Financial Impact of HSA-HDHP Reform to Improve Access to Chronic Disease Management Medications

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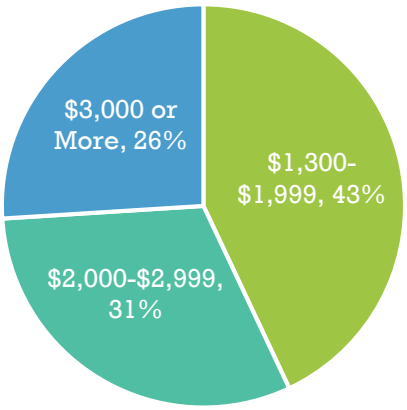
The Rise of High Deductible Health Plans and Their Consequences

More than 40 percent of Americans age 18-64 with private health coverage are now enrolled in a plan with an individual deductible of at least $1,300 or $2,600 for a family.[1] The deductible for most HDHP members now exceeds the minimum required by law (Figure 1).[1] Participation in high-deductible health plans (HDHPs) has grown significantly to over 71 million enrollees.[1,2] Thirteen percent of employers offer an HDHP as the only health benefit option.[3]

Increases in consumer out-of-pocket costs for health care have been associated with deleterious consequences. These include financial stress,[4] worse disease control,[5] increases in hospitalizations,[6,7] and exacerbation of health disparities.[8–10] A robust literature reports that these findings apply to HDHP enrollees, particularly those with chronic medical conditions and lower household income.[11] According to the National Health Interview Survey, adults age 18-64 enrolled in HDHPs in 2016 were more than 1.7 times as likely to report going without or delaying medical care due to cost.[1]

Permitted Pre-Deductible Coverage in HSA-HDHPs: The IRS "Safe Harbor"

Figure 1: Deductibles Among HDHP Enrollees with Employer-Sponsored Single-Only Coverage (2017)



Congress created Health Savings Accounts (HSAs) in 2003, with the provision that these accounts would only be available to those enrolled in qualifying HDHPs. The tax advantages of HSAs and lower HDHP premiums have driven rapid uptake among employers. In 2018, statute requires that qualifying HDHPs must have minimum deductibles of $1,350 (individual) or $2,700 (family). Guided by the Internal Revenue Service (IRS) safe harbor under section 223(c)(2)(C) of the Internal Revenue Code, HSA-eligible HDHPs may provide coverage of the following services *prior* to satisfaction of the plan deductible including:

- Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services

Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services (required by Section 2713 of the ACA and IRS Notice 2013-57);[12,13]

- Periodic health evaluations such as annual physicals and select preventive screenings not listed above (optional, per IRS Notice 2004-23);[14]
- Obesity weight-loss programs and tobacco cessation programs (optional, per IRS Notice 2004-23);[14]
- Drugs taken by asymptomatic individuals to prevent the manifestation of disease (optional, per IRS notice 2004-50).[15]

Under this IRS guidance, until the deductible is met, coverage does not include "any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications."[15] This narrow definition of the "safe harbor" is highly problematic. Primary prevention, while important, is a small component of overall health spending. By contrast, spending on chronic disease encompasses a substantial majority of total US health care expenditures.[16] For those with medical conditions, access to affordable clinician visits, diagnostic testing and prescription medications are critical components of disease management.

Amending the IRS Safe Harbor to Include Chronic Disease Medications

There is a body of peer-reviewed literature demonstrating that selectively lowering cost-sharing for high-value chronic disease management medications can meaningfully improve adherence, reduce the risk of adverse health outcomes, and, in some cases, reduce expenditures.[17] To enhance consumer choice and create a more robust HSA-HDHP marketplace, Senators John Thune (R-SD) and Tom Carper (D-DE), and Representatives Diane Black (R-TN) and Earl Blumenauer (D-OR), introduced the Chronic Disease Management Act of 2018. The bipartisan bill would amend the Internal Revenue Code to create a "safe harbor for absence of deductible for care related to chronic conditions," providing that:

> A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for care related to the treatment of any medically complex chronic condition which—
>
> > (i) is substantially disabling or life threatening,
> > (ii) has a high risk of hospitalization or other significant adverse health outcomes, and
> > (iii) requires specialized delivery systems across domains of care.

In addition to bipartisan political support, the Smarter Health Care Coalition – which counts more than 25 health plans, medical societies, business groups, employers, health sciences companies, and others as members – has championed this cause, calling for an executive order or legislation to bring about the needed change. [18]

Estimating the Financial Impact of Pre-Deductible Coverage of Medications for Common Chronic Conditions

HDHPs are appealing to employers because of their low premiums. If enhancements in prescription drug coverage are not offset by reductions in spending on other services (e.g., emergency visits and hospitalizations), adding pre-deductible coverage for medications used to treat chronic conditions could increase premiums and plan actuarial value (AV). Accordingly, the aims of this analysis were to quantify the potential financial impact on patient out of pocket costs, plan expenditures, and plan AV of providing pre-deductible coverage for 57 drug classes used to treat 11 chronic conditions (Table 1). Conditions and drug classes were selected based on the disease prevalence and contribution to member- and plan-paid expenditures.

Table 1: Diseases Included
Diabetes
Hypertension
Attention deficit disorder
Asthma
Depression
Hyperlipidemia
Hypo-functioning thyroid gland
Inflammatory bowel disease
Adult rheumatoid arthritis
Breast cancer
Multiple sclerosis

Financial Impact of Expanded Drug Coverage

Implementation of pre-deductible drug coverage can change plan-paid expenditures in three respects:

(a) *Volume*: Lower patient out of pocket costs tends to increase utilization. An estimate of enrollees' responsiveness to changes in price (i.e., elasticity of demand) was used to determine increases in utilization and related expenditures.

(b) *Shift*: Independent of volume effects, lower consumer cost-sharing shifts the cost burden from the patient to the plan. This analysis accounted for changes in the apportionment of expenditures.

(c) *Offsets*: In some clinical scenarios, greater utilization of high-value therapies can decrease spending on other services (e.g. hospitalizations). This analysis did not account for these offsets.

Baseline HDHP Characteristics

An HSA-qualified HDHP with a deductible of $2,000 was used as a baseline for the analysis (AV approximated 74 percent). Once the plan deductible was satisfied, this simulated plan imposed a 10 percent coinsurance for all covered services (including drugs) until reaching the out-of-pocket maximum of $6,500.

HDHP with Pre-Deductible Drug Coverage

An HDHP with permitted pre-deductible drug coverage for the specified 57 drug classes was simulated. Consumer cost-sharing was $5 for generics, $40 for branded non-specialty drugs, and 10 percent coinsurance for specialty drugs.

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Table 2 shows expected changes in plan- and member-paid expenses between the baseline HDHP and an HDHP with expanded drug coverage, as well as impact on plan AV. Estimated increases in premiums and deductibles needed to keep plan expenditures neutral are also presented. The modest increase in plan expenditures were split between increases in medication utilization and shifting allocation of drug expenditures. **Covering all 57 targeted classes on a pre-deductible basis with $5/$40/10% cost-sharing would require an increase in premium of less than 2 percent.**

Table 2: Impact of Pre-Deductible Drug Coverage on Total Spending

	Plan Paid PMPM	Member Paid PMPM	Overall AV	Increase Needed to Offset Higher AV	
				Premium OR Deductible	
Baseline HDHP	$319.77	$113.84	73.7%		
HDHP with Targeted Drugs Covered Pre-Deductible with $5/$40/10% Copay	$325.11 *Increase of $5.34*	$110.45 *Decrease of $3.38*	74.6% *Increase of 0.9%*	*Increase of 1.7%*	*Increase of $189*

These estimates should be considered "ballpark," as limitations apply to the underlying analyses. As Table 3 shows, limitations tend to both over- and under-estimate effect. This summary of limitations is not exhaustive.

Providing pre-deductible coverage for over 50 drug classes used to treat common chronic conditions would lower consumer out of pocket costs and increase utilization of essential medications. Such a change would lead to a small increase in plan AV, and would require a small increase in premium or deductible for payers interested in keeping the financial impact of the benefit change cost-neutral. In addition to "blunt" approaches such as increasing premiums for all beneficiaries or raising deductibles on all services, plan sponsors could pursue a range of more nuanced cost reducing strategies to create "headroom" for additional spending on high-value medications. For example, plans could steer patients to high-performing providers through centers of excellence programs or otherwise offer incentives for use of high-value sites of service. Plans could also target expenditures devoted to specific low-value clinical services, such as non-recommended screenings, unneeded imaging, wasteful pre-surgical testing, and much more. Further detail on the magnitude of potential savings, as well as practical strategies for waste avoidance, are available.[19]

Table 3: Select Limitations of Analysis
Tend to Overstate PMPM Impact • Drug rebates not included in estimation of plan-paid price. • Medical offsets due to better disease control not included in analysis. • Reduced medical utilization due to greater delays in satisfying deductible (i.e., patients with first-dollar coverage for targeted drugs may be less likely to satisfy their plans' general deductibles). • Data on copay card use were unavailable (overstate decrease in patient PMPM liability).
Tend to Understate PMPM Impact • Analyses modeled the behavior of patients with history of previous drug use, including those with suboptimal adherence. Patients not initiating indicated therapy due to high cost-sharing not included in analysis.
Indeterminate Impact • Analyses relied on a standard population, which may not be representative of any particular plan's population.

Conclusion

HDHPs are entrenched in the American healthcare landscape. The current policy that imposes high deductibles on all chronic disease services – independent of clinical value – to control spending has imparted a clinical and economic toll on Americans with chronic medical conditions. It is critical that regulations that prevent health plans from innovating be amended, such that plan designs that better meet the clinical and financial needs of millions of Americans may be made available.

Bipartisan, bicameral legislation that allows HDHPs the flexibility to provide pre-deductible coverage of high value services that treat chronic diseases has been introduced. *The claims-based simulations reported here demonstrate that generous enhancements in HDHP prescription drug coverage for several chronic conditions would lower consumer out of pocket costs and result in only modest impacts on premiums or deductibles*. Expanding the IRS "safe harbor" to permit coverage of high value prescription drugs prior to meeting the plan's deductible would increase the attractiveness and clinical effectiveness of HSA-HDHPs. Adoption of this policy has the potential to mitigate cost-related non-adherence, enhance patient-centered outcomes, allow for premiums lower than most other plan types, and substantially reduce aggregate health care expenditures.

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