

**HDHP Task Force
November 6, 2019
11:00 AM – 1:00 PM
Legislative Office Building, Room 2D**

Members Present: Ted Doolittle, Dr. Daniel Freess, Susan Halpin, Atty. Robert Krzys, Dr. Andrew Lim, Patrick McCabe, Joseph McDonagh, Cassandra Murphy, Seth Powers, Dr. Gregory Shangold and Dr. Andy Wormser;

Not in attendance: Janice Perkins

OHA Staff Present: Adam Prizio, Sean King, Kim Davis, Sherri Koss

Welcome

- Ted opens meeting at 11:01 AM

Roll Call

- Dr. Andrew Lim
- Dr. Andrew Wormser
- Cassandra Murphy
- Dr. Daniel Freess
- Dr. Gregory Shangold
- Joseph McDonagh
- Pat McCabe
- Robert Krzys
- Seth Powers
- Sue Halpin
- Ted Doolittle

Approval of Agenda

- Ted asks for discussion or motion to approve agenda, Joseph McDonagh motioned to approve and Susan Halpin seconded; no nays; no abstentions, no discussion motion carries unanimously

Approval of 10/16/19 Minutes

- Ted asks for motion to discuss or approve minutes, Joseph McDonagh motioned to approve and Dr. Andrew Wormser seconded; no nays, no abstentions, no discussion, motion carries unanimously

Public Comment

- Dr. Larry Deutsch gave comment – Hartford City Community Council
 - Speaks from 3 points of view
 - As a person who is a City Councilman
 - Responsible for budget along with the Mayor
 - Must be aware of the financial impact of different health plans in particular HDHP's
 - Asked if HDHP has proven to save money on the city's budget long term

- Claims data may initially show a reduction
- Longer term - look at workers compensation , days lost from work and the overall health of the workforce and their families, if you look longer term it is not proven to be beneficial for the city.
- Feels a more universal/comprehensive approach would be beneficial to the consumers, city, state and the nation as a whole
- As a clinician
 - Sees patients who have been deterred from seeking medical attention because of high upfront deductibles, even if it will be covered by other fiscal arrangements. Due to the cost of these high deductibles the impact on a family is worth waiting a day or two to see if they truly need care. This preserves the funding available
 - Taking the shift to high deductible accounts was to make individuals more cost conscious and more conscious of the choices they may or may not have. This has not proven to be effective
 - This deterrence affects providers as well
- As a person involved in public health
 - Feels these plans have discriminatory impact for low income population
 - Providers/nurses as well will delay care

Presentation by Dr. Victor Villagra (UConn Health Disparities Institute (HDI))

- In December 2015 HDI launched a program called Health Insurance Advance Initiative
- It's a 5 year project aimed at enhancing the value of health insurance for all Connecticut citizens, especially those at high risk for health inequities
- Before the ACA and the first open enrollment HDHP's were out and are extremely complex plans
- They are a labyrinth of rules and exceptions to rules
- They promised millions of Americans access to health insurance and access to commercial quality health plans (QHP's)
- Modeled after employer based high quality commercial products
- Concerned this complexity coupled with various levels of health insurance literacy and insurance navigation support, it would yield uneven insurance/financial outcomes
- Interest in tracking and understanding this
- Evaluating the value of being insured for money and interested in understanding how it balances out and what intimate or personal issues drive health, financial and equity issues
- Health Insurance Literacy
 - When the Health Insurance Initiative was first started there was no data collected in Connecticut on consumer understanding of the 13 basic concepts of insurance that is constant in HDHP's
 - Survey was done statewide and the overall correct answers to the survey questions was about 62% of consumers
 - There are linguistic/race disparities

- Some of the questions asked in the survey were
 - What is an annual deductible
 - Consumers think is something you can deduct on your taxes or it comes out of your check for premiums
 - What is a provider network
 - Definition of a premium
 - Consumers apply everyday meaning to terminology, logically, to the context of health insurance when purchasing a HDHP
 - Imagine the impact of not understanding “provider network” when purchasing something that has in-network and out-of-network costs
 - Education – great equalizer
 - Disparities between race/ethnicity persist
- HDI paired up with AHCT
 - Expanded survey to 3,000 participants
 - Co-insurance- When asked what the best definition, 50% thought it was a separate type of insurance to cover additional services; for tens of thousands of people who are insurance naïve, this has profound implications in performance of HDHP’s and our expectations of performance
- Navigation Support
 - Data showing how consumers choose a “just right” plan
 - Literacy and search motivation matter, when consumers are faced with difficult decisions they disconnect
 - Make sure to motivate people
 - “Dominated plans” means plans that will never be cheaper on an all-in cost basis than another competing plans; in other words, a dominated plan is a plan that for a given consumer will always be more expensive than another available selection.
 - HDI put together an education program, pilot tested it in several communities where the majority of people were people of color. Pre-post comparison shows improvement essentially in all scores.
 - Did focus groups and reflected on this and came to the conclusion that Health Insurance Literacy Education is a palliative measure to mitigate the negative impacts of HD complexity
 - These palliative measures such as education are not the root cause solution because they do not address the root cause
 - Complexity is part of the issue; many of our ills come back to healthcare pricing practices
 - Pricing practices are out of control
 - Insurance companies are trapped between consumer needs and pricing practices and they have to offer insurance products we can use
 - Used Connecticut Insurance Department report card and chose 2 questions thought to be reflective of navigation support and none of the companies are doing very well and HDI has been tracking for several years
 - No observation in trend of improvement for navigation support
 - There is a regressive federal policy when it comes to navigation support

- Complexity – Elements of HDP Excessive Complexity
 - Most challenging issue to unravel and what in particular is causing difficulties with consumers and how can we improve
 - Information overload which leads to consumer disconnect and poor choices about 50% of the time – inefficient market
 - Carriers have no motivation to improve plans
 - Confusing rules
 - Deductibles – growing financial burden
 - Co-insurance – prices and services unknown
 - Inefficient presentation
 - Plan names are misleading
 - Could simpler plan design lead to reduced prices
- Things that can be fixed:
 - Readability of materials
 - Non-intuitive plan choice menu
 - More than 50% of employees choose wrong plan
 - Misleading name of plan choices
 - Need more effective regulatory oversight
- Impact on Health – HDHP's reduces utilization of services but doesn't believe this reduces cost
 - Consumer behavior (smart shopping) has not overcome the pressure of unrestrained pricing practices; it absolutely dominates any change in behavior
 - If consumer is so good at lowering cost and changing healthcare utilization, then why are consumers rewarded with ever higher deductibles
 - Premiums mask other part of healthcare expenditures- out-of-pocket costs, including deductibles, are not so easily seen or understood by consumers during plan selection
- Financial Impact
 - As deductibles rise, consumers meet deductibles later in the year
 - In 2006 it was met in February and in 2019 in May
 - 3 things happen
 - Mounting medical debt
 - Forgone/delayed care
 - Disparities by race, ethnicity, education and income levels
 - 43% of adults have medical bills/debt
 - Affects credit ratings
 - Continuing education decisions
 - Medical Debt is a silent crisis in CT
 - HDI obtained information from the judicial department on small claims cases (under \$5,000)
 - Medical debt is never voluntary
 - 85,136 cases of consumers being sued by hospitals and doctors for a total dollar amount of over \$110 million
 - Impact of medical debt and law suits on mental health, physical health and social stigma
 - Trust (for instance between doctor and patient)
 - Continuity of care
 - Quality of care

- From the provider perspective
 - Primary care is a low margin operation
 - Since HDHP's, accounts receivables have grown
 - Providers face dual responsibilities
 - Care for patient
 - Financial integrity of their practice
 - Different between small and corporate ownership
- Suits by hospitals in other states
 - Missouri
 - 10% of paychecks can be seized along with 25% of spouses wages
 - 9% interest charged (5% in Connecticut)
 - Lien placed on patient's home
 - Virginia
 - 36% of hospitals sued 20,054 patients
 - 9,232 patients wages were garnished in 2017
 - VCU in Virginia will no longer sue patients with overdue bills
 - Connecticut Hospitals
 - Small amount of lawsuits but in order to get a better understanding it's suggested that we contact the judicial department to get their statistics and do an in-depth study.
 - Can also contact the Supreme court for cases over \$5,000
 - Definite racial/ethnic disparities in medical debt with black and Hispanics carrying the most
- Recommended Policy Considerations from Dr. Villagra to mitigate HDPs (related inequities)
 - Public Education
 - Workforce Development
 - Regulatory
 - Legislative - eliminate co-insurance altogether
 - Simpler plan alternatives
 - Administrative
 - Legal Framework
- Questions:
 - **Seth Powers:** In regard to the slide showing plans A, B, C and D with the monthly premium and deductibles, asks if Dr. Villagra was aware of any studies that provide the same "plan choice" question (4 options) including the complexity component where the complexity would increase? Dr. Villagra responds, yes there are several studies that have looked at this. For example a company gave their 23,000 employees the opportunity to create their own plan, combining several different co-pays, deductibles and out of pocket costs. This amply demonstrated this. People who utilized more are low income very frequently choose the wrong plan

- Are you aware of any consumer oriented tools that provide data based on an individual's specific health history similar questions that could provide help with more clarity where the price is more appropriate? Dr. Villagra responds, yes, AHCT is improving performance and consumer decisions support tool that includes past medical history and possible risk. It helps narrow down the decisions. Tools are proliferating in the industry
- **Dr. Freess:** You used lawsuits levied against patients as an indicator of medical debt. Do you have any data on the percentage of bills that lead to medical debt? 40-60% of all bills to patients go at least partially unpaid. Feels that those lawsuits represent less than one tenth of 1% of medical debt. Dr. Villagra responds that he feels his estimate is correct
- **Dr. Wormser:** He is in primary care and has a sense that this affects providers at this level; patients make appointments at the beginning of the year and then cancel last minute, perhaps for financial reasons; this is not as much of an issue later in the year, but now trying to pack in patients which is disruptive to our practice design. Is there any data that speaks to the effect on physicians practices of HDHP plans? Dr. Villagra shares an incident where a CFO recommends engaging collection agencies and the provider stated that no way were we going to put long time patient "Betty" into collections.
- These plans affects cash flow problems, financial, quality of care, trust, etc. bear heavily on the front line and the whole system.
- **Susan Halpin:** Comments that her concern remains the same, unintended consequences and agrees that pricing is a fundamental part of the problem. Don't lose sight that there is no employer mandate to offer health insurance. Thinks some of the suggestions offered will increase the whole cost of health insurance and render more people uninsured as a result. When discussing the cost of premiums must include cost, taxes and assessments on the insurers and mandates. Feels this is all included.
- **Dr. Shangold:** We're going further and further into the year to meet the deductible, which argues against pricing. A lot of pricing has to do with the fact that medical debt is going up and up and people aren't collecting that. One thing not mentioned, we give more money in premiums and other products to the insurance company while their profits are going up 40, 50 or even 70% a year. Meanwhile doctors hold on to more medical debt and AR going longer and higher in those areas. Insurance companies feel consequences to removing deductible is to increase premiums. Couldn't another result be their profits go down; now a presumed savings as doctors not collecting. Providers faced with harsh choices, forgive debt or go after patient harshly for payment, while profits go up and up. Aren't there other answers? Dr. Villagra responds that the insurance industry is a high volume low margin industry. Price increases for underlying healthcare services is really what drives downstream effect on providers, hospitals, etc. Reference made to an article in the NY Times by Victor Fuchs and Ezekiel Emanuel referring to authorities that point to the myth of insurance companies' huge profits. On a good year they are only about 5% but huge volume. Need to look at the totality of healthcare.

Presentation by Lynn Quincy, Altarum Healthcare Value Hub

- HDHP's have a couple of benefits
 - HSA options
 - Lower premiums

- Major downsides
 - Causes many consumers harm which outweighs the benefits
- HDHP's don't do:
 - They failed to deliver on the promise that they would drive value in the marketplace. It was thought that because consumers have skin in the game they will be smart shoppers and bring all their business to the high value healthcare providers which will force them to be better actors in our healthcare system. There is zero evidence this happened
 - There is strong evidence that consumers reduce necessary as well as unnecessary care
 - Consumers don't price shop and don't shop based on quality

Lynn discussed a pre-post study

- Large employer put all employees in a HDHP and learned:
 - Consumers with lower medical expenses didn't do any more shopping after reaching deductible; didn't drive price shopping behavior
 - There was no change in consumption of low value services (don't have a medical benefit)
 - Consumers don't know what is a valuable service vs low-value
 - Cost of service (one provider vs another one)
 - Quality of service
- Worked with Healthcare Cost Institute (HCI)
 - They have a large claim database
 - Of the gamut of non-urgent services how much spending – 30-40%
 - 7% of total spending was directed by consumers (i.e., was both shoppable and paid out of pocket by consumers)
 - Becoming better shoppers is not the tool to fix the market place
- HDHP's don't discriminate based on peoples incomes, this is a problem
- Hopes committee will look at alternative to HDHP's
 - HSA's – triple tax advantage, not taxed on money going in, out or on the earnings. It rolls over year to year
 - Data shows people use for retiree savings vehicles
 - More than 60% of benefits accrue to high earning families
- It's regressive and puts burden on low income while high income people get these tax benefits
- A 2018 study specific to CT that includes all adults including those not in a HDHP, but was only conducted in English; 50% of adults have Healthcare Affordability Burden – Leading reason
 - Types of burdens
 - Uninsured due to cost
 - 43% say cost related barrier to care
 - 24% who got care struggled to pay bill
- **Dr. Wormser:** On the slide that showed people who are economically disadvantage it appeared that those with HSA's were more stressed than those without HSA's. Lynn speculates it's the relationship between the bill and the deductible and not the HSA itself. Dr. Wormser asks if someone can be listed on an HSA and have no money in it. Lynn to check and get back to the committee

Solutions Recommendations

- Simplify insurance so consumers understand
- Healthcare affordability is the number one thing consumers want to be worked on by their legislators
- Smart affordable cost-sharing
- Address waste
- Address prevention failures
- Address excess healthcare prices
- Goal
 - Avoid barriers to care while discouraging low-value care
 - Use co-pay not coinsurance
 - Value based insurance design (VBID)
 - Slide with family income and size

Value Based Insurance Design

- Same services with same low or no cost across the board
- Very little evidence with respect to raising cost sharing for low value services, not sure how this will work out; need to keep studying VBID's
- Financial incentives don't work as well as expected-economists who proved this recently received Nobel prize in economics
- Evidence is complete that year over year increases in unit prices are far and away our largest driver in healthcare spending; largest drive of why premiums go up faster than wages and this needs to be addressed or we will run out of tools to mitigate this.
- This is a bi-partisan concern
- VBID can be clinically nuanced, for example when lowering cost of insulin for a diabetic
- The flip side is also raise cost-sharing for low-value services, for example, unnecessary Vitamin D screening

Short term Health Plans

- These are not ACA compliant and don't have to cover services that you think should be covered
- About 1/3 of healthcare is waste – low value services
- There are about 700 services labeled low or no value services
- Get these out of healthcare system
- When we under provide high value care while eliminating low value care, the spending associated with failure to provide high value care is smaller, but really important; a way to bring down premiums in the long run and make system work better without relying on benefit design

All Claims Payer Database

- This is used to identify pricing outliers
- You can have a provider or hospital in the same city and the prices can vary by 400%
- Transparency by policymakers, regulators so employers and providers get to see the data – this helps to know where the problems lie
- Needs oversight entities to review things like Medicare/Medicaid and commercial to address disparities

Questions:

- **Dr. Shangold:** cost issues not presented was medical education. People coming out with \$300,000 of debt and have to pay over 30 years. This needs to go in there as well as defensive medicine. Also feels participation rates are an issue. Providers collect less than 10% of claims from the uninsured. Lynn responds that participation rate and medical education debt are a cost driver. Economists have studied the impact in this country vs. other counties and this is not a cost driver, but agrees with defensive medicine and advised to be careful of surprise bills.
- **Seth Powers:** asks about Lynn's proposed solution of shifting away from co-insurance and to co-pays, is there any data or material to show that this shift would just drive up the cost of the co-pays? Does this create the same barrier to care issue? Lynn responds you are correct, we are shifting some of the risk to the insurance company but they are much better equipped to handle the shift as they have access to information. Patients are powerless to know what their bill is going to be. The health plan has all of the negotiated rates to help them determine who they will pay a provider. Set nice predictable co-pays.

Discussion and possible appointment of two co-chairs, per legislation

- Second appointment was tabled to the next meeting

Next Steps

- Ted advises staff to expect me to reach out to all task force members to set-up a bi-weekly call with either Sean or Adam opportunity for access to OHA ask questions or comments
- Adam shares future speakers:
 - November 20, 2019
 - Dr. Kevin McKechnie, Director of HSA Council which is part of the American Bankers Association
 - James Stirling, Principal of Stirling Benefits (a 3rd party administrator of employer benefits, that also administers HSA's)
 - December 4, 2019
 - White boarding Session – Task force to brainstorm based on information heard and read
 - Hope to have Dr. Mark Fendrick University of Michigan Value Based Insurance Design Center
 - December 18, 2019
 - Professor Sabrina Corlette from Georgetown Law Center for Health Insurance Reform. She is exploring funding from Robert Wood Johnson foundation for purpose of providing technical assistance to the committee as we draft report

Ted ask for motion to adjourn the meeting. Joseph McDonagh motioned to adjourn and Susan Halpin seconded. Meeting adjourned by unanimous vote at 1:05 PM

Next meeting will be held on
November 20, 2019
11:00 AM – 1:00 PM
(LOB) Room 2D