

Cracking Down on the 'Misuse' of HRAs with High Deductible Health Plans

By Joe Torella



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We always manage to take something great and mess with it until we render it valueless; in this case, we have time to change that.

The east coast's first generation high deductible health plans (HDHPs) drove down premium costs with clients typically depositing the savings in their pockets. This standard approach to the annual renewal – shifting costs to employees with perhaps momentary concern for employee impact – had done little to drive employee buy-in or alter healthcare buying behavior.

Enter true Consumer Driven Health Care Plans where HRAs (or HSAs) are installed to mitigate the financial impact of high deductibles on consumers, not to replace them completely. Are they easier to sell and explain when consumers have 'zero' deductible and therefore 'zero' impact? Sure, but therein lies the problem: carriers design those plans with an expectation that the deductible represents a member's personal risk corridor, encouraging them to purchase services more wisely. Carriers empower these 'new consumers of healthcare' with the cost and quality information they need by making data about prescription drugs, doctors, hospitals and other services 'transparent' or visible through the internet.

In return for an assumption of smarter, more cost effective purchasing, HDHPs are more steeply discounted for two critical reasons: 1. fewer claim dollars flow through to the carrier; and, 2. **the deductible/risk corridor, together with education and transparency, steers members to lower cost/higher quality options and/or the elimination of unnecessary services.**

For example, a knee injury is properly diagnosed by x-ray alone. The doctor/patient may agree on scheduling an MRI simply because the patient wants it and the insurance carrier will pay for it. But if the doctor's standard is 'necessity' and/or the patient has to pay for it, an MRI isn't always the next obvious or automatic step.

Underwriters and Actuaries allow for these assumptions in their pricing models. By backfilling all or a substantial percentage of the deductible/risk corridor with HRA or other funding, we seriously damage the pricing assumptions they've made. Several recently completed analyses of HDHPs reveal that utilization is outpacing projections, with buying patterns more closely resembling those connected to very rich plan designs. We've essentially created 100% plans with deficient premium levels to support them.

Is this stealing? Not quite, but we're accepting a low price for a high deductible plan that no longer exists. We're misrepresenting the price to the client, because once we substantially fund the deductible, the price reflects a product they did not purchase.

Carriers have a legitimate need to respond – for all of us. When? Immediately, because utilization spikes when funding exceeds reasonably assumed levels. Sabotaging the pricing models will continue to drive up premium levels unless there is swift and meaningful change.

For large groups, most carriers have either developed a form, or will shortly, that allows underwriting assumptions to be modified based on funding levels against the deductible. Brokers/clients need to 'certify' those

funding levels or premiums will be increased if some percentage of the deductible corridor is breached – typically in excess of 50% (although I prefer incentives to sanctions).

For small groups, only one carrier, Aetna, has thus far created an 'attestation' form; and although pricing cannot currently be impacted in New York and New Jersey, it can in Pennsylvania and other states. It would not be surprising to see other carriers follow and will be interesting to see if the States of NY/NJ allow pricing considerations.

Michael McGuire, CEO of New Jersey UnitedHealthcare, says five years of research indicates that, "CDH plans reduce costs for employers and consumers when designed to balance employer funding with the consumers' share of the deductible. With 20,000 employers and three million consumers, our goal is greater transparency of quality and cost information with tools that ensure plan participants become knowledgeable and responsible health care consumers".

We need to support these goals through appropriate funding levels, completing the forms and submitting them timely. Hopefully, this process will simply reinforce what we should have been doing all along: getting members to put more skin in the game and becoming more accountable health care purchasers thus driving down overall cost.

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