REPORT OF THE
VIRGINIA ASSOCIATION OF HEALTH PLANS

Report on the High-Deductible Health Insurance Plans and Quality and Educational Initiatives

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 39

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

HOUSE JOINT RESOLUTION NO. 818

Requesting the Medical Society of Virginia, Virginia Association of Health Plans, Virginia Hospital and Healthcare Association, Board of Medicine, and State Department of Health to meet and report concerning high-deductible health insurance plans and quality initiatives. Report.

Agreed to by the House of Delegates, February 5, 2005
Agreed to by the Senate, February 24, 2005

WHEREAS, the health insurance market remains a dynamic and changing industry; and

WHEREAS, the increase in high-deductible health insurance plans has raised awareness of the need for patients to know estimates and charges for health care; and

WHEREAS, high-deductible health insurance plans present new challenges for patients, physicians, and the carriers that offer them; and

WHEREAS, physicians, hospitals, and health care providers of all types strive to improve the quality of health care in the Commonwealth of Virginia; and

WHEREAS, providing quality health care to the citizens of Virginia is a vital concern of all members of the General Assembly; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Medical Society of Virginia, Virginia Association of Health Plans, Virginia Hospital and Healthcare Association, Board of Medicine, and State Department of Health be requested to meet and report concerning high-deductible health insurance plans and quality initiatives. The named organizations are requested to meet to discuss quality and educational initiatives regarding high-deductible health insurance plans, during the summer and fall of 2005.

The Medical Society of Virginia, Virginia Association of Health Plans, Virginia Hospital and Healthcare Association, Board of Medicine, and State Department of Health shall report jointly their findings and recommendations to the Joint Commission on Health Care no later than October 31, 2005, and shall submit to the Division of Legislative Automated Systems an executive summary and report of their progress in meeting the request of this resolution no later than the first day of the 2006 Regular Session of the General Assembly. The executive summary and report shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Stakeholders and Meeting Dates

The stakeholders participating in the HJR 818 report include the following:

The Virginia Association of Health Plans
The Medical Society of Virginia
The Virginia Hospital and Healthcare Association
The Virginia Board of Medicine
The Virginia Department of Health
The Virginia Chamber of Commerce
The National Federation of Independent Business
The Virginia Pharmacy Association
The Virginia Medical Group Managers Association
The Virginia Organizing Project
UVA Health Service Foundation
UVA Health Evaluation Sciences
The Virginia Manufacturing Association
The Virginia Governmental Employees Association

The stakeholders meet on the following dates and the agendas for each meeting are contained in the Appendix:

June 21, 2005
July 26, 2005
August 11, 2005
September 25, 2005
October 24, 2005

Executive Summary

Health Savings Accounts (HSAs) were created by the federal government to address rising health care costs by encouraging consumers to be more financially responsible for their health care decisions.

Health Care Costs are Rising

Health care spending is rising at an alarming rate resulting in increasing health benefit costs for employers and employees and a precipitous decrease in the number of employers offering health care benefits. Health insurance premiums have grown 6% to 11% faster than inflation nationwide from 2001 through 2005. The percentage of employers offering health insurance benefits dropped from 69% to 60% from 2000 to 2005. (Mercer/Kaiser Family Foundation)

Health care cost increases are driven by a number of factors combined including a demographic shift of baby boomers seeking more care, increased use of pharmaceuticals, new medical procedures, improvements in medical technology, increased rates of chronic disease, defensive medicine and provider costs. Medicare and Medicaid have not been spared by growing costs. Medicare's Part B premiums rose 13.2% for 2006 and Medicaid costs in Virginia are projected to increase at an 8% rate through 2015. (American Health Line, Senate Finance Report on Medicaid)

Policymakers Want HSAs/HDHPs to Transform Consumers

Policymakers are hopeful that HSAs combined with high deductible health plans of typically $1,500 deductible (HDHPs) will transform the behavior of consumers with an incentive to use health care more efficiently. Desired outcomes include: encouraging employers to provide health insurance coverage, reducing health insurance premium costs, reducing the number of uninsured, a reduction in the use of unnecessary health care, as well as increased consumer interest in health care quality and cost information.

Study Focused on Likely Challenges of Increased Use of HSAs/HDHP

There is some early evidence from surveys that interest and enrollment in HSAs is growing in Virginia. (Health Affairs and ehealthinsurance.com) As the number of Virginians enrolled in HDHPs and HSAs grows there will be impacts on consumers and every part of the health care industry. The parties to HJ 818 met five times and focused on three key areas: provider payment, quality information and cost information.

Provider payment: It is clear that the growth of HSAs and HDHPs mean that consumers will be paying more out of pocket for health care services. This is a substantial change for insurers, hospitals and physicians that results in consumer needing more information. Consumers will be paying out of pocket for services up to their deductible and for co-insurance amounts after the deductible. Key findings include:

- Consumers will want to know that they are paying the appropriate amount for the services provided under their policy.

- Insurers will need to be able to provide consumers and providers information on the status of their deductible and the applicable co-insurance amounts for health care services.
- Health care providers will need to collect a "promise of payment" at the time of service to ensure the collection of payments from consumers for their HDHP deductible and co-insurance amounts.

Quality Information: HDHPs are designed to promote consumer-directed care by increasing the role of patients in taking more responsibility for their care. With this newfound responsibility comes exercising personal judgment in the decisions to: seek care, choose a provider and facility, pay in the manner deemed appropriate and choose how to address the cost decisions. Key findings include:

- Basic information on the general certifications, credentialing and accreditations of hospitals, physicians and health plans are readily available on public websites from Virginia Health Information, Virginia Department of Health and the Virginia Board of Medicine and other sources.
- Basic quality information on general areas of measurement are available to the public in regard to hospitals and health plans on the Virginia Health Information website and on various national websites. VHI will soon have quality information available regarding physicians who have submitted data to the outpatient surgical database.
- Health care information is not consumer friendly in terms of assisting them in making specific decisions on the basis of a health care provider or institution's performance in addressing a particular disease or procedure.
- There is a lack of standardization of reporting criteria for physicians, hospitals and health plans. Currently, there are many national and statewide efforts to develop uniform standards for measuring health care quality. It is expected that eventually national measurement standards will yield to enhanced pay for performance programs.

Price Information: A Virginia consumer cannot simply go to a website and find out how much a procedure or visit to the doctor's office may cost. Key findings include:

- Health plans, hospitals and physicians conduct business on a competitive and contractual basis. All parties are protective of the negotiated discounts contained in their contracts. An inherent conflict exists between a consumer's interest in price information and health care competitors' business interests.
- A marketplace for providing price information is beginning to develop among health plans. Some examples in Virginia exist, but they are not accessible by the typical consumer. For example, health plans offered by Anthem, Lumenos, Definity, Aetna and Cigna all provide various levels of price information to their members on their website.
- There will be a continuing effort by health care competitors to determine what price information is desired by consumers and how to provide it.

Conclusion

The architects of health savings accounts are hopeful that consumer financial responsibility will create transformational change in the health care marketplace. While the jury will be out on the practical effect of HSAs/HDHPs in Virginia for some time, all parties to House Joint Resolution 818 are in agreement that a marketplace move towards HDHPs creates a wave of discomfort, concern and apprehension.

To fully understand the implications of these plans, the existing task force members should consider continuing to meet to discuss possible opportunities to address consumer concerns, improve data collection, cost information, and to alleviate provider concerns over payment. We are hopeful that continued collaborative efforts will assist in resolving issues stemming from an enrollment increase in HDHPs and HSAs.

General History and Information

According to the Kaiser Family Foundation, 60% of employers currently offer health benefits, compared to 69% in 2000, a 13% decrease. This decrease represents 266,000 employers who have dropped health coverage. A High Deductible Health Plan (HDHP) is essentially a health insurance policy that provides benefits after a member satisfies the deductible. HDHPs were developed as a cost effective solution to the business community but have only been popular for the past few years, despite existing for decades. HDHPs were also designed to make the consumer more involved in health care decisions, especially relating to cost and quality.

An HDHP can be coupled with a Health Savings Account (HSA), Flexible Spending Account (FSA), Health Reimbursement Account (HRA), or Medical Savings Account (MSA). HSAs, currently the most popular, are a savings account primarily intended for health expenses set up by the employer or individual alongside an HDHP. After the Medicare Prescription Drug Improvement and Modernization Act of 2003, as of March 2005, 2.4 million Americans now have an HSA, compared to 438,000 in September 2004. (Health Affairs). Virginia alone saw an 18-fold increase in the first 6 months of 2005 (Health Affairs). HSAs are not required to be used for health care expenses but are tax advantaged if used for that purpose. A penalty is applied if funds are not used for medical purposes. After the age of 65, the money can be used for any purpose, without penalty, but subject to taxation.

After the adoption of the aforementioned federal legislation, the Internal Revenue Service (IRS) implemented standards to obtain an HSA. An individual has to acquire an HDHP with a minimum deductible of $1,000 or $2,000 to cover a family. In addition, the annual out-of-pocket limit for an individual is $5,100 and $10,200 for a family. These limits are adjusted annually for inflation and percentage increase in health care costs.

The law explicitly puts the consumer in control of deciding what and when to use their HSA funds. This policy intentionally means the consumer will be increasingly responsible for their health care decisions in terms of deciding when to seek care, what care to seek, and how to choose to pay for it. If the consumer wanted to use all of their HSA funds on personal items, and not medical care, no one could legally stop them.

According to John Vellines, CEO of HSA Administrators, 86% of his customers did not use their account in the past year. He also stated the average balance of his customers was $4,300. While some think this is a solution to the uninsured, Vellines stated that the majority of his members were lawyers and doctors. HSA Administrators offers two ways for their plan members to manage their funds, through reimbursement or the use of a debit card.

As mentioned above, some individuals see HSAs as a way to decrease the number of uninsured. For example, some states, including Florida and South Carolina, have obtained a waiver from CMS to add HSAs to their Medicaid programs. However, some Virginia advocates do not believe that HSAs will help the uninsured. They see HSAs and HDHPs as significantly increasing the complexity for the consumer and proving particularly dysfunctional for low and moderate income folks. Lured by offers of "affordable" health insurance, these individuals might

find that they never have the resources to make the deductibles, making the policy nearly worthless to them, and attractive to abuse by opportunistic sellers.

Interest by the business community in HDHPs and HSAs has increased as businesses search for alternative means to provide cost effective health insurance to employees. As HDHP sales increased, a number of challenges or concerns arose prompting the introduction of HJR 818. While it is impossible to capture all of the issues surrounding HDHPs in this document, those working on evaluating the merits of HJR 818 quantified the issues into three major categories: provider payment, quality information, and cost information.

Provider Payment

As HDHPs and HSAs become more popular, the growth in enrollment will lead to more financial responsibility for health plan members out of their own pocket. Providers expect this explosion of HDHPs will lead to more collections issues related to deductible and co-insurance payments. Easing this collection of payment or promise of payment from the patients is an important tool to address provider concerns.

Challenges for Providers

The stakeholders invested significant time discussing the provider payment challenges that are presented by HDHPs and how these challenges differ from challenges arising with indemnity or HMO insurance products. Specifically, if a patient presents with an HMO product or an indemnity health plan, the healthcare provider rendering the service collects, at the time that the services are rendered, a co-pay or a deductible as is often pre-established on the member's health insurance card. With an HDHP, there are no co-pays and the determination of insurance coverage centers primarily on whether the employee has met their deductible. Currently, there is no means readily available to health care providers to make this definitive determination at the time services are rendered.

Certain deductibles are calculated on a calendar basis and other health plans calculate the deductibles for HDHPs on a policy year basis. Healthcare providers are placed in a quandary from a cash flow perspective having no means to determine whether the member has satisfied their deductible at the time services are rendered. The inability to determine this can result in the healthcare provider providing the health care service, submitting the claim to the carrier issuing the HDHP, receiving payment of the claim from the HDHP or learning that the member has not satisfied their deductible and then turning to the member to collect payment. This will result in an increase in administrative costs for the provider.

Furthermore, when an HDHP is purchased, there is no requirement that the purchaser (employer) establishes or creates a mechanism to fund the deductible under the HDHP. For example a carrier can sell an HDHP to a small business owner and there is no requirement that the small business owner set up any type of account to address the deductible for the member (employee). In addition, if the member does have an account such as an HSA, the patient can choose not to use the account for medical expenses. The funds in the account are not restricted and may be used for purposes other than healthcare. Healthcare providers do not relish the

alternative of having to proceed with collection actions against the employees in order to receive payment.

Challenges for Health Plans

Providers are not the only ones who have voiced concerns over HDHPs. As HDHPs and HSAs evolve, the health plans will need to make some changes. For example, health plans issuing HDHPs are required to track the members' deductible in order to determine if the deductible has been satisfied in analyzing who is responsible for payment of a claim. Health plans face challenges with HDHPs as a member may elect to pay out of pocket for certain healthcare services. When a member does this, a record of this payment may not be forwarded to the insurance company because the healthcare provider may not submit a claim. Accordingly, should the member receive service from a second healthcare provider, the health plan may be unaware that the member paid out of pocket for the initial services and therefore, be under the impression that the member's deductible has not been satisfied.

The challenge presented is that the member bares a responsibility for conveying to the health plan proof of what services have been paid out of pocket and are therefore accounted towards the deductible. In addition, without a claim the member could pay charges and not the negotiated rate that the health plan and provider have agreed on. If this happens, the member could be paying a lot more than needed, and thus reaching that deductible level earlier. While some HDHPs do not have discounted rates, a majority of them do.

Challenges for Members

A reason HDHPs have become so popular is that they put more control back in to the members' hands. With this increase in control comes an increase in dilemmas facing the consumer. First, members may not know the price of services offered by a particular provider. This is a frequent occurrence and generates confusion. Rates are different by both provider of the services, and what health plan the member has. Also, as mentioned above, members might be left to paying charges instead of the negotiated, cheaper rate if asked to pay up front. We have also found that it is hard for a member to obtain information on the balance of their deductible. Many health plans can calculate this information when asked, but don't readily have it on hand. Lastly, and likely most problematic, a member might not be financially prepared to cover the costs.

Recommendations

The stakeholders agreed on several recommendations to allay the health care communities concerns on provider payment.

Stakeholders agree:

- Providers should collect a promise of payment by asking for a deposit or debit/credit card account number at the time of service as a regular business practice. This would be useful in speeding payment upon receipt of an adjudicated claim.

- Insurance carriers should identify on the member insurance card if the coverage afforded was an HDHP. This would enable health care providers to make informed decisions about collecting monies upfront versus waiting until an explanation of benefits is issued and then pursuing payment. Such designation may be by numerical reference or a code provided the insurance carriers or health plans inform the health care provider community of the reference or code used.
- Health plans should have a system in place for providers and members to check what is left of the deductible.

In conclusion, the provider payment issue surrounding the increased use of HDHPs and the various means to address the payment of deductibles will continue to evolve. Stakeholders believe that education of healthcare providers' members and purchases of HDHPs is a key necessity that must continue.

Quality Information

According to a recent RAND survey, 60% of those individuals have searched for information to help make treatment decisions in the last year. 70% of those individuals chose the internet to help them make health decisions. HDHPs are designed to promote consumer-directed care by increasing the role of patients in taking more responsibility for their care. With this newfound responsibility comes the need to exercise personal judgment in the decisions to:

- Seek care
- Choose a provider and facility
- Pay in the manner deemed appropriate
- Choose how to address these cost decisions

Throughout the process of studying HDHPs, the stakeholders found many examples of existing national or statewide quality assurance or improvement programs in Virginia including: Virginia Health Information, National Committee for Quality Assurance (NCQA), and Anthem's Quality-In-Sights Hospital Incentive Program (Q-HIP).

Virginia Health Information (VHI)

VHI's mission is to create and disseminate health care information, to promote informed decision making by Virginia consumers and purchasers and to enhance the quality of health care delivery. VHI began its efforts in 1993 with passage of the Patient Level Database System Act and is the organization recognized as the source for health data reporting in Virginia. VHI is a one-stop shop for information on:

- Assisted Living Facilities
- Continuing Care Retirement Communities
- HMOs
- Home Care Providers
- Hospitals
- Nursing Facilities

- Physicians
- And other providers

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance is a not-for-profit organization dedicated to improving health care quality. NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year.

The Leapfrog Group

The Leapfrog Group's mission is to "trigger giant leaps forward in the safety, quality and affordability of health care by supporting informed healthcare decisions by those who use and pay for health care and promoting high-value health care through incentives and rewards." (www.leapfroggroup.org). Started in 2000, Leapfrog is known for reporting health care quality and outcomes data from hospitals to the consumers.

Anthem's QHIP

Anthem's Quality –In-Sights Hospital Program is a pay for performance system that judges hospitals on how well they are doing on select goals and objectives set out by Anthem. Recently, Anthem has awarded a total of $6 million to 16 hospitals for actively working to implement nationally recognized care and safety practices that can save lives.

Challenges of Quality Information

Virginia has come a long way with quality information, especially with Virginia Health Information, and other statewide programs, but these challenges still exist:

- The definition of quality is not consistent with all entities. Some will agree it can be determined with HEDIS measures, while others look at patient satisfactory as a means of quality.
- The various sources of the information and the quantity of information available has not clearly been delineated or defined. It is unknown exactly what current information exists for the consumers.
- Quality information is hard to find for the consumer. In Virginia, the only information required to be reported concerning a physician is where he/she practices, what medical school he/she attended, and if he/she has lost, not settled, a medical mal-practice suit.

- Not all organizations measure quality on the same level or with the same criteria. On many occasions it is comparing apples to oranges. Last, and most important, there is no patient satisfaction data. When a purpose of an HDHP is to give the consumer more of a choice, this last point causes much frustration for the one making that decision.

Recommendations

So where do we go from here? Stakeholders agree:

- An analysis needs to be conducted by individual entities on what quality information is available and what quality information is needed and usable for their purposes.
- Standard reporting criteria for physicians, hospitals and health plans is needed.
- With more uniform quality information, pay for performance models will be come more effective and consistent.

Price Information and Employer Tools

HDHPs re designed to promote consumer-directed care by increasing the role of patients in taking more responsibility for their care. More consumers are paying out-of-pocket and are taking more interest in how much it may cost, yet there is a discrepancy in what price information is reported by physicians, hospitals and health plans.

As of now, a Virginia consumer cannot simply go to a website and find out how much a procedure or visit to the doctor's office may cost. Some examples in Virginia do exist, but they are not thorough are easily accessible by the common consumer. Charge data is available through VHI and sometimes from hospital or physician, but don't include the possible agreed upon discount from a health plan. A couple of health plans and consumer-directed plans offer cost information.

Lumenos

A consumer-directed health plan, recently acquired by WellPoint, Lumenos uses the internet to direct its members to cost information. After signing in, members can find a doctor and check out average rates for procedures or office visits. The members can also check on their deductible and budget annual health costs. To differentiate itself from other like plans, Lumenos has a section where other consumers can rate the physician and post comments on customer satisfaction.

Definity

Like Lumenos, Definity is a consumer-directed health plan recently purchased by UnitedHealthcare. Definity posts price information for its members, as well as a 24-nurse hotline. The website can also show exactly what is left of the consumer's HSA or deductible.

Aetna

In certain areas, Aetna is providing cost information for all physicians in their network. Members will be able to access a website with this information to help them make their healthcare decisions.

CIGNA

Currently, CIGNA is using quality information to direct its members to certain providers. Started in August, if a member visits specific physicians who have a proven track record of care, the members will have decreased or zero co-pay. This pilot program will start in Richmond in January 2006.

Challenges

The primary challenge is that different entities report different price information. Hospitals and physicians usually present charge information with health plans present discount rates or what is actually paid after an adjudicated claim. Even though health plans have this information, they rarely give it do to the competitive nature of the business. Health plans, hospitals and physicians conduct business on a competitive and contractual basis. All parties are protective of the negotiated discounts contained in their contracts. Second, information is hard to find for the consumers. Only websites in which the consumer is a member, can they access cost information.

Recommendations

Stakeholders agree:

- An analysis needs to be conducted between what price information is available and what price information is usable.
- All entities need to agree on reporting the same rates.

Conclusion

HDHPs and HSAs have evolved and will continue to evolve over the next couple of years. To fully understand the implications of these plans, the existing task force should continue to meet to discuss possible opportunities to improve data collection, cost information, and to alleviate provider concerns over payment, such as allow for a promise of payment up front before services. Without this, we may see a piecemeal approach and not a collaborative effort.

Appendix

Agendas

Agenda from June 21, 2005 Meeting

Agenda from July 26, 2005 Meeting

Agenda from August 11, 2005 Meeting

Agenda from September 15, 2005 Meeting

General Background

Health Care Spending Accounts: What You Need to Know About HSAs, HRAs, FSAs, and MSAs, July 2005, AHIP

Health Savings Accounts: The First Six Months of 2005, July 27, 2005, eHealthInsurance

Study Finds HSAs Hit 1 Million Enrollments, May 9, 2005, R.J. Lehmen, *Best Week*

Catastrophic Coverage First, May 2005, Jerry L. Ripperger, *Best Review*

Patients Give New Insurance Mixed Reviews, June 14, 2005, Vanessa Fuhrmans, *Wall Street Journal*

What High-Deductible Plans Look Like: Findings From a National Survey of Employers, 2005, September 14, 2005, Gary Claxton, et al, *Health Affairs*

Provider Payment

What Do You Owe the Doctor? Swipe a Card to Find Out, July 26, 2005, *Wall Street Journal*

New Patient First Payment Policy (Patient First)

Quality Information

Blue Cross and Blue Shield Association Study Shows Consumers Want Information to Help Them Make Healthcare Treatment Decisions, September 17, 2005, Blue Cross and Blue Shield Association

Do High-Deductible Health Plans Threaten Quality of Care? , September 22, 2005, New *England Journal of Medicine*

Price Information

Insurer Reveals What Doctors Really Charge to Help People Compare Fees, Aetna Posts Some Online; A Potential Bargaining Tool, August 18, 2005, *Wall Street Journal*

Meeting of House Joint Resolution 818
Study on High Deductible Plans and Quality Issues
Medical Society of Virginia
Richmond, Virginia
June 21, 2005 – 9:30 AM

AGENDA

A. Welcome – Doug Gray, Executive Director,
Virginia Association of Health Plans

B. Introduction of Participants

C. Review of Study Resolution & Handout Materials

D. Overview of Health Savings Accounts --
(Participant Questions Welcome)

Toni Allen, Product Management Director
Anthem Blue Cross/Blue Shield

Scot Chancy, Director of Product Development
Southern Health

E. Identification & Discussion of Issues Needing More Study
To Implement High Deductible Health Plans/HSAs in Virginia
(All Participants)

F. Discuss Work Plan: Where Do We Go From Here?

G. Schedule Next Meeting

H. Adjourn

Meeting of House Joint Resolution 818
Study on High Deductible Plans and Quality Issues
Virginia Hospital and Healthcare Association
Richmond, Virginia
July 26, 2005 10:00 AM

AGENDA

A. Welcome – Doug Gray, Executive Director,
Virginia Association of Health Plans

B. Quick Reminder of Who is Participating and the Charge of HJ818

C. Review of Feedback on Issues Identified for Further Study

a. Virginia Department of Health – Greg Stolcis/Rene Cabral-Daniels
b. UVA Health Services Foundation – Marc Dettman/Chris Rudge
c. Virginia Manufacturers Association – Brett Vassey
d. Medical Society of Virginia – Scott Johnson/Mike Jurgensen
e. Virginia Hospital and Healthcare Association – Barbara Brown

D. Applying the Feedback to the Five Identified Issue Areas –

a. Provider Payment
b. Quality Information
c. Price Information
d. Employer Tools
e. HSA Plan Member Tools

E. Schedule Next Meeting

F. Adjourn

Meeting of House Joint Resolution 818
Study on High Deductible Plans and Quality Issues
Old Dominion Electric Cooperative
Glen Allen, Virginia
August 11, 2005 – 9:00 to 11:00 AM

AGENDA

A. Welcome – Doug Gray, Executive Director,
Virginia Association of Health Plans

B. Quick Reminder of Who is Participating, the Charge of HJ818 and the Process Going Forward (Describe current environment, identify potential issues and possibly make recommendations)

C. General Observations

i. HDHPs are designed to promote consumer-directed care by increasing the role of patients in taking responsibility for their care and are subsidized by multiple tax arrangements.
ii. Enrollment in HDHPs is growing
iii. The growth in enrollment will lead to more financial responsibility for employees out of their own pocket
iv. Providers expect this growth of HDHPs will lead to more collections issues related to deductible payments
v. Easing the collection of payment or the promise of payment from patients is an important tool to address provider concerns
vi. HDHPs are not a new innovation. They have existed for decades.

D. Provider Payment Issues

vii. Services Offered to HSA Account Holders and the Role of HSA Administrators
Guest: John Vellines, HSA Administrators
a. How do administrators pay providers and patients?
b. Can administrators pay providers directly?

viii. Legal Framework of HSA as an Account Holders' Investment Tool:
a. HSAs are available to be offered by a group or set up by an individual who is not covered by a group.
b. HSAs are not required to be used for health care but are tax advantaged if used for that purpose.

ix. Are there contractual, legal or regulatory issues that inhibit hospitals and providers collection of deductibles or the promise of payment from members of a HDHP?

a. Collection of Financial Information (Credit Cards, Checks, Debit Cards)
b. Collection of Partial Payment at Time of Service is Rendered (An estimated amount based upon the deductible amount and other information)
c. Collection of Full Payment at the Time of Service
d. Is there a regulatory issue regarding HMOs?

x. General deductible questions:

a. Do health plans show the amount of the deductible on the patient's member card? Can they inform the provider through their member verification system of the amount?
b. How can a patient/provider find out the status of the patient's deductible?
c. Do patient payments to out of network providers apply to HDHP deductibles?

E. Schedule Next Meeting

F. Adjourn

Meeting of House Joint Resolution 818
Study on High Deductible Plans and Quality Issues
Virginia Hospital and Healthcare Association
Glen Allen, Virginia
September 15, 2005 – 10:00 to 12:00 PM

AGENDA

A. Welcome – Doug Gray, Executive Director,
Virginia Association of Health Plans

B. Quick Reminder of Who is Participating, the Charge of HJ818 and the Process Going Forward (Describe current environment, identify potential issues and possibly make recommendations)

C. General Observations on Quality

xi. HDHPs are designed to promote consumer-directed care by increasing the role of patients in taking more responsibility for their care.
xii. More responsibility appears to mean exercising personal judgment in the decisions to: a) seek care, and b) choose a provider and facility for health care services
xiii. Many believe this responsibility includes a) making a judgment about the quality of services available from a physician and hospital and b) in some cases a decision about the price of those services.
xiv. Academic studies of healthcare quality report poor performance in meeting generally accepted standards.
xv. A consensus is forming in the payor community around the design and implementation of pay for performance programs based upon quality.

D. The Current Quality Measurement Environment in Virginia – Michael Lundberg, Virginia Health Information

xvi. What quality and price information is made available to high deductible health plan members (the public) regarding hospitals, health plans and physicians?
xvii. What do the different parts of the health care system use the information for?
xviii. How could this benefit members of HDHP?
xix. What information is not available but might be needed?

E. What Can and Will Quality Information be Used for in the Near Future? – Dr. Karen Remley, Anthem

xx. What is the status of academic medicine's reviews of health care quality outcomes in Virginia and the Nation?

xxi. Pay for Performance/Consumer Health Information
    a. QHIP Hospital Initiative/Lumenos Data
    b. CMS Program

xxii. How will this benefit patients?

F. What Quality and Price Information is Being Made Available for Members of HDHPs in the marketplace?

xxiii. By Marketers of HDHPs and HSAs?

xxiv. By Hospitals?

xxv. By Physicians?

xxvi. By Non-profit and Government Entities?

G. Schedule Next Meeting

H. Adjourn

AHIP
America's Health Insurance Plans

Health Care Spending Accounts:

What You Need to Know About HSAs, HRAs, FSAs, and MSAs

- Health savings accounts (HSAs) with high-deductible health plans (HDHPs)
- Health reimbursement arrangements (HRAs)
- Health flexible spending arrangements (FSAs)
- Archer medical savings accounts (MSAs)

July 2005

Introduction

In today's health care market, employers and consumers are looking for lower-cost health coverage, more control over their health care dollars, and broad choice among doctors and hospitals. Consumer health spending accounts are one of many product options that respond to these needs.

The major types of health care spending accounts are:

All of these products have federal tax advantages, and they allow consumers to save money for health care. Each has a different design and is subject to a unique set of federal rules. This guide answers frequently asked questions about account-based health care products.

Frequently Asked Questions

HSAs

What is an HSA?

A health savings account is a new way of saving money to pay for current and future medical expenses on a tax-free basis. HSAs were created by the Medicare Modernization Act signed in December 2003.

Who is eligible to set up an HSA?

To set up and contribute to an HSA, an individual must:

- Be covered by a high-deductible health plan that meets federal requirements.
- Not have other health insurance. (Individuals with certain limited benefit policies such as accident-only, dental, vision, workers' compensation, disability, or long-term care coverage may still be eligible for an HSA.)
- Not be enrolled in Medicare. Medicare beneficiaries cannot contribute to an HSA. They may, however, spend money contributed to an HSA prior to their enrollment in Medicare.
- Not be claimed as a dependent on someone else's tax return.

Where can individuals open HSAs?

If an individual's employer does not offer an HSA, the individual can set up an HSA with:

- A health insurance plan. A growing number of health insurance plans offer high-deductible health plans and administer HSAs.
- A bank or credit union or another organization that has been approved by the IRS to serve as an HSA trustee. *(These entities can only open up the health savings account. They do not provide high-deductible health plan coverage.)*

What is a high-deductible health plan, according to the rules governing HSAs?

A health plan with:

- An annual deductible of at least:
  - $1,000 for self-only coverage.
  - $2,000 for family coverage.
- Limits on annual out-of-pocket expenses (deductibles, co-insurance, and copayments), which may not exceed:
  - $5,100 for self-only coverage.
  - $10,200 for family coverage.

These are the requirements for 2005; the dollar amounts are indexed annually for inflation.

What are the federal tax benefits of HSAs?

- Individuals can deduct from their federal income taxes the amount of their HSA contributions, whether or not they itemize.
- Employer contributions to an HSA on an individual's behalf are not counted as taxable income.
- If someone else makes an HSA contribution on an individual's behalf, only the individual can deduct the contribution.
- Individuals can withdraw funds from an HSA tax-free to pay qualified medical expenses.
- All earnings on HSAs are tax-free.
- Employer contributions are not subject to withholding for purposes of the Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act.

Does preventive care count toward the deductible of the high-deductible health plan associated with an HSA?

The IRS has ruled that a high-deductible health plan may cover certain types of preventive care without a deductible or with a lower deductible than the annual deductible applicable to all other services. According to IRS guidance, the types of services that may be considered preventive care include:

- Routine prenatal and well-child care.
- Immunizations for children and adults.
- Periodic health evaluations, including tests and diagnostic procedures ordered with routine examinations such as annual physicals.
- Smoking cessation programs.
- Obesity weight-loss programs.
- Screening services (e.g., mammography, Pap testing, screening for glaucoma, tuberculosis).
- Limited categories of medications, including:
  (1) Medications used as part of procedures to provide any of the preventive services listed above;
  (2) Medications to prevent a disease or condition when a

person has risk factors but no symptoms of the disease or condition (e.g., cholesterol-lowering medication to help prevent heart disease for people with high cholesterol); and

(3) Medication to prevent recurrence of a disease from which a person has recovered (e.g., ACE inhibitors by individuals who previously had a heart attack or stroke);

(4) Treatment that is incidental or ancillary to a preventive care service or screening, where it would be unreasonable or impractical to perform another procedure to treat the condition (e.g., removal of polyps during a diagnostic colonoscopy).

The exceptions for preventive care do not include any service, benefit, or medication to treat an existing illness, injury, or condition.

Who can contribute to HSA?

- An employee.
- An employer on behalf of an employee.
- A self-employed individual.
- Individuals without job-based health insurance.
- Any person, such as a family member, on behalf of an eligible individual.

How much can be contributed to an HSA?

Each year, total contributions to an HSA cannot exceed the deductible of the high-deductible health plan, but in any event not more than $2,650 annually for individuals and $5,250 annually for families (adjusted annually for inflation). Individuals between the ages of 55 and 65 can make additional "catch-up" annual contributions of $600 (adjusted annually for inflation). Individuals are responsible for ensuring that their annual HSA contributions do not exceed the maximum allowed by law.

Employers can arrange for employees to contribute to HSAs through salary reduction. Employers contributing to HSAs are not required to make their entire contribution available at the beginning of the year. Once an employer contributes to an HSA, the funds become the employee's property. Employers are not allowed to take back unused HSA contributions.

Who controls the use of funds in HSAs?

The individual controls use of funds in HSAs and can decide when and how much to contribute (up to the allowable maximums). Individuals also can decide which custodian or trustee will hold the account, whether to invest any of the money in the account, and which investments to make.

What kinds of expenses can be paid with HSAs?

Individuals can withdraw HSA funds tax-free to pay qualified medical expenses, as defined by the IRS. These include, but are not limited to:

- Doctors' office visits.
- Hospital care.
- Dental care.
- Vision care.
- Prescription drugs.
- Over-the-counter medications.
- Copayments.
- Deductibles.
- Coinsurance.

Visit the link below for a list of qualified medical expenses as defined by the IRS:
http://www.irs.gov/publications/p502/ar02.html#d0e201.

Can HSA funds be used to pay health insurance premiums?

Individuals can use HSAs to pay for the following types of health coverage:

- COBRA continuation coverage.
- Health coverage purchased while an individual is receiving unemployment compensation.
- Qualified long-term care insurance.
- When age 65 or older, premiums for any health insurance except Medicare supplemental policies (also known as Medigap).

What happens if HSA funds are used for items other than qualified medical expenses or premiums?

Any amounts from an HSA that are used for items other than qualified medical expenses or premiums are subject to federal income tax plus a 10% excise tax. The 10% tax is not

paid if the individual is age 65 or older or if the distribution from the account is made after the death or disability of the individual. However, the amount still is considered income.

Can HSA funds be used to pay health expenses incurred by a spouse or a dependent?

Yes, HSA funds can be withdrawn tax-free for the qualified medical expenses for a spouse or dependent, even if they are not covered by the high-deductible health plan.

What happens if there is money left in the HSA at the end of the year?

- Individuals can keep unused funds in their HSA accounts from one year to the next.
- Individuals can use HSA funds to pay qualified expenses from a previous year, as long as they were incurred after the HSA was established.

Can employees take HSAs with them when they retire or change jobs?

Yes. Individuals can take HSA funds with them when they retire or change jobs and can designate a beneficiary to receive the funds upon their death.

Can HSAs be used in conjunction with FSAs or HRAs?

In general, no. During any time that an employer or employee is contributing to an HSA, the individual cannot have any health coverage other than a high-deductible health plan.

Limited exceptions are allowed:

- Because individuals with HSAs can have limited health benefits such as dental and vision care, an employee with a limited FSA or HRA that covers only those expenses would still be eligible for an HSA.
- Individuals with HSAs can have FSAs or HRAs that pay for medical expenses only after the HDHP deductible has been met.
- Active employees can contribute to HSAs while covered by an HRA that pays only post-retirement medical expenses.
- An employee with HRA coverage can make HSA contributions if he or she suspends the HRA coverage.

When did HSAs first become available?

HSAs entered the market in January 2004.

How many people have HSAs?

AHIP's member survey found that as of March 2005, 1,031,000 people were covered by HSA/HDHP products. This is more than double the number reported in AHIP's September 2004 survey.

Are HSAs appealing mainly to young people?

HSA/HDHP products seem to appeal equally to all ages. AHIP's March 2005 member survey found that in the individual insurance market,

- 27% of people choosing HSAs were age 50-64;
- 24% were age 40-49;
- 26% were age 20-39;
- and 22% were under age 20.

In the small-group insurance market (firms with 2-50 employees), the age distribution was similar, and 43% of people covered by HSAs/HDHPs were age 40 or older.

Are HSAs covering individuals who previously were uninsured?

AHIP's March 2005 member survey found that 37% of people who bought HSA/HDHPs in the individual market were previously uninsured. In addition, 27% of small companies offering HSAs to employees previously had offered no coverage.

HRAs

What is an HRA?

HRAs are individual health reimbursement arrangements that employers can establish to pay employees' medical expenses.

Who is eligible to set up and contribute to an HRA?

HRAs must be set up by an employer on behalf of its employees (self-employed individuals are not eligible for an HRA), and only the employer can contribute to an HRA.

Who controls the use of funds in HRAs?

Employers decide how much money to put in HRAs, and employees can withdraw HRA funds for expenses allowed under the employer's HRA plan documents. The IRS allows employers to establish HRAs with unfunded "credits" rather than with hard-dollar amounts. This arrangement is similar to a line of credit, against which employee expenses are paid with employer funds when and if they occur. Employers can determine whether employees have access to the entire annual HRA contribution at any time during the year, or whether they can access only a portion of the funds at any given time.

How much can be contributed to an HRA?

There is no limit on the amount of money an employer may contribute to an HRA.

What are the federal tax benefits of HRAs?

Employer contributions to an HRA are not treated as taxable income to the employee, and employees can spend the funds tax-free.

In addition, employers are entitled to deduct the amount of their contribution. If they fund the account with hard dollars, they can take an immediate deduction. However, if the account is funded on a "notional" basis like a line of credit, the employer can take the deduction only when the amounts are actually paid out.

Can HRAs be offered in conjunction with a health insurance plan?

HRAs often are established with a high-deductible health plan for employees. However, they can be paired with any type of health plan or used as a stand-alone account. In addition, HRAs can be offered in conjunction with a health flexible spending arrangement. Employers decide what other types of products to offer with the HRA.

What kinds of expenses can be paid with HRAs?

The IRS allows HRA funds to be used for any item that qualifies as a medical expense under the Internal Revenue Code (except long-term care services). However, it is up to employers to determine whether employees can use HRAs for any of these items or only for medical expenses covered under the employer's health benefit plan. If the employer offers an HRA in conjunction with an HDHP, the employer can decide whether to cover preventive care without requiring employees to meet the HDHP deductible.

Can HRA funds be used to pay health insurance premiums?

IRS rules allow use of HRA funds for health insurance premiums, long-term care coverage, and qualified medical expenses not covered under another health plan, but it is up to individual employers to decide whether their employees can use the funds for these purposes.

Can HRA funds be used to pay health expenses incurred by a spouse or dependent?

Under IRS rules, employers have the option of allowing employees to use HRAs for expenses of spouses and dependents of current and former employees.

What happens if there is money left in an HRA at the end of a year?

IRS rules allow employers to determine whether employees can carry over all or a portion of unused HRA funds from year to year. Employers are not allowed to "refund" any part of an HRA balance to employees.

Can employees take HRAs with them when they retire or change jobs?

IRS rules allow employers to specify in their HRA plan terms whether HRA balances will be forfeited if an employee leaves the job or changes health plans. However, former employees who buy COBRA continuation coverage can retain access to the HRA and any health plan offered with it. As long as former employees pay COBRA premiums during the COBRA coverage period, they are entitled not only to unused balances from the HRA but also to the same annual employer contribution to the HRA as that provided to current active employees.

When did HRAs first become available?

In 2000, a small number of insurers began offering HRAs. Large employers began introducing HRAs in 2001, and they became more prevalent after June 2002, when the IRS issued a ruling to clarify their treatment in the tax code.

How many people have HRAs?

According to data gathered by Atlantic Information Services, as of January 2005, approximately 2.6 million people were covered by HRAs.

Are HRAs appealing mainly to young people?

Several recent studies found no significant age differences between individuals with HRAs and those with other types of health coverage (Christianson et al., 2004; Tollen et al., 2004).

Health Flexible Spending Arrangements

What is a health FSA?

Health flexible spending arrangements are benefit plans set up by employers that allow employees to set aside pre-tax money on an annual basis to pay for qualified medical expenses (as defined by the IRS) incurred during that year.

Who is eligible to set up and contribute to a health FSA?

Health flexible spending arrangements can be set up only by employers (self-employed individuals cannot establish FSAs). Employees contribute to health FSAs by having money withheld from their paychecks on a pre-tax basis, and employers have the option of contributing.

What are the federal tax benefits of health FSAs?

Employees do not pay federal income tax on the amount of salary contributed to an FSA or on the amount an employer may contribute. Pre-tax salary reduction for FSAs reduces the wages on which Social Security and Medicare taxes are paid. In addition, employees do not pay taxes on funds withdrawn from FSAs for qualified medical expenses.

How much money can be contributed to a health FSA?

There is no limit on the amount of funds that employers and employees can contribute to health FSAs. However, the employer's FSA plan documents must specify a maximum dollar amount or percent of salary that can be contributed to the FSA. Each year, employees designate the amount of money they will contribute to the account in the following year.

Who controls the use of funds in health FSAs?

Employees choosing health FSAs have a portion of their FSA contribution withheld from their paycheck each pay period. IRS rules specify that at any point during the year, regardless of how much has been withheld from their paychecks, employees can access the entire amount designated for the year.

Can employees change the amount of their health FSA contribution during the year?

In general, no. Employees can only contribute the amount they originally designated for the year. However, the amount of an annual health FSA contribution can be changed or revoked if there is a change in family status (e.g., birth or adoption of a child) or in employment status, as specified in the employer's FSA plan documents.

Can health FSAs be offered in conjunction with a health insurance plan?

Yes. Health FSAs can be offered in conjunction with any type of health insurance plan or other employer-provided benefits, or they can be offered on a standalone basis. As explained previously, health FSAs generally cannot be established with HSAs.

What kinds of expenses can be paid with health FSAs?

Employees can use health FSA funds for qualified medical expenses, including preventive care, as defined by the IRS and specified in the employer's FSA plan documents, as long as those expenses are not otherwise covered by health insurance.

Can health FSA funds be used to pay health insurance premiums?

No. Health FSA funds cannot be used for:

- health insurance premiums;
- long-term care coverage or expenses; or
- amounts covered under another health plan.

Can health FSA funds be used to pay health expenses incurred by a spouse or dependent?

Yes. Health FSA funds may be used for qualified medical expenses of a spouse or dependent.

What happens if there is money left in a health FSA at the end of the year?

Health FSAs are subject to a use-it-or-lose it rule, which recently was modified by the Treasury Department. Until recently, the rule specified that any funds that the employee had not spent by the end of the plan year would be forfeited and returned to the employer. However, in May 2005, the Treasury Department modified the rule, allowing employers to give employees a two-and-a-half month grace period immediately following the end of a plan year to use up funds for the year. Thus if the plan year ends December 31, employers may give employees until March 15 to use their health FSA funds from the previous year.

Can employees take health FSAs with them when they retire or change jobs?

No, and employers are not allowed to refund health FSA health balances to employees when they leave. Under certain limited circumstances, health FSAs may be subject to COBRA requirements.

When did health FSAs first become available?

Health FSAs have been available for many years; they were authorized by the Revenue Act of 1978.

How many people have health FSAs?

According to the Employers Council on Flexible Compensation, an estimated 20 million employees are enrolled in health FSAs.

Archer MSAs

What is an Archer MSA?

Archer MSAs are individual medical savings accounts authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Who is eligible to set up and contribute to an Archer MSA?

Individuals who are either self-employed or small business employees and their spouses are eligible to set up an Archer MSA. Individuals with an Archer MSA must be covered by a qualified high-deductible health plan. Under the rules governing Archer MSAs, either the employer or the employee may contribute, but both cannot contribute in the same year.

What are the federal tax benefits of Archer MSAs?

Employee contributions to Archer MSAs are tax deductible, even if the individual does not itemize. Employer contributions are excluded from gross income and not subject to employment taxes, and interest on Archer MSA accounts accrues tax-free. In addition, individuals can withdraw Archer MSA funds tax-free if they are used for qualified medical expenses.

How much can be contributed to an Archer MSA?

Archer MSAs must be paired with a high-deductible health plan, and contributions are limited to 65% of the amount of the high-deductible health plan deductible for self-only coverage and 75% for family coverage. Individuals cannot contribute more than they earned for the year from the employer through which they have the HDHP. If they are self-employed, they cannot contribute more than their net self-employment income (income minus expenses).

What is a high-deductible health plan under the rules governing MSAs?

Deductibles for HDHPs paired with MSAs must be between $1,750 and $2,650 for individual coverage in 2005 and between $3,500 and $5,250 for family coverage. The limits on what consumers can pay out-of-pocket for health expenses are $3,500 for individuals and $6,450 for families in 2005. Dollar amounts are indexed annually for inflation.

Does preventive care count toward the deductible of the high-deductible health plan associated with an Archer MSA?

Yes. Treasury Department rules allow HDHP deductibles to be waived for certain types of preventive care.

Who controls the use of funds in Archer MSAs?

Individuals control use of funds in Archer MSAs and can make withdrawals for qualified medical expenses as defined by the IRS. As with HSAs, individuals can decide when and how much to contribute to Archer MSAs (up to the allowable maximums). Individuals also can decide which company can hold the account. Contributions to Archer MSAs must be in cash; stock or other property cannot be contributed.

Can Archer MSAs be offered in conjunction with a health insurance plan?

Yes. Like HSAs, Archer MSAs must be used with a high-deductible health plan. To qualify for an Archer MSA, individuals generally cannot have health coverage other than the HDHP. However, the following additional types of coverage are allowed:

- Workers' compensation insurance.
- Insurance to cover liabilities from torts or use or ownership of property.
- Coverage for a specific disease or illness.
- Per-diem coverage for a hospital stay.
- Coverage for accidents, disability, dental care, vision care, or long-term care.

Individuals enrolled in Medicare cannot contribute to an Archer MSA. However, they can still receive tax-free distributions from a previously established MSA to pay qualified medical expenses.

What kinds of expenses can be paid with Archer MSAs?

To be withdrawn on a tax-free basis, funds must be used for qualified medical expenses, as defined by the IRS, or for certain health insurance premiums.

Can Archer MSA funds be used to pay health insurance premiums?

Yes. Individuals can use Archer MSA funds to pay health insurance premiums while receiving unemployment benefits or while receiving COBRA continuation benefits. In addition, Archer MSA funds can be used to pay premiums for qualified long-term care coverage.

Can Archer MSA funds be used to pay health expenses incurred by a spouse or dependent?

Yes.

What happens if there is money left in an Archer MSA at the end of a year?

As with HSAs, individuals can roll over their Archer MSA funds from year to year indefinitely throughout their lives. And upon a participant's death, unspent Archer MSA funds can be passed on to a surviving spouse without federal tax liability. Individuals also have the right to roll over Archer MSA funds into an HSA.

Can employees take Archer MSAs with them when they retire or change jobs?

Yes. Like HSAs, Archer MSAs are portable, so that individuals can take their MSA funds with them when they retire or change jobs. However, individuals in this situation cannot make additional contributions to the Archer MSA unless they would otherwise be eligible.

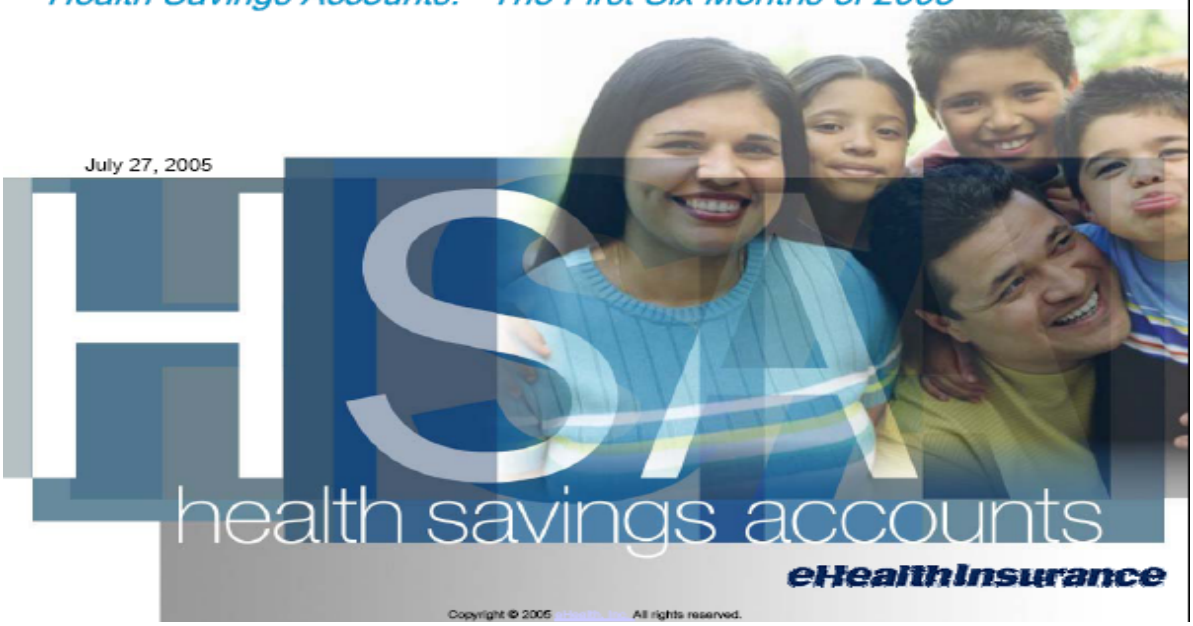
Are Archer MSAs being phased out?

Archer MSAs were created as a time-limited demonstration project. Congress has extended the demonstration several times, and currently Archer MSAs are scheduled to phase out on December 31, 2005. After that date, individuals can no longer open new Archer MSAs but can contribute to existing Archer MSAs and can use funds from existing Archer MSAs to pay qualified medical expenses.

How many people have Archer MSAs?

The number of people enrolled in Archer MSAs is much lower than the 750,000 allowed under HIPAA. In 2003, it was estimated that fewer than 80,000 taxpayers were participating in the demonstration (BNA, 2003). Analysts have attributed the relatively low enrollment to the complexity of the MSA product and restrictions on the scope of the MSA demonstration (e.g., limiting eligibility to the self-employed and small businesses and the phaseout).

Health Savings Accounts: The First Six Months of 2005



Introduction:

- On January 1, 2004, Health Savings Accounts became available as a consumer-directed healthcare option for Americans, helping people attain affordable health insurance, experience flexibility in the use of their healthcare dollars, and save for their future medical needs tax-free. As the largest source of health insurance for individuals and families, eHealthInsurance immediately began offering health insurance plans that are Health Savings Account-eligible (HSA-eligible plans) for consumers to use with Health Savings Account (HSA) banking options.
- In April of 2004, eHealthInsurance released "Health Savings Accounts: The First Three Months," the first overview of individual and family adoption of HSA-eligible plans. In response to requests for additional information, two subsequent reports were produced to review sales of HSA plans at 6 months and 1 year.
- This report, "Health Savings Accounts: The First Six Months of 2005," provides a snapshot of the HSA market, defined as HSA-eligible plans sold by eHealthInsurance to individuals and families from January 1 through June 30, 2005. This report will compare these latest figures to those provided in the 1-year report, highlighting key changes between the two.
- The report's focus is on the continued adoption of HSA-eligible health insurance plans, as well as trends in costs and plan benefits. For the first half of 2005, and with comparisons to 2004 data, this report will:
  - Identify and compare key demographics of purchasers of HSA-eligible health insurance plans;
  - Present and compare the monthly premiums for HSA-eligible health insurance plans; and
  - Outline the health insurance benefit levels included in the HSA-eligible plans purchased by consumers from January 1 through June 30, 2005.
- Comparisons with data on Non-HSA eligible plans will be presented in the annual version of this report to reflect information from eHealthInsurance's most recent "Cost and Benefits of Individual and Family Health Insurance Report".
- eHealthInsurance is the largest source of health insurance in the United States for individuals and families and represents over 140 of the leading health insurance companies across all 50 states. Our nationwide service enables us to provide a unique, unbiased analysis of consumer purchasing.

Methodology:

- "Health Savings Accounts: The First Six Months of 2005" is based on a sample of several thousand HSA-eligible plans sold between January 1 and June 30, 2005 through www.eHealthInsurance.com to individuals and families across the U.S. This report also draws from the previous release of this report for data comparison with 2004 sales.
- The term "HSA-eligible health insurance plans" is defined as those health insurance plans designated by health insurance companies to be in concurrence with U.S. Department of the Treasury HSA guidelines. These include:
  - Deductibles* of a minimum of $1,000 for individuals and $2,000 for families, and
  - Out-of-pocket limits** of $5,100 for individuals and $10,200 for families per year.
- This report does not address consumers' participation in the Health Savings Account banking portion of a HSA program.

Notes:

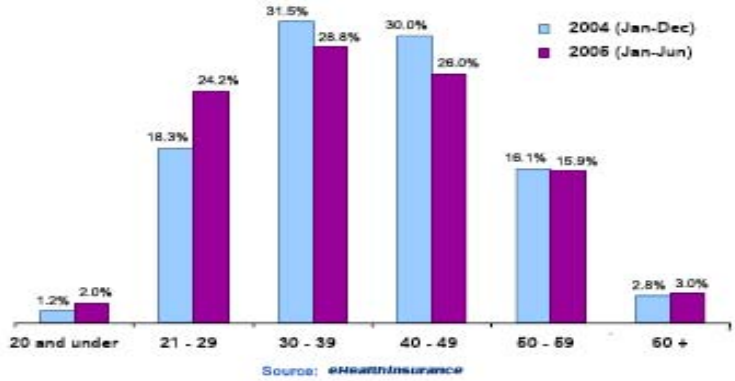
* "Deductible" is the amount of money a plan holder must pay each year to cover medical care expenses before an insurance policy starts paying. Higher deductibles usually result in lower monthly premiums.

** "Out-of-pocket limit" is the dollar amount set by an insurance company, representing the maximum amount a member is required to pay out of his or her own pocket for particular health care services during a particular time period.

Highlights on HSA-eligible plan adoption in the first half of 2005:

- In 2005 there is a modest shift toward plan purchasers in lower income levels. The percentage of HSA-eligible plan buyers in the first half of the year with incomes at or below $50K increased by 2.5 percentage points from the previous year.
- The percentage of HSA-eligible plan purchasers with incomes of $15K or less who were previously uninsured increased 5.1 percentage points from 44.4% to 49.5%.
- The proportion of people paying $50 or less per month increased by 6.3 percentage points or a 75% relative increase over 2004.
- 62.6% of all HSA-eligible plan purchasers in the first half of 2005 pay $100 or less per month for their plans.
- Overall, monthly premiums for HSA-eligible plans have decreased by an average of 15% from 2004.
- 2005 premiums for the 45-64 year old segment decreased most significantly of all age groups, with an average reduction of $38 per month or $456 annually, from 2004. This reflects a 17% average decrease over 2004 plan premiums.
- 2005 shows a shift toward younger buyers when compared with those who purchased HSA-eligible plans in 2004. The segment of 21-29 year olds has grown by 5.9 percentage points and is the primary driver of this change.
- Individuals (versus families) make up a larger portion of all HSA-eligible plan purchasers in the first 6 months of 2005 compared to all of 2004. The segment increased 5.8 percentage points to 57.1%.
- Overall HSA-eligible plans purchased in 2005 cost on average $29 per month or $348 per year less than HSA-eligible plans purchased in 2004.
- Of the HSA-eligible plans purchased in 2005, nearly 80% have prescription drug benefits and half pay 100% of the coverage after the deductible is met.
- Among HSA-eligible plans purchased in the first half of 2005, 78.5% cover hospitalization and lab/X-ray services at full cost once the plan's annual deductible is met.
- 80.8% of the HSA-eligible plans pay for 100% of emergency room visits, after the deductible is met.
- Two-thirds of plans purchased in the first half of 2005 cover office visits at full cost once the plan's annual deductible is met.

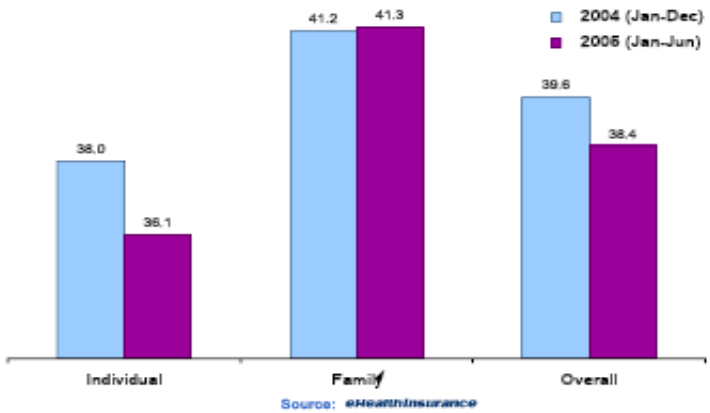
Age Distribution of HSA-eligible Plan Purchasers



- HSA-eligible plan purchasers in the first half of 2005 in the 30-39 and 40-49 age groups have decreased 2.7 and 4.0 percentage points, respectively.
- 55% of HSA-eligible plan purchasers are under 40 years of age while 45% are 40 or over.
- Nearly 19% of plan purchasers are 50 years of age or over, which has remained constant from 2004.

2005 shows a shift toward younger buyers when compared with those who purchased HSA-eligible plans in 2004. The segment of 21-29 year olds has grown by 5.9 percentage points and is the primary driver of this change.

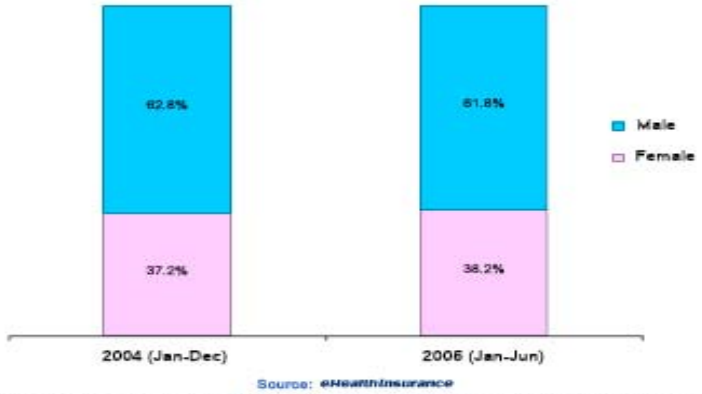
Average Age by Individual or Family Plan



- The average age of all HSA-eligible plan purchasers in the first half of 2005 is 1.2 years less than those who purchased in 2004.
- While the age of purchasers of family HSA-eligible plans remained constant, the age of individuals who purchased plans is 1.9 years less than the previous year, on average.

The average age of an HSA-eligible Individual Plan buyer has decreased by almost 2 years.

Gender Distribution of Primary HSA-eligible Plan Purchasers



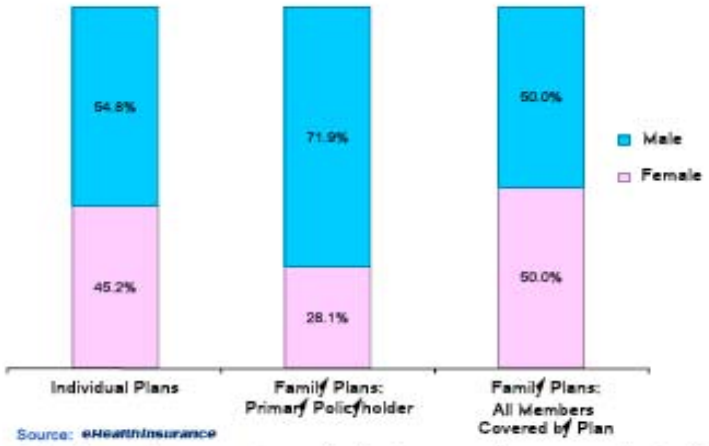
Source: eHealthInsurance

- Males continue to make up over 60% of the primary policyholders of HSA-eligible plans.

The ratio of men to women among primary policy-holders remained unchanged from the prior year.

In 2005, men continue to be the larger group of policyholders over women by nearly 24 percentage points.

Gender Distribution of All HSA-eligible Plan Purchasers in the First Half of 2005



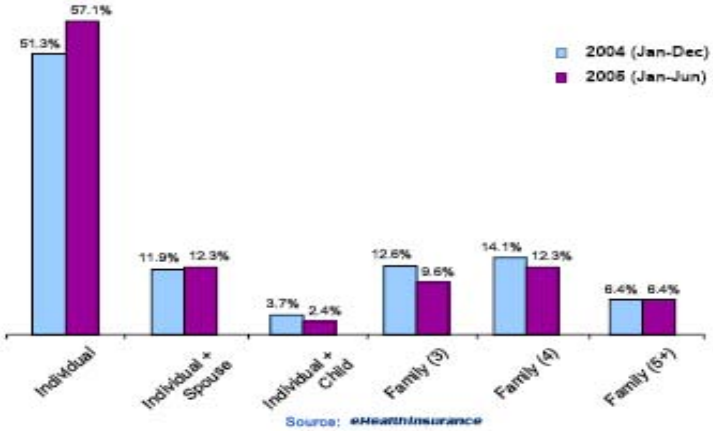
Source: eHealthInsurance

- The ratio of men to women dramatically changes when comparing individual purchasers to primary policyholders of Family Plans.
  - Among Individual Plans the proportion of men to women is approximately 55% to 45%.
  - Among the primary policyholder of Family Plans, the proportion changes to 72% to 28%, respectively.
- Among Family Plans, the gender split among all members covered on the plans is exactly 50% to 50%.

Men are more often listed as the primary policyholder on Family Plans but such plan coverage includes men and women equally.

Among purchasers of Individual Plans in 2005, the gap between men and women, at 9.6 percentage points is significantly smaller than among primary policyholders of Family Plans, at 43.8 percentage points.

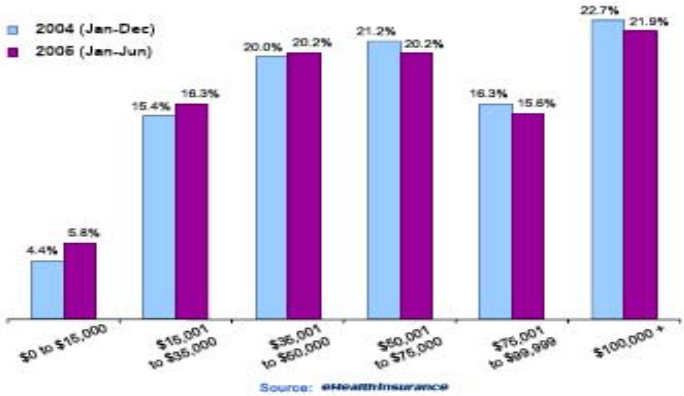
Composition of HSA-eligible Plan Purchasers



- The sales of Individual Plans have increased significantly relative to Family Plans when compared to 2004. Individual Plans have grown 5.8 percentage points from 51.3% of HSA-eligible plan sales to 57.1%.
- The family composition of buyers of Family Plans has not changed significantly since 2004.

Individuals (versus families) make up a larger portion of all HSA-eligible plan purchasers in the first 6 months of 2005 compared to all of 2004. The segment increased 5.8 percentage points to 57.1%.

Annual Income Level of HSA-eligible Plan Purchasers

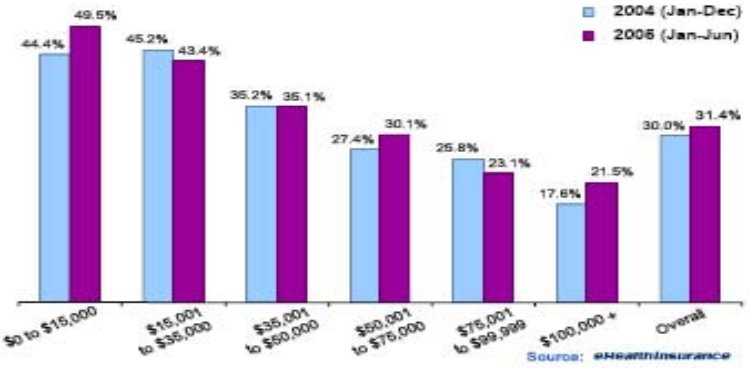


- 42.3% of all HSA-eligible plan purchasers in 2005 earned $50,000 or less annually.

Note: "Annual income" only represents a portion of the sample of records used for this report.

In 2005 there is a modest shift toward plan purchasers in lower income levels. The percentage of HSA-eligible plan buyers in the first half of this year with incomes at or below $50K increased by 2.5 percentage points from the previous year.

Previously Uninsured* by Annual Income Level

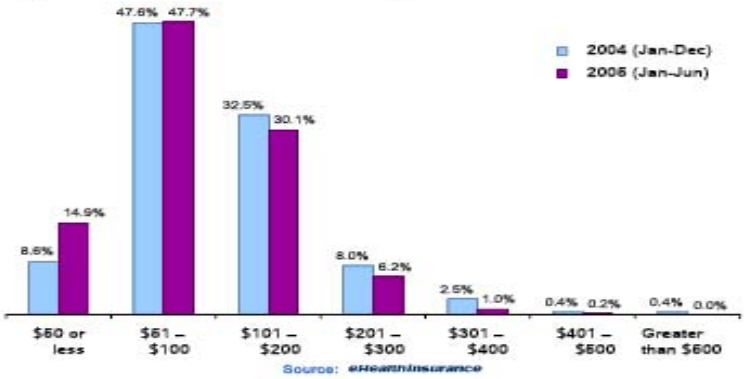


- Although the percentage of previously uninsured remained fairly constant from the past year, among plan buyers in the first half of 2005 with annual incomes of $15K or less, the percentage of previously uninsured has increased 5.1 percentage points to 49.5%. The next most significant change of previously uninsured policyholder is among those with incomes of $100K or more, with an increase of 3.9 percentage points to 21.5%.

* Note: "Previously uninsured" is defined as policyholder not having health coverage for a period of at least 6 months prior to purchasing the current coverage.

The percentage of HSA-eligible plan purchasers with incomes of $15K or less who were previously uninsured increased 5.1 percentage points from 44.4% to 49.5%.

Monthly Premiums of HSA-eligible Plans



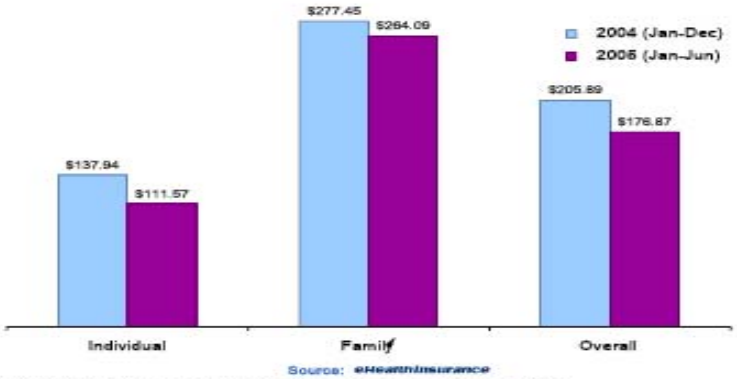
- Plans that cost $50 or less per month represent nearly 15% of all HSA-eligible plans sold in 2005, representing a 6.3% percentage point and 75% increase over 2004. The most commonly purchased plans still fall within the $51 to $100 monthly premium price point.
- The increase in lower premium plans is likely to have an impact on the affordability of HSA-eligible plans among lower income levels.
- Only 7.8% of consumers who purchased an HSA-eligible plan in the first half of 2005 pay more than $200 per month.

There has been a clear shift toward lower monthly premiums in the first 6 months of 2005 compared to 2004.

The proportion of people paying $50 or less per month increased by 6.3 percentage points, or a 75% relative increase over 2004.

62.6% of all HSA-eligible plan purchasers in the first half of 2005 pay $100 or less per month for their plans.

Average Monthly Premium by Individual or Family Plan



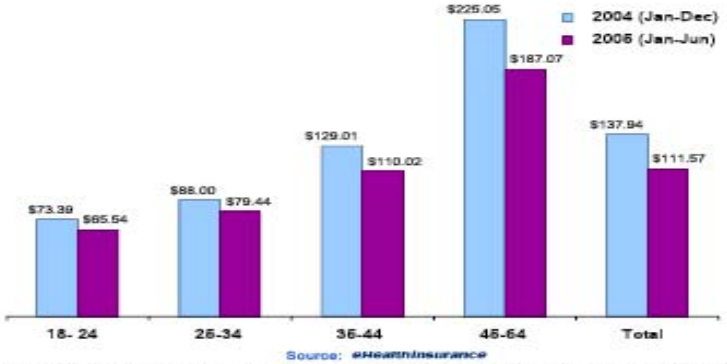
- Monthly premiums have noticeably decreased from 2004.
  - Individual Plan premiums have shown an average savings of $26.37 per month, or $316.44 annually, which represents a decrease of 19.1% over the previous year.
  - Family Plan premiums have decreased on average by $13.36 per month or $160.32 annually, which represents a decrease of 4.8% over the previous year.

Overall, HSA-eligible plans purchased in 2005 cost on average $29 per month or $348 per year less than HSA-eligible plans purchased in 2004.

Overall, monthly premiums for HSA-eligible plans have decreased by an average of 15% from 2004.

The largest decrease in premiums of 19% comes from Individual Plans.

Average Monthly Premium of Individual Plans by Age



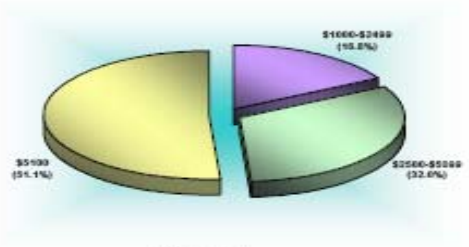
- Among Individual Plans, a decrease in price is seen universally across all age groups.
- The greatest change is seen in the 45-64 year old age group, with an average decrease of $37.98 in monthly premiums.

Note: Because premium rates are impacted by the ages of all members covered on a plan, only data for Individual Plans are shown here.

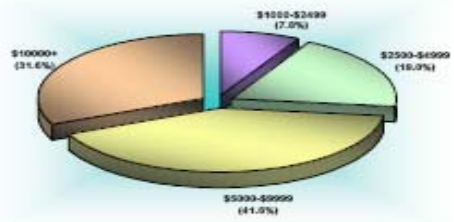
2005 premiums for the 45-64 year old segment decreased most significantly of all age groups, with an average reduction of $38 per month or $456 annually, from 2004.

This reflects a 17% average decrease over plan premiums in 2004.

Annual Out-of-Pocket Maximum for Plans Purchased in 2005



Individual Plans



Family Plans

Source: eHealthInsurance

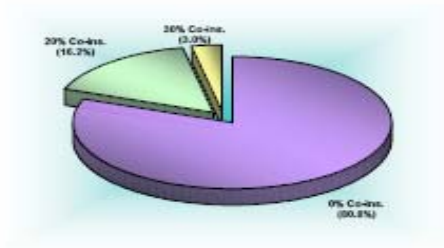
- Among plans purchased by individuals, 51.1% have an out-of-pocket limit of $5,100. This represents an increase of 14.8 percentage points over plans purchased in 2004.
- Among plans purchased for families, just over 30% have an out-of-pocket limit of $10,000 or higher.

Note: $6,100 is the maximum allowable for individual HSA-eligible plans and $10,200 is the maximum for Family Plans.

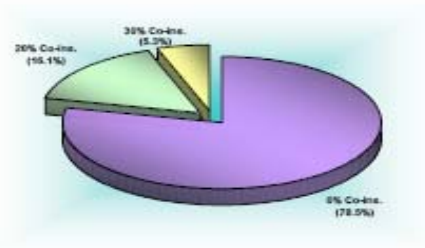
Among HSA-eligible plans purchased by individuals in the first half of 2005, nearly half of selected plans have an annual out-of-pocket limit below the maximum allowed.

Among Family Plans, the out-of-pocket limit is more widely distributed.

Benefits: ER, Hospitalization and Lab & X-ray



Emergency Room Services



Hospitalization, Lab, and X-ray Services

Source: eHealthInsurance

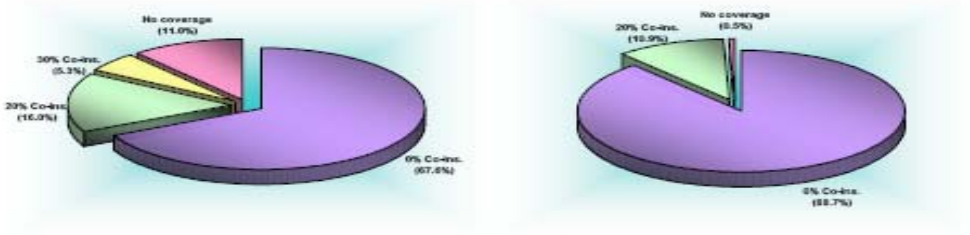
- Among the HSA-eligible plans purchased since January 2005, 80.8% offer full coverage of emergency room services, after the deductible is met, while 16.2% require 20% co-insurance.
- 78.5% of these same plans provide full coverage, after the deductible is met, for hospitalization, lab, and X-ray services, while 16.1% require 20% co-insurance.
- Compared to plans purchased in 2004, plans purchased with 0% co-insurance covering emergency room and hospitalization, lab, and X-ray costs are down 1.9 and 6.9 percentage points, respectively.

Among HSA-eligible plans purchased in the first half of 2005, 78.5% cover hospitalization and lab/X-ray services at full cost once the plan's annual deductible is met.

80.8% of the HSA-eligible plans pay for 100% of emergency room services, after the deductible is met.

All plans purchased offered some level of coverage for these two benefits.

Benefits: Physician Office Visits and OB/GYN Office Visits



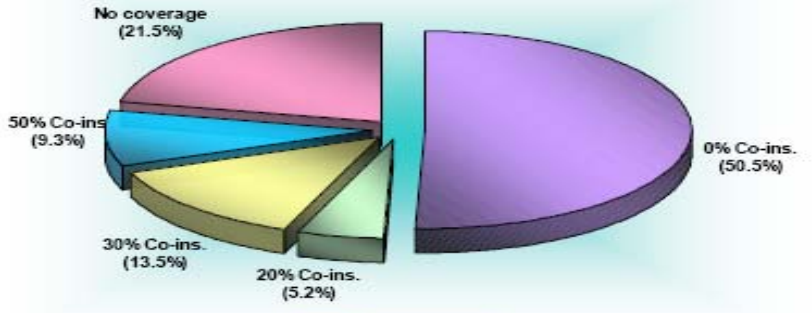
Source: eHealthInsurance

- Office visits are covered to some level in nearly 90% of the purchased plans. Of these, 67.6% provide full coverage once the deductible is met.
- OB/GYN office visits are offered in 99.5% of all HSA-eligible plans purchased.

Two-thirds of plans purchased in the first half of 2005 cover office visits at full cost once the plan's annual deductible is met.

OB/GYN office visits were covered in full by 88.7% of the plans after meeting the deductible level.

Benefits: Prescription Drugs



Source: eHealthInsurance

- 78.5% of HSA-eligible plans purchased in the first half of 2005 offer some form of coverage for prescription drugs. This represents a decrease of 20.9 percentage points from 2004.
- The largest change in prescription drug coverage is represented by plans with 0% coinsurance, which have decreased by 30.9 percentage points from plans purchased in 2004 and those purchased in the first 6 months of 2005.

Of the HSA-eligible plans purchased in 2005, nearly 80% have prescription drug benefits and half pay 100% of the coverage after the deductible is met.

Study Finds HSAs Hit 1 Million Enrollments

Enrollments in high-deductible health plans bundled with tax-free health savings accounts have more than doubled in the past six months, with many enrollees coming from the ranks of the previously uninsured, according to a new survey from America's Health Insurance Plans.

As of March 2005, enrollment in HSAs surpassed 1.03 million, compared with 438,000 in September 2004, AHIP found, as the number of health insurance and health plan providers offering the accounts more than tripled from 29 to 99 over the same period.

Created by the Medicare Modernization Act, which was signed by President Bush in December 2003, health savings accounts have in one year already surpassed the peak market penetration achieved over nearly 10 years by their predecessor, the Archer Medical Savings Accounts, noted Karen Ignagni, AHIP's president and chief executive officer. Initiated in 1996, MSA haven't surpassed 250,000 in a year, Ignagni said.

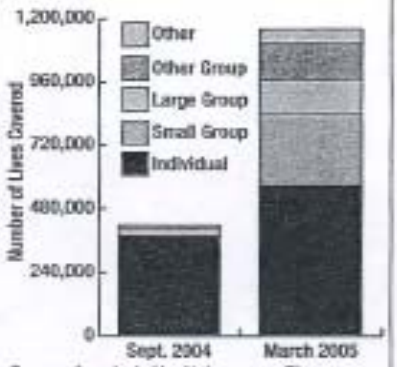
"In quite an expected fashion, the first purchasers were in the individual market, and then the small business market started getting traction," Ignagni said. "Now, we're beginning to see it in the large employer market. When you get around to talk to benefits consultants, what you find out is, because the regulations were promulgated in August, that was too late for the 2005 benefit year. What I can tell you, anecdotally, is that they are asking that this be part of the menu of products that are offered to them, in addition to HMO, PPO and point-of-service."

Though still smaller than both the small-group and individual markets, the large-group market expanded by more than 1,000% to 162,000 "covered lives" — policyholders and their dependents — from just 13,000 in September 2004, noted Jeffrey Lemieux, senior vice president of AHIP's center for policy and research.

In addition, Lemieux pointed out that AHIP members reported 77,000 insureds in the "other" category and 88,000 in the "other group" category, where the member didn't distinguish either between small and large groups or between individual and group policies. Presented in concert with "Covering the Uninsured Week" — a week-long public awareness project aimed at promoting means to provide health-care solutions for millions of uninsured Americans — the study also provided support for the contention that HSAs could serve as a partial solution.

Participation Soars

Enrollments in high-deductible health plans bundled with tax-free health savings accounts have more than doubled in the past six months.



Source: America's Health Insurance Plans

Of the 556,000 HSA insureds in the individual market — up from 346,000 last September — 37% were previously uninsured consumers. And of 147,000 in the small-group market — up from 79,000 — 27% were provided by employers that previously didn't offer coverage to their employees.

"I'm probably among the singularly most boring people in Washington, because I hate to get into the speculation game," Ignagni said. "Nonetheless, what we've seen in our early looks...point us to an active hypothesis that suggests this product is appealing to people who haven't had these kinds of affordable choices available to them."

Also, because many of the plans use existing preferred provider organization networks, consumers largely have been able to enjoy lower prices for medical services paid out of their HSAs than they would on the open market, though that development may dim some economists' hopes that the plans would leverage market forces to bring down costs in the health-care sector.

"I think the market is trying to find a sweet spot, in terms of consumer awareness of costs, while also using the tools of care management, to some degree, for people who need it," Lemieux said.

HSAs allow consumers to accrue pretax funds for future medical expenses, but they must be bundled with a high-deductible insurance policy. Unlike MSAs, which are limited to people who are self-employed or employed in small businesses without other health insurance, HSAs may be offered as an option in the individual, large group, or small group markets.

Unlike flexible spending accounts, the funds may be rolled over from year to year, and unlike health reimbursement arrangements, or HRAs, the funds belong to the employee rather than to the employer. Lemieux noted that HRAs have had a large presence in the large-group market since 2002 and weren't included in the HSA data.

Though opponents once claimed the product would prove attractive only to relatively young and healthy policyholders — raising the potential of adverse selection for more traditional health plans — Lemieux said the data show roughly half the enrollees were older than 40, and that the 22% of the market between 0-19 years old were mostly dependents.

In the individual market, premiums were lowest in the younger age brackets, Lemieux noted, adding that average deductibles ranged from $2,000 to $5,000.

—R.J. Lehmann

Health/Employee Benefits

By Jerry L. Ripperger

Provide protection, then convenience, when considering health-care options.

Catastrophic Coverage First

Increasing numbers of employers are finding that high deductible health plans can provide significant premium savings over traditional health plans, and many employers automatically deposit this savings into Health Savings Accounts for their employees to pay for first dollar health care.

Although this is a good use for the savings, financial planners should ask questions before recommending this approach to clients. By probing deeper, they can help each employer develop a more comprehensive benefit plan, strengthen their relationship with the client, and enhance their commission income.

Employee benefits come in two broad categories: catastrophic protection and first dollar benefits. Employees commonly overstate their need for the latter and understate their need for the former. After all, how many employers offer dental insurance but not long-term disability coverage? This is not surprising, as most employees plan to go to the dentist in any given year, but do not plan on being unable to work for an extended period of time.

Employers should strive to make sure that catastrophic needs are addressed first. Employees need protection from premature loss of life or loss of income due to disability. Most employees can afford to pay for a doctors' visit or a prescription drug, even if they are hesitant to admit it. Very few employees are prepared to deal with the loss of income for 12 months or the premature death of a primary wage earner.

Employers should address catastrophic exposures with a strong foundation of medical insurance, long-term disability insurance, and life insurance. Only when these needs are met should other forms of protection be included.

Medical insurance should be comprehensive in nature, covering a broad range of accepted treatments and providing the covered member a reasonable choice of providers. Disability income insurance should provide benefits to normal retirement age, replacing an adequate amount of income to maintain an employee's lifestyle. Life insurance should provide enough protection to cover reasonable funeral and estate costs as well as family financial security.

Employers have to balance the need for catastrophic protection with their budget constraints. As a result, they may need to share costs with employees. Voluntary and individual benefits are an excellent way to fill this gap. There are a wide variety of voluntary and individual products available to meet catastrophic needs, the most important being voluntary life and voluntary long-term disability.

An employer's role goes beyond merely offering voluntary coverages. The employer also needs to educate workers and to encourage them to enroll. It is important that this be an ongoing process as employees' needs change over time. New employees need to be engaged in this process as well.

After addressing catastrophic needs, employers can turn their attention to first dollar benefits. Funding an HSA, dental coverage or short-term disability should certainly be considered. Employees should be engaged in the decision-making process. The employer likely will find that employees value a broad range of first dollar benefits. This lends itself well to allowing employees to create a program that best meets their individual needs through voluntary and individual coverages.

By probing deeper, [financial planners] can help each employer develop a more comprehensive benefit plan, strengthen their relationship with the client, and enhance their commission income.

The employer has to take local circumstances into account when designing the program. If dental is offered by the majority of local employers, it likely will need to be offered to attract and retain employees.

Helping employees select the appropriate first dollar benefits involves employers in two primary ways. First, they can elect to fund certain first dollar benefits either in full or in part, increasing their attractiveness to employees. Second, they can provide both a forum and tools to learn more about the options and how they impact the employee.

It benefits both employer and employee to implement pre-tax approaches to funding these first dollar benefits. Employers should be encouraged to implement a Section 125 plan (also known as a cafeteria plan or salary reduction plan) to obtain these tax savings.

Focusing on catastrophic protection benefits the employee, the employer and the financial planner. The employee gains peace of mind, while the employer directs limited resources to where they can make the most difference. By helping the employer, the planner strengthens his or her relationship with the client.

The planner also enhances commissions. HSAs offer little, or no, compensation for the producer, but life and disability products offer attractive income while providing valuable protection. BR

Jerry L. Ripperger, a Best's Review *columnist, is director of Consumer Health at Principal Financial Group, Des Moines, Iowa. He can be reached at* insight@bestreview.com.

Patients Give New Insurance Mixed Reviews

Consumer-Directed Health Plans Can Cut Costs, but Early Users Cite Problems Comparing Price

By VANESSA FUHRMANS
Staff Reporter of THE WALL STREET JOURNAL
June 14, 2005

As the push toward consumer-directed health insurance steadily gains momentum, some of the early users of the plans are experiencing mixed results.

The early picture -- based on the experience of companies that offer the plans, and research by consultants and plan providers -- suggests that participants aren't skimping on health care as some critics had feared. They are, however, frustrated by having to be health-care consumers because medical price and quality information still is so hard to come by.

Consumer-driven health plans -- arguably the biggest shift in health-care coverage since health maintenance organizations -- typically combine a high-deductible insurance plan with some sort of savings account that participants can use to pay for care until they meet the deductible. The plans shift more of the decisions for health-care spending onto consumers, with the idea that people will be more careful about medical costs when it is their own money at stake. Because the premiums for the policies are typically lower than with traditional plans, employers and employees both can save on upfront costs.

One big concern has been that participants would scrimp on care if it wasn't covered by insurance. The latest research, and the experience of a range of companies, including Whirlpool Corp., Textron Inc. and Logan Aluminum Inc., has that shown people still will pay for care. Many large companies also have found that subsidizing and providing incentives for preventive services helps make the plans more workable for employees. At Textron, an aircraft and manufacturing company, which still covers preventive care upfront, use of services such as mammograms, prenatal care and physicals, has climbed 15% since the company began offering a consumer-directed health plan in 2002 and made the full switch in 2003.

A new survey by consultants McKinsey & Co. found that participants in consumer-directed health plans got annual check-ups, basic lab tests, prostate screenings and mammograms at an equal or higher rate than those in richer traditional benefits. The survey, of more than 2,500 people across several companies and being released this week, found that consumer-directed health plan members also were twice as likely to inquire about drug costs -- even though their employers typically continued to cover prescription drugs with a traditional benefit separate from the high-deductible plans. (McKinsey, which sells consulting services to the health-care industry, including assistance in adjusting to consumer-directed health care.)

The McKinsey survey found, however, that only 44% of plan members were as satisfied as they had been with their previous, more generous benefits. Higher costs were one factor for some, but many said they were unhappy with how hard it was to get good information to make decisions about health care.

In a recent survey by employee-benefits consultants Towers Perrin of 1,400 employees in various health plans, including traditional insurance, 85% said they needed more information and tools to make good decisions about health care.

While some form of consumer-driven health care has been around since the 1990s, it is only in the past couple of years that the approach has really taken off. Nearly four million Americans have some form of them now, with most of that growth coming in the past year since tax-free Health Savings Accounts were introduced in late 2003 as an option for the personal account portion of these plans.

At Logan Aluminum, which switched to a consumer-driven plan two years ago, human relations chief Howard Leach says the Russellville, Ky., company's health-care spending declined 6% in the first year on the plan and another 1.5% the second. While emergency-room visits are down -- largely because consumers are more likely to opt for a less expensive urgent-care clinic -- doctor's office visits have increased slightly, he says. "To me, that says employees aren't skimping on necessary health care," Mr. Leach says.

Still, he adds, the pricing information available for consumers "isn't as complete as I'd like." Through Aetna Inc., Logan's consumer-health-plan provider, employees have access to approximate cost information for various medical procedures and some background information on providers on its Web site. But no source has detailed information comparing prices from provider to provider.

Logan employee Linda Foster says that since switching to the consumer-driven plan, she has been cost-conscious, being more consistent about using a less-expensive mail-order prescription service, for instance. When the 42-year-old mother recently called a couple of urgent-care centers to ask about the cost of a visit, none would tell her the price upfront. "That's where I see the limitations," Ms. Foster says. "You really have to do some digging to get the information you need."

Aetna, for its part, says it has found that consumer-directed plans can save employers money. Data from 13,500 plan participants in 2003 -- the latest for which the company has done analysis -- showed that employers who offered such plans as a voluntary option slowed their health-care spending growth to a rate of 3.7%, while those who made the switch completely saw costs fall 11%, mostly because of fewer visits to doctors and hospitals. At the same time, the use of treatments or tests for preventive care rose faster among those in consumer-driven plans, compared with a similar population in a traditional plan.

A big reason that participants in consumer-driven plans have kept up with preventive care is the way many large employers structure their plans. Rather than HSAs, most have continued to provide the earlier-generation Health Reimbursement Account, which give employers more flexibility in designing the plan. Many early adopters also have continued to provide at least some coverage for preventive care.

For instance, Whirlpool built enough financial incentives into its consumer-directed offering that 40% of its U.S. employees opted to join it when it first began in January 2004. The company

covers physicals, immunizations and other preventive care upfront, then contributes a certain amount to the employee's personal care account before the deductible kicks in. By January of this year, the percentage of employees who joined the consumer-directed plan was 55%, says Janice Pushaw, director of Whirlpool's global benefits strategy. Logan also fully covers preventive care before patients begin to pay money out of their account.

Some insurance executives caution employers against switching their entire work forces to a consumer-directed plan. Howard Phanstiel, chief executive of managed-care company Pacificare Health Systems, cites the example of one large employer that moved its work force to a high-deductible plan, only to learn that some of its employees had trouble paying for the delivery of their babies. Pacificare offers a number of consumer-directed plans, but "they are not a panacea," he says.

Write to Vanessa Fuhrmans at vanessa.fuhrmans@wsj.com

H E A L T H T R A C K I N G :
T R E N D S

14 September 2005

What High-Deductible Plans Look Like: Findings From A National Survey Of Employers, 2005

*The prevalence of these health **plans** continues to rise, with the largest employers leading the way.*

by Gary Claxton, Jon Gabel, Isadora Gil, Jeremy Pickreign, Heidi Whitmore, Benjamin Finder, Shada Rouhani, Samantha Hawkins, and Diane Rowland

ABSTRACT:

This paper documents the availability, enrollment, premiums, and cost sharing for high-deductible health plans that are offered with a health reimbursement arrangement (HRA) or are health savings account (HSA)–qualified plans. Almost 4 percent of employers that offer health benefits offer one of these arrangements in 2005, covering about 2.4 million workers. Deductibles, as expected, are relatively high, averaging $1,870 for single coverage and $3,686 for family coverage in high-deductible health plans with an HRA and $1,901 for single coverage and $4,070 for family coverage in HSA-qualified high-deductible health plans. One in three employers offering a high-deductible health plan that is HSA-qualified do not contribute to HSAs established by their workers.

In the waning years of the 1990s, health plans retreated from restrictive managed care and tried to reinvent themselves as being more consumer-friendly. Recently, health plans, benefit consultants, and employers have begun exploring designs that combine a health plan and a sizable deductible with an employee-controlled savings account. One type of account, health reimbursement arrangements (HRAs), grew out of federal regulations made by the U.S. Internal Revenue Service in 2002, while a second type of account, health savings accounts (HSAs), were authorized in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.[1]

An HRA is a medical care reimbursement plan sponsored by an employer. HRAs are typically offered to employees in conjunction with a health plan with a relatively high deductible (for example, at least $1,000 for single coverage and $2,000 for family coverage) but can also be offered with a more traditional type of plan.[2] The plan is solely funded by the employer. Employers typically commit to making funds available up to a predetermined amount for medical expenses incurred by the employee and eligible dependents and spouses. HRAs are primarily accounting tools, and employers are not required to expend the funds they make available until expenses are incurred. Employees may use the funds to pay for medical expenses and premiums. When the funds are depleted, the employee must pay for services out of pocket until the health plan deductible is met. Then the plan becomes similar to a traditional health plan. Unspent funds can be carried over to the next year, but employees cannot take them along if they leave their jobs, although employers can make remaining balances available to former employees to pay for health care. HRA funds cannot be used for nonmedical expenses.

An HSA is a savings account created by an individual to pay for health care. To be eligible to create an HSA, a person must be covered by a "qualified health plan," which is a plan with a high deductible (that is, at least $1,000 for single coverage and $2,000 for family coverage) that also meets other requirements.[3] Employers that want to encourage their employees to establish an HSA can do so by offering a qualified health plan. Both employers and employees can contribute to an HSA, up to an annual limit equal to the lesser of the deductible in the HSA-qualified plan or a statutory cap. Employer contributions to the spending account are optional, but if the employer elects to contribute, the contributions are not taxable to the employee. Employees may contribute to the spending account on a pre–income tax basis, and earnings from investments are not taxed. Employees can use funds from the account to buy health care services. Withdrawals from the account to pay for health care are not taxable. Employees can use the spending account for nonmedical expenses, but there is a tax penalty for doing so. The savings account is owned by the employee and is portable should the worker change employers.

Most knowledge of HRAs and HSAs is from the trade and popular press. There is limited research in peer-reviewed journals about basic questions, such as enrollment, the structure of plans**,** plan satisfaction, cost savings, risk selection, and quality of care. A special edition of the journal *Health Services Research* provides findings about the experience of early attempts to offer HRAs.[4] In general, findings follow the circumstances of individual case studies. Some plans show cost savings, and others do not.[5] Some employers experience substantial risk selection, and others do not.[6]

Inside Consumer-Directed Care, a biweekly newsletter aimed at health plans, estimated that 1.2 million Americans were enrolled in HRAs in January 2004 and that the figure grew to 2.6 million in January 2005. In addition, an estimated 600,000 Americans were enrolled in HSA-qualified plans.[7] America's Health Insurance Plans (AHIP), a health industry trade group, estimated HSA enrollment at more than one million in April 2005, with the majority of these people enrolled through the individual insurance market.[8] AHIP reported that ninety-nine of its member health plans had enrollment in an HSA-qualified plan, three times the number reported in September 2004.

In this paper, based on data from the 2005 survey of employer health benefits by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust (Kaiser/HRET), we report findings on the prevalence and attributes of high-deductible health plans (HDHPs) that are offered with an HRA or compatible with an HSA. To our knowledge, this is the first random sample of U.S. employers to report on these arrangements, including employers' and employees' contributions to premiums, deductible amounts, employers' contributions to spending accounts, and employee participation rates. We refer to an HDHP offered with an HRA as an "HDHP/ HRA" and to an HDHP that is an HSA-qualified plan as an "HSA-qualified HDHP."

Study Data And Methods

Data. Study data are primarily from the 2005 Kaiser/HRET survey of employer health benefits. The survey sample is drawn from a listing of U.S. firms compiled by Dun and Bradstreet. Employers range in size from three to hundreds of thousands of workers and include public and private firms. The sample is stratified by size and industry. In 2005 our overall response rate was 48 percent, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the response rate was 51 percent. All statistical tests were performed at the .05 significance level. The methods for the core survey are discussed at greater length in the September/October 2005 issue of *Health Affairs*.[9]

Methods. In each of the past three years, the survey has asked firms that offer health benefits whether or not they offer an HDHP. For 2003 and 2004, we defined an HDHP as a plan that had a deductible of more than $1,000 for single coverage. For 2005, we modified the definition to specify plans that had a deductible of at least $1,000 for single coverage and at least $2,000 for family coverage. Firms that reported offering an HDHP were then asked whether (1) they offered an HDHP/HRA and (2) whether they offered an HSA-qualified HDHP. Of the 2,013 firms that completed the entire survey, 66 reported offering an HDHP/ HRA, and 59 reported offering an HSA-qualified HDHP. These totals include seven firms that reported offering both. Firms that reported offering either or both were asked additional questions. In the

main survey we collected information by plan type for only the plan with the highest enrollment, but for these plan sections we collected information regardless of enrollment. We did not collect information on HRAs that are offered along with plans that are not HDHPs. Specific weights were created to analyze HDHP/HRAs and HSA-qualified HDHPs separately. These weights represented the proportion of employees enrolled in both types of HDHPs. The weights were adjusted for nonresponse and were post-stratified to represent all U.S. firms.

When employers offered an HDHP/HRA or an HSA-qualified HDHP, we collected additional information on a number of plan attributes, including the type of health plan offered; the premium, employee contribution, deductible, and out-of-pocket maximum amounts; the percentage of employees participating in the arrangement; and any amounts contributed to the HRA or HSA by the employer. Information on firms' offerings was weighted at the firm level; information on premiums, contributions, and deductibles was weighted based on enrollment in each type of arrangement. Our estimates of the number of enrollees in HDHP/HRAs and HSA-qualified HDHPs do not include federal workers.

In considering these results, we note that these arrangements are fairly new to the marketplace and that the attributes that we see now may change as the products evolve. These arrangements also are new to the employers answering our survey and are fairly complicated relative to more traditional health plans. The questions we asked about HSA-qualified HDHPs and HDHP/HRAs also were much more precise and detailed than our questions about these plans in prior years. During the process of data collection and analysis, we encountered substantial confusion among employers about the different savings account options that might be available, even though the survey provided detailed definitions of HRAs and HSAs. In particular, some employers who originally reported offering an HRA were found to be offering flexible spending accounts (FSAs) instead. Because of the confusion, we attempted to call back every employer that reported offering either an HDHP/ HRA or an HSA-qualified HDHP to ensure accurate plan data.

Because we survey employers and not employees, we cannot discuss employees' attitudes about or experiences with these new arrangements. We do not know, for example, whether employees who choose these plans change the way they use health care or whether or not they are satisfied with these arrangements. A survey of employees would be necessary to address these issues.

In this paper we compare premiums and contributions in HDHP/HRAs and the HSA-eligible HDHPs with the average premiums and contributions that we find for the market overall, to provide some context for these new arrangements' premium and contribution levels. Because of the limited sample size, we could not compare HDHP/HRA and HSA-qualified HDHP features by firm size or other characteristics. Limited sample size also prevented us from comparing the attributes of the HDHP/HRAs or HSA-qualified HDHPs offered by a firm with those of other health plans offered by that same firm (in part because some of the firms offering these arrangements do not offer any other health plans). If the prevalence of these new plan types grows in the future, we plan to make such comparisons in future surveys.

Study Findings

Prevalence of HDHPs. In each of the past three annual surveys, we asked employers that offered health benefits whether or not they offered an HDHP, which we defined in 2005 as a health plan option that has a deductible of at least $1,000 for single coverage and $2,000 for family coverage.[10] One-fifth of employers offering health benefits reported offering an HDHP in 2005. Jumbo firms (5,000 or more workers) were more likely than firms in general to offer an HDHP (Exhibit 1).[11] One of every four employees with health insurance through their jobs work for a firm that offers an HDHP to at least some of its employees.

A minority of firms offering an HDHP—about one in five—offer either an HRA contribution in conjunction with the plan (9.5 percent), an HDHP that is HSA-qualified (11.6 percent), or both.[12] Large firms (1,000 or more workers) that offer HDHPs are more likely to offer one of these arrangements than firms in general (9.5 percent compared with 3.9 percent). Among all firms offering health benefits, about 4 percent offer either an HDHP/HRA (1.9 percent), an HSA-qualified HDHP (2.3 percent), or both.

HDHP/HRAs. *Offering and enrollment.* About 2 percent of all firms offering health benefits report offering an HDHP with an HRA. In firms that offer this type of arrangement, about 25 percent of employees on average participate in the plan. We estimate that 1.6 million employees are enrolled in HDHPs with an HRA in 2005—more than 2 percent of all covered workers.

Premiums and contributions. Annual employee contributions for HDHP/HRAs average $423 for single coverage and $2,654 for family coverage (Exhibit 2). Employers contribute toward these plans by making a contribution toward the health plan premium and another contribution to the HRA.[13] On average, workers enrolled in an HDHP/HRA receive a combined total annual employer contribution of $3,872 for single coverage and $7,538 for family coverage.

Although the average health plan premiums for single and family coverage in HDHP/HRAs are much lower than average health plan premiums overall, when combined with the amounts contributed by employers to HRAs, there is no statistical difference between the cost of these plans and the total premium for health plans overall for either single ($4,295 versus $4,024) or family ($10,193 versus $10,880) coverage. The differences between employees' premium contributions for HDHP/ HRAs for single coverage ($423) and for family coverage ($2,654) also are not statistically different from employees' contributions for health plans overall ($610 and $2,713, respectively).

Spending accounts, deductibles, and out-of-pocket liability. Workers receive an average contribution from their employer to their HRA of $792 for single coverage and $1,556 for family coverage, but they face an average deductible of $1,870 for single coverage and $3,686 for family coverage (Exhibit 3). Three-fifths of workers covered by an HDHP/HRA are in a plan that covers some preventive benefits before the deductible is met, and about one-third are in a plan that provides some coverage for prescription drugs before the deductible is met. The maximum out-of-pocket liability for cost sharing that workers covered by these arrangements face is $2,859 for single coverage and $5,075 for family coverage.

We asked firms not offering an HDHP/ HRA if they planned to do so in the next year. Four percent of firms reported that they were "very likely" to do so, and 22 percent reported that they were "somewhat likely" to do so (Exhibit 4). There were no significant differences between small firms (3–199 workers) and large firms (200 or more workers) on this question.

HSA-qualified HDHPs. About 2 percent of all firms offering health benefits reported offering an HSA-qualified HDHP.[14] In firms that offer these plans, about 15 percent of workers participate, on average, although the participation rate in larger firms (1,000 or more workers) is significantly lower (3 percent, $p < .05$). About 810,000 workers are covered by an HSA-qualified HDHP offered by their employer—about 1.2 percent of all covered workers.

Premiums and contributions. Employee contributions for HSA-qualified HDHPs average $431 for single coverage and $1,664 for family coverage (Exhibit 2). Workers in these plans receive average contributions (premium and HSA contribution combined) of $2,850 for single coverage and $7,337 for family coverage from their employers (Exhibit 2). This includes 37 percent of covered workers whose employer makes no contribution to an HSA for either single or family coverage.

Comparing HSA-qualified HDHPs with health plans overall, total costs (premiums plus employer contributions to HSAs) for both single and family coverage in HSA-qualified HDHPs ($3,280 and $9,001, respectively) are significantly lower than the total premium for single and family coverage overall ($4,024 and $10,880, respectively, $p < .05$) (Exhibit 2). The average worker contribution for single coverage in an HSA-qualified HDHP ($431) appears different from the average worker contribution for single coverage in plans overall ($610), but the difference is not statistically significant. However, the difference in the total cost of family coverage between HSA-qualified HDHPs ($9,001) and health plans overall ($10,880) is statistically significant. We do not have information about the extent to which employees establish or contribute to HSAs.

Spending accounts, deductibles, and out-of-pocket liability. Workers in HSA-qualified HDHPs receive an average HSA contribution from their employer of $553 for single coverage and $1,185 for family coverage (Exhibit 3), although 35 percent of firms offering these plans (covering 37 percent of the workers in such plans**)** make no contribution to their employees' HSAs.[15] Workers in HSA-qualified HDHPs face an average deductible of $1,901 for single coverage and $4,070 for family coverage, and their maximum out-of-pocket liability for cost sharing is $2,551 for single coverage and $4,661 for family coverage (Exhibit 3). Thirty percent of workers covered by an HSA-qualified HDHP are in a plan that covers some preventive benefits before the deductible is met.

Future growth of HSAs. We asked employers not offering an HSA-qualified HDHP if they planned to do so in the next year. Two percent reported that they were "very likely" to do so, and 25 percent reported that they were "somewhat likely" to (Exhibit 4). Interest is greater among larger firms (200 or more workers), where 7 percent said that they are "very likely" to offer an HSA-qualified HDHP in the next year.

Discussion

Twenty percent of firms offering health benefits offer a high-deductible health plan in 2005. The largest employers have led the way, with the result that one of every four employees today with job-based health insurance works for a firm that offers a high-deductible plan to at least some of its workers.

In the past year, an increasing percentage of these employers have begun offering a savings account option to employees in conjunction with an HDHP. Almost one-fifth of firms offering a high-deductible plan—about 4 percent of all firms that offer health benefits—offer an HDHP/HRA or an HSA-qualified HDHP. Participation rates for these new arrangements (25 percent of eligible workers for HDHP/HRAs and 15 percent of eligible workers for HSA-qualified HDHPs) seem reasonable, given how recently these plans have come onto the market and how complicated they are. Deductibles in these arrangements, as expected, are relatively high for both single and family coverage. Employers' contributions to the savings account options are, on average, much lower than the deductible amounts, which leaves enrollees with meaningful out-of-pocket risk.

The low prevalence of these new plans in the market (and our limited sample of employers

offering them) restricts our ability to analyze them in any depth. We compared the premiums and contributions in these new arrangements with those for health plans overall to provide a context about the relative cost of these new arrangements. Although we saw some apparently large differences in contributions by covered workers and total costs, in many cases these differences were not statistically significant. We will be able to say more about the relative costs of these plans to employees and employers if they become a larger part of the marketplace.

Many observers expect these new arrangements to grow during the next few years, and there is reason to believe that they could be right. One explanation for the relatively low offer rate of HSA-qualified HDHPs is that although they were authorized in 2003, the Treasury Department didn't issue regulations for the implementation of HSAs until summer 2004. This might have discouraged employers from offering HSA-qualified HDHPs in 2005. In addition, large employers (1,000 or more workers), which employ more than half of U.S. workers with health insurance, have a higher offer rate and report a stronger interest in these new plans than firms overall. These employers could provide a strong base for future enrollment growth.

NOTES

1. See Internal Revenue Service Rev. Ruling 2002-41 regarding HRAs. For a more complete description of these types of health accounts, see IRS, *Health Savings Accounts and Other Tax-Favored Health **Plans**,* Pub. no. 969, 2004, www.irs.gov/publications/p969 (12 August 2005).
2. In the survey, we focused specifically on HRAs that are offered along with a high-deductible health plan (HDHP).
3. IRS, *Health Savings Accounts.*
4. C. Clancy and A. Gauthier, eds., special issue, "Consumer-Driven Health Care: Beyond Rhetoric with Research and Experience," *Health Services Research* 39, no. 4, Part 2 (2004).
5. S.T. Parente, R. Feldman, and J.B. Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization," *Health Services Research* 39, no. 4, Part 2 (2004): 1189–1210; and A.T. Lo Sasso et al., "Tales from the New Frontier: Pioneers' Experience with Consumer-Driven Health Care," *Health Services Research* 39, no. 4, Part 2 (2004): 1071–1090.
6. S. Parente, R. Feldman, and J. Christianson, "Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting," *Health Services Research* 39, no. 4, Part 2 (2004): 1091–1112; Lo Sasso et al., "Tales from the New Frontier"; J.B. Fowles et al., "Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment," *Health Services Research* 39, no. 4, Part 2 (2004): 1141–1158; and L.A. Tollen, M.N. Ross, and S. Poor, "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.," *Health Services Research* 39, no. 4, Part 2 (2004): 1167–1188.
7. Atlantic Information Services, *Inside Consumer-Directed Care,* 7 January 2005, www.aishealth.com/Products/NewsICD.html (12 August 2005, subscription required).
8. America's Health Insurance Plans**,** Center for Policy and Research, "Number of HSA Plans Exceeded One Million in March 2005," 2005, www.ahipresearch.org/pdfs/HSAExceedMillion050405_full.pdf (12 August 2005).
9. See J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24, no. 5 (2005): 1273–1280.

10. In 2003 and 2004 the survey used a different definition and asked firms if they offered a health plan with a deductible of more than $1,000 for single coverage. The 2003 and 2004 surveys did not specify a minimum deductible for family coverage. Some of the change in the percentage of firms offering an HDHP between 2003 and 2005 may be due to this change in the definition of an HDHP.
11. The increase from 2004 to 2005 and the increase from 2003 to 2005 are statistically significant at the 5 percent level. The increase from 2003 to 2004 is not statistically significant at the 5 percent or 10 percent levels.
12. This includes 1.6 percent of firms offering an HDHP that offer both an HDHP/HRA and an HSA-qualified plan.
13. The survey asks firms, "Up to what dollar amount does your firm promise to contribute each year to an employee's HRA?" We refer to the amount that employers commit to make available to an HRA as a contribution, for ease of discussion. As discussed above, HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Employers are likely not to end up spending all of the funds they make available to their employees through an HRA.
14. Among firms offering health benefits, the prevalence of firms offering HSA-qualified plans is a little higher than the prevalence of firms offering an HDHP/HRA combination, but the difference is not statistically significant.
15. The average HSA contributions reported include covered workers in firms that make no contribution.

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What Do You Owe the Doctor? Swipe a Card to Find Out

By SARAH RUBENSTEIN
THE WALL STREET JOURNAL ONLINE
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(See Corrections & Amplifications item below.)

Patients get answers to plenty of questions at their doctor appointments. But as they leave the office, there's often still an unsolved mystery: the bill.

Now, one insurer, BlueCross BlueShield of South Carolina, is trying a new way to eliminate the wait that many patients and doctors endure before they learn how much the insurer will pay and what the patient owes. The company is offering doctors a new swipe-card reader that will let patients covered by the insurer learn those financial details while they're standing at the receptionist's counter. The doctor's office can ask the patients to pay right then.

The reader, which doctors can lease from Companion Technologies Corp., a subsidiary of BlueCross BlueShield of South Carolina, is coming to market at a time when more patients are being required to shoulder a greater share of their medical bills than a simple copayment. As deductibles of $1,000 or higher become more common, insurers say there's pressure on them to make it easier for doctors to figure out what their patients owe.

"Many doctors lose significant dollars because patients don't treat doctors' office payments like they do their Visa bill," says Harvey Galloway, president of Companion Technologies. "The advantage to the doctor's office is knowing, while they have the patient in front of them, how much the patient liability is, and not having to go after them after they leave the office."

Each patient covered by the insurer will eventually be issued a card that can be swiped in a device that can read it and connect to BlueCross BlueShield's system through a broadband Internet line. The reader will be able to process credit- and debit-card payments and communicate about insurance eligibility and claims information.

The service lets patients know what they owe right away. At the same time, patients likely would be expected to pay right away, without having in hand the full level of detail generally provided by an "explanation of benefits" form, which would be mailed later.

Companion Technologies' swipe-card reader

Companion Technologies plans to start marketing the readers to doctors in August for lease at $19.95 per month, though they are available now. The insurer is in the process of creating new cards for its members that will be swipeable and is distributing them over the course of the next year. Meanwhile, doctor offices can type in patients' insurance information.

Humana Inc. is also conducting pilot tests of a system to process certain claims in real time, especially simple ones sent in by primary-care physicians. The Louisville, Ky.-based insurer is testing the system in regions where there are large groups of Humana patients with high-deductible coverage, says Janna Meek, the insurer's national director of provider connectivity.

One benefit to Humana is building relationships with doctors, says Benjamin Slen, a Humana product manager. "If you can pay providers faster, you're going to be the providers' top choice in payers, which is going to be more beneficial to you than any benefit you might get from trying to hold claims for some longer period," he says.

The challenge is making the experience of paying a doctor as easy, for both doctor and patient, as it is to pay a retailer. Blue Cross and Blue Shield of Illinois in 2001 put in place a system that let doctors go online and submit claims for real-time processing rather than in bulk at, for instance, the end of the business day. But in practice, it usually hasn't ended up working that way. "It doesn't happen while the patient is standing there because [the doctors] don't want to send the claims one at a time," says Brad Buxton, the insurer's senior vice president of health-care management.

Immediacy remains an issue. At Humana, larger bills are still likely to require a slower processing period, to sort through the complexities and, in some cases, catch fraudulent claims, Ms. Meek says.

BlueCross BlueShield of South Carolina says some of its claims may slow down if, for example, there's no referral on record. On average, about 85% of claims that come into the insurer's system each day are processed without human intervention, the insurer says, and dealing with these should be easy.

Doctors also need a way to submit claims to multiple insurers without having to interact with each insurer separately. At this point, doctor offices usually send all of their claims to a "clearinghouse" company, which passes the claims to the individual insurers after it has adjusted the formatting to be read by each insurer's computer system, says David C. Kibbe, director of the American Academy of Family Physicians' center for health information technology.

Companion Technologies will have to convince doctors that it makes sense to use its new product, which keeps the "clearinghouse" company out of the process. Doctors' offices can swipe the card and type in numeric codes for the services the patient received. The insurer says that, within seconds, it will send back a receipt that indicates how much it will pay the doctor and how much the patient owes, plus information such as how much of the cost counted toward the patient's deductible. Doctors won't have to repeatedly type in their own identification information, location and details that are common to all of their patients, Companion Technologies says.

If a patient can't or doesn't want to pay before getting the level of detail available in an explanation of benefits, they'll have to discuss that with the doctor's office, says Stephen K. Wiggins, chief information officer for BlueCross BlueShield of South Carolina.

Ideally, it would be helpful to have the most detailed information right away, says Boyce Tollison, a family physician and past president of the South Carolina Medical Association. But even so, "it sounds like it certainly will be a means of increasing cash flow and making things paid more promptly," he says. "We would welcome that."

Several companies are developing technology to help speed up the medical payment process, including other cards that send data over phone lines or connect to desktop computers with Internet connections, says Katy Henrickson, a senior analyst a Forrester Research Inc. who focuses on health care and life sciences.

Because individual Blue Cross and Blue Shield plans usually have such high concentrations of patients in their regions, those insurers may have strong odds of convincing doctors to use their technology, Ms. Henrickson says.

Companion Technologies says it wants to integrate it with other insurers' systems as well. One goal is to work with insurers to allow the device to supply information such as patients' coverage status, copayments and deductibles, even if the insurer were not equipped or inclined to process claims.

For most patients, the wait for an "explanation of benefits" is likely to continue for the foreseeable future. For those with high-deductible plans who can't get instant information on what they owe, it still may make sense to wait for that EOB, even if you think you're going to have to pay for the whole appointment out of your own pocket. That's because if your doctor is in your insurer's network, you're entitled to any reduced rate your insurer has negotiated with a doctor. The EOB will say what that rate is.

Some patients are offering to pay their doctors cash, upfront, in exchange for a reduced rate. If you do that, make sure your insurer is aware you've made the payment and that it will count toward your deductible, if it should.

Corrections & Amplifications:

A new swipe-card reader from Companion Technologies has only one swipe slot. This article originally said it had two. Also, Janna Meek's title is national director of provider connectivity. An earlier version of this article said it was national director of product connectivity.

Write to Sarah Rubenstein at sarah.rubenstein@wsj.com

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Blue Cross And Blue Shield Association Study Shows Consumers Want Information To Help Them Make Healthcare Treatment Decisions

RAND Report Shows Consumers Are Seeking Greater Knowledge To Support Treatment Decisions And How Information Changes Behavior And Saves Money

CHICAGO - More than 60 percent of American consumers have searched for information to help them make treatment decisions in the last 12 months with about one-third saying the information they found affected their treatment choices or their choice of a healthcare facility, according to a new RAND Corporation report released today by the Blue Cross and Blue Shield Association. The report includes a national survey of more than 4,300 consumers.

"This report demonstrates that consumers - as patients - are actively seeking information about the best medical care options for themselves and their families," said Maureen Sullivan, senior vice president of Strategic Services for the Blue Cross and Blue Shield Association. The report also demonstrates consumers want more information to help make their healthcare choices and how appropriate decision-support tools can impact the decision-making process.

According to the survey, 52 percent of consumers said they wanted to make the final treatment decision for themselves or a family member - 38 percent said they wanted to make the decision together with their doctors. Consumer interest in more active care decision-making further increases the need for effective healthcare decision-support tools. A separate consumer survey conducted by Hart Research on behalf of the Blue Cross and Blue Shield Association last fall, revealed that despite their strong interest in taking an active role in their healthcare, consumers feel they are not in a position to affect the cost or quality of care they receive. Survey results showed:

- Half (50 percent) of those surveyed believe it is beyond the control of most individuals to affect the quality of the healthcare that they receive.
- Just 45 percent think there is a lot that individuals can do to make sure they receive quality care. Even fewer consumers believe that individuals can affect the costs that they pay for healthcare.
- Two-thirds (65 percent) of respondents believe that individuals cannot have much effect on their healthcare costs, whereas just 31 percent believe that there is a lot individuals can do to affect their healthcare costs.

"Although consumers perceive they have a lack of influence on cost and quality, we have seen over time that providing information to consumers and realigning incentives to promote quality care leads to higher consumer satisfaction, better healthcare outcomes and greater affordability," Sullivan said. "In short, better knowledge leads to better and more affordable care for consumers."

With consumers increasingly being asked to take a more active role in their healthcare, much of the public focus has been on information about prevention and healthy lifestyle choices. The RAND report, however, looks specifically at how consumers use information when making critical care decisions for themselves and their families.

"This report gives us a glimpse at how much demand there is for clinical decision-support tools as well as the potential for improving patient satisfaction and quality," said Mark Spranca, director of The Center for e-Health and Behavioral Sciences for the RAND Corporation. "More than 60 percent of the people we surveyed said they searched for medical information for themselves or a family member at some time in the past year. Almost all of these people had a specific condition requiring a treatment decision.

"It's also interesting that of the 40 percent of the people we surveyed who had not searched for supporting information in the last year, 94 percent said they would search for information to support their treatment choice should they or a family member need medical care," said Spranca

As part of the study, RAND reviewed existing literature on how treatment decision tools affect treatment behaviors and found that patients using decision aids are more likely to make more conservative treatment choices. For example, cardiac revascularization rates were lower among patients exposed to decision-support tools. More detailed information had an even greater impact, as RAND discovered that back surgery rates were lower among patients exposed to more detailed information than patients exposed to simpler decision aids.

"Most consumers are satisfied with the information they are finding," Spranca said. "Only seven percent of those surveyed said they were dissatisfied with the information they found."

About 70 percent of consumers surveyed said they turn to the Internet most often to find the information they need to make treatment decisions. About 60 percent said they also go to their doctor.

"This is a clear indication we should empower consumers to become better informed when making critical healthcare decisions," said Sullivan. "The challenge for physicians, hospitals and payers is to provide information to consumers in an easy-to-use format that helps them understand their treatment choices. This report shows us that there are significant opportunities to build upon the quality and affordability initiatives that already exist within our healthcare system."

In crafting the report, RAND researchers also created a matrix to evaluate the types of patient-driven clinical decisions that can increase patient satisfaction, improve outcomes and in the process provide greater affordability. For example, Rand reported that information to address the under-use of effective medical care such as Beta blockers, ACE inhibitors or statins, collectively could save as many as 70,000 lives and save the healthcare system as much as $5 billion in the first year.

Do High-Deductible Health Plans Threaten Quality of Care?

Thomas H. Lee, M.D., and Kinga Zapert, Ph.D.

Employers struggling with rising health care costs are implementing their strategy for the post–managed-care era — a shift of costs and responsibility to the consumer. As Robinson describes in this issue of the *Journal* (pages 1199–1202), this shift is likely to be accelerated by the spread of health savings accounts, which are expected to encourage as many as 25 percent of privately insured Americans to enroll in "high-deductible health plans" by the end of the decade. With these insurance products, patients bear a substantial portion of their health care costs ($1,000 or more per year for individuals). Advocates of these products hope that they will do more than shift part of the increase in health care costs to the patient: they believe that financial incentives will turn patients into "activated consumers" who exert pressure on health care providers to improve the efficiency and quality of care.

This approach raises a number of questions. First, are consumers capable of assuming the majority of the responsibility for making decisions about their own health care? Enrollment in high-deductible plans is still low, but it is increasing rapidly, and some tools for comparing hospitals and physicians are already available on the Internet. But will turning patients into consumers actually improve the outcomes of their care? Or might the health of financially concerned patients suffer because they choose not to seek care or not to adhere to medication regimens?

For critics of consumer-directed health plans, these questions were answered two decades ago. The RAND Health Insurance Experiment showed that cost sharing (requiring out-of-pocket expenditures by the patient) reduces costs by lowering health care utilization — but that it has some undesirable consequences. As compared with the provision of free care, cost sharing reduced the percentage of low-income adults who sought "highly effective care for acute conditions" by 39 percent[1] and was associated with worse blood-pressure control and less reliable use of preventive care measures such as Pap smears. In this early trial, patient-consumers did not appear to be able to differentiate necessary from unnecessary care.

Subsequent research confirms that increasing costs for patients leads to decreases in medical expenditures, but the decreases affect care that is strongly supported by evidence as well as interventions that have questionable value. After Medicare instituted reimbursement for mammography in 1991, women with supplemental insurance that covered out-of-pocket costs were found to be two to three times as likely to undergo breast-cancer screening as were women who lacked such coverage.[2] Data from the Medical Outcomes Study showed that patients with low or high copayments were less likely to seek care for minor symptoms than were patients with no copayment — and that patients with high copayments also sought care for serious symptoms at a lower rate.[3] More recently, the introduction of a tiered formulary that required high copayments for certain drugs was associated with an increase in the percentage of patients who stopped taking prescribed statins (21 percent vs. 11 percent).[4]

Since enrollment in high-deductible health plans is just starting to increase, data on whether enrollees are getting better or worse care are fragmentary at best. However, survey data collected by Harris Interactive provide little evidence of an emergence of the "market-driven health care" culture that is critical to the success of high-deductible health plans — that is, a culture in which consumers actually use data on quality to choose their hospitals and doctors. Nationally representative telephone surveys of 1000 adults conducted in 2001 and 2005 found low rates of use of information on the quality of hospitals, health plans, and physicians — and no sign of an increase in use during this period (see Table 1).

If patients have not yet turned into consumers of quality data, they are nevertheless just as sensitive to costs as they have always been. Data from a 2005 online survey of more than 900 adults who reported that they were enrolled in high-deductible health plans show that these respondents were more likely than other privately insured adults to forgo filling a prescription because of cost (see Table 2). In this survey, enrollees in high-deductible health plans were less likely to report that they had received common preventive services and were more likely to report that they had had health problems as a result of avoiding seeing a physician because of cost.

These survey data do not necessarily mean that enrollees in high-deductible health plans are actually getting worse care. Their responses could be biased by dissatisfaction with the cost sharing inherent in the design of high-deductible plans. For example, 69 percent of people enrolled in more traditional health plans said they were satisfied with their out-of-pocket costs, as compared with 44 percent of those in high-deductible health plans. Perhaps our worries based on the reports of unfilled prescriptions and forgone physician visits will not be borne out by analysis of data on what actually happened to patients who enrolled in high-deductible health plans.

Some organizations that are rolling out such plans are monitoring quality closely and report no major adverse trends to date. Nevertheless, even boosters of these plans are nervous. A national survey of 300 employers conducted by Harris Interactive in 2005 found that 80 percent believed that high-deductible health plans and health savings accounts would help to control costs by forcing consumers to spend more wisely on health care services. But 65 percent of the employers who participated in this survey also said they expected that these plans would cause consumers to forgo needed health care.

Given the findings of research to date, we believe that we should do more than worry about the dangers of shifting costs to consumers; we should prepare for the likelihood that the reliability of their care will worsen as patients realize that they are paying for it. If the rates of mammograms and Pap smears decline, and if prescriptions go unfilled, it seems clear that the results will include increases in preventable deaths from cancer, heart disease, diabetes, and other conditions.

In our view, the stakes are too high for employers, insurers, and health care providers simply to wait and see what happens. We believe that purchasers should start adjusting their plans to remove disincentives to obtaining needed care. For example, they should provide full coverage for effective preventive care and for medications for chronic conditions such as hypertension, high cholesterol levels, and diabetes. We think they should also modify product designs so that low-income patients have less exposure to financial risk. And we recommend that insurers

develop new tools and strategies for ensuring that their members understand their own benefits. Early experience with high-deductible health plans indicates that members are confused about what they have to pay for; as a result, they cut back on preventive care even when it is fully covered.

Even the very best communication tools will not be foolproof, however. Therefore, we believe that health care providers should invest in information systems and other programs to keep track of populations with chronic disease and to ensure that they receive needed care and adhere to their regimens.

We are not saying that the clock should be wound back and that these plans should be dismantled. After all, the economic pressure of increasing health care costs must be addressed, and no one is urging a return to a form of managed care that balances minimal out-of-pocket expenses for patients with severe restrictions on their choices.

However, relying on market forces alone to improve health care is a strategy fraught with hazard. We think the times call for a new approach to health insurance that combines some accountability for consumers with incentives for providers to develop systems to improve the quality and efficiency of their care. We hope that current models of high-deductible health plans will only be steps along the way to that synthesis.

References

1. Lohr KN, Brook RH, Kamberg CJ, et al. Use of medical care in the Rand Health Insurance Experiment: diagnosis- and service-specific analyses in a randomized controlled trial. Med Care 1986;24:Suppl:S1-S87. [Medline]

2. Blustein J. **Medicare** coverage, supplemental insurance, and the use of mammography by older women. N Engl J Med 1995;332:1138-1143. [Abstract/Full Text]

3. Wong MD, Anderson R, Sherbourne CD, Hays RD, Shapiro MF. Effects of cost sharing on care seeking and health status: results from the Medical Outcomes Study. Am J Public Health 2001;91:1889-1894. [Abstract/Full Text]

4. Huskamp HA, Deverka PA, Epstein AM, Epstein RS, McGuigan KA, Frank RG. The effect of incentive-based formularies on prescription-drug utilization and spending. N Engl J Med 2003;349:2224-2232. [Abstract/Full Text]

Insurer Reveals What Doctors Really Charge

To Help People Compare Fees, Aetna Posts Some Online; A Potential Bargaining Tool

By VANESSA FUHRMANS
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The growing effort to enlist consumers in reducing health-care costs has been stymied by the fact that most people just don't know what medical care costs.

Private and government health coverage has helped shield them from bills. And even with newer consumer-driven plans that employ Health Savings Accounts, which give people more of a financial stake in the issue, pricing information can be hard to come by.

Now, a major national health insurer is making an effort to change that. Starting tomorrow, Aetna Inc. plans to make available online the exact prices it has negotiated with Cincinnati-area doctors for hundreds of medical procedures and tests. The initiative, which Aetna hopes to take eventually to other parts of the country, aims to give patients the tools to comparison shop and make savvier decisions with their health-care dollars.

Paying for a Routine Checkup
What's preventive health care? The answer isn't so simple when it comes to who actually pays the doctor's bill.
Send your questions, everything from paying for doctors' visits to making sense of your insurer's "explanation of benefits," to **outofpocket@wsj.com**.

Aetna is the first major health insurer to publicly disclose the fees it negotiates with physicians. Some in the health-care industry say the move is likely to push more insurers to follow suit, which in turn would give a significant boost to consumer-driven health plans.

These plans combine high-deductible insurance policies with tax-favored savings accounts that consumers can use to pay for medical care until they meet the deductible. The idea is that because people must pay for a big chunk of their care out of pocket -- and can build up any money they don't spend on health care -- they will be wiser in how they spend that money.

For such an approach to be truly effective, consumers would need to know how much medical treatment costs. In reality, though, that hasn't been the case. Unlike in almost every other consumer industry, from airlines to apparel to restaurants, most health-care pricing isn't readily available for customers to peruse upfront. Reluctance by doctors and health insurers to provide their prices has left many patients clueless about the cost of their care until they receive the bill after the fact -- not just in consumer-driven plans, but in any managed plan where at least some of the cost is borne by the consumer.

Now, with Aetna's new listings, consumers enrolled in any Aetna health plan will be able to log on and comparison-shop for procedures and tests ranging from an annual physical to an electrocardiogram to vaccinations. The price schedules include every Cincinnati-area primary-care physician or specialist in Aetna's network, and prices for 600 common services for which the Hartford, Conn.-based insurer receives medical claims.

Comparison Shopping

Aetna's new price listings reveal variations in what specific doctors charge members for the same service:

- **Ultrasound of arteries in the head:**
  Central Cincinnati cardiologist practicing 13 years: **$193.37**
  Surburban cardiologist practicing 14 years: **$234.45**
- **Established patient visit for low to moderate problems:**
  Northeast Cincinnati internist practicing 30 years: **$62.37**
  Suburban internist practicing four years: **$51.03**
- **Electrocardiogram (EKG):**
  Eastern Cincinnati cardiologist practicing 28 years: **$28.32**
  Cardiologist in the same medical center, practicing 43 years: **$26.68**

For instance, an internist in the University of Cincinnati area charges Aetna or its members $161.32 for a visit from a new patient with moderate to severe problems, while another physician a few blocks away charges $132.23 for the same office visit. The first doctor also charges $41.89 for a chest X-ray taken from two angles, while the latter's price is $34.34.

Insured patients are supposed to be charged the same prices for their out-of-pocket costs that doctors or hospitals would charge the insurer. But insurers and many health-care providers generally consider those negotiated prices proprietary information that they don't want publicized. At most, health plans have made available just a range or estimated average of what a service costs in a specific region.

Aetna says prices vary from doctor to doctor for a range of reasons, including the doctor's prestige, the scarcity or surplus of doctors in a given specialty, or whether the doctor belongs to a small practice or large medical group -- all factors that can affect price negotiations. The negotiated fees typically are discounted from the list prices that doctors charge uninsured patients, and are available only to Aetna and its plan members. The listings, which don't include behavioral-health specialists or dentists, can be viewed by any Aetna member in the country. But so far only providers in the Cincinnati area, including parts of southeast Indiana, northern Kentucky and Dayton, Ohio, are listed.

"To create a more functional health-care market, we needed more transparency," says Ron Williams, Aetna's president.

While many health-care experts laud the Aetna initiative as a move toward sorely needed price disclosure, some say consumers still need to use the price information with a degree of caution. Most price differences have more to do with a doctor's negotiating power than with the quality of care from the physician, some doctors argue.

Molly Katz, president of the Ohio State Medical Association and a Cincinnati gynecologist, says itemized pricing alone isn't a good criterion for picking a physician. "You need more information, and sometimes it's definitely worth it to pay more for something," she says. Her own four-doctor practice dropped out of Aetna's physician network years ago over reimbursement disputes, so it won't be directly affected by the Aetna initiative, Dr. Katz adds.

Others note that while the prices of most itemized medical services don't vary tremendously from doctor to doctor, the overall cost of treating a patient can -- which is why Aetna's price disclosures are only a first step in bolstering health-care consumerism. "When you go to the doctor, you don't go to buy a procedure. You go to get a condition treated," says Ray Herschman, a national practice leader at Mercer Human Resource Consulting. "The doctor with the lower unit price might end up charging for more services." The next step, he adds, will be comparing doctors on their overall cost of treating those conditions.

As fee information becomes more readily available, it is likely to put more pressure on doctors to compete on price, says Regina Herzlinger, professor of business administration at the Harvard Business School and a leading consumer-directed health-care advocate. That, in turn, may prod physicians to publish or share data on the quality of the care they provide, she says, even though some have resisted attempts at doctor quality ratings until now. "If I were a doctor, I would want to demonstrate all the things I offer besides price," says Prof. Herzlinger.

Getting even basic price data is crucial, employers say. Owens Corning, a Toledo, Ohio, fiberglass-products maker, began offering an Aetna consumer-directed plan in 2004. Though the plan has been popular, benefits director Mark Snyder says many employees have asked for better information about prices. The new Aetna Web site will be "certainly better than what they've had," he says.

Aetna, UnitedHealth Group Inc. and other insurers already offer in some markets quality and cost-effectiveness information on some physicians, plus rough cost estimates of certain services. And health-information companies such as WebMD, HealthGrades and Subimo supply information such as physician information and hospital data on complication rates, estimated costs and available technologies.

Competition may be one reason Aetna is moving aggressively. As consumer-driven plans rise in popularity, health insurers will compete less on premiums and more on the financial and information services consumers will need to use them effectively.

Aetna says it spent a few months conducting focus groups with doctors and demonstrating the pilot project to state and local medical societies. A few doctors have voiced concerns, says Donald Nofziger, a local pediatrician and president of the Cincinnati Academy of Medicine. But he hopes the shift toward consumer-directed care represents a more effective way of controlling costs than squeezing local physicians in fee negotiations.

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