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News and Analysis of Benefit Design, Contracts, HSAs, Market Strategies and Financial Results

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*PUBLISHER'S NOTE: The next issue of **ICDC** will be dated July 14.*

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Interest in HRA, HSA Plans Remains High As Employers Eye '07, Industry Experts Say

Six months into 2006, health insurers and benefits consultants tell *ICDC* that interest in the account-based plans is growing more quickly than ever.

CIGNA Corp. says enrollment in its CDH plans will likely triple by the end of the year — from about 100,000 at the end of 2005 (*ICDC 1/27/06, p. 4*) to 300,000 by the end of the year. At a mid-June conference, CIGNA President and CEO H. Edward Hanway said he expected enrollment in CDH plans could help boost overall enrollment by up to 2% in 2006. As of the end of April, CIGNA says its health reimbursement arrangement (HRA)-based plans covered about 200,000 lives, and another 50,000 lives were enrolled in its integrated HSA product.

Humana Inc. also says it's seeing increased interest in CDH plans among all sizes of employers. And HSA-based plans seem to be leading the way. About eight out of every 10 employers that decide to offer a CDH option opt for one that is compatible with an HSA, says Beth Bierbower, vice president of product innovation. The majority of large employers (about 85%) contribute funds to their employees' HSAs, and about two-thirds of small employers set up the accounts for their employees, she says.

CDH enrollment "is growing substantially, even mid-year," says Alexander Domaszewicz, an employee benefits consultant in the Newport Beach, Calif., office of Mercer Human Resource Consulting. "Our clients are much more aggressive about adding [CDH options], and full-replacement discussions are much more frequent than in the past." However, he notes that some employers continue to approach CDH cautiously and are not anticipating meaningful enrollment. Still, Domaszewicz expects national CDH enrollment will "show a large jump" on Jan. 1, 2007.

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Next Step in CDH Evolution: Health Plans Target Improved Price, Quality Transparency

"Transparency" is the next step in the evolution of the CDH plans, which require enrollees to take on greater financial responsibility for their health care decisions. Most price transparency tools, however, still don't let patients know what they personally might be charged for a given procedure and probably won't do much to prompt members to comparison-shop online. At least not in the immediate future, industry observers say. However, as price data and information about negotiated rates become more widely available, health care providers will likely respond with more competitive prices to set themselves apart from the competition.

"Eventually, physicians and hospitals will all wind up with similar pricing. They will then need to differentiate themselves on quality," says Jay Savan, an employee benefits consultant in the St. Louis office of Towers Perrin. "Patients probably aren't going to run to their computer to check prices before heading to a hospital," he says. "But they might check quality data once that becomes available." Hospitals and physicians, though, might not feel much pressure to compete in markets where they already have more business than they can handle, Savan adds.

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This month, the Centers for Medicare and Medicaid Services (CMS) posted what it pays for 30 common elective, non-surgical procedures and other hospital admissions. President Bush proposed the idea of improved transparency last January (*ICDC 2/24/06, p. 1*). Later this summer, CMS is expected to release similar data for ambulatory surgery centers followed by information about common hospital outpatient and physician services this fall.

The ultimate goal is to disclose cost data that is "as close as you can get to the actual cost before patients actually have the procedure done," says Jim Nastri, vice president of new product development at CIGNA HealthCare. "Over time, we'll be able to develop tools that will allow a very close estimation" of costs for certain procedures, he says. "Plans will, in the very near term, start potentially piloting ways" of doing so.

But health care providers say it's the health plans that need to lead the way in price transparency. At its annual meeting June 14, the American Medical Association (AMA) passed a resolution that calls on health insurers to "end efforts to conceal their pricing systems for medical services." Pricing, AMA says, is largely determined by health plans, not providers.

Aetna Expands Transparency Project

As of Aug. 18, Aetna, Inc. says, its members will have online access to physician-specific cost, clinical quality and efficiency information in Connecticut, Washington, D.C., northern Virginia, Maryland, northern Kentucky, southeast Indiana, south Florida and several cities in Ohio. Clinical quality and efficiency information will be available for nearly 15,000 specialist physicians, Aetna says. Pricing information will be available for more than 70,000 physicians in those markets as well as in Kansas City, Kan., Kansas City, Mo., Las Vegas and Pittsburgh.

The availability of cost and quality data is especially important to people who are covered by CDH plans, but it's also becoming important for those who have more traditional coverage, says Robin Downey, Aetna's head of product development. "If you have a $10 copayment, you're not going to care about [transparency]. But plan designs are changing, and a lot of employers are eliminating copays in favor of coinsurance," she says.

Last August, Aetna launched a pilot program that let its members see the rates it paid providers for office visits, diagnostic tests and minor procedures from 5,000 individual physicians and medical groups in greater Cincinnati, northern Kentucky and southeast Indiana (*ICDC 9/9/05, p. 1*). Between 600 and 1,000 consumers a month now access the information, Aetna says.

Unlike the Cincinnati pilot, which focused solely on prices, Aetna's latest push to improve transparency combines provider rates with clinical performance, Downey explains. Some providers were concerned people would price shop, she says of the early days of the pilot. "While we did understand that the performance measures were important, we weren't prepared to offer them at that time."

Aetna's latest tool, Downey suggests, could encourage some employers to get off the fence and roll out a CDH plan. It also could make the CDH concept more attractive to employees during the fall open-enrollment season, she adds. "At this stage, patients are not really price shopping. This is more of an education tool that lets them know that an office visit doesn't really cost $15," Downey explains. "It begins the educational process, and eventually consumers will look at the overall value they receive from their provider."

CIGNA Pilots Transparency Tool

CIGNA in late April unveiled an online tool that allows consumers to access average cost data by facility for 15 outpatient procedures and three high-cost radiology services in two markets, New Hampshire and Wichita, Kan. Although CIGNA now reports hospital

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cost data only in two markets, it will expand this nationally starting in September.

Under CIGNA's initiative, members can select a procedure, such as a colonoscopy or cardiac catheterization, and then search by ZIP code for specific providers that perform the service. Providers might include hospitals, outpatient surgery centers or radiology centers. Members can select which providers to compare, and then view the average costs charged by each provider.

CIGNA calculated the average charges using a combination of fixed rates for providers — with which the insurer has negotiated such contracts — and an average of claims-based eligible charges for other facilities. For example, MRIs in both markets range in cost from $500 to $1,200, depending on the facility, Nastri says. The rates include professional and technical fees, he says, but not all medications related to the procedure or other office visits associated with diagnosis and follow-up. "We show the average," he explains.

United Healthcare Grades Colo. Hospitals

UnitedHealthcare, Inc. on June 1 unveiled a report card on 20 contracted Colorado hospitals. Facilities were evaluated on quality considerations, including patient volume, complication and mortality rates, ICU physician staffing and use of computer-assisted order entry. The insurer is using a star system, with one star for facilities in the lowest 25% of quality performance, two stars for hospitals in the middle 50% and three stars for those in the highest 25%.

The report card also includes a cost evaluation based on paid-claims data over the past 18 months. UnitedHealthcare rated the hospitals by measuring 150 procedures, including colon surgeries, knee and hip replacements, pneumonia treatments and obesity procedures.

The Blue Cross and Blue Shield Association says 17 individual Blues plans are conducting efforts to make available hospital and physician cost data in urban, suburban and rural markets across the country. Humana Inc. earlier this year started making available cost and quality data for 30 inpatient and six outpatient procedures in the Milwaukee market.

Alluding to recent price transparency initiatives from large health plans, AMA Board Member Cyril Hetsko, M.D., said in a written statement that "attempts by major health insurers to provide price information are a good start, but they do not provide patients with an entire picture of insurers' pricing. Patients are being provided with incomplete and selective information."

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Kaiser CDHMO Could Be Model For High-Performance Networks

Kaiser Permanente says its new suite of CDH products will be available in California in time for the fall open-enrollment period. While CDH is a relatively new concept for Kaiser, industry observers say the pairing of an HMO with an HRA or an HSA could work well with high-performance provider networks.

While account-based plans are new for Kaiser's California members, they were introduced in several of Kaiser's other regions last year (*ICDC 11/19/04, p. 1*). Kaiser has 8.3 million members in nine states and the District of Columbia. The majority (6.3 million) of its members are in California.

The first product from Kaiser's new CDH product line is Custom Care HealthBuilder HRA, which pairs an HMO with an HRA. An HSA-qualified HMO will be rolled out this summer and will be available for the fall open-enrollment season in California.

"I think offering a range of [CDH] products makes a lot of sense for us," says Ted Wise, Kaiser's senior vice president, health plan strategy and product innovation. "California is not that different than other parts of the country. Employers are interested in a range of products" to counter rising health coverage costs.

The health insurance industry could see rapid emergence of HMOs paired with HRAs and HSAs, predicts Jay Savan, an employee benefits consultant in the St. Louis office of Towers Perrin. The closed networks, he explains, will become particularly attractive as the idea of high-performance networks (i.e., networks made up of providers who demonstrate quality and cost effectiveness) gains traction and stability (see story, p. 1). HRA dollars, for example, could be limited to use for high-performance providers.

continued

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Will HMOs Grow Under CDH?

California will be the only region where Kaiser's CDH portfolio includes an HRA-based product. But does an HRA-based HMO make sense?, asks Lisa Suennen, managing director in the Corte Madera, Calif., office of Psilos Group, a venture capital company that helped launch Definity Health (now a division of UnitedHealth Group) in 1998.

"An HRA for Kaiser is a little odd because [Kaiser members] get virtually all the care they need anyway. And why would a member want to build up an account that can't be used outside of Kaiser unless it were to cover unfunded services or copays?," she asks. "I suppose a CDH plan with a closed network is better than having no CDH aspect at all."

But Savan says there could be tremendous value in an HRA-based plan in closed provider networks.

"I think closed-network [consumer-directed] HMOs are an inevitable market entrant," Savan says. "Some will argue that true consumerism demands choice of provider, which argues in favor of a PPO model. But to the extent high-performance networks demonstrate marked differences in quality levels, it makes sense and is a sellable solution to the market."

Kaiser piloted an HSA-compatible HMO in Colorado in early 2005. Leo Tokar, vice president of marketing, sales and business development in Kaiser's Colorado region, says about 500 groups (6,000 members) have offered such a CDH plan (see box below). Kaiser has about 465,000 members in the state. The insurer

University Offers Two Kaiser HSA Plans, Cites Low Enrollment

On July 1, the University of Denver will go live with an HSA-qualified PPO from Kaiser Permanente. The new PPO option was offered alongside a year-old HSA-qualified HMO and three other more traditional Kaiser options.

Under the HSA-compatible HMO, only services rendered by a Kaiser provider are covered (except in emergencies). While the HSA-compatible PPO has higher premiums, services rendered by non-Kaiser providers are covered, but the member is required to pay a coinsurance.

Although employee-paid premiums for the HSA-compatible plans are significantly lower than they are for the other options, neither plan attracted much interest. Of the university's 2,250 eligible employees, only 57 enrolled in the HMO/HSA option (up from 44 a year ago), and 34 enrolled in the new PPO/HSA option. Richard Gartrell, the university's director of human resources, says HSA-based plans work best for healthy people and those who have enough discretionary income to cover the deductible. He says he warned interested employees not to enroll in an HSA-compatible plan just because of the lower premiums.

"I'd be uncomfortable if enrollment [in the HSA-compatible plans] ever gets above 10%," he says. "I think they put people at risk." Gartrell's beliefs run contrary to those of CDH proponents, who argue that even the chronically ill can benefit from HSAs (*ICDC 5/12/06, p. 4*). Another explanation for the low enrollment is the average age of the employee population, which Gartrell estimates is about 10 years older than that of most other employers.

"Early adopters have been the individuals and small groups, because they are the most price sensitive," says Leo Tokar, vice president of marketing, sales and business development in Kaiser's Colorado region. He says about 500 groups (6,000 members) have made a CDH plan available in Colorado. Kaiser has about 465,000 members in the state.

Most employers have offered an HSA-based plan alongside Kaiser's more comprehensive coverage options. So far, enrollment in the HSA-qualified plans has been low, Tokar says, but he adds that enrollment in non-HSA-qualified high-deductible plans is about 35,000. Kaiser has partnered with Wells Fargo & Co. to administer its HSAs.

Contact Tokar at Leo.Tokar@kp.org.

University of Denver/Kaiser Permanente 2006 Health Coverage Options

Employee Share of Monthly Premiums — Effective July 1, 2006	Employee Only	Employee +1	Family
Kaiser Permanente HMO	$44.25	$177.00	$298.40
Kaiser Permanente POS	$154.15	$396.80	$616.02
Kaiser Permanente HMO HSA	**$0.00**	**$68.25**	**$132.24**
Contribution to Kaiser HMO HSA	$20.25	$20.25	$20.25
Kaiser Permanente PPO	$194.65	$477.78	$733.04
Kaiser Permanente PPO HSA (PPO does not include HSA contribution)	**$124.75**	**$337.98**	**$531.03**

SOURCE: University of Denver, June 2006

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expanded its HSA-based plans to Georgia and to parts of the Northwest later in the year. These were regions where Kaiser already had experience contracting with health care facilities and medical groups outside of its own group-model structure.

An HMO has an advantage over a PPO when paired with an HSA, according to Tokar. The closed network, he explains, allows Kaiser to integrate financials and health management into one product.

"We publish our fees and have the financial component of the HSA and combine it with online access to a patient's medical record and secure messaging to that patient's physician," Tokar says. "Patients can view past visits as well as their prescriptions and diagnosis history. They can even have online discussions with their physicians through a secure [Web] site."

Kaiser's Move 'Not Surprising'

Robert Taketomo, Pharm.D, a California-based pharmacist, says he's not surprised by Kaiser's decision to launch a line of CDH products given the growth of CDH nationally. HMO business models, he explains, are predicated on the ability to spread risk (e.g., cost of ill patients) over a healthy pool of payers. And that business model won't work if CDH plans entice healthy members away from HMOs.

"That would result in the HMO ending up with a sicker pool of patients — those who utilize medical services — which would drive [HMO] premiums up," Taketomo says. "That would cause employers with younger, healthier employees to find new alternatives (e.g., HSA-based plans), which would cause HMOs to end up with an even sicker pool of patients, which drives premiums up even more. It creates a vicious cycle."

California is one of six states that do not conform to federal HSA laws. California residents who open an HSA will owe state tax, but not federal tax, on any dollars contributed to the account. Wise says he doubts that will have much of an effect on adoption of HSA-based plans in the state because the tax reduction "isn't significant."

"We're enthusiastic about Kaiser expanding into these new product lines," says Henry Loubet, a consultant in the Oakland, Calif., office of Keenan & Associates, a California-based third-party administrator and insurance brokerage company. Between 1996 and 1999, Loubet was the CEO of United Healthcare's West Coast operations. Kaiser "has been very narrow in their product offerings," he adds. "We see this as a real advantage."

Contact Savan at jay.savan@towersperrin.com, Suennen at lisasuennen@Psilos.com, Tokar at Leo.Tokar@kp.org or Kaiser's Beverly Hayon for Wise at Beverly.Hayon@kp.org. ✧

CDH Can Address Retiree Benefits, Chronically Ill, Expert Says

Large employers are increasingly turning to HSA-based health plans as a way to wean employees off retiree health benefits, according to Paul Ginsburg, Ph.D., president of the Center for Studying Health Systems Change, a Washington, D.C.-based policy research organization. Ginsburg offered his thoughts on CDH plans — and the changing health insurance market — at a June 13 symposium in Baltimore sponsored by the Center for Health Program Development and Management.

"No employer in their right mind would initiate a retiree health benefits program today. It doesn't make sense," he told attendees. "The issue is the unpredictability of future health spending and the [increasing] life expectancy." Retiree health benefits, he added, typically are now available only to older employees and generally not offered to young workers or new hires. Some employers see HSAs as a less risky way to address retiree health benefits.

CDH Is More Than Cost Shifting

Between 2000 and 2005, Ginsburg said, there was a 10% buy-down of employer-sponsored health coverage in the U.S. That buy-down was in the form of higher copayments and larger deductibles. Employees, however, generally have not been asked to take on a higher percentage of the premiums, he told attendees.

"Employers are shifting costs to employees. But many of them want to do it in a way so that employees who modify their behaviors — and are more judicious in their spending — can avoid some of that burden," he explained. "Employers don't want to drive employees away from health coverage."

Employers that simply want to shift more costs onto employees can do it by boosting deductibles and copays. But those employers are likely to see only short-term cost savings, Ginsburg said. Most employers that adopt a CDH plan are in search of long-term savings. "The losers among employees typically are those with the high medical needs who can't build up [HSA or HRA] balances," he told attendees. That issue, he suggested, could be addressed by a plan design that doesn't discourage chronically ill patients from seeking important services. Instead, Ginsburg said, plan designs should include lower cost sharing for medical treatments that have been shown to be cost-effective in treating certain chronic conditions. "Where the benefits are known to be small, or just have not been established, the patient should have higher cost sharing," he explained.

While health care demands generally are not sensitive to price, Ginsburg suggested that benefits could be structured to encourage enrollees to seek care from more

cost-efficient providers. "When there are [financial] incentives to use a generic drug over a brand name, you can get some very positive movement," he explained. "The same could happen if a high-performance provider network is used." Specialists in a narrow "high-performance network," for example, might require the member to pay 10% coinsurance, for example. But the patient might pay 20% coinsurance for providers outside of that network. "If the patient chooses a provider that is efficient, that is going to save money long after the deductible has been met," he explained. "And while that won't [financially] benefit the patient, it will benefit the system."

To view a video of Ginsberg's presentation, or to download materials from other presentations, visit www.kaisernetwork.org/fe.cfm?id=2856.

Providers Could Have Tough Time Collecting From Some HSAs

Here's the scenario: A patient with a high-deductible health plan and a fully funded HSA seeks services from a physician. After the visit, the physician bills the patient's health plan, and the claim is applied to the deductible. In this example, there is not an automated payment mechanism between the health plan and the patient's HSA, so the physician then bills the patient. The patient ignores repeated collection letters and chooses not to pay the bill. Does the physician have any special rights to collect above and beyond normal fair-debt collection practices? Can the patient refuse to pay medical bills and keep the employer HSA contributions as an investment without any special recourse from the physician?

The answer: The only recourse the provider has is to take the patient to small-claims court just like he or she would have to do for any other unpaid medical debt, explains Bill West, M.D., president of First HSA, a Pennsylvania-based HSA administrator. Unlike a 401(k) retirement plan, which has "a statutory prohibition against assignment or alienation," an HSA in certain instances could be subject to claims of creditors, adds Bill Sweetnam, a principal at Groom Law Group in Washington, D.C. "I think this is going to be an issue" for providers, he says. Unless the patient mentions it, there's usually no way for the provider to know that a patient has an HSA, he adds. Prior to joining Groom, Sweetnam was the benefits tax counsel at the Treasury Dept., where he co-wrote much of the early HSA guidance.

"It would likely be like collecting from someone's Individual Retirement Account," says John Hickman, a benefits attorney in the Atlanta office of Alston & Bird. The member, he explains, can't assign rights to HSA funds (or provide a security interest) or the HSA will be adversely affected.

"This is one more reason the industry needs real-time claims administration. Once HSAs become a bigger part of health care, this will start to have a bigger impact on accounts receivables" among health care providers, West says.

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Employers Are Flocking to CDH Plans

continued from p. 1

Bill Sharon, senior vice president in Aon Consulting, Inc.'s Tampa, Fla., office says his company is seeing more interest in CDH this year than a year ago. And enrollment among employers that already have a CDH plan in place report increased enrollment in the plans. "We've had two recent implementations with over 50% enrollment," Sharon says. "One had 67% CDH enrollment in its first year, and the other had 58% CDH enrollment."

CDH plans are attracting a "broader spectrum" of employers this year, says Randy Abbott, a benefits consultant in the Boston office of Watson Wyatt. While HRA-based plans continue to be the product of choice among large, self-insured employers, Abbott says many employers are looking into HSA-based plans as they ease out of retiree medical benefits. "For mid-career employees and new hires, some employers are cutting back or eliminating retiree medical benefits. The tax advantages of an HSA might give them a way to soften the blow," he explains.

Abbott adds that he's been surprised that a growing number of hospitals and health systems are considering a CDH option for 2007 or 2008. About 16% of Watson Wyatt's hospital and health system clients already have a CDH plan in place, he notes. "Many hospitals have fought [CDH plans] because they worry about the effect they will have on bad debt," he says.

Michael Taylor, a benefits consultant in the Boston office of Towers Perrin, says clients that already have a CDH plan in place are trying to increase enrollment by improving plan designs and boosting employee communication efforts.

"Realistically, we are bound to have plateaus as product design stabilizes and other factors in the economy take effect," he says. Now that CDH pioneers Lumenos and Definity Health have been acquired by WellPoint, Inc. and UnitedHealth Group, respectively, Taylor says "there is less innovation and excitement around CDH and the philosophy of individual accountability and responsibility."

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Insurers Tout Mid-Year CDH Enrollment

Here's a look at CDH enrollment among some of the industry's largest sellers of account-based health plans. Watch for *ICDC*'s annual mid-year enrollment update this summer.

◆ ***UnitedHealth Group:*** United says it ended April with 1.75 million lives covered by its CDH plans. While new enrollment in HSA-qualified plans is now outpacing HRA-based plans, HRAs still represent 53% of the insurer's overall CDH enrollment, says Meredith Baratz, vice president, market solutions in United's Definity Health division.

◆ ***Aetna, Inc.:*** As of April 30, the insurer says, 443,000 lives were covered by a health plan that included an HRA (up from 332,000 on Jan. 1, 2005). Aetna reports even more dramatic enrollment in its HSA-compatible plans, which nearly tripled from just 43,000 lives on Jan. 1, 2005, to 121,000 16 months later.

◆ ***Assurant Health:*** Assurant says it has received individual high-deductible health plan (HDHP) applications to cover more than 300,000 people. The company's HSA-qualified HDHPs represent 51% of its new individual health plan sales, says spokesperson Rob Guilbert. The insurer says nearly 70% of HDHP purchasers are families with children, and 43% of applicants said they were previously not insured.

◆ ***WellPoint, Inc.:*** The nation's largest health insurer says enrollment in its HRA-based and HSA-qualified plans has ballooned from about 181,000 members on Jan. 1, 2005, to 507,000 members on Dec. 31, 2005. As of March 31, 2006, WellPoint says, its CDH plans covered 665,000 lives. "WellPoint has seen some significant growth in our CDH offerings during the past year, and it's a trend we expect to continue," says spokesperson Todd Siesky.

◆ ***Blue Cross Blue Shield of Minnesota:*** "Enrollment is exploding," says Joel Swanson, a spokesperson for the Minnesota Blues plan. Between January 2005 and January 2006, the insurer says, overall enrollment in its account-based products grew by 67% (from 93,043 to 154,990). On the individual side, sales of CDH plans jumped 65% during the same period. "We haven't seen any sort of a slowdown," says Melinda Pederson, product manager at the Minnesota Blues plan. "I don't think it's out of reach to say [CDH plans] will make up 25% of [overall enrollment] by 2010," as Forrester Research has predicted. Pederson says employers with more than 50 employees still prefer HRA-based plans over those that are compatible with an HSA; about two-thirds of mid-size and large employers opt for HRAs. Among individuals and small employers (fewer than 50 employees), about 75% choose HSA-compatible plans over HRAs. The Minnesota Blues plan says CDH enrollment represents less than 10% of its total membership.

◆ ***Great-West Healthcare:*** Over the past year, Great-West says, enrollment in its account-based plans has more than quadrupled. In May 2005, the insurer says, about 4,000 lives were covered by an HSA-based plan (40 employers). By May 2006, Great-West says, about 100 clients have rolled out an HSA-based plan, and enrollment now tops 22,000. Great-West, which targets employers with fewer than 250 employees, says 80% of its requests for proposals (RFPs) ask for information on account-based plans. While employers seem most interested in HSA-based products, there is modest interest in HRA-based plans, says Marc Ver Straate, Great-West's director of CDH product strategy. Over the past year, enrollment in its HRA-based plans has more than doubled from 3,000 members (six clients) to 8,200 members (12 clients). Enrollment in year two of an optional HRA-based plan, he says, typically increases between 3% and 5%, while enrollment in HSA-qualified plans typically grows by about 10% after the first year.

Contact Sharon at Bill_Sharon@aon.com,Swanson at joel_swanson@bluecrossmn.com; Abbott at randall.abbott@watsonwyatt.com; Domaszewicz at sander.domaszewicz@mercer.com or Taylor at mike.taylor@towersperrin.com. ✧

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INDUSTRY NEWS

◆ **KaiserEDU.org, a Web site of the Henry J. Kaiser Family Foundation, this month posted a narrated CDH slide tutorial.** The tutorial is narrated by Gary Claxton, vice president and director of the Kaiser Family Foundation's Health Care Marketplace Project. The 23-minute tutorial walks users through the basics of account-based health coverage, including HRA- and HSA-based models. He also discusses financing, the impact on health care spending and policy issues. A related "issue module includes research and analysis of CDH policies. To view the tutorial, visit www.kaiseredu.org/tutorials/CDHP/Claxton_Consumer.html.

◆ **The Wisconsin Athletic Club (WAC), a Milwaukee-based chain of health clubs, has partnered with Chicago-based Destiny Health to offer membership discounts** and other perks to Destiny's Wisconsin enrollees. Under the agreement, plan members who exercise at WAC at least 48 times a year will receive a subsidy from Destiny Health on monthly membership dues. With each workout, Destiny Health Plan members can earn 20 "Vitality points" that will help them earn rewards. Destiny's South African parent company, Discovery Health, has more than 1.8 million members enrolled in its account-based health plans. Destiny has about 70,000 members in Wisconsin, Illinois, Washington D.C., Virginia, Maryland, Texas and Massachusetts. Visit Destiny at www.destinyhealth.com.

◆ **The Healthcare Financial Management Association (HFMA) this month released Consumerism in Health Care,** an 18-page report that is part of the Patient Friendly Billing project HFMA launched in 2000. The report discusses the growing emphasis on consumerism in health care and the lack of price and quality transparency in the health care system. Meaningful price transparency in health care, according to the report, must provide the patient with an estimate of his or her financial obligations prior to treatment. Cost estimates for several providers, coupled with data about each provider's quality of care, would allow patients to "make meaningful decisions," the report says. The document outlines 11 areas to consider when preparing for consumerism in health care, including simplification of charge and payment systems, improved communication with patients about financial obligations and collaborations with health insurers to develop real-time electronic exchanges. The report was released in conjunction with HFMA's Annual National Institute in Orlando, Fla. A complete copy of the report can be found at www.hfma.org/library/revenue/PatientFriendlyBilling/Consumerism2006rpt.htm.

◆ **On June 1, CMS posted county-by-county hospital payment information for 30 diagnoses, and the number of each procedure performed at individual hospitals in 2005.** The data don't tell beneficiaries how much they might owe as a result of having the procedure at a given hospital, so it may be of limited use to patients trying to estimate their own financial responsibility for a given surgery. However, industry observers say the move is a giant step forward for price transparency — an increasingly important element of CDH plans (see article, p. 1). The data are available on four compressed Microsoft Excel files that can be accessed via the CMS Web site. Visit www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage.

◆ **The American Medical Association (AMA) on June 13 issued nine principles to ensure that store-based health clinics (e.g., MinuteClinic, RediClinic) provide high-quality health care to their customers.** According to a Harris Interactive poll, while 78% of the public believes that store-based health clinics could provide a fast and easy way to receive basic medical services, 75% have concerns about the quality of care the clinics provide. As CDH enrollees look to maximize their HRA and HSA dollars, such low-priced clinics could become an attractive alternative to the traditional doctor's office visit for minor illnesses. The AMA's principles recommend that store-based health clinics: (1) have a well-defined and limited scope of services; (2) have standardized medical protocols derived from evidence-based practice guidelines; (3) are staffed with practitioners who have direct access to physicians; (4) use protocols that ensure continuity of care with physicians in the community; (5) have a local physician referral system; (6) communicate the qualifications of their health care professionals; (7) adhere to appropriate sanitary and hygienic guidelines; (8) encourage the use of electronic health records; and (9) encourage patients to establish care with a primary doctor. For a complete description of the principles, visit www.ama-assn.org.

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