Consumer-Driven Strategies: What do we know about Health Savings Accounts and Other Account-Based Health Plans?

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About EBRI

- Private, non-profit, non-partisan research organization.
- Research on income security issues related to employee benefits.
- EBRI does not lobby.
- Membership organization supported by member dues.
Premiums Rising 2-5 Times Faster than Inflation and Wages, 1988-2006

Source: KFF/HRET and Bureau of Labor Statistics.
Consumerism

The movement seeking to engage and inform consumers about health care and health insurance through the use of financial incentives
Consumerism: Potential & Concerns

**Potentials**
- Lower costs
  - Reduction in use
  - Use of lower cost services
- Better engaged consumer
- More satisfied consumer
- Better health outcomes/more appropriate care
- Improve affordability

**Concerns**
- Low health literacy
  - Reduce necessary care
  - Induce demand for unnecessary care
- Lack of tools & resources to make decisions
- Impact on high cost users uncertain
- One-time savings
Issues for State Policy Makers

• Consumerism is going to be become about an informed consumer.
• Lack of information on prices.
• Lack of information on quality and outcomes.
• Health literacy issue.
• Support benefit innovation.
• Role as policy maker vs. role as employer.
Health Reimbursement Arrangement
(HRA)

• Employers started to offer in 2001
• Exist under current law
• Employer provided notional account that allows for pre-tax reimbursement of medical expenses.
• “Typically” combined with a high-deductible health plan.
• Employer funded & owned
  – Employee contributions not permitted.
• Unused balanced can roll over.
• Preventive care can be carved out.
Health Savings Account (HSA)

- 2003 Medicare Modernization Act
- Allows for tax-free accumulation of savings
  - Tax free contribution.
  - Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and LTCI premiums, retiree health premiums for Medicare-eligible retirees.
- Qualified health plan
  - Self-only: Minimum $1,100 deductible, $5,500 OOP max.
  - Family coverage: Minimum $2,200 deductible, $11,000 OOP max.
- Contributions
  - Self-only: limited to $2,850 max.
  - Family coverage: limited to $5,650 max.
- Catch-up contributions allowed once age 55 of $1,000
  - Phased-in by 2009.
<table>
<thead>
<tr>
<th>Account Feature</th>
<th>Ownership of funds</th>
<th>&quot;Use-it-or-lose-it&quot; by end of benefit year?</th>
<th>Access to account upon end of job</th>
<th>Who contributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Reimbursement Arrangement (HRA)</td>
<td>Employer</td>
<td>No, funds rollover</td>
<td>Depends on employer</td>
<td>Employer</td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>Employee</td>
<td>No, funds rollover</td>
<td>Yes</td>
<td>Both</td>
</tr>
</tbody>
</table>
# HRA & HSA Comparison

<table>
<thead>
<tr>
<th>Account Feature</th>
<th>Must be paired with high deductible</th>
<th>May be used with other accounts</th>
<th>Money can be used for non-health expenses</th>
<th>Tax treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Reimbursement Arrangement (HRA)</td>
<td>No, but often is</td>
<td>Yes, with limits</td>
<td>Yes, subject to tax and penalties</td>
<td>Not included in taxable income</td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>Yes</td>
<td>Yes, with limits</td>
<td>Yes, subject to tax and penalties</td>
<td>Reduces taxable income</td>
</tr>
</tbody>
</table>
Evidence on Adverse Selection

• CDHP tends to attract
  – Average age comparable.
  – Higher income.
  – Somewhat better health.

Can’t ignore impact of lack of choice.
Impact of CDHP on Health Care Spending

• Academic studies have simulated impact
  – Expect 4-15% reduction in spending from HDHP
  – Expect 2-7% reduction when HDHP combined with account

• Early anecdotal evidence
  – 10% savings, though some in the range of 20-25%

• Caution in interpreting these findings
  – Simulated impact not based on real data
  – Very little long-term experience with account-based plans

• Caution about using insurer findings
  – Ie 2006 insurer study found 8% reduction in trend due to CDHP compared to 4% increase in traditional trend
Impact of CDHP on Health Care Use

- Increased preventive care (including Rx)
- Reduced ER use and hospital admissions
- Reduction in acute care services
- Increase in office visits
- One study found 8% reduction in costs but increase in hospital admissions, even though inpatient costs dropped.
- Simple comparisons confounded by adverse selection
Impact of CDHP on Quality

• Cost sharing is a blunt instrument that reduces unnecessary and necessary care.
• Today’s CDHP
  – Financial incentives to participate in health promotion and disease management programs
  – Deductible often does not apply to preventive care
  – Tools & resources available to inform consumers
• Evidence on quality is mixed
  – Preventive care and patient satisfaction
Among adults with CDHP, lower satisfaction with quality of care, out-of-pocket costs, plan overall; few would recommend plan to friends/co-workers.

High out of pocket costs + premiums amount to substantial share of income, especially among those with lower income and health problems.

Higher reported rates of cost-related delays, avoidance, or skipping care or Rx, esp. lower income and health problems.

More cost-conscious decision making behavior.

Little quality/cost information provided by plans.
Percentage of Adults who Agree that Terms of Coverage Make Them Consider Cost When Deciding to Seek Health Care Services

Percent of adults 21-64 who strongly or somewhat agree

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
<td>38</td>
<td>46</td>
</tr>
<tr>
<td>HDHP</td>
<td>60*</td>
<td>61</td>
</tr>
<tr>
<td>CDHP</td>
<td>71*</td>
<td>73</td>
</tr>
</tbody>
</table>

Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account. *Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

### Cost-Conscious Decision Making, by Type of Health Plan

#### Percent of privately insured adults 21–64 who received health care in last twelve months

<table>
<thead>
<tr>
<th>Activity</th>
<th>Comprehensive</th>
<th>HDHP</th>
<th>CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checked whether plan would cover care</td>
<td>58</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>Asked for generic drug instead of brand name drug</td>
<td>48</td>
<td>54</td>
<td>60*</td>
</tr>
<tr>
<td>Talked to doctor about treatment options and costs</td>
<td>44</td>
<td>44</td>
<td>46</td>
</tr>
<tr>
<td>Asked doctor to recommend less costly prescription drug</td>
<td>31</td>
<td>41*</td>
<td>46</td>
</tr>
<tr>
<td>Checked price of service before getting care</td>
<td>20</td>
<td>23</td>
<td>26*</td>
</tr>
<tr>
<td>Checked quality rating of doctor/hospital</td>
<td>21</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Participated in wellness program offered through employer</td>
<td>11</td>
<td>15</td>
<td>20*</td>
</tr>
<tr>
<td>Used online cost tracking tool offered by health plan</td>
<td>8</td>
<td>17*</td>
<td>17*</td>
</tr>
</tbody>
</table>


Comprehensive = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

*Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
Annual Claims Distribution
Adults Ages 18-64, 2001

Average Cost = $2,454

20% of population that accounts for 80% of spending

Source: EBRI estimates from the 2001 MEPS.
15 Most Costly Conditions Account for Over 50% of Spending

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>9%</td>
</tr>
<tr>
<td>Trauma</td>
<td>7%</td>
</tr>
<tr>
<td>Cancer</td>
<td>6%</td>
</tr>
<tr>
<td>Pulmonary conditions</td>
<td>6%</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>5%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>3%</td>
</tr>
<tr>
<td>Back problems</td>
<td>3%</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>2%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2%</td>
</tr>
<tr>
<td>Skin disorders</td>
<td>2%</td>
</tr>
<tr>
<td>Endocrine</td>
<td>2%</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>2%</td>
</tr>
<tr>
<td>Kidney</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total spending</strong></td>
<td><strong>56%</strong></td>
</tr>
</tbody>
</table>
Opportunity Costs of CDHP Related to Preventive Care

The Case of Diabetes, High Cholesterol, and High Blood
Asheville Project
(J. of Amer. Pharma Assoc., 2003)

• No cost meetings with pharmacists
  – Education, home meter training, physical assessments

• Co-payments for diabetes-specific drugs and supplies were waived
Asheville Project
Direct Medical Costs Over Time

Baseline 1 2 3 4 5

$0 $1,000 $2,000 $3,000 $4,000 $5,000 $6,000 $7,000 $8,000

Other Rx Diabetes Rx Claims $

Year
Asheville Project
Ave. Annual Sick Days Among Diabetics

Baseline | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6
---|---|---|---|---|---|---
12.6 | 6.0 | 8.5 | 5.7 | 5.8 | 5.7 | 6.0
Cholesterol Lowering Drugs

• Recent Rand study, *American Journal of Managed Care*
• Increase in copayment from $10 to $20 associated with a 6-10 percentage point reduction in compliance.
• Full compliance associated with 357 fewer hospitalizations in sample studied.
• Elimination of copayments for certain patients would avert 80,000 hospitalizations and 31,000 ER visits nationally.
• National savings would be more than $1 billion.
Without hypertensive therapy

- Average blood pressure 10-13% higher (1999-2000)
- 86,000 excess premature deaths from cardiovascular disease (2001)
- 833,000 additional hospital discharges for stroke and heart attack (2002)
- Life expectancy 0.5 (men) and 0.4 (women) years lower.

$16.5 billion in direct medical costs avoided in 2002
Trends in Cost Sharing

The Relationship Between Cost Sharing and Consumerism
Average Co-Pay for Drugs, 2000-2006

Source: KFF/HRET.
### Drug Plan Incentives for PPO, Firms with 1,000 or More Employees, 1998 & 2003

<table>
<thead>
<tr>
<th>Combination of Generic and Mail Order Incentive</th>
<th>1998</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower copayment</td>
<td>32%</td>
<td>78%</td>
</tr>
<tr>
<td>Higher coinsurance</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Pay difference between generic &amp; brand name</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>No Generic or Mail Order Incentive</td>
<td>22%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Hewitt Associates.
Use of Tiered Physician or Hospital Networks, 2005

Source: KFF/HRET.
Are HSAs the Answer to Retiree Health Benefits?
EBRI

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