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**Wisconsin Family Impact Seminars**  
and the  
**The Wisconsin Public Health and Health Policy Institute's**  
**Wisconsin Health Policy Forums**

**Improving Health Care Quality While Curbing Costs:  
How Effective Are Consumer Health Savings Accounts  
and Pay for Performance?**



University of Wisconsin-Extension  
Center for Excellence in Family Studies  
School of Human Ecology  
University of Wisconsin-Madison

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# Improving Health Care Quality While Curbing Costs: How Effective are Consumer Health Savings Accounts and Pay for Performance?

*First Edition*

Wisconsin Family Impact Seminars  
and the  
The Wisconsin Public Health and Health Policy Institute's  
Wisconsin Health Policy Forums  
Briefing Report

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## Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers.

Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping 18 other sites establish their own seminars through the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension.

Family Impact Seminars are a series of seminars, briefing reports, newsletters, and discussion sessions that provide up-to-date, solution-oriented research on current issues for state legislators and their aides, Governor's Office staff, legislative service agency personnel, and state agency representatives. The seminars provide objective, nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Improving Health Care Quality While Curbing Costs: How Effective Are Consumer Health Savings Accounts and Pay for Performance?" is the 21st Family Impact Seminar in a series designed to connect research and state policy, and bring a family perspective to policymaking. Family Impact Seminars analyze the consequences that an issue, policy, or program may have for families.

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## Wisconsin Family Impact Seminar Briefing Reports

Each seminar is accompanied by an indepth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at:

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## Executive Summary

**D**uring the last four years, health insurance costs for Wisconsin workers increased four times faster than their average wages. In a recent Harris poll, Wisconsin citizens reported that the issue needing the most attention from state government is controlling the costs of health care and prescription drugs. This report overviews the drivers behind rising health care costs and focuses on two policy options: Consumer Health Savings Accounts and Pay for Performance.

**Scott Leitz**, Health Economist for the State of Minnesota, shares evidence that states, employers, and consumers have all felt the crunch of rising health care costs. State spending on health care revenue has grown faster than the increase in revenue. In fiscal year 2001, states spent an average of 30% of their total budgets on health care, compared to 16% in Wisconsin. However, Wisconsin allocated its health expenditures similar to other states, with almost two-thirds (66%) going to Medicaid and 10% to employee health benefits.

Many factors are driving health care costs including technological advances, the decline in the prevalence of managed care, inappropriate use of health care services, and consumer incentives and lifestyle behaviors. For example, advances in technology are thought to account for a majority of increases in health care spending over the long term. Overuse of health care services has also driven up costs. In a recent study, Medicare beneficiaries in high-spending regions received 60% more care than in lower-spending regions, but they did not have better health outcomes. Lifestyle behaviors have also contributed to health care cost growth. For example, tobacco smoking accounts for 7% to 14% of annual medical spending and obesity-related expenditures account for an estimated 9%. Importantly, 5% of consumers account for 55% of all health care expenditures. Any successful strategy to control costs will have to take into account these high-cost consumers.

States play three critical roles in the health policy arena, each that shape the strategies states can use to address rising health care costs. States are (1) purchasers of health care services for low-income populations through Medicaid and other programs, (2) employers that provide health benefits to employees, and (3) policymakers and marketplace regulators that affect the rules of pricing and competition. Leitz uses this framework to discuss Consumer Health Savings Accounts (HSAs), one type of tax-favored account that is paired with a high-deductible health plan that aims to promote wise spending by consumers. State policymakers will ultimately have to determine if HSAs will realize any cost savings. Will consumers have the information they need to make decisions about efficient, high-quality care, and how much will the tax-exempt accounts reduce state revenues? State policymakers will also need to consider if the high deductibles will (a) cause low-income workers to spill over into public insurance programs, and/or (b) result in the delay of needed preventive services. Moreover, as consumer pay more out-of-pocket costs, will the extent of uncompensated care increase?

Leitz concludes that long-term solutions will require more than shifting costs to other services or payers. Real solutions will address the underlying reason for increased costs and take steps to contain them. Opportunities exist in the current

system to place a greater emphasis on high-quality health care, cost-efficient services, and evidence-based medicine.

In the next chapter, **Paul Fronstin**, Director of the Health Research and Education Program at the Employee Benefit Research Institute in Washington DC, discusses Consumer Health Savings Account (HSAs). HSAs are the newest type of tax-favored savings accounts created by Congress in 2003. In a recent poll, 61% of employers would like to offer HSAs in the near future. However, because of the delay in Treasury Department and IRS guidance, most employers are not expected to begin offering HSAs until 2006.

An HSA is a tax-exempt trust that an individual can use to pay for health care expenses. An employer's contributions are excluded from a worker's taxable income, and an employee's contributions are deducted from adjusted gross income. Only employees with a high-deductible health plan (a minimum of \$1,000 for self-coverage and \$2,000 for family coverage) are eligible to set up an HSA. The maximum amount of money contributed annually cannot exceed the plan's deductible, which in 2004 is a maximum of \$2,600 for self-only coverage and \$5,150 for family coverage. Thus, the amount of money that an individual can accumulate in an HSA for retirement health care costs is typically limited.

It is too soon to know how HSAs will affect the use and cost of health care, but preliminary evidence is emerging. Advocates for HSAs believe that they will reduce overall health care spending, because consumers will understand the need for becoming more responsible and discriminating users of health care services. However, it is well known that about 25% of the population accounts for about 80% of total health care spending. It is unlikely that this 25% of the population can make decisions to substantially reduce their health care costs, because they are sicker and need more services. Unless HSAs include incentives designed to affect the spending of chronically high users of health care, it is not likely that they will significantly reduce the cost of providing health benefits.

Early evidence suggests that HSAs may be more attractive to healthy employees, which could lead to adverse selection. That is, if healthy people choose HSAs, the overall costs of their health plan would decline. At the same time, if unhealthy employees are more likely to remain in traditional plans, the overall costs of these plans could increase. However, adverse selection could be offset by wealthy HSA enrollees who tend to be older and less healthy.

HSAs may be more attractive to individuals than families, especially if some family members are significantly less healthy than others. No one in the family can have a separate deductible lower than the minimum family deductible of \$2,000. This means that for a married couple with no children, the unhealthier family member would, in effect, have a \$2,000 deductible to work off. In this case, the sicker family member would be better off enrolling in single coverage so that the deductible is only \$1,000.

In the next chapter, **François de Brantes**, Program Leader for Health Care Initiatives at General Electric (GE), describes the conundrum purchasers are currently facing: health care costs are rapidly increasing, while quality appears to be stagnating. In a recent study, patients were receiving only 50% to 60% of recommended, evidence-based care. In response, GE turned to the same business

model that it uses to design any new product. The result was Bridges to Excellence, a health care system that builds on transparency and pay for performance to reward physicians who provide high-quality care.

In collaboration with several other large purchasers and health plans, Bridges to Excellence evaluates and rewards physicians who meet evidence-based performance standards. As an example, blood sugar testing is essential to effectively treat diabetes, yet only 29% of adults with diabetes reported having their blood sugar tested in the previous year. Also, beta blockers can reduce the risk of death following a heart attack by 13% in the short run and 23% over the long-term, yet only 45% of patients who should have received beta blockers did.

In Bridges to Excellence, physicians receive bonuses for providing quality diabetes and cardiovascular care, and for adopting better information technology systems to manage their practices. Under all three initiatives, participating doctors could receive income gains of up to 10% in bonuses from employers. Patients also receive incentives to keep them focused on achieving better outcomes.

Pay for performance initiatives like Bridges to Excellence have had positive impacts on productivity, as well as the quality and cost of health care. As an example of their impact on the quality of care, patients whose blood pressure was properly controlled increased from 50% among participating physicians in 1997 to 64% in 2002. As an example of the cost of care, patients with diabetes going to physicians recognized by the National Committee for Quality Assurance cost 10% to 15% less than diabetic patients treated by physicians that are not so recognized. Half of these savings are kept by purchasers, and the other half are set aside as incentives for physicians who meet quality standards.

In the last chapter, **Tom Korpady** of the Wisconsin Department of Employee Trust Funds explains that the State of Wisconsin has taken a different approach in its Employee Group Health Benefit Program by combining consumer involvement with pay for performance. A major advantage of this new approach is that it accurately compares the efficiency of the plans using not just price, but also utilization and intensity of health care services. Certain providers may have low prices, but may actually end up costing more through over prescribing services or prescribing more expensive services.

Specifically, the Group Insurance Board redesigned the program by: (a) developing a three-tier employee contribution system in response to calls for greater employee participation in the cost of their health care, (b) incorporating a reward system to provide an incentive for health plans to deliver exceptionally high-quality care, and (c) consolidating prescription drug coverage in the state's health plans to leverage the state's huge purchasing power.

The cumulative results from each of these initiatives have been very encouraging. When most employers are facing double-digit increases in health care costs, Wisconsin has held premium increases to only 5% for current employees and actually decreased premiums by over 6% for retired state workers. At the same time, benefit levels have been maintained, and high-quality health care has been encouraged and rewarded.





# A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

**This checklist can be used to conduct a family impact analysis of policies and programs.**

✓ *For the questions that apply to your policy or program, record the impact on family well-being.*

1

## Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

2

## Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

**3****Principle 3. Family involvement and interdependence.**

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

**4****Principle 4. Family partnership and empowerment.**

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?



5

### Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6

### Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The institute has resources for researchers, policymakers, practitioners, and those who work to connect research and policymaking.

- To assist researchers and policy scholars, the institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the institute provides technical assistance on how to establish your own state's Family Impact Seminars.

This checklist was adapted by the institute from Ooms, T. (1995). *Taking families seriously as an essential policy tool*. Paper prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

The checklist and the papers are available from Director Karen Bogenschneider, Family Impact Seminar Coordinator Heidi Normandin, and Editor Meg Wall-Wild of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 130 Human Ecology, 1300 Linden Drive, Madison, WI, 53706; phone (608)263-2353; FAX (608)262-5335;

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# Health Care Cost Growth, Drivers, and Implications for States

by **Scott Leitz, M. A.**  
**State of Minnesota Health Economist**  
**Director, Health Economics Program**

**M**any factors are driving health care costs including technological advances, the decline in the prevalence of managed care, inappropriate use of health care services, and consumer incentives and lifestyle behaviors. For example, advances in technology are thought to account for a majority of increases in health care spending. According to recent studies, the overuse of health care services has also driven up costs, without improving health outcomes. Lifestyle behaviors like tobacco smoking account for 7% to 14% of annual medical spending and obesity-related expenditures account for an estimated 9%. States play three critical roles in the health policy arena, each that shape the strategies they can use to address health care costs: (1) purchaser of health care for low-income populations through Medicaid and other programs, (2) employers that provide health benefits to states employees, and (3) policymaker and marketplace regulator that affects the rules of pricing and competition. Leitz uses this framework to discuss Consumer Health Savings Accounts, one type of consumer-driven plan that aims to promote efficient, effective spending by consumers. Overall, Leitz concludes that long-term solutions will require more than shifting costs to other services or payers. Opportunities exist to place a greater emphasis on high-quality care, cost-efficient services, and evidence-based medicine.

Rising health care costs have captured the attention of citizens and policymakers alike. Although some of the factors that are driving increased costs are outside the control of policymakers, states can play a variety of roles and use a number of strategies to help control health costs. In the short run, strategies that shift costs may result in some temporary relief from rising health costs. However, strategies that reduce costs in the mid- to longer-term may require different approaches.

This chapter begins by examining how rapidly health care costs are rising, and how increased health care costs are affecting state budgets, employers, and workers. Next, the chapter examines the drivers of rising health care costs and what roles states can play in containing costs. Finally, Health Savings Accounts, a policy option that has gained attention in Wisconsin, is discussed from a state perspective.

## How Important is Health Care to the Overall Economy?

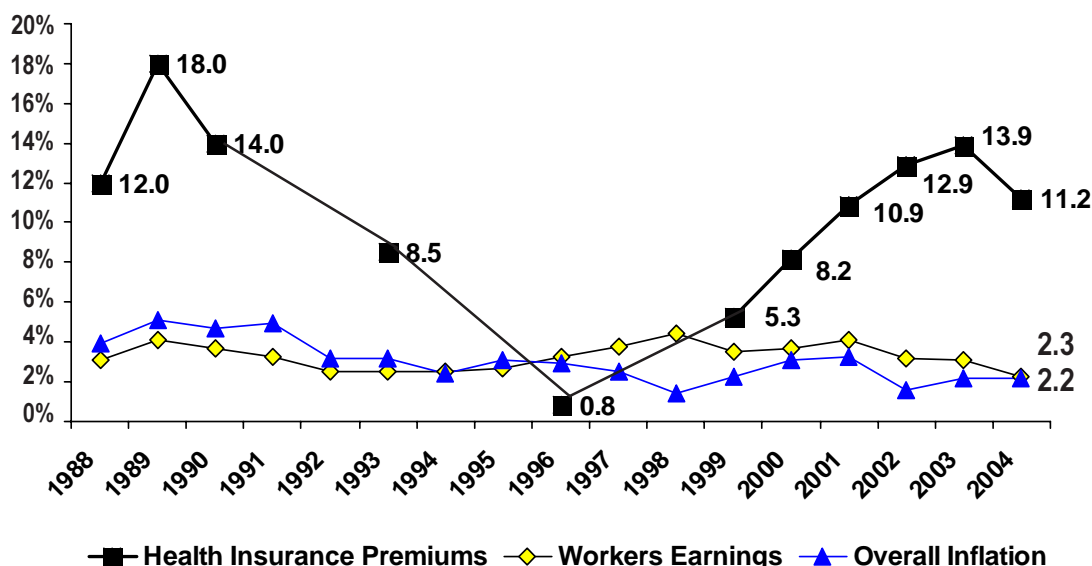
To place health care premiums and spending increases in context, it is important to know how health care fits into our economy. Overall, the United States spent \$1.6 trillion on health care in 2002. This figure reflects nearly 15% of the U.S. economic output. The portion of our economy that is devoted to health care services has grown rapidly over the past 40 years, as health care expenditure growth has exceeded growth in the overall economy.

## How Much Have Health Care Premiums and Costs Increased for Employers and Workers?

Businesses have seen the cost of health insurance provided to their employees increase dramatically since the late 1990s. As private sector health care costs have grown, pressure has been placed on both the ability of private employers to offer coverage, and on employees to continue to buy into that coverage.

Employers have faced double-digit increases in their health insurance premiums over the last four years. These increases have risen more rapidly than wages or inflation (see Figure 1). In fact, premiums increased nearly five times faster than the increase in workers' wages between 2003 and 2004. These increases have placed pressure on employees as well. For example, as increases in health insurance premiums continue to outpace the growth in workers' wages, workers are paying a larger percentage of their wages on health insurance, potentially making that coverage increasingly unaffordable.

**Figure 1: Increases in Health Insurance Premiums Compared to Workers' Earnings and Overall Inflation, 1988 to 2004 (In Percentages)**



*Source: Kaiser Family Foundation/Health Research & Educational Trust Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996.*

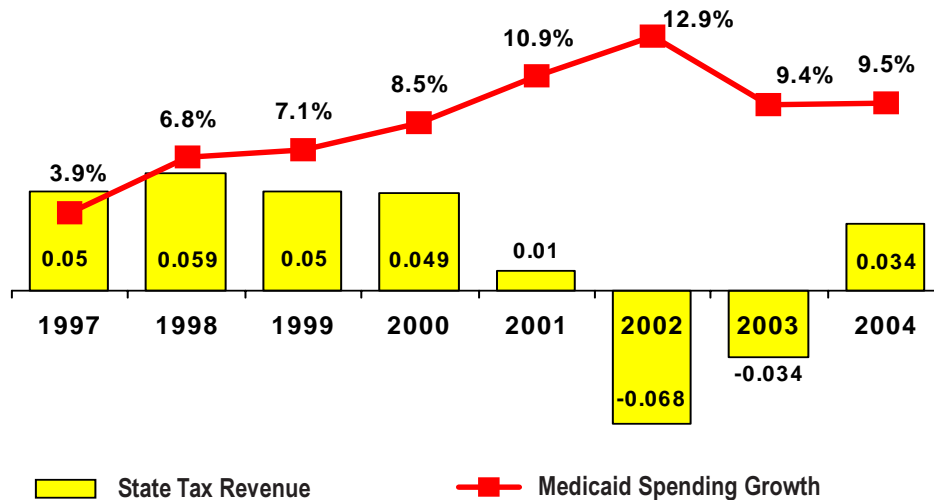
*Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.*

In addition to the increase in health insurance premiums for employers, the increase in health care costs—that is, the amount actually paid in claims for health care services—has also outpaced growth in the economy. Since 1998, the growth in underlying health care costs for privately insured consumers has outpaced overall economic growth, reversing the trend of the mid-1990s.<sup>1</sup>

## What Portion of State Budgets is Spent on Health Care?

Rising health care costs have also taken on an increasingly important role in state budgetary discussions. One reason is that state spending on health care has grown faster than the increase in revenue (see Figure 2).

**Figure 2: Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004**



Note: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

Source: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

**States spend over one-fourth of their budget on health care.** In fiscal year 2001, states spent an average of 30% of their total budgets on health care expenditures.<sup>2</sup> This increased from 29% in 2000 and 27% in 1999. As shown in Table 1, the largest share of states' health care expenditures in 2001 was allocated to Medicaid (69%); the second largest category was employee health benefits (8%).

**Wisconsin is below average in the percentage of its budget spent on health care.** In fiscal year 2001, Wisconsin spent 16% of its budget on health care expenditures (see Table 1).<sup>3</sup> However, Wisconsin distributed its health expenditures similar to the average state. In 2001, Wisconsin allocated about two-thirds (66%) of its health expenditures to Medicaid and 10% to employee health benefits.

**On average states spent 30% of their budgets on health care expenditures in 2001, compared to 16% in Wisconsin.**

**Table 1: State Expenditures on Health Care in 2001**

	Health Care Budget as Percent of Total Budget	Percent of Health Care Budget Spent on Medicaid	Percent of Health Care Budget Spent on Employee Benefits
Wisconsin	15.9%	66.3%	9.8%
U.S. Average	29.9%	69.2%	8.3%

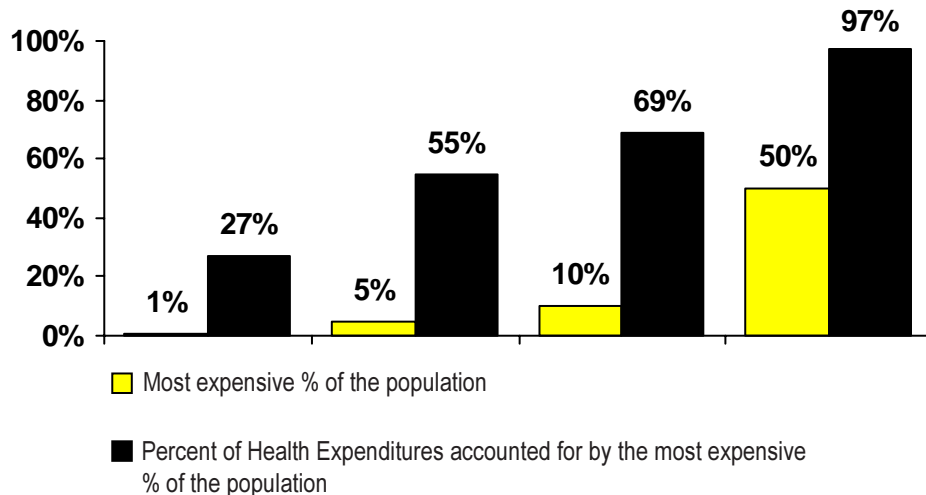
## What is Driving the Increase in Health Care Costs?

Most factors acting to increase health care costs are ones that affect both private insurance costs and publicly-sponsored health care services.

One important factor to keep in mind when examining health care cost increases or strategies that address these increases is the context within which health spending occurs at the population level. In particular, it is important to note that a relatively small percentage of the population spends the most on health care.

High health care spending is limited to a small percentage of the population (see Figure 3). Specifically, 1% of the population accounts for 27% of all health care expenditures in the United States, and 5% of the population accounts for 55% of expenditures.

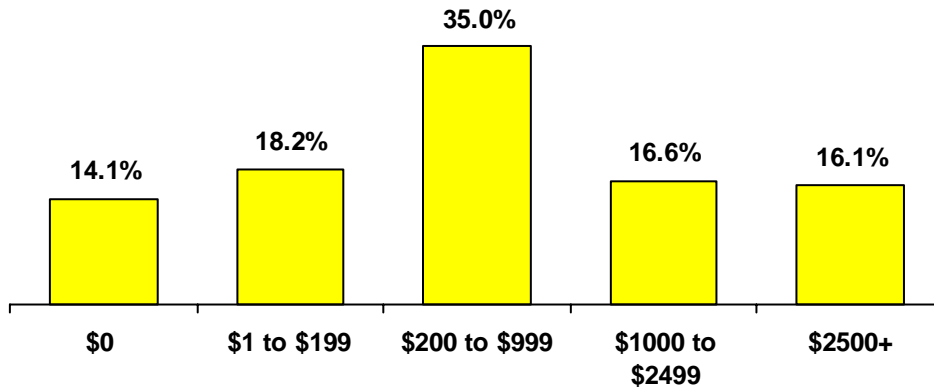
**Figure 3: Concentration of Health Care Spending in the Most Expensive Portion of the Population**



*Source: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," Health Affairs, March/April 2001. Expenditure estimates are for the civilian non-institutionalized population.*

How does this translate into dollar amounts? About two-thirds (67%) of people with private health insurance spend less than \$1,000 for out-of-pocket health care expenses. The most expensive 16% of the population spends over \$2,500 each year (see Figure 4). These numbers have important implications for strategies that states can use to control costs; any strategy will have to take into account how it will affect high-cost consumers.

**Figure 4: Distribution of Health Spending Among People with Private Health Insurance**



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

A number of drivers affect health care cost growth, five of which are mentioned here:

**Technology.** Most economists believe that technological advances account for a majority of increases in health care spending over the longer term. Economists estimate that at least half of health care cost increases are due to advances in medical technology.<sup>4</sup> This means that health conditions can now be treated more effectively, but often at a higher cost. A widely-cited study examined whether the benefits of this increased spending on medical technology outweighed the costs. In four of five conditions (i.e., heart attacks, low birthweight infants, depression, and cataracts), the estimated benefit of specific technological advancements far exceeded the costs. In the fifth condition (i.e., breast cancer), the benefits and costs were roughly equal.<sup>5</sup>

Some health care experts have recently raised concerns about a renewed “medical arms race.” If expensive technologies are available at too many regional hospitals and clinics, this duplicates services and drives up costs. Recently, hospitals’ strategic emphasis has changed significantly. In the mid-1990s, hospitals primarily competed on price through “wholesale” strategies (i.e., providing services attractive to *managed care plans*). By the early 2000s, nonprice competition was becoming increasingly important and hospitals were reviving “retail” strategies (i.e., providing services attractive to *individual physicians and the patients they serve*).<sup>6</sup>

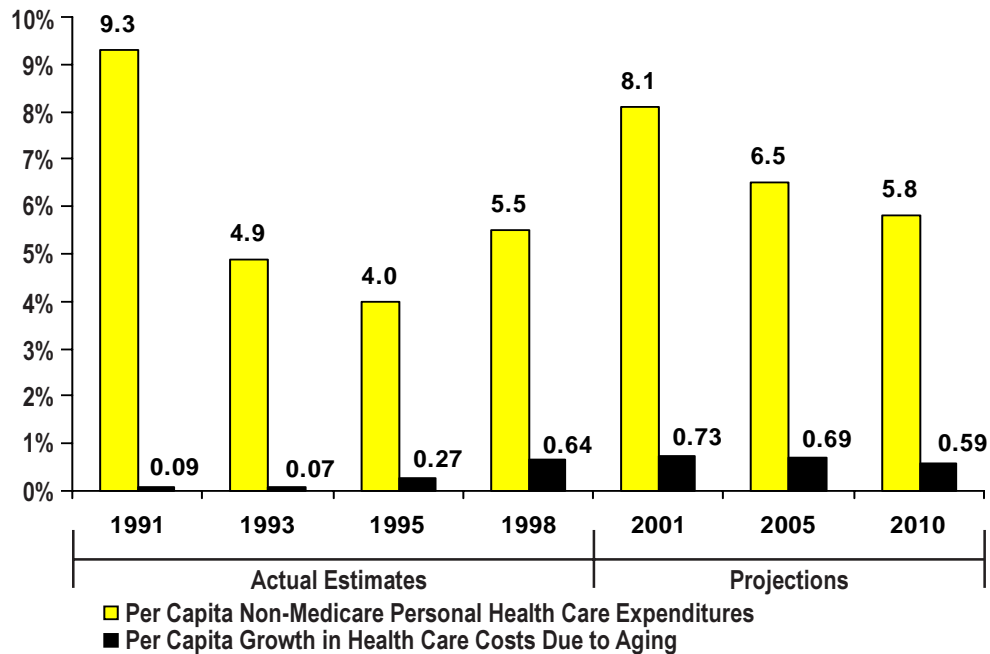
**Aging Population.** Surprisingly, most analyses show that aging has not yet become a major factor in health care cost growth.<sup>7</sup> That is, the cost of covering and treating individuals over age 65 has not resulted in dramatic increases in health care costs for the rest of the population. In 1998, for example, consumers spent 5.5% more on health care than in 1997. Population aging accounted for about 9% of this increase. Projections for 2005 and 2010 suggest that increases due to the aging population will stay around 9% to 10% (see Figure 5).

**Technological advances are estimated to account for at least half of health care cost increases.**



However, aging is expected to become increasingly important in the future. Use of hospitals, physician services, and pharmaceuticals increases with age. As the baby boomers grow older, it is likely that their use of services will increase, potentially straining current health care resources.<sup>8</sup>

**Figure 5. Effect of U.S. Population Aging on Health Care Costs  
(Annual Percentage Change)**



Source: Strunk, B.C., & Ginsburg, P.B. (2002). *Aging plays limited role in health care cost trends*, (Data Bulletin No. 23). Washington DC: Center for Studying Health System Change.

**The Decline in the Use of Managed Care.** Most analysts believe that the decline in the prevalence of managed care has contributed, at least in the short- to mid-term, to the increase in health care costs. The percentage of private health plan enrollees in HMOs rose substantially in the mid-1990s, doubling between 1988 and 1996, as employers turned to managed care to help control health care cost increases.<sup>9</sup> These plans used restricted networks to negotiate lower costs with providers. Also, tools such as utilization review and gatekeeper physicians controlled usage by plan members.

During the latter part of the 1990s, a tight labor market along with provider and media backlash against managed care led many employers and managed care health plans to loosen many of the “heavier” aspects of managed care. Managed care plans established broader provider networks and loosened restrictions on access to providers by, for example, providing more direct access to specialty care. As a result, many analysts believe this resulted in providers being able to leverage higher rates, and consumers being able to utilize more services. While these changes in the use of managed care may have brought positive results from a consumer-access perspective, they also contributed to the growth in overall health costs.



**Overuse, Underuse, and Misuse of Health Care Services.** Based on growing evidence, the U.S. health care system has high levels of overuse, underuse, and misuse of health services. In fact, many of the pay-for-performance purchasing initiatives currently under consideration are a direct response to this.

Overuse of services, in the form of unnecessary services, tests, and procedures, can drive up health care costs, while not producing any noticeable gains in health outcomes. Researchers at Dartmouth Medical School concluded that Medicare beneficiaries in higher-spending regions of the United States received approximately 60% more care than those in lower-spending regions. However, they did not have better quality of care, better access to care, higher survival rates, or better health outcomes.<sup>10, 11</sup>

Misuse of the system is evident in medical errors and preventable mistakes. These errors and mistakes not only lead to serious injuries and death, but also add to costs. The Institute of Medicine estimates that between 44,000 and 98,000 persons in the U.S. die annually in hospitals from preventable medical errors, resulting in \$17 to \$29 billion annually in increased health care costs, lost income, and lost productivity.<sup>12</sup>

Finally, underuse of the system is also prevalent and well-documented. For instance, recent studies have shown that only approximately half of adults in the United States receive recommended levels of preventive, acute, and chronic care.<sup>13</sup>

**Consumer Incentives and Lifestyle Behavior.** Because of the widespread use of third-party payment in our current health care system and the complexity of the health care services delivered, consumers are frequently removed from knowing either the cost of the services they consume or the quality of care they receive. As a result, there is little incentive for consumers to utilize care in a cost-effective manner. Some analysts believe that an increased awareness of the cost and quality of health care consumed by patients would contribute to a more efficient and effective health care system. In fact, much of the recent interest in consumer-driven health plans, including Health Savings Accounts, is based on this premise.

The lifestyles led by consumers also contributes to health care cost growth. For example, tobacco smoking is estimated to account for between 7% and 14% of annual medical spending in the U.S, and obesity for an estimated 9% of annual medical spending.<sup>14, 15</sup>

Not all factors driving health care cost increases can be directly influenced by policymakers, such as the emergence of new technology, the aging of the population, and an individual's genetic factors. Acknowledging all of these factors, however, can paint a more accurate picture of the complexity of health care costs and which aspects state policymakers can affect.

***Tobacco smoking accounts for 7% to 14% of annual medical spending and obesity for an estimated 9%.***

## What Role Can States Play in Addressing Health Care Costs?

States play three critical roles in the health policy arena.

States are **purchasers** of health care services for low-income populations through Medicaid and other programs. In recent years, Wisconsin and other states have expanded their public health insurance programs. These expansions have increased access for many people, with a corresponding increase in the state's health care budget. These budgetary pressures are even more pronounced in tight economic times. Enrollment in publicly-sponsored health programs tends to be counter-cyclical. As the economy softens and incomes stagnate, more persons become eligible for public programs; at the same time, less tax revenue is generated to operate them.

States face several challenges as purchasers of health care services for low-income populations. Budgetary constraints make it difficult to maintain or enhance payment levels to health plans and providers, or to finance future expansions.

States are **employers** that provide health benefits to their employees. Because they are among the state's largest employers and purchasing groups, state employee groups are often in a position to be a leader for other purchasers.

States face special challenges as employers, three of which will be mentioned here. First, state workforces are aging, which may increase costs because older workers are, on average, higher health care users. Second, benefits such as health care have traditionally been a tool that states, as employers, have used to recruit and retain employees. Therefore, changes to the benefit structure may affect their ability to attract a competent workforce. Finally, many benefits within state governments are collectively bargained. As a result, states face a unique challenge in innovating or reorganizing their health benefits compared to many private-sector employers.

Finally, states are **policymakers** that regulate the insurance marketplace, have responsibility for health care access issues, and affect the rules of pricing and competition. States are often prompted by businesses, consumers, and providers to act on a given issue. For example, states have been pressured to respond to increases in pharmaceutical prices, with some states making arrangements with Canadian pharmacies for reduced-cost drugs.

As policymakers, states must address consumers who are concerned about both costs and access to services. In addition, states face pressure from employers about rising costs. In the past, states have tried a variety of approaches to address these concerns, such as certificate of need programs, health planning, hospital rate setting, and, more recently, widespread use of managed care. At present, there appears to be little consensus over what the next best strategy is for curbing rising health care costs.

The state's role as purchaser, provider, and policymaker/marketplace regulator, each with their unique challenges, shape the strategies that states can use to address rising health care costs. Several strategies are described below.

*As a large employer and purchaser, state employee groups are often in a position to be a leader for other purchasers.*

## What Strategies Can States Use to Address Rising Health Care Costs?

**State as Purchaser on behalf of low-income populations.** As purchaser of health care services, states should first seek to understand the drivers of Medicaid and other health program expenditures. Medicaid programs have a wealth of data that can be analyzed and examined to identify areas of high growth. Many states have developed an increasingly sophisticated means of doing this.

Given that much of state Medicaid budgets are driven by the needs of chronically-ill populations and those in need of long term care, states have begun to invest in disease management programs (although the long-range cost savings from these programs is unclear at present). States are also continuing to examine how best to integrate support services with delivery of health care services. Finally, on the acute care side, states are increasingly using creative strategies to reexamine benefits covered under Medicaid. States are experimenting with premium subsidies and a variety of other methods that attempt to leverage existing private sector contributions to maintain or expand coverage for low-income populations.

**State as Employer.** As employers, it is important that states analyze and understand the cost drivers for their employee populations.

States are exploring a variety of strategies to control health care costs for their state employee populations. Many of these strategies are similar to those being used by large private sector employers. These include the introduction of consumer-directed health plans, examination of various pay for performance or value-based purchasing initiatives, and selective contracting with cost-effective or high-quality providers.

**State as Policymaker.** In the current political environment, it seems unlikely that most states will move toward a highly regulatory approach toward containing health care costs. Many states are likely to examine strategies which balance a competitive approach to cost containment with some level of regulation. As strategies are implemented, it is important for states to collect and analyze data to determine the drivers of health care cost increases, and monitor the impact of policy interventions.

States as policymakers are considering a variety of approaches. Some include trying to place limits on the supply side of the health care market. This might include reexamination of existing strategies such as certificate of need. On the demand side, states are examining strategies that encourage consumers to become more involved in health care decisionmaking. In the short run, consumer engagement may simply take the form of higher cost sharing by consumers. However, states may also want to examine insurance innovations such as consumer-directed health plans and Health Savings Accounts.

In addition, it is possible that states may feel pressured to decrease mandates and taxes in the system. The extent to which reducing mandates will lower overall health costs is unclear. In fact, studies indicate that mandated benefits account for only 5% to 8% of total spending. In addition, repealing mandates may produce only a one-time savings and may not address underlying cost trends. However, this cost reduction would likely be real and may produce at least some short-term cost relief.

*In the health policy arena, states are purchasers, employers, and policymakers/ marketplace regulators that affect the rules of pricing and competition.*

## What Questions Should Policymakers Ask About Health Savings Accounts?

Consumer Health Savings Accounts (HSAs) are one type of “consumer-driven” health plan. These plans aim to promote wise spending habits by making consumers aware of the costs of their health care. HSAs must be combined with high-deductible health insurance plans. Consumers face some level of out-of-pocket payments for their health care before the deductible kicks in. Advocates of these accounts argue that the account encourages consumers to use their health care services wisely and cost-effectively. HSAs raise a number of issues in each of the roles that states play in the health policy arena.

**State as Employer/Purchaser.** On average, state workforces tend to be older and more heavily unionized. States may be concerned that low users of health services, who tend to be healthier, will select HSAs. Higher users of health care are more likely to remain in traditional health plans, which could end up raising the premiums of these plans.

Another issue is the contribution requirements which could be higher under HSAs than traditional plans. In states where state employee groups are self-insured, states pay enrollee claims as they are incurred. Therefore, non-users, who account for approximately 15% of a given large group, do not contribute to the overall cost of the group. Under HSAs, however, the state would make contributions to the HSAs of both health care users and non-users. As presented in Figure 4, most consumers spend less than \$1,000 each year on health expenses. The state would, in effect, be making contributions to a low-users’ health plan, which does not occur in the current system.

State policymakers must determine whether any cost savings in the whole pool’s health insurance premiums outweigh the additional contributions that will be made to low health care users’ HSAs.

**State as Policymaker and Regulator.** Because HSAs are a new option in the marketplace, states will have to monitor their effect and ask the following questions:

- ❖ Will there be any cost savings in the system? Early studies on HSAs are mixed regarding cost savings; more research is needed.
- ❖ How will risk segmentation issues play out over time? Will the healthy and wealthy be more apt to join HSAs? We will not know the extent of market segmentation for a few years.
- ❖ How will the high deductibles under HSAs affect affordability of health insurance, especially for low-income workers? Will low-income workers be unable to afford employer-sponsored coverage and spill over into the public insurance market?
- ❖ As consumers pay more out-of-pocket costs for their care, will there be an increase in uncompensated care? Providers often find that it is more difficult to collect payment from individual consumers than from insur-

***Will low-income workers be unable to afford the high deductibles and spill over into public insurance programs?***

ance companies. Because consumers will be responsible for the first dollars spent on health care each year, providers may have more uncompensated care if they are unable to get payment for their services.

- ❖ Will consumers be more likely to use less care or delay needed care because they must pay for the complete cost of services before their deductible is met? Or will exempting preventive care from the required deductible offset this risk?
- ❖ Do consumers have the information they need to make decisions about cost-efficient and high-quality health care? If this information is not available, who is responsible for providing it?
- ❖ Finally, because HSAs lower a consumer's taxable income, will there be a noticeable reduction in the income tax states collect? The reduction is probably not large, but it may be an issue for the legislature to consider.

**Will consumers have the information they need to make decisions about efficient, high-quality care?**

## Conclusion

Many factors are driving the increase in health care costs. Some of these factors are not in state policymakers' control, yet policymakers do have opportunities to reduce cost growth. As policymakers debate their options, long-term solutions will require more than shifting costs to other services or payers. Real solutions will address the underlying reason for increased costs and take steps to contain them. Consumers have a role to play in containing costs as well, but they need more information in order to make better decisions. Opportunities exist in the current system to place a greater emphasis on high-quality health care, cost-efficient services, and evidence-based medicine.

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# The Potential Impact of Consumer Health Savings Accounts as a Market-Based Approach for Improving Quality and Reducing Costs

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**C**onsumer Health Savings Accounts (HSAs), created by Congress in 2003, are tax-exempt trusts that an individual can use to pay for health care expenses. An employer's contributions are excluded from a worker's taxable income, and an employee's contributions are deducted from adjusted gross income. Only employees with a high-deductible health plan (a minimum of \$1,000 for self-coverage and \$2,000 for family coverage) are eligible to contribute to an HSA. Advocates for HSAs believe that they will reduce overall health care spending, because consumers will become more responsible and discriminating users of health care services. However, unless HSAs include incentives designed to affect the spending of chronically high users of health care, it is not likely that they will significantly reduce the cost of providing health benefits. Because annual contributions cannot exceed the plan's deductible, the amount of money that an individual can accumulate in an HSA for retirement health care costs is typically limited. Early evidence suggests that HSAs may be more attractive to healthy employees, which could lead to adverse selection and consequently, increase the cost of traditional health plans. HSAs may be more attractive to individuals than families, especially if some family members are significantly less healthy than others.

Consumer Health Savings Accounts are part of a larger movement toward more consumer involvement in the financing and delivery of health care. Health Savings Accounts (HSAs), the newest type of tax-favored savings account, were created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Supporters believe that if consumers have more control over the funds used for their own health care, they will spend the money more wisely, especially after they are educated about the actual price of health services. In addition, these accounts are thought to be a tax-favored means of saving for health care expenses in retirement.

In a 2004 study, 61% of 270 employers would like to offer HSAs in the near future.<sup>1</sup> In December 2003, 73% of 256 small business owners were interested in the HSA concept.<sup>2</sup> Currently, however, few employers offer and few individuals have an HSA. Because of the delay in Treasury Department and IRS guidance, most employers are not expected to begin offering HSAs until 2006.

In the meantime, HSAs remain a controversial health care option. Supporters believe they will encourage individuals to become more astute and responsible health care consumers. Opponents worry that, rather than saving money, they will shift costs from employers to employees. Also, if HSAs attract only the healthiest

and wealthiest employees, they may draw relatively low-risk employees away from conventional health plans and ultimately make health insurance more expensive for those who remain.

This report examines Health Savings Accounts, outlining what they are, in what ways they differ from other health accounts, how they are being regulated, and what the implications are for employers and employees. The chapter concludes by discussing how health savings accounts may affect the use and cost of health care in the United States.

## **What are Health Savings Accounts?**

A Health Savings Account (HSA) is a tax-exempt trust that an individual can use to pay for health care expenses. HSAs, like other account-based plans, are trusts into which individuals can make tax-free monetary contributions. Contributions to the account are deductible from taxable income, even for individuals who do not itemize. In addition, distributions (withdrawals) for qualified medical expenses are not counted in taxable income.

HSAs are owned by the individual and are completely portable from job to job. Also there is no “use-it-or-lose-it” rule. Thus, any money left in the savings account at the end of the year can be rolled over and may be used for medical expenses in subsequent years. However, only employees with a high-deductible health plan are eligible to contribute to an HSA. Specifically, employees must be covered by deductibles of at least \$1,000 for self-coverage and at least \$2,000 for family-coverage. Certain preventive services can be covered in full and are not subject to the employee’s deductible. Out-of-pocket costs (including the deductible) may not exceed \$5,000 for individual coverage or \$10,000 for family coverage. The minimum deductible and maximum out-of-pocket costs will be indexed to inflation.

## **Who Contributes to Health Savings Accounts and How Much?**

Both employees and employers can make contributions to the employees’ accounts. An employer’s contributions are excluded from a worker’s taxable income, and an employee’s contributions are deducted from adjusted gross income. The maximum annual contribution is \$2,600 for self-only coverage and \$5,150 for family coverage in 2004. However, the maximum amount of money contributed annually cannot exceed the plan’s deductible. For instance, if an individual’s deductible is \$1,000, then the amount contributed to his account cannot be more than \$1,000.

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse’s plan. However, supplemental coverage, even without a high deductible, is allowed for such needs as vision and dental care, specific diseases, and hospitalization.

## **What Are the Rules for Using Funds?**

The funds in an employee’s accounts can be used at any time. Payments made using money in the account are called “distributions.” Individuals need not be currently covered by a high-deductible plan to take distributions from their

***A Health Savings Account is a tax-exempt trust that an individual can use for health care expenses.***



account as long as they set up a Health Savings Account when they had a high-deductible plan. Further, payments made on qualified medical expenses (i.e., expenses approved by the health plan) using money from these accounts are tax-free. HSAs funds can also be used on a tax-free basis for premiums for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare (other than Medigap). However, distributions for nonqualified medical expenses are subject, not only to regular income tax, but also to a 10% penalty. This penalty is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

## How Do Health Savings Accounts Compare to Other Tax-Favored Health Accounts?

Three other account-based health plans are currently available to employees: Flexible Spending Accounts (FSA), Medical Savings Accounts (MSA), and Health Reimbursement Arrangements (HRA). Although these account types are similar, they do have important distinctions. Table 1 summarizes a comparison of the four plans.

### Flexible Spending Accounts

Flexible Spending Accounts can be offered alone or as part of a larger “benefits cafeteria plan,” which allows employees to pick and choose (like a buffet style meal) from a selection of different benefits. Flexible Spending Accounts are the most well known type of health spending account with 80% of employers with 500 or more employees offering them in 2003.<sup>3</sup>

Flexible Spending Accounts are a simple and inexpensive way whereby employees can use pre-tax dollars to pay for health care services not covered by health insurance. They are funded through employee pre-tax contributions, but employees must designate their contribution in the prior year. Money that is put into the spending account is withdrawn in equal amounts from each paycheck throughout the year, but employers must make the full amount available at the beginning of the year. If an employee receives more money than he/she has contributed and then leaves the job, the employer ends up losing that money. To reduce losses due to turnover, employers usually set an upper limit on annual contributions to the plan.

Contributing to a Flexible Spending Account also reduces the wages on which Social Security and Medicare taxes are paid for both the employee and the employer. The savings to the employer are often enough to offset the cost of administering the benefit.

Few restrictions apply to the distribution of money in the Flexible Spending Account; withdrawals can be made at any time and are excluded from taxable income if used on qualified medical expenses. However, in contrast to a Health Savings Account, employees lose any money that is left over at the end of the year. In other words, the contributions do not “roll over.” Forfeiting unused funds may explain, in part, why only 19% of eligible employees participate in these plans.<sup>4</sup> However, according to one study, few employees lost substantial amounts in their accounts.<sup>5</sup>

***In contrast to a Health Savings Account, employees lose any money left over in their Flexible Spending Account at the end of the year.***

**Table 1: Comparison of Various Features in Health Savings Accounts**

	<b>HSA<sup>a</sup></b>	<b>HRA<sup>b</sup></b>	<b>FSA<sup>c</sup></b>	<b>MSA<sup>d</sup></b>
<b>Overview</b>	Tax-exempt trust or custodial account to pay for qualified medical expenses of account holder and dependents	Employer-funded account that reimburses employees for qualified medical expenses	Employee-funded account to pay health expenses on a pre-tax basis	Tax-exempt trust or custodial account to pay for qualified medical expenses of account holder and dependents
<b>Eligibility</b>	Individuals covered by a qualified high-deductible health plan	Employee whose employer offers an HRA	Employee whose employer offers an FSA	Self-employed and employees at firms with 50 or fewer employees covered by a high-deductible health plan
<b>Ownership of funds</b>	Employee	Employer	Employee	Employee
<b>Use-it-or-lose-it by end of benefit year</b>	No, funds roll over	No, funds roll over	Yes	No, funds roll over
<b>Access to account upon end of job</b>	Yes	Depends on employer	Limited	Yes
<b>Who contributes</b>	Both	Employer	Employee	Both, but not in same year
<b>Must be paired with high deductible</b>	Yes	No, but often is	No	Yes
<b>May be used with other accounts</b>	Yes, but limited	Yes	Yes	Yes
<b>Money can be used for non-health expenses</b>	Yes, subject to tax and penalties	Yes, subject to tax and penalties	No	Yes, subject to tax and penalties
<b>Tax treatment</b>	Reduces taxable income	Tax free	Reduces taxable income	Reduces taxable income
<p><sup>a</sup>Health Savings Accounts  <sup>b</sup>Health Reimbursement Arrangements  <sup>c</sup>Flexible Spending Accounts  <sup>d</sup>Medical Savings Accounts</p>				

Source: Employee Benefit Research Institute

## Medical Savings Accounts

Medical Savings Accounts are a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Employees are eligible to set up a Medical Savings Account if employed at a firm of 50 or fewer employees. Self-employed individuals are also eligible. To have a Medical Savings Account, however, you must have a high-deductible health plan. Individual coverage must have a deductible between \$1,700 and \$2,600 and family coverage must be between \$3,450 and \$5,150. Certain preventive services can be fully covered and are not subject to the deductible. The out-of-pocket costs cannot exceed \$3,450 for self-only coverage and \$6,300 for family coverage.

Both employees and employers are allowed to contribute to the account, but not within the same year. Further, neither employee or employer contributions can exceed the annual earned income or net self-employment income of the individual. Like Health Savings Accounts, distributions are tax free if used to pay for qualified medical expenses including premiums for COBRA, long-term care insurance, and health insurance while receiving unemployment compensation. Withdrawals for nonqualified medical expenses are subject to regular income tax and also a penalty of 15%.

## Health Reimbursement Arrangements

Health Reimbursement Arrangements are employer-funded health plans that reimburse employees for qualified medical expenses rather than using already existing savings to pay for those expenses, as is the case with the other account-based plans. In 2003, only 1% of all employers offered a plan with a Health Reimbursement Arrangement, although take-up rates were 9% among larger employers.

Though it is not required, these reimbursement arrangements typically accompany high-deductible plans. Health Reimbursement Arrangements often provide “first-dollar” coverage until funds in the account are exhausted. For example, an employer with an insurance plan with a \$2,000 deductible might also provide a Health Reimbursement Account that an employee could use to meet the first \$1,000 of the deductible. Employers may also cover certain preventive services and can also set up an HRA so that employees can purchase health insurance directly from an insurer.

Contributions to Health Reimbursement Arrangements usually exist only “on paper.” Employers do not incur expenses associated with the arrangement until an employee makes a claim. Leftover funds at the end of the year can be rolled over to the following year at the employer’s discretion; however, employers can place restrictions on the amount that can be carried over. As with the other tax-favored account plans, distributions from a reimbursement arrangement are tax-free when used for qualified medical expenses.

***Distributions from tax-favored account plans are tax-free when used for qualified medical expenses.***

## What Guidance have the Department of Treasury and the IRS Given about HSAs?

The Treasury Department and IRS released guidance on four separate occasions on a number of issues associated with Health Savings Accounts:

- ❖ December 22, 2003: A notice was released that provided guidance on definitions, contributions, distributions, and other aspects of Health Savings Accounts.
- ❖ March 30, 2004: A “safe-harbor” list of preventive care benefits not subject to a deductible under a high-deductible health plan was released.
- ❖ May 11, 2004: Guidance was issued on how Health Savings Accounts interact with Health Reimbursement Accounts and Flexible Spending Accounts. Generally, individuals cannot contribute to a Health Savings Account if they have also set up one of the other two accounts. The guidance addresses the exceptions.
- ❖ July 23, 2004: Guidance was issued addressing questions related to the interaction among high-deductible health plans, Health Savings Accounts, and preventive care.

### Can Employers Make Different Contributions for Different Employees?

No. The Treasury Department and IRS ruled that employers who contribute to Health Savings Accounts must make the same contributions for all comparable employees. Employers may not merely give employees the option of getting the contribution. Moreover, employers cannot use the contribution as an incentive to get employees to participate in a health assessment or prevention program.

### Is Preventive Care Covered?

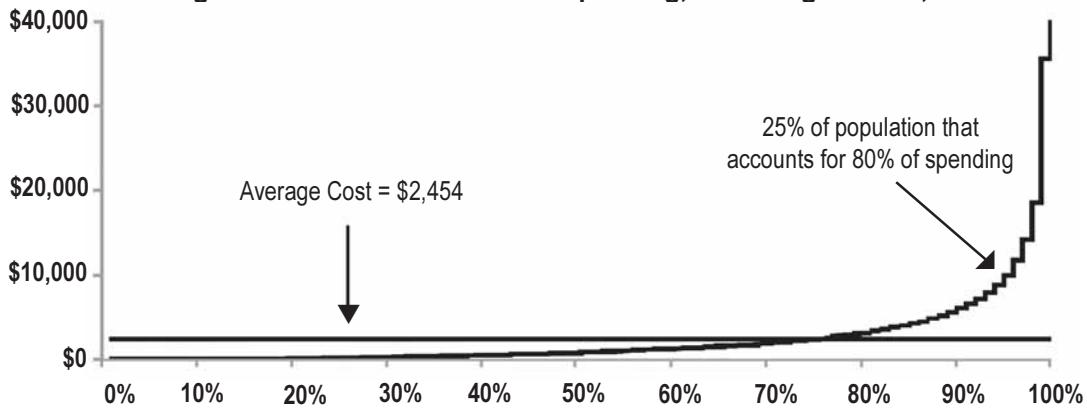
The original guidance on preventive care provided a safe-harbor list of preventive benefits that are not subject to a deductible. The new guidance adds that any treatment of a condition that is a byproduct of the original condition also falls within the safe harbor list. For example, if polyps are found during a colonoscopy that was a preventive screening, removal of the polyps would be considered preventive care and, thus, not subject to a deductible.

### Can Employers Recoup Their Contributions?

Employers are not allowed to recoup unused Health Savings Accounts contributions. As soon as the money is contributed, it automatically becomes the property of the employee. If the employee terminates employment before the end of the plan year, the employer may not recoup any portion of their yearly contribution.

***The Treasury Department and IRS provided a list of preventive services that are not subject to the deductible.***

**Figure 1. Distribution of Health Spending, Adults Ages 18-64, 2001**



Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

## How Will Health Savings Accounts Affect Use and Cost of Health Care?

It is too soon to know how HSAs will impact the use and cost of health care. However, employers have been using Health Reimbursement Arrangements for a few years and evidence is emerging on their impact. When available, research evidence is also discussed.

### Will Health Savings Accounts Curb the Growth in Health Care Spending?

Advocates for Health Savings Accounts believe they will reduce overall health care spending because individuals will understand the need for becoming more responsible and discriminating users of health care services. However, it is well known that about 25% of the population accounts for about 80% of total health care expenditures (see Figure 1). It is unlikely that this 25% of the population can make decisions to substantially reduce health care costs,<sup>6</sup> because they are sicker and need more services. Therefore, unless HSAs include incentives designed to affect the spending of chronically high users of health care, it is not likely that the cost of providing health benefits will be reduced significantly.

Health Reimbursement Arrangements (HRAs) and other high-deductible health plans are also unlikely to reduce low users' consumption of health care services. If employees do not view the HRA as their own money, they may use health care services unnecessarily. Unless the HRA is portable—and it usually is not—employees only get value from the HRA when they use health care services. In contrast, HSAs probably will not increase the use of health care because the funds in the account belong to them, not the employer, and are completely portable from job to job.

Over time, the accumulation of funds in an HRA will be enough to cover the entire deductible and even more. These additional funds could be spent on services that do not count toward the deductible such as Lasik eye surgery. Employers that cap the amount in an HRA may see employees increasing their use of health care services to “make room” for additional HRA contributions.

**About 25% of the population accounts for about 80% of total health care expenditures.**

Similarly, if funds are not portable, employees anticipating a job change or retirement might have an incentive to spend down the funds in the account for expenses that may not be necessary.

### **Will Health Savings Accounts be More Attractive to Healthier Employees?**

Because of the high deductibles, opponents believe Health Savings Accounts will be most attractive to healthy employees. If so, this would lead to “adverse selection.” If healthy people are more likely to choose account-based plans, the overall costs for these plans will decline. Conversely, if unhealthy employees are more likely to remain in traditional plans, the overall cost of these plans will increase. However, adverse selection could be offset if Health Savings Accounts are attractive to wealthy employees, who tend to be older and less healthy.

Studies on Health Savings Accounts are limited, but early evidence on Health Reimbursement Arrangements suggests that adverse selection may be a problem. Research shows that higher-income employees are more attracted to plans with an HRA than are lower-income employees.<sup>7,8</sup> What’s more, employees with fewer health claims in the previous year are more attracted to an HRA than those with more past health claims.<sup>9</sup>

### **Will Employers Move to Offer Health Savings Accounts?**

Small and large employers may adopt HSAs and HRAs for different reasons. Large employers may find Health Reimbursement Arrangements more attractive than Health Savings Accounts. This is because with reimbursement arrangements, employers pay the employee for medical costs only when they occur. In Health Savings Accounts, the employer makes immediate contributions to the employees’ account and it becomes the property of the employee, regardless of whether the employee actually needs or uses it.

In a recent study, 39% of employers reported that they would not contribute to the employees’ HSA. Employers may reject HSAs because the best way to save money is to offer only a high-deductible health plan and pocket the savings in premium costs. Moreover, some employers may prefer to direct resources toward the high users of health care, rather than funding an account of a healthy employee who has few health care needs.

Small employers may not move to account-based plans at all, because they are typically slower to change health benefits. In 2002, after three years of double-digit premium increases, only 19% of small employers made a change to their health plan.<sup>10</sup> Many employers find that maintaining their current benefits has a positive impact on employee recruitment, retention, productivity, health status, and the overall success of the business. Studies indicate that employers will make other cutbacks in staffing, employee pay, equipment, bonuses, and the like to maintain health benefits.

### **Are Health Savings Accounts More Attractive to Individuals than Families?**

Health Savings Accounts can have negative consequences for some families. HSAs are likely to be more attractive to individuals than to families, especially if some family members are significantly less healthy than others. No one in the

***Health Savings Accounts may be more attractive to individuals than families, especially if some family members are less healthy than others.***



family can have a separate deductible lower than the minimum family deductible of \$2,000. In high-deductible plans, this means that for a married couple with no children, the healthier family member who uses very few health care services would leave the unhealthier member with a \$2,000 deductible to “work off.” In this case, it would make more sense to enroll the sicker family member in single coverage so that the deductible is only \$1,000.

### **Will Health Savings Accounts Reduce Participation in Other Tax-Favored Health Accounts?**

According to the Treasury Department, individuals with a general purpose Flexible Savings Account cannot contribute to a Health Savings Account. Because Flexible Spending Accounts do not allow for roll over from year to year, it is likely that Health Savings Accounts will result in less employee participation in some other tax-favored accounts.

### **How Much Can Employees Save for Retirement?**

The amount of money that an individual can accumulate in a Health Savings Account for retirement health care costs is limited. Because there are maximum limits on how much individuals can contribute, this restricts the amount that employees are able to accumulate over time. For example, an individual who contributes \$1,000 each year (and makes the maximum allowed catch-up contribution) can accumulate about \$23,000 after 10 years, \$47,000 after 20 years, \$81,000 after 30 years, and about \$137,000 after 40 years (see assumptions in Fronstin, 2004).<sup>11</sup> An individual aged 55 in 2004 can save a maximum of \$44,000 in an HSA by age 65. This is far from the \$137,000 needed for retiree health care if the person lives to age 80.

Further, individuals may need to use the money in their accounts to pay for health care services during their working years or to pay for services while they are unemployed. For instance, if an individual rolls over 90% of a \$1,000 contribution every year for 40 years, they will have accumulated only \$25,000. If they were able to roll over 100% of that contribution in the same time, they would accumulate \$137,000

***The amount of money that an individual can accumulate in Health Savings Accounts for retirement health care costs is limited.***

## **Conclusion**

Recently, some employers have begun using high-deductible health plans with tax-favored accounts as one way of encouraging consumers to become more involved in and responsible for their own health care. Health Savings Accounts are one recent market-based approach which supporters hope will improve quality and reduce costs. To date, there are theories on how these plans will affect the health care system, but evidence is lacking.

One thing is clear, however. Currently, health care accounts for about 14% of the nation’s Gross Domestic Product (GDP). Making changes in 14% of GDP is bound to result in winners and losers, and many issues to grapple with. More research is needed to understand the real-world benefits and costs of Consumer Health Savings Accounts.

*This chapter is based on the following issue brief. Complimentary copies of the full report are available from the Wisconsin Family Impact Seminars at (608) 262-0369 or from the web site of the Employee Benefit Research Institute at [www.ebri.org](http://www.ebri.org).*

Fronstin, P. (2004, September). *Health savings accounts and other account-based health plans*. Washington, DC: Employee Benefit Research Institute.

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# Transparency and Pay for Performance: Building a Real Business Case for Better Quality Health Care

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**T**he conundrum purchasers are currently facing is this: health care costs are rapidly increasing, while quality appears to be stagnating. In response, General Electric turned to the same business model that it uses to design any new product. The result was *Bridges to Excellence*, a health care system that builds on transparency and pay for performance to reward physicians who provide high-quality care. In collaboration with several other large purchasers and health plans, physicians involved in *Bridges to Excellence* receive bonuses for providing quality diabetes and cardiovascular care, and for adopting better information technology systems to manage their practices. Under all three initiatives, participating physicians could receive income gains of up to 10%. Patients also receive incentives to keep them focused on achieving better outcomes. Pay for performance initiatives like *Bridges to Excellence* have had positive impacts on productivity as well as the quality and cost of health care. For example, patients with diabetes going to physicians recognized for quality care cost 10% to 15% less than diabetic patients going to physicians that are not so recognized. Half of these savings are kept by purchasers, and the other half are set aside as physician incentives.

Rising health care costs continue to outpace inflation. What's more, in the last four years, worker's health care premiums have risen faster than earnings. Despite fewer health benefits for working families, average premium costs have risen three times faster than earnings in 35 states and four times faster than earnings in Wisconsin.<sup>1</sup>

At the same time, recent studies by RAND have found serious gaps in the quality of care in the United States. In a study of 12 communities across the country, patients were receiving only 50% to 60% of the health care recommended by scientific evidence.<sup>2</sup> Similarly, another study found that 20% of physicians and 25% of the public have had personal experiences of serious harm due to avoidable errors.<sup>3</sup>

The conundrum purchasers are currently facing is this: health care costs are rapidly increasing, while quality appears to be stagnating. In response, a few years ago, General Electric (GE) decided to quit complaining about what is wrong with health care and take steps to move the system in a slightly different direction. GE applied the same methodology that it uses to design all new products—from jet engines to long-term care insurance—to create *Bridges to Excellence*, a health care model that rewards quality performance. This paper describes why GE decided to get involved in pay for performance, what *Bridges to Excellence* is, how it was designed and implemented, and what impact it can have on the health care system.

***Health insurance costs for Wisconsin workers increased four times faster than wages, yet nationwide patients are receiving only 50% to 60% of evidence-based health care.***

***Bridges to  
Excellence  
rewards  
physicians that  
provide efficient,  
high-quality care.***

## **Why Did GE Get Involved in Pay for Performance?**

The rationale behind pay for performance is obvious to anyone who goes in for an annual physician visit. Whether your doctor spends 5 or 15 minutes with you, whether or not he checks out the prescriptions you are currently taking, or whether he asks you all the right questions, he will be paid pretty much the same amount. So regardless of the treatment provided, there is no difference in the physician's payment.

Purchasers have contributed to the system's inefficiency and ineffectiveness by mostly purchasing health care based on cost alone. When you purchase health care based on the biggest discounts, you basically get what you pay for. Consumers continue to select their plans based primarily on differences in premiums, not differences in quality.

The initiative led by GE recognizes good physician performance with something more than simply a certificate. Just like the business world and the rest of the U.S. economy, when you do a better job, you get paid a little more. Providing the right kind of care requires an investment on the part of physicians. We need to recognize and reward that investment and make a business case for quality through pay for performance.

Pay for performance, also known as value-based purchasing, aims to create competition among providers to provide effective and efficient care. Purchasers do not pay physicians less, but instead try to reward the most efficient provider and those who demonstrate a high level of quality.

GE quickly realized that initiatives like pay for performance require the participation of a critical mass of employers or health benefit plan members. For example, if you pay physicians for evidence-based treatment of diabetics and GE has two diabetic employees, that is not enough volume to change the physician's behavior. However, if GE teams up with large employers like Ford, UPS, Procter and Gamble, and Verizon, there are enough diabetic patients to offer a real financial incentive to physicians to provide the most widely-accepted forms of treatment. Thus, GE joined with other larger purchasers, in cooperation with some health plans, to create a sustainable system of pay for performance called Bridges to Excellence.

## **What is the Pay for Performance System—Bridges to Excellence?**

Bridges to Excellence is a not-for-profit, employer-sponsored organization created to improve the quality of health care. This pioneering program recognizes and rewards health care providers who demonstrate that the care they deliver is safe, timely, effective, efficient, equitable, and patient-centered (STEEEP). The Bridges to Excellence partners include large employers such as General Electric, Procter & Gamble, Raytheon, Verizon, United Parcel Service, and Ford; health plans such as Anthem Blue Cross and Blue Shield, Humana, and United Health Care; and others including the National Committee for Quality Assurance, MEDSTAT, and WebMD Health.<sup>4</sup> Bridges to Excellence is operating in Boston and New York and in the participating regions of Cincinnati, Ohio, and Louisville, Kentucky. These organizations are united in their shared goal of improving health care quality through measurement, reporting, rewards, and education.

The effort is called Bridges to Excellence because its objective is to create a bridge to cross the chasm in health care quality. The primary supports of this bridge are performance measures. Without them, there is no way to understand the gaps in quality, nor any way to distinguish the level of performance from one provider to another. As an example, in diabetes treatment, blood sugar testing is essential to (a) assessing the effectiveness of treatment, (b) ensuring appropriate responses to poor glycemic control, and (c) identifying complications early enough so serious consequences can be prevented. Yet in a recent study, only 29% of adults with diabetes reported having their blood sugar tested in the previous year.<sup>5</sup> As another example, following a heart attack, administering beta blockers can reduce the risk of death by 13% during the first week of treatment and 23% over the long term. Yet, in the same study, only 45% of heart patients who should have received beta blockers did.<sup>5</sup>

Bridges to Excellence developed its evidence-based performance standards by working with nationally-recognized partners such as the National Committee for Quality Assurance, the American Diabetes Association, the American Heart Association/American Stroke Association, and physician experts.<sup>6</sup> In a nutshell, Bridges to Excellence is a performance-based incentive program with performance measures made public.

Currently, Bridges to Excellence is evaluating and rewarding physician's performance in three areas: high quality cardiovascular care; high quality diabetes care, and improvement of patient care management through information technology systems. The reasons for focusing on cardiovascular and diabetes care are obvious, but perhaps less so for information technology systems. About 90% of the transactions in health care today involve paper, ranging from checking on drug interactions; looking at recurring symptoms or illnesses; and ordering prescriptions, lab work, and radiology tests. Using electronic tools can help avoid medical errors and improve patient care.

Here is how pay for performance works. Participating employers contribute to a pool that is made available to physicians who meet the performance standards. Currently, physicians receive bonuses for providing quality diabetes and cardiovascular care, and for adopting better systems of care management. In addition, these physicians will be highlighted in provider directories that identify doctors with proven outcomes in treating certain illnesses or whose patient care and support systems are exemplary.

Physicians who meet the performance standards for diabetes can receive up to a \$100 bonus per patient per year. For diabetes, you either get the bonus or you don't. Physicians who meet information technology standards for managing their practices can receive up to \$55 per patient per year. For information technology, nine modules have been identified. In the first year, physicians can qualify for the full bonus (\$55) by meeting three modules; in the second year, they have to meet six modules and, in the third year, all nine modules. If a physician does not improve his or her performance for information technology from one year to the next, they still qualify for a bonus, albeit lower than the previous year.

Under all three initiatives, participating doctors could receive income gains of up to 10% in bonuses from employers.<sup>7</sup> Recently, the first round of diabetic and information technology incentives was paid to participating physicians in Boston.

***Participating doctors could receive income gains of up to 10% in bonuses from employers.***

The largest of these checks totaled nearly \$40,000 and was presented to Harvard Vanguard Medical Associates, a large medical group serving hundreds of employees in one company.<sup>6</sup>

### **How Was Bridges to Excellence Designed and Implemented?**

Bridges to Excellence was developed using a series of steps and statistical tools that are typically used to guide the development of a new product or service. (For a full discussion, see de Brantes, 2004).<sup>8</sup> One of the first steps is to agree upon a core set of principles that will be used to design the program. Given the nature of the Bridges to Excellence initiative, both physicians and consumer-patients are considered customers, and all other parties, including purchasers, are stakeholders.

Identifying, sorting, and ranking customer needs was accomplished through a combination of interviews, focus groups, and scientific research. For physicians, rewards and incentives have to be

- ❖ meaningful enough to more than compensate for the added cost associated with data collection and measurement of processes,
- ❖ perceived as fair and equitable,
- ❖ attainable,
- ❖ periodically reviewed, and
- ❖ incremental with small steps, rather than a “cliff.”

According to physicians, the performance standards should be based on well-accepted measures, which assess only what is possible for the physician or provider to attain. In addition, if performance measures are linked to health outcomes, then patient incentives should also be used to align patient behavior with performance measures. (See Table 1 for a complete list of provider incentives, rewards, and performance measures used in Bridges to Excellence.)

Consistent with physicians concerns, research has shown that it is not possible to get the full yield from managing chronic conditions like diabetes without robust patient involvement. Thus, Bridges to Excellence also developed incentives for patients to improve outcomes. In focus groups, patients indicated that having a monetary or quasi-monetary reward was important to keep them focused on achieving better health outcomes. However, these rewards did not have to be very high, but did need to be achievable. This feedback resulted in a novel program called Diabetes Care Rewards.

Diabetes Care Rewards includes tools for patients with diabetes to monitor their self-care activities, and provide them with points for lowering their blood sugar and following care guidelines. These points can be accumulated to qualify for rewards such as lower copayments on physician office visits or prescriptions. Or coupons can be redeemed for diabetic products not routinely covered by insurance such as sugar-free candies.

To administer the program, Bridges to Excellence hired an independent third party, Medstat. Medstat aggregated data files for plans and created a master patient/physician/purchaser grid that detailed the number of patients each physi-

***Bridges to Excellence also provides patient incentives to keep them focused on achieving better health outcomes.***

**Table 1. Provider Incentives, Rewards, and Performance Measures  
Used in Bridges to Excellence**

<u>Incentives and Rewards:</u>	<u>Performance Measures:</u>
❖ Ensure incentive is meaningful to providers	❖ Select performance measures that are well defined and within provider's control
❖ Establish clear expectations for performance	❖ Select thresholds that are a stretch, but attainable over time
❖ Reward in a timely manner	❖ Based on accurate and comprehensive data
❖ Evaluate the incentive program regularly; modify as needed	❖ Uses timely data to provide feedback to the provider and staff on what to improve
❖ Focus incentives on a limited number of measures	❖ Rely on absolute benchmarks of performance
❖ Collaborate and consult with providers to obtain and retain buy-in	❖ Use an independent entity for measuring performance
❖ Develop an incentive approach that is easy to understand and administer	❖ Address non-compliance by creating patient incentives
❖ Predictable cost and benefit of program	❖ Minimize burden on staff and duplication of effort
❖ Incentives that occur regularly for action providers have control over	
❖ Insurers and purchasers work collaboratively to overcome small market share	
❖ Meaningful enough to more than compensate for the added cost associated with data collection and measurement of process	
❖ Perceived to be fair and equitable	
❖ Incremental with small step increments as opposed to a cliff	
❖ Non-punitive—"A carrot not a stick"	

cian could receive a bonus for. These data also enabled each purchaser to quickly gauge what their maximum cost would be if all physicians met the performance measures. This structure ended up being simple to administer, because it is not dependent on a specific health plan or network arrangement. Moreover, it does not require a plan to modify its existing contract with network physicians.

**What Impact Can Pay for Performance Have on the Health Care System?**

Pay for performance initiatives like Bridges to Excellence have had positive impacts, three of which will be detailed here: employee productivity gains, and improvements in the quality and cost of health care.

**Productivity gains.** We know that if a patient gets better care today, they are going to be more productive and cost less tomorrow.

**Quality of health care.** Using diabetes as an example, doctors who earn recognition must show that they perform important screenings and help patients control their blood pressure, blood sugar, and lipid levels. Physicians who are recognized



perform above their peers and also establish a record of substantial, consistent improvement. For example, patients whose blood pressure was properly controlled increased from 50% among participating physicians in 1997 to 64% in 2002.<sup>9</sup>

**Cost of health care.** Several studies have demonstrated that quality can reduce overall costs, yet there is no consensus that this is true. To complicate matters further, the results vary by the type of quality improvement (i.e., reduction in overuse, misuse, or underuse), reimbursement system (i.e., fee-for-service or prepaid), and recipient of the reward (i.e., payer or provider). The existing data on cost savings due to improvements in treating diabetics or managing information flow in a physician's office are not definitive. However, purchasers believe that there is sufficient evidence to move forward.

***Diabetic patients going to physicians recognized for quality care cost 10% to 15% less than patients treated by physicians not so recognized.***

In recent evaluations, patients with diabetes going to physicians recognized by the National Committee for Quality Assurance cost 10% to 15% less than diabetic patients treated by physicians that are not so recognized.<sup>10</sup>

A fundamental premise of Bridges to Excellence is that both payers and providers must experience a positive return on investment for the project to be sustainable. To achieve this, purchasers keep 50% of the expected savings and set aside the other 50% for an incentive pool for physicians who meet the performance measures. Bridges to Excellence estimates that the cost of rewarding high performance in diabetes is no more than \$175 per diabetic patient per year with an estimated savings of \$350 per patient per year. For cardiac care, the estimated cost to employers is no more than \$300 per cardiac patient per year with savings up to \$390 per patient per year.<sup>11</sup> These numbers indicate that there is a potential for savings, but purchasers must work together to create the mechanisms to reap them.

### **What Key Lessons Have Been Learned?**

Given rapidly increasing health care costs and little system accountability, purchasers, patients, and providers may find their interests at odds. Designing any new product or service for a system with as many different interests as health care is not easy. However, the experience of Bridges to Excellence to date indicates that it is possible to meet the needs of purchasers, providers, and patients alike by developing incentives that recognize and reward health care providers who deliver safe, timely, effective, efficient, equitable, and patient-centered care.

The key principles of a successful pay for performance system include making sure that

- ❖ the incentives are attainable and meaningful to health care providers;
- ❖ the incentives are attainable and meaningful to consumers;
- ❖ the measures are achievable and yet not too easy, so as to meet the interests of purchasers; and
- ❖ the system is easy to operate and keeps the administrative burden to an absolute minimum.

*This article is based on the Bridges to Excellence website, <http://www.bridgestoexcellence.org/bte/bte.overview.htm>, Bridges to Excellence Press Releases [http://www.bridgestoexcellence.org/bte/bte\\_pressrelease.htm](http://www.bridgestoexcellence.org/bte/bte_pressrelease.htm) and the following publications.*

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# The State of Wisconsin's Employee Group Health Benefit Program: An Overview

by Tom Korpady  
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**T**he State of Wisconsin has taken a different approach in its Employee Group Health Benefit Program by combining consumer involvement with pay for performance. A major advantage of this new approach is that it accurately compares the efficiency of the plans using not just price, but also utilization and intensity of health care services. Certain providers may have low prices, but may actually end up costing more through over prescribing services or prescribing more expensive services. The Group Insurance Board redesigned the program by: (a) developing a three tier-employee contribution system in response to calls for greater employee participation in the cost of their health care, (b) incorporating a reward system to provide an incentive for health plans to deliver exceptionally high-quality care, and (c) consolidating prescription drug coverage in the state's health plans to leverage the state's huge purchasing power. When most employers are facing double-digit increases in health care costs, Wisconsin has held premium increases to only 5% for current employees and actually decreased premiums by over 6% for retired state workers. At the same time, benefit levels have been maintained, and high-quality health care has been encouraged and rewarded.

In its Employee Group Health Benefit Program, the State of Wisconsin has taken a different approach to improving health care quality and curbing costs by combining consumer involvement with pay for performance (i.e., value purchasing). This approach differs from using only the consumer-directed model in that the payor (i.e., the state) also takes responsibility for deciding which providers offer the best value, rather than leaving that task entirely to the consumer (i.e., the employee). A major advantage of this new approach is that it accurately compares the efficiency of the plans using not just price, but also utilization and intensity of health care services. Certain providers may have low prices, but may actually end up costing more through over prescribing services or prescribing more expensive services.

Building on a successful managed competition approach in effect since 1984, the Group Insurance Board redesigned the program in a way that incorporates pay for performance techniques, while maintaining the value added by the participating health plans. Specifically, the Board

- ❖ developed a three-tier employee contribution system in response to calls for greater employee participation in the cost of their health care,

***In the face of double-digit increases, Wisconsin's health insurance premiums increased only 5% for current employees and decreased 6% for retired state workers.***

- ❖ incorporated a reward system to provide an incentive for health plans to deliver exceptionally high-quality care, and
- ❖ consolidated prescription drug coverage in the state's health plans to leverage the state's huge purchasing power.

The cumulative results from each of these initiatives have been very encouraging. At a time when most employers are facing double-digit increases in the cost of their health insurance, the State of Wisconsin will see an increase of less than 5%. The premiums for retired State employees will actually go down by over 6% next year. At the same time, benefit levels have been maintained, and high-quality health care has been encouraged and rewarded. Each aspect of the State's program redesign are described in more detail below.

### **Three-Tier Employee Contribution System that Rewards High Quality Care**

The three-tier employee contribution system was developed to address several problems that existed under the old method of determining the employee's share of the premium, two of which are described here. First, for almost 20 years, the State would pay up to 105% of the low-cost health plan in each county. This system did create some competition between the plans, but it also had some unintended consequences. For example, the employer contribution was tied to 105% of the low cost plan, with employees required to pay anything that exceeded that amount. Thus, plans that bid within 5% of the low cost plan were shielded from the consequences of their bids because the employee's out-of-pocket cost would not vary. Therefore, rather than striving to submit the lowest-cost bid, plans targeted their premiums at 5% above what they estimated the low-cost bid would be. This created a situation of shadow pricing that tended to drive up premiums higher than necessary.

Second, the system also failed to account for differences in the risks faced by the participating plans. Plans that could attract a younger and healthier population could easily keep their premiums low, regardless of how efficient they were at delivering care. However, plans that attracted older or higher-cost enrollees could not compete, even if they delivered care very efficiently.

For years, the Board had collected HEDIS (Health plan Employer Data Information Set) quality measures from all of the participating health plans. Yet the Board did not have a way to reward plans for very high performance under the old premium-contribution formula. The Board did publish the HEDIS results on quality annually in the Dual Choice Enrollment Booklets distributed to all state employees, but there was little evidence that members took these measures into account when they made their enrollment decisions.

The new three-tier system has addressed these problems. Under this new system, plans are placed in one of three tiers, and the employee's share of premium varies according to that tier placement. Plans in Tier 1 cost the employee the least; plans in Tier 2 cost the employee more, while plans in Tier 3 cost the employee the most. Plans have a strong incentive to be placed in Tier 1, because the low cost share required of employees may attract the most enrollees.

Each year, the Board collects from each plan detailed cost and utilization data prior to the plan's bid submission. The Board's actuary evaluates this data. Using the demographics of each plan and a sophisticated risk-adjustment system, the Board actuary compares how cost effective each plan is in delivering health care. Because of this risk adjustment, the comparison is accurate, and plans do not benefit by having a younger or healthier population. The plans are then placed in one of three tiers. The most cost-effective plans are placed in Tier 1, moderately cost-effective plans are placed in Tier 2, and the least cost-effective plans are placed in Tier 3.

If the plans' subsequent premium bids match their data submissions, their placement in the tiers remains. If the plans bid higher or lower than their data submissions, their tier placement is adjusted accordingly. Also, at this point, plans that have very high quality results are given credit. A plan that may have been originally placed in Tier 2, but had very high quality scores could move into Tier 1. Plans that still remain in Tiers 2 and 3 are then called in for negotiations.

During the negotiation process, the Board's staff and the actuary reviews the data submission with plan representatives. Areas where the plan may be less cost effective are identified and quantified. In some cases, plans may be paying very high physician charges, or may have longer average lengths of stay. Plans are advised of specific areas where savings could be achieved based upon the performance of their peers. Finally, each plan is advised of the specific dollar amount that they must reduce their premium in order to be placed in a lower tier. Plans are then given the opportunity to submit a final bid.

This new system has proven to be very cost effective. Savings from the negotiation process this past year were in excess of \$14.5 million.

### **Consolidating Prescription Drug Coverage**

The other major strategy in the Board's new approach involved changing the way prescription drugs were purchased. In previous years, each plan was responsible for managing and covering prescription drugs. Based on the actuary's analysis of their data, some plans did this very effectively, while others did not do as well. Since prescription drug costs are one of the fastest-rising components of health care, the Board felt this area offered a real opportunity for savings.

To leverage the purchasing power of a large employer like the State, the Board carved the drug coverage out of state health plans and consolidated it under one Pharmacy Benefits Manager (PBM). The PBM that was chosen, Navitus Health Solutions, is a Wisconsin company that was specifically created to respond to the Board's needs. The Board wanted to emphasize quality and safety first, while obtaining the drugs at the lowest net drug cost. The Board (a) demanded complete transparency in all financial transactions with the drug manufacturers, and (b) required that all rebates and savings from discounts be passed through to the plan. This allowed the Board to avoid the misaligned incentives that have plagued the more traditional Pharmacy Benefits Management Industry.

The new Pharmacy Benefits Manager created a Pharmaceutical and Therapeutics (P&T) committee comprised of practicing pharmacists and physicians from all across Wisconsin. This committee developed a formulary of preferred drugs.

***The negotiation process with health plans this past year saved Wisconsin more than \$14.5 million.***

**For the coming year, the state employee plan will spend 6% less on prescription drugs than it did in 2003.**

First, the committee decided on the absolute best drugs in each class. Then, once those “best in class” drugs were chosen, the prices were considered and final formulary selections were made.

In order to encourage state employee members to support this formulary, the Board changed the drug benefit under the program from a two-level to a three-level copay structure. The first level consists mostly of low-cost generics and costs the consumer a \$5 copay per prescription. The second level consists mostly of formulary brand name drugs and cost the consumer a copay of \$15 per prescription. The third level is primarily nonformulary drugs with a \$35 copay per prescription.

This new prescription drug initiative has succeeded beyond the most optimistic projections. In the first year, tens of millions of dollars have been saved. For the coming year, the State employee plan will actually spend over 6% less than it did in 2003.

### **Conclusion**

In summary, the State of Wisconsin’s employee group health benefits system has included pay for performance (i.e., value purchasing) and consumer involvement through its (a) three-tier employee contribution system that rewards high-quality health care and (b) consolidated prescription drug coverage. The State of Wisconsin has taken responsibility for deciding which provider offers the best deal rather than leaving the decisions entirely to the consumer. For example, a consumer may select a hospital based on the lowest daily rate, but the State has additional information which also allows factoring in other drivers of the total cost of health care, such as the average length of hospital stays for a particular health condition. The State of Wisconsin was also able to leverage its purchasing power as a large employer to negotiate with prescription drug companies in ways that an individual consumer is unable to do. Consumers were also more involved in health care decisions through the development of a three-tier employee contribution system.

The initial results of this approach are promising. When most employers are facing double digit increases in health care costs, Wisconsin has held premium increases to only 5% for current employees and actually decreased premiums by over 6% for retired state workers.

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## Glossary

### **Adverse Selection<sup>1</sup>**

The potential situation where more healthy individuals choose one health plan (e.g. Health Savings Accounts) and more relatively unhealthy individuals remain in another plan (e.g., traditional health plans). The overall cost of the plan with more healthy individuals (e.g. Health Savings Accounts) will decrease, while the overall cost of the plan with more unhealthy individuals (e.g., traditional health plans) will increase.

### **Actuary<sup>2</sup>**

One who computes various insurance and property costs, particularly life insurance risks and insurance premiums. For example, the Wisconsin Department of Employee Trust Funds (ETF) contracts with a professional organization to perform the statistical analysis of ETF operations for financial reporting purposes and for determining the contribution rate necessary to pay future benefits of ETF members.

### **Benefit Package**

A defined set of specific services or benefits that an insurer is required to provide to subscriber groups or individuals.

### **Bridges to Excellence**

A not-for profit, employer-sponsored organization created to improve the quality of health care. This program recognizes and rewards health care providers who demonstrate that the care they deliver is safe, timely, effective, efficient, equitable, and patient-centered (STEEEP).

### **Coinsurance<sup>3</sup>**

A cost-sharing arrangement between an enrollee and the health plan under an insurance policy. It stipulates that the enrollee will pay a portion or a percentage of the costs of covered services. The insurer will reimburse a specified percentage of all or a portion of covered medical expenses in excess of any deductible amounts payable by the insured until the maximum liability is reached.

### **Consumer-Driven Health Plan**

Health plans that provide employees with funds that the employee, rather than the employer, uses to purchase health care services or insurance. The plans allow employees to make their own cost-benefit decisions by selecting those providers, services, and insurers that provide the most value to them as consumers.

### **Copayment<sup>4</sup>**

A fixed amount of money paid by a health plan enrollee at the time of service. For example, the enrollee may pay a \$10 “copay” at every physician office visit and \$5 for each drug prescription filled. The health plan pays the remainder of the charge directly to the provider.

### **Deductible**

As in the case of car insurance, deductibles are health-care-related costs (either annually, over a lifetime, or case-specific) that the individual must pay out of pocket before any additional costs will be picked up by the insurance policy. For example, one might be required to pay any hospitalization costs up to \$1,000. Usually, the higher the deductible, the lower one’s annual premium.

**Diabetes Care Reform**

A program of the Bridges to Excellence initiative in which patients with diabetes monitor their self-care activities and receive points for lowering their blood sugar and following care guidelines. These points can be accumulated to qualify for rewards such as lower copayments on physician office visits or prescriptions; or coupons can be redeemed for diabetic products not routinely covered by insurance such as sugar-free candies.

**Employer Contribution**

The money that an employer pays for its employees' health plan. Employer contributions vary widely and can be based on percentage of cost, length of employment, family circumstances, or a flat amount.

**Evidence-based Medicine<sup>5</sup>**

The conscientious, explicit, and judicious use of current best evidence in making decisions about the health care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from research.

**Family Practice**

A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

**Flexible Spending Account<sup>6</sup>**

An account into which employees make pre-tax contributions to be used only for qualified medical expenses in a plan year. Employers do not contribute to the account and employees must use the funds in the account before the end of the plan year or they lose the funds. Contributing to an FSA reduces the wages on which Social Security and Medicare taxes are paid for both the employee and employer. Distributions (withdrawals) are tax-free.

**Formulary**

A listing of drug products that are allowed to be dispensed (positive formulary) or are not allowed to be dispensed (negative formulary). A government body, third-party insurer or health plan, or an institution may compile a formulary.

**Health Insurance Purchasing Cooperatives<sup>7</sup>**

Public or private organizations that secure health insurance coverage for the workers of all member employers. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans, and providers to reduce administrative costs.

**Health plan Employer Data Information Set (HEDIS)<sup>8</sup>**

HEDIS is developed and maintained by the National Committee for Quality Assurance and is the most widely used set of performance measures in the managed care industry. For example, HEDIS information is submitted to the Wisconsin Department of Employee Trust Funds by Health Maintenance Organizations (HMOs).

**Health Reimbursement Arrangement (HRA)<sup>9</sup>**

An employer-funded plan that reimburses employees for qualified medical expenses; they typically accompany high-deductible health plans. Employer contributions to the fund exist only on paper, which means the employer incurs an expense only if the employee makes a claim. Leftover funds at the end of the year can be rolled over to the following year at the employer's discretion. Employees are not taxed on distributions (withdrawals) from the fund if used for qualified medical expenses.



**Health Savings Account (HSA)<sup>10</sup>**

A tax-exempt account that an individual can use to pay medical expenses. Must be offered with a high-deductible health plan. Contributions to the account are required from employers and are optional for employees. Employee contributions to and distributions withdrawn from the account are tax-exempt, even for individuals who do not itemize. HSAs are owned by the employee and are completely portable from one job to another. Funds in HSAs can roll over each year to pay for subsequent medical expenses. Created in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act (P.L.108-173).

**High-Deductible Health Plan<sup>11</sup>**

A plan in which the annual deductible is \$1,000 or more (self-only coverage) and \$2,000 or more (family coverage). Annual out-of-pocket expenses, including the deductible, copayments and coinsurance cannot exceed \$5,000 (self-only coverage) or \$10,000 (families). The minimum-allowable deductible and maximum out-of-pocket limit will be indexed to inflation. Certain out-of-pocket expenses do not count toward the annual maximums.

**The Leapfrog Group<sup>12</sup>**

Comprised of more than 110 public and private organizations that provide health care benefits, The Leapfrog Group works with medical experts throughout the U.S. to identify problems and propose solutions that it believes will improve hospital systems that could break down and harm patients. Representing more than 32 million health care consumers in all 50 states, Leapfrog provides information and solutions for consumers and health care providers to improve the safety, quality, and affordability of health care.

**Mandated Health Insurance Benefits**

A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

**Medical Savings Account (MSA)**

A tax-exempt account that individuals can use for medical expenses, including insurance. An MSA can only be offered in firms with 50 or fewer employees (or self-employed individuals) and with a high-deductible health plan. Both employee and employer can contribute to the plan, but not in the same year. Distributions (withdrawals) are tax-free if used for qualified medical expenses.

**Pay for Performance<sup>13</sup>**

See Value-based Purchasing.

**Performance Measures<sup>14</sup>**

Methods or instruments to monitor the extent to which the actions of a health care provider conform to guidelines, medical review criteria, standards of quality, or evidence-based practice.

**Pharmacy Benefit Manager (PBM)<sup>15</sup>**

A third-party administrator of a prescription drug benefit program that has primary responsibility for processing and paying prescription drug claims. In addition, they typically negotiate discounts and rebates with drug manufacturers, contract with pharmacies, and develop and maintain the formulary. The State of Wisconsin's group insurance plan, Pharmacy Benefit Manager, is Navitus Health Solutions.

**Provider**

A hospital- or individual-licensed health care professional that delivers health care services to patients.

### **Risk Pooling/Sharing<sup>16</sup>**

Insurance plans are typically based on risk pooling. The greater the number of people who are insured, the more stable the predictions of claims against the pool. That is, a large pool of people allows insurers to use anticipated savings from healthier persons to balance the risk of payments made to cover less healthy persons.

### **Risk Segmentation<sup>17</sup>**

Disproportionate movement of low-health-care users from the general insurance pool to lower-premium health plans. Low health care users spend fewer dollars on health care and may save money by moving to a high-deductible, lower-premium health insurance plan. The result may be that higher users of health care, who tend to be more expensive to cover, remain in traditional health plans. Premiums may then rise in the traditional health plans. (See Leitz chapter of this report, pp. 1-12.)

### **Tax-Favored Savings Account**

An account to which employers and/or employees contribute funds for the employee's medical expenses. Employee contributions reduce the employee's gross adjusted income. Employer contributions reduce the employee's taxable income, thus decreasing taxes paid by the employer. Employees do not pay taxes on funds withdrawn (i.e., distributed) to pay for qualified medical expenses. Some accounts allow employees to carry their balance forward from year to year and keep the balance when they leave their employer.

### **Transparency**

The disclosure of accurate and timely information about the performance of a health care plan or individual provider in treating patients. Consumers can use this information to make informed choices about how they spend their health care dollars. Employers can use the information to determine which providers to include in their health benefit offerings and in negotiating rates.

### **Uncompensated Care**

Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity cases. It also includes bad debts from persons who are unable or unwilling to pay their bill.

### **Value-Based Purchasing (VBP)<sup>18</sup>**

A concept whereby purchasers hold providers of health care accountable for both cost and quality of care. VBP brings together information on the quality of care, such as patient outcomes and health status, with data on the dollar outlays going towards health. The main focus is on managing the use of the health care system to reduce inappropriate care, and to identify and reward the best-performing providers.

<sup>1</sup>Fronstin, P. (2004, September). *Health Savings Accounts and Other Account-Based Health Plans*, (Issue Brief No. 273). Washington, DC: Employee Benefit Research Institute.

<sup>2</sup>Department of Employee Trust Funds Website, [www.etf.wi.gov](http://www.etf.wi.gov)

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<sup>5</sup>Robert Wood Johnson Foundation. *Health of the Public Glossary*. <http://www.rwjf.org/reports/npreports/healthpublicg.htm>

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## Selected Resources in Health Care Issues

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*Interests:* Health administrative rules and health-related legislation

## State Agencies

### **James Johnston, Executive Policy and Budget Manager**

Wisconsin Department of Administration  
State Budget Office  
101 E Wilson Street, 10th Floor  
Madison WI 53702  
(608) 266-3420  
james.johnston@doa.state.wi.us

*Interests:* Health care reform; health care programs at the Department of Health & Family Services (e.g., Medicaid, High Risk Insurance Pool, Badger Care, Senior Care); Office of the Commissioner of Insurance

### **Tom Korpady, Administrator**

Wisconsin Department of Employee Trust Funds  
Division of Insurance Services  
801 W Badger Road  
PO Box 7931  
Madison WI 53703-7931  
(608) 266-0207  
tom.korpady@etf.state.wi.us

*Interests:* State employee group health insurance program, insurance and health benefits

### **Mark B. Moody, Administrator**

Wisconsin Department of Health and Family Services  
Division of Health Care Financing  
PO Box 309  
Madison WI 53701-0309  
(608) 266-8922  
moodymb@dhfs.state.wi.us

*Interests:* Managed health care, health information, medical assistance, Medicaid, Badger Care, Senior Care, international health care

### **Eric Stanchfield, Secretary**

Wisconsin Department of Employee Trust Funds  
801 W Badger Road  
PO Box 7931  
Madison WI 53703-7931  
(608) 266-0301

*Interests:* Pay for Performance, quality initiatives, all employee benefit plans for public employees, retirement, disability benefits, health and life insurance, deferred compensation plans

**Wisconsin Department of Health and Family Services**

Bureau of Health Information and Policy  
Division of Public Health  
PO Box 309  
Madison WI 53701-0309  
(608) 267-9545  
www.dhfs.state.wi.us

*Reports:*

“Wisconsin Health Insurance Coverage 2003” (September 2004)

**University of Wisconsin-Madison and University Extension**

**Dr. Michael Fleming, Professor**

University of Wisconsin-Madison Medical School  
Department of Family Medicine  
777 S Mills Street, Room 3817  
Madison WI 53715  
(608) 263-9953  
Fax: (608) 263-7919  
fleming@fammed.wisc.edu

*Interests:* Family medicine and college health

**Donna Friedsam, Researcher and Associate Director**

Wisconsin Public Health and Health Policy Institute  
University of Wisconsin-Madison Medical School  
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760 WARF Office Building  
610 Walnut Street  
Madison WI 53726  
(608) 263-4881  
(608) 263-1712  
dafriedsam@education.wisc.edu

*Interests:* Health care financing, insurance coverage, access to health care, health care reform, health policy, Medicaid, special populations

**Dr. David Kindig, Emeritus Professor**

University of Wisconsin-Madison Medical School  
Department of Population Health Sciences  
760 WARF Office Building  
610 Walnut Street  
Madison WI 53726  
(608) 263-6294  
dakindig@wisc.edu

*Interests:* State health policy, population health outcomes

Dr. Kindig will not be available between February and April 2005.



**Roberta Riportella, Associate Professor and Extension Specialist**

Health Policy Specialist, University of Wisconsin-Extension  
Associate Professor, Department of Consumer Sciences  
University of Wisconsin-Madison  
School of Human Ecology, Room 370B  
1300 Linden Drive  
Madison WI 53706  
(608) 263-7088  
Fax: (608) 265-6048  
rriorte@wisc.edu  
<http://www.uwex.edu/ces/flp/specialists/riortel.html>

*Interests:* Barriers to accessing care for under-served populations and Medicare

**Robert Stone-Newsom, Senior Scientist and Program Director**

Wisconsin State Forums Partnership Program  
University of Wisconsin-Madison Medical School  
Department of Population Health Sciences  
760 WARF Office Building  
610 Walnut Street  
Madison WI 53726  
(608) 263-8298 or  
(608) 263-6294  
rnewsom@wisc.edu  
[www.medsch.wisc.edu/pophealth/StateForums/](http://www.medsch.wisc.edu/pophealth/StateForums/)

*Interests:* Value purchasing, measurement and evaluation of health care quality, regional variation in care

**David Weimer, Professor**

University of Wisconsin-Madison  
LaFollette School of Public Affairs  
201 Observatory Hill Office Building  
1225 Observatory Drive  
Madison WI 53706  
(608) 262-5713  
weimer@lafollette.wisc.edu

*Interests:* Health policy report cards

**Barbara L. Wolfe, Professor**

University of Wisconsin-Madison Medical School  
Department of Population Health Sciences  
LaFollette School of Public Affairs  
705 WARF Office Building  
610 Walnut Street  
Madison WI 53726  
(608) 262-0030  
(608) 262-0662  
bwolfe@wisc.edu

*Interests:* Health insurance coverage; public coverage; income inequality and health; welfare reform

**National Organizations and Programs**

**AcademyHealth and  
Changes in Health Care Financing and Organization**

1801 K Street NW, Suite 701-L  
Washington DC 20006  
(202) 292-6700  
Fax: (206) 221-7402  
crpe@u.washington.edu  
www.academyhealth.org  
www.hcfo.net

*Reports:*

“State of the States: Cultivating Hope in Rough Terrain” (January 2004); Available online at:  
<http://www.statecoverage.net/pdf/stateofstates2004.pdf>

*Webcasts:*

“Consumer Driven Health Plans: Potential, Pitfalls, and Policy Issues” (September 10, 2004); Available online at:  
<http://www.hcfo.net/cyberseminar.htm>

## **Center for Studying Health Systems Change**

600 Maryland Ave SW, Suite 550  
Washington DC 20024  
(202) 484-5261  
Fax: (202) 484-9258  
www.hschange.org

### *Issue Briefs:*

“Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004.” (December 2004). Available online at:

<http://www.hschange.org/CONTENT/721/>

“Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care?” (July 2004). Available online at:

<http://www.hschange.org/CONTENT/692/>

“Paying for Quality: Health Plans Try Carrots Instead of Sticks.” (May 2004). Available online at:

<http://www.hschange.org/CONTENT/675/>

## **Economic and Social Research Institute**

### **Jack Meyer, President**

2100 M Street NW, Suite 605  
Washington DC 20037  
(202) 833-8877  
Fax: (608) 263-6448  
www.esresearch.org

### *Reports:*

“Building on the Job-Based Health Care System: What Would it Take?” (August 2003); available online at:

<http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.415v1.pdf>

“Consumer-Driven Health Plans: Design Features to Promote Quality Improvement” (2004); *Benefits Quarterly*, 20(2), 23-31.

## **Employee Benefit Research Institute**

### **Health Research and Education Program**

#### **Paul Fronstin, Director**

2121 K Street NW  
Washington DC 20037-1896  
(202) 775-6352  
Fax: (202) 775-6312  
fronstin@ebri.org

### *Notes and Issue Briefs:*

“Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey.” (November 2004) Available online at:

<http://www.ebri.org/ibpdfs/1104ib.pdf>

“Health Savings Accounts and Other Account-Based Plans.” (September 2004).

Available online at:

<http://www.ebri.org/ibpdfs/0904ib.pdf>

“The Impact on Employment-Based Benefits of the Shift From a Manufacturing Economy to a Service Economy.” (June 2004). Available online at:

<http://www.ebri.org/pdfs/0604notes.pdf>

### **Kaiser Family Foundation**

2400 Sand Hill Road

Menlo Park CA 94025

(650) 854-9400

Fax: (650) 854-4800

[www.kff.org](http://www.kff.org)

[www.statehealthfacts.org](http://www.statehealthfacts.org) - State Health Facts

[www.kaisernetwork.org](http://www.kaisernetwork.org) - Webcasts of Health-Related Hearings and Meetings

#### *Reports:*

“Employer Health Benefits 2004 Annual Survey” (September 2004); Available online at:

<http://www.kff.org/insurance/7148/index.cfm>

“National Survey on Consumers’ Experiences with Patient Safety and Quality Information” (November 2004); Available online at:

<http://www.kff.org/kaiserpolls/pomr111704pkg.cfm>

#### *Webcasts:*

“Consumer-Directed Health Care: The Next Big Thing?” (July 9, 2004); Available online at:

[http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1224](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1224)

“Consumer-Driven Health Care: Evidence from the Field ” (September 15, 2003); Available online at:

[http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=961](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=961)

### **National Academy for State Health Policy**

**Alan Weil, Executive Director**

50 Monument Square, Suite 502

Portland ME 04101

(207) 874-6524

Fax: (207) 874-6527

[www.nashp.org](http://www.nashp.org)

#### *Reports:*

“Rising Health Care Costs: State Health Cost Containment Approaches” (June 2002); Available online at:

<http://www.nashp.org/Files/GNL46.pdf>

## **National Conference of State Legislatures**

7700 East First Place  
Denver CO 80230  
(303) 364-7700  
Fax: (303) 364-7800  
www.ncsl.org

### *Reports:*

“Helping States Grapple with Health Demands and Budget Shortfalls” (April 2004)  
“State Employee Health Benefits: A 2003 Overview” (September 2003)  
“A Framework for Considering Health Care Cost Containment” (July 2003)

## **The Urban Institute Health Policy Center John Holahan, Director**

2100 M Street NW  
Washington DC 20037  
(202) 833-7200  
www.urban.org

### *Reports:*

“The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003” (September 2004); available online at:  
[http://www.urban.org/UploadedPDF/411089\\_HealthInsCoverage.pdf](http://www.urban.org/UploadedPDF/411089_HealthInsCoverage.pdf)  
“Most Households’ Medical Expenses Exceed HSA Deductibles” (August 2004); available online at:  
[http://www.urban.org/UploadedPDF/1000678\\_TaxFacts\\_081604.pdf](http://www.urban.org/UploadedPDF/1000678_TaxFacts_081604.pdf)



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How Effective Are Consumer Health Savings Accounts and Pay for Performance? (2005)