

State of the Market Report on Consumer-Directed Health Plans



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32.1M

32.1 million people were enrolled in consumer-directed health plans (CDHP), as of January 1, 2019.

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The large-group market accounts for the **four-fifths of total enrollment**. The CDHP market is stable with modest growth.

35%

Enrollment in a CDHP is not a barrier to get the necessary care for the **35% of CDHP members who have at least one chronic condition**.

Introduction

Consumer-directed health plans (CDHP) combine a high-deductible plan with a tax-advantaged health savings account (HSA), authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003.¹ CHDPs offer Americans a way to save money and invest for future health care costs, while maintaining funds for current expenses, including cost-sharing. Funds contributed to, invested in, or withdrawn from an HSA are not subject to federal income taxation, but account contributions are limited: in 2019, an individual may contribute \$3,500 and a family may contribute \$7,000. In order to avoid a tax penalty, all funds must be used only for IRS-defined qualified medical expenses. The funds are owned by the individual and may be rolled over from year to year.

To provide a snapshot of the CDHP market, this report from America's Health Insurance Plans (AHIP) combines the results of a survey of AHIP member health plans and a claims-based study.

Key Findings

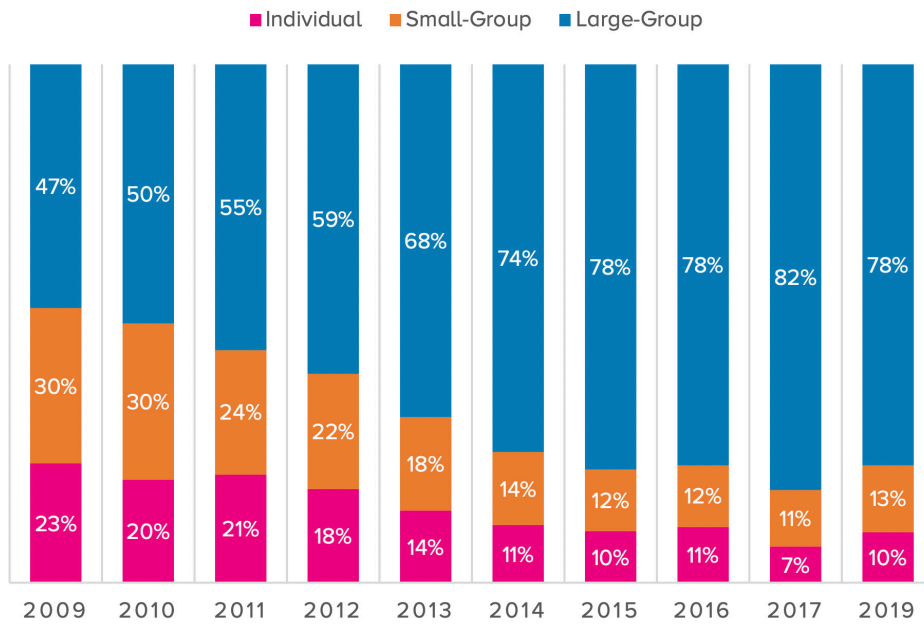
The CDHP Market Is Stable

As of January 1, 2019, 32.1 million people were enrolled in CDHPs. They accounted for 15% of the total commercial enrollment, including group plans and individual insurance. Due to changes in methodology, the national CDHP enrollment estimate is not directly comparable to the estimates from previous years.

Large-group CDHP coverage accounted for the overwhelming majority of CDHP enrollment. Generally, large-group coverage was defined as policies offered by employers with 50 or more employees. As of January 1, 2019, 78% of CDHP enrollees were in the large-group market, followed by 13% enrollees in the small-group market. Individual market accounted for a tenth of the CDHP enrollment (Figure 1).

The distribution of CDHP enrollees by market has largely stabilized over the last 5 years. In 2009, individual and small-group markets accounted for the majority of CDHP coverage. However, the large-group market has steadily increased its share, reaching about four-fifth of the CDHP coverage by 2015. Since 2015, the distribution of CDHP coverage by market remained stable.

Figure 1. CHDP Enrollment by Market Type, 2009-2019.

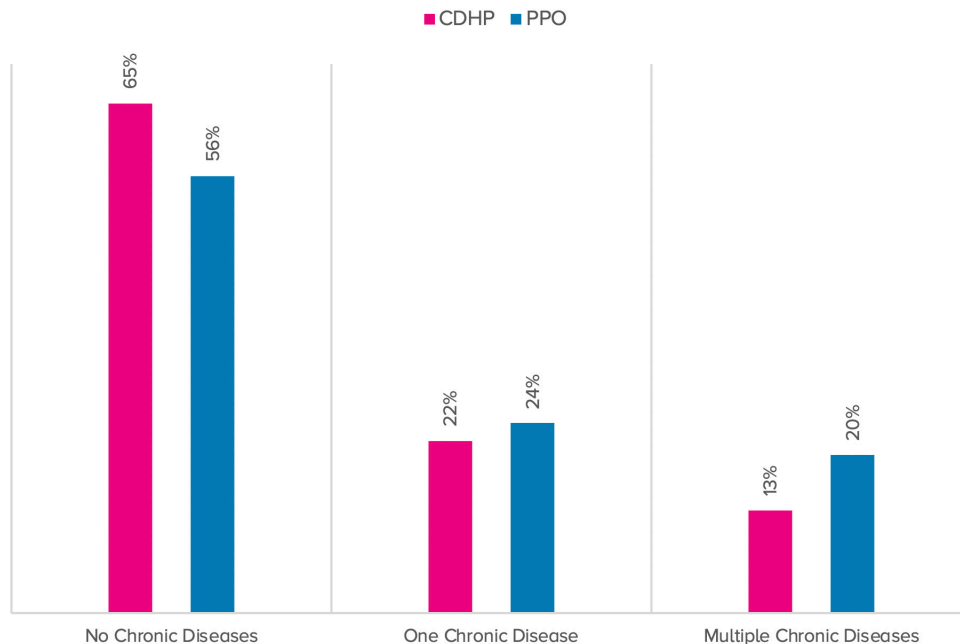


Note: AHIP did not conduct a survey in 2018. % may not equal 100% due to rounding.

CDHP Members Less Likely to Have Chronic Conditions

People with a CDHP plan, on average, tend to have fewer chronic conditions compared to PPO enrollees. Sixty-five percent of CDHP members had no chronic diseases, compared with 56% for PPO members (Figure 2). In contrast, 13% of CDHP members suffered from 2 or more chronic diseases, compared to 20% of PPO members.

Figure 2. Prevalence of Chronic Diseases by Plan Type



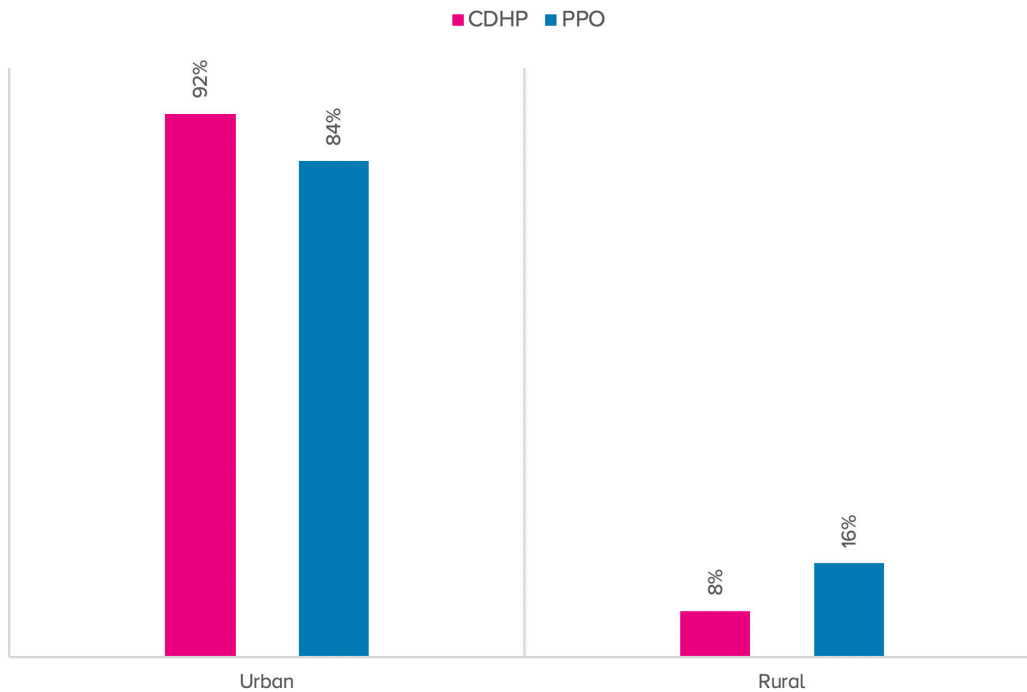
The difference in the prevalence of chronic diseases between plan types stems largely from the different demographic profiles of their enrollees.² People with a CDHP plan tend to be younger, on average, than people in PPO plans. There were more children under 18 enrolled in CDHP than PPO plans, 26% vs. 22%, respectively (Figure 3). Conversely, CDHP plans had fewer older adults, aged 55-64, enrolled than PPO plans, 14% vs. 20% respectively.

Figure 3. Age Distribution by Plan Type



CDHP and PPO plans differ in the geographic distribution of their enrollees. In our study, 84% of PPO members resided urban areas (Figure 4). The share of urban population in PPO plans was in line with the national estimate of the urban share of U.S. population.³ In contrast, a higher share of CDHP members (92%) resided in urban areas. Compared to PPO plans, people in CDHP plans were less likely to reside in rural areas. As the prevalence of chronic diseases in rural areas tends to be higher compared to urban areas,⁴ the lower share of rural population in CDHP plans may also explain some of the difference in chronic disease prevalence.

Figure 4. Geographic Distribution by Plan Type



CDHP Not a Barrier to Receiving Care for Chronic Conditions

Even though people with a CDHP plan were less likely to suffer from chronic conditions, over a third of CDHP members received treatment for one or more chronic diseases, which led to higher medical costs. The study examined whether the higher deductibles in CDHP compared to PPO plans affected the quality of care for patients. To compare the quality of care provided by PPO and CDHP plans, the study relied on the Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA).

Since preventive services are covered pre-deductible for both CDHP and PPO plans, one would expect to see no difference in their utilization. The study compared CDHP and PPO plans across several HEDIS-based quality of care measures for preventive services. Specifically, the study measured the rates of recommended screenings for breast cancer, cervical cancer, and colorectal cancer. In addition, the study measured the rates for recommended immunizations of adolescents with meningococcal vaccine and TDAP vaccine. As expected, the study found similar rates of cancer screening and adolescent immunizations for people enrolled in either CDHP or PPO plans (Table 1).

Table 1. HEDIS Measures for Preventive Care by Plan Type

HEDIS Measures	CDHP	PPO
Cancer Screening		
Breast Cancer Screening	69%	69%
Cervical Cancer Screening	51%	51%
Colorectal Cancer Screening	31%	30%
Adolescent Immunizations		
Meningococcal vaccine	73%	72%
TDAP	72%	72%

In contrast to preventive care, CDHP and PPO plans differ in their coverage of care for chronic diseases. Specifically, CDHP members must pay out of pocket for their (non-preventive) care until they satisfy the deductible. To examine the impact of high deductibles on quality of care for people with chronic conditions, the study compared CDHP and PPO plans across several HEDIS-based quality of care measures for three common chronic conditions: diabetes, asthma, and rheumatoid arthritis.

For diabetes and asthma, the study calculated the Percent Days Covered (PDC) for insulin and asthma controller medications respectively. PDC is a measure of medication adherence calculated as the ratio of the number of days a patient is covered by the medication to the number of days of treatment. For rheumatoid arthritis, the study measured the share of rheumatoid arthritis patients who received at least one Disease-Modifying Anti-Rheumatic Drug (DMARD) therapy. Since biologic DMARDs tend to be considerably more expensive than non-biologic DMARDs, the study further broke out the share of patients who received at least one biologic DMARD.

The study found that CDHP members had somewhat better medication adherence for insulin and asthma controller medication compared to PPO members (Table 2). They had similar rates of receiving DMARD therapies for rheumatoid arthritis, including the more expensive biologic DMARD therapies. Thus, enrollment in a CDHP plan did not preclude people with chronic conditions from receiving necessary care for these conditions.

Table 2. HEDIS Measures for Chronic Condition Care by Plan Type

Chronic Condition	HEDIS Measures	CDHP	PPO
Diabetes	Insulin Adherence	68%	64%
Asthma	Asthma Controller Adherence	84%	75%
Rheumatoid Arthritis	DMARD Therapy	84%	84%
Rheumatoid Arthritis	Biologic DMARD Therapy	43%	44%

Empowering Greater Choice Through CDHPs

The continued increase in popularity of CDHPs, combined with current health trends in America, mean more changes are needed to support good health and financial stability. Health insurance providers are focused on helping patients treat and manage chronic disease. They recognize that many Americans have at least one chronic illness and the importance of treating conditions early and consistently to avoid harmful and costly complications down the road.

While the study found that CDHP members with chronic conditions received the necessary care for these conditions at rates comparable to PPO members, these treatments can be costly and can place a significant financial burden on Americans. Recent estimates put the annual cost of asthma medication at \$2,000;⁵ the annual cost of insulin at \$5,700;⁶ and the annual cost of biologic DMARDs at well over \$20,000 for each patient.⁷ Presently, CDHP members must meet their full deductible before the plan can pay for most services, treatments, or medications.

There is a growing recognition that ensuring consistent access to treatment for those with chronic conditions such as diabetes, asthma, and substance abuse disorder can help prevent expensive, debilitating complications. The Administration recently issued an IRS Notice that expands the definition of preventive care under a statutory safe harbor, enabling health insurance providers to design HSA-eligible plans that can better meet the needs of enrollees with chronic health conditions. The Chronic Disease Management Act (H.R. 3709) would enshrine this expansion into law and further allow plans to design benefits that empower people in CDHPs to manage chronic conditions. This approach improves the value of HSA-qualified plans for members and enables patients to more easily access care they need to effectively manage their chronic conditions.

AHIP supports efforts to reduce the cost of health care to Americans, allowing those who opt for CDHPs to have the ability to make cost-conscious decisions that meet their health care needs. For many Americans, CDHPs are a preferred option. As an industry, we aim to ensure that employers and individuals have choices about which plan type is right for their health and their finances.

With over 32 million lives covered in HSA-qualified CDHP plans, and enrollment expected to continue in the coming years, CDHPs represent a vital option to provide Americans with greater control and choice over their health and financial security, leading to greater peace of mind.

Appendix

Survey Methodology

In September 2019, AHIP conducted a survey of its member health insurance providers on key enrollment characteristics in CDHP plans. The survey has been redesigned from previous years to improve accuracy of enrollment estimates. Due to changes in methodology, the national CDHP enrollment estimate is not directly comparable to the estimates from previous years.

AHIP embarked on a month-long recruitment program, which included repeated outreach to its member health insurance providers. Using a key informant approach, AHIP emailed survey invitations to product management, business development, and financial reporting staff from their member insurance providers, who then shared the survey with their teams, as appropriate. Data collection occurred in September 2019 and all responses were based on insurance providers' business activity as of January 1, 2019.

The survey was distributed to 86 AHIP member health insurance providers that offered major medical insurance in the commercial market. AHIP received responses from 28 member insurance providers, yielding a 32% response rate.

The **Total CDHP Enrollment** was estimated as follows. The study first calculated a weighted average of CDHP enrollment as a share of total commercial enrollment for the responding insurance providers. The average CDHP enrollment share was then multiplied by the estimated national commercial enrollment to arrive at the Total CDHP Enrollment estimate. The study used the U.S. Census Bureau data to obtain the national estimate of commercial enrollment, both employment-based and direct-purchase, in 2018.⁸ In addition, the study estimated distribution of CDHP enrollment by market type.

Claims-based Study Methodology

AHIP conducted a claims-based study to examine the impact of CDHP high deductibles on the ability of people with chronic conditions to receive necessary care. The study compared CDHP and Preferred Provider Organization (PPO) plans with low deductibles across several quality of care measures for preventive care and for three common chronic conditions: diabetes, asthma, and rheumatoid arthritis.

Data Sources

For the creation of key variables of interest, specifically plan type, demographic variables, and quality of care measures, all medical and pharmacy claims data were extracted from the IBM® MarketScan® Commercial Database for the period January 1, 2016 to December 31, 2017.

Inclusion/Exclusion Criteria

The study included only enrollees who satisfied the following conditions:

1. Continuously enrolled in 2016 and 2017
2. Enrolled in either PPO or CDHP plan
3. Remained with the same plan type throughout the study period

The final sample included 6.5 million PPO and 1.3 million CDHP enrollees.

Variable Descriptions

Demographic Variables

The study estimated the distribution of enrollees by **age group** and **urban/rural residency** for PPO and CDHP plan types. Urban population was defined as population residing in Metropolitan Statistical Areas (MSA), areas with an urban core of at least 50,000 inhabitants. Rural population was defined as population residing in non-MSA areas.

In addition, the study estimated the distribution of enrollees by the level of health risk. The study employed the measure of comorbidities developed by Elixhauser et al – the **Elixhauser Comorbidity Index (ECI)**.⁹ The ECI is a set of 30 comorbidity indicators that can be calculated based on the Tenth Revision of the International Classification of Diseases (ICD-10) diagnosis codes found in administrative claims data. It is frequently used to predict inpatient stay outcomes, such as length of stay, hospital charges, and in-hospital mortality.¹⁰ A higher ECI score indicates a greater health risk level for the patient. Thus, the study used the ECI distribution as a proxy for the overall health of the population by plan type.

For each enrollee, the study calculated the ECI score. The final ECI score was stratified into three categories:

1. No Chronic Diseases: ECI=0;
2. One Chronic Disease: ECI=1;
3. Multiple Chronic Diseases: ECI>1

The study estimated the distribution of enrollees by ECI category for PPO and CDHP plan types.

Quality of Care Variables

To compare the quality of care provided by PPO and CDHP plans, the study relied on the Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA).¹¹ HEDIS is a widely used set of performance measures across many health conditions that can be used by health systems to improve quality of care. The study calculated select measures for 2017 across two key areas:

1. Prevention and Screening Measures
2. Chronic Condition Measures

The study followed 2019 HEDIS criteria for calculating the variables. They were modified, where necessary, to account for data limitations, e.g. variable availability and lookback periods. The selection criteria for these variables are outlined below.

I. Prevention And Screening Measures

1. Adolescent Immunizations:

Denominator: Adolescents aged 12 as of December 31, 2017.

Numerator: At least one immunization shot in 2016-2017 for each of the following vaccines:

- meningococcal vaccine.
- tetanus, diphtheria, and acellular pertussis (TDaP).

2. Breast Cancer Screening:

Denominator: Women aged 52 to 64 as of December 31, 2017.

Numerator: At least one mammogram in 2016-2017.

3. Cervical Cancer Screening:

Denominator: Women aged 24 to 64 as of December 31, 2017.

Numerator: At least one cervical cancer screening in 2016-2017.

4. Colorectal Cancer Screening:

Denominator: All enrollees aged 51-64 as of December 31, 2017.

Numerator: At least one colorectal cancer screening in 2016-2017.

II. Chronic Condition Measures

1. Asthma Controller Adherence:

Denominator: All enrollees aged 5-64 as of December 31, 2017 who had at least four dispensing events for asthma controller or rescue medication in 2016-2017, of which at least one was for asthma controller medication. Excludes enrollees who had at least one diagnosis for emphysema, COPD, obstructive chronic bronchitis, cystic fibrosis or acute respiratory failure.

Numerator: Enrollees who had Asthma Controller Percent Days Covered (PDC) \geq 75%. Asthma Controller PDC is calculated as total days supply of asthma controller medication dispensed to the patient in 2017 divided by the length of asthma treatment. The length of treatment is calculated as the period between the earliest asthma controller prescription dispensation date in 2017 through the last day of the year.

2. Insulin Adherence:

Denominator: All enrollees aged 18-64 as of December 31, 2017 who had at least one prescription for insulin in 2016-2017.

Numerator: Enrollees who had Insulin Percent Days Covered (PDC) $\geq 75\%$. Insulin PDC is calculated as total days supply of insulin dispensed to the patient in 2017 divided by the length of insulin treatment. The length of treatment is calculated as the period between the earliest insulin prescription dispensation date in 2017 through the last day of the year.

Note: This is not a HEDIS measure. It is modelled after Asthma Controller Adherence measure.

3. DMARD Therapy:

Denominator: All enrollees aged 18-64 as of December 31, 2017 who had at least two inpatient or outpatient visits with rheumatoid arthritis diagnosis in 2016-2017.

Numerator: Enrollees who had at least one Disease-Modifying Anti-Rheumatic Drug Therapy (DMARD) dispensing event in 2017.

4. Biologic DMARD Therapy:

Denominator: All enrollees aged 18-64 as of December 31, 2017 who had at least two inpatient or outpatient visits with rheumatoid arthritis diagnosis in 2016-2017.

Numerator: Enrollees who had at least one biologic DMARD dispensing event in 2017.

Note: This is not a HEDIS measure. It is included to measure coverage of the more expensive biologic DMARDs that tend to be specialty drugs.

Endnotes

- 1 For 2018, the minimum annual deductible for self-only CDHP coverage is \$1,350, and the maximum out-of-pocket limit for self-only coverage is \$6,650. For family CDHP coverage, the minimum deductible is \$2,700 and the maximum out-of-pocket limit is \$13,300. These amounts are indexed annually for inflation. Internal Revenue Service. "Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans." (2019); Available at: <https://www.irs.gov/pub/irs-pdf/p969.pdf>
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- 11 National Committee for Quality Assurance. "Healthcare Effectiveness Data and Information Set." (2019); Available at: <http://www.ncqa.org/hedis-quality-measurement>