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INVITED COMMENTARY

High-Deductible Plans

What If You Can't Afford Your Share?

High-deductible health plans have captured a growing share of the health care market in the United States, especially in states such as Massachusetts, which developed a program to expand health care insurance to cover all its citizens. According to the National Health Interview Survey in 2009,¹ nearly one-fourth of US adults with private coverage, and 50% of those who purchased insurance out of group, did so through cost-sharing plans similar to Massachusetts'. Because consumers are expected to pay more of their bills, high-deductible health plans have lower premiums, an attractive feature for many people given the high cost of health insurance. In addition, it has been argued that the use of such plans would control overall health care expenditures because consumers would be more careful shoppers, shunning unnecessary care if they had to pay a bigger part of the bill.

In this issue of the *Archives*, Kullgren et al shine a light on the darker side of high-deductible plans. Based on data from patients from Harvard Pilgrim Health Care, the investigators find that lower-income families are more likely to delay or indefinitely postpone medical procedures than those with higher incomes.

Kullgren et al are not the first to demonstrate that high-deductible plans may result in patients forgoing needed care. For example, doubling copayments from \$10 to \$20 per prescription for cholesterol-lowering medicine may cause one-fifth of patients to stop taking it altogether.² Similar decreases in the use of diabetic and hypertensive medicines with higher copayments have been found in other studies as well.³ Of note, the classic RAND Health Insurance Experiment,⁴ conducted in the 1970s to determine the effect of different insurance payment methods on utilization of services, found that higher copayments were associated with patients foregoing both needed and unnecessary care. The study found no association between higher copayments and better health outcomes, a result interpreted by the investigators as the result of patients equally limiting harmful and helpful care.

We can define appropriate care as care known to offer a benefit that is greater than any potential harm. However, studies have shown that consumers cannot easily distinguish appropriate from inappropriate care in their purchasing, at least not based on the information currently available in the marketplace.⁵ Value-based insurance design may be a better model. In this design, copayments are minimized for those interventions of high clinical value, while high copayments are required for those interventions of low value.³ This could potentially decrease health insurance premiums and overall health care costs without resulting in people forgoing those treatments that would actually benefit them.⁶ As we experiment with ways to increase value in health care, we must favor models that decrease incentives for use of inappropriate care and promote use of appropriate care.

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