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Rachel Dody
Grand Valley State University

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HIGH-DEDUCTIBLE HEALTH INSURANCE POLICIES WITH HEALTH SAVINGS ACCOUNTS: A POLICY REVIEW

RACHEL DODY
Grand Valley State University

Abstract

The rise of the high-deductible health insurance plan (HDHP) is among the most significant health insurance developments in recent decades but the plans are controversial. Those in support of HDHPs argue these plans will encourage people to be “more astute health care consumers” and to make healthcare decisions “on the basis of cost and quality information” (Fronstin & Collins, 2005, p.4). This will theoretically eliminate the moral hazard with which health insurance and health care has been plagued, lead to decreased waste, and therefore lower consumption and cost. Critics, however, point to evidence that these new insurance plans will lead to adverse selection and that the high out-of-pocket costs will discourage the use of health care services, especially by those in lower income brackets or those who have chronic conditions. Critics also suggest these plans will do nothing to address the skyrocketing costs of healthcare (Weissert & Weissert, 2006, p.387, Fronstin & Collins, 2005). The passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, with its mandate that all Americans be covered by health insurance, is likely to make these lower-premium, high-deductible health plans more prevalent and therefore worthy of intense scrutiny.

Keywords: health insurance, high-deductible, health savings account, consumer-driven, consumer-directed

High-deductible Health Insurance Policies with Health Savings Accounts: A Policy Review

Healthcare costs have been spiraling out of control for some time now, and in 2010 healthcare spending accounted for more than seventeen percent of America’s GDP, meaning Americans spent over eight thousand dollars per person on healthcare in 2010 alone (Kane). There are a host of factors that contribute to these very high costs, including an aging population, unhealthy lifestyle choices, the costs of new technology, malpractice lawsuits and defensive medicine, over-utilization, insurance administration costs, and so on. High-deductible health plans offer one way to help control cost because they place more of the cost burden onto the healthcare consumer, thereby making it in the consumer’s best interest to be more judicious overall with their healthcare dollar. While there is evidence to suggest that this mechanism for cost control works well in certain situations and for certain individuals, other evidence suggests that HDHPs have the potential to lead to negative health utilization and outcomes and should warrant further study.

Background

Both employer- and government-sponsored health insurance plans have traditionally offered defined benefits, leading to moral hazard for participants who have little incentive to be concerned with price as they are insulated from the cost of their own health care, leading to increased demand for health services and subsequently increased cost (Feldstein, 2007, p.2). The more of a stake the consumer has in his or her spending, however, the more financially judicious and less wasteful he or she theoretically will behave. To address the rising cost of health care, one solution might be to “encourage more cost conscious spending by placing more of the health care financing burden on out-of-pocket spending” and high-deductible plans do just that (Blumberg & Clemans-Cope, 2009, p.1). Theoretically, participants will be actively engaged in their treatment, including selecting providers who provide
better value for their services (benefit to patient vs. cost) and be more prudent in their overall use of health care services (i.e. investigating effective, less costly treatment measures and not seeking treatment for minor problems).

Health insurance is expensive for both employers and employees; in 2010, the average premium for employer-sponsored health insurance was $5,049 for individual coverage and $13,770 for a family (Claxton et al., 2010, p.1). Policy changes, combined with rapidly rising health insurance premiums and increased global competition, means that a growing number of United States employers are looking for cost-savings measures and many are finding them in high-deductible health plans (Fronstin & Collins, 2005). In a 2010 study, Claxton et al. found the percentage of employees with a plan deductible of at least $1,000 increased from 10% in 2006 to 27% in 2010 (p. 2). In a 2013 Towers Watson study of employer healthcare purchasing (as reported by Andrews, 2013), 66% of large companies surveyed offered a high-deductible plan. As of January 2012, an estimated 13.5 million Americans were enrolled in HDHPs, up from just over six million in 2008 (America’s Health Insurance Plans, 2010).

High-deductible health plans, called also “consumer-driven” and “consumer-directed” plans, offer both employers and participants up-front cost savings in the form of lower monthly premiums (Claxton et al., 2010). These plans are essentially catastrophic insurance policies with high-deductibles of at least $1,200 for an individual and $2,400 for families. The plan participant is responsible for the entire cost of his or her health care (with exception to approved preventative services which are paid entirely by the health insurer), at the insurer’s negotiated rate until he or she meets the deductible, after which point the plan functions like a Preferred Provider Organization (PPO) and covers all health care expenses.

HDHP enrollees very often also have health savings accounts (HSAs); these are tax-advantaged savings accounts for use on approved medical expenditures and are intended to incentivize healthcare savings so participants can pay for larger out-of-pocket expenses. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) expanded eligibility for these tax-advantaged medical savings accounts and, in part, fueled the rise of the HDHP. Monies deposited into HSAs are exempt from federal income tax, interest accrues tax-free, funds are allowed to roll over from one year into the next, and can be invested much like an Individual Retirement Account (IRA). Deposits may be funded wholly or in part by employers, participants, or any other third party wishing to make a contribution to the account. HSA participants are currently allowed to contribute an annual maximum of $3,100 for an individual and $6,250 for a family, with older participants able to contribute extra for “catch-up contributions.” Balances belong to the individual insured and are therefore portable from one employer to another, and after the age of 65, the beneficiary can withdraw funds as regular taxable income without penalty.

Policy Targets

HDHPs with their tax-advantaged HSAs are alluring to health insurers and employers; for insurers, these plans decrease their administrative costs as an increased number of participants pay a majority of claims out of pocket. In this way, the insurers experience cost savings because they process fewer claims. Employers are increasingly experimenting with HDHPs because these plans lower their portion of the premium and shift their responsibility from “defined benefits to defined contributions” (Johnson et al., 2007). By 2005, 20% of employers offered HDHPs, up from 5% in 2003 (Claxton, Gil, & Finder, 2005). Employers can experience up to a twenty percent cost savings on their health spending by switching to a high deductible option (Parker-Pope, 2009).

HDHPs can also be attractive to individuals, as they offer increased consumer control and empowerment on health spending, giving health care consumers incentives to be more astute consumers. Low-consuming health insurance participants are attracted to HDHPs with HSAs because the plans allow them to pay a fairer price, one that is in line with their actual usage of health services. This often healthier, lower-consuming population is allowed to lessen their subsidy of their higher-consuming counterparts by switching to HDHPs. Additionally, high deductible plans offer a relatively low-cost option (in the form of low premiums) for otherwise uninsured independent consumers to purchase catastrophic health insurance on their own.
LITERATURE REVIEW

While high deductible plans are relatively new to the health insurance landscape, a body of research already exists on them. The foremost study pertaining to HDHPs was done by RAND Corporation between 1974 and 1982 and although it took place decades ago, it “remains the only long-term, experimental study of cost sharing and its effect on service use, quality of care, and health” (RAND, 2006, p.1). Other pertinent research includes those examining selection bias, the effects of out-of-pocket costs on utilization of services, and participant self-reporting of behavior changes. While there are some anecdotes of HDHPs being good for consumers, much of the research suggests that the way people change their behavior when asked to pay more out of their pockets may serve to reduce cost in some situations but is likely not the best for their care-seeking and for their overall health.

The RAND Corporation’s 1982 study sought to answer what effects the degree of cost sharing (free vs. varied levels of payments) would have on health care behaviors and outcomes. The study was made possible by a Health and Human Services grant and included data from 2,005 participating families, with a total of 3,958 individuals included. All participants were healthy enough not to be enrolled in Medicare and were randomly assigned to varying insurance policies for three to five years. RAND found that patients who experienced cost sharing decreased their usage of health services but the reduction “had no adverse effect on participants’ health” (RAND, 2006, p.3). Free care had a small positive impact on participant health outcomes; participants with specific conditions such as hypertension, especially those in very low income brackets that also had these conditions, benefitted the most from free care. Vision and dental care also improved among the lower-income participants on the free plan. Interestingly, cost sharing did not lead people to reduce risky behaviors or take better care of themselves; smoking habits and obesity rates remained unchanged even though the individuals would be shouldering some of the cost of treatment if these lifestyle choices resulted in need for care (RAND, 2006).

The U.S. Government Accountability Organization (GAO) found adverse selection in those who elected HDHPs when they analyzed data from two large employers who had introduced HRAs during the 2003 plan year. Studying data from 2001 through 2005, they found that those who switched to the HRA were “younger, more likely to be male, and elect single coverage than those who remained in the PPO plan” (Dicken, 2010, p.12). They were also an average of three years younger, utilized fewer services, and filled an average of six fewer prescriptions per year prior to switching, as compared to those who stayed in the traditional plan (Dicken, 2010 p.16). This in itself is not necessarily bad, but it could have negative ramifications for the older, high-utilizing counterparts who remain in the traditional plans.

Schellerhorn (2001) studied the effects of Switzerland’s 1996 health reform, which gave individuals a choice of copayments for their mandatory basic health insurance coverage, and found similar selection bias. The likelihood a person would take a higher copayment had an inverse relationship with age, probably due to older populations being more risk averse or because they expected to have health problems as they aged. Additionally, being overweight or being a smoker decreased the likelihood someone would switch to a higher copayment (Schellerhorn, 2001, p. 449).

Research suggests that as people shoulder more of the cost of a service their utilization rates drop. While this is encouraging for non-medically necessary services, the effect holds true for medically necessary services as well. Blustein’s 1995 study focused on the effects of copayments on rates of mammography and found that while only 37 percent of the women studied had a mammogram during the two-year period, women who lacked supplemental insurance (who had more out-of-pocket costs) got mammograms at a rate of only 14 percent. Clearly, requiring copayments for mammograms is an obstacle for women, even though it is a proven preventative test. Wharam et al. (2007) considered emergency department visits of individuals who had switched from traditional health plans to high deductibles and found they visited the emergency department less frequently than the control group. Emergency visits decreased from 197.5 to 178.1 per 1,000 participants, while visits among controls remained at approximately 220 per 1,000. In particular, the reductions came “primarily in repeat visits for conditions that were not classified as high severity, and had decreases in the rate of hospitalizations from the emergency department.”
Wharam et al. (2008) also studied rates of cancer screening before and after switching to HDHPs. The HDHP covered some screenings (mammography, Papanicolaou tests, and fecal occult blood testing) at 100 percent but not others (colonoscopy, flexible sigmoidoscopy, or double-contrast barium enema). His results suggested that cancer screening in the HDHP population did not change for the tests that were covered, but decreased for the tests that were not covered, perhaps because they chose to substitute these tests for another that was covered or less costly, but perhaps because they skipped it altogether.

Lieu et al. (2007) held focus groups comprised of adults whose families experienced high or unexpected out-of-pocket health care costs with their HDHP. While all participants understood the general workings of their plan, each reported having confusion due to plan complexities. Focus group members described an increased awareness of health care costs but identified a number of barriers to meaningful action to control these costs. Barriers cited included: urgent problems, incorrect expectations of coverage, and reluctance to talk about costs with their doctors. Lieu also found that HDHP participants tried to control costs by delaying or avoiding physician visits and felt that they had very little control over costs once they were actually in a treatment setting.

ANALYSIS

Intended Outcomes

Increased medical savings
An increased number of Americans are saving for their own healthcare and each is saving a greater amount; this means they will therefore have a greater stake in where and how their health care money is being spent. Overall health care savings for HDHPs with savings options has increased; there was an aggregate $7.7 billion in 5.7 million HSAs and HRAs in 2010, up from 1.2 million accounts with $835.4 million in 2006. (Fronstin, 2011).

Increased consumer awareness
HDHPs and HSAs serve to increase consumer awareness in health care by having the consumer bear a larger percentage of the out of pocket costs, having what many refer to as ‘more skin in the game.’ This reduces moral hazard and thereby decreases demand and overall health care prices. There is evidence that people in the high deductible plans are behaving differently than their comprehensive health plan counterparts; Fronstin and Collins (2005) found them to be much more likely to report their health insurance terms made them think about cost before seeing their doctor or filling a prescription. Moreover, study participants reported having “checked whether their health plan would cover their costs as well as the price of a service prior to receiving care, and to discuss treatment options and the cost of care with their doctor” (Fronstin & Collins, 2005, p.16). Health care consumers with HDHPs and HSAs also appear more likely to have a budget, ask for generic prescriptions, and ask for the price of a service (Saranow Schultz, 2011).

New negotiating tools
A number of tools are emerging to assist health care consumers to negotiate with providers; websites including Healthcare Blue Book and New Choice Health arm consumers with typical costs of medical procedures for their area. Many insurance providers list their negotiated rates on their website, which can be a useful tool for those with HDHPs. Additionally, news articles and blogs as well as professional negotiating services (such as the Medical Billing Advocates of America) are emerging, with the goal of assisting people with the task of negotiating with their health care professionals (Lee, 2009, Kullgren, 2011).

Success stories
Powerful stories of individuals with HDHPs successfully negotiating their health care bills to a fraction of its rate abound. The Cato Institute’s Michael Cannon is a “poster child” of how high deductible health insurances can
lead people to make shrewd financial decisions when it comes to their health care dollar; he injured his leg playing soccer and because he knew he would be paying the first $2,500 out of his own pocket he made a series of calculated decisions in an effort to control cost. Along with foregoing the ER and having his doctor not order an X-ray, he was able to negotiate the cost of an MRI down to $700, a “53 percent discount from the sticker price—and more than six times the discount negotiated by [his] insurance company” (Canon, 2007, p.2). A commenter on a New York Times health blog reported paying $400 for his or her initial doctor visit but when they offered to pay cash for their second visit, paid only $65 (Parker-Pope, 2009). Clearly, in some instances the effects of having more “skin” in the healthcare “game” is effective at not only lowering costs for insurers and participants but in decreasing demand for unnecessary services.

**Premium cost savings**

HDHPs can lead to overall savings for participants when compared to comprehensive plans, even if they meet their annual deductible. If the premium savings and tax advantages for their HSA monies are greater than the cost of their deductible, they experience a net gain from having a high deductible. In 2010, the average annual combined premium for employees and employers for family health insurance was $12,384, compared to $14,125 for an HMO (a difference of $1,741) (Claxton et al., 2010). This, combined with premium variation (sometimes the difference between HDHP and traditional plan offerings can be much higher than $1,741) and the level at which employers pass their premium savings on to their employees, along with the participant’s effective tax rate, can make HDHPs with savings options a good choice.

**Unintended Outcomes**

Numerous unintended outcomes of HDHPs and higher out-of-pocket costs have been recorded, including participants imprudently modifying care-seeking behavior, not applying cost-conscious behaviors to all aspects of their health care experience, adverse selection, affordability problems, limited benefits and use of the tax-advantaged savings accounts, negligible effects on coverage for the uninsured and negative effects for providers.

**Adverse care-seeking behavior and health outcomes**

Unintended clinical problems will occur if consumers do not make educated, prudent health care spending decisions. In a 2005 study of HDHPs, Reed et al. reported participants to be harmfully modifying their care-seeking behavior in response to cost: thirty nine percent of their participants self-reported “altering their emergency care-seeking behaviors, with the most frequent reports being they had delayed or avoided care or had sought help via the telephone or internet.” (p. 1149). Additionally, there is evidence to support that enrollees in HDHPs are “significantly more likely to skimp on their medications” as compared to their comprehensive health plan counterparts; 26% of people with HDHPs reported not filling prescriptions because of cost, as compared to 16% of comprehensive plans not filling prescriptions (Fronstin & Collins, 2005, p. 15).

HDHP participants are less likely than traditional health plan enrollees to fill prescriptions due to cost, more likely to forego preventative care, and are “more likely to report that they had had health problems as a result of avoiding seeing a physician because of cost” (Lee & Zapert, 2005, p.1203). Reed et al. (2009) found that consumers lacked a good understanding of their health insurance policies, including which services were exempt from their deductible. Even though a multitude of preventative procedures were covered entirely before deductible, participants were uneducated to these details and therefore indiscriminately avoided care. Participants with poor health status or with incomes less than $50,000 were “significantly more likely to report changing their behavior” (Reed et al., 2009, p.1149).

The RAND Experiment findings, discussed earlier, indicate that people with higher co-payments use less health care and “the poor and those at highest risk for disease were most negatively affected by increased cost-sharing” (Kaiser Family Foundation, 2006, p.17). The average person is not medically trained and therefore ill-
equipped to make good decisions with respect to what treatments are necessary. While care-seeking behavior changes can be good if they result in people not going to their physician for unnecessary things like the common cold, it can be disastrous if the change results in people avoiding care for more serious conditions. It is reasonable to assume that when someone skimps on their diabetes medicine and/or avoids the doctor, their health outcome will be negatively affected.

**Interaction and negotiation with care providers**

While researchers found that HDHP participants modified certain types of cost-conscious behaviors, they observed them not modifying other behaviors, including “talking to a doctor about prescriptions and costs, asking a doctor to recommend a less costly drug and checking the quality rating of a hospital or doctor” (Saranow Schultz, 2011, para. 3).

Healthcare is notoriously insensitive to typical market forces on price, due to healthcare professionals, not consumers, being the dominant force for determining demand through diagnosis and treatment plans and consumers often not having adequate information to make decisions that balance cost and quality. Steven Brill, in his popular Time Magazine piece about exorbitantly high medical bills, said of patients: “[t]hey are powerless buyers in a seller’s market where the only sure thing is the profit of the sellers” (2013). The combination of doctors often lacking pricing information and their patients’ reluctance to question treatments and prices leads to an atmosphere in which patients have little information to use their health care money wisely. Lieu et al. (2009) noted that “[p]atients were hesitant to discuss costs with doctors, despite their feeling that the HDHP had increased their awareness of costs” in part because they “felt that doctors did not have information or care about costs, or that it was not appropriate to question doctors’ recommendations based on their financial ramifications” (p. 253). Additionally, patients rarely know appropriate care options or have all the information they need to make an informed decision. While it may be difficult even for well-educated people to make health care decisions, “as many as 90 million adults have low literacy skills” such that their “ability to make informed health care decisions” may be negatively impacted (KFF, 2006 p.18). If prices and costs of medical care were transparent and more health care professionals outside of the billing department knew what prices were, there would be more room for choice and negotiation. As it is, the idea that participants will question their doctors on treatment and cost to save money may be misguided. Additionally, people often require care when they are really sick, in pain, unconscious, etc. and are therefore unable to make educated decisions, much less negotiate prices.

**Adverse selection**

Adverse participant selection is also an area of great concern, as early research suggests that “healthier and wealthier individuals are more likely to purchase HDHPs than their counterparts” (Johnson et al., 2007). For the tax year 2004, the Kaiser Family Foundation found the average income of those reporting HSA contributions was, “about $76,000, compared to $30,000 for all tax filers under age 65” (KFF, 2006, p.16). While the low-premium HDHPs combined with the ability to save tax-free has the potential to draw the young and healthy into insurance pools, it also has the very real possibility of drawing those same individuals out of existing insurance pools in which they are subsidizing the care of the less healthy. This selection allows healthier, low-risk individuals access to fairer health insurance rates but at the expense of the larger group. Healthy individuals who are also in higher tax brackets who can realize financial benefits from these plans will therefore leave the most vulnerable (less healthy, lower-income) in traditional comprehensive plans, which may become financially insolvent.

**Affordability of insurance and cost of care**

Those who have HDHPs are spending more of their income on health care than their comprehensive plan counterparts, despite similar rates of use; forty two percent of HDHP members spent at least five percent of their total income on out-of-pocket healthcare costs and premiums, as compared to twelve percent of comprehensive plan participants (Fronstin & Collins, 2005, p.1). This increased spending leads to an increase medical debt; Mahon and
Root (2005) found “more than half of adults with deductibles over $1,000 experience medical bill or debt problems, compared with one-quarter of those with no deductibles” (para. 3). This problem becomes compounded when people with chronic diseases carry high deductibles, as they are twice as likely to reach their deductible each year (KFF, 2006).

High deductible plans are often, but not always, accompanied by lower monthly premiums. The cost of high deductibles can be difficult to bear on their own, but costs can be extremely high when combined with a typical premium; Hoffman and Tolbert (2006) estimate that insurance and out-of-pocket medical expenses would take up such an extraordinary percentage of a low-income family’s annual budget that they would be left with very little money to spend on things other than basic necessities (p.2).

HSAs offer more of a benefit to young, healthy populations who have time to build considerable savings and accrue interest before the age at which they will likely need high-cost medical interventions. Without having time to build up necessary savings, older HDHP participants will therefore be at a disadvantage when they are faced with paying very high out of pocket costs until they meet their deductible.

It is unclear how this new trend in health insurance has or will affect national health care costs, if at all. As of 2010, only three percent of the entire population of the United States had HDHPs (AHIP, 2010). Even if these plans were extremely effective at reducing cost and demand in a majority of the population, they do nothing to address very costly procedures and the seriously ill, which account for a huge proportion of the nation’s health care expenses. The Kaiser Family Foundation estimated that almost half of all healthcare expenses are attributable to the top five percent of healthcare spenders, for whom (if they are seriously ill) cost sharing is “totally inappropriate” (KFF, 2006, Gwande, Fisher, Gruber, & Rosenthal, 2009).

**Tax advantages not advantageous to many**

The tax advantages that come with HSAs are most valuable to those who have higher incomes and higher marginal tax rates, leading many critics to call HSAs tax shelters for healthy, well-heeled people. A 2008 Government Accountability Office study found the average household income of people with HSAs to be $139,000, compared to $57,000 for all other filers (Dicken, 2010). The tax subsidy is of little or no value to people who have small income tax liabilities, compounded by the fact that people who earn less money have little or no spare money to place in an HSA. Blumberg and Clemens-Cope (2009) note that, despite the tax advantages, almost half of eligible participants fail to open HSAs, and “two-thirds of employers report making no contribution to the HSAs of their workers” (p.1). Consequently, people with low incomes or with higher healthcare needs who are enrolled in HDHPs will more than likely “be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy” (Blumberg & Clemens, 2009, p.1).

**Impact on uninsured**

It is unlikely that coverage rates will improve among the uninsured as a result of HDHPs with HSAs because more than two of every three nonelderly uninsured persons falls into the low-income category and have little or no tax liability. Furthermore, it is estimated that plans with high out-of-pocket costs do not offer the uninsured poor enough benefit to offset the cost of the premium and Davis, Doty, & Ho (2005) write, “few low-income individuals can afford to purchase coverage if premiums exceed 5 percent of income” (Hoffman & Tolbert, 2006, p.4, Davis, Doty, & Ho, 2005, para. 13). RAND’s findings indicate that low income individuals have the best health outcomes when they receive free care, so high deductible insurances are the least appropriate option for this segment of the population.

**Impact on providers**

Pollack, Mallya, & Polsky (2008) found that physician knowledge of a patient’s socioeconomic status and insurance deductible affected which type of testing he or she recommended for colorectal cancer screenings. They found that “the odds of receiving inappropriate colorectal cancer screening recommendations were almost five times
higher for patients with low SES in high deductible coverage than for patients with high SES in traditional low-
deductible plans,” which raises serious ethical questions with respect to high deductible plans and the treatment of
the poor.

Providers are likely to experience collection problems as enrollment in HDHPs and medical debt increases. As
previously discussed, an increased percentage of care will be subject to collection problems, which will increase
the financial burden on health care providers. It is possible that if this problem becomes pronounced, physicians
will not service HDHP participants, as some have done with Medicare or Medicaid participants, or require full
payment in advance of services. Additionally, providers should expect an increase in telephone inquiries and should
be prepared with standard procedures for handling these (Lieu et al., 2009).

DISCUSSION AND POLICY RECOMMENDATIONS

A number of measures should be considered to remedy the array of negative, unintended consequences that
come with HDHPs because it is likely that, regardless of their flaws, the prevalence of HDHPs will only increase.
Any new law or regulation of high deductible health plans should be careful not to decrease the availability or
offering of the product since the choice for many Americans is not between a traditional plan and a high deductible
plan; it may be between a high deductible plan and no insurance. If new laws and regulations make high deductible
plans less available, these new laws may only serve to increase the size of the uninsured population and amplify an
already complicated problem. In order to avoid the detrimental effects of HDHPs as they currently exist, each of the
negative outcomes previously outlined should be addressed.

Participants need to understand their plans (perhaps plans could be standardized and simplified throughout the
nation), have access to provider cost and quality information, have sufficient incentive and time to save for future
medical costs, and have access to a health care market that offers competitive pricing of services. To this end, health
insurers who offer high deductible plans should be required to provide easily-understood, easily accessible
educational materials to participants, covering their high deductible plan benefits. Additionally, health care
providers could be required to post cost and quality outcome data, which could be aggregated in an easy-to-use
public website. The federal government could also create a healthcare advisory group to consult and/or train HDHP
participants in health-related decision making. The most effective, lowest-cost treatments of minor ailments and
procedures could be negotiated by the health insurance company so that everyone’s health care dollar goes further
(i.e. procedures that can be done on an outpatient rather than inpatient basis ought to be only performed outpatient).

To encourage health saving behavior for those in lower income brackets whose behavior is not changed by
tax-free savings options, the federal government should strongly consider adding extra incentives (perhaps below the
line tax credits for monies deposited into HSAs) for lower-income individuals to save for their own health care
needs. Older participants, perhaps those fifty years of age and older, who join HDHPs could receive partially
subsidized care, perhaps in the form of lower deductibles, because they have not had time to build HSAs. In an
effort to increase affordability of these plans, low-income individuals should receive discounted premium rates and a
sliding scale for deductibles.

As it would be difficult to control HDHPs effects of adverse selection, it is expected that an increased number
of participants will have chronic conditions such as heart disease, diabetes, and hypertension. Treatment for
conditions such as these should be paid for entirely by the insurer, without regard for deductible.

CONCLUSION

The driving idea behind high deductible health plans and health savings accounts is to give health insurance
participants an incentive to be actively engaged with the quality and price of the health services they receive, as they
would be with any other product. The use of high deductibles and incentivizing saving for health expenses through
HSAs, while at the same time covering preventative measures, was thought to increase consumer participation in
health care decisions, decrease costs, and improve quality measures. These results have not yet been widely observed. Rather, HDHP participants are haphazardly avoiding or forgoing care, often have barriers to effectively control cost, and are experiencing higher out of pocket costs while often not taking advantage of HSAs. HDHPs with HSAs also attract healthier, higher incomes, which will lead to adverse selection for those who remain in traditional comprehensive plans. Once measures have been put in place to address the aforementioned flaws associated with HDHPs, the effects of high out of pocket cost on care-seeking behavior and its effect on the long-term health of participants should be further evaluated.

REFERENCES


Rachel Dody is passionate about helping people live longer, healthier, happier lives and believes the best way to approach health problems is by working to prevent them in the first place. She believes that individuals have enormous power to shape the course of their own health through making better everyday choices/habits and that communities have a responsibility to help make the healthy choice the easy choice, the fun choice, and/or the affordable choice for their citizens.

Rachel earned her Bachelors in Psychology from Hope College and her Masters of Health Administration from GVSU. She is now following her passion by working in two part-time positions, as Coordinator of 1 in 21 Healthy Muskegon County (working to help Muskegon County become the healthiest county in Michigan by 2021) and as part of the Access Health team (a community-based not-for-profit that provides affordable health coverage and emphasizes health improvement and empowerment).

Rachel serves on the Board of Directors of both the Little Red House, Inc. and her neighborhood association.