HEALTH ACCESS

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Behind the push for high-deductible plans

What is high deductible health plan?

A high-deductible health plan is one that requires single enrollees to spend between $1,050 and $5,100 on health care (families must spend between $2,100 and $10,200) before insurance benefits kick in.

What is a Health Savings Account?

A Health Savings Account (HSA) allows consumers to save and invest pre-tax dollars that can later be withdrawn to pay medical expenses, such as co-payments and deductibles.

Like other savings accounts, if the money isn't used in a year, it can be rolled over and continue to compound and accrue. To open one, however, a consumer must be enrolled in a qualified high-deductible plan.

MYTH: *High deductible health plans will help reduce everyone's health care costs.*

The drive to promote these plans relies on the myth that consumers are "over-using" medical services because their insurance benefits are too rich.

This "over-use" of health care is causing costs to increase, proponents say.

Proponents of high deductible health care plans believe that that these so called "consumer-driven" health plans could help control the fast-escalating costs of health care by causing consumers to have more "skin in the game."

By having to pay higher deductibles and higher portions of their health care costs, consumers would ostensibly 'shop around' for lower cost services, or go without unnecessary health care services.

FACTS: *High-deductible plans miss the target.*

In fact, these bare bones plans could actually cause health care costs to increase – not decrease.

Why?

- ***High-deductible plans do little to address the true cost drivers –and spenders- in the health care system.***

Ten percent of the population spends 64 percent of health care dollars. These people are extremely sick and don't have much of a choice in "shopping around." Their health costs are so high, even if they did have a bare bones, high-deductible plan, they would be spending their entire deductible anyway – costing the system the same amount of money.

- ***No way to shop for quality health care.***

Consumers have no way to shop around – based on price or quality – for health care providers or products.

- ***Consumers prefer quality over cost.***

Bare bones plans rely on the notion that consumers would look for the "cheapest" health care, if they had to pay for it. But a study on the laser-eye surgery market, a non-urgent and non-covered medical procedure, shows that 66 percent of consumers pay for mid- and premium-tier services after careful research into the quality of services.

- ***No clear instructions on which medical expenses are "covered" and can be applied toward deductibles***

Families could end up spending thousands of dollars on health-related expenses only to find out that they are no closer to getting their costs covered by insurance.

- ***Separates the market into the "healthy" and "less healthy."***

Healthier consumers, who need less care and stand to benefit most from bare bones plans, would create their own risk pool, leaving sicker enrollees, who use more health care in a separate risk pool. With fewer "healthy" people to spread the costs, this would lead to higher premiums.

- ***Preventive care could be postponed.***

Lower income enrollees could choose to forego preventive treatments, leading to more expensive and extensive treatments later on.

President Bush has proposed $11.8 billion in tax incentives a year to expand the use of high-deductible plans and encourage HSAs. That amount would encourage 8.3 million people to use high deductible plans, only 46 percent of whom were previously uninsured, according to the Center for Budget and Policy Priorities.

For that same amount of money, Bush could extend coverage to:

* 6.6 million children on Medi-Cal per year
* 4.4 million adults on Medi-Cal per year
* 2 million seniors and people with disabilities on Medi-Cal.

EXISTING CALIFORNIA LAW

There are currently no limits on out-of-pocket costs for health coverage products.

Department of Managed Health Care:

The Knox-Keene Act regulating health plans under DMHC establishes minimum basic benefits, requires plan contracts to cover all medically necessary basic services and requires health plans to assume full financial risk, giving DMHC some authority to review and revise plan benefits and limit cost sharing to some extent.

The DMHC may restrict administrative spending, but does not judge plans on whether consumers are getting value for their premium dollar.

California Department of Insurance: By contrast, CDI has no meaningful authority to set limits on out-of-pocket costs or require minimum basic benefits.

CDI may only deny health plans if the package could render an insurer fiscally insolvent.

Tax policy: In order not to encourage high-deductible plans or underinsurance, the California legislature has resisted attempts to provided tax incentives for HSAs, or otherwise conform to federal tax policy.

BACKGROUND

The number of consumers with High Deductible plans, who have health coverage requiring them to pay more out of their own pockets, is rising.

According to The RAND Corporation, while 18% of California employers offered an HDHP in 2004, this figure could increase to more than one-third of employers within two years, if employers follow their reported intentions to add HDHPs to their health plan offerings.

In 2003, federal tax changes directly encouraged higher deductible policies by allowing individuals to establish tax-free Health Savings Accounts (HSAs), but only if the accounts are combined with an HDHP meeting federal standards. HDHPs paired with HSAs are sometimes referred to as "consumer-directed health plans."

A recent insurance industry survey estimated three million people nationally have HDHPs *compatible with HSAs*, but the trade publication, Inside Consumer-Directed Care, estimates that only about one million HSA accounts existed by January 1, 2006. Harris Interactive reports that of consumers with an HDHP, only 13% have an associated financial account. This could mean that many consumers with HDHP coverage will not have the funds available to cover their deductible should they need expensive medical care or hospitalization.

The impact of high out-of-pocket expenses for insured families can be devastating.

Medical debt is a key ingredient in family bankruptcy even for insured families.

The 2003 Commonwealth Fund Health Insurance Survey found that over half of those with a deductible of $1,000 or more had difficulty paying medical bills or were paying off accumulated medical debt. The problem is more severe for lower income persons. For those with incomes under $35,000, and deductibles of $500 or less, 55% reported having problems paying medical bills or had accumulated medical debt, compared with 37% of low income persons with lower deductibles and 27% of higher income persons with deductibles of $500 or more.

Research has consistently revealed that when consumers have to pay more of the costs, they reduce the health care services they use. However, research reveals that people delay or avoid necessary, essential services and treatments, not just inappropriate or discretionary services.

Data from the 2005 Strategic Health Perspectives found that 47% of employees currently enrolled in an HDHP said they did not have a choice of health plan at the last enrollment. In addition, 19% of individuals buying individual coverage reported they did not have a choice of plan.

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