The real effects of high-deductible plans

By Lia Novotny | June 2, 2017

Eight years into healthcare reform, high-deductible health plans have become the norm. According to the Kaiser Family Foundation, 51 percent of employee-sponsored health plans have annual deductibles of $1,000 or more. Two-thirds of plans on health exchanges have deductibles that exceed $3,500 for individuals and $7,400 for families.

That dramatic shift in cost, from payers to consumers, is shifting patient behavior — and not always for the better, says Harvard economist David Cutler, senior healthcare advisor to the 2008 Obama presidential campaign and a member of the Massachusetts Health Policy Commission.

"People absolutely respond to the incentives in a high-deductible policy," Cutler says — but as they try to limit out-of-pocket costs, they often skimp on needed care. In turn, many health systems have had to change their own procedures and stare down the risk of bad debt.

athenaInsight spoke to Cutler and several healthcare executives who work with large populations of high-deductible patients — and are wrestling with the new reality of patient obligations.

Here are edited excerpts from the conversations.

'Patients will not come for fear that they'll end up with a high bill'

Cutler: The whole thing doesn't work well. It's very clear that when you raise the price, people consume less medical care. The question is: How good are people at deciding what to use, what to give up, and what not to give up? Most of the evidence is that people are not good at it. They'll cut back on images they don't need, but they'll also cut back on chronic care medications that they do.

Rick Simon, CEO, Community Care of West Virginia: What happened with the ACA was that it shifted the people who can't afford care. It used to be the people under 200 percent of poverty who had difficulty affording care. Now they are covered, but the next group up — folks making $50,000 to $100,000 dollars — are really getting stung by higher premiums and very high deductibles. It's discouraging them from doing all the appropriate follow-up or even going to a doctor for services, and especially going to specialists.

Wayne Sottile, CFO, Esperanza Health Center, Chicago: We are seeing that patients will not come for fear that they'll end up with a high bill for the cost of care. We're trying to alleviate that burden as much as we can.

Frank Beaman, CEO, Faith Community Hospital, Jacksboro, Texas: When someone has a really high-deductible health plan, what they're going to do is go to the emergency room — because the emergency room doesn't collect in most cases, they send a bill later down the road. We have seen an increase in the utilization of the ER.

Sottile: You have to look at the target audience. You can't just say, "Hey, high-deductible plans are great, because they're going to drive down costs and give you freedom of choice." For certain demographics, yes. If you have individuals who are savvy enough to read the plans and say, "Hey, I need an MRI, I have a high-deductible plan, I'm going to call around, and get the best price I can," it helps at that level. But with our patient base — 90 percent Latino, limited education and English ability — it's adding barriers to care.

'We never change the quality or services available based on ability to pay.'

Cutler: There are total savings as patients consume less healthcare, at least over three years or five years. We haven't done really long-term studies, but for some period of time, the stuff that you're not getting doesn't put you over the top to where you turn out to be really expensive. That much said, one can certainly find groups for whom the risk of an acute event is imminent enough, and severe enough, that you really don't save any money by raising cost sharing.

Beaman: From a hospital perspective, we never change the quality or services available based on ability to pay. What we are trying to do is reach out to patients after they visit and establish a relationship inside of our rural health clinic, which is cost-based reimbursed. We do try to collect something, but mostly try to move them away from using the emergency room. We always want to do that, but it's more necessary [now] to keep people from generating such a large amount of self-pay that you end up having to write it off. We're seeing a marginal impact on bad debt and collections. It has not been huge yet, but I do see it coming.

Simon: It's a matter of teaching people what is available to them and that they really have access to care all the time, even if it's ten o'clock at night. With our open-access scheduling, people know that if they have a problem they can get in almost immediately. We have put together an education program that has reduced our emergency room calls significantly.

Kristi Walker, director of outreach and enrollment, Community Care of West Virginia: It's reinforced by our patient navigators. When patients are in for a visit, if they have had an inappropriate emergency room visit, we educate the patient: "Sniffles aren't really a good reason for showing up at the emergency room. You have to wait a very long time and it's very expensive. You can come in here and be seen next morning or whenever it's convenient for you."

Sottile: Our worry is the patient who's having symptoms of diabetes or hypertension and chooses not to come in because they know they can't afford the deductible. Our care coordination teams are following up with those patients. If the concern is cost of care because of insurance, we work with them. We've been successful to a certain degree, but not as much as we would like.

Walker: What we try to do, when we are enrolling these people, is to let them know about the preventative measures that actually are covered at 100 percent, like annual well visits, mammograms, and yearly pap smears. What hasn't been done very well nationally is the marketing of those things.

Beaman: We opened our wellness center [this spring]. The place is packed; we have already had to buy extra equipment, we have people turned away. A large portion of people want to do what they can to become healthier, and stay out of the hospital. A wellness membership at 25 or 30 bucks a month is a heck of a lot cheaper than one visit to the doctor's office.

'The education needs to take place before they have committed to a plan.'

Cutler: Proponents of the higher-cost-sharing view have the idea that we need to couple the existing high-deductible plans with more and better information. It's statement number one after you say that you're in favor of high-deductible health plans. So far, no one has found anything that actually works.

Sottile: A lot of patients are not educated in what high deductibles really mean. When they get their bill, they're coming back in, and saying, "Why is my bill so much?" And we're having to explain to them that the first $1,000 or $2,000 is going to be out of pocket. The education needs to take place before they have committed to a plan.

Walker: We have an enrollment program to assist people through the ACA process, and we have a folder that we give them with all the information on income limits, all of our sites and their phone numbers. We go through and tailor that to the specific person.

Cutler: Physicians need to be talking to patients as well, reaching out and saying, 'Let's talk about what things I think you really, really should do, and what things you can probably get away with not doing.' When we talk to patients, they are always happy to have more information, more framework for the decisions that they're making. What doctors ought to remember is avoiding this conversation is not in the patient's interests. People want their doctor's help picking out what they need and what they don't, but they're afraid to ask.

Lia Novotny is a regular contributor to athenaInsight.

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