Costs & Benefits of the Minnesota Health Plan

Cost studies of single-payer health care proposals have consistently concluded that a single-payer plan will cover ***all*** people and ***cost less*** than other proposals and less than the current system. This result was reached even by the Lewin Group, a research firm unsympathetic to single-payer (now owned by United Health Group), in its review of health care reform proposals for Colorado and other states. Recently, Vermont hired Harvard health economist William Hsiao to analyze the impact of a single payer system for Vermont. Dr. Hsiao concluded that a single payer system would save a whopping 25% of total health care expenditures compared to the current system.

While these results are extremely positive, other than the Hsiao study, most of the others generally analyzed only two financial impacts of the plans: (a) the administrative savings from elimination of insurance costs of a multi-payer system, and (b) the additional cost of covering more people.

Although the MN Health Plan is *similar* to those proposals in that it uses single-payer financing, it offers a *complete* health care system that addresses all aspects of health care delivery, including the shortage of medical providers, the need for more public health and prevention, etc. As a result, the Minnesota Health Plan would provide significant additional savings from aspects of the plan which were outside the scope of other single payer proposals and previous cost studies.

Among the impacts of the MN Health Plan:

1. Reduced insurance, billing, underwriting, marketing, and other administrative functions.

The current health care system is fragmented and bureaucratic. We currently spend an estimated 31 cents of every health care dollar on administrative costs[i] such as billing and underwriting. Most clinics have multiple billing and accounting clerks to handle the billing of dozens of different health plans (each of which cover different things and reimburse at different rates for the same procedures) and thousands of patients.

By having only the MN Health Plan (MHP) pay all of the bills, all at uniform, negotiated rates, and avoiding the need to bill each patient, the MHP would sharply reduce bureaucratic costs.

Health plans also spend many millions of dollars on marketing. Under MHP, marketing would be totally eliminated.

Underwriting and associated administrative costs would also be eliminated by MHP. Underwriting by insurance companies (and health screening for potential plan enrollees) is designed to make health care more expensive and more difficult to access for the people who need it most – those who are older, sicker, and have more health problems. That is an outcome that few people would desire, yet we spend a significant amount of health care dollars for this purpose. With a single plan covering everyone, there is no need for underwriting.

Further, because there would no longer be differing reimbursement rates, deductibles and co-payments for the multitude of different plans and policies, the administrative and billing costs would be a fraction of their current amounts, for both the plan and the providers.

Under MHP, there would also be a sharp reduction in excessive salaries because top executive compensation would be capped. Several *non-profit* MN health plans have executive salaries over $1 million/year, not to mention obscene salaries at for-profit health plans such as United Health Care.

2. Timely and appropriate use of medical care, including use of a logical provider instead of more distant ones due to provider network restrictions and the use of nurse-line or urgent care instead of emergency room care.

Because of the way our current system is designed, many people end up using costly emergency room care for routine medical needs (e.g. 22,000 emergency room visits annually for dental infections[ii]). The MN Health Plan would avoid inappropriate use of emergency care by giving every Minnesotan access to regular medical (including dental) office visits and care.

The MHP would also reduce emergency room use through a 24-hour/day public health nurse phone line to help people unsure whether their medical situation merits a visit to their doctor. In addition, every Minnesotan would have access to 24-hour urgent care clinics located near emergency rooms to avoid unnecessary emergency room use.

By reimbursing providers for ***all*** patients at a fair rate, the MHP will prevent the problem of providers turning away Medical Assistance patients, which has forced many to travel long distances for care.

The Senate Health Committee heard testimony about large numbers of patients having to travel more than two hours, each way, to have dental work done because dentists in their own community will not accept inadequate compensation rates.

Furthermore, patients are not always able to use the logical health facility because it is not in their provider's network. Sometimes this requires significant additional travel and time costs for patients and families. The MN Health Plan would avoid such costs by having one statewide, all-inclusive network.

Lastly, the problem of different drug formularies for different health plans will be eliminated. The Senate Health Committee has heard from doctors dealing with new patients, who explain the health risks as well as wasted money and time caused by the need to change multiple prescriptions because the drugs the patients were using are not on their new health plan's formulary. MHP would cover all medically-necessary prescriptions.

3. Negotiations on prices for medical services and products, including pharmaceuticals, medical supplies, medical devices and equipment, and all provider rates and prices.

Our current system overcharges for many medical products and services, and pays too little for others.

For medical treatments and services, health plans negotiate lower rates for people in their plan, so their members pay significantly less for those services (even when you count both the health plan payments and the member co-payments) than uninsured patients do. Under MHP, rates for *all* patients would be negotiated by the plan, which would result in lower prices due to its strong bargaining clout.

For medical equipment, supplies, and prescriptions, negotiated savings might be even more significant. For example, prescription drug pricing in the United States is handled in a complex,

secretive, uncompetitive manner that includes financial kickbacks. As a result, Americans pay significantly more than people in other nations for the same drugs. By negotiating fair prices for drugs and other medical goods and services, *and* doing so for all patients, there would be great savings under MHP.

Salaries and reimbursement for providers will go down in many cases due to negotiations, but would increase in other cases due to provider shortages. For example, there is a shortage of primary care providers, especially in small rural communities and the MHP would compensate at a higher rate to provide incentives to practice in those communities.

4. Reduction in excess capacity of medical facilities and equipment.

The current health care system is wasteful, not only in denying appropriate care, but also in creating excessive capacity of certain costly equipment such as MRIs and other imaging technology. For example, radiation therapy clinics can cost $2-3 million to construct, yet there is one located at 1580 Beam Ave in Maplewood, and one located across the street at 1575 Beam Ave. Under the MHP, the board would ensure facilities are built where needed, not where some provider is hoping to attract patients from a competitor.

5. Increased utilization, better health outcomes, increased wellness due to prevention, early intervention and health promoting activities.

The current health care system is backwards in the manner it provides health care. For many people without health insurance, and even many who are covered, the current system does not work to prevent illness or intervene early before a problem becomes more serious. It frequently does not deliver care until the situation becomes acute, when it costs far more to treat.

The MN Health Plan would provide early intervention and treatment. The impact of this cannot be overstated. For people suffering with mental illness, this can avoid the need for costly hospitalization, or in some cases, costly incarceration. For people needing dental care, preventive visits can prevent life-threatening infections and costly emergency room visits.

The savings can be astounding. An intensive prevention program for people who are recovering from heart failure in Duluth cut re-hospitalization rates by 82%, and lowered the overall, net cost of care for these patients by almost half (48%)![iii] However, under our current system, this money-saving prevention program is actually losing money for the hospitals running the program because the intensive intervention is not reimbursed by health plans. Our dysfunctional health care system is structured so poorly that cost-saving preventive services lose money for the medical providers who run them. In the Minnesota Health Plan, preventive services like this would be funded statewide, saving lives and saving money in every community – 48% savings is real money.

Additional savings under MHP might come from its heavy emphasis on cost-saving public health services available in schools and other places where they have easier access to people for everything from mental health services to flu vaccinations. For example, flu shots save lives and they save money. By making them easily available, at no cost, including through public health nurses at schools, community centers, large employers and shopping malls we can increase efficiency, save money, and help keep more people healthy. Contrast the MHP method with the costly current method of parents taking their children out of school, driving them to a clinic for a flu shot and then returning them to school, Minnesota should be able increase its vaccination rate from less than half of the population to perhaps as high as 90%, and do so at less cost than the current system. And, for

prevention of teenage pregnancy and sexually-transmitted infections, the success rate would much greater if they were delivered by a school nurse instead of relying on sexually active teens finding their way to a family planning clinic on their own.

Note: The three following paragraphs apply to this item but also to item # 12 (non-healthcare impacts on state and local expenditures such as reduced out-of-home placement and crime costs due to mental health and chemical dependency coverage.)

Under MHP, the cost savings from prevention and early intervention would not be limited to health care; it would reduce many other costs as well. Family planning services for low income women have been shown to reduce both Medical Assistance costs *and* welfare costs by preventing unintended pregnancies. And these savings are *not* on the order of 10 – 20%. A California study showed over 400% return on investment -- $ 4.48 in reduced public expenditures for every dollar spent on family planning.[iv]

Chemical Dependency and Mental Health treatment provides another major example. About two-thirds of prison inmates are serving time for offenses committed under the influence of alcohol or other drugs. Chemical dependency treatment greatly reduces crime and prison costs. CD and Mental Health treatment also help preserve families and reduce costly out-of-home placements for children.

The savings are extraordinary. A 1993 CalData study showed that every tax dollar spent on Chemical Dependency treatment had a 700% rate of return. It saved taxpayers $7 in reduced crime, healthcare, and human service costs.[v]

6. Decreases in administrative expenses due to payment reforms, including billing and collection costs of providers, global budgeting, and elimination of uncompensated care.

In addition to the insurance-related administrative savings described under item #1, there are other administrative savings that need to be considered. As mentioned under number one above, most clinics have multiple billing and accounting clerks to handle the billing of dozens of different health plans at different rates for the same procedure, and thousands of patients. However, there are also administrative savings for providers from not having to worry about uncompensated (or under-compensated) care, and the need to shift costs to others. There are savings from not having to find out whether patients can pay, not needing to have clerks counsel patients on how to try to find coverage for a procedure, not needing to process each co-payment, and not needing to spend time and money on bill collection.

Also, rather than track each medication or service for a hospital patient's bill, hospitals and nursing homes would work from a negotiated annual budget, so they can focus on delivering care, not tracking expenses and billing for them.

7. Increases or decreases in administrative and health care expenses due to coordination of care.

There are additional expenses for care coordination. However, there may be significant savings too. Care coordinators can work with patients on health improvement. They can make sure immunizations are up to date, and ensure that patients know where to turn for appropriate care. In addition, by having a care coordinator that keeps track of medical test results, there would be fewer repeat tests on patients by doctors who were unaware that the tests had already been performed.

8. Increases or decreases in upfront and long-term utilization due to access to comprehensive medically necessary benefits, including dental care, mental health care, prescription drugs, etc.

There would obviously be an initial increase in utilization of medical care when it is available to people who are currently un- or under-insured. However, there would also be an immediate reduction in other costly care such as hospitalization for mental illness, use of emergency rooms for routine care and for preventable conditions. Over time, there would be a sustained increase in use of routine care, but also sustained, significant decreases in both inappropriate utilization, and of care that is no longer needed, because of primary, secondary, and tertiary preventive care.

9. Reduction of fraud such as a provider billing multiple payers for the same service or the same hours of work.

It is self-explanatory how the MHP would prevent the fraud (or error) of billing multiple people for the same service. However, there are additional savings because the more complex a billing and payment system is, the greater the chance for *every* type of fraud and error. A simple, straightforward system with one payer reduces fraud and error, and makes such problems easier to detect and correct.

10. Reduction of healthcare expenses from patient/doctor decision-making, such as advanced directives for determining end of life care.

The Legislative Health Care Access Commission heard testimony about how leaving care decisions to patients and doctors does not necessarily lead to more expensive care – as is usually assumed – but frequently leads to decisions not to undergo treatment or to use less expensive alternatives. For example, many patients choose not to have back surgery when a physician takes time to explain how less-invasive alternative treatments may have equally good results. Under our current healthcare system, doctors are not compensated for *talking* with patients; they are compensated for *doing things* to patients.

One of the biggest cost savings under MHP comes from doctor/patient conversations about end-of-life treatment. When patients have a chance to thoroughly discuss options for terminal illness and provide an advance directive based on that discussion, the vast majority of people say that if they are terminally ill, often in significant pain, and their heart stops, they do not want to be resuscitated. Following such advance directives can avoid costly treatments that are unwanted by the patient. With the large amount of medical costs that come from end-of-life treatment, these savings are huge.

11. Miscellaneous other factors such as: reductions in malpractice costs, elimination of direct-to-consumer marketing of pharmaceuticals in Minnesota, and ending of conflicts of interest, where doctors have financial incentives to order extra treatment at facilities they have a financial stake in.

Medical malpractice costs would be sharply reduced under MHP because the medical expenses arising from a malpractice incident would already be covered by the plan, not malpractice insurance – there would be no need to sue in order to pay medical costs. Second, just as the MHP would step in and cover medical training costs to encourage more people to go into medical fields where there are shortages, the plan would self-insure doctors for malpractice, eliminating the insurance company

expenses, and making coverage affordable. Also, advocates of tort liability limits frequently argue that juries award large settlements because they don't like insurance companies and see those settlements as a way to punish them. If so, by having the MHP be the malpractice carrier, juries would know that large settlements would simply increase costs for the MHP, which they end up paying for.

Direct-to-consumer marketing of pharmaceuticals is a $100 million per year expense in Minnesota. By ending such advertising, the MHP would have greater ability to negotiate low prescription prices. In addition, drug manufacturers only spend money on advertising because it increases the demand for expensive drugs. Eliminating such advertising, would decrease patient demand for costly drugs that may not be the most appropriate, creating further savings.

The MHP board would be required to study and then act to prevent conflicts of interest, including gifts from pharmaceutical and medical device manufacturers. This would reduce costs by eliminating financial incentives for providers to select more expensive drugs, and likewise, the incentive to order extra treatment at facilities they have a financial stake in.

12. Non-healthcare impacts on public and private expenditures such as reduced workers comp and auto insurance costs, reduced out-of-home placement and crime costs due to mental health and chemical dependency coverage, as well as impacts caused by job gains and losses under MHP.

Because the MHP would cover medical expenses arising from workers compensation and auto accidents, there would be a significant decrease, in both workers comp and auto insurance costs, but also in lawsuits related to medical care. Trial lawyers say that a major share of their lawsuits stem from people who had no desire to go to court, but felt they had no other option because an auto or workers comp insurance company cut off their medical treatment before they had received the needed care. This problem would be eliminated when people get the care they need under MHP.

There will be start up costs for the MHP, including retraining and unemployment costs for administrative workers whose positions are no longer necessary under the MN Health Plan. The MHP would be required to use some of the initial savings to pay for those dislocated worker benefits.

(There are numerous other non-healthcare cost savings to government discussed in the last three paragraphs under item #5)

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[i] Costs of Health Care Administration in the United States and Canada Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D. NEJM Aug 21, 2003 http://content.nejm.org/cgi/content/abstract/349/8/768?ijKey=485f4bb208aff8fecf079f86ce126b1f01519e75&keytype2=tf_ipsecsha

[ii] Minnesota Hospital Association

[iii] Testimony of Linda Wick, Heart Failure Program, St. Mary's Duluth Clinic, before legislative Health Care Access Commission, June 13, 2007

[iv] California Program Shows Benefits of Expanding Family Planning Eligibility **http://www.guttmacher.org/pubs/tgr/03/5/gr030501.html**

[v] http://www.drugabuse.gov/NIDA_Notes/NNVol10N2/CAStudy.html