The James A. Baker III Institute for Public Policy
and the Baker Institute Health Policy Forum
Rice University

National Healthcare Reform: Policy Options and Imperatives

James A. Baker III Hall
Rice University, Houston, Texas

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Opening Remarks at 8:30 am
Closing Remarks at 3:30 pm

Conference Presentation

Consumer-Driven Health Plans and Healthcare Reform

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Summary: Consumer-Driven Health Plans and Health Care Reform

Consumer-driven health plans (CDHPs) differ from traditional insurance and managed care in philosophy and design. Philosophically, they seek to involve the consumer more directly in health care decision making. Typically in these products, a "health spending account" is created from which the employee purchases services, often with untaxed dollars. Some form of catastrophic insurance coverage is also a key part of the benefit design. If an enrollee spends all of the dollars in the health spending account in a given year, he or she then spends his or her own money until the deductible requirement in the catastrophic insurance policy is met. In the classic CDHP model, known as a Health Reimbursement Account or HRA, the enrollee did not own the money in the health spending account. In the newer Health Saving Account (HSA) model, the account is owned by the enrollee.

In this talk, I summarize what we know about CDHPs, discussing who chooses CDHPs and assessing the evidence regarding their effectiveness. Next, I describe the potential of CDHPs to reduce the number of uninsured people, both under current law and with additional tax subsidies. Finally, I offer a qualified judgment about the role of CDHPs in health care reform proposals.

The strongest evidence we have about CDHPs is that they are chosen by highly-compensated employees, most likely because these employees are more able than others to self-fund the 'gap' between the health spending account and the deductible in the catastrophic insurance policy.

Some policy analysts have expressed concern that CDHPs will be preferred by healthy people, leaving high-cost people in the traditional insurance plans offered by employers. However, the evidence does not show that HRA plans attract disproportionately healthy enrollees. Recently, my colleagues and I analyzed data from a large company that offered both HRA and HSA plans, along with traditional health insurance. In this company, we found that the HSA attracted healthy enrollees, probably because they have the most to gain from owning tax-free savings accounts. If selection is found to be a problem, the employer has the option of totally replacing its existing menu of health plans with an HSA.

In additional research, we assessed whether CDHPs are a wise choice for people with chronic illness. We found that CDHP enrollees with chronic illness are more satisfied with their plan than are other CDHP enrollees, more likely to use information tools provided by the plan, and more likely to correctly anticipate spending all of the money in their accounts.

The trade press is replete with anecdotes that CDHPs reduce the health care costs of the employers that offer them. However, for a large employer that offered an HRA in 2001, the trend of health care costs over the next three years in the CDHP was less favorable than in the company's point-of-service plan. This company offered a very generous CDHP, with a small gap between the account and the no cost sharing of the catastrophic insurance policy.

Next, I discuss the take-up of CDHPs in the individual health insurance market and the potential of CDHPs to reduce the number of people without health insurance. My colleagues at the University of Minnesota and I built a micro-simulation model of health insurance choices to address these questions. The model accurately predicts the number of people

(about 3.2 million) who purchased individual HSA plans after they were given tax-preferred status in 2004. Using the model, we predict that an additional 3.8 million people would purchase individual HSAs if they were offered an income-related tax credit. About 2.9 million of these policies would be purchased by people who had been uninsured. Numerically, the largest take-up would occur among people in the lowest 25 percent of the income distribution, but this group would have the lowest percentage take-up because it represents the largest number of people currently uninsured. To reach this group, the subsidy would have to be targeted better, with larger credits for low-income people.

I then address the question of whether CDHPs can play a central role in health insurance reform. As background, I review the history of the tax deduction for employer-sponsored health insurance, which began during World War II as a way to circumvent wartime wage controls. The tax deduction has increased the demand for health insurance and has encouraged too many people to work for employers who provide insurance rather than purchasing it on their own. Increased insurance coverage has fueled the demand for more services, thereby contributing to medical care cost increases.

While *some* insurance coverage is desirable, the current level of tax-subsidized coverage is excessive. Consequently, the high-deductible feature of CDHPs is a step toward more rational insurance policy design. However, the health spending accounts found in CDHPs probably reduce the demand-constraining effect of the high deductible. This can be seen most clearly by considering "flexible spending accounts" (FSAs), a form of the health spending account that must be used by the end of a calendar year or else it is forfeited. Holders of FSAs have a strong incentive to use the account, even if they spend it on unnecessary medical care. There is less incentive to spend the balance in an HRA, although enrollees who switch plans or leave the firm will treat the money in an HRA as if they have to use it or lose it. Health Savings Accounts (HSAs) are the most flexible form of health spending accounts – almost fungible with cash. Yet, it is not clear why we have to attach a new form of tax-free savings to a high-deductible health insurance plan.

I believe that the centerpiece of health insurance reform will be a fundamental change in the tax treatment of health insurance coverage. Several options have been proposed: limiting the tax deduction for employer-sponsored health insurance, replacing the tax deduction with a refundable credit to purchase health insurance, and making all health care spending tax-free. My colleagues and I have simulated the effects of some versions of limiting the tax deduction and have found them to be very effective in reducing the number of uninsured, but quite expensive. There is no free lunch when it comes to reducing the number of uninsured.

Consumer Driven Health Plans and Health Care Reform

Roger Feldman

February 23, 2007

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University of Minnesota

Outline

- What is a CDHP?
- Who chooses CDHPs and what evidence do we have regarding their effectiveness?
- What is the potential of CDHPs to reduce the number of uninsured people?
  - Under current law
  - With additional tax subsidies
- Are CDHPs better health insurance?

‘Classic’ CDHP – Definity Health

Health Reimbursement Account Account (HRA)

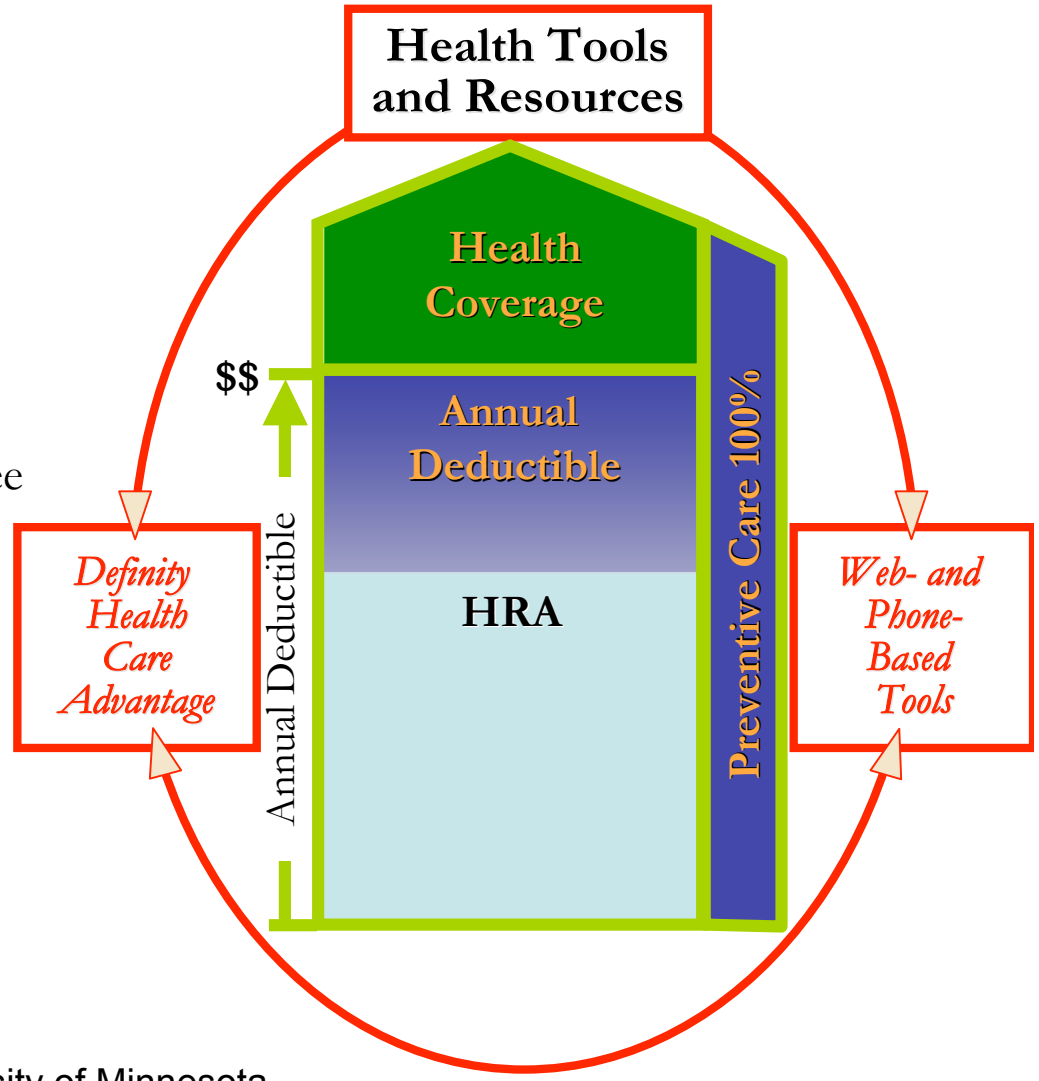
- Employer allocates $$$ to HRA
- Member directs HRA
- Account rolls over at year-end
- Account does not belong to employee

Health Coverage

- Preventive care covered at 100%
- Annual deductible
- Expenses above deductible covered at 80-100%

Health Tools and Resources

- Care management programs
- Internet enabled



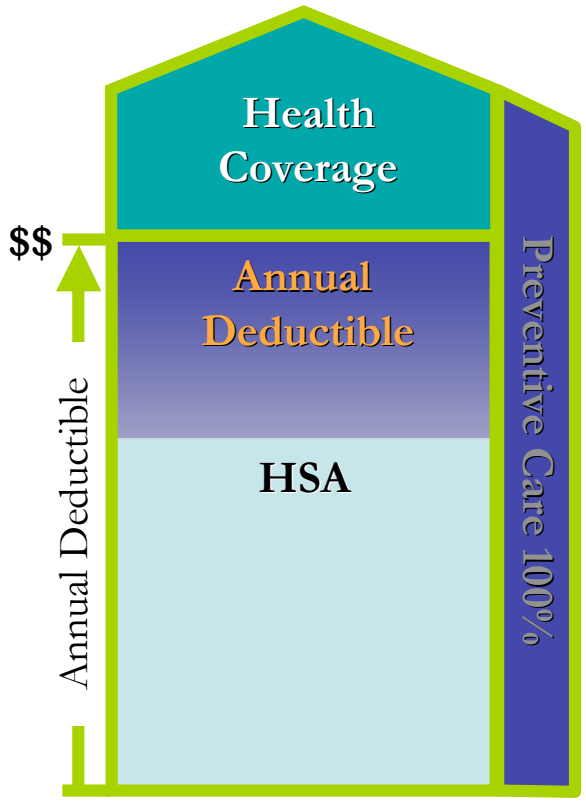
The HSA model

An HSA is a special account owned by the individual. Tax-free contributions to the account are used to pay for current and future medical expenses.

Used with a high-deductible health plan

Bush Administration has proposed refundable tax credits for individuals to purchase plans with HSAs.

HSAs are offered by UnitedHealth, the Blues, Aetna (w/preventive meds), Cigna, Humana and Kaiser Permanente



Who chooses CDHPs?

- Strongest and most consistent conclusion: CDHPs are preferred by highly-compensated employees
- A large employer that offered a PPO and POS plan introduced a CDHP in 2001:
  - 38% of employees choosing the CDHP had incomes above the firm's 75% percentile
  - 19% of POS and 29% of PPO enrollees had incomes above the 75th percentile

Do HRAs experience favorable selection?

- When the University of Minnesota offered an HRA in 2002, there was no evidence of favorable selection (Parente, Feldman, and Christianson, HSR, 2004)
- In the large employer previously mentioned, HRA enrollees had lower baseline illness burden than PPO enrollees but about equal to POS enrollees
- In our largest sample of 80,000 covered lives in 3 employers, we found evidence of mild *unfavorable* selection against HRA plans

More evidence on selection

- Recently, we obtained data from a large aerospace firm that offered HRA, HSA, and traditional health plans
- HRA experienced mild unfavorable selection (consistent with previous findings)
- HSA had favorable selection
  - Healthy people have more to gain from tax-free savings accounts

Do CDHPs control medical costs?

- Product design is important – and it's easy to screw up
  - The large firm that offered a CDHP in 2001 had a generous design: $1,000 single/$2,000 family HRA accounts; $1,500/$3,000 deductibles; and no cost-sharing after the deductible was met
  - CDHP experienced unfavorable total cost trend after 3 years compared with the POS plan (Feldman, Parente, and Christianson, 2007)
  - CDHP had some moderating effect on pharmacy cost compared with 3-tier Rx benefits (Parente, Feldman, and Chen, 2006)

CDHPS and the chronically ill

- The appropriateness of CDHPs for people with chronic illnesses has been questioned, but little information exists regarding the experience of chronically ill individuals in CDHPs
  - Parente, Christianson and Feldman (2007) combined medical care claims with a survey of employees at the UM
  - Employees with chronic illness are equally likely as other employees to join a CDHP, to understand key plan coverage features, and to report having a particularly positive or negative experience with their plan
  - CDHP enrollees with chronic illnesses assign higher ratings to their plan than do other CDHP enrollees ($p<.07$), are more likely than other CDHP enrollees to use informational tools ($p<.05$), more likely to anticipate spending all of their savings account dollars ($p<.05$), and more likely actually to spend more than the deductible

CDHPs and prevention

- Most CDHPS have 100% coverage for preventive care
- HSAs may exempt preventive care from the deductible
- Yet concerns have been raised that CDHP enrollees will skimp on prevention
- Busch et al (2006) found that employees in a large firm maintained rates of preventive care use when cost-sharing was eliminated at the same time that cost-sharing for other services was increased

Potential take-up of CDHPs

- Medicare Modernization Act of 2003 allows both individuals and employers to contribute to tax-free health savings accounts up to the lesser of the deductible (at least $1,100 for an individual or $2,200 for a family) or a maximum set by law ($2,850 for a single person or $5,650 for a family in 2007)

- Bush administration has proposed to eliminate *all* taxes on out-of-pocket spending through HSAs

- Low-income families would be offered refundable tax credits to purchase health insurance policies with HSAs

Impact of MMA 2003

	Plan Choice	Population %	Population #
INDIVIDUAL MARKET	HSA-Full Price	9%	3,155,982
	PPO_High $$	13%	4,651,023
	PPO_Low $$	1%	310,041
	PPO_Medium $$	4%	1,426,040
	Uninsured	74%	27,273,018
EMPLOYER INSURANCE OFFERED MARKET	HMO	31%	26,295,237
	HRA	2%	1,811,281
	HSA-Shared Prem	1%	530,882
	HSA-Full Price	0%	332,249
	PPO_High $$	7%	5,930,246
	PPO_Low $$	2%	1,571,384
	PPO_Medium $$	41%	34,949,793
	Turned Down	16%	13,298,512

Population is 19-64, non public insurance; source: Feldman et al, Health Affairs, 2005

Administration's* proposal

	Population %	Population %	Population #	Population #	Change	Subsidy Cost
INDIVIDUAL						
HSA-Full Price	9%	19%	3,155,982	6,971,694	120.9%	$ 6,900,791,439
PPO_High $$	13%	11%	4,651,023	4,017,191	-13.6%	$ -
PPO_Low $$	1%	1%	310,041	263,278	-15.1%	$ -
PPO_Medium $$	4%	3%	1,426,040	1,215,872	-14.7%	$ -
Uninsured	74%	66%	27,273,018	24,348,069	-10.7%	$ -
OFFERED						
HMO	31%	31%	26,295,237	26,232,550	-0.2%	$ -
HRA	2%	2%	1,811,281	1,803,079	-0.5%	$ -
HSA-Shared Prem	1%	1%	530,882	528,590	-0.4%	$ -
HSA-Full Price	0%	1%	332,249	861,387	159.3%	$ 1,174,289,915
PPO_High $$	7%	7%	5,930,246	5,921,970	-0.1%	$ -
PPO_Low $$	2%	2%	1,571,384	1,569,135	-0.1%	$ -
PPO_Medium $$	41%	41%	34,949,793	34,627,195	-0.9%	$ -
Turned Down	16%	16%	13,298,512	13,175,679	-0.9%	$ -

*Low-income tax credits to purchase CDHP with health savings account

Take-up by income quartile

Percentile of Income Distribution	Baseline # of Uninsured	Reduction in Uninsured	% reduction
0-25%	15,127,288	1,231,485	8.1
25-50%	7,106,918	952,335	13.4
50-75%	2,877,585	492,181	17.1
75-100%	2,161,227	248,948	11.5
Total	27,273,018	2,924,949	10.7

Price-elasticity* of uninsured take-up with respect to HSA premium subsidy

Income Quartile	Single Adults	Adults with Dependents
0 to 25	0.080	0.039
25 to 50	0.138	0.107
50 to 75	0.498	0.250
75 to 100	0.754	0.378
All	0.205	0.107

* = % change in uninsured / % change in premium

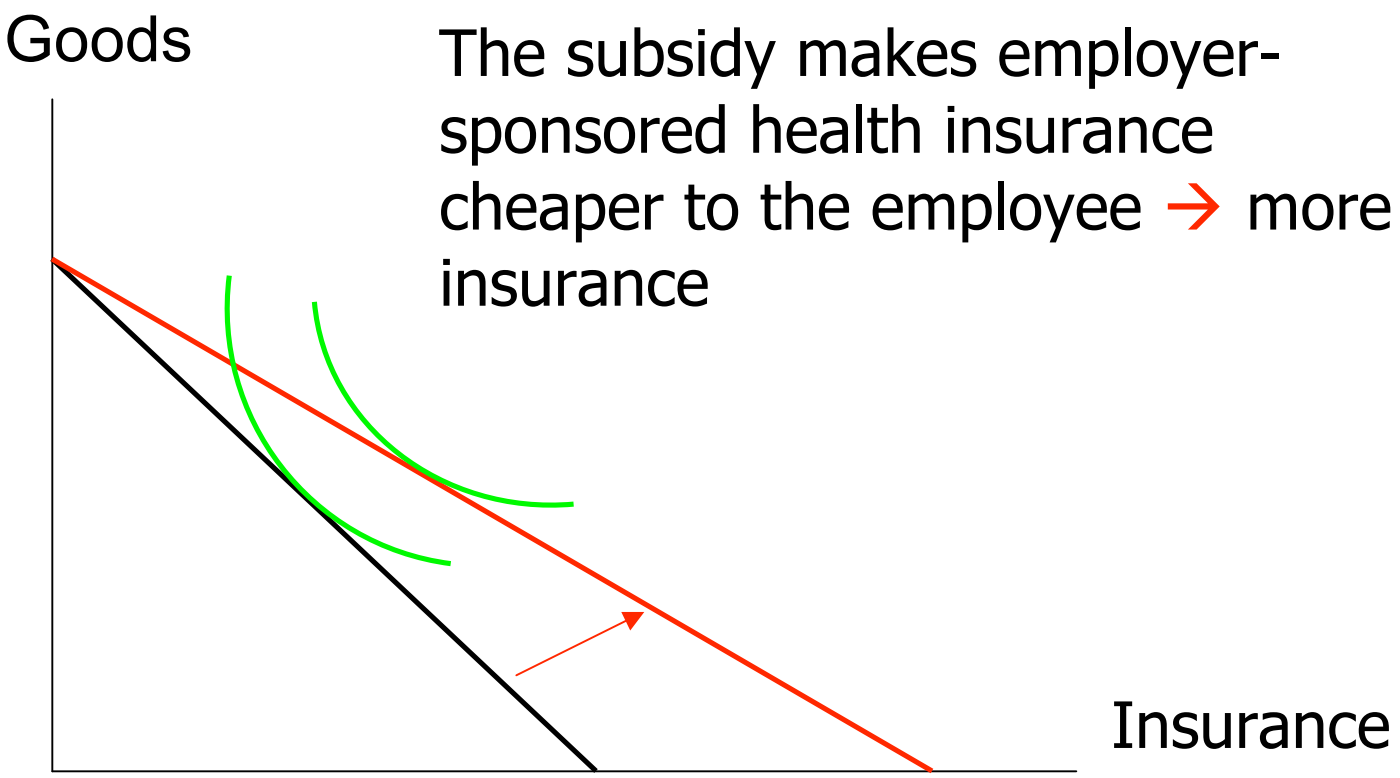
Policy implications and questions

- Compared with Medical Savings Accounts authorized in 1996, insurers are willing to offer this product and buyers appear ready to accept it
- To reduce the number of uninsured, we need to 'target' subsidy to low-income population
- Is buy-out of group market good or bad?
- Implementation complexity – tax credit needs to be available at time of premium payment; otherwise, delay could be 12 months or more

History of tax subsidy for employer-sponsored health insurance

- Tax exemption for ESI started in WW2 when wages were controlled
  - Employers such as Henry Kaiser's shipyards needed more workers
  - They could provide health insurance benefits without violating the wage controls
- IRS rulings in 1950s made the exemption permanent

Tax subsidy for ESI



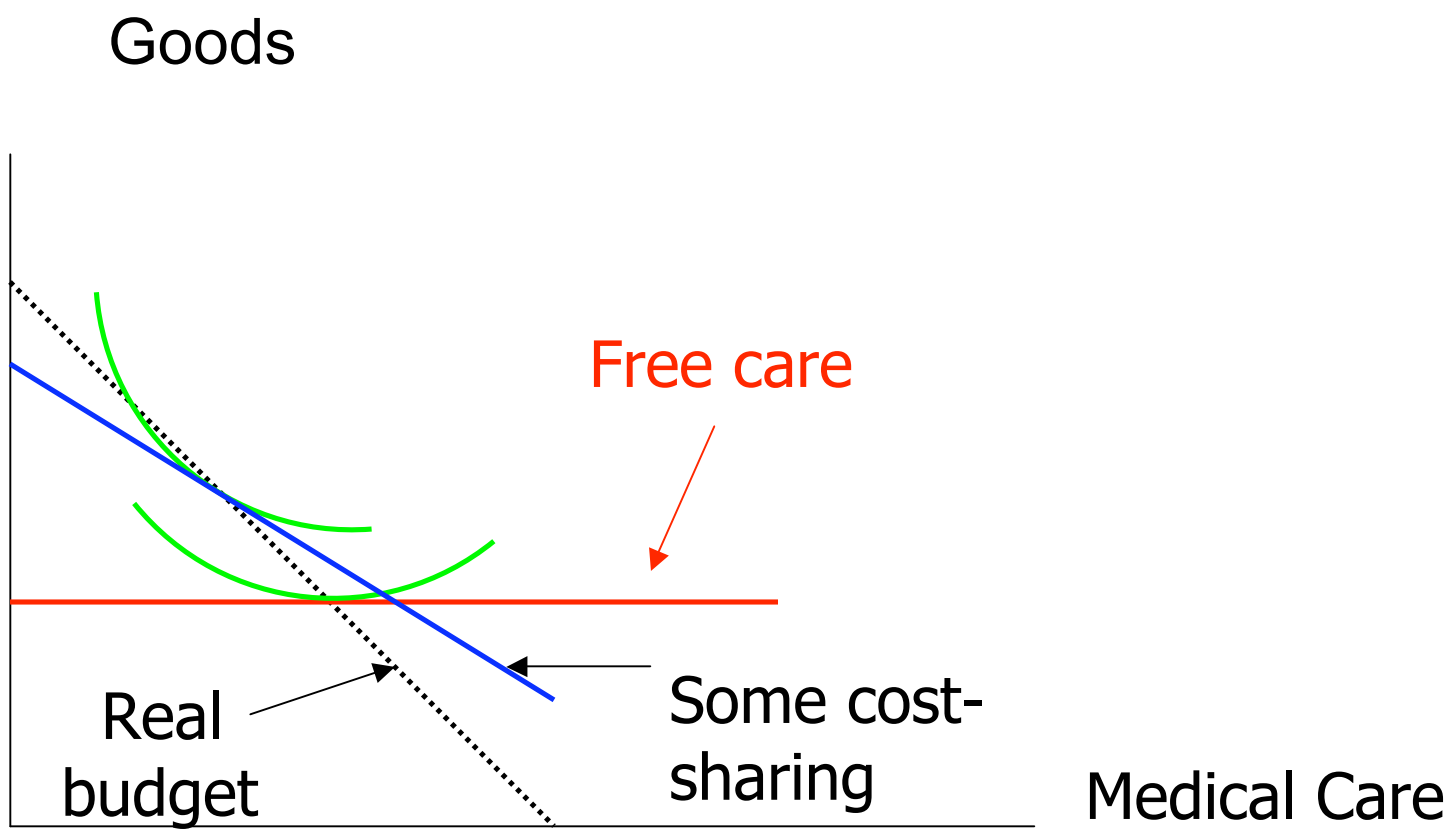
Example

- My pre-tax income is $2,000 per month and my tax rate (combined federal, state, and FICA) is 33%
  - I can have ESI for $500 premium per month
  - Leaves $1,500 taxable income so I pay $500 tax
  - If I don't purchase ESI , I pay $667 tax
  - Buying ESI saves me $167 in taxes
- The 'price' of ESI is (1-t) where t = tax rate

What's wrong with the subsidy?

- Health insurance makes health care look cheaper or even free to the consumer
  - RAND Health Insurance Experiment: complete insurance led to 40% increase in spending vs. catastrophic policy
  - Free care had "little or no measurable affect on health status for the average adult"
  - Free care led to lower mortality for poor people with high blood pressure, but a one-time screening examination could achieve most of that gain
  - Joseph Newhouse, et al, *Free for All?*, p. 243

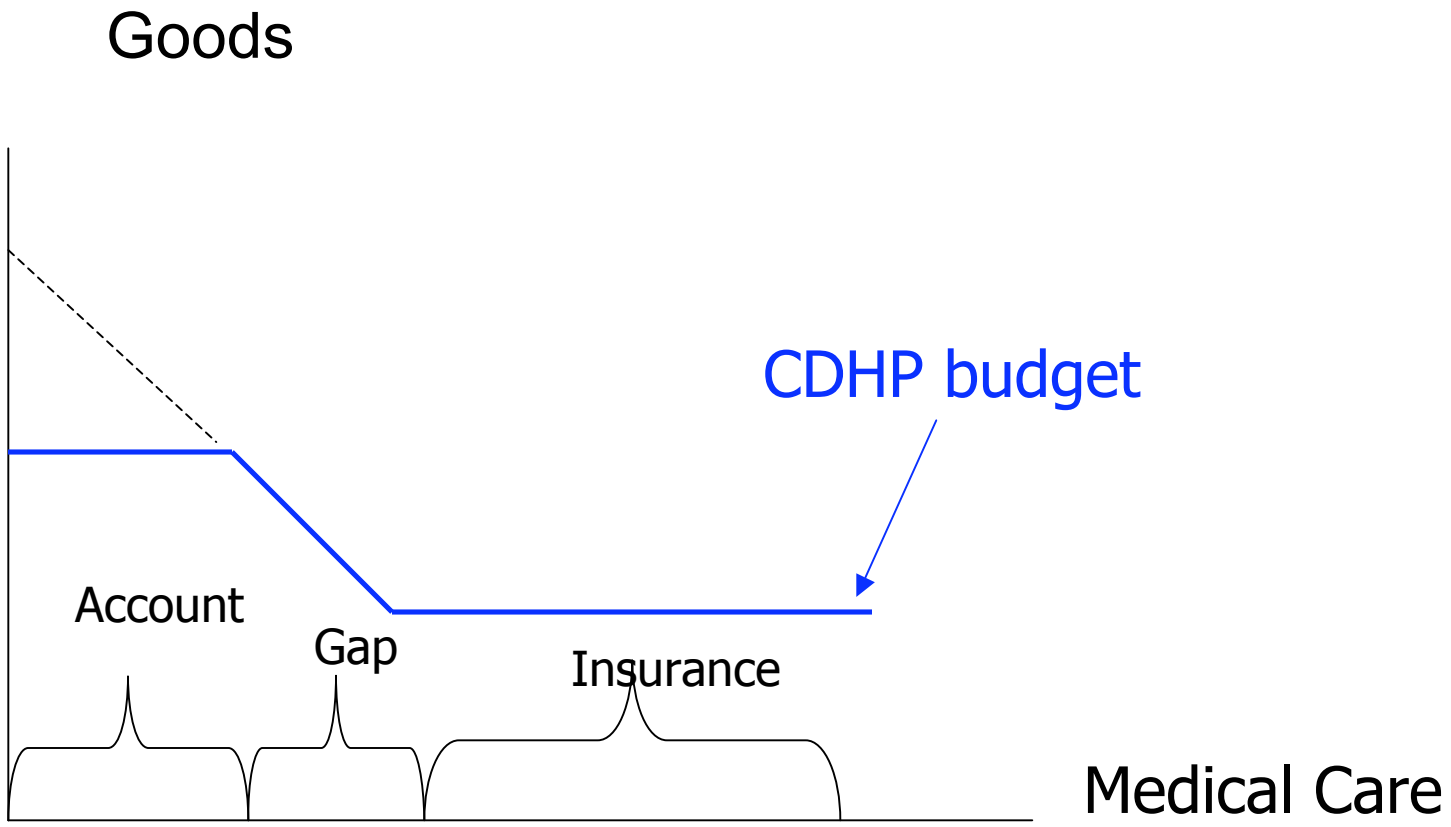
Better health insurance



Why have health insurance?

- Health insurance protects people against the risk of large financial loss, impoverishment or bankruptcy
- Up to a point, over-consumption of health care is a worthwhile cost of protection against risk
- Manning and Marquis (1996) estimated that a policy with 40-50% coinsurance and a large stop-loss limit would be optimal
- Tax subsidy tilts the tradeoff toward too much insurance

Are CDHPs better health insurance?

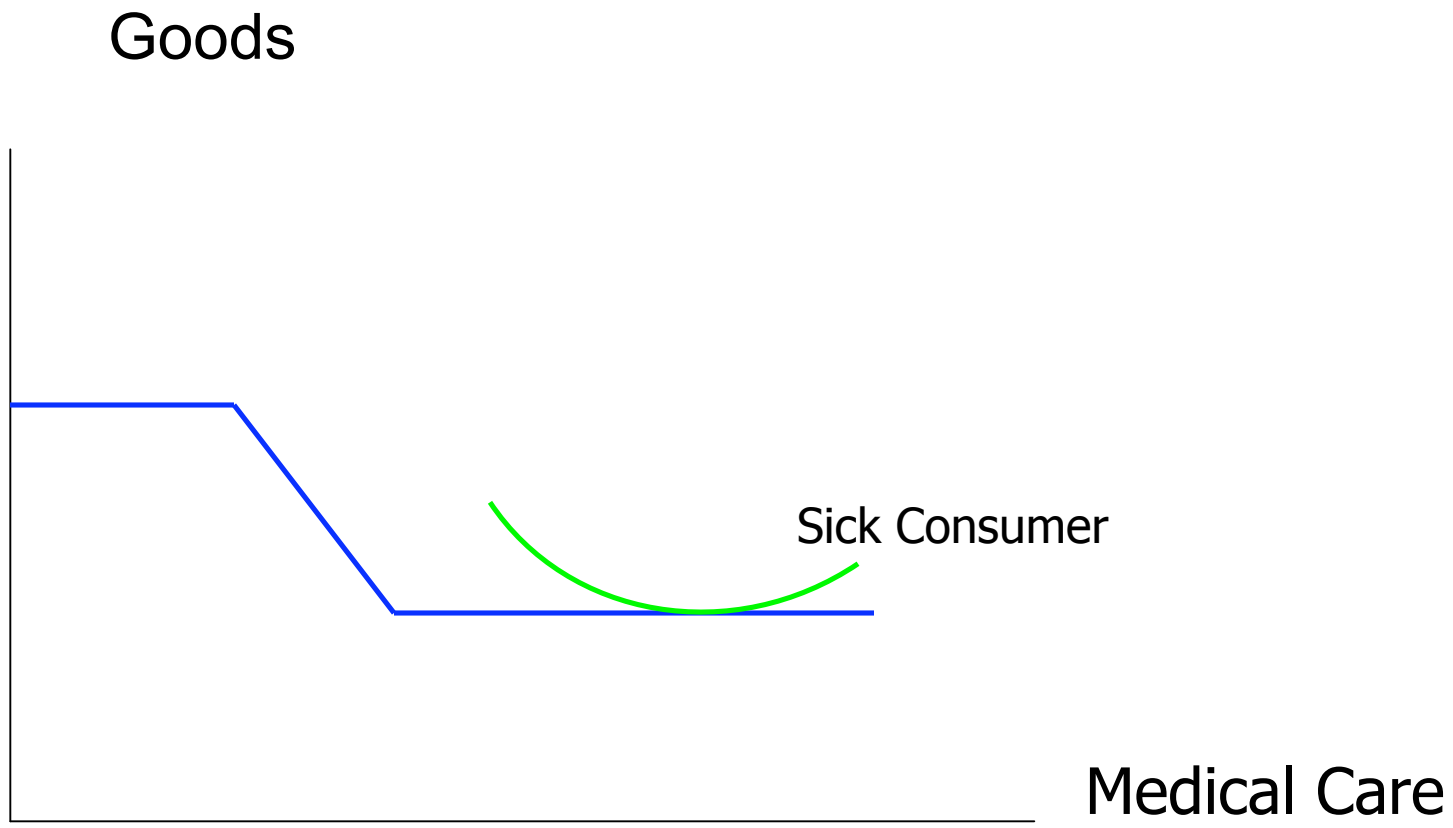


Account + Gap = Deductible

The sick consumer

- The sick consumer acts as if medical care is free
- That may not be a bad thing if the deductible is large enough
- If the deductible is too small, it may be too easy to get to the flat part of the budget
  - In the employer that had deductibles of $1,500 for singles and $3,000 for families, about 1/3 of all contract holders got to the ‘free care’ zone
  - Not all of them had severe or catastrophic illness that would justify free care

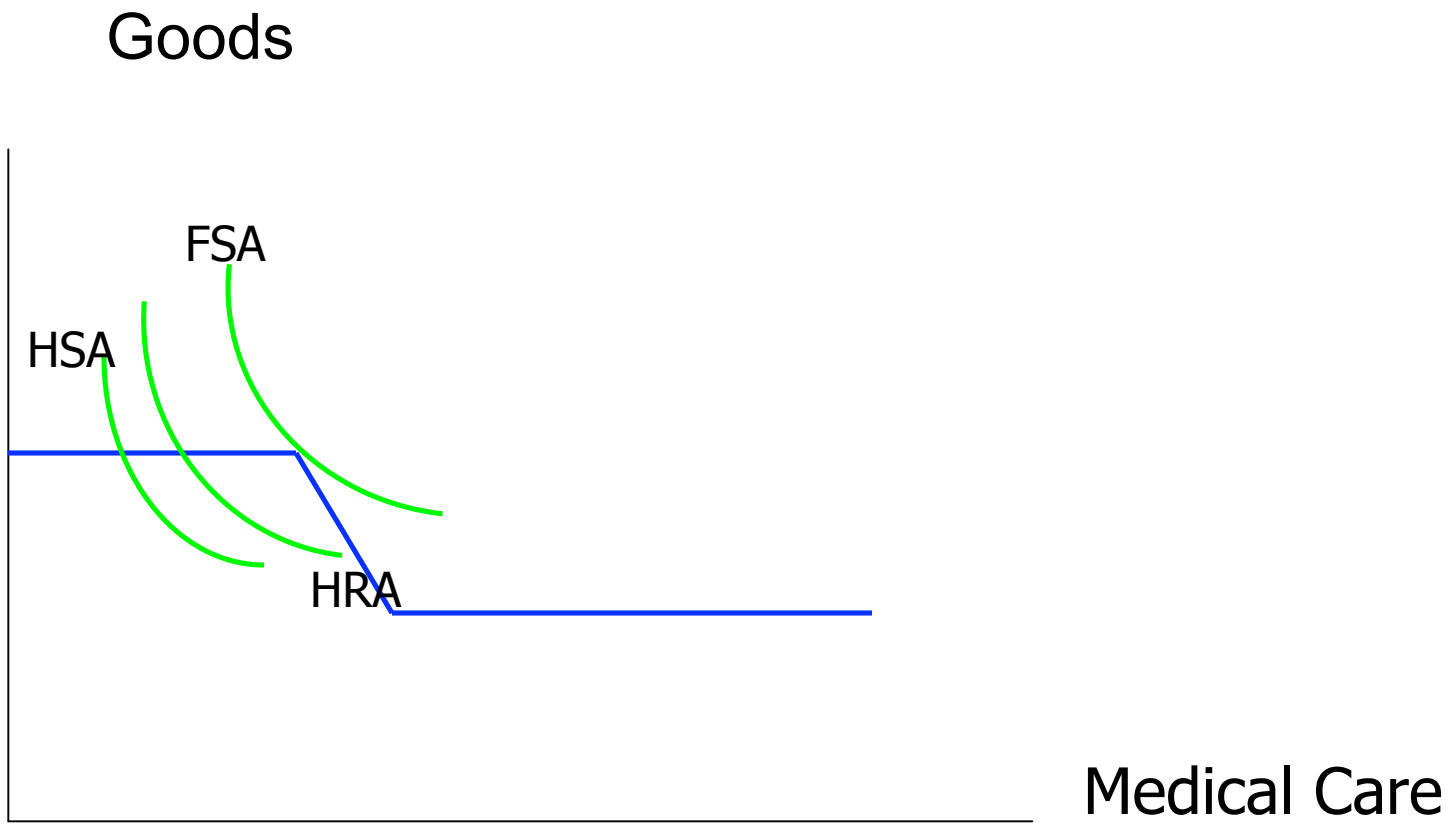
Graph of sick consumer



The healthy consumer

- Let's do a 'thought experiment':
  1. Suppose the healthy consumer has to use the account each year or lose it
  2. Suppose the account 'rolls over' but disappears if you switch plans or leave the firm
  3. Suppose the account is full portable
- The incentive to save increases as you move from 1-2-3
- This is the progression from 'flexible spending accounts' to HRA to HSA

Graph of healthy consumer



Conclusion

- As fewer restrictions are put on the account, the incentive to save increases
- But an unrestricted account looks just like a tax-preferred savings plan (401k)
- Jon Gruber, MIT economist: “It’s not clear why we need yet another tax break for savings for rich guys”

Policy options

- Limit the tax deduction for ESI
  - Proposed by Treasury Department in 1983
  - President Bush proposed a variant on this idea in 2007 State of the Union address
- Replace tax deduction with a 'refundable' credit to purchase health insurance
  - Proposed by Mark Pauly et al, *Responsible Health Insurance*, 1992, and currently advocated by AMA
- Let all health care spending be tax-free

2007 SOTU

- Replace current tax deduction for employer-sponsored health insurance with flat $7,500/$15,000 deduction for either ESI or individual health insurance
- Administration predicts ~3 million newly insured and 10-year budget neutrality
- Our model predicts larger insurance take-up but also larger cost