

High Deductible Health Plan Task Force

Final Report

February 1, 2020

Introduction

On June 26, 2019, Governor Lamont signed Public Act 19-117. Section 247 of the Act created a High Deductible Health Plan Task Force (the Task Force) “to study the structure of high deductible health plans and the impact of such plans on enrollees in this state.” The Task Force was further directed to report to the General Assembly’s Insurance and Real Estate Committee its recommendations concerning:

- 1) Measures to ensure access to affordable health care services under high deductible health plans;
- 2) The financial impact that high deductible health plans have on enrollees and their families;
- 3) The use of health savings accounts, and the impact that alternative payment structures would have on such accounts, including, but not limited to, the status of such accounts under the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;
- 4) 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;
- 5) Measures to ensure the prompt payment of a refund to an enrollee for any cost-sharing payments under a high deductible health plan that exceeds the enrollee's cost-sharing obligation under such plan;
- 6) Measures to enhance enrollee knowledge regarding how enrollee payments are applied to deductibles under high deductible health plans; and
- 7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

Task Force Membership

The following members were appointed to the Task Force by their respective appointing authorities:

- Ted Doolittle, Healthcare Advocate (Chair)¹
- Dr. Daniel Freess, Hartford Hospital
- Cassandra Murphy, CT Coalition of Taft-Hartley Health Funds
- Dr. Greg Shangold, CT State Medical Society
- Dr. Andrew Lim,
- Robert Krzys, Esq.
- Susan Halpin, CT Association of Health Plans

¹ Sean King, senior Staff Attorney for the Office of the Healthcare Advocate, temporarily served on the task force as the Healthcare Advocate’s designee for the December 4, 2019 meeting.

- Janice Perkins, ConnectiCare
- Patrick McCabe, Yale New Haven Health System
- Dr. Andrew Wormser, CT Medical Group
- Joseph McDonagh, McDonagh Insurance
- Seth Powers, Center for Children with Special Needs

Background

Definition of High Deductible Health Plan

High deductible health plans (HDHPs) are insurance designs that require members to absorb substantial initial out-of-pocket expenditures for medical services before the insurer begins to cover expenses. HDHPs formally originated in 2003, upon enactment of Section 223 the Internal Revenue Code (the Code). For calendar year 2020, the Code defines an HDHP as a health plan with: 1) a deductible of at least \$1400 for an individual or \$2800 for a family; and 2) a maximum out-of-pocket limit that does not exceed \$6900 for an individual or \$13,800 for a family.² In addition, the Code requires that an HDHP apply the deductible to all health care expenses. However, the Code provides for an exception for pre-deductible coverage with respect to preventive care services (safe harbor).

The safe harbor for preventive care benefits is limited to those services defined as preventive care under section 1861 of the Social Security Act, as well as services identified as preventive by the Secretary of the Treasury.³ By way of IRS Notice 2019-45, the Secretary recently expanded the list of preventive care services that fall within the Code's safe harbor provision.

Accordingly, the current list of preventive care services that may be covered without regard to a deductible include:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals or routine prenatal and well-child care;⁴
- Tobacco cessation programs;⁵
- Obesity weight-loss programs;⁶
- Various screening services (as listed in the Appendix to IRS Notice 2004-23)⁷

² IRS Bulletin 2019-22. CT insurance statutes have incorporated the IRS's definition of an HDHP by reference to the Code. See Conn. Gen. Stats. § 38a-493(f)

³ 26 U.S.C. § 223(c)(2)(C).

⁴ IRS Notice 2004-23.

⁵ Id.

⁶ Id.

⁷ Id.

- Any treatment that is incidental or ancillary to the preventive care services listed above;⁸
- Evidence-based items or service that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;⁹
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;¹⁰
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;¹¹
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration;¹²
- Medications prescribed to an individual who has developed risk factors for a disease that has not manifested or to prevent recurrence of a disease from which the individual has recovered;¹³
- High value services and Items used to prevent exacerbation of certain chronic conditions, as listed in the Appendix to IRS Notice 2019-45.¹⁴

⁸ IRS Notice 2004-50.

⁹ IRS Notice 2013-57 and 42 U.S.C. § 300gg-13.

¹⁰ Id.

¹¹ Id.

¹² Id.

¹³ IRS Notice 2004-50

¹⁴ IRS Notice 2019-45, Appendix A provides the following chart:

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes

It should be noted that the Secretary’s identification of services that are subject to the Code’s safe harbor does not result in a requirement that plans provide pre-deductible coverage for the identified services.¹⁵

Health Savings Accounts

Health Savings Accounts (HSAs) were also established under Section 223 of the Code. HSAs are essentially non-taxable trust accounts that are established, funded and distributed in connection with a beneficiary’s enrollment in an HDHP (as defined by the Code).

Contributions to HSAs, up to prescribed limits, are deducted from an individual’s gross income. For calendar year 2020, the contribution limits are \$3550 for individual coverage and \$7100 for family coverage.¹⁶ For individuals over age 55, an additional \$1000 in “catch-up” contributions may be deposited in an HSA and deducted from gross income. The Code does not place any limitations on who may contribute to an individual’s eligible HSA. As a common example, many employers contribute to their employees’ HSAs where the employees are enrolled in an HDHP offered under the employers’ group health plan.

Just as contributions to HSAs are deductible from gross income, distributions from HSAs are also tax-free, so long as the distribution is used exclusively for paying qualified medical expenses of an account beneficiary.¹⁷ As an exception, the Code also provides that all distributions (even for non-qualified expenses) are tax-free if the beneficiary is disabled or eligible to enroll in Medicare. HSAs offer a third benefit as well, in that any interest or other earnings that accumulate to the account are also tax exempt. In addition, HSAs are portable and balances remain accessible to the account holder even after an account holder changes health plans. In this way, HSAs can be an attractive tool for individuals who wish to build a savings fund to pay for their medical care, or to pay other expenses after they become eligible for Medicare coverage.

Purpose of HDHPs

HDHPs were initially created as a method of attempting to control health care costs. Conceptually, the higher deductibles influence members of HDHPs to make wiser health care decisions because they have “skin in the game.” Thus, in theory, members of HDHPs would

International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

¹⁵ See IRS Notice 2019-45.

¹⁶ IRS Bulletin 2019-22.

¹⁷ Interest paid on the balance of an HSA is also not taxable and can be distributed to pay for qualified expenses.

“shop” for services on the basis of quality and cost. In doing so, members would elect to forego more low value services (higher cost and lower health outcomes) and seek out higher value care (lower cost and greater health outcomes). In return, members of HDHPs would be rewarded with a lower monthly premium and the tax benefits associated with an HSA, from which they could meet their higher deductible obligation.

As discussed further herein, the benefits of HDHPs and HSAs have not manifested as expected for every member of such plans. For example, information regarding provider cost and quality is not readily available, making it difficult for members to engage as “smart shoppers.” In addition, not all HDHP members have the resources to contribute adequately to an HSA and take advantage of the associated tax benefits.

Some Health Plans with High Deductibles are not HSA-Compatible

As indicated above, the definition an HDHP under the Code is confined to those health plans with a minimum deductible and maximum total out-of-pocket responsibility, as well as limitations on the services that can be covered without regard to the deductible. However, as HDHPs have evolved, insurers have introduced into the market plans that incorporate high deductibles, but do not qualify as HDHPs under the Code – either because their out-of-pocket maximum exceeds the threshold established by the Code, or because the plan covers certain ineligible services without regard to the deductible. In such cases where the “high deductible health plan” does not conform to the Code’s definition of an HDHP, the plan’s members are not eligible to receive tax benefits for contributions to an HSA. However, such non-compatible high deductible plans do have the flexibility to offer consumers pre-deductible coverage of more services (i.e., services not subject to the IRS safe harbor). For example, some of the products currently offered on the Access Health CT insurance exchange incorporate those additional pre-deductible benefits into their product designs.

Regulation of High Deductible Health Plans

-Of interest to the Task Force was the limitation on the state’s ability to regulate health coverage provided under what is at times called a “self-insured” or “ERISA” plan. In self-insured plans, an employer maintains the capital reserve from which the claims of its enrolled employees and their family members are paid, and a third party performs the administrative functions of enrolling employees and providers, adjusting claims, and so on. The third party administrator, sometimes called a TPA, may be a traditional insurance company, or it may be a separate specialized contractor.

Approximately 65% of Connecticut residents who have health coverage currently receive that coverage through a self-funded plan. While self-funding has traditionally been the domain of larger employers, self-funding plans have made strong inroads into the small group market in recent years.

Due to a provision of the federal Employee Retirement Income Security Act (ERISA), federal law preempts states from regulating self-insured plans. Only Congress and Federal agencies can regulate self-insured plans. This places a majority of health coverage in Connecticut out of the reach of state regulation.

In contrast, fully insured health plans, by which an insurance company rather than the employer maintains the capital reserve, are regulated by the laws of the state in which they are written, as well as by applicable federal laws such as the Affordable Care Act. The Task Force is mindful that as a smaller segment of the market, fully insured plans are more price sensitive, and accordingly, certain legislative changes could potentially lead to other downstream impacts such as premium increases and dropped coverage.

The Task Force recognizes that the findings and recommendations presented herein will be primarily addressed to the smaller fully insured market in CT. However, Task Force also considered that it would be appropriate for its members, as well as elected officials, private individuals, or the General Assembly as a body, to recommend certain changes to the Congressional delegation.

Summary of Meetings and Evidence

The Task Force convened on August 22, 2019. Additional informational and business meetings were held on October 16, November 6, November 20, December 4 and December 18, 2019, and on January 9, 17 and 28, 2020.

Preliminary discussions among Task Force members identified access to care as a primary issue to be addressed by high deductible health plan (HDHP) reforms. ~~In general,~~ Task Force members perceived high deductibles as barriers to care, in that out-of-pocket deductible costs can deter patients who need health care services from seeking or obtaining those services from their providers. Task Force members further posited that high deductibles can often result in medical debts that patients are unable to pay, which too often lead to other negative financial impacts, such as credit collections, litigation and bankruptcy. Task Force members also acknowledged the relationship between deductibles and premiums and that both are a reflection of underlying healthcare ~~prices~~costs, with an understanding that the cost of healthcare and the price of healthcare are not necessarily synonymous. The Task Force recognized the need to be mindful of unintended consequences that may accompany any of its recommendations, if implemented by policymakers, in that some reforms could result in the negative indirect impacts of raising out-of-pocket costs to consumers or unreasonably limiting consumer choices. As a further example, policymakers should also be mindful that as a result of the Silver loading workaround to the federal government's recent decision to stop paying the Cost Sharing Reduction subsidies, higher premiums can result in a positive impact on federal premium tax credit subsidies, which in turn makes insurance cheaper for lower-income customers who buy insurance through the Exchange.

The task force received presentations from Dr. Victor G. Villagra, Associate Director of the UCONN Health Disparities Institute,¹⁸ Lynn Quincy, Director of Altarum’s Health Care Value Hub,¹⁹ Kevin McKechnie, Executive Director of the American Bankers Association HSA Council,²⁰ James Stirling, Stirling Benefits, Inc.,²¹ Dr. A. Mark Fendrick, Director of the University of Michigan Center for Value-Based Insurance Design,²² Ann Lopes, Product Carrier Manager for Access Health CT and Sabrina Corlette, J.D., Co-Director Georgetown University Center on Health Insurance Reforms.²³ The Task Force also receives several oral and written comments from various members of the public.

Dr. Victor Villagra – Health Disparities Institute²⁴

Dr. Villagra presented some of his research regarding HDHPs. According to his research, a substantial proportion of Connecticut residents lack the health insurance literacy needed to make effective decisions regarding plan selection and to understand their plan’s benefits. The research further exposes significant racial, economic, education-level and other disparities among healthcare consumers when it comes to selecting the “just right” plan and understanding their coverage. Dr. Villagra also highlighted several impacts of high deductibles on plan participants, including increased medical debts, avoidance of medically necessary services and increased administrative costs for providers. Specifically, there is substantial evidence that members of HDHPs underutilize high value medical and mental health procedures such as vaccinations, maintenance medications and preventive care visits. Additional findings demonstrate that:

- Nearly a quarter of insured individuals experience medical debt
- Of those individuals, 43%-67% have exhausted their savings to pay bills
- 43% have been impacted by a reduced credit rating
- 16% have been subjected to collections activity
- 18% have delayed education or career plans
- Up to 62% of bankruptcies are related to medical debt

¹⁸ Dr. Villagra’s bio and additional information regarding UCONN’s Health Disparities Institute may be found at: <https://health.uconn.edu/health-disparities/>

¹⁹ Ms. Quincy’s bio and additional information regarding the Healthcare Value Hub may be found at: <https://altarum.org/solution/altarums-healthcare-value-hub>

²⁰ Mr. McKechnie’s bio and additional information regarding the HSA Council may be found at: <https://www.aba.com/authors/kevin-mckechnie>

²¹ Mr. Stirling’s bio and additional information regarding Stirling Benefits, Inc. may be found at: <https://www.stirlingbenefits.com/about-us/>

²² Dr. Fendrick’s bio and additional information regarding the Center for Value-Based Insurance Design may be found at: <https://sph.umich.edu/faculty-profiles/fendrick-a.html>

²³ Ms. Corlette’s bio and additional information regarding the Center on Health Insurance Reforms may be found at: https://chir.georgetown.edu/faculty_sabrina_corlette/

²⁴ Dr. Villagra’s presentation materials are included in Appendix A.

- Providers' accounts receivables have grown over time in terms of amounts and duration

With respect to these financial burdens, Dr. Villagra highlighted the number of times that providers have sued their patients in small claims court (for less than \$5000). 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.²⁵ Dr. Villagra emphasized the ethical dilemma that providers face when deciding to subject their patients to collections and litigation.

Finally, Dr. Villagra posited that reforms must ultimately address the root cause of the negative outcomes identified in his research, namely the unsustainable growth in the underlying prices of healthcare services. Among his suggestions, policymakers interested in addressing these impacts should explore:

- Establishing public-private partnerships with a goal of improving health insurance literacy, particularly among marginalized groups
- Enacting regulations to gradually phase out high deductibles and coinsurance from health insurance plan designs
- Promoting performance-based regulations to set goals for improvement on Consumer Report Card data points
- Facilitating new entrants who can offer simpler plan alternatives within the health insurance market
- Improving transparency regarding provider charges and billing practices
- Reforming judicial procedures to protect individuals from unfair medical debt collection and litigation practices

Lynn Quincy – Altarum Healthcare Value Hub²⁶

Lynn Quincy presented further evidence of the negative impacts that HDHPs have on plan participants. In addition, Ms. Quincy explained that the benefits of HDHPs, which include lower premiums and opportunities for tax savings through HSAs, are substantially outweighed by the negative financial and health impacts of medical debt and avoidance of necessary care. In particular, HDHPs do not accomplish one of their intended purposes of motivating plan participants to become “smart shoppers” who will seek out the highest value services. Additional research affirms that poor healthcare literacy, as well as lack of cost and quality transparency, are major contributors to inefficient use of health insurance plans.

²⁵ Dr. Villagra's presentation identified an outlier hospital that accounted for nearly half of all of the lawsuits studied as part of his research.

²⁶ Lynn Quincy's presentation materials are included in Appendix B.

Predictably, the financial impacts of HDHPs fall most heavily on individuals and families with income less than 250% of the federal poverty level. More than 60% of the tax benefits available to members of HDHPs with HSAs accrue to families earning more than \$100,000 annually.

In Connecticut, the health consequences of HDHPs is substantial. More than half of adults have reported delaying or avoiding healthcare procedures due to the cost. Over ten percent of individuals reported problems accessing mental health care. More than one in four individuals reported leaving a prescription unfilled or skipping doses of medications.

Regarding financial impacts, ten percent of adults have reported being contacted by a collections agency, and another sixteen percent have used up all of their savings or shifted their medical debt to their consumer credit accounts. Six percent have reported being unable to pay for other necessities in order to accommodate payments toward their medical debts.

Some of the solutions proposed by Ms. Quincy include:

- Utilize copayments rather than coinsurance to distribute the costs of care between member and insurer
- Tie cost-sharing to family income – i.e., create affordability standards
- Implement Value Based Insurance Design (VBID)

Regarding VBID, the most consumer-friendly designs will focus on high value care, simplify cost-sharing and ensure benefits are based on evidence. However, current research on VBID indicates that positive responses to lower cost-sharing incentives are less than predicted, and little research exists as to whether higher cost-sharing has the intended impact of limiting just low-value services or instead reduces utilization indiscriminately.

As for the need for healthcare and insurance to be affordable, there is no current consensus on how “affordability” should be defined. However, there is substantial evidence that affordability is negatively impacted by wasteful healthcare spending. Specifically, up to one third of healthcare spending is wasted on low-value care, excessive unit costs, unnecessary administrative costs and fraud, among other things. Recommendations for reducing unit costs include increasing quality, cost and price transparency, aligning prices with costs and eliminating cost outliers.

Kevin McKechnie - HSA Council²⁷

Mr. McKechnie explained that not all HDHPs are created equal. True HDHPs and HSAs are the creation of the IRS, and are distinguished from “health plans with high deductibles,” which may look like a true HDHP but don’t have the applicable cost sharing or first dollar coverage limitations to meet the definition of an HDHP under the IRS code. HSAs come with the triple

²⁷ Mr. McKechnie’s presentation materials are included in Appendix C.

benefit of tax-free contributions, capital gains and distributions (if used for qualified healthcare costs). In addition to actual provider charges, qualified healthcare expenses include COBRA premiums and qualified long term care insurance premiums.

One of Mr. McKechnie's interests is to help States understand the relationships between coverage mandates and IRS limitations of first dollar coverage for HSA-compatible HDHPs. As an example of a failed experiment, he discussed Maryland's mandate to provide parity for male reproductive services. The mandate was found to be inconsistent with IRS rules, and ultimately disqualified several hundred thousands of Maryland residents from utilizing an HSA and paying for their healthcare with pre-tax dollars.

Mr. McKechnie acknowledged that HSAs are not appropriate for everyone. HSAs require account holders to be somewhat active participants in managing their accounts. In addition, individuals must be able to contribute, and most participants do contribute or receive contributions from their employer. Nonetheless, he cautioned against the concept that a state might mandate that all HDHPs be HSA compatible. Consumers prefer choice.

HSA contributions typically come from the account holder or their employer; however, there are no restrictions on who can contribute. A state government or other funding source can also fund an individual's HSA. However, ACA rules currently limit the ability to use premium tax credit dollars or cost sharing reduction dollars to fund an HSA.

The IRS recently updated its rules to expand the list of items that can be subject to first-dollar coverage under an HDHP with an HSA. However, there is no federal requirement that plans must cover those items without a deductible.

Minimum deductibles under an HSA-compatible HDHP are \$1400 for 2020, and average deductibles are approximately \$1650. Compared to HSA-compatible HDHPs, deductibles for "health plans with high deductibles," have grown three times faster. One of the primary mechanisms that plans use to keep premiums low is to increase deductibles. In other words, "the first healthcare dollar is the most expensive dollar to insure."

Mr. McKechnie's recommendations largely would require Congressional action. Presently, he has expressed support for HR 3796, which would allow Medicare eligible HSA holders to continue to make tax-free contributions. Because there is no political consensus on how to reform the ACA or expand Medicare, he believes the most expedient option to address some of the issues related to HDHPs is to expand the availability of pre-tax dollars to be spent on healthcare. He also expressed favor for innovations such as expanding use of HSA dollars on over-the-counter drugs and allowing for spouses to make catch-up contributions above ordinary annual contribution limits. He also expressed favor for the concept of establishing HSA-compatibility on the basis of metal-tiering level, rather than the size of a deductible.

Mr. McKechnie offered some feedback on other reform ideas, including a proposal that the deductible portion of a healthcare expense be made payable to the insurer, rather than the

healthcare provider. He explained that such a payment likely would not be a qualified healthcare expense, because it would represent a consumer debt to the insurer, as opposed to a healthcare expense owed to the provider.

Under another scenario, Mr. McKechnie addressed a concept where an individual moves from one HDHP to another HSA-compatible HDHP. He explained that IRS rules would permit the latter plan to credit the individual for deductible costs incurred under a prior plan earlier in the year. However, he stated that it must be an optional benefit for the plan to offer – if a State were to mandate such a credit, the plan would no longer conform to IRS rules and therefore would lose its HSA compatibility. As an additional cautionary statement, he indicated that individuals who switch plans must be mindful not to exceed their annual contribution limits under the IRS rules.

James Stirling – Stirling Benefits, Inc.²⁸

Stirling Benefits, Inc. provides third party administrator services for self-funded or level-funded employers. In general, Mr. Stirling agrees with the observations and research that concludes that HDHPs have not improved access to care or contributed to improvements in health. His primary thesis is that the players in the health benefits market have incentives that are misaligned with the goals of cost containment and population health improvement.

Carriers and brokers operate under high volume and low margins, with MLR capping their allowable profits from premiums. Thus, increases in profits must come from increases in premiums, which in turn incentivize inflation of the underlying costs of care. Another unintended consequence of the MLR rules is the tendency of incentivizing lower-risk, lower-cost business to move out of the fully insured market and into the self-insured market, which is not subject to the same MLR rules, thereby destabilizing the fully insured market that must bear an increasing amount of risk year-to-year.

In his experience in working with employers, about 2% of the employee population under a health plan will incur about 50% of the expenses. The next 20% of employees will incur another 25%. This represents a population that has emerging or chronic conditions with expenses typically in the range of \$10,000-\$30,000 annually. That leaves about 75% of employees who incur less than a few thousand per year, including many who never use the plan at all. Under a high deductible plan, many of these employees feel that they are effectively uninsured since they would never have the occasion of meeting their deductible in a given year. Those employees for whom HDHPs work are those who can establish an HSA and adequately fund it.

Employers who endeavor to control premium costs are typically compelled to raise deductibles as an offset. In addition, employers who are paying close attention to their margins will frequently change carriers from year to year, despite the potential continuity of care disruptions that may occur due to changes in networks. This dynamic precludes the possibility

²⁸ Mr. Stirling's presentation materials are included in Appendix D.

of carriers establishing a longer-term relationship with an employer group, which in turn disincentivizes carriers from taking a longer-term approach to employee health and wellness. In addition, wellness programs are designed more for carriers to evaluate group risk rather than to foster improvements in health outcomes. Carriers also do not share their claims data with employers, which would allow the employers to better assess any changes in the associated costs of their employee health plans.

As for recommendations, Mr. Stirling noted that employers are trending away from increasing deductibles as they view higher deductibles as an impediment to improving the health and productivity of their workforces. He would like to see policies that help employers to incentivize employees to improve health, such as placing primary care and other higher value services in front of the deductible. He would also utilize employee health information for positive discrimination, as allowed by the ACA. For example, an employee with an emerging health issue would be treated more favorably than other employees by having certain services paid for by the plan. He would also recommend greater disclosures of data including vendor fees, prescription rebates, group claims experience and provider fees. He further supports certain VBID principles, including narrow networks, but understands the complications and unintended consequences that might flow from some strategies.

Dr. A. Mark Fendrick - University of Michigan, Center for Value Based Insurance Design²⁹

Dr. Fendrick is the Director at the Center for Value Based Insurance Design (VBID) at the University of Michigan. He is the architect behind the concept of VBID and a nationally recognized expert on the development, implementation and evaluation of innovative health plan designs. Through his research, Dr. Fendrick has found that scientific innovation will continue to drive up total spending on health care, but that spending can be offset by identifying, measuring and reducing the utilization of low value services. This requires conversations to shift from the cost of care in isolation, and focus on reallocating costs from low value services to higher value services. There is enough money in the US health care system to pay for what is needed, it just needs to be spent differently.

Dr. Fendrick reported on the growth of deductibles and their impact on consumer demand for services. The downward pressure on demand for services that is generated by deductibles and other consumer-facing levers has had no impact on costs because consumers don't care about systemic costs; they only care about what a service is costing them individually. As of last year, 40% of Americans had less than \$400 in the bank and don't have the cash flow to meet a high deductible. This goes beyond requiring consumers to have "skin in the game." Rising cost shares are worsening health disparities and adversely affecting overall population health. He characterized the relationship of raising deductibles for the sake of lowering premiums as "a tax

²⁹ Dr. Fendrick's presentation materials are included in Appendix E.

on the sick.” However, the alternative equitable approach of raising premiums for all is ineffective because over 50% of consumers don’t utilize their benefits at all. The more optimal approach is to not raise deductibles or premiums any further, but address the substantial amount of money that is being spent on services that don’t make individuals any healthier.

VBID principles have been introduced into the Medicare program with bipartisan support. Among the strategies that Dr. Fendrick favors are more generous pre-deductible coverage for highly valued “secondary” preventive services that may be even more important to a patient’s health than current “primary” preventive services. If consumers don’t have the money to follow up preventive diagnoses with secondary prevention services, the former is rendered ineffective. IRS Notice 2019-45, which expanded pre-deductible coverage for chronic conditions under HSA-eligible plans was a step in the right direction, but doesn’t go as far as patients need. The Chronic Disease Management Act of 2019 (bipartisan and bicameral) would markedly expand the IRS list even further.

A corresponding strategy would be to reduce spending on low-value care, including certain diagnostic testing, imaging services and branded drugs. As an example, Dr. Fenrick referenced one study that showed 60 of the most commonly used drug classes could be covered, cost-neutrally, without a deductible by reducing spending on low value services by one percent. Cost shares could still be used to incentivize lower utilization, but those higher cost shares would be applied to low-value services to deter overuse, rather than the current system of applying cost shares on a broader category based on the type of service or place of service.

If existing dollars can be properly reallocated in this way toward high-value services and away from low-value services, the results would be flatter premiums and cost shares and improved patient health. Systems need to become more aggressive in identifying which services are low-value compared to those that are higher value. In response to task force member questions, Dr. Fendrick could not give any opinion on whether or to what extent providers should be indemnified when lower patient utilization of low value services yields a poor outcome, but he did stress that VBID strategies should incorporate increased patient accountability. Patients don’t need to get every service they ask for, but also shouldn’t have to foreclose on their house to get cancer therapy.

Ann Lopes – Access Health CT, Product Manager³⁰

Ann Lopes is the Product Carrier Manager for Access Health Connecticut (AHCT), the Marketplace for individuals and small employers. She provided an overview of the products offered through AHCT. The Marketplace is the only place where individuals can qualify for advanced premium tax credits (APTCs) and cost sharing reductions (CSRs). Connecticut has

³⁰ Ms. Lopes’ presentation materials are included in Appendix F.

approximately 3.3 million insured residents. Just over one half, about 1.7 million are presumed to be insured by large group and self-insured plans. Another substantial segment of Connecticut residents, about 1.4 million, are insured under government programs including Medicare, Medicaid and Veteran's Affairs, which leaves a small group and individual market of only approximately 230,000 people. In the group market, employers have been shifting the burden of increasing premium costs from the employer share to the employee share over the last decade.

AHCT requires its participating insurers, Anthem and ConnectiCare, to develop standardized plans as part of their product portfolios. Standardized plans provide for a prescribed measure of the various cost sharing terms for the particular plans. Ms. Lopes provided examples of some standardized plan terms. Each plan must comply with federal actuarial value (AV) requirements.

For 2020, the two insurers that participate in the Marketplace have offered a total of six individual plans that are true HDHPs, i.e., HSA compatible plans. Additional HSA compatible HDHPs are offered through the small group market. In order to qualify as HSA compatible, a plan must comply with IRS requirements, including minimum deductible and maximum out-of-pocket limits, as well as limitations on services that are exempted from applying to the plan's deductible. Cost Sharing Reduction (CSR) plans do not qualify as HSA compatible. Ms. Lopes explained that these limitations make it difficult to design a bronze level plan with a lot of services that would not be subject to the plan's deductible; however, there is one HSA compatible bronze level HDHP that is offered as standardized plan. This plan has not been changed for a number of years. There are not Silver level HSA plans available.

Presently, there are no current offerings on the Exchange without a deductible, unless an individual is between 138%-150% FPL and chooses a Silver plan (with a \$900 out-of-pocket max). Approximately 22,600 individuals in CT are enrolled in HSA compatible (individual) plans, of which about 15,000-16,000 are on-exchange. Ms. Lopes did not have details (until February 2020) as to how many of those enrollees are subsidized, but a total of about 70% of all enrollees on AHCT get subsidies. She further explained that AHCT has no way of knowing how many individuals on HSA-compatible plans actually open or contribute to HSAs. However, AHCT does offer information to enrollees as to how they can find assistance setting up an HSA account.

Ms. Lopes further discussed consumer education and health literacy initiatives. AHCT recently launched its "choose.use.be well" campaign to help enrollees access and use primary care services. Other education initiatives include healthy chats, in-home events, canvassing, and navigator assistance programs.

Ms. Lopes also reviewed snapshots of the AHCT enrollment portal to highlight plan enrollment and decision-support tools. Some features of these tools help enrollees analyze their current providers and medication costs to forecast their anticipated costs and coverage under various plan options. The tools also include information about network participation, formulary inclusion and total cost estimates that combine premium and cost shares for the identified providers and drugs. Actual plan documents are also available for review for further comparison if desired. In addition, enrollees can link directly to a carrier's provider search tool. The portal also provides enrollees with a checklist of items they will need in order to complete their enrollments. The portal has another search tool to help identify brokers and navigators to assist with plan selection and enrollment.

Ms. Lopes provided analysis of some of the ideas discussed by task force. She noted that on November 15, 2019, the federal government announced new rules intended to increase price transparency for hospitals and insurers to help consumers identify actual costs for services. Regarding proposals to offer only HSA-compatible plans, such strategies would be contrary to AHCT's stated mission. With respect to manufacturer coupons, last year's payment notice stated that carriers did not have to apply coupons to a member's out of pocket max; however, the DOL and IRS indicated that this topic would be revisited in the 2021 payment notice.

AHCT's product design committee has looked into offering VBIDs, and further discussion on VBID will come up for the 2021 plan year. One recent modification to the standard plan differentiates site of service cost sharing as a VBID component. Carriers also must be mindful of mental health parity when adjustments to certain cost share can create a disparity, which must be rejected.

Ms. Lopes reiterated the Task Force's concerns that reforms have to avoid unintended consequences like negating HSA-compatibility.

Sabrina Corlette, J.D. – Georgetown University Center for Healthcare Reforms³¹

Ms. Corlette observed that the high price of care has been the driver of the high cost of insurance for decades. At end of the day, states have to get at the prices of the providers and the prescription drugs in order to rein in insurance costs. She repeated the findings of other presenters that there is strong evidence that high deductibles, in general, cause delayed or foregone care.

Connecticut has an advantage with respect to its ability to impact costs through plan design, in that its state-run exchange can access data that federal exchange states aren't able to access. Ms. Corlette reviewed what some other states are doing with benefit designs, including

³¹ Ms. Corlette's presentation materials are included in Appendix G.

standardized plans, prescription cost sharing structures and mandates. She is not aware of any states that have extended standardization into their group markets. There are tradeoffs to standardization. On one hand, you can require pre-deductible coverage of certain services, but because of AV ratings, you would have to raise cost sharing somewhere else. Many states have been wrestling with these tradeoffs. Some states use pre-deductible coverage as a marketing tool to get more people covered or retain enrollment. Washington D.C. and California were offered as examples. Ms. Corlette was not familiar with health outcome data in states where individuals have greater pre-deductible coverage, however, she opined that not much clinical science actually goes into some of the decisions as to what services become pre-deductible.

With respect to prescription drugs, plans have explored changing formulary designs and cost sharing. Some states have limited prescription cost sharing or imposed monthly or annual caps. Some cap specialty drugs. NY bans specialty tiers altogether.

Ms. Corlette also discussed community benefit requirements and federally mandated community needs assessments conducted by non-profit hospitals. There has been an uptick in attention from policymakers at the state level, focusing on bad debt collection practices. Many bad debts are incurred by insured individuals. Approaches to addressing bad debts include hospital spending floors on community benefits (e.g., Illinois imposes a floor equal to the hospital's property tax relief) and limitations on debt collection practices. States also are imposing reporting and transparency requirements, including more frequent or more detailed reporting (such as top salaries). States have also explored conditioning mergers and CON approval on expanding community benefits.

With respect to consumer education, Ms. Corlette opined that decision-support tools are effective, but has not found great data to support that conclusion. She noted, however, that the tools must be available at time of enrollment to be most effective. Most state based exchanges have such tools, and some have been made fairly sophisticated, incorporating estimated utilization metrics to inform analysis. She noted that visual tools are also important and helpful in improving consumer literacy with respect to many general concepts like cost shares, metal tier levels and how claims are paid and cost shares are applied. She noted that state-based marketplaces spend a substantial amount of resources on navigator funding and advertising, and that CT has increased its funding for navigators. However, navigators don't assist in plan selection. Broker commissions are relatively low for marketplace plans, which can disincentivize brokers from spending time with individuals exploring those plans.

Overall, she has found that consumer satisfaction with exchange products is relatively high – but about 80% don't really use it. She suggested that it would be better to know what the rate of satisfaction is for high-utilizers.

Public Comments

Lynne Ide, Director of Program & Policy for the Universal Health Care Foundation of Connecticut provided oral and written testimony. She stated deductible costs have increased 162% over the past ten years, and that HDHPs have the effect of leaving many people functionally uninsured. In 2018, a research poll found that 43% of Connecticut residents delayed or avoided necessary care due to the cost. Another study found that HDHPs have yielded 13% reductions in per-employee health care spending, which was almost entirely attributable to underutilization.

Colleen Brunetti provided oral testimony as a patient with a rare disorder that requires her to incur over \$250,000 annually just in medication expenses. Her spouse's health plan has an HDHP with an individual out-of-pocket maximum of over \$8,000, which she is guaranteed to meet every year. She has had some relief from this financial burden in the past through the use of a copayment assistance card. Recently, however, her health plan stopped applying copayment assistance to her cost share accumulators. She urged the task force to examine this emerging practice by the insurers.

Senator Matt Lesser addressed the task force to express his gratitude for their time and effort in tackling this issue of high deductibles.

Dr. Larry Deutch, Hartford City Councilman, testified from the perspective of a local government official, a physician and a healthcare consumer. He observed that over the long term, HDHPs have not proven to be a cost benefit to the city. He has seen employees and patients avoid care due to costs, which has negatively impacted overall health of workers, reduced productivity and increased other costs such as workers' compensation. HDHPs have not otherwise had the intended impacts of making consumers more cost-conscious. He further expressed that this trend has had a discriminatory impact on lower-income populations.

Jill Zorn, United Health Care Foundation of Connecticut provided testimony that HDHPs do not protect individuals' physical or financial health. She highlighted the attention that Danbury Hospital received as a result of Dr. Villagra's presentation regarding its medical debt collection practices. She further highlighted a consumer story of a professional counsellor who could not access the care she needed because of her high deductible. Other health care professionals have reported that high deductibles are the biggest reasons (up to 30% of patients) for cancellations, no-shows and premature termination of the physician-patient relationship. Other patients cut back on regular therapy. Occurrences are higher in the early months of the year right after deductibles typically reset. She ended by acknowledging that everyone is going to have to give a little if the task force is going to have an impact on the lives of individuals.

Paula Haney testified that he is a physical therapist, Arthritis Foundation volunteer, and has a child with a diagnosis. His patients have to be able to navigate options to find what works best. Those with chronic illness don't always understand that low premium = high deductible, which may not be their best option. That deductible might get eaten up in the first month of

coverage. Nearly 44% of CT residents have less than \$1000 in savings. Thus, people go without necessary services or meds in order to pay household expenses. He suggests that preventive services and maintenance services be pre-deductible.

Jessica Black shared her personal experience as individual with HDHP. In car accident in Michigan while a student. Medical bills started rolling in. She had a \$6,000 deductible for in-network providers. Very few of her medical bills would be covered by health insurance because she was living in Michigan. Michigan no-fault law required her to use her own auto policy, which did not have medical coverage. Prior to moving there, had asked about out of state coverage, was told no problem. After accident was told should have purchased out of state coverage. Father pays \$600/mo for her coverage. Only received about \$3,000 in settlement against other driver. Left paying the balance out of her own pocket. Offering this as another example of how HDHPs do not work for Connecticut residents.

Tom Lally works with CT Ed assoc. as insurance specialist. Works with local unions to negotiate benefits portions of contracts. More than half of BOEs have HDHPs, all with HSAs (unless a member has VA benefits or TRICARE). Some have no deductible funding but share higher portion of premiums. About 90% of employers contribute to HSA, which reduces claims costs, thereby reducing trend. They assist members in understanding their plans and educating them on how to use the plan. For example, he counsels members over 65 who are still working on the benefits of postponing Medicare and continuing to fund HAS through employer. Gives 90-120 presentations at contract ratification stage of contract negotiations. Covers a lot of material. He believes the ACA excise tax was the driving force behind introduction and increase in deductibles. When it was first introduced, high deductibles were relatively low, and the premium differential between non-deductible plans and HSA plans was about 30%-35%, which was sufficient to fund the HSA. The excise tax led plans to hedge bets against the tax, and the trend for copay plans began to outpace high deductible plans, such that the cost of doing business increased, and the premium differential has narrowed significantly. In fact, most plans now also include post-deductible exposure. As a final comment, Mr. Lally thinks that the Insurance Department should be a participant in the Task Force's work, particularly to address what can't be done with respect to self-insured plans.

Dr. Victor Villagra, one of the presenters, offered additional public comment suggesting four metrics to accompany proposed Task Force recommendations. With respect to tracking health insurance literacy, he states that annual surveys are a feasible and inexpensive way to follow disparities. He further stated that tracking of small claims initiated by providers would be a good proxy for the ebbs and flows of medical debt and the impacts that HDHPs are having on consumers. Next, he suggested that tracking and publicizing consumer satisfaction scores collected by the Insurance Department would lead to recommendations for improvement in mediocre performances by insurer. Finally, Dr. Villagra expressed a need to establish a baseline for the number of dominated plans made available through the Exchange. Without further

study, there is no way to know the volume of dominated plans purchased or the economic burden of those purchases. The Health Disparities Institute is available to assist as needed.

Additional written testimony submitted by members of the public is attached as Appendix H.

Findings of the HDHP Task Force

Based on all of the information received and discussed, the Task Force makes the following findings:

- 1) Although the reasons for healthcare cost growth are complex and multifactorial, the Task Force finds that healthcare costs are increasing at an unsustainable rate

The Task Force received substantial evidence regarding the growth of healthcare costs over the last decade or more, all of which demonstrated that healthcare cost increases are outpacing increases in income and are consuming a greater and greater proportion of household resources.³² For example, government spending on Medicaid and Medicare, per enrollee, have risen 12% and 21%, respectively, since 2008, and private health insurance spending has increased by over 50% during the same time span.³³ Presently, per capita spending on health care in the United States is more than double that of nearly every other wealthy nation.³⁴

Due to the complexity of the underlying drivers of health care cost growth, the Task Force does not make any findings as to the causation of cost growth. However, the Task Force acknowledges that the Office of Health Strategy (OHS) is already leading a coalition of stakeholders who are exploring the establishment of a health care affordability standard and a health care cost growth benchmark in order to address this issue. The Task Force supports OHS's ongoing efforts in that regard.

- 2) Health insurance premiums and all-in consumer costs are most heavily influenced by the underlying prices of health care services, which may or may not reflect the actual costs of the services

The Task Force received substantial and largely undisputed evidence that health insurers set premiums, deductibles and other out-of-pocket costs primarily as a reflection of both the prices that the insurer must pay for covered services and the number of times those services are

³² See, e.g., Appendix , “The Burden of Health Care Costs for Working Families” published by the Leonard Davis Institute of Health Economics. See also “The Self-Sufficiency Standard for Connecticut 2019” available from the Office of Health Strategy at: https://portal.ct.gov/-/media/OHS/Affordability-Standard-Advisory/Self-Sufficiency-Standard/CT2019_SSS_Web_20191014.pdf?la=en.

³³ See Appendix (Corlette)

³⁴ See Appendix “Americans’ Struggles with medical bills are a foreign concept in other countries,” Los Angeles Times, September 12, 2019.

utilized by plan members.³⁵ Minimum loss ratio (MLR) requirements compel insurers to spend a minimum percentage (80%-85%) of the premiums they collect on member health care expenses.³⁶ As a result, insurers are limited in their ability to increase profits or expand other overhead expenses merely by increasing premiums or cost sharing obligations.

Instead, the prices of covered services, which must consume at least 80%-85% of premium revenues, comprise the largest driver of health insurance premium and cost share increases. As reflected in the insurers' annual rate filings with the Insurance Department, where premiums have increased, insurers' profit margins generally remain narrow and consistent from year-to-year while the trend factors of price and utilization are more volatile.³⁷

3) In order to minimizing premium increases insurers increase deductibles and other cost shares

Increasing a health plan's deductible can be effective at keeping the plan's premiums lower as underlying prices rise. As Dr. Fendrick observed, however, the shifting of costs away from premiums and onto cost-shares amounts to a "tax on the sick," in that healthier individuals will enjoy the benefits of the lower premiums while those who need to utilize services during the plan year will incur significantly greater total out-of-pocket expenses.

4) HSAs can be effective at offsetting the cost burdens of a high deductible when an HSA-compatible HDHP participant has the resources to fund the HSA

As mentioned herein, when an HDHP is HSA-compatible under IRS rules, consumers can take advantage of the three tax advantages of HSAs (tax-exempt contributions, earnings and distributions) to pay for their deductibles and other health care expenses.

In addition, employers who offer HSA-compatible plans to their employees may contribute funding toward the employee's HSA, which further reduces individual cost burdens on the employee. About one quarter of employers, include half of large employers (> 200 employees), offer HSA-compatible HDHPs to their employees.³⁸ Over the past decade,

³⁵ Using actuarial methodologies, insurers combine prices and utilization of covered services into a factor known as "trend."

³⁶ See 45 C.F.R. § 158.210.

³⁷ Connecticut insurers' individual and small group plan rate filings can be obtained from the Insurance Department at: <https://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx>. As reflected in the rate filings, risk and profit margins generally fall in the 1%-4% range year over year.

³⁸ See Kaiser Family Foundation 2019 Employer Health Benefits Survey, as referenced by Mr. McKechnie during his presentation, available at <https://www.kff.org/report-section/ehbs-2019-section-8-high-deductible-health-plans-with-savings-option/>

employee participation in HSA-compatible HDHPs has risen from approximately 6% of covered workers to 23% of covered workers.³⁹ Up to three quarters of employees covered under their employer's HSA-compatible HDHP receive a contribution from the employer.⁴⁰ In 2019, the average annual employer contribution to its employees' HSAs was \$572 for single coverage and \$1062 for family coverage.⁴¹

HSA-compatible HDHPs have also experienced slower premium and deductible growth compared with other types of health plans, which further moderates consumers' out-of-pocket cost burdens. As of 2019, the average annual premium for HSA-compatible HDHPs was \$6211 for single coverage and \$18,433 for family coverage, with employers covering approximately 75%-85% of those premiums. In addition, the average annual deductible for HSA-compatible HDHPs in 2019 was \$2476 for single coverage and \$4673 for family coverage.⁴² This represents an increase of 25% and 29%, respectively, over the past decade. By comparison, deductibles under non-HSA compatible health plans have more than doubled over the same time period.⁴³

5) HSA-compatible HDHPs are most effective when members can fund and utilize and associated Health Savings Account

In order to realize the most benefits of an HSA-compatible HDHP, consumers must have the resources available to direct funds into their HSA. Accordingly, HSA-compatible HDHPs typically work better for higher-income, higher-asset families who can afford to pay into the HSA, or who receive a substantial employer contribution, in order to meet the high deductible. The same plans are experienced as underinsurance or lack of insurance by moderate- and lower-income families.

6) Funding for HSAs can come from account holders, employers or any other public or private source, including a state or federal entity, as long as total contributions are within the applicable annual limits set by the IRS.

The Task Force notes that IRS rules apparently permit anyone, including public and private entities, to contribute to an individual's HSA. Although the traditional funding sources are

³⁹ Id.

⁴⁰ Id. Note that a disproportionate number of employees who receive employer contributions are employed by larger employers, as approximately half of smaller employers offer no contribution to their employees' HSAs.

⁴¹ See id. As noted in the survey, the overall average HSA contributions include the portion of covered workers whose employer contribution to the HSA is zero. When only firms that contribute to employee HSAs are included in the calculation, the average employer contribution for covered workers is \$768 for single coverage and \$1,433 for family coverage.

⁴² Id.

⁴³ Id. See also Appendix (McKechnie)

primarily individuals and their employers, other sources such as state and local governments, foundations, charities and other entities could also make contributions within the IRS' annual limits.

7) Non-HSA HDHPs have some advantages over HSA-compatible HDHPs

Although HSA-compatible HDHPs come with the advantages described above, non-HSA HDHPs can offer certain benefits that are not available from HSA-compatible HDHPs. Primarily, non-HSA plans have the flexibility to cover – pre-deductible – additional services not included in the IRS' safe harbor list. For example, a non-HSA plan design might include 100% coverage for regular breast cancer screening by ultrasound. In this way, non-HSA HDHPs can offer consumers additional choices in the marketplace when shopping for coverage.

8) High deductibles can present an impediment to medically necessary care when consumers delay or avoid care due to lack of resources to meet their deductible

The Task Force received substantial evidence from the presenters that individuals with high deductibles will delay or forego care because they don't have the resources to meet their high deductibles and other out-of-pocket expenses. Providers have observed that patients tend to schedule fewer appointments and procedures, and cancel or fail to show for appointments at a higher rate, at the beginning of a calendar year, as compared with the end of the year. As a further barrier to care, some providers will refuse to see patients who have presented for a scheduled appointment unless the patient pre-pays for his or her out-of-pocket cost obligation.

9) For a certain segment of the population, high deductibles can lead to incidences of medical debt, which in turn can lead to bankruptcies, collections activities and other household stressors, including negative effects on physical and mental health on individuals

The Task Force received substantial and compelling evidence regarding the connection between consumers' inability to meet high deductibles (and other cost sharing obligations) and medical debt, and its downstream financial and health consequences. In particular, the research presented by Dr. Villagra and the Health Disparities Institute elucidated the prevalence of medical debt and medical debt collection activities through small claims litigation. The Task Force adopts the following findings of Dr. Villagra and the HDI's research:

- Nearly a quarter of insured individuals experience medical debt
- Of those individuals, 43%-67% have exhausted their savings to pay bills
- 16% have been subjected to collections activity

- Up to 62% of bankruptcies are related to medical debt⁴⁴
- Between 2011 and 2015, providers in Connecticut filed 85,136 small claims actions and obtained judgments totaling over \$110 million, most of the time without any appearance from the defending patient

These consequences of medical debt and medical debt collection activities further impact individual and social health outcomes. As noted by Dr. Fendrick, rising out-of-pocket costs create and exacerbate health disparities, particularly among economically vulnerable individuals and those with chronic conditions.

10) Plan complexity, pricing opacity and various cost sharing mechanisms result in consumer inability to predict and budget for their annual health care costs

The research of Dr. Villagra and the Health Disparities Institute was particularly insightful with respect to health care and health insurance literacy among consumers. More than one-third of consumers lack a sufficient understanding of some of the basic features of their health plans, including annual deductibles, annual out-of-pocket limits and formularies.⁴⁵ Furthermore, when these data are examined in relation to consumer ethnicity and race, disparities in health care literacy begin to emerge, reflecting a greater negative impact on communities of color imposed by the complexity of the health care and health insurance system.

As a result of suboptimal health care and health insurance literacy, consumers who lack adequate knowledge or assistance frequently select health care plans that are not best suited to meet their individual health care needs, either by over-insuring or underinsuring themselves. Unfortunately, this phenomenon is sometimes exacerbated by the availability of too many consumer choices, resulting in information overload and causing consumers to disengage from plan comparison activity.

These problems are further exacerbated by the lack of access to specific pricing information with respect to health care services, which vary by plan, provider, setting, network status and several other factors. In the absence of such pricing information, particularly at the point of plan selection, consumers are unable to compare accurately the suitability of plan choices, even if they fully understand the plan's cost sharing structure and other features.

11) Improvements in healthcare literacy would positively impact consumers' ability to select plans that best fit their needs and to utilize their selected plan efficiently

⁴⁴ This particular finding is consistent with the findings of other researchers. See <http://medicaldebthub.com/2019/03/podcast-authors-of-end-medical-debt-discuss-the-problem-and-their-solutions/>

⁴⁵ See Appendix (Villagra)

The Task Force finds that consumers would benefit from efforts to improve population healthcare literacy in order to improve consumer plan selection efforts and help consumers optimize the use of the plans they select. The Task Force acknowledges the efforts of Access Health CT to improve consumer literacy via initiatives such as Healthy Chats, and improvements in its online plan selection tools. While the Task Force encourages Access Health to continue to build upon those efforts, it also finds that more support is need to assist consumers with plan selection and utilization both at the time of enrollment and throughout the term of the contract.

Suggested Recommendations by Category

1. Healthcare Literacy and Education

The Task Force received evidence that consumer literacy around healthcare and health insurance is a factor in consumers choosing plans that are economically dominated or are not right for their situation, as well as being a factor in consumer dissatisfaction with plans which have or are perceived to have high deductibles and cost sharing. In addressing healthcare literacy, the task force makes several specific recommendations. An overarching recommendation is that the state should consider piloting multiple initiatives in consumer literacy in order to see which initiative or initiatives is especially effective at improving consumer choice and satisfaction. Members of the task force cautioned, however, that efforts to improve consumer literacy might be economically inefficient if they add significantly to the costs of care.

1.1. Establish public-private partnerships to improve health insurance literacy (6)⁴⁶

The lessons that consumers learn about their health coverage are often lessons learned after an expense has been incurred. Information from the UCONN Health Disparities Unit suggests that there is an opportunity to prevent these expensive lessons through partnership between the state and educational, social service, and community organizations.

1.2. Explore expanding the health plan navigators (1), (6)

The Navigators provide assistance to individuals before and up to the point of enrollment; although Navigators are not able to recommend that a consumer choose a particular health plan. The state should examine whether there is an opportunity to provide additional effective consumer health literacy interventions through the Navigator program.

⁴⁶ The numbers in parentheses refer to the seven statutory charges of the High Deductible Health Plan Task Force, found in Public Act 19-117 §§ 247(b)(1) through (b)(7).

1.3. Improve transparency regarding provider billing and reimbursement practices and claims experiences (1), (2), (4), (6)

The Task Force is aware of the state's ongoing efforts to increase transparency in healthcare costs, and encourages the state to continue and expand these efforts.

1.4. Improve presentation of total costs in all areas of the state healthcare coverage marketplace, including but not limited to AHCT – e.g., annual fixed costs (premiums), annual maximum costs (deductible and OOP max), likelihood of a household of n size experiencing a major medical event, and individualized prediction of annual health expenditure under a particular plan based on prior claims data. (2), (6)

The Task Force is aware that Access Health CT is continually working to provide consumers with additional information that can assist in making health coverage choices. Information from the HDI suggests that more work can be done here, and the Task Force encourages improvement in this area.

1.5. Increased public awareness the availability of pre-deductible preventive services. (1), (2).

The Task Force received evidence from several presenters that the presence of high deductibles served as an obstacle to consumers seeking even preventative care which would be covered pre-deductible under the ACA. The reasons for this are myriad, including that consumers may not trust that their procedures will be billed or adjusted appropriately, that providers may not be able to state ahead of time whether a procedure is preventive or diagnostic, and that consumers fear that preventive services may lead to expensive diagnostic follow-up which hits the deductible. The Task Force feels that improvement in consumer education about the availability and scope of preventive services will have a positive effect on uptake of these services.

2. Cost Sharing Reforms

2.1. Phase out high deductibles and coinsurance, and shift more toward copayments, as forms of member cost-sharing (potentially connected with a shift toward VBID and high-value care) (1), (2)

2.2. Tie cost-sharing to family income (1), (2)

2.3. Allow for pro-rating deductible for new enrollees in the middle of plan year (1), (2), (4)

2.4. Allow for deductible credits for enrollees who switch from plan to plan during a plan year (1), (2), (4)

2.5. Carriers are responsible for paying cost shares to providers and collecting those payments from their insureds (7)

2.6. Documented advice given by Customer Service Representatives over the phone to consumers should take precedence over plan terms inconsistent with specific verbal representations (4), (6)

2.7. Incentives to encourage members to seek care early in the plan year, such as insurer allowing provider to waive collecting copay/coinsurance for primary care sought in first quarter of plan year. (1), (2)

3. Health Savings Accounts

The Task Force received evidence regarding Health Savings Accounts (HSAs) and HSA-qualified HDHPs. Individuals in HSA-qualified HDHPs, as defined by the IRS, may make pre-tax contributions to an HSA, which is at this writing the most tax-advantaged savings vehicle in the Internal Revenue Code. Funds may be contributed pre-tax to an HAS up to an annual maximum set by the IRS; appreciation of HSA funds is not subject to taxation; and withdrawals from an HSA to pay for qualifying medical expenses including long-term care premiums are not subject to taxation. For members who have the means to fund HSAs, they are a tremendous savings vehicle.

The Task Force also received evidence that lower-income members, who may not be able to afford to set aside money to contribute to an HSA, experience many of the same barriers to care that enrollees in non-HAS-qualified HDHPs experience.

The Task Force also notes that HSAs are a creature of Federal law and regulation, and fundamental reforms to HSAs or qualified HDHPs require Federal action. Nevertheless, the state may take some actions to improve HSA-qualified HDHPs without Federal action. These are the potential reforms that the Task Force has considered:

3.1. Allow enrollees in Medicare Part A to continue contributing to HSAs (3)

This would require Federal action: the state may, of course, refer this reform to Connecticut's congressional delegation.

At the present time, individuals who have enrolled in Medicare Part A are not eligible to contribute to HSAs. Individuals who have not enrolled because they have creditable employer-sponsored coverage through a qualified HDHP can continue to contribute to the HSA after age 65. Changing this policy would enable enrollees in Part A to contribute pre-tax dollars through an HSA for qualified medical expenses, including payment of long-term care premiums.

3.2. Allow spouses to make HSA catch-up contributions above current allowable limits (3)

As above, this would require Federal action.

3.3. Explore redefining HSA eligibility on the basis of metal tiering levels rather than size of deductibles and out-of-pocket maximums (3)

As above, this would require Federal action.

3.4. Require AHCT to explore, and if legally permissible, require only HSA-eligible HDHP plans. (3)

The Task Force considered recommending that the only high deductible plans on the AHCT exchange be HAS-qualified HDHPs. Federal requirements for HAS-qualified HDHPs are very narrow: the task force did not feel there was enough space within the Federal requirements to design an HAS-qualified plan that is appreciably different from

the existing offerings. This proposal has the potential to dramatically reduce consumer choice, although the Task Force has received some evidence that consumer choice in health insurance is not an unmixed good and that consumers become stymied and confused when faced with too many health plan choices.

- 3.5. Allow consumers who are in an HSA to direct any state tax refund to their HSA instead of another personal bank account, and if possible allow them to exclude the refund amounts paid into their HSA from their federal income for the next year. (This may already be permissible. Since HSAs are just a special form of bank account, people who get refunds via direct deposit maybe already can choose for the money to go to an HSA. If this is already permissible, have DRS publicize it at the point of filing.) (2), (3)

HSAs are ordinary deposit accounts which receive special tax treatment from the IRS. The Task Force is not aware of any impediment to individuals directing their tax refund dollars to an HSA so long as their total annual contribution remains below the IRS limit. Nudging HSA-qualified consumers toward contributing to their HSA may encourage those consumers to use their HDHPs.

- 3.6. Endorse using federal or any other new state or private subsidy money to fund HSAs for subsidized enrollees, and possibly go as high as possible up the income ladder with HSA funding. (2), (3)

Similar to the previous recommendation, the state should consider the impact of applying health care funding dollars directly to the HSAs of consumers in qualified HDHPs. A growing body of research shows that, in general, direct cash payments to consumers are highly effective in relieving the effects of poverty and financial distress, when compared to non-fungible services having the same cost to the state. Directly funding the HSAs of consumers, starting with subsidy-eligible enrollees and proceeding as far up the income ladder as possible, could be an efficient way to relieve CT consumers of a portion of their health care costs.

- 3.7. When considering measures to provide healthcare coverage cost relief to consumers, or to otherwise create market-based incentives to drive healthcare costs down, always consider alternatives that use state, federal, AHCT, or private funding to give consumers direct individual control over their healthcare dollars by funding individual HSAs, in addition to more traditional subsidization or cost-shifting strategies, such as reinsurance, cost-sharing reductions, or others. (1), (2), (3)

As with the previous recommendation, the State could adopt a policy of examining, for any future funding stream related to health coverage, whether direct contribution to HSAs would be an efficient and effective form of relief for CT consumers. With respect to recommendations 3.6 and 3.7, members of the Task Force noted that it is helpful for consumers to have funded their HSAs earlier in the year to overcome the problem of a high deductible being an impediment to seeking treatment.

4. Financial relief

- 4.1. Establish an affordability metric (2)

The Task Force noted with approval an existing initiative at OHS to identify a Healthcare Affordability standard. At the same time, members of the Task Force stated that health care costs and/or prices are complex, that consumers have very different health care needs and abilities to pay for treatment and insurance, and that a one-size-fits-all approach may not serve to identify when health care costs have exceeded a uniform Affordability Standard. Task Force members further pointed to ongoing efforts at some provider organizations to extend charitable assistance to households at incomes well into the middle class.

Some Task Force members pointed out that non-profit organizations such as hospitals are much better positioned to provide charity care than small, for-profit organizations such as practice groups or small providers. At present, doctors in private practice are not able to write off charity care on their taxes even though doctors provide an estimated average of \$230,000 in uncompensated care every year.

4.2. Reform judicial procedures to protect individuals from unfair medical debt collection and litigation practices (2)

The Task Force is cautiously supportive of provisions to protect consumers from unfair medical debt, such as defenses against collection of a surprise bill, or a right for consumers to receive an itemized medical bill that is accessible to a layperson, prior to judgment. At the same time, the Task Force did not conclude that providers ability to collect medical debt should be significantly constrained.

The ability of some providers, but not others, to write off bad debt in taxes was identified as a potential solution that could provide consumers some relief from debt collection practices. The Task Force also had the sense that insurers at times have sought to recoup a portion of a payment from providers who failed to pursue debt collection vigorously, on the theory that a provider who waived the member's cost share was implicitly billing at a rate lower than the allowed amount. This practice, or the perception of this practice, has had some effect on provider collection practices, particularly smaller providers who are little able to absorb the additional loss nor to fight the practice in the court of public opinion. Prohibiting carriers from recouping an uncollected cost share could relieve providers from pursuing medical debt particularly where collection is likely to be unfruitful.

4.3. In-network rate negotiation protection: If high deductible enrollees can show that their carrier's negotiated rate is above a localized benchmark (say 60th percentile of commercial plan payments) for that service, procedure, or drug, limit the patients' liability to the provider to the amounts up to the benchmark. The provider can collect the balance directly from the insurer who negotiated the rate. (1), (2), (7)

The Task Force was mixed on this proposal. Some members felt strongly that this proposal is a matter of fairness to consumers. Particularly in high deductible health plans, the consumer pays the full rate that has been negotiated between the carrier and the provider, but the consumer has not negotiated that rate and in many cases has not even seen the rate prior to treatment. Where the negotiated rate is above the benchmark the carrier should bear the cost for failing to negotiate it down.

4.4. Others on the Task Force pointed out that providers negotiate rates in the context of a total package of services that they provide, and that a provider or insurer may want to incentivize the provision of a particular service in a particular provider for myriad reasons. There is also a practical question of how the benchmark rate is to be determined for a particular location.

5. Cost & Quality Control

5.1. Establish a medical cost trend cap or other cost growth limitations (2)

5.2. Establish rules aligning prices of healthcare services with actual costs (2)

5.3. Implement VBIDs (1), (2)

5.3.1. Establish means for evaluation low- vs. high-value care (1), (2), (6)

5.3.2. Require all fully-insured non-HSA eligible HDHP plans in the state to cover all the new optional IRS list of covered services/chronic conditions. (1)

5.4. Promote performance-based goals for improvement within certain data points reported on the Consumer Report Card (2)

5.5. Address defensive medicine (1)

5.6. Address high cost of training clinicians and physicians (1), (2)

5.7. Require copays and, possibly, coupons, to count towards deductibles and out-of-pocket maximums for non-HSA plans.

5.8. Facilitate new entrants into the health insurance marketplace, including a public option