ARIZONA HEALTH FUTURES

health bullets

December 2005

Financing Mechanisms

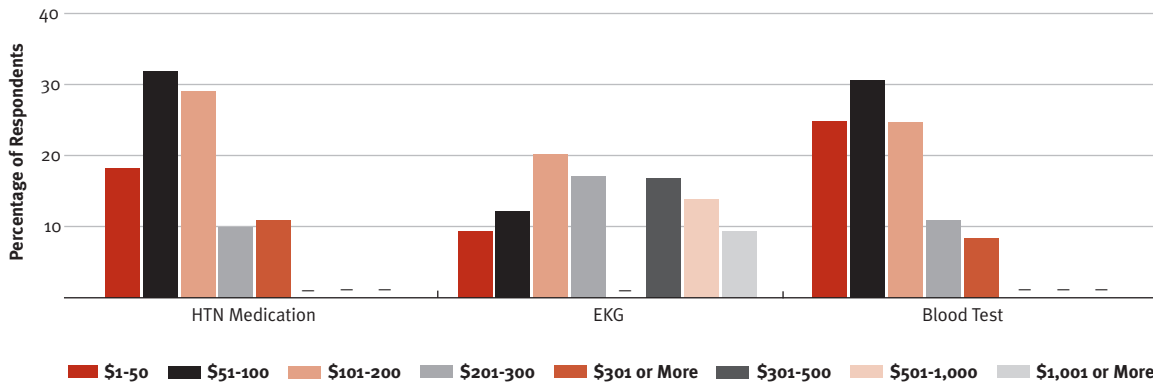
Capsule information and trends related to financing the delivery of affordable, high quality care for all Arizonans.

PRIVATE MARKET TRENDS

#1 Consumer-Directed Health Plans

- Consumer-Directed Health Plans (CDHPs) refer to several approaches, all of which combine a personal health/medical savings account with a high-deductible health plan (HDHP). Enrollment in such plans is on the rise as employers and employees seek to lower their insurance costs, and insurance companies seek to gain market share. When presented with the premise that CDHPs make health insurance coverage more affordable, 57% of Americans strongly favor a switch, and an additional 27% favor it somewhat.[1]
- The growth of CDHPs is tracked through the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.[2] The estimated percentage of firms that offer employees a high-deductible health plan reached 20% in 2005, up from just 5% two years ago.
- Among employers that don't currently offer such plans, 6% say that they are "very likely" to in 2006. However, while the percentage growth has been notable, the actual number of enrollees remains relatively modest, totaling just over one million in March 2005.[3]
- Because these new arrangements are generally more attractive to very large employers (over 1,000 employees), their future growth in Arizona's predominantly small-business environment remains to be seen. Coupled with the potentially negative impact on the providers who will have to collect high deductibles and co-payments,[4] the ability of insurers to attract an adequate provider network is an issue. Growth of HDHPs may be constrained by consumer concerns about threats to the quality of care and their ability to differentiate between necessary and unnecessary care.[5]
- The premium difference between HDHPs and conventional Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point of Service (POS) plans is considerable. In 2005, the average family premium for the latter traditional insurance plans was $10,880, while for HDHPs the cost was $8,530. The difference? In a typical HDHP plan, the average deductible is $3,686.
- Effectively utilizing HDHPs will require consumers to make knowledgeable, well-informed choices. However, public perceptions of costs for health care services are all over the board. While the actual average cost of a blood test is $300, survey respondent's average estimated cost was just $143. Similarly, at $25,000, the average actual cost of a hip replacement (excluding surgeon fees) is nearly $15,000 higher than the public's $10,639 cost estimate (see Fig. 1).[6]

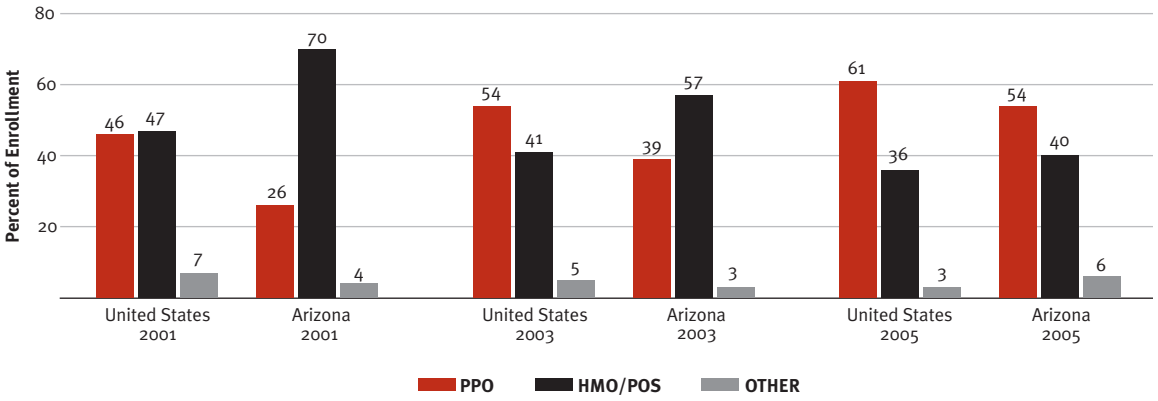
Figure 1: Cost Estimates of Health Services



#2 HMO/PPO/POS Plans

- Nationally, the trend away from HMO to PPO/POS plans continues. HMO enrollment continues to decline, from 25% in 2004 to 21% of market share in 2005.[7] In Arizona, HMOs experienced a 14.2% decline in enrollment in the past year alone.[8] Nationally, PPO plans made significant gains in market share, increasing from 55% to 61% of all health plan enrollment for covered workers.[9]
- As HMO enrollment has fallen, AZ now resembles the rest of the country (see Fig. 2).[10]

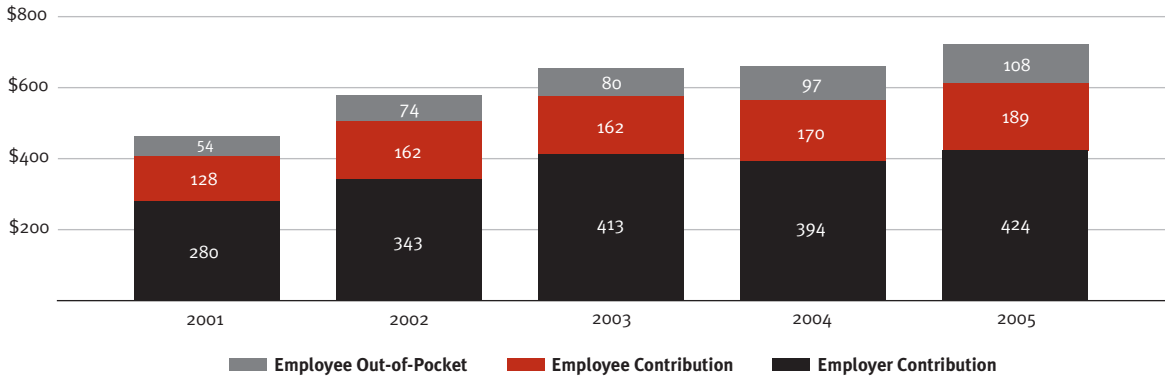
Figure 2: Enrollment by Plan Type, U.S. and Arizona 2001-2005



- Increasing PPO enrollment reflects the market preference of people for access to their provider of choice. In a recent survey, 53% of insured adults indicated that they would be willing to pay more to go to a doctor that doesn't accept their health insurance if that physician was highly recommended by someone they trust. While willingness to pay more varied by income, the underlying reasons were as much about preferential access in terms of appointment times, more time spent with the doctor and after-hours availability as they were about receiving specialized treatment.[11]

- Over the past several years, Arizonans have seen a marked increase in employee costs for employer-sponsored insurance (ESI – see Fig. 3).[12] Along with growing enrollment in high-deductible plans, the reasons for this reflect benefit design changes to PPO/POS plans that mitigate premium increases by increasing employee costs, including:
  - higher deductibles
  - higher co-payments
  - higher premium percentage paid by employees
  - higher overall premiums
  - higher out-of-pocket costs for uncovered/out-of-network services

Figure 3: Monthly Per Employee Cost for ESI (AZ)



#3 Association Health Plans

- Association Health Plans present another option for expanding ESI. Through an exemption from state benefit mandates and solvency rules, these plans would offer more flexibility in benefit design and potentially lower costs. Options include legislation championed by Arizona Representative John Shadegg that allows people to buy insurance from any state, effectively bypassing state-based insurance laws. The goal is to reduce the number of people who can't afford current insurance premiums by allowing them to buy policies with more limited benefits and thus lower premiums.[13] Opponents argue that people may end up with policies that don't provide adequate coverage, and that premium savings will be eaten up by higher out of pocket costs including higher co-payments, deductibles and uncovered services.

#4 Government-Financed Reinsurance

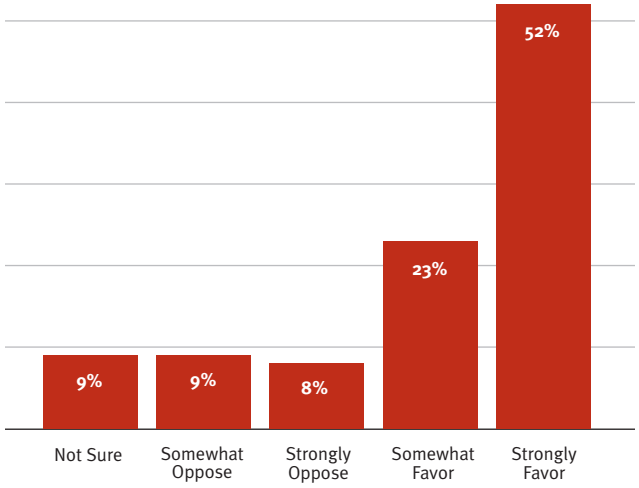
- Government-financed reinsurance for private insurance carriers has been proposed as a means of lowering premiums, increasing premium stability and reducing the number of uninsured.[14] Compared to the entire health insurance market, the commercial medical reinsurance market is small. Reinsurance is typically purchased by small- to mid-sized insurers that wish help in managing their risks. To be successful, a government-financed reinsurance program would need to address several issues, including design specifics and incentives for plans to manage their risks appropriately.

PUBLIC HEALTH INSURANCE TRENDS

"Underlying the debate over who pays for Medicaid is…a more fundamental debate about how we as a nation fill the gaps in our health care system… In the absence of broader solutions, such as universal health care coverage and reform of long-term care, policymakers must find ways to maintain, rather than shred, the Medicaid safety net."[15]

A recent national poll found that 96% of Americans support Medicare, and 91% support Medicaid. Similarly, strong support for universal health insurance has been consistent both within Arizona and across the country. Most recently, a national survey found that 75% of all adults strongly or somewhat favor universal coverage, while just 17% are opposed and 9% are unsure (see Fig. 4).[16]

Figure 4: Percentage of People Favoring Universal Health Insurance



#1 Arizona Health Care Cost Containment System (AHCCCS)

- In 2005, Medicaid provided health and long-term care for over 55 million Americans. AHCCCS, Arizona's Medicaid program, served over one million persons.
- Nationally, children account for about one-half of the enrollees, and their parents account for one-quarter, but together these groups incur just 30% of total expenditures. Conversely, elderly and disabled persons represent one-quarter of beneficiaries, but account for 70% of program costs.[17] In Arizona, the disparity is even greater – adults and children make up 84.3% of enrollees, but account for only 54.1% of expenditures, while the blind/disabled and elderly constitute 15.7% of beneficiaries, and incur 45.9% of total costs.[18]
- Enrollment in Arizona's public health insurance programs increased 25% between October 2002 and October 2004 as the full effects of both the economic downturn and the passage of a 2000 ballot initiative (Proposition 204) that set the eligibility limit for AHCCCS at 100% of the federal poverty level (FPL) kicked in. Since that time, enrollment growth has slowed considerably, to just 2.3% between October 2004 and 2005 (see Fig. 5).[19]

Figure 5: AHCCCS Acute Care Enrollment, 2001-2005

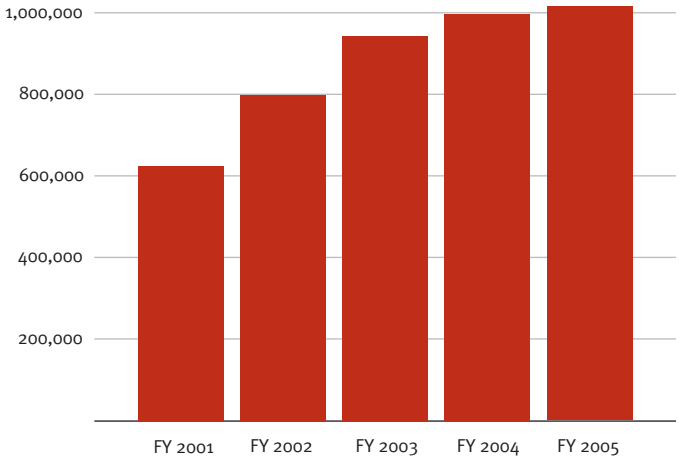


Figure 6: Percent Change in Medicaid/AHCCCS Enrollment; U.S. and AZ 2001-2005

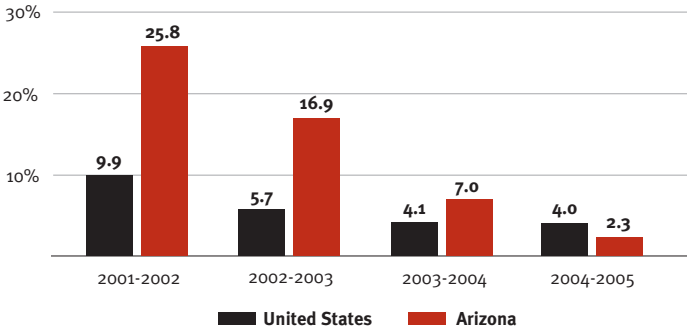
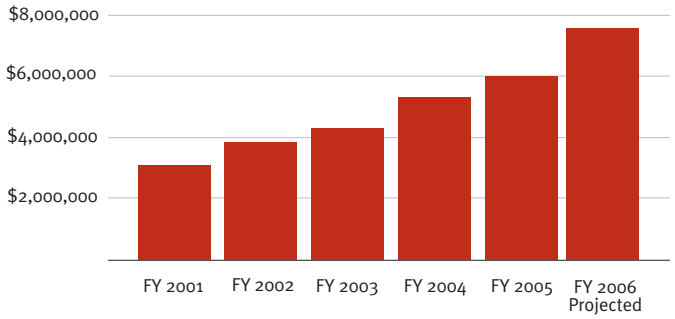
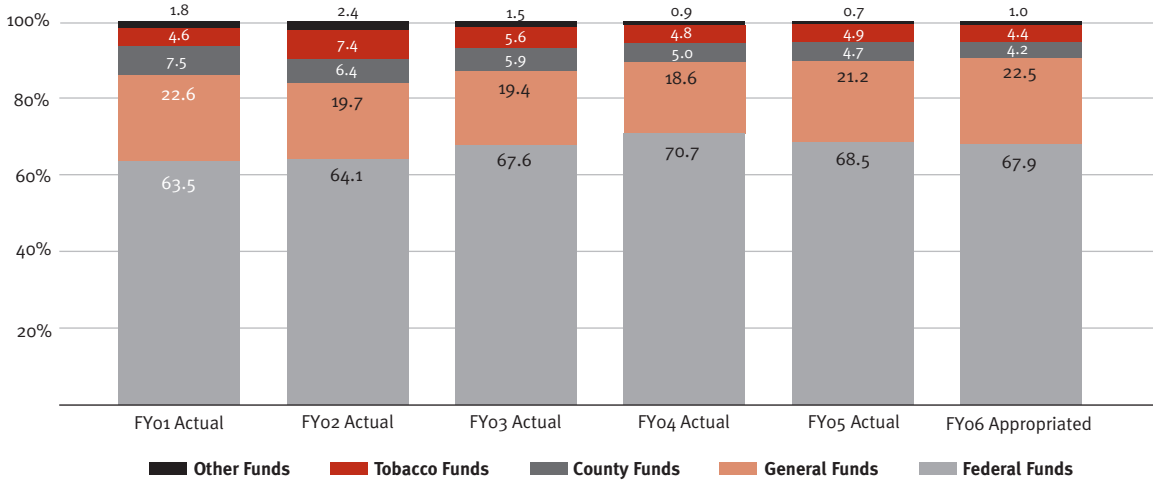


Figure 7: Total AHCCCS Expenditures, FY 2001-2006



- From a peak growth rate of 9.9% in FY 2002, average enrollment growth nationally is projected to be just 3.1% in 2006. While Arizona's enrollment growth significantly outpaced the national average in fiscal years 2002 and 2003, in 2005 Arizona's growth rate was significantly lower than the national average (see Fig. 6).[20]
- Consistent with enrollment growth, total expenditures for AHCCCS programs have also increased. Between FY 2001 and FY 2005, total expenditures nearly doubled (Fig. 7).[21]
- Compared to other states, AHCCCS is less dependent on general fund dollars, relying more upon federal and tobacco-related funds. In the five-year period from FY 2001through the end of FY 2005, state general fund expenditures for AHCCCS programs actually *decreased* by 1.4% (Fig. 8).[22]

Figure 8: AHCCCS Funding Sources, FY 2001 – FY 2006



#2 A Patchwork of Programs

- The following is a 2005 breakdown of enrollment among the myriad Arizona programs administered through AHCCCS. It demonstrates the fragmented nature of our health care system and a piecemeal approach to addressing it:
  - Arizona Health Care Cost Containment System (AHCCCS) – 527,472
  - AHCCCS for Families with Children (AFC) – 113,332
  - Health Insurance for Parents – 13,456
  - KidsCare – 50,927
  - Arizona Long-Term Care System (ALTCS) – 41,656
  - Breast and Cervical Cancer Treatment Program (BCCTP) – 90
  - Freedom to Work (FTW) – 777
  - Medical Assistance Only (SSI-MAO) – 122,880
  - Medical Expense Deduction (MED) – 4,665
  - Medicare Cost Sharing (MCS) – 9,766
    - Qualified Medicare Beneficiary (QMB)
    - Specified Low-Income Medicare Beneficiary (SLMB)
    - Qualified Individual (QI-1)
  - Federal Emergency Services (FES) – 73,820
  - SOBRA for Children – 87,112
  - SOBRA for Pregnant Women – 9,276

#3 Coordination vs. Cuts

- Considering the $7 billion in Arizona and the $300 billion in national expenditures for Medicaid, state and federal efforts to control costs have been a front burner issue for the past several years. State spending for Medicaid grew at a slower rate than total spending due to an increased federal match. However, states again faced pressure to implement Medicaid budget cuts as the temporary increase in the federal match expired, resulting in increased state expenditures in 2005 and 2006.
- A 2005 survey of cost containment strategies undertaken by the states during this time revealed a range of approaches, including:[23]
  - controlling drug costs
  - reducing/freezing provider payments
  - reducing/restricting eligibility
  - reducing benefits
  - increasing co-payments
  - instituting disease management programs
  - limiting/restricting long-term care services
- The survey also found that almost all states, including Arizona, have taken action to contain costs by restructuring provider payments. Arizona is one of a few states that have not sought legislation to further limit pharmaceutical expenditures. Somewhat paradoxically, Arizona and other states have also increased provider payments. Finally, to address the issue of a burgeoning uninsured population, 31 states either have passed or are considering legislation to expand eligibility in 2005 and 2006.[24]
- At the national level, efforts are underway to reduce Medicaid expenditures. The Medicaid Commission established by the Secretary of the Department of Health and Human Services recommended six options for reducing Medicaid expenditures by $10 billion over five years.[25] The recommendations include:
  1. Allowing states to establish pharmaceutical prices based on the Average Manufacturer's Price (AMP) rather than the Average Wholesale Price (AWP).
  2. Provide Medicaid managed care plans access to existing pharmaceutical manufacturer rebate programs that could either be collected directly by the states or exchanged for lower capitation payments.
  3. Changing the start date of the period during which Medicaid will not pay for long-term care following a transfer of assets made in order to gain eligibility.

4. Increasing from three to five years the amount of time during which asset transfers will be researched when determining Medicaid eligibility for long-term care.
5. Allowing states to increase co-payments on non-preferred drugs to encourage use of the least costly effective prescription.
6. Requiring the states to tax all managed care organizations and prevent state guarantees of the return of tax revenues paid to states by managed care organizations.

Along with other options considered by Senate committees, when the proposed legislation left the Senate, the cuts came from just three areas – and have prompted the threat of a Presidential veto.

#4 Health Care Reform in Other States

Lawmakers in at least 19 states have considered proposals to expand health coverage in 2005. This is up from 12 in 2003.[26]

- **California** – SP 840 would create the California Health Insurance System, a government-run and financed health care program for all residents. Status: passed by the assembly; will be heard next year. AB 772 would expand state-subsidized health insurance to children up to 300% of the federal poverty level. Status: passed, vetoed by the Governor.
- **Colorado** – SB 169 would create an assembly to study comprehensive state health reform. Status: passed, vetoed by Governor.
- **Connecticut** – Several bills that would create a universal health care system in the state have been referred to committees.
- **Florida** – SB 150 would create a universal health plan for children. Status: filed.
- **Hawaii** – HB 1304 would establish a temporary task force to develop a plan for implementing health care for all residents. Status: passed.
- **Illinois** – HB 806 would extend lower-cost insurance to all state children, regardless of income. Status: passed.
- **Kansas** – HB 2001 would establish a commission and create a statewide health insurance plan. Status: filed.
- **Louisiana** – HCR 142 would study the feasibility of a single-payer health insurance system for all residents. Status: passed.
- **Maine** – HB 106 would establish a universal health care system. Status: dead.
- **Maryland** – SB 727 would establish the Maryland Universal Health Care Plan. Status: introduced.
- **Massachusetts** – Two bills would establish a requirement that individuals buy health insurance and create two programs from which to choose. The third bill is similar, but also would require that employers offer health insurance or pay into a fund.
- **Minnesota** – SB 414 and SB 723 would establish a universal health system. Status: introduced.
- **Missouri** – HB 80 would establish a universal, publicly financed statewide insurance program. Status: referred to committee.
- **New Hampshire** – HB 133 would establish a committee to study whether a universal system could be implemented in the state. Status: dead.
- **New York** – Two bills would establish a government-funded health care system for all residents. Status: referred to committees.
- **Ohio** – SB 263 would establish an Ohio Health Care Plan. Status: introduced.
- **Rhode Island** – HB 6111 would extend the reporting date of a committee to study a single-payer plan. Status: passed by House.
- **Vermont** – HB 524 would establish a goal of universal access to health care services through a publicly financed system. Status: passed, vetoed by Governor.
- **Wisconsin** – SB 388 would establish a publicly financed health care system. Status: introduced.

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2 *Employer Health Benefits 2005 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust. http://www.kff.org/insurance/7315/

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22 Ibid.

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