Cost Analysis: Implementation of Single-payer Health Care Model in Minnesota; Impact on Statewide Costs and Universal Coverage.

Executive Summary

- **The Minnesota Universal Health Care Program (the Program)** creates a single, publicly-financed, publicly-administered, privately-practiced system to provide comprehensive coverage for all necessary health care services for residents of Minnesota, to take effect in 2005. This fiscally conservative Program pays for itself through substantial administrative and drug discount savings.

- **Total health care spending in Minnesota** (MN) under current law is estimated at **$20.4 billion in 1998**, rising sharply to **$31.6 billion in 2003, $37.2 billion by 2005** (9.2 % average annual increase) and tripling to **$61 billion by 2012** (7.3% average annual increase '05-'12). Per capita health care costs in 2005 are projected at $ 7,157.

- **The five major cost components of the health care system** will increase by the following amounts between 2003 and 2005: Hospital ($10.5 billion to $12.6 billion); Practitioners' services ($10.1 billion to $11.5 billion); Nursing homes ($2.3 billion to $2.5 billion); Home health care ($380 million to $452 million); and prescription drugs ($3.8 billion to $5.3 billion).

- **Total projected administrative cost savings** from elimination of excess administrative costs now incurred by private and public insurers, employers, hospitals, practitioners, nursing homes, and home health care is **$6.3 billion**.

- **Administrative savings available per uninsured resident** (not including savings from drug discounts) is estimated at **$15,175**, third in the U.S. only to Massachusetts and D.C. Projected number of uninsured residents in Minnesota in 2005 (8% of the population) is 415,760.

- **Savings from prescription drug discounts** is conservatively estimated at **$ 982 million in 2005**.

- **Estimated costs of increased utilization** of health care services for the MN Program in 2005 from covering the uninsured, underinsured and eliminating out-of-pocket payments would total **$3.9 billion**.

- **Total savings**, (the difference between increased utilization of services ($3.9 billion) and decreased administration and drug discounts ($7.3 billion) in 2005, the first year of implementation, is **$ 3.4 billion**. Thus, **Single-payer benefits expenditures in 2005 are estimated at $33.8 billion** or 9.1% less than the $37.2 billion total expenditures under current law. These savings are AFTER insuring the uninsured, upgrading coverage for the underinsured, and eliminating most out-of-pocket costs (copays, deductibles).

- **Cumulative savings 2005 – 2012**. By 2012, without reform, total statewide costs are estimated at $60.8 billion. If single-payer is implemented in 2005, by 2012 total statewide costs will be projected at $49.3 billion, with a cumulative savings from 2005 - 2012 of **$56.2 billion**.

- **One-time start-up costs for the new system**, including administrative costs of transition, operating budget for displaced worker training, construction account, and reserve account, are **$ 3 billion**. This brings the **total health plan budget to $36.9 billion**, with net savings of $320 million compared to current policy, even after including start-up costs.

- **Financing revenues for the Program** would derive from consolidation of existing government programs such as Medicare, Medicaid,, CHAMPUS/Military programs, State employees, other state and local funds (such as current state funding for mental health, indigent care), Federal Employee Health Benefits Program, plus a payroll tax of 9.5 percent, income tax of 5.1 percent (no net change since **replaces** premiums and out-of-pocket "taxes"), and transfer of workers compensation medical payments, and medical portion of automobile insurance, for a total of **$36.9 billion**. Thus, the system pays for itself, no additional costs (contains costs) compared to current law, and in the future it would save costs.

References for assumptions and calculations:

Baseline cost estimates: Expenditures for Minnesota in 1998 were from CMS (Center for Medicare and Medicaid Services, 1998 State Estimates of personal health care spending. (www.hcfa.gov/stats/nheoact/stateestimates/States98; The projected increases from 1999-2005 were based on CMS National Health Expenditures projections (www.gov/stats/NHE-Proj/2000/Tables); Expenditures through 2012 based on "Health spending projections for 2001-2012,Health Affairs,Feb 3, 2003

Administrative savings estimates: The Financial Impact of Alternative Health Care Models on Administrative and Benefits Costs in MN. Final Report, prepared for Minnesota Office of the Legislative Auditor, prepared by John F. Sheils, Randall A. Haught, Lewin-VHI,Inc. February 15, 1995.; Woolhandler S., et al. Costs of Health Care Administration in the U.S. and Canada. New England Journal of Medicine 2003;349:768-75; Harvard/Public Citizen Report by Himmelstein D.U. et al. , "Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, " With State-Specific Estimates of Potential Savings. August 27, 2003.; Charlene Harrington and Christine Cassel, et al. " A National Long-term Care Program for the United States," JAMA 266;21:3025, (December 4, 1991)

Prescription drug discount savings: It is anticipated that the Program will secure prescription drug discounts approximating that of Medicaid (15.1% of Avg Manufacturers' Price (AMP) or "best price") or Veterans Affairs (Federal Supply Schedule,the Minimum or Federal Ceiling Price (FCP) of 24% of AMP).

Increased utilization of health services estimates: " The Effect of Universal Coverage on Expenditures for the Uninsured," Pamela Farley, et al, *Medical Care*, February 1997; Projections of increased hospital and physician services for those already insured -- increases that would result from the elimination of cost-sharing (copays, deductibles) are based on methods in *Universal Comprehensive Coverage: A Report to the Masssachusetts Medical Society*, Solutions for Progress, Inc., and the Access and Affordability Monitoring Project of the Boston University School of Public Health, December 1998 (p. 32).

Estimated Financing for Single-payer Health Plan: The government share of personal health care expenditures is projected at 41%, according to CMS; The source for the Minnesota personal income projections and payroll projections is the Minnesota Bureau of Economic Affairs, http://www.bea.doc.gov/bea/regional/reis/drill.cfm.Accessed 11/06/03; Baseline figures on revenue from the medical portion of automobile insurance: MN Dept. of Commerce, Property and Casualty Unit. 2002 data; Baseline figures regarding workers compensation: Minnesota Department of Labor and Industry, Research and Statistics Unit. 2002 data inflated to 2005 using the CPI.

Cumulative cost savings: Assumes single-payer: caps state of MN cost growth to 5.5% per year, Cost growth under Current law assumed at 7.3% per year.

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