Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Ted Doolittle
Office of the Healthcare Advocate
Before the Insurance and Real Estate Committee
Re SB 902
February 28, 2019

Good morning, Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato, and members of the Insurance and Real Estate Committee. For the record, I am Ted Doolittle, Healthcare Advocate for the State of Connecticut. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a consumer-focused mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; assisting consumers in disputes with their health insurance carriers; and informing legislators and regulators regarding problems that consumers are facing in accessing care, and proposing solutions to those problems.

I appreciate the opportunity to comment in support of SB 902, An Act Concerning High Deductible Health Plans. These plans are not consumer-friendly and as discussed below are fundamentally unfair in many ways to consumers. To the extent such plans are permitted at all, they should be reformed to be fairer and more rational.

The stated rationale for high deductible health plans ("HDHP's") is that they will lower healthcare costs by turning healthcare consumers into effective comparison shoppers. The reasoning goes that healthcare consumers without enough "skin in the game" will seek out wasteful, unnecessary, or overpriced care. Whereas if we simply provide consumers with the appropriate amount of skin in the game, they will turn into smart, disciplined shoppers who will be able to bend the curve on costs in a way that apparently insurance carriers are

unable to do when they, rather than consumers, are on the hook for the first several thousand dollars of healthcare.

The HDHP strategy has been in place now for well over a decade, and has been accelerating particularly fast over the past several years. That's enough time for HDHPs to have been carefully studied by healthcare economists, and the verdict is emphatically in: HDHPs don't work to reduce healthcare spending; moreover, consumers all too often don't understand the plans, and when they have a choice, consumers shun HDHP's.

Perhaps in other economic arenas, it makes sense to assume that consumers will act more rationally and efficiently when they have more "skin in the game." But academic studies consistently show that in the healthcare arena, consumers are particularly unsuited and unable to make rational decisions. Specifically, consumers spending their own money on healthcare turn out to be completely unable to distinguish which care they should purchase, and which they should bypass. In fact, we skip both needed and unneeded care in equal measure. [1] Another obvious problem with relying on healthcare consumers to do the hard work of comparison shopping is that consumers weighing costly healthcare expenditures by definition are under great physical and emotional stress due to personal or family illness, and thus not the right group of people to drive hard, rational bargains in the marketplace.

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[1] National Bureau of Economic Research, *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, https://www.nber.org/papers/w21632 (2015) ("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 ...."); *see also* The New York Times, *Shopping for Health Care Doesn't Work. So What Might?* https://www.nytimes.com/2018/07/30/upshot/shopping-for-health-care-simply-doesnt-work-so-what-might.html (July 30, 2018) ("people do in fact cut back on care when they have to spend more for it. The problem is that they don't cut only wasteful care. They also forgo the necessary kind."); The New York Times, *The Big Problem With High Health Care Deductibles*, https://www.nytimes.com/2016/02/07/upshot/the-big-problem-with-high-health-care-deductibles.html (Feb. 5, 2016) ("There was no evidence that workers were comparing prices or making wise choices on where to cut, even after two years in the new plan. They visited the same doctors and hospitals they always had. They reduced low-value medical services and medically important ones at about the same rate ...."); Kaiser Health News, *Even With 'Skin In The Game,' Health Care Shoppers Are Not More Savvy*, https://khn.org/news/even-with-skin-in-the-game-health-care-shoppers-are-not-more-savvy/ (Jan. 19, 2016); ConsumersUnion Health Care Value Hub, *High-Deductible Health Plans – A Strategy Not Appropriate for Many Consumers* (Research Brief No. 3, March, 2015).

So the evidence clearly shows that HDHP's do not deliver on their supposed promise to lower costs. But even if they did, the plans are not staying true to their underlying logic of simply providing an appropriate amount of skin in the game. There are a number of aspects of how HDHP's are structured that give the lie to the "skin in the game" rationalization, and reveal that instead these plans are a naked attempt to shift costs onto consumers and away from carriers. Some of these features are particularly irrational and maddening. For instance:

- A family whose breadwinner switches jobs mid-year, moving from one high-deductible plan to another, gets absolutely no credit for any amounts they paid towards the first plan's deductible. A job-switching consumer who paid off one high deductible earlier in the year by definition has already put his or her "skin in the game." The proposed bill would require carriers to recognize and take into account amounts paid by consumers towards deductibles before they switched jobs.
- Likewise, it makes no sense for a consumer who joins a health plan late in the year to have to pay off the exact same deductible amount as a family who has been with the plan for the whole year. A consumer who joins halfway through the plan year should only be responsible for one-half of the annual deductible. Under the current system, when an employee joins a plan with just a few months remaining in the plan year, he or she starts paying full premiums immediately, but because the carrier is protected by the full annual deductible amount, it is unlikely that the carrier will ever have to pay any claims whatsoever for that family – rendering that family effectively uninsured (or at the minimum, dramatically underinsured) for the rest of that year.
- If a patient does comparison shop effectively, and finds a great price on a drug or other treatment, under the current system, but the drug or care is out-of-network, the carrier gives the consumer no credit whatsoever against the deductible for those purchases. A consumer who needs an expensive drug and finds it much cheaper at Pharmacy X should not be penalized just because Pharmacy X happens to be out-of-network for his plan; the consumer should be allowed to get credit against his deductible for finding quality services in or out-of-network. The plans in effect are telling the consumer in one breath to comparison shop, and then when he or she

does so successfully, they are punished by not being permitted to count these purchases against their deductible.

- Deductibles should not go up with family size. If having "skin in the game" is truly the rationale for HDHPs, and a given deductible of say $5,000 is believed to be enough to change the behavior of an individual living alone, then why is that same amount not sufficient to change the behavior of the workmate who is the sole breadwinner for a family, bringing in the same exact salary but with more expenses? Again, this does not make sense from the "skin in the game" perspective, but it does make perfect sense if the real intent is simply to shift healthcare costs away from the carriers and onto the patients.
- Any carrier who does wish to use HDHP's bears a large responsibility to provide accurate price information to the consumers that it is asking to be comparison shoppers; and of course healthcare billing and pricing is almost unbelievably complex.

High-deductible health plans do work to keep premiums down, but this is a false promise for most of the population, which is exposed directly and, before the deductible is paid off, without any insurance protection from the ever-growing high cost of health care. High-deductible health plans do work well for a small slice of the population that meet the following criteria over a long period of years: 1) Everyone in the family is healthy and unlikely to hit the deductible limit, taking into account new research showing that there is rapid turnover in the families in the top 5% of medical expenses – in other words, the most expensive families in one year will be replaced by new families in another year, meaning that most families eventually get their turn in the top 5% of most expensive spenders; [2] 2) The family must be well-off, and in particular must have enough income or savings to pay off the entire deductible if needed; 3) The family has access to matching funds in a Health Savings Account ("HSA") from their employer to help pay for the deductible – a feature not all HDHP's include; 4) The family does not have access to a comparably priced non-HDHP plan – new survey results show that as consumers become more familiar with

[2] New England Journal of Medicine, *Consistently High Turnover in the Group of Top Health Care Spenders*, https://catalyst.nejm.org/high-turnover-top-health-care-spenders/ (Feb. 1, 2018).

HDHP's, they do not like them and try to leave at the first opportunity. [3] In short, HDHP's amount to limited, catastrophic insurance that is appropriate for one limited group: well-off and rich families with substantial liquid savings, no medical histories, who are lucky enough to work with an employer who funds and HSA, and who have no better comparably priced health insurance through their work or some other source. In OHA's normal case work, we frequently encounter consumers who had no true idea of their exposure when they either selected or were required to purchase a high-deductible plan by their employer or by premium price pressures.

If comparison shopping is the goal, this Office strongly suggests that the system not rely on sick, scared and often resource-poor consumers to do the comparison shopping, which is what HDHP's do; instead, the system should rely on sophisticated, economically powerful, rational actors to be the comparison shoppers. The most impact from comparison shopping can probably be had in non-emergency, high-cost services, such as certain imaging services like MRI's, or pre-scheduled surgeries such as joint replacements. For this kind of comparison shopping, the best place to locate that responsibility is on the payers, be they large employers or sophisticated insurance companies. They, and not the individual members, are the ones who should be immersed in the marketplace year after year, and best able to find quality care or pharmaceuticals with the best price. This could result in more limited choice for consumers, or steering consumers to particular providers. For instance, a small but growing number of the most savvy large employers in the country have developed centers of excellence for certain high-cost services where they fly patients and family members from all over the country to receive quality care at a center of excellence location. [4] In addition to the consumer protection concerns, this is an economic competitiveness issue for the state and the nation. An important part of making progress

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[3] Oliver Wyman, *Waiting for Consumers – The Oliver Wyman 2018 Consumer Survey of US Healthcare*, https://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2018/october/Consumer-Survey-US-Healthcare.PDF (2018) ("Consumers don't want HDHPs. When we described two insurance approaches to them, half said they preferred a plan that costs more upfront but guarantees low out-of-pocket medical costs through the year; only 21 percent preferred a plan that costs less upfront but could result in high out-of-pocket expenditures throughout the year.')

[4] *See, e.g.*, Harvard Business Review, *Why GE, Boeing, Lowe's and Walmart Are Directly Buying Health Care for Employees*, https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees (June 8, 2017); Becker's Hospital Review, *Lowe's Wal-Mart Strike Deal With 4 Hospitals for Hip, Knee Replacements*, https://www.beckershospitalreview.com/finance/lowe-s-wal-mart-strike-deal-with-4-hospitals-for-hip-knee-replacements.html (Oct. 9, 2013).

on getting American and Connecticut healthcare costs down to a more internationally competitive level is empowering payers to say "no" to high-cost care, especially when there is little quality difference. This Office as the designated entity to look out for the interests of Connecticut's healthcare consumers stands ready to support payers (insurance carriers and employers) in educating Connecticut consumers about the benefits of such programs, so long as they are set up and administered thoughtfully and with the appropriate consumer protections.

Reforming high-deductible health plans to take out the maddening aspects like the fact that working families who switch plans mid-year are asked to put "skin in the game" twice in the same year is an important part of this transformation, and this Office would like to work with the General Assembly and the payer community to improve the system. This bill is a good start toward putting some rationality and consumer fairness into the HDHP system.

Thank you very much for your consideration of this testimony. If you have any questions concerning our position on this issue, please feel free to contact me at Ted.Doolittle@ct.gov.