Consumer-Driven Health Plans: New Developments and the Long Road Ahead

LOTS OF PROMISE BUT ALSO SOME SERIOUS PROBLEMS

By Richard M. Scheffler and Mistique C. Felton

Richard Scheffler is the Director, Nicholas C. Petris Center of Health Care Markets and Consumer Welfare, and Distinguished Professor of Health Economics and Public Policy at University of California, Berkeley. He is director of the new Mental Health Economics Training Program funded by the National Institute of Mental Health; founding director of the Scholars in Health Policy Research Program funded by the Robert Wood Johnson Foundation; and co-director of the Health Services and Health Policy Research Training Program funded by the Agency for Healthcare Research and Quality. His research is on health care markets, health insurance, the health work force, mental health economics, social capital and health, pharmacoeconomics, and international health systems. He holds a Ph.D. in economics from New York University

Mistique Felton holds a Master of Public Health degree from the University of Michigan's School of Public Health, Department of Health Management and Policy, and received her undergraduate degree from University of California, Berkeley. She is a research associate at the Nicholas C. Petris Center of Health Care Markets and Consumer Welfare.

The continued rise in U.S. healthcare spending, along with growth in the number of uninsured, has spurred the move toward consumer-driven health plans. We review new legislation covering such plans, analyze their penetration in the marketplace, and predict their growth. We also use current information about plans that are compatible with Health Savings Accounts to compare them to traditional Preferred Provider Organization plans. Next, we discuss some concerns about the impact of these plans on vulnerable populations, such as the poor and sick. Finally, we suggest how consumer-driven health plans may help to improve the functioning of the healthcare market, especially by producing more transparent information on cost and quality.

The continued rise in U.S. healthcare spending, along with growth in the number of uninsured, has spurred the move toward consumer-driven health plans (CDHP) (Holahan and Cook, 2005). These plans—including Health Savings Accounts (HSAs) and Health

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Reimbursement Accounts (HRAs)—posit that an active consumer, shopping in the healthcare marketplace, will reduce expenditures and perhaps improve the quality of care delivered.

In this paper, we provide reviews of new legislation covering such plans. We describe the structure of HSAs and HRAs, analyze their penetration in the marketplace, and provide predictions of their growth. Additionally, as an indicator of what is likely to happen nationally, we provide new information on the healthcare market in California. We provide current information about proposals by Kaiser Permanente of California to roll out HSA-compatible plans later this year, and we compare HSA plans to traditional Preferred Provider Organization (PPO) plans in Blue Shield of California. We also discuss some concerns about the impact of these plans on vulnerable populations, such as the poor and sick. Finally, we offer suggestions on how consumer-driven health plans may help to improve the functioning of the healthcare market, especially by producing more transparent information on cost and quality.

How HSAs and HRAs Are Structured

HSAs were established under the Medicare Modernization Act in 2003. These plans are linked to a high-deductible health plan (HDHP), with a yearly deductible of at least $1,050 for an individual and $2,100 for a family. These plans can be funded either by the employer or the employee, and any funds not used at the end of the year can be rolled over to the next year. The money in an HSA stays with the employee, it is portable between employers, and the amount spent on healthcare is tax-free.[1] Individuals can contribute up to $2,700 or the plan deductible, whichever is less. For families, the maximum contribution is $5,450 or the deductible. The legislation allows people over age 55 to make additional contributions to HSAs (up to $700 a year in 2006) until age 65; this increases to an additional $800 in 2007, $900 in 2008, and $1,000 in 2009. After the age of 65, people can withdraw the money and use it for any purpose without a penalty. Although the money in HSAs is taxable if used for non-medical purposes, it is similar to an IRA at age 65. Most states have also eliminated state income tax for earnings in these plans. Seven states,[2] including California, have not yet created a state tax exemption for HSAs, and four are now processing legislation to remove these penalties.[3]

Health Reimbursement Accounts (HRAs) were established in 2002 by the Treasury Department. The employer owns and funds HRAs, and money not spent in one year can be rolled over for future use. If an employee leaves the company, the money in the HRA stays with the employer. Gaming of the system and perverse incentives may arise for both employers and employees in this arrangement. Clearly, policies and procedures will need to be implemented to address this issue.

HRA accounts have a 15 percent tax if used for non-medical purposes, but are tax deductible if used for medical expenses specified in IRS regulations. These plans are quite flexible; there is no exact plan requirement and the employer can define the reimbursable expenses, under specified IRS taxable rules. For example, the employer can choose whether co-payments, deductibles, or prescription drugs are reimbursable under the plan. While HRAs can be used with any type of health plan, most employers tie them to high-deductible health plans.

HSA and HRA Growth

Although HSAs and HRAs are relatively new, they are catching on in the marketplace. Gail Wilensky, an economist and a senior fellow at Project HOPE, reports that by the end of 2004, 600,000 people had HSAs and 1.4 million people had HRAs according to the National Institute for Health Care Management (NIHCM) Foundation (Wilensky, 2006). In 2005, 1.6 million employees were enrolled in high-deductible health plans with HRAs, according to data from a Henry J. Kaiser Family Foundation/Health Research and Education Trust survey. Further, more than one million people were enrolled in HSAs in March 2005, which was twice the number just six months earlier according to surveys by America's Health Insurance Plans (AHIP). In a more recent study by AHIP, the enrollment in HSAs tied to HDHPs has jumped to 3.2 million in 2006, a three-fold increase in just one year (AHIP, 2006).

Evidence from California suggests that new consumer driven health care products are being developed. For example, Kaiser Permanente, the largest nonprofit healthcare company in the country, with approximately six million enrollees in California, rolled out HRA-compatible health plans in the Sacramento and San Diego regions and are expected to roll out these plans statewide in 2006. Kaiser also has HSA-compatible plans in Georgia,

[1]If HSA funds are spent on non-medical purposes (anything not included in the IRS rules for medical expenses) there is a ten percent penalty and becomes part of the taxable income for people under 65.
[2]These states are Alabama, California, Massachusetts, Maine, New Jersey, Pennsylvania, and Wisconsin.

[3]From National Conference of State Legislatures website on HSAs (NCSL, 2006).

TABLE 1

COMPARISON OF SELECTED BLUE SHIELD PLANS

Plan Name	PPO Savings Plan 1250 (HSA eligible)	PPO PLAN 1000 (Traditional PPO)
Sample Premiums (Individual/Family)†	$228/$509	$242/$541
Co-payment Percentage (Blue Shield Responsibility for Preferred Provider/Non-Preferred Provider)	80%/50%	80%/50%
Lifetime Maximum	$6,000,000	$6,000,000
Annual Deductible (Individual/Family) Out-of-Pocket	$1,250/$2,500	$1,000/$2,000
Co-Payment Maximum (Individual/Family)	$4,000/$8,000	$4,000/$8,000 (Preferred Provider) $10,000/$20,000 (Non-preferred Provider)
Office Visits (Preferred Provider)	20%	$45/visit (Deductible waived)
(Non-Preferred Provider)	50%	50%
Preventive Care (Preferred Provider)	$25/visit	$45/visit (Deductible waived)
(Non-Preferred Provider)	Not covered	Not covered
Hospitalization (Preferred Provider)	20%	$1,000/year + 20%
Hospitalization, Outpatient Surgery and Skilled Nursing Facility (Non-Preferred Provider)	50% up to $600/day + all charges over $600/day	50% up to $600/day + all charges over $600/day
Outpatient Surgery*	20%	$500 + 20%
Ambulance Service	20%	20%
Skilled Nursing Facility*	20%	20%
Emergency Room	$50 + 20% co-pay	$100 + 20% (Deductible waived)
Retail Pharmacy-Prescription Drugs (Up to a 30-day supply)	20%	$10 Generic, $25 Brand, $40 Non-formulary Brand
Mail Service Pharmacy-Prescription Drugs (Up to a 90-day supply)	20%	$20 Generic, $50 Brand $70 Non-formulary Brand

†Sample of premiums from a fictitious company with 15 employees in the Bay Area.

* Preferred Providers only

Washington DC, Oregon, and Colorado, and intends to roll out HSA-compatible plans in California by 2007. It is likely that the premiums for these plans will be 20-30 percent lower than the traditional HMO plans. As a Kaiser representative pointed out "The core philosophies of consumer-driven health plans come naturally to Kaiser due to the long tradition of consumer engagement, disease management and information technology management."[4] In California, options exist for both co-pay and co-insurance for HRA-based plans once the deductible is reached. HSA-compatible plans are primarily co-pay based once the deductible is reached. In addition, Kaiser Permanente's rich health content and on-line decision making tools—including new features that provide cost information for medical out-of-pocket expenses—provide a unique opportunity for Kaiser Permanente in the consumer-directed health care market.

[4]Personal communication from Kaiser Permanente of California.

Similarly, Blue Shield of California, the third-largest health plan in the state, with 3.3 million members, is currently offering HSA-compatible health plans.[5] Additionally, Blue Shield provides an online service to allow consumers to choose a hospital based on cost and selected quality indicators. Table 1 shows a sample of premiums and plan benefits for selected Blue Shield plans. The HMO plans are the most costly, ranging from $331 a month with a $15 co-pay for individuals, to $233 for the plan with a $40 co-pay.[6] The premiums of the HSA plan (PPO Savings Plan 1250) are six percent lower than a comparable traditional PPO plan, such as Shield PPO 1000. The major difference between these plans is the ability to use tax-free dollars in HSA accounts to pay for healthcare expenditures in the PPO Savings plans.

[5]All prices were given for a hypothetical small group located in the Bay Area from the website, http://www.healthplanscalifornia.com/. The plan benefit comparison chart is from Blue Shields 2-50 Group Health Plan comparison charts, *https://www.mylifepath.com/bsc/employer/download/A11368-SM.pdf;jsessionid=TORZPTBGNHWKNJP3YYRCGLNF5XDCKITT.*

[6]Data for selected HMO plans not included in table.

However, if compared to the standard PPO plan ,[7] the premiums for HSA plans are 29 percent lower.

Differences between Benefits in HSA PPO Plans and Other PPO Plans

In both of Blue Shield's PPO plans, patients pay for 20 percent of all costs for in-network use as shown in Table 1. For out-of-network use, patients pay 50 percent of costs. Both of the PPO plans provide a co-pay for preventive care. However, office visits in the non-HSA PPO plan also have a co-pay attached to them. In the non-HSA PPO plan, prescription drugs have co-pays attached to them, while the HSA plans require 20 percent of costs be paid by the patient. Consumers assume more responsibility for costs in HSA-eligible plans, possibly to promote consumer shopping. The non-HSA PPO plan waives the deductible for preventive care, office, and emergency room visits, while the HSA plan does not—although the law allows a waiver for preventive care to encourage its use. Blue Shield sales of HSA-compatible plans in 2004 were 2.7 percent of all group plans sold, and increased to 3.7 percent of all group plans sold in 2005.[8]

Additional information suggests that these plans will continue to grow rapidly in the next few years. A California HealthCare Foundation/RAND study found that four percent of firms are very likely to offer an HRA with a HDHP next year and 23 percent are somewhat likely to offer them. At the same time, two percent are very likely to offer HSAs with HDHP next year and 25 percent are somewhat likely to offer them (RAND, 2005). The exact form and pricing of these plans have yet to be worked out in the marketplace, and there will be some shakeout of the various plans depending on consumer preferences.

Policy Concerns

Data suggest that individuals who select HSAs and HRAs will be healthier on average, leading to adverse selection. The results from a study by the Employee Benefits Research Institute show that consumers with high-deductible health plans are in better health, less likely to smoke, and more likely to exercise (Fronstin and Collins, 2005). Adverse selection will cause problems in the non-HSA market because the individuals who are left in these plans will be sicker and more expensive on average, causing premiums to increase.

A second concern is one of equity, which was emphasized by Princeton economist Uwe Reinhardt in his talk at the HSA briefing by the Kaiser Family Foundation (Kaisernetwork.org, 2006): "...If a household of $40,000 can bear a deductible of $4000 and a maximum risk of say, $6000, it would mean that for congressmen and policy wonks [people with incomes of $200,000] the deductible should be $20,000 with a maximum exposure of $30,000." While provocative, it is illustrative of the lack of equity in the programs. Furthermore, Newhouse (2004) cited the well-known RAND health insurance experiment, which showed that on average, people who were poor and sick were adversely affected by cost-sharing. The annual likelihood of death increased roughly ten percent for low-income patients with hypertension. It seems likely that consumer-driven health plans will have a greater and disproportionate adverse impact on those who are poorer and sicker. One approach to address this concern would be to eliminate cost-sharing for chronic conditions.

A third concern is how well the current marketplace is set up to allow consumers to shop for healthcare. Wilensky (2006) calls attention to the need for more transparent data on hospital costs. Additionally, Reinhardt noted that individuals who went outside of their PPO network to shop for prices of physician services were unable to find systematic information (Kaisernetwork.org, 2006). Currently, it is very difficult for a consumer to shop for hospital services using any systematic data set that includes cost and quality information. This may change under a new initiative by President Bush to require the reporting of pricing information from Medicare, the Department of Defense's TRICARE, and the Federal Employees Health Benefits Plan (Medical Newswire, 2006). It is clear that for CDHPs to reduce costs and improve the quality of healthcare, reliable and comparable information will be needed in the marketplace. It will be years before we know if CDHPs improve the healthcare market and what impact, if any, they have on costs.

Conclusion

It is likely that the healthcare industry will continue to experiment with consumer-driven health plans for the next few years. Anticipated increases in information on price and quality will help people shop more effectively for healthcare. For complicated medical conditions, where consumers are less able to shop, the impact will likely be less. The decreased premiums compared to existing insurance may make health insurance affordable to people who were previously priced out of the market. However, an important consideration is the potential for costs to be driven up so high in the non-CDHP market, due to

[7]For small businesses, the standard PPO plan is the PPO PLAN 250 STANDARD.
[8]Personal communication with Blue Shield of California.

adverse selection, that healthcare becomes unaffordable. Even more important, low-income people may find it difficult to pay for the added out-of-pocket costs necessary under CDHPs. ■

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