Models Development Workgroup

Universal Model Assumptions

January 9, 2006

The main assumption we made is that there is enough money in the present health insurance system to provide health insurance coverage for everyone in the state. We identified where we thought savings could be made and created a 'unified medical insurance plan' based on those discussions.

Justification:

It is well known that the USA spends more per capita and more as a percentage of gross domestic product on health care than any other nation. While there has never been a study done of the Michigan system, there is no reason to think we are any different then the national norm. It is also well documented that this spending pattern creates a competitive problem for our manufacturers because other competing countries treat health insurance as a collective right and do not require manufacturers to bear the full burden of providing that health insurance. In this country manufacturers bear not only the burden of insuring their work force but also their retirees (legacy employees) and the uninsured.

In 2003 in the US we spent $1.6 trillion on health care. Michigan's share of that was approximately $45 billion. These amount to between 14 and 15% of the gross domestic product. The Commonwealth fund estimates that burden will rise to 18% by 2014 without reform. Health care costs rise at a rate greater than inflation.

Canada and other nations with a universal system spend 10% or less of their gross domestic product on health coverage. The average expenditure per person in 2002 in the USA was $5,267. That has risen to in excess of $6,000 in 2005. The next highest national per capita health care expenditure is Canada at $2,931 in 2002.

GAO Report:

The cost drivers that create these differences are well identified, although there are disputes between economists over which 'cost driver' is most important. In May of 2004 the GAO published a report on health care. Its title was "Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value." One conclusion, "To moderate health care spending in both [public and private] sectors, we will need to look at broad payment system reforms."

The fragmentation of the health care economic and delivery systems were identified as major cost drivers. The experts stated that greater financial commitment did not necessarily translate into better health statistics. " . . .our public and private payment systems need to be reformed." While there were other cost drivers 75% of the participants believed that the current division of 'responsibilities for health care access

and financing – currently shared by the government, employers and individuals – may need to be refined." The report concludes " . . .The US health system is highly fragmented among multiple payers, hundreds of thousands of providers often functioning in isolation, and patients with different levels of public and private coverage or no coverage at all. Such complexity and fragmentation drives up administrative expenses as well as care costs." Page 9; GAO.

Other State studies:

Studies done in other states consistently find that a major cost driver is the fragmentation of the finance and delivery systems – that is – administrative overhead. Maine passed legislation establishing the "Health Care System and Health Security Board" to study the feasibility of a single-payer system for Maine. Administrative costs for providers alone were estimated at over 20%. [Mathematica]

A study published in the New England Journal of Medicine in August of 2003 found that administrative costs for insurers was 8% lower for Medicare than for private insurance, and that for providers, comparing Canadian overhead to American was 13% to 24%. The New England JOM estimates administrative costs in Canada at $307 and in the US at $1,059. A change in the payer system was also estimated to drop the overhead for sole practitioners from 35% to around 20%. These figures were used by Emory University which did a study of the Missouri system finding that there was sufficient money to provide decent benefits to everyone in that state if the financing system were reformed.

The Lewin Group did a study in California in 2004, published in 2005, which concluded that administrative savings and bulk purchasing of pharmaceuticals combined would result in savings of over $300 in a period of 10 years. This was not the first such study in California. In 2002 the California HRSA process produced a report that included a model for single payer, funded by administrative and other cost savings. [Also see Vermont's HRSA report from 2001 done by Lewin Group.

No such study has been done in Michigan. Figures presented that suggest administrative overhead in this state is only 10 to 15% ignore the cost of administration to providers, and ignore the claims procedures studied in other states. But as early as 1991 the New England Journal of Medicine published data showing that administration in the USA was 60% higher than that in Canada. The HMO movement instituted in that time frame had a temporary beneficial effect. But administrative overhead remains higher than it needs to be.

Business Analyst:

The cost drivers identified by a financial, corporate professional, are;

Aging population
Sedentary Life style

Pharmaceuticals
Minimal focus on prevention
Defensive medicine
Medical errors
Waste – duplication, fragmentation. Presentation at Assoc. for Financial Professionals; summer 2005; Scott Lammie

Although Mr. Lammie's solution was mainly to shift cost to employees, his analsis of the problem is consistent with most other economists. However, the 'aging population' factor is true throughout the Western world. [In fact the Canadian population is older than that of the US.] The other cost drivers he defines are all addressed in the Universal Group's plan.

Michigan fragmentation:

Hospital systems report that they need to have staff familiar with 70 to 80 insurers. Our research shows the following:

1. Workers' Disability Medical coverage - in 2004 the payout to medical care providers under work related disability policies was $559 million. Provider rates are set by a 'cost containment' system that sets rates higher than Medicaid and close to or higher than Medicare. Annual report WC Bureau.

2. There are three separate funds under Workers' disability for specific types of injury or loss which paid out an additional $31 million in 2004. Annual report.

3. Michigan's No-fault plan – covers auto accident related medical without any limitation. There are no limits on the provider rates. Premiums for this coverage was about $ 2.1 billion in 2004. OFIS report.

4. Michigan's No-fault plan – includes a separate catastrophic coverage for which $700 million in premiums was collected in 2004. OFIS report. This plan is governed by the Michigan Catastrophic Claims Association. It is difficult for a non-finance person to sort out how much was spent, but MCCA has an $8.2 billion reserve, 4 times higher than the reserve for BCBSM.

5. Michigan's health insurers that function as employer-related or individual policy providers account for $11.7 billion in premiums. OFIS annual report. [I am not sure this number is accurate because I received data from Healthplus – Colleen Sproul – that indicates a total of over $7 billion in premiums, which when added to BCBSM's $5 billion plus exceeds the number I came up with from OFIS.]

6. OFIS Top 20 Accident and health insurers - $12.6 billion in premiums and $10.7 billion in claims paid. This means that almost $2 billion was profit or

administration. These 20 alone have assets in excess of $63 billion and a 'surplus' of almost $8 billion.

7. Other categories of medical coverage – The OFIS report does not allow a breakdown of medical costs only from the remaining casualty carriers. Medical coverage would be a major category of coverage for negligence protection in Dramshop insurance; premises liability insurance; business packages; homeowners' coverage; and other categories of insurance.

8. Reserves – reserve funds are important to the financial stability of an insurer. However, the amount needed in reserves for each company is often discretionary with regulators or the company's managers. BCBSM has a reserve of $2 billion on payouts of about $5 billion. The HMO's have reserves similar to BCBSM – equivalent to 2 to 3 months of claims and operating expenses. HMO's and BCBSM are required to maintain reserves consistent with guidelines established by the National Association of Insurance Commissioners. The amount is set at a range of from 200% to 1000% of subscriber reserves. The range allowed is wide.

9. Categorical medical coverages – Because of the existence of Workers' Disability; Auto; and other negligence coverage, general policies carry exclusions and either do not pay claims they believe are the responsibility of another company, or make their own claims or liens against an insurer if they believe that insurer should have paid. This results in whole industries of claims disputants and litigation at a cost unknown. One economist estimates that over 2 million people nationally are employed in the business of sorting out who should pay for medical care in specific cases. Krugman column; NYTimes.

10. Uninsurance 'tax' - FamiliesUSA estimates that one dollar out of every twelve dollars spent on health insurance goes to cover the cost of care to the uninsured. In Michigan that study found that $274 of every individual insurance policy and $740 of every family policy was used to cover health care for the uninsured.

11. Charity care - MHA estimates in excess of $1 billion in charity care by hospitals yearly, care which is 'covered', if at all, by the 'uninsured premium' identified in the FamiliesUSA study.

12. Quality or efficiency efforts – The plan we drafted includes implementing systems of disease based protocols; evidence based medicine; pay for performance and other cost saving measures. Though presently in dispute the model for this system in Maine [Dirigo Health Care] appears to have saved $43 million in a system $1/10^{th}$ the size of Michigan's.

13. Medical Malpractice reform – Depending on how a universal plan is structured a major element of damage awards, medical care in the past and future,

could be eliminated if the 'unified' system picks up the cost of all medical care. This should drive down malpractice premiums.

14. Pharmaceutical cost – The plan we developed would cut drug prices substantially by engaging in VA type bulk buying, or, as is more likely, MiRX or Medicaid type discounts to the consumer and rebates to the state.

15. Incentives – Built in incentives or disincentives should be used to encourage healthy lifestyles; keeping up with primary care requirements; being part of preventive medicine efforts, and other similar activities to create a healthier, and less 'risk-prone' population.

How much do we need to cover the uninsured?

One of the Data Requests was the monthly cost for Medicaid coverage. The estimate was $213.52 a month which translates to $2,562.24 a year per person. If we have 1 million uninsured the cost of covering all with Medicaid would be $2.56 billion a year. Our workgroup was using the figure $5.2 billion a year as needed to cover the uninsured. [It isn't clear to me if the $213.52 figure is only state expense or includes the Federal dollars.] Also, the Milliman letter finds a composite capitation rate of $100.66 per person per month for what it calls a 'low degree of managed care.'

The household survey has found that 790,000 persons are uninsured. Of those over 150,000 could be covered with expanded Medicaid, meaning federal dollars would almost match state investment for that population.

FINANCING

Our group was told not to get into financing. We did to some degree because we felt that without some idea of how to finance the system we designed that we might design something that would be impossible to fund. The unified plan would end all the categorical private coverage – such as auto coverage and workers' disability coverage for medical costs, saving employers, businesses, and auto or vehicle owners premiums. The plan has a single set of benefits, if possible, and forms, saving providers administrative overhead. A unified system would also save employers, business people, and vehicle owners the time it takes to dispute medical claims.

Our idea was to capture as much of these savings as we could in some other form, and cover all the uninsured in that manner.

1. Employers – no longer required to buy Workers' Disability medical coverage. Premiums or a fee or tax equal to or less than an employer's present premium would be collected for the fund to be administered by a commission. The amount here can be easily determined from the Bureau.

2. Businesses – no longer required to buy medical coverage under premises liability, dram shop, or other business packages. The premiums would be collected by the commission and placed in the fund. The amounts here are not known and an actuarial expert would be needed to sort out amounts.

3. Vehicle owners – no longer required to buy PIP for medical care or to pay the Catastrophic Claims Association assessment. A fee for each care each year would be collected and placed in the fund.

4. Other possible taxes or fees – The group felt a mix of several fees or taxes going into the fund would be sounder policy and create more stable cash flow.

   a. Sin tax – on alcohol and tobacco;
   b. Sales tax on health related fees and products
   c. Provider tax to recoup some of the administrative savings from fewer insurers
   d. Internet tax
   e. Payroll tax to replace some of the premium employers pay for health insurance for employees and legacy employees when fund takes over all medical coverage
   f. Income Tax on individuals or corporations could be raised

5. Savings due to quality controls and other efficiencies

   a. Protocols, evidence based medicine, pay for performance savings to cut costs – may tax insurers for savings [such as Dirigo does]
   b. Pharmaceutical bulk buying savings
   c. 'Charity care' no longer needed
   d. Control of greater amount of cash allows more flexibility in reserves – centralize one reserve in the state fund
   e. Control of greater amounts of cash allows greater flexibility in funds available for Medicaid match

6. Uninsurance tax – The fee FamiliesUSA found that employers presently pay would be covered by the fund through other sources. However, the system could be designed to capture that amount, or some portion of it as a tax.