National Alliance of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

Action Brief

RETHINKING HEALTHCARE CONSUMERISM STRATEGIES IN LIGHT OF EMERGING EVIDENCE

Consumer-directed health plans shown to reduce healthcare spending, but reductions may reduce use of needed health care services and productivity.

5 STRATEGIES TO MITIGATE ADVERSE EFFECTS OF CDHPS

1. Provide employer contributions to an HSA, especially for lower-wage workers
2. Establish wage-based benefit design
3. Reinforce how CDHPs and HSAs work and the value of preventive care
4. Provide more resources to help employees manage their healthcare decisions (e.g. advocacy, telemedicine) along with traditional CDHP transparency and other tools)
5. Implement value-based benefit designs

Employers have long sought ways to keep healthcare cost in check by offering employee benefits robust enough to attract new talent while retaining their current workforce. Over the past decade, there has been a popular and growing trend toward high deductible health plans and specifically consumer-directed health plans (CDHPs). In 2016, PwC estimated that 72% of employers offered a high deductible health plan (HDHP) to their employees, and 90% of those employers offered an HDHP compatible with a health savings account (HSA). In addition, PwC found that 25% of employers surveyed had adopted an HDHP on a total replacement basis, and 39% of employers were considering total replacement HDHPs within three years.

One feature that makes these plans attractive is the incentive for patients to engage more effectively in their healthcare choices. And research has shown that these plans help mitigate healthcare costs, at least initially. In 2015, Truven Health Analytics estimated that "CDHP members experienced consistently lower healthcare costs—ranging from $457 to $532 per member per year lower on an allowed basis over a three-year study." They also indicated that "lower claim costs resulted primarily from lower utilization rates" and that "CDHP members were less likely to receive care for their chronic conditions."

Additional studies cited below show that the reductions in utilization may not be limited to discretionary care—especially for employees at lower income levels. Employees in these plans may be more prone to avoid care for necessary services resulting in prolonged and more serious illness as well as lost productivity. This action brief highlights the results of those studies and suggests five strategies to mitigate some of the emerging concerns.

EMERGING EVIDENCE ON POTENTIAL CONCERNS

We have known for years that when patients have more cost-sharing, they will likely use less care. In the 1980s, Rand's Health Insurance Experiment[1] found cost sharing reduced the use of both effective and less effective care across the board. More recently, in its research into 68 peer-reviewed studies,

the Integrated Benefits Institute (IBI) found that those enrolled in CDHPs can cut back on care indiscriminately, both unnecessary care as well as potentially beneficial and necessary care. They also found that employees are more likely to avoid screenings and preventive care as well as forgo or delay prescriptions which can have downstream impacts on healthcare costs and productivity. Per Tom Parry, past President of IBI, "while employers have shifted health care costs to workers, they cannot shift the cost of lost productivity due to illness."

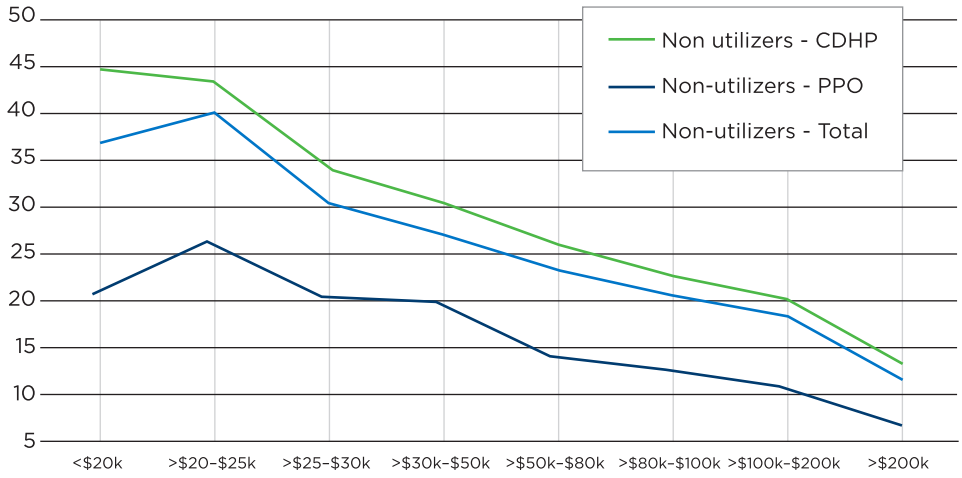
The Employee Benefit Research Institute (EBRI) has also studied the effect of CDHPs and found a decline in non-preventive outpatient physician-office visits among employees at all income levels. In one study, EBRI found a particularly strong decline in such visits for those whose income was less than $50,000 annually and an across-the-board decline in the rate of prescription drug fills regardless of worker income.[2] Surprisingly, employees even reduced their use of various preventive services (i.e. annual flu vaccines). Again, those with lower salaries were even more likely not to get these services. The same pattern was seen in the use of physician office visits for preventive care, even though such care has been covered in full under the ACA. This is also a concern since lower-income workers enrolled in CDHPs with HSAs also had more emergency department visits and inpatient hospital admissions than those at higher income levels.

The EBRI issue brief also found that an employer cut health costs by 25% in the first year after implementing a CDHP approach. Per the study, per-person spending was lower by $527 in year one but had diminished to $132 by year four. Because of this change, they caution against using only one year of results as an indicator for similar savings in subsequent years.

Bruce W. Sherman, who serves as the Medical Director for the Employer's Health Coalition and leads population health management at Conduent HR Services, recommends that employers

One report showed a strong decline in preventive-health visits for those whose income was less than $50,000 annually and an across-the-board decline in the rate of prescription drug fills regardless of worker income.

Percentage of Enrollees Not Filing Medical or Pharmacy Claims by Wage Band



POTENTIAL CONCERNS WITH CDHP

- Indiscriminate cutbacks in care
- Avoided screenings/ preventive care
- Forgone/delayed prescriptions
- Management of chronic conditions
- Indirect productivity costs

focus on the healthcare needs of low-wage workers. Data from the Social Security Administration show that 51% take home less than $30,000 annually. Benefit design plans do not typically reflect the needs of low-wage workers, who spend a great proportion of their earnings on healthcare. This was reinforced by research on high deductible plans conducted by Buck Consultants (a division of Xerox) that found that as wages declined, emergency room visits and avoidable hospitalizations increased (see graph to right). Also, medications for chronic conditions and participation in screening programs decreased significantly.

TAKING POSITIVE STEPS

"Currently, only about 1% of U.S. employers have built wage-based premiums or deductibles into their benefit design," said Sherman. Such programs subsidize care costs for lower-wage employees to reduce financial barriers to those seeking appropriate care, as noted in this article published in *Health Affairs* by Sherman and colleagues, "Health Care Use And Spending Patterns Vary By Wage Level In Employer-Sponsored Plans."[3] He also recommends that deductibles could be eliminated for certain evidence-based care for low-wage workers with chronic conditions. Too often, low-wage workers have other, more pressing concerns than their own health, Sherman said, and so have less interest in how CDHPs and HSAs work.

Paul Fronstin of EBRI has suggested that employees need to be engaged throughout the year if they are to understand how to use HDHPs and HSAs. More aggressive strategies involved implementing advocacy and support programs to engage and educate individuals when they are making specific healthcare decisions. These services can also consider the unique circumstances and concerns of the individual to help them navigate the healthcare system appropriately.

Value-based benefit designs may also be warranted to support those workers who have chronic conditions. For example, employees with diabetes could be offered coverage for supplies with no deductible or copayment to reinforce the need to take the critical steps to maintain their health and keep their conditions under control. Other strategies might include increasing HSA contributions for lower-wage workers and educating them about the value of preventive care and health maintenance.

To keep employees engaged in their healthcare, organizations must take the time to evaluate their current approaches and determine the value employees are receiving from their health benefit offerings. We encourage employers to make appropriate changes that empower employees to better manage their health. Many of the strategies offered in this brief can help employers reduce their healthcare spend, minimize the adverse effects of high deductibles and maximize the health and productivity of their workforce.

When implementing CDHPs, employers should focus on the health care needs of low-wage workers who spend a great proportion of their earnings on health care. Research shows this population may be less engaged in their health because other priorities are more pressing.

ARTICLES AND REPORTS CITED IN THIS ISSUE BRIEF

1 The Health Insurance Experiment. Brook RH, Keeler EB, Lohr KN, Newhouse JP, Ware JE, Rogers WH, Davies AR, Sherbourne CD, Goldberg GA, Camp P, Kamberg C, Leibowitz A, Keesey J, Reboussin D. The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. Santa Monica, CA: RAND Corporation, 2006.

2 Quality of Health Care After Adopting a Full-Replacement, High-Deductible Health Plan With a Health Savings Account: A Five-Year Study. Fronstin P, Roebuck MC. Employee Benefit Research Institute. EBRI Issue Brief, no. 404, September 2014.

3 Health Care Use and Spending Patterns Vary by Wage Level in Employer-Sponsored Plans. Sherman BW, Gibson TB, Lynch WD, Addy C. Health Affairs. 2017 Feb 1;36(2):250-257. doi: 10.1377/hlthaff.2016.1147.

Research from Buck Consultants showed that workers with high deductible health plans showed that as wages declined, emergency room visits and avoidable hospitalizations increased and medications for chronic conditions and participation in screening programs decreased.

RESOURCES FOR MORE INFORMATION

Health Policy Brief: High Deductible Health Plans. *Health Affairs*. This policy brief defines CDHPs as a subset of HDHPs, saying CDHPs are paired with HRAs or HSAs.

High Deductible Health Plan (HDHP). Glossary at HealthCare.Gov says HDHPs can be paired with HSAs.

Health Savings Account (HSA). Glossary at HealthCare.Gov defines HSAs as a type of savings account that allows individuals to set aside money on a pre-tax basis to pay for qualified medical expenses and explains that an HSA can be used only if the individual has an HDHP.

Health Reimbursement Arrangement (HRA). The U.S. Office of Personnel Management explains that for those who have an HDHP and who are ineligible for an HSA will get an HRA. OPM also describes the benefits of an HRA.

IRS Publications on HSAs and HRAs. This page also includes descriptions of medical savings accounts and flexible spending accounts.

Mercer Survey: Health Benefit Cost Growth Slows to 2.4% in 2016 as Enrollment in High-Deductible Plans Climbs. For this national survey, 2,544 public and private employers with at least 10 employees responded.

Value-Based Benefit Design: A Purchaser Guide. Published by the National Alliance for Healthcare Purchaser Coalitions (NBCH) in 2009, the guide gives an overview of value-based benefit design (VBBD), describes the business case for VBBD, outlines what to consider when adopting a VBBD, explains the implementation steps, describes the barriers that can impede implementation, and discusses how VBBD may be used in the future.

Employers Slowly Adopt Value-Based Health Benefit Designs. Japsen B. Forbes.com. Aug. 19, 2016.

SHRM: Additional strategies, resources and tools: https://www.shrm.org/resourcesandtools/

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