

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 the 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.