

Show Me Series: Report 3
A Universal Health Care Plan for Missouri

The Missouri Foundation for Health (MFH) was created on January 6, 2000 as a part of a negotiated agreement among Blue Cross/Blue Shield of Missouri (BCBSM), the Missouri Department of Insurance and the Missouri Attorney General following the for-profit conversion of BCBSM. The Foundation received a significant portion of the assets of RightChoice, the for-profit created by the conversion. MFH is dedicated to improving the health of the people in the BCBSM service area, which encompasses 84 Missouri counties and the City of St. Louis.

In support of its mission, MFH undertakes policy studies on topics of significance to the Foundation service area and beyond. MFH has created the Show Me Series to convey information about current health related issues of interest to a broad audience ranging from members of the general public to policymakers.

Show Me Series: Report 3

A Universal Health Care Plan for Missouri

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PREFACE

When access to needed medical care is linked to employment or eligibility for narrowly defined governmental programs, significant numbers of individuals are excluded from care. This characterizes the situation in the United States and in Missouri. It is estimated that more than 575,000 Missourians, many of them children, had no health coverage at all during 2002. When those who are uninsured for part of the year are considered, nearly 25 percent of the Missouri population under age 65 were without coverage for a part of 2002. This is despite the fact that Missouri residents are somewhat more likely to be covered by employment-based health insurance than the national average.

Studies have amply demonstrated that the uninsured are sicker and die younger than those with insurance. Particularly troublesome is the number of children included among the uninsured – they make up 18 percent of that population. Denied needed care in childhood, they carry a burden of poorer educational performance and an increased chance of lifelong poor health.

In October 2003, the Missouri Foundation for Health released a study titled *Health Care Expenditures and Insurance in Missouri* that projects expenditures of \$30 billion for the year. This study, which used a comprehensive methodology to capture all such expenditures regardless of source, was prepared by Kenneth E. Thorpe, Robert W. Woodruff Professor and Chair, Department of Health Policy and Management at Emory University’s Rollins School of Public Health. It provided the best available estimate of the total investment in medical care for citizens of Missouri. It was commissioned to give a baseline spending amount that could be the reference point for proposals to deal with the problem of uninsured and underinsured in the state.

Fig. 1. A Spectrum of Options

Single Payer Systems

- ❖ National health service
- ❖ Social insurance
- ❖ Medicare expansion

Employment-Based Reforms

- ❖ Mandatory employer systems
- ❖ Voluntary employer systems
- ❖ “Play-or-Pay”

Market-Based Incremental Reforms

- ❖ Insurance market reform
- ❖ Vouchers/tax credits
- ❖ Expansion of managed care
- ❖ Administrative cost reduction

There are many options for reducing the number of uninsured, whether nationally or in a state. The goal of most such proposals is to achieve a degree of universal coverage, whether through a single program or a mix of approaches. These options can be viewed as a spectrum (Fig.1).

The challenge to policymakers attempting to deal with the issue of the uninsured and underinsured has been selection of the option or mix of options that would reduce the number of uninsured while achieving sufficient political consensus to enable adoption. Each of the options has some benefit to the uninsured but also has a cost to one or more interest groups involved in the health system. This has tended to paralyze the policy process and preclude real progress toward reducing the number of uninsured individuals.

Professor Thorpe was asked to undertake a second study to determine the cost of a universal insurance plan covering all Missouri residents under 65, and to compare that cost to the current expenditure. The model chosen by Professor Thorpe was a single payer plan financed through a payroll tax – similar to the financing of the Federal Medicare program. The latter program already covers those 65 and over.

This paper presents the results of the Thorpe study of a single payer plan for Missouri. The Missouri Foundation for Health is publishing findings of this research as a contribution to the dialogue about how to provide health insurance coverage to the over 575,000 uninsured residents of our state. We hope this paper will spur a healthy discussion that will ultimately result in greater health care coverage for all Missourians.



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About the Author

Kenneth E. Thorpe, PhD, is the Robert W. Woodruff Professor and Chair of the Department of Health Policy & Management in the Rollins School of Public Health of Emory University, Atlanta, GA. He received his PhD from the Rand Graduate School, an MA from Duke University and his BA from the University of Michigan.

Dr. Thorpe was previously at the University of North Carolina at Chapel Hill and also spent time at the Harvard University School of Public Health and Columbia University. He served as Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services.

Dr. Thorpe has authored and co-authored over 60 articles and books and is a frequent national presenter on issues of health care financing, insurance and health care reform. Because of his expertise in these areas, he was solicited by MFH to write this paper.

Show Me Series: Report 3

A Universal Health Care Plan for Missouri

This paper estimates the necessary changes in statewide health care spending and the distribution of that spending to create a universal health care plan for the state of Missouri.¹ The estimates make the following assumptions:

- All residents of the state under the age of 65 would receive a health plan.
- On average, payments to providers would remain at rates similar to those paid today by private health plans.
- Administrative costs would be lower under the plan. The universal health care plan would include uniform and electronic billing from all private plans. There would be a single claims form similar to the one currently used by Medicare. All plans would pay hospitals and physicians using the same methodology.²
- Existing program revenues from Medicare, Medicaid and other federal programs, as well as a new payroll tax, would finance plan costs. Premiums currently paid by employers and employees would be replaced with a uniform payroll tax paid by employers and employees.
- The payroll tax would be set to finance the cost of those currently privately insured as well as those uninsured.

CHANGES IN USE OF SERVICES

Under the universal plan, health care spending for the currently uninsured would rise and spending among some portion of the insured would also increase. The plan assumes that the level of spending per uninsured individual would rise to the level of spending among those currently with insurance.³ Three different coverage options are modeled:

- Typical of private health insurance plans found in the state (similar to the Blue Cross and Blue Shield standard option plan found in the Federal Employees Health Benefits Program); or
- A plan that is 25 percent more generous (i.e., the ratio of benefits paid to total expenses is set at the 75th percentile in the distribution of actuarial plan values in the state); or
- A plan that is 25 percent less generous than plans typically found in the state.

It is assumed that spending among those with insurance – about half of those with private insurance in the state – would rise to the level of spending consistent with the level of benefits selected.⁴

Movement to a universal health care system should result in a substantial reduction in administrative costs. This reduction in administrative costs simply involves transactions and benefits; it does not relate to existing quality assurance or cost containment efforts. Rather the reduction in program administrative costs results from streamlining the claims processing system and reducing marketing costs and commissions. As a result, it is assumed that the level of insurance administration cost declines to the level reported by the Medicare program (about 8 percent less than private insurance).

Provider administrative costs are also assumed to decline as a result of the changes from the current system. This study found that in Canada's single payer system administrative costs associated with hospitals average 13 percent. Administrative costs in U.S. hospitals average 24 percent.⁵ This study's projections also assume the administrative costs for practitioners would fall from the current average of 35 percent (among U.S. physicians) to approximately 20 percent.⁶

Tables 1 through 3 present the change in spending associated with enrolling those with private insurance and the uninsured in one of the three universal plans studied. Table 1 presents the costs assuming that all are enrolled in a plan typically found in the state. Table 2 presents the costs resulting from enrollment in a more generous health plan, while the final table examines the costs associated with enrolling the population in a less generous private plan.

In each case, the savings associated with streamlined administration, a single bill and uniform payment across all plans are greater than the new costs of covering the uninsured and the costs associated with the underinsured upgrading their benefits.

Assuming the universal health care plan adopted a benefit package typically found in the state (Table 1), spending among the uninsured and underinsured would rise by nearly \$1.3 billion when fully implemented. On the other hand, the use of a streamlined, single claims and billing form (electronically billed) would reduce overall spending by about \$3 billion. As a result, spending on health care would decline by approximately \$1.7 billion.

Even if the state adopted a more generous benefit package – one more generous than 75 percent of all private insurance benefits in the state – overall spending would still decline (Table 2). In this case, spending among the uninsured and insured would rise by \$1.7 billion, yet administrative costs would still decline by \$3 billion. Overall, health care spending would likely decline by \$1.3 billion under the streamlined administrative structure.

Health care spending in the state would rise by \$734 million if the state adopted a health plan 25 percent less generous than a typical private insurance package (Table 3). However, the administrative savings of the universal plan would exceed \$3 billion (10 percent of total spending) resulting in lower health care spending than today.

RESULTS

Table 1. Health Care Spending in Missouri, Current Policy and Universal Health Plan, 2003 (millions of dollars)

UNIVERSAL PLAN – TYPICAL BENEFITS

Projected 2003 Health Care Spending Under Current Policy		\$ 29,444
Change in Spending Under Universal Health Plan		\$ 1,287
Increased spending for the uninsured	\$ 661	
Increase spending for the underinsured	626	
Potential Reductions in Spending		\$ (3,030)
Health insurance administration	(840)	
Hospital administration	(1,090)	
Physician office administration	(1,100)	
TOTAL		\$ 27,701

Table 2. Health Care Spending in Missouri Current Policy and Universal Health Plan, 2003 (millions of dollars)

UNIVERSAL PLAN – MORE GENEROUS BENEFITS

Projected 2003 Health Care Spending Under Current Policy		\$ 29,444
Change in Spending Under Universal Health Plan		\$ 1,722
Increased spending for the uninsured	\$ 790	
Increase spending for the underinsured	932	
Potential Reductions in Spending		\$ (3,030)
Health insurance administration	(840)	
Hospital administration	(1,090)	
Physician office administration	(1,100)	
TOTAL		\$ 28,136

Table 3. Health Care Spending in Missouri Current Policy and Universal Health Plan , 2003 (millions of dollars)

UNIVERSAL PLAN – LESS GENEROUS BENEFITS

Projected 2003 Health Care Spending Under Current Policy		\$ 29,444
Change in Spending Under Universal Health Plan		\$ 734
Increased spending for the uninsured	\$ 509	
Increase spending for the underinsured	225	
Potential Reductions in Spending		\$ (3,030)
Health insurance administration	(840)	
Hospital administration	(1,090)	
Physician office administration	(1,100)	
TOTAL		\$ 27,148

DISTRIBUTIONAL IMPACTS OF A UNIVERSAL HEALTH CARE PLAN

The results presented in Table 4 compare spending by employers and individuals under the current system and a universal health care plan. Existing sources of public spending – largely Medicare and Medicaid – are assumed to remain the same as under current policy. Private spending (excluding spending on health insurance premiums) would also remain the same under the plan. Premiums currently paid by employers and individuals with health insurance today would be replaced with a new payroll tax paid by all workers and employers in the state. Today, health insurance premiums are expected to total \$10.4 billion in Missouri. However, since a universal system would generate overall savings, total payroll tax receipts needed to fund the program would be lower. For instance, if a typical health plan were used as the standard benefit package, the state would only need to raise \$8.7 billion in payroll tax receipts. Even with the more generous package, payroll tax receipts would total \$9.2 billion – a \$1.2 billion reduction in private sector spending – under the universal health care plan.

Table 4. Revenue Requirements for Universal Health Care Plan, 2003 (millions of dollars)

Source of Spending	Current Benefits	Typical Benefits	More Generous Benefits	Less Generous Benefits
Federal	\$ 10,206	\$ 10,206	\$ 10,206	\$ 10,206
State and Local	3,386	3,386	3,386	3,386
Other Private Funds*	1,169	1,169	1,169	1,169
Out of Pocket**	4,199	4,178	4,163	4,190
Private Insurance	10,485	0	0	0
Payroll Tax Receipts	0	8,762	9,212	8,197
Total Spending	\$ 29,444	\$ 27,701	\$ 28,136	\$ 27,148

* Includes other private spending (largely philanthropy) as defined in the national health accounts.

** Out of pocket spending by the uninsured and underinsured would fall as more spending flows through the insured part of the benefit.

DISTRIBUTIONAL IMPACTS OF A UNIVERSAL HEALTH CARE PLAN

Table 5 compares spending on health insurance premiums during 2003 in Missouri to payroll tax receipts stratified by baseline insurance status. Today, employers that offer and contribute toward the cost of insurance spend \$8 billion per year. Individuals (both those employed and non-workers) contribute about \$2.45 billion per year toward the cost of health insurance. Under a universal approach (for a typical insurance plan), employers that currently offer insurance would contribute \$6.5 billion (assuming they account for 80 percent of the payroll tax receipts) – nearly \$1.5 billion less than today. Individuals would contribute \$1.6 billion – approximately \$800 million less than under today’s system.

On the other hand, the uninsured and employers that do not offer health insurance benefits would pay more through the tax mechanism. Payroll tax receipts among employers that do not offer benefits would rise by \$468 million and \$117 million among uninsured individuals. Table 5 also presents results for payroll tax collections using more and less generous benefit packages than typically found in the state.

Table 5. Sources of Private Spending Under Current Policy and a Universal Plan
(millions of dollars)

CURRENT POLICY

	Currently Insured	Currently Not Insured	Total
Employer	\$ 8,034	\$ 0	\$ 8,034
Employees and Dependents	2,451	0	2,451
TOTAL	\$ 10,485	\$ 0	\$ 10,485

UNIVERSAL PLAN – TYPICAL BENEFITS

	Currently Insured	Currently Not Insured	Total
Employer	\$ 6,542	\$ 468	\$ 7,010
Employees and Dependents	1,635	117	1,752
TOTAL	\$ 8,177	\$ 585	\$ 8,762

UNIVERSAL PLAN – MORE GENEROUS BENEFITS

	Currently Insured	Currently Not Insured	Total
Employer	\$ 6,876	\$ 494	\$ 7,370
Employees and Dependents	1,719	123	1,842
TOTAL	\$ 8,595	\$ 617	\$ 9,212

UNIVERSAL PLAN – LESS GENEROUS BENEFITS

	Currently Insured	Currently Not Insured	Total
Employer	\$ 6,120	\$ 438	\$ 6,558
Employees and Dependents	1,530	109	1,639
TOTAL	\$ 7,650	\$ 547	\$ 8,197

DISTRIBUTIONAL IMPACTS OF A UNIVERSAL HEALTH CARE PLAN

Finally, Table 6 examines the payroll tax rates that would be required to finance various versions of a universal health care plan in Missouri. Overall, the payroll tax rates would range from 8.2 percent if less generous benefits were used, to 8.7 percent if a typical set of benefits were the standard, to over 9.1 percent if more generous benefits were used. Assuming (which of course is a design and discussion issue) that employers contribute 80 percent of the overall costs of the plan, payroll taxes would range from 6.5 percent for the least generous benefits to 7.3 percent for more generous insurance benefits.

**Table 6. Payroll Tax Rates Associated with
Three Universal Health Care Plans, 2003**

	Employer Share	Employee Share	Total
LESS GENEROUS BENEFITS	6.52%	1.63%	8.15%
TYPICAL BENEFITS	6.96%	1.74%	8.7%
MORE GENEROUS BENEFITS	7.3%	1.83%	9.13%

A universal health care plan available to all Missouri residents could extend health insurance to all residents and potentially reduce health care spending. Whether overall spending declined would depend on key decisions concerning how the system was administered. Moving to a system that eliminated billing and placed hospitals on budgets and physicians on salaries would generate the greatest administrative savings. This approach could result in slightly lower administrative costs than those estimated in this paper.

A universal plan would involve a substantial redistribution of how health care is financed. Payments to providers would flow through the state. Revenues to fund the plan would derive from all workers and employers, as well as the federal government and the state. A key issue in such an approach is the need to control the growth in health care spending. Typically, health care spending rises faster than workers' wages. If this continues in the future, the payroll tax rates outlined in the estimates would have to rise over time to finance the program. However, by controlling all sources of provider revenue (working in conjunction with Medicare), the state would be positioned to develop effective limits on the growth in health care spending. Controlling the growth in health care spending will be a key challenge facing the state.

CONCLUSIONS

ENDNOTES

1. This paper was prepared for the Missouri Foundation for Health. Any errors are solely the responsibility of the author.
2. Alternatively, the state could place all hospitals on a budget and eliminate claims forms.
3. The change in spending is adjusted for age, gender and health status using tabulations from the Current Population Survey.
4. We have developed a distribution of actuarial values using national data from the Department of Labor. These plan designs were run through the Medical Expenditure Panel Survey to create a distribution of actuarial values for plans nationally. For instance, a person with a health plan in the 25th percentile of benefit generosity spends about 10 percent less than the same person with a plan at the median of the distribution. Thus, all those with private insurance below the median (or 25th or 75th percentile depending on the estimate) are assumed to increase spending to the level (age, gender, health status adjusted) of spending that would occur if they had a more generous (average) plan. The same estimates are made for those individuals with plans below the 25th and 75th percentile of plan generosity. This change in spending is labeled “increased spending for the underinsured.”
5. S. Woolhandler, T. Campbell and D. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine*, 349(8) 21 August 2003:768-775.
6. Expenses attributed to administration derived from Woolhandler combined with data from the Medical Group Management Association, “The Cost and Production Survey, 2001 Report” for data on total physician net revenues and expenses attributed to administration. The resulting change of 15 percent also includes an estimate of additional savings attributed to the use of internet-based electronic billing systems deployed in physicians’ offices (about a 3 to 4 percent additional savings over and above the use of uniform billing).

**Missouri Foundation for Health
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The Missouri Foundation for Health has produced several publications related to the topic of this paper, which may be of interest to the reader. They are:

- ❖ *Show Me Series: Report 1:
Innovative State Programs to
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Lessons for Missouri*
- ❖ *Show Me Series: Report 2:
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