



## Testimony to the Joint Committee on Health Care Financing

by Josh Archambault

Thursday, December 15, 2011



### Testimony on: S. 501/ H. 338 “An Act establishing Medicare for all in Massachusetts”

Thank you to Chairman Moore, Chairman Walsh and to the Committee members for the opportunity to submit testimony on this important topic. Everyone agrees that health care spending is too high, and better outcomes are desired. However, the proposal before you today raises some troubling questions that need to be further explored before this committee supports moving this bill out of committee.

Instead of offering testimony at the 20,000 foot level on the wisdom or folly of a single payer system, I have included a number of questions below to start a conversation about particular provisions in this bill that should be examined closely. But first, I think a brief discussion about implementation challenges for such a health care regime is paramount.

#### Implementation Challenges

In order for a single-payer system to be successful at the state level, a number of hurdles must be addressed. First, the federal government would need to grant waivers for all programs that use federal money. S. 501 appears to advocate for matching funds from the federal government, which would increase the overall federal dollars spent in the state as it would replace billions spend by nonself-insured employers. If true, this legislation would require additional money to be appropriated to the state.

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Secondly, self-insured companies (companies who hold all the risk for their employees health costs) are not regulated by state law, but by the Employee Retirement Income Security Act (ERISA) federal law, so a single-payer system would need these employers to opt-in to such a system.<sup>1</sup> Currently, fifty-three percent of covered employees in Massachusetts work for self-insured companies. In other words, for a successful single-payer system, every large employer would need to opt-in, or the state would be running a parallel health care system. Or a much worse outcome could be that companies simply leave the state taking jobs with them.

Finally, Massachusetts would need out-of-state hospitals and governments to work with the Commonwealth, to agree to the conditions that Massachusetts sets out for payment rates and for reimbursing for care received in the Bay State by the other states' residents. This might be a challenge given the political and budgetary realities of the other states in New England.

### **Policy Questions and Tradeoffs**

#### *Access*

- Does access to health insurance guarantee access to health care?
- What will be the impact on wait times under a single-payer system in our state?

#### *Economic/Budgetary*

- One of the mechanisms for saving money in a single payer system is to set, and often decrease, provider fees. The Legislature should explore the side effects of suppressing provider fees. Will there be provider supply issues that emerge, cost-shifting, or increased political lobbying efforts around limited resources? If

provider fees are suppressed to keep “costs down,” will a two tiered medical system emerge for those that afford to pay cash?

- Will there be significant side effects on innovation and research in the medical system? How does the less than 1 percent of Trust money for research and development set aside in the bill compare to current money being spent? [Section 19 subsection 5] How will R&D money be distributed, and what are the criteria for its allocation?
- How will the state sustain the reform with little/no penalty for free riding?

Section 20 subsection B: *“Eligibility for benefits shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by the Trust.”*

- What is the cost of the added levels of bureaucracy in the bill? For example, what is the break out in spending for the board of trustees, executive director of the Trust, director and staff of regional offices, the administrative division, the IT division, the planning division, the quality assurance division, and professional advisory committees?
- How will information technology mandates in the bill be paid for, especially at community and rural hospitals?
- What are the cost estimates and projections of the impact on economic activity for a 7.5 percent employer payroll tax, 2.5 percent employee payroll tax, 10 percent tax on the on self-employed, and 12.5 percent tax on unearned income?
- How many employees lose their job due to this act, especially in the medical services

and insurance industries? Will the state have plans in place to help with retraining and placement?

- How will additional cost overruns be paid for in the future?
- How will the care for undocumented aliens and new residents (residents for less than 90 days) be paid?
- Will the proposed payroll tax financing structure help the rich and hurt the poor?

Section 20 subsection B: *“An employer, private or public, may agree to pay all or part of an employee’s payroll tax obligation. Such payment shall not be considered income for Massachusetts income tax purposes.”* Current anti-discrimination laws require equal contribution levels for equal coverage for all employees. A switch in the law would incentivize employers to pay the tax for senior and middle management with pre-tax dollars, but the janitors would be left to pay the tax with post-tax dollars and out of their take home pay.

- How likely are lawsuits against the state given the vague nature of some of the provisions?

For example, Section 5 subsection 9: *“To ensure that all Massachusetts residents receive care **appropriate to their special needs** as well as care that is culturally and linguistically competent.”*(bolding added)

- What are the total administrative costs for administering a single-payer system including the collection of taxes and the governmental salaries to monitor compliance?
- How will the states’ Medicare-for-all program differ from the national Medicare

trend of roughly 11 percent loss rate due to fraud in the program?

### **Medical**

- How will the patient and doctor relationship be impacted, especially if some form of rationing is implemented?
- Who defines medically appropriate treatment?

Section 5 subsection (a): *“ providing reimbursement for all medically appropriate health care services offered by the eligible provider or facility of each resident’s choice.”*

- How much flexibility will be left for medical providers and hospitals?

For example, Section 12: Quality Assurance Division – deciding guidelines for *“(a) appropriate staffing levels (b) appropriate medical technology (c) design and scope of work in health workplace; and (d) evidence-based best clinical practice.”*

- The bill puts not more than 1 percent of trust income to fund future long-term care costs. Does this account fully for the oncoming wave of baby boomers if they are starting to retire now but are not enrolled in national Medicare?
- How are non-working students studying in Massachusetts covered for insurance and accessing care in this system?

### **Governance**

- Is the General Court comfortable with the Trust being run by unelected officials and without Legislative oversight?
- How broad is the regulatory authority given to the trust?

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Section 4 subsection 13, the trust is given the powers “to do any and all other things necessary and convenient to carry out the purposes of this chapter.”

- Will the executive director have the time and expertise to review and determine appropriate medical action for all individual cases of patients around the world?

Section 13: “The executive director may require that a resident be transported back to Massachusetts when prolonged treatment of an emergency condition is necessary.”

- Who will set salary levels and what will be the cut off?

Section 15: “Payments for operating expenses shall not be used to finance.... payment of exorbitant salaries.”

- How much will political considerations be injected into the single-payer system?

Section 5 subsection 13: “8 members of the public elected to the Trust...”

- What is the mechanism by which the state will collect money from non-residents receiving care here?

Finally, legislators should make sure to scrutinize every claim of savings and data presented. This discussion can quickly become one of ideology, instead of fact. In fact, there has been significant debate over the claims of slower cost growth and administrative savings by supporters of a single-payer system.<sup>2</sup> Before the Legislature radically alters the health care sector in Massachusetts, all assumptions should be questioned and examined closely. Thank you for your time and consideration.

### Endnotes

1. Employee Retirement Income Security Act of 1974.
2. For example, when accounting for growth in costs in the Medicare program, per capita spending in excess of GDP growth from 1975 to 2008, actually shows Medicare growing more quickly than private insurance [2.5% versus 1.8%]. Congressional Budget Office, “The Long-Term Budget Outlook,” Revised August 2010. Located at: <http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf> (12/13/11)

A study done by a Milliman, Inc. consulting actuary has shown that when all costs are calculated, Medicare can cost more to administer than private insurance. Mark Litow, “Rhetoric vs. Reality: Comparing Public and Private Health Care Costs,” Council for Affordable Health Insurance, 1994

### About Pioneer

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