

# Health Insurance Partnership Board

## Impact of Consumer-Directed Health Plans on the Quality of Health Care Services for Low-income Families

September 9, 2008

### Introduction

At the Health Insurance Partnership meeting on June 18, 2008, members of the Board requested information on the impact of high-deductible health plans upon the health status of low-income enrollees. When researching the request, Health Care Authority staff ran into two obstacles:

1. Research, since the arrival of Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA), often does not focus solely upon high-deductible health plans. Current articles report on Consumer-Directed Health Plans (CDHPs), which are defined as a high-deductible health plan associated with a HRA or HSA.
2. Staff did not find research on the impact of CDHPs upon the health status of enrollees.

Current research does provide indicators on how CDHPs impact the quality of care, and those indicators are summarized for the Board. To remain within the spirit of the Board's request, the summary focuses, whenever possible, upon the quality of care received by low-income CDHP enrollees.

### Indicators of declining quality of care under CDHPs

Consistent with the RAND Health Insurance Experiment, enrollees avoid *necessary* care when cost sharing increases under CDHPs, with low-income enrollees avoiding more care.

According to a national survey on consumerism in health care, CDHP enrollees with health problems or income under \$50,000 report particularly high rates of avoiding care. Among enrollees with health problems, 40% of CDHP and 21% of comprehensive plan enrollees avoid getting medical care due to cost. Among enrollees with income under \$50,000, 48% of CDHP and 26% of comprehensive plan enrollees avoid medical care due to cost. (Employee Benefit Research Institute, December 2005.)

Modeling of national data by the Commonwealth Fund estimated that twice as many low-income enrollees will have cost-related utilization problems compared to those with higher incomes. Enrollees with incomes under \$35,000 and with deductibles of \$500 or more do not fill prescriptions, receive needed specialist care, visit a doctor when they have a medical problem, or receive recommended tests – all at a

significantly higher rate than enrollees with income above \$35,000.<sup>1</sup> (Davis, Commonwealth Fund, No. 816.)

A study of a large Midwest manufacturing employer tracked the initial two years of CDHP enrollment. The employer offered a higher-deductible and a lower-deductible CDHP along with a preferred provider organization plan (PPO). In the first year, all CDHP enrollees drew upon similar risky cost-saving behaviors such as postponing or delaying services and taking smaller dosages of prescription drugs at a greater rate than PPO enrollees. Second-year enrollment revealed differences between the CDHPs: the higher-deductible enrollees continued their risky cost-saving behaviors at a significantly higher rate than the lower-deductible enrollees. Also, health care utilization by lower-deductible enrollees at all income levels rebounded to a level under that of the PPO but above the higher-deductible CDHP. (Dixon, 2008.)

Another paper published on the same Midwest employer categorized visits as low and high priority, and then focused on the utilization of these visits by low-income hourly workers and high-income salaried workers. After transferring to a CDHP, hourly workers reduced both high and low priority visits significantly more than salaried workers. (Hibbard, 2008.)

A third study on the same employer focused on prescription drug utilization. CDHP enrollees with chronic illnesses were more likely to discontinue taking medications that lower blood pressure or cholesterol than PPO enrollees. However, hourly workers did not discontinue their medications at a greater proportion than high-income salaried workers. (Greene, 2008.)

CDHP literature suggests confusion over what benefits are covered under a CDHP as one reason enrollees use less preventive and primary care. Initially, enrollees with higher incomes, and more education, have been drawn to CDHP coverage. That is not to suggest, however, that they are better able to navigate the health care system or understand their benefits any better than lower-income CDHP enrollees. Studies report a lack of useful decision-support tools and equal confusion about the potential cost and effectiveness of treatment options among all CDHP enrollees. (Lee, 2005.)

Another study used a simulation to compare a traditional comprehensive benefit design, offered through a PPO and a Health Maintenance Organization, to a “first generation” CDHP with a \$1000 HRA. The author found that “slightly” and “moderately” sick enrollees were bigger financial losers under the CDHPs than “very sick” enrollees. “Slightly” or “moderately sick” enrollees consumed health care expenditures within the 64<sup>th</sup> —95<sup>th</sup> percentile.<sup>2</sup> In *Reinsuring Health*, enrollees within that range of expenditures are commonly thought to be successfully managing one or more chronic illnesses. Low-income families make up a greater proportion of

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<sup>1</sup> This is likely the only publication in our summary where the authors could have combined the results of enrollees in high-deductible health plans not associated with an HRA or HSA with enrollees in CDHPs associated with a HRA. It is not likely that any enrollees in the analysis had HSAs because the survey was conducted in 2003, the year federal legislation authorized HSAs.

<sup>2</sup> To get a sense of the dollars that equate to these percentiles, Swartz reports in *Reinsuring Health* that people above the 50<sup>th</sup> percentile all spent more than \$500 in a year, and that people above the 90<sup>th</sup> percentile spent more than \$10,000 in a year.

unhealthy Washingtonians.<sup>3</sup> Consequently, CDHPs have the potential to place them at greater health and financial risk. (McNeill, 2004.)

### **Indicators of improvements in quality of care under CDHPs**

Also, consistent with the RAND Health Insurance Experiment, enrollees of all income levels avoid *unnecessary* care. In some cases, utilization of preventive and chronic illness care improved under CDHPs.

The previously mentioned study of a large Midwest employer observed an interesting result for second-year enrollees of the lower-deductible CDHP: they retained their reduced levels of low-priority acute visits (e.g., sore throat, acute non-specific upper respiratory infections) from the first year of enrollment and they used more high-priority chronic care visits than the employer's PPO enrollees. (Hibbard, 2008.)

In a study of this Midwest employer's utilization of prescription drugs, the authors found that enrollees in the lower-deductible CDHP were significantly more likely to use generics than the enrollees in the higher-deductible CDHP or the PPO. It is worth noting that the rate of generic drug utilization increased in the CDHP even though the rate of generic drug utilization was already high for this employer before introduction of the CDHPs. (Dixon, 2008.)

In a study of employers who offer only CDHPs, McKinsey & Company reported that enrollees often avoided "not very serious" care and they were more likely to follow their treatment regimens for chronic illnesses under the CDHP versus their previous traditional plans. (Agrawal, 2005.)

In a review of CDHP literature, several studies reported increases in preventive care services after enrollees switched to CDHP plans. (Buntin, 2006.)

In a review of CDHPs offered by large employers, Mercer reports that while utilization of primary care, emergency room visits, and admissions decreased, access to specialists did increase for some plans and preventive care consistently increased. (Mercer Health & Benefits, 2006.)

A study of enrollees covered for three continuous years in a large employer's CDHP found no difference in the use of cancer screening and diabetes-specific preventive services compared to the employer's PPO enrollees. (Rowe, 2008.)

Organizations that offer CDHPs and closely monitor quality of care do not report any adverse utilization trends. (Lee, 2005.)

Respondents to a Harris poll supported the results of case studies by reporting that CDHP enrollees were more likely than other privately insured enrollees to:

- Forgo filling a prescription because of cost;
- Skip preventive services; or
- Report a health problem because of avoiding a physician visit.

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<sup>3</sup> The Washington State Planning Grant reports that people under 200% of the federal poverty level are much more likely to report a health status of fair or poor.

The author, however, commented that these survey results do not necessarily mean that CDHP enrollees receive worse care. The responses of CDHP enrollees about their care could be biased because they also report much less satisfaction with their out-of-pocket costs. The author cautioned against reaching an early conclusion about the impact of CDHPs upon enrollees' health. (Lee, 2005.)

A study of the University of Minnesota's original CDHP found no difference in CDHP enrollee satisfaction across income levels. (Christianson, 2004.)

Some HSA-eligible plans have confirmed that HSAs are opened and funded for low-income enrollees. United Health Group found that 80% of its policyholders making \$25,000 or less who were eligible for an HSA opened one. Of those, 80% carried over an average of \$761 in their HSA from 2005 to 2006. (Hogberg, 2007.)

For high-expenditure enrollees, tax advantages coupled with the lower premiums and higher cost-sharing of CDHPs can lead to similar total costs as a comprehensive PPO. The cost of coverage and health care services presented by one paper suggest the possibility of the following scenario: Low-income enrollees who treat their chronic illnesses with regular health care services could find coverage under a CDHP, with a funded HRA or HSA, a better value than a comprehensive preferred provider organization. (Baicker, 2007.)

The percentage increase in premiums in 2005 and 2006 were below 3% for HDHPs associated with HSAs or HRAs. All other plan types (PPO, HMO, etc.) had percentage premium increases over 6% each year. (Cannon, 2006.)

The experiences of some employers suggest that CDHPs could be designed to appeal to enrollees of all income levels, and play a part in encouraging appropriate utilization and reducing total expenditures.

- An employer who attracted a broad base of employees to a CDHP experienced average claims cost of 94% compared to the cost of all enrollees.
- Another employer fully replaced its benefit package with a CDHP associated with an HRA, and observed a 1.9% decrease in utilization.
- A third employer divided members into four salary ranges and matched lower deductibles with lower pay. (Mercer Health & Benefits, 2006.)

## **Concerns and possibilities**

Although decision-support tools were supposed to help CDHP enrollees make clinical decisions, they were highly criticized as ineffective by all authors who commented on them. However, the development of quality measures, patient decision aids, and decision-support tools is progressing in Washington and should offer assistance to consumers in the future.

For CDHPs to be effective, workers must consistently establish HSAs and workers and employers must fund them. Industry officials estimate that 50 to 60 percent of enrollees in HSA-eligible plans do not establish *and* contribute to an account (Government Accountability Office, 2006). According to a Kaiser survey, 45% of workers in 2007 with single HSA-eligible coverage did not receive an employer contribution to their

HSA. Kaiser also reports that the interest among small employers to offer HSA-eligible plans is as strong as the interest demonstrated by larger employers. If deductibles continue to climb, so will the need to fund HSAs.

In an analysis of the “Freshman Class” of CDHPs, Meredith Rosenthal observed that cost-sharing in these plans was not adjusted for low-income enrollees. However, an amendment to the IRS Code, effective in 2007, allows employers to make additional contributions to HSAs for lower-income employees. It is too early to estimate the impact of this amendment.

## **Case Studies**

The utilization results and comparisons shared in this summary were often reported in case studies. Typically, the case study involved a large employer’s initial offering of a CDHP, associated with either an HRA or HSA, along with the employer’s traditional comprehensive plan. Decision-support tools were usually made available to enrollees or upgraded to coincide with the introduction of the CDHP. The studies controlled for the characteristics of the enrollees in each plan, and compared utilization between multiple CDHPs, when offered, and between a CDHP and the comprehensive plan. The studies usually reported results over the initial two or three years of CDHP enrollment.

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