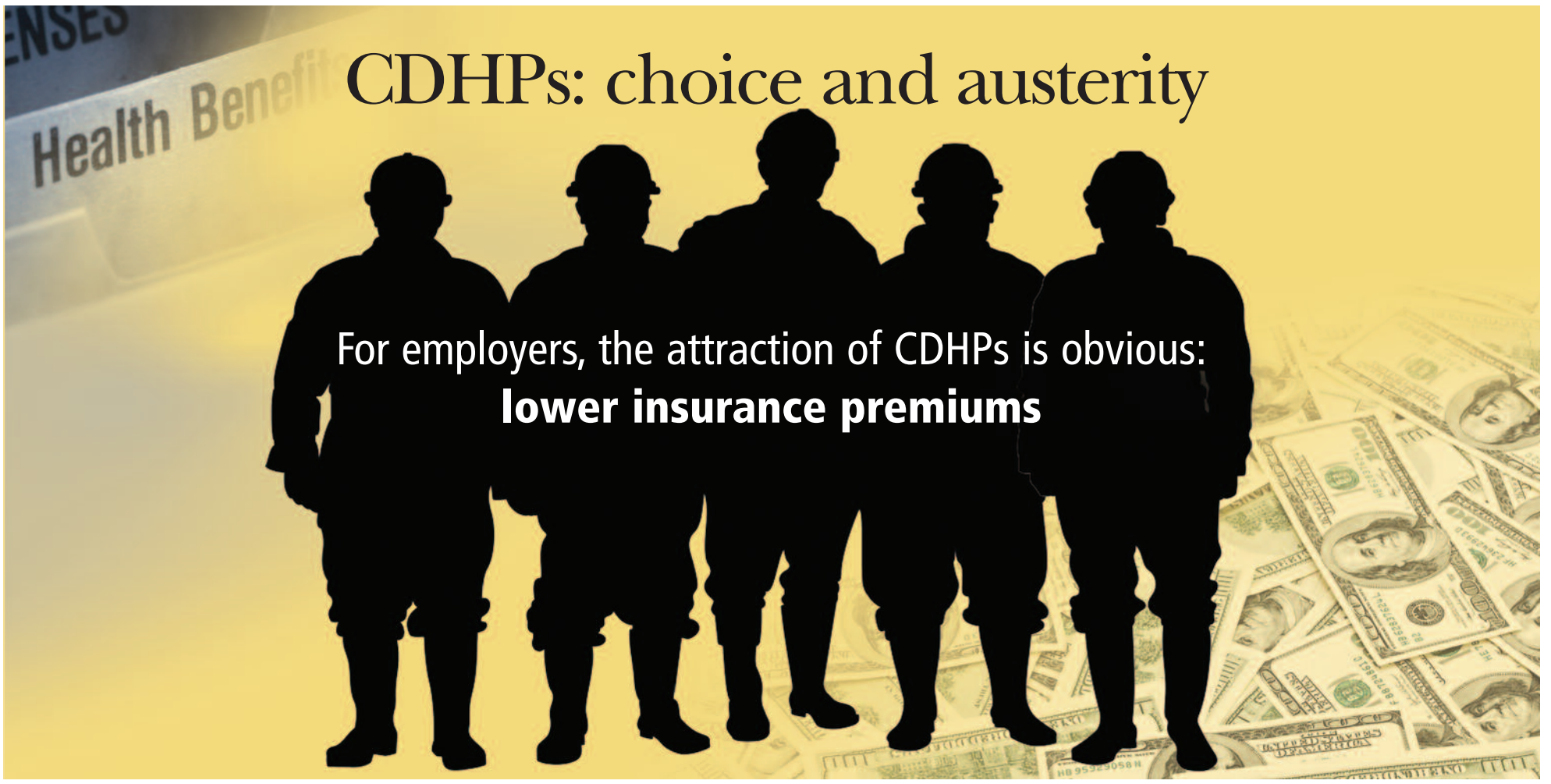


By PHIL DAVIES
Senior Writer

Over the past decade consumer-driven health plans (CDHPs) have caught on with employers as a way to reduce the costs of providing health care benefits—primarily by making employees responsible for a larger share of their medical expenditures.

CDHPs include health reimbursement arrangements (HRAs), employer-funded plans that give workers money to put toward insurance premiums and out-of-pocket medical expenses, and health savings accounts (HSAs), tax-exempt funds owned by employees that can be used to pay for health care. Both employers and workers can contribute pretax dollars to an HSA.

HSAs, and often HRAs, work in tandem with health insurance policies carrying high deductibles, either sponsored by the employer or purchased by the worker in the individual insurance market.

Since 2003, when Congress created HSAs, consumer-driven plans have grown from a niche product into a common approach to packaging health care benefits. In a survey by the Kaiser Family Foundation and the Health Research & Educational Trust, 15 percent of U.S. firms reported offering high-deductible savings plans last year, up from 4 percent in 2005. CDHPs were most popular with large employers with 1,000 or more workers; about one-third of firms with 1,000 or more workers sponsored such plans last year.

Another survey of HSA usage by America's Health Insurance Plans, a national trade association for health insurers, found that 10 million people nationwide were covered by such plans last year, a 25 percent increase over 2009. Among district states, HSA enrollment was highest in Minnesota—about 361,000 workers and their dependents. In that state and in Wisconsin and Montana, HSAs accounted for a larger share of private health insurance coverage than in the country as a whole (see chart).

For employers, the attraction of CDHPs is obvious: lower insurance premiums. With both types of plan, an employee pays medical bills out of his or her account—or, if necessary, the employee's own pocket—until the insurance deductible is met. For HSAs, that bar is set fairly high—the legal minimum for family coverage in 2010 was $2,400. Lower premiums help employers to maintain coverage for their workers, even if it's only catastrophic coverage.

For workers and self-employed individuals, such plans are tax-advantaged savings vehicles; any unspent funds can be rolled over to the next year or banked for retirement.

CDHPs and high-deductible plans in general also hold out the promise of cutting overall insurance and health care costs. By giving consumers more control over health care expenditures, the plans encourage them to spend more judiciously, seeking treatment only when necessary and comparing prices for prescription drugs and other medical goods and services.

"A high-deductible plan allows you to have choice, yet at the same time fiscal austerity," said Stephen Parente, a health finance expert at the University of Minnesota who himself has an HSA to pay family health expenses.

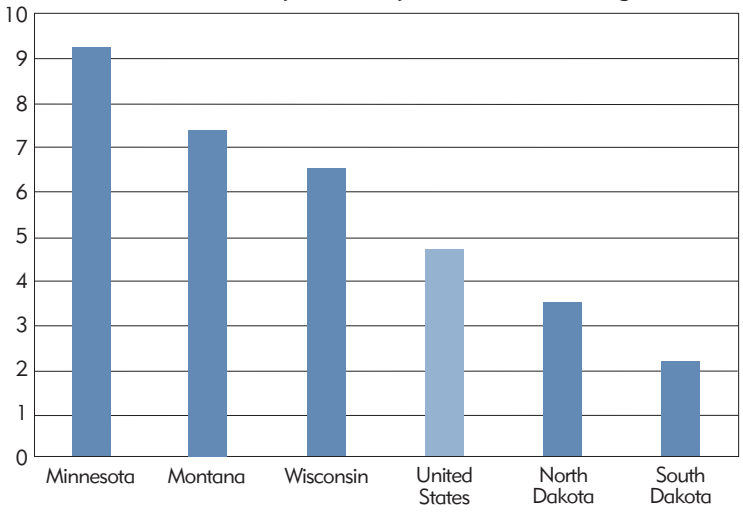
In principle, consumers facing a larger share of health care costs should help control costs and reduce insurance premiums. A number of studies have found that CDHP enrollees spend less on health care than people in health plans with lower deductibles. But research into the cost effectiveness of CDHPs has also raised questions about the long-term impact of such plans on overall health care spending.

A recent study by Parente and other University of Minnesota researchers looked at employee health spending by four large companies that switched to CDHPs from traditional health plans. The study found that while employees' health care spending dropped, they used less preventive care than before.

Less preventive care can save money, because not every screening or procedure is medically necessary. But by giving workers an incentive to skip certain screenings for serious health conditions such as cancer and diabetes, some health experts believe that CDHPs may increase total health care costs—and insurance premiums—down the road. f

HSAs popular in some district states

HSA enrollment as a percent of private health coverage, 2010



Source: AHIP Center for Policy and Research, 2010 HSA/HDHP Census, May 2010

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There's the rub with public health insurance: Some firms and workers may opt to drop workplace coverage, preferring to shift insurance costs to taxpayers. Likewise, the unemployed or low-wage workers who aren't offered insurance by employers may spurn individual policies in favor of cheaper public programs. In either case, some increased enrollment in public programs comes at the expense of private coverage instead of reducing the number of uninsured.

There's anecdotal evidence of such "crowding out" of private insurance in some states. In Massachusetts, insurance brokers reported last year that some small businesses had dropped coverage and encouraged workers to enroll in Commonwealth Care, the state's subsidized insurance program.

But economic studies of state-sponsored insurance programs have found mixed evidence for crowding out. A 2006 study by researchers at the Urban Institute in Washington, D.C., concluded that expanding coverage to parents in California and New Jersey eroded private coverage. Other studies have indicated that the degree to which it occurs depends on how public insurance plans are designed.

MinnesotaCare and, to a lesser extent, BadgerCare Plus, have provisions intended to prevent inroads into private coverage. MinnesotaCare applicants, for example, are ineligible if they've been offered workplace coverage anytime in the last 18 months. How successful these measures are at preventing crowding out is unclear.

For state lawmakers, a more pressing issue raised by expansive public insurance programs is their costs. Spending on such programs in Minnesota and Wisconsin dwarfs state government outlays in other district states, both in absolute dollars and as a share of the total state budget. For example, Medical Assistance and other government insurance programs cost Minnesota taxpayers about $3.4 billion in fiscal 2010—roughly 17 percent of overall state spending. That level of expenditure is more than three times what residents of the Dakotas and Montana pay, in proportion to total state spending.

Strained budgets due to lingering economic malaise have made it harder for states to justify continued support for expensive public insurance coverage. In Wisconsin, enrollment in the BadgerCare Plus Core plan for childless adults was frozen in 2009 because of a state Medicaid deficit; this past February, the deficit stood at $153 million for the 2010-11 biennium. Roughly 100,000 applicants are on a waiting list. In Minnesota, state budget woes have cast doubt on the state's ability to continue to fund MinnesotaCare and the expanded Medicaid program.

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Even district states with less costly public health plans are reevaluating their commitment to covering the poor. In South Dakota, lawmakers are weighing a proposal by Gov. Dennis Daugaard to slash state Medicaid reimbursements to providers by 10 percent. Such a cut could induce some doctors and clinics to turn away Medicaid patients.

ACA: An uncertain prognosis

In any discussion of health insurance, one topic dominates: the Patient Protection and Affordable Care Act, enacted by Congress a year ago. The law has provoked staunch opposition; the Republican-controlled U.S. House has vowed to repeal it, and attorneys general in Wisconsin, North Dakota and South Dakota are involved in federal lawsuits challenging its constitutionality. These and other district states may reject some or all aspects of the federal effort to revamp the health care system.

If ACA is fully implemented—its major provisions go into effect in 2014—analysts expect it to significantly increase health insurance coverage. In the district, the impact of enhanced Medicaid coverage, an individual mandate to buy insurance, subsidies for small businesses and other features of the law will be greatest in states such as Montana and South Dakota that currently have relatively high rates of uninsured. But the degree to which ACA will boost coverage in the district is as uncertain as the prospects for survival of the law itself.

One large and predictable effect of the law is expanded public coverage for low-income people. In 2014, all states will be required to meet a new income eligibility standard for Medicaid: Parents and childless adults may have incomes up to a third above the FPL to qualify for aid. The new standard will dramatically loosen Medicaid eligibility requirements in Montana and the Dakotas, where a sizable portion of the nonelderly population falls below that income threshold.

An analysis of the impact of ACA on Medicaid coverage by the Kaiser Family Foundation estimated that in South Dakota, the law will add 31,000 people to the state's Medicaid rolls by 2019, reducing the number of low-income uninsured adults by more than half. Montana would see a slightly smaller proportional drop in uninsured adults below 133 percent of the FPL.

But health policy experts expect the Medicaid expansion to increase coverage to a lesser extent in Minnesota and Wisconsin, where eligibility ceilings for Medicaid and other public insurance programs are higher. In Minnesota, many low-income people currently enrolled in MinnesotaCare may switch to Medicaid under ACA—saving them premium expenses but not shrinking the number of uninsured in the state.

To what extent the law will stimulate or erode private health coverage in district states is harder to gauge. Much depends on how individuals and firms in different markets respond to the various incentives and penalties embedded in the law.

As its creators envisioned, ACA may increase private coverage by fostering competition, rooting out inefficiency and encouraging individuals and small businesses to buy insurance.

Beginning in 2014, individuals and small businesses will be able to purchase insurance through regional health care exchanges, marketplaces set up by states to certify health plans and allow consumers to directly compare benefits and prices. Federal tax credits will subsidize premiums for individual policies purchased by lower-income people through exchanges.

However, market responses to the law may partially offset gains in private coverage due to tax breaks or more transparent prices, or even reduce private coverage. For instance, some people—particularly those whom Johnson of the Insurance Federation of Minnesota calls "the young and invincible," may opt out of the individual mandate, preferring to pay a penalty instead.

And employers struggling to pay insurance premiums might drop coverage, leaving employees to shop for subsidized insurance in the exchanges or sign up for Medicaid. The Congressional Budget Office has estimated that 8 million to 9 million workers nationwide—mostly in small firms that pay low wages—will lose their workplace coverage because of such cost shifting under ACA.

Hey, if they can cure cancer …

Paying for health insurance—both private and public—is likely to become more difficult if health care costs are not contained. Rising health care expenses put upward pressure on premiums and out-of-pocket expenses, making coverage more expensive for employers and individuals. Higher costs also increase the burden shouldered by taxpayers to support public insurance programs such as Medicaid and MinnesotaCare.

But cutting health care costs is a tall order because trends in the sector, including expensive new medical technology and a wave of aging baby boomers with chronic diseases, are pushing in the opposite direction. "Cost pressures are going to continue to erode the market," said Jean Abraham, a health insurance expert at the University of Minnesota.

Short of some medical breakthrough like curing diabetes or heart disease, the most likely path for reining in health care costs is to chip away at the margins—employing a variety of strategies that not only shift costs or cut regulatory expenses, but also achieve measurable reductions in spending on medicines and treatments.

Recently, insurers have started to pay incentives to medical providers that succeed in cutting costs while keeping patients healthy. In Minnesota, HealthPartners, Medica, and Blue Cross and Blue Shield—the three biggest health insurers in the state—have signed such incentive contracts with providers over the past three years.

Other approaches to reducing medical expenditures and insurance premiums include corporate wellness programs and value-based insurance design—lowering deductibles and copays for medicines that keep patients with serious, chronic illnesses out of the hospital.

But none of these strategies has a long enough track record to show that it can significantly reduce health care costs, keeping insurance premiums in check. "I don't think there is any single magic bullet for slowing the growth of health care costs," Abraham said. "These are incremental changes." f