Informational Hearing
March 7, 2006
Background

High Deductible Health Plans: Consumer Directed? Part 2

What is a High Deductible Health Plan (HDHP) (also being marketed as "consumer-directed" or "consumer-driven")?

An HDHP is a health insurance plan that generally doesn't pay for the first thousand dollars or more of health care expenses incurred each year (the "deductible"). HDHPs are sometimes combined with tax-favored savings accounts, including Health Savings Accounts (HSAs). For federal tax rules that apply to HSAs, the Internal Revenue Service defines an HDHP as a health insurance plan where the annual deductible is at least $1,000 but not more than $5,000 for an individual, or $2,000-$10,000 for a family. Under HSA rules, HDHPs may have first dollar coverage for preventive care (no deductible) and apply higher out-of-pocket limits, co-pays and coinsurance for health care services obtained outside of the contracted network of providers.

Most HDHPs being sold today fall into one of the following categories:

- **Stand-alone HDHPs -** (generally a Preferred Provider Organization (PPO) model product) with no associated tax-favored financial account and no federal limits or requirements on the amount of the deductible, benefits subject to the deductible or annual out-of-pocket costs;

- **HDHPs paired with an Health Reimbursement Account (HRA) -** funded by the employer, tax-favored, with no federal limits or requirements on the amount of the deductible, benefits subject to the deductible or annual out-of-pocket costs;

- **HDHPs paired with an Health Savings Account (HSA) -** funded by the employer, the employee or both, tax-favored, subject to federal requirements on the amount of the deductible, benefits which may not count toward the deductible and annual out-of-pocket maximums; and,

- **Consumer Directed Health Plans (CDHPs) –** Any HDHP combined with a tax-favored financial account (i.e., HRA, HSA or Medical Savings Account (MSA)), that also promote the availability of tools and resources intended to help consumers manage health care decisions and improve their health, such as on-line tools, wellness programs, chronic disease management and/or catastrophic case management.

HDHPs are not new. PPO health insurance products with relatively high cost sharing have been available in the market for some time. However, the phenomenon of pairing HDHPs with tax-favored financial accounts is a relatively recent trend, prompted by changes in federal tax policies designed to encourage adoption of HDHPs. In addition, the rhetoric and the promotion of these products as "consumer-directed" is an emerging market trend. Moreover, the growth of HDHPs has been accompanied by an ever increasing level of cost sharing, including higher deductibles, higher copayments and coinsurance and higher limits on annual out-of-pocket costs. As a consequence, HDHPs and CDHPs are controversial and hotly debated. The table below summarizes some of the arguments associated with the current debate surrounding HDHPs.

Table 1
Arguments by Promoters and Critics of HDHPs and CDHPs

Promoters	Critics
CDHPs reduce premiums, making coverage more affordable, and engage consumers in considering the costs and benefits of the health care services they use. HDHPs promote personal responsibility and accountability.	HDHPs shift costs from purchasers, such as employers, to consumers. HDHPs penalize those who get sick through no fault of their own, the very people whom insurance is designed to protect. Low premiums are of less value if individuals and families cannot pay the costs of the deductible.
CDHPs give consumers an individual incentive (and possibly financial reward) to do things that improve their health and to avoid things that harm their health. The current system spreads the costs for those who harm their health to everyone in the system.	HDHPs overlook the fact that individuals cannot control all of their need for health care. Many have little or no choice, such as in the case of an emergency or care for ongoing chronic conditions. There are limits on what an individual can do to avoid or limit their consumption of health care.
CDHPs give consumers greater control and flexibility in the selection of providers and the practice of medicine by those providers. Flexibility in the choice of providers and use of different health care services is especially useful for those who want to see certain specialists or use alternative therapies. Consumers are making choice in their selection of non-emergency providers and have a role in the care they receive.	Consumers rely on trained medical professionals to recommend and refer them to appropriate providers and treatments. HDHPs impose on consumers the burden of deciding when and what type of care they should seek, and from whom, heavily influenced by their financial situation. Consumers are being asked to distinguish appropriate and inappropriate care, without having the knowledge or training to make potentially life-threatening choices.
CDHPs put decision making in the hands of the individual, empowering them to choose their providers and treatments and make cost-effective choices.	Individual consumers will not be able to negotiate better prices than large employers and national health insurers or secure on their own meaningful quality and outcomes data to compare providers.
CDHPs provide consumers with the tools to make informed health care decisions and to manage their health and chronic conditions. In addition, these plans provide online support for provider selection, quality information and price negotiations.	Not all products include such tools. In the current market, there are virtually no resources for consumers to obtain comparative prices for physicians, hospitals or other providers and there is limited information about quality.

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Promoters	**Critics**
CDHPs will over time reduce the total costs of health care. Moreover, CDHPs can rein in health care costs without the restrictions of managed care.	There is no evidence that passing costs on to consumers will reduce overall costs in the system. Health care cost increases are the result of technology, the aging of the population, layers of administrative costs and profit in the system and other factors outside of the control of individual consumers.
For some consumers, and their employers, reduced benefits and premiums make the difference between having some insurance or having no insurance at all.	Uninsured persons are primarily low wage, low income workers and their families and for them, HDHPs and HSAs are not a realistic option. Their tax benefit would be minor compared to the costs.
Many health care conditions and their associated costs are the result of lifestyle choices and behaviors people can impact. If people make better choices, health care costs will go down.	Nearly 80% of health care costs are spent on the sickest 20% of the population. In an HDHP, these individuals would pay their full deductible year after year, and likely incur significant medical debt, with marginal impact on total expenditures for their health care or on total system costs.
CDHPs cover prevention and offer generous coverage above the deductible which means that people with chronic conditions could end up actually paying less under a CDHP.	There is generally no requirement that HDHPs cover prevention on a first dollar basis or have reasonable cost sharing above the deductible. If prevention is not fully covered, consumers may neglect preventive care and could end up with preventable illnesses with bad outcomes and increased health care costs.
Greater flexibility in provider selection may appeal to people with chronic conditions. CDHPs can avoid adverse selection by risk-adjusting contributions (where employers pay more for those with chronic conditions), offering only one choice of plan, the CDHP, or having the insurer or administrator cross-subsidize the CDHP and the traditional product.	There are no legal requirements or assurances that these products will be offered this way. There is, however, growing evidence that young, healthy and higher income individuals are those most likely to select HDHPs. If the healthiest people select HDHPs, it will lead to adverse selection, diluting the insurance pool, leaving sick people and those with chronic health care conditions in traditional insurance products with higher and higher premiums. In the individual market, people with chronic conditions are unlikely to be able to obtain any coverage at all or will only get coverage at significantly higher rates.

Research Highlights

- **Consumer Satisfaction**. In 2005, the Employee Benefit Research Institute (EBRI) conducted a national survey of privately insured adults which found lower satisfaction among consumers enrolled in HDHPs, compared to those in traditional insurance products, higher out-of-pocket costs for HDHP enrollees and a greater likelihood that individuals with HDHPs would avoid,

skip or delay health care because of costs. EBRI also found evidence that consumers in HDHPs were more cost-conscious than those in comprehensive plans. HDHP enrollees were more likely to have considered costs when deciding to see a doctor or fill a prescription, more likely to discuss treatment options and costs with their doctor and more likely to check whether their plan would cover services prior to seeking care. Respondents reported that few health plans of any type offered cost and quality information on providers. Most consumers had a low level of trust in information provided by health plans.

- **Access to Care.** The Commonwealth Fund Biennial Health Insurance Survey of 2003 found that adults with a high deductible have significantly greater difficulty accessing care compared to those with low or no deductible. Of those surveyed, 38% of adults with deductibles of $1,000 or more reported at least one access problem: not filling a prescription, not getting needed specialist care, skipping recommended tests or follow-up, or having a medical problem but not visiting a doctor or clinic. By contrast only 21% of those with no deductible reported these problems.

- **Medical Debt**. Medical bill problems are also more common among those with higher deductibles. The Commonwealth survey found that over half of those with a deductible of $1,000 or more reported difficulties paying medical bills or were paying off accumulated medical debt. The problem is more severe for lower income persons. For those with incomes under $35,000, and deductibles of $500 or less, 55% reported having problems paying medical bills or had accumulated medical debt, compared with 37% of low income persons with lower deductibles and 27% of higher income persons with deductibles of $500 or more.

- **Impact of cost sharing**. In the 1970s, The RAND Corporation (RAND) conducted what remains one of the most comprehensive studies on the effects of cost sharing on utilization and health. The Health Insurance Experiment (HIE) randomly assigned people to health insurance plans with different cost sharing elements. Compared with free care (full coverage), cost sharing reduced spending consistently, and was more likely to reduce utilization for outpatient mental health treatment and hospital care than for outpatient medical and dental care. Cost sharing reduced the amount of services, but not the price of services. The total cost of treatment for an episode was no less where consumers paid a share of the cost, but people sought care less frequently. Individuals with cost sharing reduced the use of both essential and less essential services, and the rate of inappropriate hospitalizations was the same in cost-share and free plans. Cost sharing led to poorer outcomes related to blood pressure control, corrected vision, and oral health.

- **Higher Co-Payments**. In a more recent analysis of pharmacy claims data and plan design, RAND found that co-payments have a large impact on the use of prescription drugs by the chronically ill. For example, doubling co-payments can reduce their use of the most common classes of medication by 25-45%. The patients most sensitive to price were those taking long-term medicines but not receiving regular care for their conditions. Even those receiving routine care cut their drug use between 8% and 23% when their co-payments doubled.

- **Singapore Experiment**. Researchers analyzing a decades-long experiment with medical savings accounts (MSAs) in Singapore found that the approach did not reduce or control health care inflation, but health care costs continued to increase. In the mid-1980s, Singapore, a developed, modern city-state of more than 3 million people, shifted from a British-style government financed health care system to mandatory MSAs, to stem the tide of rising health care costs.

The system required all citizens to have an MSA and combined that with publicly subsidized primary care and hospital services to ensure that everyone had access to basic medical services. Researchers found that the per capita costs of health care in Singapore rose more rapidly after the program began than before its inception.

- **Employer-funded financial accounts.** The evidence surrounding HDHPs is potentially more promising when employers fund and control the associated financial accounts and create an overall environment supportive of health and wellness. McKinsey and Company, a self-described payor-provider consulting practice, surveyed employees enrolled in employer-sponsored HDHPs, combined with employer-funded HRA savings accounts, where employees did not have another choice of plan. Under these conditions, employees reported they made more careful, value conscious utilization decisions. Approximately 50% reported they were more likely to ask about costs. As self-reported, these employees were three times more likely to choose a less extensive, less expensive treatment and twice as likely to inquire about drug costs. In comparison with the traditionally insured, these HDHP enrollees were 25% more likely to report engaging in healthy behaviors and 30% said they were more likely to get an annual check-up because they thought it would save money in the long run. However, employees were not as satisfied as they had been with their previous health plan and were dissatisfied with the information available to help them make health decisions.

- **Individual market**. A 2004 survey by America's Health Insurance Plans (AHIP) of member companies selling individual coverage found that approximately 13% of consumers seeking coverage were unable to get individual policies, and 30% of those aged 60-64 were denied coverage. The survey revealed that 60% of family policies were purchased by families headed by a person 25-44 years old and only 33% by families headed by someone aged 45-64. Most consumers picked plans with annual out-of-pocket limits of $4,000 or less and with lifetime maximum benefits of $1 million or more.

For additional information on HDHPs, including details regarding federal rules affecting tax-favored financial accounts, see the background prepared for Part 1 of this hearing, which can be found at the Assembly Health Committee web site at www.assembly.ca.gov.