Informational Hearing
February 21, 2006
State Capitol, Room 4202
Background: High Deductible Health Plans: Consumer Directed? (Part 1)

As health insurance premiums continue to rise, employers and individual purchasers have increasingly looked for ways to secure affordable coverage. In response, health insurers have developed products with lower premiums by reducing benefits and/or increasing consumer out-of-pocket costs at the time of service. Workers are being asked to contribute a greater share of the premium costs for employer-sponsored plans, while the coverage they receive comes with increased copayments for physician office visits, emergency rooms, diagnostic procedures, hospital stays and prescription drugs. Annual deductibles (the amount consumers must spend each year before the insurance benefits are available) have been steadily rising. Federal tax changes in 2003 further encouraged movement toward higher deductible policies by allowing individuals to establish tax-free Health Savings Accounts (HSAs), as long as the accounts are combined with a High Deductible Health Plan (HDHP) meeting federal standards. Insurers report that they are simply making an array of coverage and premium options available to both individual and group purchasers who can choose what works for them.

The phenomenon of lower cost HDHPs with greater consumer out-of-pocket costs has been accompanied by an array of health insurance marketing strategies and philosophical assertions about the role consumers play in the escalating costs of health care. HDHPs are being marketed as "consumer directed" and "consumer driven," based on the theory that consumers, when asked to pay an increasing share of the costs, will make more cost-conscious decisions, including choosing not to seek care in some instances, thereby reducing overall health care costs.

HDHPs are controversial. Proponents make the argument that individuals covered by these plans will be more astute health care consumers, choosing providers and services based on cost and quality. Supporters of HDHPs argue that traditional insurance insulates people from the financial consequences of their health care and lifestyle choices, while an HDHP encourages consumers to engage in activities to improve and maintain their individual health and wellness. Critics counter that HDHPs are a blunt instrument that will discourage the appropriate and timely use of services, especially among those with the lowest incomes and/or chronic health conditions and those who experience health problems outside of their control. Opponents view HDHPs as substituting medical expertise for consumer decision making, where consumers would have to make complex choices with limited knowledge and information, based in part on their financial status, at a time when they may be experiencing physical or mental health challenges. There is significant rhetoric and national attention on HDHPs, but only limited empirical data on their potential impact on health costs, utilization and health care outcomes.

What is an HDHP? Types of High Deductible Health Plans

In its simplest form, an HDHP is typically a Preferred Provider Organization (PPO) insurance product, or to a much lesser extent an HMO product, requiring the insured person to pay directly for health care services each year, up to a defined annual "deductible" dollar amount, before the insurance plan pays for any benefits. HDHPs have higher annual deductibles than the average PPO or HMO product. For example, the national average individual deductible for covered workers was $221 in 2004, while the Internal Revenue Service (IRS) defines an HDHP for HSA tax purposes as plans with annual deductibles of $1,000 or more for an individual and $2,000 or more for a family.

HDHPs are sometimes combined with tax-favored savings accounts. Federal law establishes three types of accounts that are most often paired with HDHPs: Archer Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs) and HSAs. As part of a cafeteria plan, employers can also establish and contribute to Flexible Spending Arrangements (FSAs) for employees who set aside pre-tax dollars for health care expenses. Medicare beneficiaries may establish a Medicare Advantage MSA, but the IRS reported none existed as of December 2005.

Federally Defined Financial Accounts For Health Savings Purposes		
Account Type	**Description**	**Federal Standards**
Health Reimbursement Accounts (HRAs)	Funded by the employer to help employees pay for medical expenses. The account is owned by the employer, not portable and unused dollars can be rolled over year to year. Self-employed persons are not eligible for an HRA. Employer contributions are not counted as taxable income.	No requirement that HRAs be paired with any type of health care plan. May be offered in conjunction with other employer-provided health benefits. Employers have complete flexibility to offer various combinations of benefits with their HRA plan and there is no limit on the amount they may contribute to the HRA. Funds in the HRA may be used for any IRS-defined "qualified medical expenses," including a broad array of medical, dental and vision services.
Health Savings Accounts (HSAs)	Funded by the employer, employee or both. Employer contributions are not counted as income and employee contributions are pre-tax. The account is owned by the individual, is portable, and unused dollars can be rolled over to the next year. Self-employed persons are eligible. To be eligible for an HSA tax benefit, individuals and families must not have any other health coverage.	Must have an HDHP. Contributions to the HSA (2005) may be made up to the amount of the HDHP deductible, but no more than $2,650 for individuals / $5,250 for families. HDHP must have a minimum annual deductible of $1,000 for individuals / $2,000 for families, and maximum annual out-of-pocket expenses (deductible, copays, etc.) of $5,100 individual and $10,200 family. May be used for "qualified medical expenses," not including premiums, but not limited to deductibles and copayments under the HDHP. Preventive care benefits, as defined by the IRS, may be outside of the deductible or subject to a lower deductible.
Archer Medical Savings Accounts (MSAs)	Funded by the employee, employer, or both, or a self-insured individual. Eligibility is limited to self-employed persons and employees in small and "growing" businesses. The account is owned by the individual, is portable, and unused dollars can be rolled over to the next year.	Must have an HDHP. Contributions are limited to 75% of the deductible or the employee's annual income from the employer. HDHP must have a deductible of $1,750-$2,650 / individuals, $3,500-$5,250 / families and maximum annual out-of-pocket expenses of $3,500 / individual and $6,450 /family.

Because the marketplace is changing at such a fast pace, terminology on the different types of products is evolving and can sometimes be very confusing. For example, in the popular press, the term consumer-directed health plan (CDHP) is often applied to all HDHPs. However, the health insurance industry and observers of the industry are currently defining CDHPs as HDHPs combined with **both** a financial account or other financial incentives for consumers to select lower cost services or providers (sometimes also referred to as tiered premium or tiered benefit plans) **and** "tools" or resources intended to help consumers manage their health care costs.

Most HDHPs being sold today generally fall into one of the following categories:

- **Stand-alone HDHPs** - (generally a PPO-model product) with no associated financial account and no limits or requirements on the size of the deductible, benefits subject to the deductible or annual out-of-pocket costs;

- **HDHPs paired with an HRA** - funded by the employer, with no limits or requirements on the size of the deductible, benefits subject to the deductible or annual out-of-pocket costs;

- **HDHPs paired with an HSA** - funded by the employer, the employee or both, subject to federal requirements on the size of the deductible, services outside of the deductible and annual out-of-pocket maximums; and,

- **CDHPs** - HDHPs combined with a financial account (HRA, HSA, MSA), and also promoting the availability of tools and resources intended to help consumers manage health care decisions and improve their health, such as on-line tools, wellness programs, chronic disease management and/or catastrophic case management.

Trends in HDHPs – Consumers Confused and Reluctant to Embrace HDHPs

There is evidence that the prevalence of HDHPs is growing and is likely to continue to grow at a rapid pace. A recent publication by America's Health Insurance Plans (AHIP) asserts that nationally there are more than three million individuals with HDHPs compatible with HSAs. According to The RAND Corporation, while 8% of California employers offered an HDHP in 2004, this figure could increase to more than one-third of employers within two years, if employers carry out their reported intentions to add HDHPs to their health plan offerings.

Despite the national coverage and visibility of HDHPs and HSAs, consumers appear to be playing catch up in their knowledge of these products. The numerous plan and coverage types, and tax-favored accounts with different federal rules, make the current HDHP marketplace confusing and overwhelming for consumers. For example, a recent Kaiser Family Foundation survey exploring consumer reactions to the President's 2006 State of the Union speech, where he called for expansion of HSAs, found that seven out of ten people (71%) have not heard of HSAs or do not know what the term means. When presented with three possible definitions, only 38% correctly identified a description of the accounts as allowing people to set aside tax-free dollars to pay for routine health costs not covered by high-deductible insurance plans.

National data from the 2005 Kaiser Foundation/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits found that where employers offer HDHPs with

financial accounts, employee enrollment is still relatively low (15% for HSA-qualified products and 25% for HRA-products).

National coverage and reporting on the trends suggests that in the early stages most employers are implementing HDHPs as alternatives rather than as replacements to current coverage choices. However, Harris Interactive reported to the California HealthCare Foundation, based on data from the 2005 Strategic Health Perspectives, that 47% of employees currently enrolled in an HDHP said they did not have a choice of health plan at the last enrollment. In addition, 19% of individuals looking to buy individual coverage reported they did not have a choice of plan.

While the insurance industry estimates three million people have HDHP products *compatible with HSAs*, data being compiled by the trade publication Inside Consumer-Directed Care shows that only about one million HSA accounts existed by January 1, 2006. Similarly, Harris Interactive reports that of consumers with an HDHP, only 13% have an associated financial account (HRA or HSA). This could mean that many consumers with HDHP coverage will not have the funds available to cover their deductible should they need expensive medical care or hospitalization. Some HDHP products associated with financial accounts include a "debit card" connected to the HSA account which consumers use for health care services not paid for by the HDHP. In some but not all instances, the debit card converts to a credit card once the funds in the HSA are exhausted, allowing consumers to continue to pay for health care services while accruing health care related debt. This is a potentially dangerous trend, since studies have shown that medical care is a significant contributor to bankruptcy for many families. In one study, researchers found that nearly half of those filing for bankruptcy in 2001 cited medical expenses as a contributor, even though 75.7% percent had some form of insurance coverage at the onset of illness.

Pending Policy Changes – President Promotes HSAs for Low-Income Families

The President proposed in his 2007 federal budget to expand the ability of employers and individuals to use HSAs, including increasing the amounts that can be set aside in an HSA account, and creating a refundable tax credit for the lowest income families. For example, a family of four with income of $25,000 per year or less would be eligible for a $3,000 refundable tax credit, if they were enrolled in an HDHP and funded an HSA of $2,000 or more. However, depending on the type of companion HDHP these families secured, their total out-of-pockets, including costs payable at the time of service, could exceed $10,000 for premiums, deductibles and copayments, or more than 40% of their income. At the same time, the President proposed to reduce the standard health tax credit targeted at low-and moderate-income families from $77 billion over five years in last year's budget to $24 billion over five years in this new budget.

Many observers are concerned that the HSA-approach is more workable and advantageous for wealthier taxpayers. For example, one estimate of the tax benefit for families under current HSA rules, using tax tables from the Treasury Department, showed that a married couple with two children and income of $40,000 in 2005 would save $630 on their federal income taxes if they had made a $5,000 contribution to a health savings account. A similar family making the same contribution of $5,000, but with an income of $120,000, would save $1,500 in taxes. The relatively low tax benefit for a lower income family of $630 does not appear to be a significant offset to the out-of-pocket costs they would have to incur for premiums, deductibles and copayments under the HDHP, which could be well in excess of $10,000 per year.

The Governor's 2006-07 revenue estimate assumes a state revenue reduction of $3 million in 2005-06 and $8 million in 2006-07 to conform state tax law to the existing federal treatment of HSAs. Presumably an increase in the federal allowance for tax-free HSA contributions as proposed by the President would increase the cost of conformity. In addition, in subsequent years, if the prevalence of HSAs increases as is generally predicted, the cost of state tax conformity could substantially increase. Bills to conform California tax laws to federal HSA provisions have not been successful to date, in part because of the controversy surrounding these products and the potentially significant loss of revenue to the state General Fund at a time of continuing state budget deficits. The introduced version of AB 115 (Klehs) of 2005 included conformity on HSAs but those provisions were amended out in the Senate. AB 661 (Plescia) of 2005 was amended to enact HSA conformity but died in the Assembly Revenue and Taxation Committee. SB 173 (Maldonado) of 2005 included HSA conformity but died in the Senate Revenue and Taxation Committee. AB 2010 (Plescia) was introduced on February 9, 2006 to conform state tax law to federal HSA provisions.

Regulation of HDHPs in California

California remains the only state in the country where health insurance products are regulated by two different state agencies, the Department of Insurance (DOI) and the Department of Managed Health Care (DMHC). As a result, HDHP products are subject to different requirements and different oversight depending on where a carrier chooses to file the product offering.

The level of benefits and cost sharing are subject to much greater review if the product is offered under the DMHC than is the case for products under the DOI. Health plans licensed under the Knox-Keene Health Care Service Plan Act (Knox-Keene) must file new products for DMHC review and DMHC has 30 days to raise concerns with the product filing. Knox-Keene establishes minimum basic benefits, requires plan contracts to cover all medically necessary basic services and requires health plans to assume full financial risk. DMHC has authority to review and limit cost sharing consistent with Knox-Keene.

By contrast, while insurers also file products subject to potential objection by the Commissioner of Insurance within 30 days, the Commissioner has virtually no meaningful authority to set limits on out-of-pocket costs, limit coinsurance amounts or establish benefit requirements (other than those mandated benefits specifically established in state or federal law). As a practical matter, anecdotal evidence suggests that DOI has become the regulator of choice for carriers seeking to develop and sell products with very high cost sharing. If this trend is borne out in the data as DMHC and DOI assess and evaluate product trends, it means that growing numbers of Californians will have HDHP coverage under DOI, with much more limited regulatory oversight and review.

Note: Additional background on the pros and cons of HDHPs, including an overview of the available research will be made available for Part II of this hearing.

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