American Academy of Pediatrics
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FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

High-Deductible Health Plans

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS

high-deductible health plan, Patient Protection and Affordable Care Act, health reimbursement arrangement, health savings account, patient-centered medical home

ABBREVIATIONS

ACA—Patient Protection and Affordable Care Act
AAP—American Academy of Pediatrics
HDHP—high-deductible health plan
HRA—health reimbursement arrangement
HSA—health savings account
PCMH—patient-centered medical home

www.pediatrics.org/cgi/doi/10.1542/peds.2014-0555

doi:10.1542/peds.2014-0555

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

FREE

High-deductible health plans (HDHPs) are insurance policies with higher deductibles than conventional plans. The Medicare Prescription Drug Improvement and Modernization Act of 2003 linked many HDHPs with tax-advantaged spending accounts. The 2010 Patient Protection and Affordable Care Act continues to provide for HDHPs in its lower-level plans on the health insurance marketplace and provides for them in employer-offered plans. HDHPs decrease the premium cost of insurance policies for purchasers and shift the risk of further payments to the individual subscriber. HDHPs reduce utilization and total medical costs, at least in the short term. Because HDHPs require out-of-pocket payment in the initial stages of care, primary care and other outpatient services as well as elective procedures are the services most affected, whereas higher-cost services in the health care system, incurred after the deductible is met, are unaffected. HDHPs promote adverse selection because healthier and wealthier patients tend to opt out of conventional plans in favor of HDHPs. Because the ill pay more than the healthy under HDHPs, families with children with special health care needs bear an increased cost burden in this model. HDHPs discourage use of nonpreventive primary care and thus are at odds with most recommendations for improving the organization of health care, which focus on strengthening primary care.

This policy statement provides background information on HDHPs, discusses the implications for families and pediatric care providers, and suggests courses of action. *Pediatrics* 2014;133:e1461–e1470

INTRODUCTION

High-deductible health plans (HDHPs) have been in existence for many years and were formally codified in 2003 by the Medicare Prescription Drug Improvement and Modernization Act (Pub L No. 108-173). They have become more prevalent in recent years and continue to grow rapidly. The early results of the Patient Protection and Affordable Care Act (ACA) of 2010 (Pub L No. 111-148) indicate that HDHPs will continue to proliferate. Therefore, it is appropriate for the American Academy of Pediatrics (AAP) to revisit HDHPs and their effects on health care for children. This policy statement seeks to enhance understanding of the basic principles of an HDHP, to evaluate how this model comports with the principles of the AAP in providing health care for children, and to make recommendations as to how (and whether) an HDHP should be implemented. Because research data on HDHPs are scarce on many points, as others have observed, "until better evidence emerges, policy

makers and employers will have to use the best available information and commonsense strategies."[1]

DESCRIPTION

For an existing HDHP to receive governmental approval, the plan must have a minimum deductible for 2013 of $1250 for an individual and $2500 for a family, with total out-of-pocket expenses (not including the cost of premiums) not to exceed $6250 for an individual and $12 500 for a family.[2] Because pure HDHP policies could discourage use of preventive services, to mitigate this effect, federal law requires HDHPs to cover basic preventive services—well-patient visits, immunizations, screening tests, and Bright Futures preventive services—with no deductibles and no copays.

An optional modification provided by the law is the addition of either a health reimbursement arrangement (HRA), which can be applied to any type of health insurance, or a health savings account (HSA), which is applicable only to an HDHP policy (Table 1).[2] Both HRAs and HSAs consist of tax-free funds that can be used to pay for out-of-pocket costs (except copays) not paid for by the insurance plan. In 2013, HSA contributions are limited to $3250 for self-only coverage and $6450 for family coverage. The mechanics of how funds are withdrawn and how the costs are paid—for instance, by special-purpose debit card or convenience checks that draw down the account—vary depending on the plan.

An HRA is both funded and owned by the employer. If the employee leaves employment, the funds revert to the employer, unless the employer opts to make them portable. At the discretion of the employer, unused funds may be carried over from year to year.

An HSA is funded by the subscriber, the employer, or both. The HSA account is owned by the subscriber, not the employer, and can move with the subscriber in the event of job change or retirement. In addition, HSA funds can be invested for interest or other gains, and those gains are not taxable. Unused HSA funds can be rolled over into an individual retirement account at age 65.

It is important to understand that if the HRA or HSA is funded by the employer at a sufficiently high level ("fully funded"), patients will not actually suffer financial harm, compared with conventional policies (ie, preferred provider organization, health maintenance organization, point of service, and indemnity plans). Instead, these features will simply induce patients to make a market calculation in seeking care because the need to tap into the savings account resource will be a much more palpable event as compared with the invisible use of resources with conventional policies. It is not known how well funded HRAs and HSAs have been, but common experience indicates that full funding of the accounts is unusual. The average HSA account balance was $1879 at the end of 2012; the average HSA account balance for accounts opened in 2005 was $4688.[3]

HDHPs are becoming a more predominant form of health insurance in the United States as they are increasingly offered by employers and chosen by subscribers. Although preferred provider organization plans remain the most common offerings by employers and cover more than one-half of covered employees, a 2013 report found that 20% of small companies and 40% of large companies offered an HDHP plan to its employees, and 20% of all employers offered HDHP plans as the only choice.[4] Whereas in 2006, only 4% of employees were covered by HDHP plans, that number is approximately 20% in 2013. One estimate is that 27% of HDHP enrollees are younger than 20 years.[5] It is estimated that more than 5 million people younger than 20 years are enrolled in HDHP plans. The health insurance marketplace, under the ACA, offers HDHP plans in the lower tiers, and the ACA allows HDHPs to continue to be offered by employers, so the number of patients covered by HDHP plans is expected to grow further.

Historically, enrollees who have chosen HDHP plans have represented a healthier, wealthier, and better-educated segment of the population. In one study, 64% of HDHP households declared themselves in excellent or very good health, and 89% earned $50 000 or more per year.[6] Increasingly, however, HDHPs are being offered by companies with a predominance of low-income workers. In 2012, 44% of covered workers at companies with many low-wage workers faced an annual deductible of $1000 or more, compared with 29% at firms with many high-wage workers. Across all employers, 34% of insured workers faced a deductible of at least $1000, with 14% required to pay a deductible of at least $2000 annually.[7] Some plans exceed the federal limits for copays or deductibles and are, thus, ineligible for adding the HRA or HSA features; whether they conform or not, however, all HDHP plans have the effect of shifting liability from the insurer to the insured.

TABLE 1 Comparison of HRAs and HSAs

Plan	Tax Savings	Funded by	Annual Rollover of Unused Funds	Portable
HRA	Yes	Employer	At the employer's discretion	At the employer's discretion
HSA	Yes (funds may be invested and earn interest tax free)	Employers and/or employees	Yes	Yes

HDHPS: FOR AND AGAINST

HDHPs represent a market-based approach to one segment of health care: the initial stages of care. In evaluating this approach, it is necessary to look at the detailed effects of HDHPs in practice as well as theory. Because of the scarcity of research data, it is necessary to use inferences and common experience of participants in the field as well as research findings.

For HDHPs

The rise in health care costs has placed unremitting pressure on employers, who remain the primary purchasers of health insurance products, and on individual purchasers as well. HDHPs offer a simple way to reduce the cost of premiums.

There have been many ideas for health care reform that would reduce total costs, but many of these ideas would be complex to enact, would require the cooperation of many who have vested interests and might be at financial risk from the reforms, and would require legislative authorization. By contrast, HDHPs are simple to implement, requiring the agreement of only the insurance company and the purchaser and no other stakeholder. In addition, legislation authorizing tax exemption for HSAs and HRAs was enacted in 2003. Simplicity of implementation is, no doubt, one of the most attractive aspects of HDHPs.

Employers, employees, and individual subscribers welcome the lower premium level of HDHP plans. Patients tend to accept HDHP deductibles and copays as familiar features, although the levels are higher than in conventional plans. Employees tend not to make the calculation that the financial risk of illness is being transferred to them from the insurer and the business owner. (As HDHP subscribers increased from 2007 to 2011, "Total per capita spending on employer-sponsored insurance grew at an average annual rate of 4.9 percent … [and] out-of-pocket medical spending increased at an average annual rate of 8.0%."[8]) Both individual subscribers and employees who are confident of their ability to make medical choices and to withstand the financial risk may find HDHPs a reasonable choice, especially if linked to an HSA or HRA. Even if they are not confident of their continued good health or medical navigational skill, subscribers of modest means can find the HDHP premium their only affordable choice and may judge running the financial risk of HDHPs preferable to being uninsured.

In addition to these practical considerations, HDHPs have been justified on a theoretical basis. With conventional private insurance, patients are shielded from the financial effect of their purchases when they seek care at the early stages of illness. As a result, patients may use more of the services than they would if they had to pay the actual cost of the services. By contrast, HDHPs require a family to confront the market price of health care services at the point of purchase—a primary care or specialty visit, a laboratory test, or a hospitalization. With "skin in the game," it is hypothesized that patients will have incentive to seek less care for minor reasons, to seek more high-quality and low-cost services, or perhaps to adopt a healthier lifestyle (eg, exercise more, lose weight, improve nutrition, abstain from or reduce smoking and alcohol consumption) to avoid medical expenditures. Because of the patient's direct exposure to the financial consequences of seeking care and his or her expected responses to this burden, HDHPs have been called consumer-directed health plans.[9]

There is evidence that patients with HDHPs do consume less health care than those in other plans.[10–13] Patients with HDHPs are prescribed generic drugs more often than other patients, make fewer visits to specialists, are less frequently hospitalized, and have fewer visits to doctors for episodes of illness and make fewer visits within those episodes.[12] HDHPs seem to reduce overall health care costs significantly.[12] How much the employer saves on HDHP policies depends on both the level of HRA or HSA funding and the utilization behavior of the patients. It seems clear, however, that total employer costs of HDHP plans are less than with conventional plans.

There is ample anecdotal evidence from knowledgeable consumers, especially medical professionals, that HDHPs have worked well for their personal health care insurance. They have been able to save money individually and for their office staff/personnel as they advise them on health care decisions, by canny utilization of the system. When they avoid visits for minor illnesses or avoid tests that seem to be an overreach of care, money accumulates in their HSA accounts. When their families are healthy, they reap the reward. Their above-average wealth allows them to withstand the risk of unexpected expenditures for illness. Although less sophisticated consumers may not be able to make such decisions, the HDHP model works for many in this specific group.

Against HDHPs

While acknowledging the success of HDHPs in reducing expenditures, at least in the short term, critics of HDHPs find many flaws with the HDHP strategy.

Appropriateness of Preferentially Decreasing Initial and Lower-Cost Care

Although most agree that cost reduction in the American health care system is essential, HDHP critics insist

that constraining "first-dollar" expenditures by excluding these costs from insurance support, while leaving the higher-cost items covered and thus unconstrained, is a poor choice. Virtually all policies today have deductibles, but the expanded level of the deductible under HDHPs means that a majority of patients will find all their primary care costs to be fully out-of-pocket (except for preventive visits), along with costs that flow from primary care encounters, such as tests, imaging services, medications, and specialty office visits. In addition, because of the higher deductible limit, many procedures will now be encompassed in the out-of-pocket domain, such as hernia repairs, tympanostomy tube placement, and even procedures such as pectus excavatum surgery.

The reason the American health care system is so expensive, however, is not generally considered to be expenditures in the low-cost sector, which represent the majority of encounters. Hospitals, procedures, prescription drugs, and imaging are generally considered the major culprits of the high cost of medical care, rather than ordinary office services. Increasingly, health policy analysts are assigning the high cost of care to high prices even more than high utilization.[14] The HDHP focus on the low-cost segment of care would thus appear to be misplaced.

Moreover, a significant amount of costs are incurred by a small percentage of high-cost patients. "Nearly two-thirds of health care costs are concentrated in 10% of patients, so to control costs, the focus needs to be on these patients, not the 50% of the population that is relatively healthy and uses just 3% of the health care dollar"[15] (see Fig 1). A way to decrease costs for these patients would be to supply more initial and primary care, not less.[16]

The conclusion, then, would be that although cost reduction is important, a better solution than curtailing costs at the low end would be curtailing costs at the high end and with high-intensity users, which are exactly the areas in which deductibles are ineffective.

Lack of Concurrence Between HDHPs and the National Strategy on Health Care Organization

Most health policy experts agree that the United States suffers from insufficient primary care and a surfeit of specialty care.[17,18] Evidence also indicates that primary care should be the foundation of a highly functional health care system.[19] Primary care is widely thought to be an essential service that, if well-used, saves money for the system. Prescriptions for waste reduction in the medical care system generally exempt primary care and have never targeted primary care for children.[20] Although studies have not shown great savings from preventive services, it is reasonable to assume that primary prevention and early detection of disease decrease morbidity and associated costs. It is also widely assumed that having a ready source of primary care prevents excessive use of emergency departments.[21,22] Starfield asserted that "Several international studies have confirmed the importance of … low

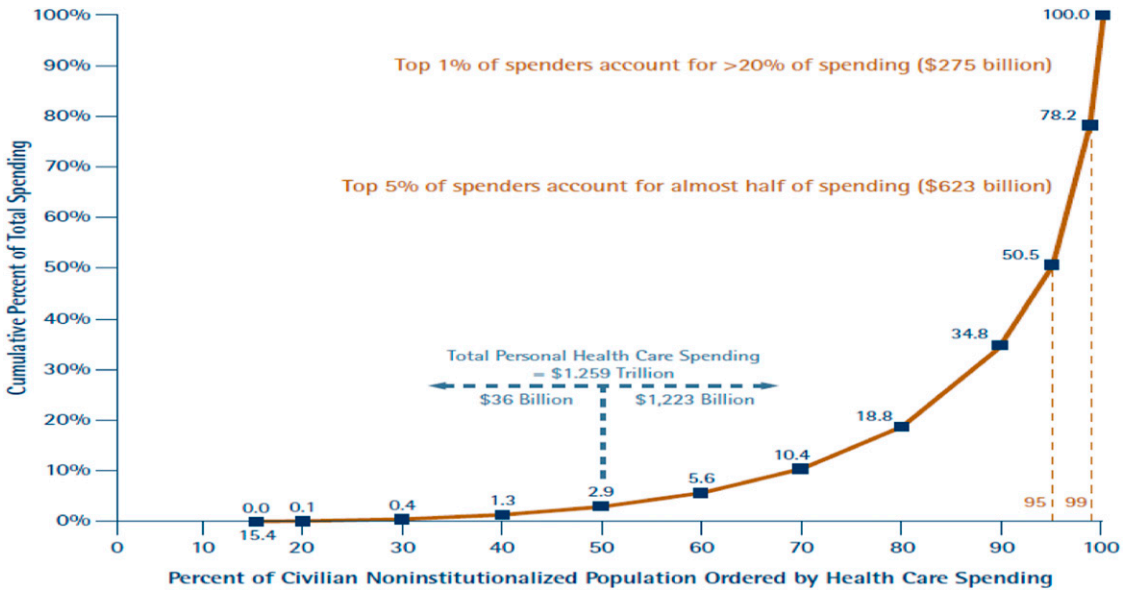

FIGURE 1
Cumulative distribution of personal health care spending, 2009. Reproduced with permission from National Institute for Health Care Management Foundation analysis of data from the 2009 Medical Expenditure Panel Service.

or no cost sharing for primary care services."[23]

One policy response to the need for buttressing primary care has been the patient-centered medical home (PCMH).[24] The PCMH is essentially a strengthened primary care office with highly personal care, greater nurse outreach and team care, an emphasis on preventive services and patient registries, education about self-care, and guidance and coordination through the medical care system. The AAP supports the PCMH model and believes that the activated primary care office will be an important component of improved health care organization.[25]

There are many potential negative effects, however, that HDHPs could have on the strategy of increasing the capacity of American primary care. HDHPs reduce the resources that could and should be invested in primary care; fewer resources expended in a sector will inevitably lead to its degradation. The PCMH strategy requires more resources rather than fewer. In addition, it is widely recognized that 2 prime deterrents to choosing a career in primary care are the imbalance of specialty/primary incomes and the difficulty of managing primary care offices. HDHPs only exacerbate both of these influences (see next section).

Specific Effects on Primary Care

Although HDHPs affect more than just primary care, primary care is perhaps unique in its reliance on relatively small payments for a large number of patients as well as the absence of higher-priced procedures. Expanding the deductible to HDHP levels makes nearly all primary care visits throughout the year (except for preventive visits) subject to out-of-pocket payments. HDHPs will, thus, have a uniquely heavy effect on primary care (as well as cognitive specialty services), making it important to define the effects.

As rational consumers, families confronted with high deductibles will often search for strategies to minimize their out-of-pocket expenditures. They may forgo visits and access information of questionable reliability from sources such as the Internet, neighbors, and the like. They may attempt to substitute telephone conversations for face-to-face visits. They may postpone needed consultations in an effort to address concerns only at well-child visits that are exempt from deductibles. They may decide not to accept physician recommendations for testing or referrals or for follow-up visits to monitor the progress of a disease process. These consumer tactics will affect both health outcomes and processes for patients as well as the operations of the primary care office. In addition, postponement of visits can contribute to the physician's risk of the most common outpatient malpractice complaint—failure to diagnose serious disease early.[26]

Even though HDHPs offer full coverage of preventive visits without reference to the deductible, HDHP patients tend to stint on preventive care, including immunizations.[10] It is reasonable to believe that early detection of disease suffers, although there have been no studies on that important subject. Continuity of care and the doctor–patient relationship suffer as primary care visits are discouraged and efforts to fulfill the requirements of PCMHs are eroded. Even if a visit would not have revealed serious illness, the calming effect of reassurance to a worried family is part and parcel of excellent medical care, frequently not only allaying anxiety but also averting further use of medical resources, and to the extent that these visits are discouraged, an essential facet of medical care is undermined.

In addition to the effects of HDHPs on care itself, HDHPs also impede the functioning of a pediatric primary care office. Although the literature might not explore these specifics, they are readily apparent to practicing physicians. Substituting telephone calls for office visits increases practice overhead and decreases income. Excessive discussions of costs increase visit times and, thus, overhead, a point that advocates for spending time discussing finances with patients ignore.[27] Bundling sick visits into preventive visits increases the time per visit and may decrease the quality of either the preventive service or the illness service or both, and it is difficult for the office to receive payment for this extra service, despite it being warranted by *Current Procedural Terminology* coding rules.

Finally, it is common experience that billing costs and bad debts are exacerbated by HDHPs. It is usually impossible to know how much a patient will owe for a visit at the checkout station because insurance company Web sites are most often problematic in delivering information that includes both the allowed charge and the deductible remaining. The method of accessing an HRA or HSA account is often opaque. Repeated billings are often necessary, with the attendant overhead, and patients are not infrequently unwilling to pay once they are away from the office and the service, and they are angry that their substantial premiums do not cover all their medical bills. Although some of these factors apply to all insurance, with HDHPs, they recur throughout the year.

Effects on Those Not Choosing HDHPs—Adverse Selection

HDHPs promote adverse selection to health insurance pools as healthier patients gravitate toward the lower premium price HDHP plans, leaving conventional private plans with disproportionate numbers of sicker, higher-cost patients. As a result, patients in

conventional plans will pay higher premiums because patients opting for HDHP plans will not be contributing fully to the common pool.

Quality of Care With HDHPs

Although the previous discussion has included observations of quality of care, it seems appropriate to reiterate these effects here. Once again, a lack of studies hampers this effort, but inferences can, nonetheless, be made. Patients frequently make poorly informed decisions in the medical care marketplace. Many of the reductions in care, not only office visits but also tests and consultations, hospitalizations, emergency care, and use of generic drugs in some cases, may be unwarranted.[28] One study has shown that patients of modest means postpone visits to emergency departments for serious illnesses.[28] This phenomenon is especially pronounced in males.[29] A report on Medicare patients has shown that increased cost-sharing has led to decreased physician visits and prescriptions but also to a higher rate of hospitalization.[30] Pediatric surgeons report informally that many patients defer elective but important procedures because of cost under an HDHP plan (personal communication, Mary Brandt, MD, professor of surgery and pediatrics, October 12, 2013). Continuity of care and the doctor–patient relationship suffer as primary care visits are discouraged under HDHPs, fewer patients receive preventive care, and fewer patients are fully immunized.[12] The ability of PCMHs to fulfill their mission is undermined. It stands to reason that with increased barriers to seeking initial care, some diagnoses and treatments of illnesses will be delayed. Haviland et al, advocates of HDHPs (referred to as consumer-directed health plans), concede that "for all populations, enrollment in [consumer-directed health plans] … leads to reductions in care that is considered beneficial."[13] In short, there are many reasons to think that HDHPs decrease quality of care and few to think that they increase it.

HDHPs and Market Mechanisms

HDHP critics question whether market mechanisms are capable of achieving the outcomes that HDHP advocates would wish. Many patients agree with the critics and think that shopping for health care is confusing and inappropriate.[31] There appear to be many discrepancies between theory and actuality.

A well-functioning market requires well-informed consumers to make rational choices, but many believe that the highly specialized nature of medical decision making, coupled with the profound information asymmetries and uncertainties that characterize these interactions, undermine the ability of market mechanisms to effectively function as expected.[32] Certainly, urgent situations are not compatible with "careful shopping," and the emotional distress accompanying acute illness often compromises rational decision making.[33]

Although in the aggregate, patients in HDHPs consume fewer health care resources in response to higher out-of-pocket expenditures, whether this consumption pattern is beneficial remains an open question, as the previous discussion of quality of care under HDHPs illustrates.

There is some evidence that patients tend to equate higher price with higher quality.[34] One study indicated that when confronted with a complicated benefit structure, patients often make suboptimal choices.[35] An example of this situation is that 80% of patients with HDHPs are unaware that their policies mandate coverage of preventive services free of the deductible or copays (supplying at least part of the explanation for poor prevention and immunization statistics under HDHPs).[36] Patients with chronic illnesses forgo care because of cost.[37] Poorer families choose to forgo care more often than families with higher income.[38]

Market mechanisms depend critically on price signals for consumers to be able to make market decisions, but few prices from clinicians, laboratories, or specialized and diagnostic services are publicly available online or even by request to the office.[39] Indeed, prices negotiated between practices and health plans are confidential by the terms of the contract. In addition, the price of a visit is uncertain beforehand, because the level of the service rendered by the physician cannot be predicted. On the other hand, because generic drugs are used more frequently and tests and hospitalizations are used less frequently than with conventional plans, one can surmise that when the primary care physician is involved in the decision making, costs can be alleviated. Economist Victor Fuchs commented, "The idea of sick patients shopping for the lowest-price medical care … is a fantasy."[40]

Finally, critics of HDHPs suggest that because patients lack medical knowledge, one of the most important functions of the primary care physician is to guide the patient in choosing among health care options. Thus, it would seem counterintuitive to encourage laypeople not to use the professional knowledge and judgment of a primary care physician, especially when a primary care visit is perhaps the least expensive encounter in the entire spectrum of health care services.

Aspects of HDHPs That Apply Specifically to Children

In health care financing, as with pediatric health care, children are not simply smaller adults. Unfortunately, there is little research on the specific

effects of HDHPs on children. Nonetheless, certain features of these plans pose significant concerns.

Families with small children tend to be high users of primary care services. As such, HDHPs would seem to be particularly inappropriate for them. Because young families are often struggling financially, they will be particularly prone to choosing the lower-premium HDHP plan but then be torn whether to make a visit for a sick child. As noted earlier, the statistics of lower use of preventive visits and lower immunization rates is sobering.

Pediatrics places special emphasis on children with special health care needs. These children and their families are specifically disadvantaged by HDHPs. If the family is insured by an HDHP, they will experience higher health care costs than under conventional insurance. If they instead obtain conventional insurance, the premiums and payments they face will be higher because of adverse selection—that is, patients without special needs will be paying less into the common pot.

In addition, some have suggested that there might be legal and ethical aspects to enrolling children in HDHPs. Although adults may be free to take chances with their own lives and health care, the state has a recognized function in protecting children. There is a risk in delaying health care that is exacerbated by financial considerations. It is possible for adults to delay seeking care for their children that turns out to have been necessary. Foreseeing this situation, it might be in the state's interest to disallow HDHPs for children.

Finally, health care for a child costs, on average, about half that for an adult younger than 65 years and approximately one-quarter to one third that for a Medicare patient. The problems of the excessive cost of American health care can hardly be attributed to children. It would seem to make sense, then, to save money on children's health care only where it is clearly ineffective and inefficient. That public policy in America favors adults and the elderly over children has been well documented; saving on health care of children while the bills of the elderly are unconstrained would seem to be foolish.

The Flow of Resources Within Medical Care Sectors

A subtle point of economic theory is worth mentioning. If HDHPs put pressure on initial care, but there is no such force on the higher-cost items experienced by higher-intensity patients, commercial innovation and research will favor the area where funds flow more freely. Costs will thus not be constrained in the areas where they most need to be, and less effort will be spent on innovation in primary care, which already lacks sufficient attention.

Disparities

Disparities in access, service, and outcomes have been a persistent concern of the AAP and health policy analysts. It is therefore important to reflect on the effect of HDHPs on disparities. If an HDHP plan is linked to a highly funded HRA or HSA, there should be little difference in access between HDHPs and conventional plans. To the extent that the HRA or HSA is less well funded, however, patients who experience high costs and patients who have lower income will experience a higher percentage of their incomes devoted to health care. In some states, the coverage envisioned under the ACA could be as high as 8% to 27% of income for a family of 4 whose income is 200% of the federal poverty level.[21] Although income effects are not the only cause of disparities, the effects of HDHPs will be to exacerbate the effects of disparate wealth, both by making HDHP policyholders less able to seek care and by making the premiums of conventional polices more expensive because of adverse selection.

To be more clear: even under the ACA, patients with low incomes—either 100% of the federal poverty level or less or 133% of the federal poverty level or less (depending on the state)—will be eligible for Medicaid. Their access to care will not be limited financially, although it will be constrained by the number of providers accepting Medicaid patients. For patients who have private insurance, the difference in ability to obtain care will depend on the level of their incomes. Higher-income patients will be only somewhat impeded by financial constraints, but those who are just over the Medicaid-eligible line will find the financial constraints more daunting. In other words, it will be the people in the middle, those "just making it" financially, who will feel most strongly the tension of balancing worry over needed care with worry over money. The conclusion, therefore, can be drawn that HDHPs not accompanied by fully funded HRAs or HSAs contribute to disparity of access to care on the basis of income.[28,38]

SUMMARY

HDHPs are an understandable response by the insurance industry and employers to the rising cost of health care. The major effect of HDHPs is to incentivize patients to balance the perceived need for initial care against the cost before the deductible is met. HDHPs have led to lower expenditures on care by their subscribers. Sophisticated medical care utilizers and healthy and higher-income patients can save significant amounts of money under HDHPs. High funding by employers of HRA and HSA plans can ensure that patients as well as employers benefit.

Critics point out that the lower-cost sectors of health care are less important for

cost savings than higher cost areas that are unaffected by HDHPs; that lower-cost patients are affected by HDHPs, but higher-cost patients are more of a cost problem; that primary care is affected negatively by HDHPs, which goes against established health policy goals; that health care quality might be negatively affected by HDHPs; that health care disparities may be accentuated by HDHPs; that using a market mechanism to induce more patient choice might be inappropriate; and that HDHPs might be particularly inappropriate for children, who are a lower-cost population than adults and who are large utilizers of primary care.

RECOMMENDATIONS

The AAP cautions that HDHPs may be a less desirable way to lower health care costs than other means that can be found, even if "other means" require more work by government, insurance companies, and other health policy participants. Consideration should be given to mandating that HDHPs be offered only to adults and not children.

Benefit Design

1. HDHP policies should permit a generous number of primary care visits to be allowed without the deductible each year or that outpatient visits be exempted from the deductible, as is proposed by the Bipartisan Policy Center for Medicare patients.[41] A list of other important and beneficial services and procedures usually provided by medical subspecialists that would be exempted from HDHP deductibles should be compiled. Examples might be insertion of tympanostomy tubes, appendectomy, and reduction and casting of fractures, for instance.
2. If children are to continue to be offered HDHP coverage, insurers should define children with certain diagnoses as "children with special needs" using the Maternal and Child Health Bureau's definition, and eliminate the burden of a deductible for these children.
3. HSA and HRA health savings accounts should be required to be funded at high levels by the purchasing employers.
4. All elements of the PCMH should be included in the plan benefit package and paid, without application of the deductible, appropriate to the relative value units, including telephone and electronic communication services. Insurers should cover and pay appropriately for all services described by the *Current Procedural Terminology* manual.

Insurance Company Administrative Policies

1. Insurance companies issuing HDHP policies should be required to devise procedures so that medical offices can easily and rapidly determine the complete bill of the patient at the time of a visit, enabling the office to try to pursue proper collection from the patient at the time of the visit.
2. Patients with HSA and HRA accounts should be issued debit or credit cards that allow medical offices to access the accounts at the time of service.
3. Because practices will incur significant additional overhead costs in administering HDHPs, insurance companies should compensate practices for those costs. One alternative would be to pay practices per-patient-per-month overhead allowances.
4. Insurers should take positive steps to emphasize the importance of preventive visits to its policyholders and to inform them that such services are not subject to the deductible or copays. Plans should be held responsible for continually assessing the completeness of preventive services utilization by its policyholders and to take appropriate steps as conditions warrant.
5. Because of the complexity of HDHP plans, especially when one considers that each company would have its own specific rules and procedures, insurance companies should ensure that they enable both patients and providers to understand provisions. Handouts for the offices and Web site explanations should be available in real time. Insurance companies should have specifically assigned representatives for each office for general issues and should be able to deal with problems in real time, and insurers should facilitate training of office staff members in handling HDHPs. Materials for patients should specifically counsel patients not to stint on primary care services, especially preventive services.

Actions by the Primary Care Offices

1. A staff member in each office should be knowledgeable enough about HDHPs to be able to explain the concept and the details to a potentially confused patient. Patient handouts describing HDHPs and especially the fact that preventive care is not subject to copays or a deductible would be helpful.
2. Offices should continue to give feedback on problems with HDHPs to the AAP by using the Hassle Factor forms (available online at My AAP at www.aap.org/moc, see More Resources).

Alternative Cost-Reduction Strategies

1. Policy makers should continue to devise alternative strategies that will

reduce costs in ways that do not negatively affect primary care. Examples include reduction of high prices rather than utilization, particularly of hospitals, procedures, pharmaceuticals, and medical devices[42]; offering incentives and support to practices to serve high utilizers with intensive primary care; increasing use of hospices and decreasing use of ICUs for end-of-life care; promoting accountable care organizations; promoting centers of excellence[43]; developing further value-based insurance plans; increasing use of publicly reported physician report cards for both primary care and specialists issued by independent practice associations as well as hospitals and medical groups; enacting tort reform; and many other strategies.[44,45]

Legislation

1. State governments should take steps to make the knowledge of prices for services at various institutions readily available to the public and primary care offices.
2. The federal government should consider restricting HDHP plans to those older than 18 years.

Research

1. Significant efforts to study the effects of HDHPs, especially on children, should be made. The potential foci of research are multifold and deserving of a report solely devoted to the topic of the specific needs for research on HDHPs.

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Pediatrics originally published online April 28, 2014;

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Pediatrics originally published online April 28, 2014;