Appendix H

Connecticut ORTHOPAEDIC Society

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December 17, 2019

High Deductible Health Plan Task Force Committee
c/o Ms. Koss
State of Connecticut
Office of Healthcare Advocate
450 Capitol Avenue
Hartford, CT 06106

Dear Members of the High Deductible Health Plan Task Force Committee,

On behalf of the 260 orthopaedic surgeon members of the Connecticut Orthopaedic Society (COS), we submit the following to the attention of the State's High Deductible Health Plan Task Force Committee members for public comment.

The Society appreciates the work of the Task Force to date and the opportunity to share the negative impact High Deductible plans have on our patients and the doctor-patient relationship. As per the charge of the Task Force, our comments and suggested resolution will be focused on High Deductible Health Plans in Connecticut and not health reform in general nor HSAs.

High deductible health insurance plans are becoming more commonplace as health insurance premiums skyrocket. More patients are seeking the lowest cost option in order to ensure some form of health insurance coverage which really amounts for many to being functionally uninsured. These plans have severely undermined the physician patient relationship as they force physician offices to become bill collectors creating embarrassing situations for patients who are not able to pay the high deductible portion of their insurance and jeopardizing their health and their family's health.

Our patients come to us for care and many are embarrassed that they are not able to pay the high deductible responsibility of their health insurance and oftentimes decide to forego necessary testing and treatment, rationing their care and their children's care. When patients are forced to obtain care due to emergency situations they may not be able to pay the high deductible before their insurance coverage begins. These patients may not come back for important follow up because they know they cannot afford to pay for the additional treatment or care. It is particularly disheartening as orthopaedic surgeons to see patients try to forego post-operative rehabilitation which threatens the success of their outcome.

As noted by our physician colleagues serving on the Task Force, there are several negative consequences to the insurance industry's high deductible policies all of which adversely impact the physician patient relationship as more and more physicians and their practices are put in

the position of debt collector. It is important to note that physicians and their practices are not equipped to assume the financial risk of a for profit industry, nor should they be. We as physicians do not require the insurance company to assume any of our responsibility or risk to care for our patients. However the insurance industry is transferring the risk of their high deductible insurance products to physicians, eroding the physician patient relationship and adding significant costs to the health care system both within our practices and by patients who do not receive appropriate care or treatment because they can not afford their deductible. The insurance industry reaps the profits while our patients suffer and our practices underwrite the insurer's cost of doing business.

It is imperative that the current High Deductible insurance market be reformed, particularly the collection process, to mitigate any further erosion of the physician-patient relationship and stop the self-imposed rationing of care by our patients. Conversely, once the high deductible is met, patients may seek unnecessary care, worried that if their symptoms increase in subsequent years they may not be able to afford it. This patient mindset created by high deductibles increases costs to the health care system and potential patient morbidity. During the last months of the calendar year, many of the Society's members have difficulty accommodating the large influx of patients seeking surgeries now their deductible is met or convincing patients that they really do not need the MRI they are requesting.

Our Society was pleased to join in the support of Senator Martin Looney's bill before the 2019 legislature, as an important first step to addressing one of several unintended consequences of high deductible plans; failure to pay for care and treatment. Building on the initial bill introduced by Senator Looney in the 2019 session, our Society proposes the Task Force consider a 2020 Legislative Session statutory change as proposed below.

Any commercial medical insurance company licensed to do business in the State of Connecticut shall take full responsibility to collect their own policy Co Pays, Co insurances and deductibles from their insured clients whether they be individual policies or group business policies.

Any commercial medical insurance company licensed to do business in the State of Connecticut must reimburse physicians, health care facilities, laboratories and imaging centers and/or any other health care delivery service with whom they have a contractual relationship with and have negotiated a fee schedule, the full fee for service at the full negotiated fee rate and follow all state statutory requirements pertaining to prompt payment and pre certification.

As advocates for our patients, we strive to preserve the doctor-patient relationship and removing the High Deductible payment barrier within the physician's office by rightfully requiring the insurance companies to collect high deductible payments as easily as they do their monthly insurance premiums is an important first step in our State.

Thank you for your consideration.

Sincerely,

Michael S. Aronow, M.D.

Michael Aronow, MD
President
Connecticut Orthopaedic Society

Good morning Mr. Chairman and Task Force members, my name is Joshua Levin. I am a senior at Central CT State University and a social work intern at the Universal Health Care Foundation of Connecticut. I have been working with the foundation to collect stories from Connecticut residents about the harmful issues high deductible plans create for them and their families.

As foundation staff members Jill Zorn and Lynne Ide have done before me, I would like to share with you yet another story of the harm high deductible health plans cause. Today I'm here to tell you about my Aunt, Charyn. She is a Licensed Practical Nurse who currently has a health plan with a $3,000 deductible through her employer.

When she was asked to explain how her high deductible plan affects her ability to seek care, she stated, "I ask my doctor for the lower milligram value of my blood pressure medication because it's cheaper, though I need to be taking the higher amount." No one should have to put their finances over their own health, but that is the unfortunate reality of our current system.

She continued on by sharing what happened during her last wellness visit. Her doctor, acting in my Aunt's best interest, decided to order an EKG, liver function study, and several other lab tests. Unknown to her at the time, none of these services were covered pre-deductible. Instead, she received a $250 bill for what she expected to be a wellness visit, free from out-of-pocket charges.

Charyn states, "I have to somehow be ahead of the game with this. Before I see a doctor, I need to call my insurance and tell them what I plan on getting done and figure out what's covered and what's not. I've been in this line of work for over 33 years and in insurance for over 25 years, yet I do not feel like this has offered me any insight. If anything, it's made me even more frustrated because I know how it should work and things change too quickly to keep up."

She has every right to feel frustrated over this. When including her premium share and out of pocket expenses into her total amount spent towards insurance in a year, as she puts it, "I shouldn't have to invest almost $5,000 before I get anything back."

When she was asked to share her thoughts with policy makers, she said, "this isn't a level playing field, especially if you are not one of the high money makers. If you're middleclass, it's really a lot out of your pocket. This is a little over 15% of my annual income, not even counting medication. I've reduced the amount of medications I take because I can't afford them."

Please keep my Aunt Charyn in mind during your deliberations and remember that she and countless people in her exact situation are looking to you for help and support. These are real people struggling to afford their health care; real people who need real action.

T1International #insulin4all

A Letter to the High Deductible Task Force

December 17, 2019

To the members of Connecticut's High Deductible Task Force:

The Connecticut #insulin4all chapter — supported by T1International — is a group of volunteer advocates raising awareness about the insulin price crisis and fighting for insulin pricing transparency and affordability in Connecticut.

We have seen first hand the detriment that high deductible insurance plans have had on our members in the state. Many individuals have expressed their struggle with affording the exorbitant list price of insulin before they meet their deductible.

My own work with this organization began because of a high deductible insurance plan. After turning 26 and being forced off of my parent's insurance, I knew I had to get an insurance plan that would offer adequate coverage for my type one diabetes care, medication, and supplies. In the end I went with a plan which had a deductible equal to my entire month's salary. My hope was that I could slowly chip away at the deductible so I could get my necessary items covered.

What I didn't anticipate was the exorbitant out-of-pocket costs for insulin. As I began researching all the different ways for financial assistance, I stopped going to the doctors. I started reusing my diabetic necessities such as needles and insulin pump supplies. Ultimately, I started rationing my insulin for months, hoping to make every life-saving drop last until I found a viable solution.

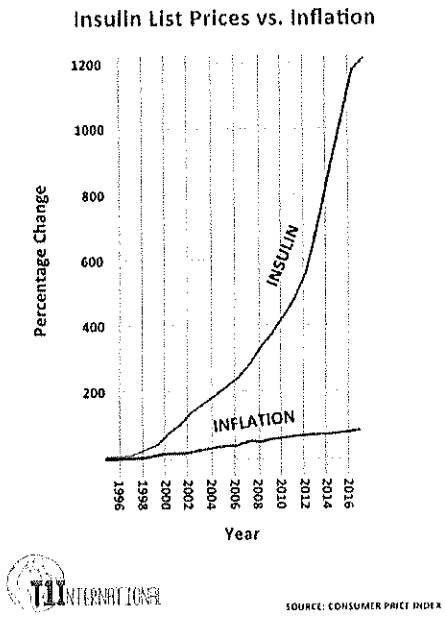
However, that viable solution never came. I called my insurance company, the pharmaceutical company, patient assistance programs, and all the prescription coupon companies I could find. Yet, I met the same response every time: they couldn't help me because I had insurance. Albeit, an insurance that couldn't prevent me from rationing the one thing that saves me from an excruciating death.

Though I have a decent insurance plan now, I am terrified of what the future may bring. If I had a high deductible insurance plan before, what prevents me from ending up in a similar plan in the

future? I hear this concern reiterated with almost every member I speak with, especially with parents of diabetics.

These concerns aren't unfounded and they aren't rare — a Yale study found that 25 percent of type one diabetics in New Haven county reported rationing their insulin. Another survey by UpWell Health found almost half of those surveyed have rationed their insulin. It's not difficult to draw conclusions as to why this is occuring: the Health Care Institute found that out-of-pocket spending by patients with type 1 diabetes on insulin nearly doubled from 2012 to 2016, increasing from $2,900 to $5,705.

We believe the rising costs of insulin and other pharmaceuticals are significantly contributing to the prevalence of high deductible health plans. Since the 1990's the cost of insulin has increased 1200 percent, far exceeding the rate of inflation.



Graph produced by Erin Gilmer for T1International with data from Hannah Crabtree.

These times require courageous action; it is time we do not let fear dictate our behavior and instead choose bold moves to protect the citizens of Connecticut. For too long Connecticut residents have had to bear the majority of the burden of our health system's inequities.

This task force represents an incredible chance to change this. The Connecticut #insulin4all chapter would like to encourage the High Deductible Task Force to keep in mind the contribution pharmaceuticals have on insurance plans. Pharmaceutical companies should be held accountable for their role in this crisis and full transparency should be sought. While insulin co-pay caps have been introduced in states such as Colorado to help limit out-of-pocket costs, patients still face some significant challenges. Those with high deductible health care plans aren't always protected and insurance plans have found ways to charge more for those who require multiple insulins for their care. We also fear that these co-pay cap bills risk insurance companies raising premiums or deductibles to compensate for any losses.

While these co-pay bills are a step in the right direction for diabetics, we believe that Connecticut can go a step further. We ask the task force to consider a prescription drug affordability board, similar to the one Maryland recently enacted. The capping of pharmaceutical prices has the potential to change the landscape for insurance plans and, more importantly, for the residents of Connecticut.

We thank the committee for taking up this critical issue and for working to enact real, lasting changes for Connecticut residents.

Sincerely,

Kristen Whitney Daniels
Connecticut #insulin4all — Chapter Leader

T1International #insulin4all

The Insulin Affordability Crisis in the U.S.

- Approximately 30.3 million people in the United States have diabetes[1]; of these, around 1.25 million have type 1 diabetes[2]
- There are over 7 million Americans that rely on injected insulin to stay alive & healthy[3]
- Since the 1990's, the cost of insulin has increased over 1,200%, yet the cost of production for a vial of analog insulin is between $3.69 and $6.16[4]
- Spending by patients with type 1 diabetes on insulin nearly doubled from 2012 to 2016, increasing from $2,900 to $5,700[5]
- Over 50% of Americans on insulin risk paying the full list price[6] – 8.8% of Americans are uninsured and 47% have high deductible insurance plans[7]
- One of every four patients with type 1 diabetes has had to ration their insulin due to cost[8]; among young adults, from ages of 18 to 25, studies have shown that 43% have rationed[9]

Diabetes in Connecticut

- Approximately 355,000 people in Connecticut, or 11.4% of the adult population, have type 1 or type 2 diabetes[9]
- Every year, an estimated 18,000 people in Connecticut are diagnosed with diabetes[10]
- Total direct medical expenses for diagnosed type 1 and type 2 diabetes in Connecticut were estimated at $2.7 billion in 2017[11]
- Many patients in Connecticut are unable to afford insulin – which has had serious consequences

"My son, Alec, died from rationing insulin. He could not afford the high cost. Why is it that, in America, the pharmaceutical companies set the price without justification?"

- Nicole Smith-Holt · Richfield, Minnesota

About T1International and #insulin4all

T1International is a non-profit organization run by people with type 1 diabetes *for* people with type 1 diabetes. We support local communities around the world by giving them the tools they need to stand up for their rights. Our aim is to empower advocates to ensure that access to insulin and diabetes supplies becomes a reality for all.

T1International takes no funding from pharmaceutical or diabetes device companies in order to avoid conflicts of interest and to ensure independent advocacy. We will continue to work with advocates until affordable insulin and diabetes supplies worldwide is a reality.

In 2014, T1International launched the #insulin4all campaign for World Diabetes Day. Over the years, the campaign and hashtag have grown into a larger movement, particularly in the United States as insulin pricing has created a crisis for Americans with diabetes. The movement intends to draw attention to diabetes and insulin affordability issues and it is used as a rallying cry across the United States and around the globe.

T1International's first U.S.A. #insulin4all Chapters launched in 2018, and have expanded to 34 grassroots Chapters in states across the country. These Chapters are made up of volunteer advocates, who have been instrumental in bringing insulin accessibility issues to the spotlight by sharing their stories and working with lawmakers to pass meaningful legislation to address insulin access issues and the insulin affordability crisis.

About Connecticut #insulin4all

Minnesota #insulin4all is a group of volunteer advocates raising awareness about the insulin price crisis and fighting for insulin pricing transparency and affordability in Connecticut.

The purpose of the Connecticut #insulin4all Chapter is to promote awareness of the price-gouging practices of insulin manufacturers and the financial burden it creates for people with diabetes; to empower individuals impacted by the high price of insulin to share their stories and fight for change toward making life-saving insulin affordable; and to push for transparency and lower insulin prices to end the insulin price crisis. The Chapter is supported by T1International.

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UCONN
HEALTH

December 3, 2019

Ted Doolittle,
Co-chair High Deductible Health Plan Task Force
c/o Insurance Committee
Legislative Office Building, Room 2800
Hartford, CT 06106

Ted,
I am writing to you in your capacity of co-chair of the High Deductible Health Plan Task Force to acknowledge the contributions of Orlando Rodriguez to the work on the medical debt situation in Connecticut and its causal relationship to HDPs. As you may recall, Orlando is a former Health Disparities Institute Employee who participated in our early discussions and meetings with you at OHA and also with Judge Bright. In preparing for my presentation on November 6th I reached out to Orlando to seek additional information about his original work. Even though he is no longer employed at HDI he was most helpful!

Best of luck in your task of assessing the role of HDPs in the health and wellbeing of CT residents.

Respectfully yours,

Victor G. Villagra, MD
Associate Director
UCONN Health Disparities Institute

Cc/Sherri Koss
Orlando Rodriguez

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Universal Health Care Foundation of Connecticut

comments before the

High Deductible Health Plan Task Force

Submitted by Jill Zorn, Senior Policy Director

November 20, 2019

Universal Health Care Foundation is dedicated to achieving access to quality, affordable health care for all Connecticut residents.

Health insurance is supposed to protect people's physical and financial health. High deductible health plans do neither. In fact, they are hazardous to both the physical and financial health of our state's residents.

For that reason, our foundation is glad the Connecticut General Assembly chose to convene this group. We are watching this task force closely, participating by giving public comment and trying to publicize the work of the task force through our blog. And we're here today to do what we can to keep the needs of patients and consumers front and center in your meetings and deliberations.

To that end, the foundation has put out a call for stories about the harms caused by high deductible health plans. My colleague Lynne Ide shared several stories with you at the October 17 meeting of the task force. And I have one to share with you today.

But before sharing that story, I want to thank the committee for inviting experts to speak to you at the previous meeting. And I'm here with an update. At the last meeting Dr. Victor Villagra of UConn's Health Disparities Institute presented his research results that showed that Danbury Hospital was responsible for about half of all small claims court medical debt cases. The public presentation of that information was noticed and picked up by the media. In response, just this week, Danbury Hospital has announced that they will be changing their debt collection practices to be more empathetic to their patients.

While the hospital is not being specific about what exactly will change, it is a good first step that they intend to establish a more humane policy. And it is certainly an accomplishment that this task force can already point to. Still, it shouldn't take public shaming to make policy change.

Now, I'd like share comments the foundation received from Allyson Platt, a licensed professional counselor, about high deductible health plans. Allyson receives health coverage on the exchange now, but prior to that she worked for two community mental health agencies that also had high deductibles. She reports that her deductibles have been in the $7,000-$8,000 range.

Allyson states, "personally, I fear that my ability to survive is threatened because I cannot always access the appropriate health care that I need to treat my condition. There are days when I am quite despondent."

When asked to share her thoughts with policy makers, this is what she wrote:

"The current system is totally unacceptable. I want to share some information from a survey I did of colleagues. In 24 hours, 79 fellow mental health professionals in Connecticut noted the negative impact of HDHPs on their clients - and, for all of us, our profession. The story all 79 told about the impact of HDHPs on their clients is consistent - it is an obstacle to essential health care. I've included some comments below:

- This is the biggest reason for my no shows and those who terminate prematurely
- Absolutely an issue. Very few can afford to put out 4K-6K up front
- I'd say 20-30% either reduce or stop (treatment)
- I have had clients make the choice early on to only come once a month or bi weekly at best due to the fact that they have not and likely will never meet their deductible. Some have put money in their flex account but also know they need to use that for other things, so they are quite judicious as to how much they use
- I've had clients who were coming weekly and would have liked to continue weekly sessions who had to cut back to monthly due to high deductible
- Have had clients discontinue after January 1 (when new plan year begins) or drop to biweekly or monthly despite need for higher frequency
- I have noticed that the high deductibles keep people from starting treatment until after their deductible is met and then terminating early because of the deductible reset date"

Allyson is a provider, whose own access to health care is hurt by HDHPs. But her comments and those of her colleagues focused mainly on the impact on patients. And, I'm not naïve, fewer patient visits has a negative impact on provider revenue. But clearly the biggest concern Allyson and her colleagues are communicating is the negative impact high deductibles have on their patients' ability to get the care they need.

The membership of this task force is dominated by providers and insurers. While I believe we all agree that high deductible health plans are far from ideal, it is not useful for providers and insurers to simply point fingers at each other, as I saw occurring at the previous task force meeting. The people of Connecticut are relying on you to have a constructive conversation, not a discussion focused on defending your specific profession or industry or accusing the other.

Please remember Allyson and her colleagues, who highlighted the harm being done to their patients. If we are going to do something about high deductible health plans, everyone is going to have to give a little. And we're going to need to keep the needs of patients and consumers front and center.

UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Universal Health Care Foundation of Connecticut's comments before the High Deductible Health Plan Task Force

Submitted by Lynne Ide, director of program & policy October 17, 2019

I am here today because the work of this task force is important. It is important to tens of thousands of families across Connecticut who struggle every day to take care of their health needs under the pressure of a high deductible health plan.

The numbers just don't add up for most people. In fact, for many without significant savings or expendable income, being in a high deductible plan equals being functionally uninsured – not merely under-insured. These people just don't go to a doctor unless it's unavoidable.

A 2019 Benchmark Employer Health Benefits Survey (released by Kaiser Family Foundation) reports a 162% increase in deductible costs in the past ten years.

A 2018 nonpartisan, statewide poll of voters showed that 43% of Connecticut adults delayed or did not get care due to costs. (Conducted by Altarum Healthcare Value Hub)

It's highly likely that many of those people struggle with high deductible health plans. An October 2 blog by Ellen Andrews of CT Health Policy Project, reports that in our state 63% of individuals and 55% of families are in high deductible health plans. (Data from the 2018 US Medical Expenditure Panel Survey)

Consider Jessica, who is a self-employed therapist. She's trying her best to deliver quality mental health care. Jessica pays $15,000 per year in premiums with a $6,000 deductible. With co-pays added in, she says it's hardly worth having a plan she can't easily use.

And then there's a church in Manchester that employs 6 people, 3 of whom are on the church's health plan. The premiums are $50,000 per year for the 3 employees and they each have a $5,000 deductible. The church feels bad about the deductible, so they have set up a fund to help defray the cost of the deductible – like so many other businesses.

My son works at a small social enterprise organization. He pays $200 a month in premiums with a $7,000 deductible. At age 29 – he just does not go to the doctor. Not many young adults living on their own, paying off student loans, can afford to take care of themselves when saddled with a high deductible health plan.

I serve as chair of the Board of Education in my town. The high deductible health plans are a consistent source of complaint among the teachers and staff in our school district, which

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1199NE Connecticut | SEIU Healthcare United for Quality Care

January 28, 2020
Astrid Lopez
High Deductible Health Plan Taskforce

My name is Astrid Lopez. I work for Whole Life Inc. in the Bridgeport area. I have worked at Whole life as direct support staff for 20 years. I've been working in the group home industry for 27 years.

I have been uninsured for over three years. Between my husband and I, we don't qualify for State insurance. On the other hand, the health insurance plan offered by my employer cost roughly $380 a month, which I can't afford. Furthermore, the deductible is $3,000 a year for the individual plan and $6,000 a year for the family plan. This effectively makes this plan too expensive to use, making me virtually uninsured. Like anyone, I have essential bills to pay and because of the high cost of health insurance, my husband and I are forced to choose between putting a roof over our head and insuring ourselves. Every day I live in fear that a medical emergency will arise and we will be unable to handle it financially.

Every day I suffer from sciatica. I was seeing a chiropractor for this but recently was forced to stop because I could no longer afford it. My visits were three times a week, $40 each visit. To truly address my condition, I would need CT scans and X-Rays, but these procedures are simply out of the question – I cannot afford them. In addition to my sciatica, I also have a tear in my rotator cuff, which requires surgery to address. Day in and day out I suffer with aches and pains, and some nights it's hard to sleep at all.

It saddens me that I am a healthcare worker and I can't afford healthcare. There are days when I go to work with bad pains and I have to suppress it to get my job done. I love the individuals I care for and want to give them the best care possible. I wish I could provide the same care for myself, but I simply can't afford to.

It is time Connecticut took real action to ensure everyone has access to truly affordable healthcare!

1199NE Connecticut | SEIUHealthcare United for Quality Care

January 28, 2020
Jennifer Brown
High Deductible Health Plan Taskforce

My name is Jennifer Brown, and I am a group home worker with two private agencies, Sunrise Northeast and Network, Inc. I used to work at a private group-home company called New Seasons, which dissolved, and was acquired by Network in July, 2019. I have been working in this industry for 25 years.

Years ago, at New Seasons, we did not have to pay for health insurance at all. If you were full-time, the company would provide you with insurance with a premium, which was good. Over the years, we started to have to pay, but even then, what we were paying was still affordable. It didn't matter if it was just you on the plan, or your kids, or your spouse, or the entire family, all the workers could afford it. Now that the company dissolved, we are forced to deal with this new health insurance. Now both of my jobs have very unaffordable health insurance, and I am forced to pay for the Network plan. I make too much money to qualify for state health insurance, and I otherwise would not be covered at all.

Even for just me, it is over $300 a month. I absolutely cannot afford to put my husband on this insurance. Our copay and our deductible are so high, it is disgusting, and so are our expenses for medicine. I have a coworker who is diabetic, and this insurance doesn't even cover some of her necessary medications that I need to continue to live and be healthy. It's just disgusting. It is hard for any of us to be healthy under this plan, because the cost of obtaining coverage and maintaining our medications is too high.

The health insurance plans offered through my other jobs are even more unaffordable. At Sunrise, the health insurance costs more than what most employees make. Many of us don't have health insurance. There is no wat that I can afford to use this plan. I have a pre-existing condition, and I need to be covered. As things are, how am I supposed to live a healthy life? How am I expected to afford it?

1199NE Connecticut | SEIU Healthcare United for Quality Care

January 28, 2020
Allison Dumphy
High Deductible Health Plan Taskforce

Healthcare shouldn't be a thing you should afford, it should be everybody's right. It shouldn't be based on how much you make. It should be everybody's right.

My name is Allison Dumphry and I work as a group home worker, which means I take care of individuals with disabilities. I can't use the health insurance provided by my job because it is very expensive. If I had to use the insurance plan, then I wouldn't be able to save to move out of my family's house and I wouldn't be able to afford a car, as I am still making payments. Between the things I need work, such as housing and a car, there's no way I could afford it. I am also in school, for which I need financial aid. I pay for all my own expenses, and I am no longer listed as my parent's dependent. The insurance offered through my job is definitely more expensive that what I get through the Access Health CT marketplace and even the marketplace is pushing my budget. To give you an idea of what I am dealing with, the monthly premium for the plan offered through my work is $1,588.00 for individuals and $4,634.48 for a family. This is not a typo. Those plans cost more per month than what many people in my field make in a month.

I used to be covered by my mother's insurance, under the Affordable Care Act. My mom works for the State of Connecticut, and our insurance was great. When I hit 26, I had to find my own insurance. At first, the private insurance company, which I chose through the marketplace, lost my paperwork. That caused me to go without insurance until open enrollment, as the period had passed for special enrollment. At that point, the plan I had wanted wasn't available and I had to pay for a more expensive plan. I had to pay $196.26 a month just to get the base plan coverage through the marketplace. Then, I started having issues with my arm, which forced me to take time off work and to start a rehabilitation program to prevent the issue from degrading further. Between the copays and out-of-pocket cost for physical therapy, the MRI, and the initial visit, the total was approximately $2,500. With all of my existing bills and expenses, it has been a long process paying off these medical bills. In fact, I'm still paying those bills off almost a year later.

I find it ironic that we are in these positions to help people, but struggle to care for ourselves due to the high costs of healthcare and outrageously unaffordable health insurance plans. I am going to school for social work. I work full-time taking care of people and I want to continue to do so. Providing quality care is something I pride myself in, however, it can be hard to focus entirely on the work at hand when I am worried about how I am going to make ends meet. If I had put off treatment for my arm, I would have needed surgery and my arm would have gotten worse. This would have potentially put me out of work or at risk for another injury. I did the right thing taking care of it, and I am rewarded with going into debt. I am not saying this to be whiny. I am in this line of work to care for the people who are physically unable to care for themselves, but if I am unable to take care of myself due to the debilitating cost of health insurance, how can I be expected to do the best job possible? I want to stay in Connecticut, and have a family, and start a life. I can't do that if I can't access affordable healthcare.

American Bankers Association
HSA Council

J. Kevin A. McKechnie
Executive Director
The HSA Council
kmckechn@aba.com

December 27, 2019

Ted Doolittle, State Healthcare Advocate
Chairman, High Deductible Health Plan Task Force
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144

By email to Ted.doolittle@ct.gov

Dear Chairman Doolittle:

Thank you for the opportunity to testify before the Task Force in November and thank you for allowing me to clarify and amplify upon my remarks.

Preventive Care

Question #1: "It was asked whether a state mandate for first-dollar coverage of the listed treatments would be compatible with HSA-qualified plans. You answered that it would not because mandating those treatments would make them non-optional and that the IRS guidance specifies that first-dollar coverage of the listed treatments must be optional. We are interested in the analysis that supports that answer. Can you share any work that the ABA has or is aware of which makes clear that this coverage must be optional to the insurer and may not be mandated by a state?"

Let me attempt to clarify what I meant. The HSA statute and IRS guidance (Notice 2004-23 and Notice 2004-50) created a "safe harbor" for coverage of preventive services without application of a deductible. This means that a health insurance plan will not fail to be treated as an "HSA-qualified" insurance plan merely because it provides first-dollar coverage of preventive services. This is the only exception provided to the general requirement that HSA-qualified plans apply a minimum deductible to all benefits covered by the plan and the source of the theory that preventive services coverage is optional.

Later, the authors of the Affordable Care Act (ACA) borrowed this feature from HSAs and mandated first dollar coverage of preventive services for all health insurance plans in the U.S. (except for grandfathered plans). The ACA further mandated first-dollar coverage for a specific set of preventive services; however, the ACA mandate went beyond the original IRS safe harbor for preventive services for HSA-qualified plans.

Consequently, the IRS clarified that the safe harbor for HSA-qualified plans included the ACA-mandated preventive services.[1]

However, it is important to understand that the original IRS guidance (Notice 2004-23) also stated that "preventive care" for HSA-qualified plans did not include "any service or benefit intended to treat an existing illness, injury, or condition." That changed this past summer when the IRS (Notice 2019-45) for the first time expanded the preventive care safe harbor for HSA-qualified plans only to include services that treat an existing chronic condition.

This allows, but does not mandate, HSA-qualified plans to cover specific services provided to individuals with specific chronic conditions without application of the policy deductible and, therefore, retain their status as "HSA-qualified" plans. Further, it "does not treat these services and items as preventive care required to be provided without cost sharing for purposes of Section 2713 of the PHS Act [the Affordable Care Act]."

IRS Notice 2019-45 does not address whether coverage of the services listed in the Appendix to the Notice may be mandated by a state. However, IRS Notice 2004-23 explains that "state law requirements do not determine whether health care constitutes preventive care under section 223(c)(2)(C)." This policy was reiterated in IRS Notice 2018-12, which further states that,

> "the determination whether a health care benefit that is required by state law to be provided by an HDHP without regard to a deductible is 'preventive' for purposes of the exception for preventive care under section 223(c)(2)(C) is based on the standards set forth in guidance issued by the Treasury Department and the IRS, rather than on how that care is characterized by state law."

Proposal to Force Health Insurers to act as Lenders

Question #2: "Some stakeholders on the Task Force are interested in a proposal to require insurers, rather than providers, to assume the credit risk for services provided before the deductible is met. How this would work is that the insurer would advance the money to the provider and then collect or attempt to collect the deductible from the member/patient. Several members of the task force, on both sides of this issue, asked you about this arrangement, but, perhaps because of how the questions were phrased, the task force did not come away with a clear understanding whether such an arrangement would be compatible with HSA-qualified plans."

[1] See IRS Notice 2013 - 57

Requiring insurers to also act as lenders – and observe all the relevant regulatory requirements and consumer disclosures inherent in being a lender – seems likely to exacerbate consumer confusion and expense instead of relieving either. The added compliance burden of acting as a lender would inevitably – and perhaps dramatically – increase insurance costs as insurers would have to contend with another layer of regulation in addition to their already comprehensive responsibilities under federal and state law.

Were a state to require health insurers to assume providers' credit risk for the cost of non-preventive medical services provided to consumers before their deductible is met would, in my view, cause a large, unresolvable problem. I believe state mandates of this kind would be viewed as a violation of the HSA statute's requirement that a minimum deductible be applied to all covered benefits (except preventive care). By advancing money to the provider, the insurer could be viewed as providing "coverage" below the minimum deductible, which, were insurers to do so, would risk disqualifying plans of insurance as HSA compatible and by extension, *disqualifying all of the state residents covered by them as eligible to contribute to their HSAs.*

The HSA Council has seen this before, in other states. If it is determined that a previously approved plan of insurance was HSA-qualified, and a subsequent state action invalidates that status, consumers covered by the plan are no longer eligible to contribute to their account; and, consumers may be liable for taxes and penalties on any money contributed in that tax year.

Consumers then usually must find replacement health insurance coverage, which by definition, is more expensive.

As I hope I said many times during my testimony, HSAs offer consumers the chance to pay for medical services tax-free; no other health insurance plan in America offers that benefit.

Question #3: May an insurer extend what is essentially credit to a member for services provided before a deductible is met, in an HSA-compatible plan?

I am unaware of any federal restriction prohibiting an insurer from also being a lender if the insurer so chooses; however, I am also unaware of laws – federal or state - compelling insurers to extend credit to members if they don't want to. It would be highly unusual for a state to compel an insurer to be creditor. Becoming a creditor is universally understood to be a voluntary, not an unwilling, position in a financial transaction.

As I also explained above, I believe mandating credit extensions would be viewed as a violation of the HSA statutory requirement that a minimum deductible be applied to all covered benefits (except preventive care). By advancing the money to the provider, the insurer could be viewed as providing "coverage" below the minimum deductible.

Question #4: Would a member's payment to the insurer, rather than the provider, for services provided before a deductible is met, be a qualifying medical expense that could be paid by an HSA?

While there is no clear guidance from the IRS on this matter, please keep in mind how unusual this requirement would be. For example, when a mechanic fixes your car, your auto insurer doesn't owe the mechanic money, you do. How enthusiastic would auto insurers be to continue doing business in a state that required them to pay mechanics who repaired cars for the drivers they insure without a dramatic increase in premium to offset the expense?

This is the underlying question I addressed in November: is the issue under debate the dynamics of High Deductible Health Plans (HDHPs), which by definition only exist in conjunction with tax-advantaged Health Savings Accounts (HSAs); or, is the issue around the financial dynamics of health plans that have relatively high deductibles, an entirely different matter?

The 2019 Kaiser Family Foundation Employee Benefit Survey (KFF) says that the average deductible for individual plans of all types is currently $1,655. Accordingly, the average health plan deductible today could qualify most health plans as HSA compatible. At the beginning of the program in 2004, a HDHP had a deductible of $1,000 for individual coverage.

In 2020, sixteen years later, as governed by Internal Revenue Code (IRC) Section 223, the minimum deductible for an HSA-qualifying plan is $1,400 for individual coverage and $2,800 for family coverage.

Over the past five years, the average annual deductible amongst all covered workers has increased 36% while HSA qualified HDHP deductibles have risen much slower; the average deductible for single plans has risen 12% while the average for family plans has risen only 6%. No other type of health insurance can make this claim.

In my opinion, the main contributors to the relative stability of HSA-qualified plan deductibles vs. the astonishing rise in deductibles in traditional plans is that the deductibles of traditional plans have increased largely in order to restrain premium increases.

The KFF data substantiates this claim - over a 10 year period, the average deductible of HSA qualified health plans increased only 29% for single plans, and 25% for family plans, while the average plan deductible for traditional health plans has more than doubled – an increase well in excess of 100%. If the Task Force has issues with high deductibles it is to this market segment that I suggest you look.

From:	Larry Deutsch
To:	King, Sean; Koss, Sherri
Cc:	Larry Deutsch
Subject:	For final TF Report: revised commentary
Date:	Tuesday, February 18, 2020 5:43:42 AM

Sean, Sherry -

I have emailed to you a contribution for final Report, perhaps text or Appendix.
May I ask that this shortened and revised text be included instead? Please let me know.

_____-

Commentary:

Our Task Force considerations have primarily considered prices and multiple cost centers for health care and disease prevention, understandably so at this moment. However, must not thorough study take a comprehensive approach with wider and longer-term consequences?

For high deductible plans, have we sufficiently looked at "*collateral damage*" of delayed or avoided health care? Have we noted evidence for *discriminatory impact* in which care is deferred or inaccessible for those with less wealth and income?

For a practicing physician and public official on a City Council, many individual and family stories arise, and academic studies published, describing impacts more difficult to quantify.

High Deductible Plans with Health Savings Accounts are designed to limit "frivolous" or unnecessary care, and indeed sometimes do so.

However, even health professionals cannot reliably and fairly differentiate when attention, screening, and lab tests are truly needed. Medical and epidemiological evidence proves that unimpeded early care is generally beneficial, necessary, and money saving.

For amateurs and professionals, high up-front cost becomes a barrier, even for moderate-income individuals like nurses, doctors, hospital administrators and budgets, and workers on the job:

* sanitation workers with "minor" injuries and infections that worsen.
* fire fighter "cannot afford my prescription"
* physicians with "gas" and chest pain.
* clerical workers in office with "just a cold" respiratory or flu symptoms.
* hospital administrators cutting costs and litigating from ill uninsured and lower-income care seekers.
* municipal or state legislators adopting a corporate trend to reduce the following year's budget — with less knowledge or prediction of the next one?
* has it happened to you or a family member?

For HDHPs, these correlates are indisputable, but indeed difficult to measure. It's well documented that public health outcomes are better in European and even some less developed

countries, while US costs for administration, direct care, and prevention are excessive.

High deductible plans have been correctly labeled a “defective product.” And their discriminatory impacts on lower-income families for health status and credit, and even medical bankruptcies among higher-income families, have now been well documented.

As we evaluate HDHP approach after this Task Force report, and then act in the State Legislature, have we been comprehensive and humane enough?

Larry Deutsch, MD. MPH
former member, Hartford City Council

January 28, 2020

Ted Doolittle,
Chair of the High Deductible Task Force

Mr. Doolittle
I am writing to add some information about potential reforms to the judicial process related to the collection of medical debt in the Small Claims court system. Attention to this matter is in keeping with one of the Task Force areas of inquiry: *"Measures to ensure that each cost-sharing payment due under a high deductible health plan and paid by an enrollee at the time of service accurately reflects the enrollee's cost-sharing obligation for such service under such plan"*. To the extent that a high volume of law suits to recover past-due medical debt affect people with high deductible plans we recommend the following reforms.

1. Require the institution of the proposed 'Small Claims Judgment Checklist' for Magistrates which sets forth a tickler series of questions for Magistrates to review and verify before judgment is rendered. The use of the Checklist helps ensure that expected standards for evidence are being met and that the public can be confident that they are being served with consistency and fairness.
   Those standards should include assurances that the following situations do not occur: (a) knowingly bringing suit beyond the statute of limitations, (b) failing to verify the defendant's address, (c) using an address at which the defendant is known not to reside, (d) failing to report to the judicial authority that a mailing was returned by the U.S. Postal Service as undeliverable, (e) filing improper attorney's fee or interest claims, and (f) failing to file an appropriate military affidavit.
   These are recommendations once considered but not adopted by the Centralized Small Claims Steering Committee as early as 2009. (See Meeting Minutes March 3, 2009)

   More recently the Health Disparities Institute in collaboration with the Office of the Healthcare Advocate initiated discussions with the Administrative Branch of the Judicial Branch to add transparency to the Small Claims process by adding the wording shown below to the ***Answer*** form, which is sent to the defendant/s after the *Writ and Notice of Suit* has been filed and then delivered to the defendant. The defendant returns the completed *Answer* form to the Small Claims Court and sends copies to the plaintiff/s or their representative/s. Defendants will have the option of checking the box next to the statement.

   ☐ This claim is for medical expenses. The defendant/s requests a debt validation notice from the plaintiff/s detailing individual items for which debt is claimed (CT Practice Book 2017 Sec. 24-20A, FDCPA 15 U.S. Code § 1692). Furthermore, the defendant/s requests a continuance of 60 days for the plaintiff/s to provide the requested documents and subsequent review of these documents by the defendant/s. (CT Practice Book 2017 Sec. 24-15).

In addition, it may be useful to develop a form that standardizes the reporting of the itemized costs information (i.e. debt validation notice) being requested by the defendant. The language and the format of such standard report should be readily understandable by the average consumer. The plaintiff would use this form to report the specific medical expenses for which the plaintiff is suing.

2. I also want to bring to your attention to two errors in the draft, the first is an inadvertent error in my slide deck (slide # 28). The sentence "Between 2011 and 2015, providers filed 85,136 small claims actions and obtained judgments totaling over $110 million, most of the time without any appearance from the defending patient". The sentence should more accurately state: "Between 2011 and *2016*, providers filed 85,136 small claims actions *seeking recovery of debt totaling over $110 million*, most of the time without any appearance from the defending patient". I will submit a corrected version of slide #28 for your records.

Thank you for your consideration to these matters

Respectfully submitted

Victor G. Villagra, MD
Associate Director
UConn Health Disparities Institute

Cc/Dherri Koss and member of the HDHP Task Force

Appendix I

Penn LDI
LEONARD DAVIS INSTITUTE of HEALTH ECONOMICS

UNITED STATES of CARE

April 2019

THE BURDEN OF HEALTH CARE COSTS FOR WORKING FAMILIES

A State-Level Analysis

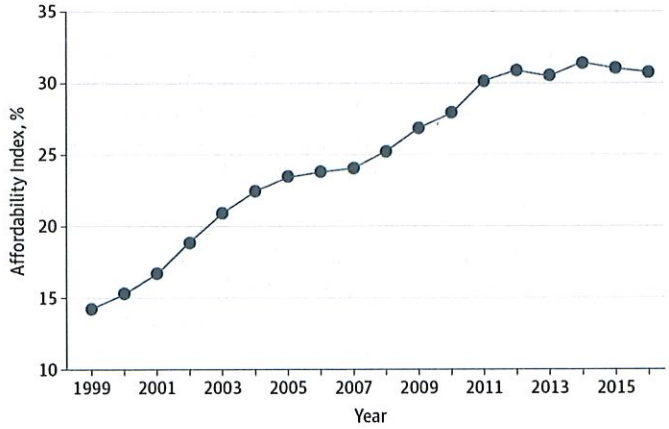
Growing concern about the affordability of health care and the cost burden imposed on working families frequently appears in public debate about the next phase of health care reform. In an earlier brief, Penn LDI and United States of Care reviewed national data on rising health care costs and different ways to measure whether health care and coverage are "affordable." Here we adapt one of these measures to provide state-level data on the cost burden faced by working families who have employer-sponsored insurance (ESI). While not all working families have ESI, it is the most common form of health insurance in the United States. We examine how this burden varies across states, and how it has changed within states from 2010 to 2016.

BACKGROUND

Our previous brief[1] discussed affordability as an economic concept, as a kitchen-table budget issue for individuals and families, and as a threshold in national policy. We reviewed different measures of affordability, all of which have their limitations. National measures can obscure important differences across states and markets, where incomes and health care costs vary substantially. As states become the testing ground for initiatives to expand access to care and contain costs, state policymakers need indicators that reflect how their constituencies experience the burden of health care costs and whether the burden is increasing or decreasing over time.

In 2016, researchers published a simple employer group market affordability index[2] by capturing the share of household income taken up by employer-sponsored insurance (ESI). Specifically, this index is a ratio of the average family premium for ESI (both employer and employee contributions) to the median household income. By this measure, health care premiums accounted for 30.7% of median household income on a national level in 2016, a share that has doubled since 1999.

Figure 1. National "Affordability Index" – Family Health Insurance Premiums as a Percentage of Median Income, 1999 to 2016



Ezekiel Emanuel et al., Measuring the Burden of Health Care Costs on US Families, (JAMA, November 2017)

Here we adapt this index to produce state-level estimates of the cost burden to working families over time, using publicly available data. A recent Commonwealth Fund issue brief used similar methods to analyze state-level trends in ESI among middle income families (roughly $62,000 per year) between 2008 and 2017. The analysis found that the average employee share of premiums for single and family plans rose from 5.1% to 6.9% of median income from 2008 to 2017. The analysis also found that spending on premiums and potential spending on deductibles grew to 11.7% of median income in 2017, compared to only 7.8% in 2008.

Our analysis builds on this work by considering the total premium for family coverage, which includes both employee and employer contributions, rather than only the component employees pay directly, as discussed in more depth below. Furthermore, we adjust state incomes based on local cost-of-living to facilitate interstate comparisons. We assess trends from 2010-2016 in each state, including the scale, variation, and changes in the burden of health care costs experienced by working families.

WHAT WE DID

We adapted the national "Affordability Index" and previous work by the Commonwealth Fund to describe the state-level burden of health care costs for working families since the passage of the Affordable Care Act (ACA). We describe trends from 2010-2016 to capture how health care cost burdens changed after the 2009-2009 financial crisis and during ACA implementation. We obtained data on ESI premiums from the Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance/Employer Component (MEPS-IC), which provides detailed plan information, including average total premiums and deductibles, for employer-based plans in each state and selected metropolitan statistical areas. We obtained data on median household income for each state from the U.S. Census Bureau's Current Population Survey (CPS).

To account for cost-of-living differences across states, we adjusted state median incomes using the Bureau of Economic Analysis (BEA) Regional Price Parities (RPP), which expresses the price of goods and services in each state as a percentage of the national level. For example, in 2016, Hawaii had the highest RPP at 118.4% and Mississippi had the lowest at 86.4%.

For each state in each year, we estimated the health care cost burden by dividing its RPP-adjusted median income by the average ESI family premium in that state. The resulting percentage represents health insurance premiums as a share of median income in each state. We describe changes in each state's cost burden between 2010 and 2016.

To more fully understand the factors that contribute to these changes, we describe rates of change in both adjusted income and ESI premiums by state. Finally, we consider changes in the employee's share of premiums paid and in deductible amounts for each state, which are more immediately salient costs faced by working families.

WHAT WE FOUND

State-level health care cost burden, 2016

In 2016, the national health care cost burden was 30%, representing average premiums of $17,710 and median income of $59,039. The burden varies across states. In 2016, the income-adjusted cost burden was highest in Louisiana at 37.1% and lowest in Minnesota at 24.4%. While half of states clustered between 27.3% and 30.5%, the ten costliest states had a burden ranging from 32.2% to 37.1%, and the ten least costly states had a burden ranging from 24.4% to 26.7% (Appendix Figure 1). Each state's cost burden is listed in Appendix Figure 2.

Trends in state-level health care cost burden, 2010-2016

Between 2010 and 2016, the average health care cost burden increased from 28% to 30% nationally, with premiums growing faster than incomes (27.7% vs 19.8%). The burden increased in all but four states, including the District of Columbia. In most states, premiums grew faster than incomes. As shown in Figures 2 and 3, the number of states with a cost burden below 25% decreased from 15 to three; the number of states with a cost burden above 30% increased from five to 13.

Figure 2. Health Care Cost Burden, 2010 (Family Premiums as Share of Median Household Income)

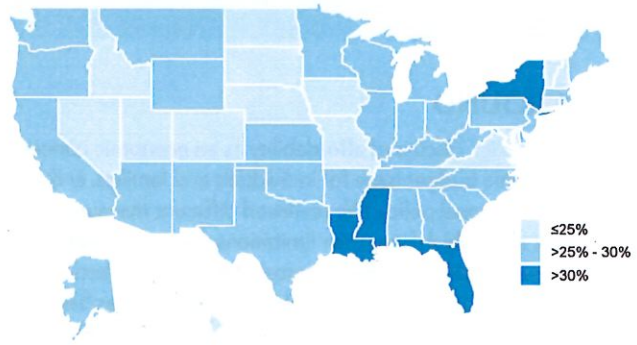
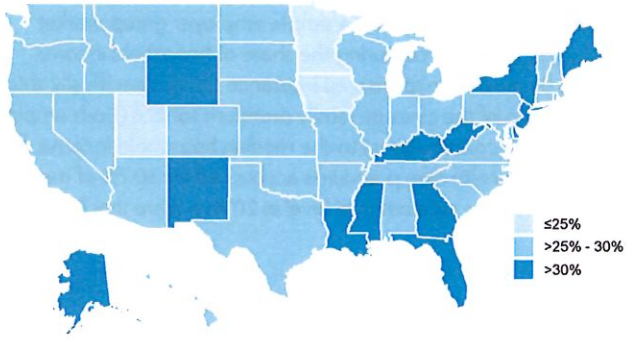


Figure 3. Health Care Cost Burden, 2016 (Family Premiums as Share of Median Household Income)



In Appendix Figure 3, we illustrate the relative changes for each state. Only four states saw their cost burden decrease; 12 states experienced an increase of greater than 15%. Minnesota's relative decrease of -5.6% reflects an absolute cost burden decrease from 25.8% to 24.4%. In contrast, Wyoming's relative increase of 28.5% reflects an absolute increase of the state's cost burden from 25.5% to 32.8% (Appendix Figure 4).

Components of a changing cost burden: income and premiums

To understand how cost burdens have shifted over time, we consider each of the subcomponents of the index. By the definition of our measure, a rising cost burden can be a symptom of stagnating income, rising premiums, or a combination of the two trends. Families can withstand rapidly rising health insurance premiums so long as incomes keep up. But if premiums rise significantly faster than incomes, then health care costs can swamp new income growth.

Insurance premiums continue to rise

Between 2010 and 2016, national average family premiums for employer-sponsored insurance rose by 27.7%, from $13,871 to $17,710 (Figure 4). Premiums rose in all states, ranging from a 14.7% increase in Mississippi to a 58% increase in Alaska. The five states with the smallest increase saw premiums rise by less than 21%, and the five states with the largest premium increases experienced a rise of greater than 39%. As shown in Appendix Figure 4, Alaska, Idaho, Montana, and Wyoming all saw premiums rise by more than 40% over six years, while Florida and Mississippi saw relatively modest premium increases of less than 20%. In 2016, the average premium across the five most inexpensive states was under $16,000, but nearly $20,000 in the most expensive states (Figure 4).

Yearly household income

Between 2010 and 2016, the national median household income rose by 19.8%, from $49,276 to $59,039 (Figure 5). Adjusted incomes rose in all states, ranging from less than a 5% increase in Maine and West Virginia to an increase of 38% in Montana. As shown in Appendix Figure 4, households in Delaware, Louisiana, Maine, Mississippi, New Jersey, New Mexico, Vermont, West Virginia, and Wyoming saw their median incomes rise by less than 10%, while incomes in Alaska, Minnesota, Montana, South Carolina, and Tennessee rose by more than 30%. In 2016, household incomes ranged from an average of about $47,000 in Louisiana and Mississippi to about $72,000 in Minnesota and New Hampshire. In both 2010 and 2016, the spread of adjusted incomes was far wider than the distribution of health insurance premiums in absolute and relative terms. The gap between the highest and lowest income states was over $20,000 in 2016.

Deductibles

The cost burden is an indicator of the "bite" taken out of household income by ESI premiums, but it does not include an important consideration: the plan deductible, which is the amount employees and families are expected to pay for health care before insurance

Figure 4. Average Premiums for Family Coverage, 2010 and 2016

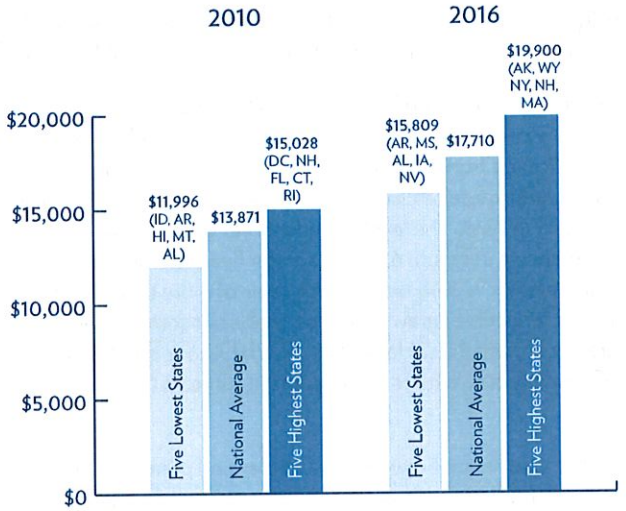


Figure 5. Median Adjusted Household Income, 2010 and 2016

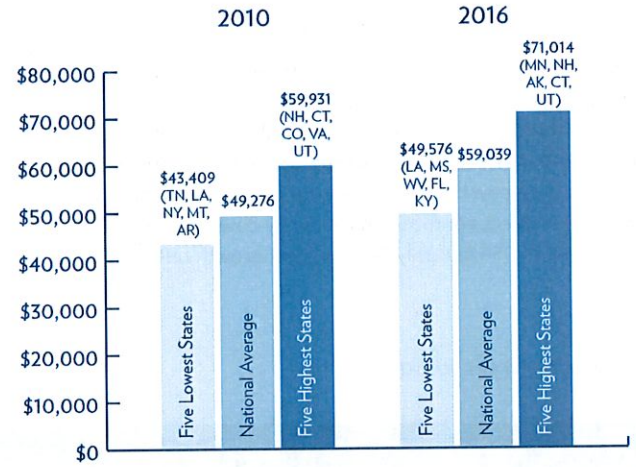
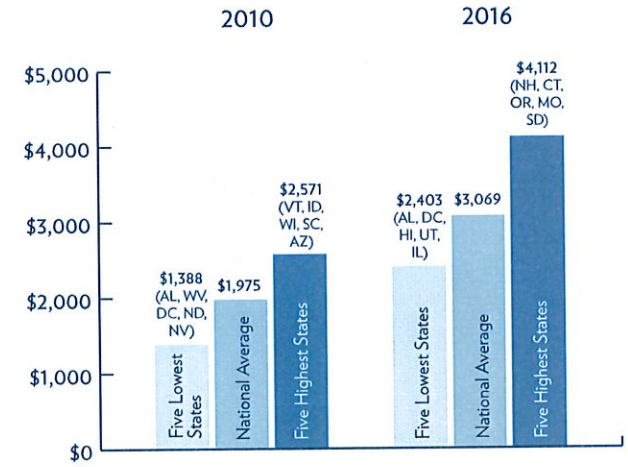


Figure 6. Average Annual Deductibles for Family Coverage, 2010 and 2016



kicks in. Unlike the premium cost, the deductible amount is only experienced by those seeking care. At a plan level, a higher deductible will usually mean lower premiums. Thus we explore whether some of the trends in state-level premiums reflect changing deductible levels.

Nationally, the presence and level of deductibles are rising. From 2010-2016, the percent of employees enrolled in health plans with a deductible climbed from 77.5% to 84.5%. The average amount of the annual deductible these families face increased as well, from $1,975 in 2010 to $3,069 in 2016. The level of deductibles varies considerably by state. As shown in Figure 6, families in the five states with the highest deductibles in 2016 faced deductibles of more than $4,000 on average. Deductibles grew 55.4% nationally, but some states saw much greater growth. New Hampshire, North Dakota, and West Virginia saw deductibles more than double in six years (Appendix Figure 4).

We find little association between deductibles and premiums at the state level. Further, we found no association between the rate of premium growth from 2010-2016 and changing deductibles. Additional work is needed to understand why higher deductibles do not appear to be holding down premiums at the state level.

Employee contributions to premiums

Most economists agree that the entire burden of ESI premiums falls on the employee, either directly through payroll deductions, or indirectly through lower cash wages. While our measure of cost burden takes this into account, for employees, the amount visibly taken out of their paycheck for premiums is particularly salient. Nationally, this direct contribution for family coverage rose 33.2%, from $3,721 to $4,956 annually. Most of that growth reflects changes in premiums themselves, rather than shifts in the percentage that employees pay directly. Overall, employees' shares grew modestly, from 26.8% in 2010 to 28% in 2016.

However, the employee share of premiums varies across states. In 2016, employees directly paid an average of 21.9% in the five states with the lowest share and 34.4% in the five states with the highest share. Generally speaking, states with higher overall premiums have a lower employee share, suggesting that families in high cost burden states experience more of the burden indirectly – through stagnating wages – rather than directly – through higher employee contributions to premiums.

State highlights

While most states share similar stories of premiums rising faster than incomes, causing a rise in health care cost burden, some outliers are worth highlighting (Table 1).

Minnesota and Tennessee are outliers in that their burdens decreased from 2010 to 2016. This was not a result of slowing health care cost growth. Premiums rose by 26.2% and 31.4% in Minnesota and Tennessee, respectively. However, both states experienced above-average growth in incomes, which outpaced premium growth, leading to a relative decrease in their health care cost burden.

In contrast, Idaho and Nevada demonstrate two paths to an increased cost burden. Incomes in Idaho rose a percentage point above the national average. However, the 53.8% rise in premiums was well above national trends and completely swamped new income. In Nevada, premiums rose 29.1% (just above the national average), but incomes remained relatively flat—only rising by 11%. Furthermore,

Table 1. State Highlights, 2010-2016

State	Premium 2016	Premium Change from 2010	Deductible 2016	Deductible Change from 2010	Income 2016	Income Change from 2010	Cost Burden 2016	Cost Burden Change from 2010
US Average	$17,710	27.7%	$3,069	55.4%	$59,039	19.8%	30.0%	7.0%
New Hampshire	$19,066	25.4%	$4,992	116.9%	$72,011	15.1%	26.5%	9.0%
Minnesota	$17,545	26.2%	$3,295	51.0%	$72,018	33.7%	24.4%	-5.6%
Tennessee	$16,721	31.4%	$3,662	79.7%	$56,922	33.0%	29.4%	-1.3%
Idaho	$17,499	53.8%	$3,410	24.0%	$60,822	20.9%	28.8%	27.2%
Nevada	$16,133	29.1%	$2,712	81.0%	$56,911	11.0%	28.3%	16.3%

while deductibles in Minnesota and Tennessee rose above the national average, deductibles in Idaho rose much more slowly than the country as a whole. New Hampshire saw the largest overall increase in deductibles, but a below average rise in premiums and income. Thus, its increased health care cost burden appears average, despite a spike in out-of-pocket costs.

KEY TAKEAWAYS

Significant variation across states. The national health care cost burden as measured by the index is high (30%). While the health care cost burden is substantial even in the "lowest burden" state of Minnesota at 24.4%, it is markedly higher in other states and is approaching 40% of median income in some cases. Although the health care cost burden increased significantly between 2010 and 2016, in 17 states, it actually decreased, or increased by 5% or less. It is likely that many state-level factors contribute to variation across states and across time, including different facets of the labor and insurance markets, such as provider concentration and network sizes. These state-by-state findings can help policymakers understand the impact of health care costs on their constituents and identify the pain points for working families.

No state escapes a high cost burden. These findings demonstrate a high cost burden imposed by rising health insurance premiums in the ESI market. Even in the least-burdened state, premiums account for nearly a quarter of a family's wages. This measure does not account for out-of-pocket expenses, such as deductibles, which have risen by 55% in six years. Families, especially those with high-cost health conditions, will incur these costs when they seek care.

Implications for families. Our estimates suggest that health care premium costs are more urgently felt in some states than others, especially at the tails of the distribution. It is important to note, however, that a state's cost burden index does not necessarily reflect how all families experience health care costs. Many families in states with a below-average cost burden may still struggle to pay health care expenses. This is especially true of families with underlying health conditions who may incur high out-of-pocket expenses or face high deductibles. In other families, employees may not see the impact of rising health care premiums directly as increased contributions, but instead may experience less noticeable changes in income, such as depressed or flat wages.

Ultimately, increases in burden are really a measure of families falling further behind, with a higher percentage of their income devoted to premiums and not available for other needs. While large increases in median wages would, by this measure, lessen the health care cost burden on families, lasting solutions will come from addressing the cost drivers that result in higher ESI premiums.

LIMITATIONS OF THIS INDEX – WHAT IT CAN'T TELL US

This measure is helpful for understanding how the burden of health care costs is growing for the average family with ESI, but its simplicity is accompanied by important limitations. By not including federal subsidies,[3] such as the tax exclusion of ESI premium payments, the cost burden appears inflated. However, this would not change the general direction and trend of the cost burden across states. It also does not reflect the cost burdens faced by uninsured families or those with public or individual coverage.

Another limitation is a technical one, in that the employer contribution to health insurance appears in both the numerator and denominator of the measure: it is included in the total average premium, and most economists would argue it is also reflected in median income (as foregone wages). Using average annual total compensation (e.g., cash wages and all benefits) as a denominator would lessen this concern, but such data are not readily available. Furthermore, while prevailing theory[4] suggests the employer contributions are ultimately paid by workers via foregone wages or other benefits, it is not clear exactly how much of employer premium payments would actually convert to wages.

LOOKING AHEAD

In this brief, we have explored one approach to measuring how the price of health insurance is experienced by working families, and how this varies across states. It is a glimpse into the trends within each state and provides some insight into cost concerns that might be particularly salient for families, such as higher deductibles or growing paycheck deductions. A fuller picture of the cost burden within each state would factor in health plan quality, out-of-pocket expenses, taxes paid for public health insurance programs, and how rising health insurance costs affect people differently along the income distribution. Further research is needed to understand the relationship between income stagnation and rising health care costs in different labor markets. Additionally, the composition of the employer-based insurance market might be changing as states expand Medicaid and families opt for ACA marketplace plans. Policymakers should consider the interplay between income growth, health care costs, and insurance market structures when looking to address working families' health care cost burden.

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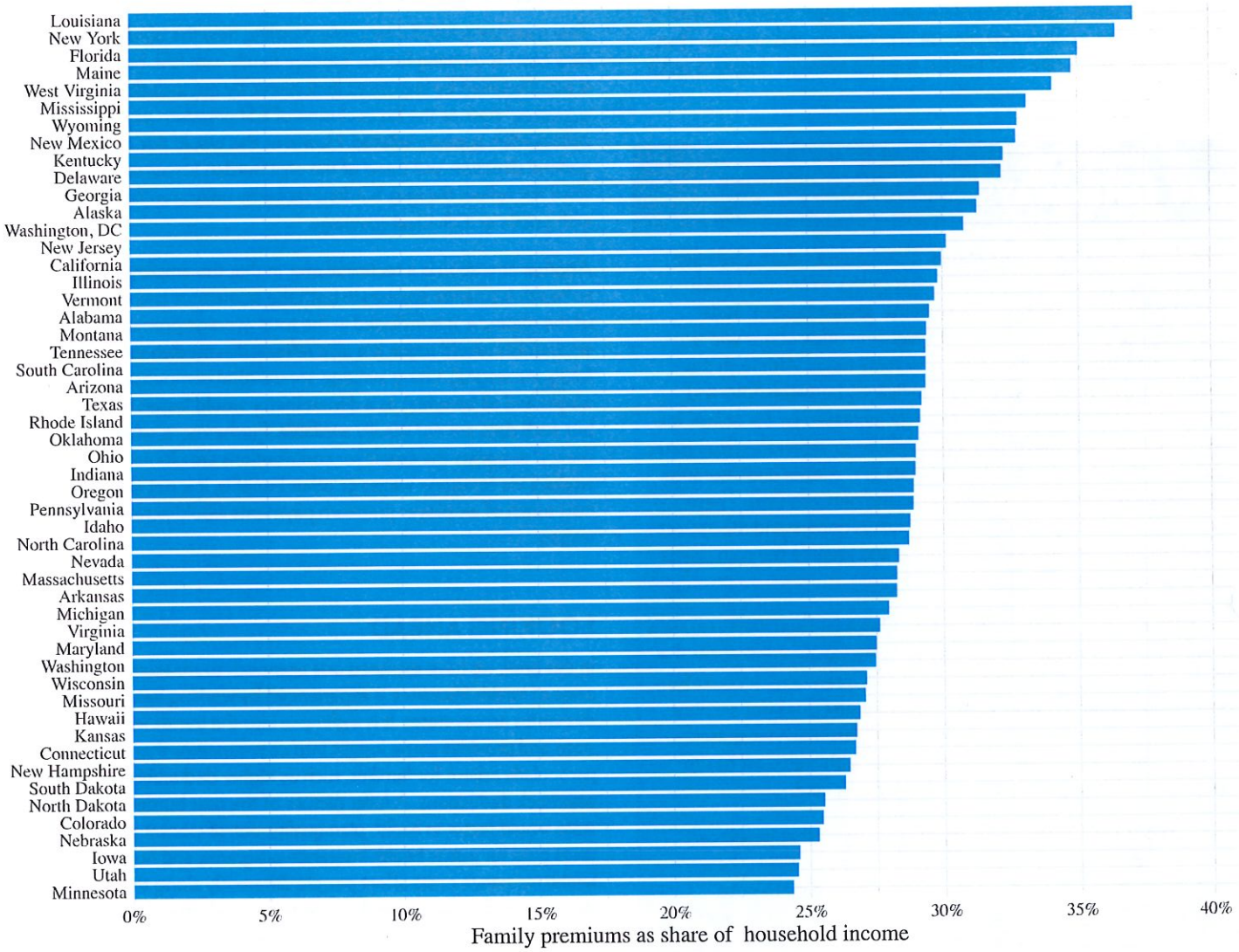
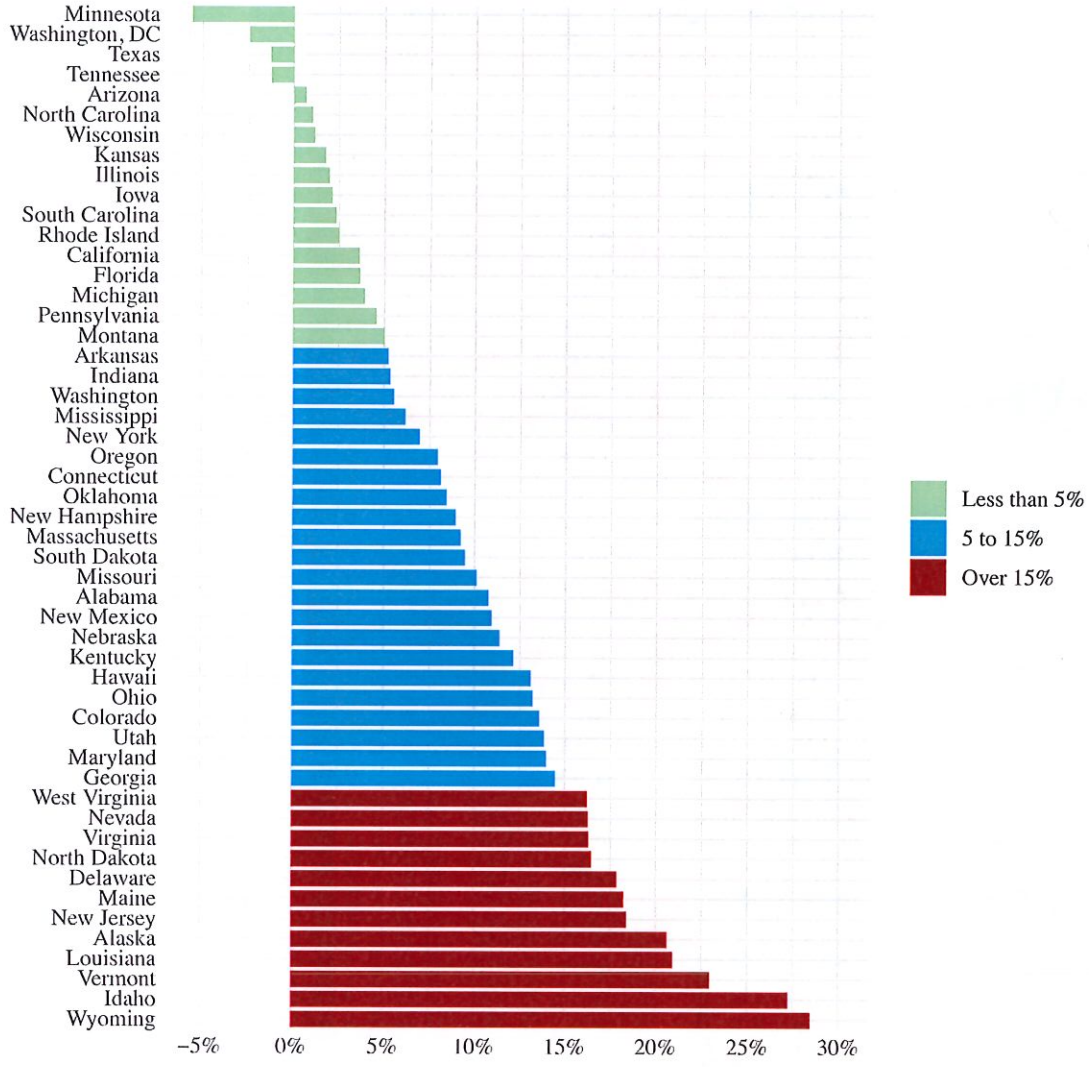
Appendix Figure 1: Health Care Cost Burden, 2016



Appendix Figure 2: State Cost Burden, 2010 and 2016

State	Cost Burden in 2010	Cost Burden in 2016	Relative Change	Absolute Change
Alabama	26.6%	29.5%	10.79%	2.9%
Alaska	26.0%	31.3%	20.61%	5.3%
Arizona	29.2%	29.4%	0.69%	0.2%
Arkansas	26.9%	28.3%	5.23%	1.4%
California	28.9%	30.0%	3.64%	1.1%
Colorado	22.4%	25.5%	13.59%	3.0%
Connecticut	24.7%	26.7%	8.12%	2.0%
Delaware	27.3%	32.2%	17.85%	4.9%
Washington, DC	31.6%	30.8%	-2.44%	-0.8%
Florida	33.8%	35.0%	3.67%	1.2%
Georgia	27.4%	31.4%	14.46%	4.0%
Hawaii	23.7%	26.9%	13.11%	3.1%
Idaho	22.6%	28.8%	27.23%	6.2%
Illinois	29.2%	29.8%	1.97%	0.6%
Indiana	27.5%	29.0%	5.33%	1.5%
Iowa	24.1%	24.6%	2.14%	0.5%
Kansas	26.3%	26.7%	1.76%	0.5%
Kentucky	28.8%	32.3%	12.15%	3.5%
Louisiana	30.7%	37.1%	20.93%	6.4%
Maine	29.4%	34.8%	18.23%	5.4%
Maryland	24.1%	27.5%	13.97%	3.4%
Massachusetts	25.9%	28.3%	9.22%	2.4%
Michigan	26.9%	28.0%	3.94%	1.1%
Minnesota	25.8%	24.4%	-5.58%	-1.4%
Mississippi	31.2%	33.1%	6.16%	1.9%
Missouri	24.6%	27.1%	10.12%	2.5%
Montana	28.0%	29.4%	4.99%	1.4%
Nebraska	22.7%	25.3%	11.39%	2.6%
Nevada	24.4%	28.3%	16.27%	4.0%
New Hampshire	24.3%	26.5%	8.95%	2.2%
New Jersey	25.5%	30.2%	18.40%	4.7%
New Mexico	29.5%	32.8%	10.96%	3.2%
New York	34.1%	36.5%	6.95%	2.4%
North Carolina	28.4%	28.7%	1.05%	0.3%
North Dakota	21.9%	25.5%	16.46%	3.6%
Ohio	25.6%	29.0%	13.21%	3.4%
Oklahoma	26.8%	29.1%	8.45%	2.3%
Oregon	26.8%	28.9%	7.95%	2.1%
Pennsylvania	27.6%	28.9%	4.56%	1.3%
Rhode Island	28.4%	29.2%	2.53%	0.7%
South Carolina	28.7%	29.4%	2.37%	0.7%
South Dakota	24.0%	26.3%	9.47%	2.3%
Tennessee	29.8%	29.4%	-1.27%	-0.4%
Texas	29.6%	29.2%	-1.30%	-0.4%
Utah	21.6%	24.5%	13.84%	3.0%
Vermont	24.2%	29.7%	22.93%	5.5%
Virginia	23.8%	27.6%	16.31%	3.9%
Washington	26.0%	27.5%	5.54%	1.4%
West Virginia	29.3%	34.1%	16.22%	4.8%
Wisconsin	26.8%	27.1%	1.16%	0.3%
Wyoming	25.5%	32.8%	28.47%	7.3%

Appendix Figure 3: Relative Change of Income-Adjusted Cost Burden in Each State, 2010-2016



Appendix Figure 4: Average Premiums, Deductibles, Incomes, and Cost Burden by State, 2010-2016

State	Premium 2010	Deductibles 2010	Income 2010	Cost Burden 2010	Premium 2016	Deductibles 2016	Income 2016	Cost Burden 2016	Premium Change	Deductible Change	Income Change	Relative Cost Burden Change
Alabama	$12,409	$1,274	$46,568	26.6%	$16,098	$2,193	$54,528	29.5%	29.7%	72.1%	17.1%	10.8%
Alaska	$14,232	$2,036	$54,832	26.0%	$22,490	$2,845	$71,843	31.3%	58.0%	39.7%	31.0%	20.6%
Arizona	$13,871	$2,371	$47,562	29.2%	$17,484	$3,652	$59,541	29.4%	26.0%	54.0%	25.2%	0.7%
Arkansas	$11,816	$1,827	$43,999	26.9%	$14,929	$2,632	$52,827	28.3%	26.3%	44.1%	20.1%	5.2%
California	$13,819	$1,942	$47,784	28.9%	$17,458	$2,790	$58,249	30.0%	26.3%	43.7%	21.9%	3.6%
Colorado	$13,393	$2,262	$59,696	22.4%	$17,459	$3,481	$68,511	25.5%	30.4%	53.9%	14.8%	13.6%
Connecticut	$14,888	$2,308	$60,327	24.7%	$18,637	$4,041	$69,846	26.7%	25.2%	75.1%	15.8%	8.1%
Delaware	$14,671	$1,997	$53,710	27.3%	$18,648	$3,112	$57,930	32.2%	27.1%	55.8%	7.9%	17.8%
Florida	$15,032	$1,862	$44,466	33.8%	$17,989	$3,118	$51,330	35.0%	19.7%	67.5%	15.4%	3.7%
Georgia	$13,114	$1,890	$47,797	27.4%	$18,252	$2,950	$58,118	31.4%	39.2%	56.1%	21.6%	14.5%
Hawaii	$12,062	$1,709	$50,801	23.7%	$16,362	$2,358	$60,923	26.9%	35.6%	38.0%	19.9%	13.1%
Idaho	$11,379	$2,750	$50,321	22.6%	$17,499	$3,410	$60,822	28.8%	53.8%	24.0%	20.9%	27.2%
Illinois	$14,703	$1,943	$50,276	29.2%	$18,510	$2,628	$62,069	29.8%	25.9%	35.3%	23.5%	2.0%
Indiana	$13,884	$1,860	$50,480	27.5%	$17,996	$3,391	$62,120	29.0%	29.6%	82.3%	23.1%	5.3%
Iowa	$13,240	$1,859	$54,951	24.1%	$16,123	$2,921	$65,514	24.6%	21.8%	57.1%	19.2%	2.1%
Kansas	$13,460	$1,750	$51,228	26.3%	$16,784	$3,056	$62,773	26.7%	24.7%	74.6%	22.5%	1.8%
Kentucky	$13,352	$1,980	$46,393	28.8%	$16,678	$3,520	$51,673	32.3%	24.9%	77.8%	11.4%	12.1%
Louisiana	$13,230	$2,083	$43,092	30.7%	$17,330	$2,738	$46,677	37.1%	31.0%	31.4%	8.3%	20.9%
Maine	$14,576	$2,281	$49,515	29.4%	$17,987	$3,714	$51,683	34.8%	23.4%	62.8%	4.4%	18.2%
Maryland	$13,952	$1,677	$57,839	24.1%	$18,519	$3,100	$67,361	27.5%	32.7%	84.9%	16.5%	14.0%
Massachusetts	$14,606	$1,639	$56,420	25.9%	$18,955	$2,746	$67,037	28.3%	29.8%	67.5%	18.8%	9.2%
Michigan	$13,148	$1,763	$48,866	26.9%	$17,113	$2,834	$61,191	28.0%	30.2%	60.7%	25.2%	3.9%
Minnesota	$13,903	$2,182	$53,884	25.8%	$17,545	$3,295	$72,018	24.4%	26.2%	51.0%	33.7%	-5.6%
Mississippi	$13,740	$2,011	$44,014	31.2%	$15,765	$3,111	$47,568	33.1%	14.7%	54.7%	8.1%	6.2%
Missouri	$12,754	$2,146	$51,888	24.6%	$16,638	$3,773	$61,470	27.1%	30.5%	75.8%	18.5%	10.1%
Montana	$12,312	$2,295	$43,962	28.0%	$17,835	$3,590	$60,654	29.4%	44.9%	56.4%	38.0%	5.0%
Nebraska	$13,221	$1,938	$58,144	22.7%	$16,617	$3,424	$65,607	25.3%	25.7%	76.7%	12.8%	11.4%
Nevada	$12,496	$1,498	$51,251	24.4%	$16,133	$2,712	$56,911	28.3%	29.1%	81.0%	11.0%	16.3%
New Hampshire	$15,204	$2,302	$62,566	24.3%	$19,066	$4,992	$72,011	26.5%	25.4%	116.9%	15.1%	9.0%
New Jersey	$14,058	$2,128	$55,187	25.5%	$18,242	$2,689	$60,484	30.2%	29.8%	26.4%	9.6%	18.4%
New Mexico	$14,083	$1,867	$47,710	29.5%	$16,954	$2,724	$51,764	32.8%	20.4%	45.9%	8.5%	11.0%
New York	$14,730	$1,728	$43,213	34.1%	$19,375	$3,099	$53,146	36.5%	31.5%	79.3%	23.0%	6.9%
North Carolina	$13,643	$1,932	$48,007	28.4%	$16,986	$3,215	$59,146	28.7%	24.5%	66.4%	23.2%	1.1%
North Dakota	$12,544	$1,435	$57,182	21.9%	$16,804	$2,877	$65,775	25.5%	34.0%	100.5%	15.0%	16.5%
Ohio	$13,083	$2,121	$51,098	25.6%	$17,523	$3,119	$60,454	29.0%	33.9%	47.1%	18.3%	13.2%
Oklahoma	$12,900	$1,977	$48,106	26.8%	$16,646	$3,051	$57,239	29.1%	29.0%	54.3%	19.0%	8.4%
Oregon	$13,756	$2,250	$51,373	26.8%	$17,127	$3,988	$59,254	28.9%	24.5%	77.2%	15.3%	7.9%
Pennsylvania	$13,550	$1,647	$49,050	27.6%	$17,900	$3,030	$61,971	28.9%	32.1%	84.0%	26.3%	4.6%

Appendix Figure 4 cont'd: Average Premiums, Deductibles, Incomes, and Cost Burden by State, 2010-2016

State	Premium 2010	Deductibles 2010	Income 2010	Cost Burden 2010	Premium 2016	Deductibles 2016	Income 2016	Cost Burden 2016	Premium Change	Deductible Change	Income Change	Relative Cost Burden Change
Rhode Island	$14,812	$1,999	$52,092	28.4%	$18,010	$2,912	$61,775	29.2%	21.6%	45.7%	18.6%	2.5%
South Carolina	$13,234	$2,396	$46,126	28.7%	$17,673	$3,133	$60,173	29.4%	33.5%	30.8%	30.5%	2.4%
South Dakota	$12,542	$2,034	$52,189	24.0%	$17,117	$3,767	$65,062	26.3%	36.5%	85.2%	24.7%	9.5%
Tennessee	$12,729	$2,038	$42,784	29.8%	$16,721	$3,662	$56,922	29.4%	31.4%	79.7%	33.0%	-1.3%
Texas	$14,526	$2,283	$49,082	29.6%	$17,529	$3,185	$60,006	29.2%	20.7%	39.5%	22.3%	-1.3%
Utah	$12,618	$1,846	$58,515	21.6%	$17,025	$2,606	$69,354	24.5%	34.9%	41.2%	18.5%	13.8%
Vermont	$13,588	$2,765	$56,209	24.2%	$17,795	$3,145	$59,879	29.7%	31.0%	13.7%	6.5%	22.9%
Virginia	$13,907	$1,866	$58,552	23.8%	$17,945	$2,683	$64,957	27.6%	29.0%	43.8%	10.9%	16.3%
Washington	$14,188	$1,888	$54,527	26.0%	$18,301	$2,747	$66,645	27.5%	29.0%	45.5%	22.2%	5.5%
Washington, DC	$15,206	$1,371	$48,162	31.6%	$18,864	$2,234	$61,244	30.8%	24.1%	62.9%	27.2%	-2.4%
West Virginia	$14,194	$1,365	$48,390	29.3%	$17,260	$3,156	$50,632	34.1%	21.6%	131.2%	4.6%	16.2%
Wisconsin	$14,542	$2,572	$54,258	26.8%	$17,477	$3,534	$64,458	27.1%	20.2%	37.4%	18.8%	1.2%
Wyoming	$13,899	$2,171	$54,433	25.5%	$19,617	$3,024	$59,802	32.8%	41.1%	39.3%	9.9%	28.5%

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