HDHP Task Force thoughts on what to address on the list of proposed recommendations:
January 9, 2020 Meeting

Dan Freess:

Suggested Findings:
#1. A
#2 B

Health Savings Accounts:
#1. 3.6
#2. 3.5
#3. 3.4
#4. 3.1

Suggested Recommendations:
Healthcare Literacy and Education:
#1. 1.4
#2. 1.1
#3. 1.2

Financial Relief
#1. 4.1

Cost Sharing Reforms:
#1. 2.1
#2. 2.5
#3. 2.2

Cost and Quality Control
#1. 5.8
#2. 5.3
#3. 5.5 and 5.6, but not directly related to focus of this task force

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Bob Krzys:
The following are my ranked recommendations as to the list of recommendations. The list has 5 distinct sections.

Within each section, I have ranked the subdomains either A, B or C. Therefore, I have not ranked each and every recommendation within each section because I either do not presently agree with them or consider them to be not feasible.

Section 1 Health Literacy and Education
1.1 A 1.3 B 1.5 C

Section 4. Financial Relief
4.2 A 4.1 B 4.3 C

Section 2 Cost Sharing reforms
2.5 A 2.1 B 2.3,2.4 C

Section 3 Health Savings Accounts
No recommendations

Section 5. Cost and Quality Control
5.1 A 5.3.2 B 5.8 C

A comment for Ted and Adam and Sean as to the list of findings
I can agree with all the listed findings although at some point before we wrap up, I would like to have a discussion about finding F. which reads "the incentives of insurers and healthcare providers are not optimally aligned to promote the containment of cost growth and improvement of quality/value." I would like to discuss what incentives are being referred to.

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Pat McCabe:

1. In the suggested findings section, I don't believe that letter F captures the complexities of the issue that impact healthcare costs. I believe that there is lots of agreement on the importance of cost containment and there is general agreement around incentives. What complicates this issue significantly is the underpayments of cost for the governmental programs that are cared for and represent the majority of

patients being treated by most providers. It doesn't also take into consideration incremental costs that have been added by increased legislative burdens that have added cost without improving outcomes. In
2. this category I would include all of the noticing to patients that the Connecticut Legislature has required that is viewed by the vast majority of our patients as confusing.
3. I am fully supportive of all the recommendations in the Health literacy and Education section
4. Cost Sharing Reforms:
    - 2.1 – Phasing out deductibles and co insurance and shifting to copayments is equivalent to shifting deck chairs on the Titanic. It doesn't reduce the burden it just shifts how the burden is delivered.
    - 2.4 – As the recommendations can only impact non erisa based plans, allowing for deductible credits would have to be calculated in the development of the fully insured premiums by the payers and as a result potentially lead to incremental costs.
    - 2.5 – As long as this doesn't negatively impact HAS utilizations
5. I am supportive of the Health Savings Accounts recommendations (Not an area I have good knowledge base)
6. Financial Relief – I have issues and/or questions on all recommendations including:
    - 4.1 – Not sure what we are trying to create here. Most institutions have charity and free care policies that already establish guidelines.
    - 4.2 – There is a federal fair debt and collection act is already required to be complied with. Providers need to be paid for the services that they provide and should be able at the provider level to utilize all legal means.
    - 4.3 – Is overly complicated (How is benchmark established) and will only result in an increase in pricing of insurance products.
7. Cost & Quality Control
    - I am not supportive of 5.1, 5.2 and definitely 5.8 as it relates to a public option.

I will be more than willing to expand on these points at the meeting.

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Sue Halpin:

On behalf of the Connecticut Association of Health Plans, first let me say that we appreciate the time and energy that the Office of Health Care Access has committed to the discussion on HDHPs. While we may agree to disagree with the suggested findings and recommendations that emerge from the Task Force, we welcome the continued dialogue.

In terms of the report, we would respectfully suggest that document lead with the premise that health care prices are what determine health insurance premiums and until and unless we, as a society, address the underlying price of health care we won't be able to address the cost of coverage whether that manifests itself in the form of higher premiums, deductibles, and/or other means of coinsurance.

Statements like those in the draft report suggesting that high-deductibles lead directly to high medical debt do a disservice to consumers who could potentially benefit from the opportunities HDHPs present and we'd suggest that the report be reviewed for similar type statements. Instead, we respectfully suggest that the report stress the importance of consumer education around HDHP's and how consumers can best make a HDHP work for their needs. For example, the report be structured as follows – which is rough, but gets the point across:

Findings

- **HDHPs and how they function in correlation with Health Savings Accounts (HSAs)**
  - HDHPs are insurance designs that require initial out-of-pocket expenditures for medical services in exchange for a lower monthly premium.
  - HDHPs should be considered in terms of their total combined out-of-pocket expenditure.
  - To be compatible with a tax-free Health Savings Bank Account, HDHP benefit packages are required by federal law to be constructed in a certain way i.e., preventive care services are covered under the premium portion of the plan while other medical services must be paid for directly to medical providers via the associated deductible. If a HDHP is not constructed according to federal law then a consumer could lose the associated tax benefits.
  - As such, there are non-compatible HDHPs, that may offer more covered benefits under the premium portion of the benefit design than HDHP/HSA compatible plans.
- **Potential Benefits of High Deductible Health Plans**
  - Monthly premiums are typically lower.
  - There are tax advantages for consumers who utilize HSAs. Unlike 401Ks where funds are taxed when withdrawn, HSA contributions are made pre-tax, any earnings are tax free, and expenditures out are also tax free.
  - Many employers fund a substantial portion of the deductible by contributing to the employees' HSAs.
  - HSAs are portable and can travel with consumers from job to job.
  - HSA withdrawals aren't subject to specific timelines. In other words, a consumer could reimburse themselves five years from now for a cost incurred today.
  - HSA funds can be used for a wide range of services including long term care needs later down the line.
  - Non- compatible HDHPs may cover more medical services up-front than HSA compatible plans due to federal rules and regulations.
  - Someone with excessive medical costs would likely benefit under an HSA, because their overall out of pocket costs would be less than if they were in a traditional plan.
- **Potential Drawbacks of High Deductible Health Plans**
  - While monthly premiums may be lower, deductibles require consumers to reserve accordingly.
  - Etc.
- **State Regulation**
  - Connecticut is limited in any ability to regulate HDHPs.
    - 65% of the insured market is self-insured meaning those plans are regulated by federal law as opposed to state law; and,
    - HSA compatible plans must be structured in accordance with federal IRS rules in order to derive tax benefits for consumers.
- **Recommendations**
  - Understanding how HDHP's work is paramount to a consumer's experience. Enhancing health literacy should be the primary recommendation of the task force.

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Cassandra Murphy:

Suggested Findings and Recommendations

Suggested Findings

A. High deductibles can lead to incidences of medical debt, which in turn are a significant cause of bankruptcies, collections activities and other household financial stressors

B. High deductibles can present an impediment to medically necessary care when consumers delay or avoid care due to the size of their deductible

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

D. Health insurance premiums and deductibles are primarily due to of the underlying costs of covered healthcare services

E. Healthcare cost growth is increasing at an unsustainable rate

F. The incentives of insurers and healthcare providers are not optimally aligned to promote the containment of cost growth and improvement of quality/value

G. HDHPs function best when members can fund and utilize an associated HSA

H. HSAs are effective for individuals with the means to fund them. Funding for HSAs can come from the member, their employer, or any other public or private source including a state or federal entity, as long as total contributions are within the applicable annual limits for the individual account holder.

Suggested Recommendations by Category

1. Healthcare Literacy and Education (ranking #2)

1.1. Establish public-private partnerships to improve health insurance literacy (6)[1]

1.2. Increase funding for health plan navigators (1), (6) **

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

1.4. Improve presentation of total costs in all areas of the state healthcare coverage marketplace, including but not limited to AHCT – e.g., annual fixed costs (premiums), annual maximum costs

[1] 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), paraphrased as follows:

(1) Ensure access to affordable health care service;
(2) Financial impact on enrollees and their families;
(3) The use of health savings accounts, and the impact on such accounts, including the status of such accounts under the Internal Revenue Code;
(4) Ensure that each cost-sharing payment reflects the enrollee's correct cost-sharing obligation;
(5) Ensure prompt refund for any cost-sharing exceeding the enrollee's obligation;
(6) Enhance enrollee knowledge regarding how enrollee payments are applied; and
(7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

(deductible and OOP max), and likelihood of a household of *n* size experiencing a major medical event. (2), (6) **

1.5. Quarterly notices to members reminding them of the availability of pre-deductible preventive services. (1), (2),

2. Cost Sharing Reforms (ranking #5)

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

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

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

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

2.5. Carriers are responsible for paying cost shares to providers and collecting those payments from their insureds (7) (We've had mixed information about the legality of this. We need a definitive answer on this before moving forward with it. Shifting the onus back to carriers could also drive up administrative costs and premiums, and only solves part of the problem for providers because it would only apply to the ~35% of people in fully insured plans in the state.)

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

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

3. Health Savings Accounts (ranking #3)

3.1. Allow Medicare eligible members to continue contributing to HSAs (3)

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

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

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

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

3.6. Endorse using federal or any other new state or private subsidy money (or any other new source of funding, including but not limited to individual mandate replacement) to fund HSAs for subsidized enrollees, and possibly go as high as possible up the income ladder with HSA funding. (2), (3) **

3.7. When considering measures to provide healthcare coverage cost relief or expand coverage access to consumers, or to otherwise create market-based incentives to drive healthcare costs down, always consider alternatives that use any source of 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 broader-based subsidization or cost-shifting strategies, such as reinsurance, cost-sharing reductions, or others. (1), (2), (3)

4. Financial relief (ranking #4)

4.1. Establish an affordability metric (2) **

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

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

5. Cost & Quality Control (ranking #1)

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

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

5.3. Implement VBIDs (1), (2)

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

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

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

5.5. Address defensive medicine (1)

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

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

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

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Seth Powers:

Suggested Recommendations by Category

6. Healthcare Literacy and Education

6.1. Establish public-private partnerships to improve health insurance literacy that is supported by evidence-based interventions and measured for efficacy (6)[2]

[2] 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), paraphrased as follows:

(1) Ensure access to affordable health care service;

6.2. Increase funding for health plan navigators in order to implement evidence-based usability improvements (1), (6)

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

6.4. Improve presentation of total costs in all areas of the state healthcare coverage marketplace, including but not limited to AHCT – e.g., annual fixed costs (premiums), annual maximum costs (deductible and OOP max), and likelihood of a household of *n* size experiencing a major medical event. (2), (6)

6.4.1. Information should include display of financially-dominated plans where there is no economic or coverage advantage to the selection of such a plan.

6.4.2. Provide funding for study of AHCT policies to determine frequency of consumers selecting financially-dominated health plans.

6.5. Quarterly notices to members reminding them of the availability of pre-deductible preventive services. (1), (2),

7. Cost Sharing Reforms

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

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

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

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

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

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

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

7.8. Recommendation to expand the Chronic Disease Management Act of 2019 to include Mental Health and Behavioral Health services

7.8.1. For non-HSA eligible HDHPs, recommend including evidence-based Mental and Behavioral Health services to be available pre-deductible and subject to co-payment that is to be applied towards participant's annual deductible.

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(2) Financial impact on enrollees and their families;
(3) The use of health savings accounts, and the impact on such accounts, including the status of such accounts under the Internal Revenue Code;
(4) Ensure that each cost-sharing payment reflects the enrollee's correct cost-sharing obligation;
(5) Ensure prompt refund for any cost-sharing exceeding the enrollee's obligation;
(6) Enhance enrollee knowledge regarding how enrollee payments are applied; and
(7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

Commented [SP1]: I am unclear as to what the specific recommendation is with this item? I am going to refrain from weighing in until I fully understand.

Commented [SP2]: I would propose first a pilot of this to evaluate if there is a difference between the study group and the control group for how frequently services are accessed. Without an evidence-base I could see this as being costly and ineffective if incorrectly implemented and/or without target metrics by which to evaluate success/failure.

Commented [SP3]: I see this as being sequential, I would be concerned that eliminating high deductibles would rocket premium costs higher however I think that eliminating (or capping) coinsurance is a reasonable approach.

Commented [SP4]: This is already done via the ACA, I'm unclear as to what unique recommendation this presents?

Commented [SP5]: I am supportive of this however we have received conflicting information regarding the issue of compliance with IRS guidelines. If there would be a way for this to be permissible, I would support and change to green.

Commented [SP6]: I am highly concerned of the unintended consequences here if insurance carriers were required to honor feedback provided by CSRs. I could see this leading to CSRs being guided to not answer any questions and instead pointing consumers back to the legal language within their policy which would create a negative customer experience.

I would be supportive of a State office (OHA?) documenting and tracking these instances and then working directly with insurance companies on training needs. I think this could be a more precise intervention that avoids the unintended consequences.

Commented [SP7]: This feels too ill-defined. The burden here is felt by providers who see unevenly distributed demand throughout the year – I'm not sure what incentive insurance companies have to waive copay/coinsurance?

See my proposed bullet 2.8

Commented [SP8]: Per legislative language, Mental and Behavioral Health would ened to be added to the list of chronic conditions by the Assistant Secretary for Health of the Department of Health and Human Services.

8. Health Savings Accounts

8.1. Allow Medicare eligible members to continue contributing to HSAs (3)

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

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

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

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

8.6. Endorse using federal or any other new state or private subsidy money (or any other new source of funding, including but not limited to individual mandate replacement) to fund HSAs for subsidized enrollees, and possibly go as high as possible up the income ladder with HSA funding. (2), (3)

8.7. When considering measures to provide healthcare coverage cost relief or expand coverage access to consumers, or to otherwise create market-based incentives to drive healthcare costs down, always consider alternatives that use any source of 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 broader-based subsidization or cost-shifting strategies, such as reinsurance, cost-sharing reductions, or others. (1), (2), (3)

9. Financial relief

9.1. Establish an affordability metric (2)

9.2. Reform judicial procedures to protect individuals from unfair medical debt collection and litigation practices and require annual public reporting from hospital systems that detail current litigation and lawsuits (2)

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

10. Cost & Quality Control

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

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

10.3. Implement VBIDs (1), (2)

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

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

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

Commented [SP9]: I'm supportive of including 3.1 and 3.2 however we should articulate that these are subject to Federal guidelines as to not risk the CT legislature introducing policy that would not align with current Federal regulations

Commented [SP10]: I think we need to explore this in greater detail before we include as a recommendation. Specifically, if there are IRS guidelines that articulate what can be covered first-dollar, there may be instances where a health plan that technically qualifies as having a high-deductible would actually be able to provide greater coverage flexibility absent an HSA

Commented [SP11]: 3.5 – 3.7 are great ideas

Commented [SP12]: To my understanding, this already has been established within the ACA, what would we be looking to recommend that is additive?

Commented [SP13]: We saw how quickly Danbury Hospital changed their practices after Dr. Villagra's presentation that was then picked up by a reporter. I think that sunlight might be the best remedy here and requiring public disclosure may guide healthcare organizations to change their practices more quickly than achieving reform of judicial procedures

Commented [SP14]: This wasn't something that I feel like we discussed in great detail and this isn't an item, at this point, that I feel like I understand the potential consequences of enough to formally support.

I would be more open to including a recommendation that reflects efforts to eliminate "surprise billing".

Commented [SP15]: Who would this cap apply to? Providers? Health insurers? Medical device mfgs? Pharma companies?

I think it's a slippery slope to implement cost controls without addressing the underlying drivers of cost

I would be supportive of a recommendation for an annual report that illustrates an aggregated view of cost increases (from all sources) in CT.

Commented [SP16]: Unclear how "actual costs" are defined. Actual Costs for a high-overhead provider organization will look very different from a small practitioner. I can't see a path for how this would be reasonably implemented

10.5. Address defensive medicine (1)

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

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

Commented [SP17]: I see these as both being out-of-scope for this report.

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Dr. Shangold:

Suggested Findings.
I would edit D. to say, "Health insurance premiums are influenced by the underlying costs of covered healthcare services."

Rankings
#1. 2.5
#2. 2.3 and 2.4
#3. 5.3
#4 5.6
#5 5.5
#6 1.1
#7 5.7
#8 4.3
#9 3.7
#10 3.6
#11 3.4
#12 3.5

The ones I did not rank, I believe are either out of the jurisdiction of the state or not helpful.

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Janice Perkins

Suggested Findings and Recommendations

Suggested Findings

A. High deductibles can lead to incidences of medical debt, which in turn are a significant cause of bankruptcies, collections activities and other household financial stressors

The statement is too broad. Surprise billing is the number one cause of medical debt.

B. High deductibles can present an impediment to medically necessary care when consumers delay or avoid care due to the size of their deductible

Consumers need support and education to get the most out of their benefit plan. For example, many consumers don't understand that preventive care services are covered before the deductible. Consumers may delay preventive care unnecessarily. That distinction needs to be made.

Health Plans all have cost estimator tools as required by law to assist the consumer in choosing the best value.

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

Support health literacy

D. Health insurance premiums and deductibles are primarily due to of the underlying costs of covered healthcare services and medical care.

E. Healthcare cost growth is increasing at an unsustainable rate

F. The incentives of insurers and healthcare providers are not optimally aligned to promote the containment of cost growth and improvement of quality/value

Despite efforts by insurers and health care providers incentives are not optimally aligned to promote cost containment and quality of care.

G. HDHPs function best when members can fund and utilize an associated HSA

To take advantage of the tax benefits of a HSA you must be enrolled in a HDHP as defined by IRS regulation. There are plan offerings that are not HSA compatible and there is much more flexibility in plan design with those plans. This statement ought to address the tax benefits of a HSA such as:

- Pre-tax contributions
- Potential for tax-free interest and investment earnings
- Tax free withdrawals for qualified medical expenses
- Contributions can grow over time and be used for medical care in retirement.
- Contributions roll over from year to year.

H. HSAs are effective for individuals with the means to fund them. Funding for HSAs can come from the member, their employer, or any other public or private source including a state or federal entity, as long as total contributions are within the applicable annual limits for the individual account holder.

Suggested Recommendations by Category

1. Healthcare Literacy and Education

1.1. Establish public-private partnerships to improve health insurance literacy (6)[1]

All funding opportunities to increase health literacy should be explored.

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), paraphrased as follows:

(1) Ensure access to affordable health care service;
(2) Financial impact on enrollees and their families;
(3) The use of health savings accounts, and the impact on such accounts, including the status of such accounts under the Internal Revenue Code;
(4) Ensure that each cost-sharing payment reflects the enrollee's correct cost-sharing obligation;
(5) Ensure prompt refund for any cost-sharing exceeding the enrollee's obligation;
(6) Enhance enrollee knowledge regarding how enrollee payments are applied; and
(7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

1.2. Increase funding for health plan navigators (1), (6)

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

1.4. Improve presentation of total costs in all areas of the state healthcare coverage marketplace, including but not limited to AHCT – e.g., annual fixed costs (premiums), annual maximum costs (deductible and OOP max), and likelihood of a household of *n* size experiencing a major medical event. (2), (6)

This is one element of improving health literacy. An educational campaign should include all the financial responsibilities associated with health plans. For example, according to Jeff Oldham, Senior Vice-President of global and Institutional Markets at Benefit focus, data revealed that millennials enrolled in an HDHP have increased their contributions by 20% from prior years after receiving education about how HSAs work.

Education should be ongoing and not just during open enrollment.

1.5. Quarterly notices to members reminding them of the availability of pre-deductible preventive services. (1), (2),

Support on going education about preventive care services before the deductible.

2. Cost Sharing Reforms

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

We know that consumers price shop and look at premiums first. Phasing out all high deductible health plans and coinsurance will remove choice from the market that may appeal to a certain constituency. We don't want to limit choice or price consumers out of the market.

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

This is already happening in Medicaid and the exchange. We should explore expanding the financial assistance from 400%FPL to 500%, with additional support coming from the state.

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

Not clear. Don't understand. How this would work.

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

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

Prohibited under IRS regulations 969. Would not qualify as a medical expense and no longer compatible with a HSA..

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

Out of scope.

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

May not be in accordance with IRS regulation.

3. Health Savings Accounts

The taskforce should include a statement that no action should be taken either through regulation or legislation that would not be in accordance with IRS regulation.

This entire section needs to be addressed at the federal level and not state.

3.1. Allow Medicare eligible members to continue contributing to HSAs (3)

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

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

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

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

3.6. Endorse using federal or any other new state or private subsidy money (or any other new source of funding, including but not limited to individual mandate replacement) to

fund HSAs for subsidized enrollees, and possibly go as high as possible up the income ladder with HSA funding. (2), (3)

3.7. When considering measures to provide healthcare coverage cost relief or expand coverage access to consumers, or to otherwise create market-based incentives to drive healthcare costs down, always consider alternatives that use any source of 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 broad based subsidization or cost-shifting strategies, such as reinsurance, cost-sharing reductions, or others. (1), (2), (3)

4. Financial relief

4.1. Establish an affordability metric (2)

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

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

Out of scope

5. Cost & Quality Control

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

Connecticut is one the costliest states in the nation for medical costs. Support efforts to rein in medical cost spending by establishing a *health care cost benchmark*. Those discussions are happening with stakeholders but is out of scope for this committee.

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

What kind of rules? Regulations? Don't understand.

5.3. Implement VBIDs (1), (2)

We should start by encouraging AHCT to implement one VBID plan design for 2021.

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

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

This will increase premiums and may force some consumers out of the market.

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

Out of scope

5.5. Address defensive medicine (1)

Out of scope

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

Out of scope

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

Check IRS regulation.

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

No. A public option isn't a new entrant into the market it's a government program competing with the private sector.

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Dr. Wormser

Suggested findings: B (most important)>F>E>D>A>C>G>H (least important).

Suggested recommendations:
--Health literacy and education: 1.4>1.3>1.5>1.1>1.2.
--Cost sharing reforms: 2.1>2.2>2.3>2.4>2.7>2.6>2.5.
--HSA: all equally important.

--Financial relief: all equally important.

--Cost and quality control: 5.3>5.8>5.1>5.7>5.4>5.6>5.2>5.5.