

Doctors Hate Deductibles: Physicians Pay Thousands to Avoid High Deductibles

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ABSTRACT

Objectives: Employees often have a choice of health insurance plans. High-deductible health plans (HDHPs) offer lower monthly premiums in exchange for higher deductibles before insurance coverage begins. HDHPs use cost sharing to reduce unnecessary health care utilization, making them attractive to employers. We examined health insurance plan selection among physicians to investigate cost differences between plan types.

Study Design: Cross-sectional analysis.

Methods: We completed a cross-sectional analysis of plan selection among 1396 physician employees of a large health system from fiscal year 2018. We created a tool that uses plan selection, annual premium, deductible, and coinsurance costs to estimate individual employee spending for a given health plan over a range of health care spending estimates from \$0 to \$30,000. We applied this tool to physician employee data to compare costs in HDHPs vs high-premium plans.

Results: About 10.8% (152/1396) of physicians in our population chose the HDHP. Enrolling in the HDHP would save \$1451 to \$3851 in combined premium plus out-of-pocket costs for physicians across plan types regardless of health care utilization.

Conclusions: Using employee health insurance data from a large health system, we identified plan selection and potential savings associated with high-deductible coverage. Nearly 90% of physicians did not choose an HDHP and thus spent thousands of extra dollars per year. HDHPs are becoming more common, yet even highly educated health professionals will pay higher premiums to avoid deductibles.

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Employees often have a choice of health insurance plans. High-deductible health plans (HDHPs) often offer lower monthly premiums in exchange for higher deductibles compared with traditional health insurance plans, which may have higher monthly premiums. HDHPs are thought to reduce unnecessary health care utilization through cost sharing, making them attractive to employers by decreasing health spending.^{1,2} The number of employers offering HDHPs increased after the Affordable Care Act.^{3,4} Despite the increased prevalence of HDHPs, there is a lack of understanding about their potential benefits. Employees have been shown to conflate paying for higher-premium plans with receiving a higher caliber of care.⁵ Additionally, concerns about the affordability of HDHPs have been shown among patients with lower incomes, with 40% reporting delayed care in HDHPs compared with 15% of those in traditional plan structures.^{6,7}

However, Nobel Prize-winning economist Richard Thaler, PhD, stated that many people select plans that are “wrong,” meaning a person could have saved money selecting a different health plan, regardless of the health care expenditures in a given year.⁸ Employees may preferentially select plans with lower deductibles despite the fact that they could have saved money if they had selected a plan with a higher deductible.⁹ Although physicians have the health sector experience, education, and knowledge to make optimal decisions about health insurance, they too have elected against enrolling in HDHPs.¹⁰ Whereas for some health plans, people have different levels of risk aversion, in many health plan options offered by employers, employees choose the health plan with the lower deductible instead of the lower guaranteed annual cost, a choice that forgoes up to \$4000.

Investigations of HDHPs have largely focused on their effects on health care utilization.¹¹⁻¹⁴ Patients may forgo needed care due to concerns over increased out-of-pocket (OOP) costs from high deductibles.^{15,16} There is evidence that employees

enrolling in HDHPs are largely healthy and of a higher income status compared with those who enroll in traditional plans; therefore, equity concerns exist in the development of these plans.^{17,18} Less is known about employee health plan selection, particularly among health care providers, and associated spending differences between HDHPs and traditional plans.

Using data from employees of a large health system, we examined health insurance plan selection and financial implications of this selection among physicians, recognizing that inertia can be a contributor to plan selection.^{19,20}

METHODS

Data

The study was conducted using the benefits data of 1396 physician employees of a large health system in New York from the employee benefit year beginning January 2018. The study was limited to physicians in family plans because that was the only benefit group where the total cost of health care (employee share of premium plus OOP costs) was lower for those in HDHPs at any spending level. The 3 employer-sponsored insurance plan options included the Value Plan, which offers higher annual premiums in exchange for a \$0 deductible; the HDHP, which offers higher deductibles in exchange for lower premiums, as well as a health savings account (HSA); and the Buy-Up Plan, which offers higher premium and coinsurance costs in exchange for both in- and out-of-network coverage. Our evaluation of the 1396 physician employees excluded the 356 physician employees selecting the Buy-Up Plan due to its mix of in- and out-of-network coverage, as well as any physicians who opted not to enroll in any of the 3 offered plans. We compared only the 2 plans with solely in-network coverage, the HDHP and the Value Plan, which have the same network and plan administrator.

The data set contains physicians' demographic information including age, years of employment, salary, number of dependents, and work zip codes. For our primary analysis, we used physician insurance plan selection, coverage type (ie, single, employee + spouse, employee + child[ren], and family), and biweekly or semimonthly paycheck deductions to estimate health insurance premium costs. Because we do not have actual claims data, we assumed that (1) all health costs less than the deductible were paid by the employee; (2) health costs in excess of the deductible but less than the maximum OOP (MOOP) amount had 20% of the costs paid by the employee; (3) employee costs in excess of the MOOP amount had 0% cost sharing²¹; and (4) because the employer makes a \$1000 contribution to an HSA for the HDHP only, the value of that \$1000 annual contribution is reduced from the overall health care expenses of those enrolling in the HDHP, not the Value Plan.

Outcomes

Primary outcomes included the number of physician employees opting into the HDHP vs the Value Plan and out-of-pocket costs incurred by these employees in the 2 plans based on the assumptions. Although the second assumption oversimplifies OOP costs with the health plan benefits, the 2 health plans have the same exact benefit structure after the deductible is reached except that the HDHP has a \$7000 MOOP and the Value Plan has a \$10,000 MOOP. The lower HDHP MOOP means that the true risk of the Value Plan is actually higher. However, if an individual used the same services under both health plans, the cost sharing would be exactly the same after the deductible is met and before the MOOP is met. The primary analysis was the development of a calculator tool that compared the total annual OOP cost of care, including both physician share of premium and estimated cost-sharing expenses for both the HDHP plan and the Value Plan based on the assumptions above.

RESULTS

The calculator validated that the HDHP costs were lower than the Value Plan costs in all health spending scenarios for family coverage, as shown in the [Figure](#). A total of 89.1% (1244/1396) of physicians selected the Value Plan instead of the HDHP. The [Table](#) displays available demographic information of all physicians in our sample. Among the largest age group cohort, those aged 35 to 44 years, 87.8% enrolled in the Value Plan. For 16.4% of physicians employed for 5 years or less, the HDHP was the plan of choice.

Family plan enrollment by age group is shown in the [Table](#). Across all age groups, nearly 90% or more enrolled in the Value Plan, which reflects the overall enrollment preferences seen in our entire physician cohort. Among this sample, the proportion of physicians enrolled in the Value Plan increased once they reached age 45 years, with the entirety of the population 65 years and older enrolled in the Value Plan. Physicians aged 35 to 44 years were the largest group to choose the HDHP when enrolling in family coverage, which was still low at 10.8%.

For family plans, at every total health spending level from \$0 to \$10,000, the HDHP is less expensive, ranging from \$1451 less expensive if the employee is spending \$3000 or more to \$3851 per year less expensive if the employee is spending \$0 on health care. This finding is reinforced in the [Figure](#), which shows that the HDHP provides the same access (plans have same network) to physicians enrolled in the family plan at lower cost for every possible health care utilization level.

The [Figure](#) shows that at all health care spending levels for physicians enrolled in family coverage, the HDHP results in lower total spending for the same care than does the Value Plan. In the [Figure](#), the gap between the HDHP line and the

Table. Physician Characteristics by Insurance Plan Type

	Number of physicians	Percentage in HDHP	Percentage in Value Plan
Total	1396	10.9%	89.1%
Age in years			
25-34	269	14.9%	85.1%
35-44	564	12.2%	87.8%
45-54	273	9.2%	90.8%
55-64	216	8.3%	91.7%
≥ 65	74	0.0%	100.0%
Duration of employment in years^a			
< 5	585	16.4%	83.6%
5-10	343	8.7%	91.3%
11-20	299	5.7%	94.3%
> 20	146	2.7%	97.3%
Salary			
< \$100,000	20	5.0%	95.0%
\$100,000-\$150,000	40	15.0%	85.0%
\$150,001-\$200,000	144	7.6%	92.4%
\$200,001-\$300,000	547	9.9%	90.1%
\$300,001-\$400,000	324	13.0%	87.0%
\$400,001-\$500,000	158	15.8%	84.2%
> \$500,000	163	8.0%	92.0%
Wellness credit program			
Enrolled	781	12.7%	87.3%

HDHP, high-deductible health plan.

^aExcludes those with negative years of service (n=5 in HDHP; n=18 in Value Plan).

Value Plan line at each spending level represents savings from the HDHP at that health spending level. Exhibits in **eAppendices A through F** (available at ajmc.com) provide greater detail on the comparison of costs for health plans.

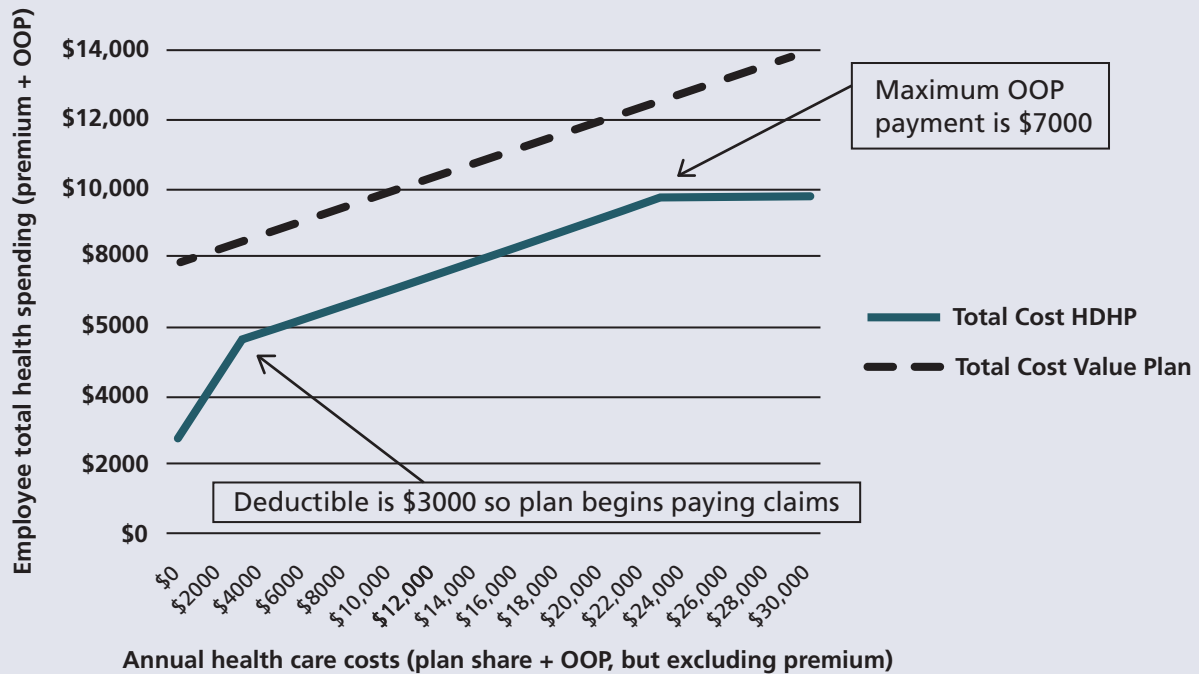
DISCUSSION

Using physician employee health insurance data from a large health system, we quantified health care costs including premium and any OOP costs associated with health insurance plan selection. For physicians who select family plan enrollment, selecting an HDHP is associated with lower total annual health care costs regardless of utilization level.

Despite this, nearly 90% of physician employees chose the Value Plan, with each employee (in a family plan) forgoing \$1451 to \$3851 in savings. This was consistent across income and experience, with some limited variation by employee age.

This result is consistent with the literature, which shows that even sophisticated consumers, such as those with MBAs or those with incomes in excess of \$125,000, frequently did not choose the lowest-cost option.²² This study shows that physicians, who have the benefit of working with health insurance regularly and thus should have a high level of sophistication as consumers, consistently selected an option that would result in higher total health care expenditures.^{20,22,23}

There are several possible explanations for lower enrollment in the Value Plan compared with the HDHP despite cost savings associated with the HDHP. A contributing factor to low enrollment in the HDHP among all types of employees could be deductible aversion, where people would simply prefer to prepay for health care in the form of premiums even if it means paying extra to avoid paying for care at the point of service.²⁴ This is consistent with findings that paying larger

Figure. Employee Spending in HDHP and Value Plan vs Health Care Costs

HDHP, high-deductible health plan; OOP, out of pocket.

sums less frequently for health care is more acceptable to individuals compared with paying small amounts many times throughout the year.²⁵

Physicians' familiarity with health insurance plans through taking care of patients could also inform their opinions of different plans. Patients have been shown to reduce their utilization of necessary preventive services when they are enrolled in high-deductible plans.²⁶⁻²⁹ These findings could contribute to physicians viewing HDHPs as negatively affecting health regardless of their own financial considerations or health care needs. Another possibility is that the inertia associated with selecting a plan other than the default is too much to overcome paired with demanding jobs and high incomes, where \$1000 to \$4000 in health savings does not impact lifestyle.³⁰ The Table shows that uptake of the HDHP varies with employee duration from 3% to 16%, indicating that inertia may be a driver.

Strengths and Limitations

The strengths of this study include utilization of physician employee benefits data from a large health system in a major

metropolitan area and the fact that the 2 plans had the exact same network and plan structure, except for deductible, MOOP, and premium, allowing prospective beneficiaries to draw the conclusion that one plan was less expensive in all scenarios, as shown in the Figure. The health insurance plans studied in this work were both established offerings in the employer-sponsored health insurance plan enrollment options for all employees included in the study prior to the study year, with the HDHP first offered in 2017. Therefore, inexperience with the plan type may contribute to low uptake. Future research could provide insight on drivers of the low uptake of the HDHP.

Our study has several limitations. The data represent employees and health care plan options from 1 health system for 1 year, which may not be generalizable to other health systems. Although our data include the annual premium amounts for each physician, we do not have claims data that reflect actual OOP expenditures, which limits our ability to accurately calculate physician health expenditures. In addition, the demographic data on the physicians selecting the health plan are limited to age, years of employment, compensation, enrollment in a wellness program, and coverage type.

Our model treats the employer contribution to the HSA as a premium reduction and does not account for any of the tax savings associated with the HSA for employees who enroll in the HDHP, so estimations underpredict potential savings in the HDHP. Finally, our data are cross-sectional in nature and cannot be used to predict future employee plan selection or associated expenditures.

CONCLUSIONS

HDHPs are becoming more common, but our study contributes to the growing body of evidence that even highly educated health care professionals who understand health insurance will pay thousands in extra premiums to avoid deductibles. If physicians who have high average incomes relative to the general population and a knowledge of health plans that is higher than average consistently select a plan that is guaranteed to have a higher cost, employers and health plans facing the deductible/premium tradeoff should consider that consumers are willing to trade lower deductibles for higher premiums when offered a direct choice.

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REFERENCES

1. Beeuwkes Buntin M, Damberg C, Haviland A, et al. Consumer-directed health care: early evidence about effects on cost and quality. *Health Aff (Millwood)*. 2006;25(6):w516-w530. doi:10.1377/hlthaff.25.w516
2. Beeuwkes Buntin M, Haviland AM, McDevitt R, Sood N. Healthcare spending and preventive care in high-deductible and consumer-directed health plans. *Am J Manag Care*. 2011;17(3):222-230.
3. Claxton G, DiJulio B, Whitmore H, et al. Health benefits in 2010: premiums rise modestly, workers pay more toward coverage. *Health Aff (Millwood)*. 2010;29(10):1942-1950. doi:10.1377/hlthaff.2010.0725
4. Rae M, Panchal N, Claxton G. Snapshots: the prevalence and cost of deductibles in employer sponsored insurance. Kaiser Family Foundation. November 2, 2012. Accessed February 21, 2021. <https://www.kff.org/health-costs/issue-brief/snapshots-the-prevalence-and-cost-of-deductibles-in-employer-sponsored-insurance/>
5. Hibbard JH, Greene J, Sofaer S, Firminger K, Hirsh J. An experiment shows that a well-designed report on costs and quality can help consumers choose high-value health care. *Health Aff (Millwood)*. 2012;31(3):560-568. doi:10.1377/hlthaff.2011.1168
6. Kullgren JT, Galbraith AA, Hinrichsen VL, et al. Health care use and decision making among lower-income families in high-deductible health plans. *Arch Intern Med*. 2010;170(21):1918-1925. doi:10.1001/archinternmed.2010.428
7. Galbraith AA, Soumerai SB, Ross-Degnan D, Rosenthal MB, Gay C, Lieu TA. Delayed and forgone care for families with chronic conditions in high-deductible health plans. *J Gen Intern Med*. 2012;27(9):1105-1111. doi:10.1007/s11606-011-1970-8
8. Thaler RH. Why so many people choose the wrong health plans. *New York Times*. November 4, 2017. Accessed February 21, 2021. <https://www.nytimes.com/2017/11/04/business/why-choose-wrong-health-plan.html>
9. Bhargava S, Loewenstein G, Sydnor G. Choose to lose: health plan choices from a menu with dominated options. *Q J Econ*. 2017;132(3):1319-1372. doi:10.1093/qje/qjx011
10. Leung LB, Escarce JJ. Consumer-directed health plans: do doctors and nurses buy in? *Am J Manag Care*. 2017;23(3):e89-e94.
11. Sinaiko AD, Mehrotra A, Sood N. Cost-sharing obligations, high-deductible health plan growth, and shopping for health care: enrollees with skin in the game. *JAMA Intern Med*. 2016;176(3):395-397. doi:10.1001/jamainternmed.2015.7554
12. Ross JS. High-deductible health plans and higher-value decisions: a mirage or are we just not there yet? *JAMA Intern Med*. 2016;176(3):397-398. doi:10.1001/jamainternmed.2015.7559
13. Agarwal R, Mazurenko O, Menachemi N. High-deductible health plans reduce health care cost and utilization, including use of needed preventive services. *Health Aff (Millwood)*. 2017;36(10):1762-1768. doi:10.1377/hlthaff.2017.0610
14. Wharam JF, Landon BE, Galbraith AA, Kleinman KP, Soumerai SB, Ross-Degnan D. Emergency department use and subsequent hospitalizations among members of a high-deductible health plan. *JAMA*. 2007;297(10):1093-1102. doi:10.1001/jama.297.10.1093

15. Abdus S, Keenan PS. Financial burden of employer-sponsored high-deductible health plans for low-income adults with chronic health conditions. *JAMA Intern Med.* 2018;178(12):1706-1708. doi:10.1001/jamainternmed.2018.4706
16. Wharam JF, Zhang F, Landon BE, Soumerai SB, Ross-Degnan D. Low-socioeconomic-status enrollees in high-deductible plans reduced high-severity emergency care. *Health Aff (Millwood).* 2013;32(8):1398-1406. doi:10.1377/hlthaff.2012.1426
17. Lave JR, Men A, Day BT, Wang W, Zhang Y. Employee choice of a high-deductible health plan across multiple employers. *Health Serv Res.* 2011;46(1, pt 1):138-154. doi:10.1111/j.1475-6773.2010.01167.x
18. Woolhandler S, Himmelstein DU. Consumer directed health-care: except for the healthy and wealthy it's unwise. *J Gen Intern Med.* 2007;22(6):879-881. doi:10.1007/s11606-007-0187-3
19. Marton J, Yelowitz A, Talbert JC. Medicaid program choice, inertia and adverse selection. *J Health Econ.* 2017;56:292-316. doi:10.1016/j.jhealeco.2017.04.006
20. Handel BR, Kolstad JT. Health insurance for "humans": information frictions, plan choice, and consumer welfare. *Am Econ Rev.* 2015;105(8):2449-2500. doi:10.1257/aer.20131126
21. 2019 Employer Health Benefits Survey: summary of findings. Kaiser Family Foundation. September 25, 2019. Accessed February 21, 2021. <https://www.kff.org/report-section/ehbs-2019-summary-of-findings/>
22. Ericson KM, Sydnor J. The questionable value of having a choice of levels of health insurance coverage. *J Econ Perspect.* 2017;31(4):51-72. doi:10.1257/jep.31.4.51
23. Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? the value of choice architecture. *PLoS One.* 2013;8(12):e81521. doi:10.1371/journal.pone.0081521
24. van Winssen KPM, van Kleef RC, van de Ven WPMM. Potential determinants of deductible uptake in health insurance: how to increase uptake in the Netherlands? *Eur J Health Econ.* 2016;17(9):1059-1072. doi:10.1007/s10198-015-0745-2
25. Atanasov P, Baker T. Putting health back into health insurance choice. *Med Care Res Rev.* 2014;71(4):337-355. doi:10.1177/1077558714533821
26. Wharam JF, Zhang F, Wallace J, et al. Vulnerable and less vulnerable women in high-deductible health plans experienced delayed breast cancer care. *Health Aff (Millwood).* 2019;38(3):408-415. doi:10.1377/hlthaff.2018.05026
27. Tipirneni R, Politi MC, Kullgren JT, Kieffer EC, Goold SD, Scherer AM. Association between health insurance literacy and avoidance of health care services owing to cost. *JAMA Netw Open.* 2018;1(7):e184796. doi:10.1001/jamanetworkopen.2018.4796
28. Wharam JF, Lu CY, Zhang F, et al. High-deductible insurance and delay in care for the macrovascular complications of diabetes. *Ann Intern Med.* 2018;169(12):845-854. doi:10.7326/M17-3365
29. Wharam JF, Zhang F, Eggleston EM, Lu CY, Soumerai SB, Ross-Degnan D. Effect of high-deductible insurance on high-acuity outcomes in diabetes: a Natural Experiment for Translation in Diabetes (NEXT-D) study. *Diabetes Care.* 2018;41(5):940-948. doi:10.2337/dc17-1183
30. Politi MC, Grant RL, George NP, et al. Improving Cancer Patients' Insurance Choices (I Can PIC): a randomized trial of a personalized health insurance decision aid. *Oncologist.* 2020;25(7):609-619. doi:10.1634/theoncologist.2019-0703

eAppendix

eAppendix A. HDHP and Value Plan Comparison for Physicians

Family Coverage	High Deductible Health Plan	Value Plan
Annual premium	\$3,432	\$7,283
Deductible-Family Coverage	\$3,000	\$0
Max Out-of-Pocket Spending	\$7,000	\$10,000
Employer HSA Contribution	\$1,000	\$0

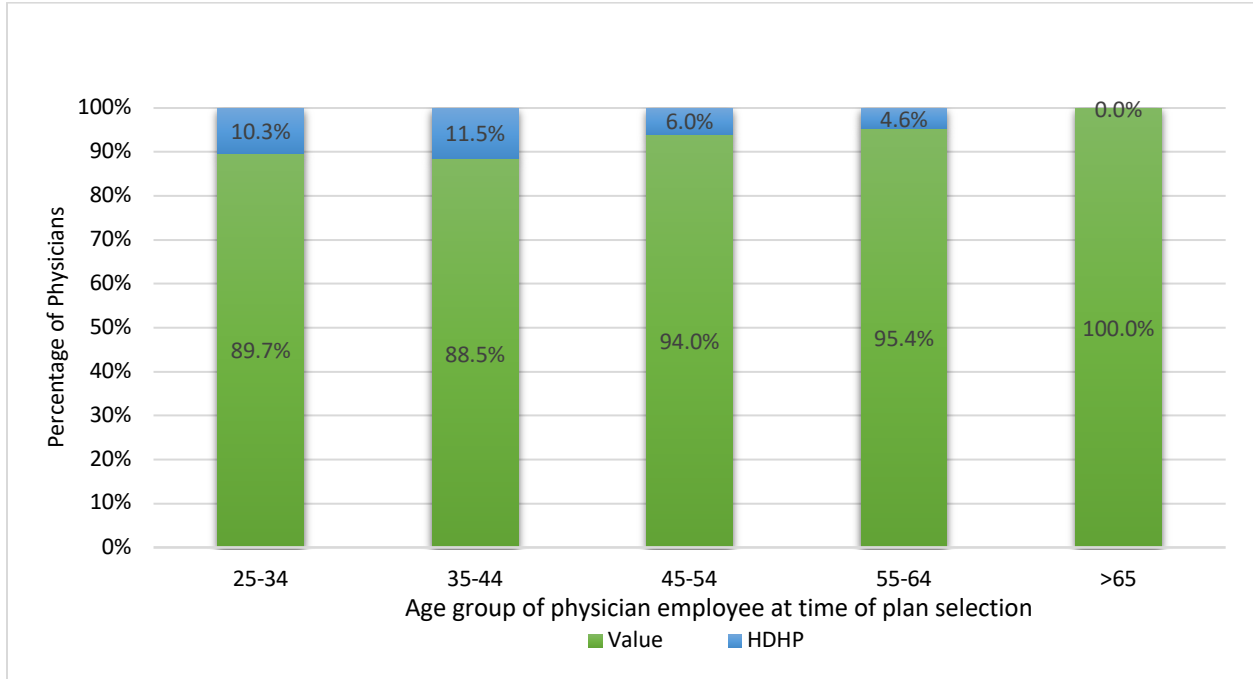
eAppendix B. Spending by Health Plan for Physicians with Family Coverage

	Value Plan			HDHP			Difference
	Total Health Premium	Cost Sharing	Total Spend	Premium	Cost Sharing	Total Spend	
\$0	\$7,283	\$0	\$7,283	\$3,432	\$0	\$3,432	\$3,851
\$1,500	\$7,283	\$300	\$7,583	\$3,432	\$1,500	\$4,932	\$2,651
\$3,000	\$7,283	\$600	\$7,883	\$3,432	\$3,000	\$6,432	\$1,451
\$5,000	\$7,283	\$1,000	\$8,283	\$3,432	\$3,400	\$6,832	\$1,451
\$10,000	\$7,283	\$2,000	\$9,283	\$3,432	\$4,400	\$7,832	\$1,451

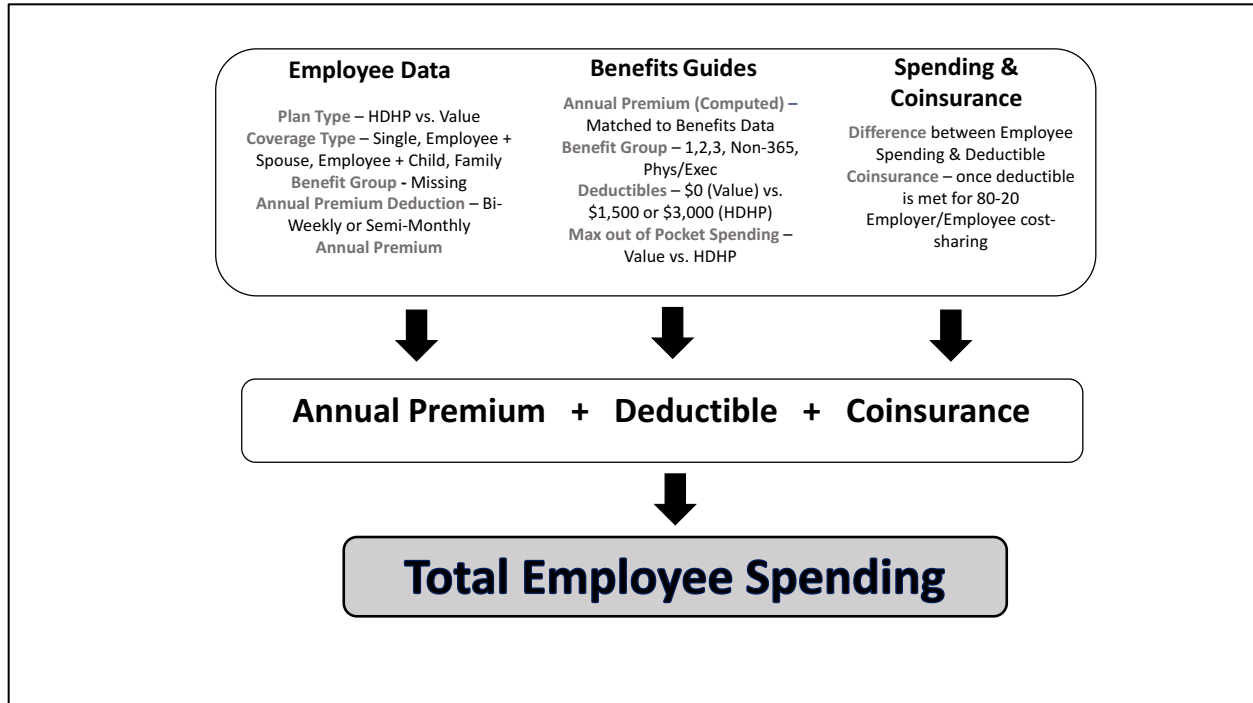
eAppendix C. HDHP and Value Plan Cost Comparison for Physicians

	High Deductible Health Plan	Value Plan
Single Coverage		
Annual premium	\$1,843	\$3,005
Deductible-Single Coverage	\$1,500	\$0
Max Out-of-Pocket Spending	\$3,000	\$5,000
Family Coverage		
Annual premium	\$3,432	\$7,283
Deductible-Family Coverage	\$3,000	\$0
Max Out-of-Pocket Spending	\$7,000	\$10,000

eAppendix D. Family Coverage Enrollment by Age Group



eAppendix E. Total Employee Spending Tool



eAppendix F. Average Individual Physician Savings-HDHP vs. Value plan

Spending	Average Savings
\$0	\$2,533
\$1,500	\$1,805
\$3,000	\$634
\$5,000	\$655
\$10,000	\$1,234
\$20,000	\$2,186