

# Stakeholder Conversations about HSA-eligible High Deductible Health Plans: Benefits, Limitations and Innovations

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## Executive Summary

As health care costs continue to consume an increasing percentage of the country's employer and household budgets, high deductible health plans (HDHPs) have generated interest from employers interested in reducing health care expenditures and engaging enrollees in their health care, in addition to consumers interested in lower monthly premiums.

HDHPs are relatively new coverage options compared to more traditional plan designs. Many experts question how well HDHPs address the evolving challenges facing our health care system. Some believe there is a need to evaluate the effect these plans have on users' health behavior and overall health care costs as evidence from a recent RAND Health Insurance experiment indicates that higher consumer cost sharing before the deductible may lead some to avoid obtaining both necessary and unnecessary care.<sup>1</sup> It is well documented that the avoidance of routine and preventive health care, particularly pertaining to chronic disease management, results in more costly complications and poor health outcomes.<sup>2</sup> In light of increasing enrollment trends in the high deductible market, additional examination is necessary to explore how these plan designs and saving options impact how employers and consumers—particularly consumers living with or diagnosed with a chronic condition—comprehend, utilize, and pay for care.

To better understand the benefits and challenges of HDHPs, the University of Michigan Center for Value-Based Insurance Design (V-BID Center) completed a series of qualitative interviews with an array of health care stakeholders in the employer and insurance markets. Participants offered diverse perspectives in their discussion of HDHPs, producing a series of supplemental considerations regarding plan benefits, insufficiencies and possible improvements. Some respondents noted that HDHPs have the potential to raise consumer responsibility and participation in their health care utilization, recognizing that these plans may have challenges meeting the needs of select populations that could result in decreased utilization of necessary treatment. Others suggested that proper education and communication measures prior to implementation—combined with seed money to offset the deductible and to promote employer engagement—may be keys to overcoming these challenges. In addition, participants offered measured insights regarding federal regulations that currently define primary, secondary and tertiary preventive services and their applicability to HDHPs. Some respondents felt that first-dollar coverage of primary preventive services below the deductible was adequate, while others indicated that expanding first-dollar coverage to secondary preventive services would be financially and ethically appropriate to encourage those living with chronic disease to seek and access care. Despite an openness to exploring ways to reduce the costs of their health care coverage and promote employee engagement, many expressed ambiguity over whether HSA-eligible HDHPs are the right tool to address chronic disease care and

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<sup>1</sup> <http://www.rand.org/health/projects/hie.html>

<sup>2</sup> <http://www.uspharmacist.com/content/s/200/c/33457/>

management – even with the option to include secondary and tertiary services as first-dollar covered services. Additional research is needed to explore how the rapid uptake of HSA-eligible HDHPs impacts cost and adherence, particularly in chronic disease populations.

## Background

HDHPs are a growing part of the health insurance landscape. In 2013, nearly 60 percent of firms with more than 5,000 workers offered an HDHP, either coupled with a health reimbursement arrangement (HRA) or health savings account (HSA). According to the 2013 annual health benefits survey by Towers Watson and the National Business Group on Health, 66 percent of companies with 1,000 employees or more offered at least one such plan in 2013. This figure is expected to grow to nearly 80 percent in 2014, according to the survey.<sup>3</sup> Among nearly 15 percent of companies surveyed, a savings account-based plan was the only option available to employees—an increase from 7.6 percent in 2010. Enrollment trends continue to rise as well with 15.5 million Americans enrolled in HSA-eligible HDHPs in 2013, up from 6.1 million in 2008.

Created by the Medicare Prescription Drug Improvement and Modernization Act of 2003, HSA-eligible HDHPs have defined minimum deductibles and maximum out-of-pocket limits.<sup>4</sup> For 2014, the minimum deductible is \$1,250 for an individual and \$2,500 for a family; maximum out-of-pocket limits are \$6,350 for an individual and \$12,700 for a family.<sup>5</sup> These rules apply when a plan with a high deductible incorporates an HSA into its benefit design. HSAs allow beneficiaries to put a set amount of money in a tax-advantaged account to be used for medical expenses. The Internal Revenue Service (IRS)-regulated savings accounts do not expire, are portable (not attached to employment, but solely to the beneficiary) and can accept contributions from both beneficiaries and employers.<sup>6</sup>

As outlined by the U.S. Treasury Department, individuals currently insured with an HSA-eligible HDHP are required to pay the full cost of most medications and services—in theory, utilizing pre-tax HSA funds—until deductibles are met. However, the 2003 authorizing legislation includes a safe harbor allowing plans to cover preventive services before the deductible is met. IRS guidance defines preventive services as including, but not limited to, the following: periodic health evaluations, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs, and a number of screening services. These services, meant to prevent the development of chronic disease, are recognized as primary preventive services, and may be covered before the deductible in HSA-eligible HDHPs.<sup>7</sup>

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<sup>3</sup> <http://www.towerswatson.com/en/Insights/IC-Types/Survey-Research-Results/2013/03/Towers-Watson-NBGH-Employer-Survey-on-Value-in-Purchasing-Health-Care>

<sup>4</sup> <http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf>

<sup>5</sup> <http://www.irs.gov/pub/irs-drop/rp-13-25.pdf>

<sup>6</sup> <http://www.irs.gov/publications/p969/ar02.html>

<sup>7</sup> A full glossary of terms in this report can be found as the first appendix.

However, IRS guidance documents specifically exclude from the definition of prevention those services or benefits meant to treat “an existing illness, injury or condition.”<sup>8</sup> This exclusion encompasses the bulk of what is known as secondary or tertiary preventive services and prohibits HSA-eligible HDHPs from offering these benefits before enrollees meet their deductibles. This exclusion precludes HSA-eligible HDHPs from providing first dollar coverage of many proven disease management strategies.

In light of increasing enrollment trends in the high deductible market, additional examination is necessary to explore how HSA-eligible HDHPs impact how employers and consumers—particularly consumers living with or diagnosed with a chronic condition—comprehend, utilize, and pay for care. The combination of the rapidly increasing uptake of HDHPs and the growing prevalence of chronic disease in the U.S. suggest that rendering these plans more effective tools for disease management is a worthwhile endeavor.

### Research Issue

The University of Michigan Center for Value-Based Insurance Design ([www.vbidcenter.org](http://www.vbidcenter.org)) has contributed to efforts in research, development, evaluation, and advocacy of innovative health benefit designs to ensure efficient expenditure of health care dollars and to maximize benefits of care since its inception in 2005. V-BID aligns consumer incentives with clinical evidence by reducing barriers to high-value services and providers and discouraging the use of low-value services and providers through differentiated cost sharing. Basing consumer cost-sharing on the clinical value of a medical service or provider visit, payers can actively engage providers to identify and limit low-value services, and simultaneously encourage consumers to seek high-value care. The V-BID Center is keenly interested in the impact that HSA-eligible HDHPs will have on health care service delivery, consumer behavior, and health economics. As the plans continue to gain popularity, the effects they have on how consumers seek and pay for care in today’s the rapidly changing health care market should be studied to gain perspective on their use.

As outlined above, HSA-eligible HDHPs are regulated by the IRS and limited as to what medical goods, services and provider visits may be covered before the deductible is satisfied.<sup>9</sup> Currently consumers are required to pay the full cost of most medications and services (in theory, utilizing their tax-advantaged HSA funds), including goods and services meant to treat and prevent the advancement of chronic disease until deductibles are met. As chronic disease currently constitutes 75% of total U.S. health spending,<sup>10</sup> there is a need to evaluate what effect the restrictions these plans place on coverage of secondary and tertiary services have on overall health care costs and outcomes.

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<sup>8</sup> <http://www.irs.gov/pub/irs-pdf/p969.pdf>

<sup>9</sup> [http://www.irs.gov/publications/p969/ar02.html#en\\_US\\_2013\\_publink1000204030](http://www.irs.gov/publications/p969/ar02.html#en_US_2013_publink1000204030)

<sup>10</sup> <http://www.cdc.gov/chronicdisease/index.htm>

For example, in accordance with primary prevention guidelines, HSA-eligible HDHPs are allowed to cover services such as immunizations, screenings, and diagnosis-related testing before the patient meets the plan's deductible,<sup>11</sup> but the plan is prohibited from covering services to treat chronic disease such as diabetes, including insulin, eye and foot exams, and glucose monitoring supplies until after the deductible is met. To date, much research exists on the subject of delaying or avoiding care due to cost, particularly for those living with chronic disease.<sup>12</sup> The V-BID Center is interested in assessing whether allowing HSA-eligible HDHPs to reduce or eliminate the patient's out-of-pocket cost for certain secondary preventive services related to chronic disease management has the potential to reduce health complications and more complex episodes of care related to non-adherence.<sup>13</sup>

The V-BID Center completed a series of qualitative interviews with stakeholders in the employer and insurance market to discuss existing HSA-eligible HDHPs and how the creation of a value-based HDHP that included first-dollar coverage of chronic disease services might impact premiums, chronic disease management, and plan uptake. The Center sought the perspective of insurance plan designers, employers who offer HSA-eligible HDHPs as “full replacement plans,” employers who offer the HSA-eligible HDHPs alongside more traditional plans, and employers who did not offer an HSA-eligible HDHPs and did not intend to in the immediate future.

The interviewer inquired about implementation successes and challenges that HSA-eligible HDHPs might pose to employers and consumers, as well as which categories of preventive services were currently covered prior to satisfaction of the deductible. Respondents were also asked to identify what specific medical goods and services might be covered in a hypothetical new plan that offered secondary and tertiary preventive services for chronic disease management prior to satisfaction of the deductible. Respondents were asked what they thought worked well and what they found problematic about HSA-eligible HDHPs, and for those who did not offer HSA-eligible HDHP options, if they would consider implementing an HDHP in the future.

### **Methods: Recruitment**

To reach a diverse array of respondents, the V-BID Center employed a snowball sampling technique to recruit participants. The V-BID Center queried its [National Advisory Board](#) to explore the topic with industry contacts they believed would have particular insight on the topic. If a contact expressed interest in participating in a one-on-one interview, the Center Director and support staff followed up with a detailed email and follow-up phone conversation introducing the discussion topic for the candidate to consider. If the contact agreed to participate, additional topic background information documents and consent forms were emailed to the individual to participate in the exploratory interview.

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<sup>11</sup> [http://www.irs.gov/publications/p969/ar02.html#en\\_US\\_2013\\_publink1000204083](http://www.irs.gov/publications/p969/ar02.html#en_US_2013_publink1000204083)

<sup>12</sup> <http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n12/Medication-Utilization-and-Adherence-in-a-Health-Savings-AccountEligible-Plan>

<sup>13</sup> <http://www.ahrq.gov/news/newsletters/research-activities/mar11/0311RA8.html>

The V-BID Center obtained consent from the following stakeholders:

- Employers who offered HSA-eligible HDHPs in addition to more traditional plans such as PPOs and HMOs;
- Employers who offered HSA-eligible HDHPs as the only employer-sponsored plan, otherwise known as “full replacement” plans;
- Medical provider consultant
- Employers who did not offer this type of plan at all and had no immediate plans to do so; and,
- Benefit plan directors who offered HSA-eligible HDHPs in addition to more traditional plans on the group and individual markets.

The breakout of respondents included:

- Three representatives from managed health care organizations that offer HSA- and HRA-eligible HDHPs in addition to other forms of coverage for over 37.6 million lives on the individual, small and large group market;
- Three large, for-profit organizations with over 100,000 domestic and international employees and retirees who currently do not offer an HDHP;
- One for-profit employer organization that offered full replacement HSA-eligible HDHP to all salaried employees totaling approximately 17,000 employees;
- One health system employer with over 20,000 employees that recently began offering an HSA-eligible HDHP;
- One medical provider corporate consultant;
- One labor-based employer offering full replacement HSA-eligible HDHP to non-negotiated non-unionized management of approximately 1500 employees;
- Three large employers totaling over 200,000 employees who offer HSA-eligible HDHP alongside other plans.

**For ease of reference, we have included the following table to identify stakeholder responses throughout the document.**

**Table 1: Respondent Descriptions**

Category of respondent	Description
Benefit Plan	Three managed health care organizations that offer HSA-eligible HDHPs in addition to other forms of coverage on the individual, small and large group market
Employer, offers HSA-eligible HDHP with other plans	Three for-profit employers that offer HSA-eligible HDHP alongside other plans options.
Employer, Full replacement HSA-eligible HDHP	One for-profit employers with domestic and international employees that offered full replacement HSA-eligible HDHP to all salaried employees; One labor-based employer offering full replacement HSA-HDHP to non-negotiated non-unionized management;
Health System, offers HSA-eligible HDHP with other plans	A health system employer that recently began offering an HSA-eligible HDHP alongside other plan options
Employer, no HDHP option	Three for-profit organizations with over 100,000 domestic and international employees and retirees who currently do not offer an HDHP
Medical Provider	Medical provider, corporate consultant

### Interview Tool

A twelve-item interview questionnaire was designed and used with all participants. A single interviewer scheduled, coordinated, and conducted all thirteen interviews via phone. Interview audio files were transcribed and compiled to create a final exploratory report. To protect participant and organizational confidentiality, no identifying data is referenced in this report.

### Interview Questions

Respondents were asked what they thought worked well in current HSA-eligible HDHPs and where the plans might be improved; what preventive services were offered in their HSA-eligible HDHPs prior to satisfaction of the deductible; if they would consider expanding preventive services coverage prior to satisfaction of the deductible if they had the option to do so; what preventive services, if any, would respondents like to see covered prior to satisfaction of the deductible; how premium prices might be affected by covering these services prior to the deductible. **The full questionnaire is available as Appendix II in this report.**



## Research Limitations

Due to the small sample size and choice of a non-probability sampling technique, the findings from these interviews should be considered non-generalizable exploratory ideas that may be built upon for future research projects. Findings from these interviews are intended to provide additional information about HSA-eligible HDHPs to discover how they perform in the expanding health care marketplace, and if there is interest in modifying these plans with an option to provide additional medical goods, provider visits, and services related to chronic disease management prior to the satisfaction of the deductible.

This exploratory project interviews only a small selection of HDHP stakeholders: particularly, benefit plan representatives and employers. A future assessment exploring the plans from consumer/enrollee perspective, or potentially, a hybrid perspective of employers, consumers, clinicians, and actuaries and might produce a more nuanced perspective particularly considering full replacement plans. Deliberately selecting stakeholders with explicit clinical knowledge might offer more information about what sorts of medical goods and services, if any, might be provided pre-and post-deductible and engaging professionals in actuarial science might more fully inform the project in terms of feasible pricing guides. Further, intentionally engaging an array of small, medium and large employers, as well as both for-and-non-profit employers to learn about the innovations and challenges these plans pose for each respective employer would further inform the subject.

Additional development of the question tool to produce an electronic, coded survey and the development of an internet-based, secure, anonymous electronic recruitment and engagement strategy would facilitate a larger sample population of employers, consumers and benefit plan representatives to produce significant, quantifiable results from a much larger group of participants offering HSA-eligible HDHPs.

Conducting quantitative analysis of HSA-eligible HDHP claims data pertaining to chronic disease medical goods and service utilization to assess whether the introduction of the plan had an impact on chronic condition care management, adherence, and overall medical spending (both in the immediate and long-term) would further inform the topic. Finally, informed by the quantitative analysis of claims data, creating hypothetical HSA-eligible HDHP models that included particular chronic disease medical goods and services (including proposed premium and plan model pricing) would be of considerable value in identifying high value services to include as first-dollar coverage options.

It is our hope that findings from this preliminary exploration will generate additional inquiries on the topic of HSA-eligible HDHPs that might lead to the development of more comprehensive methods for subsequent analysis of these plans.

## Summary of Findings

When asked about HSA-eligible HDHP utilization trends, respondents reported increased implementation and enrollment in HDHPs, and noted that the plans offer enrollees without significant health care needs as well as higher-income individuals who

can afford to pay the deductible the benefit of reduced monthly premiums and a chance to accrue savings in health savings accounts. Benefit plan representatives see increasing enrollment in these plans as an emerging opportunity, and expressed interest in expanding their accessibility to consumers to increase customer satisfaction and loyalty, particularly as a counteroffer to plans offered on public exchanges.

Respondents also noted that HDHPs have the potential to raise employee participation and increase financial responsibility for the consumer in their health care utilization. However, communication and educational strategies are seen as imperative for successful HDHP implementation to ensure that consumers understand how the plans are structured and what category of medical goods and services are subject to the deductible.

Respondents expressed concern that without sufficient education prior to plan rollout, HDHPs may discourage the utilization of medically necessary treatment, particularly for those living with chronic conditions, in an effort to avoid out-of-pocket costs. Additionally, respondents noted that HSA-eligible HDHPs may not work well for those living with multiple chronic conditions; older populations with evolving health care needs and fixed incomes; those who must manage non-generic prescription drug costs; and those of lower socio-economic status, who may not have the financial ability to meet the deductible and may be disadvantaged in understanding how to effectively navigate the plan's restrictions.

Employers noted a lack of standardization or guidance outlining which services for chronic disease management should be considered high-value in terms of cost and clinical effectiveness, and might, therefore, be available as an option prior to satisfaction of the deductible. Citing a lack of pricing transparency and consistency for medical goods and services, employers indicated that work is needed to align the value of medical goods, provider visits, and other health services so that these plans have the option to offer necessary services pre-deductible while limiting the utilization of the low value or unnecessary services that impact cost control.

When asked to consider the creation of an HSA-eligible HDHP with an option to cover secondary and tertiary services prior to satisfaction of the deductible, respondents' opinions varied. Employers that did not offer an HSA-eligible HDHP noted that expanding the coverage options in the HDHP so that disease management services were available without financial constraint of the deductible would align more closely with their organizational philosophy and existing coverage options. They voiced an interest in exploring this option with the understanding that these conversations were exploratory and many respondents encouraged innovative recommendations to generate additional perspective on this issue.

Some employers that offered an HDHP alongside more traditional plans indicated that other plan options existed for those managing chronic disease and that expanding HDHPs to include disease management services prior to satisfaction of the deductible would fundamentally alter the intent and structure of the high-deductible plan and offset any savings the plans provided. Further, some employers that offered an HSA-eligible HDHP as a full-replacement plan expressed interest in expanding services prior to

satisfaction of the deductible, but expressed concern over a lack of clear recommendations and benefit cost-analysis to determine what services should be considered necessary for effective chronic disease management. While many respondents hypothetically noted that low-cost chronic disease services and medical goods might be covered pre-deductible, the lack of a systematic rating system, such as that used to define primary preventive services, made consideration difficult.

Employers without HSA-eligible HDHPs offered several reasons why they did not plan to offer this type of plan in the immediate future. Some respondents indicated that HDHPs conflicted with organizational philosophy in terms of providing comprehensive health care coverage. Others (particularly large employers) stated that annual benefit satisfaction surveys indicated high employee satisfaction and that they were able to negotiate satisfactory coverage with more traditional plan options. Employers without an HSA-eligible HDHP also cited difficulty regulating the type of care and selection of providers that consumers accessed before meeting the deductible as a deterrent to offering the plan. Others noted that IRS guidance blocked certain groups from contributing to an HSA and this would significantly impact their employee population.

A combination of respondents expressed uncertainty as to whether HSA-eligible HDHPs are the proper tool to address chronic disease care and offered perspective on additional possibilities, innovations or improvements. Some respondents noted that chronic disease services can be more appropriately covered with by HDHPs coupled with HRAs rather than HSAs. Others indicated that organizational discretion and employee health demographics should factor considerably into HDHP design and would support a more tailored HSA-eligible HDHP design, particularly those organizations with a significant number of employees managing chronic disease conditions. Some respondents also expressed interest in creating an “HSA-eligible HDHP +” concept plan with a higher tiered monthly premium to offset the provision of additional goods or services for chronic disease care alongside a more “traditional HSA-eligible HDHP” if employers wanted a lower cost option.

Respondents generally expressed interest in having the option and increased flexibility to make the plans more responsive to individual organizational health needs particularly if the goals of increased consumer responsibility and well-outlined, evidence based standards were aligned with reasonable costs to the purchaser. Respondents expressed a desire to implement plans that improve population health, promote high-value care, and reduce the risk of more costly health complications. However, juxtaposed with rising costs and facing a variety of health care system reforms, respondents lacked a clear framework of high-value recommendations and are restricted by federal regulation as to what services they can offer in an HSA-eligible HDHP both to satisfaction of the deductible.

The following passages encompass a broad array of interview themes and quotes from de-identified respondents on HSA-eligible HDHPs, including perceived benefits and shortfalls in coverage and costs; how the plans address chronic disease care; and how they might be innovated and potentially improved.

### ***Appropriate Populations, Competitive Advantages, Effective Choices***

Respondents recognized increasing enrollment in HSA-eligible HDHPs and affirmed a widely-held notion that in general, the plans seem well-suited for people without significant health care needs who do not require routine or ongoing health services for disease management.

Satisfaction has generally been pretty high and I think that that has a lot to do with people understanding the plan and recognizing how it gets used and satisfaction tends to be higher for people who don't do a lot of healthcare every year. So--if most of what you get are a few generic medications and you do your preventive screening stuff then your out-of-pocket isn't terrifically high and you're able to build up your HSA.

#### **–Benefit Plan**

I think for some populations it is a good option. I tell my nieces and nephews to join. They're young. They're healthy. They can build up their reserves, their accounts, as long as it's an HSA. **–Employer, no HDHP**

They recognize the need to address health care costs. They tend to be a younger population and they saw this as a better way of doing it rather than just increasing deductibles and co-payments. **–Employer, Full Replacement HSA-eligible HDHP**

Respondents noted that HSA-eligible high deductible plans may provide adequate coverage for a variety of consumers interested in reduced monthly premiums, particularly now that these plans are required to offer primary preventive services for zero cost sharing before the deductible.

I believe the plans offer a degree of flexibility for an individual in terms of how they choose to spend their dollars and what they choose to insure versus what they choose not to insure. So it puts them in a pretty good position from that perspective. **–Employer, No HDHP**

For someone who doesn't use a lot of healthcare on the one hand they may not even hit their deductible in a year but their premiums are rather low. And if they have the HSA they can carry over their funds...So you can tailor your use of resources to what makes sense for you. So that works and also there's a contribution usually to an HSA by an employer and so that goes a long ways towards helping you cover the deductible.

#### **–Benefit plan**

I was very skeptical of high deductible health plans because my concern was that people who needed treatment would avoid treatment. And after the initial savings of the cost shift of the deductible and the deferral of care that goes with that, that inflation would actually go up equal or higher annual rate. I have to say that has not been our experience, that our experience is that people get necessary care and it has substantially

impacted our annual inflation of health care costs. **--Employer, Full Replacement HSA-eligible HDHP**

Almost all of the plans have first dollar coverage for preventive services and some of them, of course, there's some preventive services that are for free, especially that have no co-pay, especially on the medical side. So if you're [having] a mammography or a colonoscopy or something like that, for screening purposes they don't have a co-pay if you're in network.

#### **–Benefit Plan**

The premise behind the high deductible plans has always been that you want to increase consumerism and have people be more proactive in the participating of their health care. I think that we would agree with that concept that we think that it is important to making health care a more sustainable concept. **–Employer no HDHP**

Hoping to increase the marketability of HDHPs, benefit plan representatives viewed the increased enrollment in HDHPs as an emerging opportunity to appeal to a broader array of consumers. They expressed interest in making the plans more accessible and appealing to a diverse customer population to increase both customer satisfaction and consumer loyalty while allowing for more portable insurance coverage as the marketplace becomes more competitive and as consumers look for ways to lower their health care cost.

[W]e want people to be satisfied with our services and to stick with us. And there are a lot of people, especially younger people who most of the preventive services and the occasional visit to the emergency department is pretty much the extent of their interaction with both the healthcare system and with their plan. And so those are folks who we really like to keep on our plan. We hope that they would become loyal to us over a number of years...it's really about uncoupling employment and health insurance and enabling people to have health insurance that's truly portable. **–Benefit Plan**

[W]e have a vehicle for which our employees can provide benefit suggestions throughout the year. And [offering an HSA-eligible HDHP] has been something that's been brought up [by employees] as well our providers have brought it up...so I can say from that perspective, I know that there is certainly a part of our population that would be interested in, and is going to be pleased that we're offering it. **–Health System, offers HSA-eligible HDHP with other plans**

Benefit plan respondents also indicated that as they are currently structured, HSA-eligible HDHPs are structurally similar to some of the lower-end plans on the public health exchange marketplace such as a silver or bronze plan<sup>14</sup> and offered an opportunity to provide similarly priced plans to those in need of coverage.

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<sup>14</sup> <https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/>

Having more options will always be welcome...because as we move into the exchanges we want to be offering plans that really are able to engage and manage cost in order to really sustain affordability. The more flexibility we have in that regard will help. **–Benefit Plan**

“[If we] really start looking at the individual population...you have more uninsured [individuals] coming into the market. You have a lot more people buying this individual health insurance and if you look at those plans—they’re either HSA plans or they look a heck-of-a lot like an HSA-HDHP.” **–Benefit Plan**

Respondents noted that HDHPs have the potential to both reduce costs and improve health accountability by encouraging consumers to use market-based strategies of cost-comparison to shop for plans that meet their needs and budgets. Benefit plan respondents noted that the HSA-HDHP design necessitates more consumer accountability and may result in increased or more engaged decision-making, such as proactively accessing routine preventive care that may reduce costs.

I’ve heard [HDHP plan] described as the sentinel effect: it causes people to pay attention because they have a material share in the cost. And that prompts them to do more homework...to determine the care that they need to find the right provider for that care based on their own definition of “right”. And cost is going to be a component of that decision in ways that it wasn’t before. **–Benefit Plan**

[W]e actually have found some data that indicates that there is savings beyond just the adjustment and actuarial value because people do start thinking more about the type of care they’re getting. But we also have evidence that individuals start making better decisions about their healthcare more broadly...for example, using different resources that are available, and getting preventive care. We have data that shows that on some large employers that had gone full replace health savings account plan designs... [A]dults were seven percent more likely to get their preventive care. Particularly, employees over 40 and spouses over 40 were four or five percent more likely to get their preventive care visits that were prescribed to them based on their age. **–Benefit Plan**

Historically [it] has not been very easy for consumers to get information but we’ve been working very hard to make that kind of information, whether it’s drug price information or the estimates for treatment costs more available to consumers and more accurate and more personalized ways so they can make more informed decisions regarding the financial aspects of their care. **–Benefit Plan**

Ultimately the generic price for X prescription dropped at retail quite a bit ...from 120 dollars a month to 20 dollars a month. The mail order, which is generally cheaper than the retail, did not drop much. It went from 120 to, maybe 50 or 60. If that’s all paid at a hundred percent I never look at it. But I was motivated and had tools available to me that I could shop and I

changed how I got the drug, saved a thousand dollars a year. That's a problem. That's a problem with things paid at a hundred percent; you lose that engagement. **–Employer Full Replacement HSA-eligible HDHP**

Employers who offered an HSA-eligible HDHP as the only coverage option, or “full replacement,” as well as employers who offered an HSA-eligible HDHP as an option alongside other plans on the small-and-large-group markets articulated that they wanted more options to encourage employee/consumer engagement and proactive participation in their health care decisions.

[HDHPs] have been around for a while and you see a huge surge in popularity now because of the issues around cost but we really paid a lot of attention to how these plans actually influenced employees. And our main carrier had done a study of their own employees that showed that it did really motivate employees to become better consumers versus making them more fearful about simply spending money and withhold and denying themselves care or not seeking care when they should because of cost. And we really felt that the pendulum had switched because of a lot of the other things that were added now around free preventive care and so on.

#### **–Employer offers HSA-eligible HDHP with other plans**

Respondents also offered insights on how the portable tax-advantaged health savings accounts buffer the expense of meeting the deductible up front and long-term. They note that an HSA can be used for immediate health care expenses, has no expiration date like a flexible spending account (FSA), and is not attached to an employer-contribution like a health reimbursement account, (HRA). As such, the HSA effectively functions as a long-term personal medical savings account for future expenses.

We have a segment of our population that saves the max every year and never spends it. So if they have health care claims they're paying out of their pocket, not out of their HSA. They're using this as a long-term, tax-free savings vehicle. **–Employer, Full Replacement HSA-eligible HDHP**

And the average person...they still grow the account over 400 dollars a year typically. So you got a couple of years of that and even with the healthcare expenses you're helping the population build themselves a cushion on which to have for their healthcare expenses whether they're near term or long term. The more we can do to promote HSA's as kind of a way to help solve this whole affordability crisis by getting more engaged consumers and helping the consumer themselves be more financially prepared is good. **–Benefit Plan**

For an individual, we put 700 dollars in your health savings account. So if you don't have any claims you actually made money on the deal.

#### **–Employer, Full Replacement HSA-eligible HDHP**

When asked about the initial cost of meeting the deductible, respondents noted that while some consumers might be unprepared to cover the initial out-of-pocket costs, they

also indicated that those that who select a high-deductible plan may have intentionally have planned and budgeted for the deductible in exchange for lower monthly premiums and a tax-free, portable savings account. Further, a respondent noted that once the deductible was met, an HSA-eligible HDHP would cover all qualified medical expenses (likely including chronic disease services) at the allowable rate for the designated plan year and that this might offer significant savings to the consumer as opposed to traditional plans that had higher monthly premiums and ongoing copayments/costs.

As we look at the high deductible plan and who goes into plan...it's those that obviously can bear the burden of the risk of the higher deductible. And they're comfortable with that and it's appealing to have a lower premium...I think the qualified [HDHP] with the HSA is incredibly appealing just because of the ability to put pre-tax dollars in the HSA and the flexibility in terms of carrying those dollars. —**Employer, offers HSA-eligible HDHP with other plans**

The plans are great...from the standpoint of giving to the benefits enrollees great responsibility for managing their healthcare dollars and becoming more responsible stewards of both their health and their healthcare utilization practices and healthcare consumerism. But my concern is that people generally aren't necessarily ready to take on those responsibilities even with all of the tools and resources available to them. There are populations I think are perhaps better positioned to do this; healthier, higher socio-economic groups that may already have some familiarity with the way the healthcare system works are better positioned. I think that people that don't understand the delivery system, the basis for the benefit design approach and those who are of lower socioeconomic status are perhaps a bit less likely to derive the value that was intended through these programs or through this benefit —**Medical Provider**

I actually think employees who have very serious health conditions that cost a lot of money—they're very appreciative that there's a high deductible, but when your out-of-pocket maximum is met the plan picks up everything. So that's a lot of money for some people, hundreds of thousands of dollars, and they recognize this isn't so bad. —**Employer, Full Replacement HSA-eligible HDHP**

Overall, respondents affirmed the belief that certain populations can benefit from the lower premiums and primary prevention service coverage of current HSA-eligible HDHPs. Several respondents also noted for those aware of the deductible requirement, the benefit of reduced monthly premiums and the ability to use a tax-free portable savings account to cover medical expenses may balance out the deductible. Respondents also indicated that the plans may motivate some employees to use the HSA as a component of an effective financial management strategy and that both the savings account and the required deductible may motivate enrollees to become more engaged, informed consumers when they have a financial stake in seeking out cost-saving in their healthcare choices. Further, as individual consumers review their



coverage options and requirements, respondents noted that HSA-eligible HDHPs may function as a competitive plan option on the national health exchange as consumers seek to enroll in a plan that fits their coverage needs. Respondents focused intently on the cost benefit of the plans, rather than overall benefit provision and satisfaction and additional exploration of comprehensive consumer satisfaction with a focus on quality and accessibility of care is recommended.

### ***Challenges, Consumer Education Strategies, Communication Plans***

Respondents were also asked to consider the limitations of current HSA-eligible HDHPs as well as strategies to address perceived gaps in coverage and consumer concerns. Respondents indicated that for those living with multiple co-existing conditions, older populations, those who must manage non-generic prescription drug costs and lower-socio economic populations who do not have the financial ability to immediately meet the deductible or put sufficient money into the tax-free health savings accounts, the reality of the HSA-eligible HDHP comes with “hidden costs” that may result in delayed or avoided care, medication non-adherence due to cost, and the potential for more costly medical complications down the road.

For an older population not highly paid, when there are chronic conditions it may not be optimal. **–Employer, no HDHP**

But people who live paycheck to paycheck don't put money in their HSA. And then they get a bill and they don't have the wherewithal to pay it. **–Employer, Full Replacement HSA-eligible HDHP**

What's a problem is for people who don't put away enough in the HSA or the HRA and then they're surprised by how much they have to pay before they get to the deductible. And surprises are bad and that's a big problem I think people have with health plans; they don't read through all the documents. They may not understand all the things that are being said.”

#### **–Benefit Plan**

Employers who do not offer an HSA-eligible HDHP expressed concern about initial reductions in health care spending and what these reductions might mean in terms of employees' health. Some respondents noted that while initial data may indicate cost-savings in terms of reduced health care costs for employers, more conclusive study of both short and long-term data is necessary to determine whether the plans produce savings due to better alignment of health care services, consumer engagement measures, and reduced premiums, or due to the cost of meeting the deductible. As the plans continue to gain popularity, the effect the deductible has on consumer behavior merits both qualitative consumer evaluation and quantitative verification as to how the plans are saving money.

I am a believer in letting the employers in the plan design what they think is going to work best for them and not be limited always by legal reasons...continue to do more research and I know it's being done on HDHPs, and where the true savings are coming from...some employers

are pulling theirs back because all the data shows they are saving all their money by people just avoiding care because they can't afford the deductible. **–Employer, no HDHP**

While avoidance of care due to the deductible is a concern, employers note that eligibility constraints pertaining to HSA enrollment is another challenging variable to navigate. Current IRS guidelines prohibit certain groups, such as veterans and retirees with Medicare benefits, from contributing to a health savings account and this makes widespread adoption of the plans challenging for employers considering full-replacement strategies to reduce costs.

We've got a lot of vets here... [W]hen I've got a situation where I've got a guy who went over and served, gets wounded, is getting VA benefits...and because of that can't contribute to his HSA. My head wants to explode. And I've got to communicate that [exclusion] to my workforce. I can't think of a worse message. **–Employer, Full Replacement HSA-eligible HDHP**

When we implemented the HSA full replacement we also extended that to the flex retirees, the people who retired after 1993. And of course, that's not compatible with Medicare, at least contributions to a health savings account are not. They didn't like it because it was a change. So they collectively got together, pooled money, and sued us. They lost, but it had an impact. **–Employer, Full Replacement HSA-eligible HDHP**

A respondent also noted that HSA-eligible HDHP may not be ideal for those who live with conditions for which there is no generic or low-cost prescription drug regimen. These individuals may face immediate financial challenges in both meeting the deductible and accruing funds in the HSA. While out-of-pocket caps exist for HDHPs, (\$6,350 for individuals and \$12,700 for families for the plan year) these up-front costs limit the ability to accrue funds in the portable HSA for other expenses and limits the competitive advantage of an HDHP which is the option to shop for the best care relative to price.

[HDHPs don't work for] folks who have very high prescription costs with no options available to them. Take MS drugs. There's a \$14,000 a month drug and it's the only drug. They have no choices. They can't become a true consumer. They just have to pay. And so they're going to hit their out-of-pocket every single year and they're going to have cash flow issues on the front end of the year every single year. So they can't save in their savings account if they're using it to pay their bills. **–Employer Full Replacement HSA-eligible HDHP**

For aging populations accustomed to more traditional benefit plan offerings, employers report that the learning curve to grasp covered services (pre-and-post deductible) has been steep. Additionally, well-established workforce cultural factors can impact implementation.

A pretty substantial [communication] campaign was rolled out over probably an 18-month period prior to moving to full replacement HSA.

And I think that was largely successful. But you just have to appreciate long-time employees and it's a significant shift for them. And in attitude on this and as well as other benefits it's a move from the company will take care of you cradle to grave to you need to be engaged in your benefits. So I would say there has been and continues to be, particularly with long-time employees, a fair amount of resistance. **–Employer, Full Replacement HSA-eligible HDHP**

[A] big problem I think people have with health plans is that they don't read through all the documents. They may not understand all the things that are being said and so they get a big surprise at a pharmacy. We had somebody the other day and they said, 'Oh, I heard preventive services were free and I got a statin and that's to prevent me from having a heart attack. Then why did I get a co-pay?' Well they got a co-pay because it is on our preventive list but they got a co-pay because medications, even preventive ones, are not completely free. **–Benefit Plan**

[W]e're 90 percent male workforce. So our guys do what every male work force does, which is wait all year to go to the doc, come through every complaint that they've been holding onto. [They give] a head to toe litany of everything that's wrong and think that is the annual preventative visit...They walk out and they got a bill. So we're—we've been doing a lot of work with folks on saying, here's what a preventative visit is. If you come in and say, yeah, yesterday I was out cutting wood and I hurt my shoulder and you have the doc look at it...you're going to get billed for that. . . [T]he preventive visit part is a hundred percent, but that part isn't. So that's been a learning curve for our folks here. We've got an older workforce who's used to an old approach to an annual physical and it's just not that way anymore. **–Employer, Full Replacement HSA-eligible HDHP**

Of note, respondents also noted that diagnosis code discrepancies and provider inconsistencies at the point of service further impact coverage for both primary prevention and disease management services. These inconsistencies have the potential to affect both the quality of the employee's health care by discouraging utilization of covered preventive services and the employee's satisfaction and engagement with their health care plan when the benefit coverage is not clear or easily understood.

Because we have not defined those preventive services by type of service, we've defined it by the diagnosis code and leave it up to the submitting physician or facility on the claim then it all depends on what they determine with that primary diagnosis code. And if it's in dispute sometimes we look at secondary because there are cases--for example, people go in for a colonoscopy and they end up having some polyps removed. And depending upon how that claim is submitted what we may look at the secondary or tertiary level diagnosis codes to determine was

this really a preventive service or associated with a preventive service? But with regard to other services or even equipment it's really up to how the diagnosis code is applied. **–Benefit Plan**

If you go in for a colonoscopy and there's no reason to think there's anything wrong with you, you don't have blood in your stool and you've never had an abnormal screening in the past. You just--you're 50, 55 and you need to get one, and they find something and so they do a biopsy or they do a polypectomy or something then all of a sudden the entire cost of that is shifted from being preventive to being a treatment. And now the patient is--went in thinking this was all going to be covered...It's one of those things that makes you nuts because the expectation of the member was that they weren't going to pay for this. They were going to pay just the co-pay. **–Benefit Plan**

We look at healthcare utilization and...what we find in the [full replacement HDHP plans] is a huge percentage of people not accessing healthcare at all. So they're not even taking advantage of first dollar coverage for routine preventive services... if we look, for example, at diabetes care and measures for monitoring compliance with recommended diabetes associated or diabetes specific program of care, it's not the patients that are the problem. It's the doctor, the doctors that appear to be the problem, that people are going to the doctor yet they're not getting hemoglobin A1C testing. They are not getting evaluated for retinopathy. They're not being evaluated for kidney function... [H]ow can you manage diabetes if you're not monitoring hemoglobin A1C's and the patient doesn't appear to be using self-monitoring to assess effectiveness of treatment. So that said, I think in principle it makes a great deal of sense to help individuals by moving up stream in the care continuum to address the preventive elements. **–Medical Provider**

When asked how current primary prevention guidelines might affect chronic disease-related coverage in HSA-eligible HDHPs, respondents noted that the restrictions for coverage of certain chronic disease medical goods and services prior to meeting the deductible may be prohibitively damaging to enrollee health and potentially negate any immediate savings generated by the plans relative to the cost of providing certain disease management tools.

There are some situations where I look at something as simple as a glucose monitor—the fact that somebody's getting charge[d] for that, it's insane to have them not get it... And then of course with diabetes and metabolic syndrome, taking a look at the Lisinoprials and the Simvastatins and things of that nature to say we're nuts to not spend \$1.65 a quarter to give out a drug that's going to prevent how many catastrophic cardiac events or diabetes-related complications. **–Employer, Full Replacement HSA-eligible HDHP**

We would have to look at the question of whether the evidence for those things would be good. The other thing we would look at would be are these services something that have a return in the sense that they're going to prevent some other problem from happening down the road and therefore we really want people to do these activities...what generics or other medications would you want to give away for free because they're so valuable for people who take them. The poster child for this is generally asthma because if people don't use their inhalers they end up in the ER and that's expensive. **–Benefit Plan**

[S]tatins which are for cholesterol management, most of the generic drugs in that class we offer those with a zero dollar co-pay, blood pressure medications we do the same thing with that, so there are certain classes of drugs that just for the generics, just to hopefully increase adherence.

**–Employer no HDHP**

[T]here are some cases like that of medications that can prevent sort of a high cost problem and mostly it's things that you can show prevent some sort of medical utilization. **–Benefit Plan**

Diabetes and asthma would be the two areas where we would like to see potentially more coverage for preventive services [prior to deductible]. **–Employer, offers HSA-eligible HDHP with other plans**

If we had preventive services that were tailored to our population, so for example, we do have a large number of diabetics. We do have a lot of folks with heart disease. If we could tailor our benefits, our preventive benefits to those illnesses I am sure that they would ultimately have a positive effect on our costs. **–Employer, offers HSA-eligible HDHP with other plans**

If someone is a diagnosed diabetic and needs to go in for regular checkups to make sure their blood sugar is a certain level, they're following prescribed nutrition guidelines, they're doing preventive screening of their eyes and so on, I mean we would like to see something like that covered before the deductible. **–Employer, offers HSA-eligible HDHP with other plans**

But where we really see the biggest need is in some of the upstream conditions that, if unmanaged, lead to a deterioration in health that incurs avoidable healthcare expenses. [We're interested in ]anything that would open the door to enabling us to have more options with plan design but still be HSA qualified—for those kinds of conditions. **–Benefit Plan**

When asked about medical goods and services covered pre-deductible in existing HSA-HDHPs, most respondents reported explicitly following the USPSTF recommendations of “A” and “B” grade services for first-dollar coverage in their plan offerings. While respondents agreed that primary prevention standards serve as a valuable benchmark for essential services, they also indicated that these explicit requirements may limit

benefit design innovation that might have a positive effect on long-term health care costs and outcomes.

[Primary prevention] means just the basic preventive services that go with—USPTF services. Because otherwise it wouldn't qualified as a qualified high deductible health plan. **–Employer, Full Replacement HSA-eligible HDHP**

[M]ost of these are things where we're following the U.S. Preventive Service Task Force recommendation. That's where we base most of the decisions regarding screening exams and other things. **–Benefit Plan**

I think actually the preventive drug list is a great example of exactly...what employers have to deal with. I mean, there are certain things on this preventive list that are covered that make sense and then others that would make total sense to cover as preventive that aren't on there.

**–Employer offers HSA-eligible HDHP with other plans**

Where the guidance...does pose challenges for [employers] is enabling them to design engagement strategies for specific-condition populations to improve their health. **–Benefit Plan**

When you look at the HSA, if we had more flexibility within the regulations for preventive care--that would give the employer the option of offering richer benefits for select conditions that perhaps they're chronic conditions where--that this type of approach actually, when done effectively, doesn't just drive up costs. You actually are using it and you're applying behavioral economics to drive people's decisions that nudge them towards doing the things they need to do to maintain their conditions so that their condition is effectively managed and people are getting the care that they need. **–Benefit Plan**

Certainly all of the A and B level or A and B rated U.S. preventive services recommendations are the ones that I think most if not all employers have committed to covering. I think we still have a few grandfathered plans but those are disappearing pretty rapidly. And as such the general recommendations from the health plans have really all been in lock step with U.S. Preventive Services Task Force. **–Medical Provider**

We still get questions from employers, especially larger employers looking to move towards a full replaced HSA plan which they think is the best approach to do. But they want to make sure that their people are not neglecting the care that they should be getting. **–Benefit Plan**

Employers and benefit plan designers expressed interest in a targeted approach to injecting secondary and tertiary medical goods, provider visits and services that addressed chronic disease care prior to meeting the deductible if the services reduced the risk of more extensive and costly hospitalization or emergency room use due to delayed or avoidance of care. They expressed interest in plan options that included:

routine chronic disease care services that have a clear cost-benefit advantage; and reducing the financial hardship/barrier to care of paying completely out-of-pocket for necessary routine services. Respondents were interested in these benefit plan options as a means to reduce potentially more costly medical complications due to skipped or delayed care.<sup>11</sup>

I think that as a more surgical approach, if you will, makes a lot more sense. So for example, for diabetes hemoglobin A1C monitoring in association with an outpatient visit for diabetes care. That would make a great deal of sense. I'm just trying to think of other specific conditions or scenarios where the cost of the test for someone with a diagnosed chronic condition would be really very reasonably cost effective. So I would think any sort of one or two follow up visits a year with a specific set of tests would be absolutely reasonable in this scenario. I think it would really be a matter of needing to think through each chronic condition state and assessing what would be the absolute most critical condition status assessment and control elements and perhaps creating a curated of measures in that regard. I would think these measures probably are pretty reasonable from that perspective and using those as a guide. **–Medical Provider**

If we had preventive services that were tailored to our population, so for example, we do have a large number of diabetics. We do have a lot of folks with heart disease. If we could tailor our benefits, our preventive benefits to those illnesses I am sure that they would ultimately have a positive effect on our costs and it would probably be a wash.

**–Employer, offers HSA-eligible HDHP with other plans**

The preventive drug list is a great example of exactly what you're talking about and what employers have to deal with. I mean, there are certain things on this preventive list that are covered that make sense and then others that would make total sense to cover as preventive that aren't on there. **–Employer, offers HSA-HDHP with other plans**

However, respondents expressed uncertainty whether or not HSA-eligible HDHPs are the precise tool to address chronic disease care, indicating that the plans were designed to provide catastrophic coverage and to provide reduced coverage prior to meeting the out-of-pocket deductible in exchange for lower monthly premiums. Altering the fundamental HSA-eligible HDHP design might negate the compromise of reduced premiums with the addition of other goods and services prior to deductible.

I think the premise behind the high deductible plans has always been that you want to increase consumerism and have people be more proactive in the participating of their health care. It's next to impossible for people to get cost or quality data for a procedure they have. We are making some inroads in that space in the industry, but to date I feel like we would just be throwing people to the wolves. A lot of the people that I have talked to that have it believe a lot of their savings have come from just avoidance of

care, and that's not necessarily how we want to try to drive our savings on our health plans. **–Employer, No HDHP**

The big issue is that there is not enough data right now in the marketplace to support [expanding first-dollar coverage]. There's probably some reasonable data for diabetes showing that better care results in relatively near term cost savings. And I think most people reference a paper from the late '90's in that regard about a cumulative three year cost savings for diabetics that are better controlled. The problem is that it's not only the issue of making those services available and eliminating the financial barriers to access but also making sure that people use them. **–Medical Provider**

When we start having a conversation about well, would you like to cover more in your health--your high deductible health plan? At that point in time it's no longer a high deductible health plan. Let's be really clear. It's a donut hole plan of some sort. And I don't think that particularly solves the problem. **–Employer, No HDHP**

[I]t seems to me that the vast majority of treatments, surgical procedures and such things really should fall in the regular category should have the deductible...[N]ow we're talking about really restructuring their health plan if you can just overcome the deductible for a lot of different things. if I put in a high deductible health plan and I now cover not only wellness visits first dollar coverage but I also cover all office visits associated with your diabetes care, all office visits associated with your hypertension, hyperlipidemia, acne treatment, all this kind of stuff, right, suddenly I no longer have a high deductible health plan. **–Benefit Plan**

Employers in particular indicated that significant work is needed to align the value of medical goods, provider visits, and services with accurate pricing information and consumer education and engagement initiatives, particularly if coverage options were expanded.

I don't know where you draw the line because every treatment is preventing something, in the mindset of the employee. So it's easier to deal with this--because you're running down a slippery slope to a hundred percent benefit plan, which is not sustainable. **–Employer, Full Replacement HSA-eligible HDHP**

I do think the challenges that the plan designers face are really tied more to the market that we have today. The market makes it very difficult to actually shop as a consumer and understand pricing beforehand.

**–Employer, no HDHP**

[W]e would agree with the concept that it is important to make health care more sustainable. The reason we don't offer an HDHP is because we feel that for that [option] to be successful there has to be information available for people to make those health care purchasing decisions and we don't



think it's there yet... it's next to impossible for people to get cost or quality data for a procedure they have. It's hard to tell someone to go be a good consumer when there is not any data out there for them to be a good consumer on. **-Employer, no HDHP**

When asked how some of the perceived barriers of HSA-eligible HDHPs might be addressed, a majority of respondents cited consumer communication and education strategies as imperative measures to successful HDHP implementation. Several respondents noted that implementing a strategic communication plan ranging from six to twenty-four months prior to HDHP enrollment and using a variety of communication tools such as organizational town hall meetings, small employee focus groups, print, and electronic media messages to inform and educate employees had significant impact on the success of a plan's rollout. Additionally, having access to benefit plan support staff via phone, email and onsite was another critical employee support that contributed to HDHP success in the workplace.

We do have a cost transparency tool that we offer to employees...and we spent a lot of time trying to educate the employees on how to use the tool and made it available to them. We also did bring on a new service called Health Advocate which is free to the employee and their family members. And we're really promoting the idea that they can call Health Advocate if they have any problems understanding the cost of care and the Health Advocate employees have been instructed and will go in with the employee side by side and walk through cost comparisons with the employee on any service that they're interested in. **-Employer, offers HSA-eligible HDHP with other plans**

We did extensive communication and education. We actually started in April of 2013 for an October enrollment period. We had everything from extensive written communication that went to the home as well as electronic communication. We actually created a health zone on our intranet where we placed just numerous, numerous articles on HSA's, how they work, what the pros and cons are of each, how they differ from HRA's and FSA's. We did town hall meetings. We did webinars...We required all of our business partners, who offered medical and HSAs...to go through extensive, I think, 12 hours of training on our benefits, how they work, and then tested them on their ability to explain these benefits to our employees. **-Employer, offers HSA-eligible HDHP with other plans**

There were a number of focus groups, small group roll out meetings. Generally the layout was creating the platform, the reason for this change: long-term global sustainability, and competitiveness, moving toward greater employee engagement in their health care decisions which impact their own cost now and the company's cost. So it's a movement toward more sharing of responsibility. Explaining the tax advantage of a health savings account and the future value of it, the ability to save and spend wisely. **-Employer, Full Replacement HSA-eligible HDHP**

We are choosing on this year one to do a bit of a soft launch, a big focus on simply educating individuals. We will be offering an HSA as an option as well with the qualified plan and really looking to just simply educate individuals with regards to this concept. We have the good fortune of a lot of longevity within our employee population and so we've never offered a qualified plan with an HSA so we know there's a fair amount of education that's going to go along with that. **–Health System offering HSA-eligible HDHP with other plans**

We also extensively trained [Company Plan Benefit Manager] and urged employees before open enrollment to call and get information about the drugs that they're taking. We also sent a letter to every employee and their spouses, anyone who used the pharmacy benefit last year about the drugs that they used and the cost of those drugs and then explained in that letter that they need to make a careful choice at open enrollment and understand what their potential costs could be for pharmacy in 2014.

**–Employer, offers HSA-eligible HDHP with other plans**

Similarly, employers who offered an HSA-eligible HDHP noted that gradual implementation over a series of months, including intentional communication and education measures to ensure that employees could offer feedback and learn about the plans prior to enrollment improved consumer satisfaction and engagement.

I think it's really key to do a big job of communicating on the front end and a big part of that is you have to tell them why you're doing this, what this means from a business standpoint. But equally as important is you can't stop there. You have to keep communicating, keep refining your communication, and then—which we did not do...and I think that set us way back with employees. We lost ground in terms of employees accepting the benefit. I think we're gaining that ground back. And you have to be really honest and treat employees like adults. **–Employer, Full Replacement HSA-eligible HDHP**

We've been conducting briefings—live briefings—for the past four years in this. We also have an electronic learning management system housing all this information. We do some marketing. The other piece we're working on right now is a micro-segmentation of our work force...to find a little more effective means to engage our folks. **–Employer, Full Replacement HSA-eligible HDHP**

Respondents discussed a variety of limitations that HSA-eligible HDHPs present to those accustomed to more traditional benefit plans and those in need of chronic disease care. They questioned the ambiguity results of initial cost savings to employers and whether this is due to better alignment of medical goods and services or simply due to consumers avoiding care to avoid out-of-pocket costs. Also, respondents believe that current HSA-eligible HDHPs are not ideal plan choices for certain groups, such as veterans and retirees with Medicare benefits who are unable to contribute to an HSA in

addition to those living with multiple chronic conditions, or those unprepared for the upfront out-of-pocket cost of meeting the deductible.

Some noted that current restrictions for coverage of certain chronic disease medical goods and services prior to meeting the deductible may be prohibitively damaging to plan enrollee health and potentially negate any immediate savings generated by the plans relative to the cost of providing certain disease management tools. Also, current HSA-eligible HDHPs are not ideal choices for certain groups, such as veterans and retirees with Medicare benefits who are unable to contribute to an HSA in addition to those living with multiple chronic conditions, or those unprepared for the upfront out-of-pocket cost of meeting the deductible. Full replacement HDHP options may not be ideal for these groups without more flexibility in plan design.

While current guidelines for primary prevention services covered offers firm footing in terms of primary medical goods and services covered prior to satisfaction of the deductible, employers indicated that work is needed to align the value and pricing of medical goods, provider visits, and other health services so that employers had the option to select high value medical goods and services to cover pre-deductible for appropriate populations. Some respondents suggested a targeted approach to injecting secondary and tertiary medical goods, provider visits and services that addressed chronic disease care prior to meeting the deductible if the services reduced the risk of more extensive and costly hospitalization or emergency room use due to delayed or avoidance of care. Several respondents expressed interest in plan options that included: routine chronic disease care services that have a clear cost-benefit advantage; and reducing the financial hardship/barrier to care of paying completely out-of-pocket for necessary routine services. Respondents were interested in these benefit plan options as a means to reduce potentially more costly medical complications due to skipped or delayed care.

Respondents noted that care should be taken to assess the feasibility of moving into a high-deductible plan. To address initial consumer misconception or information asymmetries about HDHPs, respondents that offered HDHP plan options also initiated extensive communication and consumer education strategies prior to HSA-eligible HDHP plan rollout to adequately inform both employer and employee on plan construction and limits. Employers offered an HSA-eligible HDHP option alongside more traditional plan offerings did so on a graduated basis, keeping other more traditional options available with no immediate removal planned or gradually raising the premium on existing plans while incentivizing the HDHP option with seed money to offset the deductible.

### ***Possible Improvements and Innovations in HSA-eligible HDHPs***

Throughout the interviews, respondents voiced a desire to implement plans aligned with established health metrics that improve population health and promote high-value care while addressing rising health care costs. Some respondents noted that relaxing the regulation that prevents first-dollar coverage of particular medical goods and services allows employers the option to include select chronic condition services before the deductible and potentially improve enrollee health while still driving people to seek high

value care—particularly if covered chronic disease services were provided by high-value providers.

[W]hen you look at the HSA, if we had more flexibility within the regulations for preventive care that could include giving the employer the option of offering richer benefits for select conditions—perhaps they're chronic conditions—where this type of approach actually, when done effectively, doesn't just drive up costs. You actually are using it and you're applying behavioral economics to drive people's decisions so that their condition is effectively managed and people are getting the care that they need. **–Benefit Plan**

I'm thinking about again the larger employers but even smaller employers with insured plan designs where if, for example, we were able to determine that these types of plans do indeed drive better health outcomes and lower cost because you're able to apply these concepts like that Diabetes Health Plan idea that it would be--it would definitely be something we'd be interested in utilizing where we could. And particularly I'm thinking about the larger employer's plan sponsors that really want to make sure that they're able to engage their diabetic populations or other chronic populations that they know are really challenged to manage their health that have high out-of-pocket-costs. And that can only--serves to kind of exacerbate the health problem because then they don't get the care they need. So we'd be definitely interested in supporting that kind of outreach with the IRS. **–Benefit Plan**

The discussion generated a sub-dialogue about how HDHPs might be designed to address perceived gaps in coverage and to provide more effective care. Employers and benefit plan managers considered the creation of a “chronic disease management” HSA-eligible HDHP (with or without an employer HSA-contribution) with a slightly higher tiered monthly premium to offset the provision of additional goods and services pre-deductible. The plan might be offered alongside an existing “standard” HDHP as an option for enrollees interested in additional coverage.

I might be inclined to do two different [HDHP] options...the idea being that the one would be a really stripped down plan with some larger cost exposure, but a really cheap price point where the other one would be [higher priced]--particularly if I'm bringing in secondary prevention component. And really, I'd probably be targeting my older population with the preventive plan and my much younger, healthier population with the other one and be talking with them about the investment opportunities with an HSA as a long term retirement strategy. **–Employer, Full Replacement HSA-eligible HDHP**

[I'd like to get] our illness intervention systems to think about the fact that health care is different from illness care and that if we're going to do health care...we need to start thinking about what that means from a delivery

system standpoint so as we try to do really simple things, like we'll set it up so if you want to do a quick video interaction with your doc because your kid got an earache, that will be free and I'll pay the doc \$10 or whatever the case. Something along--things of that nature where we can start maximizing technology to minimize--spend--that's really unnecessary or overspending, but also maybe impact productivity. So [employees] can just do a quick email or something on their smart phone, so those kinds of things--I don't know exactly what they are yet, but we're working through the thinking on that and we're bound by the [guidance] of these plans.

#### **–Employer, Full Replacement HSA-eligible HDHP**

As one respondent noted, employers might consider separating their pharmacy drug benefits coverage from the HSA-eligible HDHP to make more drugs and services more easily available outside of the deductible. Though this would produce additional initial costs, long-term benefits might include increased drug adherence and fewer medical complications, resulting in overall health care savings.

[W]e purchased a preventive care list from our Plan Benefit Manager from Express Scripts because we wanted to make more scripts—more drugs available to our employees outside of the deductible.—**Employer, offers HSA-eligible HDHP with other plans**

Additionally, respondents that currently offer an HSA-eligible HDHP indicated that employers can offer additional support mechanisms such as increased contributions or reimbursements to an HSA to motivate consumers and assist in coverage of necessary services.

The point of that was really to support our employees for that pharmacy component at the start of the year so the money is available to our employees immediately. And then also we do have a very extensive wellness program and the rewards that an employee can get or the incentives in that wellness program are also being put into the HSA or the HRA, depending on what plan they go with. **–Employer, offers HSA-eligible HDHP with other plans**

Structuring HSA-eligible HDHPs with similar flexibility of HRA-eligible HDHPs might be an option to promote continued engaged consumerism and a reduced reliance on employer-assisted contribution to a health reimbursement account. Respondents are very attuned to what is an allowable HSA-expense and perhaps establishing a base of chronic disease services based on clinical value, similar to primary preventive services, might be an option to bridge the divide between offering no secondary or tertiary services prior to the deductible and offering only those that are clinically indicated to be high value. Similarly, employers who offered an HDHP noted that setting up sustainable HSA-contributions that both employers and employees contributed to, while making the out-of-pocket maximum charges fairly accessible might improve implementation rates for these plans. Modifying the limitations on HSAs so that more of the population could allocate pre-tax dollars into a portable, enduring health savings account could also address some of the constraints of first-dollar coverage limitations.

We spent a lot of time thinking about what the deductibles would be. We've done a huge amount of benchmarking. We spent an entire year doing benchmarking, not only against our peers but other companies nationwide through numerous large databases. And we know we're on the low end today of what a "high deductible plan" was and that was where we felt most comfortable...So we felt very comfortable at that level given that it was very close to some of the deductibles that we'd had in our previous plans. **–Employer, offers HSA-eligible HDHP with other plans**

We felt the pricing, we were able to offer very competitive contributions to our employees for consumer choice and with that felt the cost to the employee was very reasonable for consumer choice...So we are giving the employee 500 dollars for the individual and 1000 dollars for family coverage. The point of that was really to support our employees for that pharmacy component at the start of the year so the money is available to our employees immediately.**–Employer offers HSA-eligible HDHP with other plans**

We felt that with the [HSA] seed money, people still would have a deductible that would be very close to what they've had for many, many years but again, with an HSA which would allow them to roll this over. Even though they would have the cash in hand from [Company]-this was still money for them potentially if they didn't spend it. So they would really be careful in looking at what they were spending money on. I think we were very happy about the fact that preventive care is now free and is outside of the deductible so we really didn't worry that employees would not get preventive care. And that was--that's a huge issue for us because we're very, very focused on making sure that our employees do get preventive care. **–Employer offers HSA-eligible HDHP with other plans**

If you were a new enrollee, you were going to get \$250 as individual into your HSA, \$500 per family. And we're going to match any payroll contribution you make into your HSA at 25 percent, up to \$400 and \$800. So, and then for those who are re-enrollees, they're not getting a seed this year, they've gotten a seed for the past three years, we're going to keep the match. So we used a 401K strategy on the HSA to get people investing, and as we tell them, where are you going to get a guaranteed 25 percent return? It's just not going to happen. And it's tax free.

**–Employer full replacement HSA-eligible HDHP**

## **Conclusion**

Implemented both as an option alongside traditional health care plans and as a full-replacement plan, HSA-eligible HDHPs are an increasingly prevalent coverage option for employers interested in exploring ways to reduce immediate health care costs and to promote employee participation and engagement in their health care decisions. While respondents in this assessment are interested in finding ways to reduce costs

and encourage proactive consumer behavior, they also recognized that HSA-eligible HDHPs may pose challenges to employee health and well-being without careful implementation and communication strategies prior to rollout. As these exploratory findings illustrate, proper communication, education and preparation may mitigate many of the HSA-eligible HDHP challenges identified, but some issues, specifically related to chronic disease management may persist even with robust consumer education and support programs in place. For all respondents, there are many unanswered questions regarding both the cost and health value of HDHPs in the long-term and an interest in continuing to consider how HSA-eligible HDHPs may be designed to be more flexible in meeting employer and employee needs. The proliferation of these plans in the absence of data and research regarding their long-term effectiveness on overall health, cost and adherence, particularly for those who are managing chronic disease, calls for careful ongoing evaluation and consideration.

## Appendix I:

### Glossary of terms:

**Chronic disease management** is an integrated care approach to managing illness that includes screenings, check-ups, monitoring/ coordinating treatment, and patient education to improve quality of life while reducing health care cost by preventing or minimizing the effects of a disease.

**Deductible** amount owed for health care services before some health insurance plans begin to pay for covered health care services subject to the deductible. The deductible may not apply to all services.

**Excluded services** Health care services a health insurance plan doesn't pay for or cover.

**High-deductible health plan (HDHP)** is a health insurance plan with lower premiums and higher deductibles than a traditional insurance plan. HDHPs have defined minimum deductibles that consumers must pay before insurance coverage is employed and maximum out of pocket limits. HDHPs can be combined with a health savings account or a health reimbursement arrangement to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**Health savings account (HSA)** is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a qualifying high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

**Large group health plan** a group health plan that covers employees of an employer that has 101 or more employees. Until 2016, in some states large groups are defined as 51 or more.

**Out-of-Pocket maximum** is the most that an insured beneficiary should have to pay for healthcare during a plan period. Once the out-of-pocket maximum is reached, insurance will pay 100% of the allowed amount for covered healthcare expenses. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.



## Appendix II: Question Tool

**Interviewer:** Thank you for agreeing to participate in this interview on HSA-eligible HDHPs. I'd like to review with you that the answers you provide will be anonymously transcribed and compiled in a final report. Are you willing to participate in this interview?

**Interviewer:**

1. Before we delve into benefit goods and services, what is your opinion of HSA-eligible HDHP health care coverage options? (What are some benefits of offering these plans, and where do the plans potentially fall short?)
2. Please briefly review the types of plans **ORGANIZATION** offers to employees?
3. Is an HSA-HDHP option offered? If yes, how long has **ORGANIZATION** offered this type of plan?
4. Has **ORGANIZATION** solicited any feedback from employees or contracted employers regarding benefit plan satisfaction?
5. In general, are you noticing that organizations are shifting more towards offering HSA-HDHPs and if so, what are some possible reasons for this?

**Interviewer:** *Before we proceed to the next set of questions, I'd like to review some background information about HSA-eligible HDHP coverage options with you. Currently, as outlined by the U.S. Treasury Department, individuals insured with an HSA-eligible HDHP are required to pay the full cost of most medications and services until their deductibles are met. However, the HSA statute allows plans to cover certain preventive services before the deductible is met. The Internal Revenue Service (IRS) defines preventive services as including, but not limited to, periodic health evaluations, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs, and a number of screening services. These services, meant to prevent the development of chronic disease, are recognized as primary prevention services, and are covered before the deductible in HSA-eligible HDHPs.*

*However, IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat "an existing illness, injury or condition." This exclusion encompasses the bulk of what is known as secondary preventive services and prohibits HSA-eligible HDHPs from offering these benefits before enrollees meet their deductibles. This exclusion also precludes purchasers from pursuing many proven disease management strategies. As such, HSA-eligible HDHPs are limited in their ability to address chronic conditions, since most evidence-based services cannot be covered before the deductible. As we explore the following questions, please keep these parameters in mind.*

**Interviewer:** *The next series of questions includes four categories of medical goods and benefits; I will ask you separately about each of them.*

**Interviewer:** Please provide some examples of preventive services currently covered **before** the deductible is reached in your HSA-eligible HDHP. Specifically,

- a. What **doctor visits** are covered before the deductible is met? [examples might include **primary care** such as health promotion and disease prevention visits, health maintenance visits, counseling, patient education, treatment of acute and chronic illnesses in-patient and out-patient settings and **specialty care** such as services provided in the areas of anesthesiology, cardiology, otolaryngology (ear, nose & throat), podiatry, rheumatology, urology, etc.]
- b. What **drug benefits** are covered before the deductible is met? [Examples might include insulin, inhalers, anti-migraine medication, beta blockers, antihistamines, specialty medicines for arthritis, etc.]
- c. What **laboratory services** are covered before the deductible is met? [Hemoglobin A1C, LDL cholesterol testing, hyperlipidemia ]
- d. What **durable medical equipment services** are covered before the deductible is met? [examples might include blood pressure cuffs, glucose monitors, spirometer]
- e. Are there other **additional categories** of medical services that are covered before the deductible is met? [Behavior therapy for smoking cessation, weight loss management services, substance abuse counseling, case management]

**Interviewer:** *Again, the next series of questions includes four categories of medical goods and benefits; I will ask you separately about each of them.*

**Interviewer:** If the IRS changed its guidance so that companies had the option to cover additional preventive drugs and services before the deductible is reached, would you expand the coverage for individuals enrolled in HSA-qualified HDHPs? **(YES/NO)**

**Interviewer:** If **YES**, in your opinion,

- a. What **doctor visits** should be covered before the deductible is met?
- b. What **drug benefits** should be covered before the deductible is met?
- c. What **laboratory services** should be covered before the deductible is met?
- d. What **durable medical equipment services** should be covered before the deductible is met?
- e. Are there other **additional categories** of medical services that should be covered before the deductible is met?
- f. Are there categories of benefits you think **should NOT** be covered either pre-or-post deductible in HSA-qualified HDHP plans?

**Interviewer:** If **YES**, would you charge a higher premium for this “new” plan than for your existing HDHP plan?

**Interviewer:** If **NO**: What factors impact your decision not to cover additional preventive drugs and services before the deductible is reached?

**Interviewer:** *The next series of questions pertains to the potential impact these options might have on the market.*

**Interviewer:** How do you think covering additional benefits before the deductible will affect premium costs for existing HSA-qualified HDHPs?

**Interviewer:** If you currently offer an HSA-qualified HDHP, would you offer this “new” type of HDHP plan in addition to your existing plan? **(YES/NO)**

**a. If YES,** what are some potential benefits of doing so?

**b. If NO,** what factors might impact your decision not to offer this “new” plan?

**Interviewer:** Any final comments regarding the concept of HSA-qualified HDHPs that may provide increased preventive services coverage before the deductible is met?