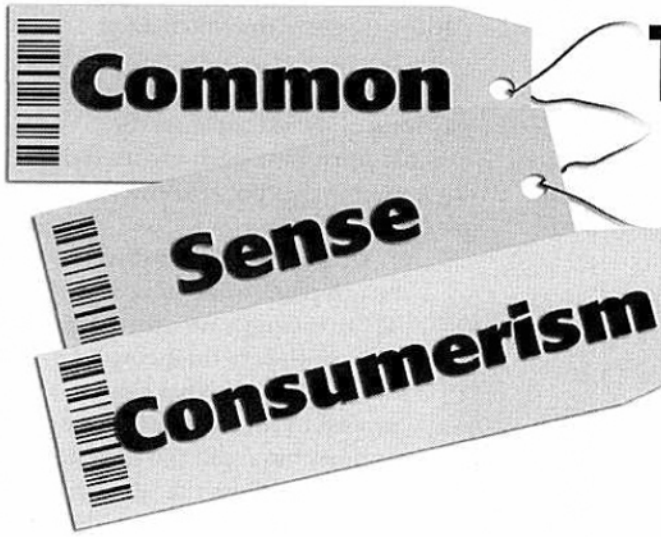

The CURE for What AILS Our HEALTH CARE System

by Scott M. Stevens, RHU

Something went wrong on the way to the doctor's office.

The individual seeking care genuinely felt that his or her health insurance was a right, not a privilege. The individual seeking health care had, in effect, a blank check to pay for whatever care was suggested by the provider.

The health care provider, after having obtained all the necessary credentials to practice medicine, not to mention all of the sacrifice and struggle that accompanies that journey, lost the ability to make health care decisions on behalf of the patient and instead must rely on the permission of a third-party payer.

The government, feeling uniquely qualified to solve all the problems associated with our complex health care system, passed (and continues to pass) laws requiring more care and less responsibility, thus increasing the cost of insurance and reducing the number of people in the country who have health insurance. (Remember when the federal government contemplated a complete overall of the health care system under the Clinton Administration, only to discover that public opinion was staunchly opposed to abandoning our current system?)

Employers, feeling the inherent pressure to keep up with the Joneses, continued to offer rich health insurance plans, which have the fundamental effect of encouraging irresponsible, imprudent health care consumption, thus driving costs up even more (e.g., the popular office visit co-pay that encourages utilization and increases costs unabated). And the story goes on...and on...and on...

Many in what the media have dubbed "America's health care crisis" have reported the statistics pertaining to the present and future state of the industry as nothing less than staggering. Annual premium increases for health insurance, exacerbated by the compounding effects of increases applied on increases, have left many employers feeling frustrated, angry, confused and exhausted. Today, most employers are given the following options by their broker/agent/consultant at renewal time:

- Reduce benefits
- Increase the employees' portion of the premiums
- Terminate the health insurance plan, give employees a bonus, and wish them luck in procuring their own coverage
- Consider a professional employer organization (PEO)
- Bite the bullet and absorb the increase.

At some point, employers reach a boiling point. They think, "There's just got to be a better way!" Well, good news and common sense have finally arrived: consumer-driven health plans.

The concept itself goes by many names, but the idea is simple—get the actual purchasers of health care more involved in the process, and make them more intelligent purchasers along the way. There are numerous tangential benefits that accompany the introduction of this approach, not the least of which is assigning the proper roles to each player in the health care system. For example:

Provider—delivers the proper care at the right setting at the best price.

Insurer—underwrites and assumes the risk for catastrophic situations.

Administrator—maintains eligibility, provides billing, pays claims.

Patient—self educates on the particular disease or disorder at hand, evaluates alternative courses of treatment and, with the help of the provider, decides the proper course of treatment.

Government—ceases passing laws that increase costs and reduces the number of insured Americans, thus concentrating on relevant legislation.

This past June, the IRS issued a revenue ruling having the potential for revolutionizing health care delivery and financing. In short, the ruling creates tremendous flexibilities for

the use of monies set aside to pay for lower-cost health care items. This ruling, combined with existing consumer-driven strategies, has significant implications for the marketplace. The realignment of roles will have the net effect of reducing costs without sacrificing quality or choice of care.

The new so-called health reimbursement arrangements are close cousins to two existing consumer-driven health financing arrangements: flexible spending accounts and medical savings accounts. However, HRAs have distinct advantages over both FSAs and MSAs.

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The underlying goal of consumer-driven health plans is to educate and involve the health care consumer in the actual purchase of health care. Our current system is set up in an absurd, contradictory fashion. In most instances, the actual "purchaser" of health care is neither paying for the majority of the cost of the care itself, nor for the cost of the insurance that is in place to cover health care-related expenses. The ultimate effect of this arrangement is over-utilization, irresponsible consumption and an uninformed buyer. Consumer-driven health's goal is to restructure the system to a point where the consumer is knowledgeable, involved and concerned about the type, cost and quality of care received. In the end, everyone comes out ahead in this type of environment.

So exactly what is an HRA? It is defined as an account that:

- is financed by the employer
- reimburses participants for medical expenses up to a maximum dollar amount in a plan year
- allows unused credits to be carried forward to the next plan year (unlike FSAs).

And, since HRAs qualify as health plans, coverage and benefits are tax-free.

Like its cousins MSAs and FSAs, HRAs are tax-preferred funding arrangements, usually established in conjunction with a high-deductible, or catastrophic, health insurance plan. Such a plan acts like a "safety net" and provides insurance protection for the higher-cost unanticipated medical expenses (much like health insurance used to do in the "old" days before co-pays, drug cards and first-dollar benefits). Significant premium savings are usually realized by implementing the catastrophic type plan in place of the more traditional, benefit-laden plans that have low co-pays, deductibles and coinsurance. With an HRA-type plan, the lower-cost, more predictable items are paid for with the funds in the account, while the larger-cost, unanticipated expenses are covered by the catastrophic health plan. Everyone wins. For example:

The employer—with lower cost insurance coverage and happy employees.

The employee—with better coverage, dollars accruing for a multitude of uses and lower premium contributions.

The provider—now able to treat patients who have more of a say in their care than the insurance company.

The insurance carrier—better able to channel its resources since the lower-dollar claims don't need to be adjudicated as thoroughly.

There are important features of the HRA that need to be taken into consideration, primarily what the HRA funds can be used for. Generally speaking, HRA funds can be used by an employee to pay for any medically related expense listed on the Internal Revenue Services section 213(d). This list includes a broad range of expenses, from acupuncture to vitamins. Additionally, HRA funds can be accessed to pay for long-term care insurance and health insurance coverage on behalf of retirees and former employees electing COBRA continuation coverage.

HRA funds cannot be used for benefits other than medical expense reimbursement, nor can they be used to pay for expenses for which a tax deduction was or is to be taken. Finally, in order to use HRA funds to pay for a qualified expense, the expense must have been incurred during the time that the HRA was in place.

Clearly, consumer-driven health plans' time has come. There is simply no other area of the health care financing or delivery systems that can be tapped to find savings. Some pundits have said the time has come to address the "demand" side of the health care system, because there is nothing left to be had from the "supply" side.

There is no question that all the savings from so-called "managed care" initiates have been realized. A recent poll found very little cost difference between plans having various levels of managed care (e.g., HMO, PPO, POS and indemnity). In order to truly address the spiraling cost increases attributable to health insurance rates, we must address the very core of the dilemma, the actual consumption of health care. The cascading effect will result in lower costs throughout the health care financing and delivery systems. ■

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