

A Guide For State Legislators

Creating An HSA State

A Market-based Solution to
Affordable Health Insurance
And
Lowering the Number of Uninsureds



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Health Savings Account (HSA) eligible health insurance plans have demonstrated their ability to increase an individual's involvement in making health and healthcare decisions, expand choices of affordable insurance products, lower premiums, increase payer and provider competition, and reduce the number of uninsured.

This document outlines steps State Legislatures and Insurance Commissioners can make to get full advantage of the fastest growing form of health insurance - Health Savings Accounts (HSAs) and HSA eligible High Deductible Health Plans (HDHPs).

A focus on individually owned portable health insurance with Health Saving Accounts can make insurance affordable for many uninsured low and middle income families. More than 40% of the uninsured state they do not have coverage because they can not afford the premiums. Approximately 20% of those without insurance protection are uninsured because their employer drops coverage or because of gaps in coverage while changing jobs. Family security should not be dependent on whether your employer continues to provide health insurance. Seeking another job or starting a new business should not mean losing health insurance coverage.

The ripple effect of the uninsured is felt throughout society. Uninsured children are more likely to have impaired development and poor school performance. Uninsured adults have more absences from work and greater rates of disability. A 2004 Kaiser Family Foundation national study found that the societal cost of the uninsured is \$125 billion.

This cost hits all of us, either through higher taxes or higher health care costs. Hospitals must add more than 20 percent to their charges for those with insurance in order to offset the uncompensated care costs resulting primarily from the uninsured. Regardless of how one views the issue, the cost to society is high. Without insurance, the health, lives and financial security of families are at extreme risk.

HSA eligible insurance plans have a preferred status in federal tax law. HSAs have triple tax advantages: (1) contributions are direct reductions from taxable income, (2) interest earnings are not taxable, and (3) withdrawals for healthcare expenses are not taxed. The 2006 Tax Relief Act added significantly to the amount of HSA dollars that could be saved each year. For example, with a \$1050 individual (\$2100 family) deductible HDHP, a single employee under age 55 could save up to \$2850 (\$5650 family) per year. With the "catch up" provision for HSAs, employees over age 55 can save up to \$3650 (\$6450 family) per year.

Since first passed into law in 2004, over 3.2 million HSA eligible insurance have been sold (through 12/31/2005). 35-40 percent of HSA eligible plans have been to individuals that were previously uninsured. Premiums for HSA eligible insurance plans are typically 30-40% less than traditional health insurance policies. Many who previously thought they could not afford health insurance now find that coverage is available within their budget.

2006 Treasury regulations approved even greater flexibility in using HSAs to reward and incent good health habits. Additional federal legislation to create the next generation of more flexible HSAs was approved in November 2006. Proposals to federal HSA subsidies for low income uninsureds may offer the best market-based solution to dealing with the long term problem of the uninsureds.

States should view these changes as an economic development opportunity to become a preferred state for new products and services by companies that focus on HSAs. There is a need across the country for a strong robust individual and small group health insurance market. Competition, or a lack thereof, is the major problem in providing citizens with access to new and creative insurance products. In most states, fewer than 5% of policies sold are to individuals. 70-80% of these sales are typically sold by a only few traditional insurers who sell individual policies.

Insurers, employers, and other health service vendors can only operate businesses within the allowed parameters set by federal and state legislation. Millions, if not billions, of dollars in capital are poised to create HSA products and services to address the health care cost, quality, and access problems we face as a nation. New companies and expanded operations of existing insurers are looking for supportive state legislative environments that encourage the develop and marketing of these products. The HSA market-based foundation and direction for dealing with the access and cost issues of health and healthcare has been set with federal legislation and regulation. The viability and impact of HSAs have been proven with several years of actual market experience. It will get better at the federal level, but states can now create changes that only they can make to further enhance a strong supportive Healthcare Consumerism market.

Insurance should consist of three parts - budgeting, risk sharing, and savings. For the first time in history, healthcare has a savings element. With existing HSA flexibilities, plans can use both the carrot and the stick to change and reinforce healthy behaviors. At the end of the day, empowerment and behavior change is what healthcare consumerism is all about. Without ownership, incentives, and behavior changes that benefit the health of the individual, the use of high deductible plan designs will only create more cost shifting. If healthcare consumerism is truly transformational it must address a State's most difficult health problems.

A key test for any new health system is its ability to provide affordable access to quality care for the poorest and sickest among us. The elimination of health disparities is essential. No one can be left behind. More than 18,000 people die every year because they are uninsured and get inadequate care, based on a report by the Institute of Medicine, which also found that uninsured adults have a 25 percent greater risk of dying than adults with insurance. Uninsured children are 70 percent more likely to go without care for common childhood conditions such as asthma, ear infections and sore throats.

The uninsured are also 33 percent less likely to get a routine physical examination and 25 percent less likely to visit a doctor for an illness. Uninsured women are 36 percent less likely to get a pap smear and 60 percent less likely to get a mammogram; uninsured men are 40 percent less likely to get a prostate examination.

Regardless of how one views the issue, the cost to society is high. Without insurance, the health, lives and financial security of families are at extreme risk. Eight out of 10 people who are uninsured are in working families. Even those covered through an employer are only a pink slip away from being uninsured, and more than 38 percent are worried or very worried about losing their insurance.

The Uninsured – It's Us

- **8 of 10 people who are uninsured are in working families,**
- **29 million of the uninsured in 2002 had household incomes of \$25,000 or more,**
- **45% of companies with 3 to 9 employees, and 24% of companies with 10-24 employees ...do not provide employer sponsored health insurance.**
- **10+ million (1 of 4) of the nation's uninsured either worked for a firm with 500 or more employees or were dependents of someone who worked for a large firm**

7

One-hundred percent coverage is achievable, through market-based solutions, private and corporate efforts, tax incentives, direct public subsidies, strong community support and faith-based outreach programs. Personal responsibility, individual ownership, portability and health care consumerism are the hallmarks of such a system.

If State legislatures want a market-based solution to healthcare, and not a national universal insurance system, it is imperative that they leverage existing federal HSA laws and regulations, encourage current market trends towards HSA ownership, support the consumerism concepts of personal responsibility, expand implementation of health information technology (e.g. electronic medical records), and promote transparency of health prices and provider quality. Each State has an opportunity to develop a unique approach for that state and lead the nation by example in the HSA movement. Legislators can save lives, improve health and lower costs by supporting the concept of making your state an “**HSA STATE.**”

Health Care and HSAs

This section outlines a legislative agenda that can be implemented in your current legislative session. It may also be possible to implement some of these ideas through the regulatory powers granted to your state's insurance commissioner or other legal authority.

“Health Care and HSAs” is an action plan for State legislatures that will improve health, increase choices, lower costs, and reduce the number of the uninsured. Only recently has it been possible to bring these new concepts and principles to bear on the problems of health and healthcare.

With the advent of Healthcare Consumerism, policymakers no longer need to rely on minor reforms, disconnected and contradictory policy strategies, and controversial elimination of state mandates to lower premiums. HSA eligible plans are comprehensive in coverage as defined under federal law. These are not “bare-bones” policies or limited benefit plans.

Government-based solutions to healthcare cost and access have focused on additional government programs, more bureaucracy, and greater third-party interventions. Nationally, healthcare has been described as a “right” that must be available and affordable. Without a new market-based vision, healthcare will likely head towards government defined and provided universal coverage with price controls. Fortunately, there is a new way that includes the concepts of competitive market-based reforms and personal responsibility.

Federal legislation and regulations since 2002 have set the stage for a new approach and a new language of Healthcare Consumerism. Market-based solutions based on Healthcare Consumerism have started a transformation that empowers individuals and incorporates personal responsibility, self-help, self-care, individual ownership, portability, and transparency of cost and quality information.

Healthcare Consumerism is the basis for developing a 21st Century Intelligent Health System. In a 21st Century Intelligent Health System, individuals have accurate, timely, personalized knowledge about their health and treatment options, including information about cost and quality. They have the assurance that their treatment is based on the most up-to-date evidence-based medicine, and there is a focus on preventive care and early intervention. The system encourages and rewards wise healthcare purchasing decisions and offers more choices of higher quality at lower cost. It is about engaging employees, employers, providers, carriers, and other stakeholders in a new relationship that deals with health rather than sickness and disease.

Legislation and regulation matters. Now is the time for the state legislatures to advance laws supporting Healthcare Consumerism and leverage recent federal legislation and regulation that have set the stage for effective market-based solutions. It is time for bold action based on a clear vision to improve the health of citizens in your state. Citizens elect representatives to make changes. In health care, we know that “Real change requires Real change.” The ideas in this guide represent a new approach to dealing with old problems. Healthcare Consumerism and expanded competition throughout the health system is needed to support and encourage market forces to offer the needed products, expand choices, increase access, and improve quality of services in a 21st Century Intelligent Health System.

Insurance matters. Insurance means better access to care, better access to care means better treatments, better treatments means better health. The Institute of Medicine concluded: “Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage.”

All citizens should be a part of the same health insurance system. Only when everyone has similar access will the gap in diversity of care and outcomes close. The access and delivery of care and treatments should be the same for all. Any difference should only be in the financing of the insurance. As with other necessities of life (e.g. food, housing), low income individuals may need financial support to afford coverage.

Today’s government run programs (e.g. Medicaid, Medicare, SCHIP) have evolved into segmented systems of access and care. Many high quality providers limit the number of patients they care for in government run programs. Treatment options are limited, care is restrictive, and provider reimbursements are generally lower than private market programs. These programs involve misuse of coverage (excessive use of emergency rooms), little emphasis on health (limited use of appropriate preventive care), a lack of personal responsibility (few have a primary care physician), and high levels of fraud and abuse (estimated to be 10-40%).

Federally Qualified Healthcare Clinics, Community Health Boards, and Free Clinics all offer different healthcare services using separate financing streams that generate well intended but uncoordinated care and limited access. The uninsureds have access to care that is paid by others through cross-subsidies to providers (disproportional share payments, indigent care funds, employer charges that are higher than costs, or other uncompensated care funding sources). The result is that the uninsured have inferior access, have fewer treatment options, and lack appropriate follow up services.

A Legislative Agenda

Mission – Pass laws in the State Legislature that will improve health, lower the costs of healthcare, reduce premiums for individual and small group health insurance, and decrease the number of uninsureds.

Goal – 100% coverage through market-based solutions, private/corporate efforts, tax incentives, direct public subsidies, strong community support, and faith-based outreach programs.

Vision - Create a market-based solution that provides access to health insurance for all citizens with care provided in a 21st Century Intelligent Health System.

Basic Principles

1. **Transformation to Healthcare Consumerism** – Minor tweaking and simple reform of the current system will not work. A bolder vision is needed that builds a 21st Century Intelligent Health System based on Healthcare Consumerism.
2. **Increase Choices** – Healthcare Consumerism is individual-centered where choice means personal decision options for care, treatment, providers, education, participation, lifestyle, wellness activities, and disease support programs.
3. **A Culture of Health** – A culture of health focuses on wellness and prevention rather than disease and treatments. Health activities should measure and reward participation in wellness assessments, compliance with a condition management programs (e.g. taking medications, diet, exercise, office visits), and maintenance of good health characteristics (e.g. blood pressure, cholesterol, nicotine use, body mass index).
4. **Security for the Sickest** – Any system that works only for the young, healthy, and wealthy is a system destined to failure. Health insurance is about financial security when sickness or accidents strike. Healthcare consumerism is intended to help the sickest patients to get the best care, treatment and understanding of condition through financial and information empowerment.
5. **Behavioral Change, Not Cost Shifting** - Healthcare Consumerism is more than high deductible health plans with an attached savings account. It is about transforming a health plan into one that puts economic purchasing power—and decision-making—in the hands of participants. It’s about supplying the information and decision support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and healthcare purchasing behaviors.

6. **Personal Responsibility** – Healthcare Consumerism combines personal responsibility with patient financial involvement to incentivize program participation, reward compliance, and support better personal health management. Incentives that reinforce a culture of health, well-being, self help, and shared responsibility can have a significant effect on outcomes.
7. **Build on Health Savings Accounts** – Federal legislation passed in 2003 favors the development and use of tax advantaged HSAs. State laws and regulations should leverage the transformational potential of HSA eligible HDHPs. While other products and plan designs may be helpful in dealing with health insurance issues, HSAs are a proven form of Healthcare Consumerism that represents a foundational building block for a 21st Century Intelligent Health System.
8. **Market-based** –The State Legislature should establish a supportive legal and regulatory environment that will allow the creative entrepreneurial market to develop the health insurance products and services for an effective transformation to Healthcare Consumerism.
9. **Increased Competition** – Competition in a free market is the best solution to lower prices, better service, higher quality, and more choices. New legislation and regulation is critical to increasing competition among insurers, providers, agents, and other service providers.
10. **Maximize Insurance, Minimize Third Party Reimbursements** - Third-party reimbursements foster an environment of entitlement and unlimited demand for healthcare services. Healthcare Consumerism minimizes third party reimbursements by putting financial power in the hands of consumers.
11. **Individual Ownership** - Healthcare Consumerism includes opportunities to accumulate HSA funds through “shared-savings”. That is, plan members can be financially rewarded for doing the right activities that improve their health and save money. The real value of HSAs is creating ownership that empowers individuals to make their own health and healthcare choices.
12. **Portability** – Individual policies that do not rely on employer-based insurance should be encouraged and expanded. Health insurance should not be dependent upon a job or lost when one changes jobs. States need a competitive, vibrant, and viable individual health insurance market.

13. **Transparency** – Market-based systems can only be effective with an abundance of information that is easily available and understood by consumers. If properly integrated into care, information can be as important to health and healthcare as a medical test, medication, or treatment. With good information people can achieve better health outcomes at lower costs. With good information consumers will be better equipped to fully accept their role in the world of Healthcare Consumerism.
14. **Create a focus is health (physical, mental, spiritual, and social)** – Health should be viewed as a dynamic state of well-being within an individual that includes physical, mental, social, and spiritual balance. A focus on “Health” recognizes the potential to improve the status of an individual in need regardless of the diagnosis or condition.

Health and healthcare are enormous businesses affecting communities, jobs, and individual lives. Program and legislative ideas need to be multi-faceted to address the many dimensions of healthcare. Healthcare Consumerism is a market-based approach that needs supportive State legislation to flourish. Passing programs to enable new markets is a difficult and complex process. A State legislatures can only do so much, but – IT CAN DO A LOT.

Below is a list of potential legislative and administrative changes for “Creating an HSA State.” Each state starts with a different history, culture, and level of political support for change. The list of programs is intended to spur the debate, spark creative ideas, and further the discussion on transforming health and healthcare to meet the uniquenesses of your State. The public debate, legislative process, and creative thinking on these topics will bring forth a program of transformation appropriate for your State.

The following items are common to many states. The Center for Health Transformation will maintain an updated list of additional ideas and initiatives developed by each state. The sharing of concepts and solutions for “Creating an HSA State” will be an important dynamic part of this transformational process.

Tax Policy

1. Eliminate state and other municipal premium taxes on HSA eligible High Deductible Health Plans
2. Equalize the state income tax deductibility of premiums for individually purchased HSA eligible HDHPs.
3. Incentivize newly formed small retail, service, and restaurant businesses to initiate HSA/HDHP coverage for employees by providing a lower graduated sales tax submittal rate of their first four business years (e.g. 25%, 50%, 75%, and 100%)

4. Provide tax credits to small employers offering HSA eligible HDHPs
5. Provide tax incentives to accelerate the use of electronic medical records (EMRS) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.

Insurance Reform

6. Allow HSA/HDHP approval reciprocity (or fast tracking approval of HSA/HDHPs) to increase individual health policy competition and choices from carriers operating in good standing under the laws and regulations of the state.
7. Expand the number of health insurers offering HSA eligible HDHPs by removing financial and bureaucratic barriers to new market entrants.
8. Remove state legal and regulatory conflicts to offering flexible HSA eligible HDHPs

Transparency (Right to Know)

9. Support the development of a “Health Travelocity” model for insurance products that would allow consumers to compare services provided by selling agents, covered benefits, and premium costs of products.
10. Require hospitals receiving state funds to release information on death rates and complication rates, with a guarantee that use of the data will include a fair risk adjustment.
11. Supporting the “right to know” initiative, providers could be required to disclose cost and quality information on all discharges as a condition of participation in the Medicaid or other state sponsored programs.
12. Provide quality comparisons of hospitals with simplified consumer friendly analysis capabilities.

High Risk Pool

13. Establish an HSA/HDHP “high-risk” insurance pool that requires participation in disease management programs and provides varying benefits based upon compliance with care and health outcomes.

Low Income Uninsured

14. Support charity subsidized HSAs for low income uninsureds.

15. Shift the current state subsidies uncompensated care from hospitals to a direct subsidy to the low income uninsureds.
16. Provide “health scholarships” for low income uninsured using subsidized HSA/HDHPs.

Project Descriptions

Tax Policy

Tax policy is a key tool that the State Legislatures can use to support and encourage beneficial programs. In some cases it may be the elimination or reduction of an existing tax or the granting of new tax credits. The following tax policy changes would support the movement of “Creating An HSA State”, where health insurance is made more accessible and affordable.

1. Eliminate state and municipal premium taxes on HSA eligible High Deductible Health Plans

State premium taxes average more than 2% of premiums, and can be as much as 7+% of the premium on policies sold in some States that also add municipal taxes from cities and counties. Premium taxes imposed by the state, counties and/or cities are similar to a sales tax. Premium taxes only apply to individual and insured group policies (generally small employers). Large self-insured employer plans, governed under federal ERISA laws, do not pay state premium taxes.

Premium taxes, collected from insurers, artificially drive up the cost of individual and small group insurance. Insurers simply build the cost of the tax and the cost of collecting the tax into product premiums. States with high premium taxes disadvantage their own state based companies. Those domestic state companies become subject to retaliatory premium taxes in other states where lower taxes would otherwise apply. High premium taxes have added to the reasons that some states have lost insurers and jobs. Insurers have moved operations to other states with lower premium taxes. More importantly, high premium taxes unnecessarily increase premiums, create more uninsureds, and disadvantaging consumers seeking affordable health insurance.

Unfortunately, premium taxes become ingrained in the political system and are difficult to eliminate. Because HSAs are still at a beginning stage, but are the basis for a 21st Century Intelligent Health System, State Legislatures can eliminate state premium taxes on HSA eligible High Deductible Health Plans (HDHPs) without losing any significant existing tax revenue. By taking this action now, a foundation for the future will be set for more affordable HSA products. New companies targeting HSA sales will find your state a business friendly environment from which to develop and sell HSA eligible HDHPs.

2. Equalize the state income tax deductibility of premiums for individually purchased HSA eligible HDHPs.

Individually purchased health insurance does not receive the same federal or state tax advantages as employer purchased health insurance. Federal legislation has been proposed to equalize the tax advantages by eliminating both federal income taxes and employment taxes for HDHP premiums. The proposed federal legislation would allow a reduction for HDHP premiums in the federal Adjusted Gross Income (AGI). For many states, the federal proposal would generate an automatic reduction to state income taxes. The State Legislature can get out in front of this tax equalization proposal by passing state income tax deductibility for individually purchased HSA eligible HDHPs. Adding the tax deductibility of HDHPs, HSA/HDHPs allows individual health policies to more closely parallel the tax advantages offered under employer-based coverage. This would be another step towards advancing individual policy sales and moving towards “Creating An HSA State.”

3. Incentivize newly formed small retail businesses to initiate HSA eligible HDHPs for employees by providing a lower graduated sales tax submittal rate of their first four business years (e.g. 25%, 50%, 75%, and 100%).

Service and labor jobs are less likely to provide workers with health insurance. About 63 percent of uninsured workers hold service and labor jobs, although these jobs only make up about 40 percent of the workforce.

Encouraging new small businesses to offer health insurance begins a process of dealing with the working uninsured. Incenting newly formed small retail businesses to initiate health coverage is a good investment in small business development and setting a State’s business tone for “Culture of Health.”

Supporting small business insurance coverage has payoffs for the state. Low employer-sponsored coverage can have significant impact on public programs, such as Medicaid and SCHIP, as well as state and local safety net providers that provide the services to the uninsured.

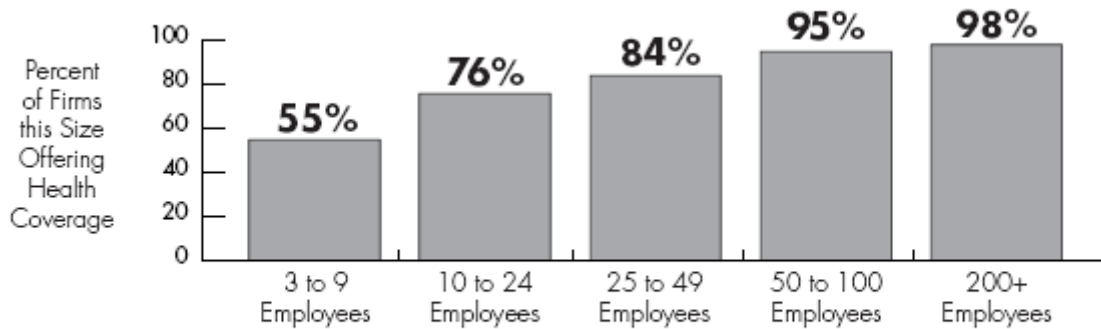
4. Provide tax credits to previously uninsured small employers offering HSA eligible HDHPs

The State Legislature should study ways to support small groups in purchasing HSA/HDHPs through tax credits or other subsidies. A three part contribution process of state, employer, and employee matching could be highly beneficial in seeding funds to leverage the market to meet the needs of uninsured citizens. An effective program of tax subsidies could lower other government supports dealing with Medicaid and/or uncompensated care.

Most uninsured are in working families. For most uninsured, at least one person in the family works either fulltime or part-time. Smaller employers are less likely to offer health insurance to their employees. Nationally, about 30 percent of workers in firms with fewer than 25 employees are uninsured.

Federal legislation has been suggested to provide a \$500 tax credit to employers who offer an HSA eligible HDHP. States can develop their own subsidy policy to encourage small businesses to offer HSA/HDHPs.

6. SMALL FIRMS LESS LIKELY TO OFFER COVERAGE THAN LARGE FIRMS



Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003" (www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185)

Evidence continues to mount on the market acceptance and success of healthcare consumerism. Milliman, one of the nation's leading actuarial firms that prices health plans for major employers and insures, showed in its 2005 annual study of healthcare premium increases:

- HMO premiums increased 8%
- PPO premiums increased 8%
- Consumerism plans with HSAs and HRAs increased 1%.

The Milliman study is important verification of what proponents of healthcare consumerism have been predicting – greater member empowerment, engagement, and lower premiums. Personal responsibility, ownership, and healthcare consumerism can lead us into a 21st Century Intelligent Health System.

5. Provide tax incentives to accelerate the use of electronic medical records (EMRS) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.

Insurance Reform

6. Allow HSA/HDHP approval reciprocity (or fast track approval of HAS/HDHPs) to increase individual health policy competition and choices from carriers operating in good standing under the laws and regulations of the state.

Legislatures should work with Insurance Commissioners to identify and accept policy approvals from other states with laws and regulations consistent with their own state. The legislature should encourage the Insurance Commissioner to develop a regional HSA market of reciprocal agreements. In addition, the Insurance Commissioner should have the authority to identify states with laws and regulations so egregious that those policies should not be sold to residents of that state.

To increase individual health insurance competition in a market typically dominated by a few carriers, the legislature should allow internet purchasing of HSA/HDHPs approved for sale in other states but not otherwise sold in their state. Allowing individual consumers to shop for a better deal in a competitive marketplace across state lines will increase the availability of health care coverage and drive down costs.

An alternative approach would be to create a “fast track” approval process so new HSA/HDHP policies with creative incentives and rewards would get immediate insurance department attention for rapid approval.

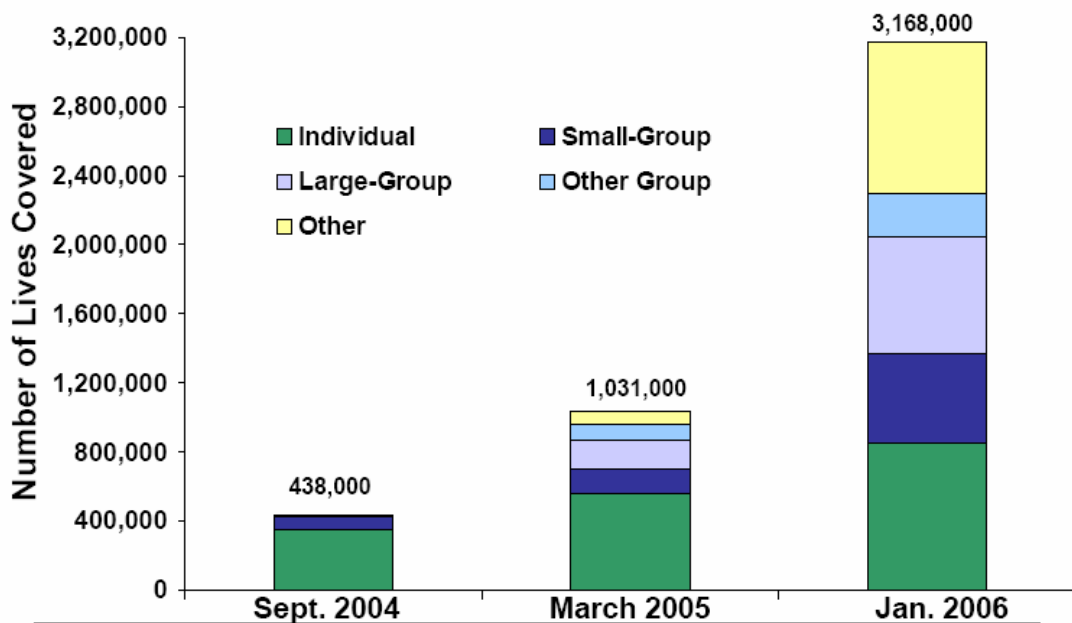
Nationally, in 2002, about 6.6% of the non-elderly population (16.5 million people) purchased individual health insurance, compared with 65.0% (163.7 million people) covered by employer-based health insurance and 16.2% (40.8 million people) covered by Medicaid or other public coverage. Another 43.3 million non-elderly Americans lacked health insurance for the entire year. The availability and prices for individual health insurance is the key to reaching the uninsured. The solution to access and cost is competition.

The biggest challenge facing the insurance market is the lack of competition for individual health insurance. Typically a few carriers dominate the individual health insurance market with 80-90% of all individual health products sold. It makes little sense for a few companies to bare the burden of developing this market. New laws can change the difficult individual market into a more conducive area for additional carriers to sell services. More competition will encourage more creative products, better services, and lower prices.

Under current laws, it is illegal to cross state borders to buy health insurance. Consumers can only buy health plans approved in their own state; however,

- New HSA/HDHP oriented companies are more likely to market to a region where one approval is widely accepted. Banks are targeting the sale of HSAs and would likely team up with new carriers to offer competitive HSA products with features not currently available.
- 82% of Americans would cross state lines in order to reduce their insurance premiums,
- 86% of Hispanics, and 85% of African Americans, were greatly in favor of this option,
- 80% of single adults and low income families support crossing state lines,
- Those with annual household incomes of \$15,000 to \$24,999 believe that crossing state lines to find lower cost health insurance is a perfectly acceptable option.

Figure 1. Growth of HSA/HDHP Enrollment from September 2004 to January 2006



	September 2004	March 2005	January 2006
Individual Market	346,000	556,000	855,000
Small-Group Market	79,000	147,000	510,000
Large-Group Market	13,000	162,000	679,000
Other Group ¹		88,000	247,000
Other ²		77,000	878,000
Total	438,000	1,031,000	3,168,000

Average Annual Premiums by State – Single Coverage, 2004

State	Policies in Survey	Average Annual Premium
New Jersey	29,198	\$6,048
Massachusetts	14,104	\$5,257
New York	5,932	\$3,743
Arkansas	1,633	\$3,435
South Carolina	6,156	\$3,328
Maryland	1,285	\$3,279
West Virginia	941	\$3,141
New Hampshire	3,348	\$3,134
South Dakota	1,944	\$3,133
Oklahoma	3,748	\$3,047
Connecticut	4,358	\$2,963
Georgia	5,742	\$2,910
Louisiana	2,541	\$2,858
Tennessee	7,647	\$2,851
Texas	27,132	\$2,836
Wyoming	1,586	\$2,734
Mississippi	3,100	\$2,729
North Carolina	13,953	\$2,623
Illinois	22,035	\$2,591
Alabama	2,415	\$2,548
Florida	162,992	\$2,539
Arizona	9,529	\$2,440
North Dakota	1,579	\$2,420
Montana	4,077	\$2,418
Wisconsin	11,876	\$2,373
Nevada	10,239	\$2,364
Virginia	50,952	\$2,332
Indiana	15,402	\$2,330
Ohio	20,043	\$2,304
Missouri	9,031	\$2,299
Nebraska	5,848	\$2,295
National	1,227,147	\$2,268
Kansas	3,835	\$2,260
Idaho	1,247	\$2,207
Colorado	16,482	\$2,198
Oregon	6,706	\$2,162
Minnesota	12,846	\$2,121
Kentucky	13,066	\$2,033
Pennsylvania	6,814	\$1,989
New Mexico	4,812	\$1,982
Iowa	6,915	\$1,965
Michigan	12,051	\$1,926
California	680,338	\$1,885

Source: America's Health Insurance Plans.

Note: Results from states with fewer than 500 policies are included in the totals, but not reported separately.

7. Expand the number of health insurers offering HSA eligible HDHPs by removing financial and bureaucratic barriers to new market entrants.

A study to identify existing barriers to market entry needs to be performed that can challenge existing status quo and can present a consumers view of “needed” protective regulations and barriers to selling products in your state.

Financial and bureaucratic barriers to new carriers entering the state should be minimized. Barriers such as banking deposits, excessive licensing costs, minimum number of employees located in the state, or any similar restrictions should be reviewed for effectiveness and appropriateness. Barriers mainly providing protection to domestic companies should be eliminated. States should create an open market, an easy environment to create jobs, sell health insurance, and build a profitable insurance business. Needed protections for policyholders should not be compromised, but any barriers not meeting a strict standard of benefiting the consumer should be removed.

8. Remove state legal and regulatory conflicts to offering flexible HSA eligible HDHPs

Certain state policy requirements and mandates should be removed so that the citizens of the State can purchase cost effective HSAs. For example, the states require out-of-network (OON) benefits to be paid at a coinsurance level of at least 60%, regardless of the level and access to care within a negotiated discount network. Other states allow from 50% to 0% for OON reimbursements under a HDHP HSA eligible plan design. The OON coinsurance requirement in a state can raise the cost of purchasing HDHPs.

A study may be needed to identify other areas where state regulations adversely affect premiums. In some cases, mandates may prevent a more cost effective product from being offered. Some states allow “bare-bones” policy designs, but few sales have been developed using this flexibility. Consumers expect certain core benefits in a “comprehensive medical plan.” The actuarial truth is that mandates do not add much to costs, and the elimination of coverage for inter-related conditions may increase overall costs of care to the affected policyholder (e.g. depression as a co-existing condition with diabetes).

Transparency (right to Know)

9. Support the development of a “Health Travelocity” model for insurance products that would allow consumers to compare services provided by selling agents, covered benefits, and premium costs of products.

The Legislature could provide for a state managed and/or privately run consumer “Health Travelocity” that offers complete and transparent health insurance information on premiums, benefits, coverage, and network providers. Clear comparison of products, exclusions, limitations, and other plan design comparisons should be as available as airline and hotel information on Travelocity or Orbitz.

Recent surveys of uninsured individuals and small businesses indicated a major problem is the lack of knowledge about affordable HSA/HDHPs. When asked how much the employee and employer could contribute to a health insurance policy, the answer turned out to be more than enough to purchase HSAs available in the market.

Carriers are now developing new healthcare consumerism products at lower costs with more choices. In 2004, Aetna consumerism plans showed cost increases of only 1.5% versus increases of more than 10% for traditional health plans. Employers that offered only consumerism plans had an average decrease in premiums of 2.9%. Similarly, United Health Care showed average cost increases of less than 1% for consumerism plans. Humana, Blue Cross Blue Shield, and other health insurers are finding similar results from their new consumerism products.

Insurers and large employers have shown the way to healthcare consumerism. Now small employers and individuals are beginning to experience the benefits of consumerism. Assurant Health reports that 43% of HSA applicants were previously uninsured. Affordability is the key. 71 percent of people who bought HSAs from Assurant Health paid premiums of \$100 per month or less. Golden Rule, another company offering HSAs, stated the majority of enrollees (52.83 percent) paid between \$51 and \$100 a month. On average, Golden Rule's customers saved 45-55 percent on annual insurance premiums. Forrester Research predicts 24% of Americans will be covered under consumerism plans by 2010.

Healthcare Consumerism can only work in a free competitive market with lots of comparative information. Information on cost, quality, service, and knowledge of health insurance is needed to reach consumers in a plain and simple way. Other industries have been using consumerism for years, it is time for healthcare to be included. The state legislature can support these efforts to benefit all citizens.

10. Require hospitals receiving state funds to release information on death rates and complication rates, with a guarantee that use of the data will include a fair risk adjustment.

The State Legislature could provide all citizens with critical mortality and complication rate information on providers for over 259 separate conditions requiring hospitalization. Citizens could have unlimited access to quality information on hospitals, whenever the need arises. Independent monitoring services and the media would have unlimited access to quality results to assure public knowledge and understanding of best practice facilities.

The data is publicly available for all Medicare discharges (Based on hospital required submittals for Medicaid patients). Similar information is available for all hospital stays, but in many states the information has been held as proprietary by the individual hospitals and the hospital associations. It is time that the consumer's "Right to Know" be recognized as more important. Hospitals can be ranked based upon their performance as compared to the average performance of all hospitals in the State.

There are four basic quality indicators used by insurers to rank hospital quality:

- 1) Volume - the more often a hospital performs a certain treatment, the better it gets
- 2) Mortality - deaths that occur in the hospital during a procedure or treatment
- 3) Major Complications - the occurrence of problems such as blood clots and infections
- 4) Failure to Rescue - deaths that occur in the hospital after a major complication

Many hospitals treat very sick patients that other hospitals cannot treat. To be fair, all of the metrics should be risk adjusted to account for the age of the patient and severity of the case. In healthcare, we have tolerated a shrouding of the variance in quality that is unacceptable. If the system can be driven to consistently deliver the quality that it is capable of, there will be tremendous savings in lives and money. A successful transformation strategy must deal with the forces which have kept the provider adoption-rates of best quality practices 25-35 times longer than industries which must compete on value.

11. Supporting the “right to know” initiative, managed care organizations could be required to disclose cost and quality information as a condition of participation in the Medicaid.

Following the 2006 Presidential executive order for federal programs to disclose cost and quality information, state should make available all payment information to providers based on contracts with state employee benefit programs and state Medicaid programs. Providers not willing to release this information should be excluded from the program(s).

12. Provide quality comparisons of hospitals with simplified consumer friendly analysis capabilities.

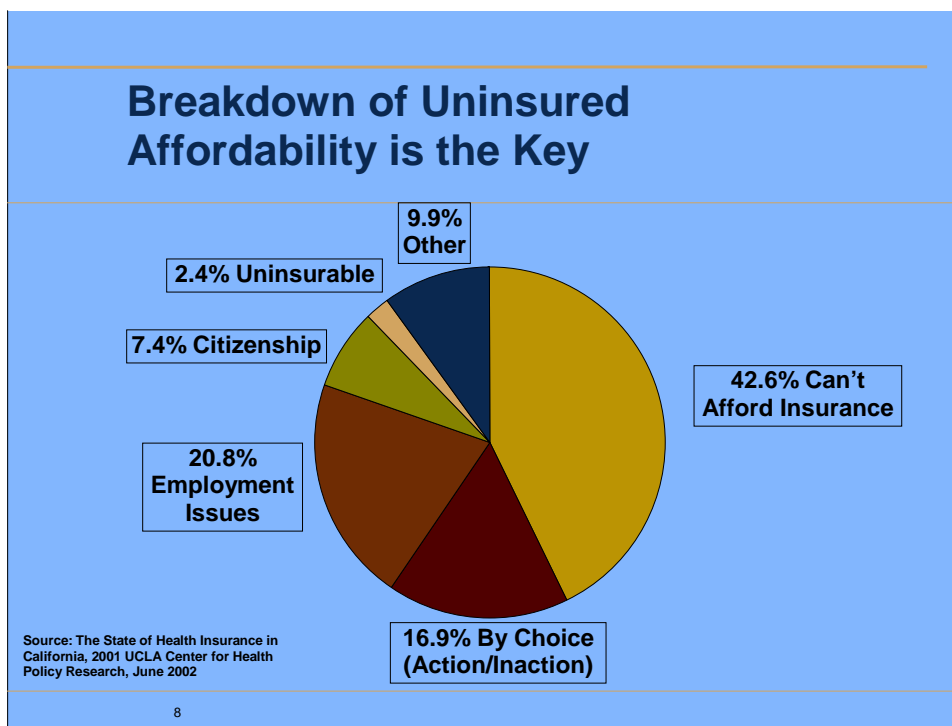
Consumer-friendly and simple to use tools are available to help make a important healthcare decisions. If a patient needs hospital care, they can use this information along with advice from doctors and other trusted sources help patients to choose a facility that is right for them. If a patient is concerned about the rankings, they can ask their doctor for more information and what they can do to make sure they get high quality care. Patients can call hospitals to find out what is being done to improve performance. This information and quality results are meant as a tool to help individuals make choices and manage their health and healthcare. It is not meant to generalize about the overall quality of a hospital. Instead, it is meant to be used to examine hospital performance in specific categories.

Consumers are taking a more active role in managing their own healthcare. In order to make informed decisions, such as where to get high quality and cost effective care, consumers need access to accurate, timely information and tools. Some states, like Florida, create a state agency to provide this type of information. Others can outsource the quality comparison tool to one of the commercially available sources that are already used by providers and insurers. There is no need for a state to create a bureaucracy to get this information into the hands of its citizens.

High Risk Uninsured

13. Establish an HSA/HDHP high-risk insurance pool that requires participation in disease management programs and provides varying benefits based upon compliance with care and health outcomes.

States can establish HSA/HDHPs as the basis for providing health insurance to individuals who are uninsurable (can not meet insurer underwriting standards). “Truly uninsurables” represent a relatively small percentage (2-3%) of the population.



A significant number of applications for individual health insurance never make it to the medical underwriting process. Overall, approximately 15 percent of total applications received were either not processed or denied for non-medical reasons; the remaining 85 percent went through the medical underwriting process and resulted in an “offer of coverage.”

87.6 percent of those processed through medical underwriting are offered coverage. Coverage offerings vary by age, ranging from 95 percent for people under age 18 to 70 percent for people aged 60-64. Only 2-3% are truly uninsurable, yet more than 12% are rejected for coverage.

Uninsurable individuals and those eligible under HIPAA and HCTC do not come from any particular sector of society. Mostly, they are hard working individuals and families seeking to provide for and pay for their own health insurance, but who, through no fault of their own find themselves in a situation where they cannot obtain coverage at any price. The insurance underwriting process of “cherry picking” must be altered for the consumer to truly have options in a 21st Century Intelligent Health System.

No one wants to legislate underwriting standards. Companies should be able to continue to develop proprietary internal standards. However, a viable individual market can not exist if only the young and/or healthy can purchase insurance. One approach to resolve this dilemma is to establish a private/public partnership that reviews rejected applications to determine if the applicant among the 2-3% that is truly uninsurable. If the applicant is truly uninsurable, they will be offered coverage in the state high-risk pool. If not, they will be assigned to a private market carrier.

Carriers rejecting applicants will be required to accept an equal number from the screening process for the high-risk pool. Carriers rejecting relatively good risks may find that they get a much worse risk in return. By using market forces in this way, carriers will begin to accept more applicants and underwriting standards will be moderated in favor of the consumer without state laws or regulations setting company underwriting procedures. This process will maximize private market coverage of health insurance and minimize the number of lives qualifying for the state high-risk pool. In an ultimate system of expanded access to insurance in a competitive market, there will be NO uninsurables because everyone will have coverage that is portable and sustainable as an individual policy.

Because of the higher costs associated with those qualifying for the high-risk pool, states generally subsidize premiums. Some states have resisted this approach as too expensive. With traditional insurance and regular high-risk pooling plan designs and administration, the cost of high-risk pool subsidies seems financially and politically untenable in some states.

There is a new approach. Using Healthcare Consumerism and new federal laws and regulations, an HSA/HDHP model can be implemented that transforms the concept of a high-risk pool into a more realistic and cost effective solution.

An example of what a health HSA/HDHP high-risk pool coverage might include is the following:

- 1. Plan Design** – Using federal HSA/HDHP requirements, provide a choice of HDHPs with deductibles from \$2850 to \$5,650 per person. Maximum OOP: \$5500 (2007 standards). Maximum coverage from \$250,000 to \$1,000,000.
- 2. Health Management** – Provide a deductible credit of \$250 for each condition satisfied: (1) Body Mass Index; (2) Blood Pressure; (3) Cholesterol; and (4) Nicotine use.
- 3. Disease Management** –Compliance awards for participation and outcomes.

4. HSA Amounts – No initial contribution by the state, but open to individual and charity contributions. State could make compliance awards based upon improved health outcomes and “shared savings.”

5. Distribution system – traditional agent/broker sales, no-low commission internet sales, and faith-based outreach.

6. Administration – Carrier based networks, best of practice wellness and disease management, enrollment, account management, and integration of program through a general manager / health plan integrator administrator.

Low Income Uninsureds

14. Support charity subsidized HSAs for low income uninsureds.

HSAs are structured so that any interested party can contribute to the HSA with the covered individuals receiving the tax deduction. Charities and other eleemosynary organizations can add to the HSA subsidy. By including these and faith-based organizations in helping low-income uninsured a community-wide effort can be enlisted to energize a unique approach to the uninsureds.

15. Shift the current state subsidies to hospitals for uncompensated care to a direct subsidy to the low income uninsureds.

Rather than paying hospitals a subsidy for providing uncompensated care, the state should shift those dollars to direct subsidies for low-income uninsureds. The fastest growing segment of uninsureds are individuals making over \$50,000 per year. Disproportional Share payments and uncompensated care may include a sliding income scale, but these hospital subsidies are inefficient because they do not target those most in need of financial support. There is also a concern that hospital uncompensated care is overstated by measuring “retail” prices rather than the true cost of care. By expanding insurance coverage to a larger portion of the population there will be less uncompensated care and less need for the indirect subsidies.

Saving Health Less Care for the Uninsured

Children - 70% more likely to go without care for common childhood conditions such as asthma, ear infections, and sore throats
- 5 times more likely to have an unmet need for medical care each year

Women - 36% less likely to get a pap smear, and 60% less likely to get a mammogram

Men - 40% less likely to get a prostate examination

General - 33% less likely to get a routine physical exam, and 25% less likely to visit a doctor for an illness.

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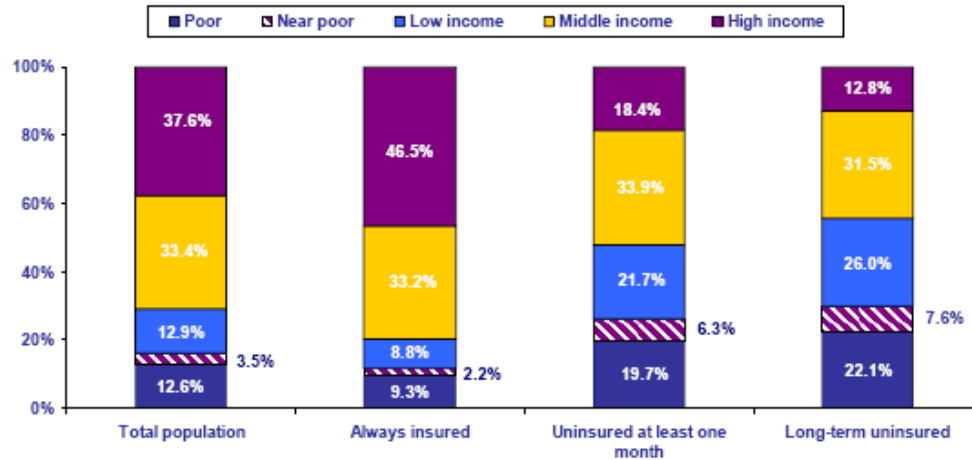
16. Provide “health scholarships” for low income uninsured using subsidized HAS/HDHPs.

Individuals with lower incomes (i.e., persons in families with income up to 200 percent of the poverty line) were disproportionately represented among the long-term uninsured over the two-year period 2002 to 2003. While poor, near poor, and low income individuals represented 12.6, 3.5, and 12.9 percent, respectively, of the population, they represented 22.1, 7.6, and 26.0 percent, respectively, of the long-term uninsured population.

In contrast, individuals with high incomes (i.e., persons in families with income over 400 percent of the poverty line) were disproportionately represented among those having health insurance throughout 2002 and 2003. Those with high incomes represented 37.6 percent of the population, but they accounted for 46.5 percent of the always insured.



Figure 4. Distribution of population and health insurance status by poverty status, U.S. civilian noninstitutionalized population under age 65, 2002 to 2003



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, HC-070 (2002), HC-079 (2003), and HC-080 (Panel 7)

Poor: income less than or equal to the poverty line; includes those who had negative income.

Near poor: income over the poverty line through 125 percent of the poverty line.

Low income: income over 125 percent through 200 percent of the poverty line.

Middle income: income over 200 percent through 400 percent of the poverty line.

High income: income over 400 percent of the poverty line.

Low income by itself does not qualify a person for most public programs. For example, low income childless adults who are not veterans may not qualify for public assistance. The “Low Income Not Eligible for Public Programs” (Not Eligible) includes those who fail to meet non-financial criteria that these programs require.

Listed below are some of the non-income eligibility criteria that may be required by public programs:

1. Low Assets	6. Under an Age Limit for Children
2. Large Family Size	7. Disability or Blindness
3. State of Residence	8. Citizenship or Residency Status
4. Pregnancy for Women	9. Military Service
5. Marital Status	10. High Medical Expenses

Federal legislation has been proposed that would provide low income uninsured a subsidy to purchase as HSA eligible HDHP. States can take the lead by establishing a Healthcare Consumerism a program for “health scholarships” that include private, charity and state subsidized coverage for low income participants.

