American Academy of Pediatrics
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POLICY STATEMENT

High-Deductible Health Plans and the New Risks of Consumer-Driven Health Insurance Products

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

Committee on Child Health Financing

ABSTRACT

Consumer-driven health care is the most noteworthy development in health insurance since the widespread adoption of health maintenance organizations and preferred provider organizations in the 1980s. The most common consumer-driven health plan is the high-deductible health plan, which is essentially a catastrophic health insurance plan, often linked with tax-advantaged spending accounts, with very high deductibles, fewer benefits, and higher cost-sharing than conventional health maintenance organization or preferred provider organization plans. The financial risks are significant under high-deductible health plans, especially for low- to moderate-income families and for families whose children have special health care needs. Of concern for pediatricians are the potential quality risks that are predictable in high-deductible health plans, in which families are likely to delay or avoid seeking care, especially preventive care (if it is not exempted from the deductible), when they are faced with paying for care before the deductible is met. This policy statement provides background information on the most common consumer-driven health plan model, discusses the implications for pediatricians and families, and offers recommendations pertaining to health plan product design, education, practice administration, and research.

INTRODUCTION

Consumer-driven health care is the most noteworthy development in health insurance since the widespread adoption of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) in the 1980s. Faced with unsustainable premium increases and heightened competition, employers are experimenting with new products, referred to as consumer-driven health plans (CDHPs).[1] The potential benefit of a CDHP is to increase the control consumers have over their health care spending and to empower them to use published information to guide their care options. The most commonly sold CDHP is a high-deductible health plan (HDHP), which essentially is a catastrophic health insurance plan, often linked with tax-advantaged spending accounts, with very high deductibles, fewer benefits, and higher cost-sharing than conventional HMO and PPO plans. HDHPs offer a new strategy for sharing risk and responsibility for health care costs among employers and employees.[2] HDHPs also represent a major shift from defined benefits to defined contributions.[3] At this time, there is insufficient information to ascertain the specific effects of HDHPs on children's access to care and the operation of the medical home; however, there is concern that

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Key Words
consumer-driven health plan, financing, high-deductible health plans, health savings account, preventive health care

Abbreviations
HMO—health maintenance organization
PPO—preferred provider organization
CDHP—consumer-driven health plan
HDHP—high-deductible health plan
HRA—health reimbursement account
HSA—health savings account
AAP—American Academy of Pediatrics

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children from low- to moderate-income families and children with special health care needs may be at risk if covered under HDHPs.

This policy statement provides background information on the most common CDHP model—the HDHP paired with a tax-advantaged spending account—and the latest research on these new insurance products. The statement also discusses the implications for pediatricians and families and offers recommendations pertaining to product design, education, practice administration, and research.

BACKGROUND

HDHPs were established by the Medicare Prescription Drug Improvement and Modernization Act of 2003. Currently, qualified HDHPs are health insurance plans with at least a $2000 deductible for family coverage and a total annual out-of-pocket maximum, including deductible, copays, and other cost-sharing, that cannot exceed $10 000 per family.[4] The spending account—either a health reimbursement account (HRA) or a health savings account (HSA)—is used to pay for a portion of health care expenses until the plan's high deductible is met; then, the HDHP functions like a PPO plan.[5]

The 2 common spending accounts differ in terms of ownership, requirements to be tied to an HDHP, discretion to carry over unused amounts into subsequent years, and portability (see Table 1). Briefly, the HRA is owned and solely funded by the employer.[6] It is typically offered with an HDHP but also can be offered with an HMO or PPO. The employer has discretion about the amount of funds to be carried over, and HRAs are not portable.[7] The HSA is owned by the employee, although the employer can contribute. It can only be used with an HDHP that has a deductible up to $5150 per family.[7] Money can be carried over from year to year, and the HSA is portable.[7]

Research shows that very large and very small employers as well as individuals in the nongroup market are most interested in offering and purchasing HDHPs. Early research suggests that healthier and wealthier individuals are more likely to purchase HDHPs than their counterparts. Individuals and families in higher tax brackets, especially those who are healthy, can benefit from this method to save for medical expenses, and possibly retirement, with pretax dollars.

According to the 2005 National Employers Health Benefits Survey[8] sponsored by the Kaiser Family Foundation and the Health Research and Education Trust, 20% of employers are offering an HDHP, up from only 5% in 2003. A minority of firms that offer HDHPs (1 in 5) offer either an HRA contribution (10%) or an HSA-qualified plan (12%). In firms that offer HRAs, approximately 25% of employees participate (1.6 million employees or 2% of all covered workers). On average, employer contributions to HRAs amount to $1556. In firms that offer HSAs, approximately 15% of employees participate (810 000 employees or 1.2% of all covered workers). Average annual employer contributions to HSAs amount to $1185, with one third of employers making no contributions. It is unclear what the average amount that employees contribute is.

Table 2 illustrates the cost differences between HDHPs and PPOs for an average family. Although the proportion of employers currently offering HDHPs with spending accounts is small, the expected growth is predicted to be sizeable. According to the 2005 National Employer Health Benefits Survey, 2% to 4% of firms reported that they were very likely to offer HDHPs next year, and 22% to 25% reported that they were somewhat likely to offer them.[9]

PREVENTIVE CARE AND HDHPs

Generally, an HDHP cannot provide any benefits before the deductible is satisfied, but there is an exception for preventive care. Referred to as the "safe harbor for preventive benefits," HDHPs with HSAs are permitted, but not required, to offer preventive care without meeting the deductible.[9] According to the Internal Revenue Code, preventive care is defined as routine well-child care and immunizations; periodic health evaluations, including tests and diagnostic procedures ordered in conjunction with routine examinations, such as annual physicals; mental health and substance abuse screening; vision and hearing screening; screenings for various pediatric conditions (ie, developmental delay, congenital hypothyroidism, lead concentration, phenylketonuria, and scoliosis); metabolic, nutritional, and endocrine screening; infectious disease screening; and maintenance drugs used by chronically ill patients.[10] Despite this important provision, the 2005 National Employer Health Benefits Survey found that only 30% of employers who offer an HDHP with an HSA covered preventive care before the deductible was met, thus eroding the relationship between the medical home and the family.[9]

TABLE 1 **Comparison of HRA and HSA**

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)	Can be both employer and employee	Yes	Yes

TABLE 2 **Comparison of Premiums and Deductibles in HDHP and PPOs**

Plan for Average Family of 4 Members	Average Annual Premiums, $	Average Annual Deductible, $
HDHP with HRA	8530	3686
HDHP with HSA	7909	4070
PPO	11 090	646

IMPLICATIONS FOR PEDIATRICIANS AND FAMILIES

HDHPs carry potentially significant coverage, financial, quality, and practice risks for pediatricians as well as families. Among the coverage restrictions, HDHPs typically offer less generous coverage for certain services (eg, drugs, mental health) compared with PPOs or HMOs.[10] Physician and hospital coverage is likely to be the same, although not necessarily in terms of cost-sharing.[8] It is often difficult to assess the coverage risks associated with preventive care, because the service may or may not be exempt from the deductible; also, information on periodicity and content may not be extensively described in consumer materials. Another more significant coverage risk of HDHPs is the potential for "destabilization" of employer-sponsored health insurance if more employers and families purchase HDHPs instead of HMOs and PPOs, which typically offer more comprehensive benefits.

The financial risks are significant under HDHPs, especially for low- to moderate-income families and for families whose children have special health care needs.[7] Because visits by children with special health care needs to specialists are not considered preventive care, parents will need to tap into their HSA or HRAs to pay for these visits as well as any laboratory tests, imaging, therapies, and other essential health care services. Once the HSA or HRA is depleted, parents will need to pay out-of-pocket until they have reached their deductible. Thus, children with special health care needs may not receive all their recommended care, and/or their families may have considerable out-of-pocket expenses. Clearly, families face greater exposure to financial risk with higher deductibles, use of coinsurance versus copays, and higher out-of-pocket maximums.[11] In addition, families may face higher per-service charges because there is not a "middle man" negotiating provider discounts.[12] Under managed care plans, discounted fees are provided in exchange for the potential for increased volume, prompt payment, and streamlined claims processing. These favorable discounts may not be available under HDHPs. In general, HDHPs with spending accounts could potentially be advantageous only if certain conditions were met—for example, if the family had few health problems, the premium was priced low, preventive care was not counted toward the deductible, benefits needed by the family were covered with affordable cost-sharing, and few services were used by the family.[13]

Of concern to pediatricians are the potential quality risks that are predictable in HDHPs in which families are likely to delay or avoid seeking care when they are faced with paying for care before the deductible is met.[14] Lower rates of preventive care and immunizations, less compliance with recommended treatment, less continuity of care, and lower use of acute and chronic care services are very real concerns.[15] HDHPs have the potential to adversely decrease access to medical homes and result in more episodic, high-priced care. Faced with difficult choices, families may seek to "load up" on a scheduled visit to save money or delay care until after the deductible is met. In the end, families will have to make many more decisions about the cost-versus-quality trade-offs, relying on Internet-based information, online patient support tools, and nurse help lines.[1]

Although decision-support tools have been identified as a special feature of HDHPs, a recent US Government Accountability Office report[16] noted that tools provided by insurance carriers to assist consumers in assessing the price and quality of health care providers and services do not provide sufficient information to allow enrollees to fully assess the cost and quality trade-offs of health care–purchasing decisions. Of concern are the methods that insurers and third-party agencies use to rate the quality of care of providers. Relying on claims data, for example, represents a flawed approach to judging quality.

A variety of pediatric practice risks are starting to emerge with HDHPs. Among them are greater administrative and collection costs and bad debt for practices.[17] This is attributable in part to the fact that some HDHP administrators have notified families not to pay the physician charges at the time of service, instead waiting for explanation of benefit statements to assess deductibles and savings account balances. Importantly, pediatricians are likely to be asked more about the costs of their services as well as the content and value of specific services.[13] In addition, families in these plans will likely request more telephone and e-mail assistance to avoid making in-person visits.

RECOMMENDATIONS

The following recommendations focus on the different groups of people and organizations affected by CDHPs. These groups include the insurance companies and third-party payers designing the plans, the families purchasing the plans, and the employers providing the plans. Also included are recommendations for physicians and practices to prepare for CDHPs.

HDHP Design

- Coverage should be provided for preventive services including, but not limited to, well-child care, immunizations, and appropriate screenings.

- Preventive services should be "first-dollar" coverage (ie, covered before the deductible is met).
- Allowed reimbursement amounts for preventive services should be age adjusted to provide adequate payment for preventive health care recommended by the American Academy of Pediatrics (AAP).
- Physicians should be allowed to collect copays and payment for nonpreventive services at the time of visit. Methods to make this simpler, such as real-time debit cards for HSAs, should be developed. Vendors should implement integrated, real-time claims-adjudication processes to help clinicians obtain payment for services from the patient more quickly.
- Payment for services before the deductible has been met should be at billed charges. If a contracted fee schedule is used, it should be adjusted to reflect the increased billing and administration costs incurred by the physician.
- Consideration should be given to payment for telephone and e-mail services, because telephone and e-mail advice will be in greater demand.

Education

- Increase pediatricians' awareness of the prevalence of HDHPs in their geographic area and their varied cost-sharing requirements and benefit designs.
- Communicate to employers the importance of covering preventive care outside the deductible and the importance of receiving preventive care in the medical home.
- Publicize to employers, patients, and the public the average costs of preventive care services, including the increased frequency of examinations and number of vaccines required during the first 2 years of life and the increased amount of time required for adolescent care.
- Consider new educational strategies to assist families when insurance decisions are made, and focus on deductible levels, preventive care coverage, cost-sharing protections, provider networks, spending accounts, and payment arrangements.

Practice Management

- Publicize the practice's policy about collecting payment for services at the time of the visit.
- Communicate the costs and reasons for preventive, acute, follow-up, and chronic medical care.
- Establish billing policies for telephone and e-mail services.
- Prepare for greater administration/collection burdens and bad debts.
- Use AAP Hassle Factor forms (available online at the Member Center at www.aap.org/moc [under "more resources"]) to inform state and national AAP leaders of issues and problems.

Quality Improvement Measures

- HDHPs should adhere to providing quality data information to consumers on the basis of measurement standards developed by accrediting organizations.
- Quality data should be based on measures that are evidence based, relevant to patient outcomes, and statistically valid and reliable.

Research

- Encourage, support, and promote research to assess the value and benefits of preventive pediatric services and promote research to evaluate the effects that HDHPs have on children's and adolescents' access to care and family satisfaction with care and cost of care.
- Examine the effect of HDHPs on the use of medical services, including preventive, acute, and chronic care.

CONCLUSIONS

CDHPs offer the opportunity of more consumer involvement in the decision to purchase specific health care items. However, of notable concern are the effects of this process on children receiving necessary and highly cost-effective preventive care and on lower- or middle-income parents, who will have to pay for a substantial amount of their children's health care out-of-pocket.

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