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The ACA and High-Deductible Insurance — Strategies for Sharpening a Blunt Instrument

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The Affordable Care Act (ACA) will cause a major expansion of high-deductible health insurance, a fact that has received little attention but has substantial implications for patients, health care providers, and employers. High-deductible health plans (HDHPs), often considered "blunt instruments" that indiscriminately reduce utilization of both appropriate and discretionary care, require annual out-of-pocket payments of $1,000 to $10,000 for many services before more comprehensive coverage begins.[1] Unfortunately, large gaps remain in our understanding of HDHPs' effects on vulnerable populations, life-saving services, and health outcomes.[2,3]

In the ACA, Congress chose market-based cost controls over measures that are common internationally, such as global budgets. Mandating coverage while requiring affordable premiums without enacting other cost-control mechanisms almost inevitably gives rise to increased cost sharing as the simplest mechanism for reducing premiums. The ACA is therefore expected to cause a "seismic shift" in HDHP enrollment.[4] Small employers newly required to purchase employees' insurance may well choose HDHPs as the least expensive coverage option. Larger employers might adopt HDHPs to achieve ACA-regulated premium levels and avoid the 2018 "Cadillac tax."

For individuals without employer-based insurance options, ACA-instituted health insurance exchanges will provide coverage at four levels of generosity (bronze, silver, gold, and platinum) to 5 to 10% of Americans younger than 65. In Massachusetts, where an exchange began operating in 2006, 84% of enrollees opted for bronze or silver plans, according to the Blue Cross Blue Shield of Massachusetts Foundation. Although such plans' deductibles will be very high (e.g., $4,000 to $10,000 for family plans in California), persons with household incomes below 400% and 250% of the federal poverty level will benefit from out-of-pocket spending limits (see table) and generous cost-sharing subsidies, respectively. However, the resulting protections may be robust only for persons with incomes below 200% of the poverty level; Cover Oregon, for example, estimates that cost sharing for Oregon families with incomes between 200 and 399% of the poverty level will include $5,000 deductibles, 30% coinsurance for

Annual Deductible and Out-of-Pocket Maximums after Implementation of Affordable Care Act Coverage Provisions.*

Insurance Coverage Vehicle	Annual Deductible/ Out-of-Pocket Maximum for a Family	Annual Deductible/Out-of-Pocket Maximum as a Percentage of Income for a Family of Four with Income at 200% of the Poverty Level
	$	
Grandfathered	None/None	NA
Individual nongroup and small-group market (non-grandfathered), including small-business exchanges	4,000/12,700	8/27
Individual exchanges, by income category		
100 to 199% of poverty level	4,233/4,233	NA
200 to 299% of poverty level	6,350/6,350	13/13
300 to 399% of poverty level	8,467/8,467	NA
400% of poverty level or higher	12,700/12,700	NA
Self-insured or larger-group market (non-grandfathered)	12,700/12,700	27/27

* Out-of-pocket maximums in the table reflect limitations originally legislated by the Affordable Care Act (ACA) for 2014, although implementation of this aspect was recently delayed until 2015; aggregate out-of-pocket maximums might in fact be higher until 2015. The ACA stipulates that the annual deductible and out-of-pocket maximums can increase yearly on the basis of the "premium adjustment percentage" as set by the Department of Health and Human Services. A family of four with income at 200% of the poverty level has an annual income of $47,100. The Internal Revenue Service determines out-of-pocket maximums annually for "grandfathered" individual and family high-deductible health plans (i.e., those that existed at the time the ACA became law) associated with health savings accounts; the 2014 values will be $6,350 and $12,700, respectively. Out-of-pocket limits for "non-grandfathered" plans are tied to these maximums. The ACA also states that annual deductible maximums for the individual nongroup and small-group markets can be increased if the insurer offering coverage is unable to achieve reasonable premium levels within regulated deductible maximums. Persons with incomes below 250% of the poverty level are also eligible for tax-credit subsidies that increase the actuarial values of silver plans to 73 to 94% on a sliding scale, depending on family income. NA denotes not applicable.

many services even after reaching the deductible, and out-of-pocket spending maximums of $8,500 to $12,700.

In general, a family of four with annual income at 200% of the poverty level ($47,100) and the highest allowable deductible could face out-of-pocket payments of 8 to 27% of its income, depending on the coverage vehicle (see table). Sentier Research has estimated that the median U.S. household income in February 2013 was $51,404, so the aggregate financial burden on middle-income Americans will be substantial.

Although expanded coverage through HDHPs is surely better than high rates of uninsured Americans, the ACA might also move people whose coverage was previously more generous into HDHPs.[5] Moreover, previously uninsured people might effectively become underinsured, and their aggregate health and economic outcomes might not improve substantially. The United States seems destined for a "bronze" health insurance system that could create financial burdens high enough to cause adverse outcomes in vulnerable populations.

The shift toward HDHPs increases the urgency of determining the benefits and unintended consequences of high cost sharing. Unfortunately, cost-sharing research over the past three decades has focused almost exclusively on low-level cost sharing (e.g., less than $50 per service).[2] Few studies since the landmark RAND Health Insurance Experiment of the 1970s and 1980s have examined high cost sharing (e.g., deductibles above $1,000 per year) for expensive services, and fewer still have focused on vulnerable populations. A review of low-level cost-sharing studies and the RAND experiment concluded that most people indiscriminately reduce their use of both essential and nonessential health services, that low-income people are at risk for adverse health outcomes, and that whether high cost sharing will reduce growth in health care spending is unknown.[2] A review focusing on modern HDHPs found that they might reduce costs, but their effects on quality and essential care are uncertain.[3] Startlingly, both reviews revealed an absence of research examining the effects of HDHPs on major health outcomes such as diabetes control, cancer survival, cardiovascular events, and mortality.

With this limited knowledge base, the United States is poorly prepared for an increasingly HDHP-centered system. An accelerated research agenda is needed, but until better evidence emerges, policymakers and employers will have to use the best available information and commonsense strategies. First, they should educate consumers about the best venues for purchasing health insurance. For example, families with incomes below 200% of the poverty level whose employers offer "unaffordable" coverage (as defined by the ACA) will receive more generous benefits if they purchase insurance through a state exchange. Second, vulnerable people should be shifted into low–cost-sharing plans. Larger employers might be best positioned to adopt this approach, by making employees' premium and deductible obligations proportional to their income. They could do so in a cost-neutral manner by cross-subsidizing low-income workers.

Third, employers could facilitate contributions to health savings accounts (HSAs), especially for vulnerable people. HSA contributions are not taxed, roll over from year to year, and are portable across employers. The accumulation of funds over time could reduce barriers to care and protect vulnerable people from major medical expenses. Employers that fund HSAs could prioritize contributions to vulnerable workers in a cost-neutral manner. State exchanges should attempt to offer HSA-eligible plans.

Fourth, state exchanges, employers, and payers could intensify education about HDHPs. Enrollees in these plans generally have a poor understanding of their benefit arrangements; they should be informed about coverage details and about choosing clinically effective, cost-efficient care. Fifth, providers, health insurers, and state exchanges should facilitate shared patient–physician decision making and access to decision tools for patients seeking care. Nurse hotlines or other rapid-communication methods might help prevent adverse health outcomes.

Researchers should evaluate the effectiveness and optimal dissemination of these five strategies. In the long term, a more sophisticated HDHP-centered system will depend on focused research, advanced decision-support tools, and evidence-based policies aiming to ensure equity and the best achievable health outcomes. Studies should examine HDHPs' long-term effects on vulnerable and chronically ill populations such as patients with mental illness, expensive conditions such as cancer, health outcomes such as cardiovascular events and mortality, and health costs.[2,3]

This research could inform the development of advanced tools to allow consumers, policymakers, and employers to predict who is at risk under HDHPs. Use of such prediction tools could improve several aspects of insurance coverage. It could allow insurers to develop "personalized insurance designs" — plans tailored to reduce costs and maximize health for specific risk groups — through mechanisms such as lower cost sharing, value-based cost-sharing exclusions, or higher HSA contributions. It could also improve the selection of types of insurance. For example, an employer with workers primarily of lower socioeconomic status could predict the 2-year health outcomes and costs under alternative benefit designs on the basis of workers' characteristics. The highest-risk people could be targeted for additional education or outreach.

Some employers or state exchanges might voluntarily adopt strategies to protect vulnerable populations and optimize health insurance designs, but national and state policies may be needed. For example, employers could receive tax credits for providing low–cost-sharing plans to workers at high risk for adverse outcomes under HDHPs. Funding could be provided to exchanges to implement evidence-based insurance-selection tools based on predicted health outcomes. Actuarial values of health plans for the four small-business insurance tiers could be increased for employers with large proportions of at-risk workers. Policymakers could also implement more sweeping strategies. Although the current economic and political climate is unfavorable, Congress might consider a future subsidy approach that recognizes that the affordability of insurance is a function of expected out-of-pocket costs and characteristics such as chronic disease, not simply premiums.

Expanding health insurance coverage will substantially increase HDHP enrollment, but the system doesn't have to be blunt and inequitable. To prevent unintended consequences, policymakers and employers should initially adopt strategies with face validity, such as preferentially funding HSAs for low-income families. In the longer term, the system will require sophisticated, evidence-informed tools that allow targeted, personalized insurance designs and outreach to at-risk patients.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Full Disclosure — Out-of-Pocket Costs as Side Effects

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Few physicians would prescribe treatments to their patients without first discussing important side effects. When a chemotherapy regimen prolongs survival, for example, but also causes serious side effects such as immunosuppression or hair loss, physicians are typically thorough about informing patients about those effects, allowing them to decide whether the benefits outweigh the risks. Nevertheless, many patients in the United States experience substantial harm from medical interventions whose risks have not been fully discussed. The undisclosed toxicity? High cost, which can cause considerable financial strain.

Since health care providers don't often discuss potential costs before ordering diagnostic tests or making treatment decisions, patients may unknowingly face daunting and potentially avoidable health care bills. Because treatments can be "financially toxic,"[1] imposing out-of-pocket costs that may impair patients' well-being, we contend that physicians need to disclose the financial consequences of treatment alternatives just as they inform patients about treatments' side effects. Health care costs have risen faster than the Consumer Price Index for most of the past 40 years. This growth in expenditures has increasingly placed a direct burden on patients, either because they are uninsured and must pay out of pocket for all their care or because insurance plans shift a portion of the costs back to patients through deductibles, copayments, and coinsurance. The current reality is that it is very difficult, and often impossible, for the clinician to know the actual out-of-pocket costs for each patient, since costs vary by intervention, insurer, location of care, choice of pharmacy or radiology service, and so on; nonetheless, some general information is known, and solutions that provide patient-level details are in development.

Consider a Medicare patient with metastatic colorectal cancer. Commonly, a component of first-line therapy for this disease is bevacizumab. The addition of bevacizumab to chemotherapy extends life by an average of approximately 5 months over chemotherapy alone. The drug is fairly well tolerated, but among other risks, patients receiving bevacizumab have a 2% increase in the risk of severe cardiovascular toxic effects. Over the course of a median of 10 months of therapy, bevacizumab costs $44,000.[1] A patient with Medicare coverage alone would be responsible for paying 20% of that cost, or $8,800, out of pocket, and that price tag doesn't include payments for other chemotherapy, doctor's fees, supportive medications, or diagnostic tests. Most physicians insist on discussing the 2% risk of adverse cardiovascular effects associated with bevacizumab, but few would mention the drug's potential financial toxicity.

This example is not isolated, and the consequences for patients are grim. The problem is perhaps starkest in cancer care, but it applies to all complex illness. The Center for American Progress has estimated that in Massachusetts, out-of-pocket costs for breast-cancer treatment are as high as $55,250 for women with high-deductible insurance plans; the out-of-pocket costs of managing uncomplicated diabetes amount to more than $4,000 per year; and out-of-pocket costs can approach $40,000 per year for a patient with a myocardial infarction re-