



DISCUSSION PAPER

PAYMENT CARDS CENTER

New Prospects for Payment Card Application in Health Care

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November 2008

***Summary:** While consumers' use of payment cards has grown rapidly in many other areas, their use in making health-care payments has been far more limited. This paper attempts to explain several reasons for the slow adoption rates and identifies four related trends and developments that can be expected to lead to more rapid growth in the future: (1) a shift away from employer-provided health care to consumer-directed health-care plans, (2) an expansion of health-care savings accounts, (3) a move toward using debit and prepaid card applications to address limitations in paper-based environments, and (4) a recent Internal Revenue Service ruling intended to improve the efficiency of electronic payment processing. While these factors are expected to contribute to the acceleration of growth for payment card applications in health care, we know less about potential barriers stemming from consumer behavior, raising a cautionary note pending further research.*

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I. Introduction

Health-care spending in the United States reached an estimated \$2.25 trillion in 2007 and is expected to double in the next decade.¹ The great majority of this is covered by public funds, such as Medicaid and Medicare, and private insurers that remit payments to medical service providers. However, out-of-pocket expenditures, which consumers pay directly to medical service providers, are not insignificant and are expected to grow from the current level of about \$269 billion. To date, most payments that flow among industry participants – hospitals, insurers, employers, and consumers – are paper-based. A recent analysis by McKinsey & Company revealed that 80 to 90 percent of health-care payments are processed in paper-based environments.²

While consumers' use of payment cards has grown rapidly in many other areas, their use in making health-care payments has been far more limited. This paper attempts to explain several reasons for the slow adoption rates and identifies four specific trends and developments that can be expected to lead to more rapid growth in the future.

Encouraged by dramatic shifts in consumer preferences for payment card use at the point of sale, payment providers have been viewing health-care payments as an attractive new market, especially for debit and prepaid applications. To date, the experience has been largely disappointing, and many pilot programs have been abandoned and major players have left the market.

In general, card-based payment providers have been frustrated by far slower-than-expected growth rates and challenged by high investment requirements. American Express cited these issues when it announced that it would discontinue its card-based health-care initiative in

¹ The spending forecast was part of an analysis conducted by First Annapolis Consulting (FAC). On April 14, Sarah Phelps, a principal at FAC, participated in a workshop entitled "Electronic Payments in Health Care," at the Payment Cards Center of the Federal Reserve Bank of Philadelphia. Additional data provided by Phelps will be referenced throughout this paper.

² A more complete analysis of processing characteristics and other health-care payment inefficiencies can be found in Nick A. LeCuyer and Shubham Singhal, "Overhauling the US Health Care Payment System," *The McKinsey Quarterly* (June 2007).

2007: “[1] the level of investment needed to take the health care payments card business to the next phase is significant, and [2] this emerging market is moving more slowly than we anticipated.”³ American Express has not been the only major card company to scale back efforts in the health-care industry. Discover Financial Services, according to a recent article in *Cards&Payments*, has also lessened its focus on health care and “backed off of some pilots it was conducting with major insurance companies.”⁴

An important explanation for these and other market disappointments discussed in this paper is the very different structure of health-care payments. Payment card providers face real challenges in adapting traditional products based on a far simpler model of point-of-sale retail purchases to this new environment.

Despite these obstacles, important trends and new developments are likely to lead to growth in the use of payment cards in health care: (1) a shift away from employer-provided health care to consumer-directed health-care plans (CDHPs), (2) an expansion of health care savings accounts (HSAs), (3) a move toward using debit and prepaid card applications to address limitations in paper-based environments, such as flexible spending accounts (FSAs), and (4) new Internal Revenue Service (IRS) regulations that address important impediments to expanding payment card use for health-care payments.

While these factors are expected to contribute to growth in payment card applications in health care, structural and behavioral barriers remain that are likely to result in this being a gradual process. The complex health-care industry and its underlying payment methods present unique challenges to payments innovators. In addition to the business and regulatory hurdles that

³ In 2005, American Express began offering a health savings account (HSA) card that also allowed cardholders to apply for revolving credit lines. The card offering did not meet expectations and was shut down in 2007. For more information on American Express’s health-care payment card business, see “HealthPay Plus Card,” at <http://www.americanexpress.com/health/includes/pdf/AMEX-APEN19-MB-r2BrochureFINAL.pdf>.

⁴ “HSA Growth Falls Short of Expectations,” *Cards&Payments* (February 2008).

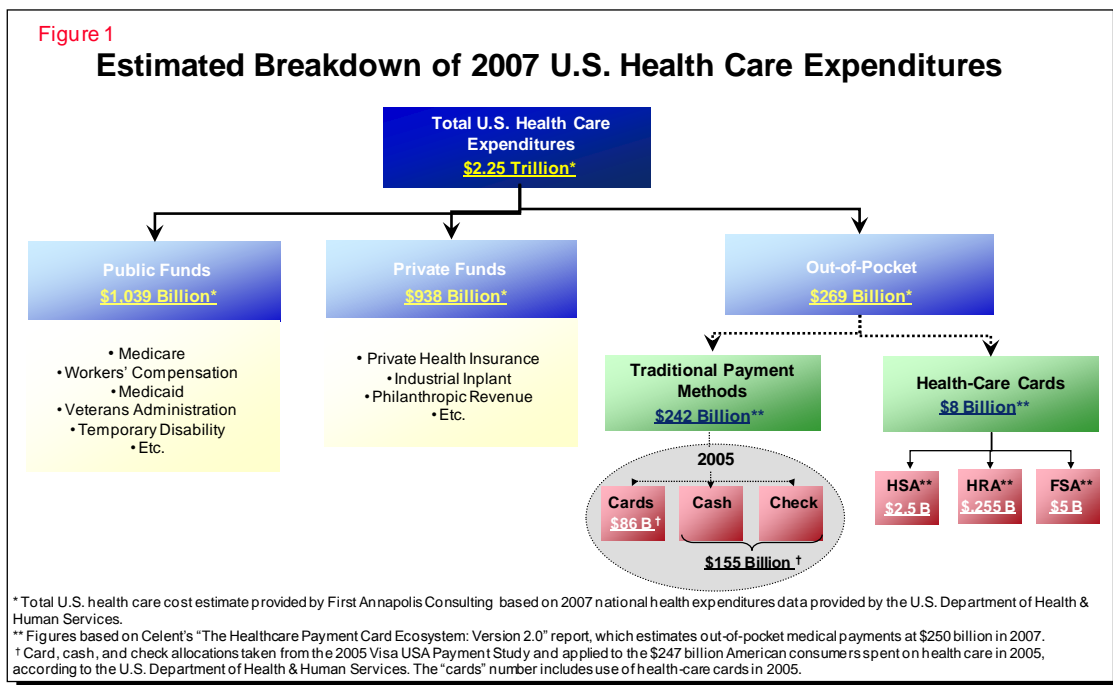
must be overcome, consumer adoption to date has been slow, and it is not clear how dramatically that will change in the near term.

II. The Health-Care Market for Consumer Payments

The U.S. health-care industry employs over 14 million people who work in 580,000 separate businesses and related professional practices.⁵ This large and complex business system generates over \$2 trillion in annual payments. This section breaks down these payment flows and focuses on those related to consumer payments and the use of payment cards. The section closes with a discussion of the challenges payment innovators face in converting consumer health-care payments to payment card alternatives.

A. Payments in Health Care

A number of reports quantify segments of the health-care market, but it is difficult to get an accurate picture of the entire market. Some studies focus on segments such as government or employer-based programs, while others examine payment mechanisms, i.e., paper-based versus



⁵ U.S. Department of Labor, U.S. Bureau of Labor Statistics. www.bls.gov/oco/cg/cgs035.htm

electronic. The data in Figure 1 represent my attempt to organize these disparate data sources in order to present an overview that captures both segments as well as payment instruments. While efforts have been made to resolve inconsistencies in the data sources, the results should be regarded as estimates.

While the top of the chart highlights the estimated \$2.25 trillion in health-care expenditures, it is also important to understand the composition of the underlying payment flows. By far, the largest proportion of payments falls under the category of public funds, accounting for nearly 50 percent of total health-care spending. Public fund expenditures for programs such as Medicare are generally composed of direct payments by government agencies to health-care providers and do not directly involve consumers in the payment process.

The next largest category, representing about 40 percent of total health-care spending, relates to private funds. Private fund payments generally represent direct payments by insurers and others to health-care providers for the benefit of consumers covered by employer-funded or other similar medical plans.

The remaining 12 percent of the \$2.25 trillion, or \$269 billion, is referred to on the chart as out-of-pocket and represents direct consumer payments to health-care providers. Drilling further into this category, we can see that out-of-pocket consumer-directed health-care spending remains largely paper-based. In 2005, the Visa USA Payment Panel Study reported that approximately 60 percent of consumer health-care expenditures were made using cash or checks.⁶ Applying this percentage to 2005 out-of-pocket expenditures translates to approximately \$86 billion spent on debit, credit, and other card products (including health-care cards). A 2007 McKinsey study⁷ found that credit card spending alone accounts for \$45 billion of out-of-pocket spending.

⁶ A table produced in the 2005 Visa USA Payment Panel Study “How Consumers Pay for Health Care” was cited in “Card Industry Looks to Seal a Health Care Payments Gap,” *Cards&Payments* (August 2007).

⁷ Nick A. LeCuyer and Shubham Singhal, “Overhauling the US Health Care Payment System,” *The McKinsey Quarterly* (June 2007).

While credit and debit card terminals are becoming more common in doctors' offices and hospitals, recently the payment card industry has focused on applications associated with the lower right-hand box in Figure 1, health care cards. Health care cards are a relatively new category made up of payments related to three specific consumer-directed health-care innovations: FSAs, HRAs, and HSAs. In part because of their relative newness, these programs have gained only modest acceptance in the marketplace. However, because of their particular characteristics, these programs lend themselves especially well to payment card applications.

Flexible spending accounts (FSAs) are the oldest of the three health-care innovations, introduced as a result of an IRS ruling in 1978.⁸ An FSA allows individuals to set aside money on a pre-tax basis for health-care expenses not reimbursed by employer-sponsored health insurance programs. The accounts are funded by monthly payroll deductions that are not subject to income tax and thus provide employees with tax savings on their direct health-care expenditures. After making authorized health care payments, such as a co-payment at a doctor's office, the employee submits her receipt(s) to the program administrator and receives reimbursement from her FSA in the form of a check or deposit to a bank account. An IRS ruling in 2003 provided guidance for the use of payment card applications for FSA payments, but by 2007, only about \$5 billion of such payments were made by cards.

Health reimbursement accounts (HRAs)⁹ are another type of health-care account offered by employers. HRAs were established under a U.S. Department of the Treasury Revenue Ruling in 2002. Like FSAs, HRAs can be offered regardless of health plan coverage, though many

⁸ More FSA facts can be found on the Employee Benefit Research Institute's website at: www.ebri.com/pdf/publications/facts/0507fact-flexspend.pdf.

⁹ The 2002 press release that was issued to offer guidance on the use of HRAs can be found on the Treasury's website at www.ustreas.gov/press/releases/po3204.htm.

employers offer HRAs alongside high-deductible health-care plans.¹⁰ Employers' contributions to these accounts are nontaxable.

From a payments perspective, HRAs are very similar to FSAs. Individuals with HRAs submit receipts for authorized health-care purchases to claim reimbursement. Card applications are also feasible, but as with FSAs, card usage for HRAs is limited, amounting to only \$255 million in 2007.

There are two major differences between FSAs and HRAs. One is in the funding of the account. HRAs are funded by employers, while FSAs are funded by employees. The second relates to unused funds at the end of the year. In an FSA, any unused funds do not roll over to the next year and are essentially lost. HRAs, on the other hand, allow any unused funds to roll over from year to year, at the employer's discretion, providing a greater incentive to participate.

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act introduced the health-care savings account (HSA).¹¹ An HSA allows anyone covered by a high-deductible health-care plan to make tax-deductible contributions to save for qualified medical and retiree health expenses.¹²

These accounts differ from FSAs and HRAs in six important ways. First, the account can be funded by the employee or the employer. Second, the employee owns the account and can transfer it when changing jobs. Third, the account must be tied to a health-care plan with a

¹⁰ A discussion and comparison of health-care accounts can be found in the article "FSAs, MSAs, HSAs, and HRAs-Confused? Comparison of Key Features of Health Care Spending Accounts," www.paybefore.com (April 2007).

¹¹ The Medicare Prescription Drug, Improvement, and Modernization Act can be found in its entirety at: www.ustreas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf.

¹² The current maximum annual contribution is \$2,850 for an individual and \$5,650 for a family. The maximum contribution is now determined regardless of your deductible. In the past, the maximum contribution was the lesser of the holder's deductible or the dollar limit (\$2,850). The new Tax Relief and Health Care Act of 2006, which was signed at the end of 2006, made several changes to health savings accounts. One of the major changes allows people to roll over money from an individual retirement account (IRA) into an HSA to use the money tax-free for medical expenses. Text for the entire act can be found at: www.thomas.gov/cgi-bin/query/z?c109:H.R.6111.ENR:.

deductible of at least \$1,000. Fourth, the account can earn investment income, and, fifth, employees can withdraw funds to cover nonmedical expenses.¹³

The sixth difference is in the payment structure of these products. Unlike FSAs and HRAs, which were originally developed around paper-based payments, HSAs were introduced in the modern payment card era, and payment cards are an integral part of the program design. Most often funds are accessed with a debit card tied to the account. It is possible to withdraw funds through checks connected to the account or via a reimbursement process, but such mechanisms are not prevalent. As discussed later, HSAs have been slow to gain much traction, and the total amount spent through HSA cards in 2007 was \$2.5 billion.

B. Why Hasn't the Industry Seen the Growth That Was Predicted in Health-Care Cards?

Early expectations for increased card spending based on these new programs were extremely high. The results to date have been disappointing, with payment card use for these programs estimated at only 3 percent of total consumer out-of-pocket expenses in 2007. Slow growth rates, high investment requirements, and the complex structure of health-care payments have all presented challenges to payment card providers looking to enter the industry.

A fundamental problem has been the relatively low consumer adoption rates of these health-care options. Metavante Corporation estimated that, in 2005, there were fewer than 20 million HSA, HRA, and FSA enrollees.¹⁴ With a 2005 workforce of approximately 142 million, this translates to a penetration rate of about 14 percent.¹⁵ As the most mature of the three programs, FSAs account for roughly five times the number of HSAs and HRAs combined. Celent

¹³ If funds are withdrawn for nonmedical expenses before age 65, the individual is subject to taxes and a penalty fee.

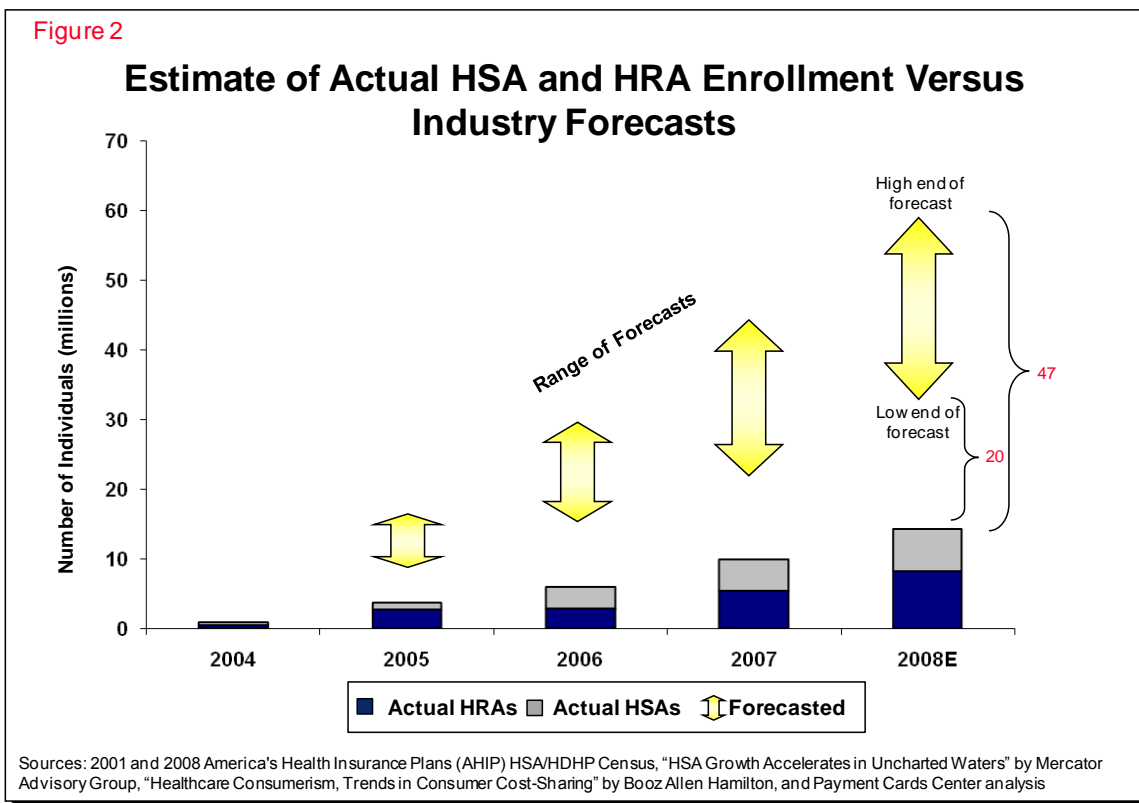
¹⁴ A proprietary Metavante Corporation report, "HSA Prepaid Cards: The Wave of the Future in Health Care Financing," as presented at the ATM, Debit and Prepaid Forum in 2006.

¹⁵ U.S. Department of Labor, Bureau of Labor Statistics website at www.bls.gov/cps/tables.htm#History_m

LLC, a strategy consulting firm for financial institutions, reported that of the approximate 16 million FSAs, only about 25 percent were attached to a debit card in 2005.¹⁶

Together, the other two programs, HRAs and HSAs, had 4 million enrollees in 2005. HSAs and HRAs are often paired with high-deductible health-care plans and can be accessed via debit cards. In 2005, debit cards were attached to 95 percent of HSAs but only 10 percent of HRAs. Though both programs were relatively new in 2005, it was generally expected that employers would increasingly turn to these less expensive health-care alternatives with their card-based payment features.

However, the analysis depicted in Figure 2 indicates that adoption of HRAs and HSAs has continually fallen below several industry projections. Absolute growth rates have been impressive, albeit from a small base, but far below the forecast that payment providers and others



¹⁶ A press release was issued in May 2006 announcing the release of Celent's proprietary study, "Flexible Spending Accounts, Flexible Cards? An Examination of Prepaid Cards in the Health Care FSA Market." www.celent.com/PressReleases/200605152/FSA.htm

may have logically used in developing business plans.

As the graphical representation notes for 2008, even the lower band of projections was more than twice as high as actual enrollments.¹⁷ The most optimistic projections were three times greater than actual, representing a shortfall of some 47 million in plan participants. Given this dramatic discrepancy between expectations and actual adoption rates, it is no surprise that many of the payment providers who developed plans for the market in 2004 and 2005 have cancelled or pulled back on their initiatives.

In addition to slow growth in consumer adoption of the card-based segment of out-of-pocket health-care programs, the payment card industry has been challenged to adapt traditional card payment processes to this unique environment. The payment card industry has been built around a far simpler and more straightforward business model: the purchase of goods from retail merchants. In the retail merchant environment, price is readily established, and once a purchase is made the transaction is generally completed. Payments for health-care services are far more complex, with the price often not available at the point-of-sale and subject to different deductibles or co-payment structures. Transactions are often linked over time as part of an ongoing treatment, and payments are subject to complicated adjudication rules. These and other complicating factors create real challenges to innovators attempting to apply basic retail payment card technology to this far more complex industry.

At the same time and as payment card providers become more familiar with the structure of the health-care industry, progress is being made. Industry observers remain optimistic that the challenges can and will be addressed. Several recent forecasts project a ramping up of growth, including one 2007 study estimating that, by 2012, 50 million individuals will be enrolled in card applicable HRA and HSA programs. The next section explores several specific developments that

¹⁷ I developed the range of forecasts in Figure 2 based on several industry research reports. The forecasts include 2004/2005 estimates of HRA and HSA growth out to 2008. The estimate of actual HRA enrollment was reported in a proprietary study published by Mercator Advisory Group. Actual HSA enrollment was reported in April 2008 by America's Health Insurance Plans (AHIP) Center for Policy and Research: www.ahipresearch.org/pdfs/2008_HSA_Census.pdf

may be expected to contribute to the acceleration in growth rates implied by these industry projections.

III. Improved Prospects for Payment Card Applications in Health Care

Underlying the improved prospects for payment card applications in health care is the ongoing shift away from employer-provided health-care plans toward consumer-directed health-care plans (CDHPs). As this trend develops, card-based HSAs are expected to become a more attractive alternative for employers and their employees. FSAs and HRAs should also benefit from debit and prepaid card applications that address limitations in paper-based FSA and HRA programs. Finally, recent changes to IRS regulations are expected to provide further impetus to the expansion of these card-based health-care plans.

A. Growing Consumer Responsibility for Health-Care Payment

The term consumer-directed health-care plan (CDHP) is generally used to describe health-care options that shift more responsibility for health-care decisions and payments from employers to employees. Aetna, Inc., a national health-care benefits company, defines CDHPs as including “three components: (1) a health fund or health savings account, (2) high-deductible medical coverage that includes preventative care not charged against the deductible, and (3) access to informational tools that help consumers make informed decisions.”¹⁸

Underlying the trend to CDHPs has been the rapid growth in overall health-care costs. Ben Bernanke, Federal Reserve Chairman, confirmed this point in a 2008 speech, noting: “Spending on health-care services currently exceeds 15 percent of the gross domestic product (GDP). Over the past four decades, this sector has grown on average, at a rate of about 2-1/2

¹⁸ Aetna, Inc.’s website at www.aetna.com/about/aoti/aetna_perspective/consumerdirectedhealthcare.html

percentage points faster than GDP. Should this rate of growth continue, health spending would exceed 22 percent of GDP by 2020.”¹⁹

Employers, faced with the growing cost of funding health-care plans, have been pursuing alternatives to lower, or at least contain, this increasing component of their business costs. In 2007, a traditional employer-sponsored health plan cost the employer an average of \$7,928 per employee. Employees enrolled in these programs paid an average premium of \$1,690.²⁰ CDHPs, which can be significantly less costly to employers, represent an attractive alternative to many businesses.

At the same time, some people have argued that CDHPs lead to improved overall efficiencies in health-care delivery and improvements in social welfare. The argument is that under traditional indemnity plans, employees have less incentive to evaluate the cost/benefits of health-care decisions. With costs more explicit and visible under CDHP plans, some posit that consumers make more efficient decisions. Some recent evidence suggests that this argument may have validity.

A study by Blue Cross Blue Shield of Minnesota (Blue Cross) compared CDHP members’ use of health services to that of members enrolled in comprehensive major medical (CMM) plans.²¹ In 2006, CDHP members in the sample made 11.2 percent fewer visits to the emergency room than CMM members and exhibited a similar decrease in prescription drug usage. The study also found that CDHP members used preventive services 12 percent more than CMM members. Nancy Garrett, director of informatics at Blue Cross, concluded, “Our findings revealed that, when it comes to services that are more within their control, our CDHP members

¹⁹ The full speech, “Challenges for Health-Care Reform,” from the Senate Finance Committee Health Reform Summit, can be found on the Board of Governors’ website at: www.federalreserve.gov/newsevents/speech/bernanke20080616a.htm.

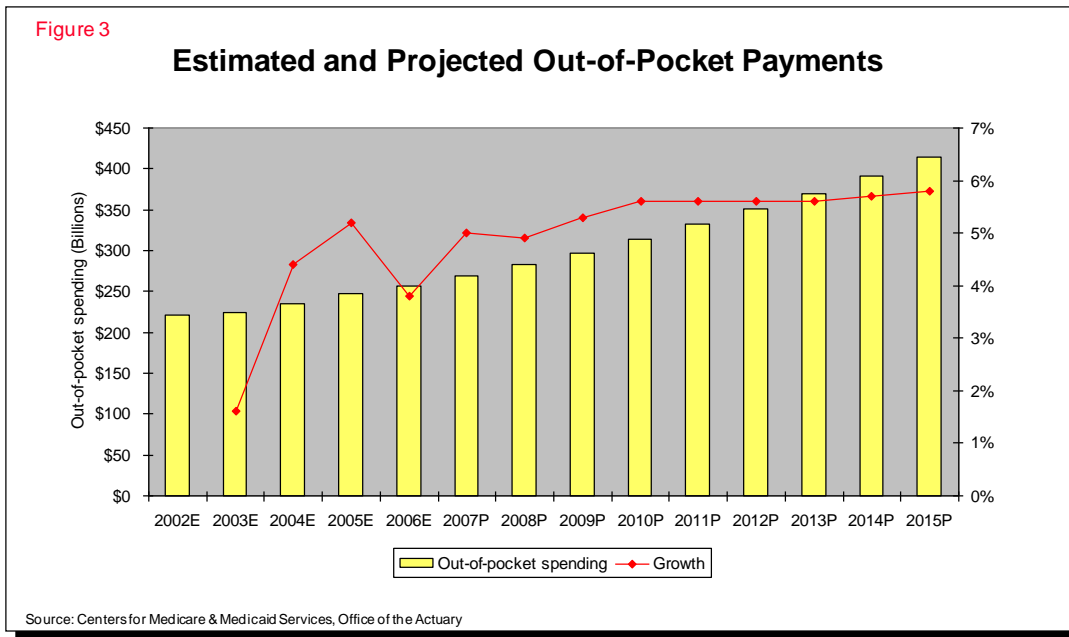
²⁰ “Hewitt Associates Data Reveals Rate of Increases for U.S. Health Care Costs Declines for Fifth Consecutive Year” www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=4358

²¹ “More Preventive Care, and Fewer Emergency Room Visits and Prescription Drugs, Health Care Utilization in a Consumer-Driven Health Plan,” *Benefits Quarterly* (2008); www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/mbc1_cdhp_util.pdf

use less than members in traditional plans, yet they are still getting the preventive care they need.”²²

CDHPs are also considered an important mechanism for extending health-care coverage to more of the working population. Small businesses that are unable to offer their employees traditional health-care plans may find CDHPs a cost-efficient mechanism for providing an improved employee benefit.

As more employers shift to CDHPs the underlying payment patterns will shift toward a greater mix of consumer-directed payment. Forecasts from the U.S. Department of Health and Human Services illustrate this point. With annual growth rates of 5 to 6 percent, consumer out-of-pocket health-care spending is predicted to reach \$314 billion in 2010 and \$414 billion in 2015.²³ Much of this growth is expected to come from the programs discussed in the previous section – FSAs, HRAs and HSAs – offering new opportunities for payment card applications.



²² “Blue Cross’ consumer-directed health plan – options Blue – members not sacrificing health for the sake of saving money,” press release (March 31, 2008) www.bluecrossmn.com/bc/wcs/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=Latest&dDocName=POST71A_114435.

²³ U.S. Department of Health and Human Services, Centers for Medicare & Medicare Services website at: www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage

B. Expansion of Health-Care Savings Accounts (HSAs)

Adoption of health-care savings accounts (HSAs), as is the case with FSAs and HRAs, has fallen short of high expectations for growth. Nevertheless, HSAs have a number of attractive consumer features that many observers predict will lead to greater adoption in the future.

Payment providers have been particularly attracted to HSAs as a potential source of new transaction growth. Unlike FSAs and HRAs, which were originally introduced with paper-based payment mechanisms, HSAs were designed with a debit card as the preferred payment instrument. Indeed, as noted earlier, some 95 percent of all HSA accounts are tied to a debit card. Furthermore, given the high deductibles generally associated with HSAs, the potential amount of money spent through these cards can be substantial, providing card issuers with greater fee income.

Given the range of attractive attributes associated with HSAs and the growing cost of alternatives, it is expected that as employers and employees become more familiar with the program, adoption rates will grow. A larger and growing user base will spur increased interest and innovation among payment providers.

C. Card Applications Address Limitations in Paper-Based Health-Care Reimbursements

Unlike debit-card-based HSAs, FSAs and HRAs have historically relied on cash or check payments. In 2003 an IRS ruling²⁴ provided guidance on the use of debit cards for FSAs and HRAs. However, as noted earlier, as of 2005, card penetration into these accounts has been limited to an estimated 25 percent of FSAs and 10 percent of HRAs. Despite current low adoption rates, the use of debit or prepaid cards for HSAs and HRAs appears to offer significant advantages over paper-based alternatives.

²⁴ Revenue Ruling 2003-43, which was released on May 6, 2003, is available on the IRS's website: www.irs.gov/pub/irs-drop/rr-03-43.pdf

To understand the structural advantages of using a debit or prepaid card to access an FSA, consider how the typical paper-based alternative functions. Employees making payments for authorized medical purchases must spend their own money first and then submit receipts for reimbursement from the FSA. In essence, the employee spends the money twice: first, when the money is taken from his or her paycheck to fund the FSA, and second, when making the health-care purchase. There may also be a significant lag between the time that the health-care purchase is made and the reimbursement form is completed and mailed and the final reimbursement received.

It is generally accepted that both the “double payment” feature and the “hassle factor” of dealing with the reimbursement process have been significant impediments to consumer adoption of FSAs. While HRAs that are funded by employers do not require employees to pay twice, all of the same cumbersome reimbursement process exists with the paper-based payments.

With a debit or prepaid card as the FSA payment access vehicle, the process is far cleaner and direct. In this environment, the employee makes only one “payment” when the account is funded. Health-care purchases made by a debit or prepaid card are deducted directly from the FSA, eliminating both the second payment and the whole reimbursement process.

Recognizing these advantages, many employers are now converting traditional paper-based FSAs to electronic debit access. In fact, card penetration into FSA programs has been reported to have grown from 25 percent in 2005 to 30 percent in 2007.²⁵ Card use with FSAs is expected to continue to increase and likely accelerate based on a new IRS ruling discussed in the next section. This new ruling is intended to streamline the process for substantiating authorized claims.

²⁵ “Livening Up the Health Care Card Business,” 2008; www.paybefore.com

D. IRS Ruling May Expand Payment Card Use for Health-Care Payments

FSAAs and HRAs require “substantiation” for reimbursement, that is, proving that the purchase qualifies as an eligible medical expense. With paper-based reimbursements, this essentially means attaching sales receipts along with the reimbursement form. When the IRS introduced the option to make eligible purchases with payment cards in 2003, it offered guidance for electronic substantiation, but in practice, many purchases still ended up requiring additional cumbersome manual processes. However, a new ruling issued in 2006 to expand and streamline electronic substantiation will take effect over 2008 and 2009.

The 2003 IRS ruling included three methods for electronic claims substantiation: (1) payment made at a medical provider based on merchant code (MCC), (2) recurring claims that have already been approved, and (3) real-time adjudication for nonmedical merchants (i.e., grocery stores and discount stores).

The most significant problems occurred with purchases made at nonmedical merchants’ where the “real-time adjudication” process never really worked as well as expected. The IRS addressed this issue in the 2006 ruling, Notice 2006-09,²⁶ which provides nonmedical merchants, such as supermarkets, grocery stores, discount stores, and wholesale clubs, with an alternative option to substantiate claims. Instead of contacting employers or plans directly to adjudicate the claim, nonmedical merchants will now be required to substantiate purchases made with health-care cards through the use of an inventory informational approval system (IIAS).²⁷ In essence, this means appending inventory control information (e.g., stock keeping units) to the transaction in order to identify the purchases as an eligible health-care expense.

Users of HSAs will also benefit from the new IRS rule. Although HSA purchases do not require third-party substantiation, receipts for health-care-related purchases need to be submitted

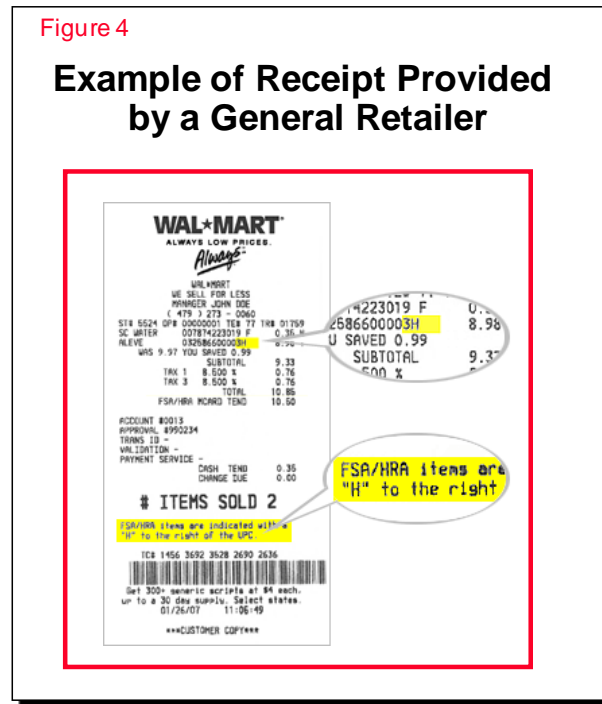
²⁶ IRS ruling 2006-69. www.irs.gov/pub/irs-drop/n-06-69.pdf

²⁷ Effective January 1, 2008, non-health-care retailers (supermarkets, grocery, discount stores, etc.) are required to implement an IIAS. Effective January 1, 2009, traditional pharmacies will be required to have an IIAS system in place to accept FSA and HRA payment cards. See *Internal Revenue Bulletin*, 2007-2 (January 8, 2007); www.irs.gov/irb/2007-02_IRB/ar09.html

to the IRS to receive tax benefits. The new IRS rule requiring that these purchases be flagged on receipts at nonmedical merchant locations is expected to make record keeping for HSA users easier and to contribute to greater consumer participation.

On its website, Wal-Mart²⁸ provides an example, reproduced here as Figure 4, of a receipt that flags health-care-related purchases.

It is too early to tell how effective this rule change will be in motivating increased adoption of payment cards for health-care payments. On the other hand, it would seem reasonable to assume that making the use of payment cards easier will reduce consumer resistance and provide payment card companies the opportunity to better position their alternatives to employers and their employees.



V. Conclusion

Health-care spending in the United States has been growing at rates that exceed growth in the general economy. While the greater percentage of such spending has involved government and health-care business transfers, consumer-directed payments are significant and growing. Many observers have been predicting high growth rates in the future as health-care plans shift toward emphasizing greater employee responsibility for health-care decisions and payments. Responding to opportunities to replace traditional paper-based consumer health-care payments, payment card providers have been developing new and more efficient electronic payment options.

²⁸ Wal-Mart's website: www.walmart.com/catalog/catalog.gsp?cat=555326

Unfortunately for these payment innovators, the expected growth in card-based health-care payments has been elusive, forcing many early entrants to postpone or abandon their plans. Among other factors, it might be concluded that policymakers and payment providers have underestimated the complexities and the barriers to adoption. They have most certainly underestimated the potential for debit card applications and other consumer-driven electronic payment options.

However, as this paper argues, several recent developments and trends suggest that there may be reasons for renewed optimism for future growth. At the same time, there is reason to urge caution in interpreting the potential impact of these developments. The four factors discussed generally address structural or process barriers that may have limited program and growth. What is not explicitly examined in the analysis is the role of consumer behavior in health-care choices. Based on the dramatic differences between historical growth forecasts and actual results highlighted in this paper, it is certainly possible that some of this disconnection may be due to under-appreciating the role of consumer behavior in this area.

While this paper argues that new product development and market trends all support more optimistic growth forecasts, more research into consumer behavior and attitudes and these issues is clearly warranted.