Savings to the University of California with Adoption of Single Payer Health Care Financing in California

A report by UC faculty for the UC Faculty Senate

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Summary

The University of California’s spending on health care for current employees and retirees is rapidly approaching $1 billion per year, with long-term obligations for retirees rising quickly and expected to reach $26 billion by 2018. Single payer health care, which provides universal tax-funded insurance with broad benefits, is likely to reduce these obligations. We conducted a study to estimate the magnitude of single payer savings to UC over ten years, 2009 - 2018.

We compared current and projected UC system-wide health care costs to costs under the anticipated financing for California’s single payer legislation, Senate Bill 810 (Leno). We assembled estimates of current and projected UC health costs for retirees (ongoing spending and long-term obligations) and for current employees from UC communications to faculty and public documents. We estimated financial obligations and health care benefits under SB 810 based on discussion with Senate health staff. We examined how savings vary according to uncertainty in the single payer payroll tax and treatment of the existing retiree health care obligation.

For the most likely single payer financing scenario, UC would save an estimated $31.6 billion by 2018. This represents $30.3 billion in transferred obligations for retirees and $1.3 billion in reduced costs for current employees. The benefits under SB 810 are more comprehensive than for UC topped-off Medicare. If half of the long-term UC health care obligation for retirees is contributed to the single payer financing pool, savings drop to $18.6 billion. Uncertainty in the payroll tax results in an uncertainty range of $30.4 - $32.7 billion in savings. We anticipate refinements in our findings as this draft report is reviewed by individuals with data about UC health care costs unavailable to us.

We conclude that single payer health care financing anticipated for SB 810 would yield substantial reductions in health care spending for the University of California.
Background

The University of California faces extraordinary economic challenges, with record budget cuts and shortfalls. A large portion of the University’s financial obligations are for health care. As noted in an October 2009 email to faculty, “In 2010, the University will pay approximately $250 million for retiree health benefits … projected to increase by about $37 million per year … by 2018 an estimated $610 million. The University’s long-term liability for retiree health benefits … is also projected to increase, from $13 billion today to nearly $26 billion by 2018.” The University spends a further estimated $500 million per year on health care for current employees.

Single payer health care financing, as currently reflected in Senate Bill 810 (Mark Leno), provides universal tax-funded insurance with broad benefits for all state residents. Financing is via a payroll tax that is lower than the health care spending of generous employers (like UC), transfer of funds currently used for Medicare and Medicaid, and additional sin and income taxes.

If California adopted single payer, the savings to UC could be substantial. These savings would accrue from eliminated or substantially reduced obligations to retirees, as well as lowered ongoing payments for the current workforce.

We conducted a study of this question: What is the magnitude of savings that would accrue to UC if California adopted single payer financing? We address this question in three steps:

(a) Quantify UC current and projected health care spending for current employees and retirees; (b) Specify provisions for single payer financing, varying them to reflect uncertainty; and (c) Calculate savings to UC, per year and total over 10 years.

Methods

We compared current and projected UC system-wide health care costs to costs under the anticipated financing for California’s single payer legislation, Senate Bill 810 (Leno). We focused on 2009-2018 because of the recent UC retirement email highlighting anticipated costs for this period, recognizing that any realistic timing for single payer is at least a few years off. We think this time
period is appropriate given current discussions. Our inputs and calculations are reported in Table 1, and discussed below.

We estimated current and projected UC health costs for retirees (ongoing spending and long-term obligations) from an October 2009 UC email to faculty about retirement issues (excerpted above). In particular, annual spending on retiree health was reported at $250 million, rising to $610 million by 2018. We assumed straight-line increases to calculate the 10-year total. This estimate, like all in this report, is undiscounted. The long-term liability (i.e., legal obligation) for retiree health is estimated by UC at $26 billion, as of 2018.

According to the health staffer responsible for the single payer legislation SB 810, Sara Rogers, financing plans anticipate releasing employers of obligations for retiree health care. With this provision, UC costs would be $0 for retiree health care. If instead UC contributed 50% of its long-term retiree health care obligation to the single payer pool, perhaps as part of budget discussions, the UC costs for retiree health would be half of the project long-term liability.

Importantly, Ms. Rogers compared benefits stipulated under SB 810 to benefits from Medicare topped up by UC’s added retiree policies. She confirmed SB 810 to be more comprehensive and lacking no benefits in the UC policies. In insurance terms, single payer benefits are actuarially superior to current UC retirement health care. Thus, UC should be under no obligation to supplement SB 810 to bring benefits to promised levels, since SB 810 exceeds those levels.

We do not have firm health spending data from UC. We estimated health care costs for current employees from the UC budget for 2008-2009, obtained online. Annual UC costs multiplied by the 59% reported for personnel (excluding benefits) is $3.3 billion. Benefits represent 12% of the budget, thus 20% of personnel. We estimated health benefits to represent 3/4 of this 20%. Thus, current annual health costs are estimated at $504 million. We project annual costs to 10 years using the same rate of growth reported by UC for retiree health benefits. We will refine these estimates based on guidance from reviewers of this draft.

Under single payer, with anticipated financing, large employers would be required to contribute 10% of payroll to the financing pool and employees would be required to contribute 6%.
However, if employee contracts (e.g., union agreements) provide health benefits that keep employee premium costs below 6% of payroll, the employer contribution would rise. The employer would need to make up the difference between current employee obligation and 6%. We had no way to estimate the scale of this issue for UC, so we assumed a UC employer contribution of 13% (i.e., substantially above the single payer floor of 10%), pending better data. Thus under single payer, UC is expected to pay $430 million per year in 2008. We project to ten years assuming the same growth rate as UC does for retiree health costs. This is generous given the link to payroll (which grows more slowly than health care costs) and controls in SB 810 on the rate of cost growth.

We examined how savings vary according to two uncertainties: possible capture of part of the existing long-term retiree health care obligation (as noted above) and uncertainty in the single payer payroll tax rate.
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<thead>
<tr>
<th>Table: Key inputs &amp; estimated savings</th>
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<tbody>
<tr>
<td><strong>Parameter</strong></td>
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<tr>
<td>Retiree health care</td>
</tr>
<tr>
<td>Annual spending on retiree health</td>
</tr>
<tr>
<td>2008</td>
</tr>
<tr>
<td>2018</td>
</tr>
<tr>
<td>10 year total</td>
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<tr>
<td>Long-term liability</td>
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<tr>
<td>Total of annual + long-term</td>
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<tr>
<td>Single payer</td>
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<td>If long-term liability released (expected)</td>
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<td>If 50% contributed to financing pool</td>
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<tr>
<td>Savings with single payer (10 years)</td>
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<tr>
<td>If long-term liability released (expected)</td>
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<tr>
<td>If 50% contributed to financing pool</td>
</tr>
<tr>
<td>Current employee health care</td>
</tr>
<tr>
<td>Annual UC cost personnel (excl benefits)</td>
</tr>
<tr>
<td>All benefits as % of personnel costs</td>
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<td>Health benefits as % of payroll</td>
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<td>Est'd annual health benefits</td>
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<tr>
<td>10 year total</td>
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<tr>
<td>Single payer, annual</td>
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<tr>
<td>10 year total</td>
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<tr>
<td>Savings (annual, initial)</td>
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<tr>
<td>Savings (10 yrs)</td>
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<tr>
<td>TOTAL estimated savings</td>
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Findings

Findings are reported in Table 1 and Figure 1, and a sensitivity analysis in Figure 2 as noted.

Projected costs

Ongoing spending on retiree health is estimated at $4.3 billion over ten years, 2009-2018. With the long-term liability for retiree health estimated to be $26 billion as of 2018, the total projected retiree health care costs through 2018 are $30.3 billion. Costs under single payer would be $0 if, as planned, employers are relieved of retiree health care obligations. If half of the long-term UC health care obligation for retirees is contributed to the single payer financing pool, costs under single payer would be $13 billion.

For current employees, the estimated annual health cost of $504 million translates to an estimated 10-year cost of $8.7 billion. Under single payer, the $430 million in annual costs yields an estimated 10-year cost of $7.4 billion over ten years, perhaps generous as explained above.

Projected savings

For the most likely single payer financing scenario, we find that UC would save an estimated $31.6 billion by 2018. These savings include $30.3 billion in transferred obligations for retirees. They also include $1.3 billion in reduced costs for current employees – the difference between 13% and 15% of payroll.

If half of the long-term UC health care obligation for retirees were contributed to the single payer financing pool, savings would drop to $18.6 billion (Figure 1).

Uncertainty in the payroll tax results in an uncertainty range of $30.4 - $32.7 billion in savings (Figure 2). The overall savings are relatively insensitive to this uncertainty in this input, because most costs and almost all savings are for retirees rather than current employee.
Fig 1. UC systemwide health care costs, projected 2009-2018

- Current system
- Single payer if no offsetting contribution: $31.6 billion saving
- Single payer if 50% retiree obligation contribution: $18.6 billion saving

Fig 2. UC projected savings in health care costs 2009-2018: Sensitivity to Single Payer payroll tax level

Savings over ten years ($ billions)

UC employer payroll tax percent for health

Initial estimate (see text)
Discussion

We conclude that single payer health care financing anticipated for SB 810 would yield substantial reductions in health care spending for the University of California. These reductions may be in the tens of billions of dollars over 10 years.

There are substantial uncertainties in the analysis. Our information on health care spending for current employees is imprecise and estimated, as noted above. We plan to revise these inputs in the next draft of this report, guided by reviewer input. (Due to the urgency of current deliberations on retirement policy, we decided to present results albeit preliminary and seek input as quickly as possible.) Since most savings derive from retiree health costs, we anticipate little effect on overall findings. A more important uncertainty is how retiree health liabilities will be treated under single payer. The plan, per the Senate office guiding single payer, is to relieve employers of all such obligations. However, it is possible that single payer financing will require concessions from multiple actors, and so we present a 50% retention of the long-term liability (as a payment into the system). This uncertainty has a larger effect on savings, and greater concessions would correspondingly lower net savings.

Finally, we reiterate that these analyses assume that single payer benefits will be at least as, or more, generous than current UC health plans, for current employees and for retirees. This assessment is supported by the generous benefits in SB 810, and by a comparison conducted by the Senate lead health staffer for the legislation. If the single payer benefits were to be cut back, UC would likely be required to pay for policies to bring benefits to levels promised to UC retirees.

Study team

The study team is comprised of three UC faculty members (from UCSF and UCB) with extensive experience in assessing the implications of health care financing reform:

James G. Kahn, MD, MPH, Professor of Epidemiology & Health Policy, Philip R. Lee Institute for Health Policy Studies, UCSF. (Email: jgkahn@ucsf.edu)

Charlene Harrington, PhD, Professor of Sociology (emeritus), UCSF
Ken Jacobs, Chair, UC Berkeley Center for Labor Research and Education

The idea for this study came from Lea Rosemurgy. We thank Warren Gold for his guidance on study framing and his support. We consulted with Sara Rogers, health consultant in the office of Sen. Mark Leno. We will acknowledge other individuals as they assist us in refining our data input and analyses for further report drafts.