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Tension Between High-Deductible Health Plans And Payment And Delivery Reform

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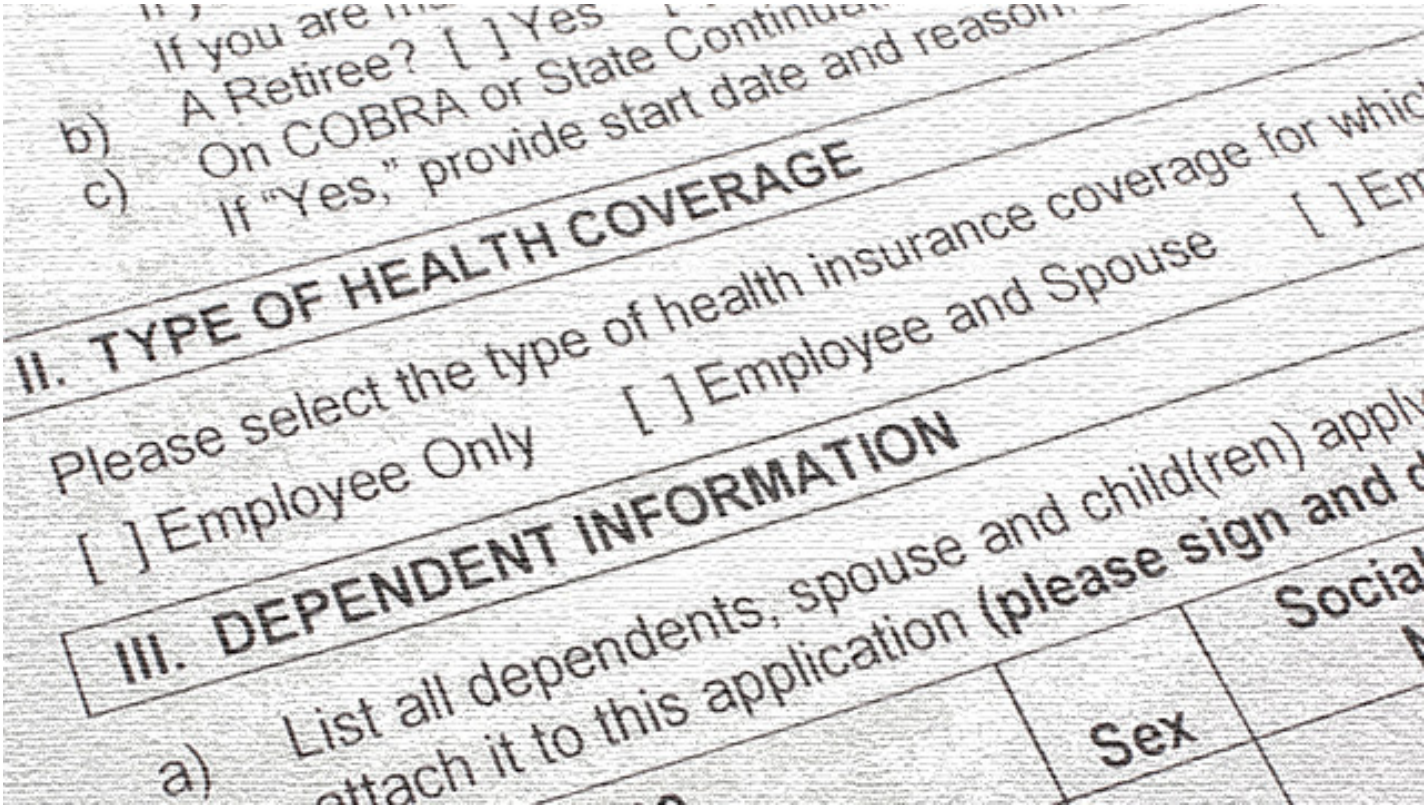

As health care costs rise, health insurance premiums quickly follow suit. This mounting cost burden affects both employers and employees, as a growing portion of each company's bottom line and employee income goes to health care. Health care stakeholders have been looking to high-value strategies and solutions to address this problem. These include putting providers at financial risk for their patients' care and adjusting benefit designs to encourage consumers to seek the care they need, but not the care they don't.

High-Deductible Health Plans Are Picking Up Steam

One of the strategies that employers have turned to is high-deductible health plans (HDHPs). These plans are a quick solution for employers and employees who are heavily impacted by rising health insurance premiums. Instead of high monthly premiums, individuals make a monthly payment that averages just below $100 per month. Enrollees are then required to pay the full cost of health care services, excluding select primary preventive services, up to the amount of their deductible. The Internal Revenue Service rules for 2018 require that the deductible be at least $1,350 for individuals, with maximum out-of-pocket expenses not to exceed $6,650, and at least $2,700 for families, with maximum out-of-pocket expenses not to exceed $13,300.

Right off the bat, employers have seen these plans lead to savings. One firm that switched from a preferred provider organization to offering only a HDHP saw a reduction of between 11.79 percent and 13.80 percent in firmwide health care spending. This may be why 61 percent of large employers offer a HDHP, and about 9 percent offer it as their only plan option. The evidence thus far shows that consumers decrease their use of health care services under HDHPs. However, this reduction includes both care that is potentially wasteful and care that may be valuable to the consumer.

As HDHPs are growing, employers and health plans have made a push toward population-based reforms, which require providers to take on financial risk for their patients' care. And from what we know, providers are not willing to assume financial risk for a patient population unless they are set up to manage and coordinate care, including primary and secondary preventive care that keeps their patients out of the hospital.

We're On A Collision Course

As Elliott Fisher and Peter Lee so accurately pointed out almost two years ago, reforms on the consumer side and the provider side are on a collision course.

Imagine this: A primary care physician in a shared risk arrangement tells her patient with diabetes to get an eye exam. The patient chooses not to get the exam because his high-deductible health plan requires him to pay the full amount out of pocket. Later on, this same patient experiences blurriness and dark areas of vision---diabetic retinopathy---that could have been prevented through careful care management. But now his eye disease is so advanced that he needs surgery. In this case, the primary care physician gets

penalized because the costs associated with this patient and others like him put her above the target budget, even though she advises her diabetic patients to get their eyes checked.

It is critical that payment reforms and benefit designs be considered in tandem, especially if health care stakeholders are going to implement high-value strategies that incentivize both providers and consumers to cut waste and drive toward better outcomes.

Evolution Of High-Deductible Health Plans

Some have suggested that HDHPs can adopt a more flexible design to encourage consumers to seek certain high-value, clinically indicated health care services.

By emulating the structure of value-based insurance design, which reduces financial barriers to clinically beneficial services, some of the flaws of HDHPs could be mitigated. Alternatively, new designs, such as the Altarum Institute Center for Payment Innovation's Medical Episode Spending Account, can turn HDHP incentives on their head to promote appropriate care-seeking behavior for those with certain chronic conditions. Some employers have even created designs that exempt a broader pool of primary care services from the deductible. Putting providers at financial risk for these patients' care could help ensure that these patients get the care they need to manage their conditions.

Under current law, HDHPs with health savings accounts are not amenable to some of these changes, but employers offering HDHPs with health reimbursement accounts have greater flexibility to implement such adaptations.

Alignment Is Critical

Assuming many employers continue on the HDHP path, how do providers caring for their populations want to be paid? They may be more interested in payment models that operate on a budget, such as capitation or bundled payment.

Providers might also want to see further evolution of HDHP incentives, such as those mentioned above. HDHPs create incentives for consumers to be cost conscious about their care, helping the provider stay within budget. But more attention to which services should be exempt from the deductible might also help. What about that diabetes patient who skipped his eye exam? Perhaps if that exam were no longer subject to the

deductible, the patient might schedule it and avoid surgery, improving his health outcomes and decreasing long-term costs to the provider.

In circumstances in which employers pursue population-health strategies instead, how might providers want to be paid? Providers may be less inclined to assume financial risk if patients are free to seek care from whomever and do not have strong incentives to use only the health care services that they need. If employers want providers to assume financial risk for their populations, providers will likely look, in turn, for employers to establish benefit designs that steer patients their way, such as a narrow network. In this set up, providers have more control over care management, coordination, and referrals because their patients have a more limited choice of providers.

Conclusion

Current reforms won't reach their potential unless we find a way to pair these payment and benefit design strategies well. This means managing the trend toward enrollment in HDHPs and the increasing tendency of providers to assume greater financial risk for patient care. We all need to do some careful thinking on the alignment of the reforms on the consumer side with those on the provider side. Otherwise, as Fisher and Lee warn, we are on a collision course!