Editorial:

What Have They Done to My HDHP?

Lawrence R. Huntoon, M.D., Ph.D.

Look what they done to my song, Ma
Look what they done to my song
Well it's the only thing
That I could do half right
And it's turning out all wrong, Ma
Look what they done to my song
Lyrics from "What Have They Done to My Song"
By Melanie Safka, better known as "Melanie"

The concept behind health savings accounts (HSAs) and high-deductible health plans (HDHPs) was simple and logical from its inception. The idea was that those who assumed more personal responsibility for their own medical care by opting for HSA/HDHPs would save money by paying lower health insurance premiums than for a traditional HMO plan with nearly first-dollar coverage. In fact, here is what the insurer's glossy advertising insert said when I signed up for the HDHP in 2006: "Consumer Directed plans allow you greater flexibility and control to work with your physicians to make smarter healthcare decisions, all while having a direct choice on how your dollars are being spent. With [Our Plan], you pay lower premiums while retaining comprehensive benefits."

Cost: HDHP vs. Traditional HMO Plan

In 2006, the monthly premium for a $2,500 deductible single HDHP was $147.32. The monthly premium for a single individual for a traditional HMO plan from the same insurance company was $352.19. Thus, the premium for the HDHP was less than half the premium for a traditional HMO plan in 2006.

In 2011, the monthly premium for the same $2,500 deductible single HDHP is $238.30, and the monthly premium for a single individual in a traditional HMO plan from the same insurance company is about $400. Thus, the cost of the premium for the HDHP increased by 62% and the cost of the premium for the traditional HMO plan increased by about 14% from 2006 to 2011. From 2010 to 2011 the cost of the HDHP increased by nearly 20%.

So, why would HDHP premiums, with presumably fewer claims filed, increase by 62% and traditional HMO plans, with presumably many more claims filed, increase by only 14%? I wondered whether the insurer was putting the HDHP plans in the same insurance pool as their traditional HMO products, in effect using the HDHP premiums to subsidize their HMO premiums, so as to limit premium increases in the latter.

Insurance Pools and Rate Setting

I contacted the representative from the insurance company that handles our policy and asked whether HDHPs were included in the same insurance pool for rate-setting purposes as their other traditional HMO products, and here is what she said:

"The small group market does include HMO style and HDHP products in the same 'pool' as you refer to it. Products are rated by size, 2-50 employees for small group, meaning that the same HDHP may have a different increase in small group vs. large group."

One hour and 25 minutes later, she sent another e-mail:

"Dr. Huntoon. I am sorry for the confusion in my explanation. Please let me clarify. Each product is rated based on the claims data from that particular product. So your HDHP premium is based solely on the utilization or claims experience of subscribers in the same HDHP."

So, based on premium increases of 62% for HDHPs and 14% for traditional HMO plans over a 5-year period, and based on the insurance representative's explanation of insurance pools/rate setting, we are led to believe that the reason HDHP premiums have increased so dramatically compared to traditional HMO premiums is because so many individuals who have HDHPs are filing an extraordinarily large number of claims. Intuitively, that made no sense at all.

So, I contacted the Public Affairs Office of the New York State Insurance Department to further investigate the nature of insurance pools and rate setting for health plans in New York State.

The insurance department told me that New York State does, indeed, allow insurers to include both HDHP products and non-HDHP products (e.g. traditional HMOs) in the same insurance pool for rate-setting purposes. He then wondered aloud why insurance companies would do that. So, I explained that the insurers are essentially charging those who have HDHPs a higher rate than is warranted based on claims experience for HDHPs, so as to effectively subsidize premiums for those who have a traditional HMO-type plan.

When HDHPs are put in the same insurance pool as HMO plans that have nearly first-dollar coverage, it greatly diminishes the cost-benefit of having an HDHP. I pointed out that those who have an HMO, with nearly first-dollar coverage, often do not care about overutilization or choosing more cost-effective services because they have coverage in place and view someone else as paying the bill. The person who has an HDHP plan, and is paying the first $2,500 out of pocket, is more cost conscious. When insurers put

their HDHP products together with their non-HDHP products in the same insurance pool, it is akin to running a collective bar tab at a restaurant whose patrons consist of drunken sailors and teetotalers. When the collective tab is split equally among the patrons at the end of the night, the teetotalers end up paying for the reckless spending and consumption of the drunken sailors.

Given the political environment in which we live, one also cannot exclude a proposed redistributive justification for having individuals with HDHPs, who may erroneously be viewed as a group consisting solely of wealthy individuals, subsidizing the captive masses who have HMO insurance provided by their employers. Much like drunken sailors would not object to the teetotalers picking up a portion of their tab, employers certainly wouldn't object to paying lower premiums based on the cost-shifted subsidy from those who have HDHPs.

Covered Benefits

Manufacturers of consumer products have learned how to conceal price increases. They know that consumers may balk at large price increases, so they produce slightly smaller packages, with the same labeling/product logo so that it looks like the same product. Manufacturers hope that consumers will not notice the actual increase in the price of the product as measured by price per unit.

Insurance companies have employed the same tactic with HDHPs. The current HDHP product has the same name and the same logo attached to bills and correspondence as it did in 2006, and the insurer hopes that the consumer will not notice that the covered benefits have substantially diminished over time. More liability has been transferred to the HDHP insured.

In 2006, for example, the annual out-of-pocket maximum for out-of-network services for a $2,500-deductible HDHP was $5,000. In 2010, the same annual out-of-pocket maximum increased to $10,000! And, of course, the insurance company charged a higher premium despite the fact that the liability transferred to the insured doubled. Other discounts that applied to services like vision care also decreased over the 5-year period from 2006 to 2011. In 2006, durable medical equipment had no annual limit under the HDHP. In 2011, durable medical equipment is subject to a $1,000 per contract year limit. Likewise, in 2006 the HDHP had no annual limit on home health care services. In 2011, HDHP home health care services are limited to 40 visits per contract year.

In the interest of full disclosure and transparency, perhaps what insurance consumers need is a per-unit liability cost, much like the per-unit price most grocers provide for their products.

In addition to shifting more liability from the insurer to HDHP insured, for a higher premium, we note that the changes in benefits were designed to give the insurance company more control by strongly de-incentivizing beneficiaries from seeking out-of-network services. This has been accomplished by managed-care-type in-network vs. out-of-network liability differentials. More control for the insurer, less flexibility and control for the insured.

Covered preventive services, with no member financial liability when the service is performed by participating providers, and a deductible plus 20% coinsurance when provided by out-of-network providers, has transformed what should be insurance into pre-paid medical care. Preventive services are not free. They are figured into the cost of the premium for the HDHP. The more "free" benefits, the higher the HDHP premium. The cost of the insurance company processing each "free" preventive care claim makes these so-called "free" services a very poor value for the consumer.

Impact of "ObamaCare"

Despite its name, Patient Protection and Affordable Care Act, ObamaCare has predictably made medical insurance less affordable. Although the President promised lower health insurance premiums, the effect has been entirely the opposite. Our insurance company representative admits that raising the age of dependents covered under the HDHP from 19 to 26, as mandated by ObamaCare, has substantially contributed to the increase in our HDHP premium. Under ObamaCare, some patients can also wait until they get sick before they obtain insurance coverage, a mandate that not only increases premiums, but will cause some insurers to stop writing certain policies. Insurance cannot work if people can buy coverage after they suffer a loss.

There is also concern that HDHPs may not be included in the developing insurance exchanges or may effectively be phased out over time, as freedom of choice and personal responsibility are elements not favored by those who support more government control of medicine.

Conclusion

So, what have they done to my HDHP? Well, as the song goes, it's the only thing that was done half right, and it's turning out all wrong.

Insurance companies, loath to give up any control or influence over the practice of medicine or the personal choices people make for their own medical care, have effectively corrupted the HSA/HDHP concept by incorporating elements of managed care, and have forced those seeking freedom by using HSA/HDHPs to cross-subsidize the very plans individuals sought to escape. They have also converted what should be true insurance (HDHP) into pre-paid medical care.

ObamaCare has worsened the outlook for HDHPs and prospects for freedom in medicine and freedom of choice for patients. Let us hope that the legal challenges to unconstitutional ObamaCare succeed so that the flame of freedom is not extinguished by the retardant of socialism.

Lawrence R. Huntoon, M.D., Ph.D., is a practicing neurologist and editor-in-chief of the *Journal of American Physicians and Surgeons*. Contact: editor@jpands.org.