HDHP Task Force
November 20, 2019
11:00 AM – 1:00 PM
Legislative Office Building, Room 2D

Members Present: Ted Doolittle, Dr. Daniel Freess, Susan Halpin, Atty. Robert Krzys, Dr. Andrew Lim, Patrick McCabe, , Cassandra Murphy, Janice Perkins, Seth Powers, Dr. Gregory Shangold and Dr. Andy Wormser;

Not in attendance: Joseph McDonagh

OHA Staff Present: Adam Prizio, Sean King, Kim Davis, Valerie Wyzykowski, Sherri Koss

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Welcome

- Ted opens meeting at 11:03 AM

Roll Call

- Dr. Andrew Lim
- Dr. Andrew Wormser
- Cassandra Murphy
- Dr. Daniel Freess
- Dr. Gregory Shangold
- Pat McCabe
- Robert Krzys
- Seth Powers
- Sue Halpin
- Janice Perkins
- Ted Doolittle

Approval of Agenda

- Ted asks for discussion or motion to approve agenda, Dr. Andrew Wormser motioned to approve and Pat McCabe seconded; no nays; no abstentions, no discussion, motion carries unanimously

Approval of 11/6/19 Minutes

- Ted asks for motion to discuss or approve minutes, Janice Perkins motioned to approve and Dr. Daniel Freess seconded; no nays, no abstentions, no discussion, motion carries unanimously

Public Comment

- Jill Zorn – United Health Care Foundation of Connecticut (Written testimony provided and distributed)
    - Health insurance is supposed to protect people's physical and financial health
    - High Deductible plans do neither, they are hazardous to the physical and financial health of our state's residents
    - Jill refers to Dr. Villagra's presentation that showed Danbury Hospital being responsible for half of all small claims court medical debt cases. That was picked up by the media and in response Danbury Hospital has announced that they will be changing their debt collection practices to be more empathetic to their patients.

- The foundation has received comments from Allyson Platt, a licensed professional counselor
- She fears her ability to survive is threatened because she cannot always access the appropriate care for her condition due to her high deductible plan.
- She conducted a survey of her colleagues and below are their comments:
  - This is the biggest reason for my no shows and those who terminate prematurely
  - Absolutely an issue. Very few can afford to put out $4,000-$6,000 up front
  - 20-30% either reduce or stop treatment
  - Clients make the choice early on to only come once a month or bi-weekly at best due to the fact they have not or will not likely meet their deductible
  - Clients who used to come weekly had to cut back to monthly due to high deductible
  - Clients discontinue after Jan. 1 (when new plan year begins) or drop to bi-weekly/monthly despite need for higher frequency
  - High deductibles have kept people from starting treatment until after their deductible is met and then terminating early due to the deductible reset date.
- Jill asks that the committee remember Allyson and her colleagues who highlighted harm being done to their patients. Everyone is going to have go give a little and keep up with the needs of patients and consumers front and center.

Presentation by Kevin McKechnie, American Bankers Association – HSA Council

- Kevin provides some of his background
  - In 2003, Kevin started the HSA Council at ABA, there were people who wanted HSA's enacted into law
  - Worked with the Bush White House staff to write regulations
  - HSA's predate the ACA which modified public health laws but did not necessarily modify IRS laws.
  - HSA's are creatures of IRS code and are managed in that code
- He helps States understand relationship between mandated benefits in your insured marketplace and their coordination with Federal IRS preventative care standards. There has been some dissonance over time.
- Kevin refers to the State of Maryland
  - Example of the problems caused by adding required services to the list of services that must be paid pre-deductible. When Maryland wanted to provide parity for reproductive services for men, offered mandatory below the deductible male sterilization services, which is not on the IRS preventative care services
  - This disqualifying even affected several hundred thousands of Maryland residents and several hundred millions of dollars that could have gone into HSA's but couldn't due to no longer being eligible to contribute because their HDHP's were no longer an HSA qualified plan but just a health plan.
  - This has been brought to the attention of national organizations and State legislators encouraging them to pass resolution that all State legislators be aware of that dynamic
  - Maintain benefit eligibility for people with HSA qualifying insurance
- There are other issues with high deductible plans
  - They are not created equal

        - If you say you have a HDHP, by IRS definition, you are saying you have an HSA qualified plan. This by definition is something that pairs with an HSA. If that pairing is broken by any regulation or eligibility problem then you have a savings account and a health plan. Other plans may have deductibles that are high, but if they do not meet other IRS requirements they are not an IRS-defined HDHP.
        - Together you are allowed to contribute to account tax free, build up tax free and comes out tax free for medical expenses. It is the only plan in America to do this
        - If anyone in Connecticut had a $1,000 claim the policy question is a simple one. Would you like that person to have to pay Federal, State, Medicare and Social Security taxes before they satisfy the claim or be exempt from those taxes before they satisfy the claim
        - It's a bright line test and you are either on one side of the divider or the other
    - Other Issues
        - HSA's are not for everyone
        - Who contributes to the account and when
        - Several studies Kevin has detailed suggest when employers contribute to an account, in self-funded arrangements, it helps people open the account or start paying for healthcare, though it won't be preventative care services necessarily
        - The Trump administration expanded the list of pre-deductible services covered at 100% over the summer.
        - Keep in mind not all plans are required to cover all preventative services
    - Kevin shares some dynamics from the Kaiser Family Foundation study in 2019
        - He is aware that in 2020, under the IRS definition, a HDHP has a minimum deductible of $1,400 for individual and $2,800 for a family
        - Average deductibles for everyone else, no matter the plan, is about $1,650.
        - He has reached out to Congress and requested the following
            - Bi-partisan legislation – HR 3796, proposing two things
                - As people age into Medicare under current law they lose their contribution eligibility; thinks ability to contribute tax free to an HSA should not be restricted by age
                - People who have an HSA qualified plan and reach the gates of Medicare, they pick a plan with no familiarity. Only plan in America that doesn't coordinate with Medicare. Thinks this discrimination should come to an end
            - Also allow those in Medicare to contribute to an HSA and open the account which would allow them to pay their expenses pre-tax
    - Federal politics – there is no consensus in Washington on how to repeal or replace the ACA
    - No consensus on how to replace with a Medicare for all
    - Fastest way to bring some relief to consumers is to provide them an option to pay out of pocket cost pre-tax
    - Responding to employer concerns - What can you spend your HSA dollars on?

- Some innovations in the news:
  - Direct primary care relationships
  - Onsite retail clinics
  - Over the counter drugs
  - Ability for spouses to make catch-up contributions
- These bills have been introduced and the ways and means committee has passed them and on their way as part of the bill for vaping, which will allow vaping companies to continue to do business but be taxed like other tobacco products.
- Every new innovation needs an act of Congress
- Kevin offers some alternatives to this
  - Instead of going to Congress to expand the list of qualifying services, qualify governmental plans of insurance as permissible under IRS code. There is bi-partisan support for this approach
  - Take ACA approach – metal tiers; change the HSA law – has actuarial value, rely on professionals that states credential so the basket of benefits meet the tiers
    - What is a 70% or 80% AV plan
- In closing
  - Average annual deductible is up 36% whereas the HDHP deductible is only up 12%
  - For a single person up 12%
  - Families 6%
  - These are calibrated by using a separate interest calculation
  - Calibrates annually by the IRS
  - Changes every year
  - Advanced knowledge of minimum deductions and maximum contributions
- HSA's have risen 29% for a single person and 25% for a family over a 10 year plan

- The problems the American Bankers Association is trying to solve is affordability and portability

Questions:

- **Dr. Gregory Shangold** asks is there a construct for a qualified medical expense; a patient sees a provider cost is generated and patient has to pay provider. The provider and insurance company have a contracted rate. Can the patient use their HSA to pay carrier directly? Kevin responds that more than likely there are prohibitions on charging extra money. He advised people who are HSA qualified to ask questions. It's about consumerism. The bill should be the bill. Dr. Shangold further states that the issue is when people can't fund the HSA and take the entire year to do so then the bill goes out for a year or two or not paid at all. He feels the carrier can pay the whole bill and pursue patient when the fund catches up. Kevin answers where you want to locate the credit risk is an interesting question. There are a couple of things to ponder:
  - In an HSA HDHP plan whatever expenses you have, funded or not, will come to you and you can pay pre-tax. In all other experiences provider will bill you and you will have to earn the money, pay taxes on it and then figure out how to pay bill
  - Second distinction in employer provided plans about half of the large HSA administrators offer something like balance accelerator where creditor is not the insurance company but employer. This makes significantly more sense especially the administrators as the consumer works for the company and it's like a secure debt or asset backed security. Kevin directs committee to

Devenir research which publishes the balances in HSA accounts and it is not correct that most accounts are not funded. They are. He can't speak to individually owned HSA's which make up about 9% of the marketplace.

- **Janice Perkins** asks for clarification that if there is a system that health plan paid, would the person lose their pre-tax eligibility? Does it affect that? So then it would not be HSA compatible? Kevin states that her understanding is correct. Janice asks if a member reaches a deductible in Sept and in October changes jobs is there a way to carry-over their money because they have already fulfilled their obligation in plan 1 vs plan 2? Kevin responds that this is an insurance problem. With respects to dynamic of the account HSA owners own their money. What they can do with it or how much they put into the account is directed by the IRS not their employer. Need to separate out:
  - What is the account dynamics in the financial institution
  - What is the insurance question
- You can split the deductible and still have a qualifying HDHP. There is an existing guidance in IRS Notice 2004-50 where it allows HSA qualified plans to provide credit for costs incurred early in the year under a prior plan. However it provides optional discretion of insurance benefit design that employers put in place, if the insurer chose to respect that benefit.
- **Ted Doolittle** asks what if insurers in a state requires them to do it. Is this acceptable? Kevin responds in your insured marketplace you are allowed to impose any rules you wish to have. ABA works very closely with NAIC and National Conference of Insurance Legislators and they passed a resolution in 2018 encouraging States to adhere to the IRS rules. Therefore if we decided that there should be a mandatory requirement that would be in violation of the optional requirement in the IRS Q&A allows the plans to be used to pay such expenses when they are option, but if the payment was made mandatory by the state it would run afoul of the requirements that the payments be "optional" which would disqualify people from contributing to their accounts, on a tax-advantaged basis, which in CT is many hundreds of thousands of people would have to search for alternative health insurance
- **Sue Halpin** asks two (2) questions:
  - Please explain what would disqualify HSA plans in Connecticut on types of regulation that would pass?
  - If you have an HSA where you travel from plan to plan (HSA goes with you) can you take whatever balance may be left in the HSA account with you? Kevin responds yes, but there are some important issues on switching jobs and taking HSA with you
    - What will new employer contributions be
    - Be careful not to over contribute as this will cost you money
  - Sue follows up with under an HSA's vs. FSA, with HSA's you can reimburse yourself five years from now for an expense incurred today. Kevin responds yes because FSA's are not accounts, they are flexible spending arrangements. Consumer has no constructive control of the money. These are accounts owned by the employer and if you don't use it by the end of the year you lose it. Sue further states that some people use their HSA's to fund their long term care costs in the future vs. 401K's where you pay taxes on it. Kevin responds that there are only two other products you can purchase with an HSA account:
    - Qualifying Long Term Care Insurance
    - Cobra Insurance
  - Other than these options you can only use the money to pay current medical costs

- **Seth Powers** asks about people of limited means. HSA's are good for people who can afford it but what about people of limited means. In your business do you have any recommendations, policy insights or perspectives on ways to make the HSA component a tool that people who are lower on the socioeconomic ladder can access. Kevin responds that the most efficient way to insure anything is to apply a deductible to it. People want good insurance, meaning they want no deductibles. Plans with no deductibles are most expensive ones to buy because you are going to have to spend that first dollar.
- **Ted Doolittle** states that a lot of Kevin's presentation premised on the idea it's from a policy perspective. Is it good to pay medical costs on a pretax basis? Is that a fair assumption? Kevin responds, absolutely. Ted asks then why do we as a country limit this ability to pay tax free to holders of certain bank accounts? Why don't we have more deductibility for medical claims which are right now difficult to deduct? Not sure it's a good policy idea to have tax free medical. Kevin responds that several Congressmen agree and it's a bipartisan movement. This is the third choice which is better than the other two choices, which seem politically problematic. There is limited consensus on inaugurate something like Medicare for all or reforming the ACA. Limited consensus on expanding the things that can be paid pretax. Ted further states his assumption through hearing your comments is that HSA paired plans are better for consumers, if available, rather than non-allied HSA plans? Kevin responds, no contest. Ted asks if a state is running an exchange would it make sense for a state to only require HSA compatible plans? Kevin responds that they asked for this law to be passed from the political bedrock of not mandating much. Choice is important. Consider this not everyone wants an HSA plan as they are engagement products and not everyone can or wants to do this. Ted asks if there is a way for a state to use ACA federal subsidy money to fund HSA's. Kevin responds not yet, they are working on that. Subsidies go to the product. Ted inquires is there any barrier, statutory or regulatory that would prohibit an attempt to structure a plan where either State of Federal dollars were used to fund HSA's? Kevin shares that literally anyone can put money into your account. If you devise a plan to use public treasury to help people open accounts, he doesn't feel there would be barriers in this instance. Ted asks if there is a way to use ACA APTC dollars or cost sharing reduction money to fund an HSA for a subsidized member. Kevin responds not at this time, it goes back to fungibility. Where would the changes have to come from, Federal law or regulations or State law or regulation? Kevin says that we would need to change the parameters of the ACA and its implementing regulation in order to change that money which goes to product and convert into cash to contribute to the accounts.
- **Dr. Daniel Freess** asks for clarification, in the paradigm someone incurs cost with an HSA and then has money due to a doctor. What if the insurance company were to bill the patient after paying contracted price to provider? Is this a qualifying cost? Kevin responds yes. Insurers will not take the credit risk for the provider.
- **Seth Powers** – if credit risk shifted to insurers from providers would individual be able to use their HSA to pay their bill to the insurance. Kevin responds no as that his not a qualified medical expense, you are incurring debt. Publication 502 at the IRS tells you what you can spend your money on. Otherwise you will pay taxes on it and be penalized 20%.

Presentation by James Stirling, CEO of Stirling Benefits

- James provides some background
    - Stirling Benefits designs and sells plans. They are a third party administrator and serve many of the functions of both a broker and insurance company
    - Design plans, set them up and pay the claims and adjudicate the claims
    - Funds are drawn from the employer bank account
    - Compete with insurance companies that are self-funded plans
- James suggests to the members to read the Obituary for Bernard Tyson, CEO of Kaiser Permanente
- What he built in an HMO model was designed to earn additional profits when people get healthy. The core of my comments are that players in the Health benefits market has misaligned benefits
- The alignment of insurance companies, providers and brokers are misaligned in reducing costs and generally improving population health
- The challenge, of this task force's work, to look at HDHP cannot exist without looking at the broader market
- James agrees with Dr. Villagra's presentation and that HSA's provide the opportunity to moderate that
- HDHP's have not contributed to access to care or improvement in health
- James speaks from an employer perspective
    - 2% of the population uses about 50% of the cost of any plan
    - 20% uses about 25%. These people have emerging or chronic conditions. They can spend anywhere from ten, twenty or thirty thousand a year
    - 75% of the population spend about three, four or five thousand
    - The population at the bottom of the pyramid hardly use the plan
    - Many large company employees make contributions but not all make contributions to HSA's, such as companies with lower income
- Other Players
    - Insurers/Carriers - BUCA (Blues, United, Cigna, Anthem & Aetna insurance)
        - Easiest way to lower premiums is to raise deductible
        - The other issue is employers change carriers often to save a couple thousand dollars a month. Because of this there is no long term relationship with their consumers
        - Many of the wellness programs carriers develop are really to stratify risk so they can know at the next renewal, how do we rate this group
            - Over 50 lives – they are rated on claims experience
            - Under 50 lives goes into a pool where rates are set in advance and it's a community rate.
        - Because people move rapidly for cost savings, the carriers have less incentive to work on long term health issues
        - Lack of claims data – carriers are unwilling to give this information to the groups
        - Employers can't determine if a 22% increase is justified or not
        - Broad exceptions to HIPPA that could allow carriers to share this information with brokers and group, but not often utilized
    - Unintended Consequences - Medical Loss Ratio (MLR) rules
        - Under the ACA these rules say that a carrier is limited as to how much of their premiums can be spent on administrative costs. If they don't spend it all they must return to the policyholders

        - The response from this is moving cases with low risk and cost out of the insured market and into self-funded market under a product called level Funding. Level funding is a form of self-funding which exempts them from medical loss ratio rules.
        - This limits the fully-insured market stability to have long term rate stability
    - Broker/Consultant
        - Incentives are misaligned
        - If there is a misalignment in the financial incentives with the goals of the population of the State of CT it is hard to justify to keep lowering cost when the broker would get a haircut they would get less money
        - The current system with the carrier and broker is driven to increase costs not lower it
    - Consumer
        - Agrees with most of what has already been said.
        - They feel they have no insurance by time they pay their premiums and deductibles
        - HSA's work great if you pay taxes and have money to put into them. They are great for a certain segment of the population. They don't' work well for those at the lower end of the economic ladder
    - Plan Sponsor/Employer
        - Most important entity who can change the dynamic we have
        - Cannot find one employer who likes the way insurance works in Connecticut, costs too much, can't control and prices go up every year
        - Employer can do much more if they had data
        - There was a bill introduced to require carriers to provide data to employers after their second renewal. Push back from carriers
        - There is a Federal ruling coming out of the Executive Branch that was just issued, requiring transparency of claims, cost and pricing. This is getting a lot of pushback by the hospital associations and carriers because they feel it's their private negotiated contracts
        - If employer knows the cost of a knee surgery and Hospital A vs Hospital B then you can urge employee to got to the hospital that charges less, better outcome and higher value. Cannot find any correlation between cost and quality
        - Connecticut has something called All Payor Claims Database (APCD) which shows some of this information. Employers need more than the employees so they can help drive employee behavior to high value provider
    - What works:
        - Eliminating the high deductible or drastically reducing it helps to improve health productivity of the employees
        - Incentives should be offered to employees to work on improving their health. Let's reward people for trying to do the right thing, for example, take a healthy living class, then we will lower your contribution to be on the plan
        - Let's build plans that meet people where they are, suburban settings don't work for all. These plans put primary care up in front of the deductible
        - Align incentives- put charges in front of deductible, providing consumer with this information for example, facility A charges $3,000 for an MRI and facility B charges $800. Their 10% is smaller on facility B

  - Disclosure
    - Vendor fees
    - RX rebates
    - Group claim experience
    - Provider accepted fees
  - This will allow employers to make improvements to their plan
  - Consumers and plan sponsor benefit from prices going down, while the Insurer, Broker and provider benefit when prices increase. This continues to drive up cost of insurance in Connecticut, making it more difficult for our citizens and employers to do business in Connecticut. This need to be aligned
- Questions:
  - **Dr. Andrew Wormser** asks how do we monetize health vs. the healthcare industry? Please speak to narrow networks and VBID. James responds VBID design says we should encourage members to go to a high value provider instead of a low value provider. Someone who does a procedure more often has better outcomes and cost less. Narrow networks refers to: if a set of providers are more effective at producing a healthy outcome, they should be put in a tier which would lower the deductible if consumer goes to them. This pushes all kinds of issues with everyone.
  - **Dr. Gregory Shangold** states that most people have long history with their providers which is cost saving because you aren't duplicating tests. When switching around they are not taking into consideration the insurance's panel. He feels employers don't really look at that too often. James responds that most employers do look very closely at impact of their employees and weigh any disruptions to employees against cost. Dr. Shangold states that the benefit of being in a network is not what it used to be. He further states that VBID would have unintended consequences with the consumer as each consumer has different risks. If employers are just looking at cost many providers will decide to choose and will suffer a lack of access to care if we bifurcate our risk. James agrees that this is a real and significant issue. Quality of care is a very difficult issue. You don't want providers firing patients due to lack of compliance. Reality is under some of these medical home and accountable care formulas need to be addressed but it shouldn't halt the conversation of alignment.
  - **Janice Perkins** agrees with James' assessment that wellness is important but asks if he is aware of other models out there that are wellness programs, such as the one ConnectiCare just launched, where the employer purchases it and no matter what plan an employee is on it gives the employer longer term view of the member and the impacts. ConnectiCare has had tremendous success with the State of Connecticut employees. James is aware of the work ConnectiCare has done and tried to contract with them as the first private sector payor to adopt states' HEP program.
- Other Business
  - **Dr. Shangold** offers a resolution (distributed) and read into the record. It solidifies the four presentations the committee has heard
  - Sean King explains that a vote on this resolution would require an amendment to the agenda, but because this is considered a special meeting we cannot modify the agenda and the vote as it needs to be properly noticed (per FOI). Therefore we can discuss, but not vote on the resolution but it can be added to the next agenda for vote. Dr. Shangold just want to make sure the committee has time to debate the issues before them
  - **Pat McCabe** asks to be reminded of what was the charge of this legislation that brought together this task force. Dr. Wormser has the public act and read it into the record (HB 7424, Public Act. No. 19-117). Sue asks why this resolution is coming before us at this time since the

summary we just received on the legislation indicates that it would not be carrying out the duties prescribed in the legislation. Dr. Shangold responds that he is just trying to ensure we keep our focus. The four presenters described issues with HDHP's and there is no solution on the table to address the seven items in the legislation. Each solution will take debate and a vote and there are only four meetings in which to do this. Sue Halpin states that the committee hasn't had an opportunity to discuss as a group the presentation heard today. It spoke to some of the benefits of HDHPs and HSAs which she feels that it contradicts one of Dr. Shangold's resolutions. She also comments that she feels it presupposes an outcome the committee has not yet reached. Also comments that she feels it goes against getting consensus

- **Dr. Freess** feels we need to structure our time to come up with some solutions, but not at the cost of getting information and focus on finding answers and coming to a consensus.
- **Janice Perkins** comments that she feels committee has made great progress and benefitted from the presentations. Doesn't want to see committee spend a lot of time debating this resolution, but should use some time to ask that Ted come up with an agenda and time line that gets us to the desired result without unnecessary resolutions. Need to structure next meetings to allow time for discussion and presentations if necessary.
- **Seth Powers** suggest setting a target at our next meeting to develop a project plan through the end of this task force so we can have timelines and deadlines in order to achieve the steps necessary to produce the report due February 1, 2020. Ted asks if this is an appropriate agenda time under FOI rules and Sean responds that scheduling items do not require an amendment to the agenda. This can be discussed today.
- **Pat McCabe** agrees that a plan needs to be developed to ensure that the task force addresses the items laid out in the legislation. He also questions on whether or not the task force needs to address the issue of appointing the second chair. General consensus is as long as it doesn't violate the public act that everyone is fine with the one chair.

Ted asks for motion to adjourn the meeting. Pat McCabe motioned to adjourn and Dr. Gregory Shangold seconded. Meeting adjourned by unanimous vote at 12:56 PM

Next meeting will be held on
December 4, 2019
11:00 AM – 1:00 PM
(LOB) Room 2D