CONSUMER DRIVEN HEALTH CARE VS CURRENT PLAN

Why do we (schools) not contribute more to health insurance? How much money does GCT have in the bank?

1. We are required to present and maintain a balanced budget. It is easier to maintain a balanced budget than it is to present one. Because of this requirement, we have to be conservative in our projections. There are times we could add more to salaries or benefits if the consequences for deficit spending the operating budget were not so severe. The amount in the bank does not help (about $3 million) because a benefit is a recurring expenditure and it is foolish and irresponsible budgeting practices to use reserves to pay for a recurring expenditure. It will eat up the reserves. **However, if we could use some of our reserves for things such as capital improvements and equipment that are not recurring expenditures and not have it count against our regular budget, we could do more with the regular budget. Also, in Missouri, we were allowed to present a deficit budget, but my budget letter always stated that due to conservative projections, we expected to end the year with a balanced budget. Seldom did I present a preliminary budget that was balanced, but I never ended the year with a deficit budget. The reason the preliminary budget was a projected deficit was because I added salary increases. I knew that the conservative projections would cover these unless we had some unforeseen situation that was very expensive. If this did occur, the state would not have threatened us with fiscal distress because we had strong fund balances. In Arkansas, superintendents have to protect the district from this because we will get that letter and our patrons will think we are not managing the finances properly.**
2. What I do with our surplus in Arkansas is restrict it for the following year and use it to help us present a balanced budget and pay as much as possible toward salaries and benefits. Generally we can only afford to do bonuses because these are not recurring expenditures and once again it protects us from deficit spending the following year.
3. Under the current rules for budgeting, I would have to reduce the staff (I don't know where) in order to pay a significant amount toward health insurance without risking a citation for fiscal distress.
4. *LAST BUT NOT LEAST – IT WOULD BE FOOLISH TO PAY MORE INTO A SYSTEM THAT WILL CONTINUE TO HAVE DOUBLE DIGIT INFLATION AS LONG AS OUR EMPLOYEES ARE NOT HELPING US RUN A CONSUMER DRIVEN HEATLH INSURANCE PLAN. WHEN THE GOAL OF THE CURRENT SYSTEM IS TO RAISE THE COST OF THE HEALTH SAVINGS ACCOUNT (BRONZE) PREMIUM AND OUT OF POCKET MAXIMUM IN ORDER THAT THEY WILL BE FORCED TO THE GOLD, WE WOULD NEVER BE ABLE TO KEEP UP WITH THE DOUBLE DIGIT RENEWAL INCREASES EACH YEAR. IT WILL BANKRUPT US!!*
5. **When you throw more money at the current system, you are only throwing money at the symptoms and not the causes!** This is why you find yourself in the same situation each year – how do we get enough money to keep the benefits where they are?
6. ***The rich plans have to go.*** These cause over utilization and adverse selection. People who are healthy are not going to pay the high cost of a rich premium and will look elsewhere for insurance because they can get it cheaper. Then if they become

unhealthy, and they can no longer get insurance on their own, they return to the group. The unhealthy used to take the Gold plan so we at least got the premium, but now they can't afford it. Besides, if they really thought about it, they know that since they are going to reach their out of pocket maximum anyway, they are better off on the Bronze and pay the lower premium. This is the worst case scenario because they not only use the insurance, but do not pay the high premium. Another major issue is that even people who may not be unhealthy, who can afford the Gold, will take it and over use it because of the zero deductible and copays.

7. We currently have a plan that is counterproductive to controlling rates and they are and will continue to spiral out of control because we have no plans to get the members to help us control the rates. We need a consumer driven plan – it has been proven to work in helping to control health care costs. ***We have to learn to manage, not just dispense funds!!!***

What is a consumer driven plan?

1. It is a plan where the employees help the company (state or school) manage their own health care costs. It becomes their plan, not just the employer's plan.
2. It is about educating employees as to why rates are so high. Most do not understand that over utilization of the benefits is a major factor and it will cost them with higher rates the following year. We must educate the members on what the true costs of insurance really are, and get them to participate in helping us control the rates while also educating them on how to manage their own health savings accounts.
3. It includes incentives to get them to participate in helping to control the rates through wise use of insurance, participation in wellness programs, and getting preventative checkups.
4. **Education Education Education !!!!! This is very lacking in our current system for school employees. Evidently, for state employees the EBD is willing to help them make wise choices which tells me they are not really concerned about the school employee plan.**
5. **Transparency is a must!! When there is a lack of transparency, people will think the worst. Me included!**

The consumer driven model originated with the Japanese auto industry. You may remember that in the 70's, the U.S. auto industry was getting trampled by the Japanese. They were building a much higher quality vehicle for less money. I can tell you for sure, because I bought one. The American cars were so poorly built the question was why? The Japanese used a quality management model that gave their workers incentives to make a quality vehicle. One of them was ownership in the company. While in America, workers were just punching a time clock and not concerned about the quality of the product, (and it really showed) the Japanese worker had pride in the product they were building because they were also reaping the benefits as the business flourished. They were allowed to participate in the success and profits of the company!! The U.S. automaker finally woke up and is now doing the same thing. You can't argue that the quality of U.S. automobiles is ~~not~~ NOW much better.

In consumer driven health care, the employees begin to realize the over utilization of the benefits only serves to cost them more out of pocket the next year. In the early 90's, insurance companies came up with these low deductible, low coinsurance plans with copays. The copays were a huge mistake. It caused the severe overutilization of the benefits and annual double digit renewal increases every year. When a person went to the doctor, they had no concern as to what the visit or treatment actually cost because they only had to pay the low copay. Under a consumer driven plan, where a person is managing their own health savings account, the consumer is going to ask the price. In fact, those in the medical offices were seldom asked what a certain procedure would cost, but if they were asked, you would more than likely get the response: why do you care, the insurance will pay for it!! The rates got so high that even the insurance companies realized that the copays were a huge mistake and that they were going to lose business if they did not help us control the rates (someone would come in and underbid them or people would just simply not have insurance.) This is one reason I question whether or not there is any real competition for our business, if there was, Blue Cross would have been leading the EBD in this direction because they have in other parts of the country.

We must change the culture to where not only the consumer will ask that question, but the medical clinics and hospitals will be forced to tell us what the cost is going to be and give us the ability to shop around for a better deal just like we would with an automobile. As it currently stands, the costs of the same procedures in different clinics and hospitals can vary thousands of dollars.

We all know the high cost of medical care is another factor that leads to high premium rates, but we have contributed to this because we have not held them accountable. A consumer driven plan will do this especially in groups as large as state and school employees.

Another factor that contributes to higher rate increases is the policy of allowing people who drop out of the plan back in once they become sick and they no longer can afford the private plan. I understand we may no longer have a choice with the new laws, but it leaves the group with unhealthy people while the healthy leave.

Do we have competition for the current business?
In a group our size, we should have interest all over the place. However, it is my understanding that the current bidding process is so specific that only one company can get the bid. If we do not have competition for the business, then we are at their mercy and this can't be allowed to happen.

I AM ASKING THAT YOU CONSIDER THE FOLLOWING.

1. Allow the schools to break away from the ASE. We are already rated separately anyway.
2. We need funding increases from the state equal to the claim trend rate for state employees in order that we can offer incentives for members to go to the Bronze Plan. (*The State Employee Plan is set up perfectly for consumer driven healthcare because you have the money to offer members incentives to direct them away from the Gold, thus,*

slowing down the utilization of the insurance.) The schools also need to contribute more – and funding equal to the claim trend rate for state employees will help as well as numbers 9 and 10 below.

3. Move to regional rating which reflects provider contract variance across the state.
4. Move completely to defined contribution. Defined contribution versus defined benefit in health insurance is like 401(k) versus pension in retirement benefits. I.e. you fix the dollar amount available to each employee per month and they choose from a range of benefit plans (8 or more varying from rich to lean). If they buy up, they pay extra. One of the lean options would be at no extra cost to them. They could contribute to their health savings account. To accomplish this, the schools must contribute more to the plans.
5. Create open competition for the business.
6. Establish a board for the school employees made up of school employees.
7. Employee a qualified consultant who is an expert in the field of consumer driven health plans.
8. We need more transparency. It is true that you can find information about the current system, but it is difficult to understand for most people – the great majority of people.
9. We must educate the members and create an atmosphere of trust (transparency).
10. We need the laws changed where schools can present a deficit budget with expectations that it will in the end be balanced. If not, then the state can issue a warning, but before doing so, they need to look at the budget closely to include the fund balances, and not just final numbers. This would allow us to use reserves to pay for one time expenditures – after all – do schools not get criticized for hoarding money? This will free up funds to help pay more for salaries and benefits.
11. When considering whether or not a school is in financial distress, look at the fund reserves not just the annual budget. This is too restrictive to allow the schools to provide more funding for salaries and benefits. We do not want that letter??

Thanks for allowing me to speak.

Jerry Noble