Connecticut State Medical Society
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Testimony in Support of Senate Bill 378
An Act Concerning Reimbursements Under Certain High Deductible Health Plans
Insurance and Real Estate Committee
March 6, 2018

Senators Kelly and Larson, Representative Scanlon and members of the Insurance and Real Estate Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS), we thank you for the opportunity to testify today in strong support of **Senate Bill No. 378, An Act Concerning Reimbursements Under Certain High Deductible Health Plans.**

The past decade has seen a drastic rise of high deductible health plans (HDHP), especially in Connecticut. In the early 2000's, as health insurance prices increased, businesses providing healthcare for employees began looking for ways to save money. The HDHP has proved popular, from the employer perspective, in that it shifts some of the costs from the employer to the employee, or rather the patient. In theory, shifting the cost of health care from employer to patient is a mechanism for moderating the cost of health insurance. Health plans that feature higher levels of cost-sharing are often more affordable, as employers and patients exchange lower premiums for higher out-of-pocket costs when they use medical services.

However, the impact of cost-sharing on patients and physicians is an ongoing concern of many, including CSMS, and with good cause. Examination of high cost-sharing finds compelling evidence that exposing patients to increased cost-sharing has unintended, negative consequences on both patient health and on the quality of the physician-patient relationship.

It is not uncommon for a HDHP to have an annual deductible reaching $5,000 for individuals and $10,000 for families or more. This means that the patient is responsible for the first $5,000/$10,000 of medical care costs incurred. "Insurance" does not kick in until the patient has first incurred $5,000 in medical costs and $10,000 for the entire family. The use of the HDHP is not limited to just employers. In Connecticut, all but one of the individual plans offered by Access HealthCT are HDHPs. A recent Connecticut Business and Industry Association (CBIA) study indicated that close to 85% of Connecticut businesses now offer at least one high deductible option.

Under the current structure of the HDHP, physicians are responsible for collecting out-of-pocket costs from patients. This presents an unfair transfer of risk from the insurance company to the patient, and by corollary, to the physicians. HDHPs were designed by insurance companies to have little to no impact on the bottom line of the health insurer. The health insurer continues to collect its monthly premiums, dictates the fees that will be paid, monitors (itself or through designees) and tallies the tolling of the deductible, but has left physician offices responsible for collecting the significant out of pocket costs from patients. A physician contract with a health insurer is fee for service contract- the physician provides a medical service and is expected to get

paid by the insurer for that service. It was not contemplated that patients could be responsible for up to the first $5,000 or $10,000 of their care and that physician offices would have to turn into de facto collection agencies to collect these deductibles. For those that might think a provision such as this this could be negotiated in a physician's contract with a health insurer, this is not the case. Health insurers present physicians with "take it or leave" it contracts that leave no room for negotiation or bargaining. The balance of power is quite simply swung drastically in favor of the health insurer leaving no opportunity for negotiation of such terms.

The fundamental problem with physicians collecting substantial payments from patients under HDHPs is the negative impact it has on patient care. Research has shown that HDHPs cause patients to forego needed medical care. A recent study conducted by the Kaiser Family Foundation showed that 43% of patients reported having trouble paying their deducible (this is up from 34%) in 2015). A study conducted by Families USA showed that more than ¼ of patients in a high-deductible plan delayed some type of medical service, such as a doctor's visit or diagnostic test. A West Engagement Solution's study found that 75% of women, 40% of men and 42% of patients with chronic disease say they have put off screenings due to high deductibles. Lastly, according to a study conducted by the Commonwealth Fund, 44% of adults with high out-of-pocket expenses delayed medical care. Patients are paying more of the health care dollar, they are experiencing significant costs and we are seeing delays in accessing care that in the long run result in more expensive care and hospitalizations.

When patients do not pay their cost-sharing, physicians have two choices: take a loss for the uncollected amount or send the patient to collections. The hallmark of the physician-patient relationship is trust: patients must trust their medical providers. When a patient is sent to collections, that trust is often damaged beyond repair. In either case, patients will often not return for necessary medical care as they are uncomfortable or even afraid to go back to their physician's office because of the outstanding debt owed to physicians.

We are often asked why physicians do not always collect the cost of the high deductible up front prior to providing patient care. Physicians have an ethical and legal responsibility to their patients to not "abandon" a patient. When a patient is under an ongoing course of treatment, physicians often must continue to treat that patient for a certain period. The inability of a patient to pay their deducible cannot impact the ethical and legal responsibilities physicians have with their patients. In addition, it is often not clear what the insurer's "allowable amount will be ahead of time, so the charge would often have to be adjusted, leading to further patient confusion and cost for the practice.

The sanctity of the physician-patient relationship is forever damaged by physicians serving as collection agencies. Shifting this collection obligation to the insurer, who controls the process, will preserve the sanctity of the physician-patient relationship thereby helping to ensure that patients seek medically necessary care.

HDHPs are having a real impact on patient practices here in Connecticut. An emergency medicine group that services two hospitals here in Connecticut had only 41% of their costs under

these plans collected in 2017. In January of 2018, they had $85,000 outstanding collections due to deductibles and as of January 31, 2018 had only collected $1,000 of that.

A recent report by West highlighted that 56% of patients now put off paying their medical bills, while 67% say that their finances make it tough to pay their medical bills in a timely manner. In fact, 12% reported always delaying payments, while 16% said they frequently delayed payments.

Faced with significant uncollectible debt, the reality is that physician practices in Connecticut can no longer afford to remain independent. The concept of the HDHP was developed by health insurers, yet the insurance companies bear no financial responsibility or risk as to the collectability of the high deductible payments. We know that ultimately this country needs solutions that will reduce deductibles and help make care affordable but until that time, we are asking that this committee take the physician out of the middle of this equation, protect the patient-physician relationship and leave claims processing and payment to the insurer.

We urge your strong support of Raised Bill 378.