High-Deductible Health Plans: Quality and Cost Issues with Increasing "Skin in the Game"

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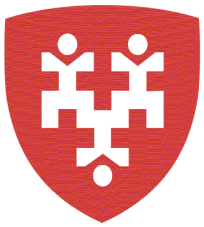

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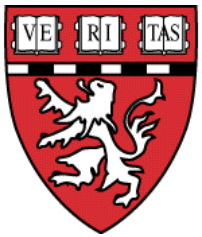
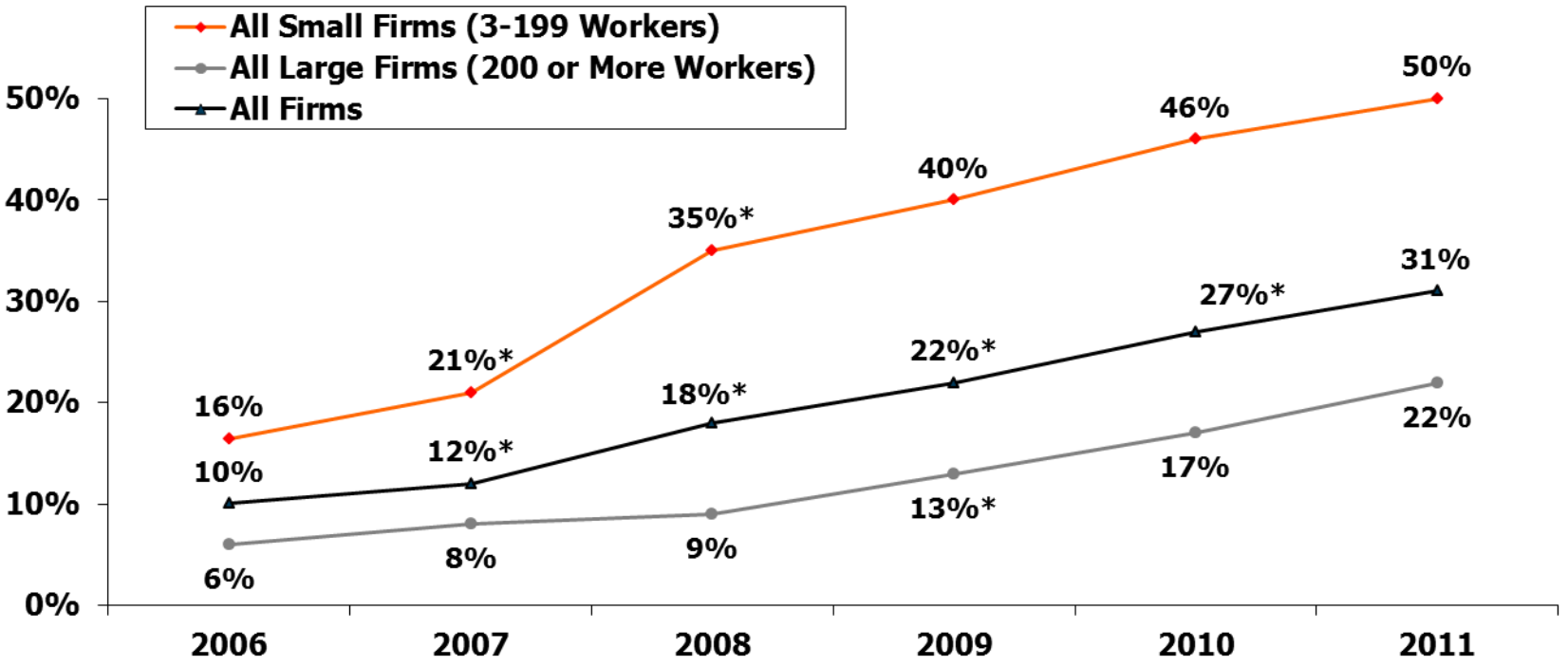


Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2011



* Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2011.

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Populations affected by high-deductible health plans (HDHPs)

- Employees
  - with or without a choice of other plans
  - with or without HSAs/HRAs
- Non-group market
  - Health Insurance Exchange enrollees
- Those with chronic conditions
- Less impact on Medicaid enrollees

Important issues going forward

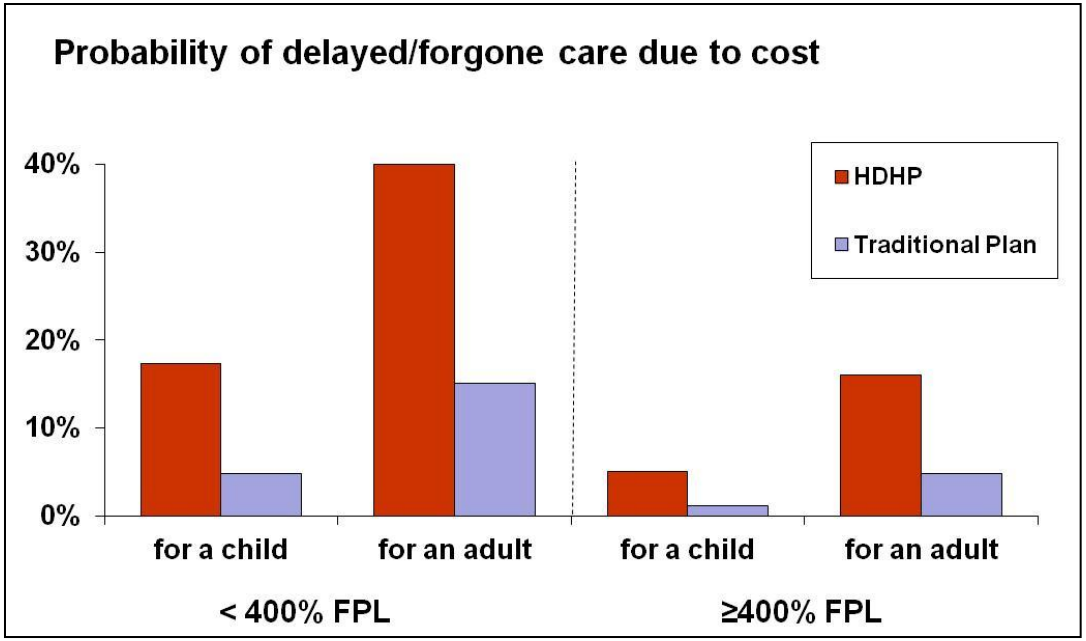
★Preserving use of needed care

★Financial burden

- Understanding benefits
- Cost transparency
- Distinguishing high vs. low value care

Preserving use of needed care

- Families with chronic conditions in HDHPs are more likely to delay/forgo care due to cost



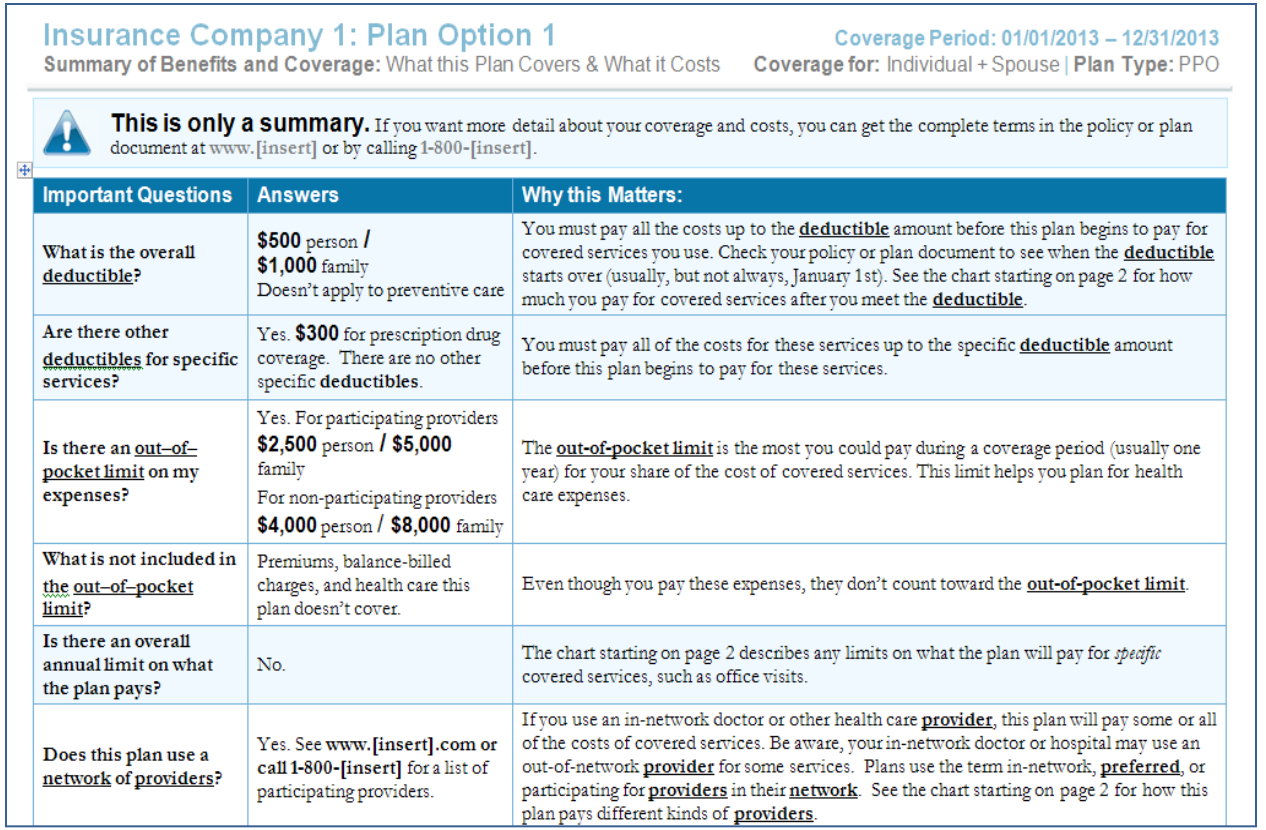
- Preventive services underused when subject to deductible
  - the converse is not always true
- ACA prohibits cost-sharing for preventive services
- Value-based insurance design could be a solution

Financial burden

- More than a quarter of HDHP enrollees spend >5% of income on out-of-pocket costs
- Almost half of families with chronic conditions in HDHPs experience financial burden
- Lower income families at greater risk
  - ACA cost-sharing subsidies may mitigate burden

Understanding benefits

- Enrollees can't use HDHPs wisely if they don't understand how they work
- Confusion over what is subject to the deductible
- Standardizing benefits information may help
  - in Exchanges
  - in ACA-mandated Summaries of Benefits and Coverage →



Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com** or call **1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Cost transparency

- HDHP enrollees can’t be good consumers without price data
- Need better tools to prospectively obtain relevant cost information
- Providers often unable to provide cost data
- Potential role for APCD

Distinguishing high vs. low value care

- Enrollees not always able to differentiate essential and non-essential care
- Input from providers is key, but discussion about costs and value is limited
- Efforts like the “Choosing Wisely” campaign could help patients avoid burdensome low-value care

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