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"Of all the forms of inequality, injustice in health care is the most shocking and inhuman."

-Dr. Martin Luther King, Jr.

Supporting a Statewide Single-Payer Health Insurance System

Health Economics and Financing Paper

Paying for Universal Health Care - and Not Getting It

Administrative Costs in Illinois' Health System and Potential Savings Under a Single-Payer Statewide Insurance Program

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About Health Care for All Illinois

Health Care for All Illinois is a coalition of physician, nurse, disability, labor, consumer and civic groups committed to supporting comprehensive health insurance coverage for all Illinoisans through a single-payer statewide universal insurance system.

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Abstract: *Illinois has among the highest per capita health spending in the developed world, yet 1.7 million Illinoisans are uninsured and millions more lack access to care. This paper quantifies the administrative costs to Illinois' health system and the potential administrative savings that could be realized from the implementation of a single-payer health system. Of Illinois' $87.2 billion in health spending in 2008, at least $24.2 billion went to administration. If Illinois' health administrative costs were streamlined to Canadian levels, $16.9 billion would be saved annually. This amount is sufficient to provide comprehensive, universal coverage to all Illinoisans without additional spending.*

Introduction

The specter of big tax hikes normally ends any discussion of plans to expand health care coverage to Illinois' 1.7s million uninsured residents. Indeed, even Gov. Rod Blagojevich's relatively modest "Illinois Covered" proposal found little political support, largely because of its $2 billion price tag. Yet a growing body of research suggests that states - including Illinois - are already paying enough for high quality, universal coverage.[1,2] Previous studies have demonstrated that reliance on private health insurance companies for health system finance diverts a massive amount of spending to profit-oriented administrative functions that have little to do with care: biling, underwriting, sales and marketing, co-payment collection and processing, eligibility determinations, utilization reviews, and payment disputes. Organization of the health financing system in this way in turn requires that hospitals, providers, and businesses maintain costly staffs to deal with the administrative burden of private insurers. Replacing Illinois' current patchwork of private insurer-based finance with a single-payer public statewide insurance system could potentially produce enough administrative savings to cover all Illinoisans without requiring any increase in net health spending. This theory finds some support in a quick comparison of Illinois' health spending with that of other industrialized nations: Illinois spent $6,714 per person on health care in 2006, yet 1.8 million Illinoisans were uninsured and millions more went without care due to cost.[3] In comparison, nations which provided universal coverage (and achieved superior health outcomes) spent far less: $3,678 in Canada, $3,371 in Germany and $3,449 in France.[4] This paper uses available data to quantify administrative costs to Illinois' health system in 2008 and estimates potential savings under a single-payer health system.

Methodology

Total Illinois Health Spending: Total health spending in Illinois in 2008 was calculated by obtaining 2004 total state health expenditure data from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.[5] 2004 spending figures were then adjusted on the assumption that their increase mirrored the rate of increase of national health expenditures provided by CMS for the years 2004-2006 and CMS projected increases for the years 2007 and 2008.[6] The calculation does not, however, account for changes in state population. The CMS-provided rate of increase and resulting rise in Illinois health spending are detailed in Table 1. Gross State Product (GSP) was calculated by multiplying 2007 GSP figures from the U.S. Bureau of Economic Analysis by the projected change in GSP for 2007 (1.5 percent).[7]

Table 1: Selected Illinois Health Spending Indicators 2004 - 2008

Year	Rate of Increase in Spending	Total Health Spending (in millions)	Spending as a % of GSP
2004	6.9%	$67,292	12.6%
2005	6.5%	$71,935	13.0%
2006	6.7%	$76,611	13.1%
2007	6.7%	$81,744	13.4%
2008	**6.6%**	**$87,220**	**14.3%**

Source: National Health Expenditure Projections, Center for Medicare and Medicaid Services; Bureau of Economic Analysis.

State Administrative Costs and Savings: Administrative costs to Illinois' health system were calculated using methodology developed by Harvard Univer-

sity researchers Drs. Steffie Woolhandler and David Himmelstein published in the *New England Journal of Medicine*.[8] Total expenditures on hospital, practitioners', nursing home and home care costs were calculated by obtaining 2004 expenditure levels and applying CMS projected spending increases through 2008. Since no data are available on state insurance overhead or employers' costs of administering health benefits, these costs were calculated as the product of U.S. per capita expenditures on these categories in 2003 and U.S. Census Bureau figures for the Illinois population in 2004. These costs were then projected to have risen at the same rate as average U.S. health spending for the years 2004-2006 and CMS projected increases for the years 2007 and 2008.

As in the Woolhandler study, base figures for insurance overhead and government program administration were based on reports for the Centers for Medicare and Medicaid Services and the Canadian Institute for Health Information (CIHI). Employers' costs to manage health benefits were based on published estimates of employer health spending for benefit consultants and internal administration related to health benefits which were projected to 1999. Because no comparable figures for Canada are available, it was assumed that employers' costs to manage health benefits (as a proportion of spending) are the same as in the U.S. Hospital administration was calculated from 1999 cost reports submitted to Medicare and data from the Canadian Institute for Health Information. Practitioners' administrative costs were calculated by summing the following: (1) the proportion of physician work hours devoted to billing multiplied by income net of practice expenses; (2) Non-physician clinical staff time devoted to billing; (3) clerical office staff time; (4) One-third of office rent and expenses; (5) one-half of other professional services, such as accountancy and legal fees. Nursing home administration was estimated from 1999 reports of nursing home expenditures in California, the only state to collect such data. Home care administrative costs were calculated from 1999 cost reports from home care agencies submitted to Medicare. Canadian administrative costs for nursing homes and home care were obtained from reports from (CIHI).

Administrative costs for each category were calculated by assuming that administration consumed the same proportion of expenditures in each of these categories that it did in 1999 (the last year for which detailed data was gathered): 100 percent of insurance overhead and

Table 2: Illinois Health System Administrative Costs in 2008 and Potential Savings Under a Single-Payer System, by Category of Expenditure

Expenditure Category	2008 Spending (in millions)	Administrative Costs (in milions)	Canadian Admin. as a Proportion of U.S. Admin. (1999)	Potential Savings to Illinois from a single-payer system in 2008 (in millions)
Insurance Overhead	$4,255	$4,255	18%	$3,490
Employer Benefit Admin.	$935	$935	14%	$805
Hospital Care	$34,200	$8,311	32.7%	$5,593
Physician / Clinical, etc.	$32,334	$8,817	33%	$5,908
Nursing Home Care	$6,074	$1,166	46.7%	$621
Home Care	$1,919	$672	30.9%	$464
Total	**$79,717**	**$24,156**	**29%**	**$16,881**

Source: National Health Expenditure Projections, Centers for Medicare and Medicaid Services; Woolhandler, S. et al, "Costs of Health Administration in the U.S. and Canada," *New England Journal of Medicine* 349 (2003).

Chart 1: Reorganization of Illinois Health Spending Under A Single-Payer Statewide Insurance System: Same Spending, More Care

	Current System	Single-Payer
Care	$63.5 billion	**$80.3 billion**
Administration	$23.7 billion	$6.9 billion
Admin. Savings	$0	*$16.8 billion*
Total	**$87.2 billion**	**$87.2 billion**

Source: Angell, M. et al "Proposal of the Physicians'' Working Group for Single-Payer National Health Insurance," *Journal of the American Medical Association* 290 (2003). and author's calculations.

employers' costs to administer health benefits; 24.3 percent of expenditures for hospital care; 19.2 percent of expenditures for nursing home care; 35.0 percent of home care expenditures; and 26.9 percent of spending on practitioners' services.[9] Administrative costs for each category were calculated as the product of projected 2008 spending in each category and the 1999 ratio of administration to total expenditure.

Potential savings through the implementation of a single-payer system in Illinois were calculated by multiplying 2008 administrative expenditures in each category by the per capita ratio between U.S. and Canadian administrative spending in each category in 1999. For example, it was assumed that the 1999 ratio of hospital administrative expenditures in the United States to those of Canada (315:103) remained the same in 2008.

The projected savings anticipated in this report are likely to be highly conservative for two reasons. First, re-applying the 2003 administrative cost ratios to Illinois assumes that administrative costs have not increased as a proportion of spending since 1999 for any of the six examined components. Second, Woolhandler's figures for administrative costs exclude spending in health sectors for which no administrative cost data were available (e.g., retail pharmacies, ambulance companies, and medical equipment suppliers). Hence, it is likely that the findings of this report significantly understate both the costs of administration to the Illinois health system and the potential savings of a statewide single-payer health system.

Results

Illinois' health spending will total $87.2 billion in 2008, or about 14.3 percent of Gross State Product. The costs of health care administration to the state in 2008 are detailed in Table 2. Non-care administrative expenses accounted for $24.1 billion (27.6 percent) of Illinois total health spending. Were the administrative costs of Illinois' health system streamlined to the levels achieved by Canada's single-payer system, the state would realize a $16.9 billion annual savings, or 70.0 percent of Illinois' current administrative expenditure. Administrative savings would amount to $9,501 per uninsured Illinois resident in 2006, the latest year for which data are available.[10] As a growing body national and statle-level research suggests, combined with other current sources of health spending (such as Medicare taxes and insurance premiums), these administrative savings would free up enough funds to provide comprehensive health coverage for all Illinoisans without raising Illinois' health spending.[11, 12, 13]

Discussion

The State of Illinois and her residents currently pay enough for comprehensive, universal health coverage for all medically necessary needs – they just don't get it. The reliance on commercial insurance companies to finance

the health system necessarily entails the generation of tremendous amounts of administrative waste as insurers find profitability in the erection of massive bureaucracies with the primary purpose of engaging in sales, marketing, underwriting, billing, collection, and claims disputes. Funds paid by Illinoisans to insurance companies in the form of premiums, co-payments, deductibles and other out-of-pocket costs often find themselves spent on these activities which have nothing to do with the provision of health care.

The single-source payment method employed by the U.S. Medicare system and the Canadian national health insurance program offers a model of how health financing in Illinois might be reorganized so as to achieve universal coverage of all Illinoisans under a comprehensive benefit package covering all medically necessary needs without raising taxes or even increasing Illinois' net health spending. Chart 1 provides a highly-generalized illustration of this process. As in the U.S. Medicare system, private insurers would be replaced by a single public or quasi-public organizer of statewide health finance. Unburdened by the need to engage in profit-driven administrative activities, at least $16.9 billion in administrative expenses would be saved. These funds would then be redirected to care provision without leaving the health system, for an estimated total of $80.3 billion in 2008. The result would be sufficient spending to provide a comprehensive, statewide insurance program without the need to increase health spending.

Funds recovered from the elimination of administrative waste would be supplemented by savings produced by the negotiation of fee schedules with physicians, the global budgeting of hospitals, bulk purchasing of pharmaceuticals and durable medical equipment, enhanced access to preventive care, and rational planning of capital expenditures. Budgeting and capital expenditure planning and control would also likely provide effective long-term health system cost-containment, relief from annual health spending increases well in excess of the rise in GDP, and assure systemic sustainability.

Individuals and families likewise stand to benefit from the implementation of a single-payer system in Illinois. All but the most wealthy will likely experience a reduction in health costs, as well as access to needed health services uninhibited by financial barriers.

Conclusion

As researchers have previously concluded in this and other states, a single-payer statewide insurance system is a viable health reform option for Illinois. Single-payer would produce $16.9 billion in administrative savings, enough to cover all Illinois' uninsured and provide full benefits for those with continually deteriorating private coverage. It would reduce health care costs for the majority of Illinois residents. In addition, single-payer offers a solution to the continuing threat rising health care costs pose to Illinois' economy and government coffers. Legislators and civic leaders should pay close attention to the single-payer solution in the interest of a healthy economy, state, and society.

Appendix A: The Likely Implications of Single-Payer Health System Financing on Illinois Families

Too often the focus on macro-finance in health policy obfuscates the effect of reform on individual families. Consultants and policy wonks may shuffle billions of dollars around their complicated charts with abandon; the implications for working families, more often than not, are less clear. This Appendix makes an attempt to use available data to illustrate the likely differences in health spending for an average Illinois family under the state's current health system (both in the employer-based and individual markets) and under a single-payer system.

Comparative Insurance Costs and Savings to Individuals: The average family premium per enrollee in employer-based health insurance was calculated from data provided by the Agency for Health Care Research and Quality (AHRQ).[15] The AHRQ figures were then projected based on the annual premium increase rate in the Kaiser Family Foundation Employer Health Benefits Survey.[15] This report assumes a conservative 6.1 percent growth in the average employer-based premium for 2008, a continuation of the lowest rate of growth since 1999 and far lower than the 7.7 percent increase reported in 2006. Average employer co-payments, deductibles and co-insurance for 2007 were obtained from the Kaiser Employer Benefits Survey.[16] A lack of data and high variation in premiums based on age, occupation and health status makes for a lack of useful facts on the individual health insurance market in Illinois.[17] To simulate options available to Illinoisans, Health Care for All Illinois researchers obtained health insurance quotes from a number of carriers for a fictional 45-year-old consultant with a family of four via the website ehealthinsurance.com. Preference was given to the plan with the lowest deductible, Blue Cross and Blue Shield of Illinois' "Blue Choice Select." This plan advertised an "as low as" premium of $7,016 annually, a $3,500 family deductible, 20 percent co-insurance after the deductible was met on both services and prescription drugs, and $30 co-pays for physician and office visits.[18] Taxes for health care were calculated to include federal and state Medicare and Medicaid expenditures, other public health programs, health benefits for public employees, and tax subsidies to private employers for providing health benefits. These expenditures were assumed to account for 59.8 percent of

Table 3: Projected Expenditures of a Family of Four in Illinois with an income of $50,000 Per Year and Experiencing a $30,000 Illness Under Employer-Based Insurance, Individual Market Insurance, and a Single-Payer Statewide Insurance Program.

	Employer-Based	Individual Market	Single-Payer
Premiums	$12,500 ($2,875 from worker)	$7,016	$0
Deductibles	$759	$3,500	$0
Co-Insurance	$5,100	$6,000	$0
Taxes	$5,717	$5,717	$6,717
Total:	**$14,451**	**$22,233**	**$6,717**
Coverage:	Co-payments on physician and hospital visits, restrictions on prescription drug coverage	No preventive coverage, limits on prescriptions, no preventive or maternity care	Full coverage for all medically necessary services

Source: Kaiser Family Foundation Employer Health Benefits Survey, 2007; Illinois ehealthinsurance.com; Rasell, E. "An Equitable Way to Pay for Universal Coverage," *International Journal of Health Services*. 29 (1999).

national health spending, the same ratio as in 1999.[19] The precise amount of health care taxes paid was calculated using a formula developed by Dr. Joel Harrison, in which figures from the Tax Foundation are adjusted using methods employed by the Center on Budget and Policy Priorities using Congressional Budget Office data.[20] This paper adjusted Dr. Harrison's formula to reflect 2008 national health expenditure levels. Individual family expenditures were then calculated for a for a family of four earning Illinois' annual median income of $49,328 per ($50,000 was used for ease of calculation) experiencing a single illness costing $30,000.[21]

Costs to individuals under the current system and under a statewide single-payer program were made by comparing the costs calculations above with the proposed single-payer financing mechanisms described by physician economist Dr. Edith Rasell: a 7 percent payroll tax and a 2 percent personal income tax which would completely replace current spending by individuals and businesses.[22] Although the financing mechanisms described in this paper are by no means the only way of structuring a stable system of single-payer financing, they are illustrative of the changes that individuals will experience and provide a starting point for discussion of the appropriate set of financial mechanisms to fund a single-payer system for Illinois.

Findings and Comment

An Illinois family earning the state's median income and experiencing a $30,000 illness would pay about $14,451 in premiums, co-payments, deductibles and taxes in the current employer-based health insurance market (excluding the portion of premiums paid by the employer – which could be classified as a partial reduction in wages), and $22,233 in the individual market. The higher spending in the individual market is due largely to bearing the full premium costs and the greatly higher cost-sharing. In contrast, the same family would pay only $6,717 for the same illness under a single-payer system, a savings of 54 percent and 69.8 percent, respectively.

Reorganization of health system financing allows for the current system of premiums, co-payments, deductibles, and out-of-pocket spending to be wholly replaced by system of progressive taxation. While the family in the single-payer system saw their premium, deductible, and co-insurance expenses eliminated entirely, their near-median income meant that their tax burden increase by only $1,000 annually. Policymakers may choose to implement analogous schemes for employers, for instance designed to "level the playing field" between those firms which offer benefits and those who do not, or to mitigate the advantage large firms have in attracting high-quality employees because of their ability to negotiate more attractive benefit packages. These findings should serve as a starting point in opening such discussions.

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