High Deductible Health Plans on Horizon

The transition to VEHI's high deductible health care plans is underway across the state, with four new plans slated to begin coverage on Jan. 1, 2018.

For your union, health insurance bargaining is based on two principles: affordable access to health care and fairness in cost sharing between schools and school employees.

You can’t have the first without the second.

With this special edition of Vermont-NEA Today, we hope to let you know the facts surrounding this major change in the health insurance landscape affecting you and your families – approximately 36,000 Vermonters. In this edition, we will:

- Remind everyone again how much is at stake, medically and financially, in this insurance transition.
- Debunk the “skin in the game” argument behind HDHPs and Health Savings Accounts (HSA).
- Reinforce the union message that every school employee must be protected equally in this transition.

Remember, we're all in this together. And together, we'll get through this.

We Seek Fair Cost Sharing, Not Unfair Cost Shifting

Some school boards, spurred by the Vermont School Boards Association (VSBA), are pushing an aggressive cost-shifting agenda, both in respect to premiums and out-of-pocket (OOP) costs. Their objectives are anti-employee and anti-family, and, if achieved, will have the effect over time of driving some school employees out of the middle class and blocking others from attaining that status.

- There are Boards demanding nothing less than a 20 percent premium co-payment, a significant increase for most bargaining units. Some are insisting they will no longer pay for spousal coverage if a teacher’s or ESP’s dependents are eligible for coverage through another employer.

- There are Boards demanding an end to the practice of paying a percentage of insurance costs. They propose instead a straight dollar amount based on tiers of coverage, so when costs rise, the district’s contribution won’t automatically keep pace and employees will have to pay all or most of the increase.

- There are Boards demanding that the sharing of OOP costs be done only through HSAs, even though they have been told by VEHI that there are school employees, young and old, including veterans, who are ineligible under federal law for contributions to this kind of account.

Clearly, certain districts are trying to lower their contribution to insurance coverage substantially and rollback their obligation to provide comprehensive health benefits. If they succeed, employees will see a significant decrease in income and experience more health care insecurity.

Don’t Fall for the ‘Alternative Facts’ about HDHPs & HSAs

HDHPs, especially when paired with HSAs, put a smiley face on cost shifting. Despite their claims to the contrary and “put more money in your pocket” pitches, HDHPs do not make us healthier, do not empower us as “consumers,” do not deliver better value or informational transparency, and do not lower the cost of our health care system.

HDHPs and HSAs won’t make everyone a winner financially, despite what Donald Trump says. Tens of millions of Americans are uninsured, and our health care system is the most expensive in the world. These problems cannot be overcome by HDHPs and HSAs.

There are two things HDHPs and HSAs will do, however, unless employers pay their fair share of costs: make workers poorer and put financial barriers between them and their doctors.

‘Skin in the Game’: Direction through Misdirection

Once upon a time, when seeking medical care, we were “patients.”

With the advent of HDHPs, we became “consumers” of health care and were told we must have “skin in the game.” Translation: we must bear an ever-larger share of our premium and OOP costs. (VSBA has adopted this “gaming” ideology. You won’t find the words “affordable” or “fair” in its bargaining recommendations to school boards.)

As “consumers,” we are exhorted to “shop” for the “best value” in health care and negotiate lower costs. We can also amass personal wealth in an HSA.

What’s missing from this fairy tale is that HDHPs, with or without HSAs, compel a lot of working folks to gamble with their medical care and, consequently, to get less than they need.

HDHPs & Medical Rationing

When health insurance costs increase dramatically, many families cut back on medical care.

This is health-care rationing based on income, and can be avoided with HDHPs only if employers pick up their fair share of costs.

A 2015 Gallup Poll found that:

- 31 percent of Americans delayed medical care in the past year because of cost.

This figure has not fallen since the ACA’s reforms.

- Americans are more likely to put off care for serious conditions.

This is not a new phenomenon. Again, according to Gallup: “Since 2001, at least 19 percent of Americans -- and much closer to a third beginning in 2006 -- have found the cost of some healthcare services so prohibitive that they or a family member has had to postpone a medical procedure.”

What procedures are postponed or eliminated? Here is short list from a policy brief by the Robert Woods Johnson Foundation:

continued on p. 2
When Did We Become ‘Consumers’ of Health Care?

“Among families in which members have chronic conditions, both adults and children are more likely to delay care when enrolled in an HDHP than in other plans.”

“Enrollees in HDHPs are also more likely to stop taking their medications for chronic illnesses. A 2013 analysis found decreased medication adherence for patients in HDHPs across four of five chronic conditions studied.”

“Individuals enrolled in high-deductible plans who live in areas with high poverty rates and low education rates reduced their “high-severity,” emergency department visits (those with a high probability of needing care within twelve hours) by 25–30 percent over two years.”

“Enrollees in HDHPs are also likely to reduce preventive care use.”

You don’t need to be a medical expert to know that when people with chronic conditions (e.g., diabetes, heart conditions, asthma, etc.) stop taking their medications or cut back on visits to the doctor, they run a greater risk of becoming sick and incurring larger medical bills.

Rationing, High Deductibles and High-Income Workers: Not What You Think

A two-year study published in 2015 by researchers at Harvard and U.C. Berkeley found that even high-income employees (median income $125,000 to $150,000) reduced their use of health care when their self-insured company switched tens of thousands of them from an insurance plan with no deductible to one with a high deductible.

Reductions in health spending by these workers spanned all categories of care – inpatient, outpatient, emergency room, pharmaceutical, mental health, primary and preventive – even though the company heavily subsidized an HSA. The sickest workers in the company cut back on medical care the most while under the insurance plan’s deductible.

One of the study’s authors, Jonathan Kolstand, said in an interview:

“When we’ve thought about the economics, we’ve generally thought this type of price change wouldn’t be problematic, that sicker people would just spend their deductible and get the care they need. This research suggests that’s not the case.”

The study found no evidence of price shopping.

Health Care is NOT A Commodity

In 2016, Consumers Union, the policy and action division of Consumers Report, said this about HDHPs:

“For decades, rising healthcare costs have strained households, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more ‘skin in the game,’ through high-deductible health plans. …But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What’s more, unaffordable cost sharing causes considerable consumer harm.”

When patients can’t afford care, they report:

“Cutting back on care. They split pills or do not fill a prescription. They put off calling the doctor.”

“Cutting back on other critical purchases like rent, groceries or other necessities in order to afford medicines or care.”

“Filing for bankruptcy. Medical debt is the single largest cause of consumer bankruptcy - outpacing bankruptcies due to credit-card bills or unpaid mortgages.”

The watchdog group also highlighted the pervasive lack of transparency in our health care system:

“A surprising amount of care hasn’t been labeled as high value or low value.”

“Prices are hidden.”

“Consumers have limited access to usable quality information.”

Vermont has its own struggles with price and quality transparency, as documented in a 2014 investigative report by the Vermont State Auditor’s office:

‘The sickest workers cut back on care the most’

“Although the underlying legal structure exists to provide pertinent information, the State has not yet implemented an effective program to help Vermont patients easily compare price and quality information in advance of care, based on their unique situations.”

Most Americans Don’t Get ‘Too Much’ Medical Care

Workers must be disciplined with high cost liabilities, the pro-HDHP argument goes, because many are inefficient or wasteful when using health care. But the facts don’t back that up.

Medical expenses are highly and persistently concentrated among a small proportion of the population. In 2014, ranked by health care expenditures...

1 percent of the U.S. population accounted for 22.8 percent of expenditures; 5 percent accounted for 50.4 percent.

The bottom 50 percent accounted for 2.8 percent of health care expenditures. The actual, fact-based truth: average annual spending for this group was $264.

Closer to home, 50 percent of Vermont school employees in VEHI plans incurred claims of less than $1,500 in 2015. Of that number, 8 percent didn’t incur any claims.

continued on p. 3
Separating Myth from Actual Fact: Most People Aren’t Rushing to Maximize Health Care Spending

Why Does the US Spend So Much More Than Other Countries on Health Care?

Citing a 2013 cross-national analyses of spending across 13 high-income countries by the Organization of Economic Cooperation and Development, the Commonwealth Fund reported that higher spending in the U.S. “...appeared to be largely driven by greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions.” It noted:

- “With only four per year, Americans also had fewer physician visits than the OECD median (6.5 visits).”
- “Data published by the International Federation of Health Plans suggest that hospital and physician prices for procedures were highest in the U.S. in 2013.”
- “In 2010, all countries studied had lower [pharmaceutical] prices than the U.S.”

VEHI’s experience confirms this. In its FY 17 rate announcement, the trust said:

- “The largest drivers of VEHI’s rate increase are rising costs in pharmaceuticals and medical inflation.”
- “The increase in claims is driven mainly by increased cost for services, as our utilization of services and number of high-cost cases remain relatively constant.”

Health Reimbursement Arrangements: Fair to Employees and Districts

Vermont-NEA and its regional bargaining councils support health reimbursement arrangements (HRAs) as the fairest vehicle to cover qualified medical expenses associated with an HDHP. There are classes of workers ineligible for HSA contributions under current IRS regulations. Moreover, a parent’s money in her HSA cannot be used to pay for the qualified medical expenses of an adult child (ages 19-23) who is not a tax dependent, or for the medical bills of an adult child (ages 24-26) unless s/he is permanently or totally disabled. These problems do not exist with an HRA.

HRAs are simple to administer with a third party administrator — school districts have deployed them successfully for years with plans offered by VEHI and Vermont Health Connect.

HRAs can help school districts save more money than under HSA proposals. This is because of lower premiums, for starters, and because employers don’t have to budget up to the maximum OOP exposure per employee with an HRA. The HRA lets them leverage savings from healthy employees (remember the 50 percent cited above who hardly get any care?) to cover the costs of less healthy employees. HRA monies, in other words, are budgeted based on actual claims experience.

HRAs are employer-owned accounts, so, unlike HSAs, funds do not leave the district if they are not used.

Checklist for a Fair Health Insurance Agreement

For School Employees & Their Families

- Lower premium charges with VEHI-HDHPs
- Premium and out-of-pocket costs shared fairly with districts based on percentages
- Out-of-pocket costs reimbursed through an HRA
- Simple and efficient administration of an HRA with a Third Party Administrator
- Financial and medical security for all employees

For School Boards

- Lower premium charges with VEHI-HDHPs
- Premium and out-of-pocket cost shared fairly with employees based on percentages
- Public dollars for reimbursement of health care costs used exclusively to cover those costs through an HRA
- Budgeting for HRA reimbursements based on actual claims experience
- Simple and efficient administration of HRA funds with a Third Party Administrator
- The ability to attract and retain quality staff by ensuring financial and medical security for all employees

With an HRA, if employees don’t get medical care, they are not entitled to reimbursement; if they do, funds are available.
Let’s Stay Together in Bargaining and Organize!

The late Dr. Martin Luther King, Jr., wrote: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

As union brothers and sisters, we’ve fought hard over the decades for the health insurance coverage we have. At every table during every negotiation over the last four decades, we’ve used the good-faith give-and-take of bargaining – as equals with our school board counterparts – to achieve pay, benefits, and working conditions that have helped make Vermont’s schools some of the best in the nation.

For decades, districts and local unions negotiating health benefits have fundamentally understood that fair cost sharing is the key to affordable access to health care, and to recruiting and retaining quality staff. This is still true today.

We acknowledge that health care in the United States is too expensive and too difficult for millions to get. And some in Washington want to make matters even worse with a repeal of the Affordable Care Act.

But High Deductible Health Plans – the types that will begin on Jan. 1, 2018 – will not solve the affordability and access crisis in health care. That must come through political reform that establishes universal, publicly financed health care as a right of all “Medicare for All,” as Senator Sanders likes to say. Indeed, your union has advocated for fundamental health care reform for decades, and will continue to do so.

But until such reform comes, we must remain true to our bargaining principles and organize in our communities to make sure every unionized and non-unionized employee has access to affordable, comprehensive health benefits.

Union solidarity and Vermont resolve: this is the only way forward.

Health Insurance: What’s at Stake

With this special edition of Vermont-NEA Today, we give you the information you need to understand how the push to high-deductible health plans will affect all of us.

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Learn the keys to a fair health insurance settlement, p. 3
Don’t Fall for ‘Alternative Facts’ on Health Spending, p. 2
Don’t Play the Cost Shift Game They Want You to Play, p. 1

Standing together in the health insurance fight is more important than ever for all of us.