Universal Coverage and Public Health: New State Studies

Recent evaluations of the California Health Service Plan (CHSP) confirmed that financing health care through a single government payer can provide universal coverage—while saving significantly on health care spending—to a degree unparalleled by alternative approaches. Public ownership of the delivery system can further provide authority and accountability for critical reforms that improve the population's health and quality of care, including coordination of the delivery system.

The federal government's State Planning Grant Program provides states with funding to develop plans to cover their uninsured populations. California created a Health Care Options Project that requested proposals that could expand coverage and contracted with a financial modeler and a qualitative analyst to evaluate the resulting plans. The CHSP was one of 9 plans evaluated through this process. (*Am J Public Health.* 2003;93:109–111)

Ellen R. Shaffer, PhD, MPH

WITH HEALTH INSURANCE premiums on the rise, the issues of health care costs and the uninsured are again appearing on the policy agenda.[1,2] The State Planning Grant program (SPG) is providing an opportunity for states to draw creatively from their own experiences and those of other countries, as well as from public health principles,[3–5] in considering how to control costs and expand coverage. The SPG program, administered by the federal Health Resources and Services Administration (HRSA), has funded 1-year grants to 32 states to collect and analyze data on the characteristics of their uninsured populations and to develop plans to provide coverage for all residents that would be equivalent to a benchmark program such as the Federal Employees Health Benefit Plan.

The California Health Service Plan (CHSP), developed as part of the California SPG program, is a case in point. Analysis showed that even by conservative estimates, the CHSP (which the author wrote) would achieve both universal coverage and savings over current spending. Delivery system reforms intended to improve the population's health and quality of care, such as expanded primary care, would also reduce costs. The plan shifts responsibility for cost control from users to providers and does not impose cost sharing such as copayments or deductibles.

STATE PLANNING GRANTS

As of 2002, grants were awarded to 32 states with a wide diversity of experience, including the percentages of employers offering coverage; health spending; demographics; and health care in rural vs urban populations. In 2000, $13.6 million in grants was awarded to 11 states: Arkansas, Delaware, Illinois, Iowa, Kansas, Massachusetts, Minnesota, New Hampshire, Oregon, Vermont, and Wisconsin. In 2001, $10.1 million was awarded to 9 states: Arizona, California, Colorado, Connecticut, Idaho, South Dakota, Texas, Utah, and Washington.[6] An additional 12 states received grants in 2002.

The resulting state reports include valuable information on access to health care and are posted on-line at the HRSA Web site.[7] Some information has been long established but little known by most Americans and many policymakers. This includes the significant savings achieved by single-payer plans[8,9] and the fact that the uninsured are predominantly working people and their families, not the unemployed.[10] States generally recognized that successful solutions would require federal involvement. Among the newer findings were those in Massachusetts, Oregon, and Delaware that many uninsured people earn incomes well

over the poverty line. Minnesota and Oregon concluded that expanding public insurance programs would not significantly "crowd out" existing employer coverage.

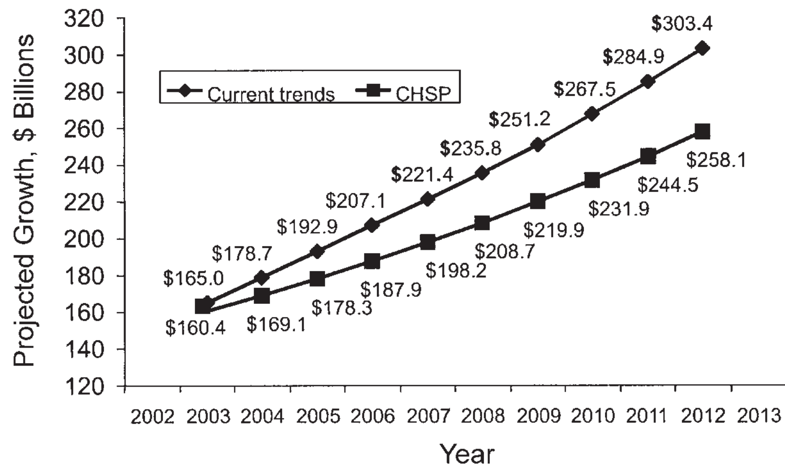
CALIFORNIA HEALTH CARE OPTIONS PROJECT

California has one of the highest rates of uninsurance in the nation—19% in the year 2000[11]—and a well-developed research establishment based in academia and nonprofit organizations regularly documents the problem. After California was selected for the SPG program, the state legislature created the Health Care Options Project and assigned responsibility to the state Health and Human Services Agency, which reports directly to the governor. As in many states, the Health and Human Services Agency directed resources to the required data collection. The agency took 2 additional steps. It issued a call for proposals to develop plans for universal or expanded coverage that would take into account the state's health care environment and demographics, and from financial modelers to assess the resulting plans. It further organized symposia in northern, southern, and central California, as well as in the state capital, for the public and legislators to interact with the authors and modelers of the plans during their development and to learn about the final results.

Nine proposals were selected for development. Four incremental proposals included expansion of the existing employer high-risk pool and State Child Health Insurance programs and offering individual and employer tax credits. Two plans sought to increase employers' contributions. Three proposal authors proposed "single-payer" plans, in which the state government would finance and pay for health services. The Lewin Group was chosen to model costs and coverage of the proposals, and AZA Consulting contracted to evaluate qualitative components, including access and cultural competence.

CALIFORNIA HEALTH SERVICE PLAN: FINANCIAL SAVINGS, UNIVERSAL COVERAGE

The CHSP proposed several features that reflect the principles of the American Public Health Association and that build on the US Universal Health Service Act (HR 3080), sponsored in Congress by Rep Barbara Lee. In addition to public funding through a single government payer, it identifies improving the health of the population as a central goal of health care reform. Public financing would automatically confer many benefits, including administrative savings that can finance universal coverage. However, explicit changes are required to organize, integrate, and improve the delivery system and to rebalance the relationship between providers



Note. The graph reflects the 10-year phase-in of savings due to increased use of primary care.
Source. Lewin Group.[12]

FIGURE 1—Comparison of projected growth (in billions of dollars) in state health spending for covered services under current trends and CHSP, 2003 to 2012.

TABLE 1—Costs and Coverage Under Selected HCOP Plans in 2002: Incremental, Employer Choice, Single Payer/State Delivery

	No. Covered, Millions	Net Reduction in Uninsured, Millions	Costs Shifted from Private to Public Sector, $ Billions[a]	Change in Total Health Spending in State, $ Billions
Incremental				
PacAdvantage (risk pool)	0.1	0.1	0.2	0.1
ITUP (tax credits)	4.5	2.6	3.2	1.4
Employer choice: Healthy California	21.6	5.7	22.4	3.0
Single payer/state delivery (CHSP)	35.1	6.6	65.1	–7.5

Note. HCOP = Health Care Options Project; ITUP = Insuring the Uninsured Project; CHSP = California Health Service Plan.
Source. Lewin Group estimates using the California version of the Health Benefits Simulation Model.[12]
[a]Includes the cost of the program less offsets to other governmental programs and any change in federal funds.

and users of health care services. Therefore, the CHSP calls for public acquisition and ownership of the delivery system to provide public authority and accountability for critical reforms. These include increasing and redistributing primary care providers, financing multidisciplinary education for health care workers, and creating group practices in which teams of providers collaborate to achieve improvements in safety and quality. Clinicians would be reimbursed by salary, with both organizational and limited financial incentives permitted for performance.

CHSP drew on state experiences with failing private hospitals in rural areas that converted to public status as district hospitals, and on lessons in financing and reimbursement from Europe and Canada. The state's increasing rate of hospitalizations that could be prevented with adequate ambulatory care, for conditions such as asthma and pneumonia, further supported the need for public health and delivery system reforms to control costs and improve health.

The CHSP plan would save $4.6 billion in the first year compared with present total health spending, and $45.3 billion in 2012, after full phase-in of primary care reforms (Figure 1). This estimate also includes the cost to the state of acquiring hospitals and other components of the delivery system.

Additionally, the financial modelers compared all the Health Care Options Project proposals to estimate the number of Californians who would be covered on complete implementation of the plan, the reduction in the numbers of uninsured, and changes in both public sector costs and total annual health spending. Table 1 shows a selective sample of the proposals in each category (including the lowest and highest cost among the incremental reforms). At best, alternative approaches to single-payer plans cover far fewer people, and none reduce total health spending.

The CHSP and the other 2 single-payer proposals varied financing through either income or payroll taxes and also varied the degree of cost sharing imposed. Modeling of these differences showed that even assuming increased utilization due to a lack of cost sharing, single-payer plans save significantly on total health spending.

The model also showed that households would save an average of $813 a year from the CHSP, after accounting for effects such as increased taxes, with variations by age and income. All households earning less than $100 000 a year would save money. Households earning $30 000 to $50 000 a year would save $1615, whereas those with incomes over $150 000 would pay an additional $234 a month, or about 1.8% of their income, in return for comprehensive benefits. Although expansions of employer-based health insurance generally would require nearly impossible changes to federal law, single-payer plans could be implemented by states.

The full proposals, and the quantitative and qualitative evaluations, are posted on-line at http://www.healthcareoptions.ca.gov, in the Documents Library. ■

About the Author

The author is with the University of California at San Francisco School of Pharmacy, Department of Clinical Pharmacy.

Requests for reprints should be sent to Ellen R. Shaffer, PhD, MPH, 98 Seal Rock Dr, San Francisco, CA 94121-1437 (e-mail: ershaffer@earthlink.net).

This article was accepted September 21, 2002.

References

1. The unraveling of health insurance [*Consumer Reports* Web site]. July 2002. Available at: http://www.consumerreports.org/. Accessed July 13, 2002.
2. Connolly C. Health care's soaring cost takes a toll; squeeze hits workers, firms and government. *Washington Post.* July 9, 2002:A1.
3. Derickson A. "Health for three-thirds of the nation": public health advocacy of universal access to medical care in the United States. *Am J Public Health.* 2002;92:180–190.
4. American Public Health Association. APHA 14 points on universal health care: toward a national health program for the United States. Available at: http://www.apha.org/legislative/Issues/14points.htm. Accessed October 28, 2002.
5. McBeath WH. Health for all: a public health vision. *Am J Public Health.* 1991;81:1560–1565.
6. US Department of Health and Human Services. State Planning Grants Program questions and answers. Available at: http://www.hrsa.gov/osp/stateplanning/newQ-As.htm. Accessed July 11, 2002.
7. US Department of Health and Human Services. Overview of the State Planning Grants Program. Available at: http://www.hrsa.gov/osp/stateplanning/default.htm. Accessed July 11, 2002.
8. Wellstone PD, Shaffer ER. The American Health Security Act. A single-payer proposal. *N Engl J Med.* 1993;328:1489–1493.
9. *Estimates of Health Care Reform Proposals From the 102nd Congress.* Washington, DC: US Congressional Budget Office; 1993.
10. Blendon RJ, Young JT, DesRoches CM. The uninsured, the working uninsured, and the public. *Health Aff (Millwood).* 1999;18(6):203–211.
11. Population distribution by insurance status, 1999–2000 [The Henry Kaiser Family Foundation State Health Facts Online Web site]. Available at: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?. Accessed September 9, 2002.
12. Quantitative analysis by the Lewin Group, Appendices B–J, p 250. Available at: http://www.healthcareoptions.ca.gov/doclib.asp (PDF file). Accessed November 4, 2002.