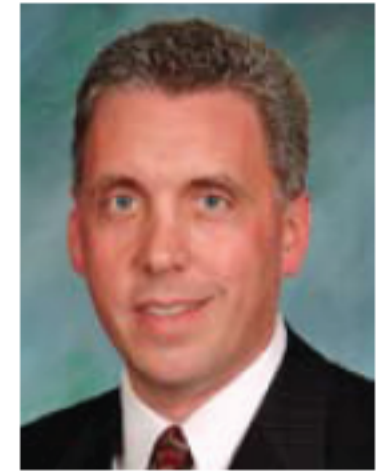


Shared Accountability for Reducing Claims

By Joe Torella



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For the year ahead, an overarching theme for these articles will be reducing claim costs; although, unlike the Government's approach, which assumes change comes quickly, true claim cost reduction will take several underwriting cycles with results lagging the initiating behavioral changes. Nevertheless, because 87% of healthcare expenditures are claims related, we have to do everything possible to mitigate behavior that is driving claims expense. We must initiate actions that bend the trend curve going forward.

Over my last three articles, I've addressed two major industry topics: a sensible approach to healthcare reform and the importance of not overfunding the deductible in a consumer-driven healthcare plan. Since both topics drew so much attention, for this first article of 2010, I'll bring them together to show how they converge; more over, how they might be inextricably linked in reducing a portion of our healthcare spending in the United States – certainly from the perspective of employer-sponsored plans. The key is consumer, employer and broker accountability.

Some criticisms I've heard of the forms for underlying plans is that the 50% target funding is arbitrary and that since small group pricing isn't impacted by it, why worry? And, some people have even commented that it's dangerous to have 'Big Brother' watching – through the use of a form – especially one that collects client information but has no direct impact on the cost of the plan or claims generated by its participants.

That this is not Big Brother in action, but an effort to better understand exactly how the funding of deductibles changes behavior. In responding to the other concerns, we must consider intent, not the policy itself. The goal quite simply is to control healthcare spending by having consumers put more skin in the game. Decisions based on quality and cost will increase when the consumer has a personal corridor of risk. The closer the consumer comes to a 100% plan, the less likely they will take an active interest in the cost of the services they receive. We've learned the same is true of plans with low co-pays.

The Obama healthcare program, portends to understand this (witness it's tax on higher end Cadillac plans) but still doesn't go far enough in its understanding of the importance of controlling claims. That's why it must remain a critical objective of the employer-based system, irrespective of the lack of immediacy in changes in premium.

One criticism has some merit: it's too strict a criteria around only a single dimension – that being a percentage (e.g. 50%) of funding. Obviously, 50% of \$5,000 is significantly different than 50% of \$2,000 and using percentages might dilute the impact of the actual dollars. However, given the widespread abuse of high deductible plans, establishing some type of guideline is reasonable and 50% is as good a starting point as any.

Another criticism is that certain coverage types, e.g. critical illness policies, cannot be counted toward the funding limit since it is unlikely that someone c/would game that type

of coverage or that it would drive behavior or impact claims.

Each of these observations suggest that program implementation must be well thought out upfront with a solid plan for engaging and educating the employer and employees in the process. Brokers will increasingly be expected to take on these responsibilities.

Under a Federal program, it's unlikely that recipients will fully appreciate the value of the benefits received or that they'll use them wisely. Medicare D participants for example only treat the 'donut hole' as something to be avoided through supplemental programs. This unfortunately means we can probably expect the US healthcare system to be over-burdened in the next 5 years. How likely?

The Senate has passed it's healthcare bill without having to fight Republican filibusters. With the final round of changes, including a compromise on the abortion issue and the removal of the 'Public Option', Obama will likely see the realization of his vision. Within the 2074 pages, there is a lot of spending (Medicare cuts to help fund the plan) but little verbiage mandating improved quality, the smarter purchase of services, a focus on staying healthy or the principle of individual accountability.

But that's what the employer-based system can, should and will continue to do.

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