Appendix C

Testimony of J. Kevin A. McKechnie
Executive Director, HSA Council,
American Bankers Association
Washington, DC

Executive Summary

Under current law, roughly 26 million Americans take advantage of the savings benefits of a Health Savings Account (HSA) offered through a qualified High Deductible Health Plan (HDHP). However, it is estimated that each American will need $180,000 in retirement for healthcare expenses alone.[1] In addition, a recent survey conducted by HSA Bank, revealed an alarming 40% of Americans never save money specifically for future healthcare expenses.[2]

HSAs are the only health account in the United States that allows people to save for future healthcare needs tax-free and pay for current out-of-pocket costs tax-free. Realizing the potential for immediate savings, the National Conference of Insurance Legislators (NCOIL) passed a resolution in 2018 encouraging states to defend state-regulated HDHPs from state legislation at odds with federal HSA regulations. The resolution passed unanimously. Connecticut is a current NCOIL member; its elected officials serve on NCOIL Committees.

We are also encouraged by recent bipartisan legislation that would improve the flexibility of HSA-qualified insurance plans recently approved by the Ways & Means Committee in the U.S. House of Representatives.

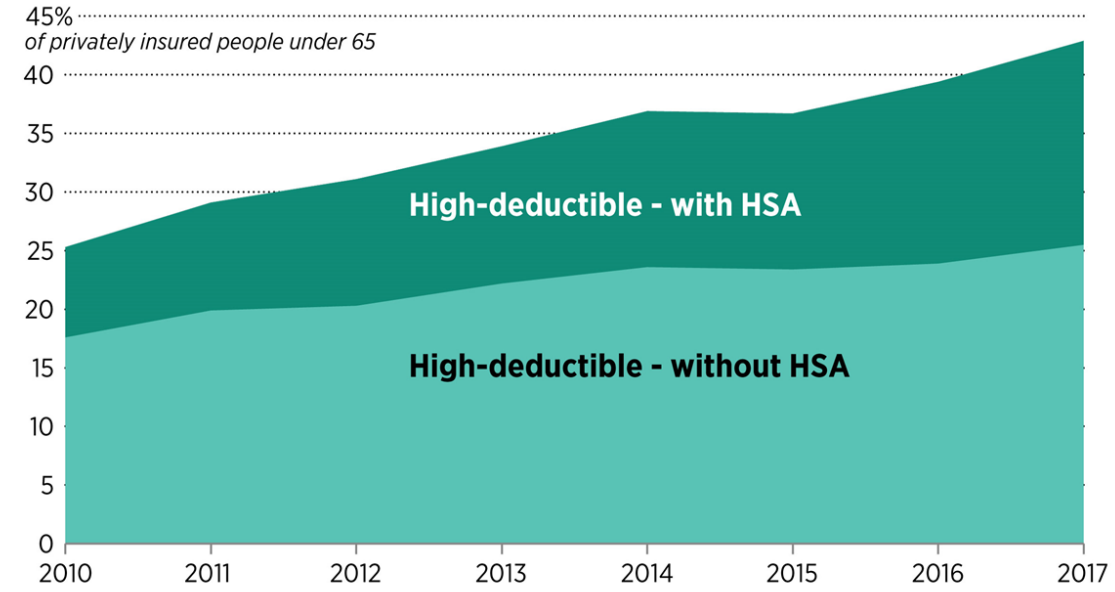
Health Savings Accounts in Demand

Signed into law in 2003, Health Savings Accounts (HSAs) were created to help individuals covered under a compatible health plan, often referred to as a High Deductible Health Plan (HDHP), set aside funds on a tax-free basis to pay for certain medical expenses when faced with paying a high deductible. This can significantly reduce the burden of high out-of-pocket costs.

Looking more broadly at American's health insurance coverage throughout the year, the National Business Group on Health shows that enrollment in consumer-driven health plans has grown by about seventy percent (70%) over the past seven years. Enrollment in HSA-qualified plans has also doubled during this same time. Estimates vary, but approximately one-third of employees are now enrolled in consumer-driven health plans. In fact, nine in ten large employers (90%) offered at least one consumer-driven health plan in 2019, and the most common design was the HDHP paired with an HSA for eighty percent (80%) of employers with any type of consumer-driven health plan. Despite this growth, many more Americans are enrolled in other plans with high deductibles that do not make them eligible for an HSA.

High-Deductible Plans, HSAs on the Rise

More people are getting covered by health care plans with high deductibles, up more than 17 percentage points from 2010. During that time, the prevalence of health savings accounts has more than doubled.



Note: 2017 data is as of June
Source: Centers for Disease Control and Prevention
Randy Leonard/CQ

Narrowing Gap of Deductible Amounts

The average health plan deductible today qualifies most health plans as a Health Savings Account (HSA) compatible plan. And as such, the requirement for an individual to have coverage under a High Deductible Health Plan (HDHP) has lost its relevancy.

At the beginning of the program in 2004, a HDHP had a deductible of $1,000 for individual coverage. Now, as governed by Internal Revenue Code (IRC) Section 223, the minimum deductible for an HSA-qualifying plan is $1,400 for individual coverage in 2020. The minimum deductibles are adjusted annually for inflation[3] and have clearly increased modestly since 2004. As premiums have risen, employers and insurance carriers have increased deductibles almost annually in an effort to moderate year-over-year premium increases.

With that said, there is a narrowing gap of deductible amounts associated with HDHPs as compared to Preferred Provider Organizational (PPO) plans and almost all other types of health plans. The average deductible for individual plans of all types is currently $1,655. Effectively, this means that the average health plan deductible for all types of plans exceeds the IRS minimum deductible threshold for HDHPs, and has done so for more than five years.

For 2020, the minimum deductible to for an HSA-qualifying plan is $1,400, for individual coverage, and $2,800 for family coverage.

According to the 2019 Kaiser Family Foundation Employee Benefit Survey (KFF), over the past five years, the average annual deductible amongst all covered workers has increased 36%, yet in that same time frame, the average HDHP deductible has risen only 12%.

HSA qualified HDHP deductibles have risen even slower during the same time period. The average deductible for single plans has risen 12% while the average for family plans has risen only 6%. No other type of health insurance can make this claim.

In my opinion, one of the main contributors to the relative stability of HSA-qualified plan deductibles vs. the astonishing rise in deductibles in traditional plans is that the deductibles of traditional plans have increased largely so that plan sponsors can attempt to restrain premium increases at a rate lower than they otherwise would be, if deductibles were static.

The KFF data substantiates this claim - over a 10 year period, the average deductible of HSA qualified health plans increased only 29% for single plans, and 25% for family plans, while the average plan deductible for traditional health plans has more than doubled – an increase in excess of 100%.

Preventative Care Services Covered

Some benefits may be covered before the deductible is met, such as preventive care services.

In 2010, the Affordable Care Act (ACA) borrowed this concept from HSAs and made coverage of preventive care services a requirement for all health plans regardless of deductible, including self-insured employer-sponsored plans. In July 2019, the Internal Revenue Service expanded the definition of "preventive care services" to include coverage of certain medical services or items for individuals with chronic conditions. Although employers and insurance carriers are not required to offer these additional services, the flexibility will allow them to address concerns that individuals with chronic conditions might face higher costs in the long-term by not accessing services that help them maintain their health status and avoid complications or worsening of their conditions.

Annual Limits Required

HSA-qualified plans are required to have an annual limit on out-of-pocket expenses. This better protects Americans from inflation and ultimately more costs.

At the beginning of the program in 2004, the annual limits for HSA-qualified plans were no more than $5,000 for individual coverage. After inflation, these limits have increased modestly since 2004. For 2020, these amounts will rise to $6,900 for individual coverage. In comparison, the out-of-pocket limit for a Marketplace plan is $8,200 for an individual.[4] If a health insurance plan does not limit annual out-of-pocket expenses to these or lower amounts for 2020, it cannot be an HSA-qualified plan.

In 2014, the Affordable Care Act (ACA) out-of-pocket limits were on par with HSA out-of-pocket limits. However, the annual inflation adjustment factor used to adjust the ACA limits is the medical component of the consumer price index (M-CPI), whereas the HSA-qualified plans limits have since been adjusted by general inflation (i.e., CPI, and more recently chained-CPI). Thus, the ACA out-of-

pocket limits have risen much faster than the HSA limits. For example, for 2020 the ACA out-of-pocket limits are $8,150 for individual coverage, which is $1,250 higher than the HSA limits.

This means that HSA-qualified plans provide better protection against high medical expenses than the ACA requires and will continue to do so as these amounts diverge further.

Rising Healthcare Costs Can be Alleviated

The HSA Council believes that bipartisan efforts are needed to address rising out-of-pocket healthcare costs that impact Americans now and into retirement. With the large retirement savings gap in place, we believe Health Savings Accounts (HSAs) are the best solution to help alleviate this concern.

Health View Services estimates that a couple retiring today can expect to pay over $360,000 to cover medical expenses in retirement – including Medicare and long-term care insurance premiums.[1] HSAs are the only triple-tax advanced account in existence, meaning funds are contributed tax free, grow tax-deferred and can be withdrawn tax free to pay for IRS-qualified medical expenses during an individual's working years and in retirement. This is a significant advantage over traditional retirement options, which are subject to income tax when withdrawn.

Continue to Build Positive Change

While small changes are being made to help alleviate current healthcare expenses, there is still more to be done.

In the U.S. House of Representatives, the House Ways & Means Committee recently passed bipartisan legislation to do just that by allowing Health Savings Accounts to work with direct primary care arrangements (H.R. 3708), allowing Health Savings Account funds to be used to pay for the costs of over-the-counter drugs and medicines without a prescription (H.R. 1922), and allow HSA-qualified plans to cover the cost of inhalers and their associated medications without application of the policy deductible (H.R. 4716).

This latter piece of legislation builds on updated guidance by the Internal Revenue Service in July 2019 allowing HSA-qualified plans to cover certain medical services and items below the deductible for individuals with chronic conditions.

This change is expected to be a boon for Americans who suffer from chronic conditions and have a HDHP with an HSA. Although employers and insurance carriers are not required to offer these additional services, the flexibility will allow them to address concerns that individuals with chronic conditions might face higher costs in the long-term by not accessing services that help them maintain their health status and avoid complications or worsening of their conditions.

Additionally, last year the National Conference of Insurance Legislators (NCOIL) passed a resolution calling on states to preserve HSAs and their associated HSA-qualified high deductible health plans by refraining from enacting new mandates that threaten their existence because they conflict with federal rules for Health Savings Accounts.

Proposed CT Senate Bills

Our understanding is that the Connecticut legislature, like many states, is wrestling with how best to address many of the same issues as Congress and has proposed two bills - Senate Bill 28 and Senate Bill 902 – attempting to restrain HDHPs. I have reviewed these proposals and should point out that they do not follow the NCOIL resolution and risk harming the only health plans that help Americans lower their out-of-pocket costs and take control of their retirement savings - Health Savings Accounts.

Senate Bill 28

Although well-intentioned, Senate Bill 28 targets only one insurance product – HSA-qualified high deductible health plans. If the problem is high out-of-pocket costs, clearly non-HSA plans also meet this definition without the advantage of allowing expenses to be paid pre-tax. In addition, the bill would off-load business risk from health care providers to insurance companies for the cost of covered benefits below the policy deductible. I would imagine every business, not just medical practices, would like their state's help to off-load their business risk onto other entities. I don't see how it makes any economic sense to do this for just HSA-qualified high deductible health insurance plans.

Senate Bill 902

Like Senate Bill 28, Senate Bill 902 also targets only one insurance product – HSA-qualified high deductible health plans. It should also be noted that existing guidance from the Internal Revenue Service (IRS Notice 2004-50, Q&A 22-24) already allows HSA-qualified plans to provide credit for costs incurred earlier in the year under a prior plan. If the Connecticut legislature intends to mandate this process, it should not single out HSA-qualified high deductible health plans. In addition, any pro-ration of deductibles must be permitted in such a way that HSA-qualified plans can meet federal rules for Health Savings Accounts.

We interpret subsection (b)(2) (i.e., lines 50-53) to preclude HSA-qualified plans from applying family deductibles where appropriate, thereby needlessly disqualifying HSA-qualified plans from using appropriate deductibles for non-single coverage. Although subsection (c) includes language intended to provide an exemption, we are not convinced that the language in subsection (c) accomplishes this objective.

We review proposals just like this one from many states for compliance with federal HSA rules. We are pleased to provide what counsel the legislature deems appropriate if it would be helpful.

Conclusion

Americans are working longer, saving less, and facing higher out-of-pocket costs than ever before. HSAs are the only health account in the country that provides an opportunity to save tax-free for future healthcare needs. It is also the only health account in the country that allows current out-of-pocket expenses to be paid pre-tax. We strongly encourage states to embrace their potential for providing residents with an immediate savings instead of singling them out, unfairly, as the problem. Bi-partisan legislation in Congress, far from restricting HSAs, is expanding their utility and even proposing to coordinate them with government programs like Medicare, TRICARE, VA benefits and Indian Health

Service programs. Congress is acting to preserve and improve Health Savings Accounts (HSAs) to help millions more Americans benefit from this tax-free health savings vehicle.

[1] "HealthView Services 2019 Retirement Healthcare Costs Data Report." *HealthView Services*. 2019. *HealthView Services.* 9 May 2019. http://www.hvsfinancial.com/2019/09/21/2019-retirement-health-care-costs-data-report/

[2] "HSA Bank Health and Wealth Index℠." *HSA Bank.* March 19, 2019. http://www.hsabank.com/hsabank/learning-center/index2019

[3]Initially, the inflation adjustment factor was the consumer price index (CPI) but this has now been changed to chained-CPI as a result of the tax reform law enacted in December 2017.

[4] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

IRS Notice 2004-50, Q&A 22-24

Q-22. If an employer changes health plans mid-year, does the new health plan fail to satisfy section 223(c)(2)(A) merely because it provides a credit towards the deductible for expenses incurred during the previous health plan's short plan year and not reimbursed?

A-22. No. If the period during which expenses are incurred for purposes of satisfying the deductible is 12 months or less and the plan satisfies the requirements for an HDHP, the new plan's taking into account expenses incurred during the prior plan's short plan year (whether or not the prior plan is an HDHP) and not reimbursed, does not violate the requirements of section 223(c)(2)(A).

Example. An employer with a calendar year health plan switches from a non-HDHP plan to a new plan with the first day of coverage under the new plan of July 1. The annual deductible under the new plan satisfies the minimum annual deductible for an HDHP under section 223(c)(2)(A)(i) and counts expenses incurred under the prior plan during the first six months of the year in determining if the new plan's annual deductible is satisfied. The new plan satisfies the HDHP deductible limit under section 223(c)(2)(A).

Q-23. If an eligible individual changes coverage during the plan year from individual HDHP coverage to family HDHP coverage, does the individual (or any other person covered under the family coverage) fail to be covered by an HDHP merely because the family HDHP coverage takes into account expenses incurred while the individual had individual coverage?

A-23. No.

Example. An eligible individual has individual coverage from January 1 through March 31, marries in March and from April 1 through December 31, has family coverage under a plan otherwise qualifying as an HDHP. The family coverage plan applies expenses incurred by the individual from January through March toward satisfying the family deductible. The individual does not fail to be covered by an HDHP. The family coverage satisfies the deductible limit in section 223(c)(2)(A)(i)(II). The individual's

contribution to an HSA is based on three months of the individual coverage (*i.e.*, 3/12 of the deductible for the individual coverage) and nine months of family coverage (9/12 of the deductible for family coverage).

Q-24. How are the minimum deductible in section 223(c)(2)(A) for an HDHP and the maximum contribution to an HSA in section 223(b) calculated when the period for satisfying a health plan's deductible is longer than 12 months?

A-24. The deductible limits in section 223(c)(2)(A) are based on 12 months. If a plan's deductible may be satisfied over a period longer than 12 months, the minimum annual deductible under section 223(c)(2)(A) must be increased to take into account the longer period in determining if the plan satisfies the HDHP deductible requirements. The adjustment will be done as follows:

(1) Multiply the minimum annual deductible in section 223(c)(2)(A)(i) (as adjusted under section 223(g)) by the number of months allowed to satisfy the deductible.

(2) Divide the amount in (1) above by 12. This is the adjusted deductible for the longer period that is used to test for compliance with section 223(c)(2)(A).

(3) Compare the amount in (2) to the plan's deductible. If the plan's deductible equals or exceeds the amount in (2), the plan satisfies the requirements for the minimum deductible in section 223(c)(2)(A). (Note that the deductible for an HDHP may not exceed the out-of-pocket maximum under section 223(c)(2)(A)(ii).)

If the plan qualifies as an HDHP, an eligible individual's maximum annual HSA contribution will be the lesser of the amounts in (1) or (2) below:

(1) Divide the plan's deductible by the number of months allowed to satisfy the deductible, and multiply this amount by 12;

(2) The statutory amount in section 223(b)(2)(A)(ii) for individual coverage ($2,600 in 2004) or section 223(b)(2)(B)(ii) for family coverage ($5,150 in 2004), as applicable.

Example. For 2004, a health plan takes into account medical expenses incurred in the last three months of 2003 to satisfy its deductible for calendar year 2004. The plan's deductible for individual coverage is $1,500 and covers 15 months (the last three months of 2003 and 12 months of 2004). To determine if the plan's deductible satisfies section 223(c)(2)(A) the following calculations are performed: (1) multiply $1,000, the minimum annual deductible in section 223(c)(2)(A)(i), by 15, the number of months in which expenses incurred are taken into account to satisfy the deductible, = $15,000; (2) divide $15,000 by 12 = $1,250; (3) The HDHP minimum deductible for individual coverage for 15 months must be at least $1,250. Because the plan's deductible, $1,500, exceeds $1,250, the plan's individual coverage satisfies the deductible rule in section 223(c)(2)(A). The maximum annual HSA contribution in 2004 for an eligible individual with individual coverage under these facts is $1,200, the lesser of (1) ($1,500/15) X 12 = $1,200; or (2) $2,600.

Source: https://www.irs.gov/irb/2004-33_IRB#NOT-2004-50)

Appendix D

High Deductible Health Plan Task Force

Presentation November 20, 2019

James B. Stirling, CEO

Stirling Benefits, Inc.

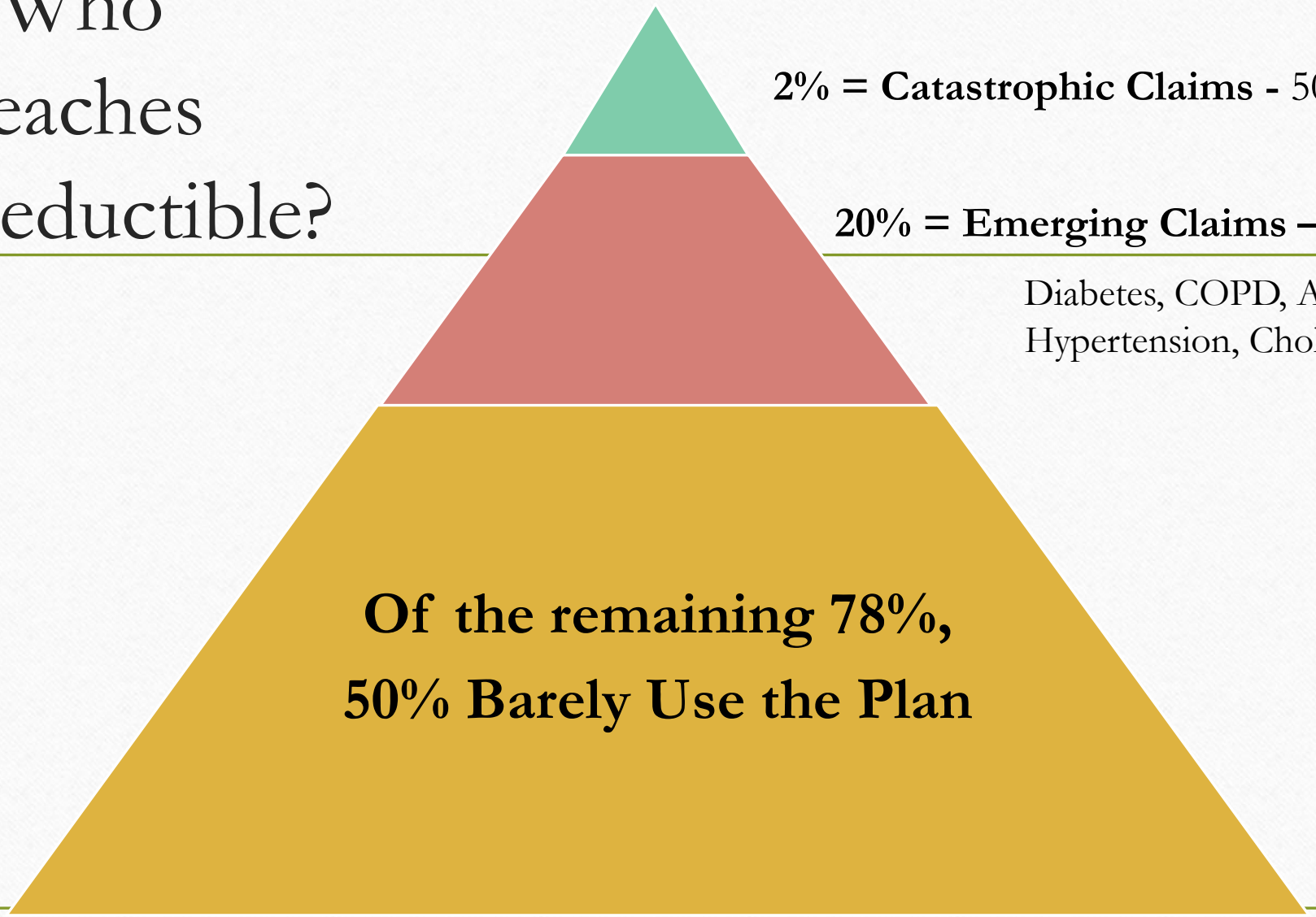
Stirling Benefits, Inc.

- A Connecticut S Corp
- Established in 1973
- Third Party Administrator (TPA) Designs and Administers ERISA Plans
  - Medical programs for groups with 20 to 400 employees, Health Savings Accounts, Health Reimbursement Arrangements, Flexible Spending Accounts, Retiree programs, COBRA and Billing, MEHIP and TRB
  - Active with employers and brokers in the mid market

Agenda

- What would the Task Force like to know today ?
- Who reaches the deductible?
- Insurer, Broker, Consumer, Employer
- Aligning incentives for productivity and lower cost
- What's working?
- What might work?

Who reaches the deductible?



2% = Catastrophic Claims - 50% of costs

20% = Emerging Claims – 25% of costs

Diabetes, COPD, Asthma, Hypertension, Cholesterol

Of the remaining 78%,
50% Barely Use the Plan

Insurer-Carrier-BUCA

- **Pressured to lower premiums**
  - Short Term thinking
  - Easiest response is to raise deductible
- **Groups Change Carriers often**
  - BUCA considered s a Commodity
  - Less incentive to improve long term health
- **Status Quo reinforcers**
  - Lack of Claims Data
  - Difficult for new carrier to enter market
  - Carrier keeps best risks
- **Profits center = Specialty RX Rebates**
  - Not impacted by deductible level

ACA – Unintended Consequences

- **Medical Loss Ratio (MLR) rules**
  - Limits administration and profit to a % of Premium
    - 15% for large group
    - 20% for large group
  - To increase profit = Increase Premiums

- **To escape MLR,**
  - Offer "Level Funded" plan to best risks
  - ERISA – Self Funded – Federally regulated
  - Level Funding = ERISA self-funding

Broker/ Consultant

- **Spreadsheet-based, one-year contracts**
  - Little long-term planning
  - Staff are often insurer trained
- **Commission Based**
  - 3% - 4.5% typical in medium sized business
  - Retention bonus if renew with current carrier
  - Financial incentive is to renew case - with increase
  - **15% premium increase = 15% broker raise**
- **Low incentive to change status quo**

Consumer

- **Previous presenters addressed consumer issues w/ High Deductibles**
  - **Unaffordable deductibles - discourages early care**
  - **Health Savings Accounts**
    - HSA's work well with family income above $100,000
    - For most employees, no money to contribute, or
    - HSA funds consumed by expenses
    - Tax advantages decrease at lower tax rates
  - **I'm paying $5,000 per year and "I got no Insurance."**

Plan Sponsor / Employer

- Pays majority of cost of medical plan
- Almost universally dissatisfied with current market
- Natural alley to improve this situation
- Concerned about employee well-being

- Poor data => poor decisions
- Employers would benefit most from
  - Transparency
  - Healthier employees
  - More efficient health care system

What works

- **Reduce or Eliminate the High Deductible**
- **Move primary care ahead of deductible - with some conditions**
  - If you get your A1C every three months, your office visit are 100% paid
  - If you get your prescription from a lower cost source, it's 100% paid
  - If you get the biometric screening, your payroll contribution is lower
  - If you don't smoke, your contribution is lower
- **Narrow networks – VBID**
  - CT cost calculator on our website

What also Works

- **Discriminate in favor of those with Adverse Health Conditions**
  - Lower costs for treatment of Chronic conditions
  - Asthma, Diabetes, Elevated Cholesterol, Hypertension, Heart Disease and Chronic pain
  - If you take the "healthy living" class your contributions go down
- **Federally Qualified Health Clinics**
  - Lower copayment to $20 in front of the deductible
- **Align financial interests**
  - Member saves when plan saves
  - 20% of $800 or $3,000 MRI – member chooses

What also Works

- **Sunshine is the best disinfectant**
  - **Require disclosure of vendor fees**
  - **Require disclosure of RX rebates**
  - **Require disclosure of group claim experience**
  - **Require disclosure of provider accepted fees**

- **With these tools, Employers can make improvements to their plan**
  - **Redirect funds to Employee health, salary and investments in productivity**

	Who benefits when Prices:		Solution
	Increase	Decrease	
Consumer			Lower out-of-pocket costs when member strives for health! Provide pricing data to help choose correct provider
Plan Sponsor			• Build plans that reward preventative care • Provide claims data to group before renewal • Provide "median accepted fee" data to group and member
Insurer			**180-degree change:** Link increased profit to improved population health
Broker			**180-degree change:** Create transparency for compensation Create incentives when plan costs decline
Provider			**180-degree change:** Publish median fee accepted and quality metrics

What might work?

Improve health education in public schools?

Explore employer tax credit

to encourage low deductible plans

DOI Action

Encourage longer term contracts

Require disclosures !!!

Create carrier incentive to lower deductibles?

Beware - Insurance regulation does not apply to ERISA plans

Other Task Force Ideas?


StirlingBenefits™
Evolving the Business of Benefits℠

Appendix E

James B. Stirling, CEO
Stirling Benefits, Inc.
20 Armory Lane, Milford, CT 06460
jstirling@StirlingBenefits.com
(203) 647-0628
www.StirlingBenefits.com

Using Value-Based Insurance Design to Improve Patient Health and Reduce Medical Spending

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org (slides available)

@um_vbid

Restoring Health to the Health Care Value Debate

1. Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
2. Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions
3. Underutilization of high-value care persists across the entire spectrum of clinical care
4. Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

V-BID

Moving from the Stone Age to the Space Age: Change the health care discussion from “How much” to “How well”

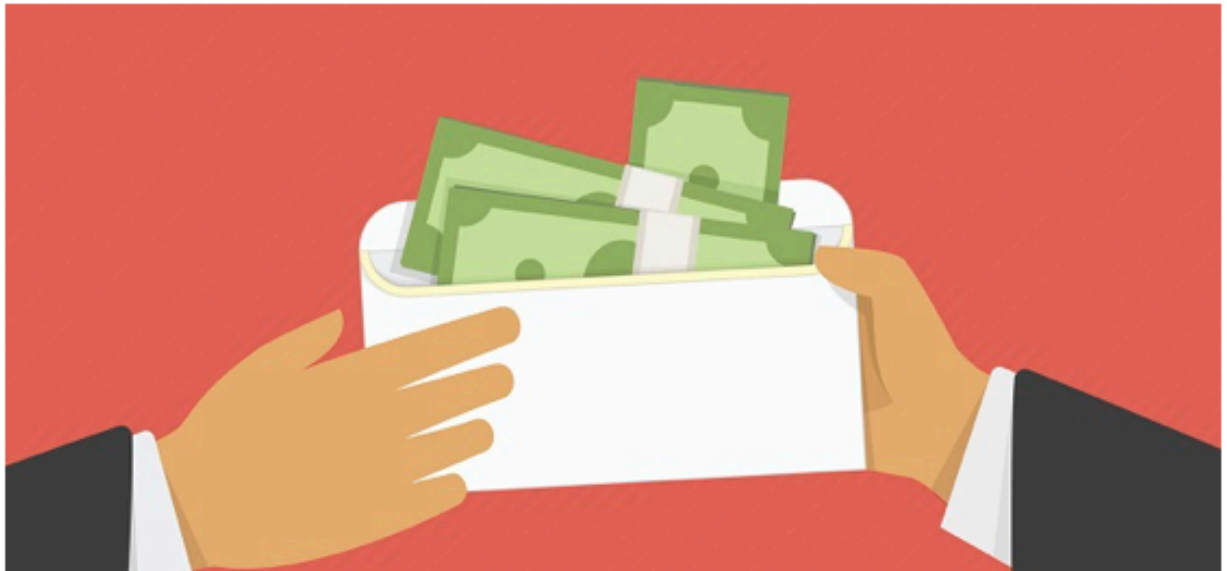
- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care
- Consumer cost-sharing is a common policy lever

V-BID

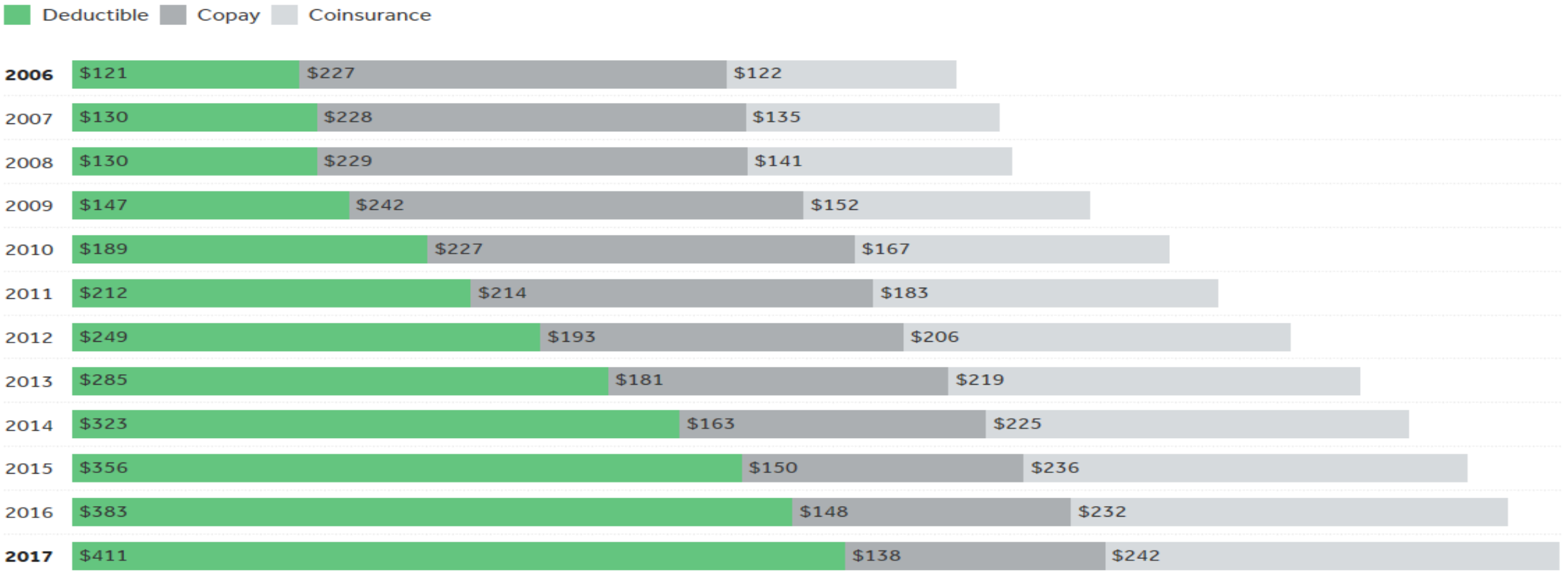
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

A report from the Commonwealth Fund noted that patients are not confident they can afford high out-of-pocket healthcare costs.



Out-of-pocket spending among people with large employer coverage, Paying More for ALL Care Regardless of Value



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

V-BID

Inspiration (Still)

“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

- Barbara Fendrick (my mother)

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3]
Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

[1]Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; [2]Thomson Healthcare, Ann Arbor, MI, USA; [3]Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; [4]Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; [5]Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

- **Rising copayments worsen disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions**

Chernew M. *J Gen Intern Med* 23(8):1131–6.

Alternative to “Blunt” Consumer Cost Sharing: Value-Based Insurance Design (V-BID)

- **Sets consumer cost-sharing on clinical benefit – not price**
- **Little or no out-of-pocket cost for high value care; high cost share for low value care**
- **Successfully implemented by hundreds of public and private payers**

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

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Better

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V-BID: Rare Bipartisan Political and Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- Commonwealth Fund
- NBCH
- American Fed Teachers
- Families USA
- AHIP
- AARP
- DOD
- BCBSA
- National Governor's Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- American Benefits Council
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- Smarter Health Care Coalition
- PhRMA
- EBRI
- AMA

Putting Innovation into Action: Translating Research into Policy

ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

Over 137 million Americans have received expanded coverage of preventive services

Medicare Advantage V-BID Model Test: Expanded Opportunities

Permissible interventions:

Reduced cost-sharing for

- **high-value services**
- **high-value providers**
- **enrollees participating in disease management or related programs**
- **additional supplemental benefits (non-health related)**

Wellness and Health Care Planning
Advanced care planning
Incentivize better health behaviors

Targeting Socioeconomic Status
Low-income subsidy
Improve quality, decrease costs

Rewards and Incentives
$600 annual limit
Increase participation
Available for Part D

Telehealth
Service delivery innovations
Augment existing provider networks

M | V-BID

Value-based insurance coming to millions of people in Tricare

- **2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers**
- **2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary**

M | V-BID

IRS Rules Prohibit Coverage of Chronic Disease Care Until HSA-HDHP Deductible is Met

PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met

U.S. DEPARTMENT OF THE TREASURY

PRESS RELEASES

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions

List of services and drugs for certain chronic conditions that will be classified as preventive care under Notice 2019-45

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
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Chronic Disease Management Act of 2019

115TH CONGRESS
2D SESSION

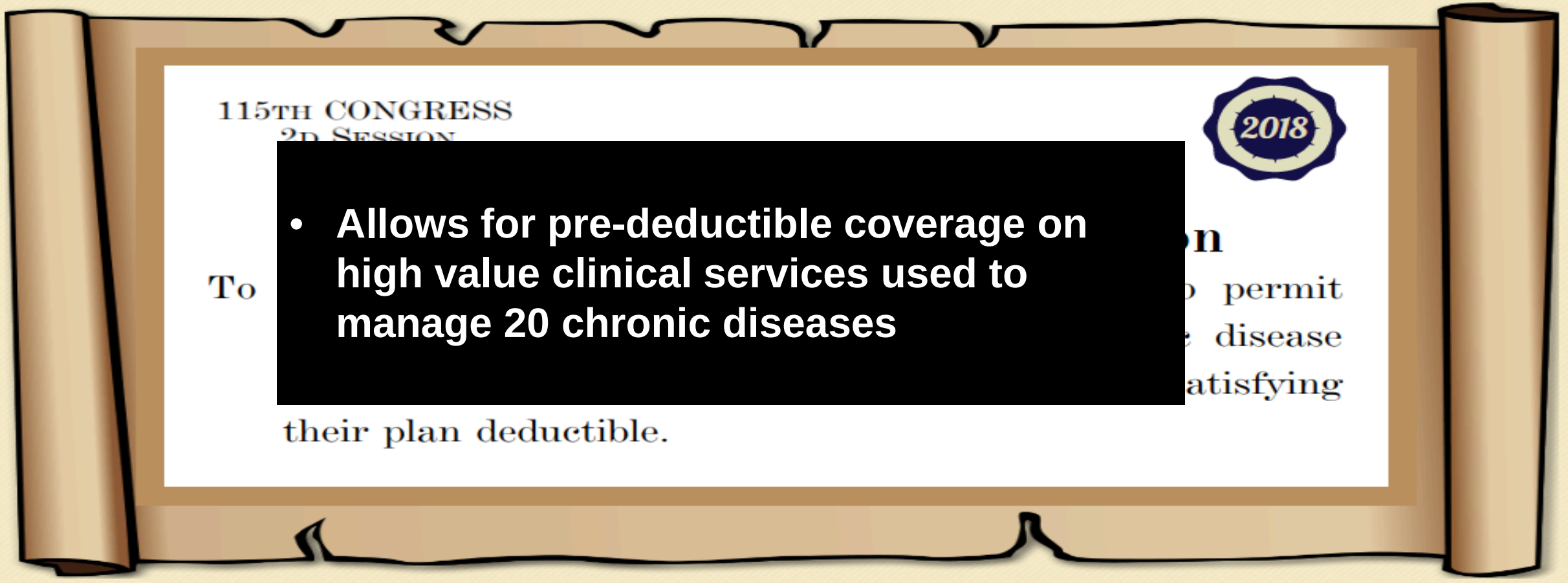
2018

S.2410 and H.R.4978

Bipartisan, Bicameral Legislation

To amend the Internal Revenue Code of 1986 to permit high deductible health plans to provide chronic disease prevention services to plan enrollees prior to satisfying their plan deductible.

Chronic Disease Management Act of 2019



- Allows for pre-deductible coverage on high value clinical services used to manage 20 chronic diseases

Where does the money come from to provide better coverage for evidence-based care?

- **Raise Premiums**

V-BID

Where does the money come from to provide better for coverage for evidence-based care?

- ~~Raise Premiums~~
- Increase Deductibles, Copayments and Coinsurance

V-BID

Where does the money come from to provide better coverage for evidence-based care?

- ~~Raise Premiums~~
- ~~Increase Deductibles, Copayments and Coinsurance~~
- Reduce Spending on Low Value Care

Reducing Low Value Care: Identify

Choose services:

- Easily identified in administrative systems
- Mostly low value
- Reduction in their use would be barely noticed

M | V-BID

Multi-Stakeholder Task Force on Low Value Care Identifies 5 Commonly Overused Services Ready for Action

1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

2. Vitamin D Screening

3. PSA Screening in Men 70+

4. Imaging in First 6 Weeks of Acute Low Back Pain

5. Branded Drugs When Identical Generics Are Available

M | V-BID

V-BID X:
Better Coverage, Same Premiums and Deductibles

V-BID

Increased cost-sharing on low-value services reduces spending...

Spinal Fusions

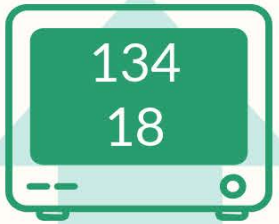
Vitamin D screening tests

Proton beam for prostate cancer

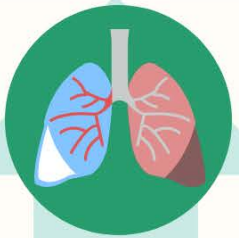
High-cost diagnostic imaging

...and allows for lower cost-sharing and increased spending on high-value services

Hemoglobin A1c tests



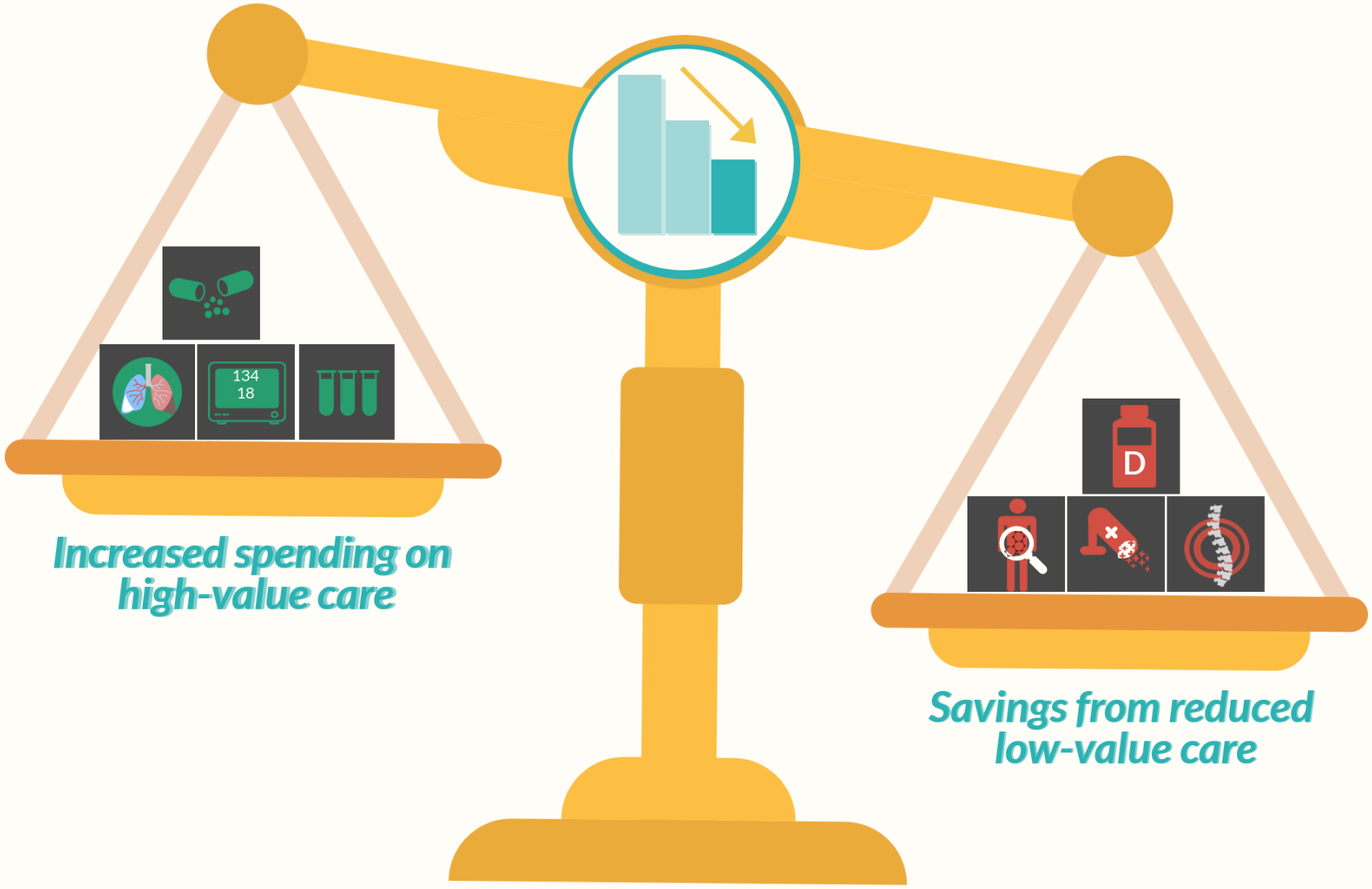
Blood pressure monitors



Pulmonary rehabilitation

High-value prescription drugs

When savings from reduced use of low-value care exceed extra spending on high-value services, **premiums will decrease**



HDHP Reform Goals

- **Expand pre-deductible coverage on high value clinical services**
  - **Determine actuarial impact of resultant increase use**
- **Identify and measure low value care**
- **Create new benefit design (e.g. V-BID X) that pays for increase spend on high value care without the need to increase premiums or deductibles**

M | V-BID

“If we don’t succeed then we will fail.”

Dan Quayle

www.vbidcenter.org

@UM_VBID

Appendix F

Access Health Connecticut

High Deductible Health Plan Task Force Discussion
December 18, 2019

access health CT

About Access Health CT (AHCT)

- **Access Health Connecticut is a place where individuals, families and small businesses can shop, compare and enroll in quality healthcare plans from brand-name insurance companies.**
  - And it's the only place to qualify for financial help, to lower consumer costs.
- **Open enrollment for 2020 plans has been extended through January 15, 2020**

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AHCT Vision and Mission

AHCT Vision

- The CT Health Exchange supports health reform efforts at the state and national level that provide CT residents with better health, and an enhanced and more coordinated health care experience at a reasonable, predictable cost.

AHCT Mission

- To increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and provider that give them the best value.

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AHCT Values in Action

At Access Health CT, it is with our customers and our employees in mind that we seek to promote these collective values and to live by these behaviors. Our culture of acceptance welcomes and values everyone. We challenge the status quo to find new ways to grow and improve our community, our company and ourselves. Our people take pride in the service we provide, and in the spirit of the common good that we share.

Authenticity	Integrity	Excellence	Ownership	One Team	Passion
Act with sincerity, credibility and self-awareness.	Commit to doing the right thing with genuine intention.	Aim high and challenge the status quo.	Take responsibility and initiative.	Collaborate to succeed.	Dedication to creating opportunities for greater health and well-being.

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Connecticut Insured Population Estimates

Category	Insured Estimate	Reference
Civilian noninstitutionalized population (insured estimate)	3,336,919	American Community Survey estimate*
Projected enrollment Individual market	111,002	Carrier Rate Filings (Insured plans)**
Projected enrollment Small Group market	120,080	Carrier Rate Filings (Insured plans)**
SUBTOTAL	3,105,837	SUBTOTAL
Medicare	633,696	American Community Survey estimate***
Medicaid	725,230	American Community Survey estimate***
VA	56,670	American Community Survey estimate***
Estimated remainder (presumably large group/self-insured)	1,690,241	

* ACS data table ID S2701 for Connecticut (2018 1-year estimate)

**Projected enrollment information extracted from Unified Rate Review Template (URRT) included in carrier rate filings submitted to Connecticut Insurance Department (CID) for 2020
Exhibits available at: https://www.catalog.state.ct.us/cid/portalApps/HCfiling2020.aspx

***ACS data table ID S2704 for Connecticut (2018 1-year estimate)

- Individual Market projected enrollment for 6 HSA compatible plans filed with CID for 2020: 22,625

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Plan Design, Consumer Education and Decision Support Tools

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2020 AHCT Standard Plans That Do Not Qualify as HDHP: Example 1

	AHCT 2020 Standard Gold	Feature compared to IRS guidance:
Plan Overview	**In-Network (INET) Member Pays**	IRS guidance pertains to 'in-network'
Medical Deductible: Individual	$1,300	Below the minimum annual deductible threshold outlined in IRS guidance
Prescription Drug (Rx) Deductible: Individual	$50	Separate Rx deductible is less than threshold per IRS guidance
Out-of-Pocket (OOP) Maximum: Individual	$5,250	OOP is less than maximum threshold outlined in IRS guidance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$20 copayment per visit	Deductible does not apply to these services…under a HDHP, all services except for preventive care must be subject to plan deductible to be in accordance with IRS guidance
Specialist Office Visits	$40 copayment per visit	
Tier 1 Prescription Drugs (Retail)	$5 copayment per script	
Urgent Care Center or Facility	$50 copayment per visit	

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2020 AHCT Standard Plans That Do Not Qualify as HDHP: Example 2

	AHCT 2020 Standard Silver	Feature compared to IRS guidance:
Plan Overview	**In-Network (INET) Member Pays**	IRS guidance pertains to 'in-network'
Medical Deductible: Individual	$4,300	Meets the minimum annual deductible threshold outlined in IRS guidance
Prescription Drug (Rx) Deductible: Individual	$250	Separate Rx deductible is less than threshold per IRS guidance
Out-of-Pocket (OOP) Maximum: Individual	$8,150	OOP is greater than maximum threshold outlined in IRS guidance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	Deductible does not apply to these services…under a HDHP, all services except for preventive care must be subject to plan deductible to be in accordance with IRS guidance
Specialist Office Visits	$60 copayment per visit	
Tier 1 Prescription Drugs (Retail)	$10 copayment per script	
Urgent Care Center or Facility	$75 copayment per visit	

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2020 AHCT Standard Plans That Do Not Qualify as HDHP: Example 3

	AHCT 2020 Standard Bronze		Feature compared to IRS guidance:
Plan Overview	**In-Network (INET) Member Pays**		IRS guidance pertains to 'in-network'
Medical/Prescription Drug Deductible: Individual	$6,200		Meets minimum annual deductible threshold outlined in IRS guidance
Out-of-Pocket (OOP) Maximum: Individual	$8,150		OOP is greater than threshold outlined in IRS guidance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit		Deductible does not apply to these services…under a HDHP, all services except for preventive care must be subject to plan deductible to be in accordance with IRS guidance
Specialist Office Visits	$60 copayment per visit after INET plan deductible is met		Service subject to plan deductible in accordance with IRS guidance
Tier 1 Prescription Drugs (Retail)	$10 copayment per script		Deductible does not apply to these services…under a HDHP, all services except for preventive care must be subject to plan deductible to be in accordance with IRS guidance
Urgent Care Center or Facility	$75 copayment per visit		

2020 AHCT Standard Plan That Does Qualify as HDHP

	AHCT 2020 Standard Bronze HSA		Feature compared to IRS guidance:
Plan Overview	**In-Network (INET) Member Pays**		IRS guidance pertains to 'in-network'
Medical/Prescription Drug Deductible: Individual	$5,685	→	Meets minimum annual deductible threshold outlined in IRS guidance
Out-of-Pocket (OOP) Maximum: Individual	$6,550	→	OOP is less than maximum threshold outlined in IRS guidance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	10% coinsurance per visit after INET plan deductible is met	}	Services subject to plan deductible in accordance with IRS guidance
Specialist Office Visits	10% coinsurance per visit after INET plan deductible is met		
Tier 1 Prescription Drugs (Retail)	10% coinsurance per visit after INET plan deductible is met		
Urgent Care Center or Facility	10% coinsurance per visit after INET plan deductible is met		

AHCT Consumer Education: Examples

Campaign: “Choose.Use.Be Well”

Access Health CT Launches ‘Choose. Use. Be Well.’ Campaign

Bi-lingual campaign focuses on preventive care and benefits of using plan benefits

- The campaign highlights the importance of *Choosing* a Primary Care Physician (PCP), *Using* the preventive services included in the plans, so that residents can *Be Well* and live a healthier life.
- Connecticut residents can use a tool to find a doctor or get more information by visiting ChooseUseBeWell.com.

HARTFORD, Conn. (May 20, 2019)—Access Health CT (AHCT) today announced the launch of the new “Choose. Use. Be Well.” campaign to help educate Connecticut residents about the importance of preventive care and plan benefit utilization.

AHCT Flyer: “After you enroll”

Get the most from your healthcare coverage

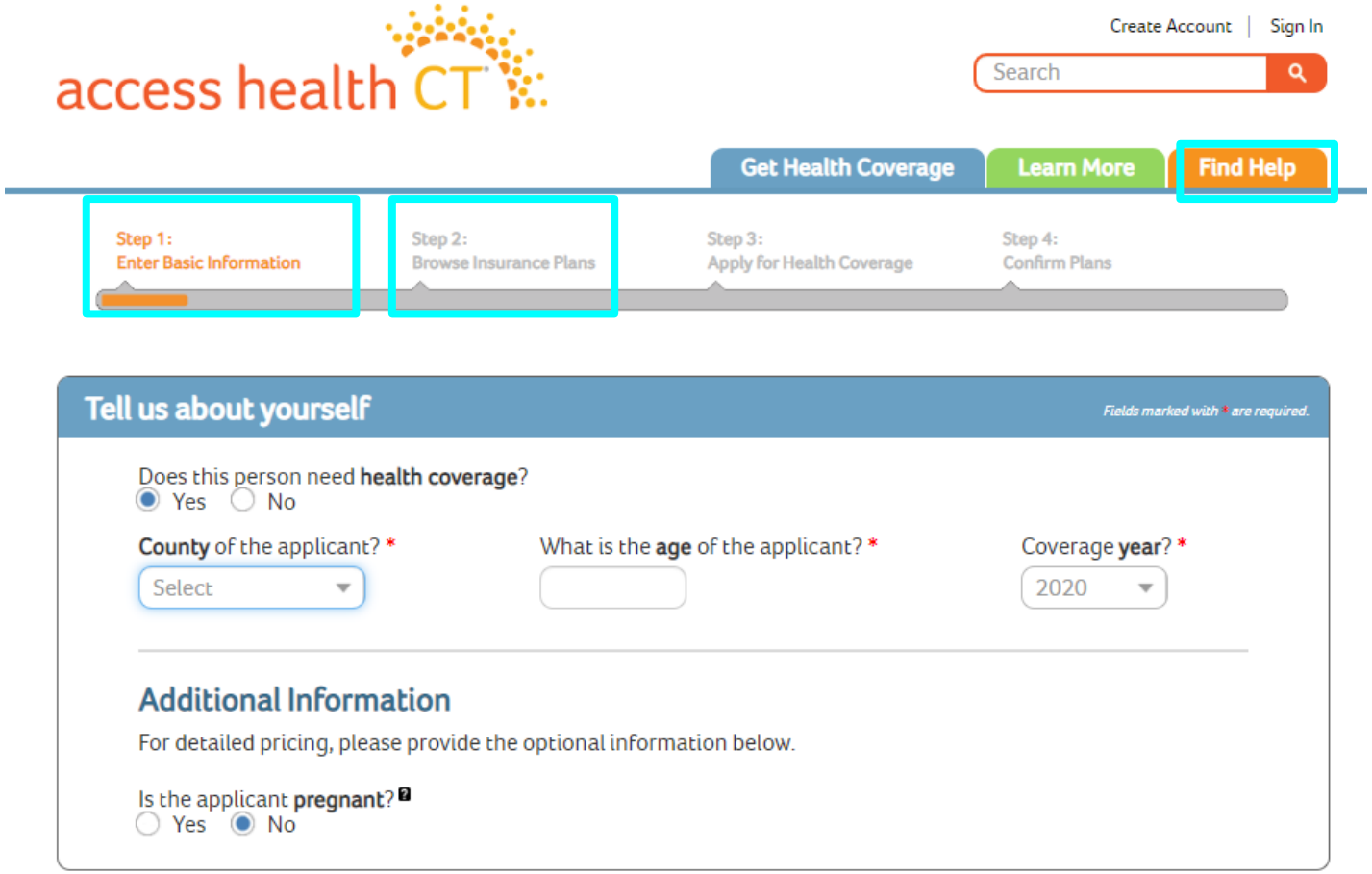
Start by choosing a primary care doctor from your insurance company’s provider directory, and schedule your annual checkup. Make sure you:

- ☐ Take advantage of key in-network preventive care visits, which are covered 100% and can help you stay healthy
- ☐ Use in-network providers and benefits whenever possible
- ☐ Save money with generic drugs and mail-order programs if offered
- ☐ Call your insurance company directly with questions or to learn more about resources available to you
- ☐ Always pay your premiums on time to avoid coverage delays or lapses

AccessHealthCT.com | Follow us on:

access health CT

accesshealthct.com



Learn about plans and coverage options

Step 1: Enter basic information that will help to identify the plans available where you live and if you qualify for financial assistance

Step 2: Browse the health insurance plans to review the coverage and costs

Find Help: Call a broker for help in selecting a plan or go to an enrollment center for help in completing the application

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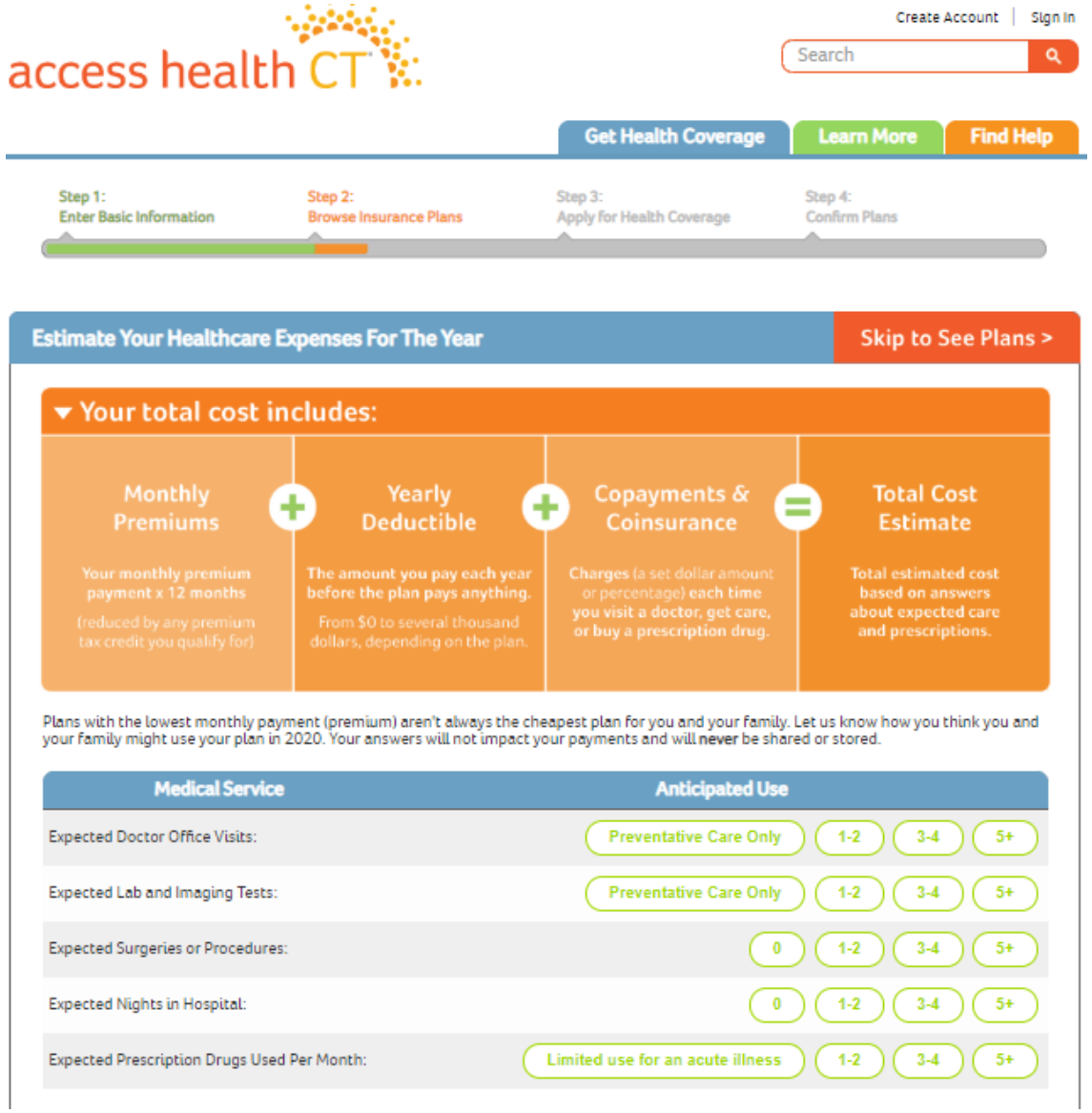
accesshealthct.com



Phase 1

Consumer Decision Support Tool

Can give consumer information to determine which plan may best suit their needs

Phase 1: Enter information on expected number of doctor visits, laboratory and imagining tests, surgeries or procedures and prescription drugs

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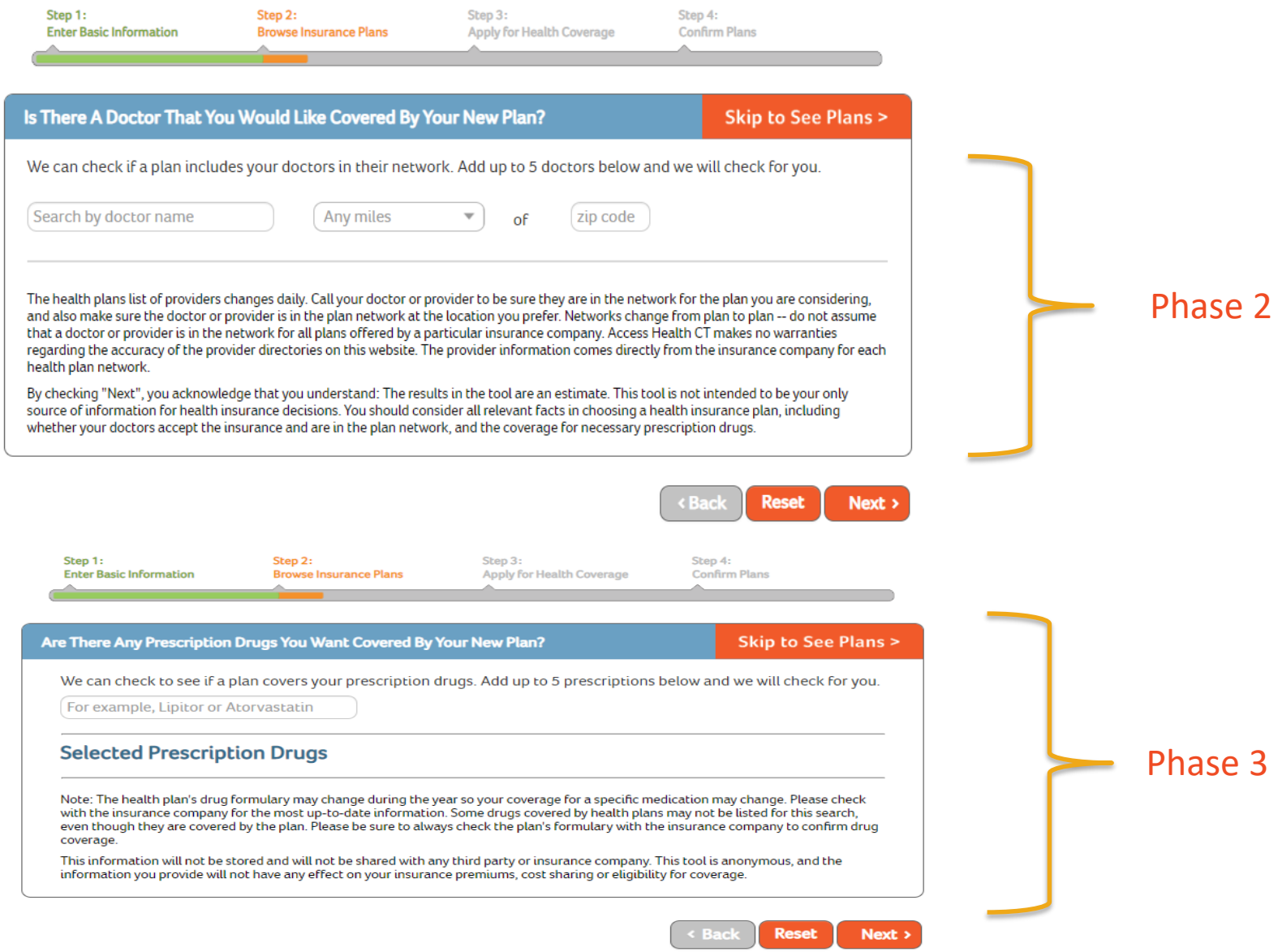
Step 2: Browse Insurance Plans



Phase 2

Phase 3

Consumer Decision Support Tool

Phase 2: Enter names of doctors

Phase 3: Enter names of prescription drugs

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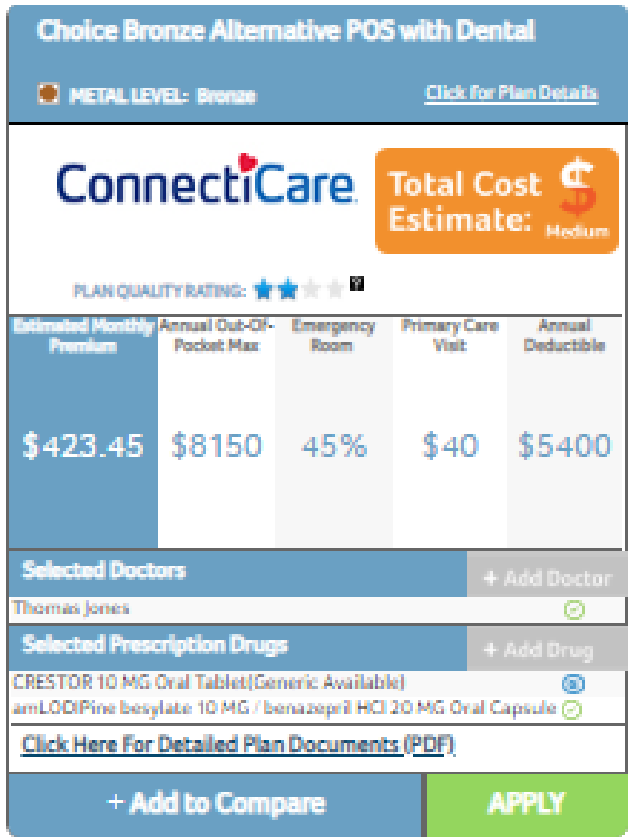
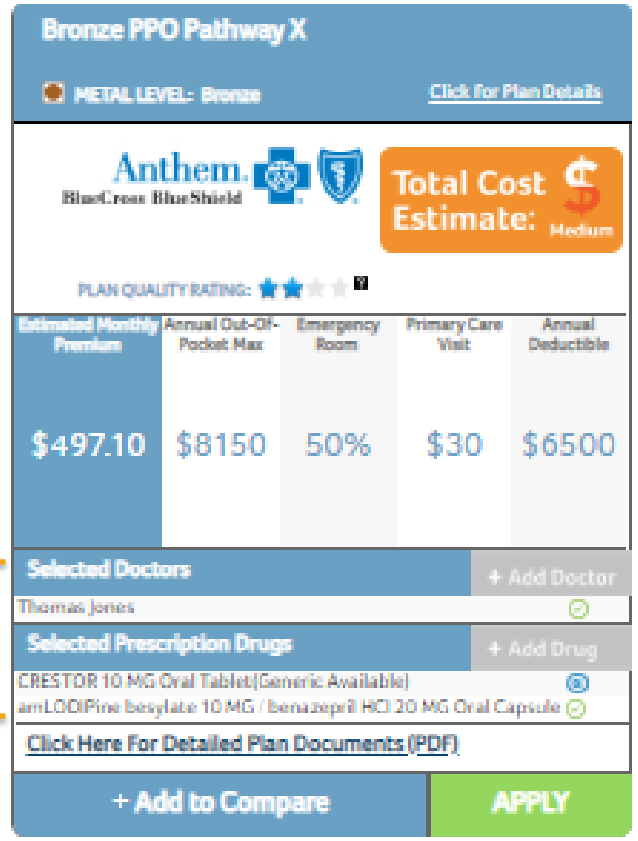


Plans display whether the doctor or prescription drug are included in a plan



Consumer Decision Support Tool

An indicator will display for each entry to show whether the plan includes the doctor and/or prescription drug

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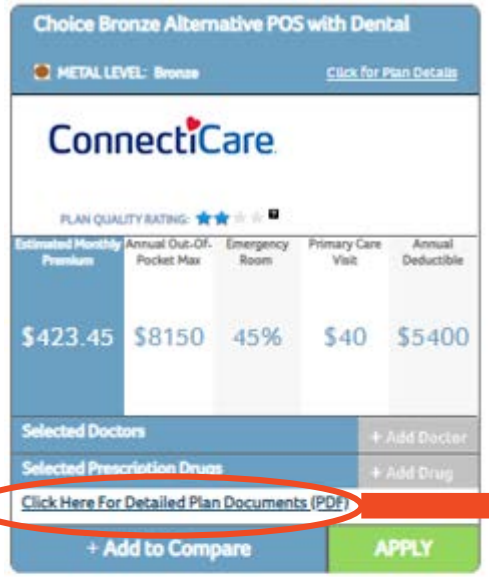
Step 2: Browse Insurance Plans



Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	**At a Sanitas Medical Center:** No cost **All other in-network:** $40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$60 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	$60 copayment per visit	50% coinsurance per visit after OON plan deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	50% Coinsurance per visit
Primary Care Provider Office Visits **(includes services for illness, injury, follow-up care and consultations)**	$30 Copayment per visit	50% Coinsurance after OON plan Deductible is met
Online Web Visits	$10 Copayment per online visit	50% Coinsurance after OON plan Deductible is met
Specialist Office Visits	$70 Copayment per visit after INET plan Deductible is met	50% Coinsurance after OON plan Deductible is met
Mental Health and Substance Abuse Office Visits	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance after OON plan Deductible is met

Browse to look at plan cost sharing

Cost sharing for health insurance plans differs by benefit and type of plan

All plans are reviewed and approved by the Connecticut Insurance Department before they can be displayed on the AHCT website

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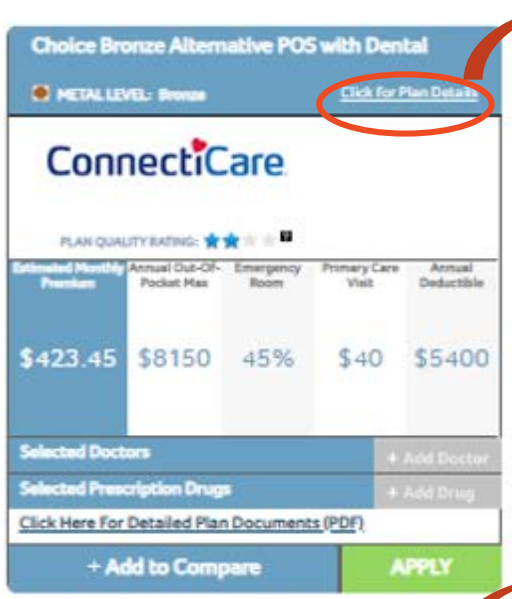
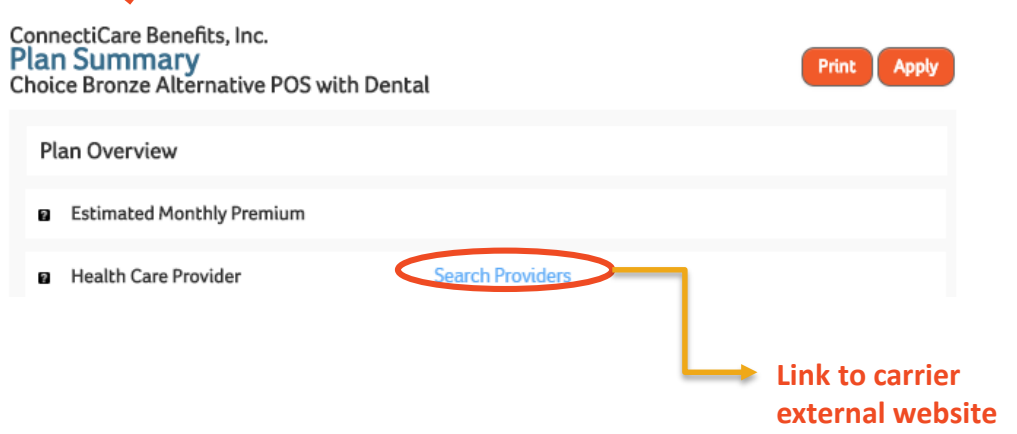
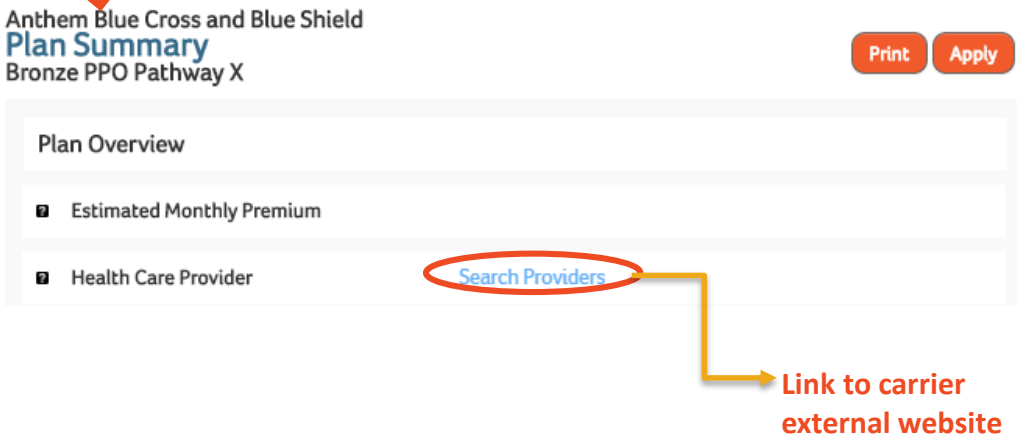
Step 2: Browse Insurance Plans







Browse to look at in-network providers

Link from AHCT website to the carrier's own online provider directory

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Enrollment Information

What do I need to enroll?

Get organized by checking off each item. For more information about what you need to provide, visit Learn.AccessHealthCT.com/Verification-Help

- ☐ **Social Security numbers** for all family members who need coverage
- ☐ **Citizenship or immigration status** and certificate of naturalization or immigration document number, if applicable
- ☐ **Tax returns for previous years**, to estimate annual Modified Adjusted Gross Income (MAGI)
- ☐ **Employer information and recent paychecks or profit and loss statement** (if self-employed), to estimate annual Modified Adjusted Gross Income (MAGI)
- ☐ **Healthcare coverage information** like policy numbers for any current health insurance plans covering members of your household, and information about employer-sponsored health plans for which you or anyone in your household may be eligible

How do I enroll?

To shop, compare and enroll:
- AccessHealthCT.com and click Compare Plans

Find Us – Find free in-person enrollment help:
- Learn.AccessHealthCT.com/Findus

Find Brokers and Enrollment Specialists:
- AccessHealthCT.com and click Find Help

Phone: 1-855-392-2428
- **Monday - Friday:** 8am - 8pm
- **Saturdays**: 9am - 3pm

We're here to help... and all help is free.

accesshealthct.com

Step 3: Apply for Health Coverage

Have the information handy that is used to identify the plans available where you live and if you qualify for financial assistance

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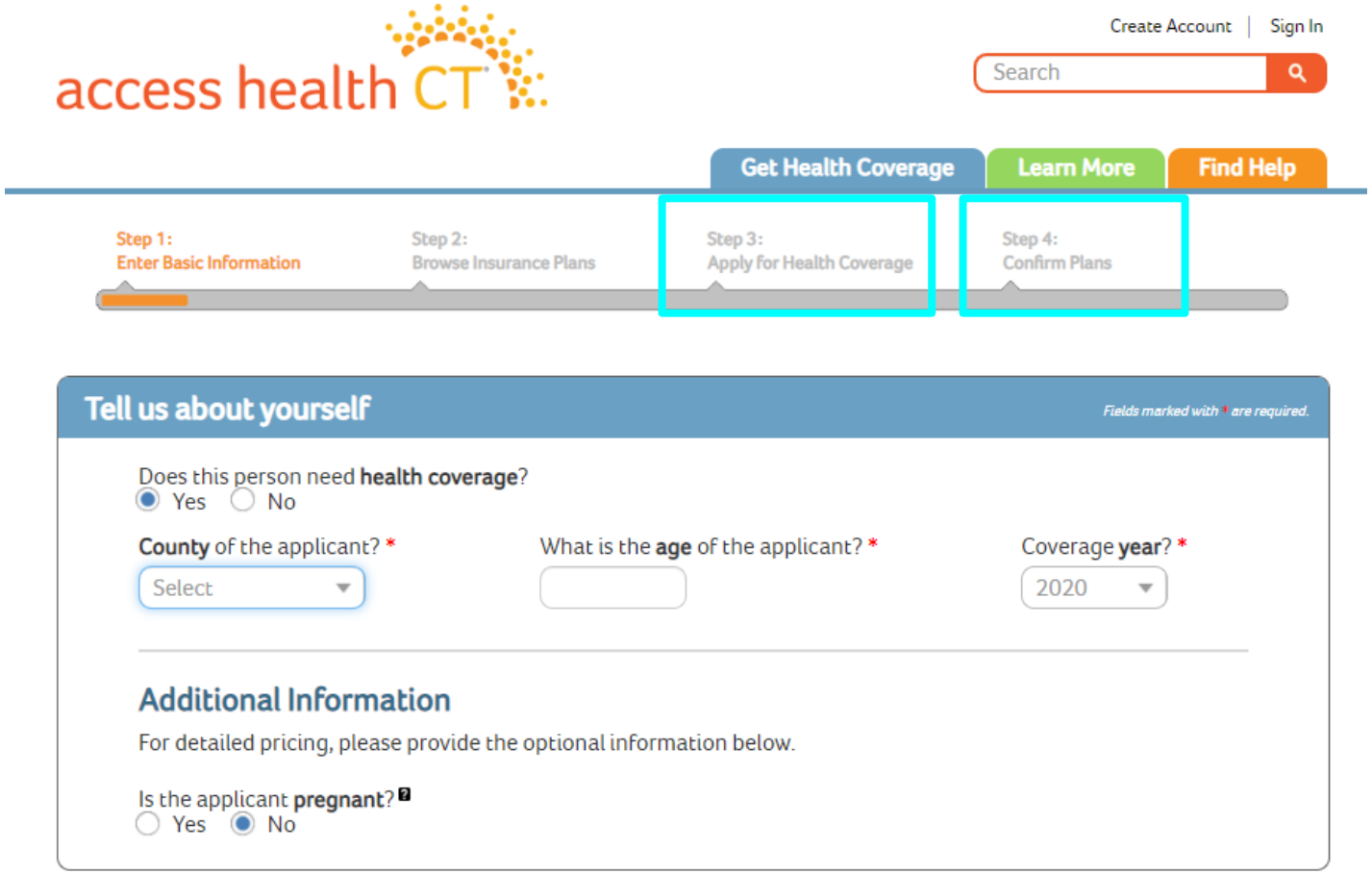
Apply for Coverage



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Step 3: Apply for Health Coverage

Step 4: Confirm Plan

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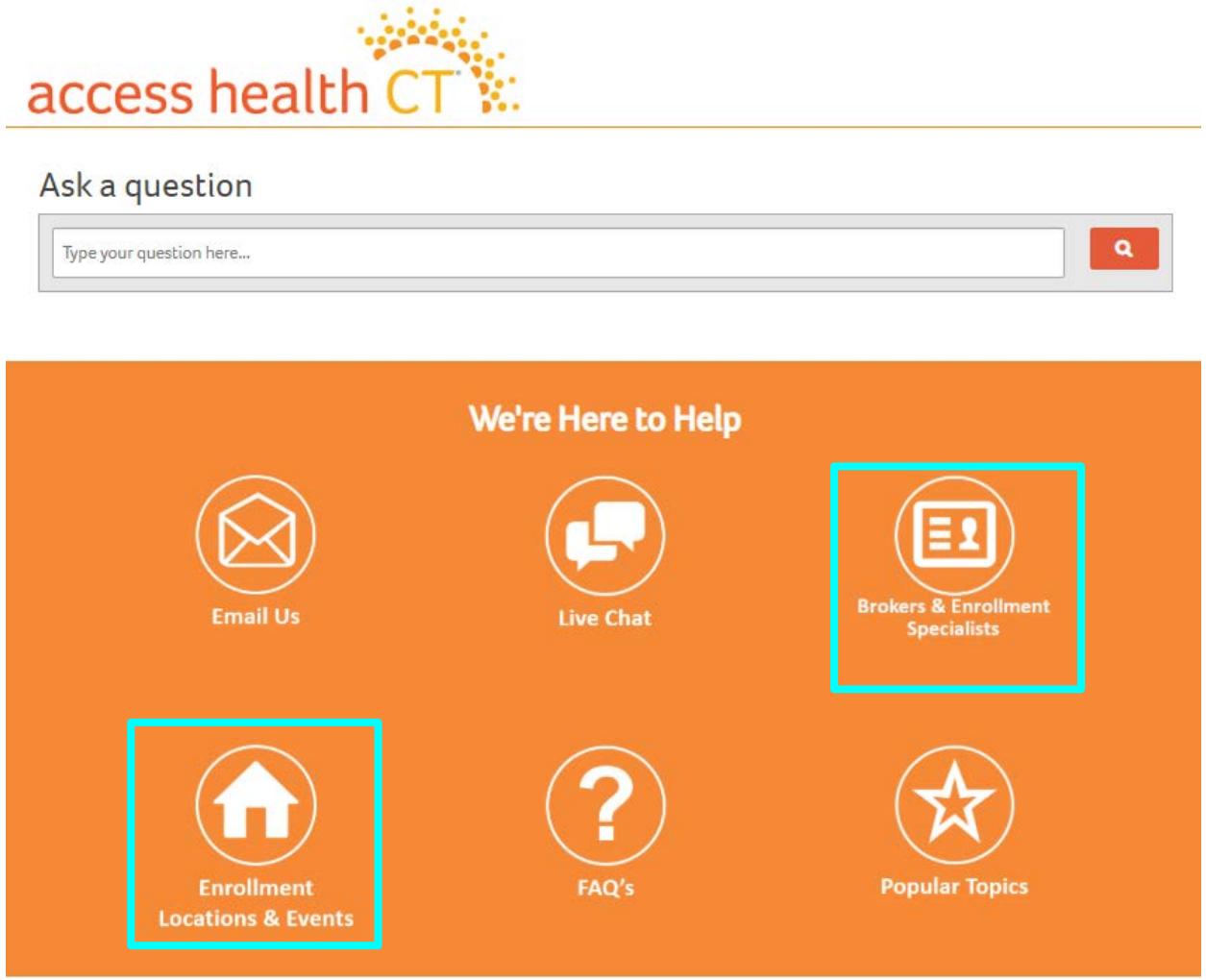
Find Help



Look for a location where enrollment assistance is available to complete an application or select a plan

There is no charge for enrollment assistance

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Annual Premium + MOOP Estimates*

2020 Standard Plan Premium and High-Level Cost Sharing in the Individual Market through AHCT

PLAN FEATURE → / PLAN ↓	Deductible: Individual (Medical)	Deductible: Individual (Rx)	Maximum Out-of-Pocket (MOOP): Individual	Age 21		Age 45		Age 60	
				Annual Premium	Annual Premium + MOOP	Annual Premium	Annual Premium + MOOP	Annual Premium	Annual Premium + MOOP
Standard Gold - Carrier 1	$1,300	$50	$5,250	$9,485.64	$14,735.64	$13,697.28	$18,947.28	$25,744.08	$30,994.08
Standard Gold - Carrier 2				$7,160.64	$12,410.64	$10,339.92	$15,589.92	$19,434.00	$24,684.00
Standard Silver 70% AV Level - Carrier 1	$4,300	$250	$8,150	$5,714.40	$13,864.40	$8,251.56	$16,401.56	$15,508.92	$23,658.92
Standard Silver 70% AV Level - Carrier 2				$5,571.48	$13,721.48	$8,045.16	$16,195.16	$15,120.96	$23,270.96
Standard Bronze - Carrier 1	$6,200	Included in Medical	$8,150	$4,953.84	$13,103.84	$7,153.32	$15,303.32	$13,444.68	$21,594.68
Standard Bronze - Carrier 2				**$3,809.88**	$11,959.88	**$5,501.52**	$13,651.52	**$10,340.04**	$18,490.04
Standard Bronze HSA - Carrier 1	$5,685	Included in Medical	$6,550	$4,767.36	$11,317.36	$6,884.04	$13,434.04	$12,938.64	$19,488.64
Standard Bronze HSA - Carrier 2				$4,092.00	**$10,642.00**	$5,908.80	**$12,458.80**	$11,105.64	**$17,655.64**

*Non-subsidized enrollee residing in Fairfield County with income >250% FPL for 2020 with covered EHB in-network only claims exceeding $8150 during the year

NOTE: Additional non-standard plans are available in the Individual Market through AHCT

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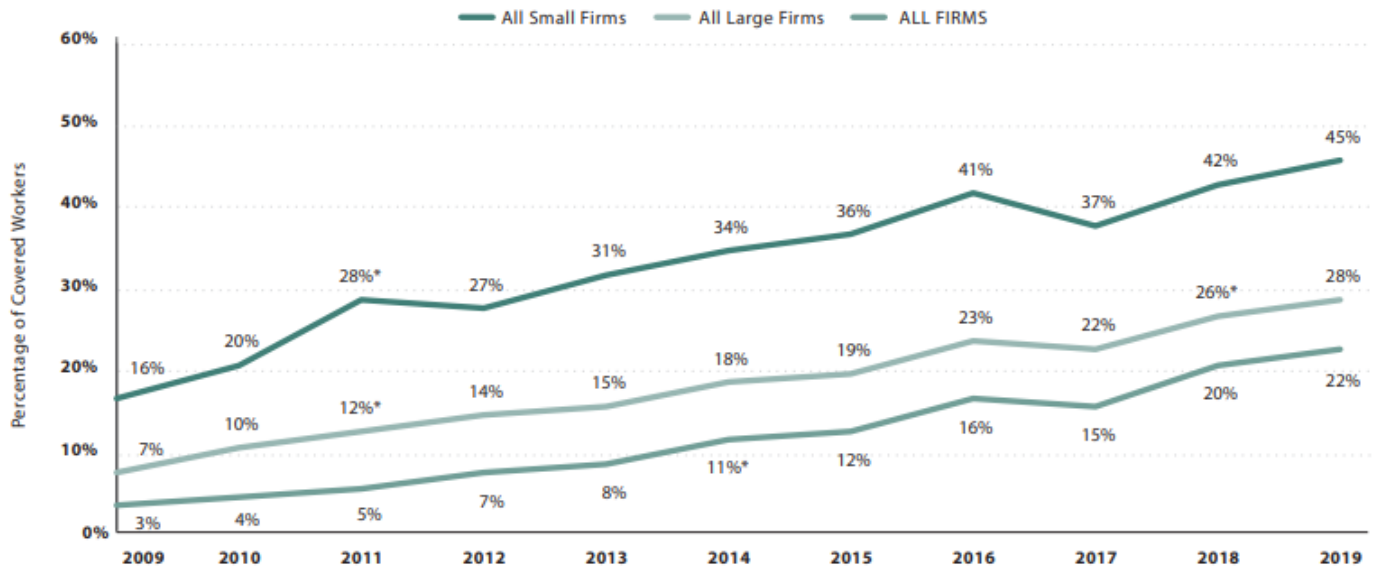
Plan Deductible: Employer Cost Shift

FIGURE F

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$)

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

"Employer Health Benefits Summary on Findings"

Kaiser Family Foundation: September 2019

http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019

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Medical Loss Ratio (MLR)

- **The Affordable Care Act requires health insurance issuers to:**
  - submit data on the portion of premium (i.e., MLR) used to pay for covered medical services and quality improvement
  - spend at least 80% (Individual & Small Group Markets) or 85% (Large Group Market) of premium dollars on medical care/quality improvement, unless an alternate standard has been approved in the state
  - provide a rebate to customers when the MLR standard is not met

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AHCT Input for HDHP Task Force

- **Numerous AHCT health literacy initiatives include Healthy Chats, In-Home events, and Canvassing, to provide healthcare education to the community**
- **Navigators are trained and able to assist consumers with health coverage applications through AHCT including completing eligibility and enrollment forms**
  - They do not provide recommendations on plan selection – licensed brokers perform this function
- **Federal regulations requiring pricing information be publicly available released November 15, 2019**
  - Calendar Year (CY) 2020 Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule
  - Transparency in Coverage Proposed Rule
- **AHCT standardized plans for the Individual Market are reviewed annually to comply with CMS guidance**
  - These typically include a focus on ensuring plans include some services not subject to the plan deductible and that provide consumers with choice to align with AHCT Mission
- **Cost sharing reduction (CSR) plans in the Individual Market through AHCT lower the amount a low-income consumer pays for deductibles, copayments, and coinsurance**
  - Included for Silver metal level plans and American Indian/Alaskan Native plans

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AHCT Input for HDHP Task Force

- **ACA requires preventive care not be subject to plan cost sharing, including for HDHPs**
- **Offering only HSA-compatible HDHPs through the Exchange is contrary to AHCT Mission to provide a marketplace that empowers consumers to choose the health plan and provider that give them the best value**
- **AHCT plans eligible for cost sharing reductions would not qualify as HSA-compatible HDHPs**
- **Consideration of funding of HSAs for subsidized enrollees should examine the possibility of plans not meeting IRS requirements to qualify for HSA (e.g., CSR plans) and potential impact of early withdrawal penalties**
- **For a plan to be considered a "HDHP", it must meet IRS requirements**
  - There are no HDHPs that are not HSA-compatible
- **ACA regulations have addressed issues pertaining to value of prescription drug manufacturer coupons counting towards plan out-of-pocket maximum**
  - FAQ released by DOL, HHS & IRS in August 2019 indicates the intent to include guidance on this topic in the HHS Notice of Benefit and Payment Parameters for 2021.

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Appendix G

Georgetown University Health Policy Institute

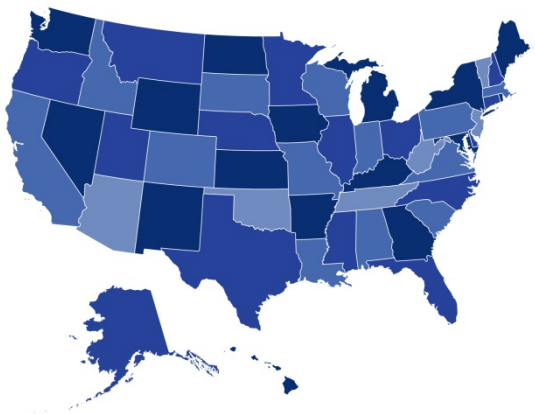
CENTER ON HEALTH INSURANCE REFORMS

Connecticut High Deductible Health Plan Task Force

State Activities to Address High Consumer Cost-sharing

December 18, 2019

Sabrina Corlette, J.D.



Support for this presentation was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About Georgetown's Center on Health Insurance Reforms (CHIR)

- A team of experts on private health insurance and health reform
- Conduct research and policy analysis, provide technical assistance to federal and state officials and consumer advocates
- Based at Georgetown University's McCourt School of Public Policy
- Learn more at https://chir.georgetown.edu/
- Subscribe to CHIRblog at http://chirblog.org/
- Follow us on Twitter @GtownCHIR

Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

Reminder About High Deductibles

2003:

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 22, NO. 3

It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

2019:

RESEARCH ARTICLE COSTS & SPENDING

HEALTH AFFAIRS > VOL. 38, NO. 1: SUBSTANCE USE, PAYMENT & MORE

It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt

Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan

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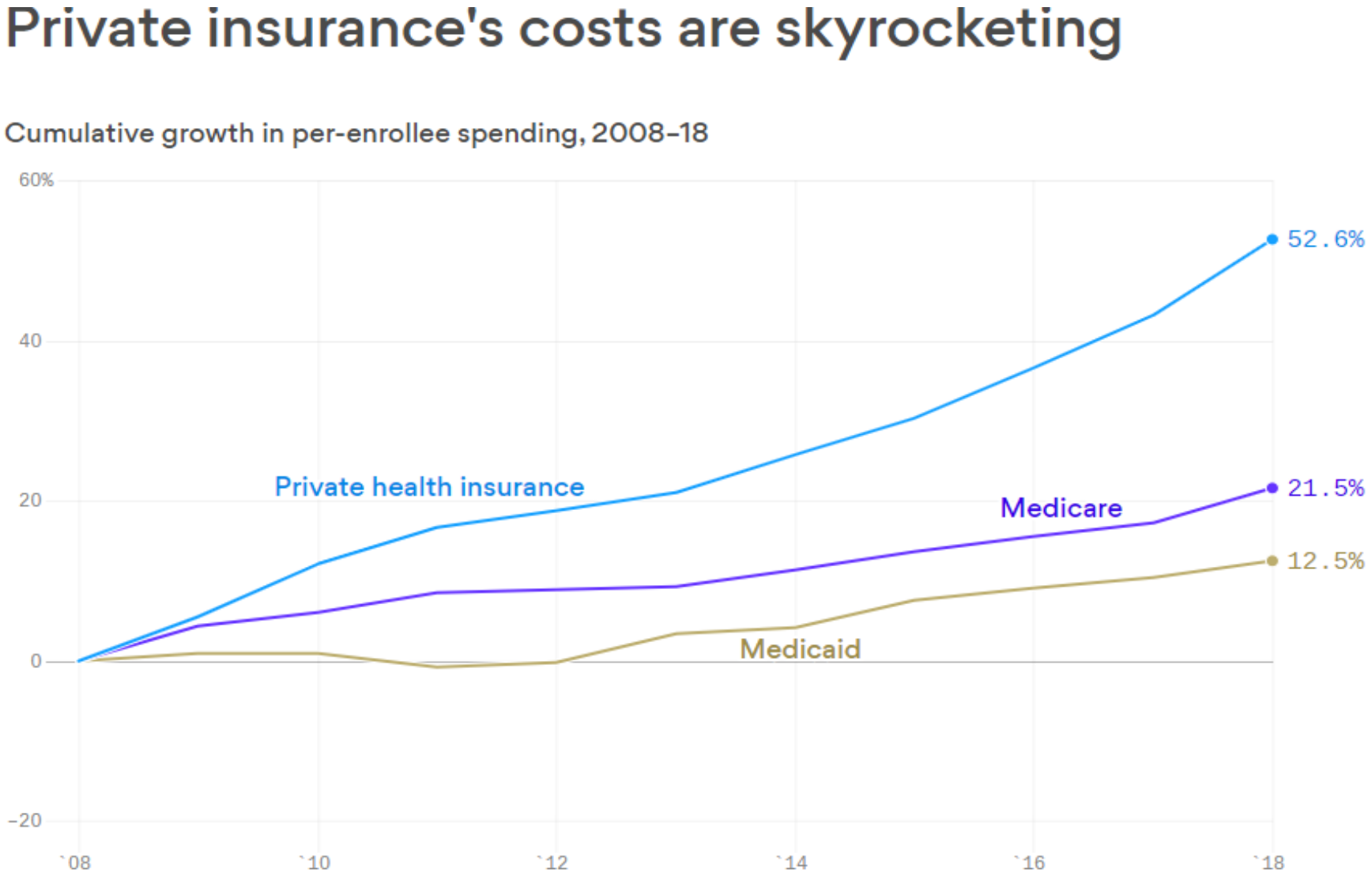
Reminder About High Deductibles



State Activity to Address High Consumer Cost-sharing

Benefit design:

- Standardized plans
- Rx cost-sharing
- Mandates

Community Benefit:

- Spending floor
- Reporting & transparency
- Public input

Consumer education/assistance:

- Decision-support tools
- Navigators/brokers

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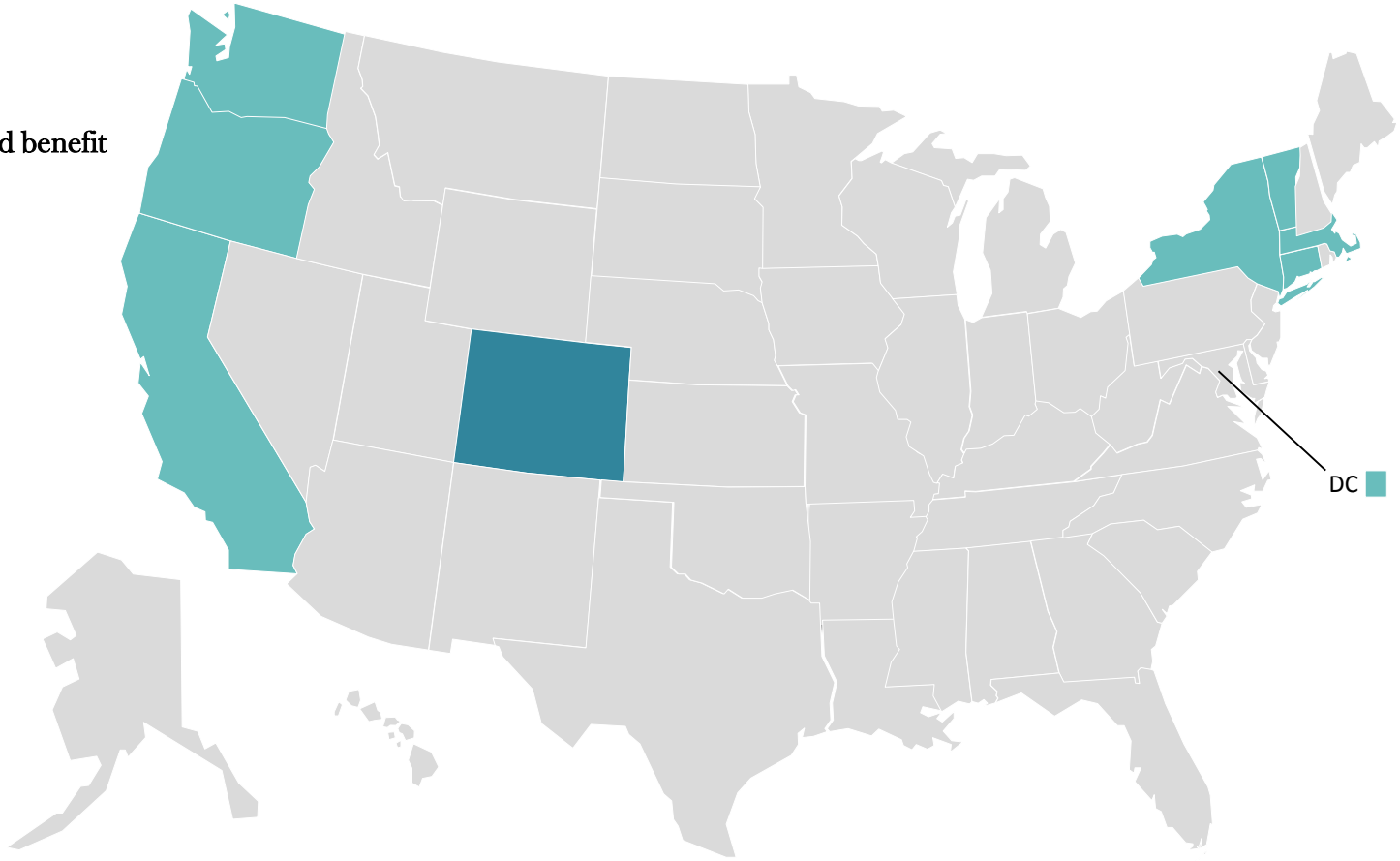
State Action on Standardized Benefit Design

- Requires standardized benefit designs
- Under consideration
- No requirement



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Source: Data collection and analysis by researchers at the Center on Health Insurance Reforms, Georgetown University

Pre-deductible Coverage: Encourage, Retain Insurance Enrollment

Jeffrey Young and 43 others follow

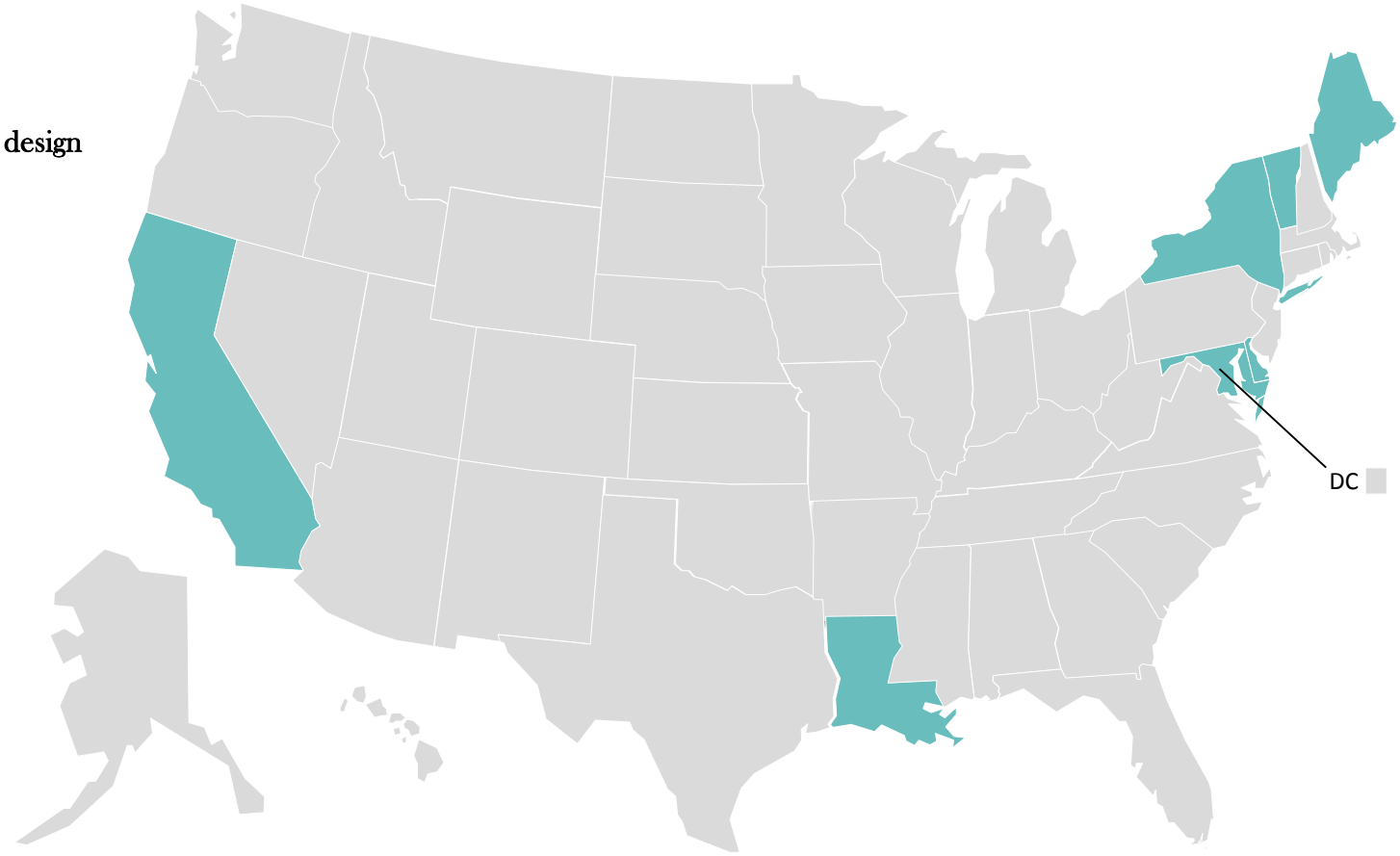
DC Health Link @DCHealthLink · 3m

If you are concerned about high deductibles, then choose a Standard Plan. These plans include no deductible for many medical services. Open enrollment ends January 31.
Visit bit.ly/TT_DCHL_SmartC...
#GetCoveredDC #StayCoveredDC

State Action to Reduce Cost-sharing for Rx

Limits on formulary design

No requirement



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Source: Data collection and analysis by researchers at the Center on Health Insurance Reforms, Georgetown University

State Activity on Hospitals' "Community Benefit"

- Spending floor (OR, IL)
- Criteria for debt collection (MN, OR)
- Billing guidelines (MA)
- Community input (e.g., CA, ME, MA, NH, CO)
- More frequent reporting/transparency (CA, GA, MD, NY, CO, VT)
- Focus on vulnerable populations (CA, RI)
- Evaluations (CA, MA, RI)
- Condition of mergers and/or Certificate of Need (NY)

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State Activity on Consumer Education

Decision Support Tools Improved in 2018 but Vary Across States

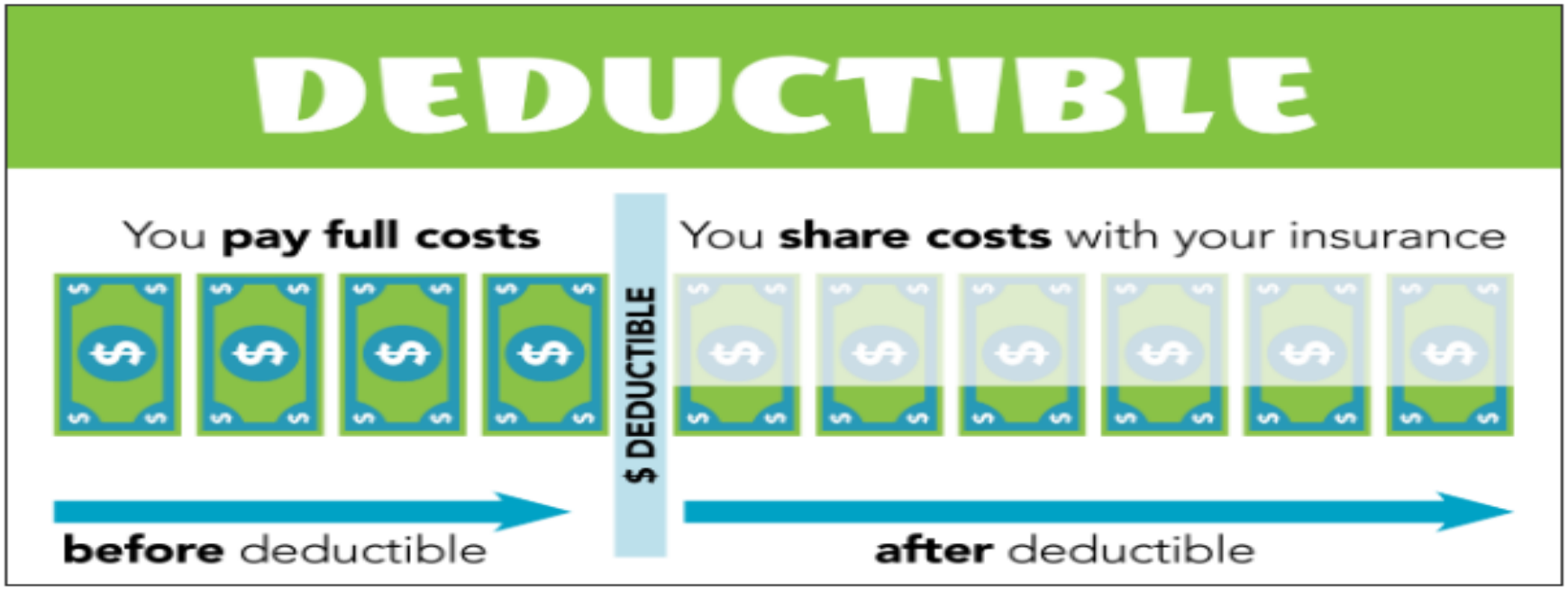
Healthcare.gov & State-Based	Out-of-Pocket Cost Calculator	Provider Lookup	Quality Rating Indicator	Formulary Lookup	Network Size Indicator
Healthcare.gov	√	√	0	√	0
California[1]	√	√	√	√	√
Colorado[2]	√	√	√	√	0
Connecticut[3]	√	√	√	√	0
District of Columbia[4]	√	√	√	√	0
Idaho[5]	0	√	0	√	√
Maryland[6]	0	√	√	√	√
Massachusetts[7]	√	√	0	√	0
Minnesota[8]	√	√	√	√	0
New York[9]	√	√	√	√	0
Rhode Island[10]	√	√	√	√	√
Vermont[11]	√	√	0	0	0
Washington[12]	√	√	√	√	0

Note: Shaded boxes indicate a new feature for indicated state as compared to 2017

Consumer Education: Visuals

Deductible

The amount you owe for health care services that your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

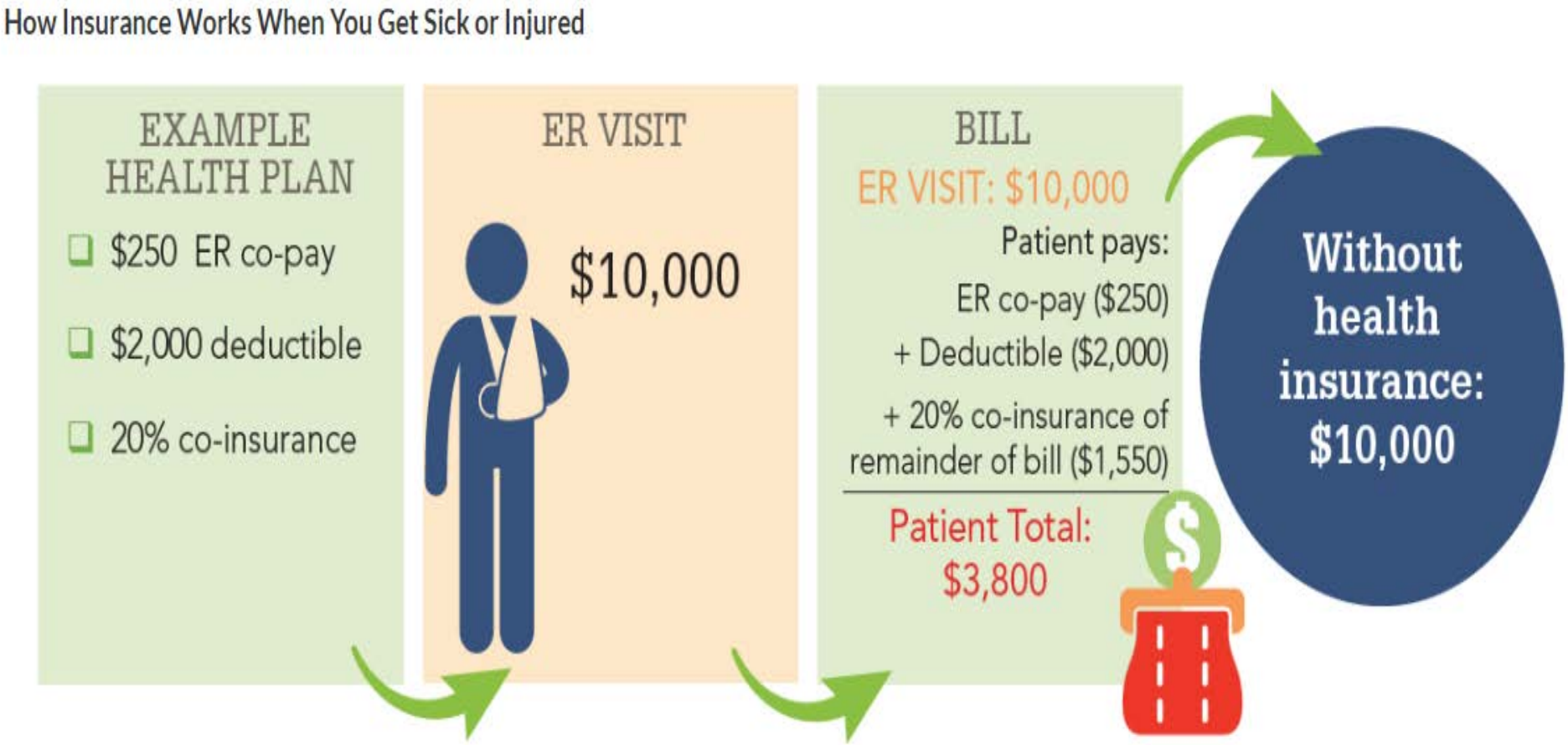


Source: Maryland Health Connection, https://www.marylandhealthconnection.gov/glossary/deductible/

Consumer Education: Visuals

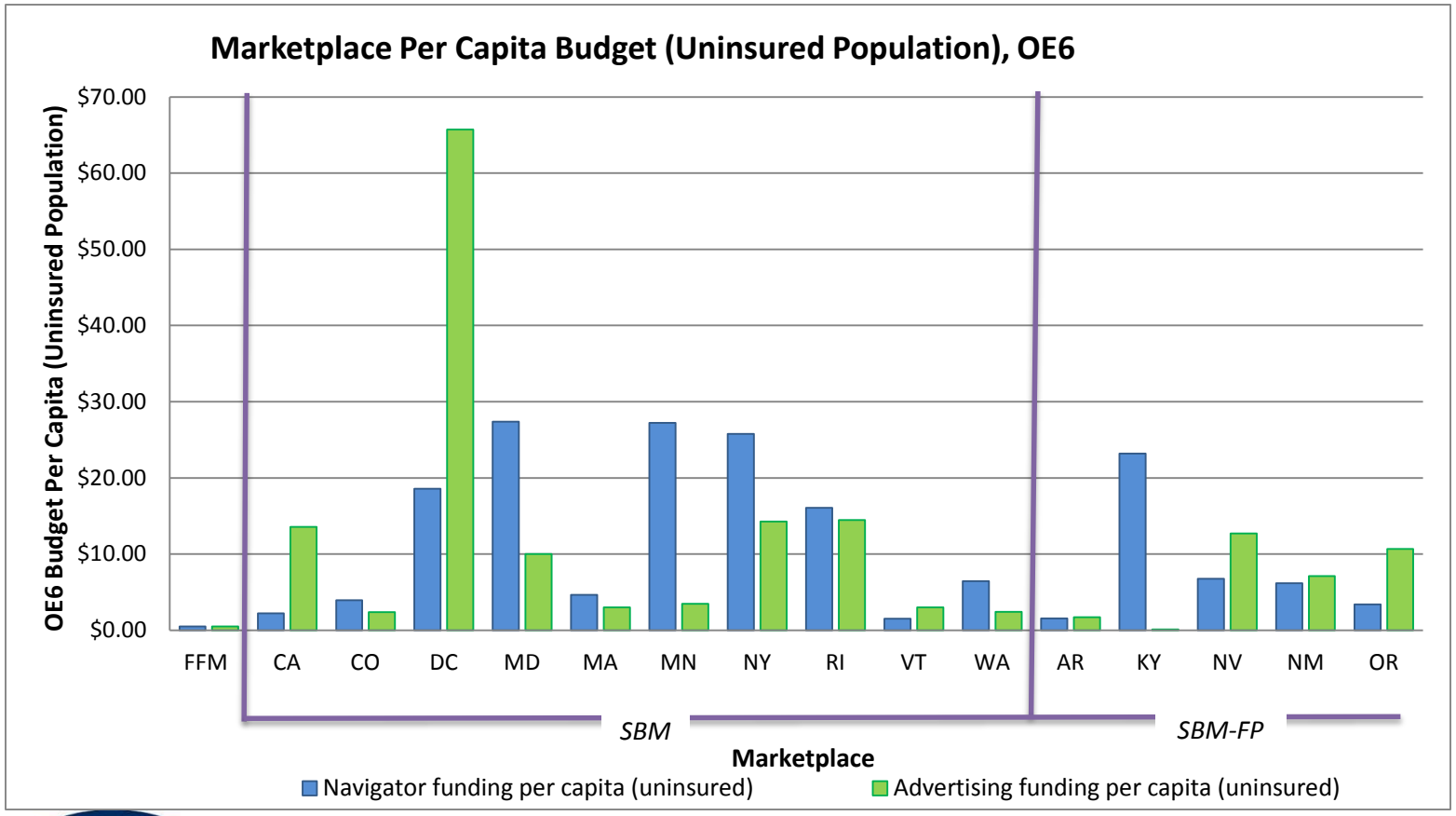
Source: Covered California, https://www.coveredca.com/see-if-you-qualify-for-financial-help/you-may-qualify/plan-levels/

Consumer Education: Visuals



Source: Washington Health Plan Finder, https://faq.wahealthplanfinder.org/know-your-plan.html

State Activity on Navigators



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Thank You!

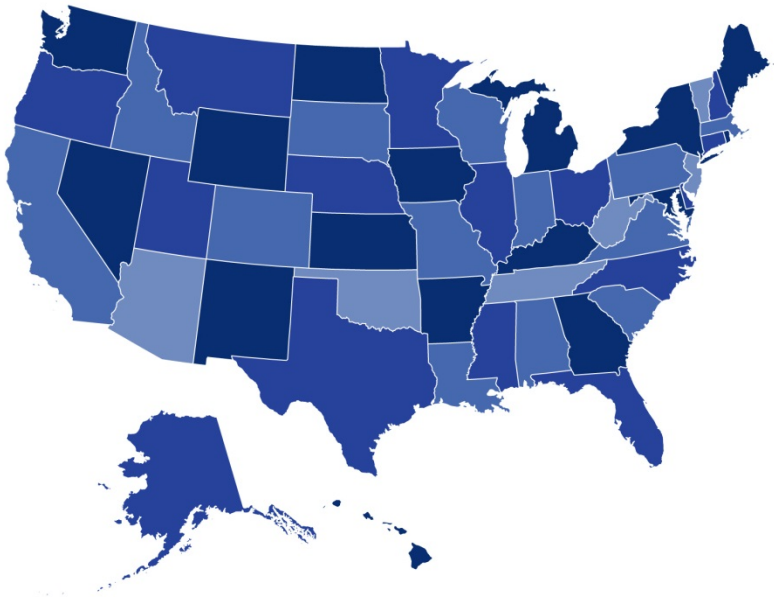
Sabrina Corlette, J.D.

Research Professor

(202) 687-0880

sc732@georgetown.edu

@SabrinaCorlette



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