

High-Deductible Health Plans: Implications for the Retina Specialist

Retina specialists need to adjust to the growing number of patients enrolled in high-deductible health plans to ensure that their offices run smoothly.

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Discussions of the effects of the Affordable Care Act (ACA) on clinical practice and office management often neglect to explore how the legislation incentivizes an expansion in the number of patients enrolled in high-deductible health plans (HDHPs). Patients with HDHPs pay a low monthly premium in exchange for a high deductible. Many of these patients are in good health and will never be compelled to satisfy their deductible. Patients who encounter costly medical bills, however, may be unprepared to satisfy their deductible. These patients may have to finance medical treatment, or forgo it altogether, if they feel that out-of-pocket costs are too high.

WHY IT MATTERS

Retina specialists need to be aware of the rising trend of health care enrollees choosing HDHPs. Research by the Henry J. Kaiser Family Foundation showed that the percentage of employee-covered workers with a deductible of \$1000 or higher for a single coverage rose from 10% in 2006 to 31% in 2011.^{1,2} The increase is greater for employees of businesses with fewer than 200 workers: in 2006, 16% of these workers had HDHPs; by 2010, that number was 46%.¹

The implementation of the so-called “Cadillac tax” in 2018 might well accelerate the trend of insured patients moving from conventional health plans to HDHPs. The Cadillac tax is an excise tax on employer-sponsored health care plans that cost greater than \$10 200 for single coverage or \$27 500 for family coverage. (These thresholds are aggregates of employer- and employee-paid premiums and all employer contributions to a health savings account [HSA] and/or a flexible spending account

[FSA].) The high tax rate—40% on money spent beyond those thresholds—incentivizes employers who compensate their employees with high-end health packages to reduce the amount spent per plan on these packages. Estimates project an increase over the next 15 years in the number of employee-sponsored plans eligible for the Cadillac tax, from 15% in 2018 to 49% by 2024, and 76% by 2029.³

The tax does not go into effect until 2018, due in large part to negotiations with labor unions over the passage of the ACA. Employers offering health plans beyond the threshold when the tax begins will likely offer reduced benefits packages to employees, many of whom will receive HDHPs. Lower employer contributions could mean that employers will offer wage increases to offset higher premiums and deductibles, but nothing guarantees that those covered will earmark such money to an HSA or FSA to cover their deductible.

FUTURE PROJECTIONS

The future economics of health care spending if an increasing number of patients enroll in HDHPs remains opaque. Data from an 800 000-participant retrospective study published by the RAND Corporation in 2011 found that, from 2004 to 2005, first-time users enrolled in HDHPs or consumer-directed health plans (ie, HDHPs with HSAs or FSAs) spent 14% less than similar families enrolled in conventional plans as a result of reduced spending in preventive, necessary, and unnecessary care.⁴ A RAND-sponsored study published in 2012 that reviewed survey data and insurance claims from 2003 to 2007 estimated that an increase in the number of consumer-directed health plans from 13% to 50% market share could reduce

annual health care spending by approximately \$57 billion.⁵ However, these studies focused on eras prior to passage of the ACA, which eliminated coinsurance payments for preventive care and expanded the number of patients with access to health insurance.

Regardless of how patients spend their money, retina specialists need to be aware of how an increase in the number of patients with HDHPs might affect their clinical practice and office management.

CLINICAL IMPACT

Retina specialists will be directly affected by this shift in insurance enrollee coverage when treating patients in acute or chronic disease states.

Acute Conditions

Patients with acute retina needs—trauma, sudden detachment, or other emergency situations—will face the challenge of satisfying their deductible if they have an HDHP with a large remainder of their deductible unpaid. Trauma patients will face the burden of paying out of pocket for emergency treatment and some of these patients will not have the cash on hand to satisfy their deductible. The nature of acute disease is such that people who require treatment are likely to receive it regardless of the status of their deductible; it is difficult to imagine a scenario involving a patient with a detached retina who forgoes surgery to save money. The long-term financial consequences of HDHPs for patients facing acute diseases should concern both HDHP enrollees and retina specialists who have to collect payment from them.

Chronic Conditions

Patients with chronic conditions managed by retina specialists present a different set of problems. Patients who require monthly or as-needed treatment will need to find out-of-pocket sources of payment prior to meeting their deductible. Patients may choose to lengthen the time between injections, reduce the number of office visits, or skip seeing a retina specialist all together if the cost of treatment is excessive. Abnormal treatment patterns could have negative consequences, and patients with chronic disease states could see their conditions exacerbated if they abstain from treatment due to financial concerns.

Working With Patients

Patients with chronic conditions who are covered by HDHPs will likely face challenges similar to those faced by patients on Medicare who do not have secondary insurance to cover the 20% coinsurance on drugs and

services. If patients with HDHPs respond to payment problems by reducing treatment episodes, then retina specialists should use as a blueprint their management of Medicare patients without secondary insurance.

HDHPs limit access to care and require patients to share in the cost of care. The aforementioned RAND studies have shown that health care spending declines when patients enroll in HDHPs. An additional study examined enrollees from 2003 to 2007 who switched from conventional health plans to HDHPs. These enrollees spent 21% less in health care in their first year. The reduction in cost was due to both a reduction in cost per episode (7.5% reduced spending) and a reduction in the number of episodes (13.5% reduced spending).⁶ There were also reductions in name-brand drug use, visits to specialists, and hospital stays.⁶

Cost reductions seem to benefit the patient, but if costs are declining because patients are seeing their doctors less frequently, then nobody wins. These data seem to suggest that drug holidays could become a major roadblock for treatment of chronic retinal disease. Conditions worsened by inadequate treatment ultimately become more expensive for patients and the health care system, especially if an acute condition develops secondary to a chronic condition.

Many of the disease states retina specialists treat require multiple office visits, monthly or as-needed injections, and imaging, the costs of which patients pay out of pocket until their deductibles are satisfied. Retina specialists who treat patients with HDHPs with unsatisfied deductibles will have to consider treatment options that include off-label or generic medications, or sustained release drugs or implants that lower the number of required office visits. Industry may eventually adjust to this changing market, but for the immediate future, retina specialists will once again be asked to consider how the cost of treatment affects patients.

Impact on The Bottom Line

An increase in the number of patients with HDHPs will force retina specialists to adjust their office management styles to ensure patients with HDHPs are identified early in the process and that payment for services is collected within a reasonable time frame.

Office staff must make sure that patients with HDHPs understand the basics of how health insurance policies operate. It may be worthwhile to ask patients if they have any questions about how their health insurance plans work, especially patients who switched from a conventional health plan to an HDHP. Being proactive can help offices educate patients who do not realize that a deductible must be satisfied before insurance picks up

the tab. It may also help avoid an uncomfortable situation involving a patient who is caught off-guard after receiving a bill for services; such a patient may become angry or upset, and may not return for future visits.

Retina specialists may also want to consider payment plans for patients, especially for those with HDHPs. Payment plans, although convenient for patients, require office staff to schedule, track, and collect payments, which further burdens the staff and adds a new obstacle to the patient-physician relationship. Some physicians may consider outsourcing collections by hiring third-party companies to collect payment in a timely manner. Offices that choose to use this service pay a premium, but it may be worthwhile to receive a large percentage of the overall payment if it means fewer headaches for the staff.

CONCLUSION

Although the prospects of an increasing number of patients enrolling in HDHPs are daunting, it is possible that patients will find alternative methods for satisfying deductibles, thus rendering moot the issues discussed above. However, retina specialists are wise to adjust their clinical and office management styles so that they are prepared for the increasing number of patients with these health plans, regardless of their consequences. ■

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