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High-Deductible Health Plans and Access to Prescriptions Medications

Access to medically necessary healthcare is critical for successful patient outcomes, yet access is often impeded or blocked entirely by cost sharing in the form of high deductibles, co-pays and coinsurance. Despite its value as a tool to limit discretionary healthcare spending, excessive cost sharing often creates insurmountable barriers between patients and medications, diagnostic tests, office visits, surgery and other needed services. There is significant concern that cost sharing limits access to medically necessary and appropriate treatment for seriously ill and economically vulnerable patients.

The Patient Access Network Foundation believes that cost sharing should not prevent anyone from obtaining medically necessary treatment.

PAN advocates for strategies that will increase access to medically necessary medications among economically vulnerable Medicare beneficiaries by reducing their out-of-pocket (OOP) drug costs.[1] This *Issue Brief* explores how high-deductible health plans (HDHPs) create barriers that inhibit patients from accessing the prescription medications they need.

What is a High-Deductible Health Plan and How High are the Deductibles?

A deductible is the amount of money that an insured person must pay OOP before their insurance policy begins to pay expenses. A HDHP is a health insurance policy that, compared to standard health plans, has a higher deductible. However, in these plans, the *premium*—the monthly OOP cost that an insured person pays to keep their policy active—tends to be lower than traditional plans. HDHPs are offered by employers and they are also available through the Affordable Care Act's marketplace exchanges.

The term "High Deductible Health Plan" has a specific meaning that is defined by the Internal Revenue Service (IRS). Updated each year, the definition is based on the minimum deductible and maximum

OOP costs that an HDHP policy holder must pay. In 2018, HDHPs were defined as plans with (1) deductibles of at least $1,350 for an individual and $2,700 for a family and (2) OOP maximums of $6,650 for an individual and $13,300 for a family. In 2019, the minimum deductible will remain the same for both individuals and families, but the OOP maximums will rise to $6,750 for individuals and $13,500 for families.

The IRS definition of a HDHP is important because people with these plans can set up a **health savings account (HSA)** that can be used to pay for qualified medical costs, including prescription medications. The money that is spent from HSAs on OOP healthcare expenses is not subject to federal taxes, but there are limits to how much people can contribute to these accounts. In 2018, the maximum HSA contribution was $3,450 for an individual and $6,900 for a family, and these figures will increase in 2019 to $3,500 for individuals and $7,000 for families.

Employers that offer HDHPs can also choose to offer **health reimbursement arrangements (HRA)** to their employees. HRAs are employer-funded accounts that reimburse enrollees if they incur medical expenses that are not covered by their HDHP up to the amount designated by the employer. Employers do not need to offer HRAs, but enrollees can set up an HSA if their HDHP meets the IRS definition. In January 2017, nearly 21.8 million people were enrolled in an HSA-qualified HDHP, up from 20.2 million in January 2016. Many employers offer online tools to help members manage their HSA accounts and their healthcare cost information, and some employers offer access to health advocates and broker consultations.[2]

What are the Current Trends in High-Deductible Health Plans?

Enrollment in HDHPs has grown significantly in recent years. A study by researchers from the Agency for Healthcare Research and Quality (AHRQ) found that only 11.4 percent of private-sector enrollees were in HDHPs in 2006, a share that increased to 46.5 percent in 2016. The researchers also discovered that people employed at smaller companies were significantly less likely to have the option of enrolling in a non-HDHP compared to employees from larger companies, and that smaller companies were also less likely to offer HRAs for their employees. Finally, the AHRQ study showed that in 2016, the average deductibles for individuals ($2,480) and families ($4,721) greatly exceeded IRS-defined minimum levels, and these deductibles went up as the size of the company went down.[3] According to 2015 Statistics of U.S. Businesses, of the 5.9 million firms in the U.S., 61 percent (over 3.6 million) have fewer than five employees, indicating that a large share of all employees work at small businesses.[4]

Research from the Kaiser Family Foundation (KFF) echoed findings from the AHRQ study concerning the growth in HDHPs and highlighted striking differences in deductibles across plan types. In 2017,

the average deductibles for single coverage were $1,175 in Health Maintenance Organizations (HMOs), $1,046 in Preferred Provider Organizations (PPOs) and $2,304 in HDHPs. The corresponding figures for family coverage were $2,732 for HMOs, $2,503 for PPOs and $4,527 for HDHPs. The Kaiser report also indicated that on average, deductibles are much higher in firms with a larger share of low-wage workers, highlighting the connection between HDHPs and economically vulnerable workers.[5]

The impact of HDHPs on patients is closely linked to whether employers that offer these plans also offer HRAs to help offset high deductibles. The Kaiser report showed that 21 percent of workers in an HDHP with an HRA and 2 percent of workers in an HSA-qualified HDHP receive an account contribution for single coverage at least equal to their deductible. Another 35 percent of workers in a HDHP with an HRA and 30 percent of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce the deductible to $1,000 or less. Nonetheless, even when employer contributions are applied to employees' deductibles, 40 percent of individual workers still have a deductible of more than $1,000 per year. Importantly, in 2017, 13 percent of companies offered HDHPs as their only plan options.[6]

How Do High-Deductible Health Plans Affect Access to Prescription Medications?

Except for certain OOP expenses for preventive care, people with HDHPs generally must pay all OOP expenses—including all costs for their prescription medications—until their deductible is met. Since many HDHPs have deductibles that are much higher than the minimum defined by the IRS, some people pay thousands of dollars in OOP costs for their medications before their health insurance kicks in. Some experts believed that HDHPs would encourage patients to become "smarter consumers" because they would shoulder a greater portion of the cost of care. However, in many cases, medical treatments—including prescription medications—are not planned, comparison shopping is difficult or there is only one effective drug available to treat a patient's health condition. Under these circumstances, being a smart consumer does not help reduce OOP drug costs for people with HDHPs.[7]

Although HRAs and HSAs can help offset the impact of these expenses, not all employers offer HRAs and HSAs may be of limited assistance to low-wage workers whose need to cover basic expenses (e.g. food, housing and utilities) prevent them from fully benefiting from these saving accounts. In addition, the relatively low maximum tax-deductible contributions that are permitted for HSAs may not help patients who require specialty medications that can cost thousands of dollars each month.

Not surprisingly, HDHPs have been shown to decrease access to prescription medications. Research on non-elderly, privately-insured cancer survivors showed that people in HDHPs were more likely to ask their doctor for lower cost medications, a reflection of their concern about OOP drug costs.[8] Another

study on diabetic patients aged 18-64 compared outcomes in patients who were mandated by their employers to switch to a HDHP and similar patients with low-deductible plans. Results showed that OOP costs rose dramatically in the HDHP group in parallel with increased emergency room visits and a decrease in visits to diabetes specialists. The investigators speculated that lower medication adherence was one explanation for the unfavorable outcomes among diabetic adults who were forced to switch to a HDHP.[9]

The most compelling evidence of the impact of HDHPs on access to prescription medications is from a 2017 systematic review of how these plans affect various aspects of healthcare utilization, including prescription medications.[10] The review found evidence that HDHPs were associated with significant reductions in drug spending among HDHP enrollees with low incomes and those with chronic conditions.[11] Decreased spending on prescription medications or interruptions in treatment among economically vulnerable and chronically ill patients frequently reflects the difficult choice between filling prescriptions or paying for other essential needs due to the financial burdens from OOP drug costs. These patients represent the subgroup of HDHP enrollees who are most vulnerable to the unfavorable impacts of high cost sharing that characterizes these health plans. These plans may be most challenging for low-income, chronically ill workers who are employed by small firms since they are less likely to offer HRAs to help offset OOP costs from HDHPs.

Is There a Connection Between Medicare and High-Deductible Health Plans?

Yes. Although Medicare is not a HDHP, many Medicare beneficiaries are subject to high OOP expenses early in the benefit year.[12] This feature of Medicare's benefit structure is similar to the high OOP costs that are shouldered each year by people with HDHPs.

Another connection involves how older workers' HSAs are affected when they become eligible for Medicare. Employed individuals who are also enrolled in Medicare Parts A and/or B are no longer able to contribute pre-tax dollars to their HSAs because these contributions can only be made by people with an HDHP and no other type of insurance. However, after enrolling in Medicare, people can still use money from their HSAs to cover OOP costs such as deductibles, premiums, co-pays and coinsurance. If these funds are applied to cover qualified medical expenses, they continue to be tax-free.[13]

Some people choose to delay enrolling in Medicare so they can continue contributing to their HSA. However, this decision may not be feasible for people who work at small companies and can also impact a person's eligibility to receive Social Security benefits. Adults who remain employed beyond age 65 and who need—or anticipate needing prescription medications—should carefully consider their personal circumstances when deciding how to ensure access to their medications once they become eligible for Medicare.

The PAN Foundation

The PAN Foundation is an independent, national 501 (c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic and rare diseases with the OOP costs for their prescribed medications. PAN provides the underinsured population access to the healthcare treatments they need to best manage their conditions and focus on improving their quality of life. Since its founding in 2004, PAN has provided more than one million underinsured patients with over $3 billion in financial assistance through close to 70 disease-specific programs.

For more information about this *Issue Brief*, contact Amy Niles, Vice President of External Relations, at aniles@panfoundation.org.

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Supporting Literature

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