

# FOR *Your* BENEFIT

## THE BRS HEALTH & BENEFITS ACTUARIAL UNIT NEWSLETTER

We are pleased to provide you with the second edition of our technical bulletin on GASB 45 and related actuarial matters analyzed by the BRS Health & Benefits Actuarial Unit. As our health and benefits practice has grown to over 150 clients in eight states, we hope this bulletin will help us keep each of you updated on our practice and technical matters of current interest. You can reach us by phone at 916-244-1100, or through our website, [www.BRSrisk.com](http://www.BRSrisk.com). We look forward to hearing from you.

### COST AND DESIGN CONSIDERATIONS FOR UNIVERSAL HEALTH CARE

Conspicuously absent from the growing controversy over universal health coverage in the United States is an estimate of cost. The following analysis addresses the issue and, hopefully, provides useful background as the national debate unfolds.

#### *Why Universal Health Care?*

Under the current system, 47 million Americans (over 15% of the population) are uninsured and many more are underinsured (recent passage of SCHIP addresses a portion of the 9 million uninsured children). The only legal right to care which applies generally to the uninsured population is for emergency care (the Emergency Medical Treatment and Active Labor Act, 1986). Half of all Americans say they have skimped on health care in the past year to save money.

Most Americans receive health care coverage through the employer of a family member. The typical employer has no expertise in providing medical care or insurance, introducing intermediaries and substantial financial inefficiencies. While the US per capita health expenditure is almost double that of the next-highest country in the world (Germany) whose population exceeds 10 million, it has relatively poor health outcomes. We rank 45th in life expectancy among 195 countries, behind most Western European nations, which typically have government-operated national health care systems. The United States

also spends six times more per capita on the administration of its health care system than peer Western European countries.

#### *What are Possible Design Implications of "US-Style" Universal Health Care?*

To raise the health of the population, decisions should be made with the population in mind. Such decisions can only be made by governments. Basic medical care should be defined in a standard manner throughout the country, requiring decisions at the federal level. States could retain an ongoing role in local experimentation (beyond basic care), such as assisted suicide laws. State coverage mandates would violate standardization and should be pre-empted by federal law.

A universal system of basic health care should protect the individual's rights to choose his/her medical providers, refuse recommended care, and make medical decisions for dependent children. The system need not make these decisions financially neutral for the individual (that is, the individual could be required to pay for some options).

Current public policy requires certain medical care, such as quarantine of highly contagious individuals and vaccinations to attend public school. These examples are driven by the need to protect others, and are a limited exception to individual choice. Meaningful exercise of individual rights requires two elements: education and access to information. The health care system will operate most efficiently when individuals receive education about how to maintain their health and utilize health care. (Proactive) prevention and health improvement rather than (reac-

tive) treatment improves quality of life as well as the individual's involvement in his/her care, and offers potentially reduced treatment needs. The government has the responsibility to maintain and make available information on the volume of procedures performed by the system's providers and the quality of outcomes. This information also allows the system to monitor and manage the providers.

A consolidated medical record for each patient allows the medical provider to review prior test results, consider drug interactions, identify allergies, etc. in order to provide better treatment and reduce duplicative care. However, the comprehensive nature of a consolidated medical record raises privacy concerns. Violations of privacy will occur in some cases. Similarly, medical malpractice will inevitably occur. Victims must be appropriately compensated and involved providers must be held responsible for their actions, whether malicious or negligent.

The definition of basic medical care will continue to evolve over time. However, all medical care is not basic medical care (for example, cosmetic surgery). Non-basic care should continue to be provided through the private market. Private providers could also provide non-covered basic care, although again the universal basic care system need not make such care financially neutral for the patient. However, for the safety of the patient, all medical care should be required to be recorded in the consolidated medical record.

The system should also charge for care beyond basic care – for example, the difference in cost of a private room over a semi-private room. Insurance products could be provided to individuals (or to employers

through group coverage) for care supplemental to the universal system. These products might require certain utilization of the universal system (say, having periodic covered physicals) in order to maintain the coverage or obtain certain benefits.

The universal care system would set a minimum for the basic medical care to which all Americans have access. Individuals or groups may seek or have rights to additional or alternative medical coverage. Thus, the maintenance of separate prison, military and veterans' health care systems seems appropriate. Workers' compensation medical benefits and existing Medicare benefits beyond basic medical care could be preserved. Non-basic or non-covered care could be covered under supplemental insurance products, perhaps retaining a portion of the current multiple payer system. The government could establish a single payer system by subcontracting with existing private payers. As there is currently a single payer system (Medicare), this design is a shift toward single payer from multiple payers, retaining both structures.

Geographic distribution of resources should also be considered. Solutions include subsidies for doctors to locate in certain communities, coverage of transportation (either patient or doctor), or use of teleconferencing, the internet, and even remote operating technology.

#### *What is the Cost of Universal Health Care?*

Much of the above design is already in place or can be accomplished in an orderly transition from the present system. While structure and financing are ultimately political decisions, replacement of the current system's revenue must be addressed. The least disruptive transition would come from retaining the current funding sources – employers, individuals and governments (governments are also primarily funded by employers and individuals). If basic care is truly universal, then individuals cannot be asked to pay for basic services when they need them (that is, co-payments and deductibles). This means that the primary sources of funds will be taxes on individuals and employers, plus existing government funding (Medicare, Medicaid, coverage of

government workers [the government as employer], workers' compensation medical benefits, and potentially prison, military and veterans' health care systems).

While preserving the existing revenue structure, it would be unfair to tax employers based on their current contribution to employee health coverage, as employers who currently provide broad health coverage would be penalized relative to those who provide little or no current coverage. Employers could be taxed based on number of employees, although this would have the effect of encouraging employers to reduce employment, particularly lower-paid employees. This, in turn, suggests a payroll tax. As medical care's cost is not pay-related, a transfer of wealth occurs from higher-paid to lower-paid workers, although less of a transfer than would occur



through expansion of the income tax as currently structured. While any general taxation method will create some economic dislocation, the payroll tax has the advantage of being a reasonable reflection of current financing, as well as straightforward to administer and consistent with current health care taxation practices (employers and employees each currently pay a 1.45% tax on all earnings for Medicare). To the extent universal basic care replaces Medicare benefits, some portion of the 1.45% can be paid to the new system going forward.

As we estimate that 91% of employees currently have access to coverage at work for which the employer pays an average of 11% of payroll, a tax of 12% of payroll would allow extension of current average benefit levels to all employees. This is a meaningful tax increase on employers not currently providing health coverage.

A payroll tax on employees would need

to replace both employees' current contributions to their health coverage and their out-of-pocket expenditures, such as deductibles and co-pays. If we estimate average employee cost as 30% of total expenditures (with the employer paying 70%), the estimated employee payroll tax would be 5.2% of payroll (12% x 30%/70%). This is a substantial tax increase on employees who currently have fully-paid employer health care with limited out-of-pocket expenses. Employees who currently have no health coverage receive a valuable benefit for their expenditure, particularly if they or family members have significant out-of-pocket medical expenses.

The proposed revenue inflow of a 17.2% payroll tax may seem shockingly large, but it is designed to replace the existing revenue inflow from these groups into a health care system on which Americans spend 17% of their Gross Domestic Product. The amounts involved emphasize the importance of minimizing economic dislocation in the transition. As coverage is being extended to the uninsured, the hope would be that savings generated by the implementation of universal coverage would both cover that cost and reduce the proposed payroll tax levels. The financial experience of nations with national health care systems strongly indicates that such savings will occur. However, the aging of the population (particularly baby boomers) and the expanding American waistline will raise costs under any structure.

A temporary income tax deduction or credit could be provided to businesses or individuals who previously did not have health care coverage but are now paying a payroll tax. However, for businesses, this is somewhat inequitable for employers who previously provided health insurance. For individuals, any tax deduction or credit should be limited by the value of newly covered medical services they receive.

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*The content of this article does not necessarily reflect the opinion of BRS.*



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