

BEYOND THE AFFORDABLE CARE ACT:

An Economic Analysis of a Unified System of Health Care for Minnesota



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GROWTH & JUSTICE

Minnesota has long been cited as a leader in health care, boasting relatively low rates of uninsured, innovative programs for low-income people and those with high-risk conditions, a history of cooperation and collaboration to improve outcomes and share best practices, internationally recognized medical research and education, leadership in the med-tech industry and a healthier than average population. Despite being a standout in high value care, these reforms, including innovations in health care delivery, have failed to diminish racial disparities in health or guarantee affordable access to quality care for all Minnesotans. Our health care costs are rising at an unsustainable rate. Minnesotans are losing ground.

According to the latest data, more than 10% of Minnesotans are uninsured and an increasing number of employers are dropping employee coverage. Premium increases are far outstripping pay increases and patients are expected to pay a growing share of health care expenses out-of-pocket. Should the federal Affordable Care Act (ACA) survive the court challenge and be fully implemented, it will expand access to insurance, but access will not be universal and a high cost-sharing burden will continue to be placed on patients in order to reduce health spending.

Minnesota should consider reforms that go beyond the critical first steps of the Affordable Care Act and aim to:

- attain universal coverage;
- assure affordability of health care;
- reduce health care inflation; and
- create a more equitable system, reducing racial and economic disparities.

One option for meeting those goals is the so-called single-payer system, a concept supported by Gov. Mark Dayton in his 2010 campaign. Growth & Justice set out to investigate whether, by moving toward a unified system and thereby reducing fragmentation, administrative complexity, and fraud, and by countering the pricing power of our consolidated insurance and provider markets, Minnesota can establish stable, affordable access to health care for every Minnesotan without increasing total health care spending.

The Lewin Group was contracted to conduct an economic impact study of a unified and universal health care system for Minnesota. Lewin modeled a comprehensive plan covering medical, mental health and dental benefits, eliminating deductibles and coinsurance, while using only minimal copays on specialists, hospitalizations, procedures, and diagnostic tests, with coverage for all Minnesota residents. The modeling used a baseline year of 2014 in order to compare to the economic impact of the ACA.

A unified system, as modeled in this report, entails

- a single system of coverage and pooled risk: everyone is in it.
- a uniform, comprehensive benefit set for everyone.
- a single network of all licensed health care providers, and an end to choice-limiting networks.
- a uniform and streamlined enrollment process.
- uniform pricing, payment rules, and payment methods, with monopsony (one-buyer) purchasing power.
- naturally appreciating financing based on wages or income.

FINDINGS

Total state health spending can be reduced by nearly 9% under a unified single-payer plan, as specified above, while eliminating uninsurance in the state. The savings are achieved despite covering the remaining 262,000 Minnesotans who would still be uninsured under the ACA.

EXECUTIVE SUMMARY

Predictable and affordable financing can be achieved through a variety of methods, such as an employer payroll tax coupled with either an employee payroll tax, an individual income tax, or both an individual income tax and a “sin tax” on tobacco and alcohol. This financing would eliminate underinsurance, defined as health care costs which exceed 10% of income.

Lewin found that an employer payroll tax of 9.99% applied to wages over \$12,000 per employee per year (an effective rate of 7.44% based on median wages) would cover the employer contribution to a health care system, retaining the federal tax preference afforded to employer-sponsored health care. Individuals or households would contribute either via a payroll tax of 4.67% applied to wages over \$12,000 per year (an effective rate of 3.36% based on median wages), or an income tax of 3.07% of adjusted gross income (based on median household income.) Adding a sin tax of \$1 per pack on tobacco and 5 cents per drink on alcohol would slightly reduce both the employer and individual contribution.

In addition to facing more predictable costs and eliminating the burden of negotiating and administering health benefits, most employers would save money. Employers who currently offer insurance would save an average of \$1,214 per employee per year. Firms not currently offering insurance would face increased costs as all employers would pay into a unified system as modeled in this report.

A unified system would save money for Minnesota families; the average family would save \$1,240 annually on premiums and would see a small increase in income due to lower employer health care costs. Families with household income over \$150,000 would see an increase in health care spending and would also experience some wage suppression as a result of the impact of the employer health tax. Because financing is based on income, people with significant illness burden would no longer face serious financial barriers to care.

A unified system contains the means and the incentives to control costs by improving efficiency and effectiveness of care. The savings in Minnesota could be as much as 12% to 33% per year by 2023. Health care spending growth on a per capita basis and as a percent of GDP would slow significantly as compared to growth under the Affordable Care Act.

Minnesota has long set goals for reining in health care spending and has consistently failed to meet them as our fragmented system makes cost containment difficult without decreasing access.

Moving to a unified system with a significantly reduced administrative burden will lead to a reduction in health sector employment. Even accounting for the increase in health care jobs in the delivery system due to increased utilization with increased insurance coverage, Minnesota could lose 42,000 jobs in health care administration, though a portion of those jobs would have been newly created under the Affordable Care Act. These lost administrative jobs would be in the insurance sector, hospitals and physician practices. Other published studies have suggested the decrease in health administration employment would be more than made up by employment growth in other sectors.

Minnesota can enact a unified system and assure access to affordable, high quality health care to every Minnesotan regardless of income, age or employment or health status while decreasing total health spending in the state. Significant hurdles remain, logistically and politically. Our escalating costs and the harmful impacts of the current fragmented system on our health and our economy will someday compel us to act boldly.

WHAT DO WE MEAN BY A “UNIFIED” HEALTH SYSTEM?

The term “single-payer” is routinely used to describe all models of universal coverage but in this report we more often use the term “unified” to describe the hypothetical model being analyzed. A unified health care system covers an entire population throughout its life span regardless of differences or changes in income, health status, employment, age or disability. A unified system is based on the concepts of equity and universality rather than on actuarially calculated risk. An ideal unified system establishes a common benefit package, fair and consistent provider reimbursement, and a financing mechanism related to income so as to eliminate financial barriers to health care. A unified system with uniform rules, payment methods and eligibility lowers administrative costs, with a greater proportion of health care dollars being spent on the provision of care. Almost all other industrialized democracies have unified systems. Whether the model is socialized (government financed and delivered) as in England and most of Scandinavia, social insurance (publicly financed, privately delivered) as in Taiwan and Canada, or largely private (using tightly regulated nonprofit insurers) as in Germany, France and Switzerland, these countries have one unified system for everyone; access to health care is equitable, affordable and secure throughout one’s lifetime.





Minnesota has long been cited as a leader in health care, boasting relatively low rates of uninsured, innovative programs for low-income people and those with high-risk conditions, a history of cooperation and collaboration to improve outcomes and share best practices, internationally recognized medical research and education, leadership in the med-tech industry and a healthier than average population. Despite being a standout in high value care, reforms – including innovations in health care delivery – have failed to diminish racial disparities in health or guarantee affordable access to quality care for all Minnesotans. Our health care costs are rising at an unsustainable rate. Minnesotans are losing ground.

CURRENT SITUATION CRITICAL

Access, cost and quality: The trifecta of health care

It has been conventional wisdom that increasing access to insurance coverage will increase health care spending and make it more difficult to control costs; and that if costs are contained, it will be by providing inadequate coverage or withholding care. This has largely been true in the United States, and describes the consequences of most health reform efforts. How reforms affect access, cost and quality, as well as equity and value, is the subject of this report. Exploring more fundamental system redesign to achieve better access, quality, equity, value, and affordability – while controlling spending – is its objective.

ACCESS is typically measured by the percent of people with insurance, though a better measure would be the percent of people who get timely, appropriate and affordable health care.

COST is measured by both per capita spending and percent of GNP spent on health care. On both measures, spending is much higher in Minnesota and the United States than in other industrialized nations, and the growth of spending over time is on an unsustainable path. We have a complex system for financing health care, using federal, state and other taxes, employer and individual premium payments, and individual out-of-pocket costs. Many cost containment strategies have simply relied on cost-shifting to other payers or individuals rather than lowering the costs of insurance or care.

QUALITY refers to the safety, timeliness, appropriateness and effectiveness of care. It refers not just to receiving care appropriate for one's condition – whether preventive, acute or chronic care – but also to avoiding medical errors, and to not getting care which is unnecessary, ineffective, or potentially harmful. Measuring quality is laudable but difficult. An oft-used benchmark measure of quality is amenable mortality – deaths that are preventable by timely and effective care.

Equity refers to the degree to which people have access to timely, affordable, quality care without regard to age, gender, income, employment, race, or health status. And value is the relationship between cost and quality, with an aim to emphasize cost-effective treatments over high cost alternatives which don't confer increased benefit.

The ultimate goal is a health care system that enables people to live long, healthy, productive lives while protecting our state and nation's economic vitality and competitiveness.

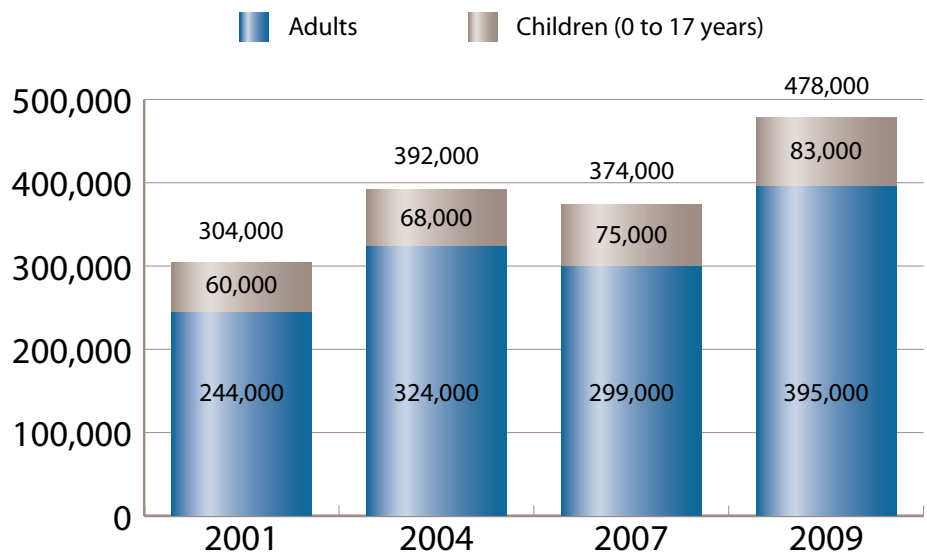
HOW DOES MINNESOTA MEASURE?

Relative to other states, Minnesota has high quality and high value health care, but more Minnesotans are losing access and costs continue to rise at an unsustainable rate. Many employers are dropping coverage, and our public systems are strained by increased need.

Minnesota has a history of bipartisan and public-private cooperation in addressing health care. Two organizations, the Institute for Clinical Systems Improvement and Minnesota Community Measurement, facilitate Minnesota's leadership in health care quality and promotion of evidence-based best practice. Governor Rudy Perpich, a

Democrat, appointed the Health Care Access Commission, a bipartisan health care reform effort which led to the establishment of MinnesotaCare, providing health insurance for low-income working families. MinnesotaCare was signed into law by the Republican governor Arne Carlson. Another Republican governor, Tim Pawlenty, formed a Health Care Transformation Task Force which put forth a comprehensive set of recommendations that formed the basis of legislation enacted in 2008. Some of the Task Force's recommendations were not included in the 2008 Minnesota legislation, but paralleled those in the federal health reform act in 2010.

Estimated Number of Uninsured in Minnesota



Source: Minnesota Department of Health

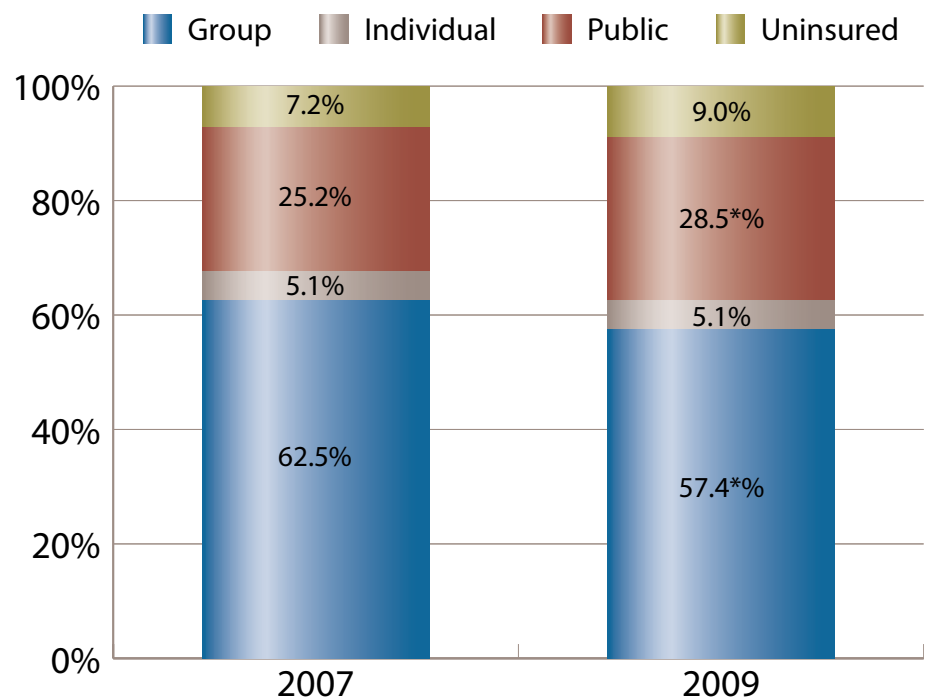
Insurance Coverage

The rank of Minnesota's uninsured grew significantly in the last decade, reaching 10.2% in 2010.¹

Minnesota had the third lowest rate of uninsurance in the country, behind Massachusetts at 5% and Hawaii at 8%. Nationally, 17% of the population is uninsured. Unfortunately, the share of uninsured children in Minnesota saw the fastest increase in the nation over the past two years.² Being uninsured can be fatal; estimates are that more than 300 Minnesotans die each year due to a lack of insurance.³

The share of Minnesotans with employer-based coverage dipped nearly 9% in the last decade, with some of those employees joining the ranks of the uninsured, some shifting to individually purchased insurance, and some moving onto public plans. Fifty-seven percent of Minnesotans have employer-based coverage, 6% purchase individual coverage, and 28% are on public plans (Medicare, Medical Assistance and MinnesotaCare). Ninety-two percent of Minnesota

Sources of Insurance Coverage in Minnesota



* Indicates statistically significant difference at 95% level from 2007.

Estimates that rely solely on household survey data differs slightly from annual estimates that include both survey and administrative data.

Source: Minnesota Department of Health

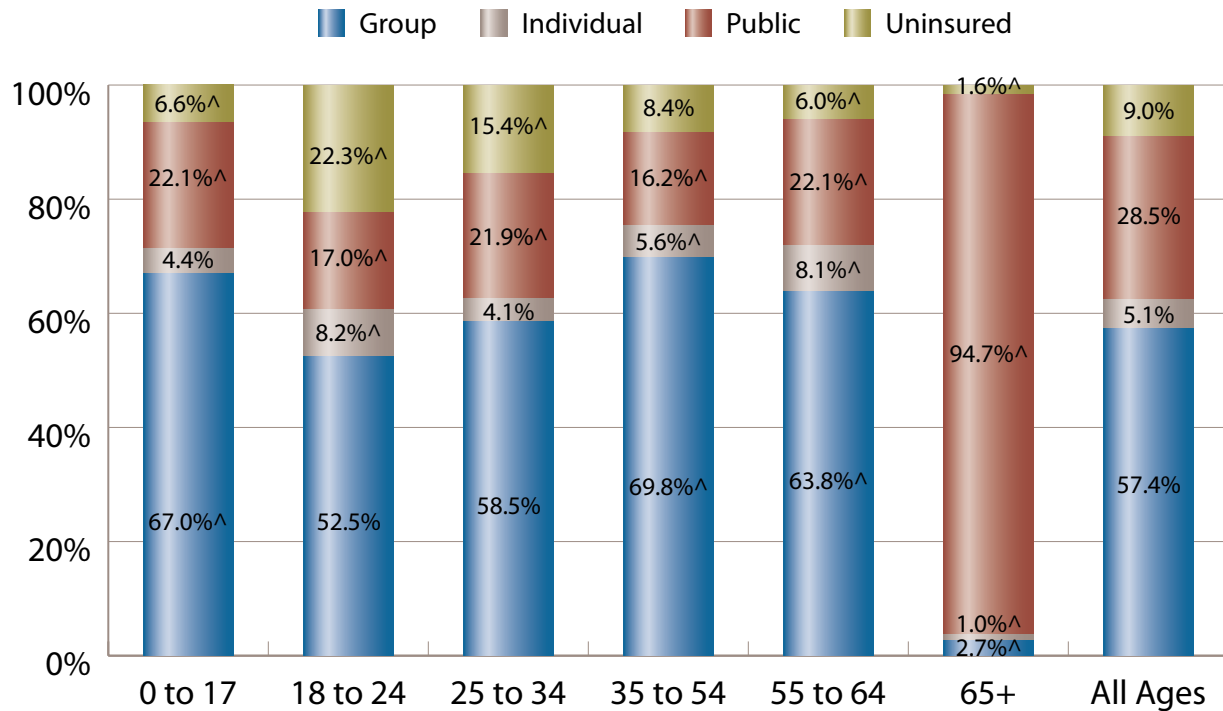
1 DeNavas-Walt, C., Proctor, B., & Smith, J. (2011). U.S. Census Bureau, Current Population Reports, P60-239. *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. U.S. Washington, DC: Government Printing Office.

2 Olson, J. (2011, November 29). Number of uninsured Minnesota kids climbs. *Star Tribune*.

3 Wikler, B. & Bailey, K. (2008). *Dying for coverage in Minnesota*. Washington, DC: Families USA.

employers with more than 50 employees and 34% of employers with fewer than 50 employees offered health insurance; nationally the rates were 96% and 39% respectively.⁴ Ten percent of small companies in Minnesota dropped health insurance coverage in 2009 alone.⁵ Most uninsured Minnesotans work: 68% of our uninsured live in a household with at least one full-time worker, and only 12% live in a household where no one works; nationally the rates are 61% and 23%.

Sources of Health Insurance Coverage in Minnesota by Age, 2009



^ Indicates statistically significant difference from rate for all ages (95% level).

Source: Minnesota Department of Health

Quality and Outcomes

According to state rankings by the U.S. Department of Health and Human Services Agency for Health Care Research and Quality (AHRQ), Minnesota has ranked in the top three states in health care quality since 2006, when the measurements began.⁶ On one key measure, amenable mortality (deaths under the age of 75 preventable through timely and effective medical care), Minnesota ranked among the best in the world.⁷ Minnesota’s hospitals, physician offices and nursing homes are particularly strong. We rate relatively poorly in terms of our home health agencies and health disparities between low income and affluent communities. In terms of care by clinical area, Minnesota does well in treating cancer, diabetes, heart disease and respiratory disease but poorly in maternal and child health measures, mainly as a result of poor access to prenatal care among non-whites.

4 The Kaiser Family Foundation statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2010 and 2011 Current Population Survey (CPS: Annual Social and Economic Supplements).

5 Benson, L. (2010, April 10). *42,000 lost small-group health coverage last year*. St. Paul, MN: Minnesota Public Radio News.

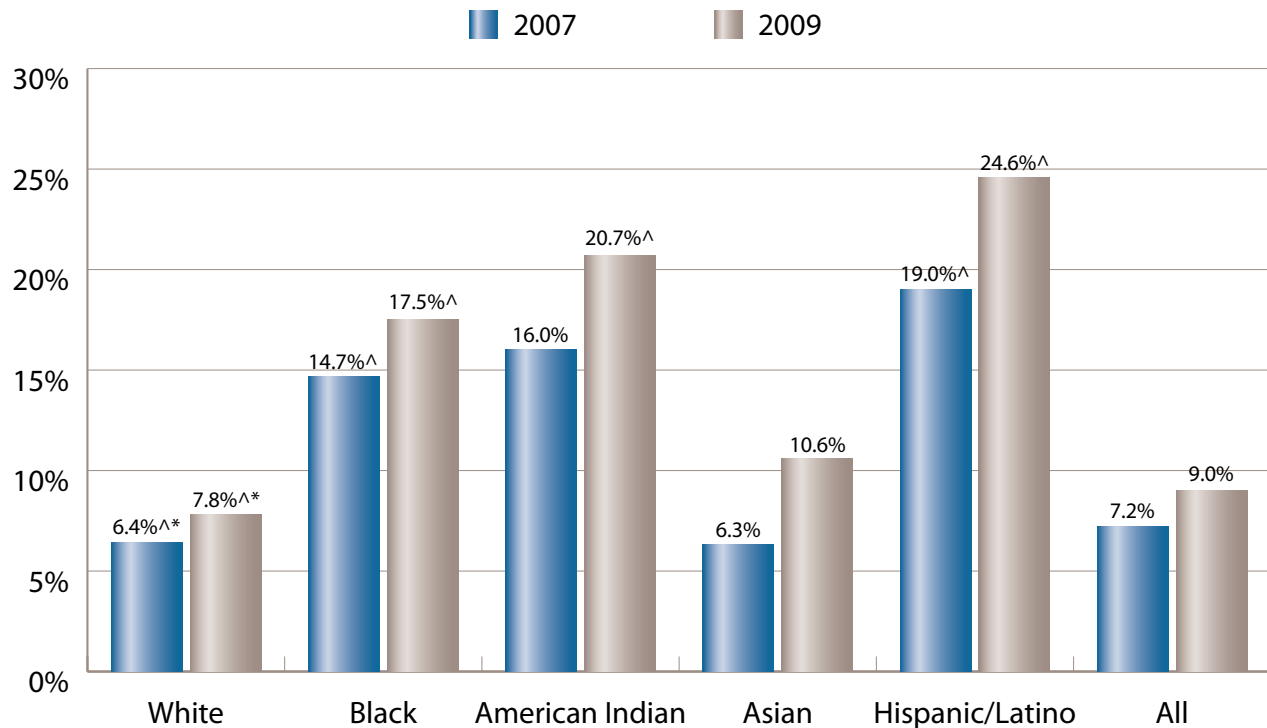
6 U.S. Department of Health and Human Services. (2010). Minnesota Dashboard on Health Care Quality Compared to All States. Retrieved from <http://statesnapshots.ahrq.gov/snaps10/dashboard.jsp?menuId=4&state=MN&level=0>.

7 Schoenbaum, S. C., Schoen, C., Nicholson, J. L. et al. (2011, August 25). Mortality amenable to health care in the United States: The roles of demographics and health systems performance. *Journal of Public Health Policy*.

Disparities

Despite our healthy population and low rates of uninsurance, Minnesota has some of the greatest health disparities in the country between whites and people of color and Native American populations⁸. While the causes are complex and include social, educational, economic and environmental factors, people of color have significantly more problems with access to health care, even when enrolled in state health programs.⁹

Minnesota Uninsurance Rates by Race/Ethnicity



* Indicates statistically significant difference (95% level) from 2007.

[^] Indicates statistically significant difference from all Minnesotans within year (95% level).

Source: Minnesota Department of Health

In 2001, Minnesota passed legislation creating the Eliminating Health Disparities Initiative to provide funding for strategies to reduce health disparities in eight key health indicators, including infant mortality, adult and child immunizations, and cardiovascular disease. A report to the Legislature on the first phase of this initiative noted incremental success in the targeted areas, but also called for better sources of measurement and improved data collection.¹⁰

Costs

Minnesota has higher per capita health care spending than the national average: \$7,409 versus \$6,815 in 2009,¹¹ although when counting only insured people, spending is in line with the national average. Minnesota health care spending as a share of the economy is lower than the national average, 14.1%¹² compared to 17.6%.¹³ But Minnesota's health care spending is rising unsustainably. Spending reached \$36.4 billion in 2009, and while the rate of

8 Minnesota Department of Health. (2011). *Eliminating health disparities initiative: Report to the Minnesota Legislature*. St. Paul, MN.

9 Minnesota Department of Human Services. (2003). *Disparities and barriers to utilization among Minnesota health care program enrollees*. St. Paul, MN.

10 Minnesota Department of Health (2011).

11 Centers for Medicare and Medicaid Services. (2009). National Health Expenditure Data. Retrieved from <https://www.cms.gov/NationalHealthExpenditure/Data/Downloads/res-tables.pdf>.

12 Minnesota Department of Health. (2011). *Minnesota health care spending and projections, 2009*. St. Paul, MN.

13 Reichard, J. (2009, March 2). Study: Health care to gobble far bigger chunk of GDP this year. *Washington Health Policy Week in Review*.

growth slowed in 2009 from previous years (3.5% compared to an average growth rate of 8.5% the previous decade), this was largely a result of Minnesotans failing to seek care due to financial trouble in the recession.¹⁴ The share of health care spending as a percent of the economy experienced its fastest one-year increase in 2009. The Minnesota Department of Health projects that health care spending will reach \$78 billion – nearly 20% of our economy – by 2019.¹⁵

Minnesotans are losing ground economically. In the last decade, health care costs grew a cumulative 117% while wages grew only 35.2% (not adjusted for inflation). Minnesotans are paying a greater share of these health care costs: Currently about 16% of all health care spending is out-of-pocket, compared with less than 10% a decade ago.¹⁶

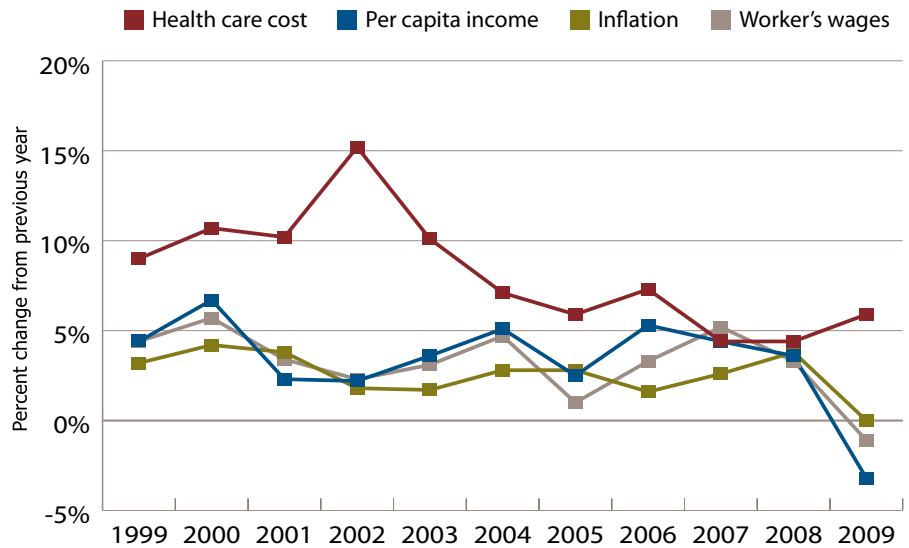
While Minnesota must continue to work on quality improvement our primary challenges are to

- attain universal coverage;
- assure affordability of health care;
- reduce health care inflation; and
- create a more equitable system, reducing racial and economic disparities.

Piecemeal reforms have not been sufficient. The public may be ahead of policymakers on this front. More than 70% of adults in a 2011 poll said the U.S. health system needs fundamental change or complete rebuilding.¹⁷ Simply put, our current health care system costs too much, covers too little, leaves too many people out and is economically unsustainable.

Key Minnesota Health Care Cost and Economic Indicators

Health care costs continue to rise faster than inflation



Health care cost is MN privately insured spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance

Source: Minnesota Department of Health

¹⁴ Minnesota Department of Health. (2011). *Minnesota health care spending and projections, 2009*. St. Paul, MN.

¹⁵ Ibid.

¹⁶ Minnesota Department of Health, Health Economics Program. (2011). *Health insurance premiums and cost drivers in Minnesota, 2009*. St. Paul, MN.

¹⁷ The Commonwealth Fund. (2011). *The 2011 Commonwealth Fund survey of public views of the health system*. Retrieved from <http://www.commonwealthfund.org/Surveys/2011/Apr/Survey-of-Public-Views.aspx>.



The 2010 passage of the federal Affordable Care Act (ACA) and the months preceding and following its passage put health care reform into the headlines on a daily basis. Should the ACA survive court challenges and be fully implemented, it will expand access to insurance. It will not, however, achieve universal access and will fall far short of needed cost containment targets. States can, and must, continue to be laboratories for reform.

THE FUNDAMENTALS OF THE AFFORDABLE CARE ACT

The ACA, signed into law by President Obama in March 2010, is the most comprehensive health insurance reform since enactment of Medicare and Medicaid in the 1960s. The ACA builds primarily on our current system of employer-based private insurance coverage. It mirrors the Massachusetts Health Care Reform Law of 2006 and contains many parallels to the work of Minnesota's 2008 Health Care Transformation Task Force. The U.S. Supreme Court has agreed to hear the legal challenge filed by 26 states and the National Federation of Independent Business on the constitutionality of the law's individual mandate.

A brief overview of the ACA follows.

Insurance Company Reforms

The ACA contains several consumer protections that are well supported by the public:

- Abolishing annual and lifetime caps on benefits paid.
- End to rescission (dropping people from insurance when they get sick), except in cases of fraud.
- Ending exclusions for pre-existing conditions.
- Ending price discrimination based on gender and medical history. (Higher premiums can still be charged based on tobacco use, age and geographic region.)
- Allowing children to stay on their parent's insurance until age 26.
- Eliminating the Medicare "donut hole" (the gap in prescription drug coverage) over time.
- Establishing a minimum medical loss ratio – the percentage of premium that must be spent on health care rather than on administration or profit. (Minnesota Senator Al Franken was the co-author of the medical loss ratio provision.)

Individual Mandate

Everyone must have health insurance or pay a penalty. As a response to the consumer protections listed above, insurance companies insisted on this provision so that people couldn't defer buying insurance until they got sick.

Expansion of Medicaid

People with income up to 133% of the federal poverty line will be eligible for Medicaid, including childless adults.

Creation of Health Insurance Exchanges

States are required to set up a marketplace for individuals and small businesses to purchase insurance, thus improving the market clout of small purchasers. The plans sold on the exchanges will have actuarial values between 60% and 90%. (Actuarial value denotes the average percent of medical expenses covered by insurance across a pool of people. The remainder would be paid out-of-pocket by the patient.) In a move which weakens consumer protections, the Department of Health and Human Services has left it to each state to establish an essential benefit set for insurance plans sold on the exchange.

Subsidies for the Purchase of Insurance

Premium and cost-sharing subsidies are available, at graduated rates, for people who earn up to 400% of the federal poverty line. The ACA also institutes small business tax credits for employers with 25 or fewer employees.

Cost Containment and Payment Reform Pilot Projects in Medicare

The ACA sets up several pilot projects in the Medicare program in an effort to control costs and reform health care delivery including an Independent Payment Advisory Board, an Innovation Center, value-based-purchasing, and promotion of accountable care organizations. The ACA also establishes a mechanism for health insurance rate review although it doesn't give the government regulatory authority.

Waiver for State Innovation

The ACA also contains a pathway to a unified system such as the one being modeled for this report. Section 1332 of the Patient Protection and Affordable Care Act would allow states to receive a waiver, beginning in 2017, from the insurance-exchange requirements of the ACA. The administration could grant a waiver if the state's alternative plan covers at least as many state residents with coverage at least as comprehensive as those under the exchange, and is at least as affordable – in terms of both premiums and cost-sharing. The alternative state plan must not increase the federal budget deficit.

Even if the ACA is fully implemented, about 262,000 Minnesotans may still be uninsured. The ACA will fall far short of needed cost containment targets and will establish underinsurance – inadequate or expensive coverage – as the norm. States can and must continue to be laboratories for reform.



AFFORDABILITY SUBSIDIES UNDER THE ACA

EXAMPLE

A family of 3 with income of \$56,000/year
(305% of Federal Poverty Level)

- Eligible for subsidy to reduce premium to 9.5% of income, capping premium cost at \$5,320
- Eligible for subsidy to reduce cost-sharing (copay, deductible, coinsurance) to \$7,973
- Total possible costs per year after affordability subsidies = \$13,293 (24% of income)

"Basically, [the ACA] is the last hope for a free-market solution for covering the uninsured. If this fails, then you either give up on the uninsured or you go to single-payer. Those are the only two options left."¹⁸

Economist Jonathan Gruber, MIT professor of economics and architect of the ACA

18 Pillifant, R. (2011, November 16). Architect of Obama's health care plan fears a 'political' decision by the Supreme Court, says Romney's lying. *Capital-NewYork.com*.

OBJECT LESSONS FROM MASSACHUSETTS

Much has been written about the successes and failures of the Massachusetts Health Care Reform Law, as it was the model for the ACA. The Massachusetts experience also serves as a cautionary tale. While decreasing their uninsurance rate significantly, Massachusetts has not achieved universal coverage; more than 320,000 state residents still lack insurance.¹⁹ Additionally, the reform has failed to bend the cost curve, causing the state to roll back eligibility for subsidies and alter the definition of affordability. Health care costs are higher in Massachusetts than any other state, though due to the market clout of hospitals and doctors, this was also the case before the Massachusetts reform. The reform slowed the decline of employer-sponsored insurance but the use of high deductible plans has tripled, and employee cost sharing via premiums, deductibles, coinsurance and copays has risen steadily. Premiums for small businesses have risen more rapidly than in the rest of the country. Underinsurance has become the norm and the reform has failed to reduce the share of people facing medical debt and medical bankruptcy.²⁰

INSURANCE DOES NOT ASSURE ACCESS TO CARE

Reforms in the United States have focused on increasing access to health insurance, but health insurance is not health care. Our increasing reliance on high deductible plans or other forms of cost shifting through coinsurance and copays has significantly increased the rates of underinsurance, typically defined as medical costs exceeding 10% of income. Thirty-two percent of working-age adults (age 19-64) in the United States spent 10% or more of their income on health care in 2010; up from 21% in 2001. Forty percent of working-age adults report problems with medical debt. One-third of adults in the country report self-rationing care because of cost: skipping tests, treatment or follow-up; not filling prescriptions or skipping doses; or not seeing a doctor when they had a medical problem. Among sicker adults the picture is worse; 42% faced barriers to needed health care due to cost.^{21,22} Sixty-two percent of personal bankruptcies in the U.S are due to medical expenses, with 77% of those filing having had insurance at the onset of illness.²³

HIGH DEDUCTIBLE “CONSUMER DIRECTED” HEALTH PLANS GROWING

Efforts at controlling total health care expenditures have increasingly focused on suppressing utilization of health care services through cost-sharing. The premise is that if people have to pay for care they will be sensitive to the cost of care and will not seek unnecessary care. Marketed as consumer-directed, they shift cost and risk from insurers and employers to patients. These plans offer lower premiums in exchange for significantly higher deductibles. The plans are paired with a health savings account (HSA), a means of saving pre-tax dollars for health care expenses. Enrollment in high-deductible health plans (HDHP) is increasing and expected to sharply rise over the next decade. Minnesota currently leads the nation²⁴ in percentage of people enrolled in high deductible plans at 14.9%. The growth of these plans is most significant in the employer based insurance market. Many employers contribute to their employees' HSAs to incent the choice of an HDHP. This year, nearly three in four employers will offer at least one high deductible plan, and industry experts expect that by 2016 the majority of all health plans will be high deductible.²⁵

19 Kaiser Family Foundation. (2011). Statehealthfacts.org Individual State Profiles, Massachusetts. Retrieved from <http://www.statehealthfacts.org/profileglance.jsp?rgn=23&rgn=1>.

20 Day, B., Nardin, R., Akers, T., Baglanceas, M., Bellin, C., Cesar, A., ...Zhou, P. (2011). *Massachusetts health reform in practice*. Boston, MA: Mass-Care.

21 Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011, November 9). New 2011 survey of patients with complex care needs in 11 countries finds that care is often poorly coordinated. *Health Affairs Web First*.

22 Collins, S., Doty, M., Robertson, R., & Garber, T. (2011). *Help on the horizon: How the recession has left millions of workers without health insurance, and how health reform will bring relief*. New York, NY: The Commonwealth Fund.

23 Himmelstein, D., Warren, E., Thorne, D., & Woolhandler, S. (2009). Medical bankruptcy in the U.S. 2007: Results of a national study. *American Journal of Medicine*, 122 (8), 741-746.

24 Berry, E. (2011, June 27). Membership in high-deductible health plans remains on the upswing. *American Medical News*. Retrieved from <http://www.ama-assn.org/amednews/2011/06/27/bisc0627.htm>.

25 Wilemon, T. (2011, December 27). High-deductible health plans on rise. *The Tennessean*.

The growth in these plans is leading to predictable negative outcomes: financial barriers to care and adverse selection. The financial barriers to health care are significantly worse for those with HDHPs than the population of insured persons as a whole. Fifty-seven percent of low-income families and 42% of high-income families with HDHPs report delaying or skipping needed health care due to cost.²⁶ Adverse selection is a natural consequence of these plans. The relatively healthy, with few expected medical costs, opt for the enticing lower premiums, leaving traditional insurance plans with a pool of sicker people which causes insurance premiums to go up, leading more healthy people to flee these plans. This cycle continues and ends in what is known as “the death spiral” when no one can afford the high premiums needed to cover the health care expenses of the remaining high-risk pool. Because the HDHPs do nothing to lower the actual cost of care, enrollees become increasingly vulnerable to the financial risks of seeking care. Health Savings Accounts paired with HDHPs disproportionately benefit the wealthy that have the means to fund them.

What many don’t realize is that even the lower premiums of these plans are a relatively bad deal for enrollees. High deductible plans are more administratively burdensome relative to medical expenses paid, making it difficult to meet the minimum medical loss ratio of 80% as mandated under the Affordable Care Act.²⁷ More of the premium dollars collected are spent on administration or kept as profit as compared to providing health care. And patients are required to pay a significant amount out-of-pocket before insurance pays a penny – not a very patient-friendly option.

The effort to increase “skin in the game” through steadily increasing cost-sharing simply erects financial barriers to health care, and rations health care by income. It is also misplaced as policy. Nearly 90% of total national health care spending is for the sickest 30% of the population – people who quickly exceed any deductible. Erecting financial barriers to care through cost-sharing for the healthier 70% of people isn’t going to have a big impact on the total bottom line of health care spending.²⁸

“As an insurance industry PR executive, I had the responsibility of helping create the perception that the high-deductible and so called limited-benefit plans that insurers and employers were forcing Americans into were consumer-friendly and essential weapons in the industry’s battle against escalating health care costs. I was expected to hype these plans as part of a ‘consumerism’ trend that was started by Americans who wanted more control over their health care and their health care dollars. To perpetuate the myth that Americans were clamoring for health insurance plans that required them to spend more of their own money for their medical care, my colleagues and I were expected to follow the lead of our CEO and industry marketing types and call these plans ‘consumer driven.’... “Just about every credible study has concluded that high-deductible plans are best suited for relatively young and healthy people who have a few dollars left over after they pay their bills. For the rest of the population, they frequently turn out to be a very bad deal.”²⁹

Wendell Potter, former head of corporate communications for CIGNA

26 Kullgren, J., Galbraith, A., Hinrichsen, V., Miroshnik, I., Penfold, R., Rosenthal, M., ...Lieu, T. (2010). Health care use and decision making among lower-income families in high-deductible health plans. *Archives of Internal Medicine*, 170 (21), 1918-1925.

27 AHIP Center for Policy and Research. (2011). *The Federal Medical Loss Ratio (MLR) Calculations – Background and Initial Costs of Compliance*. Washington, DC.

28 Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011, November 9). New 2011 survey of patients with complex care needs in 11 countries finds that care is often poorly coordinated. *Health Affairs Web First*.

29 Potter, W. (2010). *Deadly Spin*. New York, NY: Bloomsbury Press.

COST SHARING – NOT A PANACEA

The RAND Health Insurance Experiment (RAND HIE) in the 1970s and early 1980s is considered the seminal research on the effects of cost sharing, and has influenced decades of health care policy. The general finding of the RAND HIE was that cost sharing lowered health care use without adverse health consequences on average, though low-income people with chronic disease did suffer adverse consequences and highly effective care was suppressed in equal measure to unnecessary or ineffective care.³⁰

There are a number of reasons to reevaluate these findings and temper the use of cost sharing and cost shifting as a means to decrease health care utilization.

- The RAND HIE followed individuals for a period of 3-5 years, which may have been too short a time span to measure or meaningfully predict adverse health consequences, particularly for children.³¹
- University of Minnesota professor John Nyman has challenged the RAND HIE finding by revealing that people with health care needs dropped out of the cost sharing group at a rate 16 times higher than those in the control group in order to revert to better insurance coverage. This left a pool of healthier people in the cost sharing group of the study yielding an apples-to-oranges comparison of health effects.³²
- The out-of-pocket spending limits in the RAND HIE were quite low by today's standards and therefore were less likely to have adverse health impact than the cost sharing limits prevalent today. Out-of-pocket caps for copays, coinsurance and or deductibles must be linked to income in order to minimize health impact. This is not typically a feature of private health insurance.³³
- Even as a means of cost containment, cost sharing can backfire. A 2010 New England Journal of Medicine study demonstrated that a modest increase in copayments (an average increase of \$7) among elderly Medicare recipients led to a decrease in outpatient clinic visits but an increase in number and length of hospitalizations with an overall increase in cost.³⁴
- A substantial portion of total U.S. health care expenditures are for a small percentage of people with very high medical spending. These people quickly exceed any out-of-pocket caps, so cost sharing causes delayed or deferred care but doesn't address the main drivers of health care spending.³⁵
- Medical care has changed significantly in the last 30 years and conclusions about the effectiveness of treatments and their health impact might be different if the experiment were conducted today.³⁶

30 RAND Corporation. (2006). *The health insurance experiment: A classic RAND study speaks to the current health care reform debate*. Santa Monica, CA.

31 Gruber, J. (2006). *The role of consumer copayments for health care: Lessons from the RAND Health Insurance Experiment and beyond*. Menlo Park, CA: Kaiser Family Foundation.

32 Nyman, J. (2007). American health policy: Cracks in the foundation. *Journal of Health Politics, Policy and Law*, 32. doi:10.1215/03616878-2007-029

33 Gruber, J. (2006).

34 Trivedi, A., Moloo, H. & Mor, V. (2010). Increased ambulatory care copayments and hospitalizations among the elderly. *New England Journal of Medicine*, 362, 320-328.

35 Gruber, J. (2006).

36 Ibid.

REPLACING MEDICARE WITH PREMIUM SUPPORT WOULD MAGNIFY THE PROBLEM

Many in Congress are suggesting that the way to control Medicare spending is by moving away from a defined benefit to a defined contribution plan by offering seniors a subsidy, or voucher, to purchase insurance on the private market. While this privatization design could save taxpayers money, since the proposed subsidies would not keep up with health care inflation, it would do so by shifting costs to seniors. The Congressional Budget Office estimates that a premium support or voucher plan for Medicare would cost seniors several thousand dollars out of pocket for benefits similar to those currently provided by Medicare.³⁷ This change would spread the phenomenon of underinsurance – currently prevalent in working age adults – to seniors. A voucher or premium support program would magnify our problem of rationing by wealth, especially as seniors are more likely to have a fixed income and face a significantly higher illness burden. It would put the health of seniors at risk, as delayed care in medically vulnerable populations can be catastrophic.

Traditional Medicare has been more effective than the private insurance industry at controlling costs. Over the past 40 years, per capita Medicare costs for hospital and physician services rose slower than per capita costs under private insurance, despite Medicare's coverage of an older and sicker population. From 1996 to 2004, health care spending for the nonelderly (largely covered by private insurance) grew 3.4 percentage points faster than the economy; for the elderly, 97% of whom are covered by Medicare, health care spending only grew 0.3 points faster than the economy.^{38,39} Medicare Advantage plans, the existing privatized Medicare option, cost 10 to 14% more than traditional Medicare.⁴⁰ Medicare, as a unified single-payer system for seniors, has administrative expenses far lower than private insurance in large part because it doesn't have the underwriting, marketing, lobbying, and related administrative expenses that add to the cost of private insurance.



37 Congressional Budget Office. (2011). *Long-term analysis of a budget proposal by Chairman Ryan*. Washington, DC.

38 Hacker, J. (2009). *The case for public plan choice in national health reform: Key to cost control and quality coverage*. Washington, DC: Institute for America's Future.

39 Moon, M. (2003, April 10). Assessing the viability of Medicare: Testimony for the Joint Economic Committee hearing. Retrieved from: <http://www.urban.org/publications/900601.html>.

40 Angeles, J. & Park, E. (2009). "Upcoding" problem exacerbates overpayments to Medicare Advantage plans: Administration action and House health reform bill seek to address problem. Washington, DC: Center on Budget and Policy Priorities.



WE DON'T GO TO THE DOCTOR TOO OFTEN

With so many plans designed to shift the burden of cost onto patients in an effort to reduce utilization, one would assume that people in the United States go to the doctor too often. In fact, our per capita visits to the doctor lag those in most countries with universal coverage.⁴¹ Of the 30 nations in the Organization for Economic Cooperation and Development (OECD), only six have fewer per capita doctor visits than we do in the United States.⁴² The United States also has far fewer per capita hospitalizations and shorter hospital stays.⁴³ There are legitimate concerns about duplication of services due to poor coordination and the over-reliance on scans and elective or invasive procedures (also known as the intensity of services) but overall, our spending problem is not due to excessive doctor visits or hospitalizations. We must continue to reduce medical errors and address the provision of marginally beneficial or potentially worthless medical interventions by changing incentives for physicians, improving care coordination, and facilitating comparative effectiveness research, but not by erecting financial barriers which discourage patients from seeking medical care.

WHY IS HEALTH CARE SO EXPENSIVE IN THE UNITED STATES?

Some of the most significant factors in the high costs of the U.S. health care system are summarized below.

Fragmentation

Insurance is about pooling risk. The larger the pool of people, the better the insurer and the insured are protected against economic risk. We have a very fragmented health care system that finances and administers health care differently based on demographics and whims of fate. We have one program for the poor and disabled, one for the elderly, one for military families, one for veterans, one for Native Americans, a patchwork system of employer-based coverage for many working people, and no affordable option for far too many.

Fragmentation of risk pools introduces an incentive to compete for healthy enrollees and introduces problems with adverse selection (pools of sicker patients). This fragmentation also leads to administrative waste, lack of continuity of care, gaps in coverage, cost shifting, increased potential for fraud, and inadequate sharing of information that could improve medical practice. We are not immune to the perils and waste of a fragmented system in Minnesota, even though the private insurance market is consolidated with three insurers holding more than 85% of the commercial market: Medica, Blue Cross Blue Shield and HealthPartners.⁴⁴ Each insurer has a multitude of plans, with unique benefit sets, provider networks or tiers, payment rates, and premium and cost-sharing structures.

Administrative Complexity

It is estimated that administration accounts for somewhere between 25% and 31% of total U.S. health care spending.^{45,46} The multitude of insurance plans, as noted above, diverts dollars that could be spent on health care into administrative functions such as marketing, enrollment, underwriting, contract negotiation, utilization review, and claims adjudication. This administrative burden is placed not just on insurers but on hospitals, clinics, providers, pharmacies, and employers.

41 Squires, D. (2011). *Multinational comparisons of health systems data, 2011* [PowerPoint slides]. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2011/Nov/IHP%20Survey/PDF_Schoen_2011_survey_OECD_chartpack.pdf.

42 Congressional Research Service. (2007). *U.S. health care spending: Comparison with other OECD countries*. Washington, DC.

43 Squires, D. (2011).

44 Minnesota Department of Health. (2009). *Minnesota health care markets chartbook, section 7: Health plans* [PowerPoint slides]. Retrieved from <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section7.pdf>.

45 Kahn, J., Kronick, R., Kreger, M. & Gans, D. (2005). The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals. *Health Affairs*, 24 (6), 1629-1639.

46 Woolhandler, S., Campbell, T. & Himmelstein, D. (2003). Costs of health care administration in the United States and Canada. *New England Journal of Medicine*, 349, 768-775.

Spending on health care administration in the United States is approximately three times that of Canada, and twice as much as a percent of total health care spending.⁴⁷ A study published in *Health Affairs* found the cost to physicians of dealing with third party payers and their administrative requirements to be an average of nearly \$70,000 per year for primary care physicians.⁴⁸ While Minnesota's nonprofit insurers operate more efficiently than the national average, they do not alleviate the administrative burden on health care providers or on employers who must manage health care benefits.

Regulations in the ACA will compel insurance companies to spend a greater proportion of premiums on health care by mandating a minimum medical loss ratio of 80% in the small group market and 85% in the large group market. However, the ACA will not mitigate the administrative complexity for hospitals, doctors, clinics, pharmacies and other providers.

Prices

Health care goods and services cost significantly more in the United States than in other economically advanced countries. For example, the U.S. spends more than twice as much on prescription drugs per person (using U.S. dollars adjusted for purchasing parity) than the average OECD country.^{49,50} In addition, our pricing is opaque, complex, and wildly variable. A physician can be paid a different amount for the same procedure by each insurance plan billed. This phenomenon is called price discrimination. Prices are negotiated between payers and individual providers or provider groups, resulting in a range of payments reflecting buyer and seller market clout. Payers with less market clout may pay higher prices to make up for the underpayment of payers with more market clout, and everyone with coverage indirectly pays for the costs for uncompensated care, a process known as cost-shifting. In addition, trends toward hospital mergers are creating monopolies that drive up prices.⁵¹

Most countries that have multiple insurers rely on the monopsony power of government to set or negotiate prices, so that they are uniform across regions and cost escalation is held in check. (A monopsony exists when there is only one purchaser or payer for all health care services and thus the market clout to negotiate lower costs.) Moving to administratively set or negotiated prices, as in a unified, single-payer system is a means to control costs and ensure more equitable reimbursement.⁵² Maryland instituted a uniform payer system for hospitals decades ago, and it has been widely credited for successful cost containment.⁵³

Concentrated Pricing Power

In Minnesota, as in most states, there are highly consolidated insurance markets and provider systems, giving them oligopoly power (concentrated pricing power). Integrated delivery systems of hospitals, clinics, and physicians have the leverage to demand higher reimbursement rates from insurers lest the providers pull out of the insurance plans, harming the insurers' ability to attract enrollees who value provider choice. Oligopolistic insurers have the power to charge premium prices higher than costs and pass the costs on to patients. Introducing market competition – such as selling insurance across state lines – would increase the proportion of health care dollars spent on marketing and administration, increase the administrative burden on providers, further fragment risk pools and actually dilute the negotiating power of insurers as compared to providers. Using market competition increases the likelihood of insurance

47 Ibid.

48 Berry, E. (2009, June 1). Health plan requirements cost practices billions, with the per-doctor average near \$70,000. *American Medical News*. Retrieved from <http://www.ama-assn.org/amednews/2009/06/01/bil20601.htm>.

49 Anderson, G., Reinhardt, U., Hussey, P. & Petrosyan, V. (2003). It's the prices, stupid: Why the United States is so different from other countries. *Health Affairs*, 22 (3), 89-105.

50 Congressional Research Service. (2007).

51 Roy, A. (2011, August 22). Hospital monopolies: The biggest driver of health costs that nobody talks about. *Forbes*. Retrieved from <http://www.forbes.com/sites/aroyle/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about/>.

52 Reinhardt, U. (2011). The many different prices paid to providers and the flawed theory of cost shifting: Is it time for a more rational all-payer system? *Health Affairs*, 30 (11), 2125-2133.

53 Ibid.

company cherry-picking, underinsurance, and adverse selection. To combat the oligopoly power of insurers and providers, we need countervailing bargaining power on behalf of consumers (patients) as noted in the prior section.

Physician Compensation

Physician services account for about 22% of total health care spending, both nationally and in Minnesota.⁵⁴ U.S. health care professionals are generally paid higher than their counterparts around the world.⁵⁵ This is especially true for specialists. In addition to the pricing power as noted above, high compensation is driven by the high cost of medical education and the high debt load of medical school graduates which incents physicians into higher paying specialties. The United States has a lower number of MDs per capita than most of our industrialized nation peers. This lower supply may play a role in driving up compensation. Minnesota has a relatively high rate of primary care providers which may help hold down prices somewhat, though they are not well distributed throughout the state.⁵⁶

Oversupply of High Tech Equipment

Often a result of competition between hospitals or delivery systems, a glut of high tech equipment and specialty centers helps drive utilization. The United States has the second highest number of CT scanners and MRI machines per capita, surpassed only by Japan.⁵⁷ When physicians have ownership of scanning equipment or surgical centers there is a financial incentive for overuse. Former U. S. Senator David Durenberger, chair of the National Institute of Health Policy, is one of the leading critics of the medical arms race – the glut of high tech equipment and expensive specialty services.⁵⁸

Skewed Incentives

Much attention has been given to the fee-for-service system and its inherent financial incentive for doctors to increase the volume of health care services. Though this incentive exists, the volume of visits in this country is actually lower than in other OECD countries. There are a multitude of skewed incentives in our system that both increase costs and lead to cost shifting: the financial incentive for individuals to decline coverage or delay care due to cost, leading to delayed diagnosis and subsequent increased complications (especially among the chronically ill); the incentive for insurance companies to focus plan development and marketing toward enrolling a relatively healthy population, thus increasing administrative expenses and shifting costs to sicker people and increasing their reliance on public plans; the drug patent system which incentivizes development of “me-too drugs,” increasing spending on pharmaceuticals with little or no new health benefits; and our reimbursement system which incents providers to perform procedures over coordinating care or spending time with patients.

“The U.S. model of private health insurers has been proven inefficient and expensive. Insurance companies have a very strong incentive to do cream skinning. They make more money figuring out the high cost and low cost people. Rather than provide better health care at lower costs, insurance companies innovate at finding better ways of discrimination. They are inefficient because they are trying to figure out how to insure people who don’t need the coverage and keep out people who need it. With many companies, they also need to spend on marketing and advertising. The incentives are all wrong... In health, social and private incentives are totally disparate. Competition does not work in health care, especially in the health insurance market.”

Joseph Stiglitz, Nobel Laureate economist⁵⁹

54 Minnesota Department of Health. (2009). *Minnesota health care markets chartbook, section 1: Minnesota health care spending and cost drivers* [PowerPoint slides]. Retrieved from <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section1.pdf>.

55 Congressional Research Service. (2007). *U.S. health care spending: Comparison with other OECD countries*. Washington, DC.

56 Minnesota Department of Health. (2011, August 31). Health professional shortage areas & medically underserved areas/populations. Retrieved from <http://www.health.state.mn.us/divs/orhpc/shortage/index.html>.

57 Congressional Research Service. (2007).

58 Gordon, J. (2007, February). The medical arms race. *Minnesota Medicine*. Retrieved from <http://www.minnesotamedicine.com/PastIssues/PastIssues2007/February2007/FeatureFebruary2007.aspx>.

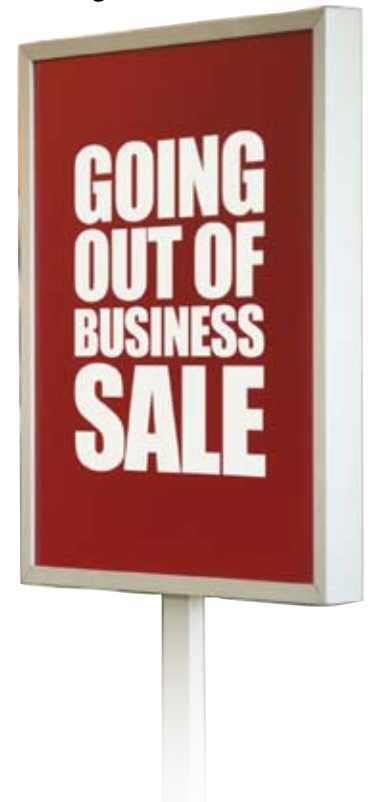
59 Nagarajan, R. (2010, November 26). The US model of private health insurers is inefficient, expensive. *The Times of India*. Retrieved from http://articles.timesofindia.indiatimes.com/2010-11-26/edit-page/28250581_1_health-insurance-single-payer-system-drug-discovery.

A Note About Our Malpractice System

The case for tort reform as a means to lower health care spending has been greatly overstated. According to a 2009 analysis by the Congressional Budget Office, instituting tort reform would lower malpractice premiums and decrease defensive medicine (generally understood as ordering tests in order to protect against liability claims). However tort reforms – the three main mechanisms are capping damages, shortening the statute of limitations, and replacing joint-and-several liability with a fair share rule – would only decrease national health spending by 0.5 percent.⁶⁰ A move to dispute resolution outside the trial system or a move to no-fault compensation or immunity from liability for following standards of practice all offer some potential to lower costs, but savings would again be minimal as a percent of total health expenditures.

HEALTH CARE IS A DRAG ON THE ECONOMY, DISPROPORTIONATELY ON SMALL BUSINESS

Health care costs are one of the biggest barriers to job creation nationally. A 2010 business survey by HealthPartners reported that employee health care costs are the biggest obstacle to business expansion in Minnesota.⁶¹ The cost of health care is especially burdensome to small business which have a competitive disadvantage in health insurance markets. The ACA insurance exchanges are an attempt to ameliorate this. A survey of small business owners in 22 states found that an average of 86% of small businesses owners who don't offer health coverage to their employees say they can't afford to provide it, and an average of 72% of those who do offer it say they're struggling to afford it.⁶² Despite increases in worker productivity, health care costs are rising more quickly and workers and employers are losing ground. Employers providing health insurance in the middle of the last decade were spending an average of 11.5% of payroll on those benefits.⁶³ In 2005, the latest year of comprehensive data, private employers in Minnesota were spending 8.3% of total compensation on health insurance.⁶⁴ Small businesses, which typically create about 75% of new jobs, pay more.^{65,66} In 2007, half of the uninsured were self-employed or worked for small businesses.⁶⁷ Linking health insurance to employment leads to job lock (the inability of an employee to freely leave a job because doing so will result in the loss of employee benefits), suppresses job creation and decreases our global competitiveness.



60 Congressional Budget Office. (2009). Letter on tort reform to Senator Orrin Hatch. Washington, DC.

61 Yee, C. (2010, February 5). Businesses: Health care costs stymie expansion. *Star Tribune*.

62 Small Business Majority. (2012). State surveys highlight small business support for healthcare reform. Retrieved from: <http://smallbusinessmajority.org/small-business-research/healthcare/states-opinion-research.php>.

63 Nichols, L. & Axeen, S. (2008). *Employer health costs in a global economy: A competitive disadvantage for U.S. firms*. Washington, DC: New America Foundation.

64 Ridgeway, J. (2005). *Minnesota employee benefits survey*. St. Paul, MN: Minnesota Department of Employment and Economic Development.

65 Clark, M. & Saade, R. (2010). *The role of small business in economic development of the United States: From the end of the Korean War (1953) to the present*. Washington, DC: U.S. Small Business Administration.

66 Small Business Majority. (2012). Small business owners pay more for health benefits than large firms. Retrieved from: <http://www.smallbusinessmajority.org/small-business-research/statistics.php>.

67 Ibid.



WHAT CAN WE LEARN FROM OTHER COUNTRIES

The United States is the only wealthy industrialized nation that doesn't guarantee health care to its entire population. Every other peer nation has determined that health care is a basic human right. Our counterparts boast universal coverage, lower costs, better outcomes and superior satisfaction ratings. Despite the fact that our industrialized nation peers have differing health care systems from each other, they share specific commonalities – primarily that they are all unified systems. Whether the model is socialized (government financed and delivered) as in England and most of Scandinavia, social insurance (publicly financed, privately delivered) as in Taiwan and Canada, or largely private (using tightly regulated nonprofit insurers) as in Germany, France and Switzerland, these countries have one system for everyone. Coverage is continuous throughout one's lifetime regardless of changes in age, employment or health status. This contrasts with our patchwork of programs depending on age (Medicare), income (Medicaid), military service (TRICARE, VA), source of employment (employer-based insurance ranging from the Federal Employee Health Benefits Plan, to the self-insured large employers and the small risk pools of small employers), or circumstance (the individual market, uninsurance). Many people cycle through these programs as their health, income, or employment situation changes, causing gaps in coverage and interruptions in care.

Other common features of our peer nations' health systems:

- A uniform benefit set for everyone. (Supplemental coverage for additional benefits may or may not be available or widespread.)
- Coverage which is delinked from employment. Even in countries where employers contribute to the financing of health care via payroll taxes, coverage is not linked to employment.
- Administratively negotiated or set prices.
- Essential health needs are met in a nonprofit system. Private insurers, if they exist, are not-for-profit and are tightly regulated.
- Coverage is based on ability to pay (i.e. related to income), whether paid by tax or premium.
- If there is cost sharing in the form of copays or coinsurance, there are caps which are typically linked to income and low by U.S. standards.
- Primary care physicians predominate the system.
- Competition is on the care delivery side, as patients are, by and large, free to choose their doctor, clinic and hospital.

WHAT IS MEANT BY A UNIFIED SYSTEM

The United States has a fragmented health care system that arose piecemeal rather than by design. The patchwork complexity of our system is administratively wasteful and economically unsustainable. A unified system is administratively simpler, more equitable, has monopsony power to lower prices, addresses public health, and relieves employers from the unwanted responsibility of negotiating and managing health insurance. A unified system means:

- One system that covers everyone.
- A single insurance pool to spread insurance risk. (The larger the pool, the more predictable the overall costs.)
- A uniform and comprehensive benefit set for everyone.
- A single network of all licensed health care providers, and an end to choice-limiting networks.
- A uniform and streamlined enrollment process.
- Uniform pricing, payment rules, and payment methods, with monopsony purchasing power.
- Financing is related to ability to pay.
- Health care coverage is delinked from employment, freeing employers from the time-consuming responsibility of administering benefits, ending job lock and removing the competitive disadvantage for small businesses.

WHAT WOULD THIS LOOK LIKE IN MINNESOTA? ECONOMIC MODELING OF A UNIFIED SYSTEM: ASSUMPTIONS AND SPECIFICATIONS

Growth & Justice set out to investigate whether, by moving toward a unified system as delineated above, Minnesota can establish stable, affordable access to health care for every Minnesotan without increasing total health care spending. Though closing our uninsurance gap and eliminating underinsurance will increase spending, reducing fragmentation and thereby reducing administrative expenses, duplication, waste, fraud and cost shifting could allow for achieving universal and affordable access, without the cost explosion and rationing by income which will continue under current reforms.

The Lewin Group, a consulting firm with decades of experience in health care reform modeling, was hired to conduct an economic impact study of a unified, single-payer health care system for Minnesota. The Lewin Group has done work for the Congressional Budget Office and for numerous private entities and states including Minnesota. They have conducted analyses of reforms for universal coverage using single-payer financing in several states, including California, Colorado, Massachusetts and Hawaii. The Lewin Group is an OptumInsight company which is a wholly owned subsidiary of UnitedHealth Group.

The system modeled by The Lewin Group would cover all Minnesota residents with comprehensive medical, mental health and dental benefits, and access to all licensed health care providers in the state. It was stipulated that there be no loss of income for providers in order to achieve universal coverage or cost savings, that cost sharing requirements for patients not erect financial barriers to necessary care and that financing of the system be stable.

The following assumptions were provided to The Lewin Group:

The economic modeling will use 2014 as a baseline year in order compare changes in health care spending under the ACA with the proposed system. Minnesota will maximize federal health care dollars available to the state under the Affordable Care Act, and will obtain waivers to operate Medicare and Medicaid (Medical Assistance) through the unified system. If waivers could not be obtained, the benefits and financing of Medical Assistance and Medicare would be unchanged, but both programs would use the unified claims administration and payment system, with provider payment rates equalized for all programs.

The economic model used the specifications outlined below.

Eligibility

All residents of Minnesota are included. If Minnesota were to enact a unified plan, residency requirements would be established.

Benefit Package

A benefit set was delineated that addresses the medical, rehabilitative, dental and mental health needs of Minnesotans, and is at least as comprehensive as both the state basic Medical Assistance benefits and the coverage provided to state employees, including our elected representatives. Benefits included in the package are:

Ambulatory care (preventive, acute and chronic)
Inpatient and outpatient hospital care
Case management
Dialysis
Maternity care
Blood and blood products
Prescription medication
Rehabilitation (inpatient and outpatient)
Emergency care, including transportation
Mental health
Substance abuse treatment

Hospice and palliative care
Dental (preventive and restorative)
Vision, including basic glasses
Hearing, including hearing aids
Physical therapy
Chiropractic
Podiatric care
Acupuncture
Durable medical equipment
Home care and Medicaid waived services (if eligible)

Long-term care was not included in the benefit set modeled, except for those meeting Medicaid eligibility guidelines. The reason for this is twofold:

- Currently only about 3% of Minnesotans⁶⁸ (10% of those age 50-84)⁶⁹ have long-term care insurance, while about 90% have health insurance. Including long-term care in a universal benefit package would close a significant coverage gap and would mean an apples-to-oranges comparison between current and proposed coverage.
- Costs would be burdensome for Minnesota. Currently there is a generous federal match for long-term care under Medicaid, which would continue for Medicaid-eligible Minnesotans. But extending long-term care coverage to all Minnesotans would leave the unified health plan to pick up the full cost for those not eligible for Medicaid, as there would be no federal match. At least until most people have begun saving, in some fashion, to meet long-term care needs, it is not economically prudent for a single state to offer universal long-term care coverage.

It is critical that Minnesota and the nation as a whole address long-term care; this is especially true given changing demographics and the coming “silver tsunami.” The Minnesota Department of Human Services is taking critical steps to raise awareness and is developing incentives to save for long-term care.⁷⁰

Cost Sharing

There are no deductibles and no coinsurance in the unified system modeled by Lewin, as removing cost barriers to primary care can lower overall costs and improve outcomes.⁷¹ There are no copays for primary care providers in pediatrics, internal medicine, family practice, psychiatry, dental and OB/GYN for health screenings and pregnancy. A modest copay of \$20 is applied for specialist care, hospitalizations, diagnostic tests and procedures. (This amount is based on the current copay amount for clinic visits in the state employee plan.) Copays are eliminated on prescriptions for chronic conditions, as copays on medications reduce use and result in increased hospitalizations and adverse health consequences.⁷² The plan was modeled with a cap on copays equal to 3% of income for households at less than or equal to 200% of Federal Poverty Level (FPL), and 5% of income for those greater than 200% of FPL.

Global Budgeting

Hospitals will be paid under a global operating budget based on historic utilization to reduce the administrative complexity of billing for each product and service and to promote efficient care delivery.

Provider Reimbursement

Income for providers is maintained in the transition to a unified system. Reimbursement rates are decreased only to compensate for the lower administrative costs of a unified system. Provider payment in the model is based on current average reimbursement. In actuality, changes in physician income will depend on their current payer mix (with uniform reimbursement, providers who only care for privately insured patients would see lower income, and providers with mostly publicly insured patients would see higher income). Over time, payment and delivery system reforms have the potential to change how providers are compensated. These reforms are discussed elsewhere in this report.

68 Crosby, J. (2011, November 19). No insurance against price increases. *Star Tribune*.

69 Citizens League. (2010). *Moving beyond Medicaid: Long-term care for the elderly as a life quality and fiscal imperative*. St. Paul, MN.

70 For an excellent analysis and recommendations on addressing long-term care in Minnesota, see the Citizens League report *Moving Beyond Medicaid*, available at http://www.citizensleague.org/publications/reports/485_RPT.Moving%20Beyond%20Medicaid.pdf.

71 Kuttner, R. (2011, November 7). A model of health. *The American Prospect*. Retrieved from: <http://prospect.org/article/model-health>.

72 Gruber, J. (2006).

Financing

There are numerous options for financing a unified system: community-rated premiums (regardless of income); sales, value-added or other consumption taxes; income-based premiums; payroll- and wage-based payments or a blend of these. In addition, there are unlimited options for income caps and floors, using flat or marginal rates, and varying the proportions paid by individuals and employers. What is most critical is that the financing be naturally appreciating, as increasing a premium or tax is politically unpopular (and thus difficult). Three financing options were modeled for illustrative purposes; all assume that current federal and state taxes that support health care would continue. The three options modeled were:

1. Employer payroll tax and individual income tax
2. Employer payroll tax and employee payroll tax
3. Employer payroll tax, individual income tax and a “sin tax” on tobacco and alcohol

These payments for financing the unified system would take the place of all current premiums, deductibles, and coinsurance paid by individuals, and all premiums and HSA contributions currently paid by employers.

DISCUSSION OF FINANCING OPTIONS MODELED

- A floor was set for payroll taxes. Options were modeled exempting the first \$10,000, \$12,000 and \$15,000 of wages from the health tax. Exempting a base of wages protects low-wage jobs from being eliminated with the imposition of an employer payroll tax. The exemption was made across all wage levels for the sake of equity and to avoid suppression of wages that are only slightly above minimum wage.
- The individual income tax was calculated as a percentage of federal income taxes paid (modeled as a surcharge on federal taxes), thus incorporating the relative progressivity of federal income tax rates. Income taxes account for both earned and unearned income and thus apply to those with investment income but no wages. Using federal income taxes paid, as opposed to adjusted gross income, allows both itemized and standard deductions and exemptions to be taken into account, thus indirectly accounting for family size.
- A cigarette tax of one dollar per pack and an alcohol tax of five cents per drink were modeled for sin taxes. Though sin taxes tend to be regressive, they can alter behavior, especially if they are applied at the wholesale level (e.g., excise taxes) and reflected in a higher shelf price. While low-income people bear a disproportionate financial burden of these taxes they also bear a higher burden for the health consequences of alcohol and tobacco use and will benefit the most from a reduction in substance use.^{73, 74}
- Though insurance will no longer be linked to employment, an employer contribution is modeled in order to maintain the preferential tax treatment of employer-based health coverage. Employer benefit costs are passed on to employees in the form of reduced wages; however, if there were no employer contribution and the employees instead were paid higher wages, those higher wages would be subject to employer and employee payroll tax and individual income tax. Both employers and employees receive tax benefits from an employer contribution under current federal law.

73 Bittman, M. (2011, July 23). Bad food? Tax it, and subsidize vegetables. *New York Times*.

74 Boonn, A. (2011). *Raising cigarette taxes reduces smoking, especially among kids*. Washington, DC: Campaign for Tobacco-Free Kids.

Growth of Health Care Spending Over Time

Health care spending is linked to aging, growth and health status of the population, the introduction of new technology, societal expectations, and changes in the way we pay for and deliver health care, making projections difficult. A unified system, as previously outlined, operates with a global budget. This budget should be sufficient to meet the health care needs of the population and should not be subject to lobbyist pressures or political influence. For the purposes of modeling, the growth of spending over time was tied to expected wage and population growth, which allows for stable tax rates. Previous recommendations by the Minnesota Health Care Transformation Task Force aimed to keep health care inflation in line with the consumer price index.⁷⁵ A unified system gives us the means to do so, by working within a global budget. A global budget provides a strong incentive to find efficiencies, reduce errors, and to optimize the delivery of effective health care so as to avoid cutting provider reimbursement, reducing benefits or raising income-based premiums. Decisions to raise additional revenue through increasing tax rates or broadening the tax base, if needed to meet the population's health care needs, would happen in a transparent, accountable way in a unified, publicly-financed system.

PERTINENT FINDINGS OF THE LEWIN STUDY

Reduction in Total Health Spending

A unified system with uniform benefits and payment rates, using a single payer and claims administrator, could significantly reduce total health spending below that expected under the Affordable Care Act. Modeling the comprehensive coverage and minimal cost sharing on non-primary care services as specified, Lewin projects nearly a 9% reduction in total health spending in the state of Minnesota in the baseline year of 2014. The unified system reduces spending while increasing coverage and access, as 100% of Minnesotans are covered. (Under the ACA, 262,000 Minnesotans are projected to be uninsured, compared to more than 475,000 today.)

CHANGES IN STATE-WIDE HEALTH SPENDING UNDER A MN SINGLE-PAYER PROGRAM IN 2014

	Amount (in millions)	
Current Health Spending ^{a/}	\$46,417	
CHANGES IN UTILIZATION		
Utilization for newly insured	\$304	
Utilization from reduced copayments	\$357	
Reduced utilization management	\$906	
Reduced managed care coverage	\$179	
Fraud reduction (Subpoena powers) ^{b/}	-\$203	
Total changes in utilization	\$1,543	
SPENDING OFFSETS		
Bulk Purchasing		
Prescription Drugs	-\$796	-\$877
Durable Medical Equipment	-\$81	
Administrative Costs		
Insurer Administration	-\$2,940	-\$4,728
Hospital Administration	-\$302	
Physician Administration	-\$1,486	
Total Offsets	-\$5,606	
NET CHANGE IN HEALTH SPENDING UNDER SINGLE PAYER		
Net Change (\$)	-\$4,062	
Net Change (%)	-8.8%	

^{a/} Excludes public health.

^{b/} State government plans possess subpoena powers that the federal government does not have, to review claims.

Source: Lewin Group estimates using MN provided data within the Health Benefits Simulation Model (HBSM).

75 Minnesota Department of Health. Health Care Transformation Task Force. Retrieved from <http://www.health.state.mn.us/divs/hpsc/hep/transform/actionplan.html>.

Savings to Employers

There are significant savings for employers that currently offer insurance. Average projected savings amount to \$1,214 per worker. The impact on individual employers will depend on the number of employees and their average wages. The biggest savings are for state, local and federal employees. Employers not currently offering insurance would see an increase in spending of \$2,124 per worker on average, varying by industry and size of workforce.

IMPACT OF THE ACA AND THE SINGLE-PAYER PROGRAM ON EMPLOYER HEALTH BENEFITS COSTS PER WORKER IN 2014: FOR WORKERS IN FIRMS OFFERING HEALTH INSURANCE PRIOR TO THE ACA (PAYROLL TAX OF 9.67% OVER \$12,000; EFFECTIVE RATE OF 7.2%; WITH TOBACCO OR ALCOHOL TAX)

	EMPLOYERS OFFERING COVERAGE BEFORE THE ACA				
	Before the ACA	Change under ACA	Total with ACA	Change From ACA under Single-Payer	Total Cost with Single-Payer
FIRM SIZE					
Under 10	\$7,251	-\$1,426	\$5,825	-\$81	\$5,744
10 - 24	\$6,611	-\$1,176	\$5,435	\$295	\$5,730
25-99	\$6,050	-\$206	\$5,844	-\$406	\$5,438
100 - 499	\$6,427	-\$289	\$6,138	-\$156	\$5,982
500 - 999	\$7,843	-\$462	\$7,381	-\$658	\$6,723
1000 - 4999	\$6,217	-\$188	\$6,029	-\$319	\$5,710
5000 +	\$8,334	-\$305	\$8,639	-\$2,307	\$6,332
Government	\$8,582	-\$2	\$8,580	-\$2,367	\$6,213
INDUSTRY					
Construction	\$6,281	-\$554	\$5,727	-\$807	\$4,920
Manufacturing	\$7,444	-\$236	\$7,208	-\$1,899	\$5,309
Transportation	\$10,434	-\$550	\$9,884	-\$2,498	\$7,386
Wholesale Trade	\$5,498	-\$75	\$5,423	-\$672	\$4,751
Retail Trade	\$6,228	-\$100	\$6,128	-\$1,144	\$4,984
Services	\$6,800	-\$245	\$6,555	-\$291	\$6,264
Finance	\$7,799	-\$285	\$7,514	-\$115	\$7,399
Other	\$8,198	-\$574	\$7,624	-\$218	\$7,406
State and Local	\$8,366	\$0	\$8,366	-\$2,308	\$6,058
Federal	\$10,363	-\$16	\$10,347	-\$2,850	\$7,497
Total	\$7,381	-\$217	\$7,164	-\$1,214	\$5,950

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

IMPACT OF THE ACA AND THE SINGLE-PAYER PROGRAM ON EMPLOYER HEALTH BENEFITS COSTS PER WORKER IN 2014 FOR WORKERS IN FIRMS THAT DID NOT OFFER HEALTH INSURANCE PRIOR TO THE ACA (PAYROLL TAX OF 9.67% OVER \$12,000; EFFECTIVE RATE OF 7.20%; WITH TOBACCO AND ALCOHOL TAX)

	EMPLOYERS NOT OFFERING COVERAGE BEFORE THE ACA				
	Before the ACA	Change under ACA	Total with ACA	Change From ACA under Single-Payer	Total Cost with Single-Payer
FIRM SIZE					
Under 10	\$0	\$93	\$93	\$2,133	\$2,226
10 - 24	\$0	\$80	\$80	\$1,846	\$1,926
25-99	\$0	\$96	\$96	\$2,040	\$2,136
100 - 499	\$0	\$356	\$356	\$2,181	\$2,537
500 - 999	\$0	\$398	\$398	\$1,672	\$2,070
1000 - 4999	\$0	\$305	\$305	\$1,858	\$2,163
5000 +	\$0	\$0	\$0	\$0	\$0
Government	\$0	\$0	\$0	\$0	\$0
INDUSTRY					
Construction	\$0	\$215	\$215	\$2,222	\$2,437
Manufacturing	\$0	\$333	\$333	\$2,869	\$3,202
Transportation	\$0	\$192	\$192	\$2,623	\$2,815
Wholesale Trade	\$0	\$66	\$66	\$2,953	\$3,019
Retail Trade	\$0	\$118	\$118	\$1,331	\$1,449
Services	\$0	\$134	\$134	\$1,851	\$1,985
Finance	\$0	\$166	\$166	\$3,555	\$3,721
Other	\$0	\$222	\$222	\$1,680	\$1,902
State and Local	\$0	\$0	\$0	\$0	\$0
Federal	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$161	\$161	\$1,963	\$2,124

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Savings to Families

The average Minnesota family would see a savings of \$1,238 each year on health care expenses and a \$124 increase in annual wages due to lower employer health care spending. Additional out-of-pocket expenses for non-primary care copays would be capped at 3-5% of income with an annual maximum of \$1,500 per person or \$3,000 per family. Moving from a premium-based financing system to an income-based financing system eliminates underinsurance, so families would never pay more than 10% of their income on health care. Income-related financing does increase health care spending for families earning more than \$150,000 per year, and those earners will also experience some wage suppression as a result of the employer health tax. While the increase will be greatest for the 3% of households with the highest incomes (those earning more than \$250,000 per year), these families are unlikely to face the financial barriers to health care that the average family faces today. The three different financing methods modeled vary slightly in financial impact across the income spectrum.

CHANGES IN FAMILY HEALTH SPENDING UNDER THE MINNESOTA SINGLE-PAYER PROPOSAL IN 2014

[No worker payroll tax; income tax (averages 2.97% of AGI); with tobacco and alcohol tax]

	Total Families	UNDER ACA			UNDER SINGLE-PAYER							
		Average Premium Payments ^{a/}	Average Copays ^{b/}	Average Total Cost per Family	Average Premium Payments ^{a/}	Average Copays ^{b/}	Average Total Cost per Family	Change in Premium & Out-of-Pocket	Payroll Tax	Change with Payroll Tax	Average Wage-Effect	Net Change with Wage Effects
FAMILY INCOME												
< \$10,000	164,877	\$385	\$609	\$994	\$58	\$46	\$105	-\$889	\$80	-\$809	\$368	-\$1,177
\$10K - \$19,999	229,152	\$903	\$686	\$1,589	\$271	\$189	\$460	-\$1,129	\$246	-\$883	\$294	-\$1,177
\$20K - \$29,999	265,964	\$1,716	\$1,015	\$2,731	\$541	\$295	\$836	-\$1,895	\$529	-\$1,366	\$618	-\$1,984
\$30K - \$39,999	246,973	\$2,035	\$1,264	\$3,299	\$554	\$369	\$923	-\$2,376	\$819	-\$1,557	\$774	-\$2,331
\$40K - \$49,999	208,321	\$2,439	\$1,427	\$3,867	\$507	\$415	\$922	-\$2,945	\$1,237	-\$1,708	\$896	-\$2,604
\$50K - \$74,999	397,887	\$3,108	\$1,782	\$4,890	\$533	\$497	\$1,031	-\$3,859	\$1,580	-\$2,279	\$1,233	-\$3,512
\$75K - \$99,999	321,776	\$3,800	\$1,882	\$5,682	\$430	\$512	\$942	-\$4,740	\$1,392	-\$3,348	\$1,316	-\$4,664
\$100K - \$149,999	357,069	\$4,089	\$2,047	\$6,136	\$309	\$530	\$839	-\$5,297	\$2,346	-\$2,951	\$647	-\$3,598
\$150K - \$249,999	212,660	\$4,557	\$2,267	\$6,824	\$371	\$555	\$926	-\$5,898	\$4,502	-\$1,396	-\$1,636	\$240
\$250,000 +	73,043	\$5,096	\$2,649	\$7,745	\$741	\$508	\$1,249	-\$6,496	\$30,197	\$23,701	-\$12,869	\$36,570
AGE OF FAMILY HEAD												
Under 25	292,122	\$1,058	\$776	\$1,834	\$55	\$130	\$184	-\$1,650	\$1,111	-\$539	\$517	\$1,056
25 - 35	439,726	\$2,189	\$1,048	\$3,237	\$14	\$218	\$231	-\$3,006	\$2,205	-\$801	\$274	-\$1,075
35 - 44	436,970	\$2,756	\$1,516	\$4,272	\$42	\$305	\$347	-\$3,925	\$1,662	-\$2,263	\$116	-\$2,379
45 - 54	452,482	\$2,857	\$1,868	\$4,725	\$67	\$441	\$5077	-\$4,218	\$3,177	-\$1,041	\$354	-\$1,395
55 - 64	386,662	\$3,448	\$2,173	\$5,622	\$201	\$601	\$801	-\$4,821	\$2,986	-\$1,835	\$588	-\$2,423
65+	469,759	\$4,037	\$1,751	\$5,788	\$1924	\$672	\$2,595	-\$3,193	\$2,418	-\$775	-\$389	-\$386
ALL FAMILIES												
All Families	2,477,721	\$2,825	\$1,557	\$4,382	\$424	\$409	\$834	-\$3,548	\$2,310	-\$1,238	\$124	-\$1,362

^{a/} Includes premium payments under Part B and Part D of Medicare. Medicare premiums are found in some families with a head under age 65 due to participation in Medicare disability or for family members age 65 and older living with adult children.

^{b/} Included copayments, deductibles and out-of-pocket payments for non-covered services

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Distribution of Health Care Resources

By significantly cutting administrative expenses, reducing fraud and using bulk purchasing, a much greater proportion of health care dollars are spent on providing health care. And by reducing physician time and resources spent on administration, providers will have more time to devote to patient care.

Bending the Cost Curve

A naturally appreciating method of financing allows for predictable health care expenses for employers,

households and governments. A global budget produces strong incentives to eliminate errors, duplication and waste, and to promote care which is effective and efficient. The Minnesota Department of Health projects health care spending to grow faster than projections by the Centers for Medicare and Medicaid. A unified single-payer system slows the rate of spending with increased potential savings each year.

EXPENDITURES FOR PHYSICIAN ADMINISTRATION UNDER THE SINGLE-PAYER PROPOSAL IN MINNESOTA FOR 2014 (MILLIONS) ^{A, B, C}

	Costs Pre-ACA	Costs under ACA	Under Single-Payer
Authorization	\$809	\$819	\$266
Formulary	\$358	\$363	\$118
Claims/Billing	\$931	\$942	\$306
Credentialing	\$58	\$58	\$48
Contracting	\$86	\$87	\$43
Quality Data	\$14	\$14	\$14
Total Insurance-Related Costs	\$2,256	\$2,283	\$796

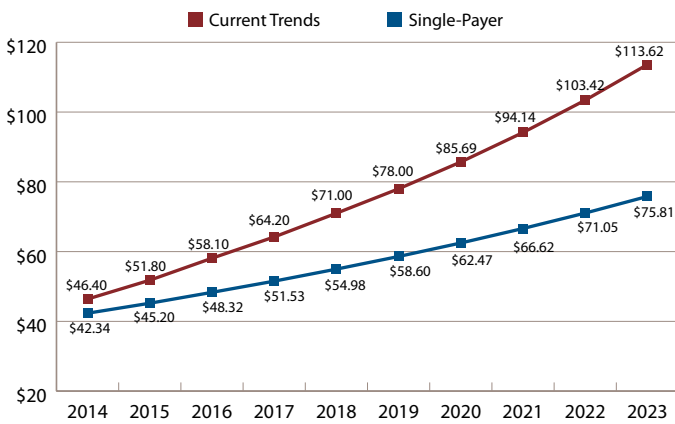
^a Estimated using projected spending in Minnesota for physician services and practice cost data using: Casalino, L., et al., "What Does It Cost Physician Practices to Interact With Health Insurance Plans," Health Affairs, May 2009.

^b We assume that physician spending for billing and collections would be reduced in proportion to the reduction in insurer claims administrative spending.

^c We assume that physician spending for quality assurance and utilization management would decline in proportion to the reduction in the amount spent on these functions for insurance administration under the single-payer program.

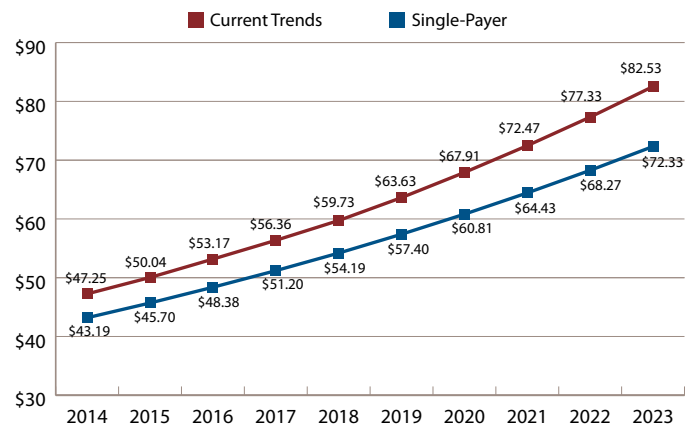
Source: Lewin Group

Projected Growth in Health Spending for MN Using MDH Growth Projections for Current Trends and Single-Payer: 2014-2023 (in billions)



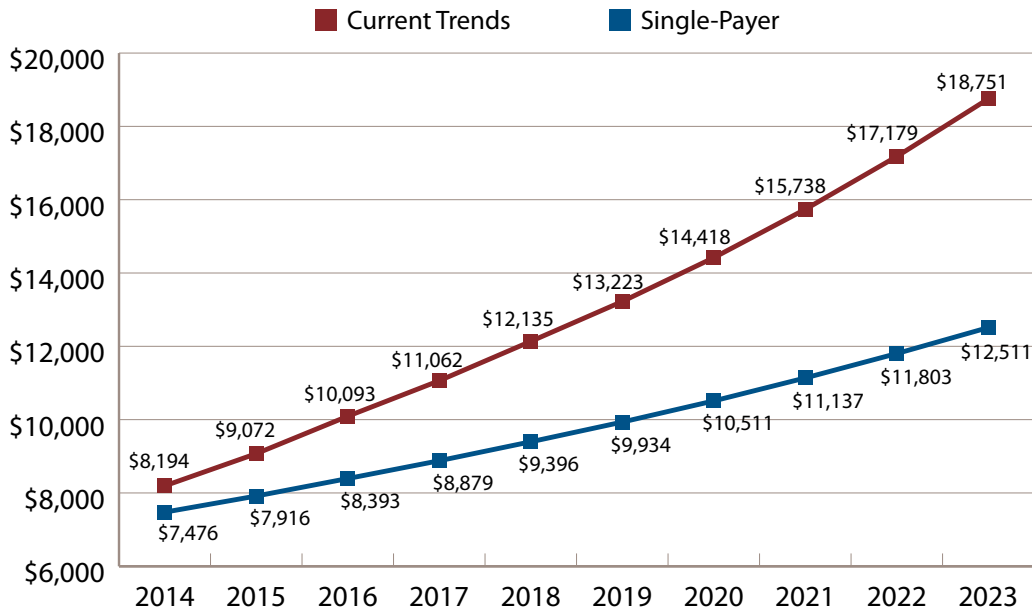
Source: MDH health care expenditure projected growth rates; Lewin Health Benefits Simulation Model (HBSM)

Projected Growth in Health Spending for MN Using CMS Growth Estimates for Current Trends and Single-Payer: 2014-2023 (in billions)



Source: CMS Office of the Actuary National Health Expenditure Projections 2009-2020; MDH current health spending; Lewin Health Benefit Simulation Model (HBSM)

Projected Health Spending Per Capita Using MDH Health Spending and Population Estimates Under Current Trends and Single-Payer: 2014-2023



Source: Lewin Group, using MDH projected health spending and Minnesota Department of Administration Office of Geographic and Demographic Analysis.

Workforce Changes

Moving to a unified system with a significantly reduced administrative burden will lead to a reduction in health sector employment. Even accounting for the increase in health care jobs in the delivery system due to increased utilization with increased insurance coverage, Minnesota could lose 42,000 jobs in health care administration, though a portion of those jobs would have been newly created under the Affordable Care Act. Other published studies have suggested the decrease in health administration employment would be more than made up in employment growth in other sectors (see the next section for further discussion).

IMPACT OF A SINGLE-PAYER PROGRAM ON MINNESOTA HEALTH SECTOR EMPLOYMENT IN 2014		
	Number Employed Under ACA	Reduction in Employment Under Single-Payer
Insurance and Programs ^{a/}	19,949	16,724
Physician Practice ^{b/}	51,740	22,160
Hospitals ^{c/}	96,172	3,911
Total	167,861	42,795

^{a/} Bureau of Labor Statistics, National life and health insurance workers allocated to Minnesota. Employment is reduced in proportion to estimated administrative savings.

^{b/} BLS data for Minnesota. Employment reduced in proportion to estimated administrative savings.

^{c/} BLS data for physician offices in Minnesota less the number of office-based physicians in the state reported by the American Medical Association (AMA). Employment is reduced in proportion to estimated administrative savings.

Source: Lewin Group

For a copy of the full report by The Lewin Group, including additional analysis and an explanation of methodology, go to: www.growthandjustice.org.



MINNESOTA CAN LEARN FROM WHAT OTHER STATES ARE DOING

States continue to innovate in health care. In May 2011, Vermont passed legislation creating a pathway to a unified, single-payer health care system (Green Mountain Care). The bill was crafted after an extensive analysis of barriers, options and opportunities, and completion of an economic analysis of reform options conducted by Dr. William Hsiao, an international expert on single-payer systems. In this new law, Vermont establishes health care as a human right and guarantees affordable health care to every Vermont resident. The health care system will be transformed over a period of several years and will rely on getting waivers from the Federal government to include Medicare and Medicaid in the unified system. (Unless there is congressional action, as noted previously, these waivers cannot be obtained until 2017.) The five-member Green Mountain Care Board has already been named and begun work. The law encompasses development of a unified single-payer system, payment and delivery system reform, and changes to the medical malpractice system.⁷⁶

Hawaii has recently appointed the Hawaii Health Authority, a board working toward a unified system of health care in that state.⁷⁷ Montana's governor has vowed to follow Vermont's lead.⁷⁸ Minnesota can share with and learn from these states.

ADDITIONAL ECONOMIC MODELING NEEDED

Several issues were beyond the scope of this project. The Lewin study did not address or estimate non-health care system benefits such as increased worker productivity (due to fewer sick days, improved management of chronic conditions and an end to job lock) nor savings in non-health care aspects of our state budget such as the criminal justice system or foster care system, though these may be significant. For example, about two thirds of prison inmates meet medical criteria for substance abuse or addiction, and another 20% are serving time for offenses committed under the influence of alcohol or other drugs.⁷⁹ Chemical dependency treatment greatly reduces crime and prison costs, and can stabilize families and reduce costly out-of-home placements for children. A California study led by the University of Chicago found a 700% rate of return for chemical dependency treatment spending. Every dollar spent on chemical dependency treatment saved taxpayers \$7 in reduced crime and health care costs.⁸⁰

The Lewin economic impact study did not involve broader macroeconomic modeling of the growth in state gross domestic product and long term job creation resulting from savings in health care spending or the resultant increases in workers' wages. Recent studies have projected job growth and business expansion under a single-payer model and other reforms that could control premium hikes.⁸¹ A national study has found that adoption of a nationwide universal single-payer system would provide significant economic stimulus, with an immediate impact of 2.6 million new permanent jobs at an average of \$38,000 per year. It would also induce significant economic activity: indirect activity due to the purchase of services or supplies by health care providers in order to meet the increased demand for health care, and induced transactions – spending by employees in the health care and indirect service sector. Combined, they would account for \$317 billion in increased economic activity.⁸²

76 For more information on the development of the Vermont plan, see *What other states can learn from Vermont's bold experiment: Embracing a single-payer health care financing system* by Hsiao, Knight, Kappel & Done, available at <http://content.healthaffairs.org/content/30/7/1232>.

77 The Hawaii Health Authority. (2011). *2011 update to: Report by the health futures task force on a new health care assurance program, January 1999*. Honolulu, HI.

78 McCarter, J. (2011, October 4). The state of single payer in the states. *Daily Kos*. Retrieved from <http://www.dailykos.com/story/2011/10/04/1022838/-The-state-of-single-payer-in-the-states>.

79 The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2010). *Behind bars II: Substance abuse and America's prison population*. New York, NY.

80 Swan, N. (1995). California study finds \$1 spent on treatment saves taxpayers \$7. *NIDA Notes*, (10) 2.

81 Cutler, D. & Sood, N. (2010). *New jobs through better health care: Health care reform could boost employment by 250,000 to 400,000 a year this decade*. Washington, DC: Center for American Progress.

82 Institute for Health & Socio-Economic Policy. (2009). *Single-payer/Medicare for all: An economic stimulus plan for the nation*. Orinda, CA.

William Hsiao's proposal for a unified system in Vermont projected a net of 5,000 new jobs in Vermont and an increase in the state GDP of \$180 million the first year a single-payer system is implemented.⁸³ These economic boosts would be a result of lower per capita health costs leading to higher wages and increased discretionary spending.⁸⁴ Vermont's population is about 12% of Minnesota's population, so Minnesota could expect proportional results.

PAYMENT AND DELIVERY SYSTEM REFORM

A large part of the cost containment debate has focused on payment and delivery system reforms, that is, how we pay for and provide health care. To a large extent, the cost-containment potential of payment and delivery system reforms are theoretical at this point, and each idea has pitfalls and risks of its own. But payment and other delivery system reforms have more potential for cost containment in a single-payer system where there is no incentive to select the healthiest patients, collaboration on comparative effectiveness and quality of care metrics is facilitated, and waste and fraud are more easily detected. Ultimately, any payment or delivery system reform that bends the cost curve without diminishing access, quality or equity can be implemented in a unified single-payer system.

In 2010, the Minnesota Medical Association convened a work group to review payment reform models and make recommendations. The group studied the benefits, pitfalls, challenges and risks of the primary payment models: fee for service; pay for coordination; pay for performance; bundled payments; and total cost of care. It evaluated these models against 11 principles of a high value health care system in which care:

- is patient-centered
- is safe and effective
- is timely and accessible
- is efficient and without waste
- is coordinated across the full spectrum of care
- is continuous, and supportive of the provider-patient relationship
- is collaborative
- is optimized by effective and efficient communication
- engages the patient
- is delivered in a system of clear accountability
- is delivered in a system of continuous innovation and learning⁸⁵



83 Hsiao, W., Gruber, J. & Kappel, S. (2011). *Vermont: A health system for the 21st Century* [PowerPoint slides]. Retrieved from http://www.leg.state.vt.us/jfo/healthcare/FINAL%20VT%20Hsiao%20Presentation%20for%20Jan1911_1.pdf.

84 Hsiao, W., Kappel, S. & Gruber, J. (2011, February 17). *Act 128 Health system reform design: Achieving affordable universal health care in Vermont*. Report submitted to the Vermont Legislature. Retrieved from http://www.leg.state.vt.us/jfo/healthcare/FINAL%20REPORT%20Hsiao%20Final%20Report%20-%2017%20February%202011_3.pdf.

85 Silversmith, J. (2011, February). Five payment models: The pros, the cons, the potential. *Minnesota Medicine*. Retrieved from <http://www.minnesotamedicine.com/tabid/3679/Default.aspx>.

FEE FOR SERVICE is easy to understand and implement, and as a reimbursement method can work across the range of delivery sites and systems. It rewards productivity but can also promote duplicative, ineffective, or unnecessary care. It is more vulnerable to fraudulent billing than any system of capitation. In general, a fee-for-service payment system does not reward care coordination or delivery outside the face-to-face clinic setting, such as care management by phone or email.

PAY FOR CARE COORDINATION is typified by the health care home model, where a care coordination fee is paid per patient per month. This encourages provider-patient communication and patient involvement, allows flexibility in where, how or by whom care is delivered, and has the potential to eliminate unnecessary or duplicative care. Care coordination is time intensive and what qualifies as care coordination isn't clearly defined. Not all patients need extensive care coordination. It may create an incentive to avoid patients with multiple medical conditions or with language, cultural or socioeconomic barriers.

PAY FOR PERFORMANCE involves payment or financial incentive for meeting defined goals related to care processes or outcomes. Pay for performance is problematic for many reasons. It can improve care quality, efficiency and collaboration for the measured conditions, but at the risk of shifting attention and resources away from conditions which aren't being measured. It creates an incentive to avoid sick patients unless sophisticated risk adjustment mechanisms are in place. These mechanisms in turn create an incentive for up-coding, or using diagnosis codes to make patients seem sicker than they are so as to improve outcome measurements.⁸⁶ Research suggests that outcome measurements more likely reflect patient demographics than physician performance,⁸⁷ and that pay for performance can potentially backfire as it interferes with the intrinsic motivation and professionalism of physicians.⁸⁸ Pay for performance also does nothing to relieve administrative burdens on providers, with data collection and reporting requirements competing for time with patient care.

BUNDLED PAYMENTS are single payments for all inpatient and outpatient services related to a particular episode of care. The goal is to promote evidenced-based care, care coordination and discharge planning, as preventable hospital readmissions would not be paid for. Bundled payments encourage managing care in the least expensive location, and reduce the administrative expenses of billing. Minnesota's 2008 health care reform law included a variation on bundled payments by defining baskets of care for several conditions including obstetric care, knee replacement, asthma and diabetes. To date, no Minnesota health plan is paying for baskets of care. In 2009 a pilot of the PROMETHEUS bundled payment model was launched in three U.S. communities. A recent evaluation by the RAND Corporation found that three years into the pilot, none of the participants had made any bundled payments. The model was found to be exceedingly complex to set up and implement.⁸⁹ As with other reforms, there is an incentive to avoid high-risk, complex or non-compliant patients.

TOTAL COST OF CARE provides a single payment for the full range of health care services for a person or group of persons for a specified amount of time. This model has several variants and is similar to capitation, but includes more sophisticated risk adjustment and incorporates quality and patient satisfaction measures. Accountable Care Organizations (ACOs) – total cost of care delivery systems that feature shared risk and shared savings – are being piloted as part of the Affordable Care Act. An ACO is an actual or virtually integrated delivery system that includes providers, clinics and hospitals. Though their benefits are largely theoretical thus far, ACOs are intended to deliver health care more efficiently, to improve collaboration, establish financial incentives to avoid unnecessary or marginally effective interventions, and to provide care in the most cost-effective setting. It remains to be seen how willing providers will be to accept a shared risk model and whether patients will perceive ACOs as limiting provider choice and potentially restricting treatment, as was the case with managed care HMOs in the 1990s.

86 Angeles, J. & Park, E. (2009).

87 Hong, C., Atlas, S., Chang, Y., Subramanian, S., Ashburner, J., Barry, M. & Grant, R. (2010). Relationship between patient panel characteristics and primary care physician clinical performance rankings. *Journal of the American Medical Association*, 304 (10), 1107-1113.

88 Wynia, M. (2009). The risks of rewards in health care: How pay-for-performance could threaten, or bolster, medical professionalism. *Journal of General Internal Medicine*, 24 (7), 884-887. doi:10.1007/s11606-009-0984-y

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The dominance of integrated delivery systems in Minnesota puts our state in a better position to move ahead with accountable care organizations relative to many other states. Three integrated delivery systems in Minnesota – Allina, Fairview and Park Nicollet – are among 32 groups practicing in 18 states that were recently named pioneer ACOs by the U.S. Department of Health and Human Services. These organizations will participate in a new Medicare ACO program.⁹⁰

As with other payment reforms, in an insurance-based, multi-payer system, ACOs will have an incentive to avoid high-risk, complex, or non-adherent patients. Risk adjustment to combat cherry-picking of patients can be administratively complex, difficult to do accurately, and resource intensive. There is again a strong incentive in ACOs for up-coding, which would not only be more lucrative in a shared savings system but would also divert health care resources away from the truly seriously ill.⁹¹

EXPANDING COST CONTAINMENT MEASURES THAT WORK

We do have evidence on measures that control costs, and improve quality without reducing access.

Continuity of Care

Long-term relationships between doctors and patients, with primary care in a predominant role, is associated with lower total health care costs.^{92,93}

Shared Decision Making

This includes providing tools and compensating doctors for reviewing risks, benefits, alternatives and expected outcomes of treatment options with patients. Shared decision making should also discuss the costs relative to the expected outcome of the intervention, but ultimately decisions should be based on health care need and most appropriate treatment. Research indicates that shared decision making lowers demand for health care services.⁹⁴

Continuous Quality Improvement (CQI) programs

Led by providers, CQI programs feature adherence to clinical standards and reduce variability in processes of care, thereby reducing waste and error, while not restricting provider flexibility in meeting the unique health needs of each patient. For example, simple measures recently put in place by the Hennepin County Medical Center pharmacy reduced discharge-medication errors rates from 92% to zero, and cut 30-day readmission rates in half.⁹⁵ The use of clinical protocols and checklists in surgery can significantly cut error rates, decrease unnecessary testing and save money. Potentially avoidable complications account for nearly 40% of spending on people with chronic conditions.⁹⁶

Comparative Effectiveness Research (CER)

Comparative effectiveness research can reduce unnecessary high-tech intervention and unquestioned adoption of expensive technology and pharmaceuticals if they don't confer added benefit. CER can also reveal those interventions that actually cause harm.⁹⁷ The ACA provides more funding for CER.

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Advance Directives and Palliative or Hospice Care

Palliative and hospice care not only result in cost savings, but improved quality of life, decreased patient and family anxiety, and oftentimes longer survival.^{98,99,100}

Disclosure Laws and Conflict of Interest Policies

Laws and policies requiring the public disclosure of payments to physicians by pharmaceutical and med-tech companies can decrease the unnecessary use of expensive drugs or devices.¹⁰¹

INNOVATION AND EXPERIMENTATION IN MINNESOTA

Some delivery systems and employers have experimented with new coverage, payment, delivery or care coordination models with promising, though mixed, results. Approximately 75% to 80% of practicing physicians in Minnesota work in integrated delivery systems so these changes and pilot programs have the probability of reaching most practices over time.¹⁰²

Health Care Homes

A recent two-year study found that the 21 Minnesota clinics certified as health care homes (also called medical homes) achieved an increase of 1% to 3% per year in patient satisfaction and a 2% to 7% increase per year in performance on quality measures for the care of coronary artery disease, generic medication use, diabetes and preventive services.¹⁰³ The improvements fell short of goals and were only slightly better than other clinics, though with payments for care coordination now in place, the Minnesota Department of Health (MDH) is hoping for further improvements. Twenty percent of Minnesota's 700 clinics have been certified as health care homes by MDH. These clinics care for about one third of Minnesotans.¹⁰⁴

Hennepin County Coordinated Care Center

An innovative program at Hennepin County Medical Center is helping coordinate a range of social service needs for their poorest and sickest patients and managing to steeply curtail costly preventable hospital admissions. The promising project is expanding into a formal demonstration for the state, using a block of money to manage the care of these patients, including their social service and community support needs, rather than being reimbursed for medical expenses as they occur.¹⁰⁵

Nursing Home Pilot Program to Cut Hospitalizations

A pilot program funded by the state is working to prevent hospital admissions of nursing home patients by instituting checklists and watching for early warning signs, enabling early intervention and preventing unnecessary hospitalizations. The fragmentation of our payment system however, means that the money saved by preventing hospitalizations accrues to Medicare, while the cost of an early intervention program falls to Medicaid, which pays for 60% of nursing home residents.¹⁰⁶

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99 Temel, J., Greer, J., Muzikansky, A., Gallagher, E., Admane, S., Jackson, V. ... Lynch, T. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363 (8), 733-742.

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105 Crosby, J. (2011, November 14). HCMC gives a new push to prevention, with smiles. *Star Tribune*.

106 Wolfe, W. (2011, November 7). Nursing homes to treat more ailments. *Star Tribune*.

Collaboration in Northwestern Twin Cities Suburbs

Allina and HealthPartners are pooling resources in a seven year project to review insurance claims data for keys to improving care and saving money. Changes such as prescribing more generic drugs and fewer antibiotics, reducing elective inductions of labor, and increasing patient education upon hospital discharge led to slower than projected growth in health care spending.¹⁰⁷ A uniform system with a single channel for claims processing would enable these care improvement and cost saving measures state-wide.

Fairview's New Payment System for Doctors

In April 2011, the Fairview clinic network began a new payment system for primary care physicians. Their pay will be based on patient satisfaction (10%), outcomes for patients with chronic conditions, such as asthma, depression, and diabetes (40%), and partly based on encounters with patients, though communication by email and phone will also be encouraged. No physician will face a pay cut initially.¹⁰⁸

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Despite the very necessary focus on access to health care and the detrimental economic impact of our current fragmented health care system, our health status is more easily predicted by our zip code than by our access to health care. Social determinants like education, income, neighborhood conditions and access to transportation have a significant impact on our health and longevity.¹⁰⁹ Affordable access to health care is essential to help address and ameliorate the effects of social determinants but a wide range of public and private policy changes are needed to address our significant racial and economic health disparities.

WORKFORCE ISSUES

Transitioning to a unified system will change the demands on our workforce. Fewer claims processors and others involved in administrative functions will be needed, but there will be increased demand for health care service delivery, from phlebotomists and medical assistants to nurses and doctors. Some of this increased demand can be met by existing providers as they will have more hours to devote to patient care as a result of fewer hours spent on administration. Some of this increased demand will be met by the trained and licensed health care workers currently working in administrative positions at insurance companies.

Reform will probably necessitate more people working to the height of their specialty with a greater share of ambulatory care being provided by advance practice nurses and physician assistants. Some care coordination and patient education will likely be carried out by nurses. A unified system will need to address the cost of provider education and increase opportunities for loan forgiveness for those working in primary care and with underserved populations or regions. Provisions for retraining and job placement assistance for displaced workers will also be needed.

ADDRESSING ERISA

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 as a means to create uniform federal standards and protect employee benefits. ERISA preempts state law from regulating benefit plans, including health care benefits, offered by self-insured employers. ERISA is often thought to create a barrier to state health care reform efforts. While Hawaii was granted an ERISA waiver, as its Prepaid Health Care Act preceded enactment of ERISA; no other state has been granted a waiver. There is no administrative process for an ERISA waiver. Changes to ERISA require congressional action, which is highly unlikely at this point.

107 Crosby, J. (2011, November 2). HealthPartners, Allina form a 'lab' for health reform. *Star Tribune*.

108 Lerner, M. (2011, September 14). Doctors' pay plan is cutting edge. *Star Tribune*.

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William Hsiao, the architect of the Vermont health reform bill, did extensive research into legal hurdles to a universal unified system, including ERISA. He concluded that existing case law is mixed and as there have been no cases of tax-based universal health care systems from which to draw conclusions, the terrain is uncertain.¹¹⁰

Hsiao and colleagues note in a recent article:

On the one hand, employers could argue that such a system violates ERISA because public benefits, even those financed through an income tax, would induce them to drop or modify their plans or, in the case of a payroll tax, force them to “double pay” for both the tax and their existing benefits. On the other hand, legal experts on ERISA point out that taxation and health care financing are traditional areas of state authority, which could protect such a system from ERISA “preemption.” Given the indirect nature of the effect on employer plans, there is some question as to whether ERISA is relevant at all.¹¹¹

Given that 40% of Minnesotans currently are covered by self-insured plans, ERISA is a significant factor. The implementation of Vermont’s law will be instructive.

IMPLEMENTATION PLANNING

If Minnesota were to move toward implementation of a unified system such as the one modeled in this report, additional legal, economic, structural and political hurdles need to be addressed. The governor could charge the Health Care Reform Task Force with systematically doing so, much as they are doing in Vermont. Our public and private sector have the expertise and know-how to address these challenges and could plan for a transition over the next several years, if evidence can trump ideological hurdles.

CONCLUSION

We will continue to be a health care leader in Minnesota; the important questions are whether all Minnesotans will benefit from our high quality care and whether we can sustain health care spending while meeting our other needs. This report demonstrates the viability of a unified system which would guarantee access to affordable, high quality health care for every Minnesotan regardless of income, age, employment status or health.

We could eliminate the financial burdens of illness and reverse the rapidly accelerating trend of shifting costs to patients, thereby providing care based on medical need rather than one’s ability to pay.

We should consider all options that move us toward universal coverage and greater affordability. If Minnesota were to develop a single statewide plan as delineated in this report, we could delink health care from employment, freeing employers to focus on their business mission and ending employee job lock, while retaining the current tax benefits of an employer-based system. We could achieve universal coverage while eliminating uncompensated care and the health and economic consequences of gaps in coverage. Significant hurdles remain, logistically and politically. But escalating costs and the harmful health and economic impacts of our fragmented current system will someday compel us to act. The economic savings would be significant; the potential health benefits are immeasurable.



110 Hsiao, W., Knight, A., Kappel, S. & Done, N. (2011). What other states can learn from Vermont’s bold experiment: Embracing a single-payer health care financing system. *Health Affairs*, 30 (7), 1232-1241. doi:10.1377/hlthaff.2011.0515

111 Hsiao, W., Knight, A., Kappel, S. & Done, N. (2011).



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