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How Can We Address Barriers to Accessing Needed Care?

Robert W. Dubois, MD, PhD

More patients today have health insurance, but they also are being asked to dig deeper into their pockets to cover a larger portion—if not all—of the costs of their healthcare treatments. This situation is made even more difficult by the prevalence of high-deductible health plans (HDHPs), which offer low monthly costs in exchange for higher costs for doctor visits, medicines, or other necessary care. Recognizing that HDHPs are forcing patients to make trade-offs in the management of their health, insurers, employers, and other healthcare stakeholders have been examining different ways to ensure that patients have access to the right treatments at the right time.

Growing Use of HDHPs

In response to the Affordable Care Act, more insurers are offering HDHPs. With these plans, premiums are generally lower than in traditional plans because enrollees must meet the higher deductibles before traditional medical and pharmacy coverage begins. Most HDHPs are offered in conjunction with a health savings account (HSA) or, less often, a health reimbursement account (HRA); both can be accessed by plan enrollees to offset the deductible expense. The intention is that these kinds of plans have the potential to contain healthcare costs and engage enrollees more fully in managing their health and healthcare decisions or, in other words, "have more skin in the game."[1]

The use of these plans is continuing to grow, with more than 70% of surveyed employers offering HDHPs.[1] In 2016, 39% of individuals younger than 65 years with private insurance were enrolled in an HDHP—up 3% from 2015—and 15% of those were enrolled in an HDHP with an HSA.[2] The average aggregate deductibles for workers with family coverage are $4321 for HDHP/HRAs and $4364 for HSA-qualified HDHPs, yet there can be wide variation.[3] HSA-qualified HDHPs are legally required to have a maximum annual out-of-pocket (OOP) liability of no more than $6550 for single coverage and $13,100 for family coverage in 2016. For a low-income family of 4 making $48,678 per year, meeting a high deductible that is a sizable portion of that income is a daunting task.[4]

Under most healthcare plans, patients must satisfy their deductible before their coverage kicks in, making care more expensive for those with lower incomes or greater healthcare needs. As a result, lower-income families are getting less preventive care and putting off care they need. They had 4 times the rate of avoidable hospitalizations compared with higher-income workers and had 3 times the rate of emergency department visits, thus incurring higher costs for themselves and for the healthcare system.[5]

To address this challenge, employers and health plans have started to test other methods for increasing patient access to necessary medicines and reducing some of the negative impacts of HDHPs, particularly for lower-income workers. Among the best practices in use are: lowering the net deductibles, minus the company HSA contribution; varying contributions to the HSA based on income or linking to incentives for wellness or consumer behaviors; implementing a broad list of preventive drugs, combined with a value-based approach in HSAs; and implementing a value-based approach to prescription drug coverage in HRA-based plans.[1]

Cost Sharing: Impact on Healthcare Outcomes and Potential Approaches

Cost sharing's impact on healthcare decisions was clearly demonstrated by the RAND Health Insurance Experiment and subsequent studies.[6] Placing more of the economic burden for healthcare treatments on patients showed that cost sharing reduced unnecessary or excess care; however, it also reduced appropriate or needed care, as evidenced by the lower-income workers' greater use of emergency care. The question, then, is how can we

steer patients toward the treatments that they truly need while reducing unnecessary use?

Although it does not entirely mitigate the sting of the high deductible, some employers and insurers have lowered cost sharing for certain treatments or covered preventive drugs before the deductible, particularly for chronic conditions like hypertension, diabetes, high cholesterol, and asthma.[1] Aetna, for example, tested the elimination of co-payments for drugs prescribed after myocardial infarction. They found that enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.[7] Similarly, Pitney Bowes adopted a value-based benefit-design approach under which drug costs for the treatment of hypertension, diabetes, and asthma were greatly reduced. Pitney Bowes recognized that increased medication adherence can reduce employer healthcare costs and keep employees healthy.[8]

Value-based insurance design (VBID) principles also are being adopted or tested. Tricare, the health plan administered by the Department of Defense, began a test program to lower co-payments for certain conditions, and Premera Blue Cross in the Pacific Northwest implemented a pilot program for diabetes, hyperlipidemia, and hypertension.[9] Like Pitney Bowes, most of these policies have been implemented for a class of drugs (eg, lowering patient OOP costs for all patients with diabetes or removing the OOP costs for eye exams) rather than for more clinically nuanced cost sharing. Under a clinically nuanced approach, a program could reduce cost sharing for patients with a positive genetic test requiring a higher-tier/higher-cost treatment, or reduce costs for patients who have tried step therapy approaches and require higher-tier/higher-cost treatments. Under current regulations, however, this would not entirely eliminate the requirement for patients to meet their deductibles first.

Several states, and some health plans, are capping the OOP costs for co-pays or coinsurance (eg, at $200), which addresses some of the big jumps in patient costs. Yet, the difference for patients who face a $10 or $50 OOP expense versus a $200 OOP expense is still significant.

Learning From Data to Improve Care

Understanding whether—or how well—these approaches are working requires an analysis of the data. Some insurers and employers have more sophisticated and interoperable information technology systems and are well equipped to track co-pays and clinical nuance, and are incorporating this information in their plan designs and performance measurement.[1] Other organizations have not yet made the necessary changes to their infrastructure. It will be very important to assess whether changes to co-pays and benefits designs are helping or hurting patients so that we can learn from these programs. Data is also important for consumers: providing them with easy-to-understand resources about their benefits and costs can help them to make better healthcare decisions.[1]

Conclusions

It is important to reduce barriers that can hamper patient access to care, especially when we know that medication adherence and access to higher-value care can make a big difference in reducing costs for both patients and our healthcare system. Armed with evidence, perhaps we can work toward ways to make HDHPs and the OOP costs less harsh. ajpb

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Send Correspondence to: Robert W. Dubois, MD, PhD, Chief Science Officer, National Pharmaceutical Council, 1717 Pennsylvania Ave, NW, Washington, DC 20006.

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