

Looking Beyond HRAs & Cost-Shifting in Health Insurance Advocacy

An Expanded Narrative of Comments Shared October 28, 2003 During the NEA-Facilitated Conference Call on HRAs

**Mark L. Hage
Vermont-NEA**

Let me emphasize, as I did during the telephone conference, that I believe it is imperative for us as union advocates to respond to the cost crisis in our health-care system by addressing the systemic and structural forces that are fundamentally responsible for that crisis. The American medical system, in my estimation, is economically unsustainable and is driving millions of working Americans from all classes into the ranks of the uninsured or under-insured. Nearly 44 million Americans are currently uninsured (most of them are working; 29.6% are young adults; racial disparities in this group are striking), and their numbers are growing. Also growing is the number of our brethren who are mired in poverty and can't find a job. Some of the working poor who are uninsured or under-insured are members who pay union dues to us to protect them. In Vermont these individuals are largely ESP members, who constitute 20% of our membership, and are also very vulnerable to medical hardship and the costs it engenders. Those members in our state who have excellent health insurance coverage for themselves and their dependents, the majority being teachers, are struggling mightily to hold on to that benefit at a cost that does not jeopardize their economic welfare. They are also caught in the pincers of a mammoth state and national cost-shifting phenomenon that is generated, in part, by the swelling population of uninsured and poor.

It is my informed opinion that the new fondness for HRAs is symptomatic of the enormous difficulty we face confronting the medical, economic and political forces that are allied in opposition to the evolution of a national health care system or to an expansion of the domain of medical financing provided by governmental institutions. I do not believe that our collective mission is best served by embracing cost-shifting mechanisms (like HRAs) that place primary responsibility for both the cost crisis and purchasing cost-effective care on the individual, and that advance the privatization of agenda of the powers-that-be. I won't belabor the second point, but it deserves a great deal more attention in this debate.

My research tells me that 80% of the population uses approximately 16% of medical care nationally. This leads me to the conclusion that most of our members, like most US residents, are either making judicious choices about the care they need or, minimally, are not using an excessive amount of "discretionary" care, whatever the latter means. Could they do better behaviorally in the pursuit of medical care? Probably.

Would they benefit from enhanced wellness programs and more information about selecting appropriate health care? Yes.

Can they be persuaded that nirvana is not found in the “purple pill,” that non-generic drugs are cheaper and just as efficacious in many cases as their generic equivalents, that routine aerobic exercise significantly reduces your chances of developing a certain variant of diabetes? I believe so.

Will HRAs make all of the above possible or easier—I have seen no evidence to date to suggest that is the case, just as I have seen no evidence that HRAs will significantly reduce utilization or lower costs without endangering people’s health. Most importantly, HRAs will not mitigate or negate the powerful underlying forces that are driving cost increases in our health system and imperiling the medical care of millions.

Here is an abbreviated list of those cost-pressure currents, with a Vermont spin in certain areas:

- **Emergency Room Care consumes 2% of the U.S. health care dollar** (American Journal of Public Health, 1997). I suspect this number is higher today because of the number of uninsured, but I don’t know this for certain;
- in 2001, the American health care system incurred **\$35 billion dollars in uncompensated medical care**, with federal, state and local governments picking up as much as 85% of it (Health Affairs, 2003). With the number of uninsured, poor people and the unemployed increasing, this bill will grow and the cost-shifting phenomenon it induces will worsen measurably. Our members have no control over this. In communities with higher uninsured rates, “access to health care services and consequent benefits are compromised even for people with health coverage” (Institute of Medicine, 2003). The fact that the number of uninsured is going up dramatically is “no longer an issue of altruism on behalf of a discredited and disadvantaged population. It is now a concern of self-interest for middle-class and working families” (Families USA, 2003). We are now seeing “...people at higher levels of income and more people who worked during the last year who are experiencing higher uninsured rates” (Census Bureau). The number of uninsured individuals in households with annual incomes of \$75,000 or more increased by 633,000 in 2002 (USA Today);
- health care **administration**, overhead, paperwork and bureaucracy **consume 31% of the health-care dollar** nationally (New England Journal of Medicine, 2003);
- from 1970-1998, there was nearly a 2,500% increase in the number of administrators in health care; during that same time, the number of physicians and nurses grew 159% (Bureau of Labor Statistics);

- on any given day, 20% of Americans will be ill or in need of care, and generate approximately 84% of health care costs (The Agency of Health Care Research and Quality/MEPS, 1999);
- 84% of the costs of running a hospital are fixed (Journal of the American Medical Association, 1999); even when patient use varies, these costs do not vary greatly;
- hospital costs constitute 33% of the Vermont health care dollar (Vermont BISHCA—Business, Insurance, Securities and Health Care Administration, 2003);
- Drug costs constitute 12% of the Vermont health dollar (BISHCA, 2003);
- Physician services constitutes 17% of the Vermont health dollar (BISHCA, 2003);
- Vermont’s health care costs of \$4,700 per person is lower than the national average (\$5,700), but higher than any other industrialized nation (BISHCA, 2003);
- 60% of the national health care dollar is publicly financed through taxes, 19% comes from employer-paid premiums, and 20% comes out of pocket (Health Affairs, 2002).

My apologies to those who disdain or find tedious such lists. My point, simply, is to document the kind of evidence that has radically challenged my thinking on the utilization/consumer-driven health care question, and that has led me to one particularly important revelation: that is, most of what we spend on health care goes to infrastructure costs, including administrative bureaucracy, hospitals, physician and nursing staff, nursing homes, etc., and these costs are largely fixed. Thus, the most effective way to control health care costs is to control the size of the health care infrastructure, and not, as is commonly asserted, by controlling utilization.

Again, let me reiterate, I have no problem with programs or initiatives that encourage better utilization behaviors or make people smarter about personal well-being, nutrition, and medical care. But these efforts, in the absence of a systemic analysis of how most costs are generated in the current health-care system, lead us down the wrong path. They do very little to control premium increases and out-of-pocket expenses that are putting health insurance out of the reach of many working Americans, including some of our members, and eroding the wage gains of educational employees and others who have insurance. Further, and this is very troubling, they keep us mired perpetually in a “cost-shifting response mode” that sees us experimenting with HRAs and other methods of cost mitigation that, to date, have not saved us from double-digit premium increases, have taken more money each year from the people we are paid to serve, put an inordinate

amount of blame for our problems on members and their utilization patterns, and, critically, do not threaten the entrenched power and profits of those who benefit from the status quo.

The “2003 Annual Employer Health Benefits Survey” by the Kaiser Family Foundation concluded that: *“During this current period of rising premiums, there are few easy or attractive cost-containment choices. Returning to managed care means that employers have to reintroduce management techniques that were extremely unpopular with the public. Consumer-driven health care approaches are unproven and require employers to substantially increase out-of-pocket costs for some of their employees, a move that may be even less popular than managed care. ...Employers...do not have a high level of confidence that current market strategies can reduce premium growth. This may explain why more significant changes in the marketplace are not being seen. [They] have not identified a future direction for their benefit plans that they believe would relieve current costs pressures.”*

The future is not so bright, my friends, that we have to wear shades, as the expression goes. A recent survey by ABC News/Washington Post found that 54% of Americans are dissatisfied with the overall quality of their health care and six in ten people say they are worried about being able to afford health insurance in the future. The Wall Street Journal reports that U.S. companies are poised to make “the biggest shift in employer-provided health care in a decade” in response to cost pressures. Not only are they contemplating shifting more cost to their employees, but health plan switching is on the rise: 62% of employers shopped for a new plan in the past year and 33% changed insurance carriers. This kind of volatility, according to the Journal, often forces people to switch doctors, substitute different medications because of different reimbursement policies, postpone preventive tests and routine check-ups, and delay record transfers and referrals. None of this is good for the individual, medically or financially, and it clearly frustrates or obstructs efforts to educate people about the principles and practices of how to secure appropriate medical care.

On the bargaining end of things, in Vermont, school boards and local Associations have swallowed premium increases for the last five years that have averaged 16% annually. This is patently unsustainable, and explains why bargaining impasses are more common again, and why some Boards are looking for ways to compel our people to move to a high-deductible/high co-insurance plan. HRAs and defined contribution proposals are the good intentions paving the road to hell. School directors aren’t thinking about utilization or fixed health infrastructure costs—they want immediate fiscal relief, and they want our people to bear more of the burden of their health insurance benefit, period. Vermont-NEA, not surprisingly, is resisting this strenuously, and we are doing all we can to maintain a united front, to keep our people loyal to our health trust (VEHI) and to state bargaining goals, and to draw a hard line on further concessions.

Our bargaining message, in a nutshell, on health insurance: stay your ground, don’t leave the trust, strike if you have to, and avoid a litany of bad proposals, including high-deductible plans sweetened with the promise of an HRA. The high-deductible plan

that is cheaper today than our indemnity or managed care options, given the above cost trends, will soon be more expensive and wedded to the other plans management loves to hate and wants an ever-increasing premium co-payment to keep offering. This scenario, if it plays out, ends with our members shackled to an insurance plan that has escalating premiums AND high deductibles/co-insurance rates. Some school boards are also demanding split benefit packages for new hires as opposed to veteran staff and waiting periods for the former before a health benefit becomes available to them. There are Boards arguing now that their responsibility for coverage extends only to their employees, not to their employees' dependents. We believe HRAs, if they take root, will exacerbate these developments, as well as encourage some locals to consider Board proposals that substitute a cold cash benefit for a guaranteed group health plan. We've been down all these slopes before. The footing is treacherous and the descent steep.

Those of us who bargain for a living know there is absolutely no guarantee that Boards that pony up funds for HRAs in any amount will continue to do so, especially when they have to juggle increased premiums as well. I can assure you that the many small school districts in Vermont that are watching their school budgets crash and burn, laying off staff, ticking off double-digit premium increases annually, and trying to pay for the new unfounded mandates associated with ESEA/NCLB will never be able to come up with real money for an HRA for any length of time while shouldering increased premiums. It isn't going to happen. To make matters worse, HRA or no HRA, our support personnel who are out in the cold, without insurance, are still left holding the wrong end of the stick and can't bargain a health benefit because it's too damn expensive.

So why should Vermont-NEA embrace HRAs or anything like them? Why should I/we continue to be complicit in designing systems of insurance coverage that shift an ever-larger share of the cost of that benefit to our (under-paid) members while we urge or cajole them to find ways to get less care? How do such systems serve the human and professional needs of the people who pay my salary, or advance the cause of organized labor? Perhaps HRAs will usher in the cost-saving revolution we were promised when managed care was the new kid on the hospital ward. Maybe I'll be proven wrong, but I doubt it.

We need to look beyond the current health care system to a high-quality alternative that is more ethical and humane, affordable, subject to public oversight, and economically sustainable. This last statement should come as no surprise given my argument in this (too-long) document. But there it is, and I'm looking for others in the NEA family who are ready to engage that idea, or, as a starting point, prepared to examine the problem of providing sustainable and affordable health care from a bolder analytical, bargaining and public policy perspective. The national landscape is pocked by labor disputes centered often on health care/insurance costs, and our society lives in general with a degree of medical vulnerability and insecurity that is unique to Western industrial democracies. In Vermont, we can't afford to wait for HRAs or other experiments of its kind to deliver what they promise. In the interim, too many employers are likely to be impressed by how WalMart has kept its per employee coverage costs to \$3,500, 40% less than the US average: require new employees to wait six months for a

health benefit, and offer plan options with deductibles as high as \$1,000 and that refuse to pay for some treatments or for pre-existing medical conditions in the first year of coverage (Wall Street Journal). Additionally, it's not just that we believe the current institutional and market focus on utilization is misplaced and, frankly, disingenuous. It's not that we are afraid of the "devil we don't know" (health insurance with HRAs look a whole lot like the old devil with a facelift). Our rejection of HRAs is also based firmly in the belief that they will never satisfy the compelling and urgent needs of our members for affordable health care, or ward off further losses in health-benefit coverage and compensation at the bargaining table.

I say all of this with the greatest respect for those of you who choose a different path and believe it is in your members' interest to do so, and I hope we will keep talking to each other. I value your insights and experience. I'll be happy to share what we are beginning to do organizationally in Vermont with anyone who is interested in pursuing this conversation further, and I'd like to know more about what is happening in your neck of the woods. Stay well.