

Protecting Consumers

in an Evolving Health Insurance Market

J U N E 2 0 0 6

NCQA

Measuring the Quality of America's Health Care

This paper was commissioned by NCQA and was prepared by Patricia A. Butler, JD, DrPH.

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EXECUTIVE SUMMARY

For over 80 years, insurance plans and products have emerged in the U.S. to provide and pay for health care. Following early prepaid group practice models and Blue Cross hospital payment plans, commercial indemnity insurance became a common workplace benefit in the 1940s. Spurred by changes in federal policy and demands from large employers to control expenditures, Health Maintenance Organizations (HMOs) grew in popularity in the mid-1980s and early 1990s. HMOs and other managed care products (e.g., Point of Service (POS) plans) helped slow the rate of medical care spending increases but prompted provider and public hostility that led to federal and state regulatory restrictions and changes in plan design that loosened or eliminated some of the controversial (and often effective) restrictions on utilization. As medical care inflation again grew rapidly in the late-1990s, employers and policy makers sought new ways to control spending, turning their attention to several approaches to contain costs, such as “value purchasing” (buying care from high quality and efficient providers, including specialty providers), “disease management” (personal case management for costly and complex conditions), and “consumer-directed” health plans (CDHP) that place greater financial responsibility on health plan enrollees to select and pay for health care services. These market trends emerged independently but are viewed by many group purchasers as complementary.

High deductible plans paired with spending accounts or other means of increasing point-of-service cost sharing have generated heated debate among health policy analysts, researchers and politicians. Ongoing research may further inform public discussion of the advantages and disadvantages of this approach to financing health care. But because market presence and participation in these products is growing, it is useful to consider whether enrollees face problems that warrant consumer protection from state insurance regulators or private accreditation organizations like NCQA.

This paper outlines the evolution of both health insurance and its regulation and summarizes the early experience with the new consumer-directed products. It then considers potential strategies that regulators and accrediting organizations could use to address problems consumers may face in an evolving insurance market, including ways in which regulators and accreditors could treat similarly organizations performing similar functions, setting standards that protect consumers regardless of the products or financing and delivery models in which they are enrolled.

States are authorized by Congress to regulate health insurance. The primary objectives of insurance regulation are:

- Protecting consumers from insolvency and fraud;
- Facilitating the insurance market's stable functioning;
- Providing access to highly valued services; and
- Assuring that promised services are available and accessible.

State insurance laws vary across and within state lines, with differing benefits mandates, managed care standards and definitions of Preferred Provider Organizations (PPOs). State licensure laws establish minimum structural standards for an insurer to operate. Voluntary private accreditation can augment state regulation by establishing higher standards that include health care processes and outcomes, identify various levels of performance and reflect current clinical practice standards.

For purposes of this paper, consumer-directed health plans include high deductible health products that can be paired with spending accounts (health reimbursement accounts or health savings accounts). In order to establish a tax advantaged spending account, a high deductible health plan must have a deductible of at least \$1050 for individuals and \$2100 for couples and families. Spending account funds can be used to pay the cost of services below the deductible or non-covered health care services. Employers are increasingly offering high deductible plans with or without spending accounts, but predictions of their long-term appeal vary widely.

Proponents of consumer-directed health plans assert that high deductibles and other cost sharing will reduce insurance premiums, leading to more insured Americans. They also contend that higher deductibles will instill cost consciousness, turning "patients" into "consumers" and reducing the growth in national medical spending. Critics of this approach doubt they can reduce medical care spending due to its highly skewed distribution (where a small fraction of Americans account for most expenditures each year due to costly chronic and/or acute illness) and the fact that costly care will quickly exceed the deductible, tempering any incentive to be a prudent purchaser. They also identify the lack of timely, accurate and usable information on provider cost and quality as a major limitation to prudent consumer purchasing. And they worry that high deductibles may cause vulnerable populations, such as people with chronic illness or low incomes, to forego or delay needed care. They also fear these cheaper products will fragment the insurance risk pool by attracting healthier people, leaving the less healthy in more comprehensive coverage that becomes increasingly less affordable.

There is limited evidence on whether high deductible health plans (with or without spending accounts) will achieve any of their objectives. Despite the optimistic predictions of CDHP advocates, however, the impact of these plans on overall medical care spending and the rate of uninsurance is likely to be limited. Increased cost sharing may

help sensitize consumers to the costs of health care as a means to engage them in policy discussions about the difficult trade-offs facing health plans and public and private purchasers. But even analysts asserting this view believe that cost sharing should be targeted to services over which consumers have discretion and that restraining medical care spending requires providers, purchasers and delivery systems to manage costly care.

People enrolled in high cost sharing plans may experience problems such as misunderstanding how to choose or use the plans, disincentives to seek appropriate care and the potential loss of access to more integrated health plans that can improve quality by providing coordinated, evidence-based care. In examining ways state regulators and accrediting bodies might address these problems, it is useful to look at the health insurance market in four categories. Because ERISA, the federal Employee Retirement Income Security Act of 1974, prohibits states from regulating private-sector employer-sponsored health plans (while allowing states to regulate insurance), states can regulate products sold to individuals, small groups and many large firms, but not self-insured plans offered primarily by large firms and covering over half of American workers.

In order to protect — and perhaps enhance — consumers’ ability to “drive” or “direct” their care, states and national accrediting bodies should consider the following steps:

1. While differences in state health care markets, political landscapes, and regulatory culture result in different health insurance regulations, greater national consistency is useful to minimize burdens on purchasers and plans. States should be encouraged to regulate more consistently by adopting National Association of Insurance Commissioners (NAIC) model laws, establishing uniform standards for all health insurance entities (e.g., HMOs, PPOs, POS, and high-deductible health plans (HDHPs)/CDHPs) while deeming accredited plans to have met comparable state standards (as many currently do).
2. Consistent with the objectives of health insurance regulation, states could oversee administration of spending accounts by insurers and accuracy of information about them and also monitor risk segmentation among health insurance products. States and accrediting bodies should also consider developing standards for high deductible health products to assure that consumers have access to the information they need to make prudent choices about whether, when, and where to seek health care. Most health plans offer decision-support services such as web-based tools and nurse advice lines, but little is known about their effectiveness. Accrediting bodies should also include such measures to evaluate the usefulness of these services in their accreditation standards.
3. To determine whether high cost sharing plans result in foregone needed care, state policy makers should examine utilization patterns by enrollees in different insurance products and determine whether to require plans to do so. Accrediting bodies should consider requiring comparisons of quality measures (e.g., HEDIS® and

CAHPS[®]) by enrollees in different product types as well as establishing standards to monitor potential underuse by vulnerable populations.

Because high deductible plans paired with Health Savings Accounts (HSAs) have been sold in the insurance market only recently, it is not surprising that state insurance regulators have not reported significant consumer problems with these products. But because there is no perceived current crisis, which could lead to hasty and possibly poorly-conceived legislation, the time is ripe for state regulators and accrediting bodies to consider joint efforts to address consumer issues in the evolving health insurance market. These discussions should include how both to avoid stifling innovation and to treat similarly organizations performing similar functions.

A. Regulatory Equity

Interstate consistency

- State insurance regulators should conform their health insurance laws (for example, internal plan grievance procedures, external review laws, and coordination of benefits rules) to a single model in order to minimize variation, reducing costs and administrative burdens.
- State insurance regulators should consider allowing HMOs and PPOs that meet relevant accreditation standards, such as provider credentialing and quality management systems, to have met those respective state standards.
- Accrediting bodies should review the NAIC health insurance model laws to consider whether they represent the state of the art for these structural standards.

Intrastate consistency

- State insurance regulators should revise health insurance standards so that all risk-assuming entities performing similar functions are regulated identically.
- State insurance regulators should explore regulation of non-risk-bearing PPOs even if they contract with self-insured ERISA plans by imposing the same standards for consumer information, network adequacy, provider contracting, and quality oversight that apply to risk-bearing PPOs.

B. Protecting Against Insolvency and Fraud

Fraud prevention

- State insurance regulations should monitor to determine whether health plans accurately represent their products and to enforce existing consumer protection standards regarding information disclosure.

Monitoring HSA administration

- States insurance regulators should consider whether HSAs not offered by licensed banks or securities firms should be regulated by a state agency with consumer protection responsibilities.
- State insurance regulators should consider requiring health plans offering HDHPs and HSAs to permit enrollees to use provider rates negotiated for payment by the plan or specifically by spending account holders.

C. Facilitating Market Function

Requiring more information on choosing among and using plans

- Under their general authority to enforce these laws and remedy consumer fraud, state regulators should be encouraged to monitor how well consumers understand and can use these new products.
- Accrediting bodies could include a specific accrediting standard for consumer information about how to use HDHP and spending accounts for plans that offer these products.

Making available cost and quality information

- Accreditation bodies should initiate discussions with NAIC about how to assure that health plan enrollees have access to accurate, relevant and usable data on provider cost

and quality, including the issue of how states might rely on independent quality measurement and standard-setting agencies to provide the most current standards and provider data.

- State regulators should consider how to assure that plans make cost and quality information available to plan enrollees and that such information is not misleading (including whether to require identification of independent website sponsors and whether information vendors should be regulated or accredited to assure data accuracy).
- Accreditation bodies should determine how best to include in its general accreditation process standards regarding whether and how appropriately plans provide enrollees cost and quality data (including CAHPS measures of how useful enrollees find this information).
- Accrediting bodies should consider adding standards regarding whether cost and quality information websites can be sponsored by organizations other than health care providers or plans and how to evaluate their accuracy and adequacy.

Decision support

- Accrediting bodies should include in their mandatory accreditation standards measures of whether and how well plans provide decision support in specific areas such as nurse advice lines and web-based decision tools to choose among treatment options for specific conditions.
- As enrollee use of these tools increases, accrediting bodies should consider including questions about how useful enrollees find their plan's specific decision support tools and service in order to guide improvements in these services.

Risk Segmentation

- States should be encouraged to monitor risk segmentation across product types, as new products, which might increase segmentation, enter the market.

D. Access to promised services

- Accrediting bodies should consider requiring comparisons of enrollees in HDHP and other product lines using HEDIS "Effectiveness of Care," "Access/Availability of Care," "Use of Services" and "Satisfaction" measures and, if feasible, comparisons of subgroups of people with chronic conditions
- Accrediting bodies should consider a mandatory accrediting standard that evaluates whether plans identify underuse of specific services needed for enrollees with specific chronic illness and report that information to providers in order to encourage more appropriate care for these populations.
- State insurance regulators and other state health policy makers should be encouraged to
 - *collect (through health plan report cards or other surveys) and analyze data about health care utilization by enrollees (particularly those with chronic illness and low incomes) in various insurance products in order to publicize information about this experience, and*
 - *consider whether there is a need for regulation requiring plans to evaluate utilization and health status among enrollees in different products.*
- Accrediting bodies should consider more comprehensive accreditation standards for PPOs, including applying HEDIS measures to permit more complete quality assessment of the array of managed care products.

SECTION I: Introduction

For over 80 years, insurance plans and products have emerged in the U.S. to provide and pay for health care. Following early prepaid group practice models and Blue Cross hospital payment plans, commercial indemnity insurance became a common workplace benefit in the 1940s. Spurred by federal policy and employer demand to control expenditures, Health Maintenance Organizations (HMOs) grew in popularity in the 1980s. HMOs and other managed care products slowed the rate of medical care spending increases but encountered provider and public hostility that led to federal and state regulatory restrictions. As medical care inflation grew rapidly in the late 1990s, employers and policy makers sought new ways to control spending, turning their attention to several approaches to contain costs, such as “value purchasing” (buying care from high quality and efficient providers, including specialty providers), “disease management” (personal case management for costly and complex conditions) and “consumer-directed” health plans (that place greater financial responsibility on health plan enrollees to select and pay for health care services). These market trends emerged independently but are viewed by many group purchasers as complementary.

High deductible plans paired with spending accounts or other means of increasing point-of-service cost sharing have generated heated debate among health policy analysts, researchers and politicians (Herzlinger 2002, Davis 2004, Garamendi 2006). Ongoing research may inform public discussion of the advantages and disadvantages of this approach to financing health care. But because participation in these products is growing, it is useful to consider whether enrollees face problems that warrant consumer protection from state insurance regulators or private accreditation organizations like NCQA.

This paper outlines the evolution of both health insurance and its regulation by states and summarizes the early experience with the new consumer-directed products. It then considers potential strategies that state regulators¹ and accrediting organizations could use to address problems consumers may face in an evolving insurance market, including ways in which regulators and accreditors could treat similarly organizations performing similar functions, setting standards that protect consumers regardless of the products or financing and delivery models in which they are enrolled. In preparing this paper, the author reviewed health policy and research literature and other published data sources and interviewed two dozen key informants, including health policy and legal researchers, representatives of state regulatory agencies, and individuals working with and on behalf of health plans.

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SECTION II: The Policy Environment

A. The Evolution of Health Insurance

Following the development of workplace disability insurance in the 1920s, private health insurance first became available in the 1930s when the Depression severely reduced hospital revenues and the American Hospital Association supported the concept of third party payment (Starr 1982). Because these early plans possessed little capital, hospitals agreed to provide services regardless of the level of reimbursement, originating the “hospital service plan” model that became Blue Cross. To avoid application of state insurance laws, in most states these plans obtained separate enabling legislation, even though they eventually secured capital to fund reserves. These plans embodied the notion of receiving services rather than merely insuring losses, although some required cost sharing and placed a ceiling on benefits. They pooled risk broadly and their premiums were “community rated” based on the costs of the entire covered population (Jacobi 1997). After initially resisting third-party payment, in the 1940s, physician groups also developed “physician service plans” to cover medical and surgical care, the forerunners of Blue Shield. Most of them included both direct payment to “participating” physicians and indemnity coverage for other physician services.

Commercial insurers had doubted that medical benefits could be insured because of their unpredictability and potential for “moral hazard” (the incentive to use more services due to the presence of insurance). But the experience of Blue Cross plans encouraged commercial insurers to offer indemnity coverage, which reimbursed insured persons their incurred expenses for hospital and surgical care (Starr 1982). Early commercial health insurance was sold primarily to individuals, but the growth of employer-sponsored group coverage led commercial life insurers to enter the health market. Commercial carriers set premiums based on age, gender, region and health status and Blues plans eventually adopted such “experience rating.”

Workplace-based insurance grew rapidly after World War II due to both the tax advantages of these expenditures to employers and employees and the enactment of labor laws that strengthened unions. Blue Cross and Blue Shield plans originally imposed no or only limited cost sharing, whereas commercial plans often imposed deductibles, copayments and coinsurance commonly found in other indemnity insurance products. Enrollment in commercial insurance plans exceeded that in Blues plans by the early 1950s. Due to competitive pressures, Blues plans began to impose more types of cost sharing in their products.

During the 1930s, some businesses and local governments employed physicians or contracted with physician groups, like California's Ross-Loos clinic and Kaiser Permanente, to provide medical care to workers for a monthly payment. After the AMA dropped its opposition to this form of health coverage in 1959 and, especially following the enactment of the federal HMO Act of 1973, enrollment in prepaid capitated plans grew as employers and other purchasers sought ways to control rapidly escalating medical care spending. HMOs offered a broad benefit package that reflected a belief in the value of preventive and primary care and relied on utilization management — rather than a limited benefits package — to control costs. “Preferred provider organization” (PPO) plans and products emerged in the 1980s to offer discounted payments to contracting providers with more choice and less active care management than HMOs. PPOs encompass benefit design features offered through a contracted network (its major distinction from indemnity options) that can be offered through insurers, third party administrators for self-insured employers, or individual employers (Hurley, Strunk and White 2004). Networks can be created by local provider groups, insurers or other organizations that credential providers, negotiate payment terms with them, develop discount policies and rent the network.

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In 1988, 73 percent of American workers were covered by indemnity plans, 16 percent by HMOs and 11 percent by PPOs (KFF 2005a). HMO enrollment peaked at 31 percent of workers in 1996. By 2005, indemnity plans covered only 3 percent of workers, HMOs covered 21 percent, “point of service” (POS) plans (HMOs allowing out-of-network use with higher cost sharing) enrolled 15 percent and PPO plans enrolled 61 percent. To avoid state benefits mandates and insurance taxes and retain more control over cash flow, most large firms self-insure some of their employee health coverage (bearing insurance risk directly rather than through an insurer), though typically they are administered by traditional insurers or other third party administrators. Over half (54 percent) of covered workers are in self-insured plans (KFF 2005a).

The reasons for the dramatic increase in PPO market share were not only the consumer and provider “managed care backlash” of the late 1990s but also the fact that PPO plans with flexible structures and subject to less prescriptive regulation in many states were more able to adapt to purchasers' demands. PPOs could, for example, design plans to accommodate employer preferences for more limited benefits, alternative delivery options and higher cost sharing while allowing enrollees broader networks (Hurley, Strunk and White 2004). Furthermore, in many markets HMOs have lost their pricing advantage over PPO products, which some analysts attribute to state benefits mandates, managed care laws and solvency requirements as well as lower administrative costs (Richard and Erb 2005, Hurley, Strunk and White et al. 2004). (Employer-sponsored HMOs remain somewhat less expensive than PPOs nationally, but their premiums have grown faster in recent years (KFF 2005a)). These analysts question whether PPOs will have any more ability to limit the trend in medical care spending than HMOs, especially because many do not have enrolled populations like

those in HMOs and (other than some Blues plan PPOs) are less inclined than HMOs to attempt to change clinical practice patterns. Organizations, like HMOs, with enrolled populations and ready access to enrollee medical records offer a particularly good opportunity to monitor, evaluate and improve health care delivery.

Enrollment in more tightly managed care plans was accompanied by a reduced rate of growth in medical care spending and group insurance premiums in the 1990s (KFF 2005a, Heffler et al. 2004). But as the backlash against managed care removed utilization management as a cost containment tool, health care premium growth resumed late in that decade, and employers sought different mechanisms to control their health coverage costs. In response to premium cost increases, employers have slightly decreased workers' share of premium payments and have increased deductibles, copayments and coinsurance in all plans they offer (KFF 2005a, Goff 2004, Robinson 2002). As discussed more fully below, in recent years, employers have begun to offer products with deductibles at or above \$1000, often funding or permitting employees to fund a health spending account (HSA). Although the rate of premium increases has decelerated and analysts project that national health spending may grow more slowly in the next few years, the health insurance market remains in flux as employers and other sponsors attempt to rein in their health benefits costs and the number of uninsured Americans continues to grow. Several states have begun to explore using consumer-directed concepts for their Medicaid populations (Milligan, Woodcock and Burton 2006).²

Health insurance currently is sold in three distinct markets: the individual market (covering about 7 percent of Americans under age 65), the small group market (firms under 100) (covering about 26 percent) and the large group market (covering about 36 percent) (Fronstin 2005). (Public programs cover about 13 percent of Americans and 17 percent are uninsured.)

B. The Evolution of State Health Insurance Regulation

States have regulated insurance for over 100 years. After state authority to do so was undermined by a 1944 Supreme Court decision that insurance constituted interstate commerce, Congress delegated insurance regulation to the states in the 1946 McCarran-Ferguson Act. Early prepaid hospital plans were not viewed as insurance in many states. But when New York's insurance commissioner determined that Blue Cross must meet all insurance regulations, the organization convinced the legislature in 1934 to create a separate enabling act to authorize it to operate without financial reserve requirements but allow the commissioner to review its rates and overall financial condition (Starr 1982). Within five years, half the states had enacted hospital service plan enabling laws. Laws allowing medical/surgical benefit plans (Blue Shield)

followed as those plans emerged in the 1940s. These nonprofit Blues plans often faced lower tax rates in exchange for requirements such as community rating and enrolling individuals regardless of health status.

States regulated indemnity health insurance under first casualty and then life insurance laws, including standards for financial solvency, marketing, enrollee information and claims processing. Many states also prohibited individual plans from being canceled or not renewed due to health status. Some states enacted laws forbidding health insurers from restricting the choice of providers (which later interfered with the development of PPOs) (Rolph, Ginsburg and Hosek 1987). Employer health plans originally covered only employees, but dependent coverage became more common in the 1950s. The first “mandated benefits” in the late 1950s and early 1960s were state requirements that family policies cover newborns upon birth (BCBSA 2004). From this narrow mandate, since the 1970s state legislatures have enacted hundreds of requirements for coverage of providers (e.g., dentists, chiropractors and nurse midwives), covered persons (e.g., adopted and handicapped children), and services (e.g., alcoholism and mental health treatment, diabetic supplies and mammography screening) (BCBSA 2004). These mandates typically apply to traditional health insurers, Blue Cross and Blue Shield plans and HMOs in both the individual and group markets and are often blamed for rising health care costs (Jensen and Morrissey 1999). Benefits mandates are justified as advancing public health goals (preventive screening) and broadly spreading the risk of publicly valued, costly services (mental health treatment), but they often benefit a narrow range of insured persons. A few states exempt products sold to small firms from many of these mandates.

Traditional group-practice HMOs generally were characterized as accepting “service risk” not insurance risk because they agreed to provide or arrange for medical services. They were licensed, if at all, separately from other health insurers. State HMO licensure became more common following passage of the federal HMO Act of 1973, which required employers of more than 25 workers offering health coverage to include an HMO option and also provided grants for HMO development. Currently, insurance departments regulate HMOs in most states (often with quality of care oversight delegated to state health departments, which are more likely than insurance regulators to have staff with medical expertise), but health departments or other non-insurance agencies are the primary HMO regulators in seven states.³ Over half the states accept private accreditation to satisfy various managed care plan standards such as a quality management program or an outside quality audit for commercial plans (and many also do so for Medicaid HMOs) (NAIC 2004). Similarly, the federal government recognizes private accreditation as meeting some of the requirements for Medicare Advantage plans. Interest in managed care plans with broader networks than HMOs led insurers to create or contract with preferred provider networks, but open-network laws in some states restricted their growth and led state lawmakers to revise health

insurance standards to allow differential cost sharing in network-based plans (Rolph, Ginsburg and Hosek 1987).

Provider and consumer complaints about managed care plan service and access restrictions led states to enact a series of managed care laws (which plans labeled “anti-managed care” laws). These began with “any willing provider” (AWP) laws in the mid-1980s and included procedures to resolve plan-enrollee disputes, post-delivery hospitalization standards, requirements that enrollees have access to certain specialists without a referral and can see providers who leave networks during the course of treatment and limits on physician contractual “gag” clauses and payment incentives (Butler 1999). Although promoted as consumer protection, these laws often protect providers seeking to participate in managed care networks or worried about interference with their medical practice. One analysis determined that AWP laws were enacted in states without much managed care activity in order to avoid it taking hold (Ohsfeldt, et al.1998). Some researchers conclude that legislatures enacted these laws under provider pressure (Jensen and Morrissey 1999). Others assert that state legislatures responded to a combination of provider concerns and consumer complaints, often fueled by media “horror stories,” and that the laws paralleled and reinforced changes plans already were making to respond to market forces and business pressures (Hall 2005, Hall 2004).

To overcome obstacles to the development of preferred provider arrangements, most states authorize such selective contracting (See Appendix A). State regulation of PPOs is uneven: states use different terminology - preferred provider “organizations” (PPOs) or “arrangements” (PPAs) or “plans,” to identify products that include a contract with a group of providers and incentives for enrollees to use providers in the network. Some states categorize PPOs as managed care organizations, while others consider PPOs or PPAs to be products that can be sold by licensed HMOs or insurers (and, in a few states, by unlicensed entities like TPAs). As shown in Appendix A, PPO organizations are subject to either HMO standards or separate state PPO rules. PPOs defined as products are not necessarily regulated directly, but the licensee selling PPO products must comply with applicable state regulations that apply to indemnity health insurers or HMOs and sometimes file reports with the regulator about the PPO products. States explicitly allowing unlicensed entities to operate PPOs impose some access and contracting standards.

Most small firms that offer coverage purchase insured indemnity, PPO or HMO products rather than self-insuring employee plans. Because it is more difficult to estimate insurance risk for small groups, the small group market often was unstable: businesses faced difficulty obtaining or renewing coverage and premiums fluctuated widely. States began to regulate this market in the early 1990s and in 1996 Congress federalized most of these standards in the Health Insurance Portability and Accountability Act

(HIPAA), requiring insurers to issue and renew coverage without medical underwriting, credit the satisfaction of pre-existing condition exclusion periods as coverage changes and allow insured people leaving small firms access to the individual market or a state high risk pool. The federal law does not regulate insurance rates, but most states do, requiring either community rating or premiums within a range around average rates, which reduces the wide fluctuations some small groups experienced. States have been more cautious in regulating the individual insurance market, which is volatile, concentrated and costly (Chollet 2005). About a dozen states require one or more insurers to issue policies to individuals regardless of health status and some require these insurers to community rate premiums. But, out of concern that they may drive insurers or healthier people from the market, most states do not attempt to regulate individual market access or premiums.⁴

Following congressional authority for tax-advantaged Health Savings Accounts (HSAs), discussed below, most states have amended laws to allow these products to be sold and, frequently, to have state income tax law advantages.⁵ Because some state laws prohibited HMOs from offering high deductible health products, most states have revised laws or interpretations of them to allow HMOs to offer HSA-compatible high deductible plans.

Table I: History of Health Insurance and State Regulation

Era	Health Insurance Developments	State Regulation
1930s	Blue Cross & prepaid group practice	Not insurance - BC enabling acts
1940s	Blue Shield & commercial insurance	BS enabling acts & indemnity insurance regulation
1950s	Growth of job-based insurance	First mandates (newborns)
1970s-80s	HMO enrollment growth	Benefits mandates growth
1980s	PPOs emerge	PPO enabling acts & "anti-managed care" laws
2002-3	Consumer-directed health plans	Removing CDHP obstacles

C. Objectives of Health Insurance Regulation

State health insurance regulation has evolved along with the changing health coverage market. The purpose of health insurance is to spread risk, and the rationale for any insurance regulation is to protect consumers who have paid for a future benefit and are unlikely to be able to determine an insurer's financial soundness or ability to deliver on its promises.⁶ Another objective of regulation is to improve insurance market stability, which states have undertaken primarily in the small employer group market. And the fact that managed care plans not only offer financial security but also promise to deliver or arrange for the delivery of benefits justifies additional standards for consumers enrolled in these plans. The objectives of regulating health insurance include:

- Protecting consumers against insolvency and fraud (by setting standards for solvency, financial reserves, rate adequacy, claims payment and accurate information disclosure);

- Facilitating the insurance market's functioning (by requiring insurers to provide consumer information to make appropriate decisions and by stabilizing the small group market, e.g., by requiring insurers to issue and renew products without regard to health status, allowing portability of pre-existing exclusion periods and limiting premium variations);
- Providing access to highly valued services (such as preventive care) or coverage of disadvantaged populations (such as certain children) by establishing minimum health benefits or coverage standards (on the theory that either consumers want these services or they are desirable from a public health perspective and that the risk of needing them should be broadly pooled);
- Assuring that promised services are available, accessible and delivered and overcoming financial incentives to underserve enrollees (by regulating managed care plan utilization review, grievance procedures and external review and network adequacy).

Plans like HMOs with enrolled populations and closed or limited networks have easier access to information that allows reporting on health care use and health status and facilitates health care quality evaluation and improvement. Over half the states require some form of process and outcome quality reporting by HMOs and POS plans (but not PPOs). Insurance regulators interviewed for this report recognize these quality measurement and improvement advantages and are concerned that HMOs may be disadvantaged by risk selection. Improving or promoting quality has not, however, been articulated by state regulators as an explicit objective of insurance regulation. Given what is known about the inconsistency in health care quality, it may be appropriate for regulators to reconsider this position.

Very few states have embraced the notion of regulatory equity - identical regulation of all entities performing the same functions. As the types of managed care plans proliferated from HMOs to PPOs to POS plans and as groups of hospitals and physicians began to offer their own risk-bearing organizations, state insurance officials recognized the need to overcome incentives to underserve enrollees. Beginning in the mid 1990s the National Association of Insurance Commissioners (NAIC) developed a model set of six laws to regulate organizations whose care management policies might limit access to needed care. These laws include the Health Care Professional Credentialing Verification Model Act, Quality Assessment and Improvement Model Act, Managed Care Plan Network Adequacy Model Act, Health Carrier Grievance Procedure Model Act, Utilization Review and Benefit Determination Model Act and Health Carrier External Review Model Act. NAIC also developed the Risk-Based Capital for Insurers Model Act by which states can determine the amount of capital reserves health insurers must have according to the level of risk they assume (often less in plans with managed care features). All states regulate these aspects of managed care organizations, but few have entirely adopted the NAIC models explicitly, and state regulation varies

considerably. NAIC currently has begun to consider streamlining policy form and rate filing procedures and is examining whether external review laws are appropriate for national standards.

D. Limitations of State Health Insurance Regulation

State insurance regulation is limited by its purpose to establish minimum acceptable standards for insurers to be licensed to operate. Although theoretically licensure could be graduated with varying degrees of performance (as restaurants are graded by health inspectors in some communities), there is no tradition of establishing different standards for a category of health insurers based on meeting standards above minimum licensure requirements or for establishing increasingly higher standards to encourage performance improvement. This is likely one reason for the development of private accreditation organizations that can create different certification levels and set standards to encourage performance improvements over time.

Health insurance regulation has grown more prescriptive over the last 30 years, with the enactment of myriad mandated benefits laws and managed care laws. Analysts have long recognized the impact of these mandates on health insurance premiums (Jensen and Morrissey 1999). Some blame state regulation for the demise of actively managed care (Rich and Erb 2005, Hurley, Strunk and White 2004). Half the states currently require a cost-benefit analysis before enacting new mandates, but most of those laws were enacted after the spate of managed care statutes (BCBSA 2004). Prescriptive standards, which are not easily changed,⁷ can impede innovation by casting certain practice patterns into stone. Others merely represent a waste of time. For example, by the point that states had mandated that HMOs offer POS plans or prohibited gatekeepers, the market already had encouraged most of them to do so (Hall 2005). The worry that physicians were prohibited from discussing options for non-covered treatment with patients or “disparaging” managed care plans that led most states to enact laws against managed care contract “gag clauses” appears to have been groundless (U.S. GAO 1997).

Because of the nature of federalism, there are wide interstate variations in health insurance regulation, resulting from different history, health insurance and delivery system characteristics and political landscape.⁸ State benefits mandates range from a low of five in Idaho to a high of 28 in Maryland and state managed care laws also vary (Buckley and Prsby 2005, BCBSA 2004). States do not necessarily regulate identically all organizations with similar risk-bearing functions. Furthermore, because ERISA prohibits states from directly regulating private employer-sponsored health coverage, while permitting states to regulate insurance, state insurance laws can protect just over half of covered workers — not those in self-insured plans (Butler and Polzer 1996).

Health insurance regulation ought to be based on sound policy rationale, such as the four objectives outlined above. Tested against these purposes, many state health insurance standards might not be justified. For example, some service mandates, such as preventive screenings, might meet public health goals, but others, such as hair prostheses for cancer patients, may not be appropriate for spreading risk across broad populations and others, such as autologous bone marrow transplant for breast cancer or maternity length of stay, might institutionalize clinical practices that become discredited or obsolete.

E. Private Accreditation

Private accreditation of health plans began in 1990 but the concept has roots going back to the 1950s with the creation of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Several health plan accrediting bodies exist in the current market including the National Committee for Quality Assurance (NCQA), URAC,⁹ JCAHO,¹⁰ and the Accreditation Association for Ambulatory Health Care (AAAHC).¹¹ NCQA accredits HMOs and other prepaid managed care organizations as well as PPOs that provide comprehensive health services to enrolled members through a defined benefits package (O’Kane 1996). NCQA was originally established in 1979 by the HMO industry but became an independent external quality review organization in 1990. It examines structural, process and outcome measures of quality. For example, it requires accredited plans to consider numbers and qualifications of physicians and to have specific plans for utilization management and consumer rights and responsibilities. NCQA also measures plan rates for providing specific services for preventive and chronic care, using HEDIS[®], the Health Plan Employer Data and Information Set and consumer experiences using CAHPS[®], the Consumer Assessment of Healthcare Providers and Systems.¹² Plans can achieve one of four levels of accreditation; information about their status is available in a public report card format. Although accredited HMOs must meet the full set of NCQA standards, accredited PPOs currently must meet only standards related to providing access to care and provider qualifications, not specific service delivery criteria related to managing clinical care, such as reporting of HEDIS measures. In addition to its mandatory accreditation standards, NCQA has voluntary standards addressing three areas in which health plans have recently evolved their activities: plan interaction with members ranging from benefits information to health assessment and health promotion (“Member Connections”); plan use of multiple data sources to target information and services to members such as prevention services and care for members with chronic illness or complex conditions (“Care Management and Health Improvement”) and plan measurement and reporting on network physicians and hospitals (“Physician and Hospital Quality”). NCQA plans to incorporate these voluntary standards into its mandatory accreditation standards over time.

Private accreditation has several advantages over state licensure. It can establish performance standards that are higher than minimum government licensing requirements. It can offer varying degrees of compliance that bring different performance ranks, and can set high expectations that encourage continuous quality improvement. While state oversight of access and quality is driven primarily by complaints, accreditation can measure these constructs in a more comprehensive and ongoing manner. Being subject to less overt political influence, accreditation organizations also can revise performance criteria more quickly than state legislatures or regulators, so that its standards can reflect the latest research on what constitutes acceptable and excellent health care.

SECTION III: Consumer-Directed Health Plans

A. Definitions

Although the term can include the growing number of employment-based plans where employees pay a larger share of the premium or tiered benefit designs (Fuchs and James, 2005, KFF 2005a),¹³ in this paper, CDHP refers to plans with high deductibles, often paired with tax-advantaged spending accounts. Besides shifting costs from employers to employees with the growth in insurance premiums, the main objective of these plans is to make enrollees more cost-conscious about whether, when and where to use health care services (Herzlinger 2002). Although high deductible health coverage has existed since the 1940s, the market moved away from those products to more comprehensive managed care plans in the 1980s and 1990s, which attempted to contain costs by influencing providers or controlling access to care. After a lull in national medical care spending growth (when health insurance premiums actually declined briefly in the mid-1990s), the recent spike in employer health care expenditures fueled a search for other means to control medical care spending in general and employer premium costs in particular.

On the assumption that higher deductibles and other cost sharing obligations will make people more prudent in seeking care, in the 2003 Medicare Modernization Act Congress included tax-advantaged Health Savings Accounts (HSAs) that must be paired with a high deductible health insurance plan (HDHP) meeting specified conditions. Several other types of spending accounts have been available under the Internal Revenue Code. For example, since 1978, employers have been allowed to establish Flexible Spending Accounts (FSAs) into which employees can divert pre-tax income to buy various services, including health care. Because the funds cannot be rolled over into subsequent years, this structure is believed to lead some employees to use remaining funds at the end of the year on non-essential services. Since 2002, the IRS has permitted employers to offer Health Reimbursement Arrangements (HRAs) that can be used to pay cost sharing for services covered by the health insurance plan (often an HDHP) or for non-covered services; these accounts can be rolled over to subsequent years (at the employer's discretion) but do not belong to the individual and cannot be taken to a new employer. Medical Savings Accounts (MSAs) were authorized between 1996 and 2006, allowing small businesses and individuals to contribute pre-tax dollars to an MSA in association with a high deductible health insurance plan, but only a total of about 1/4 million MSAs were established during the first five years of MSA authority, with 132,000 active in 2001 (Minicozzi 2006).

HSAAs were designed to overcome some of the limitations of these earlier spending account models. A person's contributions to an individual or employment-based HSA (up to the limit of the plan deductible but no higher than \$2700 for an individual or \$5450 for a family in 2006) are tax deductible to the individual; employer contributions are not taxable income to the employee. The accounts belong to the individual and can be carried across years and to other employment. HSA funds must be used only for health care. Withdrawals for other uses are taxed as income and, before age 65, also incur a penalty. Because they can be used for any purpose after age 65 by paying income tax, they are seen as a savings vehicle as well as a part of health care coverage. IRS guidelines permit HSA funds to be used for any health care service that would qualify as a deduction from personal income, including, for example, optometry, dentistry, over-the-counter drugs and transportation to medical care, many of which would not be covered by the high deductible health plans. Special rules address the coordination of HSAs and HRAs or FSAs (Fronstin 2004).

To qualify for favored tax treatment, an HSA must be associated with a health insurance plan with a deductible in 2006 of at least \$1050 for an individual and \$2100 for family coverage and an out-of-pocket limit of \$5250 and \$10,500 respectively (amounts to be indexed for annual inflation). Network plans may have higher deductibles and out-of-pocket limits for out-of-network use. The IRS permits certain preventive services to be covered without meeting the deductible, including screenings for cancer, heart disease, infectious disease, hearing and vision disorders, diabetes and other conditions. Services "incidental or ancillary to" a preventive screening also can be covered, including drugs to prevent a condition for which the person is at risk but that s/he is not experiencing or to prevent recurrence of a condition from which she has recovered (IRS 2004). For example, medication could be covered outside the deductible to lower cholesterol to prevent heart problems for which the person is at risk. But routine medications to treat active conditions are subject to the deductible.

B. Market Prevalence and Employer Contributions

Employer Offerings. Since 1999 the Kaiser Family Foundation (KFF) and Health Research and Educational Trust have conducted an annual survey of non-federal employers that provides a comprehensive picture of employer-sponsored health coverage. They estimate that one-fifth of non-federal employers offered a high deductible health plan in 2005, though only 4 percent of firms offered either an HDHP with an HRA or an HSA-qualified HDHP. Most of these offerings are only one option available to employees in large firms. Because smaller firms are more likely to offer only one product, if they offer an HSA-qualified HDHP it probably will be the sole employee plan, but the KFF survey did not report these offerings by firm size.

Enrollment. The KFF survey reported that in early 2005 about 2.4 million workers were enrolled in high deductible plans (up from 1.5 million in 2002, Gabel, Lo Sasso and Rice 2002), including 800,000 in HSA-qualified HDHPs and 1.6 million in HDHP with an HRA. America's Health Insurance Plans (AHIP) reported in January 2006 that over 3 million people were enrolled in HSA-qualified HDHPs offered by AHIP member plans to both employer groups and individuals (AHIP 2006).

Premium Costs. Employer contributions to HDHP premiums and HRAs in 2005 (\$3872/individual and \$7538/family) were somewhat higher than total premium costs for employer health coverage overall, but employer contributions to HDHP premiums plus HSA contributions (\$2850/individual and \$7337/family) were not statistically significantly different than average overall employer health coverage contributions. About one-third (35 percent) of firms offering HDHP plans made no HSA contribution. Furthermore, employer contributions to the HRA or HSA were much lower than the HDHP deductible amounts, leaving HRA enrollees exposed to average out-of-pocket costs of about \$1000 in an individual plan or \$2000 in a family plan; the gap for workers with HSA-qualifying plans was about \$1300 and \$2800, respectively (KFF 2005a).

Preventive Services. About 60 percent of employees with an HRA and 30 percent of those in an HSA-qualified plan had access to some preventive benefits independent of the deductible in 2005 (KFF 2005a, Claxton et al. 2005).

C. Trends

America's Health Insurance Plans (AHIP) (2006) reported rapid growth in HDHP enrollment during 2004 and 2005. The Kaiser Family Foundation survey reported over one-quarter of employers indicated they were very or somewhat likely to offer HDHP with either an HRA or an HSA (Claxton et al. 2005). Some health benefits consultants have predicted that as many as 6 to 10 million Americans will be enrolled in HSA-qualified plans or HDHP plans with HRAs during 2006 (ICDC 2005) or 15 million people by 2010 (HCFO 2005). Other analysts are skeptical these products will grow that fast (Rosenthal and Milstein 2005). In his 2006 State of the Union message, President Bush proposed expanding the amount of tax-advantaged contributions individuals or employers could make to HSAs and also allowing deductibility for individually-purchased premiums for HSA-qualifying high deductible health plans.

Due to lower premiums, HDHPs may be especially attractive to individuals seeking lower cost insurance or to small employers that either have not offered insurance or are considering dropping coverage. Among large employers with multiple plan offerings, it remains to be seen how many employees enroll in HDHPs and whether HSAs are funded. At this early stage of HSA development, it is not possible to accurately predict enrollment growth, but it is likely that these products will persist for some time while employers and individuals determine whether they achieve their goals.

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SECTION IV: Policy Objectives and Early Experience with CDHP

Advocates of the higher cost sharing models assert that, by imposing more costs on individuals, they will turn “patients” into “consumers” and reduce the growth in health insurance premiums and overall national health care expenditures, while improving health care quality by encouraging consumers to choose better quality providers (Herzlinger 2002, Scandlen 2005). This section of the white paper discusses the policy objectives for CDHP and evidence from the still-early research about their impacts. While it can be useful to examine surveys of plan policy or consumer experience, the most reliable information about CDHP performance comes from methodologically sound research studies.

A. Reduce Insurance Premiums

Premiums for high deductible health plans are lower than those for more comprehensive coverage. For example, according to the KFF employer survey, average 2005 premiums in an HRA plan were \$3500 per worker (\$8500 for family coverage); those for an HSA-qualified plan were \$2700 per worker (\$7900 for family coverage) and the average premium for all types of plans combined was \$4000 for individual coverage and almost \$11,000 for family coverage (KFF 2005a). Because the average employee share of premium for both individual (16 percent) and family coverage (27 percent) has been fairly stable since 1999, employees bear approximately the same proportion of premium costs across these product types for individual coverage.¹⁴

B. Reduce the Number of Uninsured Americans

CDHP proponents contend that lowering health insurance premiums will substantially reduce the number of uninsured Americans, which now stands at 45.5 million (Fronstin 2005). Lower priced insurance products might be especially attractive to small firms, which employ a large share of the uninsured, have experienced higher rates of premium growth than large firms and cite cost as the major obstacle to offering insurance (Fronstin 2005). The proportion of small firms offering a high deductible plan doubled to 20 percent in 2005 from 2004, while the proportion of small firms offering coverage declined from 63 to 59 percent (KFF 2005a). Perhaps the opportunity to offer less expensive plans has kept some employers from dropping coverage, but evidence does not indicate that these products are encouraging more small firms to offer it, although

AHIP (2005) reported that 27 percent of the small group HSA-qualified policies sold by its members by spring 2005 were to firms that had been uninsured.

There are no national data on the extent to which small firms offer a spending account along with the HDHP. Because of the small number of firms offering HRAs with HDHP or HSA-qualified plans in its 2005 survey, KFF could not report on HDHP offering by firm size. AHIP (2005) reports that by mid-2005 its members sold a slightly higher number of CDHPs to firms with over 50 employees compared to smaller firms (162,000 vs. 147,000).

Individuals purchased over half the one million HSA-qualified plans sold by AHIP members. Although HDHPs have long been the standard in the individual insurance market, low premiums combined with a tax-advantaged spending account may make these products particularly attractive. AHIP (2005) reported that 37 percent of people purchasing individual HSA-qualified products were previously uninsured. Because of concerns about adverse selection, individual market insurers often refuse coverage for people with chronic conditions, exclude the condition from coverage or charge high premiums (Pollitz, Sorian and Thomas 2001). Consequently, it is unclear whether people in poor health would have access to affordable individual market products.

C. Reduce Medical Care Expenditures by Improving Consumer Cost-Consciousness

Proponents of consumer-directed products believe that a major reason for the growth in medical care expenditures is the existence of insurance - at least for routine and/or discretionary services - which insulates people from the true cost of care through "moral hazard," a problem with any insured risk over whose occurrence an individual has some control. In keeping with a more market-oriented philosophy, they postulate that if people spend more of their own money for health care, they will be more prudent in deciding when to seek care and in choosing lower cost services, settings and providers. They promote a return to higher deductible insurance plans available from the 1950s until the 1980s when first dollar coverage became increasingly common (particularly through HMOs). As one analyst has noted, this approach is designed to change the insurer's role from managing care to "getting out from between the consumer and medical service" (Robinson 2002).

Advocates of consumer-directed health plans would instill this cost-consciousness by widespread use of high deductible plans paired with the opportunity to establish an HSA that can be used to pay some costs incurred below the deductible or saved to use at retirement. To help patients become consumers, CDHP proponents recognize the need for more information on effectiveness of various ways to care for a medical condition and price and quality of providers. They believe that plans or other vendors will provide this information if consumers demand it.

Because HSAs are such a new form of health coverage, research on their impact is still under way. In a recent survey, people enrolled in high deductible plans reported they are more likely than those in lower deductible plans to consider costs when deciding to seek care, check their coverage and discuss treatment options with providers (Fronstin and Collins 2005). Survey respondents in high deductible health plans with and without spending accounts were more likely than those in lower deductible plans to agree that their plans' deductible encouraged them to consider costs before seeking care (60 and 70 vs. 40 percent).

A few studies have examined cost and utilization experience with earlier forms of spending accounts, such as HRAs, combined with HDHPs. Researchers compared experience of employees of a large employer offering a high deductible health plan with an HRA along with an HMO and PPO, controlling for health status and other demographic variables (Parente et al. 2004b). Over the first two years of analysis, enrollees in the HRA plan spent less in total than the PPO enrollees but more than HMO enrollees.¹⁵ Interestingly, compared to the other plan enrollees, those in the HRA plan had fewer prescriptions and physician visits, but higher total physician costs and hospital admissions and costs. Because enrollees appeared healthier when they enrolled in the HDHP, the researchers suggested their higher physician and hospital costs might be due to postponed care. These researchers are expanding their study to include more employers and HSAs and to examine longer-term impacts of these models on quality, cost and utilization (HFCO 2005).

Another group of researchers surveyed 14 CDHP plans (both HRAs and plans whose cost sharing or premiums varied with provider tiers) accounting for 85 percent of enrollment in spending account models (Rosenthal, Hsuan and Milstein 2005). Most spending account plans reported reduced service use and cost and attributed cost savings to substitution of lower cost services (generic drugs or physician rather than emergency room visits) rather than reduction in rates of service use and a few reported increased use of preventive care. The authors acknowledge that these observations are incomplete and comparisons inconsistent (for example, lacking statistical analysis to control for other factors that could explain use and cost differences).

With so little evidence of the impact of CDHP models on utilization and costs, it is premature to conclude whether or not this approach can substantially reduce either short-term or long-term medical care spending. Some analysts assert that even if most health care spending occurs after the deductible is met, sensitizing people to the costs of care could help them understand the difficult trade-offs facing plans, providers and patients (Hall and Havighurst 2005). And it might make patients more amenable to the value of care coordination (Wilensky 2006). Skepticism about the ability of CDHP to contain costs and its potential adverse impacts on enrollee health is discussed in Section V.

D. Improve Health Care Quality

Although cost control is their main objective, proponents of consumer-directed health plans also contend that giving individuals more incentive to shop for their own medical services can improve health care quality (Herzlinger 2002). For example, because they recognize that information on price and quality must be available so enrollees can make prudent purchasing decisions, CDHP advocates believe people (especially the chronically ill) will choose providers on the basis of both cost and quality. As Rosenthal and Milstein (2005) reported, some CDHP plans in the current market do provide some web-based data about services and providers, but physician and hospital cost and quality data are generally acknowledged to be inadequate (as discussed in Section V).

E. Evolve to Defined Contribution Plans

Some analysts also suggest that CDHP can be the first step in an evolution from employer “defined benefit” to “defined contribution” employee health plans (Bertko 2004, Parente 2004a). In a typical employee health benefit plan, the employer contributes either a fixed dollar amount or a percentage of the premium, usually a higher share of individual than family coverage. Employers of one-fifth of workers pay the entire individual worker’s premium (KFF 2005a). To increase worker sensitivity to the growth in health insurance costs, some CDHP proponents recommend that employers contribute a fixed amount toward health coverage premiums. If employers offer a choice of plans, such a defined contribution imposes on the employee the full extra cost of more expensive plans. Although such a limited employer contribution has been a component of cost containment proposals for many years,¹⁶ it has not yet become popular among employers. Offering CDHP could be a way for employers to test or move toward the defined contribution approach.

SECTION V: Policy Concerns with High Deductible Plans

Some analysts express concern that consumer-directed products not only are unlikely to achieve promised goals but may threaten the health of people with chronic illness and/or low incomes (Davis 2004, Halvorson 2005, Jacobi 2005). They also caution that CDHP may attract healthy enrollees away from more comprehensive plans and destabilize the insurance market. This section of the white paper discusses these policy concerns and related evidence from recent research.

A. Little Likelihood of Reducing Health Care Spending

As discussed above, there is as yet little valid and reliable evidence about impacts on medical care spending of high deductible plans with spending accounts. CDHP critics raise several concerns about the likelihood that these plans will achieve this objective. First, some note that because most employees are in the 15 percent tax bracket, they have relatively less incentive to fund an HSA (compared to higher income people for whom the tax benefit is greater) (Park, Friedman and Lee 2003). Because so many uninsured people have lower incomes, some analysts doubt that access to lower priced high deductible plans will significantly reduce the number of uninsured Americans (Glied and Remler 2005). On the other hand, it is possible that people who fund HSAs may choose not to save these funds but spend them on marginally necessary care they would not have bought without the tax advantage, and employers funding spending accounts for healthy employees may then spend more if these accounts are used for services not covered by insurance (Halvorson 2004). Although this may satisfy an individual's preferences, it may not be appropriate for a tax subsidy (Jacobi 2005). Some analysts also raise the specter of unpaid provider bills for costs that exceed the HSA balance before the deductible is met, a potentially serious problem for safety net providers (Fuchs and James 2005). Patients with unpaid physician bills may be reluctant to maintain their relationship with these physicians and lose continuity of care, which might lead consumers to be dissatisfied with these products.

The most significant challenge to the likelihood that high deductible plans can reduce medical care spending is based on an examination of the distribution of medical expenses. Although the majority of Americans spend very little on health care each year, a tiny fraction of the public accounts for most medical spending. For example, each year, one percent of Americans account for over one-quarter of medical spending,

5 percent account for 55 percent of spending and 10 percent account for 69 percent of spending (Berk and Monheit 2001). This skewed distribution means that the small share of people with expensive illness will exhaust the deductible quickly (whether or not they have a spending account that helps defray those costs). Even assuming they had the opportunity to shop in advance for physician and hospital care, any incentive to do so would be limited by their relatively small stake in the overall costs of their care (Halvorson 2004). Exceeding the deductible is likely to attenuate motivation to be a prudent consumer.

Furthermore, as discussed more fully below, many people with chronic illness have large and recurring medical expenses that cannot be foregone without adverse health effects. It has been estimated that the chronically ill account for three-quarters of annual health care spending by non-institutionalized people (Hoffman, Rice and Sung 1996). Although some people with chronic conditions may be encouraged to purchase lower-priced drugs or seek care from more cost-effective providers (assuming adequate information to help them do so), CDHP critics observe that these patients are unlikely to reduce their spending sufficiently to decrease national medical care expenditures (Jacobi 2005).

B. Impracticality of Price or Quality Comparisons

Availability of data. Both opponents and supporters of consumer-directed products agree that people should be more involved in their health care — adopting healthful behaviors, understanding medical care options, participating in health care decisions-making and adhering to prescribed regimens. Nor is there dispute that more information about health care quality and cost should be publicly available to inform decisions by individuals choosing health plans or providers as well as by insurance purchasers and health plans (Wilensky 2006, Scandlen 2005, Rosenthal and Milstein 2005, Davis 2004, Herzlinger 2002). There is general consensus that currently available provider price and quality information is inadequate for consumer purchasing decisions (IOM 2006). CDHP critics observe that purchasers cannot compare the quality of health plans offered by insurers that do not report quality measures like HEDIS. They worry that quoted prices may be subject to change and doubt the practicality of expecting health plan enrollees to bargain with physicians or to shop on the basis of price and quality in an acute illness.¹⁷

The Rosenthal and Milstein (2005) survey of health insurers offering high deductible plans examined the kinds of information plans provide to enrollees regarding physician and hospital prices and quality. All spending account plans they surveyed provided some hospital clinical quality indicators but fewer provided physician quality measures; some provided per episode hospital cost information but few provided unit price information for either hospitals or physicians. Because individual provider payments

often are considered proprietary, information on costs is frequently indicated by rankings, which can show relative costs across provider groups but not specific prices enrollees might face.¹⁸ The authors concluded that in order to promote informed consumer choice, plans must provide more detailed information on efficiency and quality and allow comparisons among treatment options.

Under 20 percent of respondents (enrolled in both HDHP and lower deductible plans) in a recent survey reported that their plans provided information on hospital or physician cost or quality (Fronstin and Collins 2005). As noted above, HDHP enrollees offered such information were considerably more likely to report using hospital cost and quality data and physician quality data than enrollees in lower deductible plans. Information on prices might seem to be easier to provide consistently than that on quality. But only three-quarters of “mystery shoppers” who recently attempted to obtain information on hospital prices for tests and procedures received them, often after great difficulty and time to reach the data source, and the prices were frequently not precise enough to compare across providers (DelPo 2005).

Government agencies and private organizations are working actively to develop information about physician and hospital quality but these efforts are at a relatively early stage of development. For example, the federal government provides comparative quality reports on hospitals and other institutional providers (IOM 2006). At least 21 states publish information on hospital prices and some quality indicators. Although data on physician quality is not as well developed, several initiatives are attempting to measure the quality of clinical care by individual physicians or physician groups. In December 2005, the Institute of Medicine (IOM) released a report proposing preliminary provider performance measures, a process for collecting, aggregating and publishing data and a research agenda to develop additional measures (IOM 2006). The IOM report urges the federal government to coordinate the development of standardized measures, information systems, verification and comparative reporting capability. A challenge for developing physician quality reporting systems is that health plans without a very large market share may not have enough data about individual physicians’ patients with conditions of interest to report performance information that permits statistically meaningful comparisons.

Usefulness of data to consumers. CDHP proponents assert that as more people enroll in high deductible plans and face more individual medical care choices, they will demand more information (Scandlen 2005). Certainly, individuals indicate an interest in being more involved in decisions about their health (Shaller 2005, Buntin et al. 2005). Furthermore, information about health conditions and health care is increasingly available on the web and is frequently used (Shaller 2005, IOM 2006). For example, Fox (2005) reports that almost 80 percent of internet users (who constitute 59 percent of Americans) reported seeking health care information on the web at some point in 2004. Internet use, however, varies by age, gender, education, income

and ethnicity, with younger people, Caucasians, college-educated women and people with broadband access being more likely to use the web (Shaller 2005).

Because research on the use of cost and quality information by CDHP enrollees is at an early stage (HCFO 2005, Hibbard, Dubow and Peters 2003), evidence about how such information can be made helpful is drawn from analysis of health care consumers' use of data in other settings. The ability of people to be prudent consumers of medical care is premised on "utility theory," which posits that people can accurately articulate their preferences, are informed about alternative courses of action and their consequences, can differentiate among alternatives and make decisions to maximize their interests (Hibbard, Dubow and Peters 2003). Evidence from cognitive research, however, suggests that preferences are often fluid and that consumers are influenced by presentation because complex information, like that on health care quality, is not easy to evaluate (Hibbard et al. 2002).

This body of research suggests that people facing choices use only a small amount of available information and attempt to simplify decision making by avoiding explicit tradeoffs between conflicting choices and focusing on easily understood characteristics such as a provider's location, appearance or price rather than less comprehensible traits such as quality, even when indicated by specific measures (Shaller 2005, Hibbard, Dubow and Peters 2003). Often this reasoning is subconscious — people report that the more comprehensible features are more important to them, though they may not be, and these expressed preferences are not stable over time.¹⁹ This research helps explain why the public often does not use data on health plan performance or health care provider cost and quality (Hibbard et al. 2002, Marshall et al. 2000). For example, despite claiming to want web-based quality information, two-thirds of people report turning to friends, family or health care providers for references to choose among plans or providers, often reporting they have no other source of useful data (KFF 2004).

Information is processed using both analytic and experiential/intuitive modes of thinking, so presentation must engage both aspects of decision making in order to assure that it conveys the material's meaning. Cognitive research suggests that information should be relevant to the context and timeframe in which it is to be used and simplified in presentation and content (for instance, grading or ranking providers, considering whether to use aggregated quality measures,²⁰ interpreting the meaning of ambiguous measures and standardizing formats to avoid biased presentation (Shaller 2005, Hibbard et al 2002)). Computer-aided decision tools that take consumers through a series of analytic steps can focus on information relevant to their individual situations and their values and preferences (Hibbard and Peters 2003).

Even assuming that accurate and appropriately presented cost and quality information becomes available, some health plan enrollees may be unable to use information effectively due to poor literacy, education and confusion or discomfort with internet-based

tools (Gabel, Lo Sasso and Rice 2002, Hibbard, Dubow and Peters 2003). Besides information that is more relevant and useful to individual choices, health care consumers therefore also can benefit from decision support services, such as nurse telephone advice lines to answer specific questions, case management for people with complex or chronic conditions and tools to appraise their health risks and approaches to address them. The Rosenthal and Milstein (2005) CDHP survey revealed that most plans offer these decision support services. Hibbard, Dubow and Peters (2003) reported that CDHP enrollees use nurse advice lines about twice as often as those in conventional plans and that these services may help patients discriminate between needed and unneeded visits and reduce unnecessary utilization.

It would be premature to conclude that people enrolled in CDHP cannot make appropriate decisions about whether, when and where to seek health care. But it is clear that sufficient information on provider cost and quality currently is not available to virtually any health plan enrollees. And to be usable, that information should be developed and presented in ways that facilitate and support consumer decision making. As Hibbard and her colleagues (2003) have noted, “Being ‘in charge’ (or ‘activated’) implies more than just having the right information. It means understanding and accepting a higher level of responsibility and possessing the knowledge, skills and confidence to take this on.”

C. Impact on Health Care Quality

Critics of high deductible health plans express particular concern that they may reduce both access to needed care for vulnerable populations and plans’ use of evidence-based medicine and care management strategies.

The burden of health care costs. Health care costs are a burden to many Americans. Nearly one-quarter (23 percent) of people surveyed reported difficulty paying medical bills despite the fact that 60 percent of them had health insurance; over one-quarter (29 percent) reported that someone in the household skipped medical care or a prescribed drug in the past year due to cost (KFF 2005b). People with chronic conditions (over 40 percent of Americans) were more likely to report these cost impacts.

Reducing access to appropriate care. High deductible plans raise several access concerns. Some analysts worry that physicians with bad debt will stop serving patients in high deductible plans. Others note that, although the federal HSA law permits plans to cover preventive care outside the deductible, about 40 percent of employer-sponsored HRA plans and 70 percent of HSA-qualified plans do not do so, and there is no information on the scope of these services offered through the plans that do cover them (KFF 2005a). Although the IRS guidelines permit a wide array of

preventive screenings (including immunizations, well child care and tests and diagnostic procedures that follow from preventive examinations), they do not allow treatment (such as prescription drugs) for conditions discovered during screenings — even when necessary to prevent longer-term complications. A 2005 Harris poll reported that people enrolled in high deductible plans with a spending account were less likely than other insured people to receive a physical exam (48 vs. 62 percent) and enrollees in an HDHP without a spending account were less likely to receive physical exams (55 vs. 62 percent), cholesterol tests (59 vs. 68 percent), blood or urine tests for diabetes (48 vs. 54 percent) or blood pressure checks (72 vs. 89 percent) (Harrisinteractive 2005).

Although an HRA or HSA offers some means to pay for services before the plan deductible is met, employers have not funded spending accounts to the level of the deductible, though it is possible over several years they may reach that point (Claxton et al. 2005a). Furthermore, spending account holders may use these funds for services not covered by the health plan, like optometric or dental care, leaving less money to fund basic medical services. Critics of high deductible plans express concern that people with insufficient spending accounts will forego needed care, citing research on the impacts of cost sharing on medical care utilization. The RAND Health Insurance Experiment, which ran from 1974 to 1982, randomly assigned people to health coverage with varying coinsurance levels (from almost 100 percent to no cost sharing and with out-of-pocket maximum payments varying according to family income) and examined use, cost and health status impacts according to different cost sharing levels (Newhouse 2004, Lohr et al. 1986).²¹ Not surprisingly, people with free care used considerably more medical care than those in cost sharing plans, primarily because they were more likely to have outpatient visits or inpatient admissions (there was no difference in service intensity once people sought care). But the study also revealed that people with cost sharing reduced use of both appropriate and marginally necessary care, which resulted in worse health status for some participants. Specifically, people in families with incomes below 200 percent of the federal poverty level with free care had better control of hypertension than those with cost sharing, reducing their risk of premature death (Brook et al. 1983). Cost sharing also reduced the likelihood that lower income children and adults would receive medical care determined appropriate for acute conditions and reduce their incidence of serious symptoms (Lohr et al. 1986, Shapiro, Ware and Sherbourne 1986). And cost sharing reduced their use of preventive services such as pap smears.

More recent research continues to present a mixed picture of cost sharing impacts. For example, the introduction of prescription drug cost sharing in Quebec reduced use of both “essential” and “nonessential” medications by the elderly (by 9 and 15 percent, respectively) and low income patients (by 14 and 22 percent, respectively) after the cost sharing was implemented (Tamblyn et al. 2001). The rate of emergency department (ED) visits increased and the rate of serious adverse events among the elderly and the poor doubled, both results attributed to the reduced use of essential medications.

A multivariate analysis of Medicare enrollees showed that women with supplemental insurance (covering Medicare's cost sharing that amounted to about \$120 in 1994) were approximately three times as likely to receive a mammogram as those with only Medicare (Blustein 1995). Consistent with the notion that people seeking urgent services would not be deterred by cost sharing, one study found that cost sharing did not discourage people with ED copayment requirements from seeking care for myocardial infarction compared to health plan enrollees with no ED copayment (Magid et al 1997).

A large study of enrollees in employer-sponsored health plans examined the impact of doubling drug cost sharing on utilization of a broad range of medications (for inflammation, cholesterol, ulcers, asthma, hypertension, diabetes and depression) (Goldman et al. 2004). Increased cost sharing was estimated to substantially reduce use by the average health plan enrollee (and particularly where over-the-counter substitutes were available to treat symptoms). Among people with chronic illness, however, use was less responsive to cost sharing; these people reduced use of medications to treat the chronic condition much less than their overall prescription drug use, though the authors identified some increased ED and hospital use for people with diabetes, asthma and gastric acid disorder, suggesting that reducing drug use might adversely affect health.²² One group of particular concern was diabetic patients, who reduced use of medications (other than insulin, whose use was not studied), raising concerns about longer-term health impacts.²³

Researchers examined data from the "Medical Outcomes Study," which prospectively followed chronically ill adults for 18 months (Wong, et al. 2001). The study examined use of care for minor and serious symptoms by study participants facing no cost sharing for outpatient visits and those that paid either less than half the bill (low copay group) or more than half (high copay group). The likelihood of seeking care for minor symptoms decreased inversely with cost sharing levels. But for serious symptoms, only the high copay group was much less likely to seek care. Health status, measured by the SF-36 health status survey and adjusted for demographic characteristics, did not differ among the groups. The authors concluded that demand for care for serious symptoms is less sensitive to price than that for minor symptoms but that high levels of cost sharing may deter the use of medical care that is appropriate and necessary, even though its absence did not adversely affect health during the study timeframe (noting that none of the study participants had low income).

A recent survey sponsored by the Commonwealth Fund and The Employee Benefits Research Institute (EBRI) revealed that people in families with incomes under \$50,000 enrolled in HDHP (with and without spending accounts) were much more likely to spend a greater share of their income on health care than people enrolled in plans with lower deductibles (Fronstin and Collins 2005). Both HDHP enrollees with incomes below this level and those with chronic illness or poor health status also were

much more likely than those in comprehensive plans to forego or postpone seeking health care or filling prescriptions or to skip prescribed doses. Similarly, the 2005 Harris poll cited above reported that people with various chronic illnesses enrolled in a HDHP were much less likely to fill prescriptions (Harrisinteractive 2005).

Evidence about the impact of cost sharing on seeking care for serious conditions generally reveals that people have difficulty distinguishing between minor and more serious problems (other than emergencies), although they may reduce use for minor problems more than use for major ones. Cost sharing can be particularly burdensome to lower income people (including employed insured people). And it may discourage people with chronic illness from using appropriate care.

The value of health care to address illness. Geographic variation in use of medical care without accompanying differences in health status demonstrates that not all care is necessary or appropriate or leads to improved health (Wennberg 2004). Research has been underway for many years to determine what types of care are effective and cost-effective for different medical conditions experienced by different patients (AHRQ 2005). Clinical research generally supports the importance of specific treatment and monitoring of patients with chronic conditions. For example, a recent analysis of participants in the Framingham Heart study reported that people with uncontrolled hypertension have shorter life expectancy and greater incidence of cardiovascular disease, myocardial infarction and stroke than those with normal blood pressure (Franco et al. 2005).

Furthermore, in proposing indicators of access to care, the Institute of Medicine identified chronic conditions such as diabetes, asthma, congestive heart failure and hypertension as examples of diseases that will lead to repeated hospitalization, premature disability or death without regular medical monitoring (IOM 1993). Appropriate treatment for these conditions includes testing, counseling, medications and medical and surgical procedures. A more recent IOM study examining the importance of health care for uninsured people also concluded that care for the chronically ill, “refined as evidence for cost-effective interventions and practices has accumulated,” leads to better health status, citing data on the value of treatment for cardiovascular disease, diabetes, end-stage renal disease, HIV positive status and mental illness (IOM 2002).

One of the best known studies of quality of U.S. medical care was a detailed analysis of the extent to which Americans receive appropriate preventive services and treatment for 30 acute and chronic conditions (McGlynn et al. 2003). The study revealed that, on average, patients received only 54 percent of care the researchers determined to be appropriate and necessary. The authors identified conditions for which national guidelines and medical literature indicated consensus about appropriate treatments to prevent or cure disease or minimize complications and long-term health effects and refined these medical intervention indicators with input from expert panels.²⁴

Policy analysts express particular concern that people with chronic illness and/or low incomes will forego needed care whose costs they must pay before meeting the insurance deductible. These are vulnerable populations for whom medical care can be effective to control their conditions and prevent further — and likely more costly — illness.

Satisfaction with consumer-directed plans. Enrollee satisfaction with the experience of using the health coverage plan and obtaining care is an important measure of plan quality. As with other elements of consumer-directed plans, evidence about consumer satisfaction varies. For example, a survey of enrollees in a university's HDHP revealed overall satisfaction with the plan based on the CAHPS survey comparable to that of enrollees in lower deductible plans and somewhat better experience with customer service and paper work (Christianson, Parente and Feldman 2004). On the other hand, a recent survey of people enrolled in plans with different deductible levels revealed that people in lower deductible plans were more likely to report being extremely or very satisfied than those in HDHP or HDHP paired with an HSA or HRA (63, 33 and 42 percent, respectively) (Fronstin and Collins 2005).

Impact on care management. Another concern about high deductible plans is that they may provide less opportunity to use evidence-based medicine or coordinate care (Buntin et al. 2005). For example, Berenson (2005) cites the case of an HMO whose drug formulary limited access to COX-2 inhibitors based on evidence they worked no better than non-steroidal anti-inflammatories except for people at high risk of gastrointestinal bleeding. This use of an evidence-based formulary limited access to what later were recognized as harmful drugs. Individual patients may be less likely to seek evidence on effectiveness, and high deductible plans may have less chance to influence care seeking before enrollees satisfy the deductible.²⁵ Managed care plans also may have less opportunity to coordinate care, for example, for chronically ill enrollees, until the deductible is met. Some analysts, however, argue that managed care is compatible with high deductible health plans. Newhouse (2004), for example, believes that managed care plans are better able to control the costliness of an episode, while cost sharing can temper an enrollee's decision to initiate care.²⁶ Hall and Havighurst (2005) argue that because most costly care will occur after the deductible is satisfied, health plans have a reason to monitor care below the deductible as well as manage care above it. It does appear that not only PPOs but traditional HMOs are beginning to offer HDHP products. Because they can compare use, costs and outcomes of enrollees in higher and lower deductible products, their experience could be especially valuable to the policy debate.²⁷

D. Consumer Confusion

Health plan enrollees, who generally do not understand their coverage to begin with (Cunningham 2001), may be more confused about the functioning of savings accounts and their interplay with high deductible plans (Hibbard, Dubow and Peters 2003).

The interface between spending account and HDHP may not be seamless.

Spending accounts. Consumers may be confused about the functioning of HSAs, particularly because only the taxpayer — not HDHP or the HSA administrator — is responsible for compliance with federal tax rules. The health insurer and the HSA administrator may provide information to enrollees about how to use the spending account but are not obliged by federal law to do so. Most HSAs in the current market are offered through banks or securities firms, whose financial status and fiduciary duties are regulated by state or federal authorities. But a few health insurers administer HSAs themselves. Because spending accounts are not insurance, they are not necessarily under the jurisdiction of state insurance regulators and so may not be subject to state standards regarding dispute resolution or other applicable insurance laws (Jost and Hall 2005). If providers are not bound by the HDHP carrier to charge an enrollee negotiated prices, people paying for services may be charged considerably more than the insurer would have paid. Although fraud can be prosecuted by Attorneys General under state consumer protection statutes, there may be a need for more active state oversight of HSAs not regulated by other authorities (Jost and Hall 2005).

What costs satisfy the deductible? The tax law allows people to spend HSA funds on services not covered by the HDHP, which enrollees may not fully understand. Furthermore, the insurer may apply to the deductible only its negotiated provider payment levels regardless of what enrollees may have paid for a service. Or insurers may refuse to attribute to the deductible payments for services requiring pre-authorization (Jost and Hall 2005). Whether or not these problems are likely to be prevalent, CDHP enrollees need clear information about the interface between the spending account and the HDHP.

E. Risk Pool Fragmentation

The market has begun to offer high deductible health plans to meet consumer and purchaser preferences. Some analysts applaud the HSA law for “leveling the playing field” to give consumers options beyond HMOs (Hall and Havighurst 2005). Others, however, express concern that HDHP, especially when associated with spending accounts, may attract healthier people, leaving less healthy enrollees in more comprehensive plans (Davis 2004, Halvorson 2004). Segmenting insurance risk pools in this way could lead to the “death spiral” of lower deductible plans becoming continually more expensive as healthier enrollees flee to cheaper products — not a new problem

but one that could be exacerbated by increased enrollment in plans with lower premiums. CDHPs representing one of a carrier's several products offered to a firm would not pose risk segmentation problems. But CDHP could adversely affect the risk pool of employers offering multiple plans from different insurers as well as for the overall insurance market (Fuchs 2005, Lo Sasso et al. 2004). Some analysts worry that traditional HMOs may be especially disadvantaged by the risk segmentation created by high deductible products. Adverse selection against traditional plans could be a particular problem if employees are permitted to change health plans each year and build HSA balances while switching to more comprehensive plans when they anticipate needing more care. Although employers could risk-adjust employee premiums to minimize this problem, it is not clear whether many employers are likely to do so (Bertko 2004).²⁸

Preliminary research on the health status and utilization experience of people enrolled in HDHP provides a mixed picture. Some early studies suggest that high deductible plans do not attract healthier people. For example, Parente and colleagues (2004a) found a university plan's HDHP enrollees were about as likely as those in traditional plans to report they had chronic illness, although they had higher incomes. The same research team found enrollees in a private employer's plan to have better health (measured by significant medical diagnoses) before enrollment than HMO or PPO enrollees, but two years after enrollment, this case mix measure became comparable to that of PPO enrollees and higher than that of HMO enrollees (Parente et al. 2004b).²⁹

Other studies, however, find HDHP enrollees to be healthier. Although their age and gender did not differ, enrollees in Humana's HDHP (offered with an HRA) had somewhat higher incomes, used fewer services and had lower claims before enrolling in the high deductible plan than employees remaining in a PPO or HMO (Tollen, Ross and Poor 2004). A different study of this same population also concluded that HDHP enrollees were less likely to have a chronic health problem or recent medical visits than lower deductible plan enrollees (Fowles et al. 2004). The U.S. Government Accountability Office found that enrollees in high deductible health plans offered by the Federal Employees Health Benefits Program (FEHBP) were younger than average FEHBP health plan enrollees and were much more likely to have higher salaries (U.S. GAO 2006).

F. Summary of Experience with Consumer-Directed Health Plans

There is limited evidence on whether high deductible health plans (with or without spending accounts) will achieve any of their objectives. Despite the optimistic predictions of CDHP advocates, however, the impact of these plans on overall medical care

spending and the rate of uninsurance is likely to be limited. Increased cost sharing may help sensitize consumers to the costs of health care as a means to engage them in policy discussions about the difficult trade-offs facing health plans and public and private purchasers. But even analysts asserting this view believe that cost sharing should be targeted to services over which consumers have discretion and that restraining medical care spending requires providers and delivery systems to manage costly care. And these products could compromise quality and access, especially for people with chronic illness or low incomes.

SECTION VI: Policy Options to Address Consumer Concerns with CDHP

This section discusses policy approaches that could be adopted by state regulators and /or private accreditation bodies to address consumer protection issues raised by CDHP. Because it is uncertain whether CDHP will achieve significant market share, many of these policy options would be appropriate even if high deductible products and spending accounts are not prevalent, because health insurance cost sharing is likely to become more widespread in PPO and HMO products, raising some of the same information, quality and access concerns.

People enrolled in high cost sharing plans may experience problems such as misunderstanding how to choose or use the plans, disincentives to seek appropriate care and the potential loss of access to more integrated health plans that can improve quality by providing coordinated, evidence-based care. Because there are several health insurance markets over which state authority differs, for each market it is necessary to consider whether and how state regulators or private accreditors could address health insurance consumer problems under the objectives of insurance regulation noted above.

Table II summarizes potential roles for state regulation and accrediting bodies regarding consumer protection issues in four insurance markets:

- **Individual market.** States have the greatest authority over the individual insurance market because ERISA does not affect their ability to regulate it. Individuals with higher incomes may be particularly interested in HDHP products and HSAs, but the individual market is highly concentrated (with few insurers), very volatile, expensive and often unavailable to people with a history of serious illness.
- **Small group market.** In the employer group market, states have the greatest chance to influence coverage by small firms, because relatively few small firms self-insure. If small employers buy a high deductible plan to lower their premiums, it probably would be the sole option, because a majority of firms with fewer than 200 employees (65 percent) now offer only one plan (KFF 2005a).
- **Large group market with multiple offerings.** State regulatory authority is most limited in the large employer health coverage market. Most large firms self insure at least one of their offerings, but because most (78 percent) offer two or more plans, including some insured products, it likely that high deductible plans, if offered at all, will remain only one option. States can regulate insured products offered by employers.

- **Large group market with single offering.** If an employer offers an HDHP as the sole plan, it is likely to be self-insured, leaving no opportunity for state regulation of plan benefits, structure and administration.³⁰

Table II
Potential Sources of Consumer Protection Standards in an Evolving Health Insurance Market

Standard	Market			
	Individual	Small group**	Large group w/ choice	Large group w/o choice***
<i>Solvency & Fraud Protection</i>				
Solvency	S	S	S (insured products)	
Marketing	S	S	S (insured products)	
HSA administration	S*	S*	S*	S
<i>Facilitating Market Function</i>				
Information				
Plan choice	S, A	S, A	A	A****
Plan use	S, A	S, A	S, A	A****
Cost & Quality	S, A	S, A	S, A	A****
Decision Support	A	A	A	A***
Risk segmentation	S	S		
<i>Access to Valued Services</i>	?	?	?	
<i>Access to Appropriate Care</i>	A, S	A, S	A, S	A****

S = state regulator role ; A= Accrediting organization role (for accredited plans)

* when insurers administer HSAs

**primarily insured plans

*** presumed to be self-insured

**** if accredited plan administers self-insured ERISA plan

A. Regulatory Equity

Interstate consistency. Health insurance standards vary across and within states. Federalism — the autonomy of states to regulate commerce within their borders — is a principle valued by states and embodied in the tenth amendment to the U.S. Constitution. Interstate variation can respond to unique local circumstances and can test different policy approaches (some of which may eventually lead to more uniform federal policy, as with HIPAA’s insurance market standards). Most state insurance regulators would agree in principle that interstate consistency, if not uniformity, of laws affecting multi-state insurers is a worthy goal. Inconsistent standards among states, private accreditors and public purchasers are frustrating and often costly to insurers and multi-state employers, who may be more likely to self-insure when faced with differing state insurance standards (HCFO 2004). The purpose of the NAIC model laws, developed through a lengthy consensus process involving regulators and stakeholders, is to assist states in making their laws more comparable. Nevertheless, states need not adopt them or may revise them substantially. And once a law is adopted, it may be difficult to change.³¹ Some state laws enhance national uniformity by “deeming” that accredited HMOs meet certain state licensure standards, for example, for a formal quality assurance system or external audit.

Among the state managed care laws that increase costs and administrative burdens are those setting procedures for enrollees' internal and external appeals. All states require managed care plans to provide an internal plan process for enrollees to resolve disputes, but these procedures differ with respect to time frames and other requirements.³² External review laws, adopted by almost all states, differ regarding the health plans to which they apply, the types of disputes that can be appealed, fees, timeframes and the reviewing entity (Pollitz et al. 2002). As of October 2005, only four states had adopted the NAIC Health Carrier Grievance Procedure Model Act and only three had enacted the Health Carriers External Review Model Act.

State laws regarding "coordination of benefits" (COB) also differ, imposing administrative burdens and costs on multi-state insurers. COB laws determine which health insurance plan is the primary payer when a person is covered by two or more policies in order to assure that people are paid the full claim cost but not overpaid. Most current state laws involve coordination among only group policies and many differ as states have revised their laws in the 10 years since the adoption of an earlier NAIC model. In 2004 NAIC revised its model COB regulation to allow coordination with individual plans and high deductible policies.

- *State insurance regulators should conform their health insurance laws (for example, internal plan grievance procedures, external review laws, and coordination of benefits rules) to a single model in order to minimize variation, reducing costs and administrative burdens.*
- *State insurance regulators should consider allowing HMOs and PPOs that meet relevant accreditation standards, such as provider credentialing and quality management systems, to have met those respective state standards.*
- *Accrediting bodies should review the NAIC health insurance model laws to consider whether they represent the state of the art for these structural standards.*

Intrastate consistency. Although most group health coverage includes managed care features, almost all states retain multiple health carrier licensure categories, such as health/disability insurers, HMOs and BlueCross/BlueShield plans. Most states regulate the managed care products offered by different carriers similarly, but as Appendix A illustrates, these standards may not be identical. The NAIC model managed care laws were designed to improve consistency in state regulation managed care organizations, but state managed care laws remain varied.

ERISA imposes another source of intrastate inconsistency. States cannot regulate self-insured private employer-sponsored health plans, and state authority over non-risk-bearing PPOs contracting exclusively with self-insured ERISA plans is unclear.³³ While many PPOs organized by insurers or other licensed entities will may comply with state managed care standards when administering self-insured ERISA plans, those operated by TPAs may not and a few states, like Illinois, have concluded they have no

authority to regulate these arrangements.

- *State insurance regulators should revise health insurance standards so that all risk-assuming entities performing similar functions are regulated identically.*
- *State insurance regulators should explore regulation of non-risk-bearing PPOs even if they contract with self-insured ERISA plans by imposing the same standards for consumer information, network adequacy, provider contracting, and quality oversight that apply to risk-bearing PPOs.*

B. Protecting Against Insolvency and Fraud

Fraud prevention. If insurers violate promises, for example, misrepresenting covered preventive services or failing to assure that enrollees receive the benefit of negotiated provider prices, state regulators can take action to remedy this misconduct.

- *State insurance regulations should monitor to determine whether health plans accurately represent their products and to enforce existing consumer protection standards regarding information disclosure.*

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Monitoring HSA administration. Although HSAs are most commonly offered by financial institutions, which are overseen by state and federal banking and securities regulators, some may be operated exclusively by health insurer, yet not be insurance products.³⁴ If the insurer offering the high deductible plan administers the spending account (as some are beginning to do), it could assist consumers in using the account and complying with federal tax law. It also could coordinate claims and care purchased under the spending account with the insurance coverage, making a more seamless interface between them. Furthermore, insurer HSA administration can assure that consumers have the benefit of negotiated provider payment rates. Nevertheless, an insurer-sponsored HSA raises the question of who should protect consumers in these unregulated spending accounts.

- *States insurance regulators should consider whether HSAs not offered by licensed banks or securities firms should be regulated by a state agency with consumer protection responsibilities.*
- *State insurance regulators should consider requiring health plans offering HDHPs and HSAs to permit enrollees to use provider rates negotiated for payment by the plan or specifically by spending account holders.*

C. Facilitating Market Function

Requiring more information on choosing among and using plans. Although high deductible plans have existed for decades, especially in the individual market, many enrollees may be unfamiliar with them, particularly the relationship

between an HSA and the high deductible plan. State insurance laws currently prohibit misleading advertising. About half the states require public disclosure of benefits and price comparisons among prototype small group plans and half the states provide health plan report cards. Individual and employer purchasers also can use NCQA report cards to compare accredited plans.

Once people enroll in a licensed health plan, state health insurance laws require the plan to provide information to enrollees about benefits, coverage decisions and appeal processes (which should be available for disputes over what claims meet the deductible).

- *Under their general authority to enforce these laws and remedy consumer fraud, state regulators should be encouraged to monitor how well consumers understand and can use these new products.*³⁵
- *Accrediting bodies could include a specific accrediting standard for consumer information about how to use HDHP and spending accounts for plans that offer these products.*

Making available cost and quality information. People enrolled in high deductible plans need accurate and usable information if they are expected to “shop” for medical care for which they are paying out of pocket. There exists a baffling array of information about some prices and some quality indicators for some types of health care providers (primarily hospitals) both at the national level (through CMS, the Centers for Medicare and Medicaid Services) and in at least 21 states (by hospital associations, state agencies, or independent data publication organizations). Some health plans make some price or quality information available to enrollees. As demand for cost and quality data increases, private vendors may sell this information, raising the potential need for regulators and accrediting bodies to monitor data accuracy. The usefulness of cost and quality information to health plan enrollees is unclear and should be evaluated. With respect to quality measures, for example, one analysis found little correlation between four process and two outcome measures of hospital heart failure care in Maryland (Hines 2003).

Availability of useful price or cost information also is limited. Health plans may be unwilling to disclose negotiated rates because they are proprietary (even though people using their networks should be able to pay those rates when buying care before meeting the deductible) (Rosenthal and Milstein 2005, Trude and Grossman 2004). Unit prices are less useful than per-episode cost data for conditions requiring a course of treatment. State insurance laws could be amended to require plans and/or providers to disclose this information. NCQA’s voluntary Member Connection standards measure whether plans provide information for members to shop for services.

Leading researchers on how health plan enrollees can and will use cost and quality information have concluded that provider-level cost and quality data are not readily available and the range of quality indicators may not be specific enough to inform individual choices (Hibbard, Dubow and Peters 2003). They also express concern that if cost information is not linked with performance data, consumers may use high cost as a proxy for quality, undermining one goal of consumer-directed plans. Although some consumers may use information that is currently available, if these plans are to achieve their objectives, a carefully designed research effort should be undertaken to develop and publish cost and quality data that are useful to consumers choosing services and providers. Many public and private sector initiatives are under way to improve provider performance standards and the Institute of Medicine has urged a federal initiative to standardize measures, facilitate data collection and improve dissemination. If more private sector vendors independent of health plans begin offering quality data, it may be worth considering whether they should be held accountable for accuracy and transparency, such as through a public regulatory or private certification process. Because many CDHPs are built on a PPO platform, a related problem has been how to obtain information about health care quality from PPOs. In the past some PPO-provider contracts have not permitted access to patient medical records, but these contractual constraints appear to be changing. Furthermore, most HEDIS measures can be reported by using claims data to which PPOs have access. As NCQA has recommended in “The State of Health Care Quality 2005,” state and federal regulators, purchasers and consumers should expect accountability from these looser network products as well as from hospitals and physicians and should have access to information about both plan and provider quality.

The inadequacy and geographic variability of cost and quality data confound the issue of whether and how state insurance regulators should require carriers offering high deductible health plans to provide this information to enrollees or refer them to public data sources. On the one hand, requiring plans to provide basic cost and quality information (without specifying the source or formatting) could encourage more research about what cost and quality measures are useful to consumers and lead to improvements in collecting and presenting data. On the other hand, a non-specific information-referral standard could result in plans directing enrollees to patently inadequate published data sources. There appears to be support in the business community for government to assure that physicians and hospitals disclose prices and data on quality measures (Goff 2004). It may be tempting not to act while efforts are under way to improve measurement and data collection. Nevertheless, it seems an appropriate time for state regulators and accreditation bodies to begin a discussion about how cost and quality information should become available to health plan enrollees.

- *Accreditation bodies should initiate discussions with NAIC about how to assure that health plan enrollees have access to accurate, relevant and usable data on provider cost*

and quality, including the issue of how states might rely on independent quality measurement and standard-setting agencies to provide the most current standards and provider data.

- State regulators should consider how to assure that plans make cost and quality information available to plan enrollees and that such information is not misleading (including whether to require identification of independent website sponsors and whether information vendors should be regulated or accredited to assure data accuracy).
- Accreditation bodies should determine how best to include in its general accreditation process standards regarding whether and how appropriately plans provide enrollees cost and quality data (including CAHPS measures of how useful enrollees find this information).
- Accrediting bodies should consider adding standards regarding whether cost and quality information websites can be sponsored by organizations other than health care providers or plans and how to evaluate their accuracy and adequacy.

Decision support. Recognizing that not all health plan enrollees are willing or able to make all medical care choices without assistance, many health plans offer decision support, such as nurse advice lines, web-based medical encyclopedias and interactive decision tools for specific conditions (Rosenthal and Milstein 2005). These services can help people decide whether a condition requires treatment and the advantages and disadvantages of different treatment options. Because decision support services may evolve to meet consumer needs and accreditation is more flexible to monitor changing practices, this type of standard seems more appropriate for accreditation than state regulation. Evaluation of how well these services assist enrollees could be included in CAHPS surveys. Meaningful measurement of the value of these decision support tools requires use by a large number of health plan enrollees, so accrediting bodies should monitor enrollee use and experience with them (as under NCQA's voluntary Quality Plus standards) with a view toward including these measures in mandatory accreditation standards.

- Accrediting bodies should include in their mandatory accreditation standards measures of whether and how well plans provide decision support in specific areas such as nurse advice lines and web-based decision tools to choose among treatment options for specific conditions.
- As enrollee use of these tools increases, accrediting bodies should consider including questions about how useful enrollees find their plan's specific decision support tools and service in order to guide improvements in these services.

Risk Segmentation. While striving for a flourishing insurance market that provides products valued by insurance purchasers, state policy makers must balance the need for regulation to stabilize the market and minimize risk segmentation with the

potential loss of affordable coverage or insurers willing to sell to their residents. All states have the power to review insurance premiums to assure they are not “excessive” and are “adequate” to cover anticipated costs, but a minority of states actively regulates health insurance rates. A few states limit premium variation in the individual and/or small group market (by community rating or rate bands), to reduce premiums for people in poorer health. By raising premiums for healthier people who might then drop coverage, such rate regulation could increase the number of uninsured, as some research on the individual (though not the small-group) market has shown (Chollet 2004, Simon 2004). This research did not, however, examine the impact of premium regulation on different types of health plans, so it is unclear whether premium regulation would substantially temper the price advantage of high deductible plans or make HMOs more attractive. Markets that are highly price competitive are likely to exhibit risk segmentation (Simon 2004).³⁶ Some analysts urge employers offering a choice of plans to set their premium contributions to minimize risk segmentation across these offerings (Herzlinger 2002). While such an approach could reduce this problem, only Congress could mandate that employers risk adjust premiums; ERISA would preempt a state law requiring employers to do so.

- *States should be encouraged to monitor risk segmentation across product types, as new products, which might increase segmentation, enter the market.*

D. Access to Highly Valued Services

Mandated benefits, providers, and populations apply to high deductible products offered by licensed insurers, although (other than for federally-approved preventive services) insurers will not pay for them until the deductible is satisfied. While high deductible plans thereby reduce the impact of mandated benefits, due to federal law, it is unlikely states would require additional services to be exempt from a HDHP deductible.³⁷ Furthermore, before enacting additional benefits mandates, states should evaluate their costs and benefits, as authorized by legislation in over half the states.

E. Access to Promised services

Assessing whether enrollees in accredited plans receive appropriate care to both prevent illness and treat specific conditions is a primary purpose of HEDIS measures. As accredited plans begin to offer high deductible products, they should be required to apply HEDIS measures to enrollees in different product lines and compare their experience. Although half the states publish health plan report cards, few state insurance regulators have monitored health care processes or outcomes. States do have a role in monitoring access, however, as the insurance market is turning toward higher deductible plans. One insurance commissioner interviewed for this paper, for example, is working to refine the information the insurance department collects from carriers in

order to assess the cost and use experience of enrollees in different types of insurance products. Because PPOs are the predominant form of group health coverage, it would be useful for purchasers and enrollees to have more information on the quality of care they provide, even recognizing that they have somewhat less control over where enrollees obtain care. Another Commissioner interviewed for this report did not feel state law currently provides the authority to obtain quality data from PPOs but urged NCQA to accredit more types of plans so consumers have more information about them.

For the reasons discussed above, policy makers should be particularly concerned that chronically ill enrollees receive needed care. Some state insurance laws mandate benefits for some persons with chronic illness (for example, requiring diabetes supplies or mental health treatment). Benefit mandates, however, will have no impact on coverage in a high deductible health plan until the deductible is met. NCQA's voluntary "Care Management and Health Improvement" standards include measures about plan management of members with chronic conditions.

- *Accrediting bodies should consider requiring comparisons of enrollees in HDHP and other product lines using HEDIS "Effectiveness of Care," "Access/Availability of Care," "Use of Services," and "Satisfaction" measures and, if feasible, comparisons of subgroups of people with chronic conditions*
- *Accrediting bodies should consider a mandatory accrediting standard that evaluates whether plans identify underuse of specific services needed for enrollees with specific chronic illness and report that information to providers in order to encourage more appropriate care for these populations.*
- *State insurance regulators and other state health policy makers should be encouraged to*
 - *collect (through health plan report cards or other surveys) and analyze data about health care utilization by enrollees (particularly those with chronic illness and low incomes) in various insurance products in order to publicize information about this experience, and*
 - *consider whether there is a need for regulation requiring plans to evaluate utilization and health status among enrollees in different products.*
- *Accrediting bodies should consider more comprehensive accreditation standards for PPOs, including applying HEDIS measures to permit more complete quality assessment of the array of managed care products.*

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SECTION VII: Conclusion

High deductible health plans could be seen as a throwback to the 1950s — the logical extension of the increasing cost sharing features of employer coverage and consistent with products typical in the individual market. But this view overlooks the foundation of first dollar coverage of most early Blue Cross plans. High deductible products also arguably return to the more typical purpose of insurance — a means to spread the risk of only costly and unexpected events — but this characterization ignores both the broad risk pooling of the early Blue Cross and Blue Shield plans and the concept of paying for a wide array of health care embodied in early prepaid group practice models. On the other hand, the HSA law’s authority to cover preventive services outside the deductible based on an increasing understanding of the value of prevention conflicts with original health insurance models covering only services arising out of illness or injury. Regardless of history or theory, however, most health insurers and many purchasers have embraced high deductible plans and are likely continue to do so absent evidence that they do not achieve their predicted improvements in cost and quality. Consequently, it is important for public and private policy makers to consider ways to protect people enrolling in these plans. Furthermore, even if high deductible products with spending accounts do not become prevalent, health insurance cost sharing is likely to increase as purchasers attempt to reduce premium growth. Therefore, consumers will be expected to decide whether to seek care and bear more out-of-pocket costs and will need accurate and usable information to make these choices as well as oversight of quality and access.

The debate over the appropriate direction for financing health care in the U.S. involves strong philosophical differences — whether the risk of paying for health care ought to be broadly pooled or primarily an individual responsibility and whether the purpose of insurance is a means to prepay for preventive and primary care or to cover only catastrophic costs (Gladwell 2005, Kaplan 2005, Scandlen 2005, Jacobi 2005, Shearer 2004). While acknowledging that third-party payment can encourage wasteful behavior, analysts skeptical of the consumer-directed strategy doubt that individual patients can judge whether many of the services they seek, especially the most technically complex and expensive, are necessary or appropriate and believe there remains a substantial role for evidence-based care management. Research on the cost, utilization and health status effects of high deductible plans may inform these debates, but probably will not put to rest these fundamental philosophical differences.

There is limited evidence on whether high deductible health plans (with or without spending accounts) will achieve any of their promised objectives. Despite the optimistic

predictions of CDHP advocates, however, the impact of these plans on overall medical care spending and the rate of uninsurance is likely to be limited. Increased cost sharing may help sensitize consumers to the costs of health care as a means to engage them in policy discussions about the difficult trade-offs facing health plans and public and private purchasers and the value of care coordination. But most analysts asserting this view believe that cost sharing should be targeted to services over which consumers have discretion and that restraining medical care spending requires providers and delivery systems to manage costly care.

Public and private sector purchasers, regulators and accrediting organizations can influence the direction of health care delivery and health insurance. For example, the availability of high deductible products exemplifies the insurance industry's response to both regulation (the federal HSA law) and market pressures (primarily employer demands). Regulators, especially state insurance commissioners, have a unique role in assuring that consumers face an insurance market that is stable and fair and provides them access to both promised services and information to undertake new responsibilities their coverage requires. Enrollees in high deductible health plans will have to make more purchasing decisions, but - because the U.S. is unlikely to return to pure indemnity coverage - if consumers need expensive care, health plans will continue to manage utilization based, it is hoped, on evidence of effectiveness and efficiency. State influence over employee coverage is limited by ERISA's prohibition on state regulation of self-insured private-sector employer plans, enhancing the importance of accreditation standards in this market. States ought, however, to be encouraged to regulate more equitably organizations performing similar functions as well as to improve interstate consistency. Because accreditation standards can facilitate nationally consistent quality measurement, state regulators can enhance interstate consistency by accepting accreditation standards to meet comparable insurance requirements.

State insurance regulators interviewed for this white paper have not observed significant consumer problems with the new high deductible plans and HSAs. But precisely because there is no perceived current crisis, which could lead to hasty and possibly poorly-conceived legislation, the time is ripe for NAIC and accrediting bodies to consider joint efforts to address consumer issues in the changing health insurance market, even though it is difficult to predict how the market may evolve in the near future.³⁸ In order not to disadvantage traditional HMOs, these discussions should include how both to avoid stifling innovation and to treat similarly organizations performing similar functions. accrediting bodies also should consider how to help accountable health plans promote the advantage of measuring and reporting quality so that individual and group health coverage purchasers appreciate the value of this accountability.

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APPENDIX A: State PPO Definitions and Standards

(URAC. 1999. *The PPO Guide.*)

State	Enabling Provisions ¹	Definition	Specific PPO Regulation
AL	None	None	
AK	None	None	
AZ	None	“network plan” = health benefits plan offered by insurer or accountable health plan (state also licenses health care service plans, including those sponsored by providers)	
AR	None	None	
CA	None	Insurers may offer policies under which they pay alternative provider rates (If offered by HMOs, PPOs can be regulated by CA Dept of Managed Care)	
CO	Yes	Risk-bearing PPOs = HMOs or insurers; PPOs = products offered by managed care plans	
CT	Yes	PPO = contractual provider arrangements; included in definition of managed care product offered by insurer or other licensed entity	Documentation regarding organizational structure, provider selection criteria\
DE	None	Included in definition of managed care organizations	
FL	Yes	PPO = group of health care providers contracting with an insurer	Provide members with roster of participating providers
GA	Yes	PPO=product offered through a managed care entity contracting with providers	PPO cannot use gatekeeper to restrict access to nonparticipating providers; provide members roster of participating providers
HI	Yes	PPOs regulated as managed care plans; also defined as organization contracting with providers to deliver services	
ID	Yes	PPOs = managed care plan offered by a managed care organization	

¹ This column refers to any indication in state law that PPO-type arrangements (products contracting with providers for negotiated rates or including member incentives to use contracted providers) are allowed — may not be an explicit “PPO Enabling Act.”

State	Enabling Provisions	Definition	Specific PPO Regulation
IL	Yes	PP Arrangements=provider contracts regarding payment; products offered by insurers & HMOs or non-insurer TPAs	Non-licensed PPA administrators must register with Ins. Dept; because insurance laws don't apply to these products, law includes detailed standards for provider accessibility, direct access to ob-gyn, emergency services access, provider credentialing, due process and network participation, and member education and dispute resolution; exempts self-insured employer plans from application of the law
IN	Yes	PP plan=contract with providers regarding reimbursement	Entities offering PPOs must file form with Ins. Dept.
IA	Yes	PPO=insurer contract with providers	Non-licensed entities offering PPOs must file provider contracts with Ins. Dept.
KS	None	None	
KY	Yes	HMOs or insurers can offer PPO products as managed care plans	
LA	Yes	PPO=contracts between providers and purchasers allowing alternative rates of payment	No agency is responsible to enforce law; requires access to emergency services, ob-gyn & interpreters/translators for hearing-impaired persons
ME	Yes	PPOs regulated as licensed managed care organizations or "preferred provider arrangements" (product) offered by non-licensed administrator	Insurers and administrators using PPOs must file utilization report with Ins. Dept and legislature; standards for PPA access to providers and emergency services, provider review process, quality management program, member information
MD	Yes	PPO= product offered by insurer or contract offered by employer, TPA or other entity providing services through preferred providers	Ins. Dept may request contracts and related documents
MA	Yes	PP arrangement=contract between insurers or HMOs and health care providers	Organizations operating PPAs must pay assessments, apply to offer PPA and file with Ins. Dept provider contracts, QA plan, UR processes, and rates; must meet state standards for access, emergency care
MI	Yes	Prudent purchaser contracts=products under which purchasers can obtain services from contracting providers at lower rates; can be offered by insurers, HMOs or TPAs	PPCs must meet standards for provider contracting, participation & quality review, member access to emergency services
MN	Yes	None	PPAs must file with Ins. Dept. name of organization and contracting providers

State	Enabling Provisions	Definition	Specific PPO Regulation
MS	Yes	PPOs regulated as HMOs	
MO	None	None	
MT	Yes	PP arrangement=contract between insurer and provider	PPAs exempt from managed care plan network adequacy and quality assurance act; PPAs subject to standards for provider contracts and access to emergency care
NE	Yes	PP arrangements=contract between insurer and provider or an organization formed by providers	PPAs must meet standards regarding network access, provider due process, provider credentialing, QA plan, member grievances
NV	Yes	PPO=managed care organization	
NH	Yes	PP agreement=contract between insurer and providers; regulated as managed care insurers and managed care plans	
NJ	Yes	PPO=entity other than an insurance carrier that contracts with providers with carriers; regulated as managed care plan	PPO must submit with carrier's application for selective contracting agreement description of quality monitoring process
NM	Yes	PP arrangement=contract between insurer and provider; regulated as managed health care plans	
NY	None	None	
NC	Yes	PPO=insurer or HMO contracting with providers; also regulated as a product offered by insurers	
ND	Yes	PP arrangement=contract between insurer and provider	
OH	Yes	PPO included as "open panel plan" in definition of "health insuring corporation" (risk-assuming health benefits coverage organizations)	
OK	None	Included in definition of "certified managed care plans" licensed by Ins. Dept.	
OR	(allows provider payments)	URAC notes state regulators claim not to regulate PPOs but reports they could be regulated as "managed health insurance" because that includes products with incentives to use contracted providers	
PA	Yes	PPO=arrangement involving contract between insurer or purchaser and providers; PPOs using gatekeepers regulated as managed care plans; risk-assuming PPOs (not insurers) subject to more detailed regulation than non-risk assuming PPOs; some PPOs regulated as HMOs	Risk-assuming PPOs must meet standards for capital and reserves, provider selection, member network access, QA program, member grievance system

State	Enabling Provisions	Definition	Specific PPO Regulation
RI	Yes	PPOs included in definition of health plan (contracts with selected providers to furnish health services)	
SC	None	None	
SD	Yes	PPOs included in definition of managed care plan (contracts with selected providers to furnish health services)	
TN	None	None	
TX	Yes	PP benefit plan=insurer product that pays for a different level of coverage if enrollees use contracting preferred providers	Insurers must meet standards regarding provider selection, due process, and payment, cost sharing differentials, and member network access, continuity of care, emergency care
UT	Yes	PPO=product offered by insurer	Insurers must meet standards regarding provider selection and due process, QA plan, member grievance process
VT	None	PPO "appears to be" included in definition of managed care plan	
VA	Yes	PPO=included in definition of managed care health insurance plans (including provider contracting and member incentives to use contracting providers)	Insurer offering PPO
WA	None	None ²	
WV	None	None	
WI	Yes	PP plans=insurers using contracted providers; also included in regulation of managed care plans (incentives for enrollees to use contracting providers)	PPP must meet standards for member network access, and emergency care, provider credentialing, QA program, member grievance process
WY	Yes	Risk-assuming PPOs must be licensed as HMOs; non-risk assuming PPOs may be administered by insurers	Insurer must meet standards for PPO contracts

² Although the URAC monograph indicates no PPO authority, the author of this white paper was told by a person interviewed for the white paper that WA includes PPOs in its "health care service plan" definition.

End Notes

¹ This paper does not discuss potential roles for federal regulators, such as the U.S. Department of Labor, which administers ERISA but would require changes in federal law to regulate benefits and administration of high deductible health products offered by self-insured health employer plans.

² Florida, South Carolina and West Virginia are planning to implement federal Medicaid waivers giving beneficiaries consumer-directed health accounts. Personal accounts would be funded (often with “rewards” for undertaking healthful behaviors like prenatal care, diabetes care, weight control and smoking cessation) to buy non-covered services. Some would include vouchers to buy approved insurance products.

³ These agencies are the Department of Managed Health Care in California, Department of Health and Social Services in Delaware, and Departments of Health in Minnesota, Mississippi, Nebraska, New Jersey and New York.

⁴ Over half the states have ‘high risk pools’ that offer coverage to people whose health conditions make them uninsurable; premiums always exceed those for good risks and in some states these pools have waiting lists.

⁵ Several states have laws that require certain treatments (such home health care or services for developmentally disabled children) to be covered outside health plan deductibles and bills to conform state law to the federal HSA law are pending but not yet enacted and the IRS allows HSA-qualifying HDHP to be sold in these states for plan years ending in 2006.

⁶ While insurance is a contract between a subscriber and an insurer, public policy recognizes that subscribers do not have the ability to research an insurer’s financial soundness or the leverage to bargain and that typical contract remedies (a lawsuit to recover the “benefit of the bargain” and even for tort damages for “outrageous” insurer conduct), are generally less efficient and effective to protect insurance consumers than public regulation.

⁷ To the author’s knowledge, none of the benefits mandates or managed care laws has ever been repealed.

⁸ Most state insurance commissioners are appointed by the sitting governor or executive branch agencies, but 12 are elected directly.

⁹ URAC accredits utilization review organizations and PPOs; www.urac.org.

¹⁰ JCAHO accredits hospitals, nursing homes, home health agencies, behavioral managed care organizations and ambulatory care providers; www.jcaho.org.

¹¹ AAAHC accredits ambulatory care providers; www.aaahc.org.

¹² HEDIS is a registered trademark of NCQA. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

¹³ Gabel (2004) includes employer-sponsored ‘defined benefit’ (DB) plans and personally-designed networks as CDHP. In a DB plan, an employer contributes a fixed amount of premium, allowing employees to choose more expensive plans by paying a larger share of premium. Personally-designed networks involve individual employees selecting various benefits, networks and cost sharing features, but may not become popular due to the large potential number of choices that can cause confusion and make a choice difficult (Shaller 2005). Other analysts include in CDHP “tiered benefit designs” like prescription drug coverage where cost sharing varies according to the generic or brand name drugs, this paper will not discuss such tiered products.

¹⁴ For HRA-qualified plans, employees paid 13 percent of individual and 31 percent of family premiums; for HSA-qualified plans employees paid 16 percent of individual and 21 percent of family premiums; and for all plan types combined, employees paid 16 percent of individual and 26 percent of family coverage premiums (KFF 2005a).

¹⁵ The authors noted that only 40 percent of enrollees in the CDHP had balances remaining in their HRA the first year of the study and 28 percent the second year, suggesting that most people did not hesitate to spend funds in the spending account; 57 percent of CDHP enrollees exceeded the deductible in the second year, at which point they might have faced an incentive to consume unneeded care.

¹⁶ This payment approach was one of the features of “managed competition” proposed by Alain Enthoven (1997)

¹⁷ Trude and Grossman (2005) quote Arnold Milstein as suggesting that people with known needs for acute care can shop for providers before an acute episode.

¹⁸ A notable exception is the disclosure by Aetna of unit prices for 600 services provided by its physicians in the Cincinnati area, “Insurer Reveals what Doctors Really Charge” Wall Street Journal Aug 18, 2005, p. D1.

¹⁹ This behavior is called “constructed preferences” because a consumer constructs his/her preference in response to a question, but this response is not stable over time (Hibbard and Peters 2003).

²⁰ People tend to treat each factor in a list of attributes equally so they will weight a single construct aggregating several measures indicating different dimensions equally with other individual characteristics and may thereby miss the opportunity to weigh individual factors of importance to them (Hibbard and Peters 2003).

²¹ One little known feature of this experiment was that it gave a lump sum of the maximum out of pocket cost (up to \$1000) to each family so none would be worse off by participating in the experiment, so they had resources with which to pay cost sharing. The HIE also excluded from participation people over age 62 or with total disability.

²² The authors could not draw definitive conclusions on this point, however, because they lacked detailed data about the enrollees’ other medical coverage.

²³ The authors also noted that people not receiving ongoing care but taking long-term medications also were sensitive to price changes and could not determine whether these utilization changes might be detrimental because they were not receiving ongoing medical monitoring.

²⁴ Appropriate medical care was identified for the following conditions: alcohol dependence, arthritis, asthma, atrial fibrillation, breast cancer, cataracts, cerebrovascular disease, chronic obstructive pulmonary disease, colorectal cancer, congestive heart failure, coronary artery disease, depression, diabetes, headache, hip fracture, hyperlipidemia, hypertension, acute low back pain, eight types of preventive care, peptic ulcer disease, pneumonia, urinary tract infection, benign prostatic hyperplasia, prenatal care, orthopedic conditions and sexually transmitted diseases.

²⁵ For example, if enrollees use debit cards, as some HSAs permit, it is not clear how the high deductible plan will track spending because providers do not submit claims to the plan.

²⁶ Robinson (2005a) suggests that cost sharing could be applied to discretionary services and provider incentives, such as payment methods and network management, could be used to discourage provider-induced demand; he would tailor these incentives to encourage varying delivery models to serve different clinical needs.

²⁷ Kaiser Health Plan and the Commonwealth Fund are co-sponsoring such a study of Kaiser’s HDHP enrollee experience.

²⁸ Ten percent of employers impose lower premiums on lower wage workers (KFF 2005), so some might be willing to risk-adjust premiums according to health status. Humana did lower employee contributions for HMO and PPO enrollees and raise them for HDHP enrollees to counteract risk selection, although the HDHP still experienced favorable selection (Lo Sasso et al. 2004).

²⁹ As discussed above, the HDHP enrollees in this study also used more services than HMO enrollees during the two study years and had higher hospital admissions and costs than both HMO and PPO enrollees.

³⁰ Under ERISA, US Department of Labor regulations require employer-sponsored plans to provide a considerable amount of information to health plan enrollees about how to use their plans, benefits and limits, provider access, and appeal rights, but nothing specifically regarding access to provider cost or quality information or other standards addressing use of CDHPs (29 C.F.R 2520.102-3).

³¹ An insurance department staffer explained that the state’s attempt to make its external review time-frames for submitting applications to the external review organization conform to the NAIC model was blocked by consumers viewing the changes as weakening consumer protections.

³² Many state laws also differ from the grievance process adopted by the U.S. Department of Labor in 2000 that applies to private sector employer-sponsored employee health plans. Because states can regulate insurers of ERISA plans (as long as their laws do not prevent application of the federal standards), ERISA plans may have different appeals procedures depending on whether the plan is self-insured (subject to DOL rules) or insured (subject to state rules).

³³ States would not have jurisdiction over them as insurers (exempt from preemption). Rather, PPO regulation would have to be defended as not “relating to” ERISA plans (the operative language in ERISA’s preemption clause). But courts have held ERISA preempts state laws that affect an employee benefit plan’s “structure” or “administration” and PPO laws might fall into that category. No courts have decided a case involving a state non-risk-bearing PPO law.

³⁴ The US Department of Labor takes the position that HSAs are not employer-sponsored plans, so ERISA would not preempt state regulation of them.

³⁵ The only recourse for employees in large firms that self-insure these products is contacting the US Department of Labor, which does accept complaints for workers in self-insured health plans, though it has limited authority to remedy problems.

³⁶ Joist and Hall (2005) suggest that states could require insurers offering HDHPs in the small group market to lower premiums to reflect their leaner benefits rather than favorable risk selection, but this is not the way most states regulate small group insurance premiums and regulators interviewed in the study were not receptive to this approach. Most PPOs offering HDHP as one of several products reported they currently rate all their PPO business as a single pool, though that might change under competitive pressure.

³⁷ States with such laws are trying to amend them to conform to federal HSA law.

³⁸ Forecasting future trends is challenging for even astute health care market observers. For example, Ginsburg (2005) discusses how far the market has diverged from tightly managed care in the last 10 years and expresses caution about where current pressures for “competition” may lead. In 1999, Zelman correctly predicted health care industry consolidation and desire for value-based purchasing but also forecast risk-bearing provider networks, which largely failed to develop.

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