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Solutions for Today's Health Policy Challenges

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Utilization among Consumer-Driven Health Plans: What We Know and What We Don't

Health insurance premiums are rising at double-digit rates, pricing many employers and workers out of the market. The primary reason for those increases is health care utilization. People are using more health care than ever before.

Increased utilization of a product or service isn't necessarily a bad thing if the consumers using it are the ones paying for it and getting value for their money. Consider that people are also spending more on computers than ever before, a fact typically applauded by economists and employers. Yet the price of computers is continually going down while quality is going up.

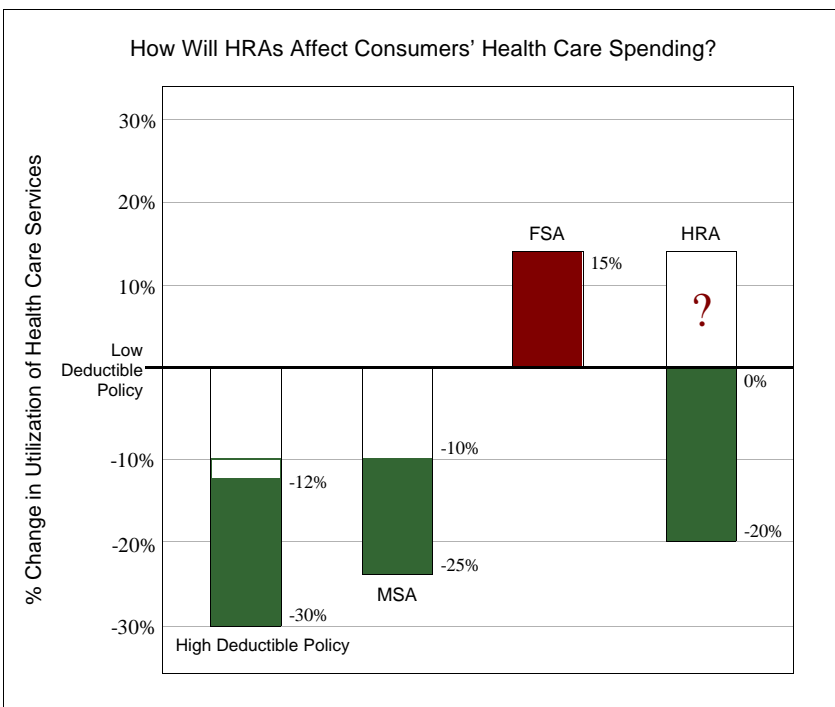
Not so in the health care system. Increased health care utilization is creating an economic and political crisis — one that politicians will try (and probably fail) to fix if the current growth trend continues.

The public policy challenge is to find a way to reduce health care utilization without discouraging or denying needed care. Can it be done? Yes, if the incentives are structured correctly.

Is There a New Option to Control Utilization? The IRS recently released a ruling regarding a relatively new type of health insurance option: Health Reimbursement Arrangements (HRAs).

HRAs allow the employee to use the employer's money solely for medical expenses. The funds are provided and owned by the employer, not by the employee, and unspent HRA balances may accumulate from year to year. Funds may only be used for medical expenditures. If withdrawals are permitted for nonmedical expenses, the plan will be disqualified for all employees, and they will owe taxes on all amounts paid out of the HRA, including all prior medical reimbursements. Employers may allow departing employees access to the balances after they have left the company, but few companies establishing HRAs do so.

HRAs, MSAs and FSAs: They're Not the Same. HRAs are the newest entry in the growing array of consumer-driven health care plans. Others include Medical Savings Accounts (MSAs) and Flexible Spending Accounts (FSAs). While some similarities exist, the three plans create significantly different incentives for health care consumers.



Only those working for small employers (50 or fewer employees) and the self-employed can make tax-free deposits to federally qualified MSAs (often referred to as Archer MSAs), which are owned by the employee. MSA money not spent by year's end may be rolled over to the next year and grow with tax-free interest.

Like Archer MSAs, contributions to FSAs are exempt from both income and payroll taxes. However, only employers can set up this program for their employees; the self-employed are excluded.

But the biggest downside of FSAs is the use-it-or-lose-it provision. While employees contribute the money, employers keep any balance unspent at year's end. As a result, employees have a strong incentive to spend — even waste — any funds remaining in their accounts in December.

The policy question facing us now is whether HRAs will be better or worse in controlling utilization than MSAs or FSAs.

What We Know: Good Incentives Control Utilization.

All economists know that when people are insulated from the cost of something they tend to use more. The more insulated they are, the more health care services they will consume. Health insurers and employers know that they can reduce health care utilization by imposing higher deductibles and copayments.

For example, high-deductible coverage (at least \$1,500 for an individual and \$3,000 for a family) can reduce utilization by 12 to 30 percent when compared to that of a low-deductible policy (no more than \$250 per individual and \$500 per family).* [See figure on the reverse side.]

Critics of consumer-driven plans often assert that consumers cannot be expected to make good choices when being admitted to an emergency room. However, most of the estimated utilization difference is for outpatient costs, not emergency care.

A more valid concern is that high deductibles discourage people from getting the care they need in a timely fashion, perhaps leading to higher health care costs down the line. Is there a way to discourage unnecessary utilization while providing funds so that people who need care don't forgo it? Yes, Medical Savings Accounts.

What We Know about Utilization with MSAs. When the annual MSA deposit is less than or equal to the amount of the high-deductible policy discussed above, Medical Savings Accounts will usually reduce utilization nearly as much as the high-deductible plan. Thus if utilization under a high-deductible policy drops by 12 to 30 percent, an MSA plus a high-deductible policy will lead to roughly a 10 to 25 percent reduction.

The reason for the reduction in utilization is that people see the MSA funds as their own, so they become more prudent health care shoppers. But the MSA also gives workers access to a special account if and when they need it, regardless of what is happening with their personal finances.

The MSA balances care and cost, discouraging unnecessary care (i.e., overutilization) while providing funds for most small but valuable health care needs.

What We Know about Utilization with FSAs. Flexible Spending Accounts create a different incentive than MSAs because workers forfeit unspent FSA funds rather than roll them over to the next year. As a result, FSAs can actually *increase* utilization costs as much as 15 percent over the low-deductible policy described above, as workers try to empty the accounts before December 31.

What We Don't Know about Utilization with HRAs. Health Reimbursement Arrangements are untested, so no credible experience exists to suggest that HRAs will de-

crease aggregate utilization. However, they do not appear to have as strong an incentive to reduce utilization as MSAs.

We know that actual utilization depends on how the insured views the money in the account, but that perception depends on several factors, including plan design, marketing of and education about the concept, and legal opinions. At this juncture, all that can be said is that HRAs will likely not lead to the 10 to 25 percent utilization reduction seen with MSAs. Depending on how the HRA plan is structured, it could reduce utilization from 0 to 20 percent, but utilization could be outside of this range in either direction. In other words, poorly designed HRAs could *increase* utilization.

Most likely, utilization reductions under HRAs will fall somewhere between that of MSAs and FSAs, depending on such factors as how government regulators interpret the HRA ruling, how well the insured understand the plan, plan design and premium levels.

Conclusion. We know how to reduce health care utilization and thus health care costs without harming patient health: give consumers a financial incentive to be value-conscious shoppers in the health care marketplace. We know that MSAs do exactly that, and that if Congress would remove the burdensome restrictions on Archer MSAs, they would do even more. We also know that FSAs do a poor job of controlling utilization, at least at the end of the year. The more HRAs look like MSAs, the more they will reduce utilization. Employers can experiment with HRAs in hopes of finding the right incentives or, better yet, they can demand that Congress reform MSAs — now.

** Estimates assume an average risk profile for someone under age 65 who pays the whole deductible out of pocket and no coinsurance above the deductible. It furthermore assumes the same level of discounts and managed care applications above the deductible for people who live in an area reflective of average nationwide costs and utilization.*

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