

**Health Reform Very Good For Many Consumers
CDH Enrollment Projections Rising**

[October 13, 2009] National enrollment in consumer-driven health plans may gain by tens of millions over time under pending health reform bills, *Consumer Driven Market Report* is predicting for the first time this week. If the Senate Finance Committee bill were enacted as is without any amendments, CDMR finds that Health Savings Accounts and Health Reimbursement Accounts would enroll 15 million or more additional enrollees by 2020.

The current CDH tabulation from current data is that CDH plans have passed the 12 million mark and will have over 15 million covered lives in January 2010, growing by almost five million a year without any reform. But starting in 2013 growth could be boosted by millions under national health reform, totalling as much as 15 million extra by 2020 when most bills are fully-implemented.

The biggest potential driver is the impact of reform on the premiums of competing legacy products. CDMR and its sister publication *HealthPlanMarkets* are predicting a major spike in the average health insurance premium in the group and individual markets under current legislation, driving people into (a) high-deductible plans without savings accounts, (b) new plans which turbo-charge consumer tools and payment technology, and (c) HSAs and HRAs which can achieve ultra-low premium levels.

A close reading of the pending bills makes clear that tens of millions of new enrollees will swarm into CDH plans in coming years as out-of-pocket costs increase and low-cost products are favored. In many ways *the entire goal of national health reform is to push the market towards the lowest-priced benefits* and use the savings to cover more of the uninsured. CDH plans are the lowest-priced option on the market, and are ideally-positioned to become a dominant benefits design under national health reform.

Although there is very little in the bill which even mentions CDH, hidden drivers of CDH growth after 2012 are contained in the Senate Finance bill in particular that will stimulate growth:

Health exchanges The impact of creating a national system of health exchanges will be to increase pricing pressure on both insurers and providers. That will translate into more affordable health plans designs – high-deductible health plans. CDH plans are more expensive than pure high-deductible plans, but will attract a percentage of the new HD products. CBO says exchanges initially will hold 27 million new enrollees, from individuals to the uninsured to small groups. CDMR predicts that *one-third* of these new enrollees will be in CDH Plans, or 9 million covered lives, split equally between HSAs and HRAs. Impact: +4.5 million each.

There are a whole bunch of indirect advantages to the health exchange model from the CDH plan point-of-view that have never been tabulated. For instance, the use of *brokers* to sell HSAs has been a barrier to adoption for years because brokers receive a smaller commission on lower premium plans. Health exchanges will reduce or eliminate this factor, and could make CDH plan premiums and pricing more visible. Other factors that will tend to benefit more affordable plans like CDH plans are the arrival of a state-wide distribution channel, standardized benefits that could allow accurate comparisons of CDH plans with legacy products for the first time, and price transparency between CDH and older plans.

How CDH Plans Might Look In 2020 (Covered Lives)

	<i>Baseline</i>	<i>Plus Reform</i>
2010	15 million	same
2013	30 million	39 million
2017	45 million	62 million
2020	65 million	80 million

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None of the discussion and political analysis of the effect of health reform on CDH plans has focused on the actual impact on plans. Last week CBO came out with the most detailed “official” review of the impact on private sector premiums, but it offers only a list of maybe’s, concluding it’s impossible to predict the impact.

But to the extent health exchanges promote and favor the best value plans (most benefits for the lowest premium), CDH plans will win and win big. This will start by adding 9 million new customers in 2013 in HSAs and HRAs, and in our preliminary estimate (above) it grows faster over time as more people get used to CDH benefits.

Premium Subsidies The health exchanges will offer a menu of several standardized benefit plans that will allow comparisons across competing carriers. Since many if not most enrollees in the exchanges will be low-income, most will probably select the lowest-priced plan with the most cost-sharing. CBO’s analysis shows that this plan – the so-called Bronze Plan – will have an actuarial value (AV) of 70% versus 88% in the average group health plan, and below 60% in the average individual plan. Basically, that means that CDH plans will be most able to offer the least costly plan, and thus attract a big share of the new market using existing deductibles and copays. Plans like today’s PPOs will be able to offer a plan which meets the same AV, but with worst benefits and/or higher deductibles. CDH plans will be able to compete quite well, and it’s very possible most plans in some exchanges will have to be HSAs.

Employers will not be required to move into the exchanges, but at least 7 million will do so anyway in CBO’s view, and many people think this is a low figure. The reason: employer-based plans are very likely to have higher premiums and over-priced benefits than exchanges. Since the exchanges will be offering many of the same health plan companies, but with lower premiums, there could be migration. That again increases the exchange population exposed to CDH choices and could drive half the group health market.

Individual coverage markets might be different, favoring CDH plans outside the exchanges because they can offer lower actuarial values than the minimum 70% (and thus lower premiums). CBO lists five ways individual coverage will be richer inside the exchanges, meaning that people without subsidies may stay with the status quo and not go into exchanges unless they are uninsured.

Tax Advantages There are multiple provisions in both the House and Senate bills that penalize high-premium plans, including a tax on the “Cadillac” policies costing over \$21,000. The latest Kaiser Family Foundation employer survey by contrast finds that the current average CDH premium is below \$11,000 for HSAs. HRA premiums are higher, but still much lower than existing plans. There are also two additional taxes on health insurers to be used to fund coverage of the uninsured. In both cases, the tax will be passed on immediately to employers in the form of higher premiums.

Adoption of the new taxes would have a two-fold incentive for the growth in market-based reform. It would remove part of the tax preference for employer-based coverage for the first time in the working lifetime of people who back eliminating that preference. And it would create a large tax-based incentive for consumers to buy CDH plans at lower prices as enrollees enjoying no deductibles or copays are exposed to out-of-pocket costs for the first time.

Risks And Missing Reforms The risks from current health reform technical details are far lower than the rewards for CDH, but they are highly sensitive to last-minute changes that are deal-killers. FSAs, for example, are *banned* from health exchanges in the latest version of the Senate Finance bill being voted on this week.

The biggest risk is that the minimum benefits requirements (the 'actuarial value' percentage) will be set too high. That could require that most health insurance in the U.S. have very low deductibles, or increase utilization and therefore premiums for current high deductible plans, narrowing the premium advantage of CDH plans, although current HSA contribution levels may not be affected.

Roy Ramthun from HSA Consulting writes "The four levels of coverage allowed by the Finance Committee have actuarial values ranging from 65 percent for the 'bronze plan' to 90 percent for the 'platinum plan.' The Senate Health, Education, Labor and Pensions (HELP) Committee prescribes three levels of coverage, with actuarial values from 76 percent to 93 percent. The House bill also calls for three levels of coverage — basic, enhanced and premium — with values from 70 percent to 95 percent. By contrast, the actuarial value of policies in Massachusetts (the only state where the purchase of health insurance is mandatory, and the model Congress is supposedly copying) can be as low as 56 percent."

Offsetting this risk is the possibility that a very large percentage of the population will opt for the lowest-premium plan anyway. In the extreme, one can envision an unexpected consequence of setting the actuarial value too high as driving almost the entire market into the lowest-premium plan. If CDH plans are able to offer the most benefits in the lowest-priced option, they gain anyway.

A broader risk in our view is that national health spending will explode under health reform in unpredictable ways. If that happens it is very likely a future Congress will simply take over the entire health financing system with wage and price controls, freezing all health insurance premiums and creating a single national payment system for all doctors, hospitals and suppliers. This could also mean a single national benefit plan and the end of health plans as we know them. The existence of health exchanges would make this much easier by the way, but also make the scenario less likely.

There are many ways that current health reform bills are still ignoring ways to *maximize CDH plan improvements* which would allow even greater coverage of the uninsured. For instance, the tax credits, premium subsidies and cost-sharing subsidies are all based on indirect payments to consumers after the fact. Use of current cash accounts would be a much better method, and drastically improve the cash flow of low-income enrollees. Employers could be allowed to make contributions into HSAs or fund HRAs using the amount of the tax credit or cost-sharing subsidy amount.

Current reform proposals, although moving in the right direction on protecting low-income enrollees from high deductibles, do not yet acknowledge that the spending incentives in CDH are just as important as the savings incentives. If they did they would create cash funds for Medicaid, Medicare, CHIP and other programs where

patients would be given limited but fully-funded accounts to manage instead of paying premiums. The coming adoption of protections for low-income people from excessive out-of-pocket costs – if successful -- will probably pave the way for Medicaid use of CDH plans as long as the 'budget incentive' is discovered by policy-makers, who now favor only 'static' tax credits and subsidies. Protecting low-income patients from cost-sharing could and should put the funds into the hands of medical consumers *immediately* so they can manage their funds while still a patient, not after the fact.

Much as many people would like to eliminate cost-sharing entirely, the entire universe is moving in the opposite direction. As the Baby Boomer retire and medical prices keep rising faster there will be even less money to provide rich benefits every year. Chances are that bankrolling the uninsured will increase demand so much that there will be higher average costs per capita for many years. Basically, thinner benefits and paying more out-of-pocket will drive all health policy for an entire generation to come.

Intangibles CBO is ignoring what is probably the biggest change in private insurance markets under reform: CDH plans and new health plan designs. CBO also scores almost nothing for things like mandated minimum prevention coverage, and ignores financial incentives like tying participation in disease management to extra HSA and HRA contributions. But what happens if these end up defining who survives under the coming cutthroat price competition?

HSA plans today for instance have on average higher coverage of prevention benefits than existing plans (over 90%), and CDH plans create the strongest financial incentives for diabetics to participate in chronic care management. Below the radar screen some legacy plans like the large regional non-profits such as Kaiser have already moved far beyond this to include advanced consumer tools: making appointments online and dozens of others. Market research shows a significant marketing advantage, along with a small marginal year-to-year reduction in per capita costs.

If health reform causes all options to have the same price, it is very likely that small marginal cost differences and even marketing gimmicks could drive millions of enrollees. That would favor two types of players: CDH plans which have the best financial incentives, and 'integrated' large-scale insurers with population management, web tools that incentivize the high-risk patient, and even snazzy offerings like online chat rooms for specialized patients. Plans which can combine both CDH and tools will have a huge advantage.

Conclusion Consumer driven health care gains from current proposals for national health reform. HSAs and HRAs would add millions more enrollees because they offer a market price that is a better value in a market environment like the new health exchanges. The demise of current health insurance plans under reform would also benefit CDH plans indirectly, including new taxes which cause higher premiums for over-priced plans.

Health plans which are not account-based such as regional integrated plans will also grow faster if they are able to create new plan designs, payment technology and patient incentives that offer tangible reductions in per capita cost. The ideal or lowest-premium plan will combine both of these models into a single competitor.

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