

AFP®



Annual Conference

OCTOBER 27-30, 2013 | LAS VEGAS

ORIGINAL→ESSENTIAL→UNBIASED→**INFORMATION**



Consumer Driven Health Care, High Deductible Health Plans

History, Present and Future. Impact on Patient Responsibility and Financing

James S. Gandolfo
SVP, Senior Consulting
Manager
PNC Bank
James.Gandolfo@PNC.com

J. Kevin A McKechnie
Executive Director, American
Bankers Association H.S.A
Council
KMckechn@ABA.com

Today's Presenters



James ("Jim") S. Gandolfo, Senior Vice President, Treasury Management, Senior Consulting Manager

Jim Gandolfo is the Healthcare lead for PNC's Treasury Consulting group (TCG). TCG provides a variety of support to both industry and PNC's Treasury Management professionals related to comprehensive solutions for commercial payments, receivables and information management. Previously, he was with PNC Global Investment Servicing, where he was responsible for their Health Savings Account administration solution (HSA). His experience also includes a long tenure with Wilmington Brokerage Services Company, a registered broker-dealer and wholly owned subsidiary of Wilmington Trust Company, where he was president and chief executive officer.

A graduate of Radford University in Radford, Virginia, Gandolfo holds a bachelor of science degree in political science and history. His FINRA licenses include Series 6, 7, 24 and 63. He is chairman of the American Bankers Association's HSA Council and a member of the board of directors of the HSA Coalition. He is based in Wilmington, Delaware.

Today's Presenters

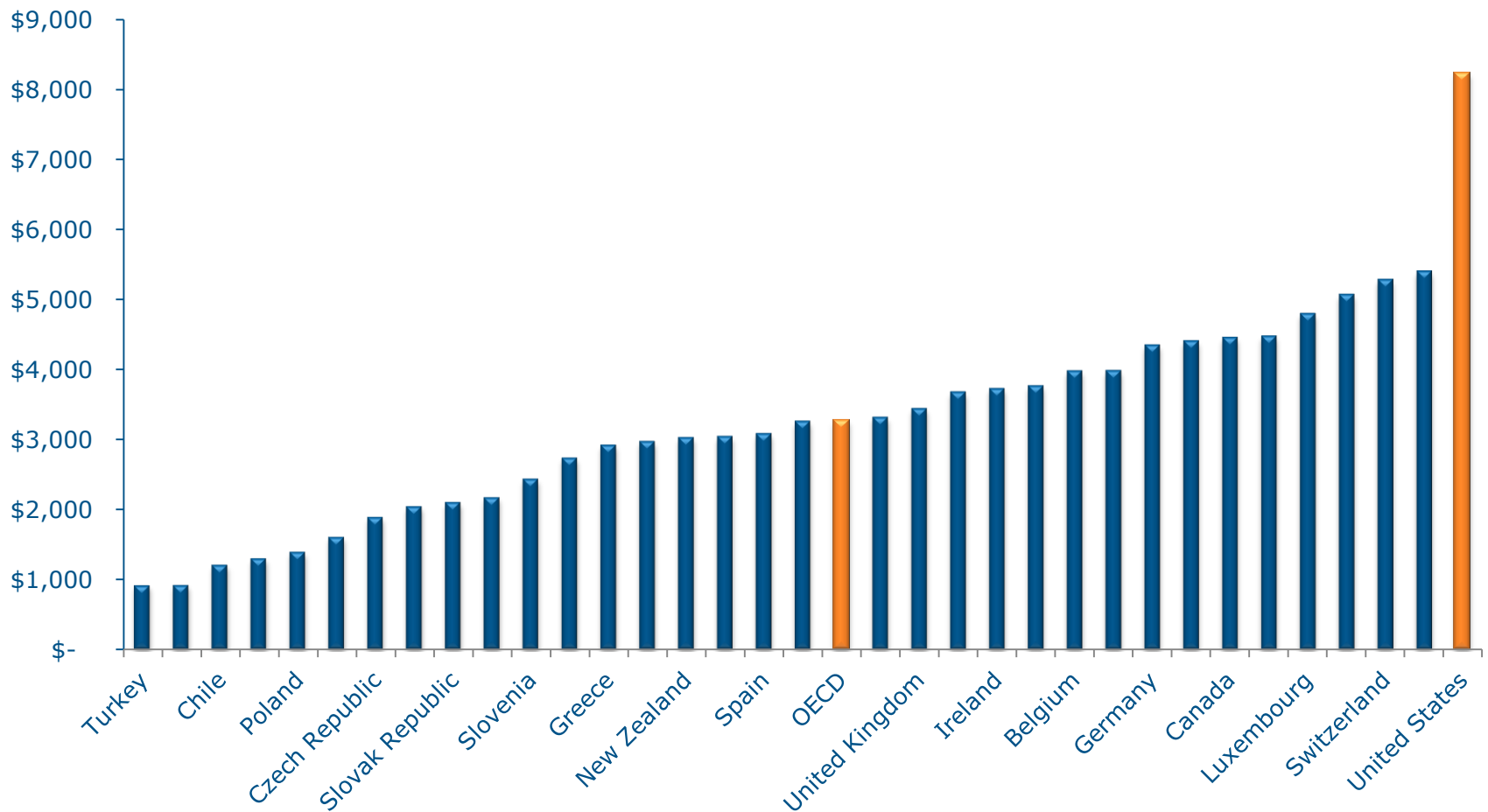


J. Kevin A. McKechnie is the Executive Director of the American Bankers Association's HSA Council, representing banks and health insurers before Congress and the federal government.

Mr. McKechnie is a nationally recognized expert in insurance generally and health insurance in particular. Mr. McKechnie won the 2011 Public Policy Leadership Award from the Institute for Healthcare Consumerism

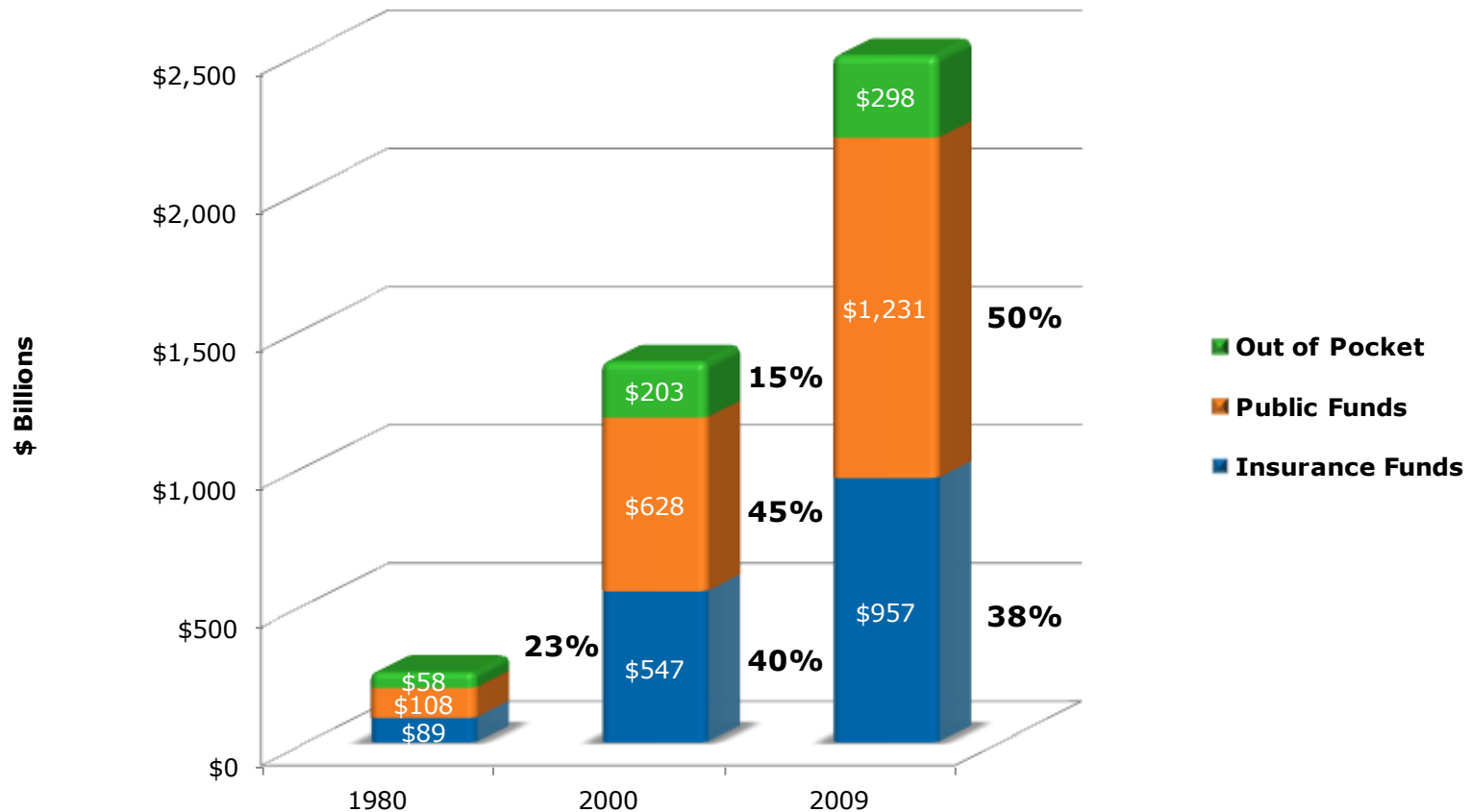
Mr. McKechnie is also a principle in HSA Holdings, an organization of global healthcare financing experts, providing health care financing expertise to several governments around the world.

U.S. Leads in Health Expenditures Per Capita

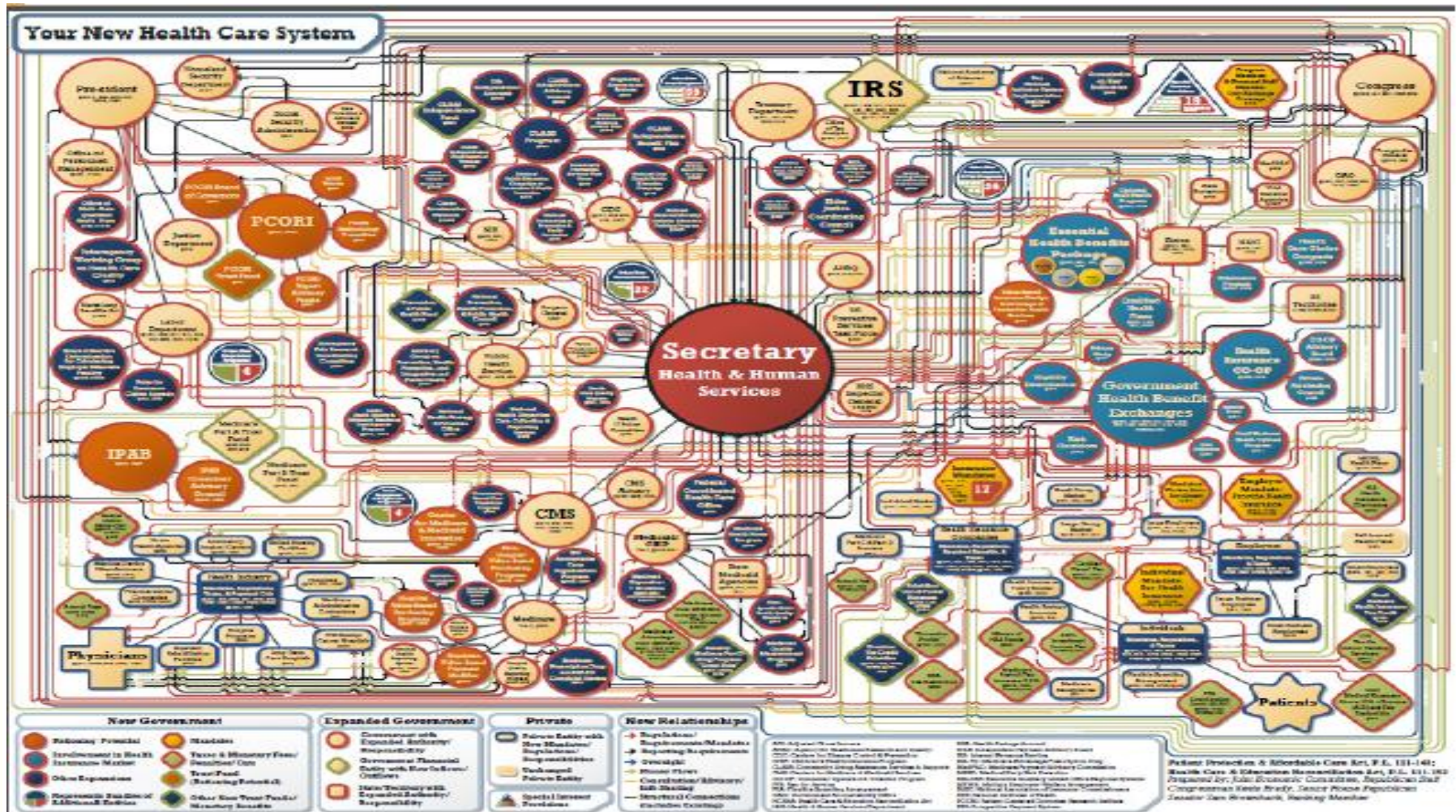


Public Funding Continues to Grow as a Source

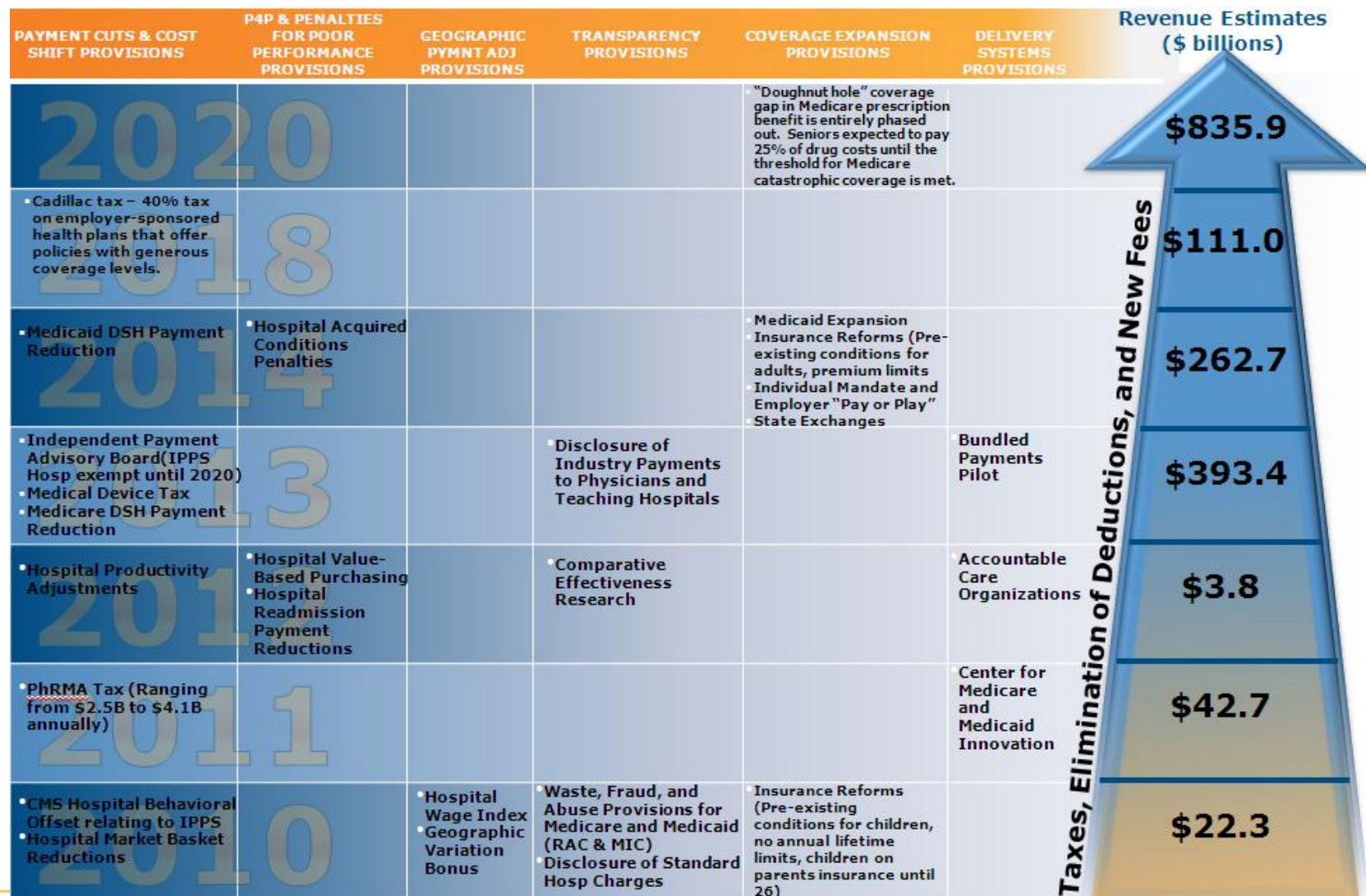
National Health Expenditures by Source of Payment (\$Billions)



The Advent of the ACA

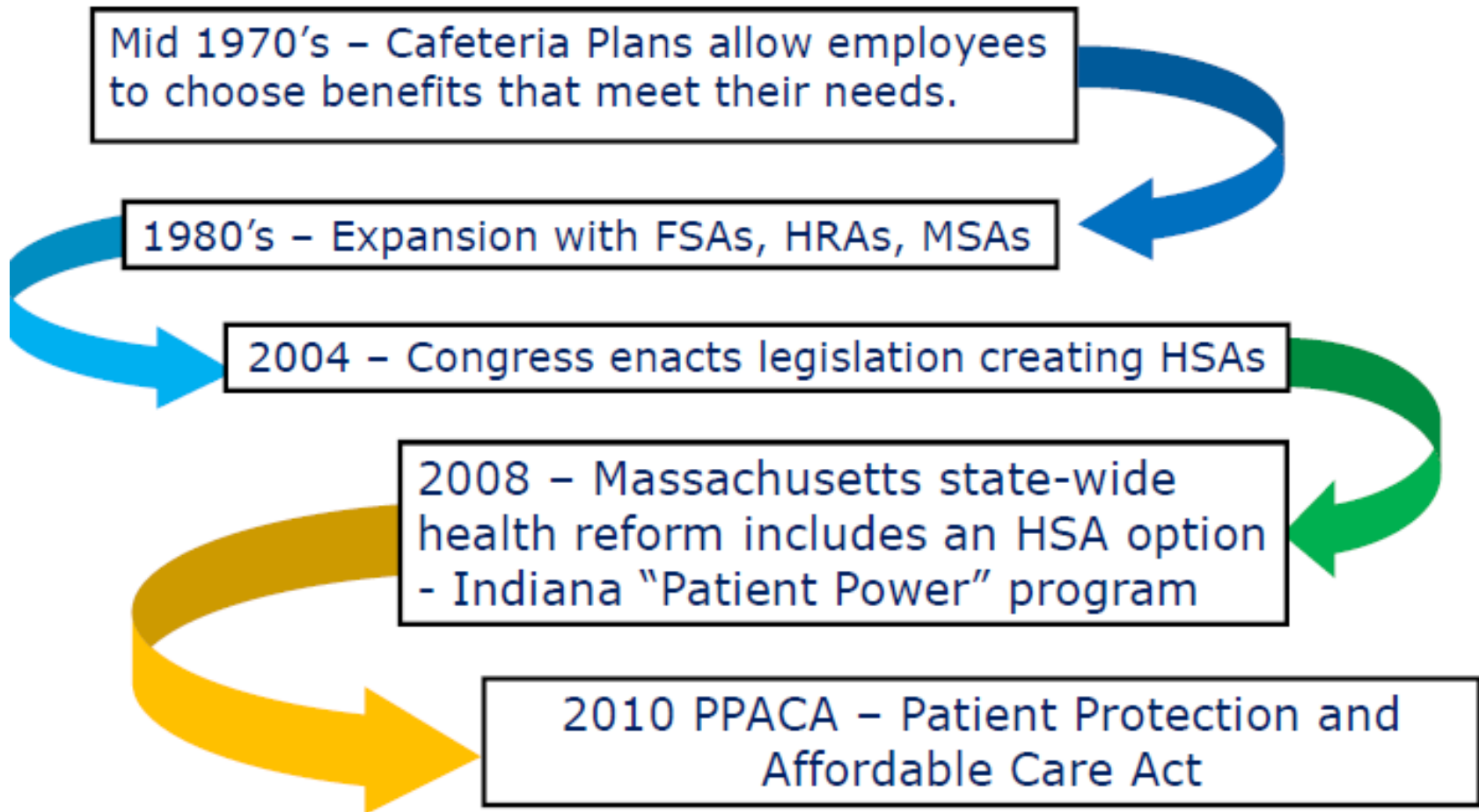


Healthcare Reform Timeline



Consumer Driven Health Care, Exchanges and Plan Options

How Did We Get Here?



HSAs – Real Growth Results

- HSAs first authorized by 2003 Medicare Prescription Drug Modernization Act; law based on existing Internal Revenue Code, uses tax incentives to encourage savings
- Foundational concepts of the Act are threefold: engage consumers, provide tax incentives, and reduce cost of plans
- **High-Deductible Health Plans (HDHP) are generally defined as health care policies with lower premiums and a deductible. The Act dictates that these plans have a) deductibles of at least \$1,200 for an individual and \$2,500 for family coverage, and b) maximum out of pocket expense per year**
- **Health Savings Accounts (HSAs) are designed to accompany these plans. By offsetting the deductible cost with tax advantages and earned interest, HSAs give beneficiaries a smart way to manage healthcare expenses. In 2013, HSA annual contributions can be no more than \$3,250 for a single, \$6,450 for a family.**
- At year end 2004 HSAs accounts numbered approximately 460,000
- America's Health Insurance Plans (AHIP) January 2012 Census reported "15.5 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)"

• Source: AHIP Center for Policy & Research 2013 Survey

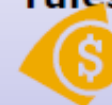
About HSAs

HSA 101

A Health Savings Account is a special tax-free trust or custodial account created exclusively for the benefit of account holders covered under a high-deductible health plan (HDHP) to use towards qualified medical expenses.

	Qualified HDHP				HSA Annual Contributions can be no more than	
	Plan deductible must be at least		Out of pocket max can be no more than			
	2012	2013	2012	2013	2012	2013
Single	\$1,200	\$1,250	\$6,050	\$6,250	\$3,100	\$3,250
Family	\$2,400	\$2,500	\$12,100	\$12,500	\$6,250	\$6,450
Allowable catch-up contribution for age > 55					\$1,000	\$1,000

No "Use it or Lose it" rules!



Unspent funds remain the property of the individual

HSAs provide a Triple Tax Benefit

1. Eligible contributions reduce taxable income
2. Account earnings are tax-free
3. Withdrawals for qualified medical expenses are tax-free

Myths Dispelled

MYTH	REALITY
HSA's are only for the young	<ul style="list-style-type: none"> • Over 60% of people covered by HSA/HDHP are family aged. (source: AHIP May 2012 data) • Only 12% are in their 20's • 26% are children; 31% are in their 30's and 40's • 31% are 50 or older
HSA's are only for the wealthy	<ul style="list-style-type: none"> • Average HSA income is \$55,000; AHIP does not have average • 75% of HSA holders earn less than \$75,000 • Source: OptumBank survey 2009
HSA's are only for the healthy	<ul style="list-style-type: none"> • Statutory out-of-pocket max caps exposure • Preventative care often covered at 1st dollar • Co-insurance is often lower
HSA's lead to people scrimping on care	<ul style="list-style-type: none"> • Separate studies by Cigna, Aetna, the Blues & Wellpoint show that HSA holders are more likely to participate in wellness programs and utilize preventative care. • AAA found that CDH plan care was received in equal or greater degrees relative to traditional plans

Consumer Driven Health Care (Statistics and Trends)

- **Employment Benefits Research Institute (EBRI) released recent data reflecting “more than 18 million adults ages 21–64 with private insurance, representing more than 15 percent of that population, were either in a consumer driven health plan (CDHP) or one eligible for a health savings account (HSA). “**

Source: EBRI: “Employer and Worker Contributions to Health Reimbursement Arrangements and Health Savings Accounts, 2006–2012”

- **In 2014 one in four employers (25%) already considering a change to their health plan offering are emphasizing high deductible health plans (HSA plans)**

Source: “2013 Employer-Sponsored Health Care: ACA’s Impact,” by the International Foundation of Employee Benefit Plans

- **According to the America’s Health Insurance Plans (AHIP) 2013 Census Report, large group high-deductible health plans have steadily & substantially increased since 2005**
- **Kaiser Family Foundation survey released April 2012 indicates half of all workers in “small” businesses (up to 199 workers) have a HDHP**

Economic Reasons Employers May Choose HSA Plans

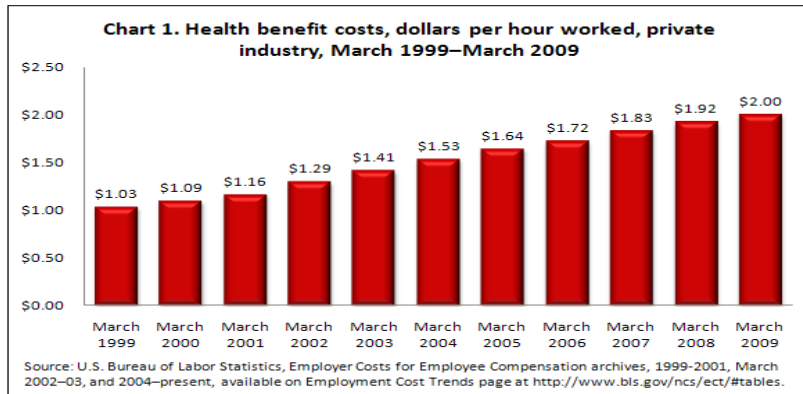
Employer

- Greater employee engagement in health care decisions and spending
- Ability to influence or control premium cost by plan design
- Potential to avoid so called *Cadillac Tax* effective 2018
- More efficient use of dollars: Provide qualified medical coverage rather than paying penalties under Employee Responsibility clause in ACA (69% of employers stated they will definitely continue to provide employer-sponsored health care in 2014)
- *Source: "2013 Employer-Sponsored Health Care: ACA's Impact," by the International Foundation of Employee Benefit Plans*
- Decrease cost for company

Why the Organic Growth?

Employer

- The cost to employers providing health insurance to employees has been rising for decades.



- With health care costs continuing to rise, many employers have been forced to reduce benefits, shift more cost to employees or drop coverage entirely.
- According to a newly released employer survey from Towers Watson & Co & the National Business Group, among large employers 66 percent offer a consumer-driven health plan (CHDP) with another 13 percent expecting to add one in 2014.
- Aon Hewitt comments that the proof is in the statistics. The Lincolnshire, Illinois-based consultancy survey showed high-deductible plans have surpassed HMOs as the second-most common plan design offered by U.S. employers.

Why the Organic Growth?

Employer

- **New research released July 2013, from the Employee Benefit Research Institute found a high-deductible health plan linked with a health savings account reduced health spending initially, and over a four year period. Key findings included:**
 - Introducing the full-replacement H S A plan reduced the plan's total health care spending by 25 percent the first year.
 - Spending on laboratory services and prescription drugs had the largest statistically significant declines (36 and 32 percent, respectively).
 - Reductions in pharmacy spending were large and mostly sustained over the four years after the HSA was adopted

Why the Organic Growth?

Consumer

- **A consumer owned FDIC insured, interest bearing deposit & investment account.**
- **Annual premium costs for families come down an average of \$2,350 for an HSA plan versus a PPO*.**
- **HSAs must have an out-of-pocket limit to protect against bankruptcy. The average out of pocket limit is \$6,066*.**
- **Over 65% of covered employees' accounts receive an average of \$1,546 per family from employers into their HSA*.**
- **RAND Research indicates families who switched to plans with a deductible of at least \$1,000 cut back on their health care spending by about 14% in the first year.**
- **2012 Cigna study found:**
 - Cigna Consumer Directed Health Plan (CHDP) customers improved their health risk by 10% in the first year compared to customers in a traditional plan (PPO or HMO).
 - Cigna CDHP customers were more likely to complete a health risk assessment and participate in health coaching programs than those in a traditional plan.
 - Cigna CDHP customers used the emergency room at a 13% lower rate than those in a traditional plan.

***The Kaiser Family foundation and Health Research & Educational Trust 2010 Annual Survey-Employer Health Benefits**

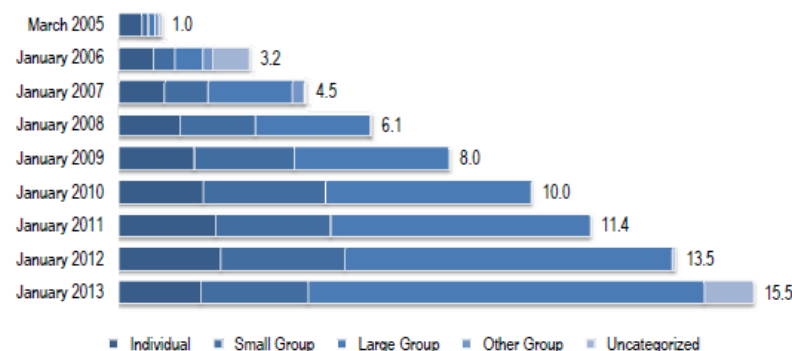
The Proliferation of Health Savings Accounts

Statistics

- January 2013 AHIP Census shows 15.5M people covered by HSA/HDHPs, an annual growth rate of approx 15% over the last several years.
- The 2012 Devenir HSA Research Report indicates HSA assets are currently \$15.5B and projects that the HSA market may exceed \$26B in total assets by the end of 2015. (Investments and deposits.)
- Devenir indicates the average investment account holder has an \$8,918 average total balance (deposit and investment account).
- A health benefits survey by Towers Watson and the National Business Group on Health estimates that in 2014 80% of companies with more than 1,000 employees will offer a HSA health plan or a similar high-deductible health plan paired with a health reimbursement account.
- AHIP statistics indicate there are more HDHPs than HSAs. Why?
- Employment Benefits Research Institute (EBRI) released recent data reflecting "more than 18 million adults ages 21–64 with private insurance, representing more than 15 percent of that population, were either in a consumer driven health plan (CDHP) or one eligible for a health savings account (HSA). "
- In 2014 one in four employers (25%) are considering a change to their health plan offering are emphasizing high deductible health plans (HSA plans)
- *Source: "2013 Employer-Sponsored Health Care: ACA's Impact," by the International Foundation of Employee Benefit Plans*

Health Savings Account Annual Growth

Figure 1. Growth of HSA-Qualified High-Deductible Health Plan Enrollment, Covered Lives (Millions), March 2005 to January 2013



Sources: AHIP Center for Policy and Research, 2005 – 2013 HSA/HDHP Census Reports.

Notes: For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards, or by state-specific requirements for each state. The "Other Group" category contains enrollment for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting. The "Uncategorized" category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies, but did not provide a breakdown by market category within the deadline for reporting. HSAs were authorized in 2003 and entered the market in January 2004.

Table 1. HSA-Qualified High-Deductible Health Plan Enrollment, Covered Lives, March 2005 to January 2013

	Individual	Small-Group	Large-Group	Other Group *	Uncategorized **	Total
March 2005	556,000	147,000	162,000	88,000	77,000	1,031,000
January 2006	855,000	510,000	679,000	247,000	878,000	3,168,000
January 2007	1,106,000	1,057,000	2,044,000	291,000	34,000	4,532,000
January 2008	1,502,000	1,816,000	2,777,000	13,000	10,000	6,118,000
January 2009	1,832,000	2,429,000	3,752,000	-	-	8,013,000
January 2010	2,053,000	2,970,000	4,986,000	-	-	10,009,000
January 2011	2,358,497	2,779,208	6,299,460	-	-	11,437,165
January 2012	2,470,840	3,019,347	7,939,023	-	72,865	13,502,075
January 2013	2,029,646	2,590,037	9,597,759	-	1,237,631	15,455,073

Sources: AHIP Center for Policy and Research, 2005 – 2013 HSA/HDHP Census reports.

Note: For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards, or by state-specific requirements for each state. The "Other Group" category contains enrollment data for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting. The "Uncategorized" category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies but were not able to provide a breakdown by market category within the deadline for reporting.

State by State Adoption Rates

Table 4. Total Enrollment in HSA-Qualified High-Deductible Health Plans and Enrollment as a Percentage of Total Enrollment in Private Health Insurance (Under Age 65), by State, January 2013

State	HSA/HDHP Covered Lives	Percentage of Commercial Enrollment
Alabama	58,847	1.7%
Alaska	26,668	5.1%
Arizona	236,675	5.1%
Arkansas	54,546	2.8%
California	808,019	3.1%
Colorado	304,651	8.4%
Connecticut	265,620	9.8%
Delaware	45,435	6.7%
District of Columbia	19,160	3.9%
Florida	539,931	4.5%
Georgia	197,818	2.9%
Hawaii	2,020	0.2%
Idaho	52,697	4.8%
Illinois	903,000	9.8%
Indiana	420,643	9.0%
Iowa	123,729	5.3%
Kansas	119,509	5.9%
Kentucky	151,703	4.9%
Louisiana	185,556	6.3%
Maine	74,216	7.5%
Maryland	336,240	7.9%
Massachusetts	150,840	2.8%
Michigan	577,208	8.1%
Minnesota	552,228	13.5%
Mississippi	22,907	1.1%
Missouri	172,404	4.1%
Montana	73,187	11.6%
Nebraska	121,773	8.9%
Nevada	59,078	3.4%
New Hampshire	70,018	7.3%
New Jersey	329,941	5.4%
New Mexico	29,181	2.2%
New York	522,388	3.6%

North Carolina	315,636	4.7%
North Dakota	30,387	5.8%
Ohio	686,616	8.5%
Oklahoma	72,343	2.8%
Oregon	148,369	5.4%
Pennsylvania	507,572	5.4%
Rhode Island	29,115	3.9%
South Carolina	171,830	5.6%
South Dakota	24,328	4.1%
Tennessee	321,469	6.9%
Texas	889,364	5.3%
Utah	255,566	12.0%
Vermont	72,616	15.4%
Virginia	259,856	4.4%
Washington	413,137	8.3%
West Virginia	23,286	1.8%
Wisconsin	216,515	5.0%
Wyoming	9,228	2.3%
Uncategorized	3,400,004	N/A
United States	15,455,073	7.0%

Sources: AHIP Center for Policy and Research, 2013 HSA/HDHP Census; U.S. Census Bureau Current Population Survey (CPS), Annual Social and Economic (ASEC) Supplement, 2012.

Note: The "Uncategorized" category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies but were not able to provide a breakdown by state within the deadline for reporting.

Reform Impact on Insurance Coverage & Health Savings Accounts

Key Points: Insurance Coverage

- Most Americans will be required to carry health insurance January 1, 2014.
- Congress has estimated that 22 million people will be newly insured.
- Health Insurance Exchanges (HIX) are being established with the intention of providing for the expansion of coverage, shift costs across the board and provide a range of choices. Exchange marketplace options are:
 - State run (16 states and Washington, D.C.)
 - State-federal partnership marketplace (7 states)
 - Federally-facilitated marketplace
- Private Insurance Exchanges are developing in response creating online portals that are populated with a variety of health-plan options from either a single or multiple carrier.
- 4 plan types will be offered, platinum (90% coverage), gold (80% coverage), silver (70% coverage), bronze (60% coverage). Bronze minimal level was designed to allow for the purchase of a qualified Health Savings Account (HSA).
- Beginning in 2014 under the 2010 Affordable Care Act (ACA), employers employing 50 full-time employees or more will be subject to Employer Shared Responsibility.
- Effective January 1, 2018, a “Cadillac” Plan Tax Excise tax of 40% will be applied to employer-sponsored coverage that has a benefit value in excise of \$10,200 for single coverage and \$27,500 for family coverage.

The Advent of The Health Insurance Exchange

CDHP Growth

- **The entire small group market may be replaced by insurance Exchanges**
- **Essentially be a super-sized “individual choice” market combined with the current individual market and uninsured people**
- **Once the employees (not the employer) are choosing their health insurance, most of them could gravitate to the cheapest plans**

CDHP Growth

Growth in CDHPs could be accelerated by mandates and Subsidies

- The government requires everyone to buy health insurance, what is the cheapest product on the market?
- Income-based subsidies will be tied to the 2nd least costly plan type (Silver plan) in the Exchange
- People can only get the maximum subsidy if they choose this plan or the only cheaper plan

The Health Insurance Exchange and POS Patient Responsibility Receivables

Lower the actuarial value means higher levels of patient responsibility
MLRs require either 80% or 85% premium to benefit ratio

Leading to potential patient responsibility between 15% and 20%

- Bronze = 60 percent
- Silver = 70 percent
- Gold = 80 percent
- Platinum = 90 percent

Yearly out of pocket expense limited to HSA limits defined by IRS code

The Health Insurance Exchange and POS Patient Responsibility Receivables

(Givens and Assumptions)

A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

- (i) \$2,000 in the case of a plan covering a single individual; and
- (ii) \$4,000 in the case of any other plan.

The Health Insurance Exchange and POS Patient Responsibility Receivables

Therefore(s) and Assumptions:

- If the policy costs \$14,000 (for example) pays out 85% of premium in the form of benefits then:
 - 15% of \$14,000 equals \$2,100 could be the patient responsibility or
 - 20% of \$14,000 equals \$2,800 for potential patient responsibility
- Leads to “time to think seriously about patient propensity to pay, financial payment counseling and payment plans

National Market Trends & Customer Value Received

Trends

- Government and private employers continue to reduce payments to hospitals and other healthcare providers
- Two thirds of a hospital's revenues are paid by third party payer's-ensuring accurate initial claims avoids processing delays, costly re-work, and denials
- Insurance denials continue to grow representing 18% of claims filed
- The Healthcare Advisory Board estimates 90% of initial denials are preventable by correcting incorrect, contradictory or missing information
- Hospitals with the best overall financial performance commit two thirds of their business office resources to the front office / POS (The Advisory Company, "Bridging the Gap")
- Employees are responsible for a greater percentage of their healthcare expenses
 - Patient pay or "self pay" is expected to increase from 20 to 35% of a hospital's net revenues in 5 years
 - On average providers collect \$0.50 of every \$1.00 owed by patients
 - 40% of patients don't understand their bill and 1 in 5 aren't sure who to pay
- Survey of PNC 150 prospects/clients Q2 2011 found:
 - 68 % rank patient collections as greatest concern
 - 29% cite registration and insurance data top
- 2012 Q2 PNC Healthcare Advisory Board identified RCM workflow and POS as top priorities


Customer Value

- Accelerates cash flow through higher POS collections
- Eliminates denials as reducing re-work and administrative expenses
- Reduces days in Accounts Receivables due to pended claims
- Increasing automation reduces costs and allows resources to be redeployed
- Total cost to collect can be reduced 1-3% meaning millions to the bottom line
- Improves patient/customer satisfaction by increasing transparency and convenience

Recommended Product Suite Components

- 1) **Patient Access Automation & Denial Prevention** – A rules-based workflow platform that streamlines patient access interactions and registration quality assurance. Each registration is assessed for missing, incomplete or incorrect data on a real-time basis. The rules engine should leverage information contained in electronic registration transactions below to define exception issues necessary for staff to follow-up:
- **Insurance Eligibility Verification** – automate insurance inquiries and responses including eligibility, scope of coverage, and care authorizations
 - **Patient Demographic Verification** – at point-of-service validates the patient's name, address, date of birth and social security number
 - **Charity/Medicaid Eligibility Assessment** – automate screening and documentation for government or hospital-based financial assistance
- 2) **Patient Responsibility Estimator** – allows the hospital/health care professional to provide the patient with a written *estimate of what they will owe out-of-pocket for services after insurance*
- 3) **Accounts Receivable & Denial Management** – the rules engine applies logic to the data contained in the claim submission and remittance data (835/837) to automatically update and re-file electronically without human intervention thereby allowing humans to intervene on exceptions only. The “intelligence” of the engine should also allow the ‘problem’ to be prioritized and routed to the appropriate personnel for resolution

Where to Buy: Types of Health Insurance Exchanges



Federal	<ul style="list-style-type: none">• CMS has contracted with CGI Federal Inc to build the federally-facilitated Health Insurance Exchange
State	<ul style="list-style-type: none">• 16 states + DC have opted to establish an exchange
Private	<ul style="list-style-type: none">• Health Insurance to Small Business• Corporate Exchange (Aon Hewitt)• Broker to Individuals

Contact Information

James S. Gandolfo, Senior Vice President
Senior Consulting Manager,
PNC Treasury Consulting Group
(302) 429 - 2832 (office)
Email: james.gandolfo@pnc.com

J. Kevin A. McKechnie, Executive Director
The ABA HSA Council

Senior Vice President & Director
The ABA Office of Insurance Advocacy

American Bankers Association
1120 Connecticut Avenue, NW
Washington, DC 20036
202-663-5163 Office

Email: KMckEchn@ABA.com