

## **Consumer Directed Health care**

### **Introduction**

Healthcare financing continues to be a significant problem in the United States. Healthcare costs are trending considerably above that of inflation. In 2002, the U.S. health care spending increased 9.3 percent - the largest increase in 11 years. It increased an additional 7.8 percent in 2003, raising total health care spending to \$1.7 trillion. According to a report issued by the Centers for Medicare and Medicaid Services, health care spending grew 5.7 percentage points faster than the overall economy in 2002, marking the fourth consecutive year in which the rate of health care spending surpassed growth in the rest of the economy. (*Centers for Medicare and Medicaid Services, Jan. 8, 2004*) As a result, employers and government officials continue to seek ways to make patients more educated consumers of healthcare. The latest innovation in this regard is consumer directed healthcare plans (CDHPs).

Between 1998 and 2003, consumers' premiums per enrollee for private health insurance rose at an annual rate of 9.3 percent, while per capita disposable personal income grew by only 5.0 percent annually, a gap of more than four percentage points per year. Growth in out-of-pocket personal health care spending accelerated to 7.6 percent in 2003, up from 6.0 percent between 2001 and 2002. Private health insurance spending for personal health care grew 8.3 percent in 2003.<sup>1</sup>

The intention of this paper is to provide some background on consumer-directed healthcare (CDH) and analyze consumer-directed healthcare plans (CDHPs) as they relate to the physician-patient relationship. More focus will be placed on health savings accounts than the other CDHPs.

### **Consumer Directed Health Plans**

Government economists and actuaries estimated that the nation's healthcare bill, \$1.8 trillion (or \$6,130 per person) in 2004, would double to \$3.6 trillion by 2014. They project an increase in health care expenditure's share of the Gross Domestic Product (GDP) from 15.3 percent in 2003 to 18.7 percent by 2014.<sup>1</sup> Further, companies' health-insurance expenses rose 13.9 between 2003 and 2002 and 11.2 percent between 2003 and 2004.<sup>2</sup> The estimated number of uninsured is 45 million. Past approaches to slow the growth of healthcare spending that have failed include: traditional health insurance until the early 1980's, price regulation for government programs until the early 1990's, and managed care and purchaser power until the early 2000's.<sup>3</sup> Today, both public and private sector financiers of medical care want to decrease their healthcare expenses and are willing to consider the new consumer-directed healthcare plans (CDHPs) as the vehicles to do so .

There are two main components of a consumer-directed health plan (CDHP). First, the plan must provide members with financial incentives or disincentives to care more wisely. Second, the plan must include decision-support tools and resources that aid in improving the member's ability to make sound medical care choices.<sup>4</sup>

CDHPs press for more consumer involvement in making healthcare decisions. This approach is congruous with the belief espoused by Nobel Prize-winning economist Milton Friedman, that "nobody spends someone else's money as carefully as they spend their own."<sup>5</sup> Technology, namely the internet, has aided in this effort as now consumers can access a plethora of health-related educational materials, compare physicians, complete secure online health risk assessments, learn about various treatment options, easily locate in-network providers, communicate directly to physicians, and track one's healthcare claims activity. According to Hewitt Associates, the popular online tools used are health plan comparison tools, provider directories, health care cost summaries, and health care spending account estimators.<sup>6</sup> Furthermore, health plans, employers, and disease management organizations can send e-mails to consumers to maintain ongoing health-related education and support.

Recently, the high-deductible health plan (HDHP) connected with a personal health savings account (HSA) has gained the most attention. To a great extent consumers have been shielded from the true cost of medical care due to the small out-of-pocket co-payments that were extremely popular with managed care health plans. There is transference of more financial and decision-making responsibilities for medical care services to consumers. HDHPs will cause consumers to adjust to be more active in making health care service selections, which may include delaying or worse yet, neglecting needed or preventive medical care.

Employees benefit by having the ability to use tax-deferred monies for medical expenses and decide how monies in the personal healthcare savings accounts should be expended. Employers benefit by reducing its tax burden due to a lower after-tax salary upon which to pay FICA. The propensity for employers to continue offering healthcare savings accounts will continue.

The two main types of CDHPs are account-based plans and tiered models. Account-based plans are the most prominent and are the focus of this discussion paper. Tiered models are either premium or point-of-care based. Premium-tiered models are those that direct the consumer by having higher premiums for looser network, looser utilization management, or more generous coverage. Point-of-care tiered models contain higher copayments for providers in higher tier. Higher tiers are composed of physicians and other providers who are segmented by the health plan based on performance and efficiency measures.<sup>7</sup>

### **CDHPs - Account-Based**

The CDHPs that include personal healthcare savings accounts are flexible spending accounts (FSAs), Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs), and the newer Health Savings Accounts (HSAs). Each of these healthcare savings accounts will be explained. For a valuable comparison developed by the Flexible Benefit Service Corporation see the health care savings account comparison at <http://www.flexiblebenefit.com/marketing/1203.pdf>.

### **CDHP Physician Implications**

There is potential for the HDHPs to have negative implications for physicians. The point that cannot be stressed more highly is for physicians to know their health plan contracts. The two main questions to ask health plans are: (1) does my contract bind me to automatically become a participating physician under any of your new plans, including HDHPs; and (2) what patient fees

can I collect at the time of service? HDHPs could lead to an increase in bad debt if patient fees cannot be collected at the time of service.

### **Increased bad debt, billing and collection costs**

It is a false notion that if patients have a debit card to access their personal health savings account (FSA, HRA, MSA, or HSA), that the physician can automatically collect the total amount due at the time of service. This is dependent upon two criteria-the physician's contract with the health insurance plan and the amount of monies in the patient's personal health savings account.

Health insurance plan contracts will have three basic collection policies for physicians to follow: (a) prohibit collecting any monies from the patient at the time of service; (b) permit the collection of copayments, only; or (c) allow for the collection of the amount due from patients but suggest that physician claims be filed and processed prior to billing the patient. The reason for not prohibiting but advising to await the explanation of provider payment (EOPP) is so that the health plan's claims editing logic can be applied. Thus, bundling will occur. EOPPs will identify the contracted rate due the physician so that the patient's Explanation of Benefit (EOB) matches what is billed by the physician. This process will reduce refunds due patients with HDHPs and ensure that the physician is billing the patient the contracted rate.

After determining what the patient owes, there is still the hurdle of collecting from the patient. Practices can likely expect their billing and collection costs to increase for HDHPs due to an additional need for statements and collection phone calls. Patients may not have accrued enough monies in their personal health savings account to pay for the provided services. Then, patients have to decide if and/or how much they will pay the physician for the already provided medical care. Will the practice make arrangements with a credit organization to assist patients with payment issues to fulfill their financial obligation with the practice? With the HDHPs shifting the upfront financial burden to the consumer, the result is a great potential for an increase in physicians' bad debt expenses.

For services for which the patient's health insurance will consider "non-covered", have the patient sign an advanced beneficiary notice and do not bill the insurance carrier. The reason to not bill the insurance company is that even though the code will not be covered a discount may be applied only obligating the patient to pay the contracted rate. This would be a recommendation for any service that is considered to be a "non-covered service", e.g. cosmetic procedures.

### **Cash flow lag**

Physicians will experience a lag in their cash flow due to having to await the health plan's explanation of provider payment prior to billing the patient and because patients will more than likely, not pay their bills as quickly as a payer. When health plans are directly paying for services, the turn-around-time on filing a claims and receiving payment is fairly expedient. Clean claims electronically filed with some health plans are paid within 15 business days.

Most health plans, either through a contractual mandate or direct physician communication, will have physicians follow normal billing procedures-file a claim with health insurance plan, await

the explanation of provider payment, bill the patient the balance due, and await the patient's payment. Patients will either pay the physician directly using an HSA check or debit card, credit card, personal check, or make installment payments. This is where the practice having an efficient collections policy and process is vital as there is a potential for administrative expenses related to billing and collections to grow. Note, patients with an HRA or HSA who have received medical care may not have the account fully-funded. They may want to wait until the account balance can cover the physician's entire bill, which could lead to an increase in the days in accounts receivables.

### **Office visit volume**

There are two schools of thought around the possible impact on patient office visit volume for those with HDHPs. On the one hand, there is a possibility for the volume of health services to decline as consumers will have a greater financial obligation for health services. A decline in the lower level office visits may translate into an increase in patients phoning or e-mailing physicians for prescription-only and/or web-based consultation requests. Interestingly, 2000-2002 research done for the University of Minnesota with 17,500 employees and 1253 enrolled in HDHPs indicated that HDHP enrollees had fewer visits per capita (7.15) than HMO enrollees (7.29), possibly using more nurse help lines.<sup>8</sup> Health plans' development of online tools and interactive support from nurses to those with chronic conditions are focused on wellness and reducing its medical losses. One approach taken by some health plans has been the piloting of web-based consultations for non-urgent, covered services with reimbursement ranging from \$25.00 - \$40.00. This is a lower cost option to health plans and its members. Keep in mind, overhead for electronic consultations is minimal as it would basically only include the physicians' time.

On the other hand, face-to-face physician visits for preventive services may increase due to the fact that most account-based HDHPs include at or near 100% coverage for preventive services. This has been evidenced by Aetna, Inc.'s findings. After its first year of offering its HDHP-HSA, Aetna HealthFund plan, Aetna found that member utilization of some preventive care measures increased by as much as 23 percent. This was coupled with the financial success that employers offering these plans as an option experienced low medical cost increases of 3.7 percent, while a full replacement plan sponsor experienced a medical cost decrease of 11 percent.<sup>9</sup>

Another possibility for an increase in physician office visits is that some employers fund the employee's health savings account. These available monies may incent employees to use the money for medical care.

### **Convenience Matters**

With more physician performance data available to consumers, qualitative factors will be increasingly important. Convenience will be a considerable factor to the consumer. Consumers' expectations for what their physicians should deliver will increase.

- a. Ease of parking and entrance into physician's office
- b. Advanced access appointments
- c. Extended office hours, including Saturday appointments
- d. Greater demand for consultations being done by telephone, e-mail, and the internet

- e. E-mail the office staff to request an appointment, ask a health-related question, or prescription refill request
- f. Real time test results

### **Quality Care Matters**

Conventional wisdom in the world of consumerism holds that as consumers are more health care literate and can identify physicians who meet certain quality and efficiency measures, they will be more selective about where and to whom they go to receive medical care. Health plans are already beginning to use quality measures and cost-efficiency to profile physicians and create tiered-networks. Health benefit plans will “direct” consumers with financial incentives to seek care from physicians in tier 1 with lower out-of-pocket obligations. The hope is that health care consumers will become more value-minded when selecting their personal physicians. Health plans have struggled with analyzing physicians’ claims (administrative) data to determine the quality of care provided. Since there has not been nationally agreed upon performance measures to use to measure quality, many physicians have been skeptical.

However, most recently, there has been national consensus on some clinical performance measures. On May 2, 2005, the Ambulatory care Quality Alliance, or AQA released a "starter set" of 26 clinical performance measures for ambulatory care. The uniform starter set comprises prevention measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and, two efficiency measures that address overuse and misuse.<sup>10</sup> For the full starter set, go to [http://www.aafp.org/PreBuilt/newsstatement\\_AQAS StarterSet.pdf](http://www.aafp.org/PreBuilt/newsstatement_AQAS StarterSet.pdf). Public and private payors will more than likely use these measures to create physician profiling criteria and pay-for-performance programs.

### **Clinical Efficiencies**

When face-to-face with the physician, patients will aim to maximize their time with the physician. Thus, office visits may be longer due to additional time educating and consulting patients. The physician’s ability to listen and advise patients will be an ever more important component of how well the patient connects to the physician. Due to a greater number of patients searching the internet for the latest clinical findings and treatment options, more questions about care options will arise.

### **Administrative Efficiencies**

The provision of quality care will not be the only component of quality that patients will attend. It will also be about service - administrative / office efficiencies - patient flow, collections, returning patient calls or e-mails. Patients will want more convenience and timely feedback to their questions and test results. One way to better maintain good customer service to patients is to obtain their feedback through a patient satisfaction survey.

### **Prescriptions**

In 2006, the HDHP/HSA plans cannot have an imbedded deductible for pharmacy benefits. Patients will have to reach their deductible before there is any coverage for medications. This could lead to a rise in patients’ demand for samples and generic alternatives. To decrease costs,

health plans will continue with developing more restrictive formularies, greater variances between the tiered pharmacy benefit levels, and higher out-of-pocket costs for each tier.

Some employers, who want to offer CDHPs but maintain lower deductibles for prescription coverage, have opted for an HRA with a carved-out prescription coverage allowing for a lower out-of-pocket threshold.

More than likely, patients will still want to know whether or not their insurance covers the prescribed medication, prescriptions written for a 90-day mail order supply, and suitability for over the counter medications for their condition. Web-based and PDA prescribing tools can keep physicians updated on health plan formularies, drug interactions, and searchable medication databases. E-Prescribing will save time and improve patient safety.

### **Patient Questions**

Consumer engagement in their medical care will lead to more questions from patients. Some questions that physicians may encounter are:

#### **Clinical**

- What are the benefits of having the recommended procedure?
- How many of these procedures have you done? For the patients upon whom you have performed a procedure, how many adverse events were experienced?
- What if I refuse or wait to have the procedure?
- What would you do if you were in my condition?
- Where can I get a second opinion?
- Is a generic drug appropriate for my condition?
- How many drug samples will you give me?
- Will you write a prescription for 90-days? 180-days? 360-days?

#### **Administrative**

- How much will today's office visit cost me?
  - Does your office staff know what contracted rate to charge the patient for provided services if contractually able to collect at the time of service?
- How much will the recommended health services cost me?
- What does my health insurance cover?
- Can I make payments?
  - What are the terms of paying over time?
  - Do you accept credit card payments?
  - Can I pay online through your practice's web site?
- How quickly will I receive my test results?
- What is the turn around time to my inquiries by phone and e-mail?
- Do you have a patient satisfaction survey?
  - What is your patients' level of satisfaction with your practice?
  - Is your office personnel kind, personal, and helpful?
- Do you use an electronic health record system?
- Can I remotely access your electronic health record that contains my personal health record?

### **Consumer Education**

Given the importance of and degree to which consumers will be more responsible for more out-of-pocket health care costs, providing tools to make decisions and educating them on health, healthy habits, and expected costs of care are all important. Some health plans and other organizations have online consumer tools to estimate the cost of the anticipated services as a way to prepare the insured on what to expect to pay.

Even prior to purchasing a HDHP, health plans who offer such plans have developed web-based cost comparison examples. This allows the employees to compare the HDHPs to traditional plans so that consumers can gain a perspective on the value of the HDHP linked with a health savings account (HRA, MSA, HSA) as a component/benefit of the HDHP.

### **CDHP Discussion**

Employers and health plans will continue to advocate for the benefits of consumer choice in health care. It takes time for employers to educate their employees on what CDHPs are and how to navigate them. Yet, many employers are committed to offering CDHPs (HRAs and HSAs) in 2006 and 2007. Supporting consumers with valid, helpful decision-support tools will be critical for the success of these plans. Consumers will need support in selecting an appropriate physician and hospital for health services. Consumer education efforts will be an area where health plans will spend a considerable amount of resources. If there is consumer backlash against CDHPs, health plans and employers will lose.

Health plans development of consumer decision-support tools will continue. Physicians will continue to play a key role in assisting their patients in this new era of consumer-directed health care. It will be even more vital for patients to rely on their personal medical home to be consulted on what viable health services options exist.

### **Conclusion**

Consumer-directed health care is in its infancy and has with it considerable challenges for the health care system. Consumers' health literacy will be pressed to improve as more and more responsibility for making health care decisions will fall to them. Accessing current, reliable information upon which sound, prudent medical care decisions can be made is vital. However, consumers will continue to ask their personal physicians questions on what to do, but will rely on the physician as more of a medical consultant versus the decision maker.

Health plans and employers are using financial incentives to change consumers' behaviors. Spend less now and save more for your retirement. Financial behavior change is not the only type of change they want to influence. Health plans are placing tremendous resources into nurse care coaching, self-care tools, and nurse help lines. Employers are offering discounts on health insurance for smoking cessation, completion of exercise regimens, losing weight, and health risk assessment forms. Possibilities do exist to work as a team with the physician as the patient's health manager. It does take the team approach to successfully manage individual's plan of care.

Lastly, HSAs are the newest vehicle with which to engage the consumer to reduce the growing health care costs. When consumers take charge of their own health care decisions, they will be motivated to learn more about their options and the cost associated with their choices. Consumers have been shielded from the true costs of medical care. Consumers will experience more transparency from the health insurance plans on medical care cost, quality of care, and physician recognition programs (such as NCQA certified). These elements will be leveraged to financially incent consumers through tiered or high performance networks to seek care from the physicians who have the best quality care at the best price. Whether or not CDHPs will survive in the long-term, the added transparency in cost, quality, and consumer education will continue.

## ***Personal health savings accounts***

### **Health Savings Account (HSA)**

Instead of redesigning the MSAs, which will sunset at the end of 2005, Health Savings Accounts ("HSAs") were created on December 8, 2003 when President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Title XII of the MMA, entitled "Tax Incentives for Health and Retirement Security," created HSA provisions in section 223(d) of the Internal Revenue Code ("IRC"). The IRC permits the creation of a trust, or health savings account, which can pay for the account beneficiary's qualified medical expenses provided that the individual's health insurance policy meets the HDHP design requirements.<sup>11</sup>

A Health Savings Account is really a combination of a health insurance policy meeting minimum US Treasury requirements for a High Deductible Health Plan (HDHP), and a separate custodial savings account for future medical expenses called a Health Savings Account (HSA).<sup>2</sup> Anyone already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or MSAs can offer HSAs.<sup>21</sup>

### **High Deductible Health Plan (HDHP)**

The US Treasury policy design requires that a HDHP is a health insurance policy that has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the annual out-of-pocket medical expenses that the employee must pay for covered expenses.

Note, the HDHP definition applies to Health Savings Accounts and Medical Savings Accounts. Health Reimbursement Accounts (HRAs) do not require a HDHP, but it is standard practice among employers to use the HDHP / HRA combination.

### **Qualified Medical Expenses**

Qualified medical expenses include those for prescriptions, vision, and dental services. To be a qualified medical expense for medical care, the expense must be a medical expense, which is primarily for the prevention or alleviation of a physical or mental defect, or illness.<sup>21</sup> For a complete list of qualified medical expenses and non-qualified medical expenses, see the IRS Publication 502, which can be found at <http://www.irs.gov/publications/p502/index.html>.

### **Eligibility for an HSA**<sup>12</sup>

In general, anyone who meets the following four qualifications may set up an HSA:

- Is enrolled in an HDHP.
- Is not covered by any other plan - exceptions: accident, disability, dental, vision, long-term care, and worker's compensation coverage.
- Cannot be claimed as a dependent on someone else's tax return.
- Is not entitled to Medicare for either age or disability.

### **HDHP limits for HSAs (YR 2005) 1**

<b>Type of coverage</b>	<b>Minimum annual deductible</b>	<b>Maximum annual deductible</b>	<b>Maximum annual out-of-pocket expenses</b>
<b>Self</b>	<b>\$1,000</b>	<b>\$ 2,650</b>	<b>\$ 5,100</b>
<b>Self and Family</b>	<b>\$ 2,000</b>	<b>\$ 5,250</b>	<b>\$ 10,200</b>

*These amounts/limits are indexed annually for inflation.*

### **HSA Contributions**

According to the IRC, any eligible individual can contribute to an HSA. For an employee's HSA, the employee, the employee's employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed (or unemployed) individual, the individual can contribute. Family members or any other person may also make contributions on behalf of an eligible individual. Contributions to an HSA must be made in cash. Contributions of stock or property are not allowed.

### **Limit on contributions**

The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have and your age. For 2005, if you have self-only coverage, you can contribute up to the amount of your annual health plan deductible, but not more than \$2,650. If you have family coverage, you can contribute up to the amount of your annual health plan deductible, but not more than \$5,150.

### **Rules for married people**

If either spouse has family coverage, both spouses are defined as having family coverage. If each spouse has family coverage under a separate plan, both are treated as having family coverage under the plan with the lower annual deductible. It is necessary to reduce the limit on contributions, before taking into account any additional contributions, by the amount contributed to both spouse's Archer MSAs. After that reduction, the contribution limit is split equally between the spouses unless you agree on a different division.

If both spouses are 55 or older and not enrolled in Medicare, each spouse's contribution limit is increased by the additional contribution. If both spouses meet the age requirement, the total contributions under family coverage cannot be more than \$6,150.

### **HSA Example**

As an example, an employer voluntarily contributes \$500 into an employee's HSA account and the employee contributes \$500. The employee may draw on this \$1,000 to pay qualified out-of-pocket medical expenses, including deductibles, co-payments, and coinsurance. Once the \$1,000 deductible is met, the HDHP begins paying benefits for covered medical expenses. Most plans will have coinsurance cost sharing until the

maximum out of pocket amount of \$ 5,150. Note, the maximum can be higher for out-of-network medical expenses.

### **Prescription Drug Plans**<sup>13</sup>

An individual who is covered by both an HDHP and by a prescription drug plan is not an eligible individual for the purpose of contributing to an HSA unless the prescription drug coverage is also an HDHP, meaning that the prescription drug plan does not provide benefits unless the required minimum annual deductible for an HDHP has been satisfied.

The IRS did make a provision that until the end of 2005, individuals who do not meet the above requirement can still contribute to an HSA.

### **Preventive Services**

The IRC section 223(c)(1)(C) provides a safe harbor for the absence of a preventive services deductible having to be included in the HDHP.<sup>3</sup> This provides flexibility to the health plans in crafting their health benefit plans. Preventive care benefits can be offered without a deductible or have a deductible below the minimum annual deductible.<sup>14</sup> Preventive services are valued and normally recommended by health plans due to the long-term cost savings in maintaining one's healthy state, versus treating an untreated chronic condition.

Preventive care includes, but is not limited to the following:

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
2. Routine prenatal and well-child care
3. Child and adult immunizations
4. Tobacco cessation programs.
5. Obesity weight-loss programs
6. Screening services include: - This includes screening services for the following:
  - a. Cancer
  - b. Heart and vascular diseases
  - c. Infectious diseases
  - d. Mental health conditions
  - e. Substance abuse
  - f. Metabolic, nutritional, and endocrine conditions
  - g. Musculoskeletal disorders
  - h. Obstetric and gynecological conditions
  - i. Pediatric conditions
  - j. Vision and hearing disorders

For the full list including subcategories for Safe Harbor Preventive Care Screenings see [Preventive Care Screenings 2](#) <sup>15</sup>.

In January 2004, the IRS provided more guidance of what may fall under the definition of a “preventive service”. Any treatment of a related condition that is “incidental or

ancillary” to a preventive care service or screening would meet the safe harbor requirement for preventive care. The example given is if the removal of polyps during a diagnostic colonoscopy was done during a preventive screening then it would fall under preventive care. Certain drugs and medications also may be considered preventive if the patient has developed risk factors for a disease that either has not been evident or not clinically apparent, or to prevent the recurrence of a disease from which an individual has recovered.<sup>14</sup>

**Who can offer an HSA**

A health insurance company or an insurance plan usually provides the qualified health insurance policy. A licensed HSA administrator and financial services company, such as a bank, usually acts as the custodian and administers the savings account portion of the HSA.<sup>15</sup>

**HSA popularity**

An ever increasing number of employers, including the federal government, are offering HDHP/HSA plans. A 2004 Mercer survey of employers indicated that among large employers (500+ employees), 14% said they were likely to offer one in 2005 and more than one fourth (26%) thought they were likely to offer one by 2006.<sup>16</sup> The cost savings that benefit various stakeholders are what is driving HSA popularity, according to America’s Health Insurance Plans (AHIP), a national trade organization more than 80 insurers in the United States offer HSAs.<sup>17</sup> Almost half the purchasers of policies eligible for coupling with Health Savings Accounts were families and 40 percent had incomes of \$50,000 or less, according to the study, which was conducted by ehealthinsurance.com, an online service representing more than 140 health insurance carriers nationwide.<sup>18</sup>

***HSA numbers***

Year	Employers offering HSAs	HSA enrollees	Market share %	Premiums
2003	1 – 2 %	500,000	<1 %	\$ 8 billion
2005	3.5 %	3 million <sup>19</sup>	2 %	\$ 16 billion
2006*	4 % - 10 %	5 - 7 million <sup>4</sup>	4 % – 6 % <sup>9</sup>	\$ 30+ billion

\* projected

What are some of the advantages to the financiers of health care services in the private sector?

**Employers**

1. Lower premiums
2. Lower payroll taxes
3. Will slow the increasing healthcare trend (healthcare cost inflation)
4. Shift most of the first dollar out-of-pocket expenses to the consumer
5. Liability shifts to the employee because the employee owns and manages the health savings account.
6. The cost of CDHC coverage can be as much as 40% less than first dollar coverage

## **Employees**

1. Lower taxable income for employees who payroll deduct HSA contributions
2. Extend another investment vehicle to save for post-retirement needs
3. HSAs are portable and independent of employment, unlike HRAs.
4. HSAs are flexible in that the account owner decides how to invest monies

## **Health Insurance Plans**

1. Could increase market share as small businesses that may not have otherwise offered health benefits may be able to do so given HDHP/HSA affordability.
2. Do not create a new network. The payer can take advantage of already established provider networks, thus easing the administrative effort and cost.
3. Increases the overall number of health benefit plans offered leading to a possible competitive advantage
4. HSAs are not under obligation under state law for prompt payment. They are like self-funded ERISA plans.

## **Potential Pitfalls**

### **Little Available Data**

There is very little data upon which to determine on the overall health effects of HDHPs. The most significant concern with HDHP/HSA plans is that insureds may delay or avoid seeking needed medical care. A Commonwealth survey found that nearly 50 percent of insured adults with an HDHP had problems paying medical bills or debts compared to 31 percent of those with lower-deductible plans. Commonwealth Fund President Karen Davis said that HDHP-enrolled persons were more likely (33 percent) than those with lower-deductible coverage (17 percent) to face a specific medical problem, but forego visiting a doctor. Twenty-eight percent of HDHP enrollees did not fill a prescription, compared with 15 percent of other privately insured survey respondents.<sup>20</sup>

### **Overall Savings may be exaggerated**

Unless high-deductible health plans include incentives to affect the spending patterns of chronically higher users of health care services, the total cost of providing health benefits is unlikely to be significantly reduced.

- HSAs have start-up costs (\$4 to \$25), monthly maintenance fees (\$1 to \$10) and transaction fees, all of which will reduce savings on premiums
- Employer communication campaigns necessary to launch the new concept to employees may also reduce savings.

### **Adverse selection**

HSAs may attract the healthiest and wealthiest individuals, making non-HDHP plans more expensive. This is highly dependent on what type of health benefit plan(s) the employer offers. If the employer does not offer an employer-based health insurance or if self-employed, an individual may purchase a HDHP/HSA. Given the small numbers of

enrollees in HDHPs and the limited number of years of data with which to analyze, no absolutes can be presently made.

### **HSA accumulation is limited**

It will be difficult in using an HSA to save money for premiums and out-of-pocket expenses. Individuals can (and may need to) use the money in the account to pay for health care services during their working years or to pay COBRA premiums and insurance premiums while they are unemployed. Distributions from the account prior to becoming eligible for Medicare will erode the value of the account.

### **Individual plans more attractive**

Under a high-deductible family plan, no one in the family can have a separate deductible lower than the minimum family deductible. This makes a HDHP less attractive if some members of the family are significantly healthier than others. A greater amount of family financial resources would be expended prior to reaching the deductible.

### **Health Reimbursement Accounts (HRAs)<sup>21</sup>**

A health reimbursement arrangement (HRA) must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including FSAs.

### **HRA Benefits**

Employer contributions can be excluded from employee's gross income. Reimbursements are tax-free if expensed were qualified medical expenses. Remaining money in the HRA can be rolled over to subsequent years to pay for qualified medical expenses.

### **Qualifying for an HRA**

HRAs are employer-established benefit plans.

- Employers have complete flexibility to offer various combinations of benefits in designing their plan.
- Health plan coverage is not a requirement.
- Self-employed persons are not eligible for an HRA.
- Limitations may apply for highly compensated participant.

### **HRA Contributions**

HRAs are funded solely through employer contributions and may not be funded through employee salary deferrals under a cafeteria plan. HRA contributions are not included in the employee's income, and there are no federal income or employment taxes on these amounts.

There is no limit on the amount of money an employer can contribute to the HRAs. However, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts not previously used.

## **HRA Distributions**

HRA distributions must be paid to reimburse the employee only for qualified medical expenses that were incurred on or after the HRA enrollment date. HRA reimbursements are allowed to be distributed to any of the following individuals:

- Current and former employees.
- Spouses and dependents of those employees.
- Spouses and dependents of deceased employees.

If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income.<sup>21</sup>

## **Qualified medical expenses**

Qualified medical expenses from an HRA include:

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage.
- Amounts that are not covered under another health plan.

For a complete list of qualified medical expenses and non-qualified medical expenses, see the IRS Publication 502, which can be found at <http://www.irs.gov/publications/p502/index.html>.

## **HRA Balances**

Amounts that remain at the end of the year can generally be carried over to the next year. The employer is not permitted to refund any part of the balance to the employee. These amounts must only be used for reimbursements for qualified medical expenses.

An employee who leaves an employer may lose access to the HRA because it is completely the employer's decision to allow for HRA portability.<sup>22</sup> In fact, the HRA is not a cash account rather, it is virtual money that can be used only for qualified medical expenses. Most employers follow the use-it-or-lose-it rule as once the employee leaves the employer HRA virtual monies stay with the employer.<sup>23</sup>

## **Employer Participation**

For an HRA to maintain tax-qualified status, employers must comply with certain requirements that apply to other accident and health plans. HRAs are the property of the employer so portability and access are somewhat limited.

## **Flexible Spending Accounts (FSAs)**<sup>21</sup>

The Revenue Act of 1978 created the Internal Revenue Code section 125 which allowed the creation of a health flexible spending arrangement (FSA). An FSA allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with the employer. No employment or federal income taxes are deducted from the employee's contribution. The employer may also contribute.

## **FSA Benefits**

Contributions made by the employer can be excluded from the employee's gross income for tax purposes.

- No employment or federal income taxes are deducted from the contributions.
- Withdrawals may be tax free if used to pay qualified medical expenses.
- Funds can be withdrawn from the account to pay qualified medical expenses even if the account balance is inadequate to cover the withdrawal. This would be the case up to the FSA contribution level indicated for the calendar year.

## **Qualifying for an FSA**

Health FSAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided benefits as part of a cafeteria plan. Employers have complete flexibility to offer various combinations of benefits in designing their plan.

Two points to keep in mind are:

- Self-employed persons are not eligible for an FSA.
- Coverage under any health care plan is not necessary to participate.

## **FSA Contributions**

Employee contributions to an FSA can be done by electing an amount to be voluntarily withheld from an employee's paycheck by the employer. This is sometimes called a salary reduction agreement. The employer may also contribute to an FSA if specified in the plan document.

The employee benefit is that one does not pay federal income tax or employment taxes on the salary contributed or the amounts the employer contributed to the FSA. However, any contributions made by the employer to provide coverage for employee long-term care insurance must be included in the employee's income.

There is no limit on the amount of money the employee or the employer can contribute to the accounts; however, the plan document must prescribe either a maximum dollar amount or maximum percentage of compensation that can be contributed to the employee's health FSA.

Contributed amounts that are not spent by the end of the plan year are **forfeited**. For this reason, it is important to base the employee's contribution on an estimate of the qualifying expenses the employee will have during the year.

## **FSA Distributions**

Distributions from a health FSA must be paid only to reimburse the employee for qualified medical expenses the employee incurred during the period of coverage. The employee must be able to receive the maximum amount of reimbursement (elected contribution amount for the year) at any time during the coverage period, regardless of the amount contributed to date.

The employee must provide the health FSA a receipt with the itemized medical expense and cost of the item or service. Advance reimbursements of future or projected expenses are prohibited.

### **Qualified medical expenses**

Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. Examples include amounts paid for doctors' fees, prescription and non-prescription medicines, and necessary hospital services not paid for by insurance. For a complete list of qualified medical expenses and non-qualified medical expenses, see the IRS Publication 502, which can be found at <http://www.irs.gov/publications/p502/index.html>.

### **Balance in an FSA**

Amounts left in a flexible spending account cannot be carried/rolled over to the next year. The employer is not permitted to refund any part of the balance to the employee.

### **Archer Medical Spending Accounts (MSAs)<sup>21</sup>**

Archer Medical Savings Accounts (MSAs) were created under a pilot project authorized by the Health Insurance Portability and Accountability Act of 1996. An MSA is a tax-exempt trust or custodial account, similar to an IRA, which is linked to a qualified high-deductible health plan (HDHP). Note, when referring to an Archer MSA, the word "Archer" is normally omitted. Deductible contributions and earnings grow tax-deferred. They are available to self-employed persons and to businesses with 50 or fewer employees.<sup>24</sup> The number of MSAs was limited with the overall number by 2004 being less than 100,000 accounts. No new MSAs will be available after the end of 2005, due to the creation of the more flexible Health Savings Accounts (HSAs).

### **MSA Benefits**

- Interest or other earnings on the assets in an MSA are tax free.
- Tax deduction for contributions can be made without having to itemize deductions on Form 1040.
- Distributions are tax free if used to pay for qualified medical expenses.
- Contributions in an MSA roll over from year to year.
- An MSA is portable so it stays with the MSA owner through job change or even when leaving the work force. Note, following an employer change, any future MSA contributions could only be made if MSA criteria were met by the new employer.

### **Qualifying for an MSA**

To qualify for an MSA, you must be either:

- An employee (or the spouse of an employee) of a small employer that maintains an individual or family HDHP for you (or your spouse).
- A self-employed person (or the spouse of a self-employed person) who maintains an individual or family HDHP.

## **High Deductible Health Plan (HDHP)**

The US Treasury policy design requires that a HDHP is a health insurance policy that has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the annual out-of-pocket medical expenses that the employee must pay for covered expenses.

## **MSA Contributions**

Contributions to the MSA can be made by the employee or employer but not by both in the same year. Employer contributions are non-taxable. The self-employed can make contributions. All contributions are optional. The annual maximum contribution for individuals is 65% of the individual deductible and for families is 75% of the family deductible. Barring extension for tax filings, contributions to MSAs for 2004 are allowed until April 15, 2005. Excess contributions may be subject to a 6% excise tax if the excesses are not withdrawn by the tax filing deadline.<sup>21</sup>

Contributions are limited to be less than one's annual salary from the employer offering the HDHP. The self-employed participants cannot contribute more than their net self-employment income.

## **MSA Distributions**

Distributions will be tax-free if used to pay for qualified medical expenses. Distributions utilized for other reasons will be subject to income tax and a 15% penalty tax. At age 65, or upon disability, MSA withdrawals are allowed for any reason without a penalty; however, they will be taxed as ordinary income.

## **Qualified medical expenses**

Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. Examples include amounts paid for doctors' fees, prescription and non-prescription medicines, and necessary hospital services not paid for by insurance. For a complete list of qualified medical expenses and non-qualified medical expenses, see the IRS Publication 502, which can be found at <http://www.irs.gov/publications/p502/index.html>.

## **Balance in an MSA**

The MSA owner makes decisions on what to do with any monies in the MSA. The tax advantages may be very appealing to those looking to maximize retirement savings.

## **Medicare Advantage MSAs**

A Medicare Advantage MSA is an MSA designated by Medicare to be used solely to pay the MSA owner's qualified medical expenses. The Medicare Advantage beneficiary must have a high deductible health plan (HDHP) that meets the Medicare guidelines. Note, to date, there are not any details on Medicare Advantage MSAs.<sup>21</sup>

# Preventive Care Screenings 1 <sup>14</sup>

## **Cancer Screening**

Breast Cancer (*e.g.*, Mammogram)  
Cervical Cancer (*e.g.*, Pap Smear)  
Colorectal Cancer  
Prostate Cancer (*e.g.*, PSA Test)  
Skin Cancer  
Oral Cancer  
Ovarian Cancer

Testicular Cancer

Thyroid Cancer

## **Heart and Vascular Diseases Screening**

Abdominal Aortic Aneurysm  
Carotid Artery Stenosis  
Coronary Heart Disease  
Hemoglobinopathies  
Hypertension  
Lipid Disorders

## **Infectious Diseases Screening**

Bacteriuria  
Chlamydial Infection  
Gonorrhea  
Hepatitis B Virus Infection  
Hepatitis C  
Human Immunodeficiency Virus (HIV) Infection  
Syphilis  
Tuberculosis Infection

## **Mental Health Conditions and Substance Abuse Screening**

Dementia  
Depression  
Drug Abuse  
Problem Drinking  
Suicide Risk  
Family Violence

## **Metabolic, Nutritional, and Endocrine Conditions Screening**

Anemia, Iron Deficiency  
Dental and Periodontal Disease  
Diabetes Mellitus  
Obesity in Adults  
Thyroid Disease

## **Musculoskeletal Disorders Screening**

Osteoporosis

## **Obstetric and Gynecologic Conditions Screening**

Bacterial Vaginosis in Pregnancy  
Gestational Diabetes Mellitus  
Home Uterine Activity Monitoring  
Neural Tube Defects  
Preeclampsia  
Rh Incompatibility  
Rubella  
Ultrasonography in Pregnancy

## **Pediatric Conditions Screening**

Child Developmental Delay

Congenital Hypothyroidism

Lead Levels in Childhood and Pregnancy

Phenylketonuria

Scoliosis, Adolescent Idiopathic

## **Vision and Hearing Disorders Screening**

Glaucoma

Hearing Impairment in Older Adults

Newborn Hearing

## Physician High-Deductible-Health-Plan Tips

1. Know thy contracts
  - a. Under the health plan's contract, how much can be collected from the patient at the time of service?
  - b. Is the provided service a covered service?
2. Know thy practice
  - a. How well-tuned are my administrative functions?
    - i. What is the timeliness of offering open appointments to patients?
    - ii. Should I consider advanced/open access scheduling?
    - iii. Once checked-in, how long do patients have to wait prior to seeing me?
    - iv. What is my bad debt expense?
    - v. What is my account receivable?
    - vi. How well do I communicate with specialists?
    - vii. Do I follow-up in a timely fashion to patients' questions?
    - viii. How is my documentation?
  - b. How are my clinical skills?
    - i. Am I up-to-date on the latest evidence-based medicine guidelines?
    - ii. What are my outcomes data?
    - iii. Is the care appropriate for the patient's presenting condition?
    - iv. What have I done to ensure patient safety with respect to medications?
    - v. Is there a certain condition that I enjoy treating, i.e. diabetes, congestive heart failure, metabolic syndrome, AIDS, etc.
3. Know thy patients
  - a. Are tools in place to obtain patients' feedback, i.e. satisfaction surveys?
  - b. How well does my office handle patient complaints?
4. Know thy patients' health savings account
  - a. What type of health savings account does the patient have?
  - b. If the patient has a debit card for an FSA, then charges for medical care can be deducted at the time of service for covered and non-covered services.