

National Trends in Health Care

A New Push (And a New Look) for Universal Coverage

Universal health care coverage is back on the front burner, but it has a somewhat new look and feel as states attempt to devise plans that will ensure coverage for all of their citizens but won't be seen as single-payer, government programs. Earlier this year, Massachusetts enacted bipartisan legislation that requires every person in the state to purchase health insurance or face financial penalties. The law requires the policies cover all of the state's 40 mandated coverages, including in-vitro fertilization, and mandates first-dollar coverage for primary care. It also requires employers with 11 or more employees to pay a \$295 annual fine for any employee that doesn't have health insurance and to cover all health care costs above \$50,000 per year for any uninsured workers they employ. A statewide risk pool, called the "Connector," simplifies the purchase of individual policies and provides subsidies to make policies affordable for low-income workers. Actuaries contracted by the state estimate the cost of coverage through the Connector would be about \$200 a month, but there is concern the estimates are unrealistically low and will quickly lead to higher taxes and assessments on individuals and employers.

Maine and Vermont have also enacted legislation designed to ensure universal coverage, and several other states are considering the concept to reduce the costs of their programs for the underinsured and Medicaid recipients. In Wisconsin, lawmakers are pondering legislation that would assess employers up to 12 percent of payroll and would assess individual employees 2 percent of their salary to fund a voucher program that individuals would use to purchase insurance from competing vendors.

Earlier this year, the American Medical Association joined the American Hospital Association in support of a federal universal health care coverage requirement. The AMA proposal would require all Americans to purchase catastrophic and preventive health insurance. Individuals earning more than 500 percent of the federal poverty level (which equates to \$100,000 for a family of four in 2006) would face tax penalties if they failed to comply. Those earning less would be eligible for subsidies or tax credits to help them pay for coverage.

The universal health care debate is expected to ratchet up this fall when the Citizens' Health Care Working Group submits its final recommendations to the president and Congress. Created as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the 14-member group held public hearings around the country to let the public debate the "services they want cov-

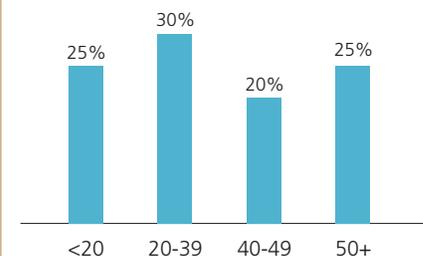
HSA's & HRAs GAIN TRACTION

After a slow start, the number of companies offering HSA-qualified plans is doubling annually.

Growth appears to be particularly strong in the large group market, which includes companies with more than 10,000 employees; the number of firms offering the coverage jumped from 1 percent in 2004 to 8 percent in 2005. The appeal of consumer-driven plans appears to be broad-based,

allaying fears voiced about the plans when they were first introduced. Although many were concerned that young people would be the primary users of HSA-qualified plans, age distribution appears to be fairly uniform. Fifty-five percent of enrollees are under age 40, while 45 percent are between 40 and 65, according to a report from America's Health Insurance Plans, a trade group representing insurers. There also appears to be no discernible difference between a person's perceived health status and plan selection. Seventy-seven percent of respondents with HSA-qualified plans reported their health status as "good" or "very good," which was identical to the responses of people enrolled in other plans. Eleven percent reported their status as "fair" or "poor," which was slightly less than the 12 percent reported by enrollees in other health plans.

HSA Age Distribution Small Group Market



Source: America's Health Insurance Plans: 2006 Census

ered, what health care coverage they want and how they are willing to pay for coverage.” The public comment period ended this summer and the final report is due out at the end of September (for more information, go to: www.citizenshealthcare.gov), but the group’s key recommendations include:

- All Americans should be guaranteed affordable health care coverage by law
- Coverage should include a legally defined set of benefits that guarantee financial protection against very high health care costs
- The core benefits/services should be selected through an independent, transparent and scientific process that gives priority to the consumer-provider relationship
- Consumers should be allowed to purchase additional coverage for services beyond the core package
- The government should use its federally funded health programs to promote quality, efficiency and cost containment

The building momentum for universal coverage doesn’t mean the nation is lurching toward Canadian-style health care. Almost all of the ideas under serious consideration would use market forces, not a government program, to ensure universal coverage. In many cases, the basic plan would be an HSA-qualified, high-deductible plan for catastrophic coverage coupled with some preventive services.

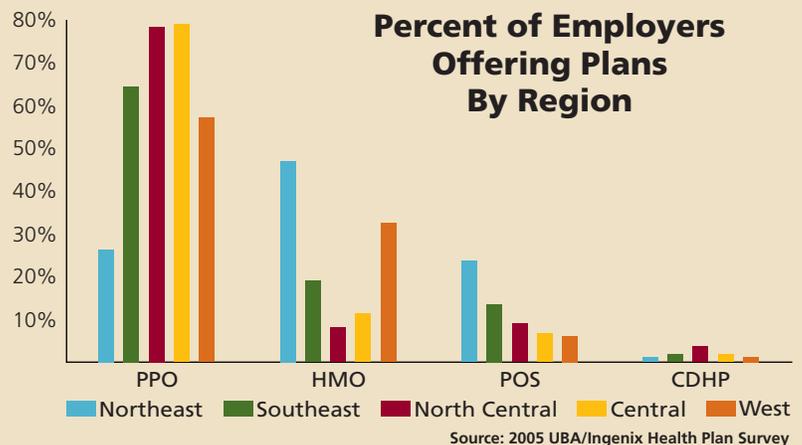
Would Universal Health Care Coverage Matter Anyway?

Even if everyone ends up with insurance, it doesn’t mean they would get any healthier. That’s the conclusion of a new Rand Corporation study, which shows that virtually every person in the United States is at risk of failing to receive needed care regardless of their race, gender, income or insurance status. The study, which assessed preventive services and care for 30 conditions that are among the leading causes of death and disability, concluded that participants received recommended care only 55 percent of the time even though the recommended treatments are widely known and accepted.

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REGIONAL VARIATIONS IN HEALTH PLANS & COSTS

Benefit plan designs vary significantly by region, demonstrating the different approaches employers have taken in specific geographic areas. This was demonstrated in the 2005 UBA/Ingenix Survey, the most comprehensive nationwide employer benefits survey undertaken. The North Central region, which includes Wisconsin, has a clear preference for Preferred Provider Organizations (PPOs) and shies away from Health Maintenance Organizations (HMOs). The North Central region also has proven to be an early leader in the adoption of consumer-driven health plans (CDHP). Though the percentage of North Central employers offering CDHPs in 2005 was small (3.7 percent), it was almost double the percentage posted in other regions. The survey also showed that North Central employers were more even-handed in their approach to premiums for single and family coverage. The typical employer paid 83 percent of single coverage and 75 percent of family coverage. In other regions, it was common for employers to make employees pay a greater share of the premium burden for family coverage. Employees in the Southeast and Central regions pay 57 percent of family premiums, in the West they must pick up 62 percent of the tab.



THE RISING COST OF CARE

The Milliman Medical Index shows a 9.6 percent climb in health care costs for family of four in 2006

Average annual medical costs for a family of four will be \$13,382 in 2006, an increase of 9.6 percent from 2005, according to the 2006 Milliman Medical Index. That is greater than the 9.1 percent increase reported in 2005, but less than the 10.1 percent increases reported for 2003 and 2004. And despite growing employee concerns about bearing a greater financial burden for their health care costs, the average family is paying a smaller portion of its medical costs now than it was three years ago. Employees will pay 38 percent of their total medical costs this year, down from 40 percent in 2003, according to the Milliman Medical Index. During the same time, the employer's share has increased from 58 percent to 60 percent.

**Annual Medical Costs
Family of Four**



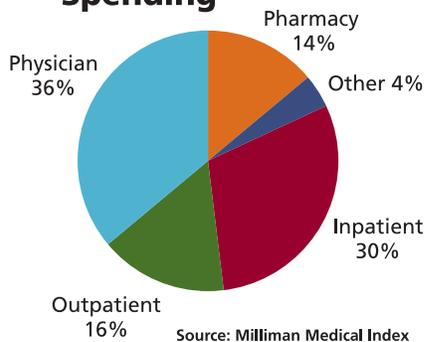
Source: Milliman Medical Index

The annual medical costs for a "typical" family of four increased 9.6 percent to \$13,382 in 2006, according to the Milliman Medical Index. Outpatient costs rose the fastest (12.6 percent). Pharmacy costs, which rose 12.8 percent in 2005, slowed to a growth rate of 8.3 percent in 2006.

The Milliman Medical Index measures the average spending for a "typical" family of four covered by an employer-sponsored PPO program. It is based on an analysis of claims costs nationwide using estimated average provider payment rates and Milliman's analysis of historical claims data and trends in provider contracting. According to the index, the average family will pay approximately \$5,020 for its health care this year. This includes \$2,810 in premium costs and \$2,210 in deductibles, copays and other out-of-pocket expenses. Inpatient and outpatient hospital services will account for 46 percent of total medical costs in 2006, followed by physician services (36 percent), prescription drugs (14 percent) and other miscellaneous services (4 percent).

Outpatient costs will increase the most this year – 12.6 percent – followed by inpatient costs (9.3 percent), pharmacy (8.3 percent) and physician costs (5.9 percent). The increase in pharmacy costs is significantly lower than the 11 percent to 13 percent increases reported in 2003, 2004 and 2005, which Milliman attributes to the increased use of three-tier and four-tier pharmacy plans and to the end of patent protection for several significant brand-name drugs.

Components of Spending



Source: Milliman Medical Index

Physician costs represent the largest portion of health care spending, accounting for 36 percent of total costs, followed by inpatient and outpatient costs.

According to the Milliman Medical Index, the average family of four will spend \$810 in out-of-pocket costs for physician office visits this year, \$575 for inpatient care, \$285 for outpatient care and \$465 for prescription drugs. Utilization and costs for a particular family varies significantly depending on family members' ages and health status. It also varies according to region; for example, average medical costs in Chicago are 13 percent higher than in Dallas but 4 percent lower than New York, according to Milliman's analysis of six selected cities.

The complete Milliman Medical Index can be downloaded at www.hctrends.com or www.milliman.com.

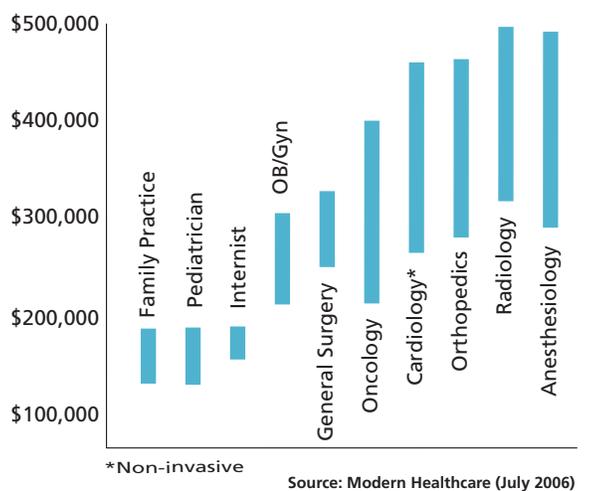
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The Rand study found that:

- People with annual family incomes greater than \$50,000 had quality scores that were just 3.5 percentage points higher than those whose families had incomes less than \$15,000
- Women were more likely to receive recommended care than men (57 percent vs. 52 percent)
- Women were more likely to receive preventive services (58 percent vs. 50 percent) and recommended chronic care (58 percent vs. 55 percent)
- Women were less likely to receive recommended acute care (52 percent vs. 58 percent)
- Younger participants were more likely to be screened, but were less likely to receive follow-up care than older participants
- Adults under age 31 were significantly more likely to receive preventive care
- People aged 31 to 64 received significantly better chronic care than those under age 31.

The study also included some surprising conclusions. African-Americans fared better than whites in several important areas. They were more likely to receive recommended chronic care than whites (61 percent vs. 55 percent), and more likely to receive the recommended treatments (64 percent vs. 56 percent). Whites also fared worse than Hispanics when it came to recommended screenings: 56 percent of Hispanics received recommended screenings, compared to 52 percent for whites.

VARIATIONS IN PHYSICIAN PAY



Primary care physicians continue to earn much less than specialists nationwide. According to Modern Healthcare's annual physician salary survey, which is based on information from 15 trade groups and physician recruitment firms, family practice physicians were the lowest-paid physicians in 2006, earning between \$142,000 and \$190,000 per year. By comparison, radiologists earned between \$325,000 and \$475,000, while anesthesiologists earned between \$284,000 and \$453,000.

Nearly 7,000 adults in 12 metropolitan areas participated in the study, which evaluated performance on 439 indicators of quality for a variety of conditions, including urinary tract infections, diabetes, asthma, high blood pressure and heart disease.

Not Much Help From the Patients

Even though a staggering 72 percent of Americans are overweight – and 39 percent are considered obese – weight loss is a low priority for most Americans, according to the 2005 Yankelovich Preventative Healthcare Study. Only 30 percent of respondents said they were actively trying to lose weight. More surprising were the responses people gave when asked the best approaches to shedding pounds. At the top of the list was “maintaining personal hygiene and cleanliness,” which was reported by 64 percent of respondents; “maintaining a positive attitude,” cited by 58 percent of respondents; and “maintaining/cultivating good family relationships,” which was selected 53 percent of the time. Diet and exercise, long considered the most effective clinical approaches to losing weight, placed 13th and 17th in the survey, respectively. The survey, which included 6,000 U.S. adults, also found that only 30 percent of individuals considered health and wellness a priority. Fifty-nine percent of respondents either had a superficial concern about their health risks or took their health status for granted, foregoing screenings and preventive care.