Guarding Against The High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*

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I. Introduction

Under the rubric of "consumer-driven health care," insurers, employers, and policy-makers are experimenting with new types of health insurance products, namely "high deductible health plans" ("HDHPs"). HDHPs allow consumers to purchase health insurance with deductibles that might range from $1000-$5000 for individuals and $2500-$10,000 for families[1] (and can reach even higher amounts if not coupled with federal tax incentives). A deductible is defined as the amount that the insured individual must pay for medical costs before the insurance company is required to pay for the costs of health care.[2]

[1] 26 U.S.C. § 223(c)(2)(A).

[2] There are exceptions where the insurance companies will provide "first-dollar coverage" for preventive care (Id. at § 223(c)(2)(C)) which will be discussed below, infra Section II.

While federal tax law provides tax exemptions to promote such plans by allowing consumers to couple them with health savings accounts ("HSAs"), their existence does not depend on the federal tax law nor on consumers' choice to fund the HSAs.[3] Rather, the growing trend in the insurance market to offer HDHPs reflects a reality that is less about consumer choice and more about consumer risks.[4] HDHPs represent yet one more market reaction to run-away health care costs and can best be described as the "hot potato" approach to health care spending: Pass along the risks of the high costs associated with constantly rising health care spending increases to consumers without addressing the underlying causes of health care inflation.[5]

As these products appear, it is critical that we understand that as much as the rhetoric focuses on expanding consumer choices, the appearance of HDHPs on the market actually narrows and obscures not only consumer choices but the ability to pursue sound policy in this area. Moreover, they are creating risks in a regulatory vacuum. This article sets out a two-fold framework for addressing the

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[3] In fact, 90% of consumers electing HDHPs who have the option of funding an HSA have failed to do so. Paul Fronstin & Sara Collins, "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumers in Health Care Survey," EBRI Issue Brief No. 288 (Dec. 2005) at 5 (www.ebri.org).

[4] See Wendy Mariner, "Can Consumer-Choice Plans Satisfy Patients?", 69 Brook. L.Rev. 485 (Winter 2004) at 541: "Consumer-choice plans shift responsibility for saving the system money from employers and insurers onto consumers…" See also, id., at 507, referring to Alain Enthoven's dismissal of "consumer-choice" plans as a euphemism for "ordinary health insurance with a high deductible" (citing Alain C. Enthoven, "Employment-Based Health Insurance is Failing: Now What," Health Affairs, May 28, 2003, at W3-239 at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1.pdf); and Karen Davis, Michelle Doty, and Alice Ho, "How High is Too High? Implications of High-Deductible Health Plans," The Commnwealth Fund Pub. No. 816 at 16: "The major effect of a high deductible is likely to be a one-time shift in spending from premiums to patient out-of-pocket outlays. Premiums to employers and workers would be reduced by 10 to 15 percent … but most of that reduction would be a reduction in covered medical outlays and a shift to out-of-pocket expenses for which patients would be responsible."

[5] See, generally, John V. Jacobi, "Consumer-Directed Health Care and the Chronically Ill," 38 Univ. of Michigan J. of L. Ref. (Spring 2005) at 535-547 for a discussion of the market-based reforms that have substituted for systemic policy yet have failed to constrain costs or stem the rise in the uninsured.

rhetoric versus the reality of consumer choice in this area. First, after describing the types of products and the experience to date, this article will address three fundamental myths that are promoted by the proponents of such plans: 1) the myth of discretionary health care spending; 2) the myth of discretionary income for health care spending; and 3) the myth of consumer power to negotiate over and make an impact on the costs of health care. In fact, this article will discuss a fourth myth that is not so much promoted by HDHP proponents as presumed: consumer choice over the selection of health insurance products and over how their collective risks are "pooled." Confronting these myths is critical to understanding why consumers require protection. If HDHPs are allowed to be marketed freely without addressing the myriad risks they pose to consumers, consumers will become increasingly "under-insured," meaning that despite having insurance, they will be faced with health care costs they cannot afford; and increasingly uninsurable, meaning that as consumers develop health care problems, the only products left to cover them will themselves be unaffordable. Therefore, the second part of this article will propose model regulatory solutions to protect consumers from the risks actually posed by these plans.

II. Background

The term "HDHPs" will be used broadly to refer to any plans that offer "high deductibles" which, for the purpose of this article, will include any amount

higher than $1000.[6] They have emerged in part as a result of federal tax exemptions for HSAs but in reality, can be and are marketed separate and apart from such HSAs. Nevertheless, this article will first describe the basic structure under federal law. In 2003, Congress adopted the Medicare Modernization Act which added section 223 to the Internal Revenue Code[7] in order to promote the marketing of HDHPs by offering tax benefits for contributions and earnings on Health Savings Accounts.[8] The basic structure is that consumers may establish HSAs with pre-tax income and can use savings in the HSAs to meet qualified health care expenses without paying a tax on the funds spent.[9] However, HSAs only can be offered if the employee has elected to use the funds in conjunction with an HDHP that meets the federal legal requirements and that is the only type of health insurance being used by the consumer.[10] Specifically, the minimum and maximum deductible amounts under the federal law are: $1000-$5000 for

[6] While the federal law provides minimum and maximum amounts, there are no consistent definitions under state law.

[7] 26 U.S.C. § 223. These built on the experience of prior "Archer" medical savings accounts which were limited in scope and have been phased out. See Amy Monahan, "The Promise and Peril of Ownership Society Health Care Policy," 80 Tulane L. Rev. (forthcoming 2006) at fn. 11.

[8] 26 U.S.C. §§ 233(e)-(f). Timothy Jost and Mark Hall have noted that this legislation is one of the major federal health policy initiatives of our time, and as such, is a unique exercise of "federalism" in the health care arena: The law neither compels states to require insurers to offer these products nor does it prohibit states from blocking such products; rather, "[i]t simply makes it clear that states that prohibit such policies will deprive their residents of access to a generous federal tax subsidy." Timothy Jost & Mark Hall, "The Role of State Regulation in Consumer-Driven Health Care," 31 Am. J. L. & Med. 395, 400 (2005).

[9] 26 U.S.C. §§ 233(e)-(f). Employees who are offered HDHPs at work are eligible to have employers also contribute amounts to the HSAs. Id. at § 223(a) (contributions may come from others on "behalf" of the taxpayer); see also Internal Revenue Bulletin 2004-2 (Jan. 12, 2004), "Health Savings Accounts," at Q-ll (http://www.irs.gov/irb/2004-02_IRB/ar09.html).

[10] 26 U.S.C. § 223(c)(1). There are exceptions for insurance for accidents, disability, dental care, vision care, and long-term care. Id. at § 223(c)(1)(B).

individuals and $2500-$10,000 for families.[11] These amounts are amounts that consumers will pay toward their health care that is additional to the amounts charged for the premiums, and once insurance kicks in, additional to the amounts charged for "cost-sharing" in the form of either co-payments or percentages of charges.

There are a couple exceptions to the basic structure. First, insurance companies may exclude certain preventive care expenses[12] from the deductible which means that the insurance company actually will provide coverage for such amounts even if the deductible is not met (referred to as "first dollar coverage"). First dollar coverage for preventive care, however, is not mandatory; i.e., it is at the plan's discretion whether to exempt preventive care from the deductible amounts.[13] In fact, IRS interpretation of federal law states that there will be no deference to state law that requires insurance companies to provide first dollar coverage for certain types of care that are broader than the narrow federal definition of preventive care.[14]

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[11] Id. at § 223(c)(2).

[12] 26 U.S.C. § 223(c)(2)(C). Preventive care is defined as including but not being limited to: periodic health evaluations, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs, and a variety of screening services for cancer, heart and vascular diseases, infectious diseases, mental health conditions and substance abuse, metabolic, nutritional and endocrine conditions, musculoskeletal disorders, ob/gyn conditions, pediatric conditions, and vision and hearing disorders. Internal Revenue Bulletin 2004-15 (April 12, 2004), "Health Savings Accounts—Preventive Care," pp. 2-3 (http://www.irs.gov/irb/2004-15_IRB/ar10.html). However, preventive care does not include any service or benefit intended to treat an existing illness, injury or condition. Id.

[13] Internal Revenue Bulletin 2004-15 (id.) at 1.

[14] Id. at 2. Note that federal guidelines provided a grace period which now has expired. See Internal Revenue Bulletin 2004-27 (July 6, 2004) at 1 (expired Jan. 1, 2006) (http://www.irs.gov/irb/2004-27_IRB/ar13.html). At the same time, states still have the power to require plans marketing HDHPs to exclude preventive care from the deductibles as long as it fits within the narrow federal definition.

Second, health insurance plans can limit what counts toward the deductible; specifically, health insurance plans that provide coverage only if "network" providers are used can choose not to count amounts actually expended on health care to out-of-network providers toward the deductible.[15] Moreover, there is a lack of clarity in the federal law or IRS interpretations on the issue of the insured's financial exposure when using network providers: First, there is no requirement that the favorable rates that insurers negotiate with network providers are the rates that will be charged the insured; and second, there is no requirement that if the insured is charged higher rates, the higher charges will definitely count toward the deductible. For example, while this Author is not enrolled in an HDHP, I recently received an Explanation of Benefits form concerning a one-day hospitalization for my son who had broken his elbow. The rate charged was close to $11,000 but the rate negotiated with my insurer was $1,100. Let's assume that I had been enrolled in an HDHP with a $10,000 deductible. It is not clear whether: 1) I would have had to pay up to $10,000 to cover the charge or whether my exposure would be limited to the amount negotiated with the insurer; and 2) whether, even if I spent up to the $10,000, whether the amount that actually counted toward the deductible would be the actual amount I spent rather than the negotiated amount of $1,100.

The scenario described above raises a further problem inherent in the coupling of the HDHPs with the HSAs. Namely, there is no legal structure for

[15] 26 U.S.C. § 223(b)(2)(B); Internal Revenue Bulletin 2004-2, "Health Savings Accounts" (Jan. 12, 2004), supra note 9 at Answer to Q-4. In an article by Hall & Havighurst, they applaud the idea of extending managed care cost-controls to HDHPs but acknowledge that it is not required. See Mark Hall & Clark Havighurst, "Reviving Managed Care With Health Savings Accounts," Health Affairs: 24:6 (Nov./Dec. 2005) at 1490.

requiring coordination or consumer information about which expenses that can be used from the HSAs actually count toward the deductibles.[16] The federal law requires only that HSAs be administered by either banks, insurance companies or other qualified trustees[17] and that, in fact, not even the administrators are responsible for determining what actually counts for the federal tax exemption since this is actually a tax benefit for which the taxpayer is responsible.[18] Therefore, where health insurance plans maintain no responsibility for the HSAs, consumers must be separately informed by the insurance plans whether expenses incurred actually meet the deductible amounts. Notably, as with any deductibles, the incentives clearly are directed against first dollar coverage by the insurers.

Apart from the federal law, insurance companies have been launching high deductible health insurance products to consumers, including both employed consumers and individual consumers.[19] For example, Blue Cross of

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[16] This is true for any out-of-pocket expenses, whether or not they come from an HSA. See also Hall & Havighurst, id. at 1497-98, explaining that there are a variety of administrative possibilities for informing consumers about which expenses count, including a retrospective review. Note that it is typical that individuals without insurance pay higher rates for care because they don't get the advantages of negotiated rates by insurers who can guarantee a certain volume of business. See Elizabeth Pendo, "Images of Health Insurance in Film: The Dissolving Critique," 37 J. of Health L. 267, 282 (Spring 2004).

[17] 26 U.S.C. § 223(d)(B). In fact, banks and insurance companies are showing significant interest in entering the market. See Eric Dash, "Savings Accounts for Health Costs Attract Wall St." The New York Times, (Jan. 27, 2006) at A-1.

[18] Internal Revenue Bulletin 2004-2, supra note 9 at Answer to Q-29: "HSA trustees or custodians are not required to determine whether HSA distributions are used for qualified medical expenses. Individuals who establish HSAs make that determination and should maintain records of their medical expenses sufficient to show that the distributions have been made exclusively for qualified medical expenses…"

[19] See Daniel Costello, "A mini price, a mini policy," L.A. Times (June 6, 2005) at F6; see also Kathy Robertson, "Kaiser plans chase dwindling memberships: New high-deductible plans slash premiums," Sacramento Business Journal (May 12, 2004).

California has undertaken a very slick youth-oriented campaign toward individual consumers (who are seeking a health insurance option outside the work-place) which includes web-based information and applications called "Tonik."[20] According to its web advertisements, it is described as follows: "Health coverage for your body, eyes, teeth. You know, the important stuff."[21] However, under the section entitled "Compare Plans," the following description was used: "Here it is. Health insurance, straight up. Three plans. Same all-around coverage: Preventive, Emergency, Rx, eyes, teeth **(no maternity)**" (emphasis added).[22] The deductibles range from $1500-$5000, two of the plans limit the consumer to 4 doctor's visits per year, and the premiums range from $64-$80 per month.[23] This is clearly being marketed to the young, healthy, and male market without chronic or intense care needs that they know about.[24] If insurers seek to launch HDHPs without HSAs, there is no federal law that puts a cap on the deductible amounts or in any other way, places limits on the structure of the HDHPs. In fact, as these insurance products illustrate, this trend is coupled with another disturbing trend: not only will the cost-sharing go up but the insurance industry is

[20] Tonik Health Insurance – Blue Cross of California (http://www.tonikhealth.com/ca).

[21] Id.

[22] Id.

[23] Id.

[24] E.g., can a person diagnosed with cancer limit himself to 4 doctor's visits?

marketing "diluted" insurance products that fail to cover comprehensive health care needs.[25]

There is a growing national interest by employers and insurers to promote HDHPs.[26] According to a national survey of employed individuals, while only 10% of the respondents had elected an HDHP,[27] enrollment is expected to grow substantially in 2006.[28] Apart from the ideological discussions which will be discussed below, there is a clear need to bring down the costs of health insurance premiums.[29] Between 2000 and 2005, overall premiums for health insurance increased a cumulative 73% while worker income increased only 15%.[30] Indeed, not only are the premiums increasing, but also there is a trend to

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[25] Note the exclusion above of maternity care coverage and the limitations on doctors' visits and hospital care.

[26] It also is a cornerstone of the current Republican agenda on health care as enunciated in President Bush's most recent "State of the Union" address. Robert Pear, "Health Care, Vexing to Clinton, Is Now at Top of Bush's Agenda," The New York Times (Jan. 29, 2006) ("Mr. Bush has a fundamentally different philosophy [from Mr. Clinton who favored a larger role for government], built on the idea that placing more responsibility in the hands of individuals will create market pressures to hold down costs.") President Bush has used his State of the Union address in prior years also to discuss high deductible policies. Gail Shearer, "Commentary – Defined Contribution Health Plans: Attracting the Healthy and Well-Off," Health Services Research 39:4, Part II at 1 (August 2004).

[27] Fronstin & Collins, supra note 3 at 21.

[28] Id. at 4, citing a survey by Mercer Human Resources Consulting which found that 73% of large employers were very or somewhat likely to offer them in 2006. In California, 18% of employes offered HDHPs in 2004 and the number is expected to increase to 33% by 2006. RAND, "'Consumer Directed' Health Plans: Implications for Health Care Quality and Cost," California Health Care Foundation Report at 6 (June 2005). At least 75 insurers offer HDHPs nationwide and they span all markets: 58 to large employers, 56 to small employers, and 47 to individuals. It at 11-12. See also, "Savings Accounts for Health Costs Attract Wall St.", New York Times, 1/27/06, A-1 (citing a study that estimates that by 2010, more than 15 million Americans, or about 10% of the insured, will have an HSA; the American Bankers Assn. is calling it a "gold rush:"); in fact, both banks and insurers stand to profit by the development of HSAs: "Banks make money each time a customer swipes his debit card at a doctors office" and "[the insurers and the banks] split the money earned for opening and maintaining the accounts." Id. at A-16.

[29] See generally, Edward Larson & Marc Dettmann, "The Impact of HSAs on Health Care Reform: Preliminary Results After One Year," 40 Wake Forest L. Rev. 1087 (Winter 2005) at 1089-1092.

[30] Fronstin & Collins, supra note 3 at 4.

pass on more costs to employees irrespective of whether HDHPs are even offered: employees are paying a higher percentage toward the premiums, co-payments are increasing, and of course, the deductibles are increasing.[31] The growing number of "uninsured" are among working people who are offered health insurance but decline to take it, many of whom do so because they cannot afford the costs of the premiums.[32] Ironically, the federal legislation promoting HSAs provides its greatest value to those in the highest tax brackets even though they have the least problems affording health insurance.[33]

HDHPs should be seen as part of a greater trend to lower premiums while promoting an insurance product that might eventually be severed from

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[31] Id.; see also Jon Gabel, Gary Claxton, et al., "Health Benefits in 2003: Premium Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," Health Affairs: 22:5 (Sept./Oct. 2003) at 117.

[32] See Todd Gilmer & Richard Kronick, "It's the Premiums Stupid: Projections of the Uninsured Through 2013" Health Affairs Web Exclusive W5-143 (April 5, 2005) (the number of uninsured is projected to increase by eleven million in the coming decade); Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey," EBRI Issue Brief No. 287 (Nov. 2005) at 13 (among the 15.2 percent of uninsured workers eligible for health benefits in 2002, nearly two-thirds reported they declined it because of the cost); and Daniel Costello, "At What Cost?" L.A. Times (April 4, 2005) (to keep health coverage, more workers are cutting back on food, heat and other necessities and still, "many of them eventually will lose the battle").

[33] As with any tax benefit, the higher the individual's tax bracket, the greater the value of the savings to the tax-payer. See Gail Shearer, "Commentary – Defined Contribution Health Plans: Attracting the Healthy and Well-Off," Health Services Research: 39:4, Part II at 1 (August 2004); see also Monahan, supra note 7 at 54: "The winners from the shift in tax policy are those with high incomes who receive the greatest tax benefit from the ability to save for medical expenses on a pre-tax basis;" id. at fn 52, citing Stephen Parente, Roger Feldman, and Jon Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization," Health Services Research, 39:4, Part II (August 2004) at 1189, 1198: an examination of one large employer showed that the consumer driven health plans attracted the highest percentage of employees from above the 75th percentile of income; GAO Report, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," GAO-06-271 at 10 (January 2006) (43% of federal employees enrolled in HDHPs had annual incomes above $75,000 compared to 23% for other plans); and RAND, "Consumer-Directed Health Plans: Implications for Health Care Quality and Cost," California Health Care Foundation, June 2005 at 13 (people with higher incomes will view the HSAs as investment tools).

employment altogether.[34] Interestingly, among consumers choosing HDHPs, only 10% are funding the HSAs,[35] suggesting that the attractiveness may not so much be the tax benefit but the lowered premium costs. By shifting more costs to the consumer, the actual value of health insurance may actually be diminishing to something akin to "catastrophic coverage" and could prove an attractive alternative to those individuals for whom work-place insurance is too expensive.

Unfortunately, this shift to consumers of increased risks for the costs of medical care is occurring even when analysts are discovering that medical debt is the leading cause of consumer bankruptcies.[36] Alongside the 45 million Americans without health insurance is emerging the growing class of "under-insured" Americans: individuals who have purchased health insurance that is ineffective in both protecting them from financial catastrophe and from ensuring

[34] There are a variety of theories as to why insurance ultimately may be severed from employment. Compare Mariner, "Can Consumer Choice Plans Satisfy Consumers," supra note 4 at 511 with Alain Enthoven, "Employment-Based Health Insurance is Failing: Now What?" Health Affairs Web Exclusive W3-237 (May 21, 2003). Despite powerful federal tax incentives that apply to employment-based health insurance (see Monahan, "The Promise and Peril of Ownership Society Health Care Policy," supra note 7 at 2), there is a growing interest in promoting more affordable premiums on the individual market with tax incentives of their own. See Robert Pear, supra note 26 (President Bush advocates for not "favoring" employment-based insurance with tax breaks unavailable on the individual market or for small businesses wishing to "band together.")

[35] EBRI Issue Brief (fn #23 above) at 5; see also id. at 13: (individuals with HDHPs reported a variety of reasons for not funding the HSAs but 30% reported they did not have the money); see also Claxton & Gabel, et al. "What High Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," Health Affairs Web Exclusive (Sept. 14, 2005) (one-third of employers do not contribute to the HSAs).

[36] David Himmelstein, Elizabeth Warren, Deborah Thorne & Steffie Woolhandler, "MarketWatch: Illness and Injury As Contributors to Bankruptcy," Health Affairs, Feb. 2, 2005. This data has been disputed by a recent analysis funded by "America's Health Insurance Plans." See David Dranove and Michael Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affairs Web Abstract (Feb. 28, 2006) and subsequent response by the original authors (Himmelstein, et al.), "Discounting the Debtors Will Not Make Medical Bankruptcy Disappear," Health Affairs Web Abstract (Feb. 28, 2006).

access to timely and necessary medical care.[37] According to a national survey evaluating the impact of HDHPs, 42% of consumers in HDHPs spent 5% or more of their income on their health care as compared with 12% of individuals in comprehensive health plans.[38] In other words, individuals in HDHPs were almost 3-1/2 times more likely to spend a substantial portion of their income on their health care, although the plans are most heavily marketed to individuals who take the risk that they will not have substantial health care expenses.[39] In fact, about one-third of individuals in HDHPs reported delaying or avoiding care due to the costs.[40] Ironically, it is the insured through their health care premiums who pay the price for the uninsured or the underinsured who cannot pay their bills: it

[37] See John Leland, "When Even Health Insurance is No Safeguard," The New York Times A-1; Himmelstein, Warren, et al., "Illness and Injury as Contributors to Bankruptcy," supra note … ; Melissa Jacoby, "The Debtor-Patient," 69 Brook. L.Rev. 453 (Winter 2004); and Cathy Schoen, Michelle Doty, Sara Collins, and Alyssa Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" Health Affairs Web Exclusive, June 14, 2005 (underinsured adults are almost as likely at the uninsured to go without needed medical care and to incur medical debt; those with greatest risk of being "underinsured" are those with lower incomes and those who are sicker; "underinsured adults" are defined as having insurance that provides inadequate financial protection as indicated by one of the following three conditions: 1) annual out-of-pocket medical expenses amount to 10% or more of income; 2) among low-income adults with incomes below 200% of the federal poverty level, out-of-pocket medical expenses amount to 5% or more of income; or 3) health plan deductibles equal or exceed 5% of income) .

[38] Fronstin & Collins, supra note 3 at 13.

[39] There is a contrast between individuals who choose HDHPs who are employed and those who buy them on the individual market. Among individuals who purchase them on the individual market, 60% report being in excellent or very good health versus 47% who purchase HDHP at work. Id. at 6. Note, however, that 51% of individuals who purchase them at work do not have a choice of another health plan offered to them. Id. At 9. See also, Laura Tollen, Murray Ross & Stephen Poor, "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana, Inc." Health Services Research 39:4, Part II (Aug. 2004) (concluding that offering a high deductible plan alongside more traditional options caused risk segmentation within an employer group).

[40] Fronstin & Collins, supra note 3 at 15.

has been estimated that health insurance premiums in 2005 increased on average $922 due to the cost of health care for the uninsured.[41]

III. Deconstructing the myths

The purported advantage of "consumer-directed health care," its principal feature being high deductibles, is that it addresses what is called the "moral hazard" in health care spending.[42] The term "moral hazard" is used to refer to the fact that an individual is likely to incur greater costs when someone else is financially responsible. This has been the basis for criticizing the consumer's role in contributing to rising health care costs in this country. As currently structured, the demand and the cost of health care are driven largely by the health care providers. Insurers pay the amounts charged while consumers' costs are negligible. The insurers then pass along the increases through the premiums charged which are paid mostly by the employers, and the employers' costs are heavily subsidized by the federal government through the tax code.[43] No party

[41] Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured," (June 2005), p. 2 (Report written by Kathleen Stoll, Director of Health Policy, Families USA; data analysis provided by Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy & Management, Rollins School of Public Health, Emory University, Atlanta, Georgia); see also The Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance" (Jan. 2006) at 9 (the costs of uncompensated care are estimated to be about $41 billion in 2004).

[42] See Deborah Stone, "Beyond Moral Hazard: Insurance as Moral Opportunity," 6 Conn. Ins. L. J. 12 (Fall 1999) at 12 note 1; Malcolm Gladwell, "The Moral Hazard Myth," The New Yorker (Aug. 29, 2005) at 44, 46; and Andre Hampton, "Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight from Health Insurance," 52 Rutgers L. Rev. 987 (Summer 2000).

[43] See Larson & Dettmann, supra note 29 at 1091-1092; Amy Monahan, supra note 7 at 7-8 and 20-22; and Alain Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s," The New England J. of Medicine (Vol. 320, No. 1) (Jan. 5, 1989) at 29 (noting the open-ended sources of financing of health

who actually has control over the costs has an incentive to minimize them while those parties who could benefit from cost-containment have minimal opportunities to exercise such control. Managed care was an experiment to place more risk and control on the providers themselves.[44] For a variety of reasons, and depending on your perspective, the "experiment" of managed care as an effective mechanism to control costs and offset the "moral hazard" is being either abandoned or augmented by the movement toward consumer-driven health care.[45]

Consumer-driven health care, then, places a greater burden on the consumer for taking on the expense of health care. However, there are three myths perpetuated by its proponents which must be addressed: 1) the myth of discretionary health care spending; 2) the myth of discretionary income for health

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care where costs are passed along to players without an incentive to control cost resulting in a uniquely American paradox of excess (high inflation and profits) and deprivation (growing numbers of uninsured)).

[44] See Thomas Rice, "Can Markets Give Us the Health System We Want?" Journal of Health Politics, Policy & Law 22:2 at 383, pp. 415-418. For a thoughtful critique of how managed care failed to live up to its expectations, see John Jacobi, "After Managed Care: Gray Boxes, Tiers and Consumerism," 47 St. Louis U. L. J. 397 (Spring 2003), pp. 399-400 (arguing that managed care had become a "classic black box." "We asked managed care to work private sector magic on problems that had bedeviled government. As with sausage making and the passage of laws, we were too often happy not to be exposed to the precise mechanisms by which managed care controlled utilization of health care.")

[45] For a thoughtful summary, see John Jacobi, "Consumer-Directed Health Care and the Chronically Ill," 38 University of Michigan J. of Law Reform 531 (Spring 2005) at 539-542; and for different perspectives, see Carl Ameringer, "Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority," 5 DePaul J. Health Care L. 187 (2002); Cara Lesser, Paul Ginsburg, and Kelly Devers, "The End of an Era: What Became of the 'Managed Care Revolution' in 2001?" Health Services Research 38:1, Part II at 337 (Feb. 2003); Rick Mayes, "Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond," 38 J. of Health L. 391 (Summer 2005); and M. Gregg Bloche, "One Step Ahead of the Law: Market Pressure and the Evolution of Managed Care," The Privatization of Health Law Reform (M. Gregg Bloche, Ed.) (2003). But see Hall & Havighurst, supra note 15 , arguing against the idea that consumer driven health care and managed care are antithetical but rather, advocating for a synergy whereby cost-consciousness and discipline are exercised equally between consumers on the demand side and managed care on the supply side.

care spending; and 3) the myth of consumer power to negotiate over and make an impact on the costs of health care.

A. The Myth of Discretionary Health Care Spending

Consumer-driven health care proponents believe that increasing consumer sensitivity to costs will help solve the problem of rising health care costs.[46] According to proponents, "imposing higher deductibles is the most effective way to turn patients into consumers."[47] However, HDHPs represent a potential solution for employers' and insurers' mutual interest in saving money and shifting costs onto consumers so that instead of denying care to consumers, "consumers deny care to their future selves as patients."[48] The question, then, is whether consumers' decisions to deny care to themselves results in cutting out those medical services that are truly discretionary. The problem is that to answer that question, policy makers would need to understand what is and is not discretionary.

Here are some areas where cutting out care might be discretionary: switching to lower cost providers, switching to lower cost drugs or technologies, utilizing preventive measures, delaying or foregoing certain care that is not

[46] See Jost & Hall, supra note 8 at 1, summarizing the arguments in favor of consumer driven health care. For a series of essays promoting the benefits of consumer-driven health care, see Regina Herzlinger (Ed.), Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers," (2004).

[47] Jost & Hall,supra note 8 at 1, note 7.

[48] Mariner, supra note 4 at 541.

medically necessary, avoiding care that is "experimental."[49] This may sound like a familiar list because these are areas where managed care and even traditional insurance historically have exercised control.[50] While patients may have challenged that control in particular instances, there is no reason to believe that patients left to their own devices would do any better of a job than the managed care plans have done.[51]

In fact, there is good evidence that consumers will do a worse job than managed care in responding to financial incentives to avoid unnecessary care because they will delay or forego care without making great distinctions and choices between medically necessary and unnecessary care. [52] The choices will impact most those with the least amount of money to spend.[53] As a result, some critics have referred to consumer financial incentives as a "blunt instrument."[54]

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[49] See James Robinson, "Health Savings Accounts – The Ownership Society in Health Care," N. Eng. J. of Med. 353;12 (Sept. 22, 2005) 1199 at 1201.

[50] Id.

[51] Paul Feldstein, Thomas Wickizer, and John Wheeler, "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures," The New England Journal of Medicine 1310 (Vol. 318, No. 20) (May 19, 1988) (finding favorable results in the use of utilization review to reduce hospital admissions, cut down inpatient days, and save total medical expenditures); see also Jacobi, "The Ends of Health Insurance," 30 U.C. Davis L.Rev. 311, 381 (one critique of consumer driven health care is that personal control of health expenditures is inconsistent with the structure of cost containment through managed care, citing studies that have looked at the lack of control over costs once the deductible is exhausted.)

[52] For a detailed discussion of the problems with putting consumers in charge of these decisions based on lack of skill and information, see Monahan, supra note 7 at 34-44. Note that there are some scholars who are promoting the idea of combining HDHPs with managed care "to create synergies that should benefit consumers and bring new cost-consciousness and discipline to the health care marketplace." Hall & Havighurst, supra note 15 at 1490.

[53] See David Himmelstein, et al., supra note 36; Elizabeth Warren, "The Growing Threat to Middle Class Families," 69 Brooklyn L. Rev. 401, 416-420 (Winter 2004) (documenting the financial vulnerability caused by medical expenses that threatens even the middle class).

[54] Davis, "Consumer-Directed Health Care: Will It Improve Health System Performance?" Health Services Research 39:4 Part II at 1230 (August 2004).

According to a landmark study by the Rand Corporation,[55] high deductibles have "selective effects:" the most vulnerable patients are put at greatest risk.[56] Because patients cannot effectively distinguish between care that is necessary and that which is "discretionary," the Rand study found that there were adverse effects on health for lower-income and high-risk individuals.[57]

More recent studies have confirmed these results: Americans with higher deductibles are significantly more likely than those with lower deductibles to report difficulty obtaining needed care.[58] According to a 2003 survey by the Commonwealth Fund, 38% of individuals with deductibles of $1000 or more reported at least one of four cost-related access problems: not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up exam, or having a medical problem but not visiting a doctor or clinic.[59] A more recent survey (October 2005) conducted by the Employee Benefits Research Institute and the Commonwealth Fund similarly found that individuals with HDHPs were significantly more likely to avoid, skip, or delay care (about 1/3)

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[55] See Manning, Newhouse, Duan, Keeler, Leibowitz & Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," The American Economic Review, June 1987 (pp. 251-277).

[56] Arnold Relman, "The Health of Nations: Medicine and the Free Market," The New Republic 23, 27 (March 7, 2005).

[57] Davis, supra note 54 at 1221-1222: Davis notes a number of additional studies reviewing care for low-income children and adults with particularly disturbing results of adverse health effects: significantly lower chances of receiving effective services for acute conditions, receiving preventive care, and avoiding inappropriate hospital admissions.

[58] Davis, Doty, & Ho, "How High is Too High? Implications of High-Deductible Health Plans," supra note 4 at 4.

[59] Id. at 8. This is compared to 21% of individuals with no deductible; see also Fronstin & Collins, supra note 3 at 15-17 (noting significant negative impacts among enrollees in HDHPs with a correlation between enrollment and skipping or not filling medications).

because of costs, with a more pronounced problem among people with incomes below $50,000.[60]

Moreover, there is a total lack of reliable and understandable information for consumers to use in making informed decisions about whether to incur expenses or not.[61] For example, there is little public information even for providers to adopt "best practices" toward high performance, nor is there good data to work from.[62] In addition, few plans provide advice for patients who are under-using services.[63] Quality and cost information are almost non-existent.[64]

[60] Fronstin & Collins, supra note 3 at 1.

[61] Id. see also Davis, supra note 54 at 1228.

[62] Statement of Charyl Damberg, Senior Policy Researcher, The RAND Corporation before the [California] Department of Insurance (Sept. 20, 2005) at 9-11, noting the absence of reliable and consistent quality and price data that is either collected or available.

[63] Davis, "Consumer-Directed Health Care," supra note 54 at 1227. See also Fronstin & Collins, supra note 3 at 19-21, noting a clear deficit of information about providers, even where more than 50% of enrollees in HMOs attempted to access such information.

[64] Davis, supra note 54 at 1228; see also RAND, "'Consumer-Directed' Health Plans: Implications for Health Care Quality and Cost," supra note 28 at 17-18, describing a number of quality indicators (e.g., Leapfrong, and JCAHO standards) used by health plans to create tiers relating cost and quality and noting that they are still too complex for either consumers or employers to utilize effectively, let alone result in pressures toward cost-effectiveness; GAO Report, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," supra note 33 at 21 (January 2006) : "Enrollees [in HDHPs] need information to help them assess the cost and quality trade-offs between different health care treatments and providers. However, the extent to which [HDHPs] made such information available to enrollees was varied and limited … Most notably lacking was specific information to assess the quality of health care provided by particular physicians and the actual prices plans had negotiated with particular providers;" and Damon Darlin, "You Think 401(k)'s Are Hard to Manage? Try Health Accounts," The New York Times B5 (Feb. 18, 2006) (noting the basic lack of consumer information to help individuals obtain price and quality information necessary to make choices).

B. The Myth of Discretionary Income for Health Care Spending

As noted above, HDHPs negatively impact individuals with annual incomes less than $50,000.[65] Despite this disproportionate impact, no provisions have been made to reduce the negative effects on this population. Most employers offering plans with greater cost-sharing do not include reduced cost-sharing for lower-wage workers.[66]

An exhaustive study investigating consumer bankruptcies found a substantial correlation with medical debt.[67] One of the most eye-opening aspects of this work was the finding that 75% of those suffering with medical debts and declaring bankruptcy had insurance.[68] These people can be referred to as the "under-insured:" Although they have health insurance, they still cannot afford their medical care. Individual examples have been documented in the media.[69] In fact, only 10% of employees who have the option of setting aside funds in Health Savings Accounts to save for their deductibles are actually putting money

[65] Fronstin & Collins, supa note 3 at 1.

[66] Davis, supra note 54 at 1222; and Pacific Business Group on Health, "Benefit Strategies to Promote Quality, Value and Access in High Deductible Health Plans" (PBGH Board of Directors Retreat 2005 Summary) (suggesting that employers consider "income-specific adjustments" on the high deductible option).

[67] Himmelstein, Warren, et al., supra note 36 at 1.

[68] Id.

[69] John Leland, "When Even Health Insurance is No Safeguard," supra note 37. See also Warren, "The Growing Threat to Middle Class Families," supra note 53, noting the increased vulnerability of working Americans, and even families with both partners working, to medical debt.

in their accounts,[70] suggesting that they may not have the discretionary income to save. This is particularly problematic for lower-income consumers because the most recent studies show that 42% of those with HDHPs spent more than 5% of their income on out-of-pocket costs, as compared to 17% of those in comprehensive health plans.[71] If they do not have the money to spend, the driving force behind the consumer's exercise of discretion will not be whether the care is necessary but whether the consumer's income is sufficient to cover the bill.

C. The Myth of Consumer Power to Negotiate Over and Make an Impact on the Costs of Health Care

It is estimated that only a small percentage of medical costs are due to expenses driven by physician recommendations and that managed care's effectiveness has been, in part, to control these costs.[72] Therefore, even if consumers did just as good a job as managed care plans[73] in negotiating over

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[70] Note that if they fund the savings accounts, those savings are theirs to keep, meaning that not funding the savings accounts truly represents a lost opportunity to save money, in contrast to the prior Health Reimbursement Arrangements where money not spent was lost. See Larson & Dettman, supra note 29 at 1101-1102.

[71] Fronstin & Collins, supra note 3 at 1.

[72] See Davis, Doty, and Ho, supra note 4 at 15-16 (total expenditures below the deductible account for only 21% of total health care spending). In fact, major contributors to health care inflation arise from costs not driven by physicians, such as prescription drugs and hospital care. See, e.g., Bradley Strunk, et. al. "Tracking Health Care Costs: Growth Accelerates Again in 2001," http://www.ebri.org; Stephen Heffler, et al., "Health Spending Projections for 2002-2012," Health Affairs, http://www.healthaffairs.org.

[73] There are multiple explanations for the reasons why managed care itself failed to achieve cost-savings but critics remain skeptical that consumer driven health care can pick up the slack. See Jacobi, "After Managed Care…", supra note 44 at. 406: "Consumer-driven health plans have migrated far from the vision

costs and reversing doctors' incentives to drive up health care spending, the impact would be modest. In fact, the great majority of total health care costs (69%) is attributable to only 10% of the population, those who are terminally and chronically ill.[74] This population would most quickly exhaust their deductibles and the incentives not to incur the deductibles would be lost quickly upon them.[75]

There is much to be skeptical about in the idea that consumers will exercise some kind of bargaining power by "shopping around" and negotiating price with a physician or any other provider.[76] Indeed, there is a strong ideological divide between those who believe that ordinary market concepts apply to health care and those who do not.[77] According to the October 2005 EBRI/Commonwealth Study, while consumers enrolled in HDHPs evidenced more "cost-consciousness" by checking on prices and discussing treatment options with their physicians, their efforts, sadly, did not drive down the actual

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of managed care as an expert organizer of medical care. They are instead a reaction to the failings of managed care, and they hold little promise of advancing social goals of cost control, increased access to coverage and improvements in quality."

[74] Davis, supra note 54 at 1223.

[75] Id.

[76] See Uwe Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," Health Affairs 2006: 26(1)57-69 (raising sharp criticisms of consumer-driven health care and its ability to function as a meaningful control over health care costs, using the Byzantine structure of hospital charges as an example where consumers could doubtfully exercise much influence).

[77] For a highly developed critique of the market approach and policies aimed at promoting consumer cost-sharing, see Rice, supra note 44. See also Andre Hampton, supra note 42; Jacobi, "Consumer-Directed Health Care and the Chronically Ill," supra note 45 at 533 ("[Consumer driven health plans are] likely to fail for two reasons. It will endanger the health and well-being of the chronically ill … and it will fail (as did the managed care 'revolution') to contain costs."); Relman, "The Health of Nations," supra note 56; and Malcolm Gladwell, "The Moral Hazard Myth," The New Yorker (Aug. 29, 2005). Compare with Hall & Havighurst, supra note 15 at 1493 (Nov./Dec. 2005) (articulating an argument for viewing consumer driven health care as "progressive, pro-consumer advance over managed care" by giving patients "more control on the micro level of spending on servicees….")

costs; instead, they simply chose to forego care.[78] Even if a consumer could negotiate price with a doctor over receiving a single service, it is highly unlikely that this negotiation would exert any meaningful effect on the costs of future services provided by that particular doctor should the patient to choose to form a doctor-patient relationship, nor on more expensive treatment options, such as diagnostics and hospital care over which that doctor would have minimal control.[79] In fact, some critics note that not only would consumers lack control over negotiating price but the health care system as a whole would lose the control necessary to institute quality of care improvements which requires coordination and integration among related treatments and providers, a stark contrast to the idea of consumers shopping around, service by service, amongst a variety of competing and independent physicians.[80]

[78] Fronstin & Collins, supra note 3 at 20-21.

[79] See Monahan, supra note 7 at 49.

[80] Relman, supra note 56 at 27: "[T]he Institute of Medicine's recommendations about quality [could not] be achieved if doctors and hospitals were expected to function as independent vendors do in ordinary markets, simply responding to the demands of consumers. The essential task of coordination and integration of services for each patient would be left to the patients themselves, and the uniform adoption of modern information technology would be impossible. A fully developed CDHC [consumer driven health care] market would be chaotic, to say the least, and in such a system continuity of care would be virtually non-existent." See also Alain Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" Health Affairs – Web Exclusive W3-237-249 (May 2003) where he criticizes consumer driven health care for bringing back the "old model" of free choice, fee for service medicine which he criticizes for simply shifting costs while avoiding "serious competition based on value for money" where cost-containment is achieved by altering the fundamental way health care is organized and delivered; and Enthoven & Kronick, supra note 43 at 31 (positing that the whole system never will realize efficiencies unless coverage is universal because of the persistent problem of "cross-subsidizing" the uninsured).

D. The myth of individual consumer choice and the risk of losing affordable comprehensive health insurance

The fundamental problem is whether consumers actually have meaningful choices about their health insurance. There are two fundamental constraints: Can employers afford the premiums and can consumers afford the premiums?[81] The majority of insured Americans are offered insurance at work and when they are offered health insurance, there is no guarantee that they are offered a choice of plans. Because employers pay the greater proportion of the health care premiums, the choices, in large part, are determined by what the employer can afford.[82] Therefore, there is an incentive for the employers and the insurers to offer products with lower premiums.[83] HDHPs help answer that problem by lowering the premiums because the employees take up a larger share of the cost through the deductibles.[84] Similarly, employees will be attracted to the lower premiums; indeed, some employees will have no choice but to select plans with the lower premiums because plans with higher premiums are increasingly unaffordable. As discussed above, a growing class of "uninsured" Americans

[81] State and federal regulations also play an important role in determining the extent to which insurers are required to accept applicants and the comprehensiveness of the coverage they are required to provide, discussed infra in Section IV.

[82] See Mariner, supra note 4 at 506: "Employment-based plans still give the employer the ultimate say in which choices are available. There is some evidence that the majority of employers pay more attention to the cost of premiums than to the quality of care or the operation of health plans."

[83] See generally, Gilmer & Kronick, supra note 32 (concluding that projected premium increases will increase the number of uninsured Americans by 11 million in the next decade, from 45 million in 2003 to 56 million in 2013)

[84] See generally, Gabel, et al., supra note 31at 117-126 (September/October 2003).

are those who are offered insurance at work but decline the insurance because they cannot afford the premiums.[85] The financial pressure may lead them to opt for HDHPs which can create great risks to health care consumers as individuals and as a group.

On the individual level, the risks of being under-insured are particularly acute for individuals with lower incomes and those with greater health care needs. As discussed above, the result could be a clear adverse effect on their health and on their financial status. However, there are further risks. As consumers feel financial pressures to opt for HDHPs, the erosion of their health insurance will lead them to forfeit key federal protections under "COBRA" and "HIPAA." Specifically, under COBRA,[86] consumers who change jobs have the option of retaining their health insurance but at 102% of the premium.[87] This is typically expensive. A much less expensive HDHP product marketed on the individual market is likely to be more attractive even if it results in far greater financial risk and even if it carries more limitations.[88] However, individuals moving to the individual market may not fully understand what they are giving up. Under HIPAA's "portability" protections, an individual cannot be excluded due to

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[85] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer, Key Facts About Americans Without Health Insurance," Jan. 2006 (www.kff.org), at 13 (20% of uninsured workers had health benefits offered to them but declined to participate).

[86] 29 U.S.C. § 1162.

[87] Id. § 1162(3).

[88] Similarly, "discount health plans" which are not even insurance products and in most states, not even regulated by insurance agencies, may be attractive, leaving the field open for perpetrating a number of fraudulent and misleading schemes on unknowing consumers. See Gerard Britton, "Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot," 16 Loyola Consumer L. Rev. 97; and Jost & Hall, supra note 8 at 401-402 (discussing the potential confusion resulting from such an interplay).

pre-existing conditions from health insurance at a new employer[89] as long as the existing insurance was as comprehensive as that offered by the new employer.[90] HIPAA legislative history indicates that deductibles can be used to determine the comparative "comprehensiveness" of a health insurance product. [91] Therefore, employers can circumvent the limitations on pre-existing condition exclusions where there is a significant differential in deductibles. By opting for more bare bones coverage and higher deductibles, consumers are putting themselves at risk of being uninsurable. Sadly, this is undermining key incremental reforms made to improve access to health insurance by limiting insurers from excluding high risk individuals.[92]

The impact of these increased risks goes beyond the individual consumers. First, any increase in unfunded medical debt will adversely effect health care providers because they will suffer the financial strain of unpaid medical bills.[93] Second, HDHPs pose a pronounced problem of "risk

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[89] Under HIPAA, an individual with prior "creditable coverage" cannot be excluded for the amount of time that the employee was previously covered; however, a new employer can provide insurance which excludes an individual based on a pre-existing condition for up to 12 months if that individual does not have "creditable coverage." 29 U.S.C. § 1181(a).

[90] 29 U.S.C. § 1181(c)(3)(B): employers can elect to extend periods of exclusion where the level of benefits is not consistent between plans.

[91] See Conf. Rep. No. 736, 104th Cong., 2d Sess. 181-182 (1996) ("[T]he inclusion versus exclusion of a category of benefits such as pharmaceuticals could be considered a difference in classes of benefits. Similarly significant differentials in deductibles could be considered differences in classes of benefits.")

[92] For a thoughtful and detailed discussion on the significance of COBRA and HIPAA protections in requiring a greater "pooling of risks" and preventing harmful segmentation , see Jacobi, "The Ends of Health Insurance," supra note 51 at 366-387. Jacobi notes the irony of these reforms emerging at the time that medical savings accounts were being promoted, explaining that the legislation emerged as a result of compromise between two competing and conflicting visions on the role of the market and government to address the "ends of health insurance." Id. at 384-385.

[93] See The Kaiser Commission on Medicaid and the Uninsured, supra note 41 at 9 (uncompensated care to physicians is neither directly nor indirectly reimbursed by public dollars and even where hospitals are

segmentation:" this refers to the phenomenon of younger, healthier individuals gravitating toward the cheaper plans, leaving the older (which includes the middle-aged) and chronically ill in the more comprehensive plans. The result is a negative spiral (referred to as an "insurance death spiral")[94] whereby the comprehensive plans cannot offset the higher risks of the older and sicker members with the lower risks of the younger members, thereby raising the costs in the more comprehensive plans.[95] Those plans will become more and more expensive, resulting in higher premiums and lower take-up rates, leaving more people either without insurance or being financially pressured into selecting the HDHPs with greater and perhaps unaffordable financial risk, again with the potential for adverse health effects. The net result of these multiple individual choices may be to drive comprehensive health plans out of the market and increase the risks for everyone.

IV. The Regulatory Vacuum

Unfortunately, there is an absence of a coherent regulatory response to the problems raised above: a) how to protect individual consumers from making bad choices about delaying or foregoing medically necessary care; b) how to

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compensated, the extent to which the Medicaid and Medicare programs are cutting back on reimbursement will result in a diminished willingness to care for the uninsured).

[94] Mariner, supra note 4 at 511.

[95] See Tollen, Ross, et al. supra note 39 at 1168: "If such segmentation occurs and plan sponsors do not adjust their contributions to counteract it, premiums for comprehensive health insurance products could become less affordable to the extent that those products primarily attract less-health employees." See also Jacobi, The Ends of Health Insurance, supra note 51 at 380.

protect individual consumers from the financial risks involved; and c) how to protect consumers generally against undue "risk segmentation" and the potential market forces which may lead to the dilution and ultimately, the elimination of comprehensive health insurance as a choice.

Proponents of consumer-driven health care have argued that market forces can help solve the public policy problem of inflationary health care expenses.[96] However, it is questionable whether ordinary contract law can counter-balance the unequal bargaining power insurers and employers exercise in determining consumer "choice."[97] The problem is that consumers exercise not only a negligible degree of control over selecting their health insurance products, but also over whether they even will be accepted or how the risks are pooled (which can lead to how premiums are raised). "Market" control over those aspects of the health insurance contract is exercised predominantly by employers who actually have a conflict of interest between them and the employees insofar as employers are interested in limiting their contributions to the premiums and in shifting costs to the employees.[98]

Because health insurance contracts between insurers and insureds generally are standardized "adhesion" contracts, individual consumers have very little power to negotiate the specific terms, a problem which is exacerbated by the

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[96] For a summary of the legislative history, see Larson & Dettman, supra note 29 at 1107-1108. In this article, Larson & Dettman note the irony of the fact that the HSAs are tax-subsidized was never acknowledged as "distorting" the market. Id. at 1108-1109.

[97] For an excellent analysis of the tensions raised by dually treating insured individuals as consumers and patients and skepticism about the role of contract law in resolving such tensions, see Mariner, supra note 4.

[98] See Kathy Cerminara, "Contextualizing ADR in Managed Care: A Proposal Aimed at Easing Tensions and Resolving Conflict," 33 Loy. U. Chic. L. J. 547, 570 (Spring 2002).

degree of control exercised by employers in controlling the choices offered their employees.[99] Indeed, because insurance contracts are fundamentally non-negotiable, some scholars have noted that the goal of insurance regulation is to "remedy[] unfairness in insurance contracts."[100] Therefore, insurance law always has represented a unique intersection of contract and regulatory law. While contracts are used to define the relationship between the insured and the insurer, state and federal regulation have been necessary to provide essential consumer protections in the areas of preventing insolvencies, promoting actuarial soundness, implementing policies related to the pooling of risks, and protecting consumers from being excluded.[101] Insurance regulation is fundamental to protect the manner in which risks are spread over groups of individuals and it is impossible for contracts between individual insurers to address the spreading of such risks.[102]

In addition, outside of specific state and federal regulatory requirements, legal theories based on civil rights and anti-discrimination claims aimed at requiring inclusion of specific individuals or of specific services have provided

[99] See generally, Mariner, supra note 4 at 522-523.

[100] Id. at 524 note 112, citing Corbin.

[101] See generally, Len Nichols and Linda Blumberg, "A Different Kind of 'New Federalism'? The Health Insurance Portability and Accountability Act of 1996," Health Affairs, Vol. 17, No. 3 at 25 (May/June 1998).

[102] This is true even though there are basic ideological divides about the role of insurance in providing a "social" good versus just a market good. See generally, Deborah Stone, "The Struggle for the Soul of Health Insurance," 18 Journal of Health Politics, Policy & Law 287 (1993); Deborah Stone, "Beyond Moral Hazard: Insurance as Moral Opportunity," 6 Connecticut Insurance Law Journal 12 (Fall 1999); and John Jacobi, "The Ends of Health Insurance," supra note 92.

only modest protections.[103] Consumer protection, thus, depends on regulation to address what in other markets might be considered market failures: the unwieldy and potentially collusive power exercised by employers and insurers to limit choices and exclude consumers from the market.[104] Without such regulation, the insurance products are at risk of being "diluted" over time. Specifically, as discussed above, the market pressures to create affordable premiums have led to HDHPs but they put consumers on an individual and general level at risk.

The regulation of health insurance itself has always occupied a unique status of being relegated predominantly to state regulation.[105] Federal law, however, has encroached in several ways. First, since the 1950s, Congress has provided generous federal tax incentives for employer-based health insurance which has resulted in a federal subsidy but this has not significantly encroached on the state role.[106] However, second, through ERISA, Congress and the courts have laid the foundation for large employers who "self-insure" to make themselves immune from any state attempts to regulate the insurance being

[103] See Sharona Hoffman, "Unmanaged Care: Towards Moral Fairness in Health Care Coverage," 78 Ind. L. Rev. 659 (2003); Elizabeth Pendo, "The Politics of Infertility: Recognizing Coverage Exclusions a Discrimnation," 11 Conn. Ins. L. J. 293 (2004-2005); and Jacobi, "The Ends of Health Insurance," supra note 92.

[104] See Jacobi, id.at 396-397 for a discussion on the role of regulations to adjust risks to prevent the type of market failure described above.

[105] It has been treated as a traditional state police power over health and safety and the state preeminence was reinforced by federal law which left insurance regulation to the states. Jost & Hall, supra note 8 at 397-98.

[106] Id. at 400.

offered.[107] Now, through HSAs, Congress has offered a tax incentive which consumers only can enjoy if they choose HDHPs as their exclusive source of coverage.[108] This offers a unique experiment in a third type of federalism over health care insofar as states are not required to take any action to authorize HDHPs but neither are they prevented from regulating nor even prohibiting them.[109] In fact, the federal regulations only touch on a few aspects of the structure of the HDHPs but otherwise leave a great deal of flexibility for state regulation over the HDHPs themselves.[110]

The areas for potential state regulatory action fall into two categories: a) the extent of state authority over HDHPs which are coupled with HSAs under the federal law; [111] and b) the role of state authority over HDHPs that are not marketed in conjunction with the federal tax incentives associated with HSAs. As noted above, state authority over HDHPs offered by ERISA self-insured plans is completely preempted.[112] This paper will address generally areas for regulatory guidance on both the state and federal levels.

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[107] Id. at 398-99. See Aetna Health Inc. v. Davila, 542 U.S. 200 (2004); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

[108] 26 U.S.C. § 223(c)(1)(A).

[109] Jost & Hall, supra note 8 at 400.

[110] Note, however, that there is a contrast over regulation of HSAs insofar as they are administered by banks which are regulated exclusively by federal law. Id. at 408.

[111] Id. at 401-403, identifying a number of areas left open for state regulation with the introduction of HDHPs coupled with HSAs; see also, Jacobi, "Consumer-Directed Health Care and the Chronically Ill," supra note 5 at 577-79.

[112] Id. at 579, pointing out that despite ERISA's preemption over self-insured plans, there is still potential for state regulation of HSAs not administered by banks, opening a possible "back-door" to ERISA preemption.

V. Formulating regulatory protections

A. Protecting individual consumers from making bad choices about delaying or foregoing medically necessary care

1. Clarify and maximize the definition of preventive care

The place to begin is to make sure that individuals, even if concerned about spending money out-of-pocket, are not deterred from obtaining preventive care. As explained above, while federal law provides a "safe harbor" for HDHPs to exclude preventive care from the deductible, the plans have discretion as to whether they will actually provide for such an exclusion. In order to maximize the benefit of the federal law, states should pass laws that requires HDHPs to exclude all preventive care included under the federal definition[113] so that it is not left to the discretion of the plans. This protection should apply to all HDHPs, whether or not they are linked to HSAs.

The federal definition, unfortunately, is limited because it excludes the chronic care needs of individuals with on-going conditions; for example, individuals with diabetes, hyper-tension, and asthma may actually avoid unnecessary hospitalizations if their conditions are controlled but doctors' visits and medications necessary to control those conditions are not included.[114]

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[113] 26 U.S.C. § 223(c)(2)(C); Internal Revenue Bulletin 2004-15 supra note 12.

[114] For example, an inhaler for someone with asthma would not be included, nor would regular visits to treat hypertension and blood sugar problems.

Extending the definition would be cost-effective and would benefit consumers by helping them avoid unnecessary declines and adverse impacts on their health.[115] Therefore, states should adopt a broader definition of preventive care for HDHPs that are not offered in conjunction with HSAs to include health care services necessary to control chronic conditions.

In addition, "case management" is a service that can help consumers, particularly those with chronic care needs, navigate amongst a variety of health care providers and under ideal conditions, promotes preventive and cost-effective care.[116] State law could include case management as a preventive service that is excluded from the deductible amounts for HDHPs not offered in conjunction with HSAs.

2. Provide consumers clear and prompt access to information so that they understand what constitutes preventive care and if they are not sure, a prompt process to answer specific questions

As discussed above, there are plentiful opportunities for consumers to become confused about what expenses actually will qualify for the deductions and which might be excluded because they constitute preventive care. First, if

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[115] See Jacobi, "Consumer-Directed Health Care and the Chronically Ill," supra note 45 at 576-77.

[116] See Arlene Luu and Brian Liang, "Case Management: Lessons Learned from Integrated Delivery to Promote Quality Care to the Elderly," 9 J. of Medicine & Law 257 (Summer 2005); see also Davis, supra note 54 at 1 (noting studies that have found overutilization often is the result of provider decisions: about one-fifth of sicker patients report receiving duplicate tests from different physicians, and medical records and tests are not readily available to them – case management would be a benefit to both the consumer and the insurer).

they are in HMOs, the plans have discretion not to allow any out-of-pocket costs incurred with respect to out-of-network providers to count toward the deductibles.[117] Second, even if such expenses might count toward the deductibles, there are no applicable rules regarding whether a discounted rate used by the plans for a similar service will create an upper limit on the deductibles. Third, there are no legal requirements placing clear duties on HDHPs with respect to informing consumers about which expenses count. Most plans, now, provide explanation of benefit forms which indicate what counts toward a deductible but these are always retrospective. That means that consumers who are concerned about whether to incur an expense but are not sure whether it will count toward the deductible, or how much of it will count, have no legal right to an answer to that question prior to incurring the cost.

To address these problems, there should be legislation that requires plans to inform consumers about which expenses count toward the deductible at three junctures: a) in the information describing benefits; b) following any encounter with the health care system; and c) upon a consumer's request prior to accessing services. Most health insurance plans utilize some types of prospective review; this would be a matter of extending the opportunities for consumer education by providing consumers with a right to access such prospective review procedures themselves.

Legislation also should require plans to give consumers access to information and staff to help them differentiate among "discretionary" and non-discretionary health care spending with an emphasis on addressing: 1) not filling

[117] 26 U.S.C. § 223(b)(2)(B); Internal Revenue Bulletin 2004-2, supra note 9.

prescriptions; 2) not getting specialist care; 3) skipping a recommended test or follow-up exam; and 4) not visiting a doctor or clinic over a medical problem. Plans should be required to reach out to consumers and make available counseling to guide them if they are having any of the above problems.

3. Collect data and analyze the extent of preventable hospitalizations, correlate to insurance products and the extent to which care was not accessed due to unused deductible

As discussed above, there already is a high correlation between HDHPs and consumers who delay or forego necessary care due to concerns about costs. Legislation could be passed which requires the collection and analysis of data to help determine whether cost-related access problems are emerging and causing preventable hospitalizations. Data should determine whether there is a correlation between preventable hospitalizations and the types of insurance products with a specific focus on the impact of HDHPs.

B. Protecting individual consumers from the financial risks involved

1. Set maximum limits on the deductibles

On the HDHPs offered with HSAs, states cannot interfere with the federal minimums but can set maximums lower than the federal levels.[118] On the HDHPs offered without HSAs, states should set maximum levels. As opposed to federal law, most states have no laws limiting the maximum amounts. The question is where to set the maximums. Studies have shown that individuals with annual incomes below $50,000 are most vulnerable.[119] Legislation could require on-going evaluation of the affordability of the deductibles based on income level. However, for the time being, the maximums should be set at a level that protects individuals below this income level.

In addition, federal legislation could require employers to fund HSAs for individuals with incomes below $50,000. Similarly, state law also could require employers that are not covered by ERISA to fund HSAs for individuals with incomes below $50,000.[120] Note, however, that this protection is limited because

[118] The federal maximums are $5000 for individuals and $10,000 for families. 26 U.S.C. § 223(c)(2)(A).

[119] See supra note 37 which defines the under-insured as people with incomes below 200% of the federal poverty level who spend more than 5% of their income on out-of-pocket medical costs and anyone else who spends more than 10% of their income on out-of-pocket medical costs. This may be considered as a benchmark for setting limits.

[120] Federal law requires employers to fund HSAs equally for all employees, thus prohibiting differential treatment even if it were done to protect lower-income employees. See Internal Revenue Bulleting 2004-2, supra note 9 at Answer to Q-32. See also Mark Hall, "Paying for What You Get, and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care," (text accompanies by footnote 46) forthcoming publication in Law and Contemporary Problems (discussing possibilities for promoting progressive practices in insurance pricing).

HDHPs that are marketed separate and apart from HSAs will impose deductibles with no opportunity for tax-subsidized savings.

In order to protect individuals from financial peril, there is a good argument that individuals below a certain income level should be exempt from spending their deductibles on catastrophic care.[121] State law could add this exemption from the deductibles.

2. Set requirements on the expenses that count toward the deductibles

Legislation could clarify which out-of-pocket expenses actually count toward the deductible. These should include any out-of-pocket expenses incurred that could be covered by the insurance plan, whether or not the consumer used a network provider in the case of HMOs, or a preferred provider in the case of PPOs.[122] If utilization review ("UR") procedures are to be used to limit which expenses can count toward the deductibles, then they must be available for prospective use by consumers who must have a clear understanding and a prompt procedure to use to access the UR process.

If the HDHP negotiates discounts with providers, then legislation could require that the negotiated rates can be used as a limit only if the consumer is

[121] In South Africa, for example, experiments with consumer driven health care have allowed for "riders" to exclude hospitalization, surgery, and chronic conditions from the deductible, the idea being that first dollar coverage is necessary to cover spending that truly is "non-discretionary." Monahan, supra note 7 at 25; see also Enthoven & Kronick, supra note 43 at 33 (suggesting a "managed competition" approach that allows only "small" copayments and deductibles for inpatient hospital services because patients have relatively little influence over decisions about the use of such services).

[122] 26 U.S.C. § 223(b)(2)(B); Internal Revenue Bulletin 2004-2, supra note 9 at Answer to Q-4.

clearly informed before making payment, the consumer has clear and accurate information about which providers are in the network, and the preferred providers are prohibited from collecting amounts that exceed the negotiated rates.

3. Set limits on out-of-pocket maximums which take into account the deductibles and the co-payments and cost-sharing.

As discussed above, the trend toward HDHPs is part of an on-going trend to shift costs to consumers. Therefore, when looking at issues of affordability, it is important to have a full view of consumers' exposure to out-of-pocket costs. These include the premiums as well as co-payments and cost-sharing beyond the out-of-pocket costs incurred in order to meet the deductible. Legislation could require that limits be set on the total out-of-pocket costs with a particular emphasis on protecting the most financially vulnerable consumers and the sickest. In addition, there are some states which are concerned with "illusory benefits." In California, for example, illusory benefits are defined as situations where the premiums paid exceed a certain percentage of claims (a loss to claims ratio).[123] Such a definition should include the payments made not only for the premiums but for the deductibles and the other forms of cost-sharing.

[123] See e.g., Cal. Ins. Code § 10291.5(b)(2).

C. Protecting consumers from undue "risk segmentation" and against losing comprehensive health insurance as a choice

The most important way to protect against "risk segmentation" is to set limits on insurers' opportunities to exclude individuals.[124] Regulatory reforms which prohibit such exclusions force insurers into the position of spreading risks among their insurance products.[125] The goal should be to retain access to comprehensive health care coverage as a viable option.[126] In order to prevent a cycle where comprehensive health insurance becomes utilized only by the sickest individuals and thus becomes unaffordable (called "adverse selection"), legislation can require insurers to absorb these risks by requiring them to offer "low-deductible" health insurance products,[127] even if they offer HDHPs.[128] Therefore, legislation should: a) require insurers to provide employers a choice of a non-HDHP with HDHPs; b) require employers to offer employees a choice of a non-HDHP with HDHPs; and c) require insurers marketing in the individual market to offer a choice of non-HDHP with HDHP. These products should be

[124] See Jacobi, "The Ends of Health Insurance," supra note 51 at 379-81.

[125] Id.

[126] See Relman, supra note 56 at 28, noting insurance is rife with the potential for "market failures" where due to competition among insurers, individuals lose access to the market and the market, left to unfettered competition, has the potential to "dilute" the products available; and Davis, "'Consumer-Directed' Health Care: Will It Improve Health System Performance?," supra note 54 at 1227 (noting that without risk adjustment, sicker and lower-income individuals will pay higher premiums, and HMOs may eventually cease to exist as unfavorable risk selection worsens).

[127] These could be defined as insurance products with deductibles below the minimum allowed by law to meet the definition of an HDHP.

[128] See Jost & Hall, supra note 8 at 412-413, discussing possible ways that both employers and insurers can spread risks across products and the potential role of regulation in ensuring that takes place.

required to keep the difference in premiums within a manageable range so that insurers will have an incentive to spread risks broadly within and amongst products. In addition, on a related front, legislation should require HDHPs to offer comprehensive health care, i.e., stop allowing HDHPs to limit access to basic health care services such as maternity care, doctor's visits, or hospital care that is medically necessary.

As discussed above, states need to be concerned about the negative impact HDHPs that are not required to offer comprehensive health care will have on COBRA and HIPAA protections. Specifically, individuals with differentials in coverage or deductibles will not have the same "creditable coverage" to prevent pre-existing condition exclusions. The federal government or the states could protect such individuals by: a) creating a "HIPAA"-like portability protection for anyone moving from an HDHP to a comprehensive health insurance product; and b) requiring a "HIPAA"-like portability protection which prohibits exclusions based on differentials in deductible amounts. Note that under federal law, states are permitted to be more protective of consumers than the federal law (a "reverse" pre-emption clause).[129]

VI. Conclusion

HDHPs offer nothing more than a temporary band-aid, at best, and at worst, a misguided and unfortunate burden on consumers in the name of curbing

[129] 42 U.S.C. § 300gg-23.

the amounts of money spent on health care without tackling cost-containment in a meaningful way. We are only forestalling the inevitable which is a more meaningful dialogue about the role of insurers in spreading risks and the role of policy-makers in controlling costs. My personal preference would be not to allow these products at all. However, short of a prohibition there must be protections.