

## Members of the High Deductible Health Plan Task Force:

Unfortunately, I will be unable to join you on January 9th and January 17th (I am scheduled to be out of the country). However, I wanted to share my perspective on what we have learned thus far and on how to proceed.

There is little good that can be said about high deductibles in the health insurance market. As we have learned they have not as originally proposed made patients into better healthcare consumers. Moreover, they have reduced access to care including preventive and primary care, inpatient and outpatient care, access to and adherence to medication, and vaccination schedule adherence resulting in measurable declines in blood pressure, cholesterol and blood sugar control. While they have adversely impacted health, they have also harmed the wallet driving up medical debt especially among those who can least afford it. Anecdotally they appear to be stressing providers as well, needlessly distorting patterns of care around whether or not patients' deductibles have been reached and adding to accounts receivables as providers assume more credit risk.

It is against this backdrop that we are charged with proposing solutions. We have been cautioned about unintended consequences but from the paragraph above it would appear that high deductible health plans (HDHP) have had their own unintended consequences of a mostly adverse nature. This perspective should frame our discussion and encourage us to think boldly and creatively on what can be done.

Likely we can all agree that the high price of healthcare regardless of its value is fundamental to the issue. Accordingly, I would favor excluding some high value services from deductibles. These could include items listed in Treasury Notice 2019-45, services and drugs for certain chronic conditions classified as preventive care. They also could include high value services listed in figure 5 of the Managed Medicare White Paper of the University of Michigan Center for Value-Based Insurance Design (distributed at the last meeting). Similarly, we could refuse coverage altogether for low value care as defined by the Choosing Wisely initiative and the US Preventive Services Task Force. A standing task force probably should be created to further define and recommend high and low value services to include or exclude from predeductible coverage. I suspect most primary care services would qualify as high value.

High deductibles are sufficiently pernicious to affordable healthcare that in my opinion they should be further constrained. We could, for instance, insist on limiting their size to the minimum annual deductible for federally qualified HDHPs. This would enable people to keep their health savings accounts but could reduce cost sharing. It will likely be argued that this will raise premiums and cause some employers to drop coverage. In response I would say that deductibles which are so high as to be unaffordable are masking an underinsurance problem and allowing policy makers to delude themselves into thinking more people have access to healthcare than really do.

I am in favor of health literacy education and health navigators although Dr. Villagra's presentation makes it clear that they are of limited value. Reminders of pre-deductible preventive services should be included. Encouraging funding strategies for HSAs makes sense although they mostly benefit the well to do. Limiting deductibles to one per person or family per annum is reasonable so that those changing plans in mid-year are not penalized. Price transparency including medical loss ratios for insurers would be helpful at achieving higher value but likely are going to face strong opposition (as we are seeing from the hospital

association at the federal level). I also would favor cost sharing maximums indexed to family income in order to improve access to care.

Thank you for your attention and good luck with your deliberations. I look forward to joining you at the third meeting in January if there is one.

Regards,

Andy Wormser