

## THE PAYERS' PLAYBOOK

# HDHPs: Cost Shift but No Swing to High-Value Care

Employers and health insurers are asking consumers to put 'more skin in the game' with high-deductible health plans but don't provide incentives for them to choose high-value care.

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Since 2005, when only a million Americans were enrolled in high-deductible health plans (HDHPs) with a health savings account (HSA), the number of Americans enrolling in these plans has grown steadily. Last year, some 21.4 million to 34.7 million Americans were enrolled in what's called an HSA-eligible HDHP, according to a recent analysis from the Employee Benefit Research Institute. In examining why growth in these plans stalled last year, the report said employers could be concerned that workers and family members in HSA-eligible plans are not getting appropriate preventive care and adhering to physicians' medication recommendations, among other factors. Despite these concerns, a high deductible of at least \$1,300 for individuals and \$2,600 for families has become a common feature of American health insurance.

The strong enrollment in HDHPs has been good for insurers because the plans shift more costs to plan members, boosting profits and surpluses for the insurers and putting some downward pressure on premium increases. Some Americans find HDHPs appealing because of the lower premiums, even if they wind up paying higher out-of-pocket costs for health care services. High deductible plans are also attractive because they are often associated with health savings accounts that members can fund with pretax dollars and roll over from year to year.

## High cost and low value

But if one of the goals of HDHPs and individuals having "more skin in the game" is to encourage plan members to use their health care dollars for higher value care, HDHPs seem to be falling well short of the mark.

Research published last year in the *American Journal of Managed Care* showed that switching to a consumer-directed health plan—an HDHP paired with a health savings account—did, in

fact, result in lower outpatient spending. But the researchers, led by Neeraj Sood, vice dean and professor at USC's Price School of Public Policy at the University of Southern California, found no change in spending on 26 commonly used, low-value services.

Sood and his colleagues defined low-value care as medical tests and procedures that provide unclear or no clinical benefit and yet still expose patients to risk and costs, such as an MRI for uncomplicated headache or spinal injection for low-back pain. They defined high-value care as preventive efforts or services or medications for patients with chronic conditions, such as drugs for diabetes or hypertension.

The study also showed that hopes pinned on price transparency may be misguided. "Price transparency does not consistently result in patient price shopping, even for those in CDHPs," wrote the researchers.

### **Bigger role for physicians**

While this is just one study, there is other evidence of a disconnect between HDHPs and high-value care. But employers and health insurers show no signs of giving up on high-deductible coverage any time soon. And many Americans, seeking relief from high premiums, leap at the chance of paying a lower one.

So what is the best way to foster the use of high-value services? Sood and colleagues suggest two approaches: value-based insurance design (VBID) and incentives for physicians and other providers to steer patients toward high-quality care. An example of the latter would be the Alternative Quality Contract that Blue Cross Blue Shield of Massachusetts uses to steer patients toward lower-priced services while maintaining a focus on quality.

Pay members to do what's best, says Neeraj Sood of the University of Southern California. "If you give a little of the carrot and that changes behavior by a lot, both the plan and its members would be happy because plans would be sharing cost savings with members."

More research is needed, though, to understand how physicians can persuade patients to choose high-value care. Sood told me it's reasonable to assume that patients don't know the difference between high-value and low-value care. Physicians are in a much better position to recognize such distinctions. "That's why you need either the doctor to have the financial incentive to steer the patient toward high-value care or you need managed care plans to add higher cost sharing for low-value care," he says.

One way to do so is with reference pricing, in which an employer or health plan offers to pay a set—or reference—price for certain tests or procedures, such as a knee replacement. Workers and plan members can go to any provider, but the employer or plan would pay only the reference price. This method of payment has been slow to catch on even though evidence has shown it to be effective at steering patients to high-value care. In an article in *Health Affairs* last year, James Robinson of the University of California–Berkeley and his colleagues used savings realized in a CalPERS program to estimate how much reference pricing might save if it were extended to all Americans in commercial insurance plans. The extrapolations ranged from \$340 million for cataract surgery to \$7.59 billion for lab tests, with the total savings coming to about \$20 billion.

How much money could reference pricing save?	
	Potential savings (in billions)
Joint replacement	\$3.38
Cataract removal	\$0.34
Colonoscopy	\$2.39
Laboratory tests	\$7.59
CT scans	\$2.14
MRI procedures	\$2.09

Source: Robinson JC et al., *Health Affairs*, March 2017

Another way to nudge people into using high-value care is to offer financial rewards to patients who choose high-quality, low-cost providers. In such “smart shopper” programs, health plans write checks to members who buy based on low price and high quality. From 2010 through 2014, Anthem Blue Cross and Blue Shield in New Hampshire reported a return of \$3 for every \$1 it invested in its SmartShopper program.

Clinically nuanced benefit design

A. Mark Fendrick, MD, director of the University of Michigan VBID Center, describes VBID as a clinically nuanced approach to paying for high-value care. Instead of plans putting low copayments on low-cost services and high out-of-pocket costs on expensive care, VBID aims to reduce the financial barriers to services that improve health and discourage the use of care that does not make anyone healthier. VBID eliminates or lowers patient costs for preventive care and treatments such as blood pressure medication.

“The main problem with high deductibles is that they are blunt instruments that discourage the use of both high- and low-value care,” says A. Mark Fendrick, MD, of the University of Michigan VBID Center.

“The main problem with high deductibles is that they are blunt instruments that discourage the use of both high- and low-value care,” Fendrick told me. “Our effort to change an IRS rule to allow HDHPs to cover more high-value services on a predeductible basis would significantly reduce the cost burden on patients with the greatest need.”

For Fendrick, some of the best examples of high-value health services are those he recommends for his patients, such as clinically indicated referrals to other physicians, or guideline-driven diagnostic tests and medications for patients with chronic conditions. “These are the services I beg my patients to take,” he says.

For physicians, incorporating VBID principles into HDHPs and related plans would increase patient adherence to doctors’ recommendations and thus could help them optimize their incentive payments under quality driven, alternative-payment models, he adds.

An internist and professor of health management and policy, Fendrick would prefer if his patients didn’t have financial barriers to high-value care. “In many HDHPs, I find it very frustrating that some of the services on which I’m benchmarked—for example, the rate my patients with diabetes receive eye exams—cannot be covered on a predeductible basis,” he comments.

Last year, the Trump administration expanded a Medicare Advantage VBID demonstration project to all 50 states starting in 2020. That’s a step in the right direction, but more needs to be done because health plans seeking to use VBID more widely face a significant and arcane hurdle, says Fendrick.

Under guidance the Internal Revenue Service issued in 2004, HDHPs are prohibited from offering predeductible coverage of services to treat an “existing injury, illness, or condition.” (The IRS is involved because of the tax advantages of the health savings accounts and related issues.) The result of this guidance is that patients with chronic conditions such as diabetes and some mental health problems need to pay their full annual deductible first.

The IRS guidance seems crazy when you consider this unintended consequence: Health plans are prohibited from offering predeductible coverage for medication-assisted treatment and naloxone at a low out-of-pocket cost for patients with opioid-use disorder, Fendrick says. Despite the Surgeon General’s call for unfettered access to naloxone, at-risk patients would need to meet their annual deductible before their insurance would cover these costs. Fendrick hopes Congress will pass the Chronic Disease Management Act this year. Both the House and Senate versions of the bill would allow these plans to cover chronic disease services on a predeductible basis, just as they do for preventive care, Fendrick says.

## Carrot or stick?

In Sood's view, health plans need to decide which approach will lead to the maximum change in behavior at the lowest cost. "And it's not just cost but you want to make your health plan attractive too," he adds. He recommends the carrot over the stick, meaning paying members to do what's best rather than penalizing them. "If you give a little of the carrot and that changes behavior by a lot, both the plan and its members would be happy because plans would be sharing cost savings with members," he says.

"Members who get a financial reward for choosing a low-cost provider may say, 'I love this plan!'" he says. The other approach may be less attractive. "If members get no reward for choosing low-cost providers, and get charged more for using high-cost physicians, they may ask, 'What's the point of this insurance?'"