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Benefit Insights

Health Reimbursement Arrangements (HRAs) – New Era of Health Insurance?

With most employers looking for answers to spiraling health insurance costs, new regulations impacting health reimbursement arrangements, or HRAs, could not have come at a more opportune time. On June 26, 2002, the IRS and Treasury Department both issued guidance clarifying the tax treatment of HRAs maintained by some employers. While HRAs have been around for some time, laws regarding the proper tax treatment of these plans have limited their use.

Using HRAs, employers would purchase basic medical coverage for employees, usually with a high deductible. Employees would be able to share in the cost of the coverage as they do now. To offset the impact of the deductible, employers deposit money into an account the employee can use for routine medical bills, prescriptions, and other substantiated health expenses. Any reimbursements made to the employee would be tax-free. Once these funds are spent, the employee would then incur out-of-pocket expenses until the deductible is met. Any funds remaining at the end of the year would carryover for use in future years.

Proponents of consumer driven health care believe subjecting consumers to the actual cost of medical care will sharpen their purchase decisions of health and pharmacy services. Once patients begin to control the payment for services, they will be more inclined to shop and inquire about the cost of care. Furthermore, consumers will tend to educate themselves more under these programs, which lead to improved quality of care and increased patient satisfaction.

Even with the advantages of HRAs, critics of consumer driven plans argue they discriminate against unhealthy and older employees. Depending on the actual plan design, this may be true to some extent. However, the flexibility of these plans offers employers the ability to structure plans with out-of-pocket costs substantially similar to those of traditional health insurance plans. Unlike Medical Savings Accounts, or MSAs, there are no stringent plan requirements with HRAs.

Another question concerning HRAs is whether they will be able to manage costs any more effectively than the HMOs of the early 90's. These two concepts could not be more different. The future of HRAs bank on consumer responsibility, while HMOs controlled costs for a short time by driving down physician and facility fees. One can rest assured that HRAs will not slow down medical inflation, as technology advances and drug development will continue to increase costs. However, a nation full of fiscally smart consumers should allow employers to continue subsidizing the cost of healthcare for employees for many years to come.

Here are a few items to note:

1. HRAs are available for all sizes of companies and concerns.
2. HRAs can reimburse only substantiated medical expenses.
3. Only employer dollars can be used to fund the HRA; however, Flexible Spending Accounts can still be used for employee savings.
4. Employers can require FSAs to be exhausted before HRA funds are accessible.
5. No cash outs or similar arrangements are permitted for terminated or retired employees.
6. HRAs are group plans subject to COBRA continuation laws.

While consumer driven medical plans have been attracting quite a bit of attention, their use has been fairly limited, due at least in part to tax uncertainties. With these worries now for the most part diminished, employers should begin examining these plans a little closer in coming years. The timing is certainly right for a shift to a consumer driven healthcare system.

Benefit Strategies, Inc. is pleased to present our quarterly newsletter which contains important information on current and/or emerging employee benefit topics.

Ultimately, our goal is to provide you relevant benefit information that will enable your organization to fulfill both its financial and benefit objectives now and into the future. As always, we welcome your thoughts and suggestions.

We appreciate your confidence in us and thank you for allowing us to serve your organization.

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Prescription Drug Plans Struggle to Combat Skyrocketing Costs

Drug spending has grown more quickly than other health spending. Price increases, higher utilization, and the use of newer, more expensive drugs all play a part in increasing drug spending.

In fact, a recent employer survey reported that health insurance premiums increased 12.7% from 2001 to 2002, the largest increase since 1990. Among the main culprits are pharmaceuticals, which have increased in cost more than 17% overall, and nearly 20% for private insurance, in the last year alone.

By offering health insurance that includes prescription drug coverage, group health insurance plans play a critical role in assuring access to needed medications. Not surprisingly, studies show that people with prescription coverage fill more prescriptions than people without coverage, and are also likely to have access to a broader array of medical treatments and therapies.

Although drug spending for beneficiaries with coverage is nearly two-thirds higher, those without coverage pay nearly twice as much out of pocket ($463 versus $253). On average, beneficiaries with coverage pay out-of-pocket for about one-third of their total spending on drugs.

Obviously, prescription coverage makes a particularly large difference in dollar terms for those in the poorest health. Among beneficiaries with chronic conditions, those with coverage had much higher total spending ($1,402 versus $944) and much lower out-of-pocket spending ($412 versus $944) than beneficiaries without coverage.

Most people who have medical insurance obtain drug coverage through the same source that provides their overall health insurance: most commonly an employer or union plan, private non-group coverage, or Medicaid. Nearly all employee plans include drug benefits for workers (although not necessarily retirees).

Until the 1980s, prescription drug coverage was not a distinct benefit, but was included in most conventional major medical plans. Coverage was subject to the same overall deductible for all medical services and to the coinsurance amounts (typically 20 percent) that applied to covered expenses. Two developments have led to changes in drug benefits.

The first is the widespread use of managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations, and point of service plans, which now cover 89 percent of workers, although a smaller percentage of retirees. Managed care plans offer a distinct drug benefit: only about 10 percent impose a deductible, and a co-payment, for example, $5 for generic drugs and $10 for brand name drugs, is used in place of a coinsurance percentage.

The second is the growth of pharmacy benefits managers (PBMs). Most managed care plans now contract with PBMs to administer prescription benefits. In addition, many large employers have "carved out" prescription drug benefits from their general health plans and contract separately with a PBM. Unlike indemnity insurers, PBMs process and pay claims at the point of sale. They develop formularies (lists of preferred or approved drugs), negotiate discounts with manufacturers and retail pharmacies, encourage use of mail-order pharmacies, and take other steps to better control escalating drug costs. PBMs are not insurers and usually do not accept financial risk for the costs of services, although their contracts with managed care plans or employers may include some incentives for cost reduction.

For more than 10 years, and coinciding with the first time prescription costs began rising more rapidly than other health care costs (1990), employers have worked diligently with their insurers and pharmacy managers to develop prescription drug plans that could better control costs.

As a result, there has been a push toward multi-tiered pharmacy benefit plans, which are thought to better control escalating drug costs. Most employers now offer 2- or 3-tier prescription drug coverage plans, with the amount of out-of-pocket cost increasing from the bottom to top tiers. While these plans vary, in most the lowest tier includes low-cost generic drugs, the second tier including brand-name drugs for which no generic exists, and the third tier brand-name drugs for which generic substitutions do exist.

The rapidly escalating costs for drugs make ensuring adequate prescription drug coverage critical. The evidence in support of the need for drug coverage is compelling. Even if employers were to stop increasing out-of-pocket costs for drugs, costs for prescriptions would be high enough to force many patients to choose which prescriptions they can afford to have filled. Unfortunately, the current health care system provides little or no assistance for individuals facing such difficult decisions.

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Generic Drugs Gaining Market Share

Controlling pharmacy cost trends has been one of the managed care industry's biggest headaches over the past couple of years. Many pharmacy management strategies rely in some way on increasing the usage of generics at the expense of brand-name medications, because generics offer an equivalent to many brand names at one-quarter of the price.

Last year, for the first time ever, generic drugs were dispensed more often than their brand-name counterparts, even if by just by a small percentage. Lower cost generics made up 51 percent of all prescriptions dispensed nationally in 2002, according to IMS Health, a Massachusetts-based research group that tracks the pharmaceutical industry.

With patents on 42 blockbuster brand-name drugs -- including anti-depressants such as Zoloft and Paxil and the antibiotic Cipro -- set to expire between now and 2007, health insurers are hoping to convert even more people to generics.

Their motivation is obvious. The average price of a generic prescription last year was about $23, according to IMS Health. The average brand-name drug cost about $76.

Insurers are sending out letters to members urging them to choose generics. They also are challenging pharmacies to increase the rate at which they substitute generics when patients bring in prescriptions for brand-name drugs. Physicians are getting bulletins from health plans when new generics become available.

Medco Health, one of the nation's largest pharmacy benefit administrators, is dispatching pharmacists to physician practices to keep doctors up to date on their generic prescribing options. Apparently their efforts are beginning to pay off. Medco says pharmacists are substituting generics more than 92 percent of the time for brand-name drugs that had lost patent protection.

Getting patients to switch to generic drugs -- or, even better, increasing the chances that patients get a generic as a first treatment -- can help insurers and employers trim health care costs. But consumers, who typically pay a much lower drug co-pay for a generic prescription than they would for a branded drug, also stand to save.

Health insurers are looking to persuade more members into taking their negotiating skills with them to the doctor's office. They want consumers prepared to seek out generic alternatives once they are available and ready to question their physician if handed a prescription for an expensive brand-name drug.

Some insurers are sending out personalized letters to members who take brand-name drugs that have generic alternatives, urging them to switch and save. Insurers point out the copay for the brand drug and the copay for a generic alternative, and let the member do the math. Of course, these companies leave it up to members and their doctors to decide whether switching makes sense.

Pharmaceutical companies, which rely on brand-name drug sales for the bulk of their profits, say their products are unfairly blamed for double-digit annual increases seen in prescription drug costs the past several years.

The Pharmaceutical Research and Manufacturers of America or PhRMA, which represents the industry's largest drug makers, points out that increased use of all prescription drugs accounts for well over half of the year-to-year increases in overall drug spending. It also notes that spending on prescription medicine accounts for only about 10 cents out of every dollar spent on health care.

Still, health plans say even small increases in generic drug use can deliver big savings for everyone involved.

Help Your Plan Members Communicate Better With Their Doctors

The Commonwealth Fund's 2002 International Health Policy Survey reported that:

- 33% of study participants left the doctor's office without getting important questions answered.
- 20% said their doctor never made clear the goals of their treatment.
- 21% said their doctor had not reviewed their list of medications in over two years.

Each if these problems can precipitate serious health consequences. How do your plan members fit into these statistics? Is there a potential drug interaction medical crisis waiting to create an outlier cost for your company to bear? Here are some pointers you can pass along to your plan members to keep the medical communication lines open and constructive.

1. Write down the names of all the medications you take, the dosage and schedule. Even if you feel that you have this information clearly organized in your mind, it's not unusual to confuse bits of data when you're trying to give information quickly or feel anxious during your doctor's visit. You can also hand the doctor your list and he can quickly extract the information he needs.
2. Think about topics that you and your doctor will discuss at this visit. For example, if you are diagnosed with high blood pressure, your doctor may have prescribed an anti-hypertensive medication, suggested restricting salt, getting more exercise and eliminating cigarettes. He will want to know what your progress has been. Write down what you plan to tell him.
3. Write down the questions you want answered as well. It's much easier to think in the comfort of your home than while you're sitting on crumply paper wearing a threadbare gown.
4. Be on time for your appointment. If you're flustered because you're late and the doctor is annoyed because his schedule has been delayed, no one is going to communicate well.
5. Remember that your doctor is neither a god whose opinion is always right, nor the enemy, deliberately ignoring your needs. He's a highly trained professional who is trying to maintain your health in partnership with you. You may feel that he sometimes forgets the point of his job; that's why you have to be prepared to help him stay on course.
6. At the start of your face-to-face time with the doctor, let him know that you have questions. In fact, it's useful to show him your list. He'll know that you are taking responsibility for your care and that will encourage him to pay attention to your issues.
7. Don't be offended if the doctor refers you to his nurse for information. Office nurses are also well-trained in the disorders the doctor treats and are very good at explaining medical information.
8. Write down the answers to your questions as well as any new instructions you receive. It's hard to remember everything that goes on during a medical visit, particularly if you are given new or surprising information.
9. Call the office if you later realize that you are confused about instructions or don't remember everything you are told. It is much better to get the information straight right away than to make mistakes in your care and medication routine.
10. Pay your bill. A doctor's office is a business. If you fail to keep up the business end of the relationship, your medical relationship can suffer. Most doctors work very hard to be sure that they are not thinking about money when dealing with their patients and are generally successful in separating business from medicine. But, doctors are only human and if your name keeps coming up on the delinquent pay list, it may have a negative effect.

Overall, encourage your members to be responsible partners in their medical care.

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