High Deductible Health Plans
What does the evidence say?

Lynn Quincy, Nov. 6, 2019
Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.
What is the Healthcare Value Hub?

*With support from the Robert Wood Johnson Foundation:*

- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best to reduce healthcare spending, improve affordability for consumers, improve outcomes and reduce disparities.
- We provide FREE resources to help YOU work on these healthcare value issues.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.
Guide to Jargon

High Deductible Health Plan (HDHP)

Health Savings Account (HSA)

= Consumer Directed Healthcare (CDHC)

HSA-Qualified Plan (Individual Deductible > $1,350)

Also Health Reimbursement Account (HRA)

Plus consumer shopping tools

HealthcareValueHub.org
HDHPs – The Bottom Line

**HDHP Benefits:**
- Lower Premiums
- ~HSA Savings Opportunity

**HDHP Consumer Harm:**
- Not getting needed care
- Affordability Burdens
What HDHPs DON’T Do: Drive Value in the Marketplace

Compared to more generous coverage, HDHP lower premiums BUT:

- Patients reduce both necessary and unnecessary care
- Patients don’t price shop
- Patients don’t shop based on quality
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<thead>
<tr>
<th>First Author</th>
<th>Journal</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Mary E. Reed</td>
<td><em>Health Affairs</em>, 2012</td>
<td>Survey of beneficiaries: fewer than one in five understood that their plan exempted preventive office visits, medical tests, and screenings from their deductible.</td>
</tr>
<tr>
<td>Neeraj Sood</td>
<td><em>RAND Forum for Health Economics and Policy</em>, 2013</td>
<td>Claims data analysis across CDHP and non–CDHPs: no evidence that, within CDHP plans, consumers with lower expected medical expenses exhibited more price shopping or that consumers exhibited more price shopping before reaching the deductible</td>
</tr>
<tr>
<td>Rachel O. Reid</td>
<td><em>American Journal of Managed Care</em>, 2017</td>
<td>Using a before/after: no change in spending on 26 commonly used, low-value services</td>
</tr>
<tr>
<td>Zarek C. Brot-Goldberg</td>
<td><em>Quarterly Journal of Economics</em>, 2017</td>
<td>Using a before/after: spending reductions are entirely due to outright reductions in quantity. We find no evidence of consumers learning to price shop after two years in high-deductible coverage. Consumers reduce quantities across the spectrum of health care services, including potentially valuable care (e.g. preventive services) and potentially wasteful care (e.g. imaging services).</td>
</tr>
<tr>
<td>Rejender Agarwal</td>
<td><em>Health Affairs</em>, 2017</td>
<td>Systematic review: HDHPs associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care.</td>
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Other evidence suggests WHY consumers don’t shop based on price or quality:

- Care is rarely labeled as high-value or low-value.
- Patients rarely know the price of a service and providers are often unable to help.
- Patients rarely know quality or likely outcomes between two treatments.
- Consumers don’t view healthcare as a commodity.
Most Healthcare Dollars Are Directed by Physicians

Consumers Direct a Small Percentage of Healthcare Spending

- Shoppable and Out of Pocket: 7%
- Spending Directed by Providers: 93%

# High Deductible Health Plans Cause Consumer Harm

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<td>J. Frank Wharam</td>
<td><em>J Clin Oncol.</em>, 2018</td>
<td>Women with breast cancer who had switched to HDHPs before being diagnosed experienced delays in every aspect of the care process: diagnostic imaging, biopsies, early-stage diagnoses, and chemotherapy treatments.</td>
</tr>
<tr>
<td>J. Frank Wharam</td>
<td><em>Health Affairs</em>, 2019</td>
<td>A similar study design: finds delays occurred regardless of income status, although delays were longer for women with lower income levels.</td>
</tr>
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<td>Alison A. Galbraith</td>
<td><em>Health Affairs</em>, 2011</td>
<td>Survey: Almost half (48 percent) of the families with chronic conditions in high-deductible plans reported health care-related financial burden, compared to a fifth of families (21 percent) in traditional plans. Almost twice as many lower-income families in high-deductible plans spent more than 3 percent of income on health care expenses as lower-income families in traditional plans (53 percent versus 29 percent).</td>
</tr>
<tr>
<td>Zhiyuan Zheng</td>
<td><em>Journal of Oncology Practice</em>, 2019</td>
<td>Survey: High-deductible health plans linked to delayed, forgone care among cancer survivors, especially if no HSA; the percentage of delayed or forgone care appeared similar for cancer survivors who had an HDHP with an HSA vs. those with an Low Deductible plan</td>
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Exhibit 1 Percentage of nonelderly adults with employer-sponsored insurance facing health care burden exceeding 20 percent of family income, by income and deductible level, 2011–13

About Health Savings Accounts

▲ HSAs are tax-advantaged savings accounts designed to pay medical expenses.

▲ HSAs must be paired with HDHPs meeting specific IRS criteria.

▲ Only one-third of individuals with a high-deductible health plan also have a health savings account.

▲ The U.S. Treasury finds that more than 60 percent of all HSA tax benefits accrue to families earning more than $100,000 annually.

Source: https://www.healthcarevaluehub.org/improving-value/browse-strategy/health-savings-accounts
Altarum’s Consumer Healthcare Experience State Survey (CHESS):

- designed to elicit respondents’ unbiased views on a wide range of health system issues
- a web panel from Dynata of ~1,000 residents 18 and older
- fielded Jan. 31-Feb. 9, 2018
- English language only

High Healthcare Affordability Burdens in Connecticut
Half of Connecticut adults had one or more healthcare affordability burdens

Healthcare Affordability Burdens: Percent of Connecticut Adults

Among Uninsured: Expense was the reason

All: Experienced Cost Barriers to Care

All: Received Care but Struggled to Pay the Bill

2018 Poll of Connecticut Adults
Cost Barrier to Care: Detail

- 33% - Delayed going to the doctor/having a procedure done
- 24% - Avoiding going to doctor/having procedure done
- 22% - Skipped recommended medical test or treatment
- 15% - Did not fill a prescription
- 13% - Cut pills in half/skipped doses of medicine
- 11% - Had problems getting mental health care

2018 Poll of Connecticut Adults
Struggled to Pay Medical Bills: Detail

- 10% - Contacted by a collection agency
- 9% - Used up all or most of their savings
- 7% - Racked up large amounts of credit card debt
- 6% - Placed on a long-term payment plan
- 6% - Unable to pay for basic necessities (food, heat, or housing)
- 4% - Borrowed money/got a loan/another mortgage on home

Healthcare affordability burdens hit lower income families the hardest.

Percent of Adults with Any Healthcare Affordability Burden in Past Year, by Household Income

- Less than $40,000: 53%
- $40,001-$74,999: 51%
- More than $75,000: 36%

QUESTIONS about HDHP evidence?
Solutions
Addressing Healthcare Affordability In 4 Easy Steps

1) Smart, affordable cost-sharing
2) Address wasteful spending
3) Address prevention “failures”
4) Address excess healthcare prices
Smart, Affordable Cost-sharing
There are numerous ways to divide the cost of needed medical care between the health plan and the beneficiary.

Cost-sharing design decisions affect how this spending is distributed across the enrolled population and only affect total spending at the margins.
Smart, Affordable Cost-sharing

**Goal:** avoid creating barriers to care while still discouraging low-value care; make cost-sharing designs understandable

- Use copays, not coinsurance; tie cost-sharing levels to family income
- Value Based Insurance Design
Value-based Insurance Design: “clinically nuanced benefit design”

Lower cost-sharing for high value services

Higher cost-sharing for low value services

Considerations for consumer-friendly VBID

- Focus on High Value Care
- Ensure Benefits are Based on Evidence
- Prioritize – overly complex cost-sharing doesn’t help patients
- Don’t Confuse VBID with Wellness Programs
Surprisingly, response to lower cost-sharing incentives under VBID is not as strong as predicted.

Because of this, the benefits of VBID “carrots” have largely accrued to patients who are already relatively health conscious and treatment compliant.

VBID “sticks” (to discourage lower value care) are rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known whether patients will respond in the nuanced way that VBID intends, as opposed to reducing the use of care indiscriminately.
What does it MEAN to make cost-sharing affordable?
Hub finds lack of harmonization across programs with respect to affordability thresholds

- IRS Tax Deductibility Threshold
- Medicaid
- CHIP
- Massachusetts (Romneycare)
- Healthy San Francisco
- ACA
- Urban Institute estimates for more generous ACA thresholds
Affordability of Premium Alone: Not Harmonized Across Programs

Income Devoted to Premium Alone
3 person family; 200% FPL

- ACA-employer
- Coverage too expensive
- ACA-subsidy
- MA
- Urban
- Healthy San Fran
Defining a Healthcare Affordability Standard

- Goal: No financial barriers to care

- Consider a “Total Cost” concept. What percent of income can a household devote to:
  - Cost of coverage (premiums)
  - Cost-sharing for covered services
  - Cost of needed services not included in the benefit package

- Standard slides with income and family size
Address Inadvertent, Surprise Out-of-Network Bills

△ Get patients out of the middle – prohibit balance billing and include a mechanism to resolve provider payment

△ Stronger network adequacy transparency provisions – at point of insurance shopping, show likelihood of getting a Surprise Bill

△ Better consumer assistance

More Info: https://www.healthcarevaluehub.org/improving-value/browse-strategy/surprise-medical-bills
Short-term Health Plans
aka skimpy health plans

- Premiums savings stems from less coverage, not duration of the policy
- Exempt from ACA consumer protections:
  - have annual and life-time caps
  - likely don’t cover minimum essential services like maternity and mental health; cost-sharing obligations can > $20,000
  - can exclude pre-existing conditions
  - not subject to MLR minimum: 80% of premium dollar spent on medical care
How are states protecting consumers?

- Prohibit sale of Short-term plans (MA, NJ, NY, CA)
- Enact term limits (MD-90 days)
- Enact state limits on renewal
- Benefit mandates to place a floor under the coverage offered by ST plans (CT)
Address Wasteful Spending
One-Third of Healthcare Spending is Wasted

- **Low-Value Care**
  - 14% of spending
  - Examples: Duplicate Tests, Choosing Wisely Services

- **Administrative Waste**
  - 8% of spending
  - Example: Billing Errors

- **Pricing Failures**
  - 4% of spending
  - Example: Excessive Profits

- **Fraud**
  - 3% of spending
  - Example: False Claims

- **Prevention Failures**
  - 2% of spending
  - Example: Missed Flu Shot

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Average Healthcare Spending per Person (2016)
$11,193

**Wasted Spending**
$3,431

**Necessary Spending**
Insufficient Comparative Effectiveness Research Undercuts Efforts

Up to 50% of our care may be provided without evidence of effectiveness
Some care is not ambiguous; tagged as low-or no-value in most cases

Source: Center for Value-based Insurance Design

Many, many other services have been identified as low or no-value.
GETTING UTILIZATION RIGHT: STRATEGIES

Provider Payment Reform

Non-Financial Provider Incentives

Patient Shared Decision-Making should be the

Insurance Benefit Design but

GET INCENTIVES RIGHT

ALSO POWERFUL

STANDARD OF CARE

KEEP IT SIMPLE
Financial incentives are not our only provider tool....

- Non-financial incentives:
  - Peer comparisons
  - Peer recognition
  - Eliminate barriers
  - Institutional support and leadership
Address “Prevention Failures”
LOW-VALUE CARE vs HIGH-VALUE CARE

LOW-VALUE CARE

- Unneeded diagnostic testing
- Unneeded imaging
- Bloodwork for low-risk surgery
- Use of branded drugs when generics are available
- Elective/unwarranted C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

For details on the strategies, go to: HealthcareValueHub.org/low-vs-high-value-care

HIGH-VALUE CARE

- Getting a flu shot
- Coordinating care for complex patients
- Cancer screening when appropriate
- Prenatal care
- Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.
ONE-THIRD OF HEALTHCARE SPENDING IS WASTED

WASTED SPENDING
$3,431

NECESSARY SPENDING

AVERAGE HEALTHCARE SPENDING PER PERSON (2016)
$11,193

LOW-VALUE CARE
14% OF SPENDING

UNNECESSARY SERVICES
Examples: Duplicate Tests, Choosing Wisely Services

INEFFICIENT CARE DELIVERY
Example: Test Results Not Shared

ADMINISTRATIVE WASTE
8% OF SPENDING

Example: Billing Errors

PRICING FAILURES
4% OF SPENDING

Example: Excessive Profits

FRAUD
3% OF SPENDING

Example: False Claims

PREVENTION FAILURES
2% OF SPENDING

Example: Missed Flu Shot
SOCIAL DETERMINANTS OF HEALTH

Economic Instability
Substandard Housing

Unhealthy Food Options
Lack of Transportation Options
Quality of Education

Public Safety
Inadequate Parks/Playgrounds

The conditions where you live, work and play impact your health outcomes.
Addressing Personal and Social Determinants of Health

- Assess community needs and capacity to address needs
- Collect better data to track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
  - Environmental nudges
  - Social-medical models of care
- Address financing silos
Addressing High Unit Prices
UNREASONABLE PRICES: STRATEGIES

- **Price Transparency to expose HIGH PRICES**
- **Anti-trust, CON/DON, foster competition to address MONOPOLY POWER**
- **Reference pricing, rate setting, price regulation to address PRICING OUTLIERS**
- **Global Budgets to cap OVERALL SPENDING**
Neither Paid Amount nor Charge Provide an Accurate Picture of the Underlying Cost

For the most part, we have no idea what the underlying cost of inputs is.

Which Price Concept(s) Should We Make Transparent?

- Listed Charges (Charge-master)
- Negotiated Charges (varies by payer)
- The fair price?
- Medicare Payments
- Patient OOP (varies by insurer)
- Cost to produce the good or service
...can help consumers budget and plan, but it is unlikely to drive value in the marketplace – especially when hospital markets lack competition.
What is a State Health System Oversight Entity?

An entity empowered to look systematically across various types of health and social spending, with tools and authority to identify where the state needs to be more efficient in terms of value for each dollar spent, including addressing quality short-comings and affordability problems for residents.

Important roles can include:

- Leadership/legislative recommendations
- Data stewardship and infrastructure
- Convener
- Innovator
- Regulator/enforcer
Health System Oversight: A Scan

**Health System Oversight by States: An Environmental Scan**

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can result in delay or foregone needed medical care and create pointed budgetary strains, medical debt, and bankruptcy. Moreover, the quality of care that patients receive does not uniformly reflect the high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers, and address the healthcare affordability and accessibility concerns of their residents. While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—only a few states have a coordinated oversight entity.

**SUMMARY**

It’s found that imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, in place, only a few states have a coordinated oversight entity that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth, and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising healthcare costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations, and implementing global budgets.

By examining these roles, it is hoped to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

**NEW: in addition to tracking the value of health spending over time, include an accounting mechanism to recognize future savings from current year investments**

**Why is an Oversight Authority Needed?**

While there will always be a federal and private payor role, there are clear reasons why much of the activity is successfully reduced when healthcare value needs to occur at the state level.

For one, our fragmented healthcare system typically limits the ability of any one payor or stakeholder to incentivize the provision of care that will lead to lower costs. States are well positioned to serve as a convenor and support the many payor coordination that is critical for meaningful progress on healthcare value.

Furthermore, broad access to coverage and getting to better healthcare value is impractical, interrelated policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollars—such as provider payment reforms—are universally promoted on populations being covered.

Moreover, state governments are uniquely positioned to remain in “strategic” approaches that lead to healthier communities. Research shows that just 10–20 percent
With APCD, learn:
- Total spending with price, utilization, location, payer and service sector components
- When claims data is combined with other data streams, learn:
  - Affordability for consumers
  - Outcomes, including medical harm
  - Patient experience
  - Disparities
- Critical to measure progress towards state goals

“APCDs are a necessary step to building healthcare transparency in states.”
QUESTIONS about:

Smart, affordable cost-sharing?
Wasteful spending?
Prevention “failures”?
Excess healthcare prices?
The Hub is here to help!
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▲ Alerts on State news and healthcare value topics;
▲ Free monthly webinars on timely topics
▲ A product type for every user

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State News

Connecticut

Connecticut has explored many approaches to improving healthcare value for consumers over the past several years. The state created an all-payer claims database in 2012 and passed a comprehensive law prohibiting certain out-of-network billing practices and establishing a “certificate of need” process for insurance companies to acquire physician groups in 2015. The law also requires health insurance companies to submit an annual report to the Connecticut Health Insurance Exchange that lists the billed and allowed amounts paid to each healthcare provider in the insurer’s network for certain diagnoses and procedures, and the corresponding out-of-pocket costs. The state launched an Office of Health Strategy in 2018 to implement comprehensive, data-driven strategies that promote equal access to high-quality healthcare, control costs and ensure better health for Connecticut residents. Among other responsibilities, the office will oversee the state’s four-year State Innovation Model grant to test multi-payer healthcare payment and service delivery models to improve health system performance, increase quality of care and decrease costs.

As of 2019, Connecticut is one of the few states that has comprehensive protections from surprise medical bills. However, high drug costs remain a significant consumer concern. The state has passed several pieces of drug pricing legislation to address these concerns, including laws that require pharmaceutical companies to disclose and explain drug price hikes; force pharmacy benefit managers to report how much they collect in rebates and how much they keep; and protect pharmacists from “gag clauses” that prohibit them from disclosing specified information to people purchasing certain drugs.
Final Questions?

Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.

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