Health Care Financing and its Consequences

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A little bit about AFSCME Ohio Council 8

- 41,000 members employed in cities, counties, schools, universities, hospitals
- Representing employees who work for some 400+ employers
- Part of the larger AFSCME family in Ohio 120,000 active employees and retirees
- Part AFSCME International, largest union in the AFL-CIO 1.4 million members

AFSCME: The American Federation of State, County and Municipal Employees

Increases in Health Insurance, Wages and Inflation
Kaiser Family Foundation Survey

	1988	1989	1990	1993	1996	1999	2000	2001	2002	2003	2004	2005	2006
Health Care	12.0%	18.0%	14.0%	8.5%	0.8%	5.3%	8.2%	10.9%	12.9%	13.9%	11.2%	9.2%	7.7%
Inflation	3.9%	5.1%	4.7%	3.2%	2.9%	2.3%	3.1%	3.3%	1.6%	2.2%	2.3%	3.5%	3.5%
Wages	3.1%	4.2%	3.9%	2.5%	3.3%	3.6%	3.9%	4.0%	2.6%	2.9%	2.2%	2.7%	3.8%

How is the cost of health care financed?

- Premium shared by employer and employees
  - Employers fully insured or self insured (with or without stop loss)
- User fees:
  - Co-pays for office visits, drugs
  - Annual deductibles before insurance kicks in
  - Co-insurance (10-20% of claim paid by employee up to a maximum)

How employers fund health care?

- 78% of employers with 1,000 – 4,999 employees are self-funded
- 53% of employers with 200 – 999 employees are self-funded
- Generally self funded plans with fewer than 6,000 employees have some sort of stop loss insurance: an insurance policy that will only kick in after claims have reached a certain level.

Stop Loss Insurance

- Individual or Specific Stop Loss: The insurance kicks in once an individual's claim exceeds a certain threshold (e.g. $100,000) in a benefit period.
- Aggregate Stop Loss: Coverage which kicks in after the total claims for the employer reach a certain amount. (generally expressed as a percentage–e.g. claims exceeding 110% or 125% of projected claims cost.)
- Small employers face the potential of "laser liabilities" from stop loss company. (The singling out of individuals from stop loss coverage until they reach a higher level of claims costs than the amount of the specific stop loss level.)

Taft Hartley Funds; VEBAs

- In these models a health care fund is created and run jointly by labor and management.
- The negotiating point becomes how much per person the employer will contribute to the fund.
- The Fund then pays claims and admin costs with the money it gets.

US has an Employer-sponsored Health Care System

- Yet 40% of employers do not offer health care.
- 71% no longer offer health care to their retired employees.
- This is not a sustainable system.

Average worker share of health care premium per month

16% of single premium	$58 single
28% of family premium	$273 family

Unionized employees often give up pay increases to avoid paying anything for health care or reduce what they pay towards a health care premium.

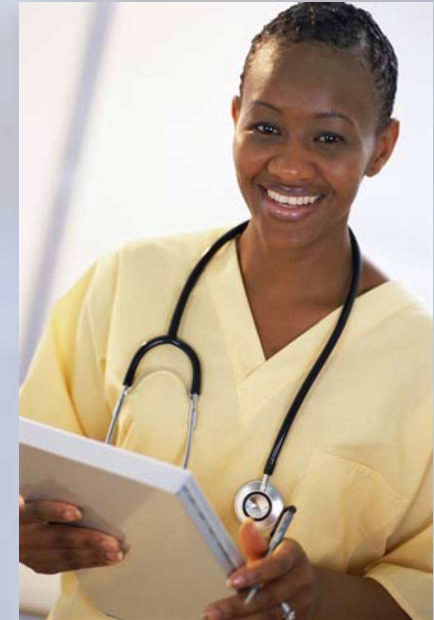
Source: Kaiser HRET Survey of Employer-sponsored health care benefits 2006

Office Visit Co-pay

- Average U.S. worker office in network co-pay

  $19*

- Specialist co-pays range from $25 to $40



*Source: Kaiser HRET Survey of Employer-sponsored health care benefits 2006

Employee Annual Deductible

<u>PPO Plans</u>

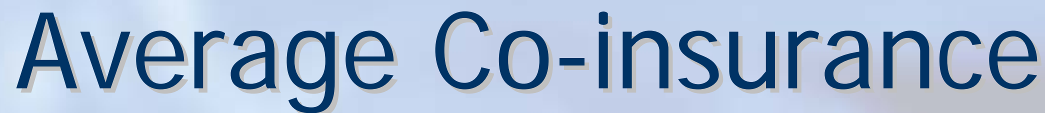
- Single: $461
- Family: $1,040

<u>HSA High Deductible</u>

- Single: $1,729
- Family: $3,596

Employee must pay this amount at the beginning of the benefit year before insurance kicks in.

Source: Kaiser HRET Survey of Employer-sponsored health care benefits 2006



20-25

Definition: Coinsurance is the percent of a medical bill that an employee pays. Generally applies to hospital stays, procedures, lab testing but not an office visit for which there is generally a flat dollar co-pay.

Source: Kaiser HRET Survey of Employer-sponsored health care benefits 2006

Drug Co-pays

- 74% of U.S. workers have a drug formulary (co-pays steer employees towards preferred, lower-cost drugs).
- Average drug co-pays

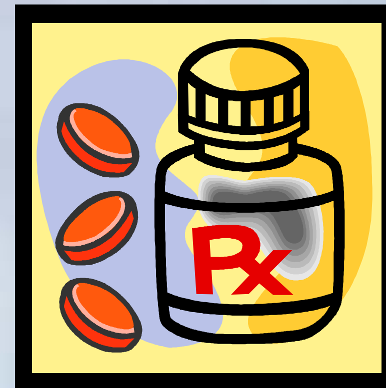
  (30-day supply)

  $11 Generic

  $23 Formulary

  $43 Non-formulary

  $71 Life style/Biotech



Source: Kaiser HRET Survey of Employer-sponsored health care benefits 2006

Some “skin in the game” makes sense

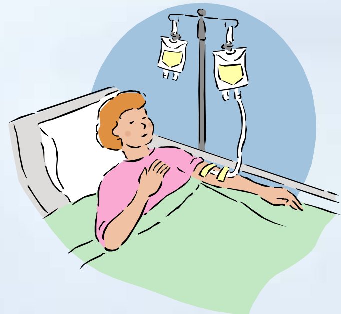
- Encourage the use of generics over brand name drugs, the doctor’s office over the ER room and use of network doctors through appropriate cost sharing.
- But lower income employees cannot afford much cost shifting.
- And the price signals should align with your overall goals of keeping claims costs down.

Cost shifting too much can have perverse consequences

The Rand study showed that requiring employees to pay for some part of their health care *will reduce costs*.

BUT

Low income people who sought "highly effective care for acute conditions" was reduced by 39%



But I thought it saved money if put off my bypass surgery

Many Insured Ohioans Cannot Afford to Finance Their Share of Health Care Costs

- Nearly 2 million Ohioans pay more than 10% of their income on health care and 86.2% of them have health insurance.
- 473,000 Ohioans pay more than 25% of their income on health care and 80% of them have health insurance.

Source: Families USA study: Too Great a Burden: Ohio's Families at Risk. December 2007

High Deductible Health Plans the latest idea in how to finance health care costs

- Shifts the first $1100 to $5000 of health care costs to the employee before insurance kicks in.
- Does not reduce the overall cost of health care unless you believe the theory that people will search out cheaper health care since they now have to pay for more of the cost. (By the way: Do you know who provides the cheapest colonoscopy or by-pass surgery?)
- Removes cost savings incentives for all claims above the deductible.

EBRI study on High Deductible HSAs December 2006

- Only 1% of privately insured population is in a high deductible plan.
- People in HSAs were more likely to forego a prescription than people in traditional plans.
- 1 in 3 people in a high deductible plan avoided care due to cost.

Now not only health care must be financed but banking costs too.

Who Drives Health Care Costs?

People	Costs
80%	20%
20%	80%

High deductible plans impact only 20% of costs

In a high deductible plan most of these costs are above the high deductible and are covered at 100%.

In all employer groups 20% of people account for 80% of health care costs.

Will claims cost escalate under High Deductible Plans?

- Under a traditional health plan 100% of an employer's costs have price signals to encourage use of network doctors, generic drugs and proper use of the ER, etc.
- Under a high deductible plan only 20% of the claims costs have those price signals to employees since all costs above the deductibles are paid at 100%, and generally 80% of the costs are above the deductible.
- Most high deductible plans do not cover wellness and prenatal care until the high deductible is met.

High Deductible Renewals and Banking Fees.

- Early reports show second year renewals for employers with high deductible plans are ranging from 30 to 45% increases.
- Plus employees are now financing not only part of health care but also the banking fees. ($3.50 a month, $4.00 additional fee for balances below $100)
- The 2,400 employees of one Ohio employer will fork over at a minimum $100,000 in banking fees a year.

National Shift in Thinking about How we Finance Health Care

From:

Employer providing benefit with little employee responsibility to contain cost (Employer financing most to all of health care.)

To:

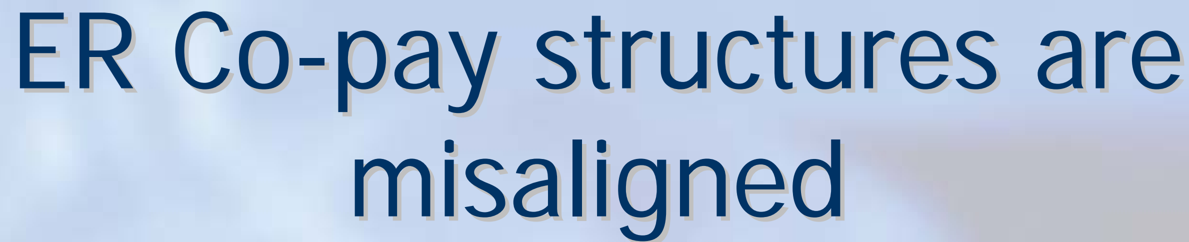
Individual accounts that promote ownership over money with the theory that this will reduce spending. (Employee financing significantly more of health care with tax breaks for doing so.)

Does the way we finance health care facilitate good health?

- Who do you want treating your employees who have cancer? A family Doc or an Oncologist? The co-pay structure suggests the employee should go to their family doc.
- What about those with diabetes, heart disease, orthopedic problems?
- You can save money by not testing your blood sugar regularly, but your diabetes could become out of control. Does your plan pay for diabetic testing supplies?

We want to encourage use of generic drugs over brand name

- But at an average $11 copay for generics, the employee is paying nearly 60% of the cost of the drug.
- Yet for brand name drugs the employees pays only around 20% of the drug.
- Insurance co-pays for generic drugs are often higher than the cost of the drug.



- Employees have their ER co-pay waived if they are admitted to the hospital–most people are not admitted, but that doesn't mean it wasn't an emergency.
- A person with a severe asthma attack, a broken bone or a laceration in need of stitches has a real emergency but will likely not be admitted.
- The co-pay could easily be waived in the case of a true emergency which is fairly easy to figure out. To do otherwise discourages appropriate use of the ER too.

Doctors incentives are misaligned

- We want to encourage diabetics to test their blood sugar regularly, eat right and exercise.
- Most plans don't pay doctors for teaching patients these important skills.
- Doctors are paid by the procedure they use not the education they provide to patients.

Doctors incentives are misaligned

Because doctors are paid by the procedure in America, we have more spinal fusion surgeries than other countries even though studies show most people do no better after the surgery than those who use rest and exercise. And of those who truly need surgery only a small fraction need spinal fusion, but rather need only the less costly discectomy which is done far less.

For more discussion on this see Dr. Jerome Groopman's book *How Doctors Think*

Disease Management to the Rescue

- Because doctors do what they get paid for, they do not help people manage their illnesses, and they really can't if they want to run a profitable business.
- Disease Management programs, many of which pay for themselves in lower claims costs, are now layered on to help people with chronic illnesses better manage their disease. Is this fragmentation good?

- Both employers and employees are struggling with how to finance health care costs. While employers pay the lion's share, employee's costs are on the rise and some employees finance health care by giving up wage increases.
- The act of shifting more of the financing of health care to employees does not generally reduce the overall cost of health care except to the extent it reduces *unneeded* care.

- Continually shifting health care costs to employees is not a sustainable solution as 2.3 million Ohioans (more than 80% of whom are insured) are struggling with the ability to pay for their health care costs.
- The way we finance health care does not align with our goals of promoting health and reducing claims costs.
- Excessive cost shifting to middle and low income workers could backfire as employees avoid *needed* care due to costs.