



MISSING THE COST CONTAINMENT TARGET

High-Deductible Health Plans Not Appropriate for all State Employees

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SUMMARY

This paper addresses the pros and cons of moving all or most state employees into high-deductible health plans (HDHP) coupled with Health Savings Accounts or HSAs. Since 2007, when state employees were first given the choice to enroll in an HDHP/HSA or stay with the default traditional plan, only 153 out of 22,000 (.7%) employees selected the HDHP option. Yet, the Cost Containment Workgroup of the Utah Legislature's Health Reform Task Force is poised to recommend that *all or most* state employees enroll in HDHPs. This group has several factors to weigh in its decision; in the current budget environment, however, the primary consideration should be the cost to the state. Fortunately PEHP has the historical claims data for state employees to perform an objective analysis of the cost of shifting employees to HDHPs—*these estimates will be available shortly*.

In summary, PEHP is not the best place to force greater use of HDHPs. As PEHP claims data will show, most of the cost is concentrated at the high-end of the claims distribution spectrum. Because people on this end of spectrum generally have a serious injury, illness, or disease that must be treated, there is little to no elasticity of demand for health care. Depending on how the HDHP plan option is designed, the short-term cost could easily be greater than what the state is paying now for benefits; difficult to calculate, the long term costs and consequences to the health of older and sicker employees may also be considerable.

Yet no matter how disappointing the results of PEHP's experience with HDHPs or questionable the ethics of favoring younger and healthier consumers, as HDHPs are known to do, the idea continues to compel interest.

WHAT IS AN HSA?

Established in 2003 as part of the Medicare Modernization Act, **Health Savings Accounts** offer tax benefits for people who purchase insurance policies with high deductibles (HDHPs). To qualify for the HSA tax break, the policy must have a deductible of at least \$1,150 for an individual or \$2,300 for a family. An HSA is a tax-preferred savings account: Deposits into HSAs can be made with pre-tax dollars. The tax-deductible contributions may be placed into an HSA by an individual, employer, or both. Money that is not used can be rolled over from one year to the next.

Individuals over the age of 65 may withdraw money from their accounts for any reason without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings. A recent GAO study confirmed that HSAs primarily benefit high-income individuals.ⁱ

SKIN IN THE GAME: THE POWER OF AN IDEA

Proponents of HDHPs mean well: their hope is that with more 'skin in the game,' HDHP enrollees will be motivated to shop for value and take better care of their health. Expectations have been raised even higher by a recent study of the effectiveness of Indiana's dramatic shift to HDHPs by Mercer, an independent actuarial firm. Indiana introduced HDHPs in 2006: today HDHPs are the dominant form of coverage for state of Indiana employees. Mercer reported significant savings (10.7%) to the state as a result of the shift to HDHP and found *no* evidence that enrollees are avoiding care. However, the Mercer study runs counter to most of the academic research about the impact of HDHPs on utilization of medically necessary care. Further, it's not clear how much faith one can have in a study that links improvement in the overall health status of Indiana residents to the use of HDHPs in state government.ⁱⁱ The problem with Mercer and Indiana is their all-or-nothing approach to HDHPs. HDHPs are simply

not appropriate for everyone. Further, by separating the young and healthy from older and sicker employees into different plans, we interfere with the way insurance handles risk. This could significantly increase costs for older and sicker employees.

However, this is not to say there is no place for HDHPs. We might view consumer-driven health care as a complement or counter-balance to the extremes of managed care.ⁱⁱⁱ When the managed care concept made its own ‘disruptive’ debut in the 1990s there was a similarly vehement reaction. Today, in fact, most Americans are enrolled in PPOs (preferred provider organizations). Yet, from a cost and disease management standpoint, certain elements of the managed care concept had merit. Some managed care ideas are being revived today in the concept of accountable care organizations and medical homes. We might similarly find a place for HDHPs in a more consumer-directed marketplace, but with safeguards in place for low and moderate-income consumers and those with significant health care needs.

BACKGROUND: THE BRIEF & UNDISTINGUISHED HISTORY OF HDHPs IN PEHP

Enrollment in PEHP’s HDHP/HSA option has been sluggish, at only .7%. Fixated on the perceived cost savings that Indiana has experienced, the Cost Containment Workgroup of the Health Reform Task Force would like this number to be much higher: some would like to force *all* state employees into these plans or make such plans the default choice. But why was participation so low? A recent Department of Human Resource Management survey of state employees found that employees were far less likely to understand high-deductible plan choices than standard plans. The same survey found that cost is the top factor in the selection of plans and that most (65%) re-evaluated costs associated with their current plan and stayed with that plan. That most employees stayed with the default traditional plan suggests that employees may be looking at broader cost considerations: not just immediate premium costs but also out-of-pocket costs in the event of illness. If employees are sticking with the traditional plan simply because it is familiar, it is no wonder the CC Workgroup is tempted to force employees into the HDHP. But before they go there, they should consider the faulty assumptions about HDHPs.

FAULTY ASSUMPTION #1: HDHPs ARE GOOD FOR YOUR HEALTH (CORRELATION ≠ CAUSATION)

Much to their credit, the proponents of HDHPs would like to motivate employees to lead healthier lives, but the notion that HDHPs will incentivize positive health behaviors rests on false assumptions. It is true that HDHPs are most attractive to the young and healthy; but just because the young and healthy tend to enroll in these plans, does not mean that the plans themselves improve enrollees’ health. Correlation does not equal causation. Most enrollees in PEHP’s HDHP/HSA are probably doing just fine—but that’s not the point. State leaders contemplating greater use of HDHPs need to weigh the structural implications of policy choices.

FAULTY ASSUMPTION #2: HIGH-DEDUCTIBLE PLANS MINIMIZE ONLY UNNECESSARY CARE

When most of the cost of care is covered by insurance and the employee is responsible for a marginal share of the cost, consumers will use medical services that are not necessary. It is for this reason that most insurance plans today include some amount of cost sharing. HDHPs are designed to reduce unnecessary expense even further for the payer. The champions of HDHPs argue that in a high deductible environment where employees have to cover most of the cost of care until their deductible is met, unnecessary care is significantly reduced. Conversely, credible academic studies show employees neglect important care when they have to fund a larger share of the cost. The much cited RAND Health Insurance Experiment found that greater cost sharing reduced the use of essential and

less essential health care.^{iv} The EBRI (Employee Benefit Research Institute) Consumerism in Health Survey also found that HDHP enrollees were more likely to skimp on needed care.^v These problems are pronounced for consumers earning less than \$50,000 per year.^{vi} HDHPs can certainly be designed to not interfere with preventive care; but if some patients only get preventive care when they seek primary care, then they may miss out on preventive care.

FAULTY ASSUMPTION #3: COST & QUALITY INFORMATION WILL DRIVE MARKET TOWARD VALUE

The promise of HDHP’s to motivate prudent and cost conscious health care decision making rests on both the availability of cost and quality information and consumers’ readiness to use that information. Unfortunately, information about the cost and quality of care is still hard to come by—even in Utah. According to one estimate, just 12-16% of insured adults have information from their health plan on the quality or cost of care.^{vii} Even with access to such information, consumers are not likely to use it to make more prudent decisions about their care.^{viii} Moreover, if it can be useful *at all*, transparency information must be presented in clear and accessible formats.^{ix}

The State’s *All Payer Data Base* is in its infancy; once fully operational, it will determine and publish cost information organized around “episodes of care.” It will be several years before consumer friendly information on high cost episodes are available. Even then, the APD will have limitations. For example, many high cost medical conditions, like premature births, cancers, burns, and congestive heart failure, have no beginning and no end, and thus cannot be considered an episode. Predicting the cost and making it available to patients for these conditions may never be possible. Yet, it is these very conditions that require costly technology and that are most responsible for the continuing increase in costs.

WHERE THE REAL COST CONTAINMENT ACTION IS: HIGH-COST CLAIMS

In both the traditional insurance and HDHP environments we will find consumers who have reached their maximum out of pocket limit due to medical conditions requiring treatment that is generally not discretionary. These consumers cannot have ‘skin in the game,’ because their care is paid in full. For them financial incentives to seek more cost effective care will not matter, because most are in no position to shop for better prices. Realistically, if you have a life threatening illness or medical emergency, cost is not an issue. Cost at that level should be the concern of the insurer or employer.

Member Claims Distribution (PEHP Claims Year Ending 2007)			
Claim Accumulation	Members	Percent	Dollars / Percent
Over \$100,000	185	0.1%	\$ 48,720,000 / 11.2%
\$ 50,000+	434	0.3%	\$ 40,890,000 / 9.4%
\$ 25,000+	1,153	1.0%	\$ 55,680,000 / 12.8%
\$ 10,000-24,999	3,730	2.1%	\$ 77,430,000 / 17.8%
\$ 5,000-9,999	7,660	4.3%	\$ 74,820,000 / 17.2%
\$ 2,501-4,999	10,617	5.9%	\$ 51,765,000 / 11.9%
\$ <2,500	156,275	86.3%	\$ 85,695,000 / 19.7%
Total	180,054	100%	\$ 435,000,000 / 100%

Source: PEHP, 2008.

7.8% of members used 68.4% of claims dollars

MOVING FORWARD: BETTER SOLUTIONS FOR RISING COSTS IN PEHP

The following concerns should be addressed before the state expands the use of HDHPs/HSAs.

- If all employees received funding for an HSA and the state continues to pay for necessary care, would greater use of HDHPs/HSAs increase or decrease the state's cost?
- What would be the *long term* impact on cost if employees neglected medically necessary care because of high deductibles? The Indiana study by Mercer fails to consider long-term costs and cost shifting.
- Should a HDHP be offered before cost and quality information is readily available to enrollees?
- What benefits should be exempt from the deductible and better managed by modifying co-payments?
- How would greater use of HDHPs impact cost for employees who stay in more traditional health plans?

In the meantime, the state should move forward with cost containment initiatives that are proven and appropriately targeted toward high-end claimants.

1. Continue building on wellness initiatives within PEHP to keep employees healthy. Expand disease and care management for employees with chronic conditions.
2. Improve transparency of cost and quality information for PEHP enrollees and teach them how to use this information. Utah's All Payer Database is on track to make cost and quality part of a more competitive environment, but this information needs to be presented to consumers in accessible formats.
3. Keep HDHPs as an option, but prepare to raise the affordability and benefit standards to the federal thresholds.

CONCLUSION

Policymakers' intentions for HDHPs are laudable. They would like these products to motivate employees to take better care of their health, but a powerful concept is not enough to justify a shift towards greater use of HDHPs. HDHP plans may have a positive impact on discretionary or comfort care, but otherwise they miss the mark. With 68% of PEHP claims costs incurred by only 7.8% of plan members, this is where the cost containment strategies need to start. These are the most chronically ill patients and virtually none of their care will be discretionary. PEHP may realize some savings by changing consumer behavior on low cost services, but the risk of higher costs due to delayed care is likely to offset any immediate savings from HDHPs. There are better, more proven ways to manage the cost of coverage for employees *and* to motivate healthy behavior.

ⁱ GAO (April 2008). Health Saving Accounts: Participation Increased and was more common among individuals with higher incomes.

ⁱⁱ Mercer (May, 2010). Consumer-Driven Health Plan Effectiveness Case Study: State of Indiana.

ⁱⁱⁱ James C. Robinson and Paul B. Ginsburg (January 2009). Consumer-Driven Health Care: Promise and Performance. *Health Affairs* Web Exclusive.

^{iv} J.P. Newhouse (November/December 2004). Consumer-Directed Health Plans and the RAND Health Insurance Experiment. *Health Affairs* 21(6): 107-113.

^v Ibid.

^{vi} Employee Benefit Research Institute/EBRI (December 2005). Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings. www.ebri.org.

^{vii} Commonwealth Fund (June 2006). Health Savings Accounts: Why they won't cure what ails U.S. Health Care. Testimony of Sara R. Collins to U.S. House of Representatives Committee on Ways and Means.

^{viii} EBRI (March 2008). Findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey.

^{ix} California Health Care Foundation (2008). Making Health Care Costs More Transparent to Consumers: A Summary for Policymakers. <http://www.chcf.org/~media/Files/PDF/M/MakingCareCostsTransparent.pdf>