SUBJECT: Creating a consumer-directed health plan option for state employees

COMMITTEE: Pensions, Investments and Financial Services — committee substitute recommended

VOTE: 9 ayes — Truitt, Anchia, C. Anderson, Creighton, Hernandez Luna, Legler, Nash, Orr, Veasey

0 nays

WITNESSES: For — Arlene Wohlgemuth, Texas Public Policy Foundation; (*Registered, but did not testify:* Brent Connett, Texas Conservative Coalition; Marisa Finley, Scott and White Health Center for Health Care Policy; Bill Hammond, Texas Association of Business; Lee Manross, Texas Association of Health Underwriters; Darren Whitehurst, Texas Medical Association)

Against — Andrew Homer, Texas Public Employees Association; Ted Melina Raab, Texas American Federation of Teachers; Derrick Osobase, Texas State Employee Union; (*Registered, but did not testify:* Elizabeth Blount, Retired State Employees Association; Rene Lara, Texas AFL-CIO)

On — Ann Fuelberg, Robert Kukla, Employee Retirement System

BACKGROUND: Under federal law, people below age 65 covered under a high-deductible health plan can make annual contributions that are not subject to federal income tax to health savings accounts (HSAs). The individual owns the account and may use its funds to pay for certain medical expenses without a tax liability. The contributions can be carried forward from year to year.

DIGEST: CSHB 1766 would amend laws related to state employee health benefits by establishing an optional consumer-directed health plan. The bill directs the Employee Retirement System (ERS) to establish HSAs and purchase or finance a high-deductible health plan whose benefits included preventive care for state enrollees and their dependents. ERS would have to begin offering coverage in the consumer-directed health plan program by September 1, 2012, and to have notified state employees about the program by July 31, 2012.

ERS also would be required to determine or establish rules regarding eligibility, dependent coverage, and the coordination of benefits for enrollees to participate in a medical flexible savings account. ERS also would have to submit a report to the governor, lieutenant governor, speaker, and Legislative Budget Board by January 2017 that identified the manner and level in which enrollees used the state-directed health plan and whether it was more cost-effective than basic coverage and should be continued.

The bill would require that state contributions for plan enrollees who would otherwise fund basic coverage would be used to pay for the high-deductible plan costs. For dependents, the state's contribution to a high-deductible plan would be the same percentage of the cost of dependent coverage in the basic plan. State contributions not otherwise spent on the high-deductible plan would be allocated to the enrollee's HSA. Enrollee contributions could be used to pay the cost of coverage not covered by the state or to fund the HSA.

The bill would take effect September 1, 2011.

SUPPORTERS SAY:

CSHB 1766 would give state employees the option of controlling their health care expenses and could help the state contain health plan costs. Consumer-directed health plans are popular with public and private sector employees, and currently 23 states offer their employees the option. The ERS actuary projects that the option would save about $1.3 million during fiscal years 2013 and 2014.

Employees would pay deductibles and other ongoing health care costs from their HSA account, and all remaining funds would build up over time and could be used to cover major future health care expenses. When employees left state employment or retired, they would be entitled to the amount remaining in their HSAs. An HSA is a better employee benefit than the TexFlex account, in which funds must be entirely spent during the year or forfeited and are not portable when an employee leaves state employment.

No employee would be required to participate in the consumer-directed health plan. Adding the option of a high-deductible plan would not affect the basic plan coverage. Most employees are satisfied with their current coverage, and few are expected to choose the new option. According to the fiscal note for this bill, the ERS actuary assumes annual enrollment at

3 percent. The consumer-directed health plan would be designed to complement, not replace, the existing plans.

Adverse selection, which is when a health plan structure incentivizes only sick people to join, would not be an issue with the introduction of a state consumer-directed health plan. ERS would keep all employees in the same risk pool, and if costs rose or fell in one plan, they would rise or fall for all state employees.

High-deductible health plans are less expensive for the state than traditional basic coverage, and part of the savings could be used to fund enrollees' HSAs. ERS would be required to create the program in a cost-neutral way, thereby staying within fiscal 2012-13 appropriations. ERS also would be required to report any findings of cost-effectiveness by 2017.

HSAs are proven means of cost containment in health care. A monograph by the American Academy of Actuaries showed that HSAs on average achieve 12 to 20 percent savings in the first year and a rate of inflation in subsequent years of 3 to 5 percent, or roughly half that of traditional plans.

The state of Indiana has seen phenomenal success with their program. In 2005, Gov. Mitch Daniels required an HSA option for state employees. The first year only 4 percent of its employees selected the option, but by 2010 over 70 percent of Indiana's state employees had voluntarily selected an HSA. Last year those employees had accumulated over $30 million in their accounts. The employees saved more than $8 million more than their counterparts covered by a traditional PPO, and the state of Indiana saved over $20 million in 2010 just by the HSA option.

State employees who chose this option would tend to be more careful consumers of health care. Traditional health insurance plans insulate patients from the cost of care, because out-of-pocket costs such as deductibles usually are a small portion of the actual cost of care. A patient who is responsible for the full cost of health treatment would be more likely to question the cost of treatment and the necessity of particular procedures.

Every person's financial and health needs are different, and people are able to determine what option would work best for them. There is no reason to believe that only healthy people would choose the consumer-

directed health plan, and sicker employees would choose basic coverage. While individuals with a chronic condition may not be able to build substantial savings in their HSA, they would still be in control of what services they purchased and would benefit from using pretax dollars to pay for their costs. Also, sicker employees still would have high-deductible insurance to cover health care costs after the deductible had been met.

Since preventive care would be required under the high-deductible plan, employees would not be discouraged from using their HSA funds to seek timely care, so their medical conditions would not get worse.

Employees leave state government for many reasons, so having HSA funds to take with them would not additionally encourage or increase turnover.

OPPONENTS SAY:

CSHB 1766 would lead to higher costs for the state and state employees as a result of adverse selection, and ultimately make the current basic plan so expensive that the state no longer would offer it. Also, claims that HSAs help cede control of health care purchasing to consumers are greatly overstated: buying health care is not the same as buying groceries or a new television. Consumers do not have access to good information about relative health care provider quality and costs, and are often not in the position to determine necessity and compare alternatives, especially for urgent or emergency care.

Adverse selection hurts any insurance pool by reducing the pool's ability to spread risk of future costs among a diverse population. This health plan option most likely would be attractive to healthy, usually young, employees who do not anticipate needing help with medical expenses. With this bill, adverse selection would take place when the healthy employees chose the consumer-directed plan option, and the employees who chose the lower-deductible basic health plan would include more people with chronic or serious conditions, the elderly, or couples planning to raise a family who wanted to protect against unknown future out-of-pocket costs. Over time, as the basic plan covered a disproportionate number of sicker employees, the plan's costs would rise, eventually becoming too expensive for the state to maintain.

Any savings to the state would be from cost-shifting the expense of health care to state employees' out-of-pocket expenditures rather than lowering

health costs. No study has shown whether accumulated HSA funds are sufficient to meet enrollees' current and future health care needs.

The $30 million accumulated now by Indiana state employees may be a big number, but no one knows whether they are saving enough to cover their health care needs. Additionally, state savings may be countered by productivity decline, when consumer-directed health plan employees choose not to seek necessary or preventive care because they did not wish to spend HSA funds, and then end up being sicker and unable to work because their medical conditions worsened.

CSHB 1766 could increase employee turnover since employees who leave state service could take state HSA contributions with them. This would be particularly problematic since younger employees, who are most likely to opt into a consumer-directed health plan, have turnover rates double that of other age groups. The state already offers employees a way to save money on deductibles and other health insurance costs through TexFlex accounts, which complements, rather than competes with, existing health plans.

OTHER OPPONENTS SAY:

The economic and demographic profile of the state workforce is not a good match with the HSA model, and the state should not spend money administering an option with such little potential benefit. All available evidence suggests HSAs are attractive primarily as a tax benefit for more highly compensated employees. A 2008 Government Accountability Office report found that the average adjusted gross income for HSA users was $139,000. On the other hand, the average pay for nonhigher education state employees is slightly more than $39,000, and only 19 percent of the state workforce earns in excess of $50,000 annually. Most state employees would find it difficult to afford a high-deductible plan.

NOTES:

The committee substitute differs from the filed version in that it contains requirements for ERS to report to the governor, lieutenant governor, speaker, and Legislative Budget Board by January 2017 to identify how and at what level enrollees use the state-directed health plan and whether it was more cost-effective than basic coverage and should be continued.