Health Savings Accounts Not the Answer for CalPERS

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Despite their growing popularity, health savings accounts are not a good solution to the problem of rising health care costs, at least not for California state employees and retirees, Fred Buenrostro said at a health care congress sponsored by the Wall Street Journal and CNBC.

Mr. Buenrostro is chief executive officer at the California Public Employees' Retirement System (CalPERS), the second largest health care purchaser in the country. CalPERS, based in Sacramento, provides health benefits to more than 1.2 million employees, retirees, and family members.

In California, out-of-pocket health care premiums have nearly tripled in 5 years, and Republican Gov. Arnold Schwarzenegger is seeking to cut the amount of premium assistance the state gives to employees and retirees. So "CalPERS, like other employers, is hearing the call of consumer-driven health care," Mr. Buenrostro said.

"We are resisting it because we don't want our highway workers, our police officers, our firefighters, our office workers, to switch from our defined benefits health care model to a defined contribution model. We oppose putting our members at risk in such a complex, broken market," he said.

Under a defined benefit plan like those that CalPERS offers, employers agree to pay for a particular level of benefits, no matter what the cost of the plan is. But under a defined contribution plan, the employer pays only a certain amount toward the cost of an insurance policy; any additional costs must be paid by the enrollee.

So CalPERS is trying other ways to cut health care costs. One technique is to avoid providers that the plan perceives to be too costly. "Two years ago, we dropped two big HMO partners because their prices went over the top," Mr. Buenrostro said.

The plan is also using generic drugs in 95% of cases, and giving members incentives to buy mail-order drugs. CalPERS has extended the length of its PPO contracts to improve its negotiating position, and is encouraging members to use "centers of excellence" for various procedures.

'We are resisting it because we don't want our highway workers, our police officers ... to switch. We oppose putting our members at risk in such a complex, broken market.'

CalPERS also is talking with other purchasers about price inequities of health care in local markets, and plans to convene a conference of purchasers on this issue later in the year.

One big part of controlling CalPERS' costs has been getting the best price for hospital services. Between 2001 and 2003, hospital prices rose 60%, which was "just unaffordable," he said. CalPERS partnered with California Blue Shield to do an analysis of the costs.

"Blue Shield came up with what was then a shocking discovery: In many cases there was no correlation between price and quality," he continued. "I thought they were kidding." For example, they found that the cost of chemotherapy could range from $135,000 to $300,000.

As a result of the analysis, CalPERS notified 38 hospitals and 17 physician practices that they were in danger of being dropped from CalPERS' provider network unless they dropped their costs and agreed to undergo performance assessments. The change would have saved $36 million in the first year and $50 million for the next few years.

CalPERS ended up dropping 24 hospitals and several physician practices as of January, forcing 32,000 members to switch their primary care physicians. Although the move resulted in complaints from members as well as the California legislature, Mr. Buenrostro has no regrets.

"It will save tens of millions of dollars for our members and the taxpayers [who pay our salaries], and the decision helped us keep our HMO and PPO premium increases for members under 65 at 9.9% without any takeaways or any increases in copays or deductibles," Mr. Buenrostro said. "We're pretty proud of that."

Despite CalPERS' success, it can't solve the long-range health care cost problem by acting on its own, he said, "We can only solve this problem if we get a national solution." ■

HSAs Encourage Healthful Behaviors, Expert Says

Health savings accounts and other consumer-directed insurance products can help lower health care utilization and encourage better health behaviors, according to an industry expert.

Consumers "begin to recognize that the behaviors that they have can lead to a health outcome that can actually cost them money in the long run," said Doug Kronenberg, chief strategy officer for Lumenos, an Alexandria, Va.–based company that sells health savings accounts.

"And therefore they begin to think about changes in their behavior that can impact that health care," he said.

When an employer or insurer combines that with a program that also shows consumers the financial benefits of changing their behavior and offers support tools, consumers really become engaged in their health care, Mr. Kronenberg said during a teleconference sponsored by the Kaiser Family Foundation.

Health Savings Accounts (HSAs) were authorized under the Medicare Modernization Act of 2003 and are portable accounts that consumers can use to pay for certain qualified medical expenses. The accounts are generally offered in conjunction with a high-deductible insurance plan, and both consumers and employers can contribute to the accounts.

HSAs and similar accounts, such as health reimbursement accounts, can also create big savings for employers, Mr. Kronenberg said. With these types of plans, consumers tend to see the money as their own, and utilization of health care services typically drops.

But Mila Kofman, J.D., assistant research professor at the Health Policy Institute at Georgetown University, Washington, said that HSAs coupled with high deductible plans are just shifting the cost burden for health care from the insurer and the employer to the consumer.

And one of the possible pitfalls of the plans is that consumers who are facing deductibles of $1,000 or more each year will simply forego needed medical care because they can't afford to pay for it.

—Mary Ellen Schneider

Class Action May Help MDs Recoup Losses

BY ALICIA AULT
Contributing Writer

Physicians frustrated with seemingly arbitrarily denied claims will have their day in court later this year with at least six insurers, thanks to a recent Supreme Court decision to deny the plans' appeal of a class action suit. But settlements related to improper denials by Cigna and Aetna are likely to provide vindication even sooner.

The legal actions affect almost every practicing physician in the United States—about 900,000 doctors.

A series of suits, originally filed by several state and county medical societies, was consolidated in a U.S. District Court in Florida in 2000 and certified as a class action in 2002. The filing named Aetna, Anthem, Cigna, Coventry, HealthNet, Humana, PacifiCare, Prudential, UnitedHealthcare, and WellPoint as defendants, and alleged that the plans violated the Racketeer Influenced and Corrupt Organizations Act (RICO) by engaging in fraud and extortion in a common scheme to wrongfully deny payment to doctors.

Aetna and Cigna broke off and entered into negotiations, an enormous process involving more than 100 attorneys, 19 state and county medical societies, the American Medical Association, and the plans' CEOs.

The two insurers settled in 2003, but the other parties have vowed to continue to fight, and are scheduled for trial in September in the Florida courtroom of Judge Federico Moreno. Another suit, with 60 Blue Cross and Blue Shield plans as defendants, is also before Judge Moreno.

Still, the other insurers may follow in Aetna and Cigna's lead.

The Aetna claims deadline has passed, and physicians had until Feb. 18 to make a claim against Cigna, with two options for recouping losses. One was to make a general claim on Cigna's $30 million settlement pot, which will be divided equally among all who make such a claim. Or, physicians could reconstruct claims and seek repayment according to either a general amount per CPT code or a more specific amount based on a complete medical record.

Physicians who did not meet that deadline will still reap the benefits of the settlement, according to David McKenzie, reimbursement director at the American College of Emergency Physicians, who explained the various options to physicians at a recent ACEP meeting in Orlando, Fla.

Aetna agreed to set aside $300 million for prospective relief, and Cigna agreed to a $400 million figure. These amounts represent what is likely to be paid to physicians now that the two insurers have also agreed to a number of changes in business practices.

Cigna and Aetna will disclose physician fee schedules, change them only once a year, and help physicians determine payment in advance.

For instance, both will pay for vaccines and their administration. And the insurers will no longer automatically downcode evaluation and management codes, and will separately identify and pay modifier –25, which allows physicians to bill for evaluation and management service on the same day as a procedure. Other coding and editing changes will also lead to future income for physicians.

Both insurers agreed to disclose physician fee schedules and to change the schedules only once a year. Aetna's schedules were posted on a Web site, and Cigna agreed initially to post schedules via e-mail. Both also said they would make a preadjudication tool available so physicians could determine in advance what they might be paid for a claim.

Clean claims have to be paid within 15 days. Aetna agreed to pay interest at the lesser rate of prime or 8%, and Cigna agreed to 6%.

A dispute resolution process was established to ensure that Cigna and Aetna are complying with the settlement agreements—in fact, three external independent review boards are monitoring the situation.

In the settlement Cigna and Aetna agreed to endow two nonprofit foundations devoted to improving medical practice. For more on the foundations, go to www.physiciansfoundation.org. ■