The following text contains the testimony of Dr. David Himmelstein at a hearing on "Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families" organized by Health, Employment, Labor and Pensions Subcommittee of the House Committee on Education and Labor on April 23 in Washington.

April 23, 2009

Mr. Chairman, members of the Committee. My name is David Himmelstein. I am a primary care doctor in Cambridge, Massachusetts, and associate professor of medicine at Harvard. I also serve as national spokesperson for Physicians for a National Health Program. Our 16,000 physician members support nonprofit, single-payer national health insurance because of overwhelming evidence that lesser reforms will fail.

Health reform must address the cost crisis for insured as well as uninsured Americans. My research group found that illness and medical bills contributed to about half of all personal bankruptcies in 2001, and even more than that in 2007. Strikingly, three-quarters of the medically bankrupt were insured. But their coverage was too skimpy to protect them from financial collapse.

A single-payer reform would make care affordable through vast savings on bureaucracy and profits. As my colleagues and I have shown in research published in the New England Journal of Medicine, administration consumes 31 percent of health spending in the United States, nearly double what Canada spends. In other words, if we cut our bureaucratic costs to Canadian levels, we'd save nearly $400 billion annually — more than enough to cover the uninsured and to eliminate co-payments and deductibles for all Americans.

By simplifying its payment system, Canada has cut insurance overhead to 1 percent of premiums — one-twentieth of Aetna's overhead — and eliminated mounds of expensive paperwork for doctors and hospitals. In fact, while cutting insurance overhead could save us $131 billion annually, our insurers waste much more than that because of the useless paperwork they inflict on doctors and hospitals.

A Canadian hospital gets paid like a fire department does in the U.S. It negotiates a global budget with the single insurance plan in its province, and gets one check each month that covers virtually all costs. They don't have to bill for each Band-Aid and aspirin tablet. At my hospital, we know our budget on January 1, but we collect it piecemeal in fights with hundreds of insurers over thousands of bills each day. The result is that hundreds of people work for Mass General's billing department, while Toronto General employs only a handful — mostly to send bills to Americans who wander across the border. Altogether, U.S. hospitals could save about $120 billion annually on bureaucracy under a single payer system.

And doctors in the U.S. waste about $95 billion each year fighting with insurance companies and filling out useless paperwork.

Significantly, these massive potential savings on bureaucracy can only be achieved through a single payer reform. A health reform plan that includes a "public plan option" might realize some savings on insurance overhead. However, as long as multiple private plans coexist with the public plan, hospitals and doctors would have to maintain their costly billing and internal cost tracking apparatus. Indeed, my colleagues and I estimate that even if half of all privately insured Americans switched to a public plan with overhead at Medicare's level, the administrative savings would amount to only 9 percent of the savings under single payer.

While administrative savings from a reform that includes a Medicare-like public plan option are modest, at least they're real. In contrast, other widely touted cost control measures are completely illusory. A raft of studies shows that prevention saves lives, but usually costs money. The recently completed Medicare demonstration project found no cost savings from chronic disease management programs. And the claim that computers will save money is based on pure conjecture. Indeed, in a study of 3,000 U.S. hospitals that my colleagues and I have recently completed, the most computerized hospitals had, if anything, slightly higher costs.

My home state of Massachusetts recent experience with health reform illustrates the dangers of believing overly optimistic cost control claims. Before its passage, the reform's backers made many of the same claims for savings that we're hearing today in Washington. Prevention, disease management, computers, and a health insurance exchange were supposed to make reform affordable. Instead, costs have skyrocketed, rising 23 percent between 2005 and 2007, and the insurance exchange adds 4 percent for its own administrative costs on top of the already high overhead charged by private insurers. As a result, 1 in 5 Massachusetts residents went without care last year because they couldn't afford it. Hundreds of thousands remain uninsured, and the state has drained money from safety-net hospitals and clinics to keep the reform afloat.

In sum, a single-payer reform would make universal, comprehensive coverage affordable by diverting hundreds of billions of dollars from bureaucracy to patient care. Lesser reforms — even those that include a public plan option — cannot realize such savings. While reforms that maintain a major role for private insurers may seem politically expedient, they are economically and medically nonsensical.

Physicians for a National Health Program
29 E Madison Suite 602, Chicago, IL 60602
Phone (312) 782-6006 | Fax: (312) 782-6007 | email: info@pnhp.org
© PNHP 2009