Testimony for Vermont Senate Committee on Finance. Re: S. 245

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I had difficulty deciding how to start my remarks about this seemingly straightforward bill, as there are so many issues here that go to the heart of my daily practice of family medicine in Williston.

In my 36 years of primary care practice, I have never seen things so bad at the front lines in terms of health care delivery and financing: The cost and complexity of health insurances, the costs of care even with insurance, the lack of access to enough good primary care practitioners, the financial barriers to accessing even the most basic care, testing, and medications (like epi pens or insulin). Perhaps examples later.

Well meaning people trying to help seem to usually make things worse. We are spending millions on grand unproven schemes, yet simple solutions like S 245 are readily available.

S 245 could start to solve some very substantial problems:

Reduce financial barriers to accessing primary care, giving first dollar coverage.

- Patients would not delay care for acute problems, or avoid care for chronic problems
  - Less requests for phone care when a visit is needed
  - Better compliance with follow up visits, and better chronic care management
- PCPs could provide medical services during wellness visits without patients worrying about the extra costs, or practitioners worried about not being paid.
- Overhead costs at PCP offices would go down. Less balance billing, delayed payments, collection letters, upset patients.

The overall cost of care will likely go down.

- Care in PCP offices is **in**expensive. Currently only 5.9% of Medical spend goes to traditional primary care. (GMCB report to VT Legislature 2019)
- Use of ERs and Urgent Care, and unnecessary specialty care should go down.
- Increase spend on primary care reduces overall spend.
- Patient's incentives will tip towards getting care from their PCP when possible.

The Rhode Island Care transformation Collaborative is a sentinel example: Commercial insurers were required to increase their primary care spend 1% per year for 5 years. It went from 5.7% to their target of 10.7% in that time. Total health care expenditures declined 14%. Overall savings were $88 M.

I refer you to: Investing in Primary Care - A state level analysis PCPCC July 2019

Countries with much lower health care costs, and better outcomes typically have delivery model based on a core of primary care. Typically, half their doctors are primary care, not less than a quarter of them. They may be single payer, and some may have bottlenecks for specialty care, but they don't put up barriers to primary care.

Primary care Workforce: The Rhode Island experience also saw that increased resources to primary care grew their PCP workforce, the only New England state to do so.

If Vermont is to compete for the very sought after primary care practitioners, we must take steps like S. 245 and others to reduce administrative burdens, improve PCP wellbeing, and strengthening the relationship of patients with their PCPs.

The NYT opinion piece from Jan '18, submitted by BCBS to this committee concludes that prevention improves quality of life at a reasonable price. It was apparently used to show that covering prevention will cost more, and raise premiums. The article is off point for discussion of S.245. S.245 addresses barriers to, and improves coverage of, all primary care, not just prevention which is already covered without cost-sharing.

Primary care is inexpensive, and extremely high value, especially if you consider all the excess costs saved by giving Vermonters access to a primary care practitioner without the barriers of co-pays or deductibles. It would save ER and urgent care visits, delays in care due to financial barriers, and early detection, prevention, and management of chronic diseases… The NYT piece indicates a rise in such costs with the ACA…but there are many more factors involved that limited access to primary care services other than prevention.

The One Care model is predicated on better chronic care management and prevention. Yet we have not removed financial barriers to their care, or incentivize them to get their care in the most cost efficient settings. S. 245 takes an important step that OneCare should consider for all its attributed lives.

Representing Evergreen Family Health, and Healthfirst, the statewide Independent Practice Association, in support efforts like 245 to reduce financial barriers to Vermonters accessing primary care

I caution that Insurers not be allowed to increase premiums, or reduce payments to primary care or other practitioners as a result of such legislation, since the change should result in less overall costs.

Additionally, the Insurers should be encouraged to track and report the results of these changes, especially in the impact on overall costs, quality, and effect on the primary care workforce.

APPENDICES:

A) Unintended outcome of the ACA Prevention Coverage

An unintended consequence of the ACA, removing cost sharing for traditional "physicals," cancer screenings, immunizations, is that insured patients, can now access their primary care practitioner for health counseling, diabetes and HTN screenings, pap smears and flu shots. But if diabetes is found, they now must pay a copay or the full cost of office visits until the deductible is reached. This is also true for OVs for influenza, injuries, management of chronic conditions like heart failure, COPD, depression, etc.

A much higher percentage of our patients now get their wellness exams and screenings. But now they often save up their multiple acute and chronic medical problems to be addressed during their annual wellness exam to avoid having to pay more. Can't fault them, they and their employers are already

paying some of the highest health care premiums in the country. This delays care, and results in an untenable situation in the doctor's office.

When separately identifiable acute and chronic problems are managed during a wellness visit, practitioners are supposed to code and bill them as such. This results in practitioners being appropriately paid for their work. But it leads to upset patients who complain to their health plans and to office billing staff, and to their employers. And it drives a hurtful wedge between the primary care practitioners and their patients.

When a doctor's office submits the charges to the health plan, the "non wellness" charges are rejected if deductibles are not met. Then the patient gets billed, understandably upset and confused. Primary care offices have responded in various ways:

- Have patients come back for a separate visit later,
- Post signs and provide handouts to educate patients about the grey space between preventive care and medical services.
- Provide the additional professional services and forego payment.
- This problem led to so many complaints to Insurers that they are looking at reducing payments to primary care practitioners for their extra billings

There is much that a wellness exam covers, and that your practitioner is required to include when doing a "physical" (screenings, ordering tests, counseling, vaccinations, updating medical records, completing Advanced directives, etc…) Patients should also bring up issues that are of concern to them. However, if patients need problems managed…which might include a symptom directed exam, ordering tests, prescriptions, or referrals to specialists...then what?

B) <u>Financial barriers limit appropriate and necessary care</u>

i. **48 yo woman with depression**, hesitated for months coming to PCP due to large deductible… the depression affected the marriage and family, with high school daughter now having significant school and anxiety issues. PCP started medication and recommend counseling. Patient hesitant to try counseling because money is tight and would have to pay full amount til deductible reached.. husband very concerned about cost, and he would be mad at her for this expense, and expanse of follow ups with PCP.

ii. **63 year old woman calling about non classic UTI symptoms**. She lost her job and does not qualify for Medicaid, state exchange insurance too expensive. No insurance. Wants to be treated over phone instead. Told that it is not good medical practice to treat without evaluating the urine and doing an exam to rule out more serious problem, or different diagnosis… She became angry at PCP for not treating her over the phone, claimed we didn't care about her, only about money, and stated "the health care system is screwed up. it is much too expensive to get care" She refused to come in and stated she would try home remedies, and go to a hospital walk in if needed where they wouldn't make her pay, and it would just get added to what she owes them in collections already.

iii. **32 year old male follow up for ADHD** and new onset depression. Reports he has new job, and health plan with high deductible. New Rx for antidepressant and plan for follow up in one month...but arranged instead for a portal message to report status in a month and provide on-line feedback, rather than a visit. No payment to practitioners for this type of professional work, and lesser care as cannot evaluate and counsel him like a face to face visit for treating depression.