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HEALTHCARE VALUE HUB

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High-Deductible Health Plans—A Strategy Not Appropriate for Many Consumers

High deductible health plans (HDHPs) are plans that feature higher-than-average deductibles, typically $1,000 or more for an individual. When these plans meet certain criteria, they may be accompanied by a tax-advantaged health savings account designed to encourage consumers to reduce the use of (unnecessary) health services in order to build up the balance in their account. The IRS sets rules for what constitutes a "qualifying" health plan annually. Not every HDHP qualifies for a tax-advantaged savings account (see Table 1).

Tax-advantaged health savings accounts can take two forms: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs). Only HSAs are required to be paired with a HDHP that follows IRS rules. For both types of accounts, funds contributed to the accounts are not subject to federal income tax at the time of deposit (see Table 2). Overall, 26.1 million individuals with private insurance, representing 15 percent of the market, were either in an HRA or an HSA eligible plan.[1] Employers place funds in these accounts about half the time.

Consumer Directed Health Plan (CDHP) is a term often used interchangeably with HDHP but is sometimes used to indicate the plan qualifies for a tax-advantaged savings account or that additional decision aids are present to help consumers shop for care.

SUMMARY

High-deductible health plans—sometimes called consumer-directed health plans—place a large financial responsibility on consumers. The increased cost sharing is meant to incentivize consumers to make wiser health care purchasing decisions.

While studies show that increasing deductibles can lead to lower premiums, a more complete examination of the evidence suggests that this strategy is very limited in its ability to drive our health care spending towards better value.

How are HDHPs Supposed to Help Increase Health Care Value?

Proponents of HDHP plans see them as a cost-control strategy that exposes consumers to the financial implications of their treatment decisions. By making the consumer more aware of the costs associated with the care they receive, the hope is they will make more judicious use of health care services.

What Does the Evidence Say?

Several studies have found first-year premium savings from health plans with deductibles greater than $1,000. While these plans tend to attract healthier participants, savings persist after controlling for this favorable selection. HDHPs are intended to steer patients away from health care services that are considered low value, such as unneeded office visits or medical tests. However, several studies show that both low-value and high-value care is being reduced, and there is little evidence that consumers in these plans have become more careful shoppers of health care services. Further, longer-term savings have not been proven.

Reduced Premiums

A 2012 RAND study found that HDHPs resulted in significant premium cost savings.[4] The analysis examined plans with a range of deductibles but found cost savings of

Table 1 - IRS Rules for Qualifying HDHPs in 2015

Minimum Deductible
Individual: $1,300
Family: $2,600
Maximum Out-of-Pocket Amounts (Includes deductibles, copayments and other amounts, but not premiums)
Individual: $6,450
Family: $12,900

Table 2 - Tax-Advantaged Health Savings Accounts

Health Savings Accounts (HSA)
• May be used for qualifying, unreimbursed medical expenses. • May be used to pay Medicare Part B, C or D premiums, but not other types of premium. • Funds may be contributed by an individual or an employer.[1,2] • Funds are "owned" by the individual. • Funds roll over and accumulate year to year if not spent, and can be taken with the employee if they leave the employer.
Health Reimbursement Arrangement (HRA)
• May be used to pay premiums or qualifying, unreimbursed medical expenses. • Must be funded by an employer—not from the employee's salary. • Funds are "owned" by the employer. • Funds roll over and accumulate year to year if not spent, but the employee cannot take the funds with them if they leave the employer.

significance only for enrollees in plans with a deductible of more than $1,000 per person. Other studies have also found first-year savings.[5,6] Additional research needs to be done to assess long-term savings, if any.

Where Do Savings Come From?

The very act of shifting more of the cost of care to enrollees will always lower premiums. But the 2012 RAND study also found savings because families consume less care. They found that families enrolling in an HDHP spent an average of 14 percent less in the first year than similar families in traditional health plans.[7] Not surprisingly, HDHPs seems to generate the greatest reductions in lower-cost treatments that are paid for as part of the deductible.

These plans generated greater spending reductions among low- or medium-risk enrollees than high-risk enrollees and spending reductions were concentrated among outpatient services and pharmaceuticals.[8] Researchers have found evidence of modest favorable health selection accounting for some of the observed savings, but this appears to be an issue that needs additional research.[9] While these plans tend to attract healthier participants, savings appear to persist after controlling for this favorable selection.

HDHP Enrollees Don't Become Better Health Care Shoppers

The data does not suggest that consumers become more careful shoppers of health services. A 2013 RAND study found little evidence that consumers engage in more price shopping.[10] Further, RAND'S findings also show that participants in high-deductible plans use less of both low-value and high-value services. Particularly concerning was the reduction in the use of free preventive services offered by their employer.[11]

The theory of consumer response to financial incentives would predict that these high-value preventive services would be used at a higher rate because they are offered as exceptions to an enrollee's deductible and hence fully covered.[12] The fact that the theory did not play out suggests that consumers do not fully understand how cost-sharing arrangements such as HDHPs work and we need to be very cautious in interpreting consumers' response to financial incentives.

These findings confirm survey data where consumers acknowledge avoiding needed care due to concerns about out-of-pocket costs. Roughly two in five adults who had deductibles that were high relative to their income reported avoiding needed care because of the out-of-pocket costs associated with their deductible.[13]

Barriers to Treating Health Care as a Commodity

Available evidence also suggests that consumers don't approach purchasing healthcare like other commodities. Aside from consumers' difficulty navigating these plan designs and affording their share of the costs other barriers to "shopping" for providers and treatments have been identified:

- The reluctance of consumers to choose medical care based on price;[14]
- Discomfort of doctors and patients to bring price into treatment decisions;
- Lack of trusted, usable data on prices, quality and relative value offered by providers and treatments; and
- Lack of comparative effectiveness data for many treatments.
- Lack of cost knowledge on the part of providers.

Consumer Considerations

HDHPs are a blunt instrument that may save employers money in the short term, but often at a high cost for consumers who find the cost-sharing unaffordable or who don't understand the benefit design well enough to get the care they need.

For that reason, payers, regulators and others seeking to lower costs should carefully consider other policy options that more directly incentivize providers to deliver high-value care and provide better guidance to help consumers decide between high-and low-value treatments.

More appropriate strategies might include:[15]

- Value-Based Insurance Designs
- Provider payment reforms, including treatment bundling
- Delivery system reforms
- Global budgeting approaches for providers

HDHPs can cause financial difficulties and adverse health impacts and are unlikely to generate better health-system value. Consumers direct a very small percentage of what our nation spends on health care—even with the growth in high-deductible health plans and other patient cost-sharing schemes. As such, they have relatively weak influence on the healthcare market.

In the midst of a medical problem…patients are even less likely than usual to adhere to economists' standard assumptions about rational choices.

AHRQ, *Implementing Consumer Financial Incentives: A Decision Guide for Purchasers* (November 2007)

A Potential Benefit to Wealthier Consumers

A subset of consumers—those who are financially well off such that deductible costs are not a barrier to care—may prefer these plans. Indeed, the greatest benefit from the tax-advantaged savings accounts appears to accrue to families with higher marginal tax rates—in other words, higher-income families. Not surprisingly, higher-income families participate in these plans at the highest rate. As reported by the U.S. Government Accountability Office, in 2007 the average adjusted gross income for tax filers aged 19 to 64 reporting contributions to, or withdrawals from, an HSA was about $139,000, compared to $57,000 for other filers.[16] In fact, HSA plans are often promoted as a way to reduce taxes and save for retirement.

It may be appropriate to preserve this benefit for these families, but the tax-advantaged benefits that accrue to high-income families should be measured annually and weighed against the other funding needs that help subsidize health care for our poorest citizens or, better yet, spent to reduce healthcare spending overall through alternative, proven methods of addressing health costs.

Conclusion

High-Deductible Health Plans are becoming increasingly common and have many defenders. Ten years ago, less than five percent of the insured population was enrolled in an HDHP, compared to more than 20 percent today. In addition, a high deductible used to be in the $500 to $1,000 range. Today, 81 percent of HDHP enrollees have deductibles of more than $2,500.[17]

However, the research suggests that these plans are inappropriate for many consumers, leading them to cut back on both necessary and unnecessary care, possibly leaving them with unmanageable amounts of medical

debt. Given the numerous alternatives to address high healthcare costs, it is curious why these plans continue to be so vigorously defended.

For higher-income families that do not encounter the downsides of these plans, a sense of fairness suggests better and regular accounting of the tax expenditures that are accruing by income level, to ensure that these expenditures are appropriate given the competing needs we have for our tax dollars.

Because it is generally useful to consumers, providers and policymakers, we also recommend continued research on the relative value of treatment choices, as well as how to make public information about prices, quality and treatment choices actionable and usable for all stakeholders.

Notes

1. Kaiser Family Foundation, *Employer Health Benefits: 2013 Annual Survey*, Washington, D.C. (2013). The survey, which covers both small and large employers, found that about half of employers fund HSA accounts. Of those that do, they deposit $950 for singles with health savings accounts, on average, and $1,680 for families.
2. Ibid.
3. Buntin, Melinda B., et al., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans, RAND," *The American Journal of Managed Care*, Vol. 17, No. 3 (March 2011).
4. RAND Health, *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, Washington, D.C. (2012).
5. Massachusetts Health Policy Commission, *A Report on Consumer-Driven Health Plans: A Review of the National and Massachusetts Literature* (April 2013).
6. Buntin (March 2011)
7. Bundorf, Kate, *Consumer Directed Plans: Do They Deliver?*, Robert Wood Johnson Foundation, Princeton, N.J. (October 2012).
8. Barry, Colleen L., et al., "Who Chooses a Consumer-Directed Health Plan?" *Health Affairs*, Vol. 27, No. 6 (November 2008).
9. Sood, Neeraj, et al., *Price Shopping in Consumer-Directed Health Plans*, RAND, Washington D.C. (March 2013).
10. Ibid.
11. Ibid. Also, Reed, Mary E., et al., "In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care," *Health Affairs*, Vol. 31, No. 12 (December 2012).
12.. Generally, an HDHP cannot provide any benefits before the deductible is satisfied, but there is an exception for preventive care. With "safe harbor for preventive benefits," HDHPs with HSAs are permitted, but not required, to offer preventive care without meeting the deductible.
13. Collins, Sara R., et al., *Too High a Price: Out-of-Pocket Health Care Costs in the United States*, The Commonwealth Fund, Washington D.C. (November 2014).
14. Quincy, Lynn, *Consumer Views on Health Costs, Quality and Reforms*, Consumers Union, Washington D.C.
15. For a discussion of these strategies, see *HealthCareValueHub.org*.
16. General Accountability Office. *Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes* (2008). See also: EBRI report for recent data on how HSA/HRA account holders are distributed by income. *http://www.ebri.org/pdf/notespdf/EBRI_Notes_06_June-14_ShrtFlls-HSAs.pdf*
17. Kaiser Family Foundation (2013)

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