

Health Policy Brief

FEBRUARY 4, 2016

High-Deductible Health Plans. As high-deductible health plans become increasingly prevalent in both group and individual markets, it remains to be seen how they will affect health care access and outcomes.

WHAT'S THE ISSUE?

Over the past twenty-five years, health care spending growth overall has exceeded gross domestic product (GDP) growth, and total health care costs now account for more than 17 percent of GDP. A combination of factors—including technology, inefficiency, population health status, and insurance coverage rates—have historically been the major contributors to cost growth. Higher health care costs have translated into higher insurance costs, in both the individual and group markets.

Increasing plan deductibles has emerged as one potential solution to slowing health care cost growth by reducing use. A higher deductible reduces a plan's monthly premium payment, while increasing the amount consumers are responsible for paying for their care before their insurance pays for benefits. This effectively increases the price consumers face when deciding whether or not to seek care and may in turn reduce medical spending.

High-deductible health plans (HDHPs) are increasing in prevalence in both the group and individual markets. In the group market, rising insurance costs make HDHPs more attractive to employers. Employers now spend an average of \$5,179 and \$12,591 on health insurance premiums for their employees in

individual and family plans, respectively. A recent Henry J. Kaiser Family Foundation [survey](#) of employers shows that deductibles have increased 67 percent since 2010. Nearly one-quarter of workers are enrolled in an HDHP, up from 4 percent in 2006. Nearly half of workers are covered by an insurance plan with a general annual deductible of at least \$1,000 for individual coverage.

In the individual market, almost 90 percent of enrollees in Affordable Care Act (ACA) Marketplaces are in a plan with a deductible above the amount that qualifies a plan as an HDHP: \$1,300 for an individual and \$2,600 for a family (not including cost-sharing reductions) in 2015. The increasing number of enrollees in and prevalence of HDHPs raises a number of policy questions.

WHAT'S THE BACKGROUND?

HDHPs are plans with a minimum deductible and maximum out-of-pocket limits as defined by the Internal Revenue Service (IRS). Other than certain preventive services, all medical care must be paid for out of pocket until the deductible is met. Network plans such as preferred provider organization (PPO) plans can be HDHPs, as the designation of a plan as a PPO or point-of-service (POS) plan refers to preferred benefits for services provided by network providers.

HDHPs with a savings option (health savings account [HSA] or health reimbursement arrangement [HRA]) are also referred to commonly as consumer-driven health plans. This name connotes an increased role for consumers in shopping for services and reducing the use of unnecessary care.

Consumer-driven health plans were first offered by employers in 2001 but didn't experience large growth until after creation of HSAs through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The concept of consumer-driven health plans was to apply cost controls to the demand side of health care (instead of reducing provider costs, and so forth) by increasing consumers' exposure to the true costs of care. HDHPs can also be paired with a HRA, in which the employer contributes tax-free dollars to an account that workers can use to pay for out-of-pocket medical expenses. The key difference between HSAs and HRAs is that an HSA is a savings account that employees own, while an HRA is a reimbursement arrangement between employers and employees. HSAs are available to all qualified HDHP enrollees, not just those in an employer-sponsored plan. Employers can also contribute to an HSA.

More recently, the ACA created actuarial value tiers for all nongrandfathered plans sold in the individual and small-group markets and created a defined set of benefits (essential health benefits) for all nongrandfathered plans. These actuarial tiers—platinum, gold, silver, and bronze—correspond to the percentage of health costs that each plan covers. Platinum plans cover the most; and bronze plans the least. Another important provision of the ACA ties premium tax credits to the premium of the second-lowest-cost silver plan in each Marketplace. This means that consumers who are eligible for premium tax credits pay the least in premiums by selecting a silver or bronze plan. Cost-sharing reductions are available only to consumers who purchase a silver plan.

Because of these provisions, large portions of consumers in the Marketplaces are enrolling in silver and bronze plans. As of April 2014, 85 percent of enrollees were in a silver or bronze plan. As of March 2015, this number was nearly 90 percent. The average silver plan deductible nationally is more than \$2,500 for an individual, although most silver plan enrollees are eligible for cost-sharing reductions. The average bronze plan deductible is more than \$5,300 for an individual. While not

all silver and bronze plans qualify as a HSA-eligible HDHP, about 25 percent of the plans offered nationally on the Marketplaces are HSA-qualified. For employer-sponsored coverage, the average deductible for individual coverage is \$2,196 for HSA-qualified HDHPs.

WHAT'S THE LAW?

A high-deductible health plan is a legal designation for HSA eligibility. Enrollment in a plan with a deductible above the IRS-defined threshold is a prerequisite for HSA qualification. Each year the IRS determines the qualifying HDHP deductible, out-of-pocket limit, and maximum HSA contributions. HDHPs are often identified as HSA-eligible, signaling that they meet this set of requirements.

In 2015 the qualifying deductible was \$1,300 for an individual and \$2,600 for a family. The maximum out-of-pocket limit was \$6,450 for an individual and \$12,900 for a family. When consumers are enrolled in a qualified HDHP, HSAs allow them to put tax-preferred money into accounts to help pay for medical expenses. In 2015 this contribution was limited to \$3,350 per year for an individual and \$6,650 for a family. Unlike HSAs, enrollment in an HDHP isn't required for HRAs.

Section 2713 of the ACA requires all private, nongrandfathered plans to cover a set of preventive services without imposing any form of cost sharing, including a deductible. Services covered by this provision include those that have earned an "A" or "B" rating from the US Preventive Services Task Force such as disease screenings, routine immunizations, and counseling for drug and tobacco use. Enrollees in HDHPs should be able to access these services without having to meet their deductible.

WHAT'S THE DEBATE?

The central debate over HDHPs is whether or not the plans reduce health care costs and use in a way that could negatively affect health. The Institute of Medicine estimates that 30 percent of health spending is waste. HDHPs are designed to reduce unnecessary use. There is mounting evidence that HDHPs are successful at reducing costs and care use, but results are mixed on the impact of this reduced care use on health status. Cost sharing can reduce the use of beneficial as well as unnecessary services. Prior to the ACA's preventive service requirement, some HDHPs made preventive services free of cost sharing to provide consumers with incentives to continue using high-value care.

67%

In the employer market, deductibles have increased 67 percent since 2010.

"Increasing plan deductibles has emerged as one potential solution to slowing health care cost growth by reducing use."

Reducing care use and costs

A number of studies have analyzed consumers' sensitivity to health care prices via cost sharing and how they respond.

The [RAND Health Insurance Experiment](#) is considered the seminal work on the impact of cost sharing on insurance use and costs. Running from 1974 to 1982, the study randomly assigned families to plans with various deductibles from \$0 to \$1,000. Ultimately, the study concluded that higher deductibles did reduce use of care. Those enrollees assigned to the 95 percent coinsurance plan (most comparable to today's HDHPs) reduced spending by 30 percent.

Subsequent studies have continued to confirm this central theory: Higher deductibles will result in less care use across the board and, in turn, lower costs. Actuaries from the Centers for Medicare and Medicaid Services project that the proliferation in HDHPs "may be significantly offsetting the effects of the coverage expansion in the Marketplaces on growth in the number of physician office visits made by consumers with private health insurance." A survey of New England HDHP enrollees published in *JAMA Internal Medicine* found high levels of delayed or forgone care for a period of six months across income levels, largely as a result of costs.

A recent [study](#) published by the National Bureau of Economic Research (NBER) followed a firm that switched its plan offering to employees from a non-HDHP PPO to an HDHP. Following this change, costs substantially decreased across a number of categories: preventive, emergency, outpatient, and pharmaceutical care. Overall spending decreased between 10 percent and 15 percent for the two years after the change. The decrease in spending was attributable entirely to reductions in care use.

Necessary or unnecessary care?

A number of studies have shown that increasing consumers' share of costs reduces their care use. But evidence is mixed on the health impact of this reduction. At least some of the research so far seems to indicate that high deductibles and out-of-pocket expenses reduce use of necessary as well as unnecessary care, particularly in specific populations. There are varying ways to measure this impact: Some studies, such as the RAND Health Insurance Experiment, look at health status.

Others look at use by individuals with particular conditions.

The RAND study concluded that HDHPs reduce use of both effective and less effective care, but without a measurable impact on health status for most patients. However, there was an adverse impact on low-income patients and those with chronic conditions. Those populations on plans with no deductible or cost sharing had better outcomes on four of the thirty health conditions measured.

The increased prevalence of chronic conditions such as diabetes, hypertension, and so forth in the United States require medications or other regular interventions to remain under control. High cost sharing is of concern for people with chronic conditions, mental health disorders, and other conditions that require expensive prescription drugs or long-term service use. Among families in which members have chronic conditions, both adults and children are more likely to delay care when enrolled in an HDHP than in other plans. The NBER study found that the sickest enrollees decreased their medical spending by more than average, between 18 percent and 22 percent in the first year. These enrollees had relatively high incomes and even received a subsidy in the amount of the deductible in an HSA. Even if certain types of care for chronic conditions are desirable, HSA-qualified plans cannot pay for them in advance of the deductible.

The families with HDHPs who have family members with chronic conditions also have higher levels of financial burden, with nearly half reporting problems paying medical bills or other bills because of health care costs. Enrollees in HDHPs are also more likely to stop taking their medications for chronic illnesses. A 2013 [analysis](#) found decreased medication adherence for patients in HDHPs across four of five chronic conditions studied. Better adherence to taking prescribed medications for some chronic conditions results in less health care use, so this decreased adherence may not save money in the long term.

Low-income individuals and families are also disproportionately affected by high deductibles because they may not have sufficient assets to meet the out-of-pocket requirements. Individuals enrolled in high-deductible plans who live in areas with high poverty rates and low education rates reduced their "high-severity," emergency department visits (those with a high probability of needing

25%

Nearly one-quarter of workers are enrolled in a HDHP, up from 4 percent in 2006.

“Enrollees in high-deductible health plans are likely to reduce preventive care use and are largely unaware of the fact that preventive care is free or low cost.”

care within twelve hours) by 25–30 percent over two years. Individuals with higher socioeconomic status reduced only lower-severity visits, or those that can likely be substituted with a primary care visit. Other studies have echoed the finding that individuals with lower incomes are significantly more likely to forgo care than those with higher incomes when enrolled in an HDHP.

Enrollees in HDHPs are also likely to reduce preventive care use, even when covered without cost sharing, and are largely unaware of the fact that preventive care is free or low cost. Even though a number of preventive care services are covered pre-deductible as required by the ACA, consumers may not be aware and take advantage because of fears of high out-of-pocket payments. Challenges remain to entice consumers to shop for health care and to use available information to do so. The NBER study found no evidence of consumers’ shopping for care and substituting lower-cost services. Another recent [study](#)—surveying both those enrolled in an HDHP or a traditional plan—found similar results. Those enrolled in an HDHP were no more likely to compare costs or change providers despite having higher levels of cost sharing.

WHAT’S NEXT?

Coverage

With an increased health system focus on value, one policy to more specifically target unnecessary care use may be value-based insurance design. Plans using this design incentivize services that have a clinical evidence base and that can improve outcomes and reduce costs. Patients pay less for higher-value treatments and more for lower-value treatments. Value-based insurance design plans are more nuanced than the “blunt instrument” of HDHPs by better aligning deductibles and copayments with the value of health services. While HSA-qualified HDHPs do include high-value preventive services for free, other services are not covered in large part until the deductible is met.

Although more than ten million individuals have purchased Marketplace coverage,

there are still ten million eligible people who have not, including seven million who would receive premium assistance. Surveys have indicated that a primary reason for not enrolling remains premium affordability. Some policy makers have proposed the creation of “copper” plans at a lower actuarial value to address this issue. These plans would have sizeable deductibles, as they would cover even a smaller percentage of costs than bronze plans, but would also have lower premiums. To meet the health law’s coverage requirements while reducing the proportion of medical expenses insurers pay to 50 percent, a plan would have a deductible of \$9,000 per person, according to the Kaiser Family Foundation.

Costs

Another impending policy set to take effect in 2018 could have a major impact on deductibles in the employer-insurance market. The so-called Cadillac Tax is an excise tax of 40 percent on employer-sponsored plans valued at more than \$10,200 for individual coverage and \$27,500 for family coverage. Research indicates that employers may shift costs on to employees through deductibles as one way to keep plans below the level of taxation. This could further increase the share of employees enrolled in plans with high deductibles.

Initial [modeling](#) indicates that 16 percent of employers offering health benefits would have at least one health plan that would exceed the \$10,200 individual coverage threshold in 2018, the first year that plans are subject to the tax. The percentage would increase to 22 percent in 2023 and to 36 percent in 2028. As employer-sponsored insurance remains the source of insurance for most individuals, this potential cost shifting could subject a large number of consumers to high deductibles.

Health care costs have slowed in recent years but are growing once again. Forecasting predicts that health spending will continue to grow faster than the GDP, at a rate of 5.8 percent from 2014 to 2024, and will rise to 19.6 percent of the GDP by 2024. As health care spending climbs, the prevalence of high-deductible plans will likely continue to increase. ■

RESOURCES

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