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High Deductible Health Plans

What does the evidence say?

Lynn Quincy, Nov. 6, 2019

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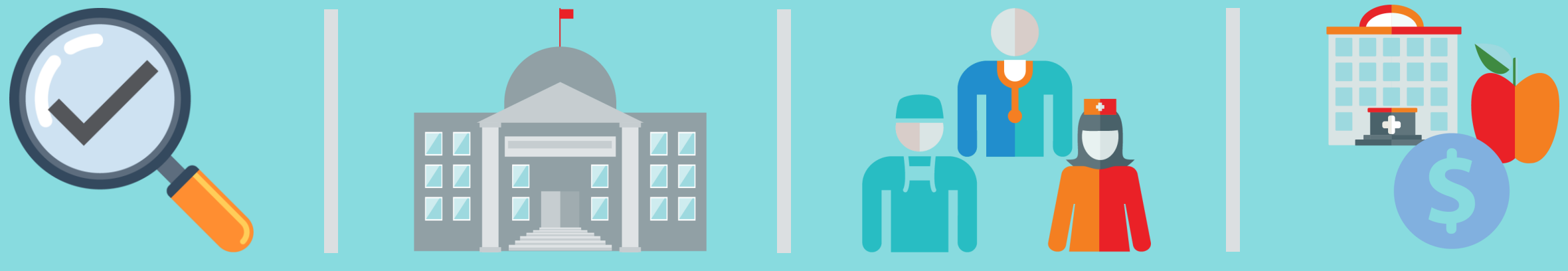


Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.

What is the Healthcare Value Hub?

With support from the Robert Wood Johnson Foundation:

- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best to reduce healthcare spending, improve affordability for consumers, improve outcomes and reduce disparities.
- We provide FREE resources to help YOU work on these healthcare value issues.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.

Guide to Jargon

High Deductible Health Plan (HDHP)

HSA-Qualified Plan (Individual Deductible> $1,350)

+

Health Savings Account (HSA)

Also Health Reimbursement Account (HRA)

=

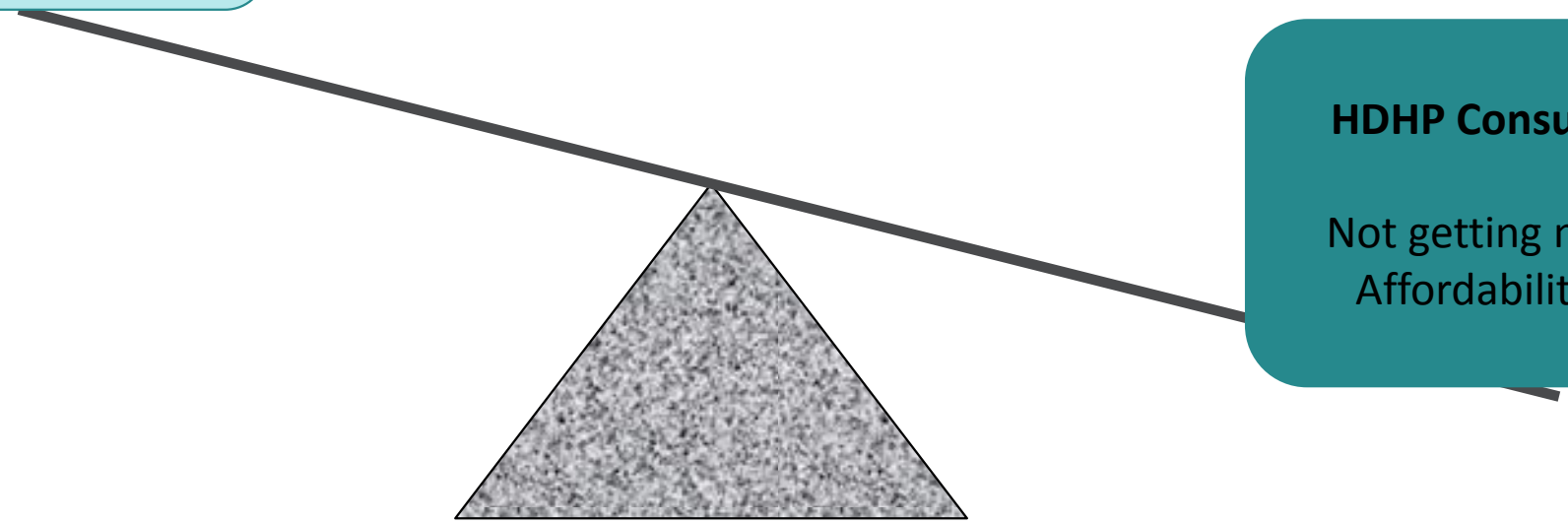
Consumer Directed Healthcare (CDHC)

Plus consumer shopping tools

HDHPs – The Bottom Line

HDHP Benefits:

Lower Premiums
~HSA Savings Opportunity



HDHP Consumer Harm:

Not getting needed care
Affordability Burdens

What HDHPs DON'T Do: Drive Value in the Marketplace

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RESEARCH BRIEF NO. 11 | APRIL 2016

Rethinking Consumerism in Healthcare Benefit Design

High healthcare costs are a concern for consumers and payers alike. Insurance premiums have risen faster than wages and the economy in general for nearly two decades (see Figure 1). High levels of health spending crowd out other important spending. For households, this means lower wages and less money for competing priorities. For state and national governments, it means less to spend on education, infrastructure and other public needs.

SUMMARY

For decades, rising healthcare costs have strained household, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more "skin in the game," through high-deductible health plans. When accompanied by shopping aids, these plans are sometimes called consumer-directed health plans. But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What's more, unaffordable cost sharing causes considerable consumer harm. Instead, efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending. Our country needs to rethink the role of the consumer in healthcare to be fair, patient-centric and evidence-based. Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care and not have their choices curtailed due to unaffordable cost sharing.

There is consensus that we can cut back on waste in the system (including prices that are too high) in order to reduce spending without harming our health outcomes.

An oft-used strategy to address high healthcare costs are insurance products called high-deductible health plans, or more generally, consumer-directed healthcare. Nearly half of Americans with employer-provided insurance were required to meet an individual deductible of more than $1,000 in 2015, and many plans go much higher, with deductibles in the $5,000-$6,500 range.[1] The basic idea is that by requiring consumers to pay substantial cost sharing these plan designs will incentivize consumers to extract better value from the healthcare marketplace, helping to stem the tide of rising healthcare costs and reducing the use of low-value care.

There's just one problem—we have little evidence to suggest that these high-deductible plan designs work. To control spending and bring better value to our healthcare system, we need a new vision for what the consumer's role should be.

The Theory Behind Consumer-Directed Healthcare and High-Deductible Health Plans

Whether described as a high-deductible health plan or consumer-directed healthcare—either paired with a tax advantaged account like an HRA or an HSA[2] or not—the theory is the same: If consumers face the consequences of their health spending they will spend their dollars more wisely. With up to 30 percent of healthcare spending classified as "waste" by the Institute of Medicine,[3] the goal is for consumers to cut out unnecessary or "wasteful" spending and put downward pressure on prices.

Compared to more generous coverage, HDHP lower premiums BUT:

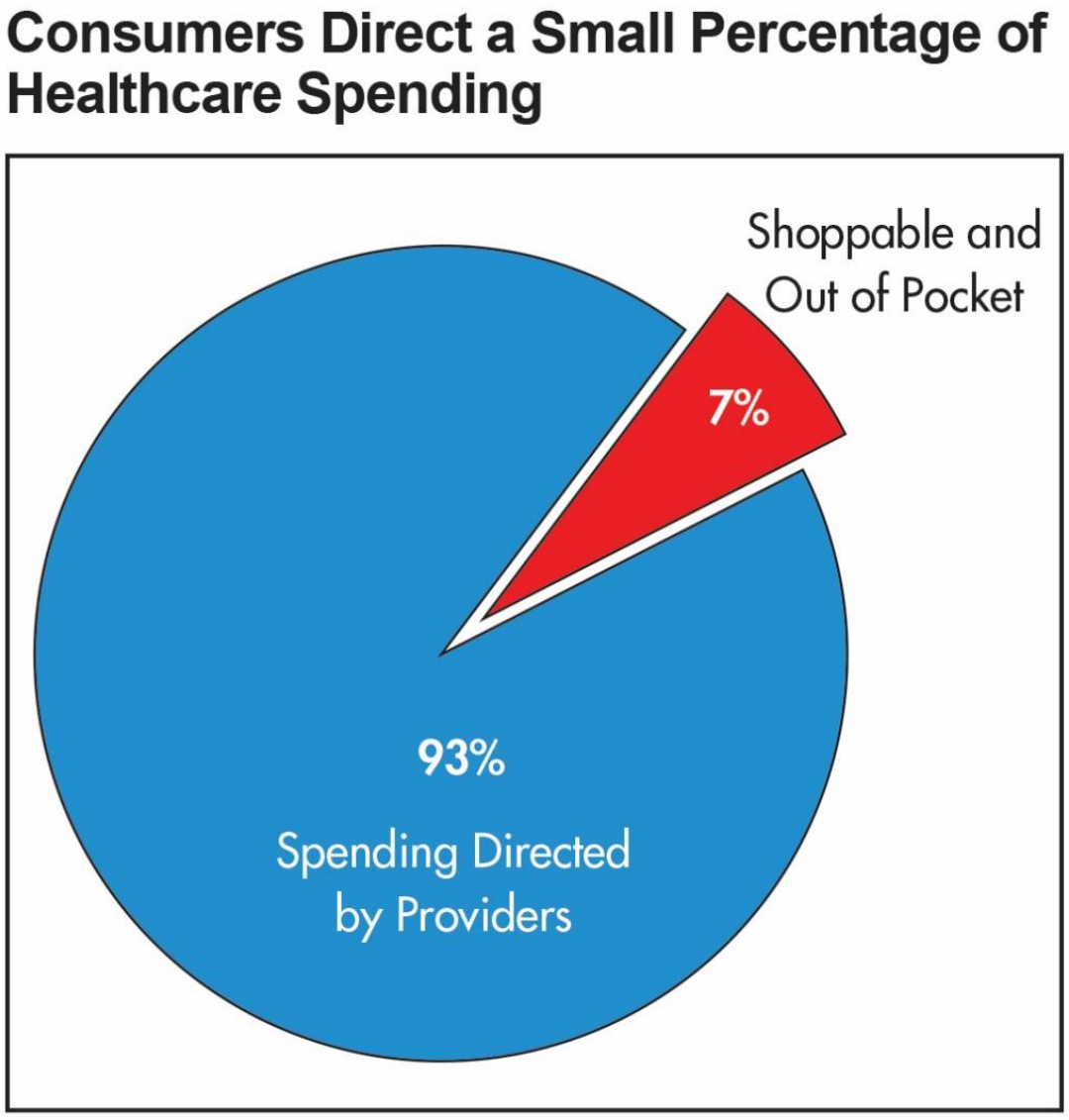
- Patients reduce both necessary and unnecessary care
- Patients don't price shop
- Patients don't shop based on quality

First Author	Journal	Findings
Mary E. Reed	*Health Affairs*, 2012	Survey of beneficiaries: fewer than one in five understood that their plan exempted preventive office visits, medical tests, and screenings from their deductible.
Neeraj Sood	*RAND Forum for Health Economics and Policy,* 2013	Claims data analysis across CDHP and non –CDHPs: no evidence that, within CDHP plans, consumers with lower expected medical expenses exhibited more price shopping or that consumers exhibited more price shopping before reaching the deductible
Rachel O. Reid	*American Journal of Managed Care, 2017*	Using a before/after: no change in spending on 26 commonly used, low-value services
Zarek C. Brot-Goldberg	*Quarterly Journal of Economics*, 2017	Using a before/after: spending reductions are entirely due to outright reductions in quantity. We find no evidence of consumers learning to price shop after two years in high-deductible coverage. Consumers reduce quantities across the spectrum of health care services, including potentially valuable care (e.g. preventive services) and potentially wasteful care (e.g. imaging services).
Rejender Agarwal	*Health Affairs,* 2017	Systematic review: HDHPs associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care.

Other evidence suggests WHY consumers don't shop based on price or quality:

- Care is rarely labeled as high-value or low-value
- Patients rarely know the price of a service and providers are often unable to help
- Patients rarely know quality or likely outcomes between two treatments.
- Consumers don't view healthcare as a commodity.

Most Healthcare Dollars Are Directed by Physicians

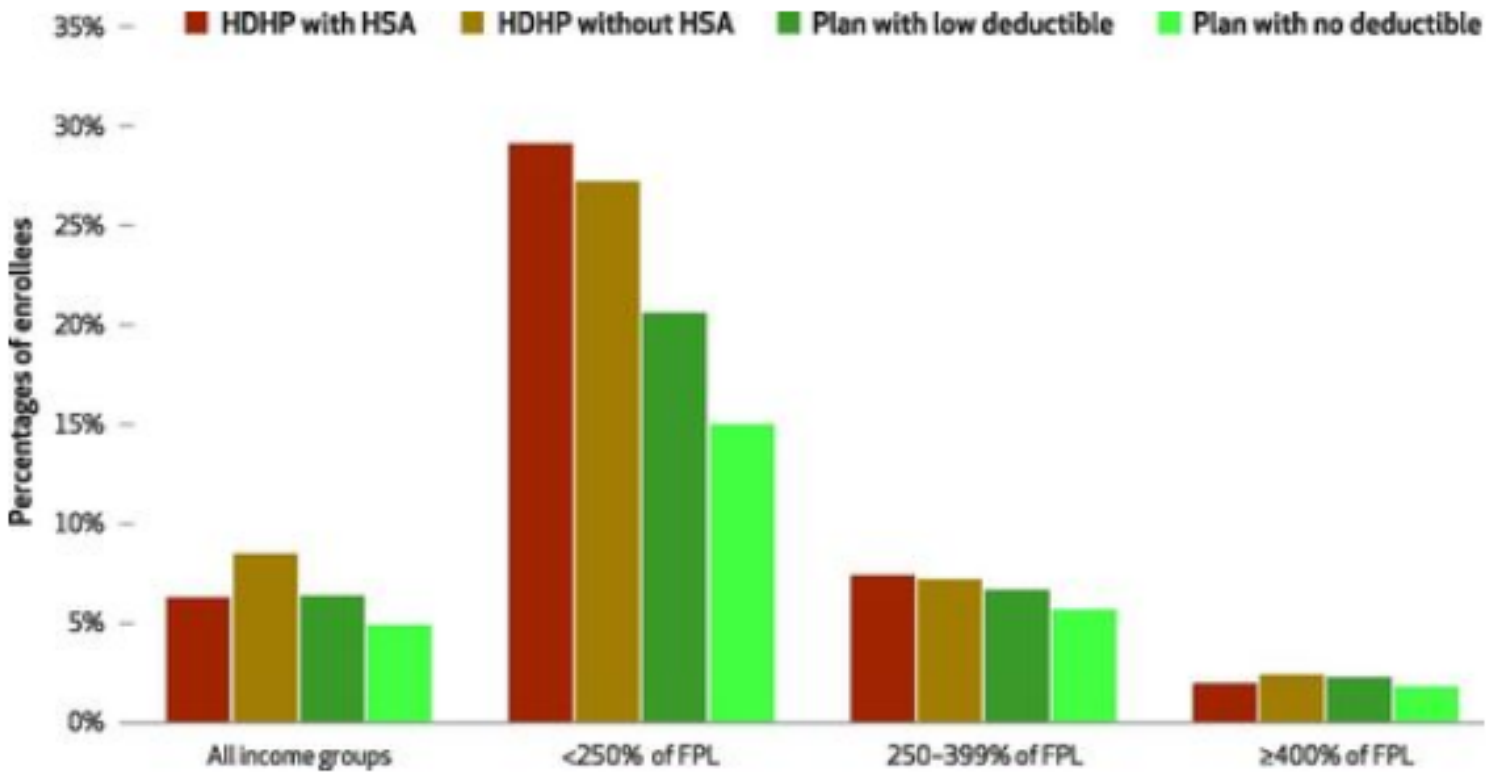


Source: Healthcare Value Hub, Rethinking Consumerism in Healthcare Benefit Design, *Research Brief No. 11 (April 2011). Adapted from Health Care Cost Institute,* Spending on Shoppable Services in Health Care, *(March 2016).*

High Deductible Health Plans Cause Consumer Harm

First Author	Journal	Findings
J. Frank Wharam	*J Clin Oncol*., 2018	Women with breast cancer who had switched to HDHPs before being diagnosed experienced delays in every aspect of the care process: diagnostic imaging, biopsies, early-stage diagnoses, and chemotherapy treatments.
J. Frank Wharam	*Health Affairs*, 2019	A similar study design: finds delays occurred regardless of income status, although delays were longer for women with lower income levels.
Alison A. Galbraith	*Health Affairs*, 2011	Survey: Almost half (48 percent) of the families with chronic conditions in high-deductible plans reported health care-related financial burden, compared to a fifth of families (21 percent) in traditional plans. Almost twice as many lower-income families in high-deductible plans spent more than 3 percent of income on health care expenses as lower-income families in traditional plans (53 percent versus 29 percent).
Zhiyuan_Zheng	*Journal of Oncology Practice*, 2019	Survey: High-deductible health plans linked to delayed, forgone care among cancer survivors, especially if no HSA; the percentage of delayed or forgone care appeared similar for cancer survivors who had an HDHP with an HSA vs. those with an Low Deductible plan

Exhibit 1 Percentage of nonelderly adults with employer-sponsored insurance facing health care burden exceeding 20 percent of family income, by income and deductible level, 2011–13



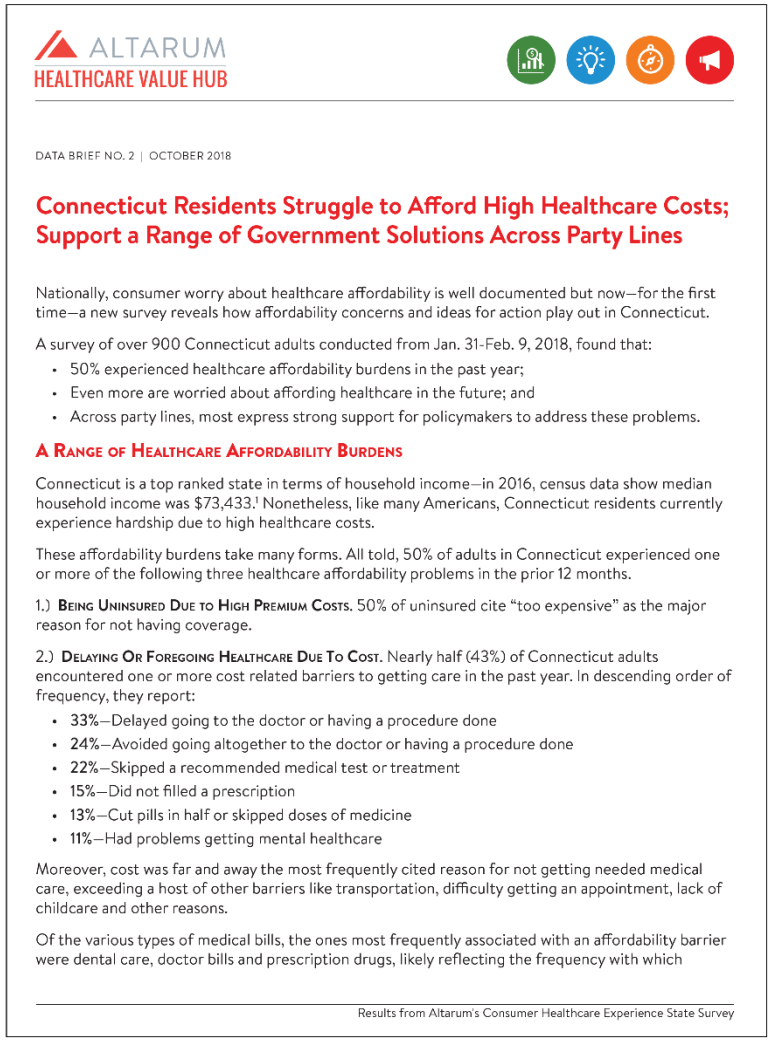
Source: Salam Abdus, Thomas M. Selden, and Patricia Keenan. "The Financial Burdens Of High-Deductible Plans," *Health Affairs*, December 2016

About Health Savings Accounts

- HSAs are tax-advantaged savings accounts designed to pay medical expenses.
- HSAs must be paired with HDHPs meeting specific IRS criteria.
- Only one-third of individuals with a high-deductible health plan also have a health savings account
- The U.S. Treasury finds that more than 60 percent of all HSA tax benefits accrue to families earning more than $100,000 annually

Source: https://www.healthcarevaluehub.org/improving-value/browse-strategy/health-savings-accounts

2018 Poll of Connecticut Adults



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DATA BRIEF NO. 2 | OCTOBER 2018

Connecticut Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines

Nationally, consumer worry about healthcare affordability is well documented but now—for the first time—a new survey reveals how affordability concerns and ideas for action play out in Connecticut.

A survey of over 900 Connecticut adults conducted from Jan. 31-Feb. 9, 2018, found that:

- 50% experienced healthcare affordability burdens in the past year;
- Even more are worried about affording healthcare in the future; and
- Across party lines, most express strong support for policymakers to address these problems.

A Range of Healthcare Affordability Burdens

Connecticut is a top ranked state in terms of household income—in 2016, census data show median household income was $73,433.[1] Nonetheless, like many Americans, Connecticut residents currently experience hardship due to high healthcare costs.

These affordability burdens take many forms. All told, 50% of adults in Connecticut experienced one or more of the following three healthcare affordability problems in the prior 12 months.

1.) **Being Uninsured Due to High Premium Costs.** 50% of uninsured cite "too expensive" as the major reason for not having coverage.

2.) **Delaying Or Foregoing Healthcare Due To Cost.** Nearly half (43%) of Connecticut adults encountered one or more cost related barriers to getting care in the past year. In descending order of frequency, they report:

- 33%—Delayed going to the doctor or having a procedure done
- 24%—Avoided going altogether to the doctor or having a procedure done
- 22%—Skipped a recommended medical test or treatment
- 15%—Did not filled a prescription
- 13%—Cut pills in half or skipped doses of medicine
- 11%—Had problems getting mental healthcare

Moreover, cost was far and away the most frequently cited reason for not getting needed medical care, exceeding a host of other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier were dental care, doctor bills and prescription drugs, likely reflecting the frequency with which

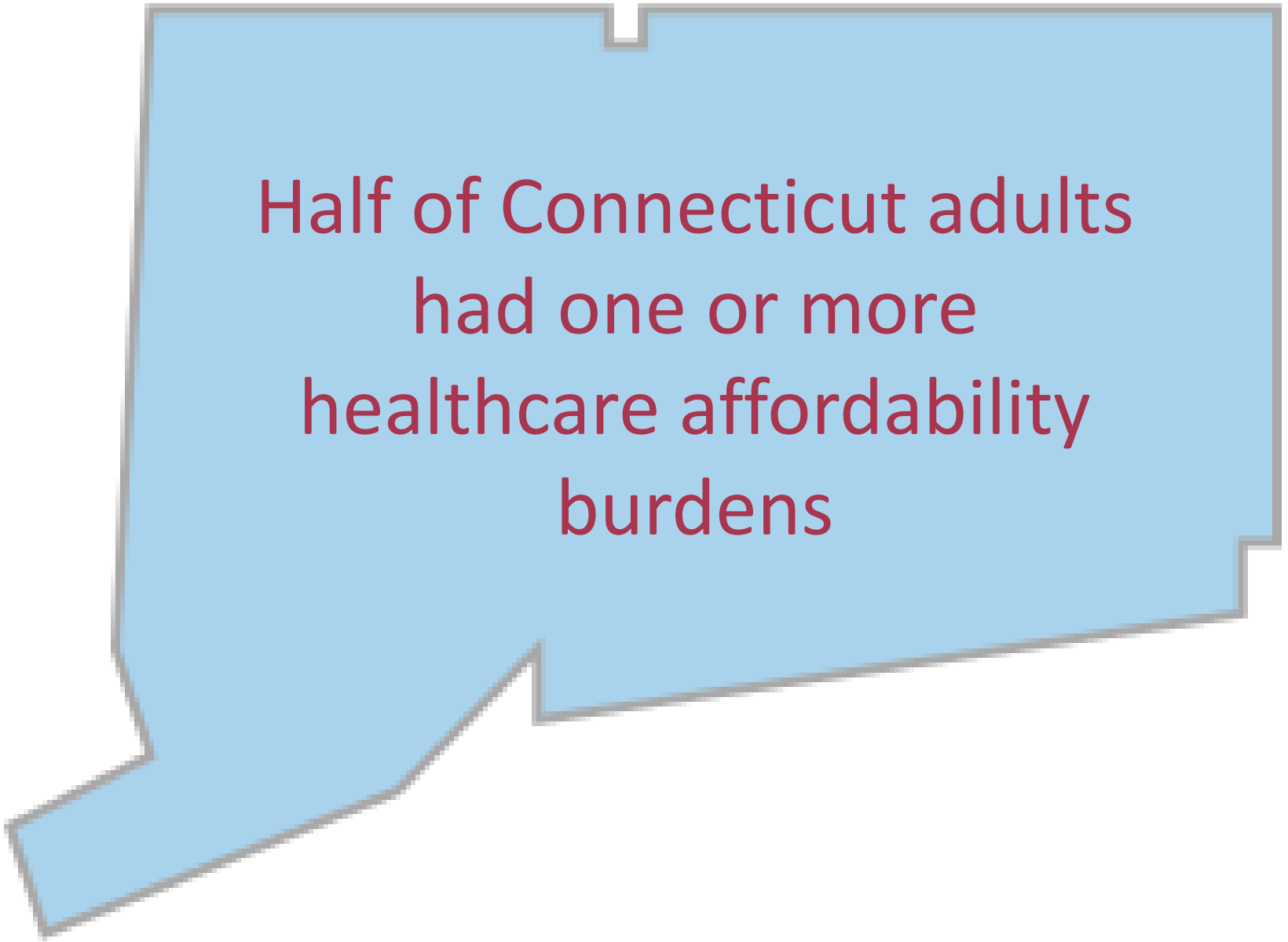
Results from Altarum's Consumer Healthcare Experience State Survey

Altarum's Consumer Healthcare Experience State Survey (CHESS):

- designed to elicit respondents' unbiased views on a wide range of health system issues
- a web panel from *Dynata* of ~1,000 residents 18 and older
- fielded Jan. 31-Feb. 9, 2018
- English language only

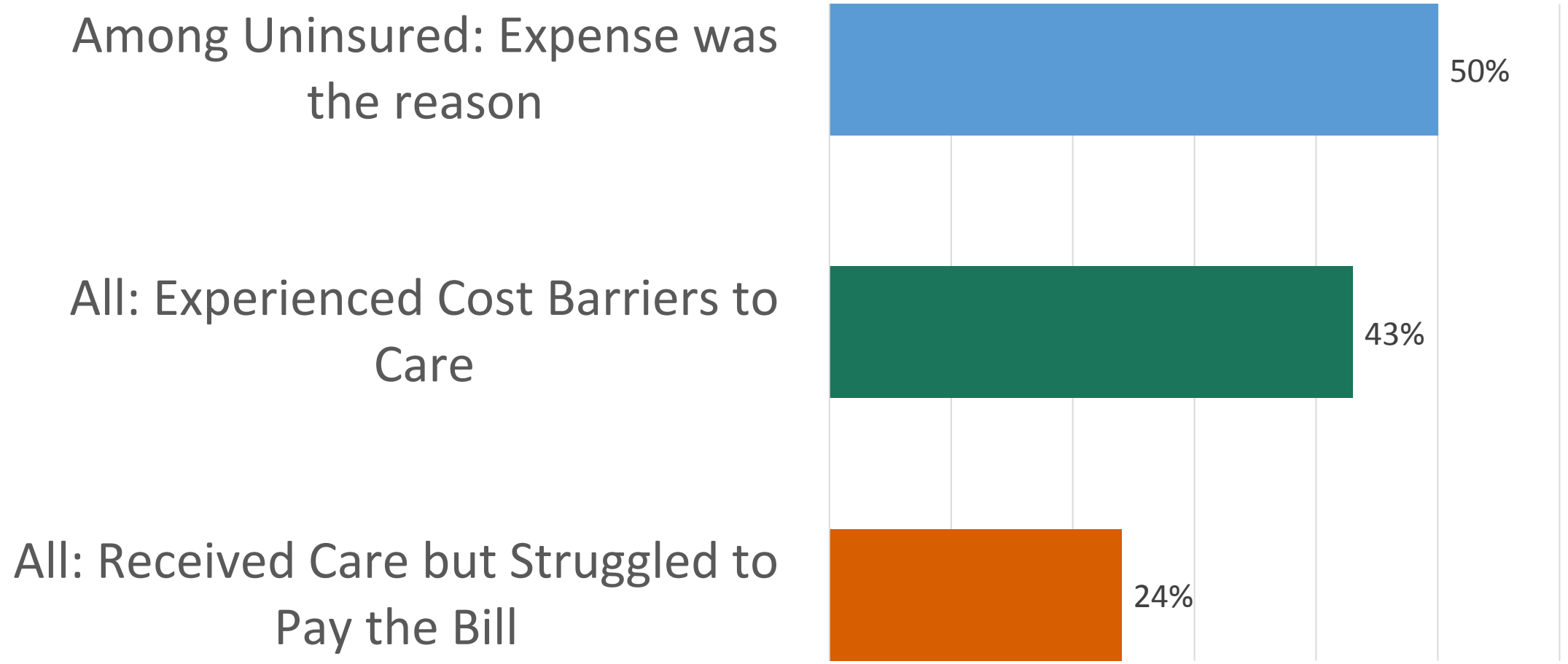
More methodology and demographics available at:
HealthcareValueHub.org/CT-2018-Healthcare-Survey

High Healthcare Affordability Burdens in Connecticut



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

Healthcare Affordability Burdens: *Percent of Connecticut Adults*



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

2018 Poll of Connecticut Adults

Cost Barrier to Care: Detail

- **33%** - Delayed going to the doctor/having a procedure done
- **24%** - Avoiding going to doctor/having procedure done
- **22%** - Skipped recommended medical test or treatment
- **15%** - Did not fill a prescription
- **13%** - Cut pills in half/skipped doses of medicine
- **11%** - Had problems getting mental health care

Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

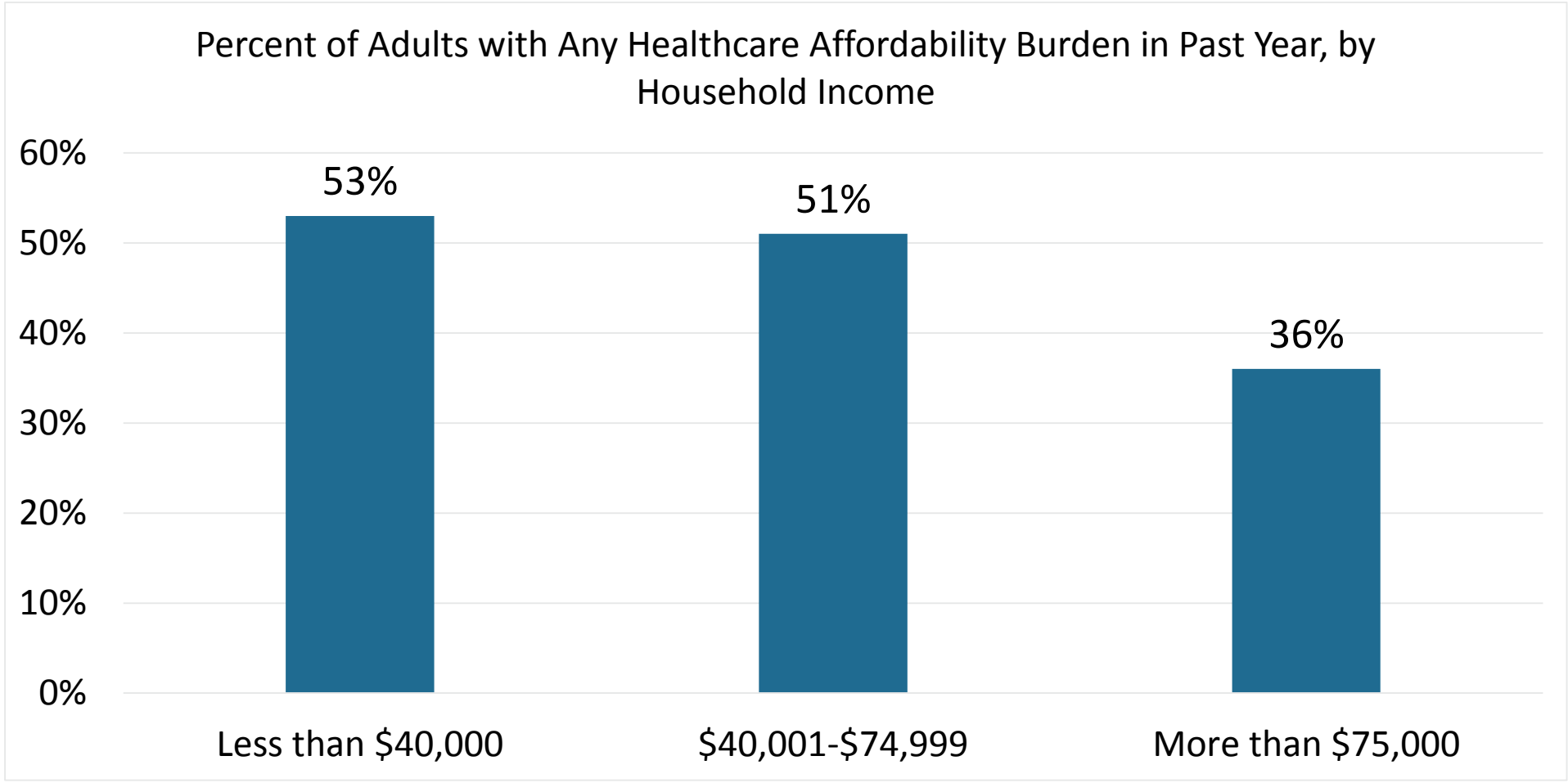
2018 Poll of Connecticut Adults

Struggled to Pay Medical Bills: Detail

- **10%** - Contacted by a collection agency
- **9%** - Used up all or most of their savings
- **7%** - Racked up large amounts of credit card debt
- **6%** - Placed on a long-term payment plan
- **6%** - Unable to pay for basic necessities (food, heat, or housing)
- **4%** - Borrowed money/got a loan/another mortgage on home

Source: 2018 Poll of Connecticut Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Healthcare affordability burdens hit lower income families the hardest….



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

QUESTIONS about HDHP evidence?

Solutions

Addressing Healthcare Affordability In 4 Easy Steps

1) Smart, affordable cost-sharing
2) Address wasteful spending
3) Address prevention “failures”
4) Address excess healthcare prices

Smart, Affordable Cost-sharing

Reminder

- There are numerous ways to divide the cost of needed medical care between the health plan and the beneficiary.
- Cost-sharing design decisions affect how this spending is distributed across the enrolled population and only affect total spending at the margins.

Smart, Affordable Cost-sharing

Goal: avoid creating barriers to care while still discouraging low-value care; make cost-sharing designs understandable

- Use copays, not coinsurance; tie cost-sharing levels to family income
- Value Based Insurance Design

Value-based Insurance Design: “clinically nuanced benefit design”

Lower cost-sharing for high value services

Higher cost-sharing for low value services

Considerations for consumer-friendly VBID

- Focus on High Value Care
- Ensure Benefits are Based on Evidence
- Prioritize – overly complex cost-sharing doesn’t help patients
- Don’t Confuse VBID with Wellness Programs

VBID: What Does The Evidence Say?

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EASY EXPLAINER | NO. 5 | JULY 2016

Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality

Health insurance plans have long included various forms of consumer cost sharing, in the form of deductibles, copays and coinsurance. Value-based insurance design (VBID) introduces a new twist by aligning the amount of cost sharing with the relative value of care: reducing or eliminating cost sharing for high-value care while increasing cost sharing for low-value care. By reducing financial barriers, the goal is to incentivize consumers to make better healthcare treatment decisions.

VBID was originally conceived as a way to encourage patients with chronic conditions, such as diabetes, to adhere to long-term treatment plans. Insurers have since expanded VBID to encourage the use of preventive services and other types of high-value care. The Affordable Care Act (ACA) embraced this concept by requiring that key preventive services be provided with no patient cost sharing. More recently, HHS announced a Medicare Advantage VBID trial in seven states starting in 2017.

By reducing patient cost sharing—providing a "carrot"—insurers hope to incentivize the use of high-value care, ultimately leading to better health outcomes and lower costs. Ideally any savings associated with having healthier beneficiaries would then be passed onto consumers in the form of lower premiums. In contrast, by increasing cost sharing—providing a "stick"—VBID may be used to discourage the use of healthcare that is deemed low value. Here, the target is not patient health, but rather preventing wasteful spending on services that are either over-used or not considered cost effective. An example of low-value care would be prescribing an antibiotic for a viral sinus infection or performing an MRI for back pain that has not been given time to heal.

What Does the Evidence Say?

Surprisingly, the response to lower cost-sharing incentives under VBID is not as strong as originally predicted. An analysis of thirteen studies found an average three percent increase in treatment adherence among patients with chronic conditions. These results indicate that factors other than, or in addition to, cost continue to prevent many consumers from using the high-value care that VBID aims to promote. In many cases, consumers may simply lack the information, expertise or motivation to change their behavior. Because of this, the benefits of VBID "carrots" have largely accrued to consumers who are already relatively health conscious and treatment compliant.

Perhaps for these reasons, the evidence is mixed on the effect of VBID on health outcomes. Although some studies show health improvements, others found improved treatment adherence did not necessarily lead to better clinical outcomes.

Early but promising research shows that employing VBID as one piece of a larger and more comprehensive strategy can encourage healthy behavior. Studies indicate that plans are more effective at boosting treatment compliance when they provide more generous benefits, target high-risk patients, include wellness programs and employ mail-order pharmacies.

The other side of VBID—providing a "stick" to discourage lower value care—is rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known

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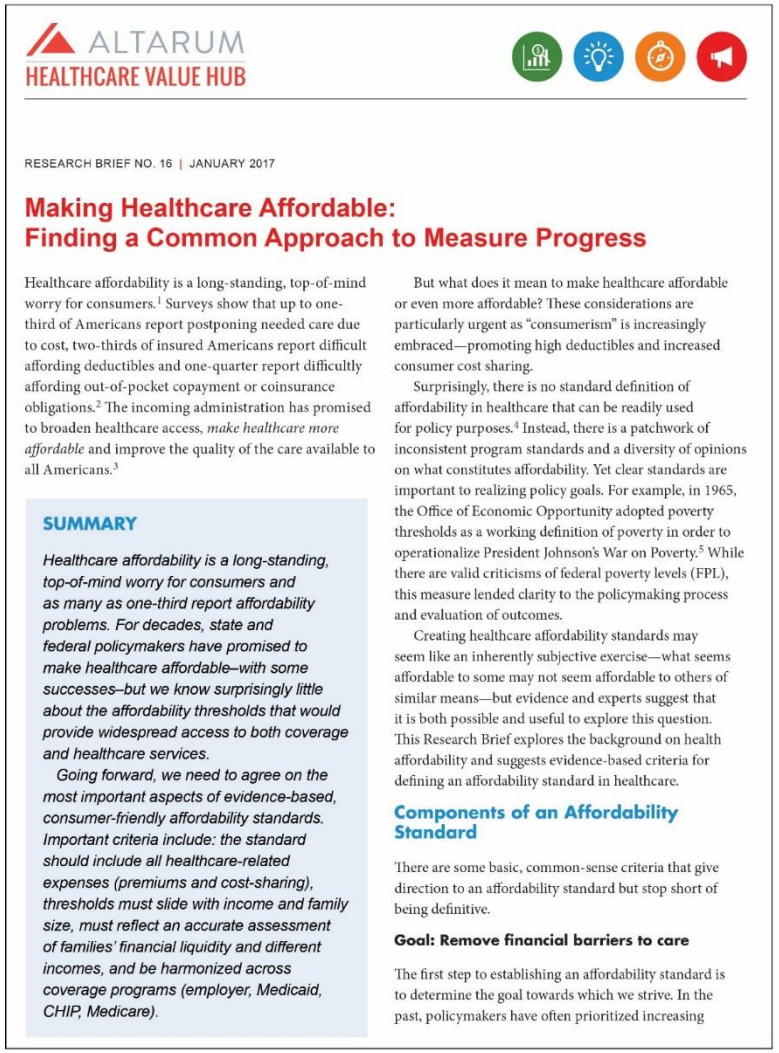
- Surprisingly, response to lower cost-sharing incentives under VBID is not as strong as predicted.
- Because of this, the benefits of VBID "carrots" have largely accrued to patients who are already relatively health conscious and treatment compliant.
- VBID "sticks" (to discourage lower value care) are rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known whether patients will respond in the nuanced way that VBID intends, as opposed to reducing the use of care indiscriminately.

What does it MEAN to make cost-sharing affordable?



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RESEARCH BRIEF NO. 16 | JANUARY 2017

Making Healthcare Affordable: Finding a Common Approach to Measure Progress

Healthcare affordability is a long-standing, top-of-mind worry for consumers.[1] Surveys show that up to one-third of Americans report postponing needed care due to cost, two-thirds of insured Americans report difficult affording deductibles and one-quarter report difficultly affording out-of-pocket copayment or coinsurance obligations.[2] The incoming administration has promised to broaden healthcare access, *make healthcare more affordable* and improve the quality of the care available to all Americans.[3]

SUMMARY

Healthcare affordability is a long-standing, top-of-mind worry for consumers and as many as one-third report affordability problems. For decades, state and federal policymakers have promised to make healthcare affordable–with some successes–but we know surprisingly little about the affordability thresholds that would provide widespread access to both coverage and healthcare services.

Going forward, we need to agree on the most important aspects of evidence-based, consumer-friendly affordability standards. Important criteria include: the standard should include all healthcare-related expenses (premiums and cost-sharing), thresholds must slide with income and family size, must reflect an accurate assessment of families' financial liquidity and different incomes, and be harmonized across coverage programs (employer, Medicaid, CHIP, Medicare).

But what does it mean to make healthcare affordable or even more affordable? These considerations are particularly urgent as "consumerism" is increasingly embraced—promoting high deductibles and increased consumer cost sharing.

Surprisingly, there is no standard definition of affordability in healthcare that can be readily used for policy purposes.[4] Instead, there is a patchwork of inconsistent program standards and a diversity of opinions on what constitutes affordability. Yet clear standards are important to realizing policy goals. For example, in 1965, the Office of Economic Opportunity adopted poverty thresholds as a working definition of poverty in order to operationalize President Johnson's War on Poverty.[5] While there are valid criticisms of federal poverty levels (FPL), this measure lended clarity to the policymaking process and evaluation of outcomes.

Creating healthcare affordability standards may seem like an inherently subjective exercise—what seems affordable to some may not seem affordable to others of similar means—but evidence and experts suggest that it is both possible and useful to explore this question. This Research Brief explores the background on health affordability and suggests evidence-based criteria for defining an affordability standard in healthcare.

Components of an Affordability Standard

There are some basic, common-sense criteria that give direction to an affordability standard but stop short of being definitive.

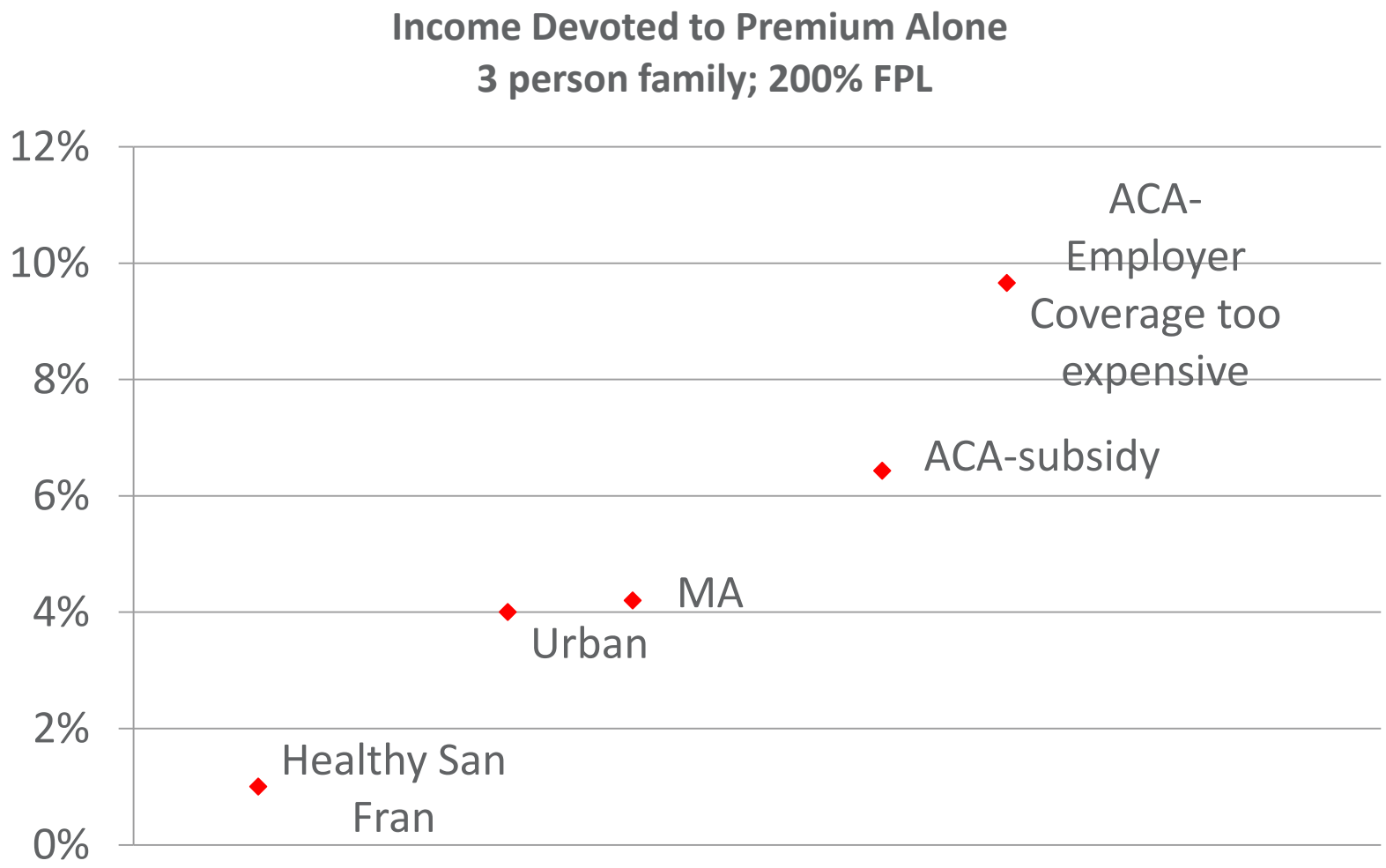
Goal: Remove financial barriers to care

The first step to establishing an affordability standard is to determine the goal towards which we strive. In the past, policymakers have often prioritized increasing

Hub finds lack of harmonization across programs with respect to affordability thresholds

- IRS Tax Deductibility Threshold
- Medicaid
- CHIP
- Massachusetts (Romneycare)
- Healthy San Francisco
- ACA
- Urban Institute estimates for more generous ACA thresholds

Affordability of Premium Alone: Not Harmonized Across Programs



Defining a Healthcare Affordability Standard

- Goal: No financial barriers to care
- Consider a “Total Cost” concept. What percent of income can a household devote to:
  - Cost of coverage (premiums)
  - Cost-sharing for covered services
  - Cost of needed services not included in the benefit package
- Standard slides with income and family size

Address Inadvertent, Surprise Out-of-Network Bills

- Get patients out of the middle – prohibit balance billing and include a mechanism to resolve provider payment
- Stronger network adequacy transparency provisions – at point of insurance shopping, show likelihood of getting a Surprise Bill
- Better consumer assistance

More Info: https://www.healthcarevaluehub.org/improving-value/browse-strategy/surprise-medical-bills

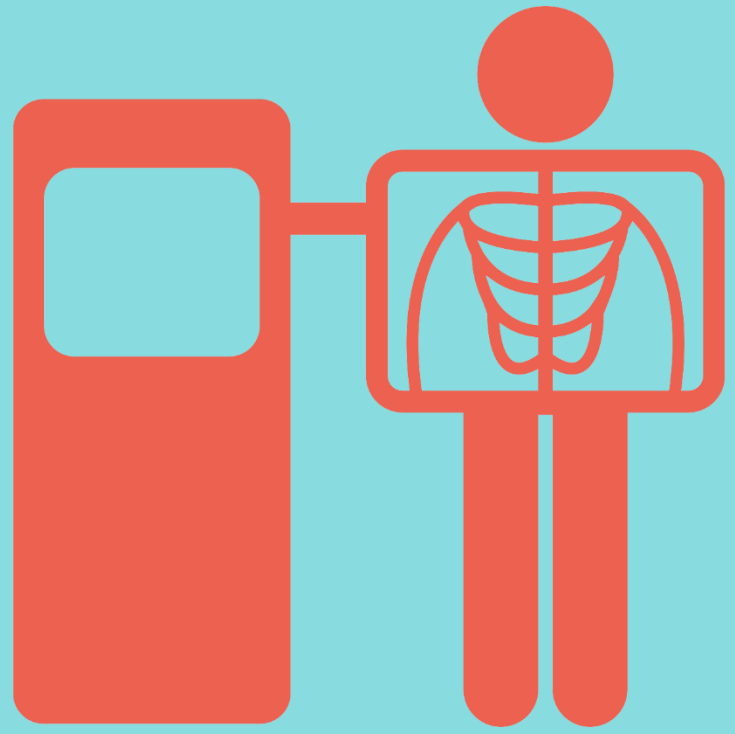
Short-term Health Plans
aka skimpy health plans

- Premiums savings stems from less coverage, not duration of the policy
- Exempt from ACA consumer protections:
  - have annual and life-time caps
  - likely don’t cover minimum essential services like maternity and mental health; cost-sharing obligations can > $20,000
  - can exclude pre-existing conditions
  - not subject to MLR minimum: 80% of premium dollar spent on medical care

How are states protecting consumers?

- Prohibit sale of Short-term plans (MA, NJ, NY, CA)
- Enact term limits (MD-90 days)
- Enact state limits on renewal
- Benefit mandates to place a floor under the coverage offered by ST plans (CT)

Address Wasteful Spending



One-Third of Healthcare Spending is Wasted

Average Healthcare Spending per Person (2016)

$11,193

Wasted Spending

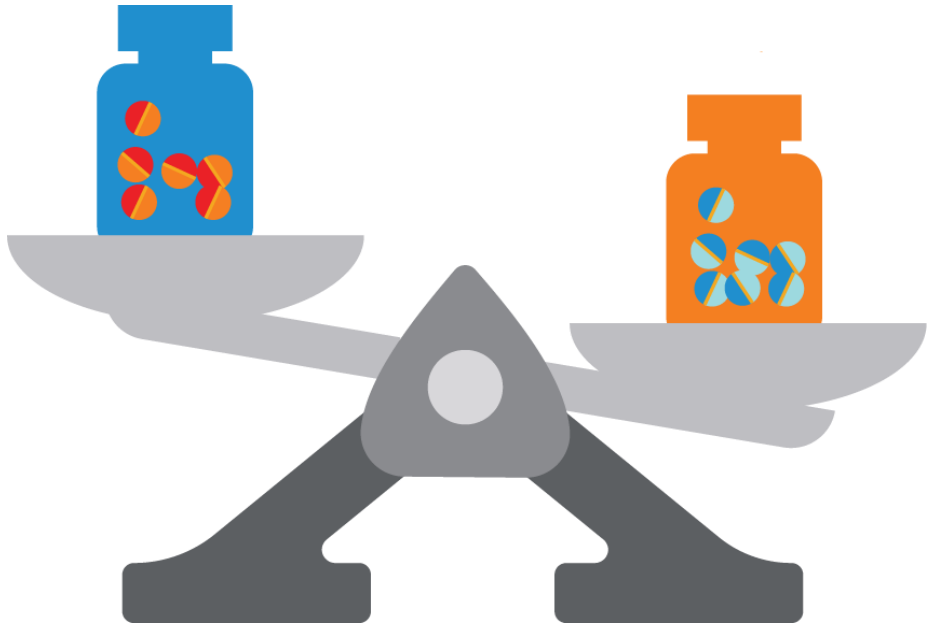
$3,431

Necessary Spending

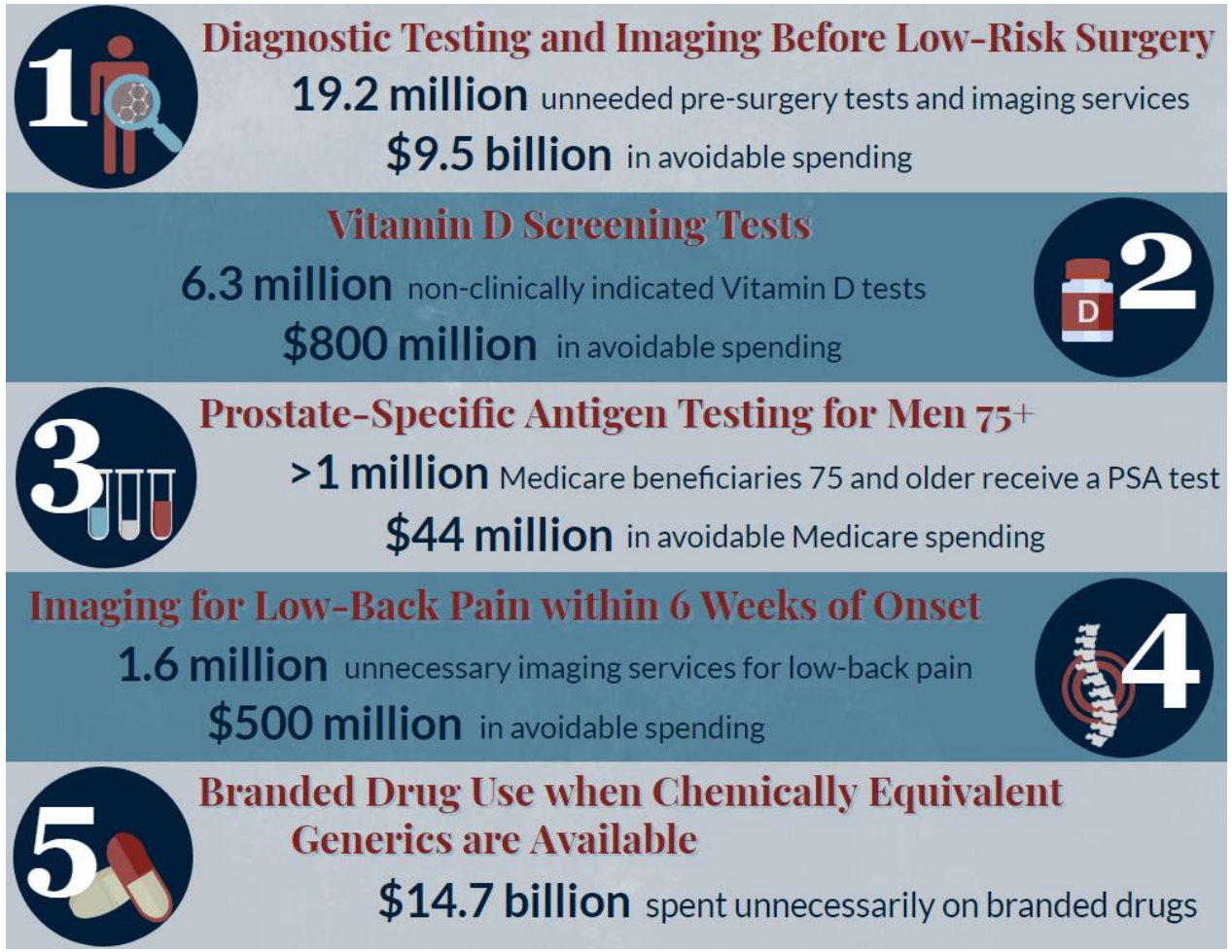
Low-Value Care	**14%** of spending	**Unnecessary Services** *Examples: Duplicate Tests, Choosing Wisely Services* **Inefficient Care Delivery** *Example: Test Results Not Shared*
Administrative Waste	**8%** of spending	*Example: Billing Errors*
Pricing Failures	**4%** of spending	*Example: Excessive Profits*
Fraud	**3%** of spending	*Example: False Claims*
Prevention Failures	**2%** of spending	*Example: Missed Flu Shot*

Insufficient Comparative Effectiveness Research Undercuts Efforts

Up to 50% of our care may be provided without evidence of effectiveness



Some care is not ambiguous; tagged as low- or no-value in most cases



Source: Center for Value-based Insurance Design

Many, many other services have been identified as low or no-value.

GETTING UTILIZATION RIGHT: STRATEGIES

Provider Payment Reform

GET INCENTIVES RIGHT

Non-Financial Provider Incentives

ALSO POWERFUL

Patient Shared Decision-Making should be the

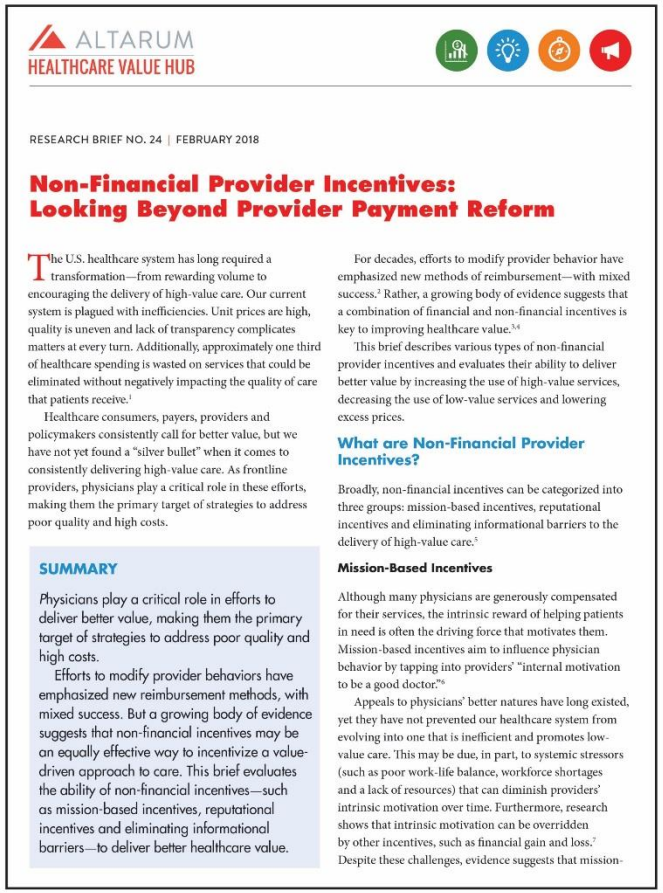
STANDARD OF CARE

Insurance Benefit Design but

KEEP IT SIMPLE

Financial incentives are not our only provider tool….

- Non-financial incentives:
  - Peer comparisons
  - Peer recognition
  - Eliminate barriers
  - Institutional support and leadership



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RESEARCH BRIEF NO. 24 | FEBRUARY 2018

Non-Financial Provider Incentives: Looking Beyond Provider Payment Reform

The U.S. healthcare system has long required a transformation—from rewarding volume to encouraging the delivery of high-value care. Our current system is plagued with inefficiencies. Unit prices are high, quality is uneven and lack of transparency complicates matters at every turn. Additionally, approximately one third of healthcare spending is wasted on services that could be eliminated without negatively impacting the quality of care that patients receive.[1]

Healthcare consumers, payers, providers and policymakers consistently call for better value, but we have not yet found a "silver bullet" when it comes to consistently delivering high-value care. As frontline providers, physicians play a critical role in these efforts, making them the primary target of strategies to address poor quality and high costs.

SUMMARY

Physicians play a critical role in efforts to deliver better value, making them the primary target of strategies to address poor quality and high costs.

Efforts to modify provider behaviors have emphasized new reimbursement methods, with mixed success. But a growing body of evidence suggests that non-financial incentives may be an equally effective way to incentivize a value-driven approach to care. This brief evaluates the ability of non-financial incentives—such as mission-based incentives, reputational incentives and eliminating informational barriers—to deliver better healthcare value.

For decades, efforts to modify provider behavior have emphasized new methods of reimbursement—with mixed success.[2] Rather, a growing body of evidence suggests that a combination of financial and non-financial incentives is key to improving healthcare value.[3,4]

This brief describes various types of non-financial provider incentives and evaluates their ability to deliver better value by increasing the use of high-value services, decreasing the use of low-value services and lowering excess prices.

What are Non-Financial Provider Incentives?

Broadly, non-financial incentives can be categorized into three groups: mission-based incentives, reputational incentives and eliminating informational barriers to the delivery of high-value care.[5]

Mission-Based Incentives

Although many physicians are generously compensated for their services, the intrinsic reward of helping patients in need is often the driving force that motivates them. Mission-based incentives aim to influence physician behavior by tapping into providers' "internal motivation to be a good doctor."[6]

Appeals to physicians' better natures have long existed, yet they have not prevented our healthcare system from evolving into one that is inefficient and promotes low-value care. This may be due, in part, to systemic stressors (such as poor work-life balance, workforce shortages and a lack of resources) that can diminish providers' intrinsic motivation over time. Furthermore, research shows that intrinsic motivation can be overridden by other incentives, such as financial gain and loss.[7] Despite these challenges, evidence suggests that mission-

Address “Prevention Failures”

LOW-VALUE CARE .vs HIGH-VALUE CARE

LOW-VALUE CARE

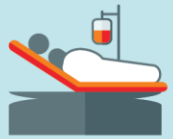
EXAMPLES

Unneeded diagnostic testing

Unneeded imaging

Bloodwork for low-risk surgery

Use of branded drugs when generics are available



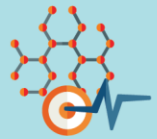
Elective/unwarranted C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

HIGH-VALUE CARE

EXAMPLES

Getting a flu shot



Cancer screening when appropriate

Coordinating care for complex patients

Prenatal care

Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.

For details on the strategies, go to:

HEALTHCAREVALUEHUB.org/low-vs-high-value-care

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One-Third of Healthcare Spending is Wasted

Average Healthcare Spending per Person (2016)

$11,193

Wasted Spending

$3,431

Necessary Spending

Low-Value Care	**14%** of spending	**Unnecessary Services** *Examples: Duplicate Tests, Choosing Wisely Services* **Inefficient Care Delivery** *Example: Test Results Not Shared*
Administrative Waste	**8%** of spending	*Example: Billing Errors*
Pricing Failures	**4%** of spending	*Example: Excessive Profits*
Fraud	**3%** of spending	*Example: False Claims*
Prevention Failures	**2%** of spending	*Example: Missed Flu Shot*

SOCIAL DETERMINANTS OF HEALTH

The conditions where you live, work and play impact your health outcomes.

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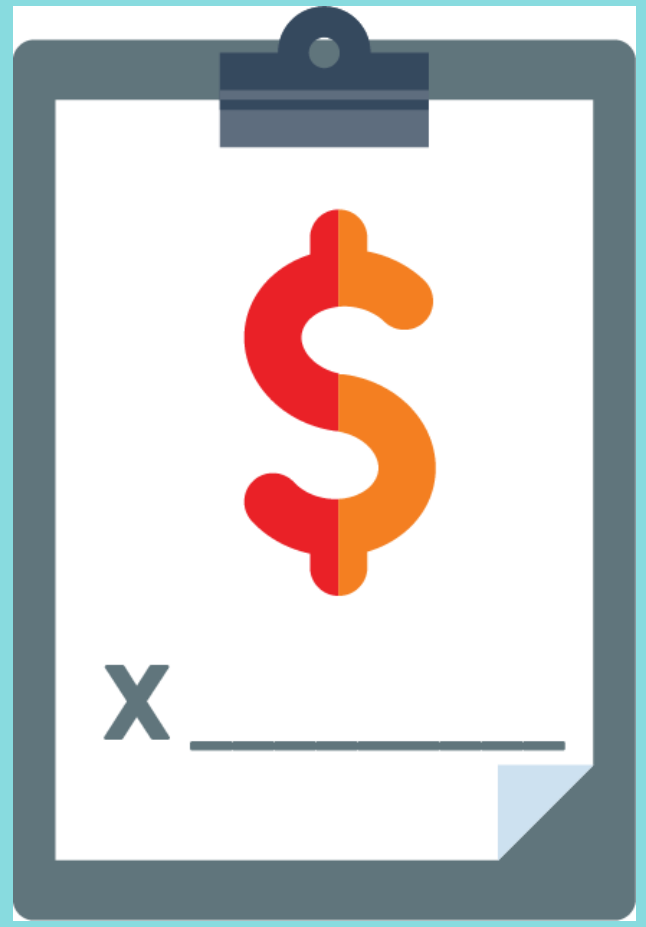
Addressing Personal and Social Determinants of Health

- Assess community needs and capacity to address needs
- Collect better data to track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
  - Environmental nudges
  - Social-medical models of care
- Address financing silos

Addressing High Unit Prices



UNREASONABLE PRICES: STRATEGIES

Price Transparency to expose

HIGH PRICES

Anti-trust, CON/DON, foster competition to address

MONOPOLY POWER

Reference pricing, rate setting, price regulation to address

PRICING OUTLIERS

Global Budgets to cap

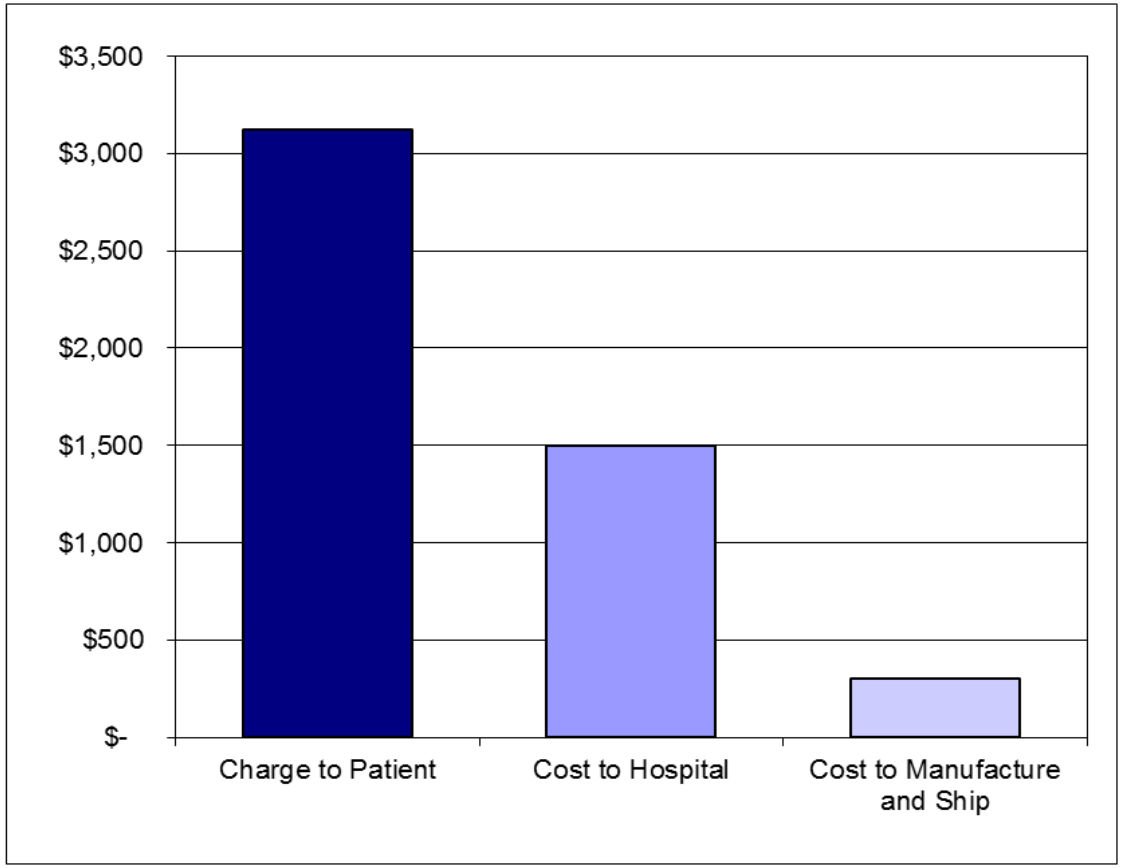
OVERALL SPENDING

Neither Paid Amount nor Charge Provide an Accurate Picture of the Underlying Cost

For the most part,

we have no idea what

the underlying cost of inputs is.



Source: Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," Time, March 4, 2013

Which Price Concept(s) Should We Make Transparent?

Listed Charges (Charge-master)

Negotiated Charges (varies by payer)

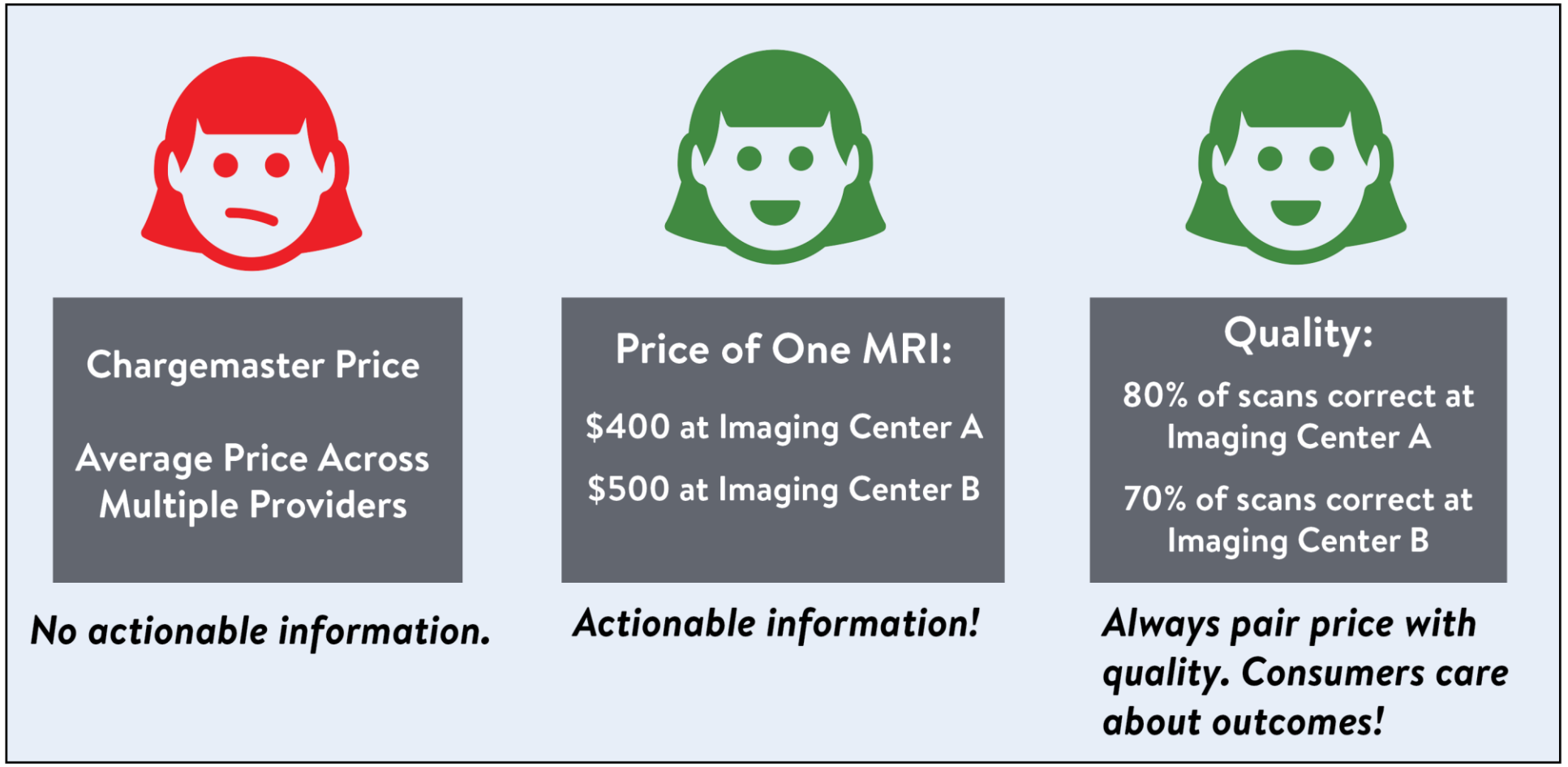
The fair price?

Medicare Payments

Patient OOP (varies by insurer)

Cost to produce the good or service

Healthcare Price Transparency…



…can help consumers budget and plan, but it is unlikely to drive value in the marketplace – especially when hospital markets lack competition

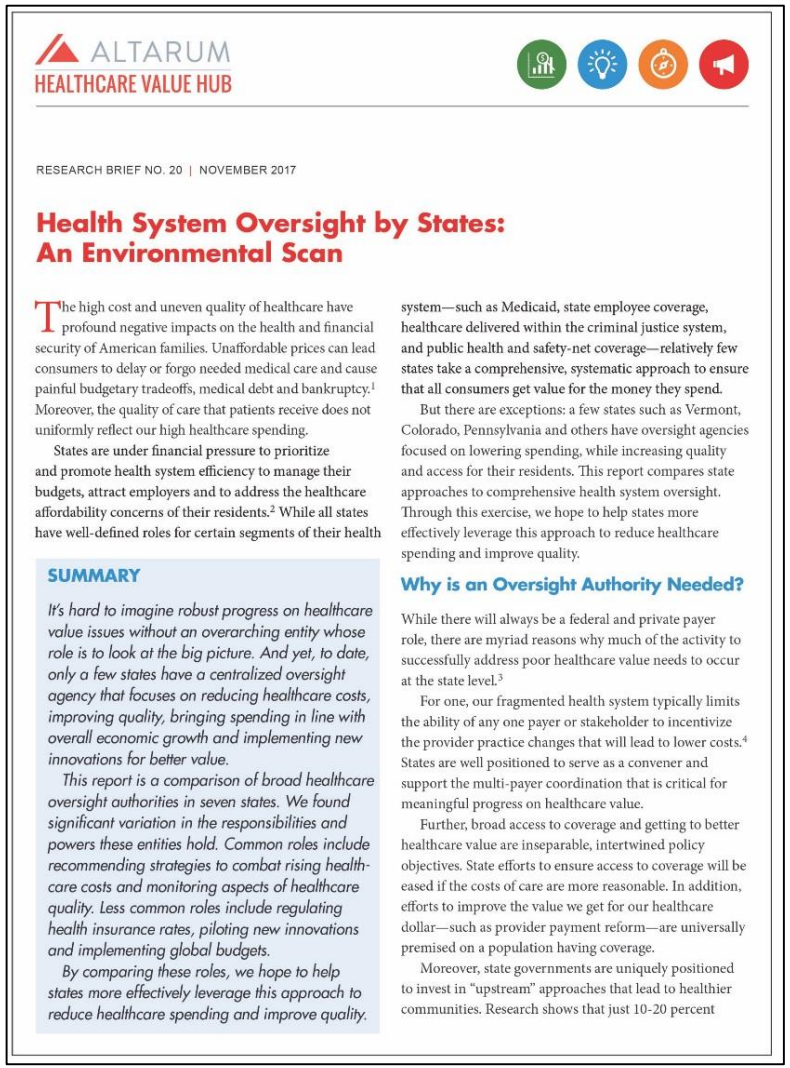
What is a State Health System Oversight Entity?

An entity empowered to look systematically across various types of health and social spending, with tools and authority to identify where the state needs to be more efficient in terms of value for each dollar spent, including addressing quality short-comings and affordability problems for residents.

Important roles can include:

- Leadership/legislative recommendations
- Data stewardship and infrastructure
- Convener
- Innovator
- Regulator/enforcer

Health System Oversight: A Scan



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RESEARCH BRIEF NO. 20 | NOVEMBER 2017

Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.[1] Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.[2] While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising health-care costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.[3]

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.[4] States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

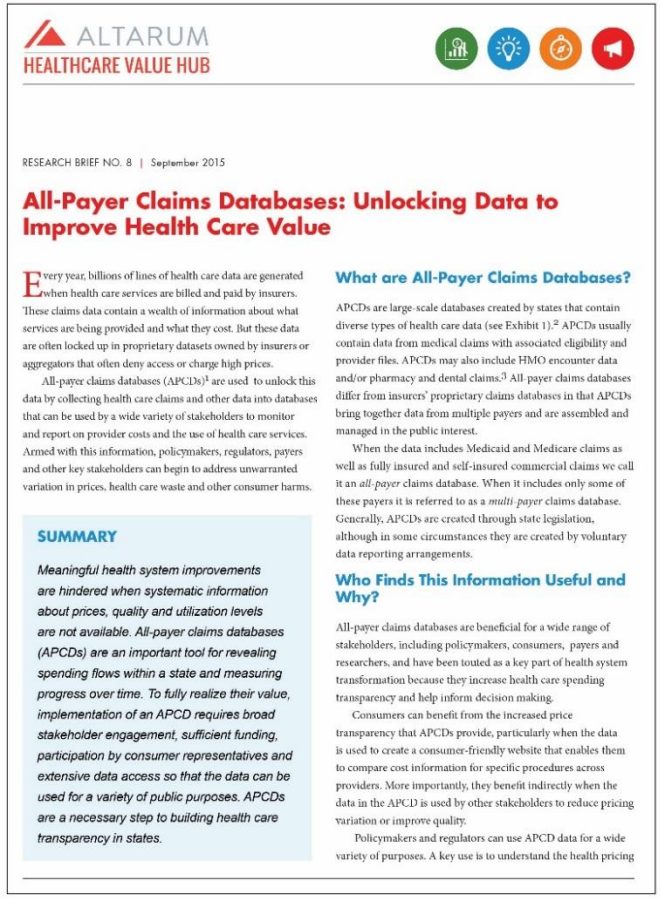
Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in "upstream" approaches that lead to healthier communities. Research shows that just 10-20 percent

NEW: in addition to tracking the value of health spending over time, include an accounting mechanism to recognize future savings from current year investments

HealthcareValueHub.org/state-accountability

All Payer Claims Datasets (APCD) Support Success



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RESEARCH BRIEF NO. 8 | September 2015

All-Payer Claims Databases: Unlocking Data to Improve Health Care Value

Every year, billions of lines of health care data are generated when health care services are billed and paid by insurers. These claims data contain a wealth of information about what services are being provided and what they cost. But these data are often locked up in proprietary datasets owned by insurers or aggregators that often deny access or charge high prices.

All-payer claims databases (APCDs)[1] are used to unlock this data by collecting health care claims and other data into databases that can be used by a wide variety of stakeholders to monitor and report on provider costs and the use of health care services. Armed with this information, policymakers, regulators, payers and other key stakeholders can begin to address unwarranted variation in prices, health care waste and other consumer harms.

SUMMARY

Meaningful health system improvements are hindered when systematic information about prices, quality and utilization levels are not available. All-payer claims databases (APCDs) are an important tool for revealing spending flows within a state and measuring progress over time. To fully realize their value, implementation of an APCD requires broad stakeholder engagement, sufficient funding, participation by consumer representatives and extensive data access so that the data can be used for a variety of public purposes. APCDs are a necessary step to building health care transparency in states.

What are All-Payer Claims Databases?

APCDs are large-scale databases created by states that contain diverse types of health care data (see Exhibit 1).[2] APCDs usually contain data from medical claims with associated eligibility and provider files. APCDs may also include HMO encounter data and/or pharmacy and dental claims.[3] All-payer claims databases differ from insurers' proprietary claims databases in that APCDs bring together data from multiple payers and are assembled and managed in the public interest.

When the data includes Medicaid and Medicare claims as well as fully insured and self-insured commercial claims we call it an *all-payer* claims database. When it includes only some of these payers it is referred to as a *multi-payer* claims database. Generally, APCDs are created through state legislation, although in some circumstances they are created by voluntary data reporting arrangements.

Who Finds This Information Useful and Why?

All-payer claims databases are beneficial for a wide range of stakeholders, including policymakers, consumers, payers and researchers, and have been touted as a key part of health system transformation because they increase health care spending transparency and help inform decision making.

Consumers can benefit from the increased price transparency that APCDs provide, particularly when the data is used to create a consumer-friendly website that enables them to compare cost information for specific procedures across providers. More importantly, they benefit indirectly when the data in the APCD is used by other stakeholders to reduce pricing variation or improve quality.

Policymakers and regulators can use APCD data for a wide variety of purposes. A key use is to understand the health pricing

"APCDs are a necessary step to building healthcare transparency in states."

- With APCD, learn:
  - Total spending with price, utilization, location, payer and service sector components
- When claims data is combined with other data streams, learn:
  - Affordability for consumers
  - Outcomes, including medical harm
  - Patient experience
  - Disparities
- Critical to measure progress towards state goals

QUESTIONS about:

Smart, affordable cost-sharing?
Wasteful spending?
Prevention “failures”?
Excess healthcare prices ?

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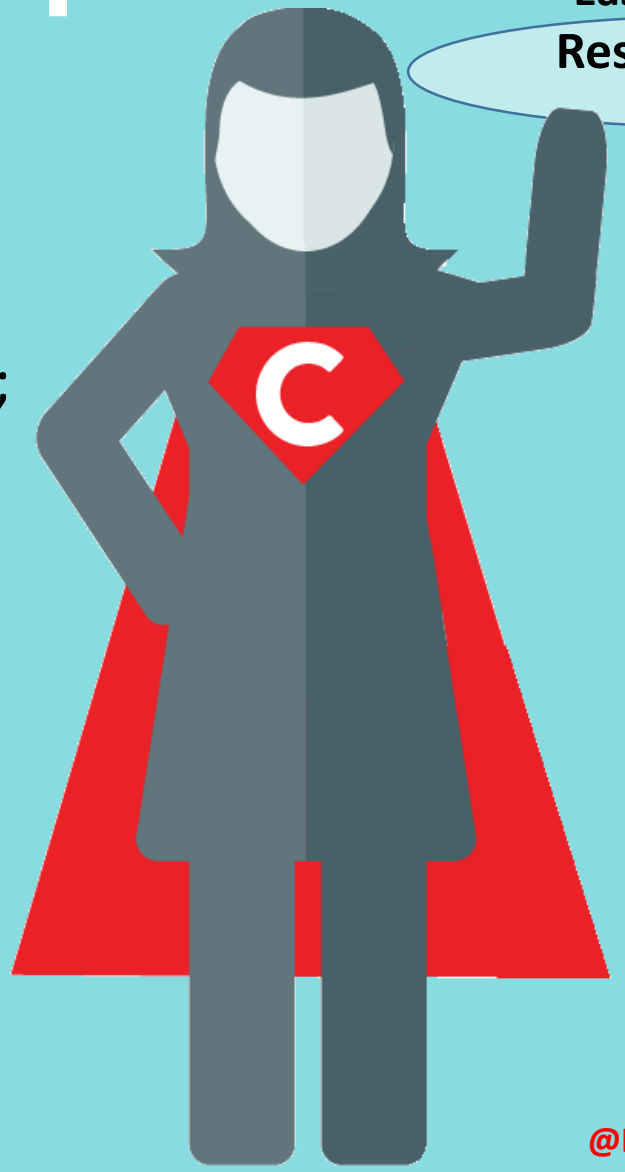

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State Survey

Connecticut 2018 Consumer Healthcare Experience State Survey

State News

Connecticut

Connecticut has explored many approaches to improving healthcare value for consumers over the past several years. The state created an all-payer claims database in 2012 and passed a comprehensive law prohibiting certain out-of-network billing practices and establishing a "certificate of need" process for insurance companies to acquire physician groups in 2015. The law also requires health insurance companies to submit an annual report to the Connecticut Health Insurance Exchange that lists the billed and allowed amounts paid to each healthcare provider in the insurer's network for certain diagnoses and procedures, and the corresponding out-of-pocket costs. The state launched an Office of Health Strategy in 2018 to implement comprehensive, data-driven strategies that promote equal access to high-quality healthcare, control costs and ensure better health for Connecticut residents. Among other responsibilities, the office will oversee the state's four-year State Innovation Model grant to test multi-payer healthcare payment and service delivery models to improve health system performance, increase quality of care and decrease costs.

As of 2019, Connecticut is one of the few states that has comprehensive protections from surprise medical bills. However, high drug costs remain a significant consumer concern. The state has passed several pieces of drug pricing legislation to address these concerns, including laws that require pharmaceutical companies to disclose and explain drug price hikes; force pharmacy benefit managers to report how much they collect in rebates and how much they keep; and protect pharmacists from "gag clauses" that prohibit them from disclosing specified information to people purchasing certain drugs.

Final Questions?

Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.

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