Maryland
Hospital Association

Senate Bill 514 – Health Facilities – Hospitals – Medical Debt Protection

Position: *Oppose*
February 25, 2021
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 514. Maryland hospitals have only one core mission: to provide the best patient care possible in the state. Hospitals believe every person should receive the care they need without financial worry. Maryland hospitals make every effort to inform patients about available financial assistance, including free or reduced-cost care. That includes helping patients enroll in Medicaid or other insurance options and set up reasonable payment options when needed.

Maryland Leads in Consumer Protections

Hospitals' financial assistance and billing collections practices are governed by extensive state and federal laws. Just last year, this legislature strengthened the state's already-robust hospital financial assistance laws by passing HB 1420, Chapter 420, Hospitals – Financial Assistance Policies and Bill Collection. These comprehensive reforms took effect Oct. 1, 2020, and hospitals worked diligently during the COVID-19 pandemic to ensure timely implementation. As seen in the attached slides, hospitals routinely engage patients throughout the financial assistance and billing process. In addition, federal law addresses nearly every aspect of financial aid and billing practices. Established by the Internal Revenue Code §501(r)[i], these laws set thresholds for free and reduced-cost care; define notice requirements for financial assistance and collections; create application period timelines; and outline actions hospitals may take to pursue outstanding bills.

Extensive Overhaul Threatens Maryland's Unique Model

The complex and comprehensive reforms included in SB 514 are based on model legislation that does not account for Maryland's all-payer system. In Maryland, every patient has access to every hospital, regardless of ability to pay, because uncompensated care is equitably funding in the system among all hospitals and all payers. We agree patients who cannot afford to pay should not. As the Health Services Cost Review Commission (HSCRC) points out, we must balance our efforts to make reasonable attempts to collect. Otherwise, hospital rates increase due to increased uncompensated care—straining Maryland's agreement with the federal government and raising prices for all health plans and patients. Maryland's unique fixed budget system keeps hospitals from growing volume to cover uncollectable accounts, further focusing the need for hospitals to reasonably collect on bills. Any proposed overhaul would need to be considered against the impact on our system.

For these reasons, after this bill was introduced last session, the hospital field evaluated our process over the summer and identified best practices for the field. As part of this endeavor, MHA surveyed members

about hospital billing and collection practices, held focus groups, and engaged a dedicated work group to consider these reforms. This process considered each of the reforms included in SB 514 for operational feasibility, interactions with the new financial assistance requirements, and, most importantly, impact on the Total Cost of Care Model, as noted by HSCRC. MHA briefed this committee on many of those findings, including existing laws and best practices last November.

These efforts culminated in a series of in-depth conversations with bill sponsors and proponents to identify potential agreement ahead of this legislative session. Working with hospital members, MHA offered alternative language to add consumer protections and payment plan requirements established by HSCRC and strengthen insurance appeal notification and aligned notices with existing financial hardship laws. MHA was, therefore, surprised to see that many of the points where we believe there was mutual agreement were unfortunately not included in SB 514. **The bill as introduced retains the provisions that were identified as longstanding and major concerns.**

Maryland Must Address the Real Cause of Outstanding Bills: High-Deductible Health Plans

The direct relationship between a rise in outstanding bills and an increase in high-deductible health plans is well established. Quite simply, **high-deductible health plans leave many people functionally uninsured.** The increasing individual financial obligations for health insurance results in avoided preventive care, and unexpected burdens when individuals obtain health services. This is because insurers have thinned coverage, shifting the burden of health costs onto consumers.

> *Over the past decade, premiums and deductibles have risen faster than worker's wages nationally. In Maryland, premiums have increased 24% from 2013-2019 and remain over the national average. Deductibles increased 55.6% in employer-sponsored plans: In 2013, the average deductible was $1,075. In 2019, that number had jumped by nearly $600 to $1,673.*

Individuals in these plans often do not understand that their coverage only kicks in after the several thousand-dollar deductibles is met. True reform in medical debt must bring insurers to the table with solutions to protect and educate consumers when choosing coverage for health services in lieu of comprehensive health insurance coverage.

A Connecticut Task Force, created by the Legislature issued a February 2020 report that explored how rising out-of-pocket costs create and exacerbate health disparities, particularly among economically vulnerable individuals and those with chronic conditions. The report noted "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." The Task Force identified **consumer literacy** around health care and health insurance as a factor in consumers choosing plans that are economically dominated or are not right for their situation. They outlined several recommendations to support this finding. **They also recommended cost-sharing reforms, including phasing out high deductibles and coinsurance and making carriers responsible for paying cost shares to providers and collecting those payments**. The report found:

> *In light of the evidence regarding the relationships between high deductibles and medical debts, many Task Force members viewed this proposal as an opportunity to preserve the provider-patient relationships (particularly among smaller provider groups) that are harmed by debt collection activities and avoidance of care, which can also impact patient and population health. Some Task Force members also predicted that the additional certainty of receiving payments for services would lead to more providers joining carriers' networks and thereby improving access to care.*

This reform has been considered in other states as well.

We ask this committee to consider new approaches to the health care billing process as part of true reform we have seen succeed in other states.

Maryland hospitals give every patient the ability to seek financial assistance and fair payment options to pay medical debt owed. Senate Bill 514 as introduced does not take into account the laws, resources, and steps hospitals take to work with every patient. Nor does it balance the need for changes in provider processes with the need to address the impact of insurance practices.

For these reasons, we urge an ***unfavorable*** report.

For more information, please contact:
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[i] www.irs.gov/charities-non-profits/billing-and-collections-section-501r6

Financial Assistance

Hospital practices to assist patients with financial assistance

Assist with Obtaining Needed Documents

- ID
- Death/Birth Certificate
- EOBs
- Itemized Bills
- Home visits for screening and pick up of documents

Tracking down family/next of kin

- Research online
- Call payers
- Review previous admissions
- Checking social media profiles

Checking State, Federal, & Credit Agency data bases

- Vital Records
- IRS
- Work Number
- Experian/credit reporting
- DSS Inquiries

Contracting with vendors and state caseworkers to assist patients

- DSS Caseworker
- DECO/Medical Assistance Vendor Partners
- Navigators

Enhancements to Financial Assistance Process in Response to Passage of HB1420 in 2020

- Increased financial eligibility threshold to 500% of FPL
  - Most hospitals already included up to 400% of FPL
- Excluding certain assets such as
  - Any resource excluded for Medicaid Eligibility determination
    - MAGI (under 65 and not disabled) qualifications do not count assets
  - Retirement Plans
  - First $10,000
- Developed plain language financial assistance summaries in multiple languages
- Developed consumer complaint and appeal process (HSCRC & HEAU)
- Preparation for Annual Financial Assistance Report

Assistance Starts At Patient Admission

- Hospitals counsel patients on assistance options and provide information on how to get help with financial assistance.
- Information provided in multiple ways; directly to patient at registration, included in discharge packets, posters in hospital, posted on website, mailed with billing statements, etc.

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

Adventist HealthCare is committed to meeting the health care needs of our community through the ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance.

Availability of Financial Assistance: You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full your expected out-of-pocket expenses for emergency and other medically necessary care that Adventist HealthCare provides.

Eligibility: Adventist HealthCare provides financial assistance based upon need. To determine need, we review your household income and compare it to the Federal Poverty Level guidelines set by the U.S. Department of Health and Human Services. We also review the amount of charges for which you are responsible.

If you and/or the party responsible for payment has combined income equal to or below 200 percent of the federal poverty guidelines, you will have no financial responsibility for the care that Adventist HealthCare provides. If you fall between 200 percent and 600 percent of the guidelines, you may qualify for discounted rates for our care.

Financial Assistance

FAP Plain Language Summary

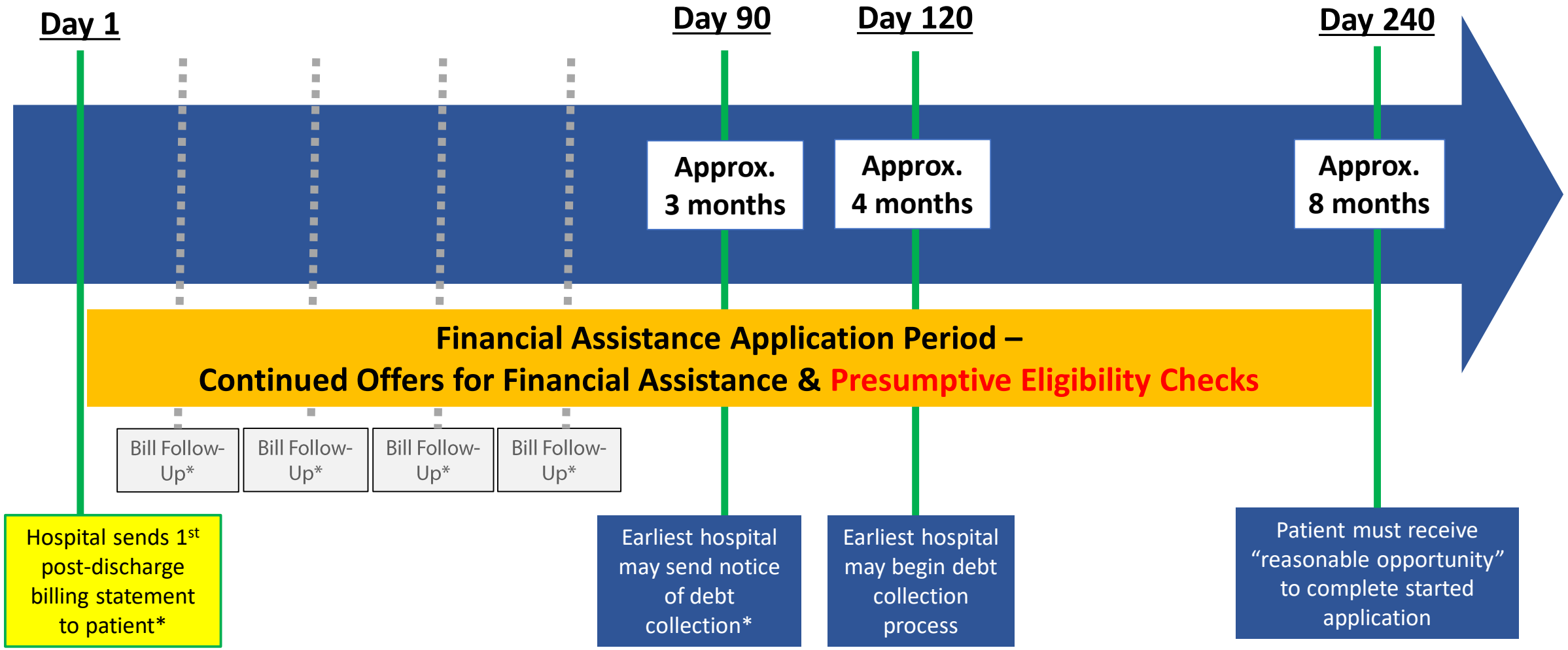
Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

Please Note:

- We treat all patients needing emergency care, no matter what they are able to pay.
- Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. See the list of physicians who provide emergency and other medically necessary care in the hospital facility whose services are not covered under this policy. You can call **410-821-4140** or **877-632-4909** (toll free), or email CBOService@umm.edu if you have questions.
- You will never be charged for emergency and other medically necessary care more than **amounts generally billed** to patients who are not eligible for financial assistance under the financial assistance policy. Rates are set by the State of Maryland.

Timeline of Financial Assistance Availability



* Denotes when the financial assistance policy information sheet must be given to patient.

High Deductible Health Plan Task Force

Final Report

February 24, 2020

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Executive Summary

In the 2019 budget, Governor Lamont and the Connecticut Legislature asked for a Task Force to look at how health insurance plans with high deductibles (HDHPs) were affecting consumers. (A deductible is money that the consumer has to pay for their health care before the insurance will begin to pay for care.)

The Task Force heard from many experts about issues with high deductibles. Deductibles which are too high can lead people to avoid necessary care because they cannot afford to pay for it. Some people avoid care even when it will be completely paid for by the insurance company. Some do not understand or trust that their care will be paid for by the insurance company, and some do not want to pay for follow up care that may be necessary. Insurance companies use deductibles to lower monthly premiums by shifting more of the costs directly to consumers. Both premiums and deductibles have grown over the years because the price of medical care has gone up a lot.

The Task Force heard how high deductibles prevent people from getting health care that they need even when they have health insurance. At the same time, deductibles do help some people to save money, especially people who are able to put money into a Health Savings Account, which is one the best tax shelters in the tax code. The Internal Revenue Service has put forth rules on which HDHPs allow people to put money into an HSA. Not all HDHPs qualify.

The Task Force heard about how high deductibles lead to medical debt, especially for people who do not have a lot of money to begin with. Medical debt is a problem for both consumers and providers. Consumers tend to avoid going back to doctors when they owe money and are not able to pay. Providers have to choose between serving the needs of the patient who owes them money, and making sure they can stay in business to serve all of their patients.

The Task Force considered many possible changes to HDHPs that could address some of the problems that high deductibles contribute to. Those changes are described in this report, as well as what the Task Force thinks about each change. The possible changes fall into five basic categories:

1. Helping people understand their insurance better
2. Changing how deductibles work
3. Making HSAs work for more people
4. Helping people pay for health care
5. Bringing health care prices down

A majority of the Task Force adopted many of the recommendations that had been considered, while several other proposals were rejected. None of the recommendations had unanimous support from the Task Force membership.. In general, Task Force members looked favorably on efforts to teach consumers about their health plans, while at the same time noting that the complexity of health insurance is itself an issue. The Task Force further supported reforms to

encourage people who qualify for HSAs to fund them, and to encourage the state to consider funding the HSAs of people who qualify but do not have the income to fund their own. Task Force members also recognized that a main cause for the growth of HDHPs is the growth of the underlying health care costs, and expressed its support for existing efforts to identify a Healthcare Affordability Standard and a Health Care Cost Benchmark. Finally, Task Force members supported certain cost sharing reforms intended to mitigate consumer and provider concerns that necessary or high-value care is cost-prohibitive due to a high deductible.

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, CT College of Emergency Physicians
- Cassandra Murphy, CT Coalition of Taft-Hartley Health Funds
- Dr. Greg Shangold, CT State Medical Society
- Dr. Andrew Lim, Bristol Hospital
- Robert Krzys, Esq.
- Susan Halpin, CT Association of Health Plans
- Janice Perkins, ConnectiCare
- Patrick McCabe, Yale New Haven Health System
- Dr. Andrew Wormser, CT Medical Group
- Joseph McDonagh, McDonagh Insurance
- Seth Powers, The Center for Children with Special Needs

[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.

Background

Definition of High Deductible Health Plan

High deductible health plans (HDHPs) are health insurance designs that, in exchange for lower premiums, require members to absorb greater initial out-of-pocket expenditures for medical services (other than "preventive" 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 Internal Revenue Service (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]
- Any treatment that is incidental or ancillary to the preventive care services listed above;[8]

[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). In addition to the IRS limits on out-of-pocket maximums applicable to HDHPs in 2020, federal law also limits out-of-pocket maximums under all group health plans at $8150 for self-only coverage and $16,300 for other than self-only coverage. See 42 U.S.C § 300gg-6.
[3] 26 U.S.C. § 223(c)(2)(C).
[4] IRS Notice 2004-23.
[5] Id.
[6] Id.
[7] Id.
[8] IRS Notice 2004-50.

- 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 (USPSTF); [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]

[9] IRS Notice 2013-57 and 42 U.S.C. § 300gg-13. A listing of the recommendations published by the USPSTF is available online at: https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
[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
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders

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] HSAs offer a third benefit as well, in that any interest or other earnings that accumulate to the account, which can feature investment option similar to other tax-sheltered retirement accounts such as 401(k)s or Individual Retirement Accounts, 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. After age 65, HSA funds may be withdrawn without penalty for any non-medical purpose, though unlike qualified medical expense withdrawals, such non-medical withdrawals after 65 are subject to normal income tax. 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.

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.

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 "shop" for services on the basis of quality and cost. In doing so, members would elect to forego more low value services (potentially higher cost with lower health outcomes) and seek out higher value care (potentially lower cost with 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 plans that incorporate high deductibles, but do not qualify as HSA-eligible 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 HSA-eligible 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 such additional pre-deductible benefits into their product designs, and thus are not HSA-compatible.

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 assumes the risk and 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 and paying claims, and

so on. The third party administrator, sometimes called a TPA, may be a traditional insurance company providing administrative services only, or it may be a separate specialized contractor.

Approximately 65% of Connecticut residents who have health coverage through an employer currently receive that coverage through a self-funded plan.[18] 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 of 1974 (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 from which the medical claims are paid, 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 (ACA). 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 that are within the federal rather than the state purview to the state's Congressional delegation.

[18] See https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/

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, January 17, January 28 and February 5, 2020.

At its October meeting, preliminary discussions among Task Force members initially identified access to care as a primary issue to be addressed by high deductible health plan (HDHP) reforms. At the time, Task Force members perceived and later received evidence that high deductibles present 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. This deferment of care can result in consequences to an individual's health and wellness. Task Force members further posited that high deductibles can 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 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 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 attempts 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 receive subsidies to buy insurance through the Exchange.

The task force received a series of presentations, which sought to articulate for the Task Force the benefits and challenges associated with HDHPs.[19] The presenters included Dr. Victor G. Villagra, Associate Director of the UCONN Health Disparities Institute,[20] Lynn Quincy, Director of Altarum's Health Care Value Hub,[21] Kevin McKechnie, Executive Director of the American Bankers Association HSA Council,[22] James Stirling, Stirling Benefits, Inc.,[23] Dr. A. Mark Fendrick,

[19] The information presented was not independently validated by the Task Force and represented the opinions of the presenters.
[20] Dr. Villagra's bio and additional information regarding UCONN's Health Disparities Institute may be found at: https://health.uconn.edu/health-disparities/
[21] Ms. Quincy's bio and additional information regarding the Healthcare Value Hub may be found at: https://altarum.org/solution/altarums-healthcare-value-hub
[22] Mr. McKechnie's bio and additional information regarding the HSA Council may be found at: https://www.aba.com/authors/kevin-mckechnie
[23] Mr. Stirling's bio and additional information regarding Stirling Benefits, Inc. may be found at: https://www.stirlingbenefits.com/about-us/

Director of the University of Michigan Center for Value-Based Insurance Design,[24] Ann Lopes, Product Carrier Manager for Access Health CT, Sabrina Corlette, J.D., Co-Director Georgetown University Center on Health Insurance Reforms[25] and Paul Lombardo, Director of the Life and Health Division of the Connecticut Insurance Department.[26] The Task Force also received several oral and written comments from various members of the public.

Dr. Victor Villagra – Health Disparities Institute[27]

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
- 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 2016, providers filed 85,136 small claims actions seeking recovery of debt totaling over $110 million, most of the time without any appearance from the defending patient.[28] Dr.

[24] 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
[25] 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/
[26] Additional information regarding the CT Insurance Department's Life & Health Division may be found at: https://portal.ct.gov/CID/About-Us/The-Life--Health-Division
[27] Dr. Villagra's presentation materials are included in Appendix A.
[28] Dr. Villagra's presentation identified an outlier hospital that accounted for nearly half of all of the lawsuits studied as part of his research.

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 Hub[29]

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.

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.

[29] Lynn Quincy's presentation materials are included in Appendix B.

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,[30] 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 Council[31]

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, and therefore are not HSA-compatible. HSAs come with the triple 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, Medicare 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

[30] Ms. Quincy acknowledged that the practice of "defensive medicine" plays a role in the overutilization of some lower-value services.

[31] Mr. McKechnie's presentation materials are included in Appendix C.

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, or contributing to their HSAs on a pre-tax basis.

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 financially 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.[32] 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 individuals 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 reform 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 paid by the member to the insurer, rather than the healthcare provider, and that the insurer instead of the member would pay the healthcare provider directly for such expenses. He explained that such a payment likely would not be a qualified healthcare expense, because once the insurer paid the charge and sought

[32] See fn 14, *supra*.

reimbursement from the member, the amount 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.[33]

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, as the ACA's Medical Loss Ratio (MLR) rules, which require healthcare plans to spend 80%-85% of the premiums they collect on medical claims, cap their allowable profits from premiums. Thus, insurer profits can only increase when premium collections increase, which in turn incentivizes 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

[33] Mr. Stirling's presentation materials are included in Appendix D.

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 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, *i.e.* allowing plans to pay for such services before the patient satisfies her 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 to the employer, 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 Design[34]

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

[34] Dr. Fendrick's presentation materials are included in Appendix E.

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 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 in any given year. 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 for poor patient outcomes when lower patient utilization of low value services yields the 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 Manager[35]

Ann Lopes is the Product Carrier Manager for Access Health Connecticut (AHCT), Connecticut's ACA 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 the ACA's advanced premium tax credits (APTCs) and cost sharing reductions (CSR) subsidies. Connecticut has 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 (*i.e.*, employer-paid premiums) to the employee share (*i.e*., patient-paid premiums, deductibles and other patient responsibility) 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, thus allowing consumers to compare plans with similar coverage. 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 two individual plans that are true HDHPs, *i.e.*, HSA compatible plans. The Connecticut Insurance Department reviewed and approved five other individual plans available outside of the Exchange that were identified as HSA compatible, although these may not all be marketed by the submitting carriers. 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). Based on the information included in the Individual rate filings for 2020 plans submitted in July of 2019, approximately 22,600 individuals in CT were projected by the carriers to be

[35] Ms. Lopes' presentation materials are included in Appendix F.

enrolled in HSA compatible (individual) plans, of which about 15,000-16,000 were 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, carriers offering plans through AHCT do offer information to enrollees as to how they can set 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 federal payment notice stated that carriers did not have to apply coupons to a member's out of pocket max; however, the federal Department of Labor and IRS indicated that this topic would be revisited in the 2021 payment notice.

AHCT's product design committee has looked into offering VBID features, 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 (*i.e.*, federal and state rules requiring parity between medical and mental health coverage) 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 Reforms[36]

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 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 we 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 Certificate of Need (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

[36] Ms. Corlette's presentation materials are included in Appendix G.

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.

Paul Lombardo – Connecticut Insurance Department

Paul Lombardo is the Director of the Life and Health Division of the Connecticut Insurance Department. He presented an assessment of a few of the recommendations that the Task Force had been considering during its deliberations. First he addressed a concept whereby coverage would be required, pre-deductible, for some or all of the 14 items added to the IRS's safe harbor pursuant to IRS Notice 2019-45. Presently, pre-deductible coverage of those items is optional. If some or all of the items were required to be covered pre-deductible, it would likely increase premiums, although the amount of the increase could not be calculated without further information. It would also create a potential impact on the AV calculator. Whenever you change cost sharing, it can move a given plan outside of a particular metal tier. In addition, carriers would have to recalculate parity to ensure compliance with mental health parity rules.

Regarding a second proposal, Mr. Lombardo noted that mandating pre-deductible coverage of mental/behavioral health and substance abuse benefits would require federal input with respect to HSA-compatible plans. Including first-dollar coverage of such items is unequivocally beyond the IRS safe harbor parameters. With respect to non-HSA plans, this proposal would have similar results as with the mandate of the 14 new safe harbor items. The additional pre-deductible coverage would likely increase premiums, affect AV calculator and require new parity calculations. Mr. Lombardo also recognized that this proposal raised an issue related to "reverse-parity," which prohibits plans from offering first dollar coverage of just mental health services without also establishing comparable coverage for medical services.

In response to Task Force member questions, Mr. Lombardo noted that the mandated coverages discussed above may have the potential for improving health benefits, but because health insurance premium rates are only approved for one year it would be difficult to predict or compare those downstream health benefits with present costs of mandating those coverages. In other words, the premium rate filings cannot capture the potential health savings

beyond the one year rate review period. Rates are reviewed from an actuarial perspective through a well-defined, transparent and public process, which largely occurs from July through September. Rate filings include data regarding utilization, trend and other information. Mr. Lombardo was not aware of any other state that allows for a multi-year rate review process.

Regarding a proposal whereby insurers pay providers the deductible portion of covered charges, and then collect the deductible from members, Mr. Lombardo noted that it might raise issues regarding tax qualified status of HSA-compatible plans. In addition, he posited that carriers' administrative structures are not currently set up to collect deductibles, and that it would potentially increase premiums because if plans paid all the deductible amounts and then had to seek reimbursement from their members, plans would likely end up paying more claim dollars due to uncollectible debts. He is not aware of any similar recommendations being contemplated by the National Association of Insurance Commissioners (NAIC).

Public Comments

Throughout the sessions, The Task Force was presented with both written and in-person testimony from individuals who have experienced the negative effects of HDHPs. These stories of unaffordable medical care, unpredictability of health care costs, and an ever-increasing financial burden on consumers and businesses went beyond the academic presentations and provided the necessary contextual realities that many Connecticut residents face when it comes to health care and HDHPs.

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, former 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, of the 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 to the Task Force 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 she is a physical therapist, Arthritis Foundation volunteer, and has a child with a diagnosis. Her 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. She suggests that preventive services and maintenance services be pre-deductible.

Jessica Black shared her personal experience as an individual with an HDHP. She was in a car accident in Michigan while she was 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's no-fault law required her to use her own auto policy, which did not have medical coverage. Prior to moving there, she had asked about out of state coverage, and was told she would have no problem. After the accident, she was told she should have purchased out of state coverage. Her father pays $600 per month for her coverage. She only received about $3,000 from a settlement with the other driver. She was left paying the balance out of her own pocket. She offered this story as another example of how HDHPs do not work for Connecticut residents.

Tom Lally works with the Connecticut Education Association as an insurance specialist. He works with local unions to negotiate the benefits portions of contracts. More than half of Boards of Education have HDHPs, all with HSAs (unless a member has VA benefits or TRICARE). Some have no deductible funding but share a higher portion of premiums. About 90% of employers contribute to an HSA, which reduces claims costs, thereby reducing trend. His organization assists members in understanding their plans and educating them on how to use the plan. For example, he counsels members who are over 65 and still working on the benefits of postponing Medicare and continuing to fund HSAs through their employer. He gives 90-120 minute presentations at the contract ratification stage of contract negotiations. He 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 previous Task Force 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. (A "dominated plan" is the term for a plan that is always more expensive than at least one other available plan, regardless of the individual's level of utilization of medical services. By definition, a dominated plan from the financial perspective is never the right choice for the consumer.) 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.[37] 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.[38] Presently, per capita spending on health care in the United States is more than double that of nearly every other wealthy nation.[39]

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 state 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

[37] See, e.g., Appendix I, "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; "What's likely to drive medical cost trend in 2019?" available from PwC's Health Research Institute at https://www.pwc.com/us/en/industries/health-industries/library/hri-survey-2018.html (highlighting that prices, rather than utilization, have driven trend and that those increases are influenced by expanded access points, provider mergers and physician consolidations)

[38] See Appendix G (Corlette)

[39] See Appendix I "Americans' Struggles with medical bills are a foreign concept in other countries," Los Angeles Times, September 12, 2019.

utilized by plan members.[40] Likewise, medical loss ratio (MLR) requirements compel insurers to spend a minimum percentage (80%-85%) of the premiums they collect on member health care expenses.[41] The Connecticut Insurance Department also subjects health insurance premium rates to rigorous actuarial review and approval to ensure that rates are not insufficient, excessive or unfairly discriminatory. As a result, insurers are limited in their ability to increase profit margins or expand other overhead expenses merely by increasing premiums or cost sharing obligations on products subject to regulatory approval.

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.[42]

3) In order to minimize premium increases, insurers have introduced benefit designs that include increased 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 can be viewed as 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 can reserve 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, tax-exempt earnings and tax-exempt 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

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

[41] See 45 C.F.R. § 158.210.

[42] 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. Some Task Force members observed that notwithstanding these narrow profit margins, insurers' net earnings, in terms of absolute dollars, have grown substantially over the past several years, potentially reflecting greater profitability in other business areas such as the self-insured ASO (administrative services only) or non-health (e.g., life insurance) markets.

employee. About one quarter of employers, including half of large employers (> 200 employees), offer HSA-compatible HDHPs to their employees.[43] Over the past decade, employee participation in HSA-compatible HDHPs has risen from approximately 6% of covered workers to 23% of covered workers.[44] Up to three quarters of employees covered under their employer's HSA-compatible HDHP receive a contribution from the employer.[45] In 2019, the average annual employer contribution to its employees' HSAs was $572 for single coverage and $1062 for family coverage.[46]

HSA-compatible HDHPs have also experienced slower premium and deductible growth compared with other types of health plans, including non-HSA compatible HDHPs, 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.[47] 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.[48]

5) <u>HSA-compatible HDHPs are most effective when members can reserve funds and utilize an associated Health Savings Account.</u>

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.

[43] 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/

[44] Id.

[45] 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.

[46] 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.

[47] Id.

[48] Id. See also Appendix C (McKechnie)

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 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 under HSA-compatible HDHPs. Primarily, non-HSA plans have greater flexibility to cover additional services on a pre-deductible basis that are not included on the IRS's safe harbor list. For example, a non-HSA plan design might include 100% coverage for regular breast cancer screening by ultrasound, though this would be prohibited for an HSA-compatible plan. 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 some 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 UConn Health Disparities Institute (HDI) 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 debt[49]
- 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. [50] 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

[49] 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/

[50] See Appendix A (Villagra). Dr. Villagra further emphasized that while his research characterized the issue in terms of consumer literacy and understanding of the terms of their healthcare plans, the primary issue is the plans are too complex and should be simplified as a means of improving consumer comprehension.

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.

The Task Force finds that consumers may 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 CT to continue to build upon those efforts, it also finds that more support is needed to assist consumers with plan selection and utilization both at the time of enrollment and throughout the term of the contract.

Recommendations Supported by the Task Force

The Task Force was presented with a number of proposals for possible reforms that would potentially address some of the issues related to HDHPs, as described in this report. The reform ideas discussed by the Task Force were generated from a number of sources including the formal presentations, written materials distributed to members and from Task Force member discussion. Many of the proposals were adopted as recommendations for the General Assembly to consider for further action. The following section of this report provides a summary of the proposals supported by the Task Force, including a synopsis of the Task Force's discussions regarding each recommendation.

1. Healthcare Literacy and Education

The Task Force received evidence that consumer literacy around healthcare and health insurance is a significant factor when consumers choose plans that are economically dominated or are not right for their situation, and also when consumers become dissatisfied with plans that 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 are 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.

Establish public-private partnerships to improve health insurance literacy. (6)[51]

A majority of the members of the Task Force supported this recommendation. 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 Institute suggests that there is an opportunity to prevent these expensive lessons through partnership between the state and educational, social service, and community organizations. While the Task Force is supportive of this recommendation, it does not identify specific partnerships for recommendation, and notes that multiple programs may need to be piloted and measured for sufficient outcomes to ensure a positive return on investment of resources.

Explore expanding access to health plan navigators. (1), (6)

A majority of the members of the Task Force supported this recommendation. The Navigators provide assistance to individuals before and up to the point of enrollment; however, Navigators are not able to recommend that a consumer choose a particular health plan. The state should

[51] 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).

examine whether there is an opportunity to provide additional effective consumer health literacy interventions through the Navigator program.

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

A majority of the members of the Task Force supported this recommendation. However, the Task Force is also aware of the state's ongoing efforts to increase transparency in healthcare costs, including but not limited to the All-Payer Claims Database and HealthscoreCT cost estimator. Carriers also have improved the tools available to their customers in this regard. The Task Force encourages the state and the carriers to continue and expand these efforts.

Improve information presented to consumers regarding total costs of healthcare coverage both on and off the Exchange. (2), (6)

A majority of the members of the Task Force supported this recommendation. 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. For example, upgraded planning tools help consumers understand a health plan's potential annual fixed costs (premiums) and annual maximum costs (deductible plus out-of-pocket max). These tools could be enhanced to also provide additional metrics, such as the likelihood of a household of *n* size experiencing a major medical event, or an individualized prediction of annual health expenditures under a particular plan based on prior claims data. Information from the HDI suggests that more work can be done here, and the Task Force encourages improvement in this area.

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

A majority of the members of the Task Force supported this recommendation. The Task Force received evidence from several presenters that the presence of high deductibles served as an obstacle to consumers seeking even preventative care that would be covered pre-deductible under the ACA. The reasons for this are myriad, including: consumers may not trust that their procedures will be billed or adjusted appropriately; providers may not be able to state ahead of time whether a procedure is preventive or diagnostic; and 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 higher-value services.

2. Cost Sharing Reforms

The Task Force considered several proposals that contemplated reforms to the way that insurers could utilize deductibles and other cost sharing to spread risk, reduce premiums, address underlying costs and otherwise address the negative impacts felt by consumers.

Shift HDHPs toward VBIDs with an emphasis on high-value care. (1), (2)

A majority of the members of the Task Force supported this recommendation. Regarding this proposal, the Task Force endorses a shift towards VBID (value-based insurance designs), which may include designs that increase cost shares on low-value services and decrease cost shares on high value services.

Healthcare Affordability. (1), (2)

A majority of the members of the Task Force supported this recommendation. The Task Force considered the concept of tying cost-sharing to affordability, and ultimately concluded that it would defer to the work of the Office of Health Strategy with respect to the development of a healthcare affordability standard.[52]

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

A majority of the members of the Task Force supported this recommendation. The Task Force considered a requirement that health plans must pro-rate deductibles for members who enroll in the middle of the plan year. While some members of the Task Force generally endorsed this concept as a matter of fairness, Task Force members also recognized the difficulties of administering such a requirement, including its impact on the rate setting process, as well as unanswered questions regarding the compatibility of such a requirement with IRS rules regarding HSAs.

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

A majority of the members of the Task Force supported this recommendation. The Task Force also discussed this concept on general fairness principles, acknowledging the financial burden of consumers having to meet two full deductibles within the same year when they switch from one plan to another – typically in connection with a job change. Similar to the concerns

[52] See Appendix J.

regarding pro-rating of deductibles, however, Task Force members recognized similar concerns regarding administration and impact on HSAs. In addition, this proposal was further complicated by the fact that not all plans are on a calendar year renewal, which would result in further logistical obstacles and other complex issues with implementation. Also problematic is the mixing or overlapping of markets. The Task Force further noted that such a proposal would have to also consider credits toward maximum out-of-pocket limits.

Make carriers responsible for paying deductibles to providers and collecting those payments from their insureds. (7)

A majority of the members of the Task Force supported this recommendation. The Task Force engaged in substantial debate regarding a proposal that would shift the risks and administrative burdens (including costs) of collecting deductibles from providers onto insurers. The Task force recognizes that any additional cost share shift from deductibles onto copayments or coinsurance would be equally detrimental to the doctor-patient relationship. In light of the evidence regarding the relationships between high deductibles and medical debts, many Task Force members viewed this proposal as an opportunity to preserve the provider-patient relationships (particularly among smaller provider groups) that are harmed by debt collection activities and avoidance of care, which can also impact patient and population health. Some Task Force members also predicted that the additional certainty of receiving payments for services would lead to more providers joining carriers' networks and thereby improving access to care.

Other Task Force members raised concerns that implementation of this proposal may result in greater premiums due to the increased administrative burdens on carriers to set up systems for tracking and collecting cost shares. Other task force members cited these burdens are already reflected in provider administrative burdens. It also was not clear to the Task Force whether or to what extent this burden shift would translate into reductions in provider prices for the cost of services. Task Force members also raised concerns about unintended consequences. For example, Task Force members were concerned about whether unpaid deductibles could lead to disenrollment, and how carriers would establish proper accounting of the cost shares among its actuarial and other reportable calculations such as minimum loss ratios (MLR). Another open question concerned the impact of such a cost shift on HSA-compatible plans and whether the result would destroy the tax benefits of the HSA. Regarding this issue, the Task Force was presented with legal memoranda from the law firms of Husch Blackwell and the Groom Law Group,[53] presenting competing opinions regarding the effect of this proposed shift on HSA utilization and compliance. In order to resolve this conflict, a final opinion would be required from the IRS itself. A majority of members of the Task Force strongly support this proposal, while a minority expressed fierce opposition.

[53] See Appendix K

Recommend to expand the Chronic Disease Management Act of 2019 to include Mental Health and Substance Abuse services.

A majority of the members of the Task Force supported this recommendation. The Federal Chronic Disease Management Act of 2019 expanded the covered services that were eligible as pre-deductible interventions. This recommendation reflects the value in supporting mental health services and the significant challenges that arise when mental health care is delayed or avoided due to costs to the consumer. The Task Force received feedback from the CT Department of Insurance that this may create reverse-parity issues that would need to be further explored by regulators.

For non-HSA eligible HDHPs that would not require an expansion of the Chronic Disease Management Act of 2019, the Task Force recommends including Mental Health and Substance Abuse services as pre-deductible services and subject to co-payment.

3. Health Savings Accounts

In light of the substantial evidence regarding the advantages of HSAs, the Task Force considered several proposals that could potentially increase access to HSAs and the appurtenant tax benefits, particularly among lower-income consumers. The Task Force acknowledges, however, that HSAs are a creature of Federal law and regulation, and fundamental reforms to HSAs or qualified HDHPs would require Federal action. Nevertheless, the state may take some more limited actions to improve HSA-qualified HDHPs without Federal action. In addition, the state may wish to recommend some potential reforms to members of its Congressional delegation or other Federal regulators. These are the potential reforms that the Task Force has considered:

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

A majority of the members of the Task Force supported this recommendation. As noted, this proposal would require Federal action in order to implement, which the state may recommend 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.

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

A majority of the members of the Task Force supported this recommendation. As above, this would require Federal action, but it would expand consumer access to pre-tax dollars in order to make payments toward medical expenses.

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. (2), (3)

A majority of the members of the Task Force supported this recommendation. 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. The Task Force notes that this may already be permissible, as people who get refunds *via* direct deposit maybe already can choose for the money to go to an HSA. If this is already permissible, the Task Force would recommend having the Department of Revenue Services (DRS) publicize this option at the point of filing.[54]

When considering measures to provide healthcare coverage cost relief to consumers, or to otherwise create market-based incentives to drive healthcare costs down, 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)

A majority of the members of the Task Force supported this recommendation. The State should 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. 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.

[54] The Task Force further notes that if this option is available, individuals will need to be mindful, or reminded, that deposits from all sources cannot exceed the IRS's annual limits without incurring a tax penalty.

4. Financial relief

In addition to other financial reforms discussed above, the Task Force considered several concepts for providing further financial relief to consumers enrolled in HDHPs under current market conditions.

Support the existing initiative at the Office of Health Strategy as it pertains to a healthcare affordability standard. (2)

A majority of the members of the Task Force supported this recommendation. The Task Force noted with approval an existing initiative at OHS to identify a Healthcare Affordability standard, and recommends that the state continue to support those existing efforts. At the same time, members of the Task Force noted 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.

The Task Force is cautiously supportive of provisions to protect consumers from medical debt collection practices, such as defenses regarding the lack of transparency in the calculation of the medical debt, or a right for consumers to receive an itemized medical bill that is accessible to a layperson, prior to judgment. (2)

A majority of the members of the Task Force supported this recommendation.

5. Cost & Quality Control

The final group of proposals considered by the Task Force centered around establishing mechanisms for slowing the rate of cost growth and improving the quality of delivered services. Given that one of the Task Force's primary findings is that healthcare costs are increasing at an unsustainable rate, the Task Force explored several cost growth containment concepts for recommendation to the General Assembly.

Implement Value Based Insurance Designs (VBIDs). (1), (2)

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

A majority of the members of the Task Force supported this recommendation. As noted in connection with its Cost Sharing Reform Recommendations, the Task Force views VBIDs favorably and notes that implementation of such product designs will require further exploration of which services may be deemed low-value vs. high-value, and under what circumstances those designations may apply.

Encourage all fully-insured non-HSA eligible HDHP plans in the state to cover as many as possible of the new optional IRS list of covered services/chronic conditions, and urge insurers to include pre-deductible coverage of the IRS list in HSA-eligible plans. (1)

A majority of the members of the Task Force supported this recommendation. The Task Force recognizes that the IRS safe harbor list is largely, if not entirely, comprised of services that are very high in terms of value or return on investment. Accordingly, the Task Force recommends that HDHPs be encouraged to voluntarily cover safe harbor items pre-deductible whenever possible, and within any further limitations under IRS guidelines, as part of a broader effort to implement VBIDs. In addition, the Task Force recommends that a mechanism be put into place to attempt to capture the health outcomes as a result of such coverage, which can be compared to the increased costs that may be imposed through increased premiums or cost shares (if any). Since covering these new services is optional, it is appropriate for the Task Force to encourage carriers to consider offering plans that do cover these new services.

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

A majority of the members of the Task Force supported this recommendation. In general, the Task Force recommends that any reforms intended to have a particular impact should be accompanied by appropriate tools to measure and report on the actual impact to determine whether the intended result was obtained.

Reform Proposals Rejected by the Task Force

As discussed above, the Task Force considered a number of reform ideas that it did not support. The following section summarizes the Task Force's discussions regarding each of the rejected proposals, and reasons therefore.

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

A majority of the members of the Task Force rejected this recommendation. This proposal arose from the experiences of staff at the state Office of the Healthcare Advocate (OHA) who hear complaints from consumers who sought answers regarding how their plans work and were misinformed about coverage and benefits by insurers' CSRs. Although Task Force members acknowledged that consumers should not have to bear the consequences of such misinformation, the Task Force was concerned about unintended consequences, particularly the likelihood that carriers would respond by limiting the assistance that CSRs would provide in response to consumer inquiries, thereby leading to even poorer customer service experiences. Task Force members further recognized that plans already must provide a rigorous appeals process to consumers, which can resolve such disputes, and that consumers also have the ability to avail themselves of the services of OHA, which has among its core mission assisting consumers in navigating their health plans. The Task Force therefore did not endorse this proposal.

Provide and promote incentives to encourage members to seek care early in the plan year, such as insurers allowing providers to waive collection of copay/coinsurance for primary care sought in first quarter of plan year. (1), (2)

A majority of the members of the Task Force rejected this recommendation. This proposal was generated in response to evidence that was presented on the tendency of individuals to schedule appointments for the end of the year, after their deductible has been met. However, Task Force members acknowledged that asking individuals to come in early may not be the solution, as it could result in tipping the scale too far in the opposite direction.

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

A majority of the members of the Task Force rejected this recommendation. As with other proposals that have to do with HSA eligibility , this would require Federal action, but it would expand consumer access to pre-tax dollars in order to make payments toward medical

expenses because more plans would qualify as HSA-compatible based on metal tiering, as opposed to deductible and out-of-pocket limits.

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

A majority of the members of the Task Force rejected this recommendation. The Task Force considered recommending that the only high deductible plans on the AHCT exchange be HSA-qualified HDHPs. However, because Federal requirements for HSA-qualified HDHPs are very narrow, the Task Force did not feel there was enough space within the Federal requirements to design an HSA-qualified plan that is appreciably different from the existing offerings. In addition, this proposal has the potential to dramatically reduce consumer choice, in that non-HSA-compatible plans that offer pre-deductible coverage beyond the IRS safe harbor would be unavailable, although the Task Force did receive some evidence that excessive consumer choice in the complex world of health insurance is also detrimental to consumers' ability to engage in "just right" plan selection. Overall, the Task Force did not support this recommendation.

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)

A majority of the members of the Task Force rejected this recommendation. It was suggested that 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.

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)

A majority of the members of the Task Force rejected this recommendation. Some members felt strongly that this proposal is a matter of fairness to consumers, who must count on their carriers to negotiate good prices. 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.

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. Members also expressed concern that the additional payments by the carriers would eventually be passed on to consumers in the form of higher premiums. Others also felt that it would be more appropriate to compel the provider to accept the benchmark rate. There is also a practical question of how the benchmark rate is to be determined for a particular location.

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

A majority of the members of the Task Force rejected this recommendation. The Task Force ultimately rejected this concept on the basis that it assumed without sufficient evidence that prices don't align with costs, and fails to account for the variety of costs that are considered in the overall delivery of care, which include provider services, other fixed costs, cost shifts due to governmental reimbursement rates, administrative burdens of payment and collection activities, and investments in capital, programs and innovations. The Task Force further contemplated that this issue would be explored further pursuant to the Governor's executive order.

Address defensive medicine. (1)

A majority of the members of the Task Force rejected this recommendation. Members of the Task Force felt that this recommendation was outside of the scope of its charge, and at best was one of the myriad complexities discussed under Finding #1 (regarding underlying costs of care).

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

A majority of the members of the Task Force rejected this recommendation. Members of the Task Force felt that this recommendation was outside of the scope of its charge, and at best was one of the myriad complexities discussed under Finding #1 (regarding underlying costs of care).

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

A majority of the members of the Task Force rejected this recommendation, as it presented numerous administrative complications regarding the tracking of coupons, and overall impact of coupons on efforts to get individuals to use less expensive (higher-value) drugs more efficiently. In this context, it was noted that the United States is one of only two countries that allows advertising of drugs on TV.

Facilitate new entrants into the health insurance marketplace.

A majority of the members of the Task Force rejected this recommendation. The Task Force generally supported the idea of new entrants into the health insurance market but several members expressed concerns if the new entry is a public option. Those concerns arose from past experience with under reimbursement by government payers and the resulting cost-shifting onto other commercial payers. Others felt that this recommendation does not present a solution to HDHPs or underlying health care costs, and in any event, endorsement of this recommendation or a public option would be outside of the scope of the Task Force's charge.

Conclusion

The members of the High Deductible Health Plan Task Force wish to thank the General Assembly for this opportunity to study the healthcare and health insurance landscape in Connecticut, particularly as it relates to HDHPs. We hope that the research, evidence, ideas and recommendations offered in this report will be a useful resource to policymakers as they continue to wrestle with the healthcare access and coverage challenges faced by our state and its communities.

Appendix A

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High Deductible Plans A Product Assessment from the Consumer Perspective

High Deductible Plan Task Force
August 6, 2019

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

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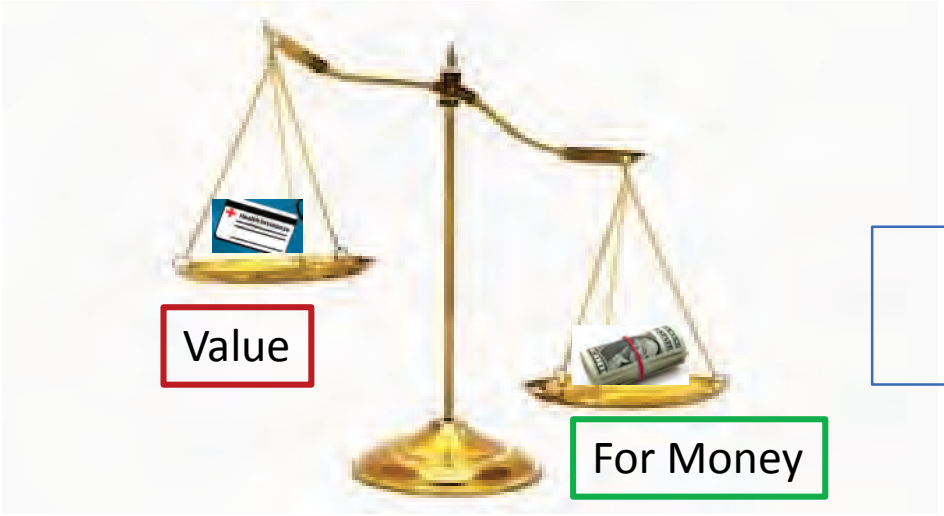
Health Insurance Advance Initiative

A five-year project aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities



Health Equity ?

Complexity of HDPs + **Low Insurance Literacy** + **Poor Navigation Support** = **Health Impact** + **Financial Impact**

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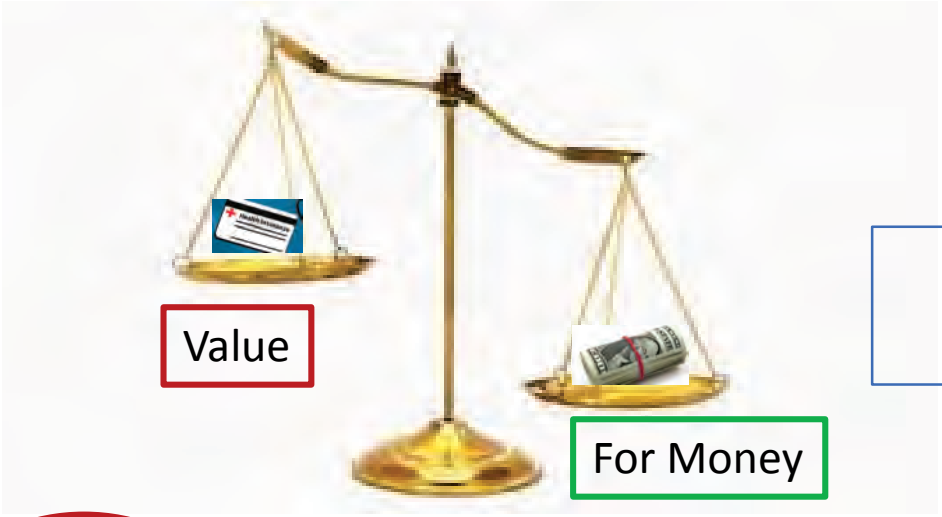

Health Equity ?

Complexity of HDPs + Health Insurance Literacy + Navigation (Product) Support = Health Impact + Financial Impact

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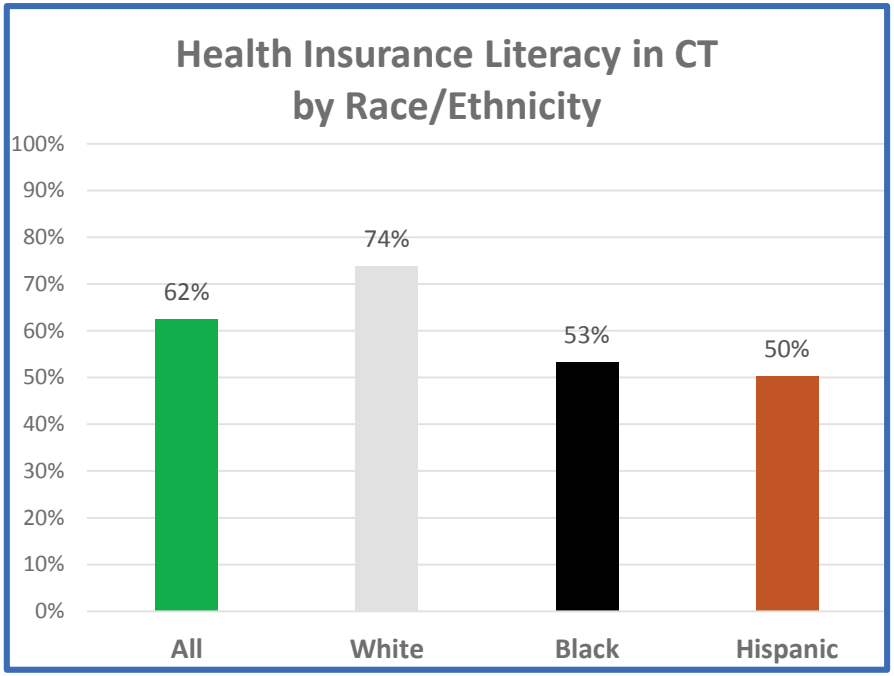
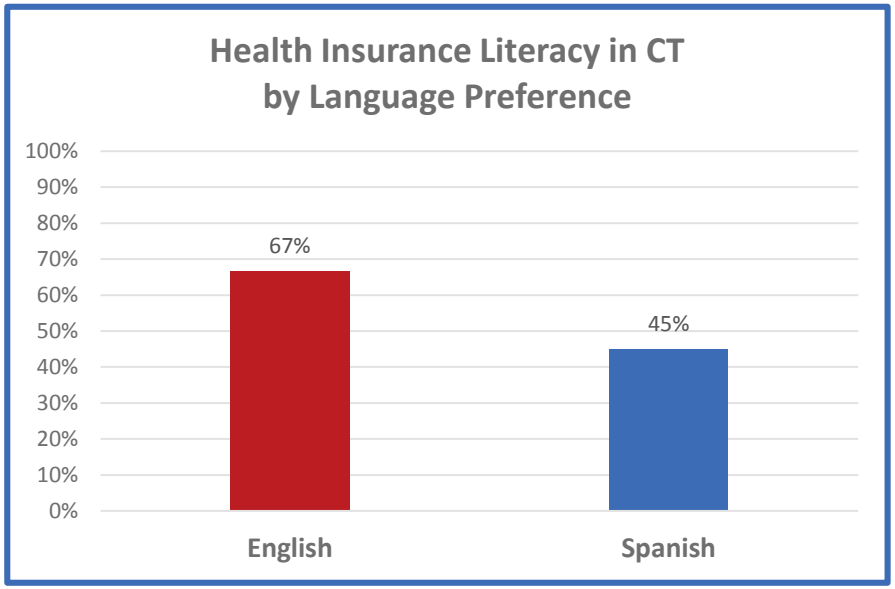
1. Health Insurance Literacy: Consumer Understanding of Basic Features of HDPs

Survey: Statewide, % correct answers to 13 basic concepts





Reference: Am J Manag Care. 2019;25(3):294-e298

1. Health Insurance Literacy in Connecticut by Race/Ethnicity and Language Preference

HIL question	All	White	Black	Hispanic	English	Spanish
Premium definition	75%	88%	66%	61%	80%	56%
Premium Payment	94%	98%	94%	88%	96%	84%
Annual Deductible	64%	**85%**	**44%**	**42%**	**72%**	**29%**
Hospital Bill Amount	31%	44%	25%	15%	37%	7%
Annual Out of Pocket Limit	**55%**	**70%**	**42%**	**39%**	**60%**	**31%**
Copay	78%	89%	71%	63%	83%	54%
Health Insurance Formulary	36%	44%	27%	29%	37%	30%
Provider Network	73%	**89%**	**60%**	**57%**	**79%**	**49%**
Inpatient Care	45%	47%	34%	51%	44%	50%
Appeal Definition	68%	80%	63%	51%	74%	44%
Appeal True or False	83%	91%	75%	76%	85%	77%
Information Source	58%	72%	48%	41%	64%	32%
Less Choice HMO vs PPO	51%	61%	44%	40%	53%	41%
Percent correct of all 13 HIL	62.4%	73.8%	53.3%	50.3%	66.5%	44.9%

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Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference

Am J Manag Care. 2019;25(3):294-e298

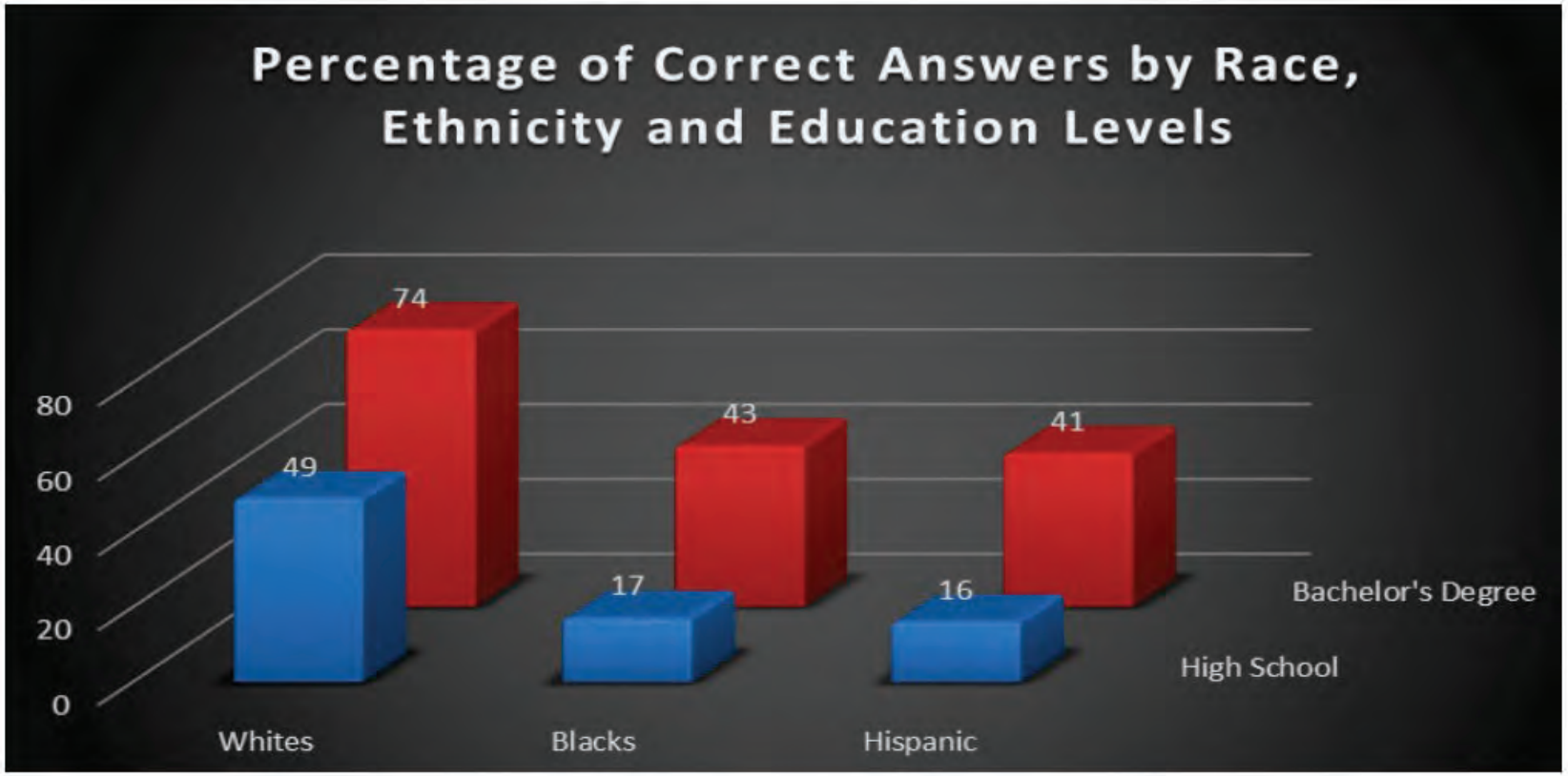

Figure 1: Health Disparities Institute, 2016

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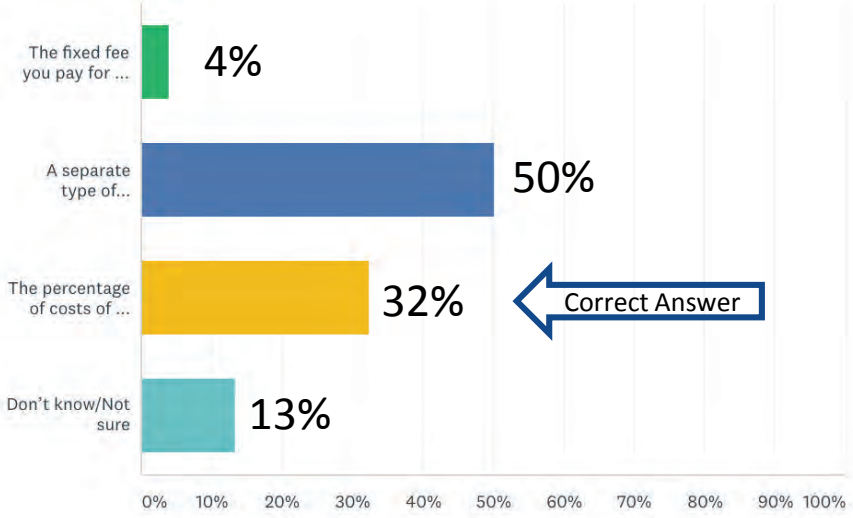
HDI-AHCT Insurance Literacy Survey (2018)

Which of these best defines "coinsurance?"

Answered: 3,329 Skipped: 29



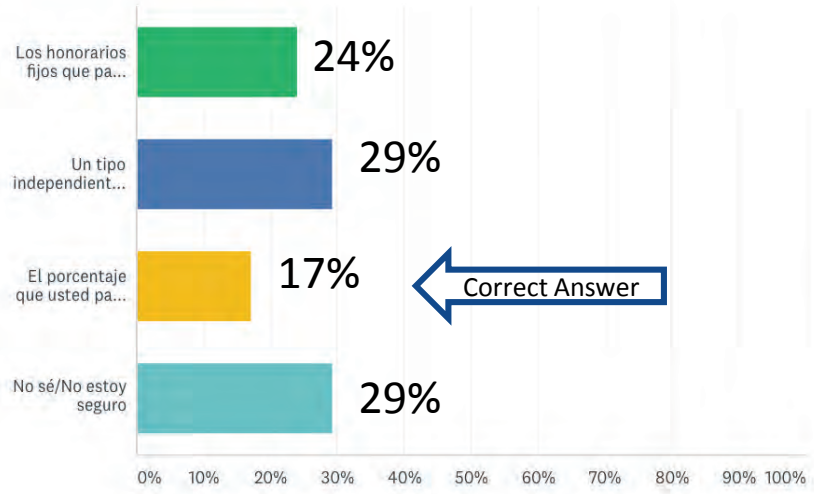
QUIZ STATISTICS

Percent Correct	Average Score	Standard Deviation	Difficulty
32%	0.3/1.0 (32%)	0.47	1/12

ANSWER CHOICES	SCORE	RESPONSES	
The fixed fee you pay for a doctor visit or other health care service.	0/1	4.06%	135
A separate type of insurance to cover additional services.	0/1	50.20%	1,671
✓ The percentage of costs of a covered health care service you pay.	1/1	32.41%	1,079
Don't know/Not sure	0/1	13.34%	444
TOTAL			3,329

¿Cuál de estas opciones define mejor "coseguro"?

Respondidas: 58 Omitidas: 1



ESTADÍSTICAS DEL TEST

Porcentaje de correctas	Puntuación promedio	Desviación estándar	Dificultad
17%	0,2/1,0 (17%)	0,38	3/12

OPCIONES DE RESPUESTA	PUNTUACIÓN	RESPUESTAS	
Los honorarios fijos que paga por una visita al médico o a otro servicio de atención médica.	0/1	24,14%	14
Un tipo independiente de seguro para cubrir servicios adicionales.	0/1	29,31%	17
✓ El porcentaje que usted paga de los costos de un servicio de atención médica cubierto.	1/1	17,24%	10
No sé/No estoy seguro	0/1	29,31%	17
TOTAL			58

HDI-AHCT Insurance Literacy Survey (2018)

English Version: 3 hardest concepts

- "Coinsurance"
- "Formulary"
- "Bronze vs Silver vs Gold"

Spanish Version: 3 hardest questions:

- "HSA"
- "Formulary"
- "Coinsurance"

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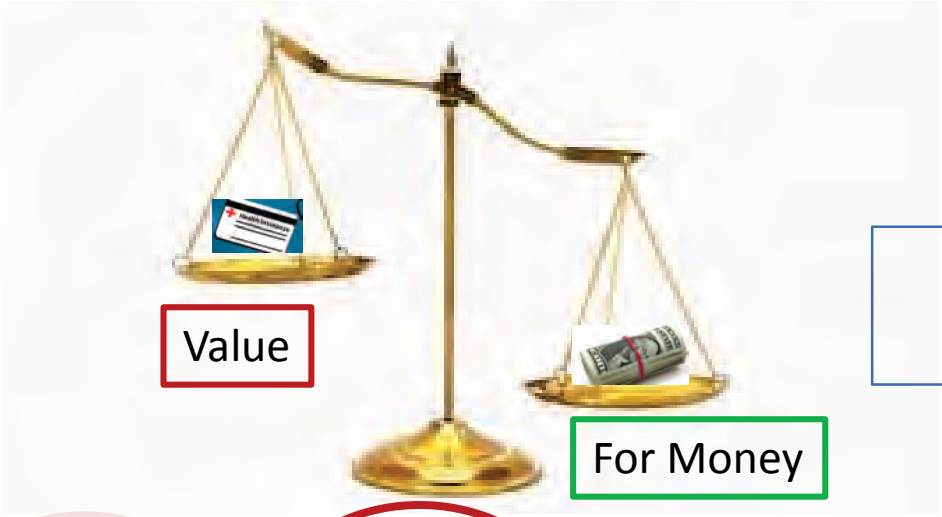
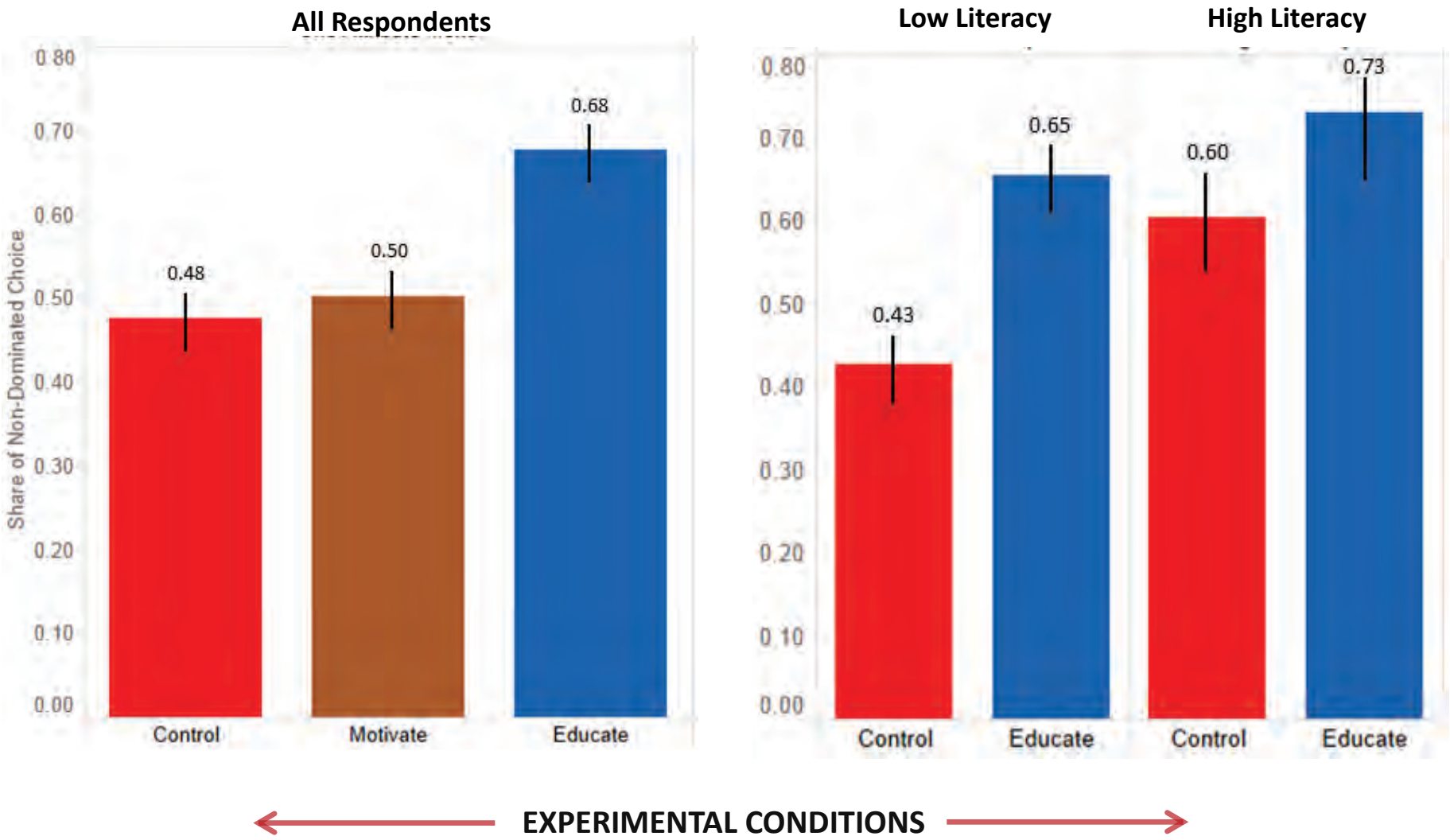


Health Equity ?

Complexity of HDPs + **Health Insurance Literacy** + **Navigation (Product) Support** = **Health Impact** + **Financial Impact**

Choosing a "just right" health insurance: Literacy and search motivation matter



Source: George Loewenstein, Carnegie Mellon University

HDI Pilot Health Insurance Literacy Educational Program

	HIL question (13)	% Pre	% Post
1	Premium Definition	40.2	54.6
2	Premium Payment	48.5	59.9
3	Annual Deductible	30.3	49.2
4	Hospital Bill Amount	17.4	23.5
5	Annual Out of Pocket Limit	37.1	56.1
6	Copay	47.0	66.7
7	Health Insurance Formulary	15.9	20.5
8	Provider Network	43.2	62.1
9	Inpatient Care	27.3	30.3
10	Appeal Definition	53.8	61.4
11	Appeal True or False	62.9	72.0
12	Information Source	52.3	72.0
13	Less Choice	22.7	62.1

HIL Education= Palliative measure to mitigate the negative impacts of HDP complexity

CT Insurance Department Consumer Report Card (product support)

Q5) In the last 12 months, how often did the written materials or Internet provide the information you needed about how your health plan works?

2019

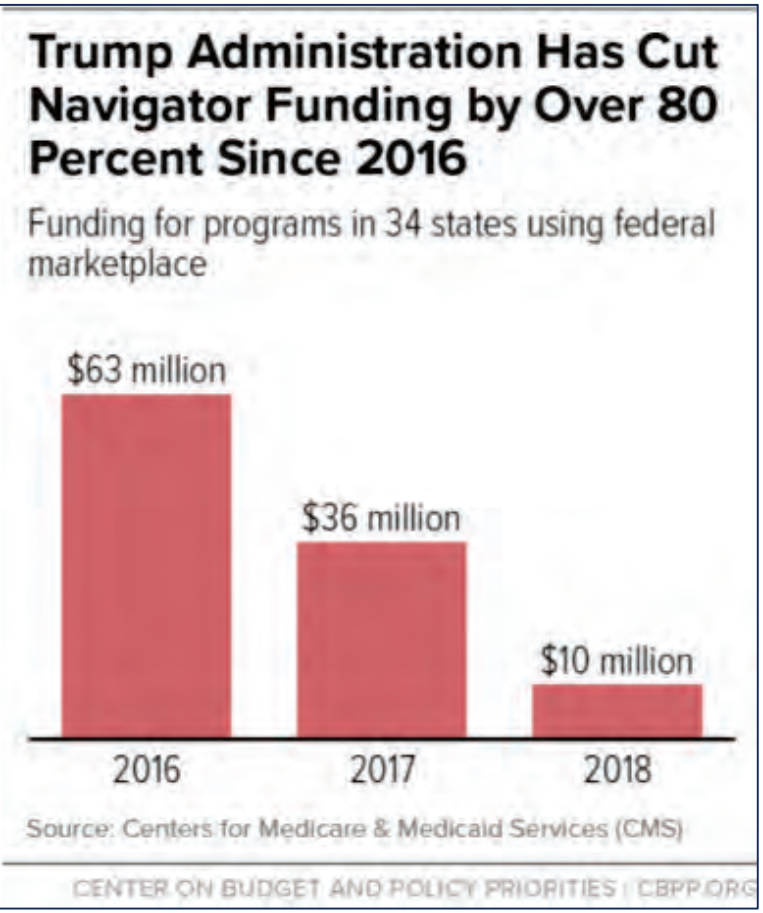
	Aetna Health	Anthem	ConnectiCare	Harvard	Oxford
Never	0.0%	1.5%	7.6%	0.0%	4.0%
Sometimes	40.0%	40.0%	0.0%	22.2%	31.0%
Usually	60.0%	38.5%	46.2%	48.1%	45.0%
Always	0.0%	20.0%	46.2%	29.7%	20.0%

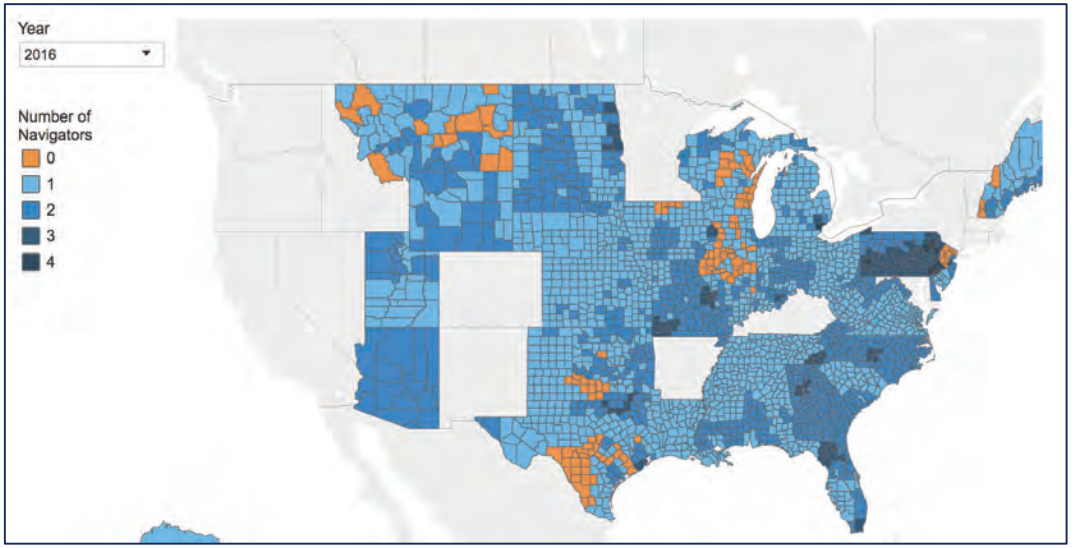
Q6) In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

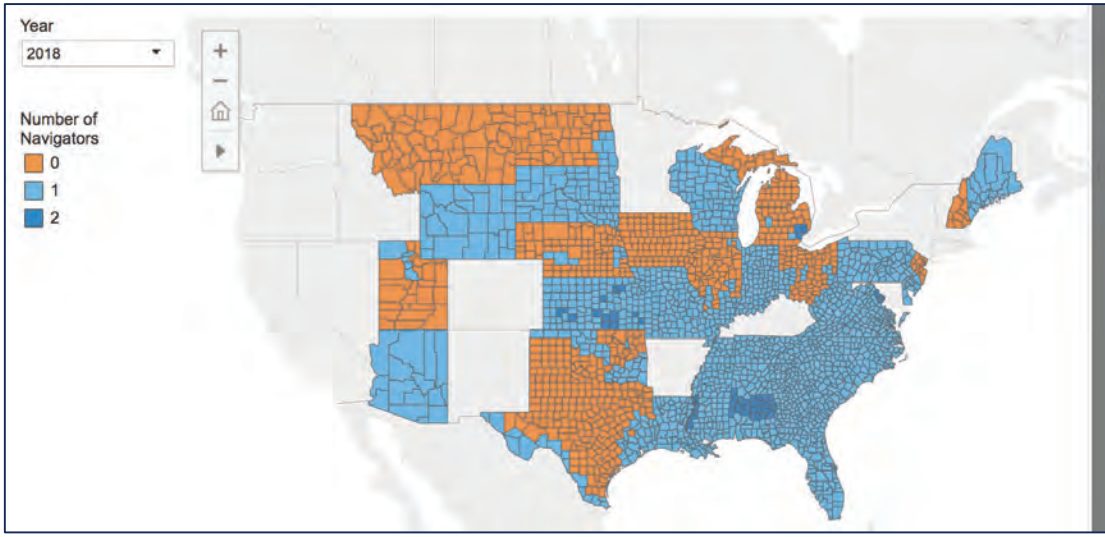
Never	0.0%	1.5%	8.3%	0.0%	3.0%
Sometimes	0.0%	18.8%	8.3%	22.7%	9.0%
Usually	33.3%	36.2%	41.7%	40.9%	29.0%
Always	66.7%	43.5%	41.7%	36.4%	59.0%

Source:\https://ct.gov/cid/cwp/view.asp?a=4903&Q=587026

Navigation Support: Regressive Federal Policy







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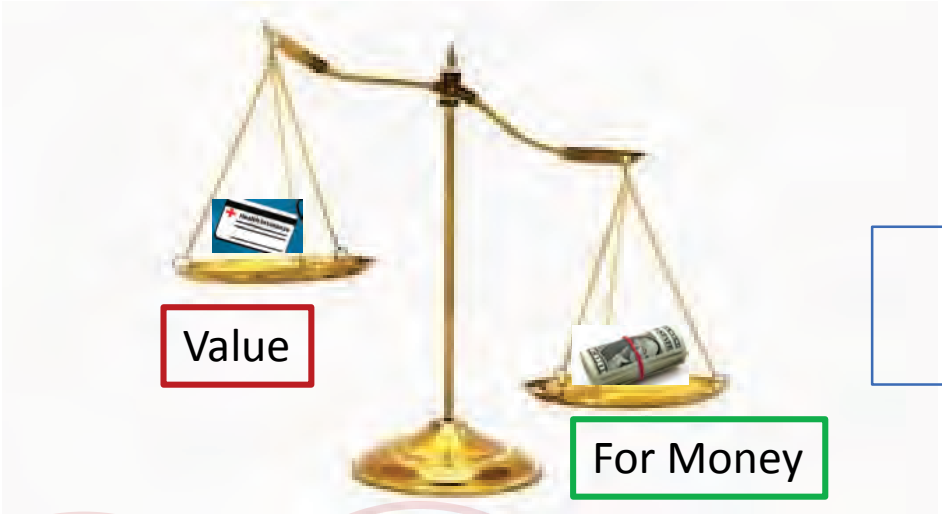


Health Equity ?

Complexity of HDPs + **Health Insurance Literacy** + **Navigation (Product) Support** = **Health Impact** + **Financial Impact**

Elements of HDP Excessive Complexity

- Large number of plan choices: Information overload → disconnect.
- Confusing rules, exceptions, jargon: Claims denials →provider and patient hassle, administrative cost.
- Deductibles: Growing consumer financial burden →Medical debt
- Co-insurance: intractable because prices of service and product are unknown → Surprise medical bills.
- Inefficient presentation (menu) of plan choices → 24% excess spending over optimal choice.
- Coverage uncertainty → Forgone care including preventive services.
- Misleading plan naming (e.g.: Bronze, Silver, Gold): marketing ≠ information.

Readability of a HDP Materials

- A typical subscriber agreement (SA) is over 100 pages long.
- A typical Bronze PPO plan in CT had a Flesch-Kinkaid Reading Ease score of 30.7 corresponding to a **16.5 grade level** (10-12 is roughly high school)

Non-Intuitive Plan Choice Menu

Which health plan option would *you* choose?

Assume the plans have identical coverage and provider network and covers all costs after the deductible has been met.

Option	Annual Deductible	Monthly Premium
A	$1,000	$72
B	$750	$110
C	$500	$118
D	$350	$163

Bhargava, S., Loewenstein, G. & Sydnor, J. (2017). **Choose to Lose: Health Plan Choices from a Menu with Dominated Options.** *Quarterly Journal of Economics, 132(3): 1319-1372.*

Circle the correct answer: A B C D

Better Plan Information

Which health plan option would *you* choose?

Assume the plans have identical coverage and provider network and covers all costs after the deductible has been met.

Option	Annual Deductible	Monthly Premium	Annual Premium
A	$1,000	$72	$864
B	$750	$110	$1,320
C	$500	$118	$1,416
D	$350	$163	$1,956

To save $250

Pay $464

Bhargava, S., Loewenstein, G. & Sydnor, J. (2017). **Choose to Lose: Health Plan Choices from a Menu with Dominated Options.** *Quarterly Journal of Economics, 132(3): 1319-1372.*

Circle the correct answer: A B C D

In a real world experiment more than 50% of employees chose a "wrong plan"

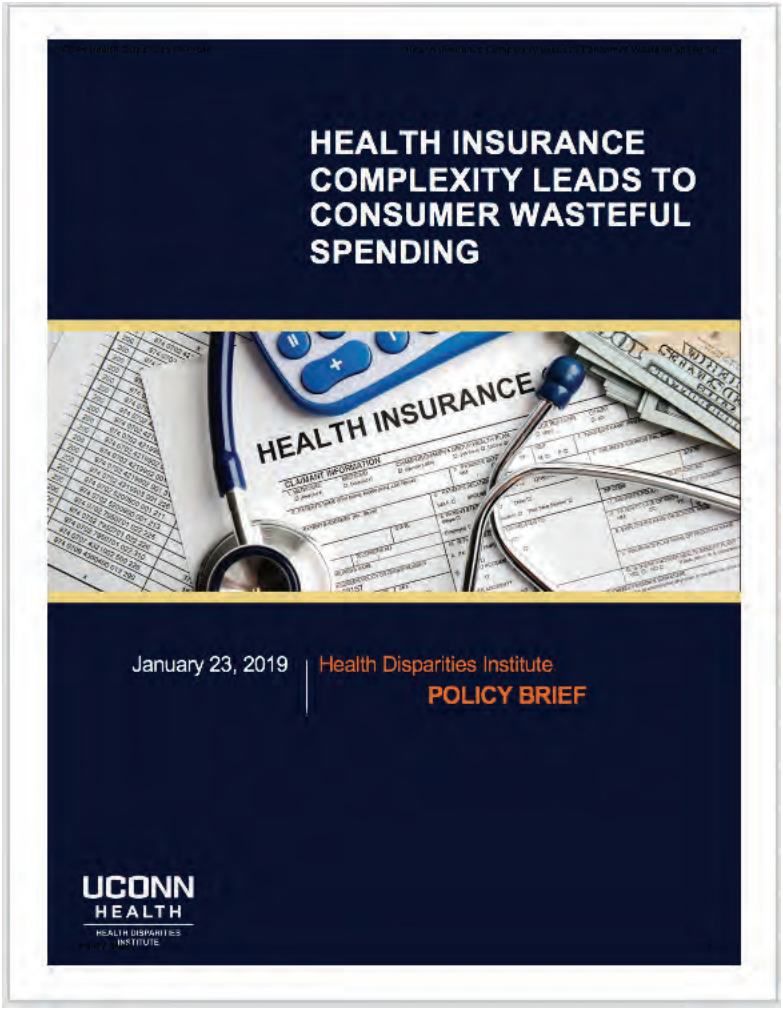
Misleading (unwittingly) Naming of Plan Choices

Naming convention	Over-insured	Just right	Under-insured
Metal	43%	24%	33%
Medical need	19%	53%	28%
Neutral name	37%	40%	23%
Recommended	34%	47%	19%

Selection based on medical need yielded the highest proportion of just right choices. It is estimated that "guided" by metal naming consumers overspend an average of $888/year (Ref).

Behavioral science & policy | volume 3 issue 1 2017

HDPs: Complexity + low literacy + poor product support



- Creates consumer confusion and promote poor buying choices.
- Companies respond with more disclosures that further confuse and obfuscate consumers
- Calls for more effective regulatory oversight

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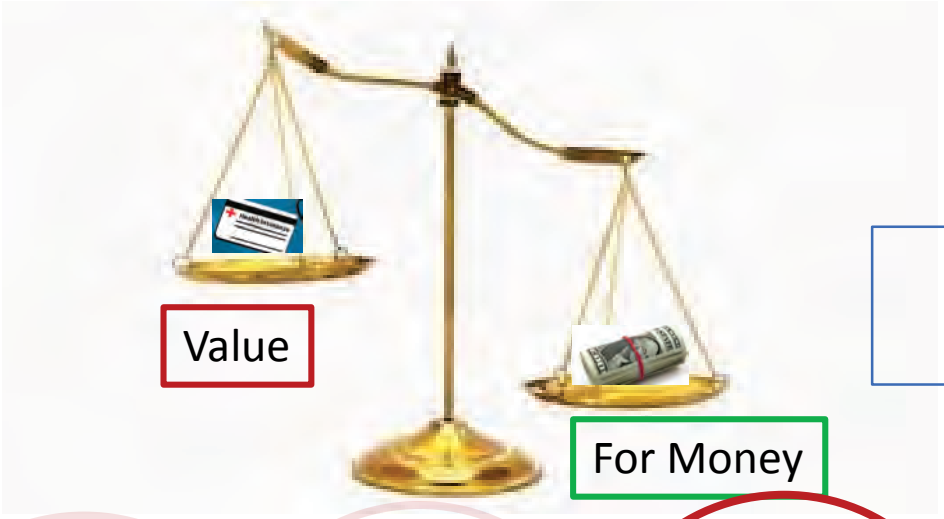

Health Equity ?

Complexity of HDPs + Health Insurance Literacy + Navigation (Product) Support = Health Impact + Financial Impact

HDPs are associated with reduced utilization of services,[1]

Q: What types of services are affected by HDPs that can have a negative impact on health status?

- Vaccinations. [2]
- Prescription drugs. [3,,4,5,6]
- Mental health visits.[7]
- Preventive and primary care. [8,9,10,11,12]
- Inpatient and outpatient care. [13,14]
- Decreased adherence to medications.[15,16,17]
- Increased rates of uncontrolled hypertension and hypercholesterolemia. [18]

Source: Evidence and references adapted from the original Kaiser Family Foundation report. References listed in the Appendix

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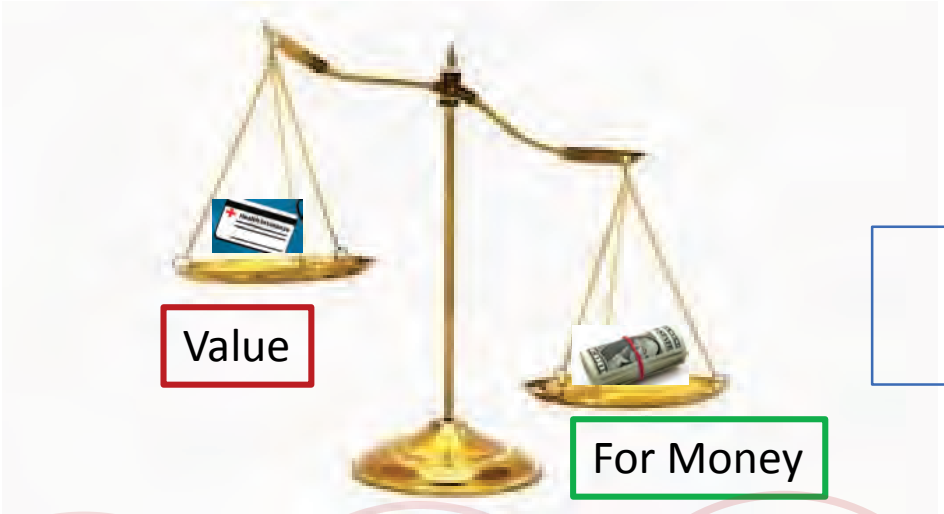

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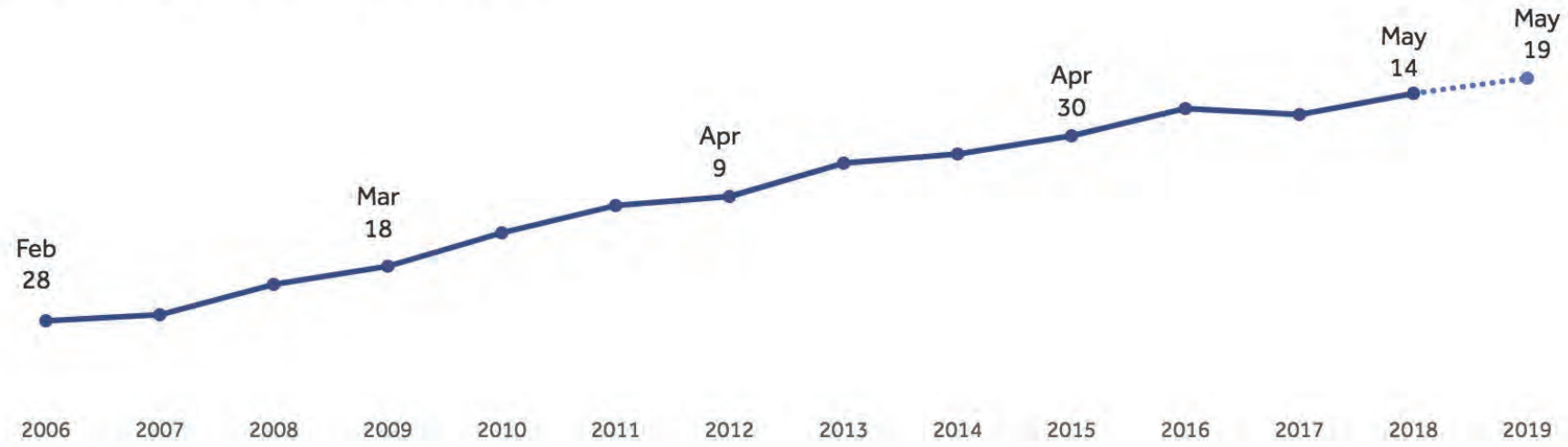
HDPs Deductible Relief Day

As deductibles rise, people with employer coverage meet their deductibles later into the year

Day of the year when average health spending among people with large employer coverage exceeds the average deductible in that year



Source: KFF analysis of data from IBM MarketScan Database and the KFF Employer Health Benefit Survey
• Get the data • PNG

Peterson-Kaiser Health System Tracker

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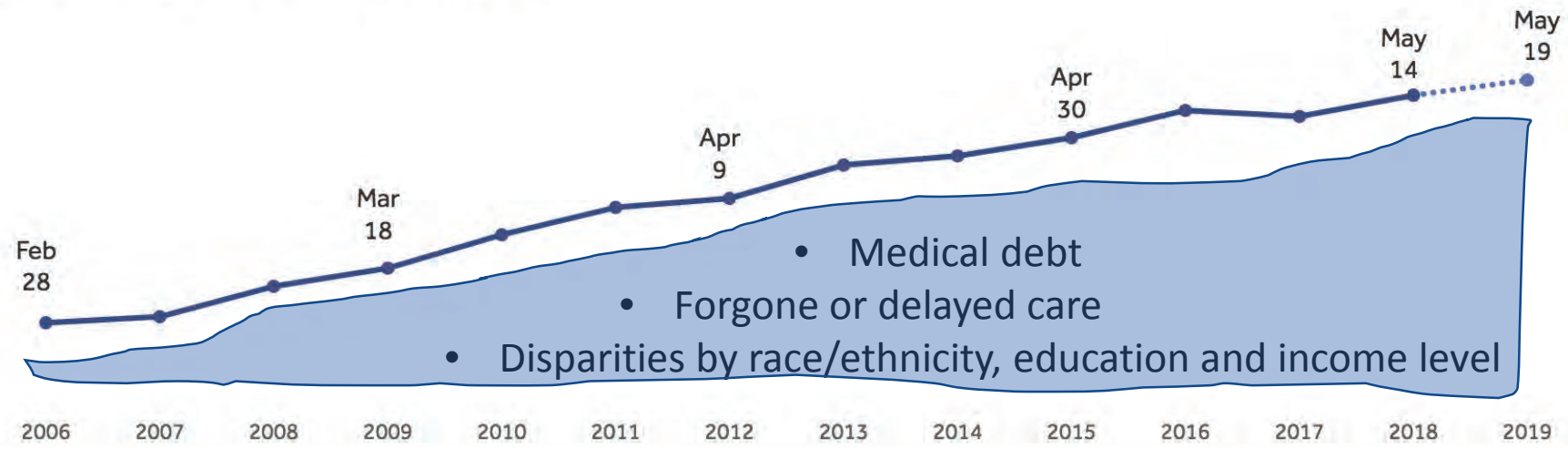

Source: KFF analysis of data from IBM MarketScan Database and the KFF Employer Health Benefit Survey
• Get the data • PNG

Peterson-Kaiser Health System Tracker

HDPs → Medical Debt

- Among adults 43% have problems with medical bills or medical debt
- Among the insured 23% percent still had medical debt, compared to 31% of uninsured people.
- Among those with medical debt
  - 43%-67% have used up all their savings to pay their bills
  - 43% had received a lower credit rating as a result of their debt
  - 16% are contacted by collection agencies
  - 18% delay education or career plans.
- Personal bankruptcies: Depending on methodology between 2% (KFF) and 62% (Health Affairs 2009) are healthcare related.

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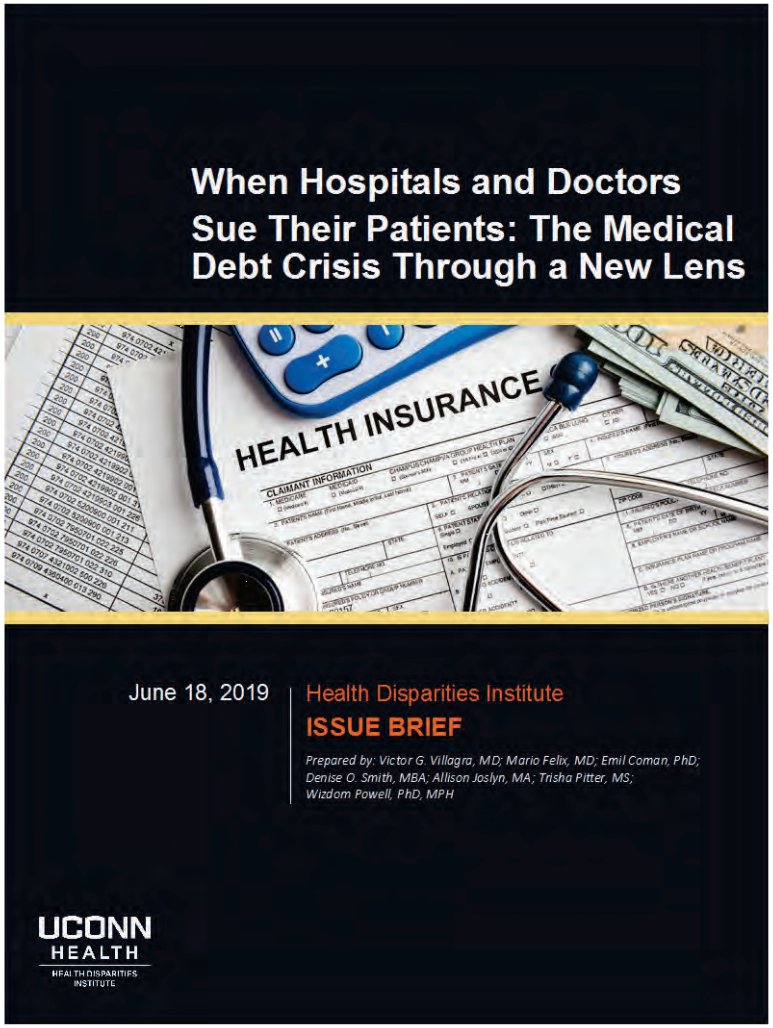
Medical Debt: A Silent Crisis in Connecticut



- Unpaid debt carries a social stigma
- Medical debt is difficult to measure
- HDP and medical debt are causally linked
- HDI obtained data from the CT Judicial System
- Small Claims only (≤ $5,000)
- Unlike other debt (mortgages, credit card, car loans, etc.) medical debt is never voluntary
- A window into the magnitude of medical debt in CT

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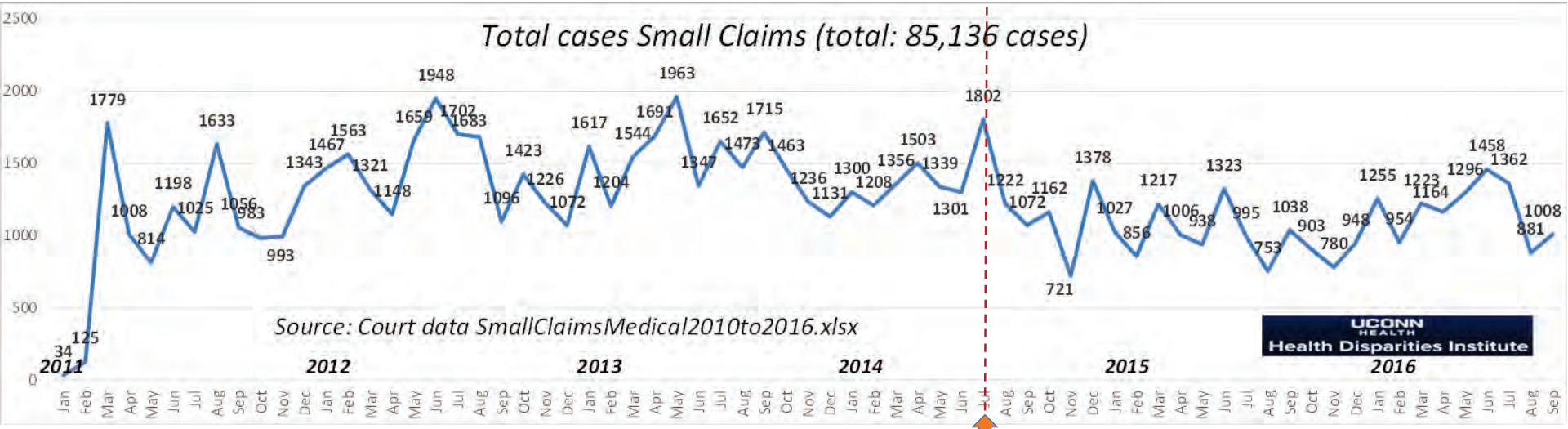
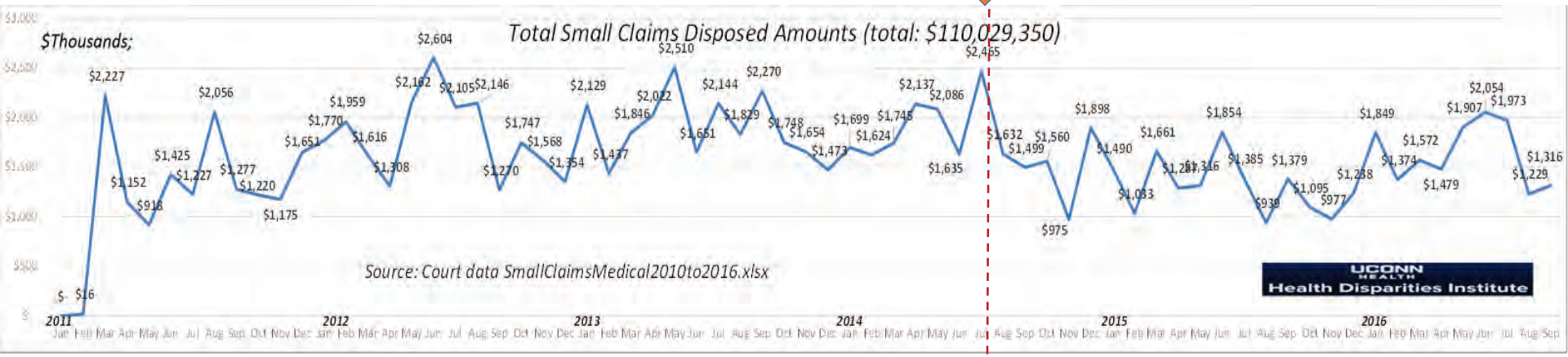
Connecticut Hospitals and Doctors Sue Their Patients

Medical related Small Claims Court Cases in CT: 2011- 2015

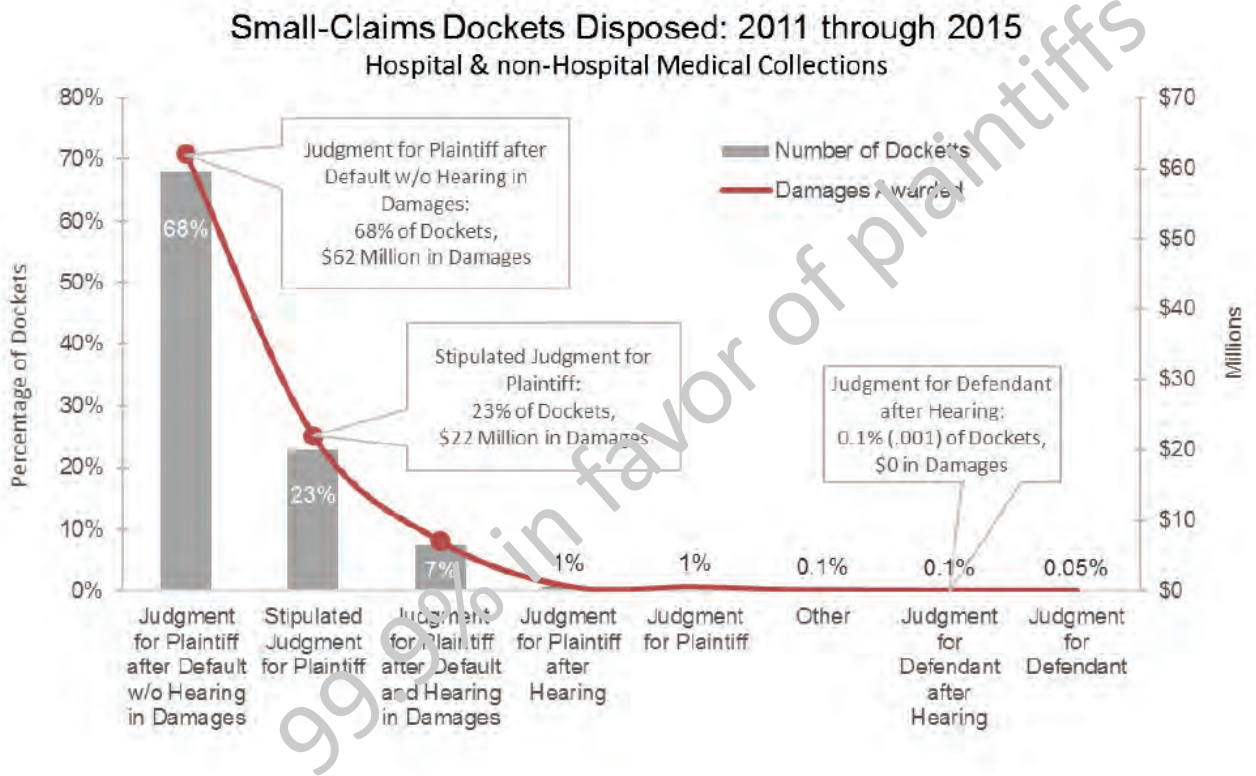


Pre ACA

Post ACA



When Connecticut Hospitals and Doctors Sue Patients: Outcomes?



While these figures do not represent the number of unique defendants or the actual amount of debt recovered or attempted to recover, they do expose the magnitude of the medical debt problem and raise important questions that have received relatively little attention by the medical community, policy makers or the public at large.

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Medical Debt ≠ Being Sued

Hospitals and Doctors Suing Patient

Medical Debt Problem

Providers faced with a medical malpractice law suit have expressed a range of emotions including anxiety, fear, frustration, remorse, self-doubt, shame, betrayal and anger.

Source; Rehm SJ, Borden BL. The emotional impact of a malpractice suit on physicians: Maintaining resilience. *Cleve Clin J Med*. 2016;83(3):177-178. doi:10.3949/ccjm.83a.16004

What is the impact of debt and law suits on patients' mental health, physical health and social stigma?

What is the impact of law suits on the patient-provider relationship?

- Trust
- Continuity of care
- Quality of care
- Physician agency *("I am on your side")*

The Provider Perspective: Ethical Dilemma

- Primary care is a low margin operation, even a "loss leader"* segment of the healthcare delivery system
- Since the advent of High Deductible Plans "accounts receivables" have been growing (duration and amount)

> *"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."* Excerpt of physicians' Hyppocratic Oath

- Providers face dual responsibility to care for their patients and to protect the financial integrity of their practices: Ethical dilemma
- Difference between small practices and corporate ownership of medical practices.

A **loss leader** is a product or service that is offered at a price that is not profitable, but it is sold to attract new customers or to sell additional products and services to those customers.

Hospitals Suing Patients in Other States

St. Joseph Missouri:

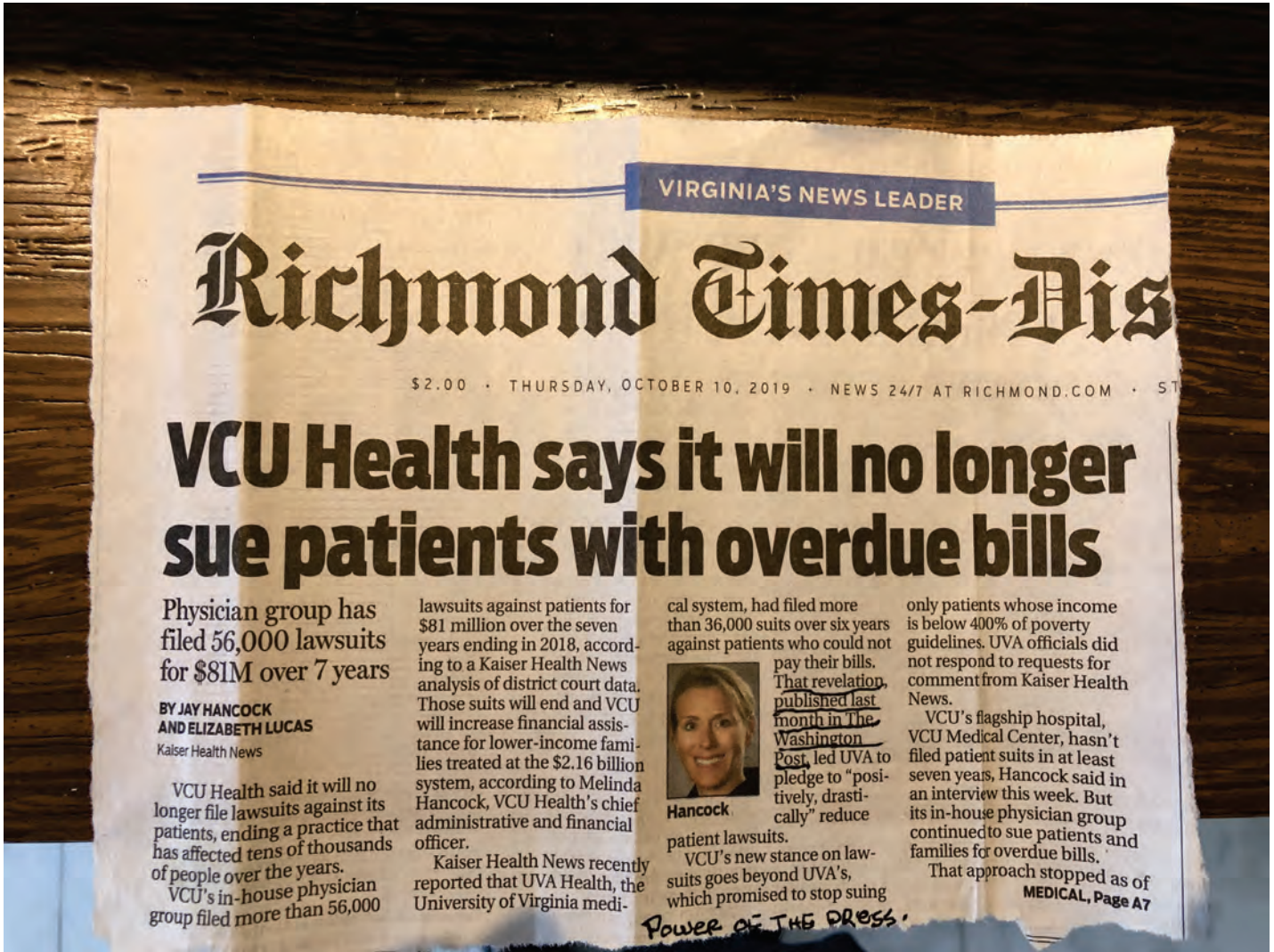
- Heartland Hospital sued this uninsured patient, a truck driver making $30,000/yr.

- Seized 10% of his paychecks and 25% of his wife's wages
- Charged 9% interest
- Placed lien on the patient's home

Virginia Hospitals: 2017

- 36% of hospitals sued 20,054 patients.
- And garnished wages from 9,232 patient s in 2017.
- Five hospitals accounted for over half of all lawsuits
- All but one of those were nonprofits.
- Mary Washington sued the most patients, according to the researchers.
- 300 summons for 1 day, most are "no-shows"

News From Virginia



VIRGINIA'S NEWS LEADER

Richmond Times-Dis

$2.00 · THURSDAY, OCTOBER 10, 2019 · NEWS 24/7 AT RICHMOND.COM · ST

VCU Health says it will no longer sue patients with overdue bills

Physician group has filed 56,000 lawsuits for $81M over 7 years

BY JAY HANCOCK AND ELIZABETH LUCAS
Kaiser Health News

VCU Health said it will no longer file lawsuits against its patients, ending a practice that has affected tens of thousands of people over the years.

VCU's in-house physician group filed more than 56,000 lawsuits against patients for $81 million over the seven years ending in 2018, according to a Kaiser Health News analysis of district court data. Those suits will end and VCU will increase financial assistance for lower-income families treated at the $2.16 billion system, according to Melinda Hancock, VCU Health's chief administrative and financial officer.

Kaiser Health News recently reported that UVA Health, the University of Virginia medical system, had filed more than 36,000 suits over six years against patients who could not pay their bills. That revelation, published last month in The Washington Post, led UVA to pledge to "positively, drastically" reduce patient lawsuits.

Hancock

VCU's new stance on lawsuits goes beyond UVA's, which promised to stop suing only patients whose income is below 400% of poverty guidelines. UVA officials did not respond to requests for comment from Kaiser Health News.

VCU's flagship hospital, VCU Medical Center, hasn't filed patient suits in at least seven years, Hancock said in an interview this week. But its in-house physician group continued to sue patients and families for overdue bills.

That approach stopped as of

MEDICAL, Page A7

Power of the Press.

Connecticut Hospitals Suing Patient

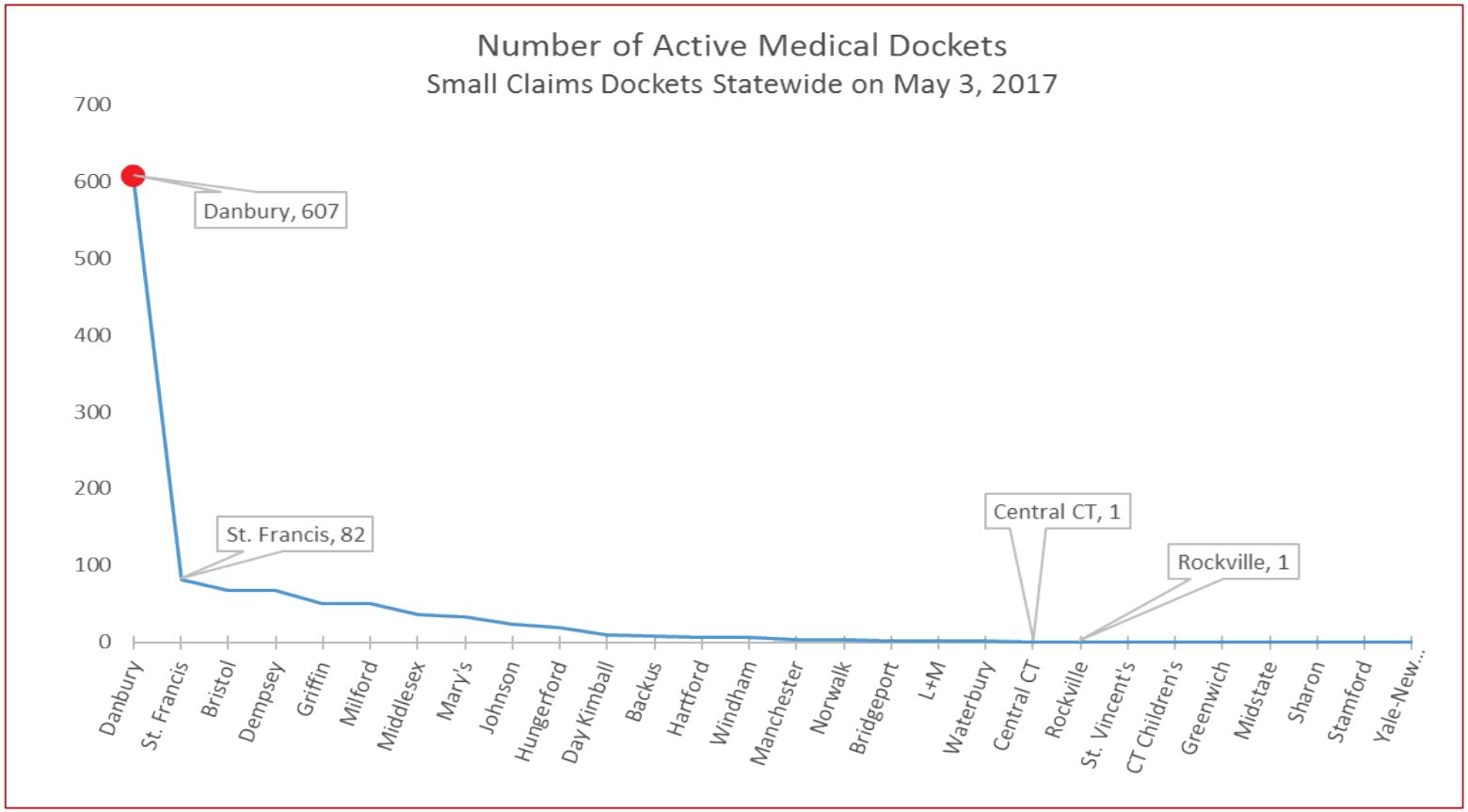
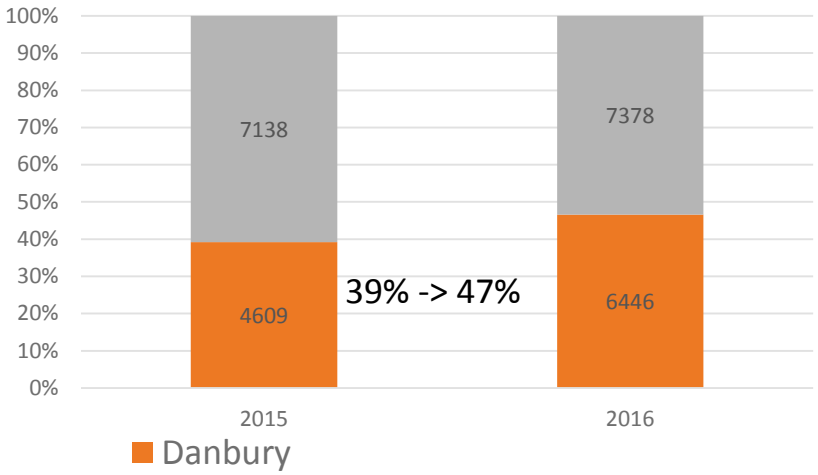


Chart shows that on May 3rd, 2017, Danbury Hospital had 607 total active dockets in small claims courts throughout Connecticut. This was a significantly higher number of dockets compared to the other 28 short-term acute care hospitals in CT

Danbury Hospital Small Claims Lawsuits Against Patients for Medical Debt vs. All Other Hospitals in Connecticut

Total number of cases 2015-2016



N = 11,747 & 13,824, (2015 &

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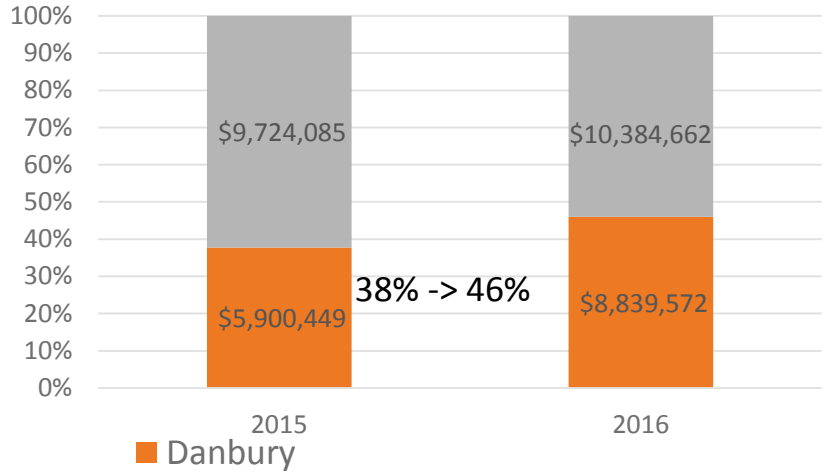
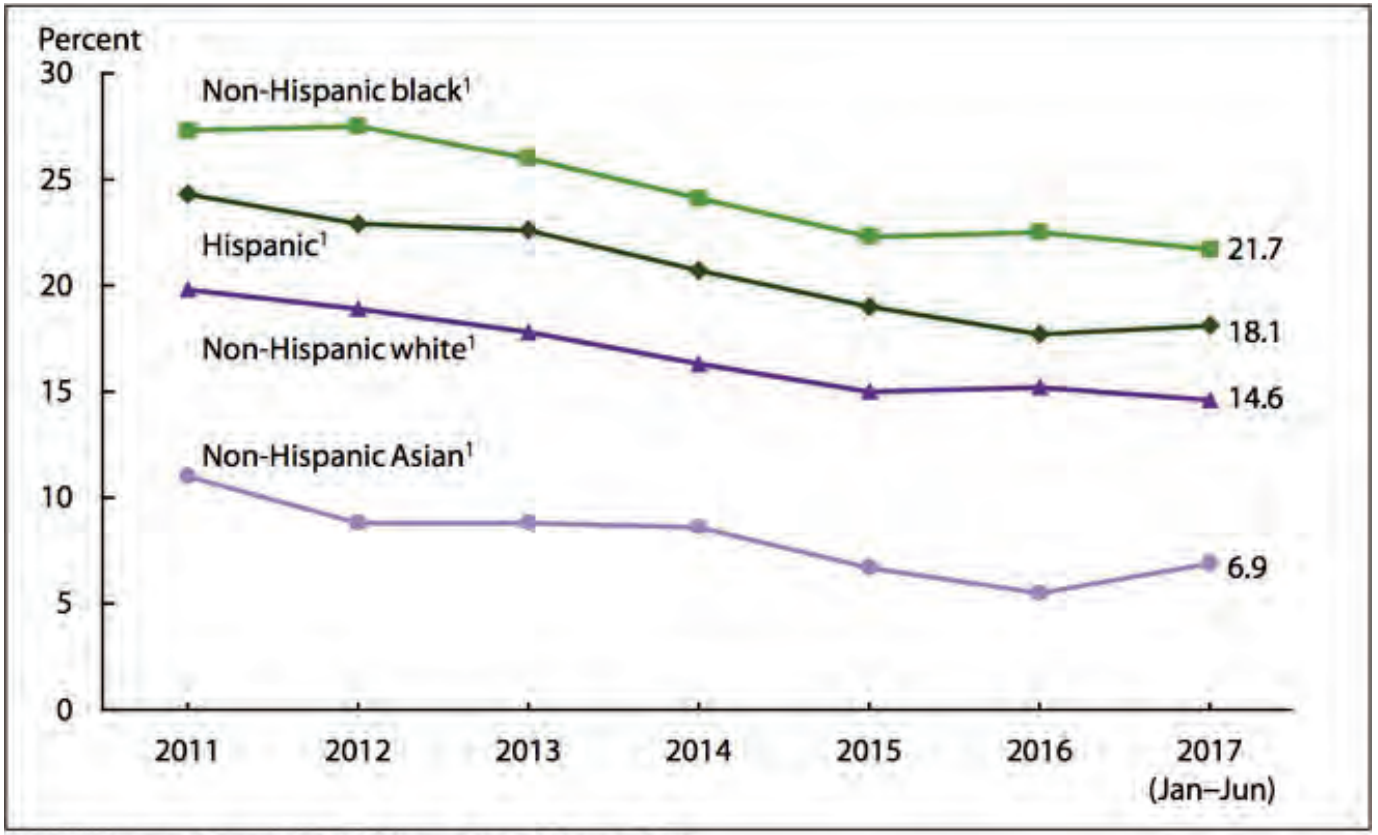
Total dollars awarded 2015-2016



N = 11,747 & 13,824, (2015 &

Racial/Ethnic disparities in medical debt



[1]Significant linear decrease from 2011 through June 2017 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2011–2017.

Policy considerations to mitigate HDPs-related healthcare inequities

- **Public Education:** Private-public partnership for statewide health insurance literacy campaign.
- **Workforce Development**: State and private funding for health insurance navigators training and deployment in underserved communities.
- **Regulatory** (Performance-based regulation): Aggressive goals for year-to-year improvement in CID Consumer Report Card scores.
- **Legislative:** Elimination of co-insurance and gradual phase-out of deductible features from all non-ERISA plans.

- **Simpler plan alternatives**: New entrants (e.g.: public option)

Policy considerations to mitigate HDPs-related healthcare inequities

Policy considerations to mitigate HDPs-related healthcare inequities

- **Administrative (for medical debt)**:
  - Transparent and standardized (understandable) hospital and provider billing statements
  - Judicial system administrative reforms to protect consumers against unfair medical debt collection practices and litigation
- **Legal framework** to control healthcare pricing practices

UCONN HEALTH | Bioscience Connecticut Health Disparities Institute

Health Insurance Advance Project

A five-year initiative (2016-2020) aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities

From a consumer point of view our research posits that HDPs meet customary criteria for A DEFECTIVE PRODUCT

Rationale: when used as designed and marketed HDPs

- Are often unreliable
- Widen healthcare disparities [19,20,21]
- Can lead to health and financial harms
- Affect a substantial portion of Connecticut citizens, specially racial/ethnic minorities.

Thank you

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(for slide 37)

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4. Bisakha Sen, et. al., "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama," *Health Services Research* 47, 4 (September 2012):1303-1620.
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(for slide 37)

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High Deductible Plans Widen Disparities

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Appendix B

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HEALTHCARE VALUE HUB

High Deductible Health Plans

What does the evidence say?

Lynn Quincy, Nov. 6, 2019

@HealthValueHub

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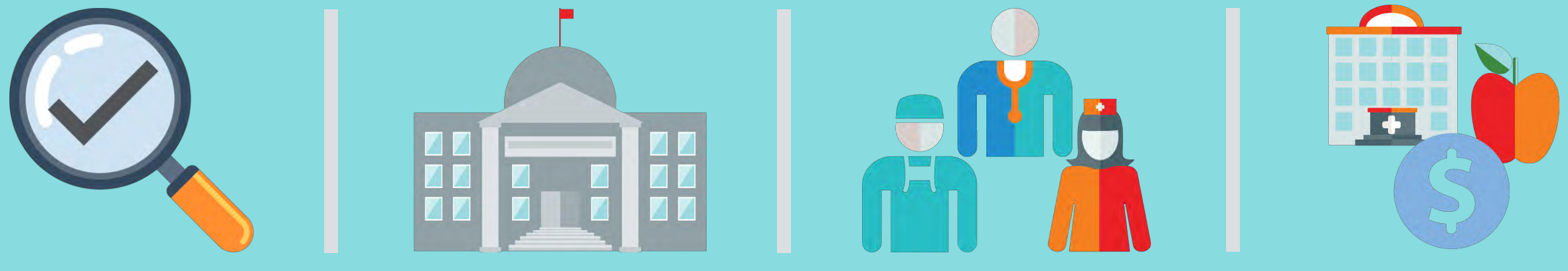
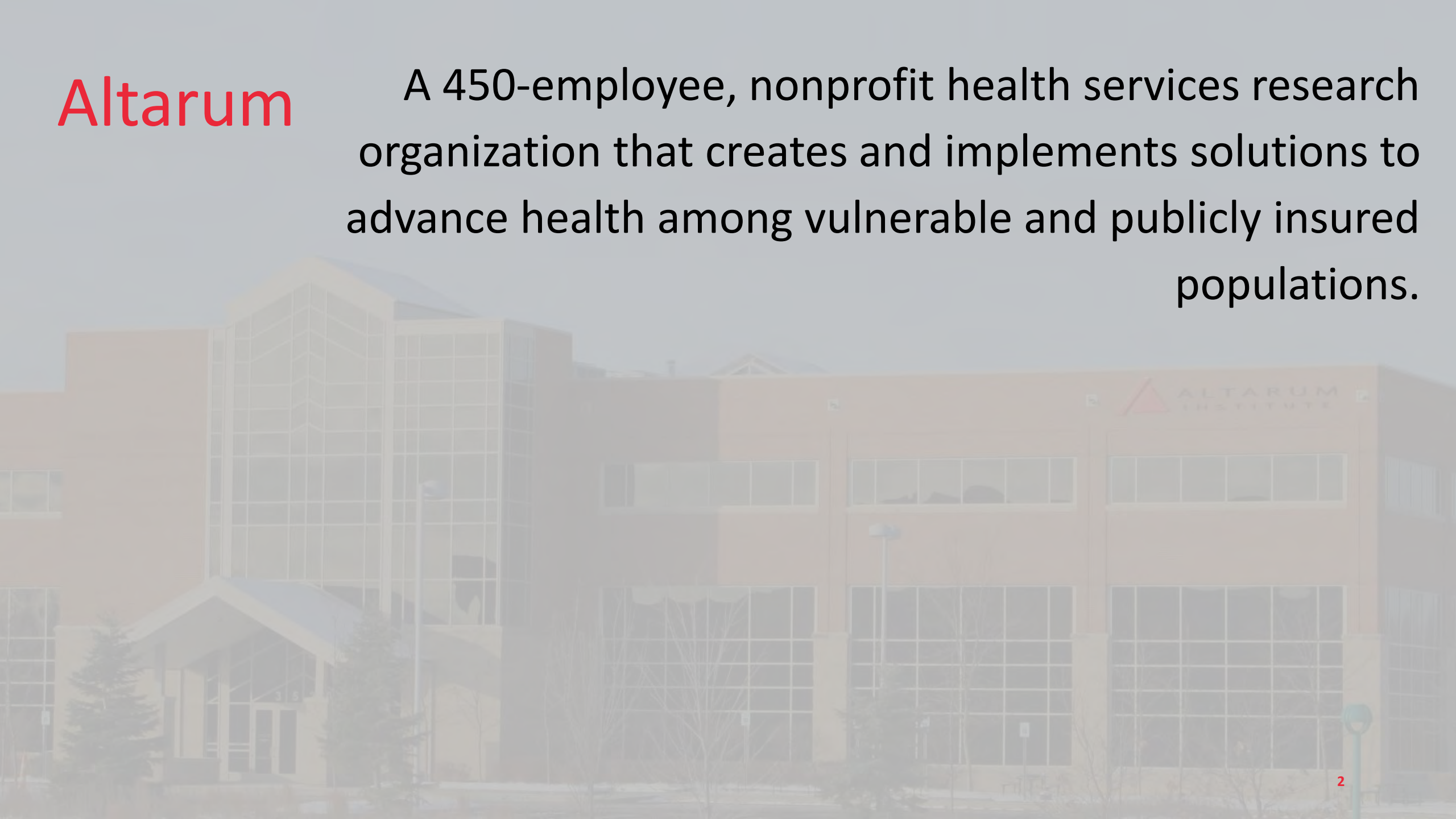


Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.



What is the Healthcare Value Hub?

With support from the Robert Wood Johnson Foundation:

- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best to reduce healthcare spending, improve affordability for consumers, improve outcomes and reduce disparities.
- We provide FREE resources to help YOU work on these healthcare value issues.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.

Guide to Jargon

High Deductible Health Plan (HDHP)

HSA-Qualified Plan (Individual Deductible> $1,350)

+

Health Savings Account (HSA)

Also Health Reimbursement Account (HRA)

=

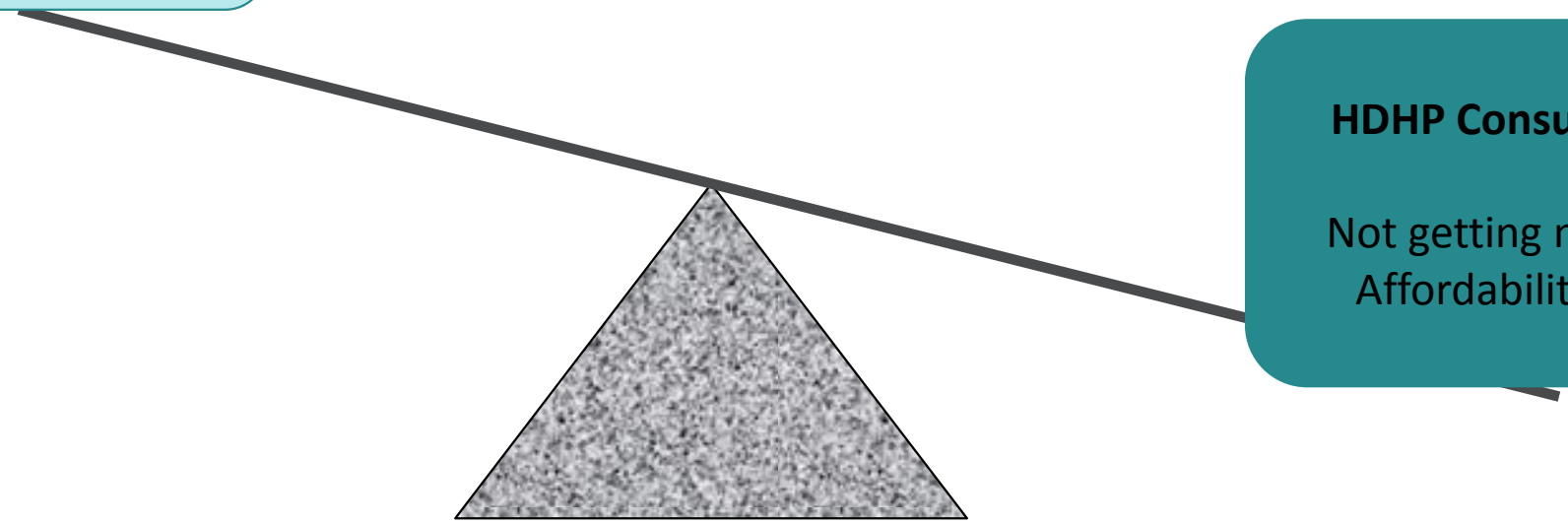
Consumer Directed Healthcare (CDHC)

Plus consumer shopping tools

HDHPs – The Bottom Line

HDHP Benefits:

Lower Premiums
~HSA Savings Opportunity



HDHP Consumer Harm:

Not getting needed care
Affordability Burdens

What HDHPs DON'T Do: Drive Value in the Marketplace

ALTARUM
HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 11 | APRIL 2016

Rethinking Consumerism in Healthcare Benefit Design

High healthcare costs are a concern for consumers and payers alike. Insurance premiums have risen faster than wages and the economy in general for nearly two decades (see Figure 1). High levels of health spending crowd out other important spending. For households, this means lower wages and less money for competing priorities. For state and national governments, it means less to spend on education, infrastructure and other public needs.

SUMMARY

For decades, rising healthcare costs have strained household, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more "skin in the game," through high-deductible health plans. When accompanied by shopping aids, these plans are sometimes called consumer-directed health plans. But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What's more, unaffordable cost sharing causes considerable consumer harm. Instead, efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending. Our country needs to rethink the role of the consumer in healthcare to be fair, patient-centric and evidence-based. Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care and not have their choices curtailed due to unaffordable cost sharing.

There is consensus that we can cut back on waste in the system (including prices that are too high) in order to reduce spending without harming our health outcomes.

An oft-used strategy to address high healthcare costs are insurance products called high-deductible health plans, or more generally, consumer-directed healthcare. Nearly half of Americans with employer-provided insurance were required to meet an individual deductible of more than $1,000 in 2015, and many plans go much higher, with deductibles in the $5,000-$6,500 range.[1] The basic idea is that by requiring consumers to pay substantial cost sharing these plan designs will incentivize consumers to extract better value from the healthcare marketplace, helping to stem the tide of rising healthcare costs and reducing the use of low-value care.

There's just one problem—we have little evidence to suggest that these high-deductible plan designs work. To control spending and bring better value to our healthcare system, we need a new vision for what the consumer's role should be.

The Theory Behind Consumer-Directed Healthcare and High-Deductible Health Plans

Whether described as a high-deductible health plan or consumer-directed healthcare—either paired with a tax advantaged account like an HRA or an HSA[2] or not—the theory is the same: If consumers face the consequences of their health spending they will spend their dollars more wisely. With up to 30 percent of healthcare spending classified as "waste" by the Institute of Medicine,[3] the goal is for consumers to cut out unnecessary or "wasteful" spending and put downward pressure on prices.

Compared to more generous coverage, HDHP lower premiums BUT:

- Patients reduce both necessary and unnecessary care
- Patients don't price shop
- Patients don't shop based on quality

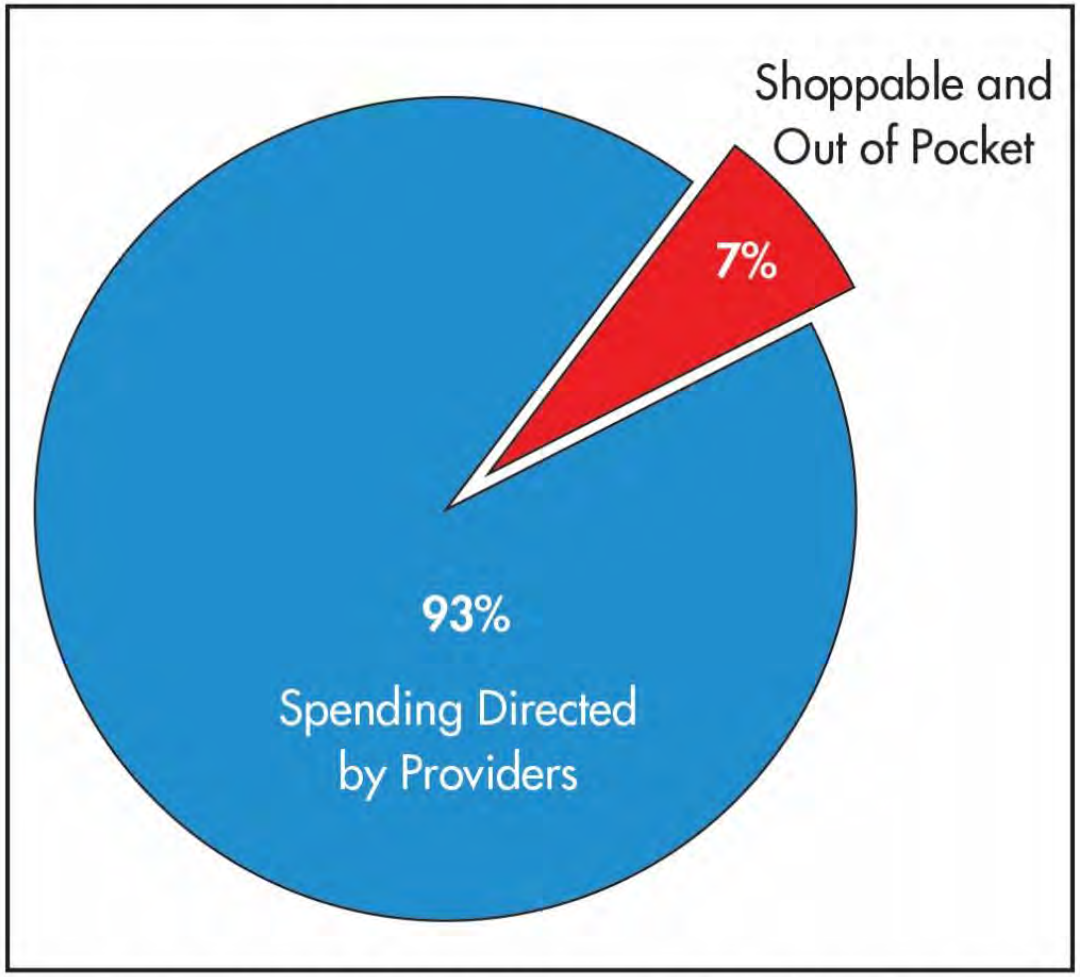
First Author	Journal	Findings
Mary E. Reed	*Health Affairs*, 2012	Survey of beneficiaries: fewer than one in five understood that their plan exempted preventive office visits, medical tests, and screenings from their deductible.
Neeraj Sood	*RAND Forum for Health Economics and Policy,* 2013	Claims data analysis across CDHP and non –CDHPs: no evidence that, within CDHP plans, consumers with lower expected medical expenses exhibited more price shopping or that consumers exhibited more price shopping before reaching the deductible
Rachel O. Reid	*American Journal of Managed Care, 2017*	Using a before/after: no change in spending on 26 commonly used, low-value services
Zarek C. Brot-Goldberg	*Quarterly Journal of Economics*, 2017	Using a before/after: spending reductions are entirely due to outright reductions in quantity. We find no evidence of consumers learning to price shop after two years in high-deductible coverage. Consumers reduce quantities across the spectrum of health care services, including potentially valuable care (e.g. preventive services) and potentially wasteful care (e.g. imaging services).
Rejender Agarwal	*Health Affairs,* 2017	Systematic review: HDHPs associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care.

Other evidence suggests WHY consumers don't shop based on price or quality:

- Care is rarely labeled as high-value or low-value
- Patients rarely know the price of a service and providers are often unable to help
- Patients rarely know quality or likely outcomes between two treatments.
- Consumers don't view healthcare as a commodity.

Most Healthcare Dollars Are Directed by Physicians

Consumers Direct a Small Percentage of Healthcare Spending

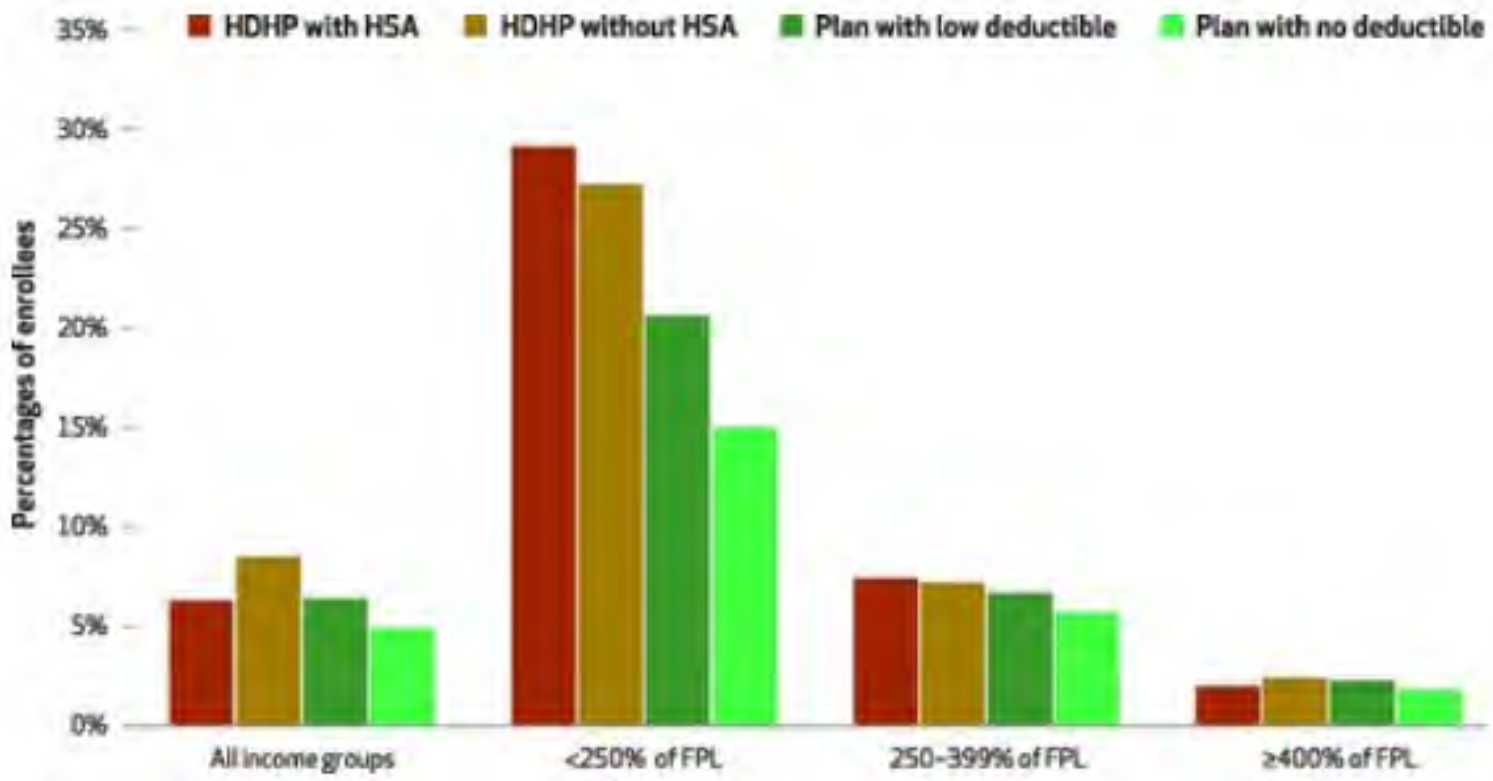


Source: Healthcare Value Hub, Rethinking Consumerism in Healthcare Benefit Design, *Research Brief No. 11 (April 2011). Adapted from Health Care Cost Institute,* Spending on Shoppable Services in Health Care, *(March 2016).*

High Deductible Health Plans Cause Consumer Harm

First Author	Journal	Findings
J. Frank Wharam	*J Clin Oncol*., 2018	Women with breast cancer who had switched to HDHPs before being diagnosed experienced delays in every aspect of the care process: diagnostic imaging, biopsies, early-stage diagnoses, and chemotherapy treatments.
J. Frank Wharam	*Health Affairs*, 2019	A similar study design: finds delays occurred regardless of income status, although delays were longer for women with lower income levels.
Alison A. Galbraith	*Health Affairs*, 2011	Survey: Almost half (48 percent) of the families with chronic conditions in high-deductible plans reported health care-related financial burden, compared to a fifth of families (21 percent) in traditional plans. Almost twice as many lower-income families in high-deductible plans spent more than 3 percent of income on health care expenses as lower-income families in traditional plans (53 percent versus 29 percent).
Zhiyuan_Zheng	*Journal of Oncology Practice*, 2019	Survey: High-deductible health plans linked to delayed, forgone care among cancer survivors, especially if no HSA; the percentage of delayed or forgone care appeared similar for cancer survivors who had an HDHP with an HSA vs. those with an Low Deductible plan

Exhibit 1 Percentage of nonelderly adults with employer-sponsored insurance facing health care burden exceeding 20 percent of family income, by income and deductible level, 2011–13



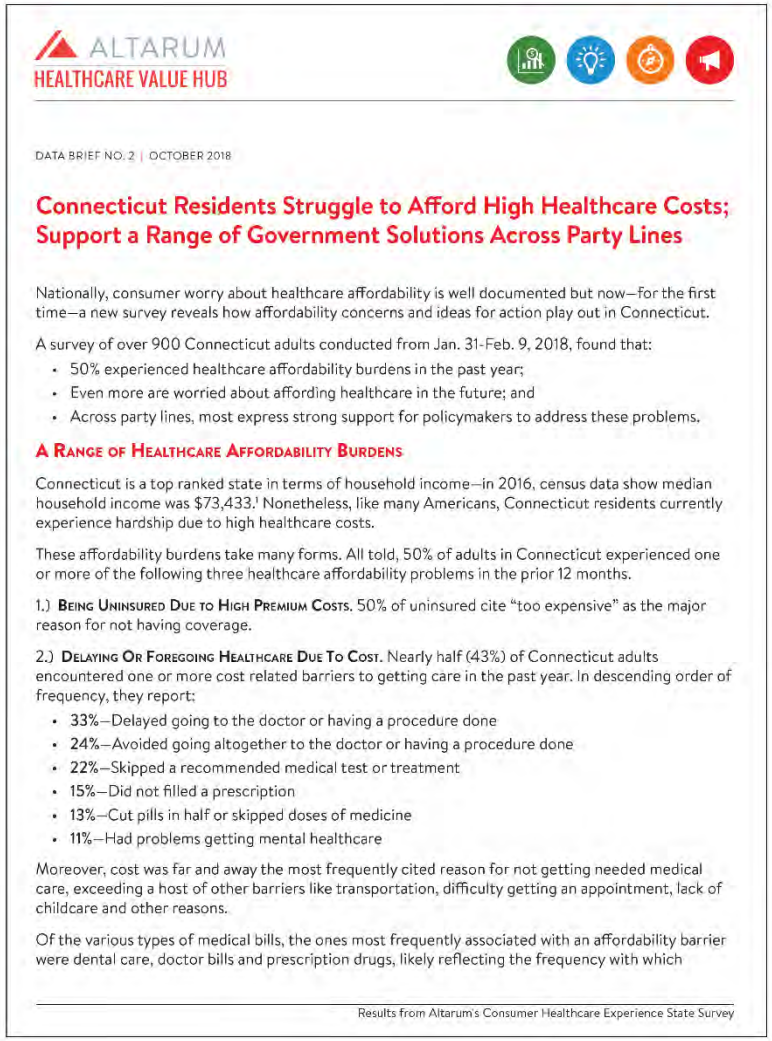
Source: Salam Abdus, Thomas M. Selden, and Patricia Keenan. "The Financial Burdens Of High-Deductible Plans," *Health Affairs*, December 2016

About Health Savings Accounts

- HSAs are tax-advantaged savings accounts designed to pay medical expenses.
- HSAs must be paired with HDHPs meeting specific IRS criteria.
- Only one-third of individuals with a high-deductible health plan also have a health savings account
- The U.S. Treasury finds that more than 60 percent of all HSA tax benefits accrue to families earning more than $100,000 annually

Source: https://www.healthcarevaluehub.org/improving-value/browse-strategy/health-savings-accounts

2018 Poll of Connecticut Adults



ALTARUM
HEALTHCARE VALUE HUB

DATA BRIEF NO. 2 | OCTOBER 2018

Connecticut Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines

Nationally, consumer worry about healthcare affordability is well documented but now—for the first time—a new survey reveals how affordability concerns and ideas for action play out in Connecticut.

A survey of over 900 Connecticut adults conducted from Jan. 31-Feb. 9, 2018, found that:

- 50% experienced healthcare affordability burdens in the past year;
- Even more are worried about affording healthcare in the future; and
- Across party lines, most express strong support for policymakers to address these problems.

A Range of Healthcare Affordability Burdens

Connecticut is a top ranked state in terms of household income—in 2016, census data show median household income was $73,433.[1] Nonetheless, like many Americans, Connecticut residents currently experience hardship due to high healthcare costs.

These affordability burdens take many forms. All told, 50% of adults in Connecticut experienced one or more of the following three healthcare affordability problems in the prior 12 months.

1.) **Being Uninsured Due to High Premium Costs.** 50% of uninsured cite "too expensive" as the major reason for not having coverage.

2.) **Delaying Or Foregoing Healthcare Due To Cost.** Nearly half (43%) of Connecticut adults encountered one or more cost related barriers to getting care in the past year. In descending order of frequency, they report:

- 33%—Delayed going to the doctor or having a procedure done
- 24%—Avoided going altogether to the doctor or having a procedure done
- 22%—Skipped a recommended medical test or treatment
- 15%—Did not filled a prescription
- 13%—Cut pills in half or skipped doses of medicine
- 11%—Had problems getting mental healthcare

Moreover, cost was far and away the most frequently cited reason for not getting needed medical care, exceeding a host of other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier were dental care, doctor bills and prescription drugs, likely reflecting the frequency with which

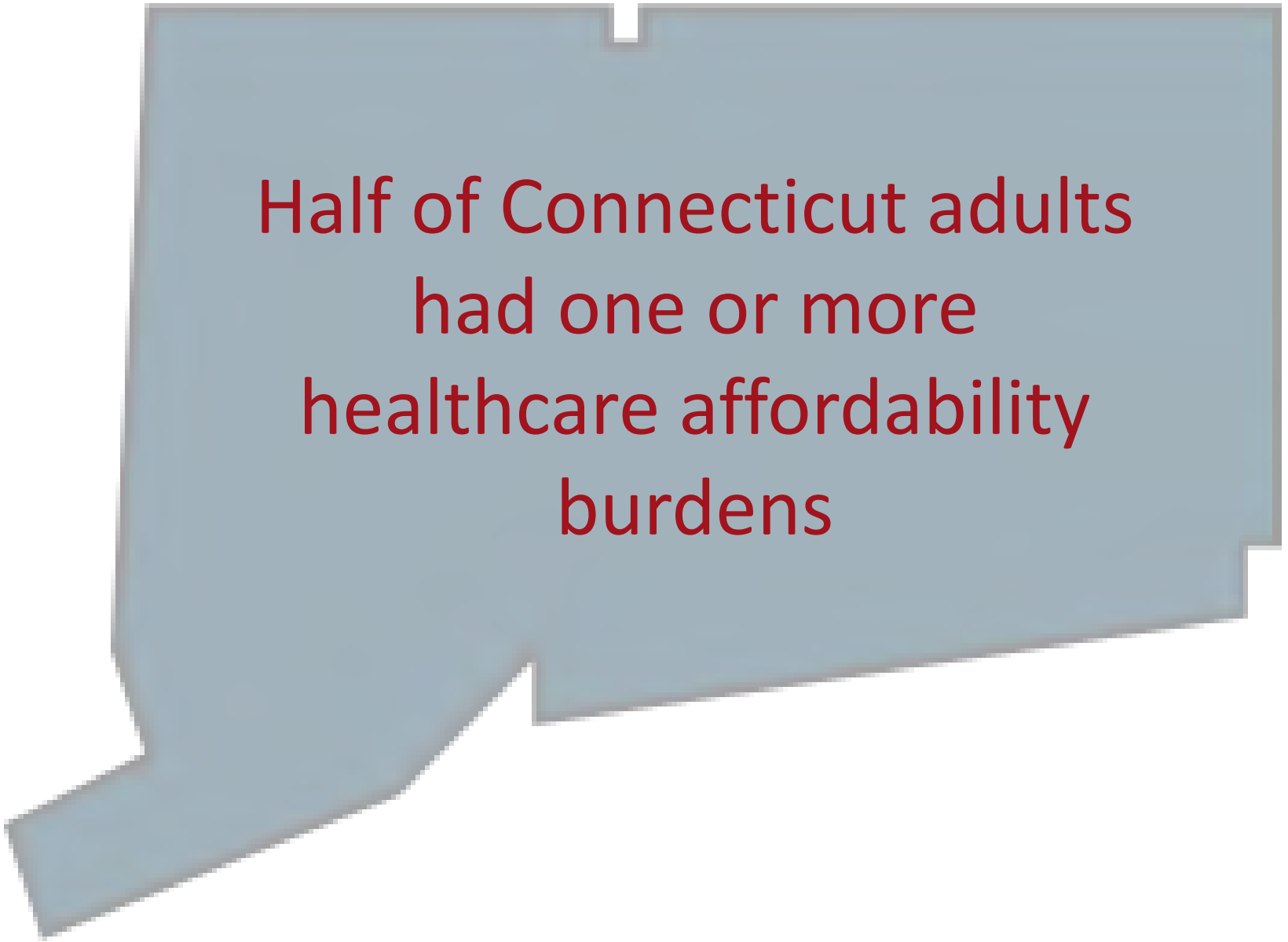
Results from Altarum's Consumer Healthcare Experience State Survey

Altarum's Consumer Healthcare Experience State Survey (CHESS):

- designed to elicit respondents' unbiased views on a wide range of health system issues
- a web panel from *Dynata* of ~1,000 residents 18 and older
- fielded Jan. 31-Feb. 9, 2018
- English language only

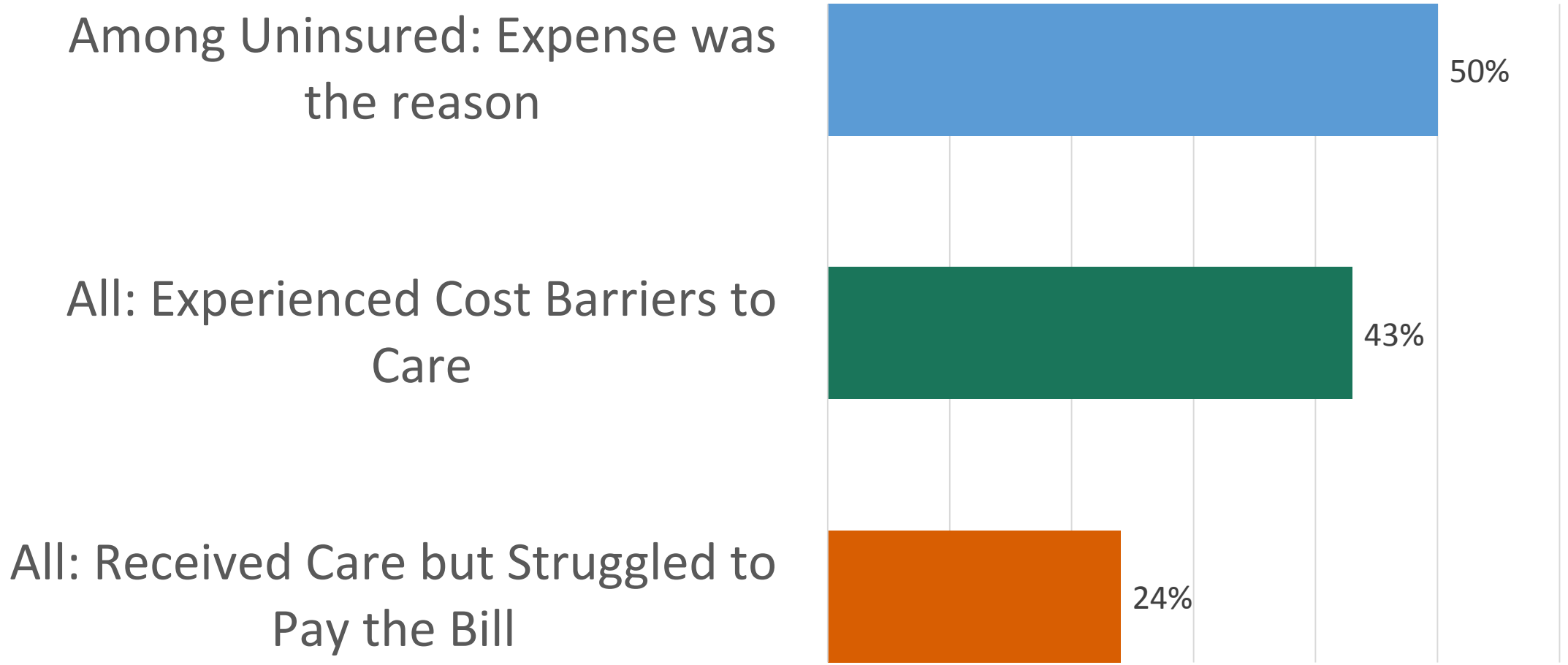
More methodology and demographics available at:
HealthcareValueHub.org/CT-2018-Healthcare-Survey

High Healthcare Affordability Burdens in Connecticut



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

Healthcare Affordability Burdens: *Percent of Connecticut Adults*



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

2018 Poll of Connecticut Adults

Cost Barrier to Care: Detail

- **33%** - Delayed going to the doctor/having a procedure done
- **24%** - Avoiding going to doctor/having procedure done
- **22%** - Skipped recommended medical test or treatment
- **15%** - Did not fill a prescription
- **13%** - Cut pills in half/skipped doses of medicine
- **11%** - Had problems getting mental health care

Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

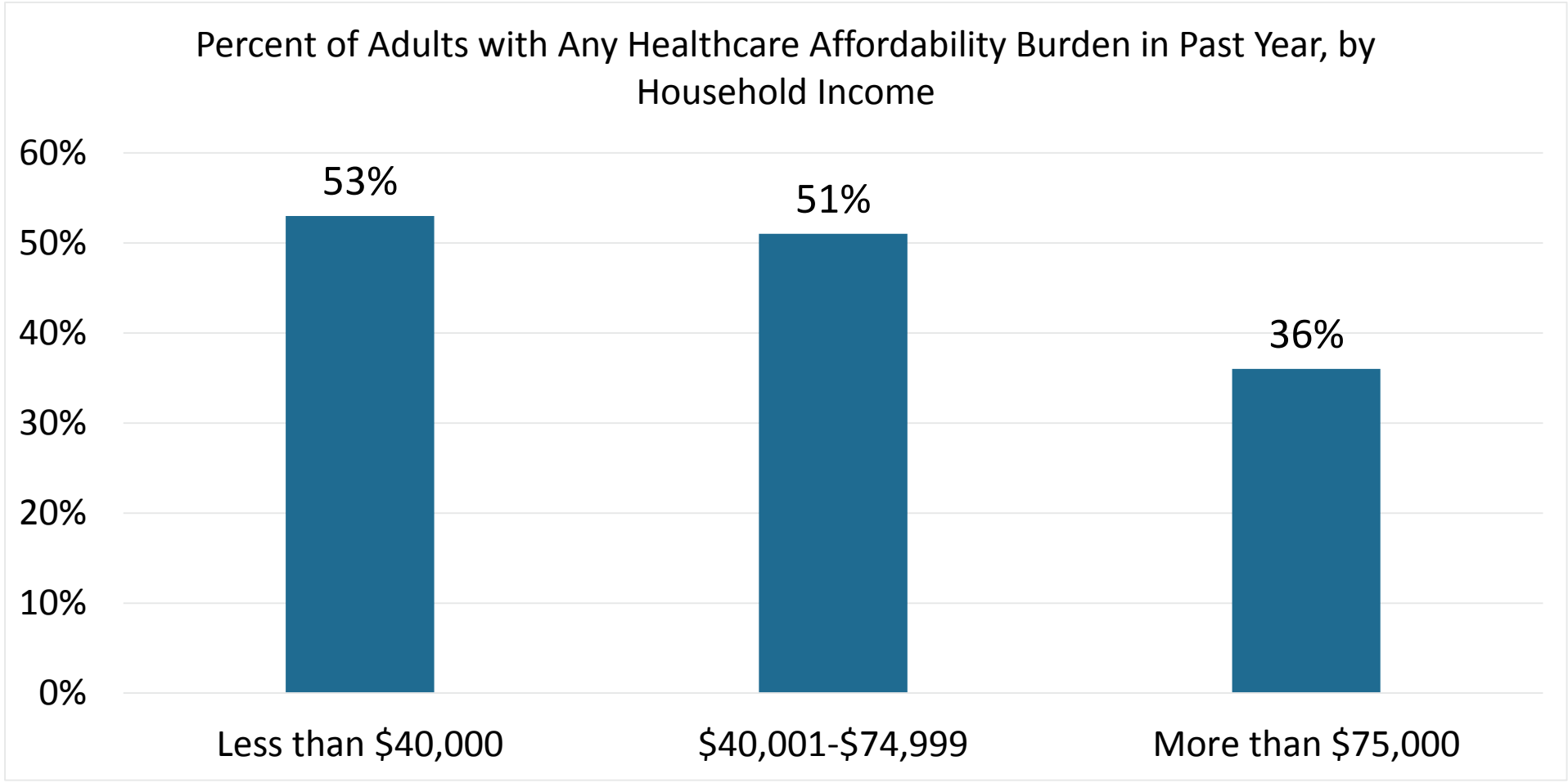
2018 Poll of Connecticut Adults

Struggled to Pay Medical Bills: Detail

- **10%** - Contacted by a collection agency
- **9%** - Used up all or most of their savings
- **7%** - Racked up large amounts of credit card debt
- **6%** - Placed on a long-term payment plan
- **6%** - Unable to pay for basic necessities (food, heat, or housing)
- **4%** - Borrowed money/got a loan/another mortgage on home

Source: 2018 Poll of Connecticut Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Healthcare affordability burdens hit lower income families the hardest….



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

QUESTIONS about HDHP evidence?

Solutions

Addressing Healthcare Affordability In 4 Easy Steps

1) Smart, affordable cost-sharing
2) Address wasteful spending
3) Address prevention “failures”
4) Address excess healthcare prices

Smart, Affordable Cost-sharing

Reminder

- There are numerous ways to divide the cost of needed medical care between the health plan and the beneficiary.
- Cost-sharing design decisions affect how this spending is distributed across the enrolled population and only affect total spending at the margins.

Smart, Affordable Cost-sharing

Goal: avoid creating barriers to care while still discouraging low-value care; make cost-sharing designs understandable

- Use copays, not coinsurance; tie cost-sharing levels to family income
- Value Based Insurance Design

Value-based Insurance Design: “clinically nuanced benefit design”

Lower cost-sharing for high value services

Higher cost-sharing for low value services

Considerations for consumer-friendly VBID

- Focus on High Value Care
- Ensure Benefits are Based on Evidence
- Prioritize – overly complex cost-sharing doesn’t help patients
- Don’t Confuse VBID with Wellness Programs

VBID: What Does The Evidence Say?

ALTARUM
HEALTHCARE VALUE HUB

EASY EXPLAINER | NO. 5 | JULY 2016

Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality

Health insurance plans have long included various forms of consumer cost sharing, in the form of deductibles, copays and coinsurance. Value-based insurance design (VBID) introduces a new twist by aligning the amount of cost sharing with the relative value of care: reducing or eliminating cost sharing for high-value care while increasing cost sharing for low-value care. By reducing financial barriers, the goal is to incentivize consumers to make better healthcare treatment decisions.

VBID was originally conceived as a way to encourage patients with chronic conditions, such as diabetes, to adhere to long-term treatment plans. Insurers have since expanded VBID to encourage the use of preventive services and other types of high-value care. The Affordable Care Act (ACA) embraced this concept by requiring that key preventive services be provided with no patient cost sharing. More recently, HHS announced a Medicare Advantage VBID trial in seven states starting in 2017.

By reducing patient cost sharing—providing a "carrot"—insurers hope to incentivize the use of high-value care, ultimately leading to better health outcomes and lower costs. Ideally any savings associated with having healthier beneficiaries would then be passed onto consumers in the form of lower premiums. In contrast, by increasing cost sharing—providing a "stick"—VBID may be used to discourage the use of healthcare that is deemed low value. Here, the target is not patient health, but rather preventing wasteful spending on services that are either over-used or not considered cost effective. An example of low-value care would be prescribing an antibiotic for a viral sinus infection or performing an MRI for back pain that has not been given time to heal.

What Does the Evidence Say?

Surprisingly, the response to lower cost-sharing incentives under VBID is not as strong as originally predicted. An analysis of thirteen studies found an average three percent increase in treatment adherence among patients with chronic conditions. These results indicate that factors other than, or in addition to, cost continue to prevent many consumers from using the high-value care that VBID aims to promote. In many cases, consumers may simply lack the information, expertise or motivation to change their behavior. Because of this, the benefits of VBID "carrots" have largely accrued to consumers who are already relatively health conscious and treatment compliant.

Perhaps for these reasons, the evidence is mixed on the effect of VBID on health outcomes. Although some studies show health improvements, others found improved treatment adherence did not necessarily lead to better clinical outcomes.

Early but promising research shows that employing VBID as one piece of a larger and more comprehensive strategy can encourage healthy behavior. Studies indicate that plans are more effective at boosting treatment compliance when they provide more generous benefits, target high-risk patients, include wellness programs and employ mail-order pharmacies.

The other side of VBID—providing a "stick" to discourage lower value care—is rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known

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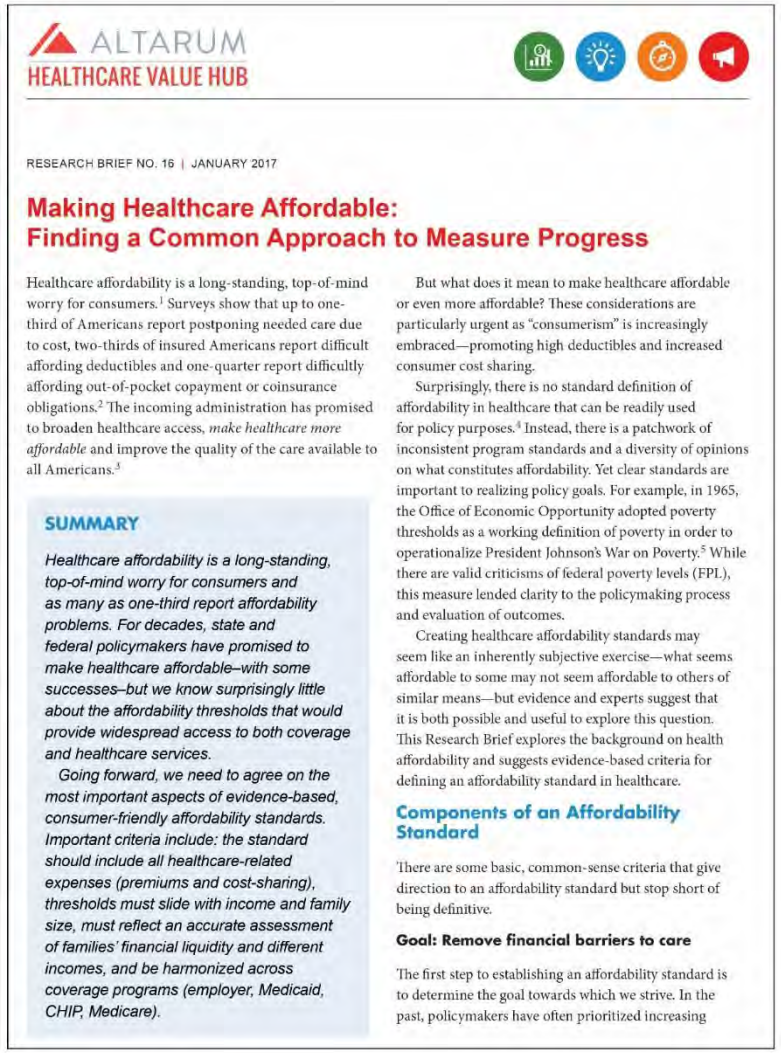
- Surprisingly, response to lower cost-sharing incentives under VBID is not as strong as predicted.
- Because of this, the benefits of VBID "carrots" have largely accrued to patients who are already relatively health conscious and treatment compliant.
- VBID "sticks" (to discourage lower value care) are rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known whether patients will respond in the nuanced way that VBID intends, as opposed to reducing the use of care indiscriminately.

What does it MEAN to make cost-sharing affordable?



ALTARUM
HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 16 | JANUARY 2017

Making Healthcare Affordable: Finding a Common Approach to Measure Progress

Healthcare affordability is a long-standing, top-of-mind worry for consumers.[1] Surveys show that up to one-third of Americans report postponing needed care due to cost, two-thirds of insured Americans report difficult affording deductibles and one-quarter report difficultly affording out-of-pocket copayment or coinsurance obligations.[2] The incoming administration has promised to broaden healthcare access, *make healthcare more affordable* and improve the quality of the care available to all Americans.[3]

SUMMARY

Healthcare affordability is a long-standing, top-of-mind worry for consumers and as many as one-third report affordability problems. For decades, state and federal policymakers have promised to make healthcare affordable–with some successes–but we know surprisingly little about the affordability thresholds that would provide widespread access to both coverage and healthcare services.

Going forward, we need to agree on the most important aspects of evidence-based, consumer-friendly affordability standards. Important criteria include: the standard should include all healthcare-related expenses (premiums and cost-sharing), thresholds must slide with income and family size, must reflect an accurate assessment of families' financial liquidity and different incomes, and be harmonized across coverage programs (employer, Medicaid, CHIP, Medicare).

But what does it mean to make healthcare affordable or even more affordable? These considerations are particularly urgent as "consumerism" is increasingly embraced—promoting high deductibles and increased consumer cost sharing.

Surprisingly, there is no standard definition of affordability in healthcare that can be readily used for policy purposes.[4] Instead, there is a patchwork of inconsistent program standards and a diversity of opinions on what constitutes affordability. Yet clear standards are important to realizing policy goals. For example, in 1965, the Office of Economic Opportunity adopted poverty thresholds as a working definition of poverty in order to operationalize President Johnson's War on Poverty.[5] While there are valid criticisms of federal poverty levels (FPL), this measure lended clarity to the policymaking process and evaluation of outcomes.

Creating healthcare affordability standards may seem like an inherently subjective exercise—what seems affordable to some may not seem affordable to others of similar means—but evidence and experts suggest that it is both possible and useful to explore this question. This Research Brief explores the background on health affordability and suggests evidence-based criteria for defining an affordability standard in healthcare.

Components of an Affordability Standard

There are some basic, common-sense criteria that give direction to an affordability standard but stop short of being definitive.

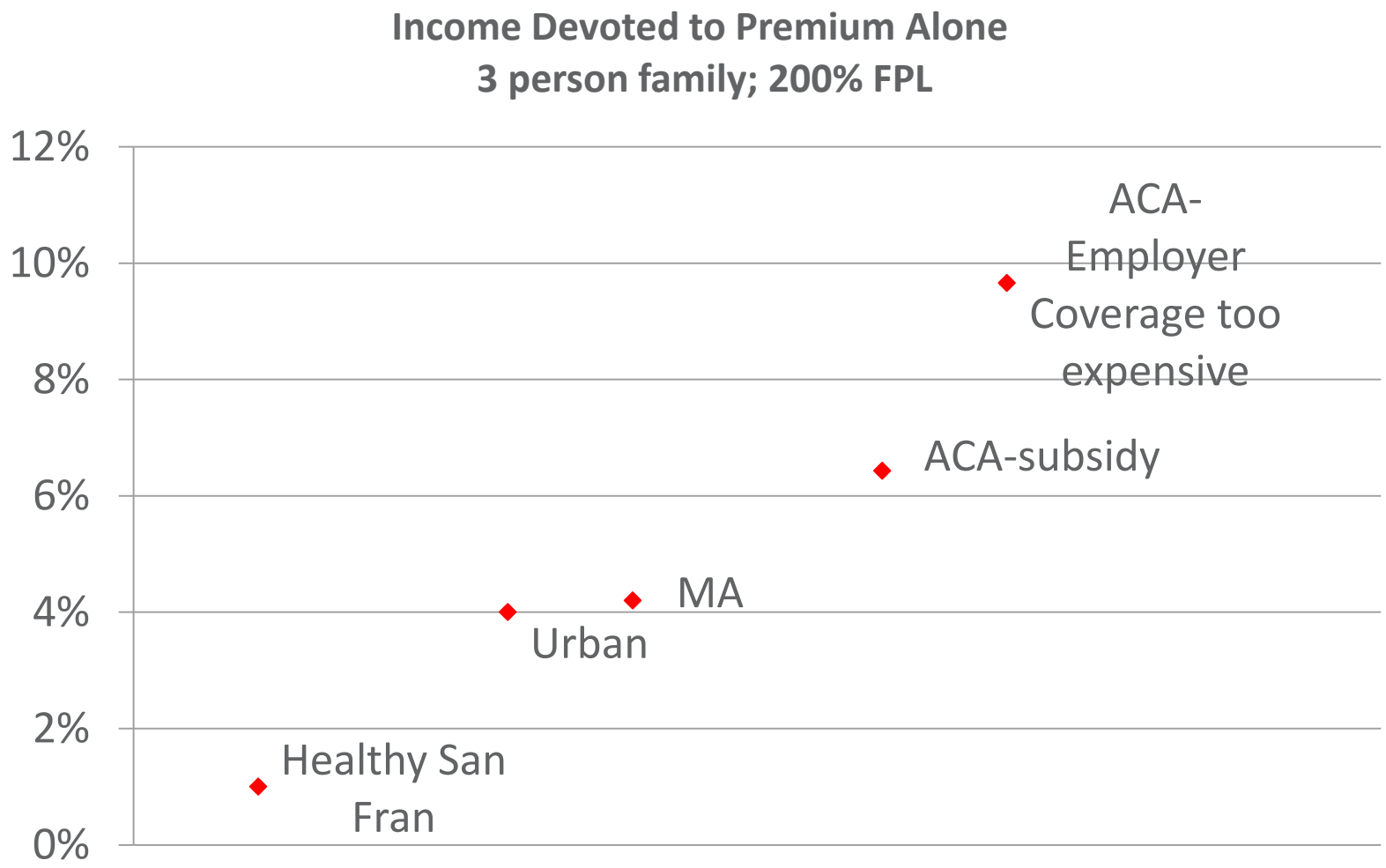
Goal: Remove financial barriers to care

The first step to establishing an affordability standard is to determine the goal towards which we strive. In the past, policymakers have often prioritized increasing

Hub finds lack of harmonization across programs with respect to affordability thresholds

- IRS Tax Deductibility Threshold
- Medicaid
- CHIP
- Massachusetts (Romneycare)
- Healthy San Francisco
- ACA
- Urban Institute estimates for more generous ACA thresholds

Affordability of Premium Alone: Not Harmonized Across Programs



Defining a Healthcare Affordability Standard

- Goal: No financial barriers to care
- Consider a “Total Cost” concept. What percent of income can a household devote to:
  - Cost of coverage (premiums)
  - Cost-sharing for covered services
  - Cost of needed services not included in the benefit package
- Standard slides with income and family size

Address Inadvertent, Surprise Out-of-Network Bills

- Get patients out of the middle – prohibit balance billing and include a mechanism to resolve provider payment
- Stronger network adequacy transparency provisions – at point of insurance shopping, show likelihood of getting a Surprise Bill
- Better consumer assistance

More Info: https://www.healthcarevaluehub.org/improving-value/browse-strategy/surprise-medical-bills

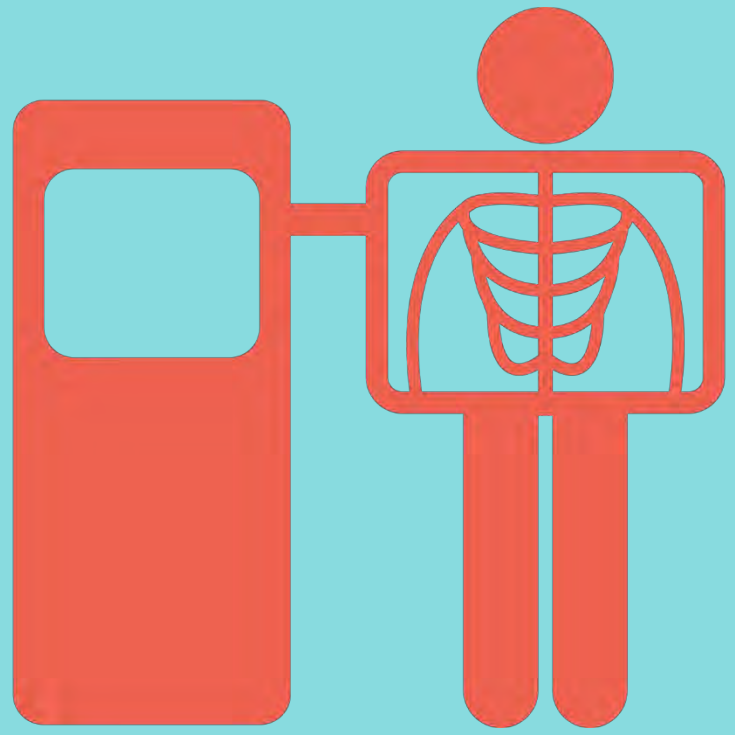
Short-term Health Plans
aka skimpy health plans

- Premiums savings stems from less coverage, not duration of the policy
- Exempt from ACA consumer protections:
  - have annual and life-time caps
  - likely don’t cover minimum essential services like maternity and mental health; cost-sharing obligations can > $20,000
  - can exclude pre-existing conditions
  - not subject to MLR minimum: 80% of premium dollar spent on medical care

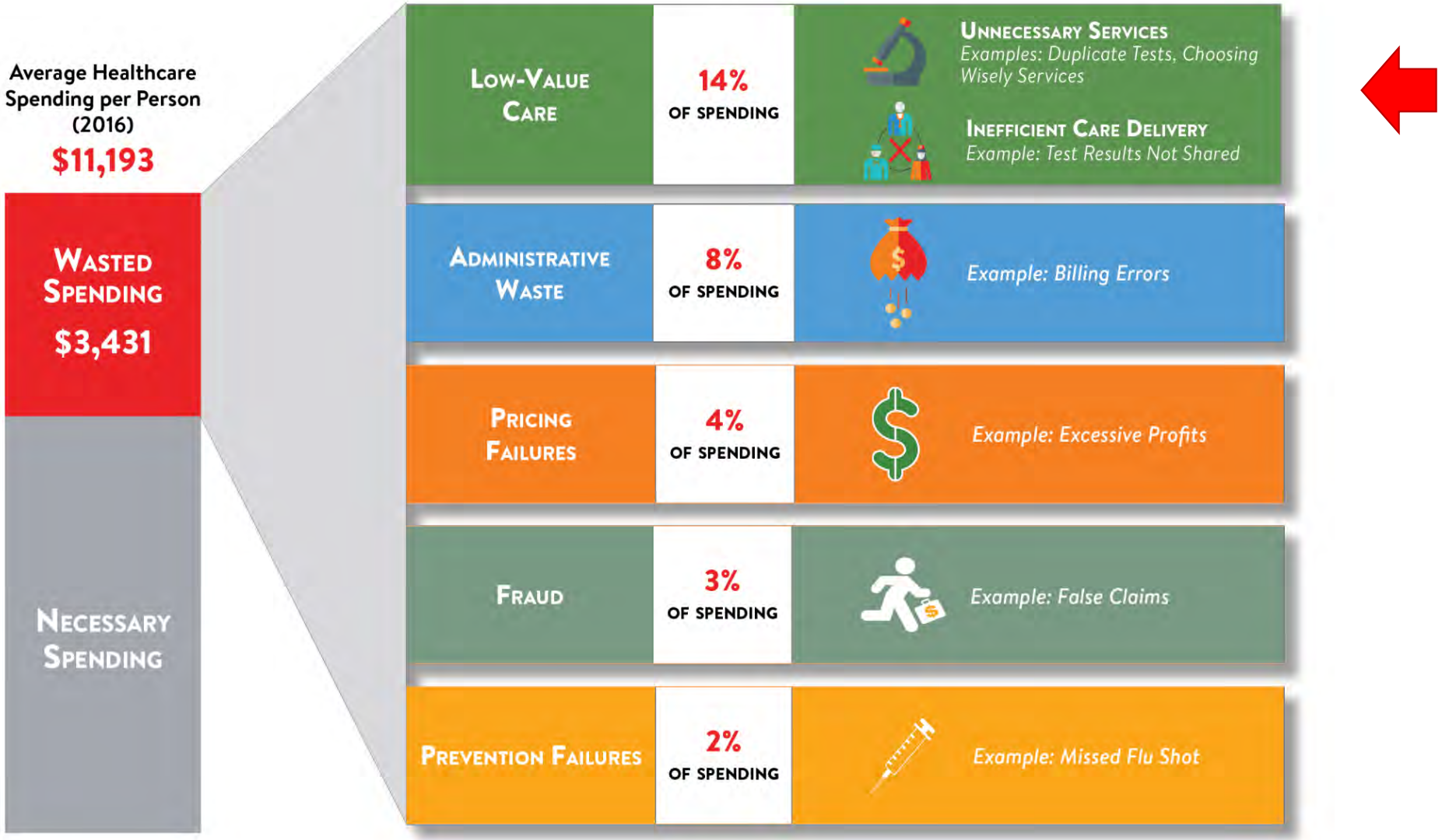
How are states protecting consumers?

- Prohibit sale of Short-term plans (MA, NJ, NY, CA)
- Enact term limits (MD-90 days)
- Enact state limits on renewal
- Benefit mandates to place a floor under the coverage offered by ST plans (CT)

Address Wasteful Spending

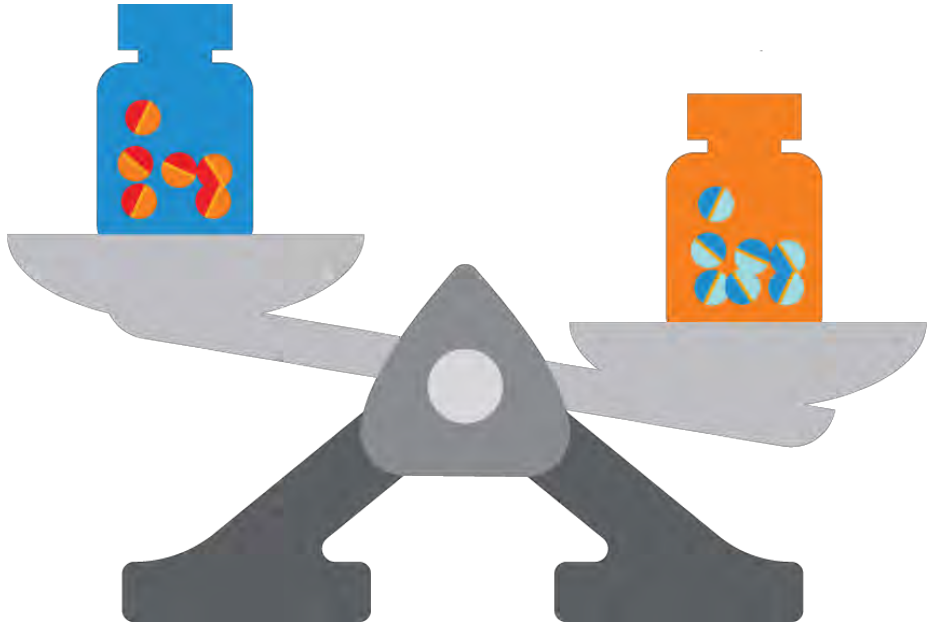


One-Third of Healthcare Spending is Wasted

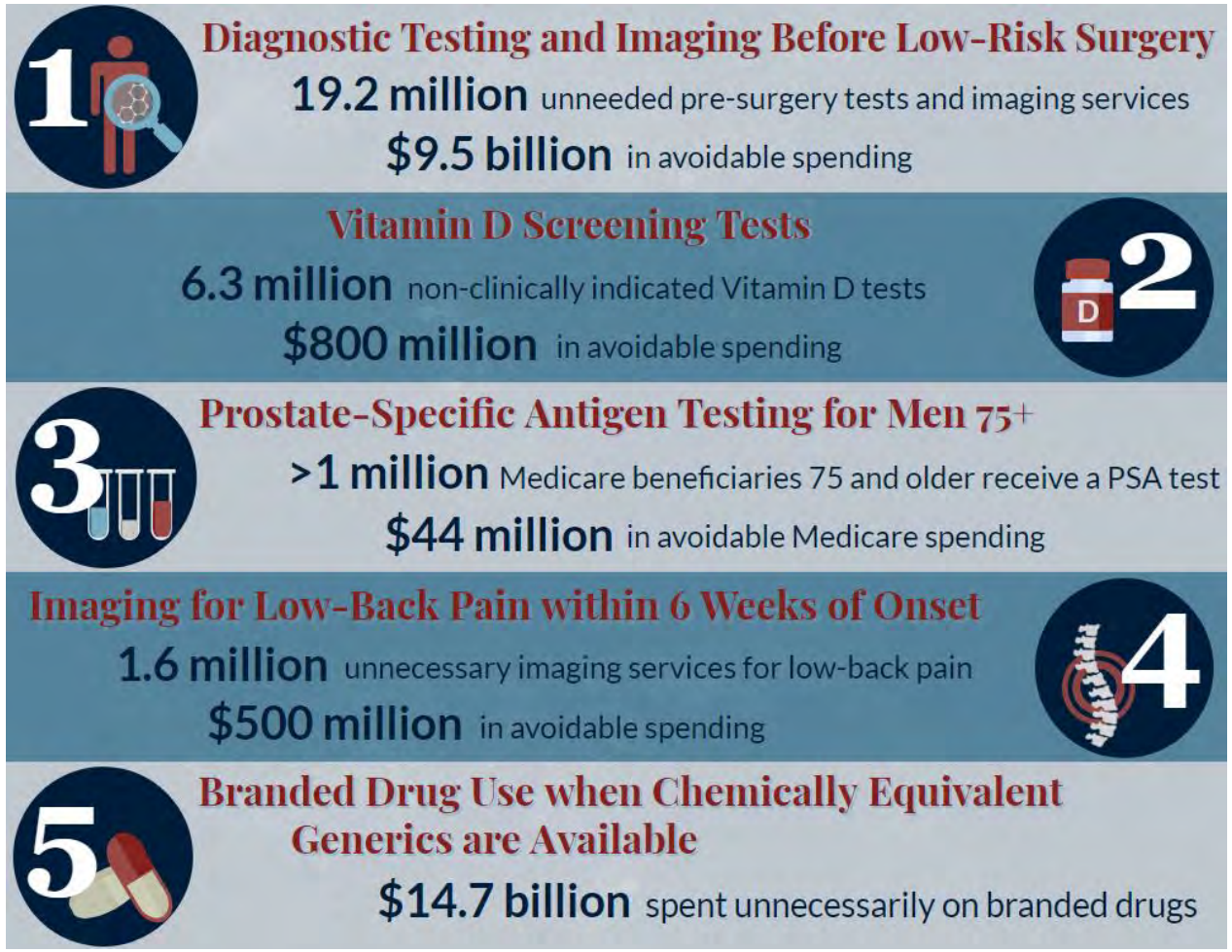


Insufficient Comparative Effectiveness Research Undercuts Efforts

Up to 50% of our care may be provided without evidence of effectiveness



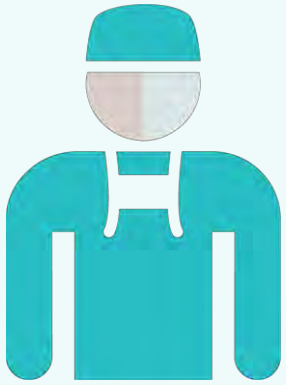
Some care is not ambiguous; tagged as low- or no-value in most cases



Source: Center for Value-based Insurance Design

Many, many other services have been identified as low or no-value.

GETTING UTILIZATION RIGHT: STRATEGIES



Provider Payment Reform

GET INCENTIVES RIGHT

Non-Financial Provider Incentives

ALSO POWERFUL

Patient Shared Decision-Making should be the

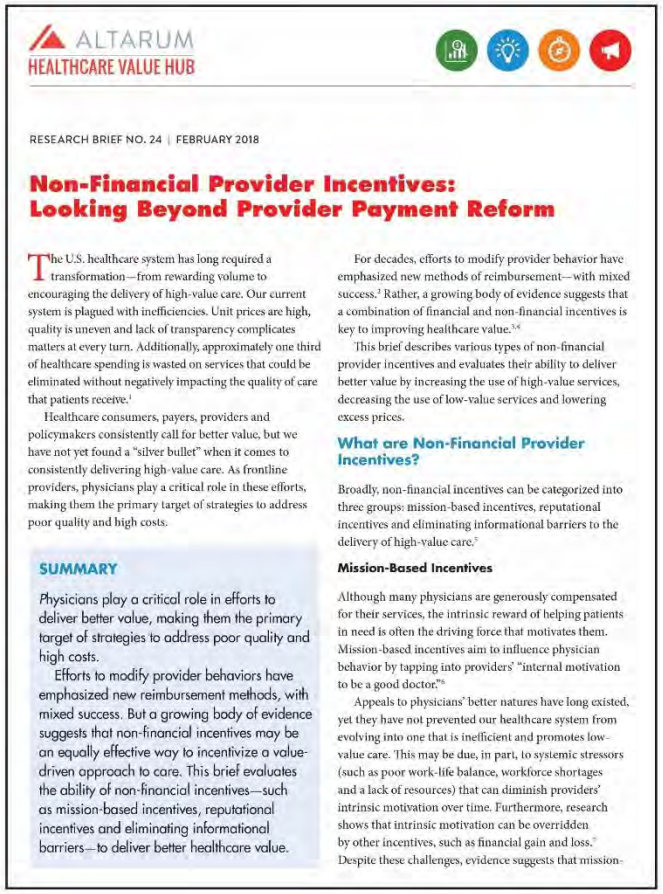
STANDARD OF CARE

Insurance Benefit Design but

KEEP IT SIMPLE

Financial incentives are not our only provider tool….

- Non-financial incentives:
  - Peer comparisons
  - Peer recognition
  - Eliminate barriers
  - Institutional support and leadership



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HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 24 | FEBRUARY 2018

Non-Financial Provider Incentives: Looking Beyond Provider Payment Reform

The U.S. healthcare system has long required a transformation—from rewarding volume to encouraging the delivery of high-value care. Our current system is plagued with inefficiencies. Unit prices are high, quality is uneven and lack of transparency complicates matters at every turn. Additionally, approximately one third of healthcare spending is wasted on services that could be eliminated without negatively impacting the quality of care that patients receive.[1]

Healthcare consumers, payers, providers and policymakers consistently call for better value, but we have not yet found a "silver bullet" when it comes to consistently delivering high-value care. As frontline providers, physicians play a critical role in these efforts, making them the primary target of strategies to address poor quality and high costs.

SUMMARY

Physicians play a critical role in efforts to deliver better value, making them the primary target of strategies to address poor quality and high costs.

Efforts to modify provider behaviors have emphasized new reimbursement methods, with mixed success. But a growing body of evidence suggests that non-financial incentives may be an equally effective way to incentivize a value-driven approach to care. This brief evaluates the ability of non-financial incentives—such as mission-based incentives, reputational incentives and eliminating informational barriers—to deliver better healthcare value.

For decades, efforts to modify provider behavior have emphasized new methods of reimbursement—with mixed success.[2] Rather, a growing body of evidence suggests that a combination of financial and non-financial incentives is key to improving healthcare value.[3,4]

This brief describes various types of non-financial provider incentives and evaluates their ability to deliver better value by increasing the use of high-value services, decreasing the use of low-value services and lowering excess prices.

What are Non-Financial Provider Incentives?

Broadly, non-financial incentives can be categorized into three groups: mission-based incentives, reputational incentives and eliminating informational barriers to the delivery of high-value care.[5]

Mission-Based Incentives

Although many physicians are generously compensated for their services, the intrinsic reward of helping patients in need is often the driving force that motivates them. Mission-based incentives aim to influence physician behavior by tapping into providers' "internal motivation to be a good doctor."[6]

Appeals to physicians' better natures have long existed, yet they have not prevented our healthcare system from evolving into one that is inefficient and promotes low-value care. This may be due, in part, to systemic stressors (such as poor work-life balance, workforce shortages and a lack of resources) that can diminish providers' intrinsic motivation over time. Furthermore, research shows that intrinsic motivation can be overridden by other incentives, such as financial gain and loss.[7] Despite these challenges, evidence suggests that mission-

Address “Prevention Failures”

LOW-VALUE CARE .vs HIGH-VALUE CARE

LOW-VALUE CARE

EXAMPLES

Unneeded diagnostic testing

Unneeded imaging

Bloodwork for low-risk surgery

Use of branded drugs when generics are available

Elective/unwarranted C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

HIGH-VALUE CARE

EXAMPLES

Getting a flu shot

Coordinating care for complex patients

Cancer screening when appropriate

Prenatal care

Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.

For details on the strategies, go to:

HEALTHCAREVALUEHUB.org/low-vs-high-value-care

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One-Third of Healthcare Spending is Wasted

Average Healthcare Spending per Person (2016)

$11,193

Wasted Spending

$3,431

Necessary Spending

Low-Value Care	14% of spending	**Unnecessary Services** *Examples: Duplicate Tests, Choosing Wisely Services* **Inefficient Care Delivery** *Example: Test Results Not Shared*
Administrative Waste	8% of spending	*Example: Billing Errors*
Pricing Failures	4% of spending	*Example: Excessive Profits*
Fraud	3% of spending	*Example: False Claims*
Prevention Failures	2% of spending	*Example: Missed Flu Shot*

SOCIAL DETERMINANTS OF HEALTH

The conditions where you live, work and play impact your health outcomes.

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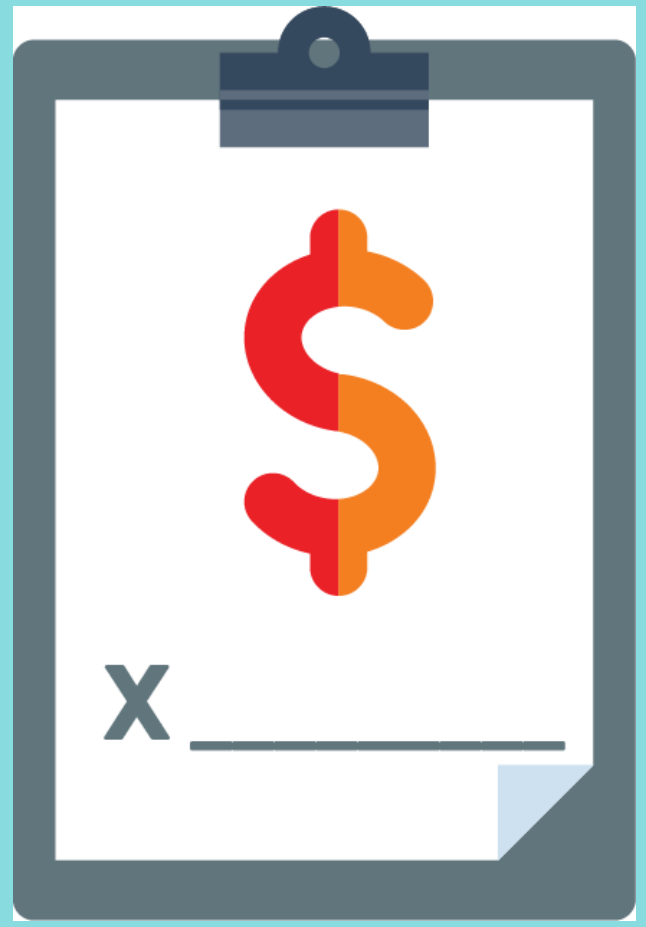
Addressing Personal and Social Determinants of Health

- Assess community needs and capacity to address needs
- Collect better data to track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
  - Environmental nudges
  - Social-medical models of care
- Address financing silos

Addressing High Unit Prices



UNREASONABLE PRICES: STRATEGIES

Price Transparency to expose

HIGH PRICES

Anti-trust, CON/DON, foster competition to address

MONOPOLY POWER

Reference pricing, rate setting, price regulation to address

PRICING OUTLIERS

Global Budgets to cap

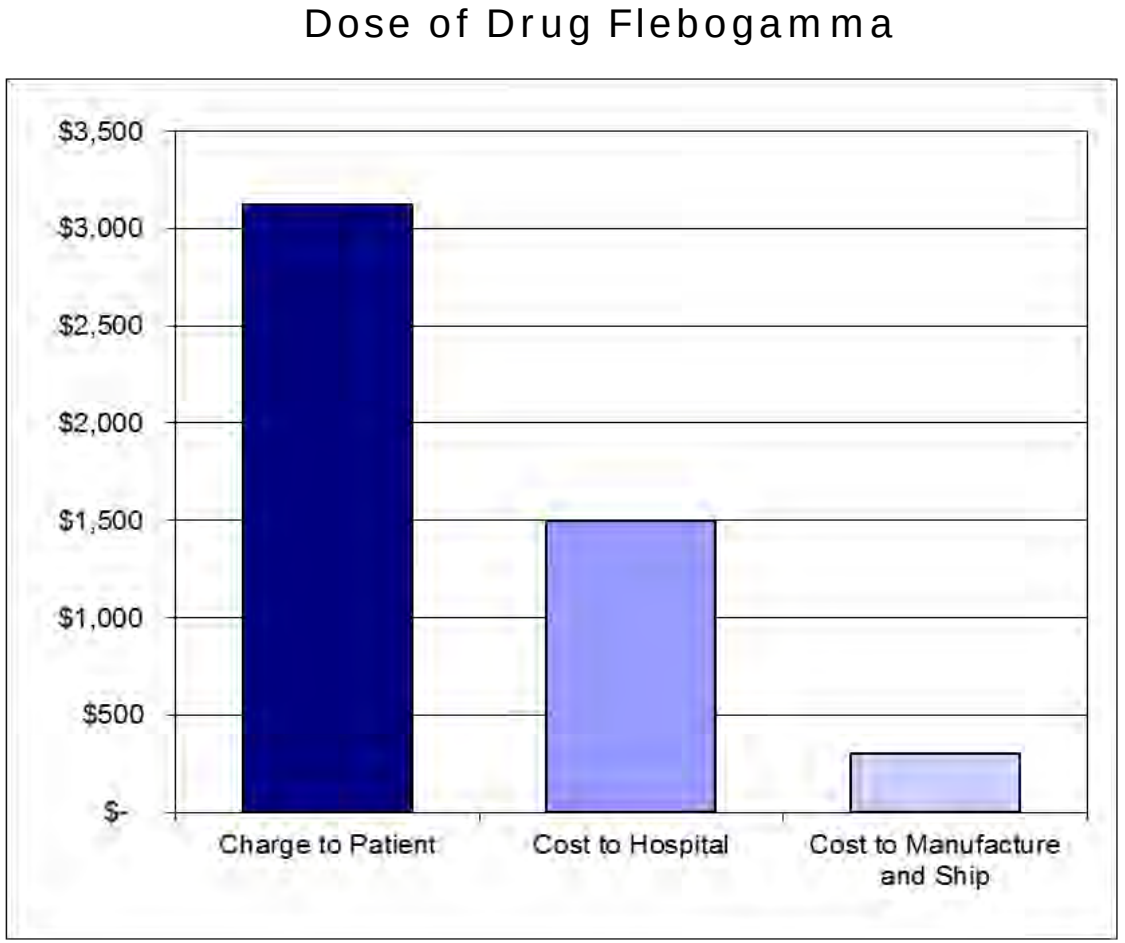
OVERALL SPENDING

Neither Paid Amount nor Charge Provide an Accurate Picture of the Underlying Cost

For the most part,

we have no idea what

the underlying cost of inputs is.



Source: Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," Time, March 4, 2013

Which Price Concept(s) Should We Make Transparent?

Listed Charges (Charge-master)

Negotiated Charges (varies by payer)

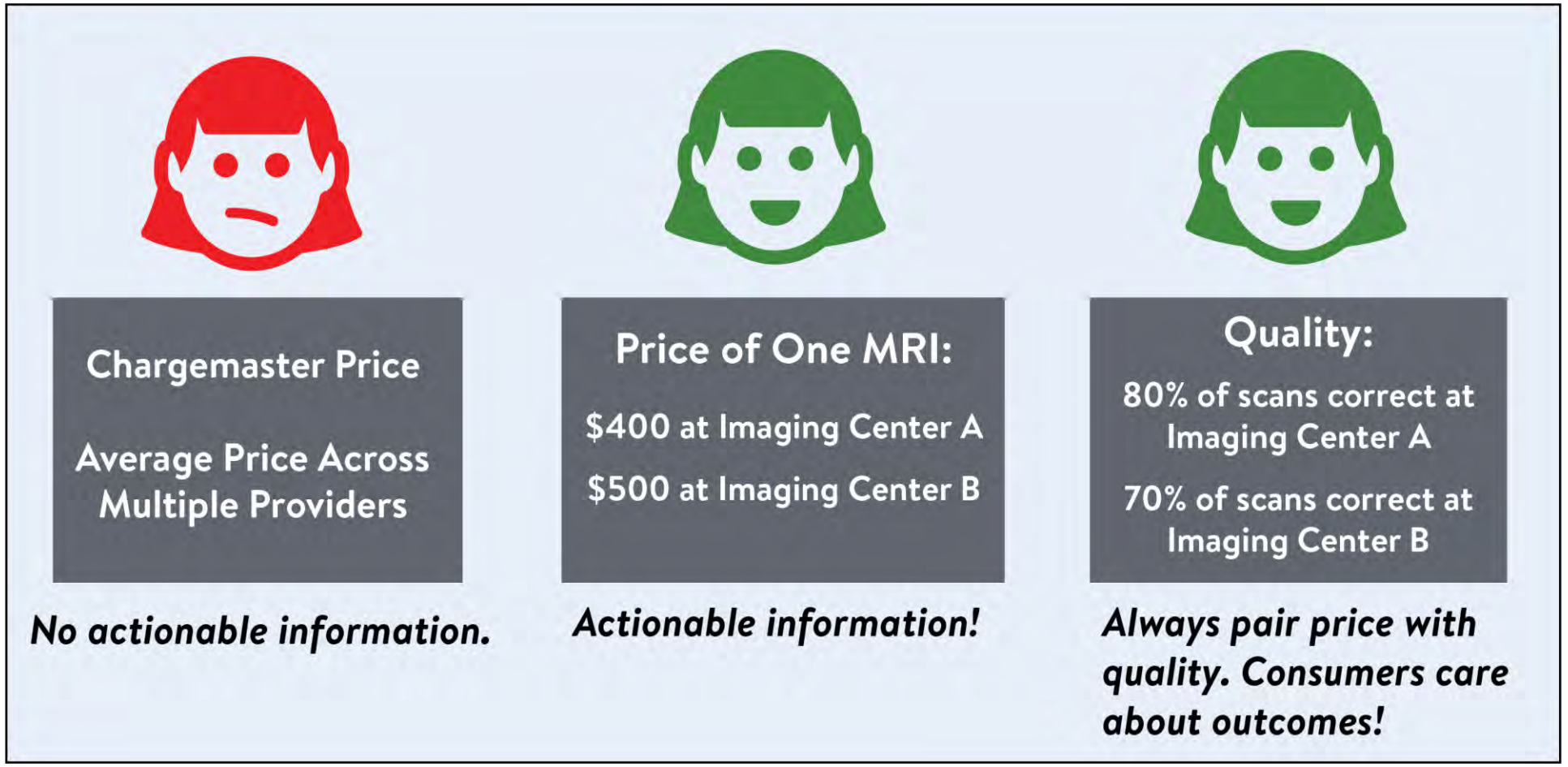
The fair price?

Medicare Payments

Patient OOP (varies by insurer)

Cost to produce the good or service

Healthcare Price Transparency…



…can help consumers budget and plan, but it is unlikely to drive value in the marketplace – especially when hospital markets lack competition

What is a State Health System Oversight Entity?

An entity empowered to look systematically across various types of health and social spending, with tools and authority to identify where the state needs to be more efficient in terms of value for each dollar spent, including addressing quality short-comings and affordability problems for residents.

Important roles can include:

- Leadership/legislative recommendations
- Data stewardship and infrastructure
- Convener
- Innovator
- Regulator/enforcer

Health System Oversight: A Scan

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RESEARCH BRIEF NO. 20 | NOVEMBER 2017

Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.[1] Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.[2] While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising health-care costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.[3]

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.[4] States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

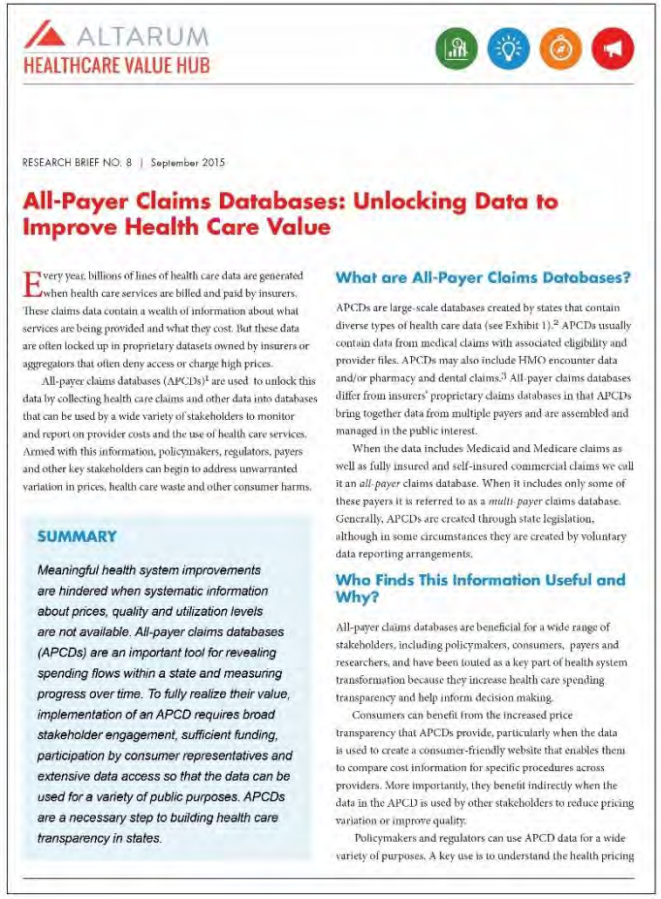
Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in "upstream" approaches that lead to healthier communities. Research shows that just 10-20 percent

NEW: in addition to tracking the value of health spending over time, include an accounting mechanism to recognize future savings from current year investments

HealthcareValueHub.org/state-accountability

All Payer Claims Datasets (APCD) Support Success



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RESEARCH BRIEF NO: 8 | September 2015

All-Payer Claims Databases: Unlocking Data to Improve Health Care Value

Every year, billions of lines of health care data are generated when health care services are billed and paid by insurers. These claims data contain a wealth of information about what services are being provided and what they cost. But these data are often locked up in proprietary datasets owned by insurers or aggregators that often deny access or charge high prices.

All-payer claims databases (APCDs)[1] are used to unlock this data by collecting health care claims and other data into databases that can be used by a wide variety of stakeholders to monitor and report on provider costs and the use of health care services. Armed with this information, policymakers, regulators, payers and other key stakeholders can begin to address unwarranted variation in prices, health care waste and other consumer harms.

SUMMARY

Meaningful health system improvements are hindered when systematic information about prices, quality and utilization levels are not available. All-payer claims databases (APCDs) are an important tool for revealing spending flows within a state and measuring progress over time. To fully realize their value, implementation of an APCD requires broad stakeholder engagement, sufficient funding, participation by consumer representatives and extensive data access so that the data can be used for a variety of public purposes. APCDs are a necessary step to building health care transparency in states.

What are All-Payer Claims Databases?

APCDs are large-scale databases created by states that contain diverse types of health care data (see Exhibit 1).[2] APCDs usually contain data from medical claims with associated eligibility and provider files. APCDs may also include HMO encounter data and/or pharmacy and dental claims.[3] All-payer claims databases differ from insurers' proprietary claims databases in that APCDs bring together data from multiple payers and are assembled and managed in the public interest.

When the data includes Medicaid and Medicare claims as well as fully insured and self-insured commercial claims we call it an *all-payer* claims database. When it includes only some of these payers it is referred to as a *multi-payer* claims database. Generally, APCDs are created through state legislation, although in some circumstances they are created by voluntary data reporting arrangements.

Who Finds This Information Useful and Why?

All-payer claims databases are beneficial for a wide range of stakeholders, including policymakers, consumers, payers and researchers, and have been touted as a key part of health system transformation because they increase health care spending transparency and help inform decision making.

Consumers can benefit from the increased price transparency that APCDs provide, particularly when the data is used to create a consumer-friendly website that enables them to compare cost information for specific procedures across providers. More importantly, they benefit indirectly when the data in the APCD is used by other stakeholders to reduce pricing variation or improve quality.

Policymakers and regulators can use APCD data for a wide variety of purposes. A key use is to understand the health pricing

"APCDs are a necessary step to building healthcare transparency in states."

- With APCD, learn:
  - Total spending with price, utilization, location, payer and service sector components
- When claims data is combined with other data streams, learn:
  - Affordability for consumers
  - Outcomes, including medical harm
  - Patient experience
  - Disparities
- Critical to measure progress towards state goals

QUESTIONS about:

Smart, affordable cost-sharing?
Wasteful spending?
Prevention “failures”?
Excess healthcare prices ?

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State News

Connecticut

Connecticut has explored many approaches to improving healthcare value for consumers over the past several years. The state created an all-payer claims database in 2012 and passed a comprehensive law prohibiting certain out-of-network billing practices and establishing a "certificate of need" process for insurance companies to acquire physician groups in 2015. The law also requires health insurance companies to submit an annual report to the Connecticut Health Insurance Exchange that lists the billed and allowed amounts paid to each healthcare provider in the insurer's network for certain diagnoses and procedures, and the corresponding out-of-pocket costs. The state launched an Office of Health Strategy in 2018 to implement comprehensive, data-driven strategies that promote equal access to high-quality healthcare, control costs and ensure better health for Connecticut residents. Among other responsibilities, the office will oversee the state's four-year State Innovation Model grant to test multi-payer healthcare payment and service delivery models to improve health system performance, increase quality of care and decrease costs.

As of 2019, Connecticut is one of the few states that has comprehensive protections from surprise medical bills. However, high drug costs remain a significant consumer concern. The state has passed several pieces of drug pricing legislation to address these concerns, including laws that require pharmaceutical companies to disclose and explain drug price hikes; force pharmacy benefit managers to report how much they collect in rebates and how much they keep; and protect pharmacists from "gag clauses" that prohibit them from disclosing specified information to people purchasing certain drugs.

Filter News by State

Connecticut

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State Survey

Connecticut 2018 Consumer Healthcare Experience State Survey

Final Questions?

Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.

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