Potential Effects of CDHPs on Health Spending and Outcomes

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What is CBO?

- Nonpartisan agency that provides budgetary and economic analyses to Congress
  - Estimates costs/savings for proposed legislation
  - Produces testimony and reports
  - Estimates for tax policy proposals are made by the Joint Committee on Taxation
- Does not make policy recommendations
- Any views expressed here that are NOT contained in the report are my own and should not be attributed to CBO

Scope of the Study

- Examined the evidence available to address 3 sets of questions about CDHPs:
  - Effects on use of services and spending if enrollment is broadly representative
  - Effects on prices and quality of care and on health outcomes
  - Potential for favorable selection into CDHPs and implications for insurance markets
- Considered both HSAs and HRAs

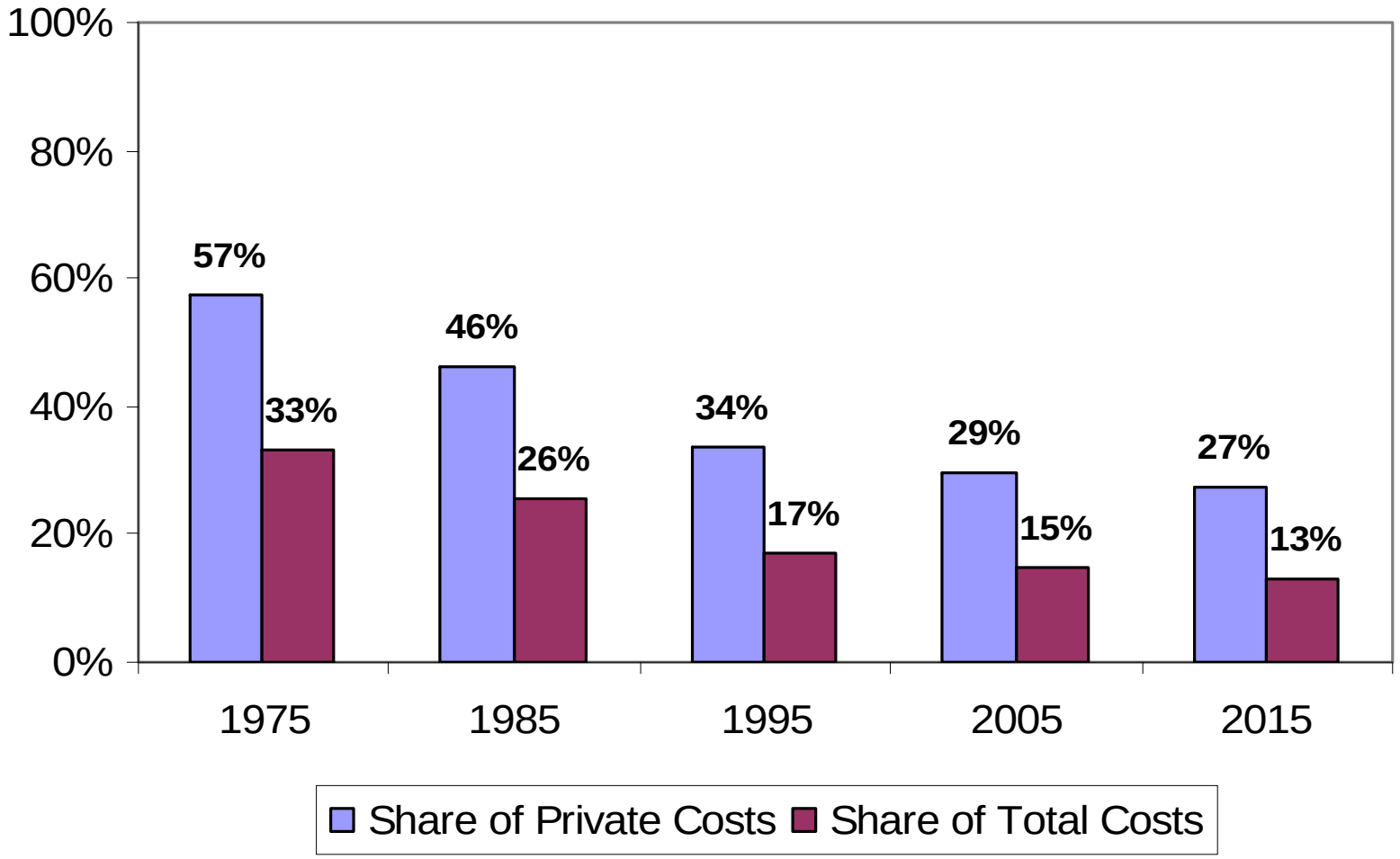
Analytic Challenges

- Limited information available because CDHP designs are new
- Industry reports may not hold plan values equal in comparisons, and may focus on insured costs rather than total health costs
- Problems of “selection bias” in data – individuals and firms that adopt CDHPs early may be different

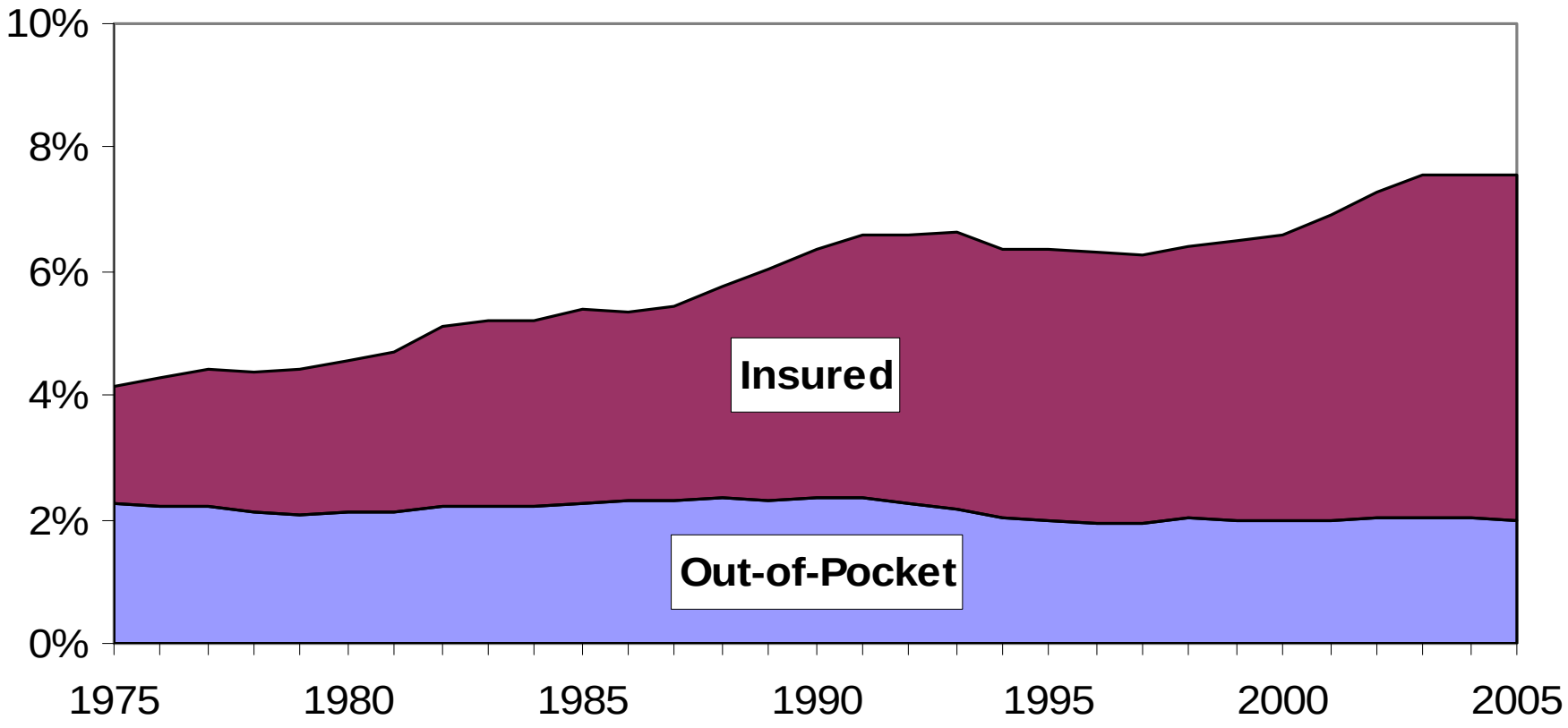
Rationale for CDHP Designs

- Seek to provide stronger incentives to use health care prudently
  - Could do with high-deductible plan alone; innovation is tax-sheltered account for out-of-pocket costs
  - Account makes CDHP more attractive
- A step toward “leveling the playing field” between insured and out-of-pocket costs
  - Prior to CDHPs, tax incentives generally favored covered costs
- Reaction against managed care, other considerations

Share of Health Care Costs Paid Out-of-Pocket



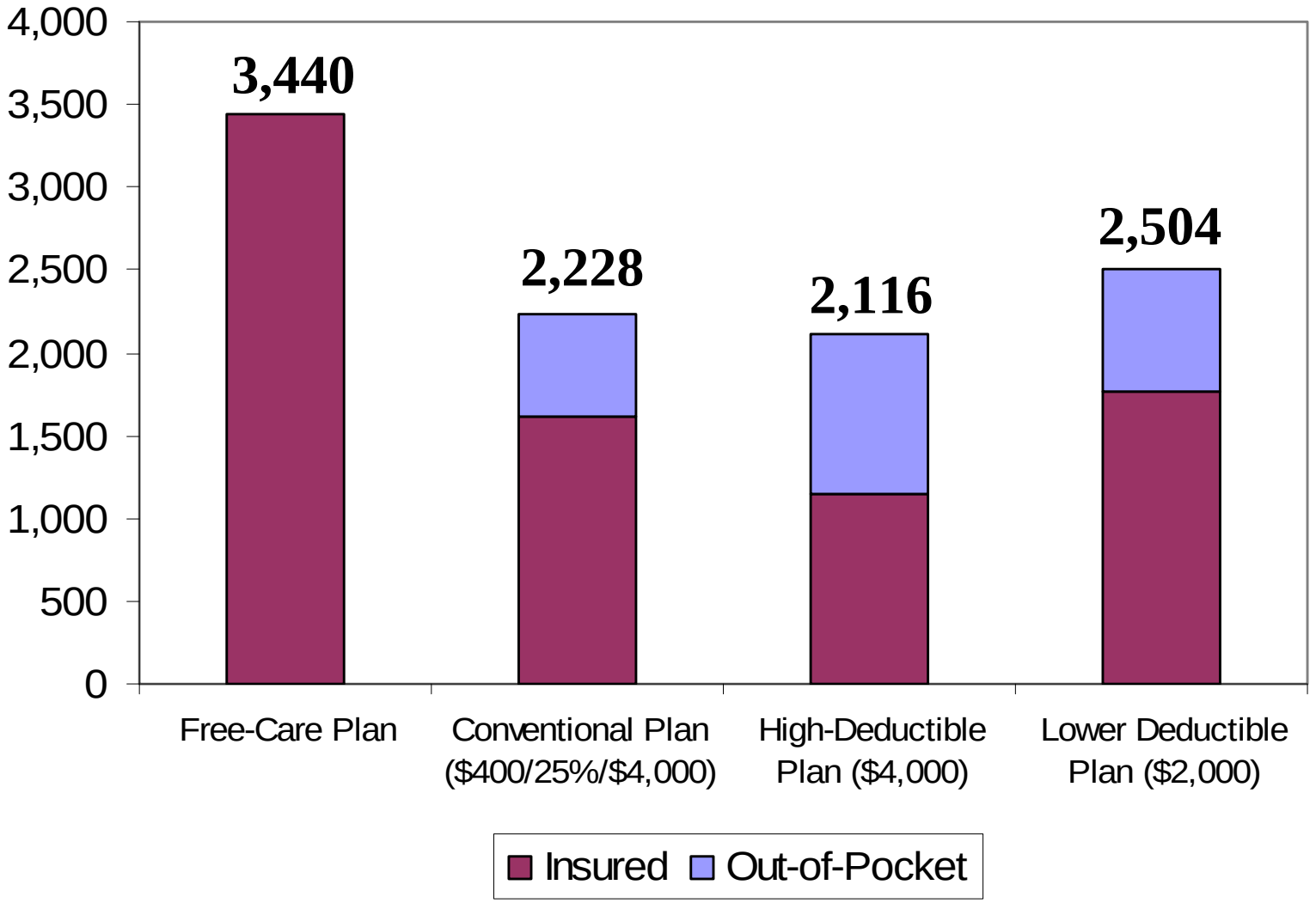
Growth and Allocation of Private Health Care Costs (Share of GDP)



The RAND Health Insurance Experiment

- Conducted between 1974 and 1982
- Randomly assigned thousands of non-elderly individuals and families to different insurance plan designs
- Plans ranged from free care to $1,000 deductible (basically) with variations in between
  - Comparable deductible today is at least $4,000
- Studied effects on health spending and health outcomes

RAND Experiment Results
(Average Costs Projected to 2004 Spending Levels)



Limitations of the RAND Experiment

- Older Study
- Differs from Current Conventional/CDHP Comparison
- Under RAND:
  - Plans did not have equal actuarial value (but could be equalized with account contribution)
  - OOP costs were paid with after-tax dollars
  - Basis was indemnity insurance; did not use a PPO
  - RAND did include an HMO (offering free care)

Effects on Spending/ Use of Services for CDHPs

- American Academy of Actuaries study (2004) compared HRA and PPO designs of same value
  - Found HRA would reduce average spending by 2-5%
  - Similar effects likely for HSAs
- HMOs can provide the same benefits as PPOs at 5-10% lower costs
  - Implies that CDHPs may not reduce spending — and could raise it — relative to HMOs
- Again, assumes representative enrollment

Effects on Prices

- CDHP enrollees have some incentives to negotiate prices; could stir competition
- But third-party payers – conventional insurers – have similar incentives
- CDHP enrollees may prefer to “contract out” the task of price negotiation
- Evidence is that virtually all CDHPs use plan-negotiated prices (mostly PPO)

Effects on Quality

- CDHP enrollees need information on both prices and quality to determine value
- Currently, limited data on provider quality is a constraint for CDHPs and conventional plans
- Better data is coming – but it will help both types of plans
- Not clear how comparison of plan designs will be affected

Effects on Health (I)

- Results from RAND:
  - Cost-sharing had no adverse health effects for average enrollees
  - Only significant difference was for low-income participants who were in poor health to begin with
  - Compared to free care plan, those participants had poorer blood pressure control when they faced cost sharing
  - Increased their predicted probability of death from 1.9% to 2.1% (over 3 year period; statistically significant)

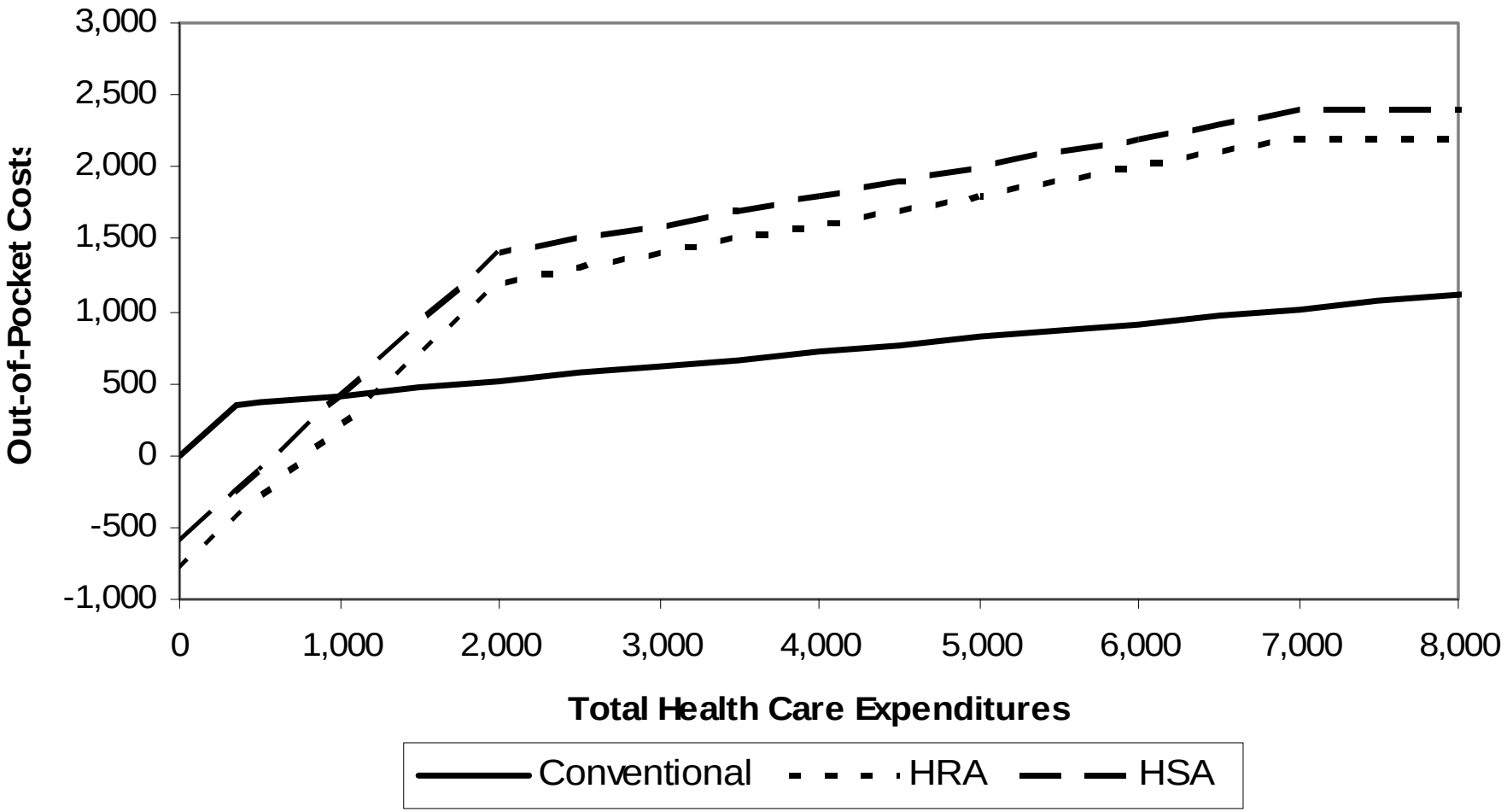
Effects on Health (II)

- RAND study found no significant health differences across *cost-sharing* plans
- Most of the gains in blood pressure control under the free-care plan came from a one-time screening exam
- CDHPs may cover preventive care below the deductible (although some do not)
- Potential concern remains, but little evidence of adverse health effects

Potential for "Selection" in Employer-Sponsored Coverage

- Those with low health costs would save money in a CDHP, while those with moderately high costs would pay more
- Health costs vary for many reasons and are hard to predict precisely, but costs reflect health status and show some persistence
- Those with higher costs might have more flexibility in a CDHP, but would have to weigh that against higher out-of-pocket costs

Comparison of Plan Designs with Equal Value



Evidence about Selection into CDHPs

- Age is a poor proxy for the health status of CDHP enrollees
- Comparisons of health status often fail to distinguish individual and employer-based purchasers of CDHPs
- Available studies have conflicting findings
  - McKinsey (2005) “shift in mind-set” probably reflects self-selection by firms converting fully to HRAs
  - EBRI/Commonwealth (2006) found similar health status for workers in CDHPs and conventional plans
- To soon to tell about insurance market effects

Effects on the Uninsured Population

- About one-third of *individual* HSA buyers had been uninsured, and some small firms newly offered HSAs
- Unclear what individuals and firms would have done otherwise — with no HSA option — or whether firms are new firms (start-ups)
- Some studies suggest offsetting reductions in coverage, primarily among small employers
- Net effect on the uninsured population is uncertain, but certainly smaller than the gross number of HSA purchasers who were uninsured

For Additional Information

- CBO Study: “Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes” (December 2006)
- Provides additional information and analysis as well as citations and sources of data
- Available at www.cbo.gov