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

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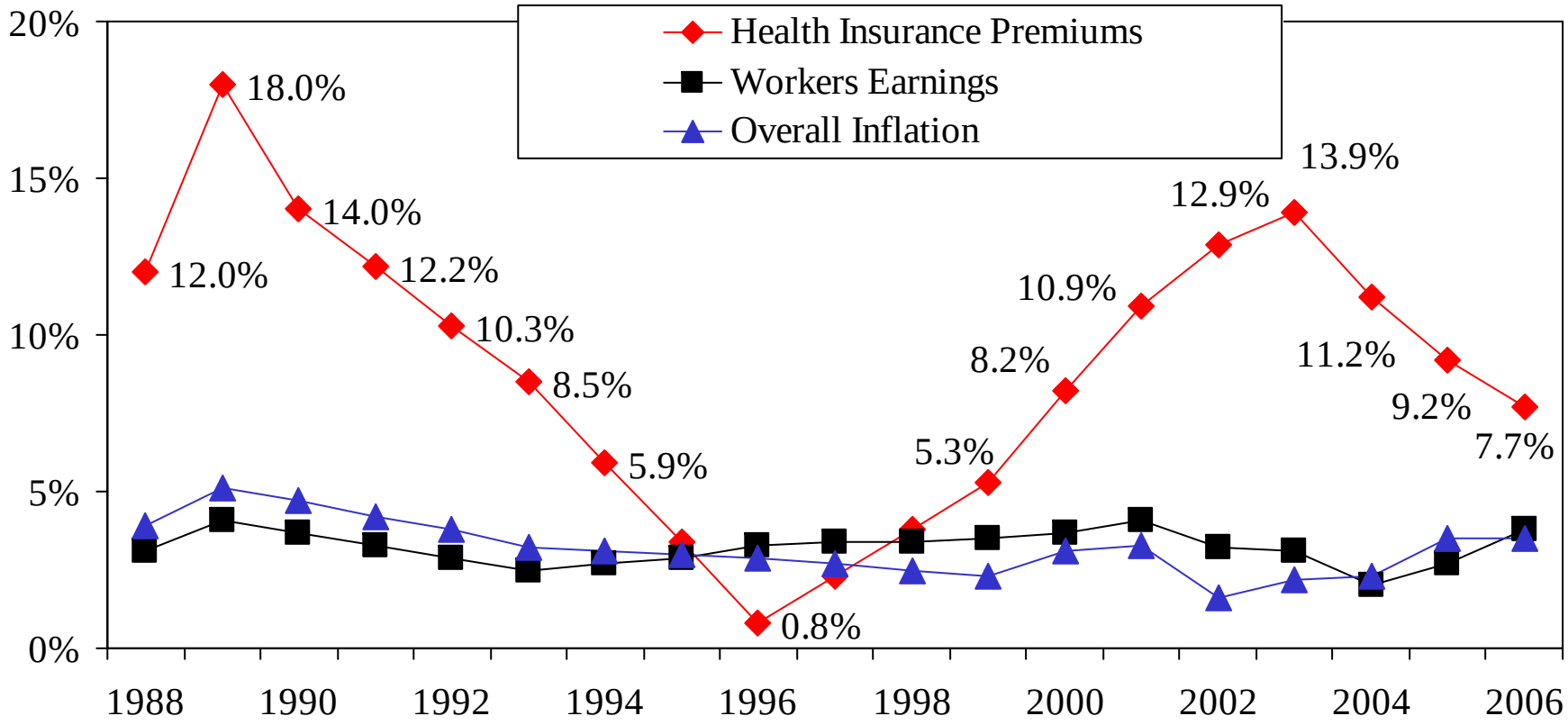
About EBRI

- 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.

HRA & HSA Comparison

Account Feature	Ownership of funds	"Use-it-or-lose-it" by end of benefit year?	Access to account upon end of job	Who contributes
Health Reimbursement Arrangement (HRA)	Employer	No, funds rollover	Depends on employer	Employer
Health Savings Account (HSA)	Employee	No, funds rollover	Yes	Both

HRA & HSA Comparison

Account Feature	Must be paired with high deductible	May be used with other accounts	Money can be used for non-health expenses	Tax treatment
Health Reimbursement Arrangement (HRA)	No, but often is	Yes, with limits	Yes, subject to tax and penalties	Not included in taxable income
Health Savings Account (HSA)	Yes	Yes, with limits	Yes, subject to tax and penalties	Reduces taxable income

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

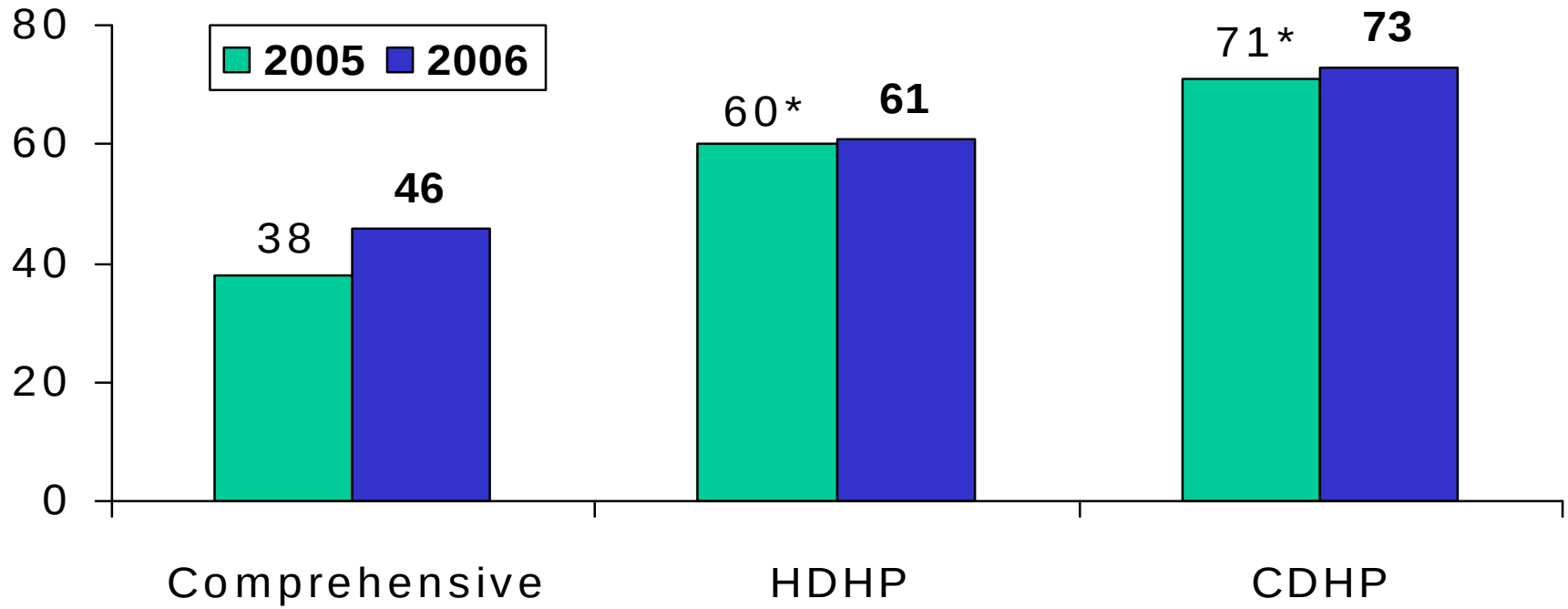
- Cost sharing is a blunt instrument that reduces unnecessary and necessary care.
- Today's CDHP
  - Financial incentives to participate in health promotion and disease management programs
  - Deductible often does not apply to preventive care
  - Tools & resources available to inform consumers
- Evidence on quality is mixed
  - Preventive care and patient satisfaction

EBRI/Commonwealth Fund Consumerism in Health Care Survey

- 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

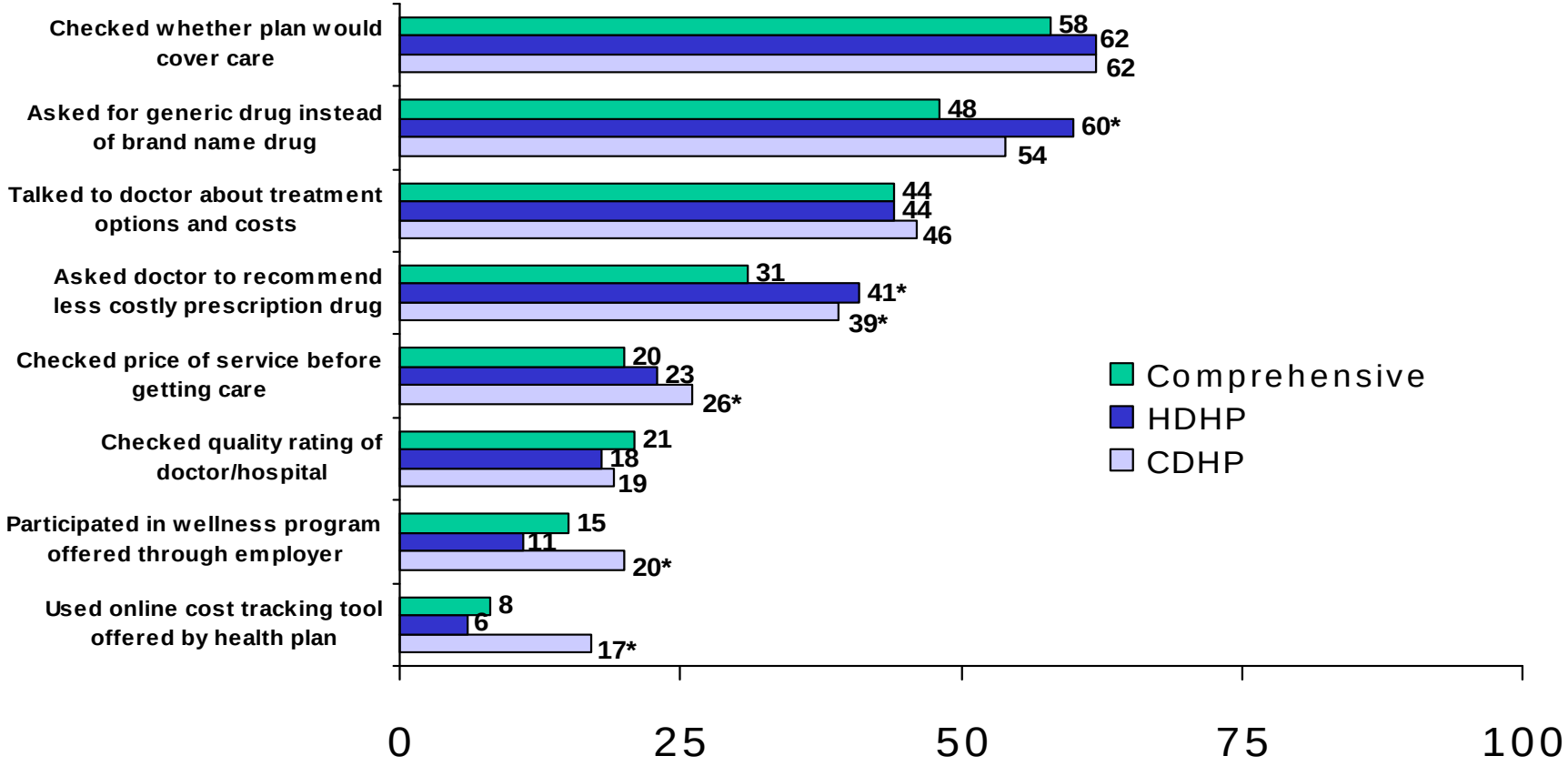
Percent of adults 21-64 who strongly or somewhat agree



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.
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2006.

Cost-Conscious Decision Making, by Type of Health Plan

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



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006.

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

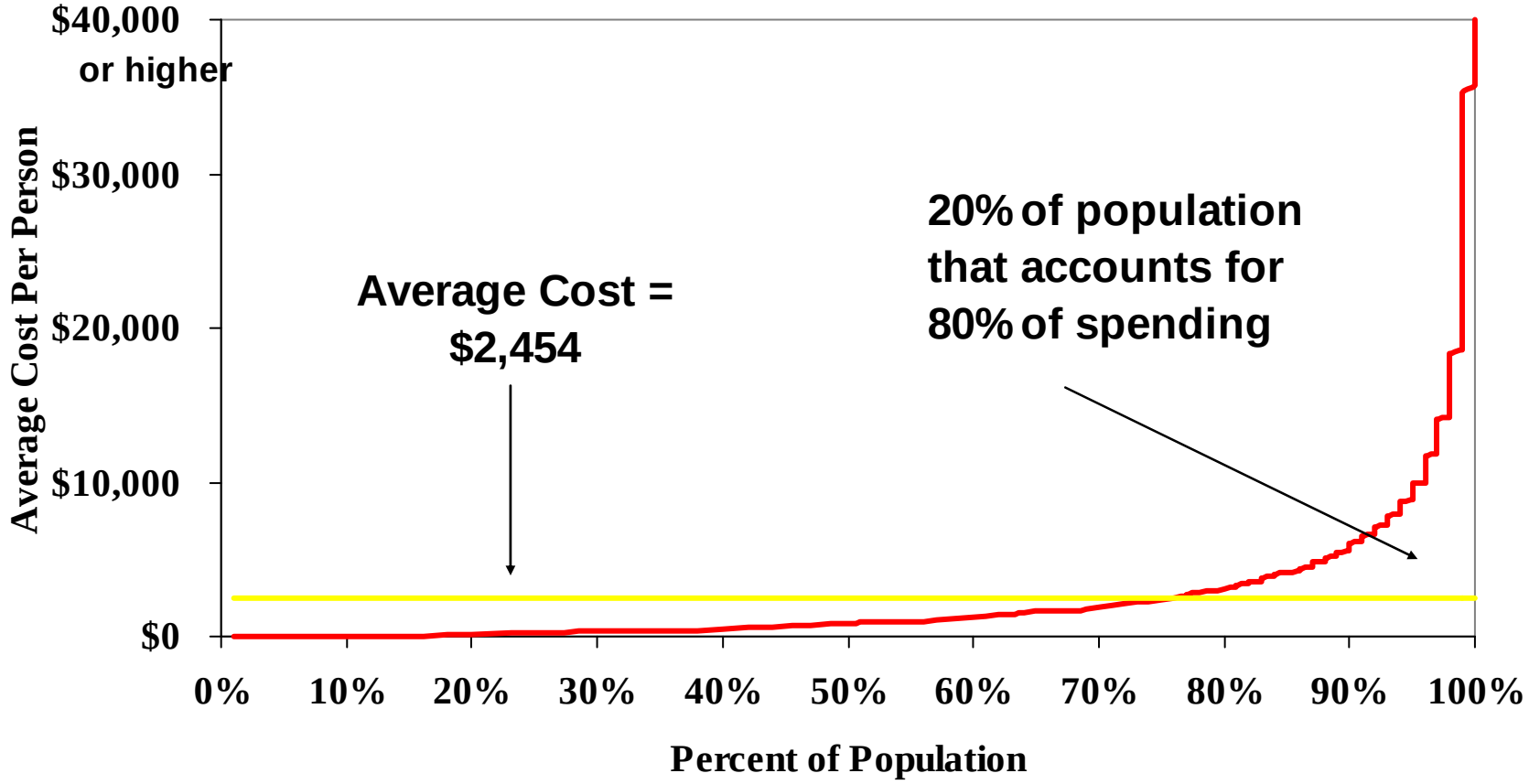
HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

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



Source: EBRI estimates from the 2001 MEPS.

15 Most Costly Conditions Account for Over 50% of Spending

Heart disease	9%
Trauma	7%
Cancer	6%
Pulmonary conditions	6%
Mental disorders	5%
Hypertension	4%
Diabetes	3%
Arthritis	3%
Back problems	3%
Cerebrovascular disease	2%
Pneumonia	2%
Skin disorders	2%
Endocrine	2%
Infectious disease	2%
Kidney	1%
Total spending	**56%**

Opportunity Costs of CDHP Related to Preventive Care

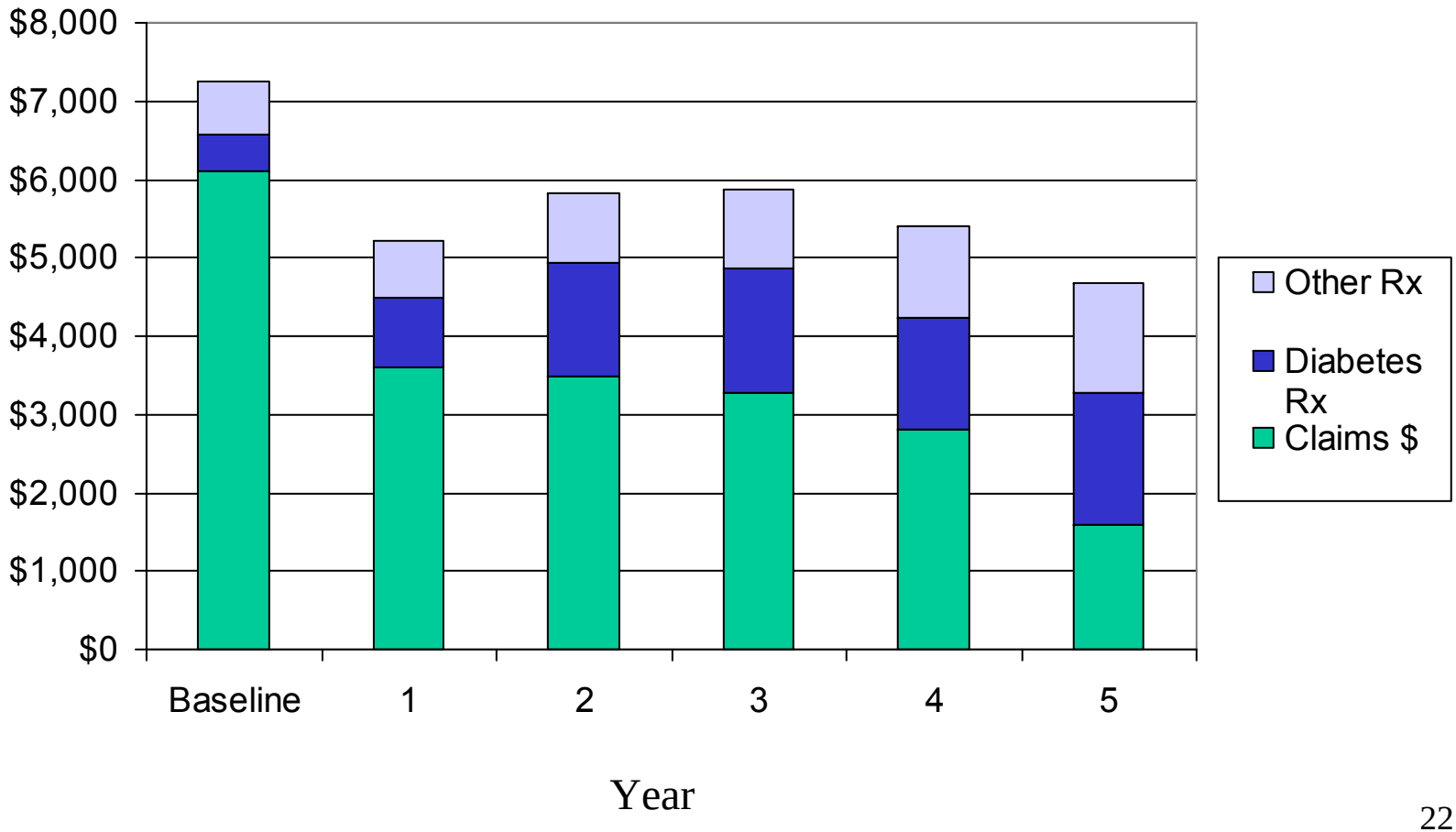
The Case of Diabetes, High Cholesterol, and High Blood

Asheville Project

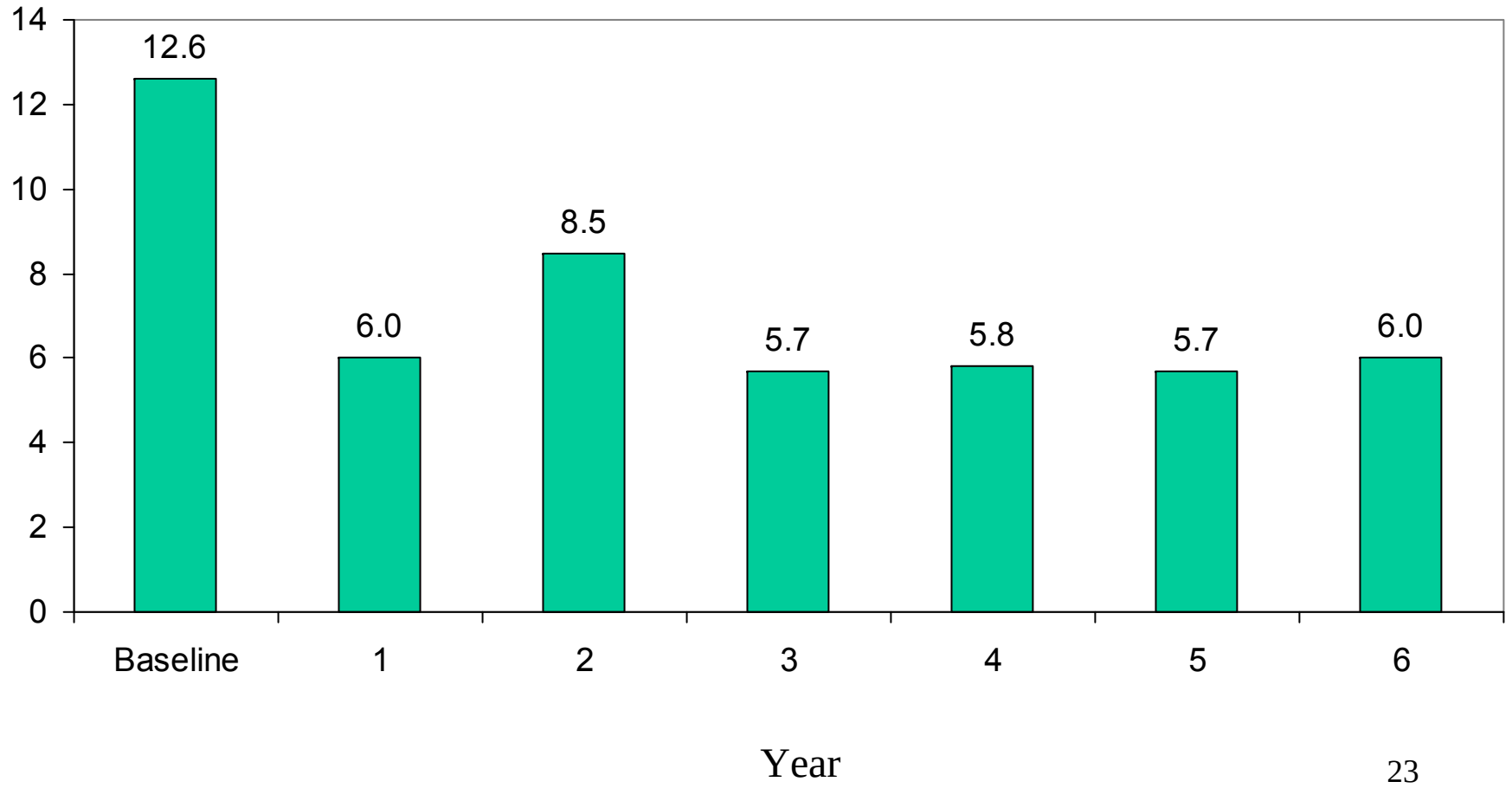
(J. of Amer. Pharma Assoc., 2003)

- 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



Asheville Project
Ave. Annual Sick Days Among Diabetics



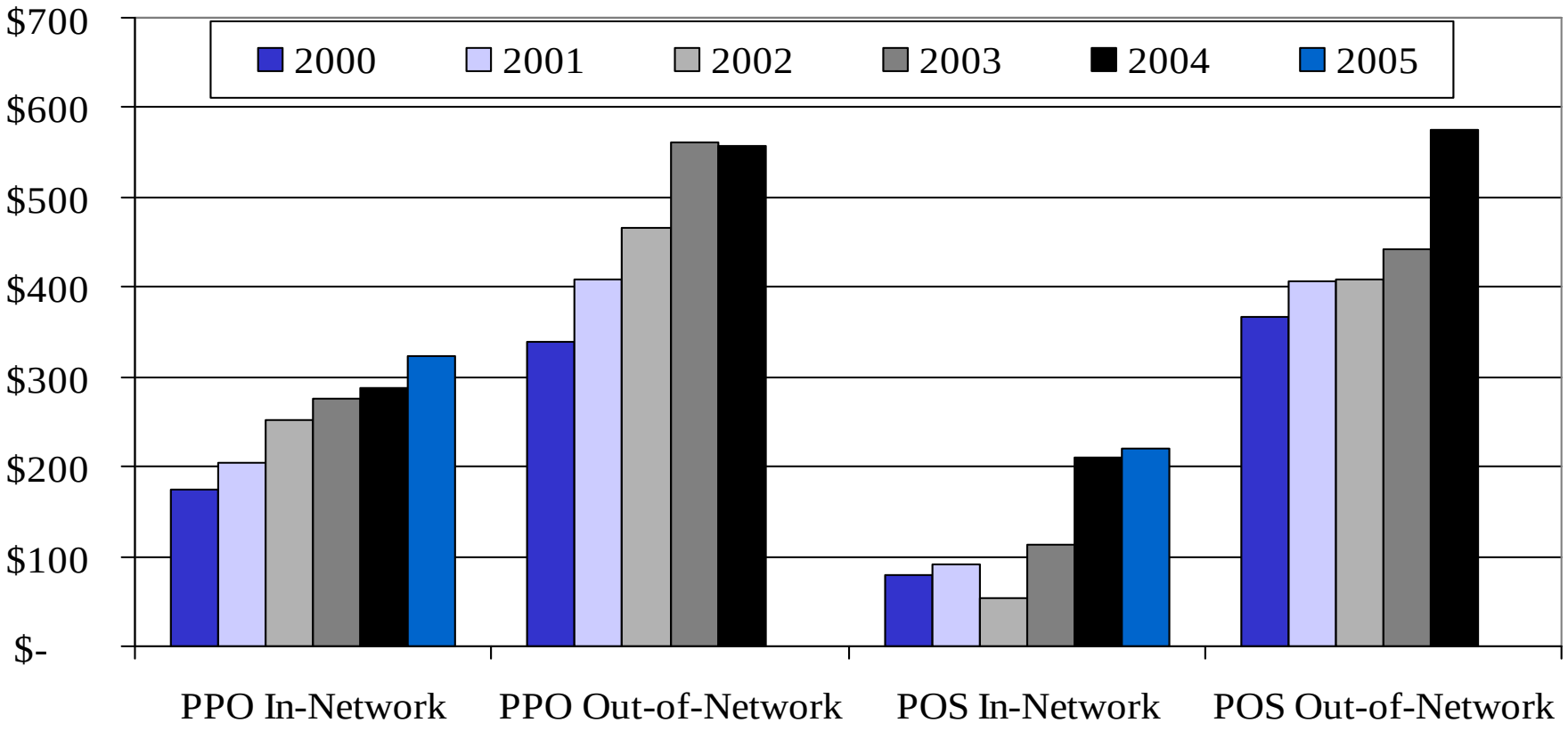
Cholesterol Lowering Drugs

- 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.

NBER Paper
Value of Antihypertensive Therapy

- 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

Average Annual Deductibles for Employee-Only Coverage, 1996-2005



Source: KFF/HRET.

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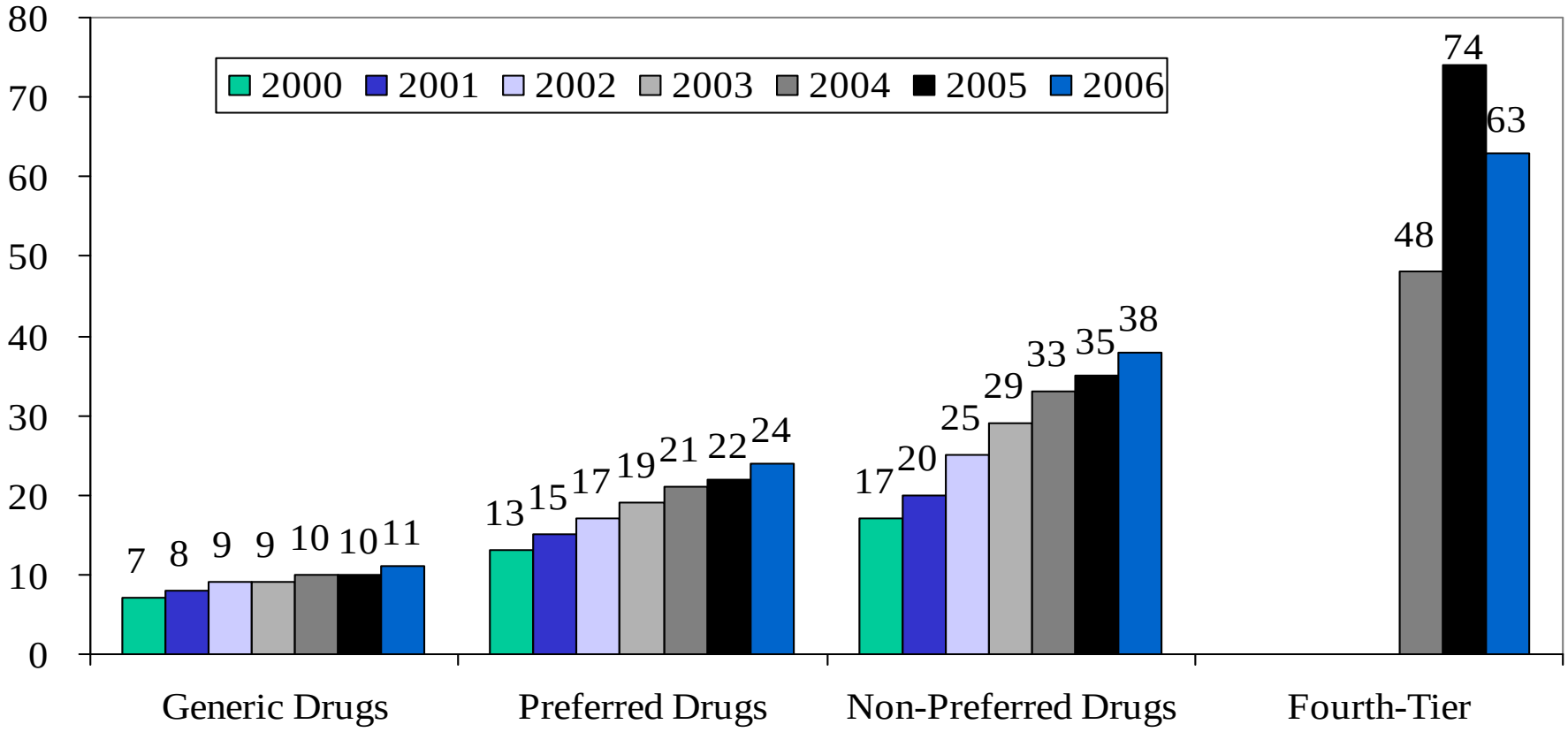
Trends in Cost Sharing

The Relationship Between Cost Sharing and Consumerism

Average Co-Pay for Drugs, 2000-2006



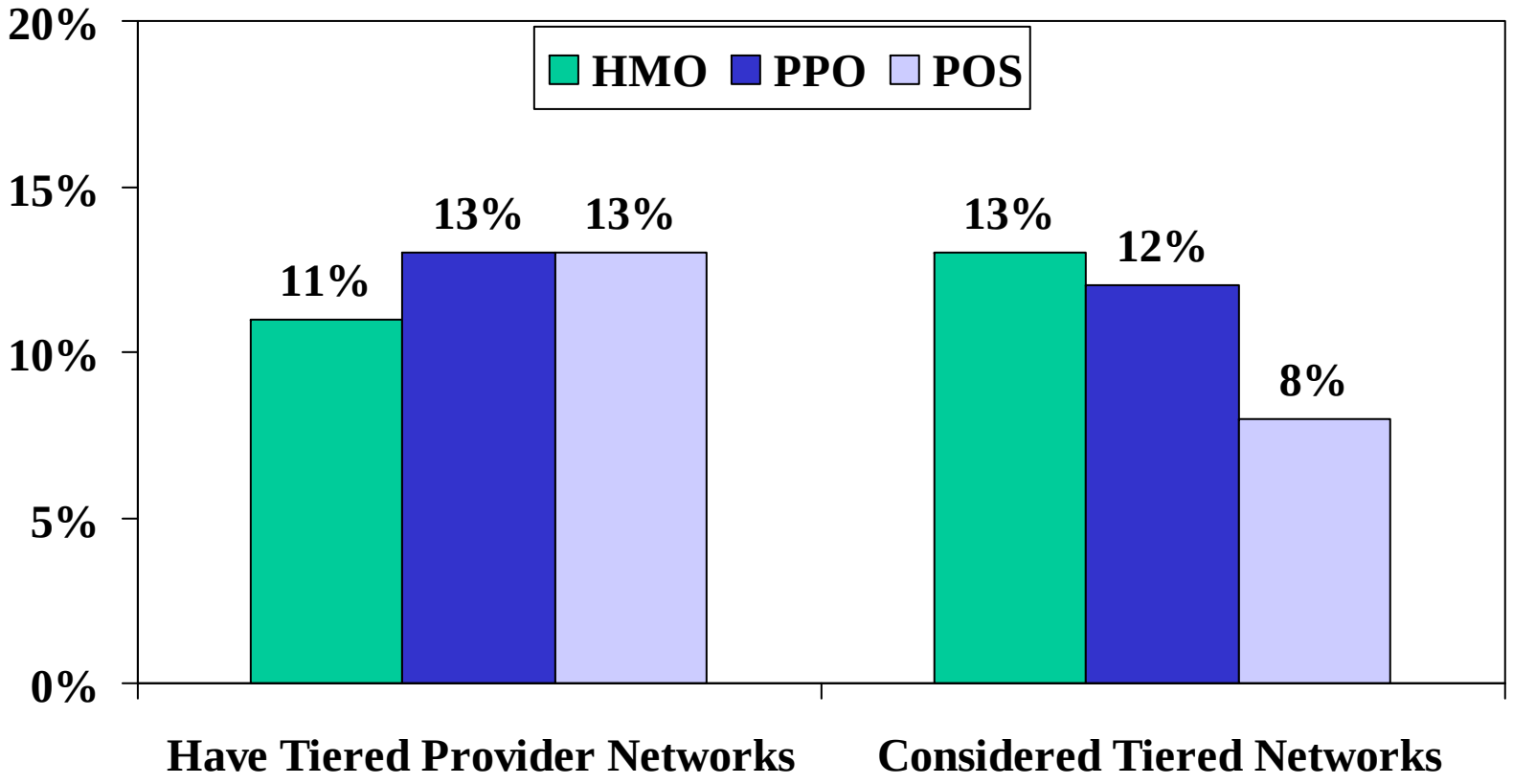
Source: KFF/HRET.

Drug Plan Incentives for PPO, Firms with 1,000 or More Employees, 1998 & 2003

Combination of Generic and Mail Order Incentive	1998	2003
Lower copayment	32%	78%
Higher coinsurance	1%	1%
Pay difference between generic & brand name	2%	6%
No Generic or Mail Order Incentive	22%	6%

Source: Hewitt Associates.

Use of Tiered Physician or Hospital Networks, 2005



Source: KFF/HRET.

Are HSAs the Answer to Retiree Health Benefits?

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