

# Health Savings Accounts: Are You Prepared?

**H**ealth savings accounts coupled with high-deductible insurance plans have the potential to groom a new brand of healthcare consumer—namely, patients who are more cost conscious and “invested” in their care. While such consumer-directed health care could go a long way to promote patient responsibility, it also could present new challenges for process-heavy hospitals that will have to re-engineer parts of the revenue cycle. In the following roundtable, sponsored by Siemens, two providers, a benefit plan consultant, a banking leader, and a medical economist discuss the growing popularity of consumer-directed health care and the emergence of high-deductible health plans coupled with health savings accounts. They also discuss ways that hospital financial managers can start reviewing their patient access protocols to prepare for patients making use of these types of payment arrangements.

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**Projections vary widely as to how likely consumers are to select high-deductible health plans during the near future. What are your predictions?**

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**Jeff Bauer:** I think growth will happen more quickly than many other experts are predicting. The consensus seems to be that 10 percent of all insured patients will have consumer-directed plans by 2010. I will not be surprised to see an actual rate of 20 percent to 30 percent adoption by 2010. The existing forecasts seem to consider only the growth of consumer-directed health plans as defined by the 2003 Medicare Modernization Act. I think the real issue is high-deductible health plans, with or without the health savings account component that defines a consumer-directed health plan. High-deductible plans are likely to grow rapidly as payers transfer more payment responsibility to their employees.

**James Gandolfo:** At present, estimates show there are more than 3 million enrollees in high-deductible health plans with health savings accounts. Specific to us, we have had a significant increase in the number of health savings accounts from 2004 to the end of 2005. We had roughly 1,000 by the end of 2004. The amounts in these accounts also appear to be increasing. At the end of 2004, we had \$2 million in these accounts. As of October 2006, this increased to \$20 million. By next fall, we predict both the number of accounts and amount of assets will likely double.

In general, we are seeing more individuals roll over their funds in health savings accounts and the balances

in them grow. People are starting to be savvier and exercise more control in the way they spend their dollars. Also, employers are spurring some of this growth by offering high-deductible health plans on a level with their traditional PPOs.

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**How are high-deductible health plans being marketed toward employers?**

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**James Gandolfo:** They are being positioned as a way for employers to contain their healthcare expenses and make employees more cost-conscious, while at the same time being able to offer employees greater choice in their care.

Certainly, there is a real need to control healthcare expenses and the way that employees use their benefits. Employers face health insurance premiums that have increased by 73 percent since 2000, according to the National Coalition on Health Care. Meanwhile, the average employee contribution has increased 143 percent, and the average out-of-pocket expense has increased about 115 percent.

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**Will participation in high-deductible plans be mandatory or optional?**

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**James Gandolfo:** Right now, it is rare for an employer to do a full replacement. Instead, employers are introducing high-deductible health plans alongside their HMO and PPO offerings. Employers are merely sticking their toe in.

**Jeff Munn:** We continue to see larger employers add these plans. A few employers have gone full replacement, but this is rare. Typical enrollment might be 2 percent to 5 percent.

What happens in the future in terms of employer support will largely depend on the experiences that some of these frontrunners have—particularly those that have high enrollments. If these plans are shown to save money and give access to health care that people have not had to this point, then we will see these plans take off. On the other hand, if we see that people are forgoing care that they need and becoming more frequently or acutely sick as a result, then these plans will suffer.

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#### **Providers, what are you anticipating in terms of high-deductible health plan usage in your markets?**

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**Cynthia Fry:** As a system, we are taking the high-deductible health plan movement seriously and believe the penetration rate among our patient base is going to grow. One reason is because consumer-directed health care is politically and legislatively supported. Politicians have been under pressure for several years to “do something” about the rising cost of health care and the number of uninsured Americans.

CMS released in July 2006 a 48-page strategic plan that calls for integrating health savings accounts into Medicare by 2007 and requiring wealthy seniors to pay a higher share of program costs. Massachusetts is requiring health insurance for all residents in 2007. We anticipate many of these plans will be high-deductible health plans.

**Martin D’Cruz:** In the local market, most of our hospitals are getting ready for the onslaught of high-deductible health plans in the next year. We are working with our local employer forum in Indianapolis to identify large employer groups that might offer these plans in 2007. These groups include

#### **PARTICIPANTS**

**Jeffrey C. Bauer, PhD,** is a medical economist and health futurist, and a Chicago-based partner in the consulting practice of ACS Healthcare Solutions, Dearborn, Mich.

**Martin D’Cruz** is vice president of managed care services for St. Vincent Health, which includes 16 hospitals serving central Indiana. St. Vincent Health is a member of Ascension Health, the nation’s largest Catholic healthcare system.

**Cynthia Fry** is system vice president of revenue for Catholic Health East, headquartered in Newtown Square, Pa. The system includes 33 acute care hospitals and numerous other long-term care, continuing care, behavioral health, ambulatory, and community-based services located in 11 states from Maine to Florida.

**James Gandolfo** is senior director and vice president of global business development for PFPC, Inc., a Wilmington, Del.-based provider of business solutions for the global investment industry and a member of The PNC Financial Services Group.

**Jeff Munn** is a principal in the health management consulting practice for Hewitt Associates, Falls Church, Va.

the State of Indiana. From our experience, less than 3 percent of our patients participate in these plans at this time.

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#### **How can hospitals and physicians tell if a patient has a high-deductible health plan?**

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**Cynthia Fry:** Right now, these patients are somewhat hidden. We definitely see these plans in some markets but are having difficulty identifying them, as the insurance cards typically state “PPO.” We know that a patient is covered by a high-deductible plan when we verify insurance and see what the deductible is. Then, our insurance verifiers check if that deductible amount is equal to or greater than the IRS floor. That’s the only way we can tell at present. It is also hit-and-miss identifying whether the patient has a health savings account and figuring out how to record the information to facilitate an appropriate claims process flow.

In our contracting with payers, we would like to negotiate transparency in identifying these types of plans. Also, to recognize any unfavorable financial impacts of these types of plans, we have to determine how to identify and record them: whether to create new insurance plan codes or track by some other means.

**Martin D’Cruz:** From a patient access perspective, we need to identify patients with high-deductible plans at the front end, so they can negotiate a rate with us if we are not contracted.

We also have a policy that if the patient has a high-deductible plan, we want to be able to collect 75 percent of costs upfront. We want to minimize the burden of collecting at the back end, where patients may be challenged to come up with the payment due.

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#### **Who typically administers health savings accounts?**

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**Jeff Munn:** We are seeing two primary models. One is an integrated model in which the health plan owns or partners with a bank. This arrangement is the most popular so far. It offers one-stop shopping for the employee with everything packaged together. As the banking systems begin to talk to the healthcare systems more effectively, I think we will see the rise of a plug-and-play model. In this model, both sides will be able to work together. Those administering the health plan will be able to access the health savings account balance information, and those administering the health savings account will know the deductible.

**James Gandolfo:** Right now, banks administer almost 90 percent of every health savings account in the United States. But some insurers have already chartered banks so they can administer and underwrite these plans. We see an opportunity for banks to bring standardization to the process—think ATM networks and credit card networks. For example, insurers are developing systems that will benefit providers by allowing claims to be paid faster.

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**What do you think about benefits cards that include some form of payment capability through access to the patient's health savings account—for example, a credit or debit component?**

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**Jeff Munn:** A couple of insurers are starting to market these cards, which offer what they call “multi-purse” functionality. Such a card would pull from different buckets of money: the health savings account, the flexible spending account, or a credit facility. The card would know, based on the plan designs and the preference of the user, which accounts to pull from.

I think the credit function, in particular, is primarily aimed at providers' concerns that they are going to have uncollected receivables because of lack of access to balances in the health savings accounts. I have not seen a lot of employers interested in providing this credit feature to employees.

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**How will preregistration and registration processes change?**

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**Cynthia Fry:** We are going to have to shift a preponderance of revenue cycle activities and skills upstream from the business office to patient access to enable enhanced communication with the patient. For example, self-pay responsibilities are typically discussed with the patient after billing and insurance payment. These discussions need to take place upfront. Patients will need to have an estimate of their payment responsibility so they can make use of financial counseling, when needed. In addition, there are problems with some payers regarding the insurance verification process (HIPAA Transaction Code Sets 270/271). How can providers verify benefits prior to service when the payer databases are sometimes inaccurate and outdated and claims are subsequently denied when the database is updated? Clearly, there are some serious issues to work out.

Some major payers are instructing patients not to pay copays or deductibles upfront, and these same payers have changed their provider manuals to reflect the same. This is also a major concern given the substantial increase in patient out-of-pocket responsibilities. Providers will be challenged in managing the public perceptions regarding collection of large copayments and deductibles unless they take steps to negotiate contracting protections, reengineer patient access tools and work flows, and upgrade skill requirements.

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**How might these issues affect decentralized registration?**

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**Cynthia Fry:** Many hospitals implemented decentralized registration for patient convenience. But if providers are required to increase the number of activities performed in patient access, such as financial counseling, we may be forced to centralize registration once again. How can any hospital manage 20 registration spots, keep all of its employees

properly trained, and provide patients with the service and information they need? Another option is to centralize preregistration and, again, move more activities upstream into preregistration, so that when the patient reports to be registered, all activities, including financial counseling and discussion of out-of-pocket payment responsibility, have been communicated and resolved prior to the visit.

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**Do you think this will require a different kind of staff?**

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**Cynthia Fry:** Yes. Patient access will require a higher level of employee. Typically, a registrar does not have the same insurance knowledge or experience as a collector in the business office, and this knowledge will be a requirement. In addition, staff performing this work will need to be skilled in customer service and able to discuss financial issues in a professional and caring way.

But it is not just about staff. Excellence in front-end revenue cycle activities demands new or revised patient access work flows. Employees also will need different, new tools that enable them to be well organized, agile, and quickly responsive in a cost-conscious and effective way to new questions, such as pricing, quality, and how much a patient owes out-of-pocket.

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**In your opinion, how can hospitals best support consumers “shopping” for health care?**

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**Martin D’Cruz:** We are seeing a lot of patients requesting prices, but that has been a challenge because confidentiality arrangements with payers do not allow us to divulge net prices. Instead, we can only provide a range. For example, if a patient comes in for a knee arthroscopy, we would say the price range would be \$4,000 to \$5,000. But this can be misleading, because the range doesn't include professional fees, which can be significant.

**Cynthia Fry:** Providers need to be transparent about what their prices are and why and how they are developed. From a process perspective, we endorse a “one call does it all”



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concept in which patients are able to obtain quality data, price quotes, and appointments all in one call. This is the future vision, and it is a challenge. That said, I find it difficult to believe that someone with a serious illness would be price shopping. Actually, that is one of the ethical issues that we struggle with at Catholic Health East. Many of the consumer-directed healthcare goals are laudable—but are they practical or reasonable? Ill health is ill fortune. I know some in the industry have suggested having care counselors to help patients through the process. And there are web tools that are supposed to help patients with healthcare decision making. However, these tools appear to be targeted at English-speaking, computer-literate, educated consumers. What about those who don't fall within these categories?

**Jeff Bauer:** Although the challenges are daunting, they cannot be ignored. The impact of high-deductible plans is going to become very big, very fast. Hospitals will need to get serious about finding new ways to work with people who owe them money. In our country, we now have a negative savings rate and a drop in inflation-adjusted real income for most Americans. Ability to pay is declining as healthcare costs are increasing. Consequently, hospitals need to develop mechanisms that will allow them to collect from patients over a long period of time. For example, providers may need to help patients secure credit cards, extend credit for 12 months same as cash, or help patients qualify for research programs that could subsidize their care. Creative, patient-sensitive approaches to collections will quickly become a differentiator in the medical marketplace.

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**How can hospitals educate employers and patients in their communities about how hospitals will be accommodating those covered by high-deductible plans?**

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**Martin D'Cruz:** At St. Vincent, we have formed a committee to look at consumer-directed health plans, including people from patient access, the revenue cycle, and managed care. The committee's purpose is to identify and discuss pricing and payment activities with the employers in our area

who are going toward health savings accounts and high-deductible health plans. We also are inviting the health plans to come in and educate us on what they are going to offer for 2007.

**Jeff Munn:** Several factors will drive how successful these plans are from the consumer's standpoint. One is the level of education provided to enrollees. People are not used to buying health care. Rather, they are used to having it paid for. Such a huge shift makes a lot of people uncomfortable. Still, payers that have taken time to educate enrollees about high deductibles and health savings accounts have gotten good results. Another factor is the amount and quality of information that's out there. Right now, there isn't enough good data about hospital performance, physician performance, and accurate pricing.

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**Any last words of advice for hospital executives?**

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**Jeff Bauer:** Hospitals must directly confront the issue of pricing. Their historical pricing practices make absolutely no sense to consumers who are being asked to pay a much bigger portion of the bills for their health care. Hospitals have to start from scratch and fix their pricing methods to take into account the customer's point of view. Developing a fair and reasonable pricing policy over the next two years is one of providers' biggest challenges.

**Jeff Munn:** Right now, everyone is pushing toward the same goal of transparency. The most important thing as consumer-directed health care develops is that every stakeholder be as collaborative as possible. We are all going to need to compromise a little to get a system that works.

**Cynthia Fry:** All evidence points to the proliferation of high-deductible health plans in the near future. As good stewards of our institutions, it falls to us to develop a proactive strategy that reduces our financial risk and improves upfront scheduling, preregistration, and registration. Our patients deserve to receive their health care in a patient-centered and compassionate environment in which their privacy, dignity, and individuality are respected at all times. Excellent business processes complement excellent medical care.

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