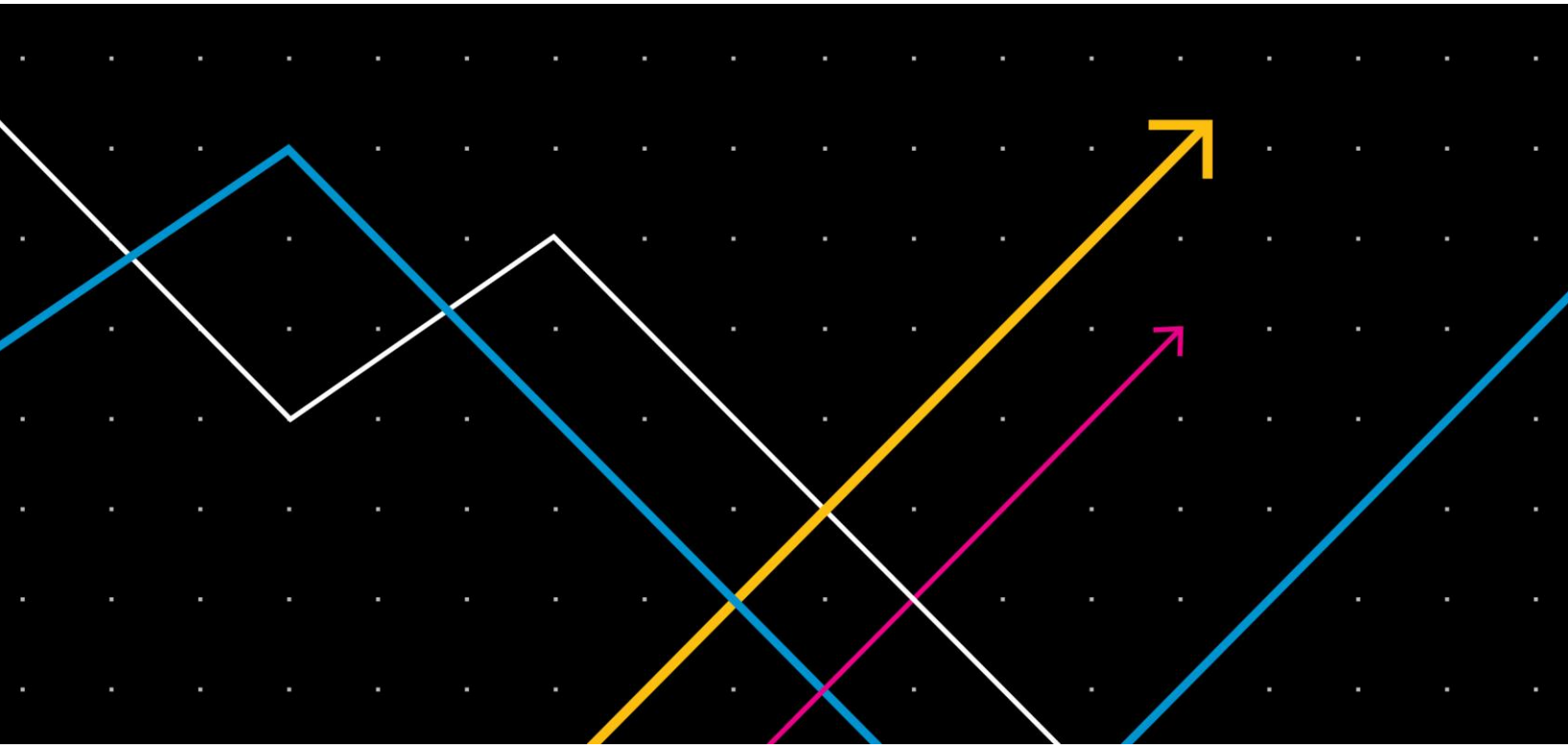

RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

High Deductible Health Plans

Suzanne F. Delbanco
CATALYST FOR PAYMENT REFORM

Roslyn Murray
CATALYST FOR PAYMENT REFORM

Robert A. Berenson
URBAN INSTITUTE

Divvy K. Upadhyay
URBAN INSTITUTE

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OUR HEALTH CARE SYSTEM NEEDS CPR

CATALYST FOR PAYMENT REFORM

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the seven benefit designs discussed in the report *Benefit Designs: How They Work*. All reports and chapters can be found on our project page: Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care.

High Deductible Health Plans

High deductible health plans (HDHPs) require consumers to cover 100 percent of their health care costs up to a certain amount—the deductible—at which point their insurance coverage and other cost-sharing arrangements, such as co-pays and co-insurance, begin. According to IRS standards, a plan is considered a high deductible plan, and eligible for a tax advantaged health savings account (HSA), if the out-of-pocket maximum limit is $6,450 for individuals and $12,900 for families, and if the deductible is between $1,300 and $3,350 for individuals and $2,600 and $6,650 for families. While consumers who choose high deductible plans pay more for their care prior to meeting the deductible, they typically have a lower premium contribution. This can be attractive to consumers as premiums continue to rise. Many employers and other health care purchasers believe this arrangement will make employees and their dependents more cost sensitive.

In an HDHP, some services, such as primary preventive services, have first-dollar coverage and are not subject to the deductible. Consumers in HDHPs must understand what is, and is not, subject to the deductible. Often a normal exam has no cost-sharing, but an abnormal one is subject to out-of-pocket costs. For example, a colonoscopy screening would normally be covered as a primary preventive measure. However, it would be subject to the deductible as a secondary preventive measure if the

patient were to show symptoms of bleeding. However, for most services covered under an HDHP, the individual is responsible for determining whether care is worth the out-of-pocket costs. The balance of evidence shows that this can be problematic, as greater cost-sharing for the consumer may mean delayed or avoided care, whether or not the care is high value. Higher cost-sharing has been shown to discourage consumers from seeking care, whether that discouragement is appropriate or inappropriate.

HDHPs are often paired with a tax-advantaged account that consumers use to pay for medical expenses, which can help defray their out-of-pocket costs under the deductible. A health reimbursement account (HRA) reimburses the employee for medical expenses approved by the employer. Only an employer can fund an HRA. An HSA is an individual's tax-exempt account to be used for medical expenses as defined by the IRS, with contributions made by the consumer, his or her employer, or both. HSAs are more commonly used with HDHPs, but only for plans that meet the IRS requirements for the size of the deductible.

Key Objectives of HDHPs

When a third-party payer covers a large majority of consumers' health benefits, consumers use more services than they would if they were financially responsible for the costs of health care. The high deductible is meant to counter this phenomenon by requiring consumers to pay the full cost of care up to the point they reach their deductible. Therefore, one key objective of HDHPs is to make consumers more cost sensitive to reduce unnecessary care. Another objective of HDHPs is to encourage consumers to shop for lower-priced providers instead of just consuming less medical care.

Consumers and purchasers of health care are concerned about rising premiums. Therefore, another objective of HDHPs is to create plans that offer consumers lower premiums in exchange for higher deductibles and maximum out-of-pocket costs. However, constraining premiums may not mean lower costs overall for consumers who use or need expensive services; the deductible may more than make up the difference.

Strengths

- Research and results have shown that high deductibles lower health care spending.

- By having consumers bear a large portion of the cost of care upfront, HDHPs can make them more cost and use sensitive and encourage them to choose more affordable care options.
- HDHPs may save consumers money, even with a high deductible, as these plans feature lower monthly premiums, regardless of the effect on spending.
- Patients who have high deductible health plans still receive first-dollar coverage for primary preventive services.
- Patients with an HSA can pay for services subject to the deductible with their tax-advantaged accounts, helping to defray the financial barriers to care.
- If consumers are more cost sensitive and use less care, providers may offer lower-cost alternatives, such as care through telecommunication or care provided by health professionals other than doctors, such as nurse practitioners, registered nurses, or physician assistants.

Weaknesses

- HDHPs decrease health care spending by reducing use, but this holds true for both beneficial and non-beneficial services.
- While primary preventive services have first-dollar coverage, secondary preventive services, such as the care someone with a chronic condition needs to keep an illness from progressing, do not. It is difficult for consumers to make the distinction between what is primary prevention and therefore covered, and what is secondary prevention and subject to the deductible.
- Individuals that use fewer services benefit from HDHPs because of lower premiums, even though they may not meet the deductible. However, frequent users and those with higher medical costs will also enjoy lower premiums, but will need to pay more between the deductible and the cost-sharing after meeting the deductible. Therefore, HDHPs place a disproportionate burden on lower-income and more medically needy consumers.
- Patients with complex conditions requiring many services may quickly reach the deductible, at which point most of the incentives inherent in HDHPs disappear. Yet, patients are still subject to cost-sharing until they reach their maximum out-of-pocket costs. Given that these patients may anticipate this level of spending, they may be unaffected by the incentives to be cost sensitive before reaching their deductibles.

- Most deductibles in HDHPs are such that the variation in price over a year isn't going to give patients the marginal incentive to be cost sensitive. For example, a patient having a baby will likely blow through her deductible during the course of care.
- Deductibles may not be an effective way to create incentives around specific health-care-seeking behavior. Critics of HDHPs suggest that nuanced cost-sharing from first-dollar use could be a more effective tool, such as value-based insurance design.
- While HDHPs are intended to counter the incentives of fee schedules, they can create tension between a provider who has an incentive to provide care and a patient who has an incentive to refuse care.

Design Choices to Mitigate Weaknesses

Size of the Deductible

To qualify as a high deductible health plan by IRS standards, the deductible and out-of-pocket maximum has to be no more than $6,550 for individuals and $13,100 for families. The out-of-pocket maximum must be within this range to pair with a health savings account or other tax-advantaged account.

Services Exempt from the Deductible

HDHPs, like other plans subject to the requirements of the Affordable Care Act, must give primary preventive services first-dollar coverage and make them exempt from the deductible. Other services can have first-dollar coverage as well, depending on the incentives the designer wishes to create. However, if the plan is associated with a tax-advantaged account, secondary preventive services cannot receive first-dollar coverage, according to IRS standards. Otherwise, certain secondary preventive services and prescriptions for particular conditions, or other underused services the plan or purchaser wishes to encourage, could be designed to receive first-dollar coverage.

Availability of Price and Quality Information

Price information should always be available to patients who have not met their deductibles, so they can see how much a service will cost them out-of-pocket. Additionally, in conjunction with cost information, quality information can show patients the relative value of particular services or providers and can point them toward higher-value options.

Tax-Advantaged Account

An HRA or HSA can be paired with an HDHP. Patients can draw from these accounts to pay for any qualifying health care service, according to IRS standards, that are then subject to the deductible. For consumers who cannot bear the financial liability under the deductible and choose to forgo needed care, a tax-advantaged account can help defray out-of-pocket costs. Additionally, the account can be used for future health care needs.

Compatibility with Other Benefit Designs and Payment Approaches

Other benefit designs could mitigate some weaknesses of high deductible health plans. HDHPs are often ineffective for certain populations of consumers. Low-income consumers may not have the financial stability to tolerate a high deductible, which may prevent them from seeking needed care. However, some employers allocate premium contributions based on salary to mitigate the effect on lower-income employees. Alternatively, implementers could consider pairing the HDHP with value-based insurance design, which can significantly reduce cost-sharing for services critical to particular patients (i.e., diabetes care for a diabetic). Theoretically, plans could use reference pricing to mitigate these effects by establishing an "up to" amount the plan will cover for a particular service, with any costs above that limit subject to the deductible.

Additionally, HDHPs may do little to incentivize patients with multiple complex conditions to be cost sensitive; they may blow through their deductibles quickly. In this case, implementers could consider split-benefit designs—a concept designed by Chernew, Encinosa and Hirth (2000)—which would offer patients who have already met their deductibles either incentives to choose low-cost services or providers, or penalties for not doing so.

There are mixed views on the compatibility of high deductible health plans and payments that operate under a budget, such as different forms of capitation, global budgets, or bundled episodes. In this case, some incentives for consumers and providers are aligned; HDHPs incentivize consumers to be more cost conscious about their care, and the budgeted or capitated payment incentivizes providers to be more efficient or cost effective. However, these arrangements may make it more difficult for providers to manage their patients' care. Patients with a high deductible health plan may skimp on needed care, which could lead to adverse clinical outcomes. Additionally, it would be operationally difficult to administer the patient's deductible based on their care if is not on a fee-for-service chassis.

There are similarly mixed views on the compatibility of HDHPs and fee schedules. While HDHPs were originally created to counter providers' incentive to perform too many services by making consumers cost sensitive, HDHPs create a conflict of interest between the two parties. In this arrangement, the interests of the provider and patient are not aligned, because the provider seeks to deliver care and the patient seeks to avoid it.

Focus of Performance Measurement

If an HDHP provides first-dollar coverage only for primary preventive services, patients with chronic conditions may choose to forgo necessary secondary preventive services, because patients foot the entire bill up until they meet their deductibles and out-of-pocket maximums. Consumers who forgo necessary care may experience adverse consequences. With an HDHP, it would be important to assess whether these patients receive necessary screening treatments by using measures such as blood pressure control, HbA1c testing for diabetics, and so on.

Potential Impact on Provider Prices and Price Increases

HDHPs are intended to create a retail market in which consumers shop for health care services at their own expense—when the services are subject to the deductible. This structure is meant to make consumers more cost sensitive, which in theory could prompt certain providers to lower prices to compete for patients. HDHPs would probably have a greater effect on use of ambulatory care than hospital care, as most hospital care is costly enough to bring consumers well past their deductibles, at which point richer insurance coverage begins.

Reference

Chernew, Michael E., William E. Encinosa, and Richard A. Hirth. 2000. "Optimal Health Insurance: The Case of Observable, Severe Illness." *Journal of Health Economics* 19 (5): 585–609.

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A technical expert panel advised the project team and reviewed the reports at different stages.

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2100 M Street NW
Washington, DC 20037

www.urban.org