

GAO

Report to the Chairman, Committee on  
the Budget, House of Representatives

April 2006

# CONSUMER- DIRECTED HEALTH PLANS

## Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage





Highlights of [GAO-06-514](#), a report to the Chairman, Committee on the Budget, House of Representatives

## Why GAO Did This Study

Insurance carriers, employers, and individuals are showing increasing interest in consumer-directed health plans (CDHP). CDHPs typically combine a high-deductible health plan with a health reimbursement arrangement (HRA) or health savings account (HSA). HRAs and HSAs are tax-advantaged accounts used to pay enrollees' health care expenses, and unused balances may accrue for future use, potentially giving enrollees an incentive to purchase health care more prudently. The plans also provide decision-support tools to help enrollees become more actively involved in making health care purchasing decisions. Because CDHPs are relatively new, there is interest in the extent of enrollment and in other aspects of the plans.

GAO was asked to review the prevalence of CDHPs, how the associated accounts are funded and used, and the factors that may contribute to the growth or limit the appeal of these plans. GAO examined survey data on CDHP enrollment and interviewed or obtained data from employers, insurance carriers, individuals, financial institutions, and other CDHP experts.

[www.gao.gov/cgi-bin/getrpt?GAO-06-514](http://www.gao.gov/cgi-bin/getrpt?GAO-06-514).

To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

# CONSUMER-DIRECTED HEALTH PLANS

## Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage

### What GAO Found

Enrollment in CDHPs accounts for a small but growing share of the 177 million Americans with private health insurance coverage. From January 2005 to January 2006, the number of enrollees and dependents covered by a CDHP—either an HRA-based plan or an HSA-eligible plan—increased from about 3 million to between about 5 and 6 million. An increasing number of health insurance carriers and employers began offering CDHPs during 2005.

Most employers made a contribution to their employees' health accounts, and the share of account funds spent by enrollees varied. Employers commonly contributed to their employees' HRAs from \$500 to \$750 for individual coverage and \$1,500 to \$2,000 for family coverage in 2004. Most HRA-based plan enrollees spent some or all of these HRA funds in that year. For HSAs, industry representatives noted that not all HSA-eligible plan enrollees opened and contributed to an HSA, and survey data indicate that two-thirds of employers offering these plans contributed to their employees' HSAs. Industry representatives indicated that while most HSA account holders withdrew a portion of their account funds in 2005, some account holders used other, out-of-pocket funds, rather than their HSAs, to pay for medical care.

According to industry officials and experts, the primary factor responsible for the growth of CDHPs is the rising cost of health care coverage. Prompting the growth of enrollment among individuals is the desire to lower premiums and accumulate tax-advantaged savings, according to the officials. Experts noted that employers would be more likely to offer a CDHP if the plans demonstrate the ability to restrain rising costs, and employees would be more likely to enroll in a CDHP if employers offered more comprehensive CDHP benefits coupled with education about the plans.

Experts and industry officials cited several factors that may limit the appeal of CDHPs. Certain federal requirements for HSAs and HSA-eligible plans may preclude changes desired by some, such as higher annual contribution limits for HSAs. Certain state insurance requirements or income tax laws in eight states do not reflect federal statutory provisions for HSAs and HSA-eligible plans. Insurers are generally unable to determine the amount to be deducted from the patient's CDHP account at the time of service or offer decision-support tools that provide enrollees with sufficiently detailed data on the cost and quality of health care.

GAO received technical comments from organizations that provided data for this report, and incorporated the comments as appropriate.

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## Abbreviations

AHIP	America's Health Insurance Plans
CDHP	consumer-directed health plan
HDHP	high-deductible health plan
HRA	health reimbursement arrangement
HSA	health savings account
HMO	health maintenance organization
IRS	Internal Revenue Service
MSA	medical savings account
PPO	preferred provider organization

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United States Government Accountability Office  
Washington, DC 20548

April 28, 2006

The Honorable Jim Nussle  
Chairman  
Committee on the Budget  
House of Representatives

Dear Mr. Chairman:

Since 2000, premiums in the group health insurance market, which covers the majority of Americans, have risen nearly five times faster than the overall rate of inflation and the rate of increase in workers' wages, leading to debate about ways to reduce the growing cost of health care coverage. Employers and insurance carriers are showing increasing interest in consumer-directed health plans (CDHP), which combine a high-deductible health plan (HDHP) with a tax-advantaged health reimbursement arrangement (HRA) or health savings account (HSA) that enrollees can use to pay for a portion of their health expenses.<sup>1</sup> HRA accounts are owned by the employer, and only the employer may contribute to them. HSAs are owned by the enrollee; may be contributed to by both employer and enrollee; and unlike HRAs, may be taken by the enrollee to a new employer.

Proponents of CDHPs contend that CDHPs can help restrain the growth in health care costs. They maintain that because CDHP enrollees may use account funds rolled over from one year to pay for health care in subsequent years, enrollees have an incentive to seek lower-cost health care services and to limit their discretionary spending on health care by

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<sup>1</sup>Throughout this report we refer to two types of CDHPs—HRA-based plans and HSA-eligible plans—used in conjunction with their associated health accounts. The Internal Revenue Service affirmed that employer contributions to employee HRAs are to be excluded from gross income for income tax purposes. Rev. Rul. 02-41, 2002-2 C.B. 75; Notice 02-45, 2002-2 C.B. 93. Tax advantages for HSAs associated with HSA-eligible HDHPs were established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §1201, 117 stat. 2066, 2469. HSAs are usually administered separately by a financial institution. Medical savings accounts (MSA) are another type of tax-advantaged CDHP that must be used in conjunction with an HDHP. MSAs were authorized by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301, 110 stat. 1936, 2037; however, the number of MSAs opened is relatively small and no new accounts could be opened after December 31, 2005.

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obtaining care only when necessary. The higher deductibles associated with the HRA-based and HSA-eligible plans<sup>2</sup> typically result in lower health insurance premiums because the enrollee bears a greater share of the initial cost of care.<sup>3</sup> Although not required to do so, insurance carriers typically provide CDHP enrollees with decision-support tools, such as Web-based information on costs of services and quality of providers, to help them become more actively involved in making health care purchasing decisions.

Critics, however, question whether CDHPs will help restrain the growth in health care coverage costs, and whether they will do so by changing consumer behavior or merely by attracting healthier individuals who use fewer health care services. If CDHPs do attract a larger share of healthier individuals, premiums for traditional plans could rise faster than they otherwise would because of a disproportionate share of less-healthy enrollees with higher health care expenses remaining in those plans. Critics also worry that employers will use CDHPs to shift the cost of health coverage to employees, either by failing to reduce employee premium contributions or by insufficiently funding their employees' accounts.

Because the CDHP is a relatively new concept in the design of health care plans, there is interest in determining the extent to which insurance carriers and employers are offering such plans, how the accounts are funded and used, and the factors that may contribute to the growth or limit the appeal of these plans.<sup>4</sup> You requested that we explore these and other issues related to CDHPs. We examined the following questions:

1. How prevalent are CDHPs?
2. How are the associated health accounts funded and used?

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<sup>2</sup>HDHPs that are designed to be associated with an HSA are called HSA-eligible plans. The enrollee is not obligated to open or contribute to an HSA.

<sup>3</sup>Many health plans require enrollees to pay out of pocket for a portion of their health care costs up to a specified limit, known as the deductible. Once the deductible has been met, the plan pays most of the remaining costs.

<sup>4</sup>We recently reported on the early experiences with CDHPs offered to federal employees. See GAO, *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, [GAO-06-271](#) (Washington, D.C.: Jan. 31, 2006), and *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, [GAO-06-143](#) (Washington, D.C.: Nov. 21, 2005).

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3. What factors may contribute to the growth of CDHP enrollment?

4. What factors may limit the appeal of CDHPs?

To determine the prevalence of CDHPs, we summarized existing literature and industry surveys regarding the extent to which employers offer and individuals enroll in CDHPs, and the extent to which insurance carriers and financial institutions offer the plans and their associated accounts.

To determine how the associated accounts are funded and used, we interviewed representatives of five of the largest CDHP insurers, six of the largest financial institutions that administer HSAs, CDHP experts, and industry officials. We obtained HRA funding and use data from three of the insurers we contacted, obtained HSA account funding and use data from one of the financial institutions we contacted, and obtained tax data on HSA contributions and deductions from the Internal Revenue Service (IRS).<sup>5</sup> IRS data may not be nationally representative of HSA account holders because the data do not capture individuals who opened HSAs and made no individual contributions, even if their employers contributed, or those who did not claim an HSA deduction. We did not independently verify the account data we received from insurers and financial institutions; however, we performed certain quality checks, such as determining consistency between data elements provided and discussing data reliability and limitations with the private entities providing the data, and determined that the data were sufficiently reliable for our purposes. We also discussed the use of HSAs during eight focus groups with 75 HSA-eligible plan and traditional plan enrollees at three large employers in the public, energy utility, and insurance sectors.

To determine the factors that may contribute to the growth or limit the appeal of CDHPs, we conducted interviews with

- officials at the Department of the Treasury and IRS;
- industry officials representing health insurance carriers, America's Health Insurance Plans (AHIP), Blue Cross Blue Shield Association, HSA Insider, and a nationwide health insurance broker;
- representatives of employers offering CDHPs;
- representatives of financial institutions administering HSAs;

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<sup>5</sup>Two other financial institutions we contacted were able to provide limited HSA account funding and use data, but we determined that the data they provided were not sufficiently reliable for our purposes.

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- provider association officials, such as the American Hospital Association and the American Medical Association; and
  - CDHP experts, including the American Academy of Actuaries, benefit consultants, and health policy analysts.

We also obtained information from five large employers in the retail, health care, financial services, technology, and beverage industries that offer HRA-based plans and obtained information from the focus groups of HSA-eligible plan enrollees. We evaluated the decision-support tools on provider quality and prices for medical services that five large multistate CDHP insurers made available to their enrollees. We reviewed federal statutory requirements and guidance related to CDHPs. To validate information provided by a health insurance trade association on the effects of state requirements on the appeal of HSA-eligible plans, we reviewed selected state insurance and tax laws related to CDHPs. We summarized existing literature and surveys by benefit consultants on factors influencing the growth of CDHPs and factors that could limit their appeal. We conducted our work from November 2004 through April 2006 in accordance with generally accepted government auditing standards.

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## Results in Brief

CDHPs constitute a small but growing share of the private health insurance market. Publicly available survey data indicate that the number of enrollees and dependents with CDHP coverage increased from about 3 million in January 2005 to between about 5 million and 6 million in January 2006—still a small share of the 177 million enrollees and dependents with private health insurance coverage. Many health insurance carriers offer CDHPs to employers and individuals, and the number of employers offering them to their employees increased from about 1 percent in 2004 to 4 percent in 2005. Large employers were more likely than smaller employers to offer a CDHP, and large employers were more likely to offer HRA-based plans, whereas small employers were more likely to offer HSA-eligible plans. When employers offered a CDHP as one of two or more health plan options, the percentage of employees enrolled in the CDHP was generally lower than the percentage enrolled in the traditional plan. Most individuals enrolled in an HSA-eligible plan in 2004 and 2005 purchased the plan directly from a health insurance carrier rather than obtaining it through their employers.

Most employers made a contribution to their employees' health accounts, and the share of account funds spent by enrollees varied. Employers are required to contribute to the HRA accounts associated with HRA-based plans, and data from three multistate insurance carriers indicate that the

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most common employer HRA contribution in 2004 ranged from about \$500 to \$750 for single coverage and \$1,500 to \$2,000 for two or more persons, or family coverage. Insurance carrier data we obtained also indicate that almost three-quarters of HRA-based enrollees with single coverage and more than 95 percent with family coverage spent some or all of their HRA funds in 2004. For HSAs offered by employers, a national survey of employer benefits reported that about two-thirds of employers made a contribution to their employees' accounts, and the average employer HSA contribution in 2005 was \$553 for single coverage and \$1,185 for family coverage. Industry officials noted that not all HSA-eligible plan enrollees opened and contributed to an HSA, estimating that up to half did not. Data from IRS indicate that among tax filers who claimed a deduction for an HSA in 2004, the average amount was \$2,100 and increased with income. While data from one large financial institution indicate that most HSA account holders withdrew a portion of their account funds in 2005, representatives from three of the six financial institutions we contacted indicated that some account holders chose to use other, out-of-pocket sources to pay for medical care, rather than withdraw the funds from their HSAs.

The rising cost of health care coverage is the primary factor contributing to the growth in employers offering and individuals enrolling in CDHPs. According to CDHP experts, industry officials, and employers we interviewed, other factors that lead employers to offer CDHPs include a desire to promote cost-consciousness among employees, expand employees' choice and control of health coverage options, and provide a tax benefit for employees. Experts reported that employers would be more likely to offer a CDHP if the cost of health care coverage continues rising significantly or if CDHPs demonstrate the ability to reduce these costs. With regard to factors that lead individuals to enroll in CDHPs, experts and enrollees in HSA-eligible plans cited enrollees' desire to lower their health insurance premiums, accumulate tax-advantaged savings, and gain greater control over their health care decisions. Experts also reported that individuals were more likely to enroll in a CDHP offered by an employer if the employer offered a generous CDHP package and effectively communicated with and educated its employees about the plan.

Experts and industry officials identified a number of factors that could limit the appeal of CDHPs. Representatives from a health insurance trade association and a policy research organization that promotes HSAs suggested that certain federal requirements for HSAs and HSA-eligible plans—such as those precluding coverage for most prescription drugs before the deductible is met and establishing maximum HSA contribution

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limits—could limit the appeal of CDHPs to certain segments of the population. A health insurance trade association also cited insurance or income tax requirements in eight states that do not reflect federal statutory provisions for HSAs in that they limit the extent to which HDHPs may be coupled with HSAs or because they do not allow state income tax deductions for HSA contributions. The association noted that states have recently revised their insurance requirements and tax laws to be more consistent with federal requirements. Experts and provider association officials cited additional factors, including the inability of the patient or provider to know at the time service is delivered the amount to be deducted from the patient’s CDHP account, and decision-support tools that do not provide enrollees with sufficiently detailed information about the quality of health care providers and the cost of health care services. Experts and industry officials also cited the fact that CDHP products were priced too high by insurance carriers, a “wait and see” attitude by some employers, and questions about the suitability of these plans for certain segments of the population—such as the aged or the sick—as being among other factors that may limit the wider appeal of these plans.

We provided excerpts of a draft of this report to IRS and other organizations that provided us data, and we incorporated technical comments as appropriate.

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## Background

The majority of Americans receive their health coverage through the private health insurance market. Over the past several years, insurance carriers selling coverage in this market have added CDHPs to their portfolio of insurance products. The most common types of CDHPs are HRA-based and HSA-eligible plans used in conjunction with the associated health account.

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## The Private Health Insurance Market

Private health insurance plans are offered in two primary markets—the individual and the group markets. The individual market includes health plans sold by insurance carriers to individuals who do not receive coverage through an employer or other group. About 17 million individuals and their dependents received health coverage through the individual market in 2004.<sup>6</sup> The group market includes health plans offered by

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<sup>6</sup>Employee Benefit Research Institute, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey,” Issue Brief No. 287 (Washington D.C.: November 2005).

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employers to employees, either by purchasing the coverage from an insurance carrier or by funding their own health plans, and health plans offered by other groups, such as professional associations. About 159 million individuals and their dependents received health coverage through the group market in 2004.<sup>7</sup> Most employers subsidize a share of the cost of their employees' health coverage purchased in the group market, whereas individuals purchasing coverage in the individual market typically must pay the full cost.

Private health plans are subject to various state and federal requirements, depending on the market in which they are offered and the manner in which they are funded. Health plans purchased from health insurance carriers, either by an individual in the individual market or by an employer in the group market, are subject to state insurance requirements. In contrast, health plans that are self-funded by employers in the group market are generally not subject to state insurance requirements, but rather to federal requirements that apply to employer-sponsored benefits.<sup>8</sup> Larger employers are more likely to self-fund their health plans, whereas small employers are more likely to purchase coverage from insurance carriers.<sup>9</sup>

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## Consumer-Directed Health Plans

Although insurance carriers and employers offer several variants of CDHPs in the private health insurance market, these plans generally include three basic components—a health plan with a high deductible; an associated tax-advantaged account to pay for medical expenses under the deductible; and decision-support tools to help enrollees evaluate health care treatment options, providers, and costs.<sup>10</sup> In addition to including

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<sup>7</sup>Employee Benefit Research Institute, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey.”

<sup>8</sup>Federal law establishes several requirements for private health plans that apply to both fully insured and self-funded coverage, such as certain fiduciary and reporting requirements, as well as standards for continuation and portability of coverage and coverage of certain conditions and procedures.

<sup>9</sup>States typically define small employers as those with fewer than 50 employees for purposes of establishing regulations that apply to health plans offered in the small-group market.

<sup>10</sup>Average CDHP deductibles are about \$1,900 for single coverage and about \$3,900 for family coverage, compared to an average of about \$320 and \$680, respectively, for the most common type of traditional plan. See Henry J. Kaiser Family Foundation and Health Research and Educational Trust (HRET), *Employer Health Benefits 2005: Summary of Findings* (Menlo Park, Calif.: 2005).

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these three basic components, the health care billing process is different for CDHPs than for traditional health plans. The two most prominent CDHP models are HRA-based plans and HSA-eligible plans, used in conjunction with their associated savings accounts.<sup>11</sup>

## HRAs and HRA-Based Plans

An HRA is an employer-established arrangement designed to reimburse employees for qualified medical expenses that occur prior to meeting the deductible.<sup>12</sup> When enrollees in an HRA-based plan receive medical care, the costs are paid from a tax-advantaged HRA account. Once the HRA funds are exhausted, enrollees are typically responsible for paying for a certain amount—known as a bridge amount—out of pocket before reaching their deductible. Although employers are not required to couple an HRA with a high-deductible health plan, in practice the two are typically combined. HRA-based plans are only offered by employers to employees in the group market, and only employers may contribute to the HRA accounts. Account balances can accrue from year to year, and the accounts are typically not portable—that is, employees do not own the accounts and cannot retain unspent funds when they change jobs.<sup>13</sup> HRAs are administered by the employer or an insurance carrier. IRS affirmed in 2002 that employer contributions to HRAs are to be excluded from gross income for tax purposes.<sup>14</sup>

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<sup>11</sup>MSAs, another type of tax-advantaged CDHP, must be used in conjunction with an HDHP; however, the minimum deductible levels are higher and the allowable contribution amounts lower than for HSAs, and eligibility is restricted to individuals working for employers with 50 or fewer employees and self-employed individuals.

<sup>12</sup>Qualified medical expenses include expenses intended to prevent or alleviate a mental or physical condition, including vision and dental services. Qualified medical expenses may also include certain insurance premium costs, long-term care insurance, and the costs of transportation to obtain medical care.

<sup>13</sup>HRAs are generally set up as notational arrangements—employers do not actually deposit funds into the accounts for their employees. Instead, employers reimburse employees for their medical expenses as they occur. Unused HRA contribution amounts allotted during the year are made available to the employee for use in future years. Both HRA-based plans and HRA account balances are subject to continuation of coverage provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires employers to continue to offer coverage to individuals, with certain exceptions, who otherwise would have lost employer-based health coverage, for a specified length of time. *See* Pub. L. No. 99-272, Title X, 100 Stat. 82, 222 (1986).

<sup>14</sup>IRS Rev. Rul. 02-41, 2002-2 C.B. 75; IRS Notice 02-45, 2002-2 C.B. 93.

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## HSAs and HSA-Eligible Plans

An HSA is also a tax-advantaged account established for paying qualified medical expenses, but it is the employee rather than the employer who owns the account. Individuals are eligible to open and fund an HSA when they have a high-deductible HSA-eligible plan and no other health coverage, with limited exceptions.<sup>15</sup> In order to be considered an HSA-eligible plan, a health plan must meet certain criteria, including a minimum deductible amount—\$1,050 for single coverage and \$2,100 for family coverage in 2006—and a maximum limit on out-of-pocket spending—\$5,250 for single coverage and \$10,500 for family coverage in 2006. Preventive care services may be exempted from the deductible requirement; however, coverage of most other services, including prescription drugs, is subject to the deductible.<sup>16</sup> Health insurance carriers offer HSA-eligible plans to employers in the group market and to individuals in the individual market. HSA-eligible plan enrollees are not required to open or contribute to an associated HSA. A financial institution, such as a bank or insurance company, typically administers the HSA. An employer may partner with a financial institution to offer an HSA alongside the HSA-eligible plan offered to employees, or it may defer to employees to open the account. Both employers and individuals may contribute to HSAs, and individuals may claim a deduction on their federal income taxes for the HSA contribution regardless of whether they itemize deductions or claim the standard deduction. Account balances can accrue without limit, and the accounts are fully portable. Contributions, withdrawals, and interest earned on the accounts are not federally taxed if used for health care; however, enrollees may use accrued balances for purposes other than medical care subject to a tax penalty and, for retirement income, subject to income tax. Tax advantages for HSAs were authorized in December 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Table 1 compares key features of the two CDHP plan types.

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<sup>15</sup>Limited coverage (including specific injury or accident, disability, dental care, or vision care) in addition to the HSA-eligible plan is permissible.

<sup>16</sup>The IRS definition of preventive care includes periodic health evaluations, tests and diagnostic procedures ordered in connection with routine examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services.

**Table 1: Comparison of HRA-Based and HSA-Eligible Plans and Account Features for 2006**

	HRA-based plans	HSA-eligible plans
<b>High-deductible plan features</b>		
Deductible requirements	No requirements, but most employers pair HRAs with high-deductible plans	Minimum of \$1,050 for single and \$2,100 for family coverage; to be adjusted for inflation in future years
Maximum out-of-pocket limits <sup>a</sup>	IRS does not specify a maximum out-of-pocket limit	Maximum of \$5,250 for single and \$10,500 for family coverage; to be adjusted for inflation in future years
<b>Account features</b>		
Portability	No requirements, but most employers do not make accounts portable	Accounts are fully portable, so individuals retain the accounts if they leave their employers
Ownership	Employer owned	Individual owned
Who may contribute	Employers only	Employers, individuals, and family members
Annual contribution limits	No requirements; employers typically determine contribution amounts	Contributions allowed up to 100 percent of deductible, but not more than \$2,700 for single or \$5,450 for family coverage; to be adjusted for inflation in future years
Unspent funds	May roll over from year to year; some employers limit the maximum amount that may accumulate	May roll over from year to year without limit
Definition of qualified medical expenses	As specified by IRS <sup>b</sup>	As specified by IRS; <sup>b</sup> however, payment for health insurance premiums is restricted to long-term care coverage, certain continuation coverage, coverage while receiving unemployment benefits, and coverage after age 65 (except Medigap) <sup>c</sup>
Tax treatment	Withdrawals for qualified medical expenses are exempt from federal income taxes; employer contributions to account are excluded from gross income by employers and are not treated as taxable income to employees	Withdrawals for qualified medical expenses and earned interest are exempt from federal income taxes; employer contributions are excluded from gross income and employee contributions are deductible from federal income taxes
Nonmedical withdrawals	Not allowed—all withdrawals must be for documented medical expenses	Subject to income tax; additional 10 percent penalty assessed for nonmedical withdrawals before age 65

Source: GAO analysis of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003; IRS Rev. Rul. 2002-41; IRS Notice 2002-45; and additional IRS guidance on HSAs.

<sup>a</sup>Premiums and services not covered by the insurance plan do not count toward the out-of-pocket maximum.

<sup>b</sup>Qualified medical expenses include expenses intended to prevent or alleviate a mental or physical condition, including vision and dental services. Qualified medical expenses may also include certain insurance premium costs, long-term care insurance, and the costs of transportation to obtain medical care.

<sup>c</sup>Medigap is private supplemental insurance available to Medicare enrollees. It helps to pay for some of Medicare's deductibles, copayments, and coinsurance amounts, as well as some benefits Medicare does not cover.

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## Decision-Support Tools

Decision-support tools, including information on the price and quality of health care services and providers, can help CDHP enrollees become more actively involved in making health care purchasing decisions. These tools may be provided by health insurance carriers to all health insurance plan enrollees, but are likely to be more important to CDHP enrollees, who have a greater financial incentive to make informed trade-offs between the quality and costs of health care providers and services. Experts suggest that in order to make informed provider choices, enrollees need data to assess the quality of different providers. These data may include the volume of procedures performed, the outcomes of those procedures, and indicators demonstrating whether providers followed certain recommended treatment guidelines. In order to assess the price competitiveness of different providers, experts also suggest that enrollees need reliable and specific information about the cost of services. CDHP insurance carriers may also provide online access to health accounts for enrollees to manage their health care spending.

## Health Care Claims Processing

CDHP insurance carriers process and reimburse health care claims differently than traditional insurance carriers. Unlike enrollees in traditional health plans, enrollees in CDHPs are typically not required to make a copayment or pay a coinsurance amount to providers at the time they receive care. Instead, providers send the complete claims to the insurance carriers, which process the claims and inform the providers of the correct amounts to charge the enrollees. The providers then bill the enrollees, who pay from their HRA account or HSA by check, by debit card, or by authorizing the insurance carriers to allow the providers to directly debit their account funds. If enrollees have exhausted all of the HRA or HSA funds in their accounts, but have not yet met the deductible, the enrollees must pay the full amounts owed the providers using out-of-pocket funds. Once the deductible has been met, however, the insurance carriers cover all or most of the costs of covered services.

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## CDHPs Constitute a Small but Growing Share of the Private Health Insurance Market

According to publicly available survey data, the number of enrollees and dependents covered by HRA-based or HSA-eligible plans is small but growing. In January 2006, total CDHP enrollment was almost evenly split between HRA-based and HSA-eligible plans. An increasing number of health insurance carriers are offering CDHPs, and a small but growing share of employers are offering them to their employees. Large employers were more likely to offer HRA-based plans, whereas small employers tended to offer HSA-eligible plans.

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## Available Surveys Suggest That a Small but Growing Share of Privately Insured Enrollees and Dependents Were Covered by a CDHP

Although no national database of CDHP enrollment exists, we estimate that the number of enrollees and dependents covered by these plans increased from about 3 million in January 2005 to between about 5 and 6 million in January 2006, based on publicly available survey data.<sup>17</sup> About 3 million of the 5 to 6 million enrollees and dependents were covered by HRA-based plans, and from 2 to 3 million by HSA-eligible plans. These estimates represent a small share of the approximately 177 million enrollees and dependents with private health insurance coverage.

The number of enrollees and dependents appears to be growing faster for HSA-eligible than for HRA-based plans. According to a series of surveys conducted by a health care information company, the number of enrollees and dependents in HRA-based plans grew from about 2.5 million in January 2005 to 2.9 million in January 2006, and the number of enrollees and dependents in HSA-eligible plans during this period increased from about 600,000 to about 2 million.<sup>18</sup> A second series of insurance carrier surveys provide a higher estimate for HSA-eligible plans.<sup>19</sup> These surveys—conducted by a health insurance trade association—estimate that the number of enrollees and dependents covered by an HSA-eligible plan increased from about 438,000 in September 2004 to about 1 million in March 2005 and to about 3 million in January 2006. In 2004 and 2005, more than half of these enrollees and dependents were covered by an HSA-eligible plan purchased in the individual insurance market, rather than obtained from an employer.<sup>20</sup> None of these surveys indicate whether HSA-eligible plan enrollees opened HSAs.

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<sup>17</sup>See Inside Consumer-Directed Care, *CDH Enrollment Increases to 4.9 Million; HSA-Qualified HDHPs Gain on HRA Plans* (Washington, D.C.: 2006). See also America's Health Insurance Plans, *HSAs Triple in Ten Months: Over 3 Million Enrolled in High-Deductible/HSA Plans* (Washington, D.C.: 2006), and *Summary: Number of HSA Plans Exceeded One Million in March 2005* (Washington, D.C.: 2005).

<sup>18</sup>Inside Consumer-Directed Care, *CDH Enrollment Increases to 4.9 Million*.

<sup>19</sup>America's Health Insurance Plans, *HSAs Triple in Ten Months*, and *Summary: Number of HSA Plans Exceeded One Million in March 2005*.

<sup>20</sup>Preliminary data for 2006 suggest that the number of HSA-eligible plan enrollees in the group market is growing faster than in the individual market.

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## An Increasing Number of Health Insurance Carriers Are Offering CDHPs

The number of health insurance carriers offering CDHPs in the individual and group insurance markets is increasing. A survey of health insurance trade association members reported that 99 offered HSA-eligible plans in March 2005, up from 29 in September 2004.<sup>21</sup> In addition, the plans are being offered widely in the United States. Another health insurance trade association survey reported that members offered HSA-eligible plans in the individual market in 40 states, in the small-group market in 44 states, and in the large-group market in 46 states in 2005.<sup>22</sup> Further, a survey of group health insurance carriers in 2005 reported that 93 percent of survey respondents expected to offer an HRA-based or HSA-eligible plan within the next year.<sup>23</sup>

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## A Small but Growing Share of Employers Offer CDHPs, and the Type Offered Varies by Employer Size

Although many insurance carriers have made CDHPs widely available to employers, only a small percentage of employers offer CDHPs to their employees. This percentage is growing, however. According to national employer benefit surveys, about 1 percent of all employers that offered health benefits offered a CDHP in 2004, and about 4 percent offered one in 2005.<sup>24</sup> Large employers were more likely than smaller employers to offer a CDHP. According to a 2005 benefit survey, 22 percent of employers with 20,000 or more employees offered a CDHP, compared to 2 percent of employers with less than 500 employees.<sup>25</sup> One recent employer benefit survey indicated that the number of employers offering CDHPs would likely increase in 2006. It found that 22 to 25 percent of employers said they were somewhat likely, and 2 to 4 percent said they were very likely, to begin offering a CDHP in 2006.<sup>26</sup>

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<sup>21</sup>America's Health Insurance Plans, *Summary: Number of HSA Plans Exceeded One Million in March 2005*.

<sup>22</sup>BlueCross BlueShield Association, *States Where BCBS Plans Offer HSA Health Plans* (Chicago: 2005).

<sup>23</sup>Milliman, *2005 Group Health Insurance Survey* (Seattle: 2005).

<sup>24</sup>See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey* (Menlo Park, Calif.: 2005), and Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2004 Survey Tables* (New York: 2005).

<sup>25</sup>Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Tables* (New York: 2006).

<sup>26</sup>Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*.

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Almost all employers that offer CDHPs also offer one or more traditional health plans. According to a national employer benefit survey, only 1 percent of employers offering a CDHP in 2005 did not also offer one or more traditional plans.<sup>27</sup> However, benefit consultants and insurance carrier representatives told us there is growing interest among employers in fully replacing their traditional plans with CDHPs. For example, one employer we spoke with offered an HSA-eligible plan, an HRA-based plan, and a traditional plan as options for employees in 2005, but only offered the CDHPs in 2006. The findings of employer benefit surveys, as well as industry officials and benefit consultants we spoke with, indicated that large employers were more likely to offer a CDHP as one of several plan options, whereas some small employers that offered HSA-eligible plans offered them as their only option.

When employers offered a CDHP as one of two or more options, enrollment in the CDHP was generally lower than in the traditional plans. For example, data from three large multistate insurance carriers indicated that the average 2004 enrollment rates in their HRA-based plans when those plans were offered alongside one or more traditional plans was 17 percent. According to a national health benefits survey, among employers with 1,000 or more workers that offered an HSA-eligible plan, 3 percent of employees were enrolled in the HSA-eligible plan in 2005.<sup>28</sup>

Employer characteristics typically determine the type of CDHP offered. According to industry representatives and benefit consultants, HRA-based plans are typically offered by large employers that self-fund their health coverage. Large employers are more likely to offer an HRA-based plan because they have more flexibility in designing the plan benefits, they can specify how the funds are to be used, and they can retain unused account balances. Small employers are more likely to purchase rather than self-fund their health insurance plans and are less likely to offer an HRA-based than an HSA-eligible plan.

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<sup>27</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Tables*.

<sup>28</sup>Gary Claxton, et al., "What High-Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs*, September 14, 2005. This estimate includes employers that offered the HSA-eligible plan as one of a number of plan options and those that offered it as their only option. However, employers with 1,000 or more employees typically offer a choice of health plans.

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## Most Employers Contributed to Health Accounts, and the Share of Account Funds Spent by Enrollees Varied Widely

Most employers made a contribution to their employees' health accounts, and there was wide variation in the share of account funds spent by enrollees. Employers are required to contribute to the HRA accounts associated with HRA-based plans, and the contribution amounts varied. Almost three-quarters of HRA-based plan enrollees with single coverage and more than 95 percent with family coverage spent a portion of their HRA funds in 2004, and the year-end balances varied. Industry officials noted that not all HSA-eligible plan enrollees actually opened an associated HSA, and estimated that about 50 percent to 60 percent did so. According to survey data, about two-thirds of employers offering HSA-eligible plans made a contribution to employees' HSAs, and the average employer HSA contribution in 2005 was about \$553 for single and \$1,185 for family coverage. Data obtained from IRS indicate that tax filers who claimed a deduction for an HSA claimed an average amount of \$2,100 in 2004. Early experience with HSAs suggests that some individuals are using their account funds to pay for medical care, whereas others are choosing to pay for care with other, out-of-pocket sources, rather than withdrawing the funds from their HSAs.

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## For HRA-Based Plans, Employer Contributions Varied, and Most Enrollees Spent a Portion of Account Funds

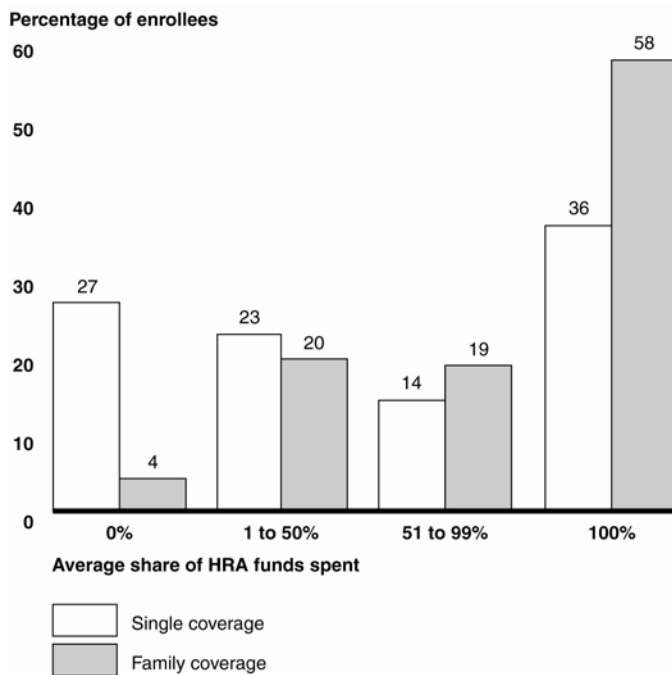
The amount of money employers contributed to their employees' HRA accounts varied across employers, both for single and for family coverage. Based on HRA account data provided by three multistate insurance carriers, the most common annual employer HRA contribution in 2004 ranged from about \$500 to \$750 for single coverage and from about \$1,500 to \$2,000 for family coverage. For single coverage, a small number of employers contributed less than \$500, and a very few contributed more than \$2,000. For family coverage, a small number of employers contributed less than \$1,000, and a very few contributed more than \$3,500.

Bridge amounts—which employees must pay out of pocket after they exhaust their HRA funds but before they meet their deductible—varied widely for employees whose employers purchased plans from these three insurance carriers. Some employees with either single or family coverage had a bridge amount of \$0. Others were responsible for paying up to \$6,750 with single coverage or up to \$8,150 with family coverage before reaching their deductible. According to our analysis of a recent national employer

benefit survey, the average bridge amount in 2005 was about \$1,078 for single and \$2,130 for family coverage.<sup>29</sup>

In 2004, most enrollees in HRA-based plans spent a portion of their account funds. HRA-based plan enrollees with single coverage were less likely to spend their HRA funds than enrollees with family coverage. Specifically, data provided by the three multistate insurance carriers indicate that almost three-quarters of HRA-based plan enrollees with single coverage and more than 95 percent with family coverage spent some or all of their HRA funds in 2004 (see fig. 1). The average amount of unspent HRA funds at the end of 2004 was \$470 for single coverage and \$401 for family coverage.

**Figure 1: Average Share of HRA Funds Spent by Enrollees, 2004**



Source: GAO analysis of HRA account data supplied by three large, multistate insurance carriers.

<sup>29</sup>We calculated the average bridge amounts by subtracting the reported average employer HRA contribution from the reported average deductible for an HRA-based plan. In this survey, family coverage is defined as coverage of four individuals. See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*.

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## Not All HSA-Eligible Plan Enrollees Opened and Contributed to an Account

According to industry officials, not all HSA-eligible plan enrollees opened and contributed to the associated HSA. National data sources are limited, but officials we spoke with estimated that the share of all HSA-eligible plan enrollees that had opened and contributed to an HSA was about 50 percent to 60 percent. Supporting this estimate, based on publicly available survey data and data obtained from IRS, about 55 percent of HSA-eligible plan enrollees claimed an HSA deduction or reported an HSA contribution in 2004. Moreover, one insurance carrier representative reported that about 60 percent of the carrier's HSA-eligible enrollees who obtained coverage through an employer opened and contributed to an HSA. Regarding employer contributions, data from a national employer benefits survey indicate that about two-thirds of employers that offer HSAs made a contribution to their employees' accounts in 2005. Some health policy analysts have expressed concern that some individuals who enroll in an HSA-eligible plan but do not open or contribute to the account will be unable to afford the high deductibles out of pocket.

Nationally representative data sources on employer and enrollee contributions to HSAs are limited. Data from one national employer benefit survey indicate that in 2005 the average employer HSA contribution was \$553 for single and \$1,185 for family coverage.<sup>30</sup> Data from IRS show that among tax filers who claimed a deduction for an HSA contribution in 2004, the average amount was about \$2,100.<sup>31</sup> The average deduction amount generally increased with income level.

CDHP experts and industry officials stated that some account holders are primarily using HSAs as a tax-advantaged savings vehicle. Representatives from three of the six financial institutions we contacted characterized HSA account holders as falling into one of two groups—spenders or savers. Spenders use their account funds to pay for medical expenses, whereas savers, who, according to financial institution representatives, tend to be more highly compensated individuals, pay for care from other, out-of-pocket sources, rather than withdraw funds from their HSA, in effect using their HSAs as tax-advantaged savings. One financial institution provided

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<sup>30</sup>See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*.

<sup>31</sup>Data are based on a sample of 2004 tax returns and are reported on a per-return basis, and thus could include contributions to more than one HSA account in some instances. Moreover, the data do not distinguish between deductions claimed for HSA contributions made by enrollees with single or family coverage or for HSA-eligible coverage obtained in the group or individual markets.

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data showing that during the first three quarters of 2005, about 72 percent of its account holders withdrew funds from their HSAs, including about 20 percent who exhausted their accounts. The average amount rolled over by this financial institution's HSA account holders at the end of 2004 was \$950. We could not determine whether HSA-eligible plan enrollees accumulated balances because they did not need to use their accounts—because they paid for care from other, out-of-pocket sources or did not need health care during the year—or because they reduced their health care spending as a result of financial incentives associated with the HSA.

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## Desire to Restrain Rising Cost of Health Care Coverage Is Primary Factor Driving Growth of CDHPs

The primary factor responsible for the growth of CDHPs is the rising cost of health care coverage. CDHP experts and employers we interviewed reported that employers offered the plans to lower their cost of health care coverage and their employees' premiums, as well as for other perceived benefits. Individuals enrolled in CDHPs through an employer or the individual market primarily to lower their health insurance premiums, accumulate tax-advantaged savings, and gain greater control over their health care purchasing decisions, according to CDHP experts and participants in our focus groups. CDHP experts also reported that individuals were more likely to enroll in a CDHP offered by an employer when the employer offered a generous contribution to the CDHP premium and associated savings account, offered more comprehensive benefits, and effectively educated its employees about the plans.

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## Employers Offer CDHPs Primarily to Help Lower Cost of Health Care Coverage

Industry officials and other experts we spoke with told us that the primary reason employers offer CDHPs is to help lower their cost of health care coverage.<sup>32</sup> These officials reported that some employers believe one way to restrain the growth in the cost of health care coverage is to promote cost-consciousness on the part of their employees by making them aware of the true cost of health care services. According to these officials, by offering the ability to roll over unspent account balances and take account balances from one employer to another, some believe that CDHPs provide incentives for enrollees to select the best treatment option at the lowest available price. Employers also want to offer their employees a tax benefit that can create the opportunity to save for future medical expenses,

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<sup>32</sup>In the group health insurance market the cost of health care coverage—or premium—is typically shared by the employer and employee. Employees may incur additional costs in the form of a deductible, copayment, or coinsurance when they visit a medical provider.

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including saving for medical costs in retirement. Industry officials and experts also noted that employers offer CDHPs in response to dissatisfaction among employees with tight utilization controls under managed care plans, such as health maintenance organizations (HMO).<sup>33</sup> In addition, according to these officials, employers would be more likely to offer a CDHP in the future if health care premiums continue rising significantly or if CDHPs demonstrate the ability to reduce the rising cost of health care coverage.

Publicly available employer surveys cite factors that encouraged employers to offer CDHPs to their employees. In four surveys we reviewed, employers responded that they offered CDHPs to reduce the cost of health care coverage and provide employees with greater plan flexibility and a tax benefit.<sup>34</sup> Our interviews with five employers that offer CDHPs showed that the key reasons for offering a CDHP were to reduce company spending on health care coverage, to promote cost-consciousness among employees, to lower the cost of health insurance coverage to employees, and to attract and retain employees. (See table 2.)

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<sup>33</sup>Some managed care plans require a referral from a primary care provider before enrollees can see a specialist.

<sup>34</sup>See Aon Consulting/ISCEBS *Survey Shows Consumer-Driven Health Plans Becoming More Popular* (Chicago: March 2005); Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health* (New York: 2005); Watson Wyatt, *Managing Health Care Benefit Costs in a New Era: 10th Annual National Business Group on Health/Watson Wyatt Survey Report* (Washington, D.C.: 2005); and Hewitt Associates, *Health Care Expectations: Future Strategy and Direction* (Lincolnshire, Ill.: February 2005).

**Table 2: Factors Driving Employers to Offer CDHPs**

	Employer				
	#1	#2	#3	#4	#5
Factors related to employer					
Reduce company spending on health care		.	.	.	.
Promote cost-consciousness among employees	.	.	.	.	.
Factors related to employees					
Provide employees with lower-cost health insurance coverage	.	.		.	
Increase employee share of health care premiums in the future	.				.
Encourage savings for postretirement medical care		.			
Respond to employee dissatisfaction with features of managed care, such as utilization reviews or the use of gatekeepers	.	.			
Respond to employee dissatisfaction with managed care’s limited provider networks <sup>a</sup>	.				
Attract and retain employees	.	.	.	.	.

Source: GAO interviews with employers offering CDHPs.

<sup>a</sup>Certain managed care plans, such as HMOs, require patients to receive care from certain providers with which they have prenegotiated payment rates.

### Individuals Enroll in CDHPs to Lower Their Health Insurance Premiums and Accumulate Account Balances

A broker that sells CDHPs on behalf of insurance carriers nationwide reported that in the individual health insurance market, individuals seeking to lower their premiums, accrue tax-free savings for health care expenses, and gain greater control over their health care decision making are increasingly purchasing HSA-eligible plans. An official representing the broker noted that some individuals—particularly low users of health care services—view HSA-eligible plans as an affordable way to protect against a catastrophic health care expense, while providing greater control and savings account features. Participants in our focus group who were enrolled in employer-sponsored CDHPs also cited the desire to lower their monthly outlay for premiums, build up savings to pay for retirement or other nonmedical care expenses, and exercise greater control over health care decisions as the reasons for selecting an HSA.

Industry officials and CDHP experts reported that the key factors in determining whether employees enroll in a CDHP when offered are the level of employer contributions, both toward the CDHP premiums and toward the associated savings accounts, and the communication and education efforts undertaken by employers. The officials noted that the appeal of CDHPs was increased where the employer offered a larger contribution to the CDHP premium and associated savings account and

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more comprehensive benefits. A survey of employers indicated that employees were more receptive to CDHPs when the employees believed that the employer was not switching to a CDHP solely to shift rising costs onto them, but also to encourage them to take more control of their long-term health care needs.<sup>35</sup> One employer in the survey achieved high levels of employee engagement and satisfaction with its CDHP offering by using its employees as advocates to explain the new benefit design and the rationale for the benefit change to both employees and their spouses, and comparing its plan to CDHPs offered by other companies. The company also offered its employees financial incentives, wellness programs, and training for online decision-support tools that allowed employees to compare the cost and quality of different treatment and provider options.

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## Federal and State Requirements, Inadequate Consumer Tools, and Other Factors Could Limit the Appeal of CDHPs

Industry officials and CDHP experts we interviewed cited several factors that could limit the appeal of CDHPs, including a lack of flexibility in the federal statutory provisions and guidance establishing HSAs and HSA-eligible plans and insurance or income tax requirements in eight states that do not reflect federal statutory provisions for HSAs. Officials of provider associations and experts suggested additional factors, including the inability of the patient or provider to know at the time service is delivered the amount to be deducted from the patient's CDHP account, and the inadequacy of decision-support tools provided by insurance carriers to help enrollees assess the cost and quality of providers and treatment options. Industry officials and CDHP experts cited other factors that could affect wider adoption of these plans, such as insurance carriers pricing CDHPs too high and a "wait and see" attitude by some employers.

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<sup>35</sup>McKinsey & Company, *Consumer-Directed Health Plan Report - Early Evidence Is Promising* (Pittsburgh: June 2005).

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## Industry Officials Suggest Certain Federal Tax Laws and Guidance May Limit Changes to HSAs and HSA-Eligible Plans That Could Increase Their Appeal

A health insurance trade association and health policy analysts that advocate HSAs reported that certain federal tax laws and regulations may limit changes to the accounts or plans that could increase their appeal to employers or individuals. For example, these groups cited IRS guidance stipulating that HSA-eligible plans may not provide coverage for most prescription medication before the annual deductible is met as potentially limiting the appeal of these plans.<sup>36</sup> In contrast, traditional plans typically allow enrollees to receive coverage for prescription drugs before the deductible is met—a benefit that is very common among employers. In addition, annual contributions to an HSA for 2006 are capped at \$2,700 for single and \$5,450 for family coverage.<sup>37</sup> An industry official noted that higher contribution limits could reduce the gap between the allowable HSA contribution and the annual plan deductible, thereby encouraging more individuals to enroll in these plans. However, increasing the contribution amounts would result in additional revenue loss to the federal Treasury because of the tax-exempt status of the accounts.

IRS guidance precludes certain changes to CDHPs that health policy analysts and experts believe could increase the appeal of CDHPs to certain high-risk groups that typically incur higher medical expenses. For example, some experts have suggested allowing financial incentives for employees with chronic illnesses or for employees who participate in wellness programs. With certain limited exceptions, IRS guidance penalizes employers that vary the amount of the account contributions they make to comparable classes of employees, based on factors such as employee participation in a disease management program, by imposing a tax equal to 35 percent of the amount of the employer contributions.

An industry official also noted that IRS guidance can limit the flexibility of HSAs for individuals who enroll in an HSA-eligible plan later in the calendar year. If an HSA-eligible plan is purchased after the first of the year, IRS guidance states that the allowable contribution must be prorated

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<sup>36</sup>The guidance cited is based on an Internal Revenue Code provision that precludes coverage for primary care services before the annual deductible is met. 26 U.S.C. § 223 (c) (2). This restriction would pertain to most prescription drugs.

<sup>37</sup>The President's 2007 budget would seek to increase the maximum HSA contribution for all individuals up to the out-of-pocket spending limit for an HSA-eligible plan, which for 2006 is \$5,250 for single coverage and \$10,500 for family coverage. These out-of-pocket amounts are indexed annually for inflation. See Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2007*. <http://www.whitehouse.gov/omb/budget/fy2007/> (downloaded Feb. 21, 2006).

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based on the number of months left in the year, even though the enrollee is subject to the full annual deductible. This could create a potential shortfall between the prorated contribution amount—available to offset the annual deductible—and the annual deductible.

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### Health Insurance Trade Association Reports That Some States Maintain Insurance or Income Tax Requirements That Do Not Reflect Federal HSA Statutory Provisions

According to a health insurance trade association, three states currently impose requirements that limit the extent to which HDHPs may be coupled with HSAs. HMO requirements in three states prevent them from offering HDHPs coupled with HSAs. These three states—Illinois, Missouri, and New York—all specify maximum combinations of deductibles and copayments, allowable charges, or out-of-pocket costs that HMOs may charge to enrollees, thereby preventing them from offering HDHPs consistent with federal statutory provisions.<sup>38</sup> New York also imposes another requirement on all individual health insurance plans, requiring them to provide coverage of certain standardized benefits, which include major medical, comprehensive, or comparable benefits.<sup>39</sup> Under the Internal Revenue Code and applicable guidance, HDHPs coupled with HSAs may not provide coverage for primary care or other services intended to treat an existing illness, injury, or condition before the annual deductible is met.<sup>40</sup>

The association also indicated that five states currently offer lower incentives to HSAs because they do not allow state personal income tax deductions for HSA contributions. These states are Alabama, California, New Jersey, Pennsylvania, and Wisconsin. According to the association, the remaining states have incorporated federal tax treatment of HSA contributions into their own laws by referring to the relevant federal provision, have revised their own tax laws to parallel federal law, or do not impose a personal income tax.<sup>41</sup>

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<sup>38</sup>Ill. Admin. Code tit. 50, § 5421.110 (2006); Mo. Code Regs. Ann. tit. 20, § 400-7.100 (2006); N.Y. Ins. §4321(b) (McKinney 2006). These restrictions pertain only to HMOs.

<sup>39</sup>See New York Insurance Department Circular Letter No. 4 (2004).

<sup>40</sup>However, first dollar coverage is permitted for preventive care. 26 U.S.C. § 223(c)(2); IRS Technical Guidance, Notice 2004-23. IRS will temporarily treat health plans as meeting these minimum annual deductible requirements to be coupled with HSAs when the sole reason for not doing so is compliance with certain state-mandated benefits. See IRS Technical Guidance, Notices 2004-43, 2005-83.

<sup>41</sup>Although New Hampshire and Tennessee do impose tax on certain personal income, neither state taxes salaries or wages.

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## Delayed Account Transactions May Hinder Appeal of CDHPs

CDHP experts and provider association officials reported that the appeal of CDHPs may be limited by the inability of the patient and provider to know at the time of service the amount to be deducted from the CDHP account. Enrollees typically do not pay for services from their HRAs or HSAs when they receive care from a provider because the amount to be withdrawn from their account is not yet known.<sup>42</sup> Instead, an enrollee authorizes the insurance carrier to debit his or her account after the claims adjudication process is complete. Alternatively, the enrollee may elect to write a check to the provider to settle the outstanding charge after the claim is adjudicated by the CDHP insurance carrier. CDHP experts and provider association officials noted that the current system is confusing for providers and patients. The association official cited an example whereby a provider submits a claim to the insurance carrier after the CDHP patient has been treated. The claim is adjudicated by the insurance carrier, which sends the provider an explanation of benefits detailing what the insurance carrier will pay and what the patient must pay out of his or her HSA. Based on this explanation—sometimes received up to 6 weeks after the service was delivered—the provider bills the patient directly and is left wondering when payment will be received. During this period, the patient, who may incur other health care expenses, is left uncertain of the amount that will be withdrawn from the HSA, and therefore cannot determine the remaining balance.

A few vendors have, or are developing, technologies that can electronically determine the amount to be deducted from the patient's CDHP account at the point of service and execute this transaction shortly thereafter. For example, a major CDHP insurance carrier recently introduced an integrated, real-time claims adjudication process that it anticipates will simplify administrative tasks and help physicians obtain payment for services from the patient more quickly. The insurance carrier reported that instead of duplicative manual keying of claims and benefit information, the new system submits the claim and returns the adjudicated claim before the patient leaves the doctor's office. Similarly, a company that handles commercial credit card transactions recently partnered with a major nationwide health insurance carrier to launch a real-time debit card for HSAs. According to the insurance carrier, the debit card can be used at the physician's office or hospital, or to pay bills online. The card is swiped

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<sup>42</sup>To determine the amount that should be deducted from an enrollee's account, the insurance carrier must adjudicate the claim by making determinations as to whether the deductible has been met, whether the service is a covered benefit, and whether any cost sharing applies.

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by the patient at the point of service, allowing funds to be withdrawn from the HSA automatically and a payment for the insurance carrier's portion of the medical claim to be made directly to the provider simultaneously. Financial institutions we interviewed have expressed a desire to switch to these new technologies as they become available.

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### Inadequate Decision-Support Tools May Hinder Appeal of CDHPs

According to CDHP experts and employers, the tools provided by insurance carriers to assist consumers in assessing the price and quality of health care providers and services do not provide sufficient information to allow enrollees to fully assess the cost and quality trade-offs of health care purchasing decisions.<sup>43</sup> The decision-support tools we reviewed from five of the largest CDHP insurance carriers included hospital- and physician-specific quality data and provider cost information that was limited. For example, five of the insurance carriers provided three or more measures of hospital quality, such as outcomes data, procedure volumes, and patient safety ratings; however, none provided similar process or outcome measures to assess individual physician quality.<sup>44</sup> Three insurance carriers provided information on medical board certifications, and each carrier provided other information about physicians, such as medical education and hospital affiliation. Three of the insurance carriers provided average hospital payment rates and average physician payment rates within a specified geographic area for selected services, but none provided the actual payment rates that would be charged to enrollees that the carrier had negotiated with specific hospitals or physicians.<sup>45</sup> All insurance carriers provided information that allowed enrollees to track their account balances, and all provided some information on health education. Appendix I summarizes the information included on each CDHP insurance carrier's Web site.

Other recent assessments of CDHP decision-support tools found similar limitations. For example, one study concluded that most CDHP decision-

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<sup>43</sup>The decision-support tools we reviewed from five of the largest CDHP insurance carriers included hospital- and physician-specific quality data and provider cost information identified by experts as being important when making health care purchasing decisions.

<sup>44</sup>Process measures indicate whether providers follow certain guidelines for care, and include such measures as the share of patients for whom recommended treatment guidelines were followed.

<sup>45</sup>One insurance carrier had begun a pilot project to publish facility-specific, negotiated prices for selected medical services with plans to expand this to additional markets in the next year.

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support tools did not provide sufficiently detailed measures of cost and quality to allow enrollees to identify higher value treatment options.<sup>46</sup> Another survey found that almost 90 percent of the insurance carriers surveyed did not adjust their cost information and 67 percent did not adjust their quality information to reflect severity of illness.<sup>47</sup>

CDHP experts and representatives of health care providers cited several reasons that existing decision-support tools contain limited quality and cost data. A provider association reported that the biggest challenge is providing the cost and quality data in a way that consumers can understand and interpret. The association also stated that there are potential legal barriers to greater price transparency, such as antitrust laws and health plan contracts, which may preclude the sharing of negotiated pricing. Additionally, there are many complexities involved in making providers' prices more transparent, as well as a lack of consensus on what would make ideal quality measures.<sup>48</sup> Furthermore, experts note that providers may resist making quality information more transparent, allowing consumers to shop for medical services based on price and quality, and the data needed to build the cost and quality tools for patients are dispersed among several publicly funded health programs, as well as private insurers and self-funded employers.

Representatives of insurance carriers whose tools we reviewed told us that they are currently limited in their ability to provide some of the information experts identified as important. Multiple representatives expressed concern over the lack of consensus across the industry on what constitutes ideal quality measures and methodologies for developing quality data. A representative noted that his company does not offer patient satisfaction ratings for hospitals or physicians because of concerns over the difficulty in achieving a meaningful rating that is based on a high enough volume of respondents. Another representative told us that physician-specific cost and quality data would be difficult to collect and

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<sup>46</sup>See Meredith Rosenthal, Charleen Hsuan, and Arnold Milstein, *A Report Card on the Freshman Class of Consumer-Directed Health Plans*, *Health Affairs*, vol. 24, no. 6 (2005).

<sup>47</sup>Reden & Anders, Ltd, *Consumer Directed Insurance Products: Survey Results* (Minneapolis: April 2005).

<sup>48</sup>These factors include the structure of the health plan and the rates of medical complications or other comorbidities of the population treated by the provider. See also McDermott, Will & Emery, *Encouraging a Responsible Approach to Consumer-Driven Health Care* (October 2004).

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report until the physician community agreed that the value of providing these kinds of information to consumers outweighed any potentially negative personal ramifications. These representatives stated that they were planning to offer actual negotiated physician costs in selected markets in the coming years and that one insurance carrier has plans to offer hospital process indicator data.

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### Other Factors May Limit the Appeal of CDHPs

Other factors were cited by some CDHP experts and industry officials as potentially affecting the wider adoption of CDHP plans. An industry official said that CDHPs have been priced too high by insurance carriers, and as a result, the difference in premiums between CDHPs and traditional low-deductible preferred provider organization (PPO) plans has not been enough to attract more attention from employers interested in reducing the cost of health care coverage. For example, a national broker of health insurance in the individual market reported that in 2005 its nationwide average single-coverage monthly premium for HSA-eligible plans with deductibles between \$2,000 and \$2,999 was \$166, compared to \$213 for non-HSA plans with deductibles under \$500. Surveys by benefit consultants indicate that some employers have been hesitant to offer or promote CDHPs or HSAs, instead taking a “wait and see” attitude. One survey reported that almost one-third of employers not considering a CDHP think the concept is too new and want to gauge other employers’ experiences with CDHPs before deciding to offer one themselves.<sup>49</sup>

Recent studies also raise questions about whether CDHPs can appeal to certain segments of the population—such as the aged or the sick—who may not have the inclination to select a CDHP or the desire to actively participate in making complex health care decisions.<sup>50</sup> These studies caution that high users of medical services are more likely to prefer to remain in traditional plans, and that some employers are concerned that

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<sup>49</sup>See Aon Consulting/ISCEBS, *Survey Shows Consumer-Driven Health Plans Becoming More Popular*, and Mellon Financial Corporation, *Health Reimbursement Arrangements/Health Savings Accounts: National Trends, Survey Results Report* (Pittsburgh: April 2005).

<sup>50</sup>American Academy of Actuaries, *The Impact of Consumer-Driven Health Plans on Health Care Costs: A Closer Look at Plans with Health Reimbursement Arrangements* (Washington, D.C.: January 2004); Center for Studying Health System Change, *Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care* (Washington, D.C.: July 2004); and Karen Davis et al., *How High Is Too High? Implications of High Deductible Health Plans*, The Commonwealth Fund, no. 816 (New York: April 2005).

regardless of the amount of education they provide, spending accounts are too complex for certain segments of their workforce. Three-quarters of individuals polled by the Kaiser Family Foundation cited the fear of high medical bills when asked about HDHPs.<sup>51</sup> Focus group participants who are enrolled in PPO plans cited lower and predictable out-of-pocket costs, satisfaction with their current plan, and an unwillingness to manage their own health care as the reasons for not enrolling in an HSA-eligible plan. The focus group participants also noted that HSA-eligible plans were confusing and complicated. For example, participants complained that the HSA booklets were too confusing and convoluted and that the HSA-eligible plan was more complicated and required more of the enrollee's time for reviewing paperwork.

Employers we interviewed cited challenges they faced as they implemented their CDHPs. These included the administrative complexity of billing and claims processing, limited or insufficient information on the quality and cost of provider and treatment options, and employees' unfamiliarity with and apprehension about CDHPs. (See table 3.)

**Table 3: Challenges Faced by Employers Implementing a CDHP**

Challenge	Employers				
	#1	#2	#3	#4	#5
Employer-related challenges					
Administrative complexity of claims processing and billing procedures	.		.		
Inadequate resources allotted to educate employees		.			
Limited or insufficient availability of quality data for providers	.				.
Limited or insufficient availability of data on cost for providers or treatment options	.				.
Employee-related challenges					
Employees unfamiliar with consumer-directed products	.	.	.	.	.
Employees apprehensive about consumer-directed approach	.	.	.		.

Source: GAO interviews with employers.

Similarly, employers responding to a benefit consultant survey said that the key challenges they faced in implementing their CDHPs were providing education and promoting understanding of the CDHP product, pricing the CDHP product properly relative to other health plan options,

<sup>51</sup>Kaiser Family Foundation, *Kaiser HealthPoll Report* (Menlo Park, Calif.: September/October 2004).

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contending with the potential for the CDHP product to attract primarily healthier employees,<sup>52</sup> and selecting the right health insurance carrier and financial institution to administer the plan and accounts.<sup>53</sup>

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## Concluding Observations

In recent years, federal and state governments have taken steps to authorize and encourage the development of CDHPs, and insurance carriers and employers have begun including the plans as an option within their broader portfolios of health insurance offerings. While enrollment in the plans is growing, CDHPs currently cover a relatively small share of the privately insured population. In addition, a significant share of individuals who enrolled in an HSA-eligible plan did not open and contribute to an associated HSA to set aside funds to pay for health care expenses under the higher deductibles. Nevertheless, the factors that have stimulated the initial development and acceptance of these plans, such as the rising cost of health care coverage and the desire to stimulate more cost-consciousness among plan enrollees, are not likely to abate in the near term.

Further enrollment growth in CDHPs will depend on several factors. The likelihood that employers will increasingly offer CDHPs may be influenced by how, or if, the plans demonstrate cost savings. On the one hand, the plans may restrain costs by encouraging employees to become more informed, cost-conscious purchasers of health care. This may depend in part on the ability of health insurance carriers to improve and expand upon the cost and quality information they make available to enrollees. On the other hand, apparent CDHP cost savings may result primarily from a cost shift from healthy to less healthy employees if healthier employees disproportionately migrate to these plans, thus causing traditional plan premiums to rise faster. The likelihood that individuals will increasingly select a CDHP where given a choice may be influenced by the generosity of the CDHP benefit package relative to other health plans offered by employers and the experiences of early plan enrollees. Interest among employees is likely to be greater if they perceive that the higher deductibles are largely offset by employer contributions to employees'

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<sup>52</sup>Some employers try to mitigate this concern by designing benefits, plan premiums, and account contributions to be as attractive as those offered under more traditional plans.

<sup>53</sup>Mellon Financial Corporation, *Health Reimbursement Arrangements/Health Savings Accounts: National Trends, Survey Results Report* (Pittsburgh: April 2005).

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accounts and lower monthly premiums, and if early enrollees report positive experiences using the plans.

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## External Comments

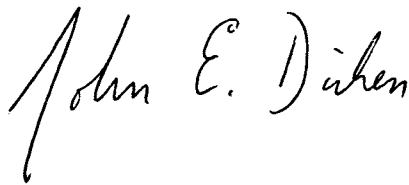
We provided to IRS, AHIP, and several other private-sector organizations excerpts of a draft of this report pertaining to the data each had provided us. We received technical comments from IRS and AHIP, which we incorporated as appropriate. Other organizations that responded said they approved of our presentation of the data they had provided to us.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. At that time, we will send copies of this report to other interested parties. We will also make copies available to others upon request. This report will also be available at no charge on GAO's Web site at <http://www.gao.gov>.

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Sincerely yours,



John E. Dicken  
Director, Health Care

# Appendix I: Summary of Information Included in Decision-Support Tools Offered by CDHP Health Insurance Carriers

**Table 4: Information Included in the Decision-Support Tools of Five Multistate CDHP Insurance Carriers**

Tools	Insurance carrier #1	Insurance carrier #2	Insurance carrier #3	Insurance carrier #4	Insurance carrier #5
<b>Member account access</b>					
Progress toward deductible tracked by tool	●	○	●	●	●
HSA account balance	●	●	●	●	●
<b>Health education information</b>					
General preventive care	●	●	●	●	●
Common medical procedures and conditions	●	●	●	●	●
Treatment options for certain conditions	●	●	●	●	●
Disease management program <sup>a</sup>	●	●	●	<sup>b</sup>	●
Health-risk assessment tool <sup>c</sup>	●	●	●	●	●
24-hour nurse hotline	●	●	●	●	●
<b>Hospital-specific quality data</b>					
Process indicators <sup>d</sup>	●	○	○	○	● <sup>e</sup>
Outcomes data <sup>f</sup>	●	●	●	●	● <sup>e</sup>
Procedure volumes	●	●	●	●	● <sup>e</sup>
Patient safety ratings <sup>g</sup>	●	●	●	○	● <sup>e</sup>
Patient satisfaction ratings	○	○	○	○	○
Links to other Web sites that contain hospital quality data	○	○	○	●	●
<b>Physician-specific quality data</b>					
Board certifications	●	●	●	○	○
Process indicators <sup>d</sup>	○	○	○	○	○ <sup>h</sup>
Outcomes data <sup>f</sup>	○	○	○	○	○
Patient volumes	○	○	○	○	○ <sup>h</sup>
Patient satisfaction ratings	○	○	○	○	○
Links to other Web sites that contain physician quality data	○	●	●	●	●
<b>General physician-specific information</b>					
Medical education information (e.g., school, year of graduation)	●	●	●	●	○
Hospital affiliation	●	●	●	○	●
Personal characteristics	●	●	●	●	●
<b>Provider cost information on plan Web site</b>					
Actual negotiated, hospital-specific payment rates	○	○	○	○	<sup>i</sup>
Average hospital payment rates <sup>j</sup>	●	○	●	●	○ <sup>k</sup>
Actual negotiated, physician-specific payment rates	○	○	○	○	○
Average physician payment rates <sup>j</sup>	●	○	●	●	○ <sup>k</sup>
Actual pharmacy-specific prescription drug prices	○	●	●	○	● <sup>l</sup>
Average retail prescription drug prices	●	○	●	●	● <sup>l</sup>

**Appendix I: Summary of Information Included  
in Decision-Support Tools Offered by CDHP  
Health Insurance Carriers**

<b>Tools</b>	<b>Insurance carrier #1</b>	<b>Insurance carrier #2</b>	<b>Insurance carrier #3</b>	<b>Insurance carrier #4</b>	<b>Insurance carrier #5</b>
Actual mail-order pharmacy prices	●	●	●	●	● <sup>i</sup>
Estimated out-of-pocket prescription drug costs	●	●	○	○	○

Source: GAO review of the decision-support tools provided by CDHP insurance carriers.

Legend:

● = Information provided

○ = Information not provided

<sup>a</sup>A disease management program is a voluntary program offered by insurance carriers for those with certain high-risk conditions, such as diabetes, asthma, and congestive heart failure. Patients generally have access to a case manager who coordinates physician care and educational materials to help them learn how to effectively manage their disease and improve their quality of life.

<sup>b</sup>This insurance carrier does not have a formal disease management program, but it offers personalized information from a health coach on major medical conditions, such as diabetes, asthma, and heart disease.

<sup>c</sup>A health risk assessment generally includes a questionnaire about health-related behaviors and risk factors that generates a report that provides guidelines on ways to reduce the risk of disease.

<sup>d</sup>Process indicators measure whether providers follow certain guidelines for care and include indicators such as the share of patients for whom recommended treatment guidelines were followed.

<sup>e</sup>For a limited list of procedures.

<sup>f</sup>Outcomes data are collected by hospitals and physicians to track patient outcomes following a treatment or procedure, such as mortality rates, complication rates, and average length of hospital stay.

<sup>g</sup>Patient safety ratings include data on compliance with safety practices, such as meeting certain staff-to-patient ratios.

<sup>h</sup>Insurance carrier currently offers physician process indicators and patient volumes for a small number of conditions in one pilot market but plans to expand in the future.

<sup>i</sup>The information provided is limited. Insurance carrier provides the actual, hospital-specific, out-of-pocket costs (based on the plan's coinsurance) for certain procedures. In cases where the out-of-pocket cost exceeds the enrollee's maximum out-of-pocket spending limit, which is very often the case, that spending limit is shown rather than the full cost.

<sup>j</sup>Average payment rates were available for a limited list of services.

<sup>k</sup>Insurance carrier currently offers a range of hospital- and physician-specific payment rates for selected procedures in one pilot market and plans to expand in the future.

<sup>l</sup>Insurance carrier shows retail prescription drug prices for enrollees in an HDHP.

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# Related GAO Products

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*Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts.* [GAO-06-271](#). Washington, D.C.: January 31, 2006.

*Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan.* [GAO-06-143](#). Washington, D.C.: November 21, 2005.

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