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Update on Benefit Issues and Trends

Presented to: **Webinar**

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What We Will Cover

- ✓ Illinois Cost Trends for 2009/2010
- ✓ Other Trends
- ✓ Federal "Reform" – why its current format

Cost Trends

Trend: the expected change in claim payments due to changes in pricing and utilization.

Example:

Year	# Services	x	AverageCost / Service	=	Total Cost	Trend
2009	100	x	$100	=	$10,000	Base
2010	105	x	$105	=	$11,025	+10.2%
2010 (Alt)	103	x	$103	=	$10,609	+ 6.1%

Note: Trend can be modified by influencing Average Cost (primary care, generics, etc.) and/or Utilization (unnecessary tests, etc).

National Cost Trends

	2009	2010
• Medical		
• HMO:	+10.0%	+10.0%
• PPO:	+10.4%	+10.5%
• High Deductible:	**+10.6%**	**+11.2%**
• Dental (PPO):	+ 5.9%	+ 5.5%
• Vision (Indemnity):	+ 4.9%	+ 4.1%
• Disability	Up during recessions	
• Life/AD&D	No Change (some carriers are up due to low margins)	

Source: Segal Health Plan Cost Trend Survey

National Cost Trends

	2009	2010	
Claim	$10,000	$10,500	
Less: PPO Deductible	- 500	- 500	
$ Paid by Plan	$ 9,500	$10,000	
Change:		$ +500	+5.3%
Claim	$10,000	$10,500	
Less: High Deductible	- 2,000	- 2,000	
$ Paid by Plan	$ 8,000	$ 8,500	
Change:		**$ +500**	**+6.3%**

The same $ change means higher % change for HD plans.

Illinois Insurance Cost Trends

Approximately +2% higher than Countrywide due to:

1. "Dependents" covered to Age 26
   - Unmarried, but not limited by student status, residency or financial dependence.
   - Applies to renewals on or after 6/1/2009
2. Autism Spectrum Disorders
   - Individuals under the age of 21 can receive coverage of up to $36,000 per year.
   - Applies to renewals on or after 12/12/2008
3. Illinois Continuance
   - Expanded to 12 months, easier terms
   - Includes Medical/Dental/Vision
   - Subsidized for Involuntary Terminations on or after 6/1/2009

Other Trends

- Most employers are **not** changing benefits, eligibility or cost-sharing significantly at this time.
- More insurance companies are expanding their product offerings to include **supplemental** health products, or limited health plans (mini-meds).
- More insurance companies are developing new products and marketing strategies to **best capitalize on ethnic** preferences.
- **Web-based** materials and enrollments are increasing.

Other Trends (cont)

- Insurance companies have been **reducing their employment levels** over the past 12 months.
- **Wellness plans are proliferating**. However, few employers go beyond **voluntary compliance** and few have significant savings.
- The number of Health Savings Accounts had increased through 1/1, but have leveled off due to the current public debate.

National Health Care Reform

Medicare Prescription Drug Improvement and Modernization Act of 2003

1. Medicare Prescription (Part D)
2. Medicare Advantage (Part C)
3. Health Savings Accounts

President Bush’s health care reform.

National Health Care Reform

Medicare Prescription Drug, Improvement and Modernization Act of 2003

	For	Against	NotVoting
House Republicans	204	25	0
House Democrats/Inds	16	190	0
Total House	**220**	**215**	0
Senate Republicans	42	9	0
Senate Democrats/Inds	12	35	2
Total Senate	**54**	**44**	2

Very partisan voting.

National Health Care Reform

Pre-election stated goal of Democratic Party:

“Making sure everyone has **access to affordable health care**, starting by **fixing the prescription** drug program and investing in stem cell and other medical **research**.”

www.democrats.org/a/national/american_dream/affordable_health_care

National Health Care Reform

Post-election stated goal of Democratic Party: Healthcare for All

The American people understand that good health is the foundation of individual achievement and economic prosperity. Ensuring quality, affordable health care for every single American is essential to children's education, workers' productivity and businesses' competitiveness. We believe that covering all is not just a moral imperative, but is necessary to making our health system workable and affordable. Doing so would end cost-shifting from the uninsured, promote prevention and wellness, stop insurance discrimination, help eliminate health care disparities, and achieve savings through competition, choice, innovation, and higher quality care.

Health care reform must also provide adequate incentives for innovation to ensure that Americans have access to evidence-based and cost-effective health care. Research should be based on science, not ideology. For the millions of Americans and their families suffering from debilitating physical and emotional effects of disease, time is a precious commodity, and it is running out.

www.democrats.org/a/national/american_dream/affordable_health_care

National Health Care Reform (cont)

Underlying concerns that have shaped current proposals:

- Health insurance carriers **should not profit** from expansion to most of the current uninsureds. Only a public option can keep carriers from exploiting the public. Pre-ex limitations should be removed.
- Employers (that are not exempted) **should pay** for health insurance
  - by providing "acceptable health coverage"
  - or, by paying additional payroll taxes.
- Individuals should be charged on a **sliding scale**, based on:
  - regional differences
  - age (limited)
  - **taxable income**
  - certain **behaviors** (such as discounts for non-smokers or voluntary participation in a wellness program).
  - There should not be any limitations for pre-existing conditions.

National Health Care Reform (cont)

- Health Care Providers need to be:
  - informed and monitored
  - should be paid reasonable but not excessive fees for **non-discriminatory** best practices.
- Wellness is to be encouraged, but not mandated.
- Americans should have access to **full legal remedies**.
- The Feds are best equipped to:
  - Determine what is "**acceptable** health coverage" at "**affordable**" rates
  - Collect data and develop "**best practices**" to improve quality and system performance, at affordable costs.
- **Electronic health records** of users of health care is essential in order to carry out these goals.

National Health Care Reform (cont)

Expected Results:

- **Not all US residents will be insured**.
  - Many exemptions and exceptions (such as for small employers and individuals that cannot afford health insurance at any price).
- Expected to **reduce the disparity in health status** by race and ethnicity.
- Program should be cost neutral.
  - (nice goal, but CBO estimates a significant deficit.)
- Health Plans would be required to reimburse:
  - a **minimum of 70% to 76%** (but no more than 93% to 95%) of claims in order to be considered "acceptable health coverage."
  - May need actuarial attestation similar to Medicare Part D.
- **Public options can include Dental and Vision**.

National Demographics

		Res/Prof.
• US Residents		
• With Insurance	261 million	
• Without Insurance	46 million	
• Total	307 million	
• Accountants	1,300,000	236
• Lawyers	800,000	384
• Primary Care Physicians (PCP)	250,000	**1,228**
• Specialist	383,000	802

Sources: US Census Bureau; BLS

Dilemma: Relatively few PCPs to serve population.

Limited Entry to Medical Profession

- Medical Schools 130
- New Students Admitted per year 18,000
  - 3% of the 633,000 medical doctors
  - Not all students graduate
  - Not all graduates go into private practice.
  - Not all in private practice go into underserved areas.

Source: AMA

Dilemma: US Medical Schools can barely replace retiring physicians. How can current system extend primary care to another 46 million?

Total Spending

• GDP	$14.1 trillion
• Health Care @16.5%	$ 2.3 trillion
• Health Care $ per resident	$7,700/year
	$ 640 PMPM

Source: US Bureau of Economic Analysis (Dept of Commerce)

Dilemma: How much do costs have to decrease to become "affordable?"

The Uninsured

• Non-Citizens	9.5 million
• Eligible for Public Aid	12.0 million
• **Uninsured less than 12 months**	**9.0 million**
• **Earned $84,000 plus**	**7.3 million**
• Low Income, Long Term	7.8 million
• Total	45.6 million

Source: Congressman Mark Kirk, 10th District, Illinois

Dilemma: Many US residents elect not to purchase health insurance at current costs.

Personal Health Care Per Capita Spending by Age

Age	Population Millions	% Total	2004 Spending Per Capita	HRMS's 2009 Estimate (*)
0 – 18	40	13%	$ 2,650	$ 3,800
19 – 44	**74**	**24**	**3,370**	**4,800**
45 – 54	**43**	**14**	**5,210**	**7,500**
55 – 64	**46**	**15**	**7,787**	**11,200**
65+	104	34	14,797	21,300
Total	307	100%	$ 5,276	$ 7,700
Working Age	**163**	**53%**	**$ 5,106**	**$ 7,300**

Source: CMS

* Total spending increased from $1.6 trillion to $2.3 trillion (+44%) from 2004 to 2009 (5 years).

Effect of Uni-Age Rates

Age	Population Millions	% Total	HRMS's 2009 Estimate (*)	Average Cost	Net Effect of Avg Rates
19 – 44	74	45%	$ 4,800	$ 7,300	**$2,500 "Tax"**
45 – 54	43	26	7,500	7,300	$ 200 "Subsidy"
55 – 64	46	28	11,200	7,300	**$3,900 "Subsidy"**
Working Age	163	100%	$ 7,300	$ 7,300	Cost Neutral

Dilemma: To make insurance more "affordable" for older workers (who tend to be higher users), insurance companies must charge premiums for young workers in excess of actual costs. Is this "fair" and "affordable?"

Effect of Uni-Age Rates by Median Income

Age of Householder	Households Millions	2004 Income	2009 Income(*)	Net Effect of Avg Rates
15 – 24	7	$ 28,497		
25 – 34	19	46,985		
35 – 44	23	58,578		
SubTotal	**49**	**49,934**	**$ 56,800**	**$2,500 "Tax" / Adult**
45 – 54	**23**	**63,068**	**$ 71,700**	**$ 200 "Subsidy" / Adult**
55 – 64	**18**	**52,077**	**$ 59,200**	**$3,900 "Subsidy" / Adult**
Total 15 – 64	90	52,562		
65+	23	25,336		
Total	113	$ 45,817		

* Avg Wages (CPI-W) have increased by +13.7% from 2004 to 2009 (5 years)

Sources: US Census Bureau; BLS; SSA

Dilemma: To make insurance more "affordable" for older workers (who tend to be higher users), insurance becomes less affordable for youngest workers.

2004 Personal Health Care Spending by Age and Source

Age	Private Insurance PerCapita	Out of Pocket	Total Private	Total Public	Total All Sources	% PHI
0 – 18	$ 1,200	$ 338	$ 1,558	$ 1,092	$ 2,650	45%
19 – 44	1,749	520	2,269	1,100	3,370	52
45 – 54	2,860	899	3,760	1,451	5,210	55
55 – 64	4,147	1,225	5,371	2,415	7,787	53
Total 19 – 64	2,395	722	3,117	1,395	4,511	53
65+	2,682	2,205	4,888	9,909	14,797	18
Total	**$ 2,119**	**$ 802**	**2,921**	2,355	5,276	**40%**

Sources: CMS National Health Expenditure Data

Dilemmas:

1. **Private Insurance pays less than Governmental sources.**
2. **Within Private Plans: insurance paid 72.5%; OOP 27.5%.**

Example: Percentage of Costs Paid by Insurance

	Monthly Premium	Monthly Deduction	Annual Deductible	Annual OOPMax	Expected Ded+OOP	Expected EE Cost	Expected ER Cost	
Single	$ 400	$100	$1,000	$2,000	$ 800	$2,000	$3,600	64%
Family	$1,000	$400	$2,500	$4,000	$1,600	$6,400	$7,200	53%

Dilemma: Many Employer plans will not measure up to the minimum standards currently being discussed by Congress.

Other Issues with Employer Sponsorship

- Employees of Employers that sponsor 88.2%
- Employees that are eligible 77.1%
- Take-Up rate (those eligibles that elect) 81.0%
- % Population covered by group plans 59%

Very few part-time Employees have access.

Source: Kaiser/HRET

National Health Care Reform (cont)

If you are concerned about lack of information or the speed at which Reform is being passed, **contact your elected officials.**

The Leaders of both Houses are expecting to pass legislation by mid-September.

Conclusion

The current uncertainty in National Health Care has nearly paralyzed the Medical/Dental/Vision marketplace.

Once reform is passed (in whatever form and level), expect a flurry of innovative products and employer activity.

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