customer value. It could be at the core of a functional, cost-effective, and humane health care system.

In his final State of the Union address, FDR proposed a Second Bill of Rights to include “the right to adequate medical care and the opportunity to achieve and enjoy good health.” On the 3rd anniversary of Social Security in 1938, FDR declared, “We must face the fact that in this country we have a rich man’s security and a poor man’s security and that the Government owes equal obligations to both. National security is not a half and half matter: it is all or none.”[xiv]

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[i] Jeffrey Sachs. Testimony to the House Oversight and Reform Committee on Examining Pathways to Universal Health Coverage. March 29, 2022

[ii] Jeffrey Sachs. Testimony to the House Oversight and Reform Committee on Examining Pathways to Universal Health Coverage. March 29, 2022

[iii] The Commonwealth Fund. Mirror, Mirror 2021: Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries. August 4, 2021. https://www.commonwealthfund.org/publications

[iv] Jennifer Tolbert, Patrick Drake, and Anthony Damico . “Key Facts about the Uninsured Population.” The Kaiser Family Foundation (KFF). December 19, 2022. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[v] Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons, and Lawrence P. Casalino. “US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers.” Health Affairs. August 2021. https://doi.org/10.1377/hlthaff.2010.0893.

[vi] Matthew Rae, Gary Claxton, Krutika Amin, Emma Wager, Jared Ortaliza, and Cynthia Cox. “The burden of medical debt in the United States.” Peterson-KFF. March 10, 2022. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/

[vii]Dan Weissmann. “An Arm and a Leg’: Hello? We Spend 12 Million Hours a Week on the Phone With Insurers.” Kaiser Health Network. Podcast. October 18, 2021. https://khn.org/news/article/an-arm-and-a-leg-hello-we-spend-12-million-hours-a-week-on-the-phone-with-insurers/

[viii] Jeffrey Pfeffer, Dan Witters, Sangeeta Agrawal, James. K. Harter. Magnitude and effects of “sludge” in benefits administration: How health insurance hassles burden workers and cost employers.” https://jeffreypfeffer.com/wp-content/uploads/2020/10/AMD-Benefits-Pfeffer.pdf

[ix] CMS.gov. 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund. https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

[x] The Commonwealth Fund. Mirror, Mirror 2021: Reflecting Poorly. https://commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly. Accessed December 8, 2022.

[xi]Galvani AP, Parpia AS, Pandey A, Sah P, Colón K, Friedman G, Campbell T, Kahn JG, Singer BH, Fitzpatrick MC. Universal healthcare as pandemic preparedness: The lives and costs that could have been saved during the COVID-19 pandemic. Proc Natl Acad Sci U S A. 2022 Jun 21;119(25):e2200536119. doi: 10.1073/pnas.2200536119. Epub 2022 Jun 13. PMID: 35696578; PMCID: PMC9231482.

[xii] PBS Newshour. “U.S. life expectancy falls to lowest level since mid-1990s due to COVID and drug overdoses.” December 22, 2022. https://www.pbs.org/newshour/show/u-s-life-expectancy-falls-to-lowest-level-since-mid-1990s-due-to-covid-and-drug-overdoses

[xiii] Michael Fine. (2018) *Health Care Revolt*. PM Press.

[xiv] Social Security.gov. “FDR's Statements on Social Security” https://www.ssa.gov/history/fdrstmts/html.